

Tackling Health Inequalities in a Social Inclusion Partnership: A Case Study

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Abstract

UK Governments recognise the links between poor health and poverty and have attempted to tackle the health divide. Key public health and social policy documents have linked inequalities in health with the problem of social exclusion, which is believed to exert its effects in disintegrating/degenerating communities. National and local attempts to reduce inequalities in health are thus shaped by discourses in which attention is directed downward to the problems of (potentially) sick individuals and (allegedly) sick communities. Health promotion is, increasingly, a vital part of such policy initiatives. The original studentship, from which this thesis has developed, placed an emphasis on the investigation of advocacy as a health promotion strategy with which to address inequalities in health. As the research progressed this emphasis shifted subtly, as both the literature review and early fieldwork revealed the implicit rather than explicit forms that health promotion advocacy may take, and pointed to the profound impact of current health and social policy imperatives on health promotion and other agencies seeking to address health inequalities.

In Scotland, the policy agenda is shaped by a concern with social inclusion and social justice. Here, as throughout the UK, an important policy focus is the funding of area-based interventions with an explicit focus on partnership and collaboration at the local level. Such initiatives claim multi-sectoral partnership working and community engagement as effective ways of tackling the problem of health inequalities. Local authorities are seen as key partners in and, frequently, leaders of, such initiatives, many of which seek to employ health promotion strategies. Yet detailed accounts and analyses of the complexity of multi-sectoral partnership processes and relationships, as they struggle to implement national policy at the local level, remain relatively rare. This thesis contributes to the diverse field of research and practice aimed at tackling inequalities in health by presenting an ethnographic case study of a Social Inclusion Partnership (SIP) in Scotland. The East Kirkland SIP, a multi-sectoral partnership which aims to reduce health inequalities in its communities through a broad health promotion approach, was chosen as an exemplary site to explore the complexity of implementing such initiatives.

My research traces the development of the Partnership and the difficulties encountered by and within this group from October 2000 to February 2002. The business meetings of the SIP, together with other significant events, provided the basis for conducting ethnographic fieldwork. The account presented in this thesis is

structured by significant phases in the Partnership's development: the contested processes involved in achieving community representation on the SIP Board; the tentative integration of established and new partners; and the development of confrontational relationships. Analysis focuses on explicating the social processes of partnership work through 'thick' description. The multiple discourses and competing ideologies apparent in research findings around health inequalities, policy making and health promotion, were both played out and challenged at this local level, but nevertheless remained strangely marginal. The key business of the Partnership was to spend the funding allocated by the Scottish Executive: this generated competition between different vested interests and some conflict between participants. My research found that a number of paradoxes beset this 'forced partnership'; that different types of partner mounted competing claims to legitimacy; and that engagement in partnership work carried different risks for individual participants. These challenging issues were further compounded by uncertainty within the Partnership as to how best to tackle health inequalities at community level.

Although generalising from one case should be undertaken with considerable caution, the findings from this research may apply to other partnerships seeking to address health inequalities and social exclusion. At the levels of both national policy and local implementation, the rhetoric of partnership and community involvement as a key strategy in tackling health inequalities is fed by conflicting ideologies and involves some deep ambiguities of practice. In particular, unresolved and undiminished tensions between professional prescription and lay empowerment still exist. This thesis concludes that responsibility for achieving significant and sustainable health and social change is increasingly being devolved to community level but, given the deeply embedded nature of health and social inequalities in our society, local partnerships may (unintentionally) have been set up to fail.

(No. of words in main thesis: 108,960)

Declaration

In accordance with University regulations, I declare that this thesis is my own work and has not been submitted for any other degree or professional qualification:

Sandra Carlisle
November 2002

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Absit invidia verbo

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PART I

CHAPTER ONE

INTRODUCTION

1.1 Background

The thesis is the outcome of a collaborative (CASE) studentship, based in Public Health Sciences at the University of Edinburgh, funded primarily by the Economic and Social Research Council (ESRC) and also by the Health Education Board for Scotland (HEBS) in the role of non-academic partner. The original studentship from which this thesis has been developed placed an emphasis on the investigation of advocacy, through a case study, as a health promotion strategy to address inequalities in health. Early objectives were to develop and publish a conceptual framework for health promotion advocacy in Scotland and the UK, of use to a range of institutions and groups concerned with health inequalities, and a review of the health inequalities literature. The conceptual framework for advocacy was published in *Health Promotion International*. The health inequalities review was published in *Critical Public Health*. Copies of both papers are provided as *Appendices 1a)* and *1b)*. Although these goals of the studentship have been achieved, the original focus on health promotion advocacy has evolved over the three years of this research as decisions about the case study were made, and as the case study itself progressed.

Both the literature review and early fieldwork revealed the implicit rather than explicit forms that health promotion advocacy may take, and pointed to the profound impact of current health and social policy imperatives on health promotion and other agencies and sectors concerned with health inequalities. The grounded nature of my work led to engagement with the explicit links being made at policy level between health inequalities and 'social exclusion', links that are now making a profound impact on the work of many public sector agencies. Across the UK, one of the consequences of policy makers' stated intent to tackle the problems of health and social inequality has been the emergence of a plethora of multi-agency partnership initiatives. Many of these mandate community involvement and see regeneration of 'deprived' areas as ways of tackling the problem of inequalities in health. It would seem that partnership working and community engagement are assumed to be amongst the most effective ways of tackling the problem of health inequalities. Such

concerns are central to both contemporary health and social policies and to health promotion theory and practice. This apparent convergence of the principles of a relatively marginalised discipline with current policy trends deserves greater attention.

Local authorities are seen as key partners in and, frequently, leaders of, such initiatives, many of which seek to employ health promotion strategies. Yet detailed accounts and analyses of multi-sectoral partnership processes and relationships, as they struggle to implement national policy at the local level, remain relatively rare. This thesis contributes to the diverse field of research and practice aimed at tackling inequalities in health by presenting an ethnographic case study of a Social Inclusion Partnership (SIP) in Scotland. The East Kirkland SIP is a multi-sectoral partnership that aims to reduce health inequalities in its communities through a broad health promotion approach, which explains why it was chosen as an exemplary site to explore the complexity of implementing such initiatives. *N.B. It should be noted that 'East Kirkland' is a pseudonym, as are all proper names used in this thesis.* The case study of this SIP, presented in Chapters Six to Eight, reveals difficulties and risks in implementing partnership working and community engagement at local level, where national policy makers' initiatives and priorities may collide with those of local statutory and voluntary sector agencies, and the communities they purport to serve.

1.2 Reviewing the Literature

1.2.1 Health inequalities: debates and discourses

Knowledge of the existence of health inequalities reaches back to the 19th Century (Macintyre 1997). The literature on health inequalities is vast, constantly growing and of interest to a broad range of academic disciplines: epidemiology, economics, health promotion, public health, geography, sociology, social anthropology, evolutionary psychology and social policy, to name only the most prominent. Chapter Two provides a limited review of how, over the past few decades, epidemiological research has produced a wealth of data convincingly demonstrating the existence of a social patterning in inequalities in health – a 'health divide' between the most and least advantaged members of society (Whitehead 1998, Shaw *et al* 2000). Although a number of explanatory models have been developed in the literature the 'pathways' to health inequality are not yet clearly understood and the

search for better data and better explanations continues within the research community (HEA 1999).

Multiple, sometimes contradictory, perspectives are apparent between (and within) disciplines and these mount different ontological claims for the origins and causes of inequalities in health. Dominant epidemiological analyses pinpoint as principal causal mechanisms either the material effects of poverty and disadvantage or the psycho-social effects of a polarised social structure (e.g. Davey Smith *et al* 1999, Wilkinson 1997b, 1998a). The divide between the two is sometimes unclear and both types of explanations recognise social inequalities at their core, but their different emphases point to different ways of tackling the problem, principally the eradication of poverty or the re-integration of a polarised society. Sociological critiques suggest that epidemiological research constructs the individual social actor as an effect of 'structure', and highlight both the inadequacies of this perspective and the potential danger of an under-theorised focus on 'agency'.

The contemporary research literature on health inequalities is now replete with policy recommendations – something of a departure from tradition (Macintyre 1997). It would seem that opportunities for the research community to inform policy making have never been greater, as the UK Governments (encompassing Westminster, the devolved Scottish Parliament and the National Assembly for Wales) explicitly recognise the links between poor health and poverty and have attempted to tackle the health divide (Department of Health 1998a, 1998b; Scottish Office Department of Health 1992, 1998; National Assembly for Wales 2000a, 2000b). However, the understandings that underpin contemporary explanatory frameworks are 'troublesome' in the sense that, regardless of implicit scientific claims to objectivity and neutrality, they are neither value-neutral nor devoid of moral content and political import: elements of discursive construction come into play. I therefore draw on Levitas's discourse models of RED (Redistribution Discourse), MUD (Moral Underclass Discourse) and SID (Social Integration Discourse) (Levitas 1998). Originally developed through her analysis of the discursive political frameworks that surround social exclusion, I explore their resonance with the multiple discourses that potentially constitute different solutions to the problem of health inequalities.

1.2.2 Health promotion: policy, participation and partnership

The relationship between research and policy is much debated. In Chapter Three I draw on Booth's 'political' model of this relationship as particularly appropriate when considering attempts to tackle health inequalities as it helps to explain the subtly reciprocal nature of the contemporary relationship between government policy and health promotion. The second section of Chapter Three reviews the emergent status of health promotion as a vital component of some key health and social policy interventions. Health promotion possesses the capacity to provide shelter for diverse practitioners, multiple organisations and apparently incompatible theoretical and political philosophies. Such built-in flexibility is of value to policy-makers: the compatibility of the theory and practice of health promotion with much 'joined-up' policy rhetoric arguably reflects broader ideological changes relating to ideals of democratic participation and responsible citizenship. Cribb usefully distinguishes between health promotion as a relatively circumscribed field of specialist activity, often related to specific interventions, and health promotion as a process, encompassing an indefinite number of general social, political and environmental processes including the public policy context as a whole (Cribb 1997). This distinction between the 'activity' and 'process' ends of the spectrum suggests that health promotion has escaped disciplinary confines and expanded into a significant body of knowledge and related technologies that potentially impact on every area of life, both individual and social.

Although it seems that few areas of contemporary life lack the potential for health promotion activity, the breadth of vision, arena and practice within the discipline raises questions of control and power that are not always addressed explicitly (Adams and Pintus 1994). This raises the critical question of community involvement in health, the subject of an extensive literature briefly reviewed here. In the final section of Chapter Three I then turn to the similarly burgeoning literature on partnership working, given the centrality of this concept to health promotion theory and practice and to contemporary government policy, and its particular relevance for the case study. Intriguingly, the review finds both broad support for, and stringent critique of, the trends towards community participation and partnership working.

1.3 The Philosophy of Enquiry

To ask about health inequalities and the ways in which disciplines such as health promotion seek to reduce (or ameliorate) them directs attention to the ontological and

epistemological perspectives underpinning the researcher's status claims for both data and analysis. This thesis is located within a broad research tradition surrounding an observed and measurable social phenomenon - the existence of socially stratified inequalities in health - which may or may not be inevitable or acceptable within our society, and which constitutes a researchable problem for the natural and social sciences, albeit from within different epistemological and ontological paradigms. Scientific disciplines such as epidemiology generally claim to produce objective truths about a knowable world that exists independently of the ways in which we apprehend it. However, the phenomenon of health inequalities is also arguably a 'social construction' in the sense that it is the discursive product of particular types of knowledge, especially public health and epidemiological knowledge (Silverman 1997). Observable tensions exist between the positivist ontology and epistemology that characterise epidemiological accounts – which in large part have provided the evidence on which the health inequalities debate is founded – and the type of constructivist/interpretivist methodological strategies that underpin the different concerns of qualitative social science.

Chapter Four describes how my own methodological stance has been to adopt a 'subtle realist' approach to my data production processes whilst acknowledging the importance of an epistemologically interpretivist approach to analysis (Hammersley 1998). This enables a critical purchase on participant *and* researcher accounts, and supports the claim that the research refers to a social structure that is in some sense 'real' (stratified and unequal), beyond our acknowledgement that the concept of 'health inequalities' is socially constructed.

1.3.1 The Case Study

The case study has a lengthy research pedigree but has experienced fluctuations in popularity over the years (Mitchell 1983, Denscombe 1998). Multiple ways of conceptualising case study research exist and, as Chapter Four demonstrates, even the most eminent researcher-practitioners seem undecided whether the term should be used to refer to a method, a design feature or, more broadly, a frame. Definitions, then, are hazardous, although Denscombe's view that

'case studies focus on one instance (or a few instances) of a particular phenomenon with a view to providing an in-depth account of events, relationships, experiences or processes occurring in that particular instance..' (Denscombe 1998 p32)

provides a workable guide, subject to some extension. I draw on Stake's conceptualisation of cases as of 'instrumental' research interest (Stake 1994) in selecting the particular case. Given the explicit focus on partnership work in contemporary social policy and its importance within the discipline of health promotion, this thesis presents a case study of a strategic health partnership that has, as its *raison d'être*, the explicit goal of reducing local health inequalities. Chapter Four describes at some length both the rationale and early empirical work underpinning the selection of the case, explaining how this study's multiple conceptual foundations found an empirical focus in the East Kirkland Social Inclusion Partnership (SIP). Although such a case appears bounded by factors such as locality, setting and membership, this thesis represents it as embedded in a wider context beyond its own social world.

1.3.2 An ethnography of partnership

The selection of the case to be studied was instrumental in shaping the choice of ethnographic fieldwork as research method. Detailed ethnographic descriptions of the complexity of local partnership processes and relationships, and what these might mean for the implementation of national policy, remain relatively rare. In Chapter Five I describe the interwoven processes of observation, interview and analysis: the 'business' of the SIP was organised around committee-style meetings: these regular episodes, together with a number of other significant events, provided the basis for conducting participant observation, in combination with interviews and numerous *ad hoc* discussions held with participants. I discuss the nature of my research role as 'professional stranger' and the development of my relationship with other participants. I explain the formation and relevance of key research questions in this dynamic context, where decisions about whom to interview, when, and what to ask were largely made during fieldwork (and as a consequence of the reflexive integration of observation and analysis), not before. I also discuss the considerable ethical problems encountered in researching an identifiable case and describe the strategies adopted to address these.

The narrative form is characteristic of ethnographic writing and is employed in Part IV of the thesis to reflect what Hammersley and Atkinson call '*the fundamental importance of the temporal ordering of human experience*' (Hammersley and Atkinson 1993 p249). Ethnographic writing displays the patterning of action and interaction, the routine, the unpredictable, and the crisis: the process of writing is

therefore fundamentally intertwined with analysis. I trace the development of the partnership and the difficulties encountered by and within this group over some seventeen months, from November 2000 to February 2002. My analysis focuses both on explicating the social processes of partnership work through 'rich' or 'thick' description, and on the constructions of that experience via in-depth interviews. One of the inherent dangers of an ethnographic approach to case study research is the temptation towards a 'reproduction model' of research. Research as reproduction is based on the questionable assumption that the phenomena we study are independent from us, that direct access to such phenomena is possible and that the validity of knowledge thus generated is certain (Hammersley 1998 p50). I have tried to draw on an alternative, 'representational' model of research, wherein social phenomena are reflexively represented from a specific point of view which renders some features of the phenomena relevant and others irrelevant, and acknowledges that 'truth' should always be regarded as contingent (Hammersley 1998).

1.4 The East Kirkland Social Inclusion Partnership

Chapters Six, Seven and Eight separate my ethnographic account into three periods, structured by significant phases of partnership development: the contested processes involved in achieving community representation on the Partnership Board; the tentative integration of established and new partners; and the development of ultimately confrontational relationships. The descriptive and explanatory structure of this Part of the thesis thus has a narrative emphasis appropriate to a contextualised and temporal analysis of the nature of the East Kirkland SIP. Interpretative themes that emerged during the course of fieldwork, shaping the development of research questions and the direction of analysis, are knitted into the narrative. This charts both progress and setbacks, coalescence and conflict, but the account is presented as contingent and partial: other voices may choose to tell the story differently and other interpretations are conceivable.

The Introduction to Part IV describes the policy background. Forty eight Social Inclusion Partnerships have been funded by the Scottish Executive, some for as long as ten years, initially led by local authorities who act as banker. Some are thematic; others are area-based. Statutory sector representatives on SIPs are usually senior officers within their respective organisations (e.g. the health board, local authority, local enterprise companies etc.) Community and voluntary sector representation on Partnership Boards is mandatory. Although the Scottish Executive has presented

such Partnerships as a new initiative, some critics consider them to be a replacement for former urban funding programmes and thus a continuation of former Conservative Party policy in Scotland.

Chapter Six, 'A Differentiated Partnership', gives an account of the origins of the East Kirkland SIP and its early structure in the form of an Interim Management Group. This chapter traces the Group's belated attempts to involve the community in securing representation on the Board, from the initial public 'launch' to the conflict-riven election of community representatives, i.e. November 2000-March 2001. Chapter Seven, 'Forced Partnership/Contested Legitimacy', traces the processes involved in developing a degree of integration in the relationship between the established partners of the statutory sector and the new partners from the community and voluntary sector. Over this period a number of paradoxes and contradictions in the nature, purpose and function of the SIP gradually became apparent and are laid out at the end of the chapter in the form of an analytical framework. Chapter Eight, 'The Risky Business of Partnership', covers the final period of fieldwork up to February 2002. Although positive progress had been made in the earlier months, this phase in the social processes of the partnership cumulated in conflict, crisis and the resignation of one of the community representatives - the Chair of that sub-group. This section therefore concludes with an analysis of the seldom-explored risks of partnership working for both community representatives and other types of partner.

1.5 Summary of Discussion

Chapter Nine places the case study within the broader context of policy initiatives and implementation and assesses the contribution of this work to the fields of health promotion and medical sociology. My analysis shows that the multiple discourses and competing ideologies apparent in research findings around health inequalities, in policy making and in health promotion, are both played out and challenged at this local level, but nevertheless remained strangely marginal. '(Not) talking about health inequalities' was a surprising research theme. The 'real' business of the partnership was to spend the funding allocated by the Scottish Executive. Unsurprisingly, this generated competition between different vested interests and some conflict between participants. In exploring the social processes of partnership work at this local level, the case study presents a dynamic narrative account of prescriptive structures and unequal power relations, problematic legitimacy and minimal community participation, and differing economic and social priorities.

I outline how key public health and social welfare policy documents have drawn on the overarching discourse of 'social justice' to address both inequalities in health and their perceived linkage with the problem of social exclusion, which exerts its effects in disintegrating/degenerating communities. This chapter argues that discourses of reintegration of the 'excluded', regeneration of 'bad' areas and the reform of 'unhealthy' people currently prevail over arguments for redistribution. National and local attempts to reduce inequalities in health are thus shaped by discourses in which attention is directed downward to the problems of (potentially) sick individuals and (allegedly) sick communities. Partnership work is increasingly viewed as the main pathway to healthy people and places, although the case study and the broader literature document difficulties with this approach (Balloch & Taylor 2001). The East Kirkland case study exemplifies how the rhetoric of partnership and community involvement as a key strategy in tackling health inequalities is fed by conflicting ideologies and involves deep ambiguities of policy and practice. In particular, unresolved and undiminished tensions between professional prescription and lay empowerment still exist.

PART II

REVIEWING THE LITERATURE(S)

HEALTH INEQUALITIES, HEALTH PROMOTION AND POLICY

Introduction

In some ways the literature search strategy has been a natural progression, moving from reviewing the topics of advocacy and health promotion, to the literature(s) on health inequalities, to policy documents, and thence to reviewing research on and informed critiques of partnership working and community engagement. Engaging with the multiple literatures that inform this thesis has required me to develop a purposefully selective review strategy – one that snowballed in a number of directions, as the bibliography at the end of this thesis demonstrates, but remained eclectic rather than haphazard in nature. This is not a systematic literature review, as that term is commonly understood in academic work. With regard to health inequalities, for example, it was apparent that anything resembling a comprehensive review of the vast body of epidemiological literature was not only beyond the scope of, but was inappropriate for, the purposes of this thesis. My literature search in relation to this and other relevant fields was driven primarily by the need to gain understanding of the many complexities inherent in these steadily accumulating bodies of knowledge and awareness of the critical commentaries thereon.

As part of the support arrangements for this collaborative studentship, my HEBS supervisor had arranged for a two-week induction/library research period at HEBS at the beginning of the study. This enabled access to the considerable resources of the HEBS library catalogue and other databases. I conducted keyword searches of both the HEBS and University of Edinburgh library databases, using a Boolean search on multiple terms (e.g. 'advocacy AND health OR health promotion', 'inequalities AND health', 'communities AND development AND/OR health', 'partnership AND community', 'participation AND health', 'social AND exclusion OR inclusion' etc etc). More productive searches along these lines were conducted with specific search engines, such as ScienceDirect and SwetsWise. The early stages of the literature review of health promotion were informed by my participation in some of the MSc modules in Health Promotion (Health Promotion and Health Promotion Practice)

provided by the Department of Public Health Sciences. With regard to the limited literature on advocacy, using the academic databases and other electronic links provided by the University of Edinburgh, I was able to search for both published and grey literature/dedicated web sites – of which many now exist. I obtained Government policy documents *via* their public websites. I also drew on the expertise available through the email discussion forum of HEN (the Health Equity Network), where a number of established researchers kindly provided me with advice on essential reading in the health inequalities field, including both journal articles and significant edited collections.

I regularly searched numerous journals for articles I judged to be relevant for the purposes of my research, including but not restricted to *Health Promotion International*, *Critical Public Health*, *Critical Social Policy*, *Epidemiology & Community Health* and the *BMJ*. Reading both primary research and reviews helped me bring together important critical arguments. Some of the most relevant and useful research and other publications were obtained, almost serendipitously, from the references cited in such articles. As the research progressed, research published in journals that I would not at first have considered particularly relevant at the beginning of the PhD, such as *Urban Studies* and *Public Money & Management*, also became increasingly useful. The number and type of journals consulted over the course of the thesis thus broadened considerably, as initially tangential issues (such as regeneration) achieved greater relevance and centrality.

The two published papers that are based on my initial literature review are contained in *Appendix 1*: these provide a more in-depth review of aspects of health promotion and health inequalities research than is covered here. The purpose of this literature review is to bring together, selectively, multiple strands of research and policy critique, deploying these literature(s) in order to provide an overall framework for this thesis. This is necessarily a selective process, as the material spans multiple fields that do not necessarily communicate with each other but which are nevertheless essential background to my subject matter.

- Chapter Two presents an inevitably partial and limited account of the mainly epidemiological body of research on health inequalities and the contributions/challenges of other types of knowledge. I then use Levitas's analysis of the policy discourses around social exclusion as a tool with which to explore the links currently being made between social exclusion and inequalities in health, the

different types of solutions proposed, and the implications for action (Levitas 1998, 1999).

- Chapter Three considers the relationship between health promotion in late/post-modern society and contemporary health and policy. I draw on Booth's analysis of the role of research in policy-making and implementation to argue that his 'political model' is particularly appropriate to the health inequalities field (Booth 1988). I then address some of the extensive literature on community participation in health, a key aspect of policy and a fundamental principle of contemporary health promotion. The concept of participation is particularly problematic for a number of reasons – not least, the problems of defining 'community' and of unrealistic expectations of what community participation can achieve. Chapter three also considers the research and critique surrounding the concept and practice of multi-sectoral partnership work, given the significance of this field to contemporary health promotion, its prominence in government policy as a way of tackling social exclusion and disadvantage, and its particular relevance for informing the case study itself.

CHAPTER TWO

HEALTH INEQUALITIES: DEBATES AND DISCOURSES

2.1 Historical Origins

The main purpose of the (mainly epidemiological) body of research on health inequalities has been to provide indisputable evidence of the existence of this phenomenon: such evidence has also provided many disciplines and organisations with a sound platform for public health advocacy. Indeed, it is questionable whether health inequalities would have achieved its prominent place on the current policy agenda without sustained advocacy over several decades by the multi-disciplinary research community associated with the new public health. However, the interest in and debate around the social patterning of inequalities in health is not new (Davey Smith *et al* 2001). Britain has a long history of public health interest in differentials in death rates between socioeconomic groups, dating back to the 1851 census (Macintyre 1997). Such differentials were stark at that time, with the average age of death in 1840 for a professional man being 35 and for labourers, mechanics and servants, just 15.

Macintyre has described how, in the latter part of the 19th and early part of the 20th centuries, debates about the causes of inequalities in health were shaped by three different types of explanations: hereditarian, behavioural and environmental (Macintyre 1997). Hereditarian explanations for class variations in disease and premature death argued that people's social position depended on biologically determined natural abilities. Variations in health were therefore inevitable and little could be done about them. Behavioural explanations viewed the high infant mortality rate found in the labouring classes and bad health of poorer sections of the population as a consequence of working class maternal ignorance and generally unhealthy or feckless ways of living. Environmental explanations regarded the widespread poverty and material conditions of urban industrial life as central to the social distribution of disease and premature death. Thus the existence of inequalities in health and mortality rates was not in dispute, but the causal mechanisms were. To some extent, contemporary research on health inequalities in Britain continues to mirror those earlier debates. Such competing explanations have implications for how

health inequalities can be tackled, both at the level of social policy and within the discipline of health promotion (Carlisle 2001).

2.1.1 Contributory or competing explanations?

Inequalities in health are socially patterned: that is, they are both constitutive and reflective of wider configurations of social inequality. Patterns in the distribution of health change over time and there is evidence to link such changes to social policies (Davey Smith *et al* 1999). As this phenomenon is clearly neither inevitable nor irremediable, health inequalities have both moral and political significance. It is now well known that mortality rates declined during the course of the 20th Century for all social groups in the UK, but the rate of improvement has been markedly unequal. Epidemiological evidence of a widening gap – a health divide between richer and poorer groups in society - has steadily accumulated (Whitehead 1998, Shaw *et al* 2000). After years of political disinterest, reducing inequalities in health is now a matter of urgent public policy concern (Department of Health 1998a, Scottish Office Department of Health 1998, National Assembly for Wales 2000a). The priority attached to this matter by the current UK Labour Government was signalled by the commissioning of an independent inquiry in the early stages of its first period of administration (Department of Health 1998a). Yet despite a lengthy research tradition in this area, existing accounts for health inequalities are not fully developed and much remains to be discovered about the fine grain of the mechanisms and pathways that create and sustain them (HEA 1999).

Structural-material and psycho-social explanations and interpretations have contributed to a rich and steadily expanding body of knowledge, although important gaps remain. Arguments for the causes (and effects) of inequalities in health may be located mainly within the social structure/environment or mainly within the individual, although the links between the two are not in doubt. Individualistic explanations for health inequalities (in terms of unhealthy lifestyles and choices) still exist, although epidemiology and the social sciences have produced extensive evidence of the harmful impact on health of poverty, deprivation and social exclusion at both individual and population levels (Davey Smith 1996, Townsend 1998, Wilkinson 1998b, Bartley *et al* 1997, 1998a, 1998b, Popay *et al* 1998, Macintyre and Hunt 1997). It has been estimated that, in Britain alone, about 800 empirical and conceptual research papers have been devoted to demonstrating the existence of health inequalities over the last two decades of the 20th Century (Macintyre 1997).

The 1982 report of the Working Group on Health Inequalities (widely known as the Black Report) is a key early document in the field (Townsend *et al* 1998). This report provided striking evidence that, despite declining overall mortality rates during the last century, differences in health status between different occupational groups still existed and were increasing. The findings and recommendations of the Black Report were politically unacceptable to a new Government committed to a reduction in public spending (Macintyre 1997). The research community responded by defending the field of social inequalities in health against charges that they did not exist, or were not increasing. Much public health, medical and social science research energy was thus spent in keeping health inequalities on the political agenda rather than on empirical investigation of the processes by which inequalities are generated and maintained (Macintyre 1997). Less attention at that time was paid to specific recommendations to tackle the problems for much the same reason but this has changed markedly.

Various ways of typologising the differences between explanatory models for health inequalities can be discerned in the literature (e.g. Krieger 2000, Lynch 2000). From a critical perspective, Popay claims that two main constructions continue to dominate the field, both closely related to the risk-factor approach of epidemiology (Popay *et al* 1998). Firstly, the view that unwise individual behaviours and lifestyles are principally responsible. Secondly, the view that inequalities in health are a mirror for wider social inequalities (Bartley 1994, Davey Smith 1996) and relative deprivation (Wilkinson 1997a, 1997b, 1998a, 1998b). A third view is still extant, although resisted by many in the research community: that lower socioeconomic groups share and reproduce an unhealthy, underclass culture – a ‘cycle of deprivation’ that is transmitted from each generation to the next (Sir Keith Joseph, quoted in Alcock 1997 p30). Many researchers now acknowledge the cumulative impact of disadvantage over the life course in producing health inequalities. This explanatory framework focuses upon the contrasting and cumulative impacts of biological programming, social positioning, and contextual area-based influences over the duration of the life course. Health inequalities are believed to result from the differential accumulation of exposures and experiences – the distinctive and divergent trajectories associated with socio-economic position (Whitehead *et al* 2001) – as, although some elements of risk may be common to all in late-modern society, the risks may be greatest of all for those experiencing some form of structural-material disadvantage (Beck1992).

This explanation for health inequalities includes work suggesting that an element of *in utero* and/or early life biological programming has effects on health throughout life (Barker 1992), together with research that posits the cumulative health effects of lack of support at critical or sensitive periods throughout life (Bartley *et al* 1997). Although there have been marked disagreements between exponents of biological and social programming, it now seems accepted that those individuals in society with the fewest bio-material advantages are most likely to experience poor health (Bartley *et al* 1998). The 'vulnerable organism' hypothesis implied in this interpretation is neatly expressed by Wilkinson:

'Just as it is the weakest trees that are blown over in a storm, so it is those people whose lung or cardiovascular function is already impaired who are most endangered by new challenges.' (Wilkinson 1998a p413)

From this perspective, health in adulthood is the outcome of *socially* patterned processes acting across the entire lifecourse (Lynch *et al* 1997). Graham has described this lifecourse-in-context framework as '*the joined-up science of health inequalities*', one that brings together the concepts of cumulative exposure and pathways of disadvantage and locates these within changes in the socio-economic structure (Graham 2001). This explanatory model is not restricted just to a temporal perspective on individual lives, as the geographical clustering of inequalities in specific historical contexts has been confirmed (e.g. Shaw *et al* 2000, Mitchell *et al* 2000). Whilst some explanatory models draw on large national and international datasets, operating at the macro-level of explanation in terms of aggregated individual health, the accumulation of disadvantage framework arguably provides a sharper focus, drawing closer to theorising a contextualised view of individual lives within specific social locations. It has also proved attractive to those who draw on explanations for health inequalities based on political economy (e.g. Davey Smith and Gordon 2000).

Lynch similarly frames health inequalities in neo-materialist terms, arguing that health outcomes result from the differential accumulation of exposures and experiences that have their sources in the material world (Lynch *et al* 2000). Under a neo-materialist interpretation, the effect of income inequality on health reflects a combination of negative exposures and lack of resources held by individuals, along with systematic under-investment across a wide range of human, physical, health, and social infrastructure. An unequal income distribution is one result of historical, cultural, and political-economic processes that influence the private resources

available to individuals and shape the nature of our public infrastructure: education and health services, transport, environmental controls, availability of food, quality of housing, occupational health regulations etc. (Lynch *et al* 2000 p1204). In short, this cumulative framework of understanding suggests the most complex and interactive of pathways, incorporating elements of material and social inequality with socio-spatial and temporal contexts. It requires the integration of the existing epidemiological evidence base of health inequalities over the lifecourse with research on structural processes and analyses of how government policies may moderate or amplify broader inequalities associated with socio-economic position (Graham 2002).

2.2 Questionable Pathways and Contested Knowledge(s)

There is an apparent historical continuity between 19th century environmental explanations for health inequalities and contemporary explanations based on poverty, deprivation and relative inequality or psycho-social stress. There are also elements of continuity between behaviourist/hereditarian models that posit the pathology of lifestyles and cultures, the determining impact of biological factors, or the endemic nature of inequality in all societies. A recent update on trends in life expectancy by social class between 1972 and 1999 show that there are still wide variations in life expectancy by social class (Office of National Statistics 2002a), but explanations are still perceived as incomplete and potentially contestable, and boundaries between types of explanation are seldom clear (Health Education Authority 1999). Particular inadequacies are perceived in explanations of the relationship of class inequalities in health to gender or to ethnicity (Macintyre and Hunt 1997, Nazroo 1998).

Explanations that suggest the causative effect of psychosocial stress acknowledge the problem of an inequitable social structure but see the generative mechanism for health inequalities in the relationship between social structure and individual psyche (Wilkinson 1997b, 1998a), Elstad 1998). Explanations that suggest an individual deficit interpretation similarly acknowledge social inequity but are less focused on restructuring society than on tackling the problem at the level of individuals (Charlton and White 1995, Charlton 1997). Individual deficit types of explanation for health inequalities may seem particularly contentious, but this interpretation can be deployed in two different ways: as a more or less *neutral* explanation for the universality of health inequalities, or, in its *pejorative* version, as the potential basis for lifestyle-focused victim- and community-blaming discourses (Crawford 1977).

Many researchers in the field acknowledge the combined effects of life circumstances and lifestyles and the improbability of any one single factor being the sole causal mechanism. The differences lie mainly in the relative weight given to explanations of particular causal pathways. However, Scambler points to the unlikelihood of discrete and identifiable pathways running directly from specific causes to outcomes, suggesting that there might be '*innumerable, changing and different routes to the same end points*' (Scambler 2002 p104). He posits as an alternative, six key types of 'capital': biological, psychological, social, cultural, spatial and material. Biological capital refers to both genetic inheritance and physical health over the life course. Psychological capital refers to the generalised ability to cope – resilience in the face of adversity. Social capital is generally taken to refer to social integration or cohesion at the level of communities. Cultural capital is embedded in primary socialisation and formal education and attainment, which have relevance for employment and income. Spatial capital is taken to refer to area-based influences on health. Scambler argues that it is material capital that should be accorded priority, because of its influence on other types of capital and its direct responsiveness to how society is organised in terms of class relations. The conceptualisation of various types of capital is interesting in that it draws on the concept of flow, avoiding the linear unidirectionality of the pathways metaphor but whether this perspective on conceptualising health inequalities will prove influential still remains to be seen.

Popay suggests that the emergence of a scientific discourse on health inequalities means that most studies directed at understanding health inequalities have been unidimensional risk factor epidemiology (Popay *et al* 1998). Natural science disciplines presume the existence of externally verifiable realities that can be uncovered through rational thought and scientific study, assumptions that have been challenged by social scientists espousing less positivist perspectives. One epidemiological response might be that multidimensional risk factor studies are now becoming increasingly common, made possible by the steady accumulation of data over the years and by the explosion in computing power that has enabled more finely detailed analyses of large databases (Bartley *et al* 1998b). Another might be that epidemiology is fundamentally multi-factorial and multi-dimensional (Krieger 2000). But for some researchers in the field these arguments continue to miss the point, as increasingly sophisticated developments in statistical manipulation fail to address problems of the relationship between structure and agency (Thomas 1999, Rogers *et al* 1997). In addition, although the evidence provided by the epidemiological

literature is vast, it is unable to provide complete explanations for inequalities in health because of its incapacity to address lay understanding and experience (Popay *et al* 1998, Thomas 1999, Rogers *et al* 1997, Nettleton 1995).

Epidemiology is concerned with aggregating data relevant to populations rather than individuals: bodies are either absent or constructed as material, physical entities. Theoretical challenges to such assumptions have come from anthropology and sociology, where conceptualisations have included social, symbolic and political embodiment (Douglas 1998, Schepher-Hughes and Lock 1987). There is a marked absence in the epidemiological literature on health inequalities of knowledge grounded in everyday experience and its relation to structural circumstances. One way of accessing such lay knowledge and experience is through narratives of embodiment, as these have the potential to illuminate the relationship between social structure and individual agency (Watson 2000). Popay argues that lay knowledge differs from expert knowledge in that it has an ontological purpose, orientating behaviour to the individual's understanding of her/his place in their life-world (Popay *et al* 1998). This form of knowledge is antithetical to traditional models of cause and effect such as that given prominence within the inequalities research literature and as such challenges expert knowledge. She also suggests that the oppositional discourses of lay/expert forms of knowledge may hinder developments in inequalities research (Popay *et al* 1998) but it seems equally likely that explanations will continue to remain incomplete if those who are perceived as experiencing health inequality remain invisible, inaudible and disembodied.

Blaxter raises the key question of how people themselves think about inequalities in health, a topic that remains fundamentally difficult to address (Blaxter 1997, Cunningham-Burley *et al* 2002). Blaxter's analysis combined large-scale survey evidence with a review of the extensive body of qualitative and biographical research on attitudes to health. The survey found a high level of agreement in all social groups that health is mostly dependent on behaviour and is a personal responsibility. The spread of health promotion knowledge and the concept of the 'epidemiological paradox' partially explain this: widely shared knowledge of risk factors contributes to a lowering of publicly recognised risk thresholds. However, this knowledge of 'the facts' is belied by personal knowledge of the exceptions: risk factors for the group provide no necessary predictors for the individual and lay experience is well aware of this (Blaxter 1997). Her analysis of the qualitative work revealed more complex views: that lay respondents held seemingly opposed concepts of health and

illness in equilibrium. She argues that health inequality is not a meaningful concept because health is neither experienced as a unitary component of life nor seen as the opposite of illness:

'What both quantitative and qualitative data do make clear is that it is necessary to distinguish, not only between public and private accounts, but also between the cause of illness and the cause of health, between the cause of general ill health and the cause of specific disease, and between what is held to affect the health of society in general and what is perceived as influential in one's own life.' (Blaxter 1997 p755)

She suggests that to inquire about the subject's own health is to invoke biography, as the research process asks respondents to actively engage in the construction of their ideas and the presentation of their social identity. Admitting to health inequality is not acceptable because individual health is bound up with notions of morality and the socially defined self. It is therefore unreasonable to expect people to devalue their social identity by labelling their own inequality: people prefer to claim health if possible (Blaxter 1997). Moreover, as the topic of health inequality is constantly being rediscovered by the media, it seems to have a low priority for the general public, compared to traditional health care services. This has implications for the multiplicity of interventions designed to tackle the issue via public involvement and community engagement, and for the endeavours of the scientific community involved in researching the issue.

2.2.1 The vexed question of structure and agency

Although agency is not absent from debates in either research or policy, outside the qualitative literature it tends to be reduced to discussions of health behaviour (Thomas 1999). For Thomas, the polarised debate between materialist/structural versus cultural/behavioural views operates to reduce agency to health knowledge and behaviour, with the former continuing to search for the 'real' aetiological factors such as poverty, poor housing etc (Thomas 1999). The individual social actor is typically constructed as a bundle of (unhealthy) behaviours responding to a deterministic social structure. This leaves some key elements unexplained, notably the micro-level of individual experience and the capacity for agency in relation to the social structure (Giddens 1999). Certain types of explanations for inequalities in health amongst poorer socio-economic groups may implicate the 'culture' of deprived neighbourhoods and the beliefs, attitudes and behaviours of the people who live there (Murray 1994, Field 1990). This style of explanation – which extends the individual deficit model to include communities - is unpopular with many

researchers and policy analysts who believe it unhelpful to 'blame the victims'. There are good reasons, then, for claiming deterministic structural effects. It should be noted, however, that the contributory capacity of individual behaviour to unequal health outcomes is rarely rejected outright. Hoggett, for example, calls for a re-conceptualisation of agency in order to incorporate the tragic dimensions of human existence, acknowledging our capacity for destructiveness towards both self and others (Hoggett 2000).

The danger of bringing agency back into the debate is the familiar one of holding people primarily responsible for their own suffering. This much-resisted discourse remains ubiquitous. Although pejorative accounts of individual/community deficits as explanations for health inequalities are both contested and rejected by many epidemiologists, public health practitioners and social scientists, they hold considerable, if controversial, appeal for policy makers. If the social structure is granted deterministic power, individual human beings are arguably reduced to blameless 'structural dopes'. If, on the other hand, people are believed to possess powers of agency – to reflect on and change aspects of their own situation – then they are presumably accountable for the choices they make. The relationship may be conceived as mutually constitutive: people are constrained by their social situation but also have some power over their own lives *and* are actively implicated in reproducing the existing social structure (Parker 2000, Giddens 1991, 1999, Archer *et al* 1998, Bhaskar 1998). This perspective implies a degree of autonomy applicable, perhaps, to most adults but scarcely available to infants and young children, although this period of the lifecourse is identified as particularly significant by much research. Beliefs in the change-capacity of human actors are fundamental to the contemporary community of policy makers and to health promotion, given their mutual orientation towards individual (as well as social) change. Such beliefs are capable of sustaining apparently incompatible ideological stances, principally along lines of community coercion or empowerment (although it is not always easy to distinguish between the two).

2.2.2 Bringing class back into the debate?

Few of the explanatory frameworks or knowledges explored above address the fundamental causes of social inequality, leading a number of critics to condemn much contemporary analysis as sociologically timid (Lynch 2000, Coburn 2000, Scambler and Higgs 1999, 2001). Nazroo, for example, argues that the continued

search for causal mechanisms in health inequalities obscures wider social inequalities; that difficult and dramatic interventions continue to be avoided; and that disciplines like health promotion simply focus on improving our understanding of pathways and designing interventions along them (Nazroo 1998). Inequalities in health thus become a problem for individuals rather than a reflection of social malaise (Nazroo 1998 p727). More radical analyses point to the underlying generative mechanisms of capitalist class society. Scambler draws on critical realism, a theoretical perspective that posits the stratified nature of reality, to direct attention to the long-ignored dimension of social class theory (as opposed to social class analysis, which is usually conceptualised by epidemiology in terms of occupational or socioeconomic status group) (Scambler 2002). These strata or levels of reality are made up of: events (the actual); experiences (the empirical, or our knowledge of such events); and the underlying generative mechanisms that exist independently of our observation of them – the real. Most contemporary class analyses focus on the levels of the actual and the empirical, i.e. the occurrence of and evidence for the non-random over-representation of poorer social groups in data on premature mortality and morbidity.

Such analyses fail to address the largely ignored generative structural mechanisms of capitalist, globalised society that lead to poorer health and premature death for what Scambler calls the (perhaps temporarily) ‘displaced segment’ of the working class – the unemployed, the old, the sick, the economically inactive (Scambler 2002). Scambler prefers the term ‘displaced segment’ to that of ‘underclass’: he and other critics point out that this concept suggests a group underneath the class structures of society and reject its use as, at best, premature and at worst, a perpetuation of pejorative neo-liberal terminology. He argues that the activities of the strongly globalised capitalist-executive and weakly globalised power-elite classes in a contemporary context of late (disorganised) capitalism, combine to produce the outcome of vast inequalities in power, wealth and health, particularly for this displaced segment of the working class. Such an analysis is nearly unique in unapologetically re-directing attention upwards towards the ‘*greedy bastards*’ at the pinnacle of the social hierarchy (for example, the multi-billionaires on The Times’ ‘rich list’ and chief executives and chairmen of the FTSE 100 companies whose annual salaries and bonuses may well be in excess of six figures) (Scambler 2002). This reconceptualisation of the causes of social and health inequalities combines agency as well as structure, but this is a type of agency that has rarely been the subject of research attention. Reversing normative judgements, this perspective

asserts that deficient, delinquent and dysfunctional elements are found at the apex, not the bottom, of the social structure and that the health and welfare of society is endangered by the voluntary self-exclusion of the very rich and powerful.

2.3 Troublesome Discourses

The review of the health inequalities debate above highlighted some of the pertinent but contentious conceptual issues emerging in current research, and provides the ground for considering policy and practice in tackling the issue. In this section I draw on the concept of discursive construction (Howarth 2000), arguing that discourses around health inequalities are becoming intertwined, particularly at the policy level, with discourses around social exclusion (Department of Health 2001b, Social Exclusion Unit 2001) and that we need to explore the implications of this. My purpose is not simply to draw attention to the ways in which meanings can be contested in health inequalities research, health promoting activity and government policy-making: the concept of discourse invokes, creates and reflects *practice* in a way that, for example, that ideology does not. The issue of practice is also central to the arguments in Chapter Three, where the relationship between health promotion and contemporary policy is examined more closely. In the remainder of this section, I argue that the understandings that underpin contemporary explanatory frameworks for health inequalities and associated recommendations for action are troublesome in the sense that, regardless of implicit scientific claims to objectivity and neutrality, they are neither value-neutral nor devoid of moral content and political import.

2.3.1 Redistribution, social integration and the underclass

Levitas developed the discourse model outlined below as a way of teasing out the various meanings of social exclusion embedded within current political debate (Levitas 1998, 1999). Levitas argues that to talk about language as discourse means

‘that sets of interrelated concepts act together as a matrix through which we understand the social world. As this matrix structures our understanding, so it in turn governs the paths of action which appear to be open to us. **A discourse constitutes ways of acting in the world, as well as a description of it.** It both opens up and closes down possibilities of action for ourselves.’ [Emphasis added] (Levitas 1998 p3)

She identified three different discourses: RED (a redistributionist discourse; MUD (a moral underclass discourse, related to pathological culture/behaviour); and SID (a

social integrationist discourse). The latter is shown to be disproportionately present in political discourse, and overwhelmingly associates social inclusion with being in paid work. Her model thus identifies the language and arguments that are used to construct a vision of a particular moral order. From this perspective, discourse analysis

'underlines the fact that the matrix of concepts through which we understand the world and act in it profoundly affects those actions and thus the world itself, **without denying the material character of social relations.**' [Emphasis added] (Levitas 1998 p3).

Although developed for a different context, I suggest Levitas's discourse model is an appropriate conceptual tool for considering the debates around inequalities in health as both social exclusion and poorer health are explicitly linked with 'lower' social classes and disadvantaged communities. For example, on August 14th 1997 Peter Mandelson (then Minister without Portfolio) announced in a Fabian Society lecture that the Government was setting up a special underclass unit in the Cabinet Office to target action against poverty and social exclusion and in April 2000 the Government announced a 10 year strategy to turn round some of the country's poorest communities with funding to modernise homes, improve health, create jobs and fight crime. Levitas's RED, MUD and SID model is deployed here as a way of conceptualising approaches to tackling health inequalities and exploring their limitations.

2.3.1.1 Redistributionist Discourse (RED)

The RED approach to health inequalities is unmistakably linked to explanations for health inequalities that pinpoint poverty and deprivation as causal mechanisms. From this perspective, (normally located amongst writers on the political left), a more equitable distribution of resources in society and the restructuring of socioeconomic policy is required (Bartley 1994, Townsend 1998, Davey Smith *et al* 1999, Wilkinson 1998b):

'There is **one central and fundamental** policy that should be pursued: the reduction of income inequality and consequently the elimination of poverty. Ending poverty is the key to ending inequalities in health.' (Emphasis in original) (Davey Smith *et al* 1999 p163)

The redistributionist discourse frames the problem as one of wealth as well as poverty. It acknowledges the role of relative inequality in its focus on downward

redistribution through reformed welfare policies. It rejects welfare dependency arguments and argues for the strengthening rather than the reduction of the welfare state (e.g. Bartley *et al* 1997). This perspective is also found in the report of the Independent Inquiry into Inequalities in Health (the Acheson Inquiry), which states that:

'We consider that without a shift of resources to the less well off, both in and out of work, little will be accomplished in terms of a reduction of health inequalities by interventions addressing particular 'downstream' influences.' (Department of Health 1998a)

One problem with the redistributionist approach is the related belief (amongst, for example, some health promotion professionals) that increases in income will be accompanied by an increase in healthy types of expenditure. Poverty as the determining factor for health-related behaviour is challenged by Bourdieu's (1984) social anthropological conceptualization of the class-related habitus. He argues that the tastes, behaviours and preferences of any socioeconomic group are not only shared, but become internalised as 'natural'. From this perspective, it is not certain that increases in income will lead automatically to healthy tastes and behaviour because preferences in such things as diet or physical activity cannot be simply mapped onto a simple healthy/unhealthy dichotomy. They carry social meanings that need to be understood and related to the physical, social, economic and cultural context within which they occur (Bourdieu 1984).

Exponents of RED argue that we live within an inequitable capitalist society and their preferred solution is the redistribution of wealth and resources. Through their advocacy roles at national and international level, disciplines such as public health and health promotion arguably have the capacity to influence social and economic policy in the direction of poverty elimination (WHO 1986). However, this will undoubtedly be an uphill struggle as it is far from clear who should be responsible for taking action (Cribb 1997). Moreover, both Bourdieu's and Scambler's analyses explicitly argue that efforts to reduce social and economic inequality, by action to transform the social structure, will be actively resisted by those whose entrenched interests will thereby be threatened (Bourdieu 1984, Scambler 2002).

2.3.1.2 Moral Underclass Discourse (MUD)

The concept of a 'moral underclass' resonates with explanations of health inequalities that focus on individual (ir)responsibility for health, given the profound

associations between perceived moral turpitude and illness in contemporary society (Blaxter 1997). MUD-type approaches believe the solution to lie with individuals themselves, who should change their reprehensible behaviour and accept responsibility for their own health. From the MUD perspective, social and health inequalities are endemic in all societies: recommendations for action therefore tend to be cast in terms of individual adaptation to inevitability rather than social change. This type of discourse can be related to pejorative versions of individual and/or community deficit type explanations for health inequalities. The solution is to increase the margin of resources at individual or community levels by increasing resources or reducing needs (Charlton and White 1995). This can imply a conventional health promotion/empowerment approach, providing adaptive skills and reducing needs through increasing lower socioeconomic groups' understanding of and resistance to advertising techniques and peer pressure (Charlton and White 1995). A community development approach may also be endorsed, as the creation of mutual help networks (e.g. food co-ops and credit unions) would have the additional benefit of leaving financial input virtually unchanged.

Some argue that policy goals should address the subjective experience of inequality at the level of individuals, which is where its effects are felt (Charlton 1997). A pragmatic, if admittedly second-best solution is to create a step-like inequality – a stratification of classes, with egalitarianism within strata (Charlton 1997). This type of encapsulation would provide a protective insulation from invidious comparisons with more advantaged social groups as differentials between strata may be compatible with equality within strata:

'If resource differentials are indeed a reliable consequence of a delayed-return, surplus economy, then inequality might be regarded as an endemic injustice which cannot be eradicated but must nevertheless be negotiated... the inequity of inequality therefore requires containment, compensation and compromise at the 'capillary' social level – the family, the workplace and the community.' (Charlton 1997 p422)

However, the 'casualty' approach implied by an individualistic discourse fails to acknowledge the role of structural inequalities in facilitating or preventing access to basic components of health such as adequate housing, decent food, education, transport income and employment. It also carries unacceptably stigmatising overtones of personal social, economic and moral failure. This type of discourse is usually deployed in association with the individualist neo-liberal political ideology of the New Right. The research community generally rejects this as inappropriate and

unhelpful, but the contribution of individual behaviour to health inequalities is never dismissed outright. The majority of workers in the fields of health services and community development, for example, would justifiably counter suggestions that they knowingly utilise a moral underclass discourse. Nevertheless, Government initiatives based on empowering types of health promotion and community development activities can unwittingly be a thinly disguised veneer for the classic victim blaming approach and marginalisation of the problems of poverty, relative deprivation and poor health identified by critical social policy analysts (e.g. Wainwright 1996).

2.3.1.3 Social Integrationist Discourse (SID)

The social integrationist discourse around health inequalities is closely related to the perceived relevance of social cohesion and social capital to health and to psychosocial stress as a potential explanation for health inequalities. In conceptualising social capital, the community rather than the individual or the social structure is the unit of analysis. Two quite different approaches are identifiable in the literature, exemplified in the writings of Putnam and Bourdieu. Putnam's neo-liberal/pluralist version defines social capital as

'features of social life – networks, norms and trust – that enable participants to act together more effectively to pursue shared objectives' (Putnam 1996 p4)

The concept has proved attractive to both health promotion and policy makers (Gillies 1998). Some argue that low social capital is a key causal factor in health inequality and that income inequality only exerts its effect through this variable (Lomas 1998). Building social capital has been seen as a relatively inexpensive means of tackling the structural determinants of health and disease and offsetting the most abrasive effects of health inequalities (Gillies 1998). SID-type solutions suggest that creating and sustaining social cohesion or social capital at the community level is the most appropriate way to tackle the problem. However, despite its obvious appeal, the concept of social capital has attracted critical attention (Lomas 1998, Coburn 2000, Fine 2002, Morrow 2002). For example, Muntaner *et al* argue that social capital is being conceptualised in unsophisticated ways and that care needs to be exercised in making such claims (Muntaner *et al* 2000). They suggest that the concept is being used as an alternative to materialist-structural explanations for inequalities and invokes a romanticised view of communities.

SID-type solutions tend to assume that material circumstances are without significant influence after certain threshold levels are passed but this remains doubtful (Elstad 1998). Lynch *et al* suggest that a decontextualised psychosocial approach can be appropriated for regressive political agendas (Lynch *et al* 2000). For example, claims may be made that we lack the social cohesion of the past, that problems of poor and minority communities are really a result of deficits of strong social networks, and that local communities must solve their own problems (Lynch *et al* 2000). These authors argue that there has been little discussion of the possibility that focusing on what materially and politically disenfranchised communities can do for themselves is a kind of community-level victim blaming that reinforces low expectations for structural change. They seem to share a preference for Bourdieu's neo-marxist definition of social capital, which is closely linked with the durability of class and power relations (Bourdieu 1984).

Work on developing social integration and cohesion at the community level and combating social exclusion is currently being undertaken in many communities as 'bottom-up', grass roots initiatives have experienced a steady rise in popularity over the last couple of decades. However, promoting social citizenship as one of the principle responses to inequalities and other difficulties in society is unsustainable without adequate social welfare safety nets (Bartley *et al* 1997, Hutton 1996). Critics have also pointed out that encouraging communities to develop their own strategies for combating social problems is a less than admirable way for the Government to solve pressing problems with regard to social (dis)order and the increasing costs of the welfare state (Wainwright 1996, Lund 1999). For example, it has been suggested that increasing social capital and social inclusion at the community level will reduce crime and social disorder (Kawachi, Kennedy and Wilkinson 1999). In this sense, SID-type actions remain within a containment paradigm.

2.3.2 RED, MUD and SID in policy

RED, SID and MUD provide three potential bases for policies and remedial action at individual, community and social structural levels (Benzeval *et al* 1995) but they remain partial and incomplete like the explanatory frameworks on which they are based. Contemporary policy initiatives include an emphasis on reducing 'pathogenic' lifestyles, e.g. by eating a better diet, quitting smoking and increasing physical activity – with little reference to the social context within which such behaviour occurs (MUD-type solutions). This is combined with a plethora of

community-based activities, founded on the explicit assumption that multi-level, multi-sectoral partnership working at community level, e.g. through Healthy Living Centres and Health Action Zones, is the best way to tackle the problem (SID-type solutions). Most UK policy initiatives aimed at tackling poverty provide a better fit with a social integrationist discourse model, rather than a redistributionist approach. Work is seen as the best route into a healthier life, principally through the New Deal and Welfare to Work initiatives, even though being in paid employment work guarantees neither freedom from poverty for the individual nor integration for the community.

There are similarities between redistributionist and social integrationist approaches in seeking to narrow the gap between rich and poor, but the latter type of discourse is arguably dominant in contemporary social policy. Utilizing RED-type solutions aimed at poverty elimination is undoubtedly an uphill task, as this approach requires political will to action that extends beyond the life of any one parliament. Such policies are likely to meet with considerable resistance on both ideological grounds (e.g. accusations of nanny state-cum-social engineering tactics) and pragmatic grounds (e.g. unpopularity with certain sectors of the voting population). Although the radical redistribution of wealth and resources is not necessarily a revolutionary suggestion, (as capital is the not the only structuring feature of the complex contemporary social and economic order and its removal is neither a precondition for combating poverty, nor a guarantee of it [Alcock 1997]), the collapse of communism in the Soviet Bloc has arguably undermined such socialist ideals. Despite the weight of evidence indicating that inequalities in health can only effectively be tackled by policies that reduce poverty and income inequality (Shaw *et al* 2000), individualistic explanations and solutions to health inequalities are probably the most acceptable to any government. Such approaches are inevitably less costly (in economic and political terms) than redistribution of resources through increased welfare benefits for the poor and progressive taxation for the wealthy.

Table 1 below presents a simple heuristic framework, encapsulating the different perspectives on problems, solutions and action found within the RED, MUD and SID discourses on health inequalities. The explanations and proposed solutions to health inequalities delineated here all recognise the role of broader social inequalities: the key point is that their focus for action differs.

Table 1

Problems, causes, solutions and action

(from Carlisle S (2001) Inequalities in health: contested explanations, shifting discourses and ambiguous policies. *Critical Public Health* **11** 267-281)

Discourse Level	Source of problem	Explanatory level	Causal mechanism	Solution	Action level
Redistribution (RED)	Concentration of resources in higher socio-economic groups	Social structure	Inequitable social distribution of resources	Relieve poverty/ redistribute resources downwards	Socio-Economic Policy
Social integration (SID)	Social polarization of socioeconomic groups	Interaction between individual and social structure	Relative inequality and social stress in disadvantaged groups	Reduce gap/ increase social integration	Community
Moral underclass (MUD)	Lower socio-economic groups	Individual experience and action	Narrow resource margins	Help poor people develop coping strategies	Individual

CHAPTER THREE

POLICY, PARTICIPATION AND PARTNERSHIP

3.1 The Policy-Research Relationship

Health inequalities are, by definition, a policy problem (Forbes 2000) and the field of inequalities in health research is unavoidably politicised – through the political context in which such research is conducted, through the competing explanatory frameworks advanced, and through the linked discourses that propose or imply particular solutions to the problem. Yet scientific research is seldom explicitly aligned with political issues: the value of research findings is linked to their neutral status and presentation of the facts observed, the hypotheses verified (D'Andrade 1995). Nevertheless, political ideology has a crucial role in shaping both the commissioning of research, the type of evidence that gets accepted, and subsequent policy action (Navarro and Shi 2001). Nowhere is this revealed more explicitly than in the new (in 1988) Conservative administration's hostile reception of and response to the Black Report, commissioned under an outgoing Labour government. Despite widespread acknowledgement that our understandings of the pathways to health inequality remain partial and incomplete, and that the causes of health inequalities are complex, multiple and interactive, policy interventions still appear to be driven by the desire for improvement in relatively narrow indicators: premature mortality and morbidity (Scottish Office Department of Health 1998, Department of Health 2001a, National Assembly for Wales 2000a). Health is thus clearly constructed in terms of the absence of disease: a biomedical, rather than social framework for action.

Currently, activities in the UK are shaped by a number of key explanations that have been developed through large-scale, well-established health inequalities research. As outlined in Chapter Two, these embody multiple pathways – biological, psychological, social, cultural and economic - which implies that we need to move beyond current narrow indicators but also presents considerable problems both for measurement and, less obviously, for how individuals and communities are viewed. The lack of consensus around the causes of and pathways to social inequalities in health is not necessarily negative in itself. It may be argued that such diversity facilitates theoretical and methodological development and refinement within the multi-disciplinary research community concerned with the issue of health

inequalities. Nevertheless, this lack of consensus around causal mechanisms provides policy makers (and practitioners) with a dauntingly complex field from which to construct remedial action. What is the relationship between the inherent diversity and uncertainty of this research field and the policy-making response? A sceptical view of the effect of research findings on policy suggests that

'large social issues are usually resolved on the basis of party politics ... in general, research which bears out the predilections of administrators or their Ministers, is far more likely to be used than research which runs counter to them.' (Thomas 1983 p121)

Although the perennial response of the academic community is inevitably that more research is needed, the assumption that more information makes for better decisions may be mistaken. Booth suggests that the real question for policy makers may be, '*how to choose what to safely ignore?*' (Booth 1988 p229). He argues that the view from the frontline of policy making is that it is more rational to accept ignorance as a condition for action than to strive for certainty or to rely too much on the help which research can give. Research casts events in a fundamentally different light to policy and rarely provides the breadth of vision that policy makers require. Epidemiological research, for example, abstracts a number of variables from the wider context and examines them in a controlled and systematic way that bears little resemblance to the 'real world' of policy making. As Thomas says,

'it is one thing to analyze society's problems, quite another to suggest remedies which should be embedded in legislation' (Thomas 1983 p117).

Given the diverse nature of the field, it is unsurprising that no one discipline or research method has been able to provide unitary or definitive accounts of the cause of inequalities in health on which policy could be based. Even complementary (rather than obviously contradictory) research findings are open to multiple interpretations. In this respect Weiss has cogently argued that,

'(a)s more studies are done, they often elaborate rather than simplify. They generate complex, varied and even contradictory views of the social phenomena under study, rather than cumulating into sharper and more coherent explanation. The effect may be to widen and enrich our understanding of the multiple facets of reality, but the implications for policy are **less** simple and clear cut. When the diverse research conclusions enter the policy arena, the direction they provide for policy is confused. Advocates of almost any policy prescription are likely to find some research generalisations in circulation to support their point of view.'
[Emphasis in original] (Weiss 1986 p39)

In order to reflect on the implications, for policy making and health promotion, of such diversity in the field of research on inequalities in health, it is helpful to consider some general models of how research findings relate to social policy making processes. Booth outlines four models of the relationship between research utilisation and policy (Booth 1988). The 'purist' model (research generates knowledge that impels action) and the 'problem-solving/ engineering' model' (policy requirements drive research) are both rejected for their overly narrow view of the functions of research, simplistic view of the workings of the policy process, and inapplicability to the field of social policy (Booth 1988). Two more relevant models are the enlightenment and political models.

3.1.1 The enlightenment model

This suggests that research creeps into policy in diffuse ways by a slow process of osmosis, helping to shape policy makers' perceptions of reality and their understanding of possibilities for action. Research is used for ideas as much as data, subtly altering the parameters of the debate (Booth 1988). The evidence for continued social inequalities in health has accumulated for over a century in Britain, and contemporary social policies reflect this filtering effect. For example, in the shift from seeing socially stratified differentials in health as variations under Conservative administrations, to their explicit acknowledgement as inequalities under the present New Labour government. Booth argues that the reality of the fragmentation of power and responsibility means that many are involved in a slow, cumbersome process of policy decision-making (Booth 1988). In short, policy decisions are not made: they accrete. From this perspective, the enlightenment model is pertinent to the utilisation of research that merges with other forms of knowledge (including common sense) in shaping policy. However, although more sophisticated than purist or problem-solving models, the enlightenment model neglects to take account of how political discourse shapes the relationship between research and policy – in particular, what type of evidence is accepted.

3.1.2 The political model

This argues that research is a political activity in an adversarial system of policy making. Different groups, different interests and different ends are all involved in the policy process. Research can fulfil multiple purposes for policy makers: it can legitimate policy, vindicate action, function as a mechanism of control, have

symbolic value or decorative effect, or '*lace policy making with the appearance of rationality*' (Booth 1988 p289). Research can also be used as political positioning, as a tactical ploy to head off criticism, delay action, or as a source of ammunition for fighting political wars. I suggest that the health inequalities debate has arguably fulfilled most of these functions for all political parties in the UK. Within this model, research information is partisan – promoting some interests and undermining others. Given the diversity of interpretations surrounding inequalities in health, this model is particularly apposite: competing explanatory discourses are frequently used to invoke solutions of differing political significance and economic cost. Booth argues that such ambiguity is essential (from the policy maker's perspective), as it leaves policies open to a variety of interpretations compatible with many interests and allows flexibility in dealing with problems arising from implementation (Booth 1988). I suggest that the contested nature of the various explanations around health inequalities facilitates such flexibility. One result of this is ambiguous policy initiatives that conflate responsibility for action at national government strategy level with action at the community and/or individual level – a conflation that is both intuitively appealing and difficult to challenge. Health promotion is at the heart of many such initiatives.

3.2 Health Promotion: Activity and Process

Health promotion has been described, from a global perspective, as a necessary and timely reconsideration of public health rather than a new and separate discipline (Kickbusch 1986) but in practice the two may differ at the practitioner level. Health promotion practitioners are to be found working in a wide range of agencies and sectors: their efforts can be directed towards improving the health of entire populations, defined communities or groups, and single individuals (Mechanic 1999). In the latter decades of the 20th Century health promotion as a discipline increasingly sought a role in the development and implementation of healthy public policy at the local, national and global level (WHO 1988, 1991). In part, this was a response to the perceived over-emphasis on curative medicine and the behavioural approach to disease prevention that has characterised much health policy development (Kickbusch *et al* 1990). Health promotion is clearly multi-level, multi-sectoral and multi-disciplinary. As an activity it evinces characteristics of a visionary movement, concerned with equity and justice in society as well as environmental protection on a global scale (WHO 1997, 1991). These aspects of health promotion are shared with other so-called 'new social movements', reflecting

broader cultural trends towards the decline of mass/class politics in favour of a micro-politics of identity and protest (Forbes 2000).

Although it seems that few areas of contemporary life lack the potential for health promotion activity, the breadth of vision, arena and practice within the discipline raises questions of control and power that are not always addressed explicitly (Adams and Pintus 1994). Seedhouse, for example, points out that while health promotion may be done on request, it may also be carried out without the intended recipient or recipients asking for it (Seedhouse 1997). Critics perceive a sharp contrast between health promotion rhetoric of community participation and co-operation and its paternalistic role in constructing people as uninformed, ill-educated and in need of the services of interventionists who claim to know better (Wenzel 1999). The multidimensionality of health promotion is well known: the term encompasses both a body of theory and practice (Jones and Sidell 1997) and an ideological product of modernity and postmodernity (Kelly and Charlton 1999). Two other major characteristics are neatly summed up by O'Brien when he suggests that health promotion represents an '*almost ideal discursive system... emphasising autonomy and empowerment*' and '*a movement intrinsically in tension with itself, attempting to reconcile the requirements of different actors*' (O'Brien 1997 p201-202). These and other contradictions inherent in the discipline are familiar to its practitioners (Naidoo and Wills 1998, Scriven and Orme 1996).

Cribb usefully distinguishes between health promotion as a relatively circumscribed field of specialist activity, often related to specific interventions, and health promotion as a process, encompassing general sociopolitical processes including the public policy context as a whole (Cribb 1997 p236). The distinction between activity and process is a useful conceptual tool with which to consider a number of key issues. For example, health promotion activity is not solely the preserve of specialists. Health inequalities are linked to wider social inequalities and disadvantage and many different disciplines, including health promotion, are involved in responding to the problem. The English and Scottish White Papers on health have implications for sectors other than those with overt responsibility for health and health care (Department of Health 1998b, Scottish Office Department of Health 1998). Conceptualising health promotion as an activity broadens its scope beyond disciplinary boundaries as, obviously, many organisations and agencies outside the formal health services are involved in health promoting activity, such as local government. Conceptualising it as process, however, potentially extends the

remit of health promotion into every sphere of life and enables us to see it as an elastic canopy capable of sheltering diverse practitioners, multiple organisations and apparently incompatible theoretical and political philosophies (Furbey 1998).

Tackling health inequalities is now a policy priority for all the UK governments and health promotion is a central component. Policy documents have stressed the importance of individual health behaviours and lifestyles, based on the assumption that individuals control their own lifestyles and that approved changes will improve health outcomes (Department of Health 1992). More recent policy documents have begun to acknowledge the role of poverty and social inequality in shaping life circumstances and impacting on health (Department of Health 1998b, 1999b). Nevertheless, targets remain firmly fixed on reducing the 'Big 3' – cancer, heart disease and stroke (Scottish Office Department of Health 1998, Department of Health 2001a). Recent policy documents also emphasise the importance of community engagement in initiatives aimed at tackling poor health in poor neighbourhoods (Social Exclusion Unit 2001, Scottish Executive 2002a, 2002b, National Assembly for Wales 2000b). Health promotion as a discipline/form of specialist activity is well placed to lead or advise on initiatives relating to lifestyle and life circumstance improvement and community development work, but health promotion as a social process is arguably of even greater utility to policy makers. For example, the surveillance critique draws attention to the fact that health promotion makes people feel responsible and culpable for their health status (Nettleton and Bunton 1999). From this perspective, health promotion can be seen as

'one of many forms of contemporary governance which, through the establishment of appropriate social identities, forms a crucial dimension of social regulation.'
(Nettleton and Bunton 1999 p53)

The surveillance critique of health promotion argues that social and cultural pressures intersect around actual or potential health and illness, and that people come to feel responsible for their own health status (Fitzpatrick 2001). In the name of health promotion, economic and political interests and priorities become embedded in the regulation of multiple aspects of people's lives (O'Brien 1997 p253). In effect, advocating an individualistic lifestyle-driven form of health promotion, as promulgated in policy documents, may displace advocacy for inevitably contentious structural change. However, the principles that underlay health promotion and guide practitioners' work also emphasise the crucial importance of processes of *community* participation, not just individual behaviour change.

3.2.1 Community participation in health promotion

It is well over two decades since the formation, at the Alma Ata conference in 1978, of the concept of community participation in health. Advocates of participation now have a greater appreciation of its difficulties and complexities and the concept and practice has been exhaustively discussed in multiple case studies. Many of the debates over participation have been conducted between anthropologists, on the one hand, and epidemiologists, managers and policy makers on the other (Morgan 2001). The former group are typically concerned with conceptual issues, such as what community participation means to those involved in implementation, whilst epidemiologists, managers and policy makers are concerned with how to operationalise, implement and measure levels of participation. Anthropological research into community participation has emphasised the importance of context and culture – of understanding the social and power relations through which participation must be achieved, and what participation means within a particular setting.

Although the concept of community participation in health may be attributable to large multinational health organisations like the World Health Organisation, its implementation is the responsibility of local programme initiators, who may find it far from straightforward. Morgan suggests that, because participation usually involves a set of material demands (e.g. redistribution of resources), its meanings will be contested at the levels of rhetoric and social practice (Morgan 2001). Jewkes and Murcott note that the literature on community participation in health appears to have developed in isolation from discussions of community in analytic social commentary, and that this has produced a number of confusions and ambiguities, to the extent where they call for the concept of community participation in health to be re-thought (Jewkes and Murcott 1996). I outline below some of the key issues around community participation in health promotion documented in the literature.

Zakus and Lysack relate the difficulty of finding evidence of successful community participation in health-related activities to a number of factors, not least the great variety of health initiatives using community participation as a strategy; the complexity of community participation processes; and problems around what community participation is understood to mean, as this varies according to context (Zakus and Lysack 1998). They argue that although community participation is accepted as guiding principle in health policy and practice, it has managed to elude significant critical analysis and is beset by an inherent conceptual ambiguity that underlies many failed expectations (Zakus and Lysack). Despite its widely reputed

health and social benefits, they suggest that there is an accompanying lack of empirical studies that specifically demonstrate these benefits (Zakus and Lysack 1998). They and other writers note that community status gets 'conferred' on localities and groups and that the concept of community attracts positive language and powerful images of harmony, equity, reciprocity and mutual concern. Such language may disguise less egalitarian undertakings: in the absence of investigation of those who are called, or call themselves, communities, what is the basis for the assertion of community status? Do communities have the capacity to contribute and participate? Do they even want to, or may other priorities displace health on their agenda?

Purported benefits for individuals and communities include: a heightened sense of responsibility about health, gains in power through new skills and control over resources, more equitable relationships between clients and providers, greater diffusion of health knowledge in the community, use of indigenous expertise, and enhanced future employment opportunities (Rifkin 1996). Services also benefit from community participation – they may be provided at lower cost, lever in additional resources and/or volunteers, lead to a better determination of need and more appropriate activity or decreased alienation of clients. Rifkin argues that the concept of community participation in health is based on a set of fundamental assumptions:

- that people will make better use of existing health services and ensure sustainability of new services by being involved in decisions about development.
- that people will be able to contribute scarce resources of money, manpower, materials to supplement resources allocated for health care;
- that people will change their poor health behaviours when they have been involved in exploring the consequences of this behaviour;
- that people will gain information and experience which will help them gain control over their own lives and thus challenge the existing social, political and economic systems which have deprived them of this control (Rifkin 1996).

Unfortunately, community participation does not seem to have fulfilled these expectations. Why does this gap between rhetoric and reality exist? For Rifkin, the above assumptions place unrealistic expectations on what community participation can achieve (Rifkin 1996). She also suggests that definitions of community participation remain deliberately vague and flexible, that there is as yet no common agreement about how to develop community participation and that we lack a

common frame of reference. However, she identifies two particular frames of reference as dominant in thinking about health improvement since WWII, which in turn provide for two different approaches from health planners:

1. The target-oriented frame, rooted in western scientific tradition and a biomedical model of health and illness. Community participation is viewed as a means to improve the health status of people, measured in rates, and outcomes are seen in terms of the product. Although top-down, the target-oriented frame of reference also aims to provide more acceptable services and sustainability.
2. The empowerment frame, rooted in concerns over inequity in resource distribution. This frame of reference for community participation views it as a means for people to gain information, access to resources, and control over their own lives, but also as an end in itself - a dynamic process that cannot be measured in numbers of people involved or rates of change. Within the empowerment frame, planners address health improvement politically – community participation is seen as a catalyst for social change.

Rifkin suggests that the two frames are not only too constricting but are burdened with unrealistic expectations of community participation in terms of both process and product (Rifkin 1996). Analysing community participation in terms of either frame restricts our understanding about and expectations of community participation, because both view it as an intervention and analyse it as linear and causal. She suggests that community participation might be better viewed not as an intervention but as a result of a learning process by which outcomes are the result of adapting to change as change occurs (Rifkin 1996 p87). This emphasis on the importance of learning is found in much of the literature on both participation and partnership.

Morgan, in common with other writers in the field, notes two paradoxes in the development of community participation: the standardisation of approaches (contradicting the move towards more flexible and context-specific methodologies); and the technical, rather than empowerment-oriented, use of participatory methods (Morgan 2001). Both suggest a superficial understanding of the original empowerment principles underpinning the concept of participation. It seems that the community participation model, though popular, is flawed because many initiatives do not deal with the complexity of community differences – age, economic status, ethnic grouping, religious faith, gender etc. If the community is treated as a benign entity with shared goals and values, relationships within the community mean that

some individuals can be isolated or harmed. Even work with small, apparently simple communities may be difficult – groups may mobilise around issues of particular concern but trying to engage them in others, such as health, may be difficult. Groups have widely differing opportunities to present their views, and some may be muted.

One of the most recent – and stringent - critiques of the focus on community involvement in health draws on the experiences of Health Action Zones (Crawshaw *et al* 2003). Crawshaw *et al* argue that initiatives such as HAZs allow experts to guide the community in becoming responsible for their own health – individualising health not just so that the individual can manage their own well-being, but also so that they have a duty to participate in the well-being of their community. New initiatives like these do not represent a departure from previous approaches to tackling health inequalities but are a continuation of discourses from 1960s urban policy and development of the new public health from the 1970s. The new focus on place rather than people still fails to address the structural nature of inequality. From this perspective, processes of community development and discourses of empowerment and engagement act as a new moral technology aimed to regulate and survey the most vulnerable members of communities (Crawshaw *et al* 2003 p38). Crawshaw *et al* argue that ‘third way’ politics operationalise community as a means of reinventing the relationship between the individual and society, championing civic responsibility, and appealing to notions of active citizens with rights, responsibilities and the duty to participate (Crawshaw *et al* 2003 p36). In short, community is currently promoted as a panacea for reconstructing civil society.

This reinvention of community as a site of social and political action is influential in both policy and academic discourses, leading to the emergency of new concepts such as social capital and capacity building. Within policy discourses, community is a resource to be accessed, the target for interventions, and a tool for both the political left and right (Crawshaw *et al* 2003). Rose suggests that community is a site for the new territorialisation of political thought: the social (society as a collective macro-construct) has been reconfigured and replaced by community as a new site of governance of the conduct of individuals, as the state has failed to achieve this (Rose 1996). Responsibility is no longer understood as a relationship with the state, but as one of obligation to those close to the individual – family, neighbourhood, workplace, community. Community-based partnerships can therefore be viewed as a potential site of political action – working towards health improvement through

fostering new partnerships between service providers and facilitating bottom-up, community-led solutions to health inequalities. A diverse and innovative range of programmes can be understood as capable of addressing the broad determinants of health, but this presents challenges both for implementation and evaluation. Crawshaw *et al* suggest that the underpinning political philosophy is one of communities having to be prepared to invest in themselves (Crawshaw *et al* 2003). This involves classic formulations of neo-liberalism: self-government, choice, self-promotion, and control over one's fate. As part of state-sponsored processes, schemes are often designed to work within existing power structures rather than challenge them and methods rest on the following fundamental assumptions:

- Needs often vary as a result of geography and certain areas are more in need of intervention others because of factors such as high levels of unemployment, poor health or social exclusion
- Such communities are often disempowered and need additional help to manage their own lives better
- Communities must be involved in identifying their own needs and the possibilities for improvement
- Communities can be mobilised to work for themselves through the guidance of experts skills at bringing about participation, involvement and change (Crawshaw *et al* 2003).

These are methods employed in a variety of settings for over half a century. However, Crawshaw *et al* argue that community development is not capable of challenging the structural factors which may be the root cause of the community's disempowerment: it starts where people are at, and remains where people are at, so is not about the redistribution of power (Crawshaw *et al* 2003). Initiatives like HAZs tackle health inequalities at the micro-level to build capacity and allow people more control over their own health, working with specific groups on the basis of shared place, experience, ways of life or characteristics. Such communities are typically identified as disadvantaged and specific groups within them are targeted, such as young mothers and drug users, but it is questionable whether such coherent communities exist in conditions of high/late/post-modernity, which theorists tend to describe in terms of individualising processes and the disintegration of communities as a result of de-traditionalisation and globalisation (Beck 1992, Giddens 1999). Communities may resist such initiatives because of their limited vision, short-term funding and the danger of creating unrealistic expectations.

The original impoverishment of the public realm by the politics and ideology of the New Right may be extended under some aspects of third way policies, where community is promulgated as a solution to the disintegration of broader public society and the new comunitarianism becomes a means of reconstructing civil society at this devolved level (Crawshaw *et al* 2003). As Farrant has pointed out, the discourse of community can be employed as a mechanism of social control, safeguarding the interests of the ruling class through reinforcing power relations within an illusory discourse of community empowerment and self-direction (Farrant 1991). This discourse masks the true nature of power relations and places responsibility for health firmly at the feet of the most disempowered (Crawshaw *et al* 2003 p43). These debates problematise the existence of community as a construct and the political motives behind its championing as a social form, arguing that community has been appropriated as a means of accessing individuals to involve them in projects which foster taking responsibility for their own health. It is questionable whether community involvement can ever be achieved in the way prescribed by contemporary third way policy. Some argue that such strategies are typically peripheral to the main provision of health services: they are not a key element of healthcare strategies but an attractive - and ultimately ineffective - add-on (Farrant 1991 p435).

3.2.2 Defining 'community'

If community participation in health promotion raises some thorny issues, operationalising and implementing the concept of community for practical working purposes is no less fraught. As Jewkes and Murcott have observed, *'the deceptively simple notion of 'community' is one of the most contested in the social sciences'* (Jewkes and Murcott 1996 p555). They argue that the debates about community are dominated by normative prescription rather than description: what community should mean, rather than what it does. The broad distinctions between community-as-locality and community-of-interest are widely accepted but fail to capture the essence of the problem which is, who is defining 'the community', on behalf of whom, for what purposes, in what particular circumstances, and with what consequences? This approach treats the idea of community as a folk model – a topic of investigation in its own right, rather than as a tool of social analysis, drawing on pre-existing assumptions. Although multiple meanings of community can be found in the analytic social science literature and in empirical data, Jewkes and Murcott suggest that in the

health literature, the meanings of community tend to be constructed by those responsible for operationalising and implementing the concept in terms of community participation (Jewkes and Murcott 1996). These workers often regard themselves as non-members of the target community and the views of putative members are not taken into account in their constructions.

Anthropologists have long represented community as constructed by its members, and argued that the concept of sharing is fundamental to the meaning people attach to their own community. Such perceptions of sharing are central to the delineation of boundaries around and between groups, encapsulated in Cohen's conceptualisation of communities of aggregation and relation (Cohen 1985). The notion of an 'aggregational community' signifies a group of people who have something in common that distinguishes them from others; the notion of a 'relational community' expresses the opposition of one community to others. Both invoke the concept of boundaries, of sharing *and* difference. Boundaries can be both tangible and mental constructs, with imagined and objective manifestations: they also have symbolic value, in that they provide people with a repository of meaning. In Cohen's words, *'the distinctiveness of communities and, thus, the reality of their boundaries, lies in the meanings which people attach to them, not in their structural forms'* (Cohen 1985 p98). This perspective argues for a shift towards an interpretative representation of what community means for its members. Community membership, argues Cohen, is highly context specific and temporal (Cohen 1985). In the health literature, however, communities are *assumed* to be coherent units whose members could operate together for shared purposes – such as expressing health needs and planning services.

Such assumptions of shared needs pre-empt debates about whether members of a community do share them. For example, Macqueen *et al* claim that an appropriate definition of community for participatory purposes is *'a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings'* (Macqueen *et al* 2001). However, having raised their heads above the definitional parapet they then confess that, although the participants in their research tended to define community in this way, people with diverse backgrounds experienced community differently. These writers, in common with many others, note that contradictory or incompatible assumptions about community are likely to invalidate models for collaboration.

Jewkes and Murcott point out that sharing is only assumed when community is constructed by non-members, rather than being integral (Jewkes and Murcott 1996). In their research with community workers, such assumptions were generally discovered to be unfounded when put into practice. In their ethnographic study they looked at what 'community' means to those who work with it in their professional lives. Although their informants could be assumed to be members of multiple communities in their own right, they all spoke of working with communities using metaphors of distance – accessing, reaching, getting hold of, meeting, tapping into etc. In other words, speaking about a notional community with which they worked but were not members: on the outside, looking towards the community. Jewkes and Murcott claim that, despite recurring themes, many of the definitions they found were conflicting and suggest that what one person regards as a community, another would not (Jewkes and Murcott 1996). Thus there is a singular lack of specificity and agreement about what the community whose participation is regarded as so essential, actually is. They found that their informants used plural meanings, continuously switching between different ones, or juggling several simultaneously. This leads them to comment that *'if the 'members (of a defined community) were to perceive themselves to be a community, it would surely be coincidental'* (Jewkes and Murcott 1996 p560).

Constructions, by non-members (i.e. practitioners/researchers), of communities and their boundaries are tested in the course of their daily work against the notions of community as envisaged by community members. From Jewkes and Murcott's research, it appears that non-members fail to impose their constructions – community members resist the imposition of alternative boundaries. Such boundaries can be negotiated/changed, however, if benefits are likely to accrue to the community. Those working to promote community participation in health are forced to adjudicate on competing meanings in order to operationalise the concept (Jewkes and Murcott 1998). What are the implications of particular choices for what may be achieved by the participating community or group? The critical analysis of community and participation outlined above suggests that an important part of the value bestowed on working with communities is either misplaced or inaccessible. It also suggests that recognition of the differences in the construction of communities by non-members and members is essential, not least because it demands a fundamental and critical re-thinking of the concept of community participation in health promotion (Jewkes and Murcott 1996 p562). These writers argue that we need to drop expectations that community participation will either radically improve health or be the catalyst for

structural change (Jewkes & Murcott 1996). Expectations should be based on particularistic responses to specific situations, not universalistic models, because although processes might have general characteristics, solutions will be local.

3.2.2.1 Engaging disadvantaged groups/communities

Projects to improve health may be working in a context where their target group or community is disinclined to participate, for a variety of reasons. There may be little interest in participation from communities/groups that have a history of consultation then being ignored, which can lead to reluctance, if not outright refusal, to participate. Participation may be an extra burden of participation for disadvantaged groups: it may be easier for privileged groups to take part (Zakus and Lysack 1998). It has frequently been suggested in the literature that when ordinary individuals participate alongside project managers and other professionals, those with intimate knowledge of the system and greatest professional prestige will have greater impact on processes than their numbers would suggest. Zackus and Lysack also argue that the ideology of community participation often, unintentionally, ends in consolidating the power of professionals rather than achieving the ideal of broad-based local involvement (Zakus and Lysack 1998).

Anthropologist Lynne Morgan says that, paradoxically, neither of the two most widely used notions of participation call for it to be initiated entirely by community members; each entails some degree of outside motivation (Morgan 2001). 'Encouraging participation', practically by definition, assumes something that has come from above/outside. The uncomfortable fact that participation may require external prompting needs to be balanced with an acknowledgement that marginalised or disenfranchised communities cannot initiate participation precisely because they have no power. Participation may also be restricted if the goals of a project are perceived as irrelevant: disadvantaged groups may have other priorities than health. For example, fear of crime and racial harassment may be the main issues for minority ethnic groups (Kai and Hedges 1999). There seems to be a broad agreement within the literature that a community or group's level of participation reflects the underlying level of power in its possession. However, the issue of the balance of power within disadvantaged communities and within community organisations is persistently troubling: pre-existing tensions between segments of the population may be exacerbated, not ameliorated, by participation. It has been suggested that, to be successful, community participation needs to become an integral part of a

disadvantaged or fragmented community's common experience, not remain as a structure imposed from outside (Zakus and Lysack 1998). Not only does this require a better understanding of the nature of communities and of human interaction and community participation, it is also likely to take considerable time. Documented difficulties in working with fragmented/excluded groups include low numbers participating, a restricted range of participants, difficulties in recruiting and maintaining participants, declining rates of participation over time, and limited target group influence and power (Boyce 2001).

3.3 Community Representation

Working with the community (however large this may be envisaged as) normally translates into working with established groups, thus avoiding definitional tensions by drawing on a folk model of 'communities within the community'. There are clearly important differences between the ideological notions that non-members have of community and how they experience it in practice. The ideology of sharing and coherence renders it possible for some community members to speak on behalf of others – obviating the need to work with/consult everybody. Whilst this implies a substantial degree of, if not absolute, homogeneity, it contrasts with practitioners' knowledge of what communities are like – heterogeneous, with relationships characterised by competition and conflict. One 'community' or group may be designated as the problem or targeted for action by 'the community'. Given likely differences in gender, education, experience, social class, values and priorities, this is not surprising but does have important implications for 'working with' community. Assumptions of sharing and coherence may be well founded with respect to some areas of life, but not others:

'people engaged in assessing the health needs of 'the community', or working with the community to identify its own needs, might find that the needs presented differ substantially from those which might emerge if the 'community' was engaged in a different way or a different part engaged.' (Jewkes and Murcott 1996 p562)

Depending on the size of the community, participation may take the form of representation by a smaller number of individuals. Zakus and Lysack suggest that there are innumerable difficulties relating to such representation, not least the potential for conflict between personal, community and health system agendas (Zakus and Lysack 1998). Minority segments of the community may not share the values and priorities of dominant or decision-making segments. In these contexts, is

representativeness the key or is it the capacity for meeting the needs expressed? Methods used to select organisational members and the degree to which they represent local issues are crucial in determining the perceived legitimacy of the representatives in the eyes of the population served (Zakus and Lysack 1998). Groups may have conflicting views, and objections to participation include that of atypical representatives. The rise of citizens juries is a recent example of how representative community participation can make decisions about health-related policy, although it has been suggested that lack of congruence between national and local policy concerns may undermine the legitimacy of healthy public policy-making at local level (Macdonald 1998).

Community participation has been characterised as '*the essence of a democratic health promotion approach*', and community representation is an important part of this (WHO 1991). A key question is, therefore, how do representatives of communities get elected to the steering groups and other organisational structures identified by a number of writers as crucial to the success of community health promotion? Jewkes and Murcott argue that the demands of the representative's role are such that particular interpretations of community achieve ascendancy – in particular, that community may be interpreted as part of the voluntary sector, but that this may compromise a democratic approach (Jewkes and Murcott 1998). This is not necessarily seen as desirable by those implementing health promotion initiatives – it is a pragmatic response to the multiple complications outlined above. One of the main difficulties is the construction of the role of community representative as being to represent the 'community view' to steering groups, which conflicts with people's experience of communities as heterogeneous. Community workers can thus find themselves set up to fail – being expected to adopt the role of the good representative and present their view of their constituency, whilst knowing that there is no coherent community view most of the time (Jewkes and Murcott 1998). The literature suggests that the roles of community representatives are very difficult, perhaps intrinsically impossible. In the absence of formal election processes they may lack a mandate from the general population they purport to serve. Projects may recognise that community representatives may not always be very representative, but lack the ability to do anything about it. Participants (and outsiders) may be concerned that the 'wrong' groups are benefiting. Those whose health problems are, ostensibly, being addressed in project work may not be round the partnership table. The critical literature briefly addressed here suggests that projects need to avoid conceptualising community representatives as representing a notional community, and to stop

pursuing 'what looks like some holy grail of community control' (Jewkes and Murcott 1998). Honest appraisal of problems and, in particular, a thorough discussion of any failures that occur, is seen as necessary if learning rather than window-dressing is to be a realistic outcome.

3.4. Policy and Partnership

'Partnerships for health will be required at different levels: international, country, regional and local. They are needed for the formulation of health policy; for increasing people's perception and understanding of health issues; for developing the potential will for action; for target-setting, carrying out policies and programmes and shaping service delivery; increasing the selection of priorities and resource allocation; and for monitoring and evaluation of outcomes.' (WHO 1999 p16)

The critique of community participation in health outlined above is continued to some extent here as, although this section focuses mainly on the literature on developing multi-sectoral partnerships for health, these invariably strive for some element of community involvement. Despite tremendous resources expended on individual risk factors, disparities between the health of those who are most advantaged and those with fewer economic and social privileges have continued and in some cases have increased (Schultz *et al* 2002a). Gillies argues that individually focused behavioural interventions have an impact, at best, on an average of one in four of those who participate – and that these tend to be the better off, better motivated and better educated (Gillies 1998). There is therefore the potential for health promotion to increase inequalities in health. This understanding focuses attention on factors that affect health but are beyond the control of individual influence on behaviours or experience – the social determinants of health. Widespread acceptance of such social determinants points to the need for policy and action on health inequalities to extend beyond the limited domain of professional health practice (Marmot and Wilkinson 2000).

Within the UK, the Labour government has placed increasing emphasis on partnership working as the key mechanism for delivery of policies aimed at tackling a range of enduring social problems, acknowledging the limitations of single agency approaches, and many policy initiatives now have a strong health promotion focus (Pearson 2001). Gillies, in her review of partnership within both developed and developing world, defines a partnership for health promotion as a voluntary agreement between two or more partners to work co-operatively toward a set of

shared health outcomes, though she draws a broad distinction between micro- and macro-level partnerships (i.e. between collaborations which do not/do seek to affect the structural determinants of health) (Gillies 1998). The idea of partnership is now at the centre of the policy arena: it is no longer an option for many public sector organisations, which now have a statutory duty to work in partnership (Department of Health 1998b). Reid identifies a first and second wave in the UK partnership policy agenda: the first relates to former Conservative government policies of privatisation, market hegemony and the new public management, all of which de-emphasised the role of local authorities. The second wave, under New Labour, emphasises the provision of help for vulnerable individuals and disadvantaged communities and restores local government to a central place (Reid 2001). Partnerships play a pivotal role in the modernisation agenda of New Labour, supported by financial incentives to bring potential partners together (Balloch and Taylor 2001). Partnership initiatives across multiple fields are required to bid for government funding through multi-agency partnerships. Collaborative partnerships between the different professional groups concerned with promoting health are not a new phenomenon. What is relatively recent is UK Government recognition of intersectoral collaboration and partnership as an effective strategy for promoting the nations' health, to the extent where this emphasis has been described as enshrined in both rhetoric and policy (Scriven 1998b). A key characteristic of contemporary partnerships for health is the focus on public participation, reflecting ideals of participatory democracy and equality between partners. For example, joint neighbourhood working is at the heart of the National Strategy for Urban Renewal and New Deal for Communities (Social Exclusion Unit 2001).

Research from the evaluation of complex community wide initiatives in the United States of America provides a useful insight into the potential for large-scale partnership work. In the USA, the Urban Health Initiative funded by the Centres for Disease Control have established three substantially funded Urban Research Centres to address the social determinants of health (Schultz *et al* 2002a, 2002b). These research centres have created strong partnerships between the academic institutions, public service organisations and community-based organisations, on the basis that traditional research and intervention approaches have been criticised for their failure to effectively engage community assets such as knowledge of local values, leadership, social networks and experience in the process of designing and implementing interventions. Traditional approaches have often served to decontextualise the field and failed to engage local residents who are most affected in

the process of understanding solutions to the health and social problems they faced and participatory approaches arose, in part, to address such shortcomings. Community-based public health/health promotion partnership approaches have been developed in recognition of the ways that differences in social status can influence the ability of participants to work together effectively.

Schultz and colleagues argue that partnerships using these approaches recognise that social inequalities as fundamental determinants of health, are not abstract and distant entities, but are relationships that are produced and reproduced through human interaction (Schultz *et al* 2002). Thus, inequalities shape interactions between professionals and community members (e.g. in differences in access to resources or in terms of what counts as valid knowledge), which has implications for the development of equitable and productive working relationships. Schultz *et al* place an emphasis on participation, equity and the integration of research and practice as ways of addressing the particular challenges that face residents and community-based organisations within economically marginalised communities (Schultz *et al* 2002b). Many of the interventions described address change at individual or small group level, which may be viewed as a limitation when the objective is to challenge the broader social determinants of health. On the other hand, these foci emerged from the expressed need of community residents for concrete action to address immediate health and social concerns. Schultz *et al* argue that concrete products arising from collective efforts are an important aspect of building solidarity among members of a community: as partnerships develop and mature they may move from identification of specific individual or small-group concerns and strategies, towards initiatives that address more macro-level causes of those concerns, that is, the underlying social and economic processes that influence social conditions.

Some central elements underlie these successful partnerships: each partnership site possessed a theoretical model of the social determinants of health that made explicit the links between social factors and health and guided the partnerships' moves towards addressing social policy and broader community change. Early stages were characterised by efforts to build trust and relationships as a foundation for partnership action, and participation was viewed as a means to the end of offering meaningful opportunities to influence choice of projects, design and implementation, and the research and evaluation questions asked.

3.4.1 Critiquing partnership work

One of the consequences of the contemporary focus on joined-up health and social (welfare) policy is to encourage the engagement of individuals (who are perceived as responsible for self-improvement) and of communities, largely through the medium of multi-sectoral partnerships, which become responsible for local improvements in health and the social fabric. However, this is arguably the most challenging aspect of partnership work, as power differentials are at their greatest between professionals and lay people and between formal organisations and community groups (Popay and Williams 1998). For example, Little *et al* note the risk of discursive incommensurability when different (lay/professional/managerial) voices are brought together in partnership/board work (Little *et al* 2002). In this context, the personal anecdotes used by lay members tend to carry little weight compared to the numbers talk or pooled experience of professional/managerial others.

Whilst the problems of engaging formal health organisations in multi-agency partnership and collaborative work are well known, the pivotal role granted to local authorities in leading social inclusion partnerships has also been subject to critical review. Writing of anti-poverty strategies, for example, Pearson notes that local government is dominated by the demands of funding and bureaucracy, that representatives on such partnerships may feel that their frameworks and boundaries are set by local government outside the partnership agenda, and that the potential for changes in the balance of political power through local elections produces ongoing instability (Pearson 2001). In her analysis of how stakeholders in Scottish Urban Partnerships conceived of their inter-relationships within the contemporary political context, Hastings suggests that the term partnership is overused, ambiguous and politicised (Hastings 1996). She concludes that urban partnerships are limited applications of the potential of the partnership approach and that access to funding is increasingly limited to groups or organisations that are willing and able to form partnerships.

Some write of the positive aspects to the trend toward partnership: political commitment to combating poverty, deprivation and poor health widens the policy agenda beyond issues of material poverty to address the multiple and interrelated difficulties found by people facing social exclusion (Pearson 2001). Active citizenship is promoted through the intention to engage and empower individuals and groups otherwise excluded from political processes (Balloch and Taylor 2001). Reid notes, however, that the concept of partnership is now also being used in a 'more



abstract and nebulous way, as a doctrinal component of the new social policy and regeneration agenda' (Reid 2001 p79). Partnerships may adopt exclusivist or pluralist structures (restricted to local elite or open to every sectoral and political interest) (Smith and Beazley 2002). Balloch and Taylor's extensive review of partnership work also argues that these arrangements actually leave existing power relations intact: communities remain on the margins of decision-making and smaller partners lack the resources to engage effectively with better-resourced and larger organisations (Balloch and Taylor 2001). Partnership work at community level, then, is subject to enduring tensions, notwithstanding its popularity at the policy-making level.

3.4.2. Power and participation

The issue of power underpins the concept of partnership. Mayo and Taylor draw briefly on Lukes' conceptualisation of the three dimensions of power in their discussion of partnerships (Lukes 1974 in Mayo and Taylor 2001 p40-41). The visible aspect of power, the first dimension, is that of decision making and therefore the capacity to shape outcomes. The second, that of nondecision, relates to the ability to shape the agenda, to limit the range of alternatives to be considered, or to ensure that certain issues never emerge at all. The third dimension is widest of all and relates to the power of ruling interests in society to define and shape the framework of debates, and to place particular issues as beyond the realms of the possible or even the desirable. These authors suggest that contemporary partnerships confronting multiple social problems provide ample illustration of all three dimensions. These dimensions of power are particularly relevant to the discussion, in Chapter Two, of the discursive constructions of health inequalities in research and policy and the potential for their solution.

In her extensive review of both published literature and unpublished case study reports, Gillies draws on evidence which strongly suggests that alliances or partnership initiatives to promote health across sectors, across professional and lay boundaries and between public, private and non-government agencies, *do* work - in tackling the broader determinants of health and well-being in a sustainable manner, and in promoting individual health-related behaviour change (Gillies 1998). Interestingly, Gillies suggests that the published literature on partnerships does not reflect the extent to which health promotion in practice is tackling these determinants, whereas many of the (unpublished) cases studied were clearly

identified macro- rather than micro-level partnerships (i.e. tackling the broader social determinants of health. (Gillies 1998). The review of best practice in health promotion drawn from the case studies endorses a commitment to multi-sectoral alliances/partnerships and lay involvement in agenda setting, implementation and policy-making. Foundational elements of successful partnerships included relevant needs assessment, combined with the establishment of committees crossing professional and lay boundaries to steer, guide and account for the activities and programmes implemented.

Unlike the published literature, case study outcomes focused on initiating and maintaining partnerships and on connections in communities. Other key outcomes from the case study review included getting agencies to work together; engaging local people; training and supporting volunteers and networks; creating committees; capturing politicians' interest and sustaining political visibility; resource allocation; reorienting organisations and services; promoting flexibility in working practices; and undertaking needs assessment as a way of identifying priorities and galvanising interest. In sum, successful outcomes required a concern for the practicalities of changing the context within which health promotion takes place, and in sustaining such changes. In the case studies, policy development was seen as a major achievement and indicator of success. Gillies suggests that the greater the level of local community involvement in setting agendas for action and in the practice of health promotion, the larger the impact: durable local structures to facilitate planning and decision-making are key factors in successful alliances, whilst volunteer activities, peer programmes and civic activities help to ensure maximum benefit from community approaches. In sharing power, responsibility and authority for change, partnerships also provide a means for reflection and dissent from local people (Gillies 1998). Her review found that the existence and implementation of policies for health promotion activities was crucial to sustainability at all levels, from neighbourhood to regional and national levels.

Nevertheless, some interesting caveats are attached to this largely positive message: she suggests that for partnerships to succeed in promoting increased community participation for control over the wider organisational and systemic influences on health (as well as individual factors), there must already be measurable co-operative civic engagement, or social capital, in communities. There should also be a minimum level of infrastructure, with not too much hardship, to allow for the possibility for the development of social trust, exchange and co-operation for mutual benefit to happen.

This level of minimum requirements for success perhaps helps to explain other research findings that fail to endorse partnership so wholeheartedly. For example, Pickin *et al* note a number of factors restraining strategic level community-statutory sector partnerships (Pickin *et al* 2002):

- Professional attitudes that view the public as ‘passive consumers of care rather than co-producers and maintainers of health, an over-estimation of professional expert knowledge, and a paternalistic approach to lay people.
- Power imbalances that work to exclude lay people from strategic decision-making processes.
- Inflexible working practices and structures in the statutory sector, rather than responding to community structures, and a lack of skills and time for managers to engage with communities.
- Funding processes that do not allow sufficient time for public involvement, especially if the community is fragmented or needs to build its capacity for engagement. Short-term funding means that partnerships are difficult to sustain.

They, and others, have summarised the main problem as being the lack of a strategic approach to working with communities (Pickin *et al* 2002):

(u)nderstanding the relationship and power balance between individuals and communities on the one hand and statutory organisations on the other is crucial to the promotion of the health and well-being of a population. Policies must develop the capacity of statutory organisations to develop more participatory and equal relationships with local populations. However, to do this will require a radical shift in how most such organisations think and behave. (Pickin *et al* 2002 p40)

They also identify a range of factors that contribute to this lack of strategy: the community’s capacity to engage; the skills and competences of organisational staff; a dominant professional service culture; and the dynamics of local and national political systems. They suggest that the statutory sector lacks the capacity to respond to active communities and note conflict between the entrepreneurial culture of the voluntary sector and the strong public sector ethos of ensuring accountability for public money within the statutory sector. They argue that the latter still tends to operate with the concept of deficit communities.

Smith and Beazley’s research on the nature of community involvement in regeneration also foregrounds the concepts of power, participation, and partnerships (Smith and Beazley 2000). They argue that how partnerships are set up, who is

involved and for what reason are crucial to the perceived representativeness and legitimacy of partners (Smith and Beazley 2000 p865). The selection of partners is viewed as particularly problematic for community representatives, who may experience tensions between a culture of consultation on the one hand, and a culture of confidentiality from other partners (Smith and Beazley 2000). They suggest that enhancing the legitimacy of community representatives on partnership boards might be achieved through the delivery of community objectives, but note that individual agendas may not be mutually supportive and projects supported by one partner can work to the detriment of those supported by another. They suggest that one method of measuring community empowerment is to distinguish community objectives from partnership objectives, and to monitor the impact of partnerships on community objectives – a suggestion echoed by Laverack and Labonte (Laverack and Labonte 2000). Like other writers, they note the difficulties of attracting disadvantaged groups and, therefore, of tackling social exclusion, and suggest that structure is an important factor in consideration of community involvement (Smith and Beazley 2000 p866). The language used, physical access arrangements and the timing of meetings may be designed to accommodate the statutory sector, not the group whose involvement is sought. They cite a number of key factors relating to the ‘values’ of partnership - trust, sharing and willingness to learn – but stress that these are not solely related to goal alignment as community goals are inevitably different to the goals of other partners if defined narrowly, but if too broadly they cease to have meaning. They argue that partnerships need to build on diversity, set mutual goals and learn.

With regard to generating mutual goals, Hastings notes that community priorities tend to be centred round the capacity of an initiative to generate appropriate responses to local need (Hastings 1996 p261). Involvement is enhanced under conditions of what Smith and Beazley call ‘policy synergy’, which is presented as inclusive and democratic, as opposed to simple ‘resource synergy’ which suggests an exclusionary politics of partnership (Smith and Beazley 2002 p867). They argue that it is the latter model that seems to characterise much of the partnership arrangements emerging from government funding. Smith and Beazley claim that mutual transformation occurs within a partnership when it is characterised by a desire to learn, as well as teach, though they note that this is not easy to achieve. The suggested focus on learning, on partnership as a mutual struggle for transformation, conflicts with idea of mutual goal alignment, where each partner seeks to convert others to their way of thinking/acting. One-sided transformation tends to be

anticipated by government (and, perhaps, by the more powerful partners in a partnership). When partnerships pull in different directions, this casts doubt on the ability of partnerships to deliver effective community involvement: incongruent goals highlight disparities in power leading to the marginalisation of those groups with low systemic and command power, who find themselves in a weak bargaining position (Smith and Beazley 2002).

In their review of collaborative partnerships, Roussos and Fawcett (2000) suggest that partnerships aim to improve population-level health outcomes by creating important and sustainable environmental changes in community and thus differ from more modest preventive interventions or programmes that target change in only limited segments of a community. They draw two broad conclusions from published literature on collaborative partnerships for health improvement: firstly, that partnerships are increasingly popular as a strategy; secondly, that there is limited empirical evidence of their effectiveness (Roussos and Fawcett 2000). They also note that funding for such programmes is usually much less than for demonstration projects/trials. Given the minimal contemporary understanding of the contexts and mechanisms within which most partnerships operate, they argue that evaluating partnership effects may not be prudent (Roussos and Fawcett 2000 p374). Roussos and Fawcett report that leadership was the most frequently cited factor, in their research, for effectiveness in creating community or system change: partnership leaders were often the only full-time paid staff (Roussos and Fawcett 2000). Leadership competencies include communication, meeting facilitation and networking, although they note that different skills may be more useful during different stages of development. They also suggest that partnerships with dispersed leadership may be less vulnerable to manipulation, reduced efficacy or dissolution than those that rely on only one leader (Roussos and Fawcett 2000 p386).

In common with other writers, they list a formidable series of challenges for partnership working: engaging those who most experience the focal issue or concern (often those with relatively little money or status); collaborating with community leaders in sectors outside the professional field of the lead organisation in a partnership; sharing risks, resources and responsibilities amongst participating people and organisations; confronting and overcoming conflict within and outside the partnership; maintaining adequate resources and continuity of leadership long enough to make a difference; communicating the needs and negotiating for the time and other resources needed to affect outcomes; and transformation of the broader

social and economic factors that limit effectiveness (Roussos and Fawcett 2000 p394).

Taylor draws on several decades of policy initiatives to argue that community involvement and partnership still remain difficult to achieve (Taylor 2000). She notes that local authorities are now key players after a decade in which powers were systematically removed and vested in a range of local organisations. Local authorities are thus implicated in the transition from government to governance – using powers to enable rather than control, with prospects for moving beyond the revolving door of past initiatives, where the same neighbourhoods have appeared in policy initiative after policy initiative (Taylor 2000 p1020). She questions, however, how likely policy initiatives are to change the distribution of power on the one hand, and financial, human and social capital on the other, and whether partnership is a viable solution to the problems of urban decay. By the mid-90s, most research was suggesting that even recent attempts to involve communities in regeneration had failed to deliver (Taylor 2000 p1020). Structural economic decline was outstripping attempts to regenerate; public sector cultures remained dominant; community involvement was not adequately resourced; and lead-in times were too short. The drive to partnership is different from previous attempts, however, partly because of the range of agencies now operating at local level (Taylor 2000).

However, Taylor argues that the proliferation of partnerships at local level threatens to deliver, at best, a fragmented holism (Taylor 2000 p1021). New policy initiatives are accompanied by central regulation which is risk-averse, often inappropriate, and inflexible. She argues that, in the contemporary policy and funding context it is not possible to fail, so achievements are over-hyped and failures are hidden: learning is not acknowledged or shared. Smaller organisations are disadvantaged in this environment, whilst those who do engage risk, being co-opted and losing their distinctive characteristics. She provides an admittedly pessimistic analysis, suggesting that moves towards partnership are driven by the need to incorporate dissent and provide symbolic legitimacy for an essentially divisive capitalist system (Taylor 2000). The economic costs of capitalism are too profound to address through managerial solutions and power is entrenched in cultures and discourses that enshrine particular ‘scripts’ and ways of seeing. From this perspective, policies to tackle social problems are, at best, a ‘*sticking plaster*’ to mask the wounds of social exclusion and stop them infecting the outside world. (Taylor 2000 p1022). More pragmatic analyses may reject this zero-sum and adversarial vision of power, seeing

opportunities to redress the balance between different interest groups and to equip the least advantaged to compete more effectively. Nevertheless, Taylor notes that the consensus of successive studies of community involvement is that community have, by and large, remained on the margins of power in most partnership programmes to date, even when those have been well organised (Taylor 2000). Community representatives are peripheral insiders – at the table but unable to influence central issues.

She claims that this pessimistic analysis is reinforced by the continued dominance of political imperatives, by the discourse and rules of engagement within which partnership is constructed, and by professional and public sector cultures which have proved remarkably resistant to change. Tensions exist between the time required for involvement and the concrete evidence of achievement required by both politicians and community members, and frameworks laid out for the development of partnership tend to reflect existing power relations. The existing exercise of power continues to frame the discourses of partnership and empowerment and thus the ways in which individuals and groups think about what is possible (Taylor 2000 p1023). In Government guidelines for partnerships, the assumption seems to be that the partnership is formed and then seeks to involve the community, after boundaries have been determined. Rules of engagement are firmly controlled by the public sector, conveyed in the ways that partnerships are defined and structured, meetings run and decisions made – even when residents are in the majority. Community institutions thus come to reflect the structures of their public sector partners in a process of ‘institutional isomorphism’ (Taylor 2000). They may be forced to do so (a process of coercive isomorphism) or choose to comply because it is the norm to which all conform (normative isomorphism). Government guidelines promote ‘mimetic isomorphism’ – not doing things differently. The insistence on mandatory indicators defined from outside not only controls the ‘how’ – the processes of partnership; it also reinforces top-down definitions of the ‘what’ – the needs of disadvantaged areas. Stereotyping can entrench area-based social exclusion: the requirement to map needs on the basis of outside assumptions takes ownership and the power of definition away from local communities at an early stage. The complexity of accountability requirements ensures that power remains with those who have the sophistication and resources to understand and cope with these demands, and who effectively act as interpreters of the boundaries within which any partnership can operate - usually the public authorities. Partnerships thus become *‘colonised by the requirement that essential processes are undertaken in auditable*

ways' (Taylor 2000 p1024). Participating organisations are forced to become more formalised in order to negotiate the system – another force for isomorphism.

Taylor argues that the balance has tended towards over-hasty measurement of the wrong things and that initiatives need to be allowed to fail if progress is to be made. An acceptance that there will be failures will reduce the gap between rhetoric and reality and allow risk and learning, rather than resistance, smoke-screens and window-dressing (Taylor 2000 p1025). Regeneration and social inclusion require more than partnership: the investment of financial capital is needed to replace the investment that has been lost from many disadvantaged areas as a result of economic restructuring. Human, social and institutional capital is also required. Communities can rarely contribute financial assets: the equity they bring is seen as a negative value – they are 'the problem' that needs to be solved, the deficit that needs to be reversed. As partnerships demand a significant investment of time from local residents, some financial recognition should be provided – a community participation 'wage', perhaps (Taylor 2000 1026). Communities bring significant knowledge to the table – a resource that has been consistently undervalued in the past – e.g. about what will work locally and what will not, what facilities will be used and what will be daubed in graffiti and abandoned. She argues that the capacity of partnerships to draw on local knowledge will depend on the way the partnership is structured as, in common with Pickin *et al* (2002), she believes there is still a strong tendency to assume that the skill deficit lies within communities rather than partner institutions. Nevertheless, excluded communities are no more homogeneous than any others, and the first impact of intervention can be to expose the conflicts within a locality, as different needs emerge and as parts of the community are seen to become empowered at the expense of others. Taylor argues that the 'tragedy' for today's excluded communities is that they have neither the strong ties of the past nor the weaker ties that are an essential currency in today's society: the task is to re-establish such ties but the formalisation of informal relationships and networks can destroy them (Taylor 2002 1027).

The high expectations that apparently large sums of money create can make disappointment inevitable when substantial funds are divided between objectives: the drive for a piece of the action can seriously impair the development of trust and relationships. Widespread involvement is essential to effective implementation, but the core work of partnership is likely to be confined to the few, whatever the appeal of the wider issues. Community leaders who have struggled against the odds to

achieve a say in the decision-making process may not find it easy to cede control to others:

It is not hard in the community development literature to find examples of community leaders who climb up Arnstein's famous ladder of participation and then pull it up after them. (Taylor 2002 p1028)

In common with others, she notes that there are now severe problems of burn out for many communities who have been through successive rounds of regeneration initiatives. Those areas where there has been a tradition of investment in community development and in dialogue between local community and voluntary organisations and local authorities seem more likely to be able to work together than those who have not. Taylor argues that the real task has to be to improve the quality of existing services and their management (Taylor 2000).

PART III

PHILOSOPHY AND FIELDWORK

'To acknowledge the density and complexity of the social world (principally its layered and multi-faceted character) is not in the least to deny the existence of, or to abandon the search for, various kinds of 'best approximations' to the truth.'
(Layder 1998 p142)

Introduction

This section forges the links between the literatures reviewed in Part II and the empirical work that forms the second major component of the thesis. It elucidates the methodological assumptions that have underpinned decisions made about the research and details the practical procedures involved in the process.

- In Chapter Four I outline the longstanding philosophical tensions between conventional, now arguably stereotypical, categorisations of research positions and more recent (but still problematic) attempts at philosophical synthesis. Given the empirical aim of this studentship in developing an appropriate case study, I then briefly review the case study literature. I describe the sampling strategy that led to the shift in empirical focus and selection of the East Kirkland Social Inclusion Partnership, and to the construction of a provisional theoretical framework of generic and historically contextual research questions. These foreshadowed issues and my choice of case helped shape the research questions which, rather than being formulated at the beginning of the process, changed and developed through the joint processes of reading and fieldwork.
- Chapter Five addresses the interwoven processes of conducting ethnographic fieldwork and analysis, guided by Lofland and Lofland's three canons of ethnographic validity (Lofland and Lofland 1995). These are: a description of the ethnographer's path; the provision of adequate ethnographic evidence; and the use of theoretical candour in accounting for the particular form of analysis used. I describe the processes of negotiating access and obtaining consent; integrating participant observation and interviews; constructing fieldwork boundaries; my gradual shift in status from 'professional stranger' to 'honorary member'; the exchange of 'rapport' for 'complicit reflexivity'; the problems of researching an identifiable group; and the final stage of withdrawing from the field.

CHAPTER FOUR

A ROUTE THROUGH THE METHODOLOGICAL MAZE

'It has become a kind of orthodoxy among philosophers and social theorists alike to broach what exists exclusively in terms of what can be reasonably said to be known about what exists; that is, to reduce ontology to epistemology. What unites realists is the conviction that there exists a natural world independent of our perceptions of it. It stays even if people go. But what of the social world? There is less unity among realists here; and the social world can hardly stay if people go.' (Scambler 2002 p42)

4.1 Paradigmatic Positions

There are multiple positions from which researchers may speak, frequently represented in the past in terms of incommensurate paradigms: positivist *versus* naturalist, objectivist *versus* subjectivist, or realist *versus* relativist; and utilising quantitative *or* qualitative approaches – to name only the most familiar distinctions. Such positions are conventionally outlined in some of the major qualitative methods texts as constituting the philosophical frameworks that guide research enquiry (e.g. Denzin and Lincoln 1994, Guba and Lincoln 1994). For some, the loosely-termed 'quantitative-qualitative' divide has either broken down or is rejected as irrelevant (Hammersley 1998): for others, it remains firmly in place as a useful distinction (Stoeker 1991). A number of authors note, however, that these terms and their assumption of competing traditions and approaches may obscure diversity within alternative paradigms (Schwandt 1994), the potential for confusion between them, and (erroneously) promote the idea that specific research methods are necessarily confined to a particular methodology (Hammersley 1998). For example, it is perfectly possible to undertake certain types of qualitative research from a positivist-realist position – and indeed many anthropologists have done so in the past (Kuper 1991). Silverman reminds us that, in writing up research, we tell structured stories about data so readers and other audiences need to know how and why such data were gathered and given their final form (Silverman 2000). In the following sections I address the philosophical issues of ontology and epistemology in order to clarify the paradigm within which I have chosen to work.

4.1.1 Researching health inequalities: realism or relativism?

This thesis is located within a broad research tradition surrounding an observed and measurable social phenomenon: the existence of socially stratified inequalities in health, which may or may not be inevitable or acceptable within our society, and which constitute a researchable problem for the natural and social sciences, albeit from within different epistemological and ontological paradigms. In terms of philosophical inquiry as applied to this research, what does it mean to ask about health inequalities and to seek to investigate the ways in which professional disciplines like health promotion, or organisations like health authorities or local councils, seek to reduce (or ameliorate) them? This question directs attention to the priority of methodology over method, to the ontological and epistemological perspectives guiding research enquiry and underpinning the validity of analyses based on empirically generated data. Scientific disciplines such as epidemiology claim to produce objective truths about a knowable world that exists independently of the ways in which that world is apprehended. From within the positivist ontology of epidemiology, inequalities in health are 'real' phenomena, knowable through valid, generalisable scientific procedures. This epistemological position is categorised as 'naïve realism' by those who assert that we have no way of directly apprehending reality, which is always mediated *a priori* by linguistic structures (Clifford and Marcus 1986, Richardson 1994). It is also now widely acknowledged that social processes are deeply implicated in the procedures and findings of the natural sciences (Archer *et al* 1998).

We may therefore choose instead to argue that the concept of health inequalities is a social construction in the sense that it is the discursive product of particular types of knowledge, especially public health and epidemiological knowledge (Silverman 2000). If we pursue a more extreme version of this position, as some postmodern theorists have done, we are likely to argue for the relativism of all knowledge and the impossibility of knowing what is 'right' or 'true' because such terms cannot be disembedded from the context within which they are applied (Fox 1993). Notwithstanding the insights generated by the postmodern turn in the philosophy of the social sciences, extreme relativist epistemologies are, increasingly, viewed warily by some medical sociologists and anthropologists, as undermining rather than promoting the possibility of a reasoned social critique and as providing a view from nowhere (O'Meara 1995). This is illustrated, for example, in the 'get real' critique that emerged as a theme in the national BSA Medical Sociology conferences papers during 2000 and 2001. As Scambler observes, extreme relativism, as adopted by

some postmodern theorists, has detached itself from its modernist origins, rendered itself immune from rational and empirical interrogation, and become more conservative than radical in the process (Scambler 2002 p137). Conversely, exponents of critical realism reject any claim that focusing solely on the subjective and the experiential, the agent and the lifeworld, is an adequate basis for sociological inquiry (Bhaskar 1998, Archer *et al* 1998). As noted in Chapter Two, they argue that natural and social worlds alike are composed not merely of events (the actual) and experiences (the empirical), but also of underlying generative mechanisms (the real) that exist, govern or facilitate events '*independently of whether they are detected or not*' (Scambler 2002 p43). The role of social theory in this formulation is clearly to identify such mechanisms but it raises some questions about whether 'the real' can be made readily accessible in empirical work. If realism tends to be naïve and relativism provides a nihilistic trap for the unwary, what kind of epistemological position will assist an empirically focused researcher in the search for a 'best approximation' to *a*, rather than *the*, truth? Rather than a harmonious integration of methodology with method, the researcher is apparently confronted with a rebarbative maze of theoretically derived alternatives from which to choose and is, accordingly, responsible for justifying such choices. In briefly highlighting the range of ontological and epistemological positions as active research *choices*, I suggest that the theoretical underpinnings of research have political, as well as philosophical, import.

4.1.2 Representing 'reality'

I view Hammersley's ontological and epistemological conceptualisation of subtle realism as offering one potential route through the philosophical maze (Hammersley 1998). Although he is referring explicitly to ethnographic theory and practice, there seems no *a priori* reason why subtle realism should not be applied to the broader spectrum of qualitative research. His explanation of this epistemological position is worth quoting in its entirety:

'... subtle realism retains from naïve realism the idea that research investigates independent, knowable phenomena. But it breaks with it in denying that we have direct access to those phenomena, in accepting that we must always rely on cultural assumptions, and in denying that our aim is to reproduce social phenomena in some way that is uniquely appropriate to them. Obversely, subtle realism shares with scepticism and relativism a recognition that all human knowledge is based on assumptions and purposes and is a human construction, but it rejects these positions' abandonment of the regulative idea of independent and knowable phenomena. Perhaps most important of all, subtle realism is distinct from both naïve

realism and relativism in its rejection of the notion that knowledge must be defined as beliefs whose validity is known with certainty.' (Hammersley 1998 p52)

From this perspective, people's beliefs, actions and accounts still need to be viewed as constructions: this includes those of the researcher, who is automatically part of the social world s/he studies. This means that we can recognise that accounts are selective constructions without abandoning the idea that they may represent phenomena independent of themselves, and of the researcher, more or less accurately (Hammersley 1998 p5). Instead of approaching the issue in terms of competing alternatives, therefore, Hammersley urges us to see methodology as

'involving a complex of assumptions and arguments, some of them in conflict, and a range of strategies and techniques that have advantages and disadvantages for particular goals and in particular circumstances.' (Hammersley 1998 p197)

Subtle realism offers both guidance and challenges: it provides an epistemological basis for practice but may make the assessment of validity of findings more problematic and the justification of this type of social science research to a sceptical public more troublesome. Validity (or 'truth') relates to how accurately an account represents those features of the phenomena that it purports to explain, describe or theorise (Kirk and Miller 1986). The assessment of validity involves identifying the main claims made in a study, and comparing the evidence with what is judged to be necessary, given the claim's plausibility and credibility. Such assessments and judgements are not the sole responsibility of the researcher, but also that of his or her readers/audience within the academic community. My methodological strategy has been to draw on a subtle realist approach to data generation and analysis. My research account seeks to represent, and provide evidence for, a particular reality and requires a constructivist epistemology in producing analysis. This approach helps to maintain a critical purchase on both research observations and participant accounts. It also helps to support the claim that research refers to a social structure that is in some sense 'real' (stratified and unequal), beyond our acknowledgement that the concept of health inequalities (and the data generated through research) is socially constructed.

These have not been issues to be resolved once and for all, tidied neatly out of the way before the empirical research work could start. Tensions between ontological and epistemological considerations were evident in the original description of the substantive area of the studentship and have underpinned and inevitably influenced

the conduct of the research at all stages, from early familiarization with the relevant literature to the final research product in the form of this thesis.

4.2 Case Study

'The concept of case study captures an important aspect of the decisions we face in research. It highlights, in particular, the choices that we have to make about how many cases to investigate and how these are to be selected.' (Hammersley 1992 184-5).

As the empirical part of the thesis is based on a particular case study it is necessary to provide a brief review of this methodological approach before describing the selection of the case itself. Case study has enjoyed a fluctuating reputation within the social sciences over the 20th Century but now seems to have regained a position first established with the work of the urban sociologists of the Chicago School (Mitchell 1983, Stoeker 1991). A number of methodological texts on qualitative research methods devote whole chapters to case study (e.g. Denzin and Lincoln 1994, Robson 1993) and there are now several separate publications on the subject (e.g. Gomm *et al* 2000, Stake 1995). Most advocates of the approach agree that the decision to use a case study is a strategic decision that relates to the scale and scope of the investigation: it does not dictate the method to be used and flexibility of method is agreed as integral to the approach (Stoeker 1991). Researchers recognise that case study is both process and product. Some writers advocate a theoretical focus (Yin 1994), others an empirical (Stake 1994 and 1995, Stoeker 1991). There is no single definition of what a case study is. Yin, for example, defines case study as

'an empirical enquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used.' (Yin 1994 p28)

Denscombe suggests that

'case studies focus on one instance (or a few instances) of a particular phenomenon with a view to providing an in-depth account of events, relationships, experiences or processes occurring in that particular instance.' (Denscombe 1998 p32)

I have found both definitions useful and relevant. Stake argues that most naturalistic, holistic, ethnographic and phenomenological case studies emphasise

'objective description and personalistic interpretation; a respect and curiosity for culturally different perceptions of phenomena; and empathic representation of local settings, all blending (perhaps clumped) within a constructivist methodology.' (Stake 1994 p242)

There thus seems to be agreement amongst some practitioners that opting for a case study approach means buying into a broad set of related ideas and preferences. Debate surrounds the extent to which case studies should be used to illuminate the idiosyncratic features of a particular case, to make comparisons between cases, or to extend case study findings to a more general population. Stoeker, for example, believes that we can and should compare cases, but warns of the danger of beginning with a comparative focus. He suggests that the researcher may end up by neglecting the integrity and idiosyncracies of each case and reducing the case to a few comparable variables (Stoeker 1991). Similarly, Stake argues that comparison is a powerful conceptual mechanism that may fix attention upon the few attributes being compared and obscure other knowledge about the case (Stake 1994). Comparison may therefore be the opposite of thick description. From this perspective, generalisations from differences between any two cases are much less to be trusted than generalisations from one: the researcher's chief concern should be to optimise understanding of the case, not to generalise beyond. Denscombe, however, suggests that, although each case is in some respects unique, it is also an example of a broader class of things. We may be able to generalise findings from the case study to other examples in its class, depending on how similar the case study is to others of its type (Denscombe 1998).

Moving from the issue of generalisation to that of selection, Denscombe reminds us that

'(w)hatever the subject matter, the case study normally depends on a conscious and explicit choice about which case to select from among a large number of possibilities. **This selection needs to be justified.**' [Emphasis in original] (Denscombe 1998 p33)

The literature contains a number of different suggestions as to how cases should be selected. A large population of hypothetical cases has to be narrowed to a small sub-population of accessible cases. Stake is optimistic about the potential for learning important things from almost any case and argues that balance and variety are at least as important as sampling by attributes: the opportunity to learn is of primary importance (Stake 1995). Stoeker argues that a case should be chosen for its explanatory power rather than its typicality (Stoeker 1991). Denscombe prefers cases

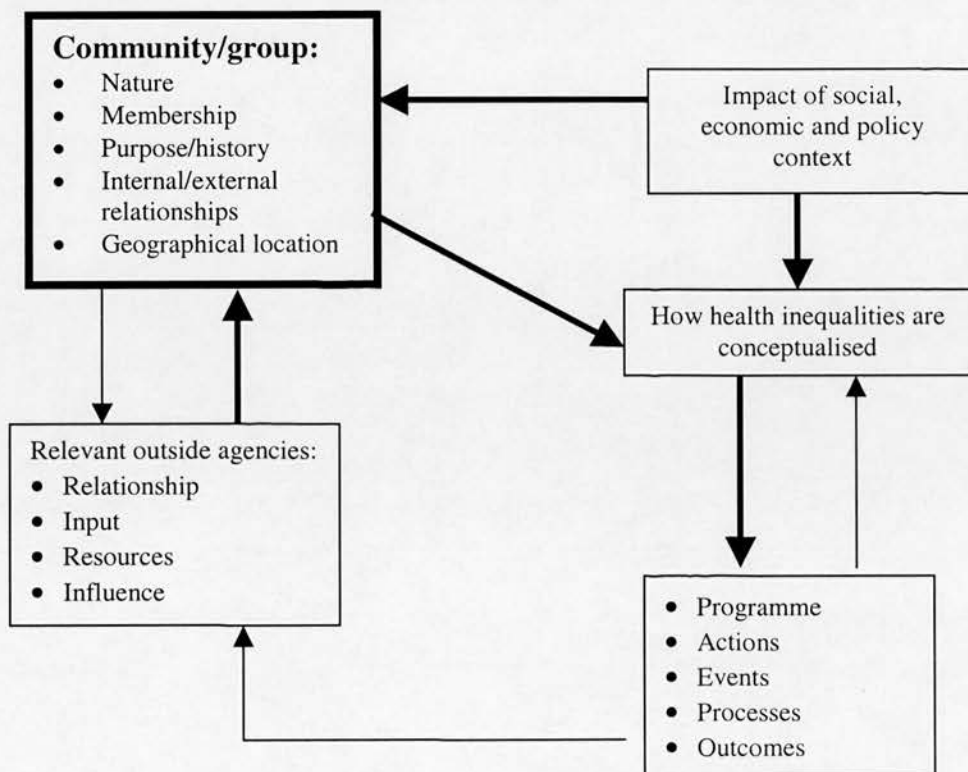
to be selected on the basis of suitability for specific purposes. A case might be selected on the basis of typicality - i.e. similarity to others that might have been chosen, so findings may apply elsewhere. On the other hand a case might be selected as an example of an extreme instance, providing a contrast with the norm and the effect of this would be highlighted. Selection might proceed because the case is a test-site for theory testing or theory building (Yin 1994): the rationale is that the case contains crucial elements and that researcher should be able to predict certain outcomes based on theory. Or the case may be chosen as an example of a least likely instance that can be used to test the validity of theory by seeing if it occurs where least likely to. Although Robson, Yin and Stoeker separately identify a considerable number of different types of case study (Robson 1993, Yin 1994, Stoeker 1991), Stake identifies two types I found particularly relevant to the case I later identified. The *intrinsic case study* is undertaken because one wants better understanding of a particular case. The *instrumental case study* provides insight into an issue or refinement of theory, with the case being chosen for its capacity to expand our understanding of these (Stake 1994).

4.2.1 Framing the case

It is logical to construct a case study framework before the case has been selected, as research always begins with some problem or set of issues, what Malinowski long ago referred to as the 'foreshadowed problems' revealed to the researcher by her/his theoretical studies (Malinowski 1922/1992). Foreshadowed problems influence methodology and are instrumental in shaping research design (Hammersley and Atkinson 1993, Malinowski 1922/1992). Some of these issues were highlighted in the literature reviews in Part II and *Appendix 1* and helped shape the initial conceptual framework set out below. A conceptual framework covers the main features (aspects, dimensions etc) of a case study and their presumed relationship: it can be either descriptive or diagrammatic and enables the researcher to be explicit about what s/he is doing, and why (Robson 1993). A conceptual framework thus aids selectivity in deciding on important features and relationships and what data should be collected and analysed. The conceptual framework illustrated in *Figure 1* below illustrates my initial conceptualisation of the key dimensions I felt needed to be considered in a case study purporting to focus on events, roles and relationships in any group, taking account of the broader contextual factors such as the policy context. With hindsight, the conceptual interconnectedness of the varying dimensions shown proved a useful guide for observation and analysis, even though the

foreshadowed issues given diagrammatic form in the framework were constructed before the case was selected. Although determining the frame of the case study may mean determining the boundaries of the case in advance, in this case study design has been an ongoing process during the research, linking research questions, data collected and conclusions drawn.

Figure 1
Case Study Framework



4.3 Selecting the Case: The East Kirkland SIP

A number of key assumptions underpinned my approach to the process of identifying a suitable case. The first assumption concerns the breadth of health promotion as a field of study. Not all health promotion activity (and perhaps not even the most important) takes place within health promotion departments or Health Boards. This is recognised in the discipline's own focus on the need for partnership and collaborative working. In my early thinking about selecting the case I chose to make a distinction between health promotion *practice* as the fairly narrow preserve of

professional specialists - and health promoting *work* (thus amending and extending Cribb's (1997) distinction). Health promotion work incorporates specialist practice but also acknowledges the health promoting potential of other sectors (e.g. local authorities, voluntary organizations), alliances (e.g. social inclusion partnerships) and policy processes (such as community planning). This usage also helps to anchor the research within the broader social context of efforts to tackle health inequalities. My second, related assumption is that it makes little sense to consider health inequalities in isolation from action on wider social inequalities and disadvantage – to which health promotion as a discipline can make a major contribution, but on which it may not necessarily be able to take the lead (Labonte 2001).

Given the original aims of the study, I believed that there might be more to learn about the potential for health advocacy from studying environments other than explicitly health promoting organizations such as Health Boards. This is not to deny or undermine the specialist skills and knowledge of health promotion professionals, but to emphasise the essentially broad nature of the context in which work on tackling health inequalities is increasingly taking place. The question then became, if an explicit focus on health promotion *practice* (as the preserve of specialists) was not to be the sole theoretical driver in choosing the case, and if the potential for health promoting *work* is so broad, what selection criteria should be used? My conceptual framework (see *Appendix 1a*) was useful for thinking through the different dimensions of health promoting work, but had expanded rather than contracted the potential field for research. Placing the central research emphasis on exploring work around tackling health inequalities still required considerable narrowing of focus, in order to obtain a sense of the range of relevant groups/activities around Scotland, before a suitable case could begin to be selected. This indicated the need for some preliminary sampling work.

Sampling in qualitative research is often described as purposeful, driven by concerns for validity, richness and quality of the data rather than by the desire for generalisability or representativeness, as those concepts are usually applied to quantitative research (Robson 1993). This is not simply a question of method: it is related to the ontological and epistemological stance of the researcher, both of which inform methodological decisions (Guba and Lincoln 1994). With regard to sampling strategies for small studies, purposive sampling provides the researcher with purchase on the research questions (Robson 1993). Sampling choices are determined by research questions and by the conceptual framework governing these. Qualitative

research sampling demands a rigorous approach, employing systematic rather than standardised selection criteria and techniques (Mason 1998). I used the above theoretical perspective on the potential breadth of health promotion work as a way to construct a strategic and purposeful approach to investigating potential cases. I sampled a range of organisations across Scotland that were involved to varying degrees in tackling health inequalities through community development work, health promotion, strategic health partnership work, and social policy.

The remainder of this section provides details of the sampling process itself and of the key themes that emerged during the nine interviews conducted as part of that process, themes that resonated with my findings in the subsequent case study. Early fieldwork thus informed the subsequent selection of the case, and as such needs reporting here rather than in those parts of the thesis detailing the main empirical work. At this stage in the research development 'advocacy' retained its central focus. However, as shown below, I found that advocacy was regarded by a number of sources with some scepticism, even wariness. Interview respondents judged it as an implicit rather than explicit strategy for action, confirming that other issues had greater resonance for them: in particular, the current policy agenda of multi-sectoral co-operation as one of the major strategies to tackle health inequalities and the related requirement to involve communities. Early fieldwork was thus instrumental in developing the empirical focus of this thesis. In order to fulfill a central requirement of the studentship (to conduct a piece of empirical work relevant to policy and practice across Scotland), the focus of the research needed to be responsive to the powerful impact of contemporary health and social policy on efforts to tackle health inequalities. As illustrated below, this early fieldwork proved instrumental in the selection of a Social Inclusion Partnership as the basis for a case study, and provided valuable insight into some of the foreshadowed issues and themes that emerged as significant during the case study work.

Before describing the findings of this sampling stage of fieldwork, however, one other source of information needs recording. The response of participants to a multi-national advocacy workshop in which I took part was also significant in the decentring of advocacy as the main focus of this thesis. The workshop took place during the XVIIth World Conference on Health Promotion and Health Education, held in Paris in July 2001, where one day of this event was dedicated to discussions of advocacy with Ron Labonte and Simon Chapman – both noted exponents of advocacy – as keynote speakers. These two speakers facilitated the workshop that

followed, attracting a large group of participants (Labonte 2001, Chapman 2001). My fieldnotes, taken at the time, record that doubts about the utility and acceptability of advocacy were raised by numerous participants in the hall. One commented that health promotion as a discipline tended to generate abstract concepts without considering their utility to practitioners. Another questioned her right to advocate for other people and sought greater clarity on what the terminology meant. A number were unhappy with the political aspects of advocacy, feeling this lay outside their remit. Advocacy was seen as only one amongst many other strategies. Most surprising to me was the comment that advocacy was linked with 'spin' and the idea of not being truthful. Yet another participant said that '*public health people don't have the skills to do advocacy*' and that truth was never the issue. Labonte summed up by acknowledging the difficulty of advocacy work in certain contexts and that health promoters are more comfortable in empowerment roles than in advocacy roles.

4.3.1 Sampling

I had initially planned to sample the range of health promotion strategies identified during the literature review attached as *Appendix 1a*), i.e. social policy advocacy, 'traditional' health promotion for education and behaviour change, community health development, and strategic health partnerships. I wanted to attain a sense of what key individuals understood by health advocacy and the relevance of this approach to their work, and to assess the potential of different groups/locations for the study itself. I initially thought of looking for evidence of a declared intent to address health inequalities as a core criterion for sampling groups. On reflection, I concluded that the current unprecedented policy emphasis on tackling health inequalities would probably permeate practice in most sectors and at most levels. In the attempt to put my sampling strategy on a systematic basis, I decided to try and interview a small 'quota' of:

- at least three senior health promotion specialists, based in health boards of different sizes and in different types of location across Scotland (i.e. urban, rural, mixed);
- at least three community development workers with health as part of their remit;
- at least three individuals working in key positions with/for health alliances or partnerships across Scotland;

- at least one local government officer with responsibility for and involvement in community health issues and policy.

The above criteria were obviously not, by themselves, sufficient to narrow the range of potential interviewees to more manageable proportions. Other resources were used to identify a number of key health promotion professionals and relevant community-based projects and health alliances. For example, a contact list obtained from HEBS was used to locate Health Board-based health promotion professionals with a remit for health inequalities work. I also read through all 300-plus entries on the (former) HEBS database before narrowing the potential range of projects by searching using specific key words, such as advocacy, health inequalities, community development, poverty, deprivation, and policy. Although only six projects specifically mentioned health inequalities, it seemed likely that many more would also be working to address this topic so I consulted the Glasgow-based CHEX (Community Health Exchange), as a source likely to possess more in-depth knowledge of the many health projects in existence around Scotland. Serendipitously, the CHEX worker had been asked by the Scottish Executive to compile a reasonably short list of projects from the CHEX/HEBS databases, for invitation to a conference on community health involvement. The worker felt that this list (17 projects in total) would be an appropriate starting point as it covered a wide range of different types of community health projects around Scotland. She indicated which projects were currently perceived as being over-consulted and therefore less suitable for case selection because of 'research fatigue'.

For sampling at the health partnership level, I was particularly interested in the 48 Scottish multi-agency Social Inclusion Partnerships (SIPs) because of their potential involvement in health inequalities work (Scottish Office 1999). I was also interested in the issue of community-level participation on the SIPs, after listening to community representatives' debate on this topic at a Big Issue conference held in Glasgow during May 2000 (they were unanimously critical of SIP management Boards' handling of the community participation process). I therefore consulted the SIP network facilitator for community representatives, based at the SCVO in Glasgow, who provided access to the SCVO database on the SIPs, as well as additional documentation such as partnerships' annual reports. SIPs may be either area-based or thematic e.g. focusing on particular age groups (especially young people) or issues. As with the community projects mentioned above, health issues are a core part of many SIPs' work as all are based in areas of multiple deprivation.

My informant from the SCVO used his extensive knowledge of the relevant SIPs to suggest those that would be particularly relevant to my research interests, and also outlined the problems in some partnerships that meant they were unlikely to be suitable research sites. In one, for example, internal conflict had reached a level where original partnership arrangements had been abandoned and re-started. This was not deemed a suitable site for research. I was thus directed towards conducting a sampling interview with another of the SIPs with a particular interest in health – ‘East Kirkland’.

4.3.1.1 The sampling interviews

Most of the interviews were set up after numerous phone calls as the particular person I wanted to speak to was often on holiday or otherwise engaged. Given that there are more pressing demands on people than answering research questions, this process understandably took some time. Some individuals I had wished to interview said they did not have the time or felt that they were not the most appropriate person to speak to, but usually referred me to other colleagues. Certain individuals and their organizations/activities fell into more than one category of the quota and it became obvious during the interviews that most were working in the health and policy arena, some at local level but others at both local and national level. Nine interviews were conducted during August 2000, eight of which were with women. I gained access to four Health Board workers – three senior health promotion specialists and one public health specialist (the solitary male). One of these individuals represented the local Health Board on two SIPs; another was on the management committee of a SIP and a Community Health Development Project. Two specialists had a background in public health and the other two in community development work. I interviewed three voluntary sector workers involved in community health development projects. A fourth voluntary sector worker, from an anti-poverty forum, was also interviewed. These workers were all actively involved in a number of partnership or alliance activities, e.g. Healthy Living Centre bids, Social Inclusion Partnerships, and the CAP (Communities Against Poverty) network. All had extensive experience of community health development. The Local Authority worker was a senior council officer responsible for community development within the local Regeneration Partnership, with a professional background of practice in this type of work. She also chaired two local SIPs and represented the Authority on another.

Each interview was preceded by an explanation of the research and assurance given that any sensitive information they gave me would not be shared with anyone other than my supervisors at that stage. I also alerted respondents to my interest in potentially developing a case study in their arena of activity. The interviews lasted from between 45 minutes to over two hours and were tape-recorded. Additional notes were taken: as is not unusual, notwithstanding any initial caveats about limited time (*'I can only spare you an hour'*), interviewees continued to talk even after indicating that their time was up and the recorder had been switched off. My main purpose was to gain a broad (if perforce shallow) sense of what work on health inequalities is being carried out by whom, and at what level, across Scotland. Most of the interview participants (7) had a background in or knowledge of community development work and experience of community health projects. Overall, these interviews took the shape of focused discussions of varying degrees of structure and flexibility. Each interview tape was listened to three times: no notes were taken during the first playing. During the second playing, extensive notes were taken, paying particular attention to utterances that seemed relevant and/or significant to the research questions. These notes do not form a full transcription, unlike the interviews conducted during the case study itself. They were initially recorded on the left hand page of a spiral bound A4 notebook. At the third playing, emerging themes were noted on the right hand page. Both kinds of notes were subsequently entered onto a word processor. Although this procedure might seem to have elements of redundancy (especially the handwritten stages), I believe that maximum familiarity with data enhances analytical thinking – the mental processes of sifting and sorting. Tape recordings usefully trigger memories of non-verbal action and interaction that may be lost when the focus of analysis is purely on text.

4.3.1.2 Asking about advocacy and health inequalities work

I had already been sensitised to the potential difficulty of discussing the concept of advocacy when setting up these interviews. When explaining what I wanted to talk to them about, most prospective participants had said something along the lines of 'I haven't read anything about advocacy recently' or 'I don't really work in that area'. Given the status of advocacy as a key strategy for health promotion, I found this initially surprising but came to realise during the interviews that advocacy, even when not explicitly acknowledged as such, underpinned a broad range of respondents' activities. The issues of health inequalities and contemporary policy initiatives aimed at tackling these were, however, explicitly recognised as highly

pertinent for all categories of respondent. Given the degree of significance accorded to these issues, and my own desire to conduct a piece of grounded and relevant research, at this stage of the research my thinking re-focused and sharpened. Those speaking from a health professional perspective saw the need for Health Boards and Health Promotion departments to be very clear about their own role in and responsibility for reducing health inequalities (given their limited resources), and where other sectors and agencies should be drawn in. Not surprisingly, Local Authorities were seen as the key partners who could effectively be involved through the community planning process. The need to prioritise health improvement goals and negotiate responsibility with others informed these participants' discussions. The renewed political acceptability of the participatory and partnership approach to health improvement was broadly welcomed, particularly in view of its novelty for other potential health service partners such as GPs, Local Health Care Co-ops (LHCC) etc. However, the reality of developing partnerships between organisations with different structures, resources and perceived lines of accountability was, perhaps inevitably, perceived as an uphill struggle.

During these early fieldwork interviews I used the 'grand tour' approach to questions around health inequalities, framing initial questions on this topic along the lines of 'can you tell me how your organisation is trying to address health inequalities in this area? The nature of the answer gave a reasonably clear indication of how health inequalities were being conceptualised by the respondent and her/his organization. In the case of voluntary sector workers, responses frequently took the form of an explanation of the (often precarious) history of the organization, leading up to its present form and function, before addressing the specific issue of health inequalities work. The four voluntary sector participants spoke strongly of the need for empowering and enabling approaches in working with disadvantaged groups. One community worker said:

'I think, unless we're empowering people and leaving the skills in this community, then what is the point of flinging monies at community level because we always seem tae ... well, 'we'll come and do this big piece of work' and then in-out and nothin's left. Nobody's left with any skills or whatever.' (Project Manager, Community Health Project)

Health Board/Local Authority interview participants were more likely to speak first of all in terms of organisational responses to the changing political climate and the impact of this on their work. All participants articulated social explanations for inequalities in health, whilst admitting that official documents still tended to use

individualised solutions. For a number of participants, the 'new' focus on health inequalities was often more a matter of re-labelling existing activity as a matter of political expediency. Long-established work in areas such as support for smoking cessation, coping with stress and healthy eating initiatives such as food co-ops were likely to be re-badged in this way. For others, the rhetoric was not matched by practice: *'plenty of speak but little action'* was how one senior health promotion worker put it. The greatest perceived challenge was that of changing people's 'life circumstances' – the multiple tasks of reducing poverty, maximising income, improving environments and creating hope for the future. Not surprisingly, for health promotion specialists the targets relating to health topics and lifestyles were perceived as easier to tackle via familiar types of health promoting programmes. Three specific themes seemed salient to the interview participants: the improved political context, the increasing imperatives for partnership work, and competing claims to legitimate representation of community interests.

The improved political context for work on health inequalities was mentioned by all interview participants, expressed by one health promotion specialist as *'a move from margins to mainstream'*. The 1997 change of Government at Westminster, the processes of devolution for Scotland and the Scottish Executive interest in inequalities were seen as providing a more permissive environment in which it is now acceptable to speak of social inequalities in health. The Scottish White Paper on this topic has been seen as an essential catalyst: one participant said, *'if we can't make a difference now with this political agenda, we never will.'* However, welcome though the lead provided by the White Paper was, another health promotion professional felt that the structure for action provided by the separation of health topics, lifestyles and life circumstances was insufficiently strategic and overly devoted to *'categories in boxes'*. Most participants spoke of the need for a stable political environment to achieve long-term change, and of too much emphasis on achieving measurable change in the short-term. The changing role of Health Boards, with their new remit to reduce health inequalities and achieve health gain as well as their potential for becoming public health organisations, provides part of the context from which health promotion respondents spoke. A number of participants commented on the lack of a clear understanding of health inequalities within Health Boards, and of different interpretations being utilised by public health and health promotion: the type of definition that got put into practice was perceived as linked to the influence of local power relationships.

The new policy agenda on social inclusion seems to have had as much as an impact on organisations such as Lothian and Greater Glasgow Health Board as the health White Paper. The former health promotion department in Lothian Health has been split between two new Directorates – Public Health/Health Policy and Social Inclusion, with the great majority of health promotion resources being located in the latter. The participant from Lothian Health saw Public Health as taking the lead on health inequalities in Lothian, whereas Health Promotion led Greater Glasgow Health Board's efforts. In Glasgow, the four geographical health promotion teams have been re-structured into one, which in turn is sub-divided into six teams to support the six local SIPs. None of these SIPs were managed by staff with a health promotion background. The role of senior health promotion staff was to link the local LHCCs with the SIP agenda, whereas less senior staff still had a role in delivering health promotion programmes. One worker spoke of her Health Board '*reeling from recent history*', of inertia rather than leadership from a former Director of Public Health and the current lack of an adequate health inequalities strategy. The lead on tackling health inequalities lay (inappropriately, in this worker's view) with the local Council and their anti-poverty strategy. Health inequalities were being addressed only minimally through the Health Improvement Programme at Health Board level.

The four voluntary sector workers spoke from a far less stable environment than even the public sector participants, who had experienced many re-organisations deriving from changing government policy over the years. For the voluntary sector, funding was a matter of chronic uncertainty that rendered difficult their attempts to comply with external funding bodies' demands for sustainable projects. Inherently flexible, they had managed to survive over a number of years by adapting their short-term objectives in response to new funding opportunities (the Urban Programme, Priority Partnership Areas, Urban Regeneration programmes etc), without losing sight of their longer-term community development aims.

The increasing imperatives for partnership work between service providers and the public permeates contemporary life, whether in formal policy documents or in media reporting. However, current political imperatives surrounding partnership work can obscure dissenting voices from different assumptive worlds. Even in so small a sample, very different views on partnerships for tackling health inequalities emerged. Health promotion specialists felt that they had to work in two different directions at once – shifting NHS partners' medically-bound views towards greater

awareness of social causes of ill health, and shifting local government views towards awareness of the health impact of poor social circumstances. Other types of partnership were also problematic. For example, the public health specialist spoke of voluntary organisations in his area as '*slippery*', hard to hold to account, given to offering unwelcome challenges to existing policy and unexpected amendments to previously agreed areas of activity. From the perspective of community workers, however, such '*slipperiness*' entailed an essential flexibility, a key survival strategy in constantly shifting circumstances of insecure and short-term funding. Health Boards and Local Authorities were perceived as sometimes remote from the everyday existence of their disadvantaged communities and the renewed political emphasis on community participation legitimised the community development approach, even though this was seldom matched by a financial commitment:

'Since the change of Government and the change of policy, people/projects like ours have been recognized at Board level. It still hasn't made any difference to our funding, as of yet. We're very well aware that the Health Board need to be working alongside us if they're going to get anywhere, because they've been told by the Government that they need to be working more at grass roots level ... we've been asked to work beside them (the two local health promotion teams) developing community health action partnerships. But ... from my point of view they need us because they cannae develop/do development work without us because they dunnae hae the skills and the knowledge to work at our level ... But you can see, for some people it's quite scary and 'Oh my God!' A lot of power – gatekeeping and things like that – have to be taken down. Because that's a big issue for us and all of the gatekeepers. I mean, for all they're tryin' to help ye..... And because you're quite/well a community development project is quite ... political ... sometimes gates can be closed for that reason.' (Project Manager, Community Health Project)

Another community health worker felt that health promotion specialists could be patronising in their approach to communities. She recognised that they try to avoid this but that a gulf remains between health promotion and community development:

'Professionals say, "why do they (community members) no' do it when I want them to do it? Why do they no' turn up to meetin's when I've said I'm going to be there?" Community development workers understand why not. Health Promotion say, "we've run this twelve week thing". Good for you – but what has it achieved? Our outcomes are more difficult – did so and so get out of her bed this morning? Is she there on time? Is she walking up the street with her head in the air? Can she speak to folk? It's difficult to explain these types of health gain.' (Project Manager, Health Alliance project)

A health promotion specialist spoke of deeply embedded tensions between the existence of different '*vested interests*' involved in partnership working and the perceived necessity of a '*collective response*' in order to obtain Government funding. '*Vested interests*' refers both to professional territoriality between different 'partners'

and to the occasionally vitriolic nature of national political party politics across Scotland. Both types of interest were seen as barriers to effective partnership working. One health promotion professional assumed I was interviewing her because of the disastrous reputation of her local SIP: she strongly advised me against trying to study this partnership because of the intense and damaging nature of the political in-fighting that had led to the forced resignation of the SIP manager. Within this context she suggested that the Health Board was seen as an '*honest Joe*' working outside the political arena, but that local health promotion workers risked being dismissed by local politicians as out of touch with the grim social reality of poverty and unemployment, and therefore not able to understand local people's best interests.

Competing claims to legitimate representation of community interests were apparent between public and voluntary sector interview participants' accounts of community needs and participation in decision-making on health issues. Given the centrality of this issue in much contemporary policy, this is clearly an important preliminary finding and relevant to the potential for health promoting partnership work. For example, the Local Authority participant claimed that '*people only want good services, not endless consultation*'; that it was the responsibility of the statutory sector to provide such services; that the voluntary sector in her area was too under-developed to make much of an effective contribution; that 'community representatives' could be anything but; and that it should be recognised that there were times when professionals knew best. These were intriguing comments, given this participant's own background in community development work, role as Community Development Manager and Chair of the East Kirklands SIP, a partnership with the stated aim of tackling local health inequalities. Moreover, SIP documentation from the Scottish Executive places great emphasis not only on multi-sectoral co-operation but on community involvement and active participation.

4.3.2 Summary: refocusing the research aims

As this section has shown, though advocacy may be an explicitly espoused strategy for health promotion, the concept of partnership work in tackling health inequalities and social exclusion had greater salience for those whom I interviewed and, in the cases of both Lothian and Greater Glasgow Health Board, the social inclusion agenda had led to some major organisational restructuring. The sampling process referred to above makes it clear that many organisations and groups are involved in tackling health inequalities around Scotland, whether explicitly or implicitly. Health

inequalities are linked to wider social inequalities and disadvantage and many different disciplines, including health promotion, are involved in responding to the problem. The English and Scottish White Papers on health have implications for sectors other than those with overt responsibility for health and health care (Department of Health 1998b, Scottish Office Department of Health 1998). My initial fieldwork led me to conclude that, although a variety of cases have considerable potential for providing insight into how health inequalities are being addressed, the new Social Inclusion Partnerships were particularly likely to prove empirically and theoretically fruitful. The Scottish Executive has given considerable prominence to a strategy for social inclusion that includes the reduction of health inequalities, based on an underlying commitment to the empowerment of individuals and communities (Scottish Executive 1999a, 1999b). It has set up the Social Inclusion Network and a number of related Action Teams, funded the SIPs and emphasised the central role of community planning. Given this very broad agenda, there are likely to be close connections between SIPs, community planning and local work on health inequalities.

Most SIPs have a life span of ten years, far longer than that normally granted to community health development projects. The partners are drawn from many sectors and levels of working and funding arrangements are more generous than those used to support most community development projects. I believed that an exploration of how the relationship between people, place and health is conceptualised by those involved in such partnerships would be likely to prove a fertile area for research. I was also aware, from the literature reviewed above, of the substantial problems (as well as rewards) attaching to partnership work. After interviewing the Chair of the East Kirkland Social Inclusion Partnership in August 2000, I decided that the SIP she had recently established would present an appropriate case to study. In selecting the East Kirkland SIP I was influenced by its relevance to the interests of this research, in particular its specific focus on tackling health inequalities through working at individual, community, partnership and policy levels. The timing was also apposite as this Partnership was to be 'launched' and community involvement sought during late 2000.

The definitions suggested by Denscombe and Yin (see above) seemed to fit well with my interest in selecting and researching this type of case although these definitions needed some extension in scope by ensuring that the phenomenon in question is placed in its broad social, historical, political and economic context. My choice of

case study is best conceptualised in Stake's terms as 'instrumental', i.e. selected to provide insight into and expand our understanding of issues and to contribute to the refinement of theory. In this case, the key issues are contemporary health and social policy initiatives, their relationship to community-level and multi-agency partnership work in tackling health inequalities, and the implications for health promotion. Stake argues that the case plays a secondary role to this primary function: I would argue that this case also possess intrinsic, as well as instrumental, interest. In other words, a case study of the East Kirkland SIP has the potential both to illuminate aspects that are unique to a particular context, and to expand our understanding of its broader significance for theoretical issues around policy making and partnership working for health.

The original research aim was to explore and clarify the role of advocacy in health promotion with specific reference to health inequalities. However, for reasons outlined above, the original focus on advocacy strategies developed as literature reviews and the flexible nature of fieldwork foregrounded the importance of the contemporary policy context to the many organisations and agencies charged with responsibility for tackling health inequalities and social exclusion. Health promotion as process is heavily implicated in this relatively new form of governance, and health promotion as activity is also viewed as a mechanism for desirable change. There has been a marked shift in the health policy agenda to focus on 'deprived' areas and 'disadvantaged' people, together with a shift towards 'modernised' and 'joined-up' government. This has taken place within an overarching discourse of social conscience, cast in policy terms as social justice. This, then, is the broader context for the selection of the East Kirkland SIP as a case study.

The choice of a Social Inclusion Partnership for case study re-frames the main research interest into a focus on how the contemporary (national) policy context shapes (local) action on health inequalities, and how such local action determines processes and creates outcomes that may facilitate or thwart policy intent. In electing to study a contextually-bound phenomenon like a Social Inclusion Partnership in a way relevant to the interests of medical sociology, the discipline of health promotion, and policy makers, at least two types of questions need to be developed: broad generic (sociological) questions; and specific or 'historically-particular' questions (Lofland and Lofland 1995). Both are important, may involve *a priori* research assumptions about significant elements, and are also amenable to change and development during the research process. Generic questions focus around

issues such as, what type of social system is this? What are the origins of the phenomenon? What social relationships and processes are involved? Historically-particular questions focus on the specific context. Who participates in this partnership and why? What conceptualisations of health inequalities are evoked and to what purpose? How is the relationship between people, place and poor health conceived? What kinds of decisions and actions do such typifications lead to? What other aims, beliefs, goals are significant? What are the key relationships within and outside the group? What is the interface between policy directives and agency at the local level? What are the implications for health promotion, as practice and process? These are some of the questions underpinning the analysis presented in Part IV but the process of finding answers (and other questions) is described in the next chapter.

CHAPTER FIVE

AN ETHNOGRAPHIC APPROACH

'Once upon a time, the Lone Ethnographer rode off into the sunset in search of his "native". After undergoing a series of trials, he encountered this object of his quest in a distant land. There he underwent his rite of passage by enduring the ultimate ordeal of "fieldwork". After collecting "the data", the Lone Ethnographer returned home and wrote a "true" account of "the culture".'
(Rosaldo 1993 p30)

5.1 A matter of Method

Having selected the case itself and considered the initial framing of research questions, it is now appropriate to turn to specific issues of method. To study an evolving group by utilising the in-depth interview as sole method is perfectly feasible but would present a missed opportunity to record and analyse the social processes involved. To study such a group using purely participant observation is also feasible but may render the status of analytical claims dubious, if we believe that multiple voices should be heard through the research process and not just that of the researcher. I felt that both methods were called for in a case study that intends to track development, process and relationships, within a particular context and over a period of time, *and* the meanings attributed to such developments, processes and relationships to participants. In other words, I believed an ethnographic approach to be required. This does not necessarily entail a wholesale commitment to the romantic, masculinised and semi-mythic status of the 'lone ethnographer' satirised above by Rosaldo. Contemporary ethnography is likely to be based on 'anthropology at home', where fieldwork is something less of an ordeal and where we cast a critical eye over our own truth claims, knowing that they will be subject to the routine scepticism of others.

Two of the inherent dangers of an ethnographic approach to social inquiry are the tendencies to utilise either a naturalistic or reproduction model of research (Hammersley 1998). 'Naturalism' refers to the long-standing temptation in anthropology to believe that, as ethnographic practice is normally situated in naturally occurring settings, the researcher comes closer to the reality of social actors' lived experience than survey-based research would. 'Research as reproduction' is based on the related assumption in some ethnographic writing that we can study social phenomena from some neutral or objective perspective and that

the validity of knowledge thus generated is certain (Hammersley 1998 p50). Much anthropological writing has drawn simultaneously on both naturalistic and reproduction models of research. I have tried to utilise instead the alternative 'representation' model of research (outlined in section 4.1.2 above) wherein social phenomena are explicitly and reflexively represented from a point of view that justifies rendering some features of the phenomena relevant and others irrelevant. The case study approach is not necessarily synonymous with ethnography but is compatible with an ethnographic approach that draws on an epistemology of subtle realism and treats the role of the 'lone ethnographer' with caution. There is nothing inherently 'natural' in a Social Inclusion Partnership: it is a constructed and bounded entity, a product of national policy initiatives given local form. My fieldwork with the SIP involved the production of data (actively selected from events otherwise impossible to capture in their entirety) and their subsequent interpretation, in an ongoing and reflexive analytical process. Claims to knowledge thus generated are inevitably contingent and open to future revision.

Lofland and Lofland suggest that the canons of ethnographic validity require three types of discussions and practices, which are partially presented in this chapter (Lofland and Lofland 1995 p150-151). Firstly, I describe what they call the ethnographer's path: this involves a full account of access to the setting plus reporting those whom I observed, with whom I interacted, in what sequence, and how. Secondly, they suggest that sufficient fieldnote evidence must be displayed and that this involves reporting the procedures of assembling and processing the data, as well as presenting sufficient amounts of empirical materials. This latter requirement is addressed more adequately in Part IV of the thesis, although the ethnographic path described below necessarily entails the provision of a reasonable amount of empirical detail. Detailing the ethnographer's path can, however, be problematic: one reason fieldnotes are rarely published or distributed is that they tend to be entirely unintelligible to anyone who does not take for granted the same things as did the fieldworker at the time the notes were recorded (Kirk and Miller 1986). Thirdly, theoretical candour is required: this relates to the explanation given for the particular form of analysis used to organise the data (see section 5.3 below). The connecting theme of these three validating practices is that of demonstrating methodological concern and caution by acknowledging and calling attention to possible difficulties and shortcomings in the data.

5.2 Fieldwork – Processes and Procedures

'The norms of scholarship do not require that researchers bare their souls, only their procedures.' (Lofland and Lofland 1995 p13)

I conducted fieldwork in the East Kirkland SIP from November 2000 to February 2002 although my involvement and negotiations for access had begun in August 2000. This might seem a fairly lengthy fieldwork period, but it should be borne in mind that my research was mainly organised around specific events – SIP Board meetings, community conferences, training sessions etc. Rather than the full-time immersion of the researcher in setting that is the hallmark of traditional ethnography, in this context I prefer the more limited connotations of an 'ethnographic approach'. There are, of course, other important elements in such an approach, such as becoming familiar with the geographical setting - the ambiguously bounded spatial context for Partnership initiatives - by spending time walking around the area (ten neighbourhoods and the town centre), observing and making notes later. The subsections below address a number of key elements in my ethnographic path: negotiating access and obtaining consent; integrating participant observation and interviews; the discovery and construction of fieldwork boundaries; how embodied ethnography led to a gradual shift in status from professional stranger to 'honorary member'; the exchange of rapport for complicit reflexivity; the problems of researching an identifiable group; and the final stage of withdrawing from the field.

5.2.1 Negotiating access and consent

I first interviewed the Chair of the East Kirkland SIP, Helen Cameron, at her offices in Riverbrae Council in August 2000 during the strategic sampling process referred to in section 4.3.1 above. As part of the Riverbrae Civic Centre, the Council offices are large, modern and imposing, constructed of glass, steel and concrete on a number of levels on a hill site. They give an initial impression of civic affluence that is belied by a defunct, rubbish-filled ornamental pond on one of the lower levels, and a number of small businesses that did not seem to be particularly thriving, located on one shadowed and chilly side of the main concourse. The interview had been set up for late in the working day as Helen could not spare any time within normal office hours. I discovered that she was a senior officer at executive level within the council, Community Development Manager and Chair of both the Dunloan and East Kirkland SIPs. She was also a council representative on the Riverbrae SIP and had responsibilities for Community Planning.

The interview was conducted in Helen's own office, down the corridor from the first-floor glass-enclosed reception area that fronts the Chief Executive's department. I judged her to be in her mid-40s, of Glaswegian origins. She provided coffee and I explained my interest in the East Kirkland SIP as an organisation trying to tackle health inequalities through a strategic partnership. I asked for permission to tape-record the interview and the machine was placed on the small coffee table between us. I explained that I wanted to find out more about the SIP, her own role and that of the other partners involved, how the SIP hoped to reduce health inequalities in its area, and what had been done up to now. Building work being carried out in the council offices was clearly audible throughout the interview, which was also interrupted a couple of times by other staff members needing to speak urgently to Helen. She smoked a thin black cigar during part of the interview and had a cough that eventually led to her being unable to speak any more, at which time I ended the interview. This lasted well over an hour and provided a lengthy and fascinating account, from the perspective of a key individual, of the challenges involved in multi-agency partnership working on health inequalities and community representation in this strategic level of work. I observed some elements of moral accounting – the presentation of one's self and one's aims in a positive light, familiar to social science interviewers.

After reflecting on this first interview and deciding that the East Kirkland SIP held considerable research interest, I contacted her again *via* email to discuss the possibility of my researching this group. Helen indicated she had no objections to my becoming involved but that she wished to discuss it further with me and with the Manager of the East Kirkland SIP. After a number of email communications we finally met up again in November 2000 and this time the SIP manager, Moira Carruthers, was also present. I learned that Moira had taken on this role by secondment, as no-one deemed suitable (i.e. in terms of knowledge, experience, qualifications) could be recruited through more usual channels, despite what seemed a generous salary of well over £30,000 per year. She had retained her job title of Urban Programme Officer within the Council, as to change this would require the job to be advertised again. This meeting was very informal and was cut short by workmen who required the building's offices to be empty by five o'clock. I did not tape-record this meeting, but took notes at the time and transcribed later. I was also introduced to Susan Courtney, assistant Chief Executive of Riverbrae Council, and had the opportunity to explain my research to her. I repeated to Moira details already given to Helen about the nature and structure of the PhD and the methods I planned

to use (regularly attend meetings and other events, take notes, gather relevant documents, interview key participants).

I had presented myself as a mature student, reasonably aware of (but not expert in) the current health policy context and the health inequalities debates, and as having some understanding of the difficulties involved in the work they were trying to do. I also stated my own beliefs that health promotion is not solely a matter of specialist practice. In brief, trying to establish both partisanship *and* neutrality. Elements of self-presentation that did not need stating were my female gender, (middle)age and generally unthreatening appearance! I promised confidentiality in the sense of preserving the privacy of individual identities – a promise I later found only partially successful in the process of writing up this research. They requested, and received, a brief outline of the research for distribution to other SIP members (see *Appendix 2*). Thus gaining access and obtaining consent at this stage was accomplished with relative (and, in my experience, somewhat atypical) ease. Gatekeeper consent, however, is only part of the process and was likely to have some impact on the research as Helen's first interview had conveyed some sense of factions and divisiveness within the SIP even before the community was 'on board'. Both Helen and Moira stated a belief that it might prove useful to have an '*outsider*' involved to record processes and development and, in particular, the kinds of practical difficulties of which both women believed the Scottish Executive (the driving force behind the SIPs) to be ignorant. In these terms, my status was that of external witness. I was therefore entering a particular type of closed setting as a known investigator, where taking overt notes would be a contextual norm for much of the time.

Helen and Moira updated me on their activity, in particular the community conference they had planned as a formal mechanism to find out from existing community activists how to go about ensuring acceptable community participation. This was finally to be held in November 2002 at a local Kirklands venue. They said that the Chief Executive of Riverbrae Health Board would be speaking about local health inequalities at the conference. They told me that the SIP had been running for a year under the aegis of an Interim Management Group (IMG), and although a number of projects and activities had been funded and carried out, no formal efforts had yet been made to secure community participation. Both women said they would be attending the community conference but could not attend a SIP IMG meeting to be held earlier that day as Riverbrae council employees were to be on strike and they

were members of UNISON. They had had to get special permission to attend the evening conference – Helen said she had threatened to resign her union membership if this was withheld. We agreed that it would not be appropriate for me to gatecrash the daytime SIP meeting without prior introduction. I asked if I could attend the Conference as an observer - they agreed readily. Helen told me she had submitted an abstract for the 2001 UKPHA annual conference, in Bournemouth. I told her I planned to speak at an international health promotion conference the following year about my research with this SIP. (This was the XVIIth International Conference on Health Education and Health Promotion, held in July 2001 in Paris, at which extra I was able to present my early findings through extra research funding provided by HEBS.) They seemed to have no reservations about this.

My next contact with the research setting was, appropriately enough, the first community conference itself, held in November 2000 at the Kirklands Community Centre. This was a one-storey building, unusual in not being signposted from the main road, built next to a pub located in one of the neighbourhoods covered by the SIP. It scarcely needs pointing out that, in this type of public forum, negotiating access and gaining informed consent is neither possible nor strictly ethically necessary. After the formal presentations and question and answer sessions I asked Helen if I could sit in on a workshop, to which she agreed. The workshops were for voluntary sector representatives and members of the community only, as the purpose was to produce a strategy for community-level participation in the SIP. Some members of the Interim Management Group were also present in the hall. The result of this evening conference was that twelve interested people volunteered to form an Interim Community Representatives Sub-Group, with the remit of establishing a formal mechanism for electing six representatives to SIP Board places. I therefore had some initial contact with this group, but little chance to formally obtain their consent to my involvement: when the meeting ended, the hall emptied rapidly. I next met them at their first scheduled meeting with the SIP Chair and Manager, in early December 2000 at the Kirklands Community Centre, and was able to explain to members of the group my interest in both the SIP as it stood, and in the issue of community participation. Thereafter I attended all their meetings, up to and including the second community conference and election.

The third level of access was the Interim Management Group (IMG). My first opportunity to meet them arose in early December 2000: Helen had told me that the IMG were meeting the two civil servants from the Scottish Executive responsible for

monitoring SIPs in this region of Scotland, and that I could attend. Given below is an extract from my notes of this event:

On arriving at the council offices I see a number of names already in the visitors' book for the SIP meeting and am slightly surprised as I'm still early. I go up to the Chief Executive's reception office on the first floor, where the SIP secretary comes through to meet me and asks if I have the right day, as Helen and Moira are in a meeting with the Scottish Executive. I say I'm here for that meeting. She says it started an hour ago! - the meeting had been brought forward, she had not been asked to contact me, and did I still wish to go in? At this stage we're outside the Boardroom, which I can see is full of people I don't know, and have serious misgivings about entering a meeting of this nature without introduction - even consider missing the meeting rather than do this.

Fortunately, at that moment the Health Board policy director comes out of the meeting to answer his mobile phone and I am able to slip in under cover of this hiatus and apologise to Helen for being late. She apologises for forgetting to let me know about the change of time, tells me to 'grab a cup of coffee' and indicates an empty seat. This is clearly a very formal meeting: those present are wearing business suits and are seated around a large rectangular table with information packs in front of them. The room is large, with windows down both sides (one with vertical blinds, overlooking the corridor) and an overhead projector and screen at the far end. I get coffee, sit down at one of two empty seats on the right hand side of the long table, take up the pack in front of me and begin to make notes, trying to give the impression that I belong here.

I feel, however, like a complete intruder - few round this table know me, except for the SIP Chair, the Manager, the health promotion rep and the Health Board policy director. The others are unknown to me. I feel frustrated that I've not only missed an hour of the meeting, and have no idea of what's been said, but probably also lost the best chance to introduce myself to the IMG. They might reasonably feel concerned at the presence of a total stranger appearing in the middle of an important, significant and - possibly - confidential meeting. I'm also wondering whether the 'oversight' in not telling me about the meeting time is deliberate... (Fieldnotes: meeting between EKSIP and SE representatives, Riverbrae Council Offices, Committee Room 4, 7.12.00, 2.00 p.m.)

Consent was thus obtained more by proxy than good practice, via the research protocol given to the Chair and Manager and their sponsorship, but never formally negotiated with the rest of the group. As it turned out, no objections to the research or my presence were ever raised and my relationship with all Partners was unfailingly cordial. I felt, however, that the processes of gaining access to the field and consent of all participants fell short of rigorous ethical injunctions about being perfectly open and explicit about research at every step of the way.

5.2.2 Integrating observation and interviews

The bulk of my fieldwork has been based on observation of and varied participation in:

- the monthly meetings of the Interim Management Group (November 2000 to March 2001);
- the first community conference (November 2000), designed to launch the SIP and generate interest in community representation on the SIP Board;
- all Community Sub-Group meetings resulting from the conference (December 2000 to March 2001);
- the second community conference (March 2001) for the election of six community sector representatives onto the SIP Board;
- the two SIP training sessions funded by the Scottish Executive and delivered by the Scottish Community Development Centre (four days in all during December 2000 and June 2001);
- a planning day for the SIP Support Team in (May 2001), the aim of which was to review the existing themes of the SIP;
- a weekend training session for the 'new' partners to get to know the 'established' partners and review their training needs (June 2001);
- other relevant events such as the Health Campus (July 2001) and Social Marketing Workshop (October 2001);
- all but one of the Community Representatives' pre-meetings held prior to full Board meetings;
- all full SIP Board meetings (held from May 2001 to February 2002);

Meeting observations routinely included the time, date and location of the event, noting who attended (and whether this was a normal or infrequent occurrence), who sat where, who spoke (and to whom), who was silent, what kinds of topics were covered? How were such topics broached and received? How were decisions made and justified? With what degree of consensus? Where disagreements occurred, what was their source and whose arguments carried weight? What appeared to be the relationship between policy directives and group actions? What was the balance between statutory/voluntary/community sector participant contributions to the event? What was the emotional 'tone' of the meeting? What appeared to be 'sensitive' issues, and why? Such questions provided a basic framework but did not constrain what was recorded and were not always relevant.

Over this fieldwork period I conducted eleven planned, in-depth interviews with individuals whom I judged to be particularly significant and knowledgeable informants and held numerous impromptu conversations with others. I therefore used a process of integrating interviews and observation work, noting how different

themes that appeared important to participants and relevant to the research questions emerged in different contexts. I briefly describe below the chronological order of the key interviews and how these relate to the development of the SIP. The particular value of interview data in this context is that questions around sensitive issues (such as those around conflict within the Partnership) can be posed, and observations checked out with others involved. For example, my first interviews with the SIP Chair and Manager enabled me to gain a sense of their orientation to this particular policy initiative and the problem of health inequalities generally. This proved a useful basis for constant comparison with the perspectives of other members of the SIP, especially those representing the community, given the importance accorded to this group in contemporary policy.

During the first community conference I had introduced myself to one of senior health promotion specialists present involved in the SIP, but found that the health promotion presence on the Interim Management Group was flexible, with a number of people representing that department of the Health Board. This senior worker gave me the name of Sheena Munro as the health promotion representative most closely involved in the Partnership. I contacted her shortly afterwards and arranged to interview her to gain the perspective of a health promotion worker on trying to tackle health inequalities in a Local Authority-led partnership. She highlighted a number of themes that later proved important, and suggested a number of community activists as useful informants (two of these turned out to be members of the Community Representatives Sub Group). The interviews with Local Authority and Health Board representatives on the SIP were conducted early in the fieldwork process partly to gain access and partly because their perceptions, beliefs and experiences were all relevant to my research interests and crucial in the ongoing process of developing research questions.

The second community conference, held in March 2001 to elect six community representatives to the SIP Board, provided the stimulus to interview some of the (now defunct) Community Representatives Sub-Group about this process. One seat on the Board had been reserved for a young person, as the SIP wished to focus their efforts on this age group. However, no one came forward and this place still remained empty when I left the field. I had deliberately delayed interviewing community participants, given the interim nature of the whole partnership but by this stage these individuals were reasonably well known to me through my attendance at their meetings with the SIP Chair and Manager. Three of the Sub Group members

had been nominated as representatives beforehand by their own supporters and had, according to the convoluted mechanisms they had themselves helped to establish, been *automatically* elected to the Board, i.e. no public vote was involved. This outcome had not been fully apparent to the individuals involved until that occasion but, not surprisingly, the election procedures provoked considerable anger amongst the audience on the night of the conference. Some SIP partners voiced accusations of '*rent-a-mob*' to me, whilst the organisers of the conference were in turn publicly accused of '*anti-democratic procedures*' by some community participants.

I interviewed two of these new partners shortly thereafter, both of whom represented community projects in two different neighbourhoods. One of these interviews turned into a group interview, as other members of her project team were keen to be involved – a useful opportunity to talk to those at the absolute margins of, but affected by, funding decisions taken at the SIP Board table. I decided to interview the third new partner at a later stage, as her diary was particularly busy. The third person interviewed at this stage had been a member of the community sub-group but could not be nominated or stand for election because of illness. She had been a vocal member of the group but, as a result of the election, her neighbourhood (generally perceived as a particularly deprived and troubled area) was not now represented by any of the new partners and she had led the opposition to the election process and outcome. One seat on the Board had been allocated to the voluntary sector. Wilma Edwards, as co-ordinator of a local umbrella organisation supporting this sector, had been given a place at the suggestion of the SIP Chair and Manager. She was well known to members of the Community Representatives Sub Group and, as far as I can tell, no objections to her selection were ever made. I interviewed Wilma during March 2001.

I interviewed the two newest of the new partners (i.e. those elected at the March conference with no prior contact with the SIP) and the outstanding member of the former Community Representatives Sub-Group in October and November 2001. The process of conducting a lengthy interview with the two new participants was deliberately delayed until they had experienced a number of training sessions and had the chance to become familiar with the workings of the SIP Board and form judgements of the experience. However, in the intervening months we spoke frequently on the subject. Both new partners were residents of two different neighbourhoods: one was a member of a local Tenant's Association; the other had a lengthy history of volunteer work and community activism. At this later stage I also

interviewed, at length, the other SIP partner with a primary interest in health – a senior officer in the Kirklands LHCC. I did not formally interview the other SIP partners, but nevertheless spoke informally to all many times during the various meetings and events we attended together during the year.

The structure of earlier interviews was shaped by questions to which I sought specific answers, such as ‘*what does the term “health inequalities” mean to you?*’ and ‘*how and why did you get involved in the SIP?*’ etc. However, my strategy of conducting interviews at key stages in the development of the Partnership and with different categories of Partner (i.e. statutory *versus* voluntary/community sector) meant that no one set of questions was appropriate for these later interviews. The interview format in this context was open to issues raised by participants, underpinned by broader questions about their experiences of participating in the SIP to date, if (and how) their opinions had changed over time, and how they perceived progress. These were not one-sided encounters with the researcher striving to maintain a neutral presence whilst simultaneously controlling and directing the interview. As I knew my participants reasonably well, the interviews were lively encounters – conversations with a purpose, in Burgess’s terms (Burgess 1993) – that entailed flexibility rather than structure, and a degree of disagreement over interpretation of events and actions as often as not. An indication of the types of questions I asked and areas I attempted to explore during the earliest interviews is given in *Appendix 3*.

5.2.3 Discovering/constructing boundaries

The notion of a case must carry with it some idea of a boundary and the case study must contain an explicit account of what the boundaries are (Denscombe 1998). Denscombe believes that cases have well-established boundaries prior to investigation that are not generated by the researcher (e.g. membership of an organisation, formal structure/span of operations). A key research task is to identify boundaries that already exist. However, he suggests that in specifying such boundaries there is an in-built tendency to create an artificially closed system that may exclude external factors that have a genuine impact on activities, processes and relationships within the case study. Boundaries may ignore things that happen to those involved when they are away from the defined area and create difficulty dealing with occasions when outside factors temporarily intrude on the zone of the research. (Denscombe 1998 p39). Boundaries may be physical, geographical, social,

historical and structural. Physical boundaries are rarely defined by geographical area, and are more likely to be organisations whose boundaries coincide with areas. This is likely to be a practical but artificial boundary, excluding those things outside the physical boundary that will have an impact on what happens inside.

In many ways, researching a social phenomenon that has the form of a bureaucratic committee is the ideal site for ethnography. To be able to sit silently for much of the time, observing and taking full notes without the burden of having to simultaneously participate or being perceived as necessarily odd, is a gift indeed. Consider, too, the plentiful opportunities for recording (and learning from) the casual asides of other participants, the opportunities for impromptu questions and time spent chatting over the coffee cups before getting down to business every month. The downside, of course, is that such opportunities are temporally and spatially bounded by the calendar of meetings. Just because the members are not physically present round the board table does not mean that activity ceases, just that it is not accessible to direct observation. The work of the SIP proceeded in places and at levels that were impossible for me to record. Case study boundaries were clearly significant. Some boundaries were a feature of the situation being researched. The SIP is historically bounded by its period of funding (ten years) and geographically bounded by the area it covers. The name of the East Kirkland SIP is a constructed entity, referring to a number of neighbourhoods categorised as 'deprived', rather than the whole town in which they were located. The significance of the SIP's problematic boundaries is explored further in Chapter Seven.

Other case study boundaries were of my own choosing. For example, I did not seek access to the Policy and Resources Committee of the local authority, although this body had the power to overturn any decisions made by the SIP management board. I did not focus much research attention on the work of the SIP's Support Team, which was set up roughly a quarter of the way through the process of fieldwork (May 2001), although I did attend the Team development day and had prolonged contact at a later stage with the Development Officer for Community Capacity (DOCC). Nor did I ask to attend any of the sub-groups or mini working parties that were set up during the organisational evolution of the SIP, or attend more than one of the 'Health Campus' meetings. I imposed these boundaries partly because of resource constraints in terms of time, travel etc, and partly because the other types of organisations did not seem as central to my research interests (and it has to be seriously doubted whether I would have obtained access to a private Council

committee within the fieldwork timeframe). With hindsight, however, I feel that gaining access to the SIP sub-groups would have been relevant and regret not having done so. Fortunately, the deliberations of these groups were always subsequently brought to the Board table, and I checked out such official accounts at a more informal level with community representatives who had been present.

Finally, there is the issue of the boundary between observation and participation. As noted above, during SIP meetings I was in the enviable position of being able to take copious notes, for the most part without restraint. I know, from informal comments made by other participants, that after the initial surprise at being observed, my presence eventually came close to being taken for granted. There are some exceptions to the opportunity for routine notes. On occasions when I was participating in events, such as the exercises as part of training sessions, note-taking was more restricted. At other times, issues would arise as part of the formal SIP Board meetings that led the Chair to instruct the SIP secretary, '*don't minute this*'. At such times I felt it a necessary courtesy to *appear* to observe these flags of sensitivity by also not writing until the issue had been addressed – and then hastily noting down what had taken place at the first opportune moment. On other occasions, outright conflict would arise between various members of the partnership. Although such issues urgently required recording, I again felt it impossible to do so overtly – to continue to write would certainly have drawn attention to what I was doing and would, I believed, have been judged unfavourably by other participants. This was a matter of deciding on the boundaries of appropriate and ethical behaviour in the setting: balancing sensitivity with, perhaps, a minor degree of deception.

As most ethnographers discover, the term participation covers multiple activities. On a very small number of occasions during fieldwork I chose to intervene actively in events - in both cases, giving considered feedback to participants. In both instances I judged intervention to be justifiable and relevant, as to conduct intensive research of this nature whilst simultaneously giving no feedback to participants is ethically problematic in itself. Importantly, in neither case could I detect any negative consequences of my actions – for example, in terms of changing the courses of action within the SIP, or of changing participants' attitudes towards me or towards others. In one case, my action enabled participants in a workshop to complete a task, as a group, that had previously stymied them. In the other case I was able to give some hopeful feedback to the leaders of the partnership at an otherwise low point for them. In addition, intervention of this nature can be ethically appropriate in that it enables

the researcher to declare herself to other participants, stating her own views/perspectives, and thus ameliorating the otherwise one-way flow of situated information.

5.2.4 Embodied ethnography

Sandelowski has pointed out that

'disembodied views of participant observation and a virtual neglect of the material world have led to qualitative work that is not as full-bodied as it should be.'
(Sandelowski 2002 p104)

Embodied ethnography, on the other hand, acknowledges that the full range of human senses is involved and that fieldwork is a physical as well as cerebral activity. Observation involves monitoring and interpreting the body language of other people and our own reactions: as researchers we do not simply watch, listen and write – we respond in multiple ways to the situations in which we find ourselves, ways that may involve emotions such as anger, fear, suspicion, humour, confusion etc. For example, on a number of occasions I was unable to understand exactly what was happening, although the setting itself was familiar enough from past experience. I frequently experienced a degree of confusion at that stage in the agenda of formal Board meetings when the Manager summarised the latest budget statement, invariably with great rapidity - not, I believe, because she intended to confuse her audience but simply because this was a routine and mundane a performance for her. Another, less trivial, matter was my ongoing sense of unease that the 'real' business of the SIP must be happening elsewhere as – in some respects – the formal Board meetings revealed so little. Were the 'real' decisions being taken behind closed doors by those whom I viewed as the core partners? Incipient paranoia is, perhaps, part and parcel of ethnographic work though we may not always be happy to admit this! I later discovered that feelings of confusion and suspicion were shared by others, even by those statutory sector partners who had been involved with the SIP since its earliest days. I therefore found my own responses to various situations to be an important analytical resource. This meant abandoning the (perhaps illusory) goal of achieving complete comprehension of events and processes in favour of a more partial, but experientially grounded understanding and interpretation – shared by some, but not all participants, at some, but not all of the time.

5.2.5 From 'professional stranger' to 'honorary member'?

Ethnographic research rarely involves a static presence over time. My notes record a gradual shift from being a relatively silent, passive presence at early meetings of the Interim Management Group, community conferences and potential community representatives meetings, to becoming a fully active participant in some of the less formal events. There is obviously a continuum between participation and observation roles and I deliberately varied the degree to which my role has been mainly participant or mainly observer, according to context and what felt right in ethical terms. In the context of the formal and bureaucratic SIP meetings, held monthly, following a tightly observed agenda and invariably accompanied by a substantial amount of paperwork to facilitate rapid decision-making, I took the role of observer. During the more relaxed and discursive meetings with the Community Sub Group and SIP Chair and Manager I was also mainly an observer of process and interaction. However, occasions arose when it would have felt inappropriate not to participate. For example, the Dedicated Support Team planning day was held very shortly after this team had been constituted and office accommodation found, and I discovered that I knew more about the history and processes of SIP work than some members of this new team. Similarly, during the informal training sessions, which involved group discussions and exercises, non-participation would have felt like straining after an artificial and unrealistic detachment. And on such informal occasions my participation as a member of the group was clearly expected by others present.

During formal Board meetings, there was considerable informal interaction with all SIP members prior to the Chair calling the meeting to order. I retained a limited interactive presence in Board meetings once the Chair had initiated this division between informal chatting and getting down to business. In this forum, for example, my interaction took the form of (very infrequently) asking questions for clarification; being occasionally consulted about research-related issues, or being asked to confirm someone's interpretation of an event I had also attended, for purposes of Minuting events. Apart from the SIP Manager who was invariably present on every occasion, I can claim to have attended more SIP events than any other participant. The copiousness of my notes and record keeping were jokingly referred to, with the Chair and Manager often commenting that it would not matter if any SIP documents were lost, as I would have a copy. It was this familiarity with events, history and participants, perhaps, that led the voluntary sector representative to refer to me as an '*honorary member*' of the SIP. This may makes my research role sound comfortable, even cosy, but if so, the portrayal is inaccurate: a more accurate

representation would be that my relationships involved a complex interplay of degrees of trust and scepticism, engagement and detachment, partisanship and neutrality.

Having gained entrée through the SIP Chair and Manager, it would not have been surprising had some suspicion attached itself to my role in the eyes of the community representatives but I had little sense that this was the case. Community representatives would frequently say something along the lines of, '*we know you're not on our side as such, but ...*' and then proceed to discuss whatever issue they wished to raise with me, which frequently took the form of a grievance. Conversely, the core partners and leaders of the SIP (Chair, Vice-chair and Manager) were quite aware that I spoke separately to the community representatives, but appeared to bear no resentment. One occasion made me acutely aware of the complex ethical position I was in: after an unusually fraught, even hostile encounter between Chair and community representatives in a SIP meeting, Helen the Chair asked me to say behind for a short while. I did so and listened (with some sympathy, I should say) to the exasperation she, the Manager and the Vice Chair had felt with the events that had just taken place and with the all too apparent and ongoing gulf between the perspectives of the community representatives and themselves. In that context, it appeared 'natural' for me to participate in a discussion of the representatives with the core partners.

However, when I left this post-mortem meeting I found the community representatives still there, sitting smoking and talking animatedly in the waiting area outside the committee room – doubtless with similar exasperation to that just conveyed to me. In this changed context, I felt unmasked as a partisan of the more powerful partners and my discussion of a few moments previously suddenly felt closer to betrayal. Lofland and Lofland suggest that the only way to confront the moral complexity of research is with dispassionate concern (Lofland and Lofland 1995). Most of the time I found that practicing dispassionate concern translated into a feeling of sitting on the fence – an uneasy position, but preferable to climbing down on one or other 'side'.

5.2.6 Complicit reflexivity – acknowledging 'counterparts'

A description of how the researcher built or established rapport is often made explicit in qualitative research texts (particularly those based on interviews). The term has

also been used, more implicitly, as a covering shorthand for the messier aspects and predicaments of engagement in ethnographic fieldwork (Marcus 2001). As Marcus has pointed out, attempts to create rapport reflect a Western, culturally-specific concern with being accepted and with gaining trust (albeit in a superficial and frequently one-sided sense), driven by the underlying and questionable assumption that achieving good relations with research subjects by itself somehow increases the validity of the research (Marcus 2001). 'They' are judged as more likely to tell 'us' 'the truth' if 'they' accept and trust 'us'. This classic process of othering in research has never really been overturned although alternative norms and forms for fieldwork are possible. Fieldwork accounts are not the sole construction of the 'lone ethnographer'. They are the product of a researcher's own foreshadowed problems and questions, certainly, but also of the interaction of the researcher with knowledgeable others in the field, whether this interaction takes the form of pre-planned intensive interviews or *ad hoc* spur-of-the-minute conversations. Marcus frames this in terms of reflexive complicity, rather than rapport. Our 'subjects', like ourselves, are involved in reflexively accounting for the world and their place in it. Moreover, with perhaps one or two exceptions, the participants in my account do not easily fit into the category of marginality characteristic of much ethnographic research. The more influential partners are certainly better described as '*fully inside and complicit with powerful institutional engines of change*' (Marcus 2001 p523). There are therefore certain affinities and identifications between the reflexive predicaments of the fieldworker and those whom s/he studies.

I came to appreciate the collaborative connotations of reflexive complicity when conducting the eleven interviews with the SIP participants. I experienced a marked contrast to the earlier sampling interviews, which was not simply a matter of having a surer sense of the questions on which to focus but rather a product of having a basis for discussion in shared experience. These transcripts record active discussions, where my co-participants and I offer sometimes similar and sometimes quite differing accounts and interpretations of the topics under discussion. The final analytical product of such interaction is a mutual construction – the '*de facto but unrecognised coauthorship of ethnography*' (Marcus 2001 p521). 'Subjects' become counterparts – co-producers of interpretations that we elicit and share or contest in our fieldwork encounters.

5.2.7 Researching an identifiable case

Stake underlines the considerable ethical responsibilities of the case study researcher when he warns that

'(t)hose whose lives and expressions are portrayed risk exposure and embarrassment: loss of standing, employment, self-esteem ... it is imperative that great caution be exercised to minimise risks.' (Stake 1994 p244)

I faced two main ethical problems throughout the fieldwork period. Firstly, trying to convince the members of the SIP that they were indeed exposing themselves to some risk in allowing me to study them, whilst simultaneously avoiding causing such alarm that they would decide it safer to ask me to leave. Although I raised the issue of dissemination on a number of occasions towards the end of fieldwork, the group expressed few qualms: they saw themselves as easily identifiable because of certain unique features but appeared to trust that honest reporting would not damage them. I strongly suspect that they also felt protected by the amicable nature of our mutual relationship. The potential danger of being 'subjects' of research did become obvious to them, however, on publication of an academic research project that they had themselves commissioned into drug use in the particularly deprived neighbourhood referred to above. This research was highly critical of a major public service in the local area: this service had a representative on the SIP Board who had not been especially vocal until this point. Neither this person nor the other partners had fully realised that the research findings would be disseminated by the academics involved to those audiences whom they felt appropriate, such as the Health Board. The researchers, not the SIP, seemed to own the findings: the SIP had only paid for the work. To say this caused embarrassment and resentment within the pilloried agency and its representative is an understatement, and redoubled my concerns.

The second, related, problem has been a source of ongoing concern: that is, deciding what to report and in what detail, given the impossibility of making analytical claims about a specific setting or group without substantiation in the form of empirical materials. The East Kirkland SIP is only one of 48 such partnerships across Scotland but although most may not be able to identify it, I suspect that those individuals with more knowledge of contemporary social policy and the historical-industrial landscape of Scotland might. As the names of all SIP Chairs and Managers are public knowledge and easily obtainable, and the names of other representatives are not secret, the potential for identifying this SIP and its members remains a possibility. Access was generously given: to repay via potentially harmful exposure is scarcely

justifiable, even when based on claims that such partnerships operate in the public domain and that research contributes to wider knowledge.

I promised confidentiality in the sense of not revealing people's names, but to hide their roles and obscure their identity within the setting would render honest and meaningful analysis impossible. For example, information obtained from the 'leaders' of the SIP needs to be acknowledged as such, because of their powerful influence in shaping this organisation. Some data, from various sources, are identifiable as slanderous and libellous, e.g. unsubstantiated allegations of professional malpractice or misappropriation of funds: others, as revelations of an extremely personal nature. Information like this is obviously given in confidence and I have avoided its inclusion. The other major issue, that of revealing information with the potential to harm existing, but fragile working relationships has been a constant anxiety as practically anything worth saying about this SIP does indeed involve this potential. This may be doubly problematic for community members of the partnership, some of whom were financially dependent on grants from other participating agencies.

Pseudonyms have been used where extracts from fieldnotes are reproduced in the text as, although this does not ensure anonymity, participants' utterances were at least made in public where others also heard them. With regard to reproducing quotations from data gathered during interviews and *ad hoc* conversations, I have used two main strategies to preserve anonymity. Firstly, direct quotations from research informants, where gathered *informally*, have not been included in the text, as – although undeniably enlightening – it is probable that on most occasions such utterances were made in a context where individuals could forget, or be unmindful of, my research role. The incorporation of direct quotations could therefore be seen as ethically dubious, given respondents' possible lack of awareness that their words could be publicly reported. There is one exception to this, where I record that the SIP Chair describes herself as '*fed up with being seen as the enemy*'. This is included because, firstly, this is a self-ascription, not a description attributed by others – and I have no doubt that all SIP participants would agree that this was an accurate perception and not one subject to conflicting views. Secondly, the quotation is included because this perception is analytically important when considering the risks of leading such multi-sectoral partnerships.

With regard to my second strategy to help preserve anonymity, I had initially planned that quotations reproduced from interviews would not only give some indication of the status of the speaker (e.g. C/VR for community/voluntary sector representative, SSR for statutory sector representative), but would also include an identifying number, to enable the reader to make distinctions amongst the different contributors and avoid the impression of homogeneity within groups. However, for anyone familiar with the members of this SIP, careful scrutiny of these might make it possible to detect a speaker's identity. Such numbers have therefore been removed, as have the dates of the interviews. Whilst the different types of partners were ready to make critical observations of each other and episodes of outright conflict were not uncommon, I judged that they also wanted and needed to continue to try and work together, notwithstanding some lingering resentments. In presenting my account of the Partnership I have therefore tried to balance honesty with caution, and honouring trust with maintaining the integrity of the research.

5.2.8 Leaving the field

To some extent leaving a relatively temporary setting such as a business-like partnership is easier than departing a scene of intensive, long-term personal involvement. Yet leaving the field is still one of the most difficult parts of ethnographic work. There is always the temptation to believe that something of vital significance will happen just after one's departure, something which would dramatically change the shape and form of analysis, if only one were there to observe it - an argument which would ensure that no research would ever be completed. I was not the only person to withdraw involvement. By the end of my fieldwork the SIP Chair, Helen Cameron, was preparing to hand over this role to her unofficial vice-chair (Graham Hamilton, the health promotion policy director of the local Health Board). Moira Carruthers' (SIP Manager) period of temporary secondment was drawing to a close and her post was about to be advertised, along with a number of others. Three of the original statutory sector partners had been replaced by other colleagues during processes of internal re-organisation in their agencies. One community representative had resigned during an acute period of conflict and crisis around the allocation of funds earmarked for supporting community involvement in the Partnership. Flux, not stability, seemed a defining characteristic of the Partnership.

My responsibility at this time lay in negotiating ways of gaining the members' consent to dissemination of my findings. As stated above, few of the partners viewed anything I might be likely to say as a problem, with the exception of the LHCC representative, who clearly saw the potential for damaging relationships *via* incautious exposure. Towards the end of 2001 I raised this issue at SIP meetings and arranged for a feedback session early in 2002. I did not view the meeting as useful for triangulation purposes or 'member checking' as I do not expect research participants to necessarily share my analytical perspectives (with the caveat that if they differ substantially, it is necessary to provide an explanation). I did feel it essential that they be made aware of how I would be speaking of them in other public fora, both as a matter of professional ethics and common courtesy. The meeting in which my feedback was an agenda item was reasonably small – only one community representative, for example, could stay for the whole meeting and my 'slot' was at the end of this. The partners were interested to hear my interpretations of their work and relationships and, although these interpretations were critical in many respects, had no expectation that I would change this where they were not in total agreement with me. Where disagreement of interpretation or emphasis existed, I made note of their comments and promised to incorporate them when writing up the research. I agreed that the identity of the SIP and its members would be anonymised in future publications. I also promised to send a draft of any paper intended for publication to the SIP manager for dissemination to the partners, to give them the chance to raise objections before going into print. They invited me to return again in a year's time, to see how things would change under the new structure about to be implemented and I left with a strong sense of regret for inevitably unfinished business.

5.3 Analytical Strategies

The process of analysis briefly described below was shaped by the interaction between pre-identified research interests, the methodological position outlined earlier, and the particular ethnographic path documented above. The following sections describe how I constructed, handled and treated the data and the theoretical form of the analysis.

5.3.1 Data management

It will be obvious that fieldnotes cannot cover every aspect of an event – some selection is inevitable and in this case was shaped by specific research questions, as

indicated in section 4.3.2 above. I transcribed such notes onto a personal computer (using Microsoft Word) as soon as possible after the event, using single spacing but leaving a wide margin on the right for later manual coding. Files were named according to the event, and dated, for ease of identification and retrieval. Each separate field record was followed by an addendum in the form of a reflective memo, laying out what I perceived as important themes in the data and speculating about the interconnections between this event and others, or between this event and data produced via interviews. Such addenda largely shaped the initial coding process. Each addendum was copied to my running fieldwork log file on the PC, specifying context and ordered chronologically, for later use in formal analysis. I also transcribed my own interview tape recordings onto the computer – a labour-intensive but useful process – again named and dated for ease of retrieval. Separate copies of all computerised documents were kept on two separate hard drives (personal and university PCs) and on both floppy discs and CD in case of an irrecoverable system crash. A key housekeeping task was to ensure that up to date backup copies were maintained. All documents on the machine with potential for access by others were password-protected to ensure confidentiality of data. Two sets of each document were printed out – one for retention as a master copy, another for analytical use. These were kept in my office at home.

My fieldnotes of the various meetings and events ran to over 200 single-spaced pages of text (over 100,000 words) and the eleven semi-structured interviews with SIP/community representatives produced 187 pages of single-spaced text (again, roughly 100,000 words). An additional data source was the large number of ‘official’ documents available, principally the Minutes and Agenda of each meeting. Other documents included the annual reports to the Scottish Executive; the (many) drafts of the Development Plan; and the Minutes of the community representatives’ separate meetings (made available to me, but not the statutory sector partners). These data were stored with my own records in six large box files: these files formed the master copies, kept in chronological order for regular review from beginning to end.

5.3.2 Questioning, coding and emergent analyses

In most qualitative research work, analysis is clearly not a separate activity. The act of transcribing handwritten fieldnotes facilitates the process of developing analytical thinking, as does the personal transcription of interview tapes. Thus the researcher comes to the task of writing up already intensely familiar with the data but in an open

and questioning frame of mind, constantly asking 'what does this mean? Of what category is this an instance?' At the stage we normally if artificially designate as 'formal' analysis (i.e. after fieldwork is complete) I read through my copies of fieldnotes and accompanying documents and interview transcriptions from beginning to end several times before beginning the process of formal coding. As well as chronological reading, I also found it useful to split these textual materials into different types, to be read together or sequentially: for example, fieldnotes of meetings; official minutes; agenda documents; interview transcripts. Microsoft Word has a number of useful features that facilitate coding, particularly the computerised versions of manual cut and paste. Also, with the windows feature, multiple files can be open and consulted at will, making use of the 'find' and 'go to' features within the edit menu to locate and retrieve text items. Qualitative software analysis packages are increasingly popular, and I feel the need to justify not having used the one made available to me (NVivo). It has been often said that such software packages are a useful tool to aid the physical tasks of coding but are no substitute for conceptual work. I also suspect, despite claims that they are suitable for ethnographic input, that they work best in cross-sectional mode, i.e. tracking codes and concepts across a body of similar data such as interviews. I was not confident that I would be able to achieve sufficient competence with the software in the time available and I doubted the capacity of such software (in my inexperienced hands) to maintain an adequate sense of the temporality and developmental context of ethnographic fieldwork.

Analysis is an emergent product, what Lofland and Lofland call '*the fieldworker's derivative ordering of the data*' (Lofland and Lofland 1995 p181 [emphasis in original]), rather than a mechanical process. Coding and memoing are the core physical activities of developing analysis, resulting from the basic open questions any researcher asks of the data. Codes begin the process of categorising and sorting, summarising and synthesising the data. They thus operate as shorthand labels, forming a pivotal link between data production and its conceptual rendering. During this process, some codes begin to assume the status of overarching ideas or positions that come to occupy a prominent place in analysis. Memos, on the other hand, operate as a prose form for elaborating the shorthand of codes but may also relate to any aspect of the study – substantive, methodological and personal. They are therefore one of the '*most useful and powerful sense-making tools at hand*' for the researcher (Miles and Huberman 1994 p72). As an example, I give below the memo I wrote after my first interview with the Chair of the East Kirkland SIP. Potential analytical categories are emboldened:

I felt that there was an interesting tension between the 'moral' aspects of her account of her desire to help local people who are subject to health and broader social inequalities, and her doubts about conventional wisdom around 'community development' approaches, which always imply empowerment. Does the possession of **expert knowledge** about what communities 'really need' undermine the possibility of meaningful **community participation**? I was struck by a number of other themes which seemed significant, given their expression by a powerful and influential a member of this (and other) strategic partnership(s). Most of these implied some potential for **conflict of interest** between community, Partnership and SE. Her account indicated extensive difficulties in achieving **authentic community representation**. She also spoke of **structural and systemic barriers** involved in tackling health inequalities generally and facing this SIP in particular. These include the **traditional policy focus** on certain aspects of the formal health services rather than on health improvement, and the **power and relative autonomy of other public sector agencies**, such as primary care. This perspective automatically raises questions about the **capacity for agency at partnership level**. She seemed to suggest that the SIP's desire to focus on health inequalities was not unproblematic, in that **different priorities** existed at policy-making and community levels. The way she spoke of health inequalities implied a broad-based 'social determinants/life circumstances' perspective, which may be at odds with health policy imperatives around the reduction in specific disease states. However, she may not put her money where her mouth is – most of the specific SIP-funded activities she mentioned could be placed fairly and squarely in a 'lifestyle' category. (EKSIP Chair interview 17.08.00 memo 18.08.00)

Analysis is therefore a second order construct – an interpretation of data I had already generated, which was in itself inevitably interpretative. Some themes seemed worth pursuing, only to be re-evaluated at a later stage as less relevant: others I came to view as of fundamental importance in explaining the processes I observed and the accounts I was given, or helped construct. As part of the analytical focus in Chapters Six to Eight, I make use of the term discourse when referring to research participants' explanations or comments, both during one-to-one interviews and during periods of participant observation. I am not using this term to indicate the formal strategy of discourse analysis: that approach is usually reserved for comparatively short pieces of text, written or verbal. Moreover, although 'discourse analysis' is an appropriate approach to interview data, it is entirely inappropriate when applied to ethnographically derived fieldnote data: fieldnotes focus on multiple aspects of a research situation and therefore rarely capture sufficient verbatim utterances by participants to enable the researcher to provide an adequate discourse-based analysis. I employ the term in a broader sense: that of representing participants' constructed accounts as drawing on a set of interrelated concepts that act together to provide a way of understanding and acting in the social world (Levitas 1998, Hastings 1998).

One of the enduring problems in social theory is the tensions between structural constraints, the subjective involvement of human agents in creating such constraints and their capacity to respond, resist and actively reshape the structures and systems in which social life is embedded. This broad theoretical awareness provides part of the backdrop for the analysis of this case study, where I focus on the elaboration of both the context of this case study and the strategies developed and employed by participants. In other words I draw on a situation-strategy approach as a way of reflecting on the larger problem of the relationship between structure and agency. My approach has been to describe and explain the specific social processes of the SIP as a way of illuminating the relationship between agency and structure. I have chosen to separate these into periods marked by some important change of structure in development and growth. These periods can be conceptualised in terms of *episodes* (such as the two community conferences), *cycles* (such as the formal, monthly committee/business-type Board meetings), and *sequences* (linking specific outcomes to prior causes, such as the resignation of a community representative as, in part, a result of intra-group conflict).

Strauss's work on social worlds has also been a useful analytical tool (Strauss 1978, 1982). This attempt to provide a formal framework for an approach to analysis is common to much sociological work: the idea that society is constituted by multiple social worlds that both touch and interpenetrate is not new. Social world theory in Strauss's formulation involves three key processes: the inevitable segmentation or differentiation of social worlds into sub-worlds; the quest for authenticity or legitimacy in matters pertaining to the relevant world; and the process of intersection – the overlapping of worlds or sub-worlds. No particular level for analysis or theory development is assumed *a priori* (e.g. macro/micro, formal/substantive). Characteristically, a social world will be dominated by one main activity, have sites for that activity, involve technologies of one form or another, and be structured around some form of organisation (Tovey and Adams 2001). Crucial to this perspective is the fluidity of such worlds – they fragment and proliferate into numerous sub-worlds, forming and re-forming as a consequence of the processes within and between different groups.

I believe that multi-agency partnerships such as SIPs can usefully be conceptualised as an instance of the intersection of the social worlds of the statutory and voluntary/community sectors. In a Social Inclusion Partnership these social worlds are segmented at the micro-level into the multiple sub-worlds of the various statutory

agencies (e.g. health and local government services) and those of the voluntary sector and community-based organisations. For example, the sub-world of a Health Board obviously incorporates multiple other sub-worlds, such as the operational and strategic elements of that organisation. Similarly, the sub-world of the Local Authority incorporates both elected members *and* professional officers and staff responsible for day-to-day service delivery. The sub-world of the community/voluntary sector incorporates multiple organisations serving different target groups and/or communities. The study of process is central to the analysis of social worlds, in alignment with the scrutiny of structural features. A social world perspective is particularly useful for the analysis of an ethnographic case study as it trains attention on matters of history – origins, present formation and possible future trajectory.

5.3.3 Ethnography as process and product

'There are social actors and social life outside the text, and there are referential relationships between them' (Hammersley and Atkinson 1993 p255)

The relationship between the text and its subject matter is not arbitrary but reflexive. Researchers using an ethnographic approach produce readable texts, constructing accounts through 'natural' rather than scientific language (Hammersley and Atkinson 1993). In constructing such accounts, the process of writing cannot logically be separated from the processes of fieldwork and analysis. The mechanical procedures of coding and memoing are only one part of analysis: the meanings they contain need to be conveyed to the reader and evaluator of the research work by being woven into the research text through the craft of writing. This activity in itself provides a further context for reflection and discovery that may change earlier ideas, or modify certain themes. My transformation of the field into the text has been achieved through the narrative reconstruction of a particular social world, wherein analytic claims are grounded in the particularities of observed social interaction and process. This necessarily entails a trade-off between comprehensiveness and comprehensibility, which means that certain data are discarded as less relevant or simply as just too much detail. Ethnographic writing employs narrative techniques *knowingly*, to create particular kinds of order, constructing, for example, accounts of intentions and actions and unintended consequences. It is important that the reader/ audience be aware that my ethnographic writing does not constitute a transparent or neutral medium of communication, but neither does this entail an abandonment of a commitment to realism.

Part IV

TACKLING HEALTH INEQUALITIES IN A SOCIAL INCLUSION PARTNERSHIP: A CASE STUDY

Background

This introduction to Part IV presents a brief review of the relevant policy background to Social Inclusion Partnerships. Although the contemporary policy focus on tackling health inequalities is recent, targeted programmes for attacking issues such as poverty on the basis of central-local government partnerships are not new. They were introduced by the Labour government in 1977 and developed in Scotland by regional authorities such as Strathclyde in the early 1980s (Foster 1999). The following Conservative administration introduced New Life for Urban Scotland (NLUS) in 1988, an initiative that actively sought local government and community participation. NLUS offered regeneration programmes funded by the Scottish Office that aimed to lever in resources from the private sector and to introduce the perceived benefits of market forces to the worst areas of urban dereliction, in the form of four pilot projects across Scotland. Solutions were cast in terms of improving the employability of the pilot populations through training, and improving their housing environment through mixed tenure and property development. NLUS prioritised partnership with the community as part of the development of Conservative policy in Scotland: stress was placed on developing entrepreneurial values and curbing the perceived 'dependency culture'. Assessments of NLUS generally agree that the initiative improved the urban environment in the pilot areas but did little about poverty and unemployment, and serious problems of ghettoisation developed in two of the areas. Critics have pointed out that such policy developments followed the demise of traditional heavy industries formerly providing massive employment in Scotland, and the associated decline of a working class community power base in the form of the trades unions (Foster 1999). Involving the community in redevelopment was thus seen as part of the process of changing undesirable social values in poorer areas.

Others have pointed to some continuity between such programmes and the newer Social Inclusion Partnerships introduced by Donald Dewar, First Minister of the new Scottish Parliament, in 1999 (Collins 1999, Foster 1999). The emphasis on

empowering and regenerating local communities is carried forward from previous approaches. The social inclusion approach focuses on agencies (from both public and private sector) working collectively with individuals and groups, 'listening to communities' in order to draw them into the mainstream of social life and promote a culture of active citizenship. Social inclusion initiatives have been subsumed in Scotland under the yet more recent policy agenda of social justice, which presents 29 milestones for improvement in the lives of all Scottish citizens under the overarching theme of '*a Scotland where everyone matters*' (Scottish Executive 1999b). Foster suggests that harnessing the expertise that exists in different agencies at local level and targeting it at the social inclusion project appears to be the main innovation (Foster 1999). However, he also notes that although unemployment, low income, high crime environments, broken families, poor housing and poor health are identified in policy documents as obstacles preventing significant numbers of people from enjoying access to prosperity and equality of opportunity, the underlying causes of such problems remain unanalysed (Foster 1999).

Forty-eight Social Inclusion Partnerships (SIPs) have been established across Scotland within Local authority Areas, funded by the Scottish Executive for up to ten years in some cases. Some SIPs are area-based, with relatively clear geographic boundaries. Their focus tends to be on social and economic regeneration and tackling the problems of poverty and deprivation. Other SIPs are thematic, focused around particular aims, such as routes out of prostitution, or around interest groups, such as young care leavers. Most SIPs have at least a partial focus on improving health within their chosen communities. The majority are found in urban areas, although the scattered rural communities of areas such as Argyll have archipelago SIPs. All Partnerships are subject to regular monitoring and evaluation procedures, originally by the Area Regeneration Division of the Scottish Executive. This Division has since amalgamated with the former quango, Scottish Homes, into a new Executive Agency, Communities Scotland. Scottish Homes was formerly a key agency partner in most area-based SIPs and the implications of this major change are not yet clearly understood. All SIPs are, at least initially, Local Authority-led: this means that the local council acts as banker to the SIP, although in practice this means that the council carries a large overdraft as payments from the Scottish Executive are made in arrears. It also means that stringent accountability procedures are in place, and SIP decisions on expenditure usually need to be independently approved by a separate Local Authority body. The bases of Partnerships in Local Authorities

means that Councillors usually have a seat on the SIP Board, thus introducing the additional complexity of both national and, especially, local Party politics.

Some SIPs are direct descendants of former policy initiatives such as NLUS, Priority Partnership Areas and the Urban Programme, and thus are able to build on existing experience of partnership and a history of alliance work, as is the case for SIPs within the Glasgow Alliance. Other partnerships are newly established. The partnership composition of any SIP depends on its particular focus or theme, but representation of the community and voluntary sectors on a Partnership Board is mandatory. That this is an inherently problematic and contestable issue will be demonstrated in the description and analysis of the East Kirkland SIP provided in the following chapters, but I suggest that the problems encountered by this Partnership are not unique. For example, a SIP Conference was held in May 2000 in Glasgow, aimed at voluntary and community sector representatives on SIP Boards and entitled 'A Community Response to Social Inclusion Partnerships'. One of the main concerns voiced by some participants from these sectors was the potential for their marginalisation by Partnership Boards. Some Boards seemed to prefer to engage communities via alternative mechanisms such as people's panels or citizens' juries. Conference participants questioned the validity and authority of these fora for a number of reasons, not least because recruits may be paid to take part. A more fundamental objection was their belief that most community residents may not have the knowledge or expertise to play an appropriate role in influencing local services, but may be selected in preference to known community activists perceived as potential trouble makers. From the evidence of this conference, it seems that perceptions of legitimacy of community representation may be based on widely differing assumptions of what counts as representation and, indeed, what counts as a community.

In the chapters that make up this Part of the thesis my analysis is represented as a narrative, chronologically developing form: this form refers to an experienced reality, made accessible through what Geertz has called thick description, i.e. a research interpretation firmly grounded in the data (Geertz 1973). However, it must be remembered that interpretations may change over time and this account should therefore be regarded as contingent and capable of revision. One of my intentions is to enable the reader to grasp - and critique - this particular ethnographic path. The narrative is structured in terms of three temporal stages in the Partnership's development: its origins, themes and early structural form; the period following the

integration of community representation; and, corresponding with my final phase of fieldwork, the emergence of open conflict between elements of the Partnership. These are also significant stages in terms of the research themes and questions (see section 4.3.2) and my analytical focus on social processes.

- Chapter Six provides an account of the SIP's contextual origins and early development. I describe how the structure of the partnership became differentiated into two types of representative: an established interim management group and a sub-group of potential community representatives, both of which were arguably influenced, motivated and led by a small, committed leadership core. The final section of the chapter describes the contested processes leading to the establishment of a full Partnership Board.
- Chapter Seven begins by presenting the critical reflections of the new Partners on participatory processes up to the end of March 2001. I then move on to describe progress towards collaboration within the Partnership. This chapter also draws the SIP Support Team into the process of analysis. At this stage in the Partnership's development, my analysis foregrounds two related issues: the 'forced' nature of such partnerships and the associated contest between participants for the status of legitimate representatives of and speakers for community need. Analysis explores the multiple boundaries and problematic status of the SIP; and the problematic status and accountability of the Partnership representatives themselves.
- Chapter Eight covers the final period of fieldwork, where initial integration within the SIP collapsed into episodes of conflict, leading ultimately to the resignation of the Chair of the community representative group and a crisis of legitimacy for the entire Partnership. I also describe how the Partnership regrouped and recovered following this period. Recovery strategies included revisiting earlier, contested decisions and the provision of a more active role for community representatives over which they had considerable control. This chapter also presents the under-explored risks experienced by SIP members, particularly the community representatives in their developing engagement with the broader Partnership, and the SIP leaders themselves.

CHAPTER SIX

THE EAST KIRKLAND SIP: A DIFFERENTIATED PARTNERSHIP

6.1 'East Kirkland' in context

The Partnership had been in existence for over a year prior to my research involvement. The account given below of the origins and purpose of the SIP is pieced together from various sources but is mainly based on the extensive account given to me by the SIP Chair during our first interview and should be interpreted in this light. Some care should be exercised in taking accounts of these times at face value: over the course of fieldwork, I came to judge some aspects of this interview as representing a polished or moral account as some contradictions emerged over time and from other sources, as described in later sections. In subsequent sections I reconstruct the story of the SIP's early stage of development, again drawing partly on accounts provided by key informants but also drawing extensively on my own fieldwork notes. There is thus a mixture of frontstage and backstage knowledge. The distinction is important, as some SIP-related activity took place at times and in places inaccessible to fieldwork processes.

6.1.1 Divided communities

Riverbrae and its environs have been targeted for a number of urban aid programmes over the years since the 1980s. Kirklands is one of many towns within this wider area to be hard-hit by the demise of its traditional heavy industry and consequent dramatic change in local employment patterns. The problems have been far-reaching and, as yet, inadequately redressed. The area has a history of Irish immigrant labour to serve local industry, resulting in an acknowledged division into Catholic and Protestant elements of the community. Such divisions are long-established: for example, exhibits relating to the 19th Century at the local industrial heritage museum reveal that, whilst skilled English workers moving into the area to serve local industry were given good quality accommodation, Irish immigrants were housed in far poorer conditions. Today, the major employers in the area are the Local Authority and Health Board. For people without formal educational qualification, most contemporary employment is in the poorly paid service sector, such as in the retail parks that have sprung up on former industrial sites. According to the Benefits

Agency, unemployment in the area is up to 57% in some wards whilst, according to a local public health physician, more people claim disability benefits and income support than job seekers allowance. The area has a reputation for the low quality and poor condition of its social housing: the worst areas have now been demolished, rebuilt by housing associations and original tenants re-housed, but there is undeniably still room for improvement. The town centre is small, concentrated on one main street, and has many pubs and fast food outlets. There are several large supermarkets a short distance from the centre. Walking round the area, I found no shops that might conventionally be regarded as up-market: most seem to cater for people on low incomes. It is perfectly possible, for example, to buy a pair of shoes for an adult for around £5.00. Such furniture shops as there were, offered rates of credit that might be viewed as extortionate (50% APR). A number of credit unions exist but, amongst poorer sections of the area, loans from companies such as Provident remain the norm. The town has a reasonably large and popular leisure centre and several parks. There are also a number of play parks for children, although in some areas these have been vandalised or taken over by drug dealers/users, so are no longer used by other members of the community.

A distinction needs to be made between Kirklands the town, and those parts of the town designated for SIP status. The East Kirkland SIP covers ten localities or neighbourhoods within the town of Kirklands. They are not all contiguous, with two areas perceived as particularly deprived being divided from the others by a major road and industrial estate. The population of the aggregated neighbourhoods of East Kirkland is roughly 20,000. The worst areas of tenement housing are concentrated in these neighbourhoods. Car ownership is low and public transport infrequent: taxis are one of the most popular forms of local transport. Roads have been narrowed in places, in an attempt to 'calm' traffic, which means that buses occasionally have to mount the pavement. There are several primary and secondary schools in the SIP area, many of which reflect the sectarian division into Catholic and Protestant members of the community. Retail outlets are mainly of the corner shop variety, with many fast food take-aways and off-licenses. Other local businesses include tanning and hairdressing salons, and small garage workshops.

6.1.2 Local health inequality

The Director for Public Health speculated in his Year 2000 Annual Report about the possibility of a '*Riverbrae effect*', as the comparison of this whole area in health

terms with the rest of Scotland remains inexplicably poor. The local Health Board reports Kirklands as the most deprived population in Riverbrae with a '*generally poor picture on a range of indicators of mortality and morbidity*': a high proportion of smokers; high levels of incomplete immunisations; low breast feeding rates; and high limiting long term illness rates. According to the SIP Chair, the ten neighbourhoods that make up the East Kirkland SIP score higher on the Carstairs index of deprivation than other parts of the town. An LHCC report quoted an all-cause SMR of 108 for the whole Kirklands population, broken down into 110 for CHD, 105 for stroke and 104 for cancers (other than skin cancer). It also quoted a high standardised limiting long term illness ratio (123). According to the local 1996 health and lifestyle survey, 18% of the population suffered from depression; 34% smoked daily; 20% exceeded recommended levels for alcohol; 79% ate less than five portions of fruit and vegetables daily; 60% took no regular exercise and 17% had a BMI >30. (This information cannot be properly referenced, as to do so would inevitably identify the geographical area.)

The SIP commissioned and published its own analysis of health trends from 1995-2000 for the selected neighbourhoods of East Kirkland. This reported an all-cause SMR of 120, higher than surrounding areas. Unsurprisingly, problems with using small-area data were noted but CHD, cancer and respiratory disease were reported as resulting in the greatest number of deaths and highest death rates in adults in East Kirkland. These conditions were seen as linked to the industrial past and '*poor lifestyles*' of the inhabitants, particularly current smoking habits. Accidents accounted for over 40% of mortalities in young people under 25 years of age. In the words of the East Kirkland SIP Chair,

'in the Riverbrae context you've got three of the poorest health areas in Scotland. I mean, as y'know, we've got them bad/Riverbrae's bad in Scotland and there's bits of Riverbrae which are even worse. And in East Kirkland, we've got one of the worst health records in/in the western world, I keep saying!' (Interview with Helen Cameron, EKSIP Chair, Riverbrae Council Offices, 17.08.00)

However, the Chair also spoke to me of her experience of holding community workshops to discuss the poor health record of the area, where she found that this does not have a high local priority. She cited the example of a participant at a workshop who, confronted with the research evidence that living in a particularly deprived area might lead to premature mortality, said '*well what's the point o' livin' another ten years? So what? Ten years o' this?*' Sheena Munro, the health promotion specialist whom I interviewed because of her part-time allocation to the

SIP, also believed that people living in the SIP area would dismiss such evidence of health inequalities as practically irrelevant, compared to the immediacy of problems of poverty and unemployment. She also spoke of local dissatisfaction with primary health care services. A major issue for residents of East Kirkland in this regard appears to be that the Health Centre is outside the community and located in the middle of the town: this is seen as too distant. There are also problems with waiting times to see the GPs, whose services are generally regarded as poor. I concluded from these two accounts that concerns about health promotion/illness prevention are unlikely to have a high local priority. However, Sheena Munro also felt that there is now '*lots of public discussion*' about health and social inclusion in East Kirkland and felt that people were '*gradually waking up*' to the wider problems in this area.

Drug and alcohol misuse is perceived as a particular problem amongst younger people: '*Buckfast Alley*' is the local nickname for a lane behind one of the larger secondary schools where gangs of young people routinely congregate at weekends, with bottles of the eponymous, cheap, fortified wine. One local worker based in the education sector analysed the situation in this area in the following terms:

'the breakdown of traditional industries has meant that well-qualified people have left the area. People are left with no chance of job for them or their families. There's been a whole breakdown of the community - mental health and alcohol problems and suicide in men. We're into the 2nd generation of the unemployed but education of the young is still about delivering the curriculum, not the social education they need.' (Community Sub Group Representative, Working together/Learning together training session, [-] football stadium, December 2000)

6.2 Setting up the East Kirkland SIP

The Annual Report for the Year 2000 by the Director of Public Health of the local Health Board states that '*partnership became the central theme in 2000 for much of the work done by the Health Board in promoting the health of the people of Riverbrae*'. I learned during my interview with Sheena Munro that the Health Promotion department had restructured to facilitate local partnership working and several staff members had been allotted to the SIPs in the Board area. The concept of working in partnership was also central to Riverbrae Council strategy, as I had found during my earlier interview with the East Kirkland SIP Chair, Helen Cameron. She told me that the Riverbrae Partnership had been set up in the mid-1990s as the main mechanism for community planning, a strategic partnership made up of chief-executive level representatives of all the major public sector organisations

throughout the area. The SIPs sat below this group in the strategic hierarchy. Though not a member of this high-level group, Helen Cameron was one of a group of senior officers reporting to it. As Manager of the Council's Community Services Department, she said she had been instrumental in establishing two area-based SIPs in Riverbrae, one of which – Dunloan SIP - she chaired from the mid-1990s. The other, the Riverbrae SIP, provided continuity of funding to a number of voluntary sector and community-based projects across the whole area after the termination of regeneration initiatives such as the Urban Programme. I later discovered that five such projects were either based in, or delivered a service to, the neighbourhoods of East Kirkland.

6.2.1 Achieving SIP status for East Kirkland

Helen told me that Kirklands was not targeted for any existing source of additional regeneration funding despite the perceived status of particular neighbourhoods within the town as deprived and despite the record of poor health statistics. So in August 1999 she submitted a hastily-constructed bid to the Scottish Executive Area Regeneration Division for ten specific parts or neighbourhoods of Kirklands to be awarded thematic SIP status under the sobriquet of East Kirkland:

HC: 'we had the two area-based SIPs and then we had the opportunity to bid for thematic status – the Scottish Executive found they had some spare money. They won't admit it (laughs) but that's the way it happened.' (Interview with Helen Cameron, EKSIP chair, Riverbrae Council Offices, 17.08.00)

The main theme for this new SIP was that of tackling health inequalities, with a particular focus on children and young people but, given its specific boundaries, the proposed SIP was clearly something of a hybrid between thematic and area-based partnerships. Helen believed that this application succeeded in the competitive bidding process because of its explicit focus on the twin national policy priorities of social inclusion and health improvement. Because of her involvement in two existing SIPs, both of which had an interest in health improvement, she had established a close working relationship with a health promotion policy director of the Health Board, Graham Hamilton, who had an unofficial role as vice-chair of East Kirkland. I found later that this small group, which included the SIP Development Manager appointed from within Helen's department, formed the leadership core of the East Kirkland SIP.

6.2.2 Under Interim Management

Thus, when I first gained access to the East Kirkland SIP it had already been in existence for over a year in the guise of an Interim Management Group (IMG). The designation as interim acknowledged that a full partnership structure was not yet in place, as there was no community or voluntary sector representation on this Board. Given the focus on health and the explicit acknowledgement of the problems of deprivation and poverty in the target area, the IMG was made up of what the Chair called '*the usual suspects*': i.e. representatives from: the Local Authority; the Health Board (both public health and health promotion); the Primary Care Trust (PCT); the LHCC; the Benefits Agency; Scottish Homes; Scottish Enterprise; the Community Health Council (although no representative from this organisation ever attended SIP meetings during the course of fieldwork); and (somewhat less usual) the Police. In addition to the Chair and the Manager, Riverbrae Council was represented by an elected member, who attended meetings infrequently. I learned later that this was considered a mixed blessing by the Chair and Manager as the Councillor neither interfered with the work of the SIP, nor championed it within the Council. The Chair told me that much SIP work took place '*away from the table*', with agency partners championing certain aspects of SIP activity.

6.2.2.1 IMG activity

The East Kirkland SIP had been awarded roughly £750,000 for each of its ten years of operation (but considerably less in the first year, as SIP funding was awarded for only part of this financial year), plus an annual increase to allow for inflation. It seemed that the IMG had not been idle during its first year of operation: Helen Cameron listed a number of health promoting initiatives funded by the SIP in the East Kirkland neighbourhoods. For example: a smoking cessation programme offering free nicotine patches (before these became available on the NHS); 'stress busting' sessions offering free complementary therapies; free family swim tickets for a popular leisure centre; a peer-led breastfeeding initiative; and smart cards in a number of schools, enabling children from poorer families to obtain school meals without the stigma of the ticketing system. The latter initiative also facilitated data collection on children's eating habits and encouraged healthy choices via a linked reward system. An inter-agency awareness-raising workshop had taken place, for operational-level workers from the major public sector agencies. Work had been carried out on an early endowment programme, investigating the support needed by pregnant women and young mothers on low incomes. A major research project had

been commissioned from a university-based academic team, mainly at the instigation of the public health Partner on the SIP, into illegal drug use amongst young people in the two particularly deprived neighbourhoods within the SIP area mentioned above. This project proved influential to the Partnership board because of the significance - and potential generalisability to neighbouring areas - of its findings. Based on rigorous ethnographic fieldwork, the research report on this project provided me with additional insight into a broad range of local perceptions of living in a disadvantaged area, and an extremely useful account of some of the sharp divisions within and between local communities.

6.2.2.2 The SIP fund

During our first interview the SIP Chair had made it clear that the SIP fund had a dual purpose: to raise awareness within the community of the existence of the SIP and of its health improvement message; and to pilot or pump-prime a range of intentionally and inevitably short-term initiatives. The aim of doing so was '*to find out what works*', and then to persuade the relevant service-delivering agency to incorporate the initiative into its normal service. In other words, a key purpose of the SIP (and a major challenge) was '*to bend mainstream budgets*'. Improving both the life styles and circumstances of the East Kirkland population was certainly the ultimate aim, but she spoke of the impossibility of doing this with so small a budget:

HC: 'seven hundred thousand is peanuts, compared to what the large agencies round here spend annually – a hundred and fifty million. The local GP prescribing budget is six and a half million - are you telling me they cannae spare some o' that for nicotine replacement therapy?' (Interview with Helen Cameron, EKSIP Chair, Riverbrae Council Offices, 17.08.00)

The long-term sustainability of specific initiatives was thus seen as beyond the remit of the SIP. I learned during fieldwork that applications for SIP funding were submitted by organisations or groups to the Partnership Manager and presented to the IMG at their monthly meetings, for consideration. None of these initiatives could be approved or set up without separate authorisation of expenditure from the Council's Policy & Resources Committee, meetings of which were held quarterly. So the work of the Partnership was shaped from its earliest days by the requirement to fit in with specific bureaucratic and financial funding cycles. This does not mean that no projects or initiatives from the community and voluntary sector were funded over this period of interim management: it does, mean, however, that this sector had no say in how the larger fund was allocated.

6.2.2.3 Agreeing priorities

Helen Cameron gave a number of reasons for the absence of community and voluntary sector representation on the SIP. Firstly, it seems that there was some difficulty in agreeing appropriate funding priorities amongst the diverse group of partners. Some apparently wished to draw on SIP funding to augment services they already provided, whereas the Scottish Executive had directed that it should provide additionality - an early indication of how local service providers' priorities could differ from those of policy makers. Achieving a form of consensus and shared understanding around themes and goals therefore took some time, including dedicated time-out from the usual format of monthly committee business meetings, for extended debate amongst the interim partners:

HC: 'We've spent a lot/a lot of time putting the partnership together because we've now introduced people who've been involved in the health service in a very/quite narrow disciplines ... and suddenly they've been exposed to people like me! D'you know? Who say ... so that's been quite/I mean quite interestin'... at the end of the day we want to keep them on board as partners but at the end of the day, doctors are not gods, y'know? We spent a lot of time, a number of sessions, getting people together, spending time planning out what we're going to do. It'd be quite useful if the Scottish Executive actually realised how long that all takes and the amount of planning that that all takes, y'know. There's a whole thing about somehow, the Scottish Executive think, 'partnership' - ding! (snaps her fingers) And it'll all just happen .. somehow. Erm .. and it doesn't.' (Interview with Helen Cameron, EKSIP Chair, Riverbrae Council Offices, 17.08.00)

Despite taking time for debate, the Chair did not claim that any real consensus was reached and agreed by all: partly because re-organisation within some agencies disrupted continuity of individual representation over the period; and partly because of the inherent complexity of the issues the group were trying to tackle, such as the linkages between poverty, deprivation and health. However, she also spoke of an equally fundamental difficulty – persuading representatives of large partner agencies to depart from their national priorities and recognise their local role:

HC: 'I would say things to [names partner agency],"well, you set that target around the SIP", but they say, "no, no, no, we deal in national programmes and anybody can access them". And I was saying, "no but **surely** you need to recognise that some people need a bit more of a puddy-up than others?" See, there's a perception in some of the organisations that that's your lot. If you're poor, that's your lot - and there really isn't any way out of that. Which always surprises me, because most of the people who work in the public sector are from working class backgrounds. And they've actually all done very well – I mean we've all done well in terms of our education, getting good jobs and all those kind of things, which somehow ... are not for these other people. So we spend a lot of time cajoling

She admitted that she was reluctant to have this kind of '*bun fight*' in front of community and voluntary sector representatives and that some kind of agreement on tackling health inequalities therefore needed to be reached before the SIP's representation widened. Helen did not detail the SIP's themes and objectives during our interview, and I first saw them in written form at the community conference held in November 2000. For the sake of clarity the overall vision for the SIP is shown below in an extract from the SIP Implementation Plan of April 2001, after a number of minor revisions to the wording had taken place during preceding months.

Box 1

East Kirkland SIP: the 'vision'

(reproduced from the East Kirkland SIP Implementation Plan, April 2001)

'We aim to improve health in East Kirkland. We will reduce the poor health record of the area, closing the gaps in health indicators between the SIP area and the rest of Riverbrae. We will do this by:

- co-ordinating our health-based activity;
- integrating it with other regeneration activity to improve life circumstances; and
- encouraging and facilitating the local communities to participate in this work.

We will target those who are 'excluded' and in greatest need, particularly children and young people.'

This vision was accompanied by five key themes and three main objectives. Specific themes for the implementation of the Partnership vision were outlined as: lifestyles; early intervention; income generation; community capacity; and communication and integration. Stated objectives were community and partnership development; consultation and information; and monitoring and evaluation. In all official SIP documentation, such as the Implementation Plan, Annual Report and Development Plan, brief explanatory paragraphs accompanied these statements, but these explanations did not accompany the short documents put out for public consumption, as at the two community conferences. The themes provided an overall framework for the Partnership but had no community level input and were never seriously reworked, despite attempts by the Chair and Manager to involve other key players in doing so. One such attempt is described in Chapter Seven where, as the first task for

the newly appointed SIP Support Team, the SIP Manager tried to engage them in considering and revising the appropriateness of the existing themes and objectives.

6.2.2.4 Explaining community absence

The second major reason given for the lack of community and voluntary sector representation during the first year of SIP operation was the absence of any member of staff with sufficient time available to establish the mechanisms with which to secure such participation. Care and thought were required for this process as, in the Chair's words, *'ye cannae just walk intae a community and pluck someone out of thin air – they represent no-one'*. This resource problem was only addressed by the secondment of Moira Carruthers to the post of SIP Development Manager from her existing Council post in urban planning. The main barrier to recruiting suitably qualified and experienced staff appears to be the short-term status of the employment contracts on offer. As another seconded SIP officer I later spoke to put it, *'naebody in their right mind would gie up a permanent Council post and pension tae work in a SIP fer a couple o' years'*. The final reason for the lack of voluntary sector representation was the alleged underdevelopment of this sector: I was told that the SIP had funded a training programme to improve the capacity of voluntary organisations in the area. One of the aims of the training programme was to enable these to improve their ability to secure funding from a range of sources. Helen spoke of the dependence of this sector on statutory sector funding, admitting that organisations like her own had helped to produce fierce competition between voluntary organisations for the limited funds available.

It must be remembered that the above account is, in the main, constructed from the perspective of a key individual, which of course influences the way the story is told and non-participation by the community justified. Judging by this (inevitably partial) account, the overall direction for the Partnership was significantly shaped by the commitment and interests of the core Partners. Others shared this view, as I found during the course of fieldwork, but attributed significantly different meanings. The issue of the delay in community and voluntary representation on the Partnership produced alternative interpretations and accounts, described below and in the following chapter.

6.2.2.5 SE meets IMG

The ongoing lack of community representation was clearly a matter for disapproval by the funding body, the Scottish Executive's Area Regeneration Division. I was able to witness this concern during my first encounter with the SIP Interim Management Group (IMG) which was, serendipitously, also the occasion of the annual review visit by senior civil servants from the Division (December 2000). The tenor of this meeting was both formal and slightly antagonistic. For example, the two officials from Area Regeneration suggested to the IMG that their focus on health rather than regeneration might have been the wrong decision, as poverty was probably a more important problem for the area. The whole IMG clearly disagreed with this suggestion. The representative from the Benefits Agency spoke of '*the value of learning the bureaucratic geography*' of other public sector organisations, whilst acknowledging that the stumbling block for each agency lay in '*finding an appropriate role*' for itself. The public health representative (locally renowned for blunt speaking) urged the Area Regeneration representatives to tell the Scottish Executive to re-think its '*blunderbuss*' approach to health targets and monitoring and its '*trivial*' focus on reducing CHD, and accept that poverty and poor health are inextricably interwoven problems for many communities. He asked the civil servants to urge their Ministers to listen to the SIP leaders, and amend policies in the light of SIP experience. (I judged his colleagues to be torn between agreement with his statements and various degrees of semi-amused horror at his lack of diplomacy, an interpretation confirmed by subsequent comments made during *ad hoc* conversations.)

The Area Regeneration officers were aware that the SIP had attempted, during the previous year, to involve the community via a Citizens' Jury aimed at eliciting the views of a group of randomly selected residents' on the type of health services (broadly defined) that should be available to young people in the SIP area. However, as neither the Chair nor the Manager had been satisfied with the relevance of the facilitated process or the quality of the evidence provided to the Jury, they had not felt it appropriate to pursue the process. The civil servants seemed to view this as a missed opportunity for community feedback and involvement. '*We've heard about the IMG*', said one officer, following the Manager's presentation of SIP themes, priorities and current membership, '*but when does the process proper start?*' The Executive's officers were reassured by the Chair and Manager that plans were in hand to obtain community representation on the partnership Board by the end of the financial year. A Community Representatives Sub-Group had been set up as a result

of a Community Conference held during the previous month (November 2000) and this Group would help establish the necessary processes. The civil servants were also told that representation of the voluntary sector had been separately agreed by the IMG. This place on the Board would be held by Wilma Edwards, the co-ordinator of a local umbrella organisation for the voluntary services. (I noted that Wilma was present at this IMG meeting, but her invitation to attend seems to have been intended mainly to placate the Executive's visiting representatives and as a signal of future intent. She did not reappear in this forum until the first full Partnership Board meeting was held in May 2001.)

6.2.3 'Community involvement' through the lens of key agencies

The different perspectives of two key partners from the Local Authority and Health Promotion on the vexed question of community involvement in partnerships are briefly considered here, based on my interviews with the SIP Chair, Helen Cameron, and the SIP health promotion specialist, Sheena Munro. Despite the spread of partnership representation, the main agencies and dominant partners involved in the East Kirkland SIP are clearly identifiable as the Local Authority and the Health Promotion department of the local Health Board. Sheena told me of local community activists irked by what they saw as exclusion from the decision-making processes of the SIP, and gave me the names of two such individuals as useful informants (who were later nominated to the Partnership via the process described in section 6.2.7 below). Half her working week was allocated to SIP work. She spoke of working with other agencies and other sectors as familiar and routine:

'in health promotion, if we didn't work in partnership with others, we'd never get anything done'.

She felt that Social Inclusion Partnerships brought diverse agencies together, '*forcing us all to work, in a positive way, with partners*'. From a health promotion perspective, working with the other key agency - the Local Authority - could be easy or difficult, depending on the particular circumstances. Still, she felt that this forcing of partners together was an artificial rather than natural way of working as these key partner agencies sometimes have little in common:

SM: 'we have different business planning processes, different budget cycles, different policies on confidentiality, different agendas and different drivers.' (Interview with Sheena Munro, EKSIP Health Promotion Specialist, Riverbrae Community Hospital, 19.11.00)

Sheena felt that Local Authority views of health promotion as '*narrow health education*' could be problematic, in that expertise in community-based work tended to be overlooked in favour of technical expertise in delivering particular programmes such as smoking cessation. In particular, she felt that although *language* might be shared, *meanings* might well differ between these two key agencies. In relation to community participation this meant that,

SM: 'when we talk about community development, we're actually talking about two different things but not really acknowledging this. The local authority thinks of community development in terms of regeneration and the economy. That's their language – capital and revenue. But we think in terms of people's participation and empowerment.' (Interview with Sheena Munro, EKSIP Health Promotion Specialist, Riverbrae Community Hospital, 19.11.00)

6.2.3.1 Questioning participation

However, although the SIP was committed to extending their membership to include community representation, the whole basis of achieving community empowerment via participation was actively questioned by the SIP Chair, who emphasised instead the importance of delivering good public services to people living in disadvantaged circumstances. For her, community involvement had many possible meanings and did not necessarily require direct, personal representation. The following section from this lengthy interview is worth quoting in its entirety. The context of the quote is that I had just commented on my understanding of the many difficulties surrounding community representation on multi-agency partnerships:

HC: I've got particular views that's not always shared by the Scottish Executive, I've got to say. Poor people are expected to turn out an' be community representatives. I mean I do work lots of nights but I certainly don't go out on a Tuesday to sit on some management group. An' I think there's a real issue about that, y'know, if you're poor you're expected to turn out three or four nights a week. And we actually criticise community reps/community people for not **wantin'** to be involved. When all they want's good services. And we have a responsibility in the public sector to deliver those good services, quite frankly. Now that view's not shared, I've got to say, by too many people, because currently the Scottish Executive are **obsessed** ... they've suddenly discovered community empowerment. I've come almost through that, in as much as I don't think you do have to turn out. For example, in Dunloan what we're looking at is, we've got a citizen's panel established. We're looking at citizens' juries. We've got community connections, we're looking at buying space in the local press. We're doing a whole host of things. Because if you don't want to be involved, you don't have to be. You'll be informed of what's happening – you'll have an opportunity to comment. I think we have a responsibility/we have a responsibility to find out what people's needs and wants are. But I don't think we need them to turn out three nights a week to do that. If you're poor and you're unemployed then I think the last thing you wantae do is run

out on a Tuesday night to talk about your police service. It's just dreadful! I mean, community representatives, there are people who **always** want to be involved in their community, and that/that's great. That's not to say the people who want to come out won't have the opportunity, but we shouldn't rely on that. That's my view. Community representation is only one part of a very, very complex equation. (Interview with Helen Cameron, EKSIP Chair, Riverbrae Council Offices, 17.08.00)

Under this formulation, the potential for the bottom-up, active shaping of services by community agents is downplayed in favour of top-down consultation – beneficent in intent, but possibly disempowering in practice. This is probably not an unusual stance: it may well be shared by many working in the public sector, even if they do not always choose to articulate their personal orientation so frankly. Given that this perspective was expressed in an interview *prior* to my selecting this SIP as a site for a case study, it may be that she spoke more bluntly in that context than would otherwise have been the case. But such views are undoubtedly significant, given the influential role of the Chair within the Partnership.

6.2.3.2 The problem of community representation

Achieving authentic and legitimate community representation in any kind of multi-sectoral partnership emerged as a consistently problematic theme during my interview with the SIP Chair. She spoke for example, of her previous experience of trying to achieve community representation in another deprived area under the aegis of a different regeneration initiative:

HC: 'Now you need to know that community reps who are on those management groups will speak to no-one, it'll be their opinion that you'll be getting and I would suggest that some of this is mebbe not a correct community view. When I worked in [area], I mean it was a bloody nightmare in terms of one or two people who represent [area]. Mr and Mrs [area], who turn up at everything and do not speak to another living soul across [area] – ever! What you are getting, and what you need to be quite clear you are getting, is Mr and Mrs [area]'s views. That's cosy, but its ultimately unhealthy for the agencies and the communities.' (Interview with Helen Cameron, EKSIP Chair, Riverbrae Council Offices, 17.08.00)

From the perspective of the Chair, although achieving direct representation on the SIP was a key Partnership goal for the coming year(s), so too was a strategy of ensuring that '*different voices, not just the usual suspects*' would be heard, which required a range of different approaches. Understanding these multiple meanings surrounding community involvement is fundamental to subsequent analysis of the many tensions between Chair and community representatives.

6.2.4 Launching the SIP

I was present when the East Kirkland SIP was officially launched on the community during the first Community Conference that took place in November 2000 and this section is closely based on fieldnotes taken at this event. Conference Packs handed out contained a statement of the SIP's aims, although I had some doubts about the legitimacy of SIP claims to be a '*community development-based health improvement strategy*', given the obvious lack of any such element during the first year of the SIP's operation. The conference was held in a large room obviously doubling as both dance floor (judging by the disco-type glitter ball hanging from the ceiling) and gym (ropes hung from the longer walls, with climbing bars on the shorter walls). Plastic bucket seats were set out for roughly 80 people, with long tables at the front of the room for speakers: behind them stood large poster displays bearing the name of the East Kirkland SIP. An overhead projector and screen occupied one corner of the front of the room: flip charts stood in two other corners, for workshops. Although the room had been virtually empty when I arrived and greeted Helen and Moira, it filled rapidly. Participants were told that the purpose of the evening was to introduce the SIP to them and provide an account of its early work, and to engage members of the community in deciding how to go about obtaining community representation on the partnership Board.

This first public interaction between leaders of the SIP and members of 'the community' provided a number of important themes. For example, the goals of the Health Board were stated by the Chief Executive as tackling lifestyle issues, particularly smoking, and specific diseases (heart disease, cancer and stroke), all of which are clearly drawn from the contemporary health policy agenda and shape Health Board work. The SIP Manager in her turn spoke about problems of poverty, unemployment and poor housing – issues central to social policy and to the work of local government. Questions from the floor of the hall, however, centred on drug and alcohol use amongst young people and mental health problems amongst long-term unemployed men. There was thus an early indication of some difference in priorities between three major elements of the Partnership. In the workshop groups that followed the main presentations, community activists present stated their belief that the ten selected neighbourhoods would be in competition with each other for SIP resources: they said that community representatives would find it difficult to represent the whole SIP area in this context. These constructions of the situation by potential community representatives seemed to refer to long experience of competing amongst themselves for additional resources and/or services, rather than working

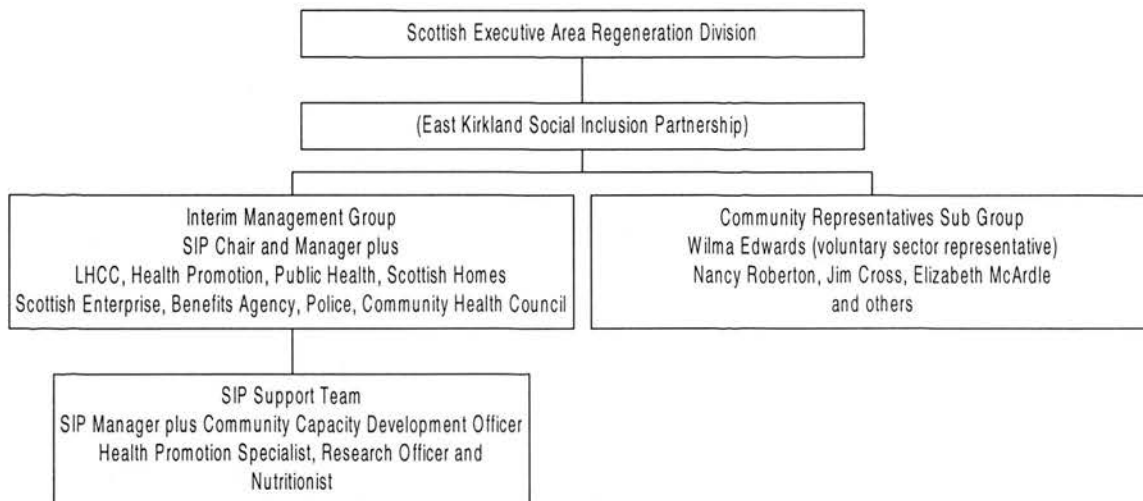
together for the benefit of a larger area. From my perspective, their comments on the likelihood of representatives having '*vested interests*' mirrored the earlier observations of the SIP chair, on the similar tendencies of the larger (and certainly better-funded) agencies. Indeed, during the lively workshop discussions, Helen Cameron's co-facilitator, Graham Hamilton, warned potential SIP representatives from the community that if they allowed themselves to be split by partisan neighbourhood allegiances, they were likely to be subject to divide and rule by partner agencies for the benefit of those agencies. Graham Hamilton was the Health Board policy director and the only SIP member invited to facilitate the community workshop discussions with the SIP Chair and Manager. (During my early interview with her, the SIP Chair had told me that she spent more working time with this SIP partner than with her own council-based colleagues.)

6.2.4.1 Election planning processes

The outcome of this key event was that twelve local people agreed to constitute a group with authority to devise an appropriate mechanism to select people to fill the six places that the IMG had decided to make available for community representation. At the end of the Year 2000, therefore, the Partnership was differentiated into the established decision-making forum of the Interim Management Group and the newly constituted Community Representatives Sub-Group, illustrated in *Figure 2* below. The name of the East Kirkland SIP is shown in brackets to signify its lack of formalised community representation, and thus incomplete Partnership status at this stage. Of the twelve people who put their names forward to constitute the Community Representatives Sub Group, I identify below four individuals who subsequently became members of the SIP. The significance of particular details (such as an individual's status as East Kirkland resident/non-resident, paid worker/community activist) relates to the legitimacy claims of individual representatives. Those resident and working in/for the area claimed greater legitimacy than others who worked in East Kirkland but who, as non-residents, were not so much a part of their community. Their names will recur throughout later sections as part of my analysis of the social processes surrounding community representation on and involvement in the Partnership. My reason for focusing on the issue of community representation is that, although community engagement is a central plank of many contemporary policy initiatives, the complexity of the processes involved is frequently glossed over. Other representatives on the Community Sub-Group included individuals from a number of local tenants' associations, a social club and a

single representative of the statutory sector, eligible to join this group because of his role in running a community-based sport and health project for young people.

Figure 2
East Kirkland SIP Structure



An important contextual point must be made here. All of the interim community representatives named above and in *Box 2* below were closely involved with voluntary sector or community-based organisations previously funded by the Riverbrae SIP, which at this time was approaching the end of its funded life. The East Kirkland SIP, in its incarnation as the Interim Management Group, was currently in the process of negotiating the future funding for three of these, two of which were perceived as particularly contentious (see section 7.2.5 below). This precarious situation was a source of considerable tension and anxiety for all concerned. Although names have obviously been changed, preserving anonymity of other details would therefore strip away crucial aspects of context and negate the analytical import of meanings attributed to particular types of status. The first meeting of this group was chaired jointly by the SIP Chair and Manager, but after this the SIP Manager, Moira Carruthers, ran the meetings by herself. These were invariably noisy, even boisterous, mostly good-humoured events, accompanied by a dense cloud of cigarette smoke generated by a number of the women present. Most of the representatives seemed to know each other and Helen and Moira well and showed no hesitation in voicing disagreement with the latter: the SIP officers occasionally struggled to keep order in the meetings. In this forum there was little

overt dominance by the SIP Chair and Manager, but their prior knowledge and experience of two other SIPs was clearly influential in shaping the decisions made. They also took on all the behind-the-scenes, practical work involved. My role was mostly restricted to that of an observer, making notes, although I was able to talk informally with members of the group during coffee breaks.

Box 2

Community Sub-Group representatives

- **Wilma Edwards**, resident in East Kirkland, paid co-ordinator of an umbrella organisation for the voluntary sector based outwith East Kirkland but serving that area in addition to others. Voluntary sector representative on the East Kirkland SIP.
- **Nancy Robertson**, resident in East Kirkland, community activist and volunteer Chair of the management group of a play scheme within a neighbourhood of East Kirkland. Community representative on the East Kirkland SIP.
- **Jim Cross**, non-resident, paid co-ordinator of a community centre within a neighbourhood of East Kirkland. Community representative on the East Kirkland SIP.
- **Elizabeth McArdle**, non-resident, paid co-ordinator of an older people's project based outwith East Kirkland but serving that area in addition to others. Community representative on the East Kirkland SIP.

This group met three times: 7th December 2000, 17th January and 8th February 2001, in the evenings at the Kirklands Community Centre. Attendance by community-based members was variable and partly explains subsequent disagreements over the interpretation of events. This needs to be borne in mind as, whenever I refer to 'the Sub Group' in the paragraphs below, this term does not necessarily encompass the same individuals on every occasion. For example, Nancy Robertson was not present at the first meeting so did not find out about the 'Working together/Learning together' (WtLt) training session, organised for the following week for a number of SIPs in that region of Scotland, although this session provided the opportunity for

members of the Sub Group to meet members of the IMG and community representatives from a broad range of other SIPs. I later learned that she had not been told later of this first sub-group meeting: whether this was an intentional oversight is debatable. What is not in doubt, however, is that the existing relationship between Nancy's project and the SIP leaders was particularly tense because of the ongoing negotiations around funding. Although he had been a vocal participant in the first community conference, Jim Cross only attended the first Sub Group meeting but not the remaining two, nor the WtLt training session – possibly because of the short notice given, and he lived some distance from the area. His project was also under scrutiny by the IMG for future funding.

Over the three meetings of this group, a process for securing community representation on the SIP was slowly thrashed out, although unanimous agreement could not be achieved on every point. At the first meeting of the Sub Group, one of the main concerns expressed by some community members was that individual representatives would fight for the area they came from, rather than the improved health and wellbeing of the wider community. They would bring particular interests to the partnership, potentially '*running amok for the best interests of themselves*', as one participant put it. They thus confirmed the theme of neighbourhood partisanship and competition noted during the first Community Conference held in November. The SIP Chair and Manager promised a short period of intensive residential training for new representatives, when in place, to help overcome problems of partisanship. Guided by suggestions made by the SIP officers, the group agreed that a second Community Conference would be held and would include a formal election. However, the Group foresaw problems of engagement beyond those of neighbourhood partisanship: they also referred to '*community apathy*' and '*people's lack of confidence*' on many occasions, suggesting that it would only ever be an interested minority of activists who would seek to take part.

It was agreed that the second conference would be widely advertised throughout the local press, the ten communities of East Kirkland, and all public sector organisations in the area. Considerable care was taken over choosing an appropriate time and place for the conference: for example, the local bingo night was considered '*sacred*' and any event that clashed with this could be sure of a low turnout. Moreover, the venue had to be '*neutral*', i.e. not associated with either Catholic or Protestant churches or schools. '*Let's keep politics out of it*', remarked one community member. There was some questioning of the numbers of 'health' representatives on the SIP (up to five at

that time), but the Group was told that this would '*slim down*' to two after the elections. One health place would go to a senior officer of the LHCC and the other to the health promotion policy director of the Health Board. There was some dissent over the SIP focus on young people, but members of the Group were reassured by the Chair and Manager that this was rather a matter of emphasis than of intent to exclude people of other ages. The Chair suggested that one place be reserved for a young person or someone representing that age group. She argued that this would send a '*symbolic message*' to the community, emphasising the SIP's commitment to improving health in younger people. Members of the Sub Group agreed, but, judging by their comments made over the three meetings, none of them believed it likely that any young person in the area would wish to become involved with a committee-type organisation such as the SIP - a belief borne out by subsequent events. They also said that no one young person could represent the whole of East Kirkland.

The second meeting of the Sub-Group was convened in January 2001 to ratify the decisions taken at their last meeting, to discuss the Election Pack which Helen and Moira had developed in the intervening period, and to agree on the format of the conference itself. Some representatives turned up who had not been present at the first meeting, which meant some covering of old ground but the Pack was approved, subject to minor amendments, tentative voting procedures agreed, and the format of the conference decided on. The task of organising the conference and election was shouldered by the two SIP officers but there were no objections from members of the Sub Group. The conference and election was scheduled to take place on the evening of Thursday 8th March. It was agreed that nominations for community representatives would be sought *via* advertisements, with one place being exclusively dedicated to either a young person or a youth representative. Deadlines were set by the Manager for sending out advertisements, posters, leaflets etc, and for the return of nominations to her office. Nominations would have to be supported by at least one other person, and provide a statement of why the person sought election. Nomination was agreed as open to all living in the area, plus (after some disagreement between the group) those working for a voluntary or community (but *not* statutory) sector organisation. Moira later commented to me that the exclusion of statutory sector workers automatically limited the number of people likely to volunteer for the youth representative place as the local authority employed most youth workers in the area.

During the third meeting, Moira suggested that if fewer than six nominations were received before the conference then the Chair would seek extra nominations from the floor at the event. This was not to be publicised, as people might choose to ignore the nomination process. After some debate, confusion and expression of misgivings it was also agreed that, if six or fewer nominations were received, and if those nominees met the relevant criteria of residence/work base, support and a statement of justification, then they would *automatically* become members of the Board *without* having to go through a public election process. Whether all present fully understood the implications of agreeing to this, is debatable. Agreeing the format of the conference was relatively uncontentious. The first part of the event would involve the award of a healthy eating prize to two primary schools that had taken part in a SIP-sponsored competition (*'a fly way of getting people in through the door'*, commented one Sub Group member, approvingly). This would be followed by an overview of the aims and progress of the SIP to date, to be given by Moira, as Manager. Finally, before a break for coffee and the main point of the event – the public election – a member of the Sub Group would speak of his/her experience of involvement in the SIP to date. Although Nancy volunteered to do this as she was *'well used to public speaking'*, Moira suggested that as she had not attended the WtLt training event in December, she had less experience of the SIP than others in the group, and asked Elizabeth to do this instead. My interpretation was that this action might also have been motivated by some trepidation over what Nancy might have chosen to say.

The Group agreed that eligibility to vote on the night of the conference was restricted to all over-16s living (rather than just working) in the East Kirkland area: participants would be issued with a voting card after being checked off on the electoral roll. It was agreed, again after considerable debate, that each eligible person would have one vote for the position of youth representative and one for the remaining general places. Voting procedure would be by holding up the card for the first vote – the youth place: such votes were to be counted by members of the IMG in attendance. People would then be asked to vote in turn for each of the other candidates, again by holding up their card, but this time, after these were counted the card would be removed from them. *'One person, one vote'*, said the Manager. The Group were not entirely happy with this and unable to predict how this process would be received, but were resigned to the fact that *'someone's bound to complain, whatever way we do it'* - an accurate forecast. A description of this eventful second conference is given below in section **6.2.7**, but firstly I give an account of the training event that

provided the sole opportunity for the Community Sub-Group and Interim Management Group to meet. This event took place between the first and second Community Sub-Group meetings.

6.2.5 Bringing the Partnership's Parts together - temporarily

At the end of the first meeting with the Sub Group referred to above, Helen Cameron told participants of a forthcoming training event for all SIPs in the region, funded by the Scottish Executive and delivered by the Scottish Community Development Centre. This two-day event was part of an ongoing programme of training and familiarisation for both SIPs and Working for Communities Pathfinders, and was to be held the next week (13th and 14th December 2000) at a well-known local football ground/conference venue. I had been debating how best to go about requesting a place at this event, but to my surprise both Helen and Moira invited me to attend as part of the SIP. They gave me a copy of the programme, commenting that it seemed too long, overly academic, and they would really have preferred '*two days funding to get the SIP together for some development work*' as they believed good relationships and sound planning to be fundamental to effective partnerships.

6.2.5.1 'Working together/Learning together'

The event was held in a long, narrow conference room at the football ground, uncomfortably air-conditioned, given the time of year. The extreme ends of the room were arranged for workshop/plenary sessions, separated by long tables and chairs set out for meal breaks etc. My conference pack indicated that I was a member of the East Kirkland SIP (which made me feel slightly fraudulent as I fitted none of the SIP participant categories, i.e. SIP officers, agency representatives, and community/voluntary sector representatives). East Kirkland was listed as only one of a number of SIPs to be taking part in the region-wide event. I noted that some key partners of the East Kirkland SIP had been split up across the three SIPs in their area, presumably to ensure a spread of representation as they held similar roles in each of the SIPs, but scarcely conducive to relationship development. It also turned out that two particularly vocal community activists were absent from the event (members of the Sub Group later to become SIP members). The programme indicated that the event would be structured at different times into lecture-style plenary sessions; facilitated single-SIP workshop sessions; and sessions where specific types of SIP representative from all the partnerships present would have chance to meet up and

compare experiences. As delegates arrived, I saw that neither the entire IMG nor the entire Community Sub-Group for East Kirkland was present and knew that some of those who were present had never met each other before. For the duration of the event, the otherwise clearly differentiated IMG and Community Sub-Group thus came together in a temporary, partial and tentative preliminary to partnership.

6.2.5.2 Emergent themes...

At various times during the event I had the opportunity to join both the very large group of community representatives from all the SIPs present, and the smaller SIP officers group. I do not intend to provide a detailed account of the whole two days, but found attending these sessions valuable to the research process. For example, it provided an opportunity to talk informally with different types of participants. My role over the two days alternated between observer and participant, depending on context. The event also gave me the chance to listen to the experiences of other SIPs and to begin to perceive aspects of the East Kirkland SIP as general or particular. For example, although the focus on health inequalities distinguished the East Kirkland SIP from some others, a strong sense of division in terms of *'us and them'* was articulated by all the voluntary and community sector representatives present, when referring to their statutory sector partners. Although the facilitator of the community representatives group suggested that the purpose of the event was *'not about blame or stitching anybody up'*, the concerns articulated by all members of this group centred around their past and present history of seeing partnership as a *'power struggle'*, particularly over decisions about funding. Members of this group shared many anecdotes of perceived statutory sector wrongdoing. For those members of the Community Sub Group from East Kirkland who were present, this was, as one put it, *'an eye-opener'*. The contributions made by members of the East Kirkland Community Sub Group were indicative, I felt, of future problems in partnership working. One person, for example, made frequent reference to being afraid to ask questions of the SIP, in case it endangered her own project's future funding status. Another spoke of her understanding that the SIP appeared to be subsidising a number of public sector agency projects that should have been funded by the relevant parent agency. There was certainly a consensus of belief that most of the SIP fund had been awarded to areas other than the community and voluntary sector. Concerns about the distribution of available funds to the Local Authority and Health Board emerged during this event as a major bone of contention for the community and voluntary sector, and recurred many times during later fieldwork.

6.2.5.3 ...and missed opportunities

For most of those present from East Kirkland, the training and development agenda of the course was insufficiently flexible to adapt to this group's temporary status as working partners. I noted that opportunities to deal with some serious differences of understanding and interpretation between the IMG and Community Sub Group were missed or actively avoided by the facilitator. For example, during one East Kirkland SIP session a Community Sub Group member repeated a comment I had heard him make during a preceding community representative discussion, referring to a one year consultation period with the community that the SIP should have undertaken. This statement had been news to me and, when repeated in this forum, immediately prompted the Manager to ask in evident surprise, '*what consultation period?*' The facilitator, however, glossed over this instance and moved the group onto the next item on the training agenda. I could only conclude that either he did not feel able to deal with issues likely to provoke conflict, or he did not wish to foster conflict within the group.

6.2.5.4 Tentative connections

Although time for the two parts of the Partnership to come together was limited, and although most of the comments made (to me) by the community representatives had been critical of existing Partnership arrangements, I felt that there were also signs of the potential for affinity. For example, during one session towards the end of the second day the group had been asked to complete an exercise in evaluating the East Kirkland SIP in terms of its efforts at inclusiveness and willingness to learn from others. By this stage, a number of agency partners had left and community representatives were in the majority. The scores allocated to the SIP in the exercise were the lowest of those possible and the Manager seemed understandably embarrassed by this. However, when the facilitator - who also seemed a little uneasy at this result - spoke of moving beyond such '*negative outcomes*' to more positive issues, the community representatives themselves defended the SIP, saying that such low scores were only to be expected from a Partnership still trying to find its way. The final exercise also tested this group's ability to reach agreement on a contentious issue. This was to decide on an example of good practice within the Partnership, and to visit another SIP and share this. Moira manned the flipchart but few comments were forthcoming from the group. I was hesitant about offering a potentially contentious opinion and reluctant to be identified as an ally of the SIP leaders but, encouraged by the community representatives' willingness to defend the SIP,

eventually suggested that the time and care taken by the SIP to develop a number of community engagement mechanisms might be considered good practice. Somewhat to my surprise, the group accepted this suggestion (though I suspect with some private reservations) and Moira developed her flip chart presentation on this basis, one of the community representatives commenting '*maybe it's no' such a bad thing that the SIP have taken their time*'. This was a relatively rare example of my direct intervention (which has slightly different connotations from participation) but I could not detect any negative consequences (such as a subsequent change in community representatives' attitudes towards me) of this action.

6.2.5.5 Summary

The critical comments I heard and noted over the two days from different types of participant therefore provided both data for reflection, and a source of further foreshadowed issues around which to construct research questions. I had observed instances of hesitation and silence amongst the Sub Group during the formal training sessions and interpreted these as indicative of their perceived ambiguous status, as I believed they felt they had little formal legitimacy or influence until formally elected. This was confirmed when they themselves pointed this out, after being asked by the facilitator to help plan future SIP development. At the end of the first day, the facilitator had commented to me that he found the group worryingly cohesive. My interpretation, however, was that participants in the group were exercising caution as they neither knew nor trusted each other well enough at this stage, and those present were therefore wary of entering into argument. Although the event ended on a fairly optimistic note, I felt that some significant foreshadowed issues had emerged in relation to the potential for successful partnership relations. Firstly, the community and voluntary sector representatives' perceptions of exclusion from the SIP's decision-making processes – a concern also voiced in other SIPs. Secondly, their suspicion that the SIP fund was being used to support the major public sector agencies of Health Board and Local Authority in delivering services they should have been undertaking in any case - an experience shared by other SIPs. And thirdly, that although these perceptions were readily articulated to their peer group drawn from those other SIPs, they were not disclosed before members of the East Kirkland SIP itself – possibly because of fears for the future funding of their own organisations or neighbourhoods.

6.2.6 The Interim Management Group

The lack of legitimate partner status of members of the Community Sub Group was underlined at the next IMG Board meetings, which met in January and March 2001, to neither of which was any member of the Community Sub-Group invited. These meetings were held in the formal surroundings of one of the Local Authority's committee rooms. Unlike the earlier encounter of this group with the representatives of the Scottish Executive, the January meeting was my first opportunity to observe business as usual in the IMG. I had received no papers before the meeting, and – unlike the agency Partners present – had not received a copy of the minutes of the last meeting (November 2000). However, the secretary present provided me with copies of the agenda and the relevant agenda papers. The Chair also gave me the opportunity to introduce myself to the IMG, and vice versa, at the beginning of the meeting. The IMG had also had a copy of my research proposal. The tenor of the event was informal but businesslike, with the Chair and Manager introducing and speaking to each agenda item and other partners remaining relatively silent. Apologies were given and recorded, minutes approved and seconded.

6.2.6.1 Business as usual

I learned during the course of this meeting that the Community Services Department of the Local Authority had agreed to fund a three year SIP post described to the IMG as a community engagement officer. This new post would be part of the SIP Support Team, which was expected to be in place in the centre of Kirlands by the end of the month (this turned out to be an over-optimistic prediction). It was intended that the successful recruit would play a substantial role in the strategic development of a community engagement strategy for the SIP. The SIP Chair and Manager then spent considerable time in briefing the IMG about progress made by the Community Sub Group in agreeing an election process for the six available but unfilled places. One Partner acknowledged the amount of work involved for the Chair and Manager in establishing such processes, and congratulated them on the success of the first community conference. I found other agenda items far more difficult to follow, particularly those relating to the various budgets and funds apparently at SIP disposal, even though the papers were there in front of me, full of tables and neat columns of figures (that unfortunately still failed to convey much). I felt it quite impossible to halt proceedings to request clarification or to ask questions that I feared would be perceived as stupid, so remained somewhat flummoxed. At any rate, I judged that no-one else listening to the financial briefing seemed to feel the need to

ask anything. I guessed other participants to be familiar with the flow of financial information and able to understand it – an interpretation quite at odds with their own experience, as I later discovered.

I managed to gather that a substantial unallocation of funds remained to be disposed of by the SIP during what remained of this financial year. This apparently provided the SIP with a problem, as the budgets for the following financial year had been nearly totally committed. Therefore the IMG had to ensure that any funding decisions taken this year did not impinge on the next. The Chair told the IMG that she wanted to transfer some of the underspend to the smoking cessation project, using it to buy NRT patches for the next financial year. The senior health promotion team representative readily agreed, but this was clearly an example of a sensitive area of negotiation in that it involved the transfer of funds within the group, members of whom could have objected, and without external scrutiny. The Chair flagged another issue as particularly sensitive – the continued funding for a number of substantial community-based organisations about to be inherited from the Riverbrae SIP, as this organisation had now reached the end of its funding period. Three of these organisations were managed by members of the Community Sub Group who had a stated interest in becoming SIP Partners. It seems reasonable to assume that the Chair wanted the funding issue resolved before the end of the financial year, and before such potential partners joined the Board. She told the IMG that the proposals put forward by the groups were too ambitious for their present capacity: ‘conditions’ needed to be built into any funding offer:

HC: So we’ll fund some things but not everything. We can’t give them capital. We need to offer a deal, with conditions – lots of support but limited money. (EKSIP Chair, IMG meeting, Riverbrae Council Committee Room, 11.01.00)

Although the projects under discussion here were defended by a health promotion representative who knew them well, others agreed with the Chair’s suggestions.

I observed the IMG discuss initiatives proposed by individual members of their own group, some of which were also subject to critical questioning before being approved. For example, an application for part funding for the LHCC to set up a youth team was critiqued as overly medical and ‘*one hundred per cent behind the CHD agenda*’ by the public health representative, who took some convincing that the project would work to involve young people. Some funding decisions were approved for reasons I initially found hard to fathom: why, for example, would a SIP focusing

ostensibly on health improvement and social inclusion fund a charitable organisation whose focus was on a specific medical disease? I later learned that small amounts of funding were given to local projects deemed worthy but otherwise irrelevant because this *'bought good press and good will'*. I also learned that such funding could be allocated to projects in search of relatively small amounts of money and with no access to other funders - for example, providing new crockery and cutlery for a social club for older people.

After this meeting ended, one statutory sector representative remarked to me how sensitive and confidential some of the items that had been discussed were, and how this would not have been possible if community/voluntary sector representatives had been present. In this person's experience, ground rules about confidentiality had not always been honoured and trust had been misplaced, with the end result of potentially embarrassing revelations. I then asked the SIP Manager for copies of all past minutes, to which Moira agreed, warning me that these documents were intentionally bland rather than an accurate record of the IMG's debates, as they were available for public scrutiny.

6.2.6.2 Community nominees

The last meeting of the IMG of the financial year was held on 1st March 2001. Again, under agenda items referring to finance, Helen Cameron spoke of the remaining unallocated funds, and asked for comments and suggestions from other members of the IMG: none were made. The Chair then moved on to speak about the community conference and I learned at this point that nominations had been received for Nancy Ferguson, Jim Cross and Elizabeth McArdle from the Community Sub Group, who had thus been automatically elected to the Partnership. These names seemed familiar to the IMG. Helen went on to reiterate that a place had already been reserved for Wilma Edwards, as representative for the voluntary sector. This meant that three places still remained vacant, one of which was reserved for a young person or youth representative. I give here an extract from my field notes, which records the subsequent verbal interactions between group members:

Helen then tells them that 'some comment has been generated re. the unopposed nominees'. She warns of possible conflict at the conference – explains about local politics and other objections raised – principally that all 3 nominees are involved in current SIP projects, so accusations of self-interest seem likely. Says 'so it's up to local people to object, and to nominate others.' (I wonder if Helen or Moira will want to warn the 3 reps [Nancy, Jim and Elizabeth] that they may face some opposition

on the night? Suspect not.) Moira tells the group that the nomination packs were widely publicised, so people did have the opportunity to nominate others of their choice. Sheena Munro asks, what happened to Henry? (member of community sub group who might have sought nomination). Helen says, he's a teacher and doesn't live locally. Moira says she's spoken to him and he doesn't want to stand anyway. Sheena Munro says that Jim and Elizabeth both live outside the SIP area, and she feels there will be local dissent to their election. Moira says that they both work in the area, so are eligible (but I remember this as criterion being suggested by the group themselves, so the accusations of self-interest aren't adequately refuted in this way).

Sheena Munro says the objections will be on the basis of independence. Helen says the issue was debated by the Interim Reps group – says I can confirm this, which I do, having little alternative. Graham Campbell talks about the need to counter such 'vested interest' objections. Helen stresses the need to deal sensitively with the issue – clarifies who's able to vote: over 16, living locally. Sums up problems semi-jokingly with, 'there's democracy for you. And this is only the start – it can only get worse!' (IMG meeting 01.03.01, Riverbrae Council Committee Room)

6.2.6.3 Asking new questions

Reflecting on my experience of the two meetings, I felt that I had observed strangely little of the substance I had been expecting, but a number of rather different puzzles. I had seen some of the substantial work performed by the Chair and Manager in a number of fora, but what role did their other partner agencies have? Was the 'real' work of the SIP being conducted elsewhere? Where was the ongoing strategic debate about tackling health inequalities that I had believed would inform Partnership decisions? Given that little money remained for the forthcoming financial year, what would be the role of the new community representatives? And what impact would the Partnership's ultimate control over funding allocations for at least two significant community projects, have on the relationship between incoming and established partners? Understanding of such issues was slowly gained over the coming months, and forms a key part of the analytical substance of Chapters Seven and Eight.

Before moving on, however, I need to give an account of the second community conference and election to the remaining community seats on the SIP Board. The sections above have to some extent tracked forward and backward in time, occasionally introducing data or theoretical insights not in strict chronological order, in an attempt to render the account more comprehensible. The final section of this chapter, however, adheres particularly closely to the fieldwork notes made during the election process, albeit in an abbreviated form. I believe this event was particularly significant in shaping community representative perspectives, and my notes provide

the evidence for such an assertion, bearing in mind nevertheless that however open the approach of the researcher, observations are inevitably partial and selective.

6.2.7 Election night fracas: 8th March 2001

I arrived early for this event at the Kirklands Community Centre and found the SIP Manager and secretary already there, together with another council staff member. A table had been set up outside the entrance to the main hall, with an electoral roll for checking off participants' residence and right to vote, plus a pile of square white cards to be used in the voting process. A large cardboard box held many white plastic folders, containing the agenda for tonight plus other information such as the intended role and responsibilities of a community representative. The third council staff member was despatched to the local shop, returning with a number of plain white postcards and small sticky pads, which she and the secretary then turned into name badges. I assumed these would be for officials present: SIP Board members plus the three community representatives already nominated. Following the arrival of Sheena Munro and Helen Cameron, this group discussed whether Councillors were eligible to vote, and decided that they were, if they lived locally. The group discussed moving the table to a better lit area, so they could see the electoral roll more easily, but the Chair was keen to stop people just walking in without being checked off and without receiving a voting card. A number of the Community Sub Group arrived together, stopping to talk amicably to the SIP officials. The Manager told me she had received objections from Bridget (a member of the Community Sub Group) about nominations from certain neighbourhoods being accepted unopposed, whilst her own area had no candidate (she had been the likeliest person but was ill during the nomination period).

The hall was set out with roughly 100 chairs and a long table at the front with three seats, behind which were three large poster displays advertising the SIP, as at the first conference. Graham Campbell, Moira Carruthers and Elizabeth McArdle, the representative of the Community Sub Group who had been asked to speak tonight, took up their places there. Also at the front of the hall was an overhead projector and screen. Graham Campbell chaired the event - a deliberate attempt, I was told, to try and distance the election from the Local Authority. The SIP Chair and Manager were both aware that the SIP, insofar as it was known at all to the community, was seen merely as an extension of the Council. Tea/coffee and biscuits were available at the back of the hall. People began arriving and by 7:15 p.m. the hall was full.

Several children were present. I chose to sit at the extreme outer end of one row to get as good a view of events as possible. Other members of the IMG and Community Sub Group took their seats in various parts of the hall. Graham Campbell began the Conference by welcoming people and explained that the purpose of the event was to elect community representatives to the SIP Management Board. He told participants that three posts were up for election, one of which was reserved for a representative of local youth. He also told them that the conference was an opportunity to celebrate the interest shown in the SIP by two primary and two nursery schools and that there would be a prize-giving ceremony resulting from a healthy eating project. The format for the conference would be for the SIP Manager to tell participants about SIP activities, followed by the prize giving, then a presentation by a representative from the Community Sub-Group. Nominations to the Board would then be sought and voted on.

The Manager then provided the audience with a quick run-through of information about the SIP: the ten geographical areas covered; the funding timescale of ten years and budget of roughly £750,000 per annum; its unusual status as a thematic health-based SIP with a focus on health inequalities and young people; and its overall aim of improving the poor health record of the area. She spoke of local health statistics showing a high incidence of coronary heart disease and stroke, together with lifestyle issues of poor diet and lack of exercise. She told the audience that the SIP had been in existence for nearly two years and had funded a range of initiatives as taster sessions for possible future services. She said the SIP had a central theme of empowering the community and community organisations, as part of which they had employed consultants to help local voluntary organisations develop and increase their capacity. She also listed the numerous health-related initiatives the SIP had funded, including a new nutritionist post for the area. She then spoke about SIP objectives – of using a broad definition of health, of trying to change the circumstances of people inside the area by looking at the *'whole picture of improving health, not using a disease focus'*. SIP Partners had committed themselves to changing and developing their services for the area: now the SIP needed to find ways of engaging with the community – hence this event. She then told the audience that the priority for tonight was to involve the community in the SIP management structure. She said the SIP would also talk to the community in different ways – through focus groups, surveys, and people's panels. She spoke about the issue of additionality, of adding on to existing services and the importance of sustainability. She spoke about supporting regeneration across many sectors – transport,

environment, anti-poverty, and education. She referred to the development of a community engagement strategy, the central elements of which were '*representation, consultation and information, and capacity building*'. Other tasks for the SIP involved developing a monitoring framework and achieving the targets set by the Scottish Executive. The Management group was to develop targets around improving health in the East Kirkland area. She also spoke about the current Community Projects Fund application round, intended to '*make small bits of money available*' to community-based organisations.

The next session of the conference dealt with the prize-giving, which passed off relatively free of hitches and seemed to be well-received by the audience. This was followed by Elizabeth McArdle's presentation, which was hard to hear as, at this point, many people began talking amongst themselves and some (mostly children and their relatives) took the opportunity to leave. Elizabeth spoke about her experience in the role of an '*interim rep*' and the networking benefits resulting from the WtLt conference and contact with the SCVO website for community representatives. As a result, she had been in contact with another SIP, some members of whom were in attendance at this event as they wanted to learn how to conduct a community election process. Elizabeth emphasised she was '*no*' here to represent *ma project or any specific part of East Kirkland*' and that representatives must be prepared to represent the whole area and all the views of the local community. Representatives would be responsible to people in the community and answerable to them. The audience applauded as she finished in haste.

Graham Campbell then began to speak about the voting procedures, but I could hardly hear him over the many other people talking. I could not tell what was being said, but it seemed that the presentations up to this point had certainly succeeded in generating audience interest – whether of approval or criticism I was unable to judge. The SIP Manager again moved to the OHP, and went through a series of detailed overheads describing the process by which the voting procedures had been decided. She then presented a list of community representative responsibilities. (These were also provided in the conference pack, and a number of people around me were reading theirs at this point.) She spoke of plans for SIP development sessions to be held with all partners, once the community representatives had been elected. She put up an overhead showing the names of those representatives who had already been nominated – Elizabeth McArdle, Nancy Robertson and Jim Cross. She told the audience that three places remained available, one of which must go to a youth

representative. She described eligibility for nomination – candidates had to live locally or work for a community/voluntary organisation in the East Kirkland area and had to be supported in their application by two other individuals. She said that voting would be required if more than three nominations were received during the event (one nomination being reserved for a youth representative). People would have one vote in each category, with the young person's representative being voted for first. She told them that representatives would '*get in on a majority vote*'. Voting cards would be handed in after the second vote. Finally, she asked if there were any questions?

None were raised so Graham sought nominations for the young person's representative. No one was nominated (as the Sub Group had predicted). He then asked for nominations for the two remaining places. The first to be nominated, a man named Stewart Orr, was duly supported by two other eligible voters, as required. Moira Carruthers repeated this information for the benefit of the audience, as by this stage many people were speaking at once. She was asked to speak up. A female member of the audience proposed the name of Margaret Kinnaird, who was also duly supported. The third nominee, proposed by Bridget, came from one of the neighbourhoods at the extreme edge of the SIP. Moira repeated the names of the three nominees and reiterated that the two who received the most votes would be elected. She told the audience that there would be one vote for each person. She then asked each of the three new nominees to give the hall some details of why they should be elected as a representative, which they did – briefly, in the case of the male nominee, more extensively in the case of the two female nominees. The third nominee read what appeared to be a prepared speech.

The man seated next to me asked the Chair about the criteria for getting a white card, which neither he nor his wife had been given: they were not the only ones to lack a card, although all lived locally. The Manager left the hall to check the electoral roll whilst Graham told the audience that they would be asked to hold cards up, to vote. He then sought votes for the first newly nominated candidate, but one man sitting a few rows behind me objected that voting should not be done on a show of hands – cards should be collected. There was now evident confusion around the hall and noise levels rose further. It seemed that many participants had expected that they would be asked to write names on cards – people stood up, left their seats and went round the hall to consult others. The Chair listened to objections then asked the hall to vote on whether they wanted to write one name on the card, or two. The vote was

held on a show of hands – Helen stood behind me, counting these. The count was given as 15 votes for the ‘one name’ suggestion, 14 for two names. Because this was so close and people continued to object, the Chair asked for a recount. This time it was 16 votes for one name. I felt that the small number of votes, compared to the numbers present in the hall, probably reflected that few people were actually listening at this point - and that those who were might well be finding it hard to understand proceedings.

Critical comments were audible from Bridget sitting at the back of the hall: *‘this is very wrong!’* One of the IMG members present spoke up, saying that the organisers had not explained things properly. Another, particularly vocal, man in the audience continued to voice criticisms and *‘points of order’*. At this stage the Chair seemed to decide it was time to regain control, over-riding continuing objections by stating that the majority in the hall had voted for one name on the card and that he would accept no more objections/points of order. Bridget stood up at the back to object that participants were only getting the opportunity to vote for one person although there were two places. She and a representative of the local social club put their coats on and left the hall, returning shortly afterwards, perhaps unwilling to let it go at this. People began writing on their cards and handing these over to waiting members of the IMG. Having taken the votes for the first two candidates, the Chair then asked for those for the third remaining person. Few in the hall seemed happy with the proceedings at this stage. The Chair then read out the results after members of the IMG had counted these. Stewart Orr had received nine votes, Margaret Kinnaird fifteen and the third candidate had received seven. Stewart Orr and Margaret Kinnaird were declared elected to the SIP but this was again rejected as *‘totally wrong’*, by Bridget at the back of the hall. The Chair summed up by saying that the event had turned out to be controversial and tried to carry on speaking, but few could have heard him over the background noise. He thanked people for attending, and some clapped. Bridget then went to the front of the hall to address the audience, saying *‘this has been a farce’*. She spoke of her intention to *‘speak to a higher authority to complain’* about it. She identified herself as one of the interim community representatives and seemed to imply that the election process as implemented was not what had been agreed at previous meetings. She and Elizabeth McArdle then entered into a disagreement about which process had actually been agreed and the conference ended in some disarray.

As people started to leave I went to talk to Graham, Helen and Moira who had gone to standing outside the building. This group were clearly very dispirited by the outcome. Nor were they happy that a member of their IMG had publicly criticised their organisation of the event. Helen repeated the comment made publicly at the last IMG meeting: *'that's democracy for you!'* She told me that one local man had suggested that they elect his wife as the young person's representative, because of her voluntary involvement with this age group, which would solve the problem of a place for the unsuccessful neighbourhood's candidate, but the SIP Chair viewed this as an over-simplification of the issues involved. Graham, Helen and Moira all believed that thwarted efforts at tactical voting had caused the conflict. The residents of the unsuccessful neighbourhood had been too few in number to ensure the election of their candidate at the event so they had needed the support of another area, but could not get this if people only had one vote to cast. Graham spoke of the tradition of such tactical voting procedures in trades unions, a process local people felt comfortable with and had expected at this conference. This interpretation was later confirmed from an unexpected source – a community member who told me that supporters of one of the successful candidates had said to her, *'why didn't you bring rent-a-mob? That's what we did.'*

6.3 Reflections

In this chapter I have tried to give an account of the East Kirkland SIP that is necessarily partial and interpretative but which nevertheless refers to a reality wherein all participants (including me) were actively engaged in sense-making activities. By March 2001 I felt that a number of themes had emerged as significant, some of which were derived from fieldwork and some of which related to those constructed from earlier interviews. For example, East Kirkland's artificial nature, as its boundaries are not the same as those of identifiable neighbourhoods: in other words, there exist tensions between the bureaucratic designation of a SIP area and the heterogeneity of the 'community' so designated. Strong local identities had been articulated, together with perceived tensions around representation of neighbourhood *versus* East Kirkland. Yet a parallel discourse of community apathy and lack of community confidence had also been deployed on numerous occasions by both community representatives themselves and by SIP leaders. This may be a strategy of self-legitimation and justification on the part of those who do seek to act in this arena, but it may also render questionable policy makers' assumptions that communities are ready and eager to engage in partnership with service deliverers.

I had noted some dissent from the focus on young people and the focus on health inequalities. In relation to the latter, there was also some indication of tensions between the emphasis on lifestyle choices and the acknowledgement of the social-structural determinants of health that seemed to be shared by members of both the Interim Management Group and community representatives. I felt that the complex rationale underpinning the specified health-promoting activities required further exploration, as this would throw light on how the members of the Partnership conceptualised health inequalities. A range of conceptual understandings had been apparent up to now, including both medical and social approaches to health promotion, utilising apparently incompatible discourses of social *and* individualised responsibility. I had also noted the existence of marked power imbalances and some suggestion of struggles over issues of legitimacy e.g. within the IMG; between the IMG and the Scottish Executive; and between the SIP leaders and the community. The SIP seemed sandwiched between accountability to a 'community' that they had themselves constructed and to the bureaucratic arm of the funding body, the Area Regeneration Division of the Scottish Executive. From the perspective of the SIP leaders I had detected a degree of powerlessness in the face of Ministerial prioritisation of health services and of being overwhelmed by multiple and conflicting policy imperatives whilst having no role in a policy dialogue.

It had become apparent that the community representatives believed that double standards and different rules were being applied by the SIP in relation to funding applications from statutory public sector bodies, such as the Health Board, and those from the voluntary or community sector. The second community conference had surprised me by the depth of passion and anger expressed and displayed by members of the various communities – the first occasion I had witnessed this. I was in no doubt that the theme of neighbourhood allegiance/partisanship and the related fear of exclusion from funding opportunities had to be judged significant in the light of government rhetoric around the inclusive aims of SIPs. I was also sure that it was reasonable for my research to ask where national policy concerns about health inequalities might fit into these local processes and priorities, and to analyse how the Partnership would function, given that the new Partners might be disinclined to trust their more powerful and established Partners. These questions are thus based on emergent themes significant to the original research questions and to participants themselves.

A focus on social processes fundamentally assumes complexity and is directed towards unravelling the encounters and negotiations between different interest groups: it predicts constant evolution (Strauss 1978). I judged an analytical focus on the social processes involved in this local manifestation of national policy initiatives around partnership formation and working for health improvement and social inclusion to be amply justified by the evidence of complexity and conflict up to this point. I was beginning to understand - without necessarily coming to share - the very different perspectives of both the more and less powerful research participants. I believed I had established reasonably good relationships with key members up to now without wishing to feel completely at home with them. And, given the evidence of a potentially schismatic Partnership with at least two, and possibly three sides (SIP leaders, statutory sector agency established partners and community/voluntary sector new partners), I realised that the task of maintaining field relationships and sustaining my own, deliberately marginal, position would require continuous effort and careful monitoring.

CHAPTER SEVEN

FORCED PARTNERSHIP/ CONTESTED LEGITIMACY

7.1 Introduction

The last chapter traced the development of the East Kirkland SIP from the early stages of 'interim' management to its more inclusive form as a partnership with community representation, following the election. This chapter is structured into a number of sections. The next section explores the perspectives and experiences of selected members of the Community Sub Group, using data gained *via* in-depth interviews. The following sections are based on participant observational fieldwork with the SIP Support Team and with the newly constituted full Management Board, from March to August 2001. Narrative detail, data extracts and analytical comment are interwoven throughout the chapter and formally encapsulated in the penultimate section, in terms of a framework depicting the crucial paradoxes besetting the Partnership.

7.2 Perspectives from the Community Sub Group

Following the election conference I judged that those new partners who had formerly been members of the Community Representatives Sub Group (i.e. the voluntary sector representative and three of the community sector representatives) would now be in a position to reflect on their knowledge and experience of the East Kirkland SIP. I therefore arranged to interview three of these during March 2001. One participant lived and worked in the East Kirkland area; another lived in the area but worked for an organisation with a larger geographical remit; and the third worked in the area but lived elsewhere. Their claims to the status of local representative thus rest on different bases. The interview with the fourth elected representative was postponed until later in the year because of that representative's busy schedule. A fourth interview was conducted with an individual who had been an active member of the Sub Group, lived in the area and had attended the second conference but had not sought nomination to the SIP. Unlike the other interview participants, the SIP did not support this person's community-based project: there was therefore a degree of neutrality - or, at least, of critical distance - in this account. One interview turned out to be a lively group discussion: the community representative involved was a

leader of a local project and members of the team wanted to participate. Extracts from the group interview are labelled as such, to distinguish them from the individual interviews with other community representatives.

7.2.1 'Insider' accounts

These interviews provide insider accounts of the SIP but they should not be taken simply at face value. They perform a dual and complementary function: as a source of information about events and as revealing the perspectives and discursive practices of those who produce them (Hammersley and Atkinson 1993). During the interviews I asked participants what health inequalities meant to them and what they thought the term might mean to local people. I sought to ascertain their opinions of the SIP – its achievements, its aims - and enquired whether they thought local priorities were compatible with these issues. I also asked them about their views of health promotion, deliberately leaving this question vague so as not to constrain their responses. I asked them about their experience of participating in the SIP up to now. I used both non-directive and directive types of questions, depending on the function of the question, i.e. seeking clarification or probing an issue further. There was no fixed sequence of questions and the format of the interviews remained highly flexible. The interviews were conducted in the setting of the local projects to which each representative was attached, enabling me to gain some familiarity with the surrounding area, and note features of the neighbourhood. For example:

The Borrowdale Play Project is located not far from the Social Club and the Neighbourhood Centre – the latter of which is a rival project as far as funding and user groups is concerned. Borrowdale itself is made up of mixed housing and a couple of schools. Some of the housing is of frankly appalling quality – tenement-style blocks long overdue for demolition. These tenements are closest to the Centre. Other social housing, closer to the main road leading to Kirklands town centre, is of better quality and many have cared-for gardens. I drive too far down the road, looking for the Project, and turn round – cautiously – in the car park belonging to the Social Club: the ground is littered with empty cans and broken glass and seems unlikely to be used by any car owner. (Group interview fieldnotes, Borrowdale Play Project, 20.3.01)

The extracts given below shed light both on the context of community engagement with the SIP, and on the particular perceptions brought to partnership work by those seeking to represent this sector. The interviews were also useful in terms of my research relationship with these participants, as I believe they helped to establish my credibility as someone interested in understanding their views and experiences but as reasonably 'neutral' in terms of the Partnership. Moreover, I was able to draw on the

data generated through these interviews to interpret representatives' remarks made during subsequent SIP meetings. In the light of these discussions, I became reasonably sure that on a number of occasions, some of their comments, which might otherwise have seemed innocent, were really intended as oblique criticism of the SIP leaders and their statutory sector partners.

7.2.1.1 Speaking freely

I had expected some degree of wariness from participants in all these interviews. Although I had found them friendly and forthcoming enough during all our previous informal encounters, they could conceivably have viewed me as an ally of the SIP leaders who had introduced me, which might in turn affect their readiness to speak openly. I had also expected some caution in their expressed views of the SIP, given the partial financial dependence on this organisation by three of their projects. However, although there was some initial wariness at the beginnings of the interviews this was lessened when I told participants that comments would not be attributed to identifiable individuals. Some of the interview comments are sharply critical and were given in confidence. It would be unethical to facilitate the attribution of such comments to potentially identifiable individuals so, although I introduced the community representatives who were to become members of the SIP in the previous chapter under pseudonyms, in this section all interview participants are anonymised. They are described as C/VR (for community/voluntary sector representative) or worker (for other categories of participant in the group interview): interviews are neither numbered nor dated, as this might enable identification of a particular individual.

7.2.2 Unstable meanings of health inequalities

The issue of health inequalities was generally the first to be with participants: I felt that the abstract nature of the topic, though complex, might initially be easier to discuss than their own observed problematic involvement with the SIP. The difficulty of getting lay people to talk about inequalities in health is recognised (Blaxter 1997), so I was not surprised that my interview participants found the subject difficult to talk about at length or in depth. In addition, it seems that not only is the issue hard for people to talk about, it also seems hard for them to maintain a consistent stance. When comparing interview data with fieldnotes, for example, I found that respondents' constructions of health inequalities shifted across contexts:

attitudes expressed during planning or training events sometimes differed from those given at interview. Nor were they necessarily stable even during the *same* context, which perhaps reflects the intrinsic difficulty of finding and holding a 'fixed' position on this complex subject. For example, at the beginning of one interview a respondent challenged the SIP's perceived focus on health and exercise for young people, but concluded the interview by saying that children's health suffered because they did not get enough PE in schools.

Not surprisingly perhaps, most interview participants also equated inequality in health with inequality in provision of or access to health services or health-related welfare benefits. As one respondent succinctly put it, '*the only health inequalities you'll get in this community is, "that one's getting mobility" or "that one's getting DLA".*' Concepts of health were constructed more in terms of the availability of adequate life chances and opportunities, and the ability to make choices - in other words, in terms of the capacity for human agency within an insufficiently equitable social structure. Talking about health rather than health inequality proved initially easier for some, but inequality *per se*, and inequity, formed a significant part of their responses. Poor health was seen as only one consequence of a broader-based social inequality. The links between health, poverty, deprivation, inadequate housing, lack of educational qualifications and unemployment, were noted by all respondents. Most were familiar with some well-known research findings on the subject, as will be seen in the following extracts - though I felt that some uncertainty surrounded these. The issue of drug and alcohol use amongst young people in the ten neighbourhoods was a consistent theme. Influences of environment and lifestyle were both mentioned, though the former was accorded a greater priority in this context. A distinction was made by some between the knowledge of health inequality that ordinary people in the community were likely to have, and that possessed by those actively involved in working for the community and in contact with knowledgeable others.

In the following extract, my informant is talking about geographical disparities in health, a well-known feature of this particular part of Scotland, but after some hesitation around such abstract issues (indicated by the pauses in speech) moves onto the more concrete matter of local disparities in facilities and service provision. This participant is comparing the local neighbourhood with '*them down the road*' (a neighbourhood perceived as disdainful of its poorer neighbours and derided

accordingly as ‘*Spam Valley*’), drawing on a discourse of justice, equity and entitlement in so doing:

C/VR: Aye, if ye live in a certain area ... a certain part, then ye should be OK. There is a lot o’ heart problems in this area... I mean it’s got the worst heart trouble anywhere in Britain. An’ I take/I don’t know whether I’m right or no’, but I take it, in the health.. they’re talkin’ about the drugs an’ tha’ as well.... I don’t know whether what they say is right or no’, but ... I do feel sometimes, if ye’re livin’ on the breadline ... that ye get less chances than other ones. I definitely feel tha’. Ma reaction/gut reaction is well, why don’t we get the same facilities as them down the road? We pay the same rates as everybody else. We pay wer/wer house rates, wer council tax. If and when any of them in this particular area here are workin’, they pay their taxes the same as everybody else. They pay their rent an’ they’re entitled tae the same medication.

The following extract from a different interview suggests a strategy of distancing local experience from ‘*the people wi’ the stats*’ and the perceived links between disease and behaviour, before the discussion shifts to more solid - and enduring - local problems:

SC: Can you tell me what the term health inequalities means to you?

C/VR: Well, East Kirkland, according to the people wi’ the stats, has a/has a massive problem with every bloody illness, regardin’ the amount o’ people who smoke, the amount o’ people who consume alcohol ... coronary heart disease ... that’s why it was given the SIP. Certainly the housing stock is improving, through this project and tenants and residents, an’ Scottish Homes, so we have seen a marked improvement in housin’ stock. But they’re still puttin’ in the same people wi’ the same er lack of finance. They’re still local Wellbank people who were in the tenement blocks that were demolished. We’ve got the Housing Association so they’re doing all of Wellbank Road. So I think the community gettin’ decanted, the people goin’ in are the same people that were comin’ out. When I come in I seen the problems, we’ve certainly eradicated some/certainly the housing stock has been improved but when you move the same families in, you’ve still got unemployment, you’ve still got the poor health, you’ve still got the poor diet, you’ve still got the lack of money and the poverty trap. So we still need to address that.

Another participant was frank about her lack of formal knowledge of health inequalities, finding it easier to define health in a holistic manner. This respondent too, progressed rapidly on to similar perceptions of regeneration policy responses that seem to involve a strategy of papering over existing problems:

SC: ...which brings me onto the subject of health inequalities - what does that mean to you?

C/VR: I haven’t a clue!

SC: OK, what about health in general? What does that mean?

C/VR: health means influences... it doesn't just mean the physical being, it means the/ I don't know how you'd describe it. It doesn't just mean the physical person – it's about life chances, opportunities an' everythin' – if those are available, people's confidence and self esteem/they need to feel good about themselves, the environment they live in, the environment they work in. An' it's not just about building new houses because I mean, if you go through the area, essentially it doesn't look as if there's much poverty there. But in actual fact, in lots of these areas all they've really done is to paper over – like put a fresh coat of paint on or something. They really need to address some of the issues/underlying issues... because you could pull down [area], for example, and build new houses which they have half done, but the problems are still there – drugs, crime, alcohol abuse, healthy eating problems, all these kinds of things – no education, skills. I mean I hadn't thought about it that way until a couple of people who lived out of the area said, "it doesn't look as though there's a lot of poverty". But putting someone in a nice environment ... it's about treating the symptoms rather than the disease itself.

7.2.3 Tackling the problem

Conventional health promotion activities funded by the SIP, aimed at encouraging healthy eating, exercise and smoking cessation in East Kirkland, received a mixed reception. The major health promotion initiative of the previous year was acknowledged to be a popular success, but condemned for its short-term nature. The problems of initiating healthy policies within community projects and of encouraging healthy lifestyles for individuals were noted, together with doubts about the prescriptive philosophy underpinning traditional health promotion:

SC: What's been your experience of working with a health promotion approach?

Worker1: Well, we tried it. We brought the Health Board down here tae the Youth Club and she was wantin' tae speak about healthy eatin'. An' it was just ... the wrong philosophy or whatever. Mebbe it was the way she approached them. "Ye cannae eat yer pizzas or have a wee drink". They went on the defensive, and somebody started tellin' her, but she wouldn't listen. She never come back!

One participant had attempted to restrict smoking on his own project premises, but acknowledged that a total ban would mean the loss of probably 50% of community users. Others spoke of the difficulties of following a healthy lifestyle and ensuring that children get exercise on a low income:

C/VR: I mean, if people are livin' on a very low income ... how do you take the children out? How can you take them tae all these different places if ye havnae got the money?

Worker: And with diet as well – with diet it's the same.

C/VR: I know this scheme in the school is working at givin' the kids a wee bit of fruit. But it's OK givin' the kids a piece of fruit here eleven o'clock in the mornin' here in the club, but when they go home at night ... what's a fruit bowl fer? I

was watching Elaine Smith earlier – “what’s a fruit bowl fer? – kirbies an’ loose change!” (laughs) Never a truer sayin’ – she’s speakin’ from experience. A fruit bowl in the east end of Glasgow (laughs). Hey, we don’t need the University of Aberzaijan to say we eat a poor diet – we know it! (laughs)

This participant also suggested a potentially insoluble cause of poorer health - the climate:

C/VR: There’s a major problem in the country we live in, the climate, we’re all pale skinned and peely-wally and ill health because we’re spendin’ ten months o’ the year blethered in snow an’ rain.

The preferred solution for this informant was for the Government to fund poorer families to have annual overseas holidays in sunnier parts of the world.

7.2.4 A local priority?

I also asked participants if they thought health inequalities would be seen as important and a priority for action by people living in the community:

C/VR: I don’t think so. I think they’d be important tae the people who want tae make it part of their life and be important ... and this is probably community activists, who won’t like my views on this. But I think the general run of the mill community .. no.

Participants in the group interview echoed this, drawing attention to what they perceived as greater priorities for the community *and* to the fact that poor health is, in some sense, normal in this area and therefore a less urgent issue than living on an inadequate income:

Worker1: I think the day to day struggle, to manage from day to day and week to week on a benefit book takes priority for people.

(this comment elicits general agreement from the others)

Worker2: An’ I think probably people outside look at those statistics an’ say “oh isn’t that terrible – thank God we don’t live there”, but people inside don’t have that same kind of view. Cause you don’t know anythin’ else, y’know.

This sense of routine familiarity with death and disease was echoed in another interview:

SC: Do you think health inequalities matter to people out there, living in the community? Is it meaningful to them – is it a priority?

C/VR: When you say health inequalities, probably not. But I think they all know. I mean, they know that they're at high risk of cancer, heart attack, stroke, it happens around them every day.

All participants stressed the importance of the SIP listening to what local people actually wanted. One suggested that this might not necessarily accord with SIP aims and objectives:

SC: So what d'you think the SIP can do – I mean, the aim is to improve the living conditions of people in East Kirkland and reduce health inequalities?

C/VR: What the SIP can do is actually start by speaking to the community and find out the real burning issues. For example, one of the things that comes through this office, day in, day out, is play areas. There's been all the debates about we'll put this here, we'll do that there – but that's not what the community wants. They want somewhere where the kids can go and feel safe.

This theme, based on the perceived lack of community safety across the area, was to recur many times during subsequent fieldwork. However, even though doubts had been expressed about the focus on health inequality and on young people, most participants believed it a suitable starting point, a '*foot in the door*' for addressing the wider needs of the ten communities:

C/VR: ... an' if it means/if SIP is able tae help us, and able tae listen tae what it is the place is needin, then aye, go fer it. I mean, ye've gottae get yer foot in the door somehow. An' if that's yer foot in the door for SIP/fer health, then aye, we'll take tha'. An' mebbe further down the line we can find somethin' else that we're all mebbe needin' that we should look a', an' go fer somethin' else. But at the moment, if that's wer foot i' the door, then that's the one we'll take.

There are thus some intriguing parallels with the experience of people in positions of greater power and influence, such as the SIP Chair, who had similarly spoken to me of accepting the national policy agenda of funding priorities and striving to make this applicable and responsive to the local context.

7.2.5 Evaluating Participatory Processes

Although the three community representatives interviewed had been elected to the SIP at the beginning of March, they had received no official confirmation of this by the time of our discussions. They were also aware that SIP meetings were still being held without their involvement:

C/VR: I was notified that I was elected unopposed on the ... publicity poster that went out. I've still no been given er a formal letter tae say, not

“congratulations”, but “you are now an elected member of East Kirkland SIP”. That has not been done, and I don’t think that’s a good way tae start. There was a SIPs management group meetin’ on the 19th and there’s one scheduled for the 29th – why haven’t we been invited? Why aren’t we there? We’re elected members! I know other community reps – I’ve met one – has the same situation, the same thinkin’. We’re thinkin’ of draftin’ a letter about, tae say, “hey, we’re members – why aren’t we in there?” If we’re there as real reps, real representation, real equal partners as the Scottish Executive are sayin’, why aren’t we at the meetin’s?

I knew, having attended one of the meetings referred to, that this had been a particular event to finally sort out the more sensitive funding decisions for the forthcoming financial year, including this representative’s project, but I scarcely felt able to admit this. This sense of continued exclusion was also present in the other interviews. Although interview participants had now been *marginally* involved with the SIP for a number of months, they all spoke of it as virtually unknown to the population it professed to support and engage. For example,

C/VR: The population of East Kirkland wouldn’t know what SIPs was. If it jumped out in the middle of Kirklands, they wouldn’t know what SIPs was.

The group interview confirmed this, and drew a distinction between how ordinary people - ‘*the punters in the street*’ - and those involved in local project work would make sense of information, whether about the SIP or about health inequality, in public meetings:

C/VR: People in Kirklands – you live either in Bridgekirk, or you live in Cossains, or you live in Borrowdale – and that’s how people talk about the area. And suddenly you’ve got East Kirkland. So the ordinary people mebbe comin’ intae a meetin’ felt that they weren’t really .. you know ... that aware’ae it. An’ the only ones that would be aware’ae it is people that are frae projects, an’ they know that kind o’talk. “That’s East Kirkland, that’s SIPs”, not “what does SIPs mean?”

Worker1: With the regeneration problems we knew we were goin’ intae SIPs. An’ we heard from people, “Wha’ is SIPs? Wha’ is this East Kirkland? Wha’ is tha’? Who’s tha’?” I mean, we can ask questions within groups o’people .. but how does the punters in the street understand this? But wha’s all this health? I mean, that’s it – wha’s all this about health?

SC: Does this issue not ... make any sense to people?

Worker1: Naw. It doesnae make sense tae **me** anyway.

Worker2: I think a lot of the community has real difficulty because they don’t know about it, because they’re intimidated by the language. The health issues are ... like ... they’re decided by the people who are sittin’ on the pots of money.

Prior attempts at encouraging community participation were viewed as questionable, particularly the citizens’ jury conducted by a firm of consultants commissioned by

the SIP. The latter failed to contact the ‘*right people*’, i.e. those with sufficient knowledge, understanding and expertise in the relevant issues to enable them to participate meaningfully. Those who did participate did so for the ‘wrong’ motives:

Worker 3: An’ I really didn’t think they had gone round the community, for the jury thing ... the consultant people ... because they’re payin’ people tae actually come along, the consultant people are payin’ whatever – twenty five pounds. An’ a lot of people in the street, because they’re in quite a deprived area, p’raps they think, “oh well we can get some money for this” an’ don’t really understand the ethos behind it, and how important what they say, you know, they can change things or make an input intae things.

C/VR: They really didn’t do that with people who are mebbe workin’ in the community.

Worker2: They didn’t tackle the right people.

SC: The right people?

Worker 3: Aye, they didn’t tackle the right people. Because I felt like, y’know ... there’s a lot of kinda.. voluntary groups within the community. If **they’d** a went along tae that meetin’ they’d hae been able tae have given a real good insight, because they’re workin’ with the people within the community. But the people they brought .. were mebbe like caretakers of [local projects], y’know. They just open it and shut it and wouldn’t get involved in **anythin’**. And most of them went because they were gettin’ paid. It was the financial aspect.

They thus echoed comments made to me by the SIP Chair, during our interview, about the Citizens’ Jury having been ‘*a jury of ignorance*’. I suggest that claims to expert knowledge are being made here that challenge the familiar distinction between professional-lay knowledge. To those actively involved in community projects and voluntary work, it seems that lay people are those who do not get involved and who therefore have little to contribute, whether this be attributed to ‘*apathy*’ or ‘*lack of confidence*’. The issue of community worker knowledge being at least as valid as, if not superior to, the professional knowledge of the statutory sector services recurred later in these interviews and emerged during subsequent full Partnership meetings.

7.2.6 Claiming authenticity

During the interviews I also discerned participants’ concerns with justifying the role of their projects in the community, conveying their own knowledgeability and experience of the problems of disadvantaged areas in general. They seemed anxious to present themselves as authentic speakers for, and legitimate representatives of, the community: in other words, I felt that they were drawing on a discourse of entitled advocacy. The following extract shows how a representative handled one of my

questions, a question that he seemed to interpret as questioning his claim to the status of legitimate community advocate:

C/VR: We now have/we now operate seven days a week, with twenty seven different user groups.

SC: The project sounds well used.

C/VR: From Monday till Friday from nine in the mornin' till ten at night .. and a Saturday and Sunday, Saturday from nine till two and Sunday from... half four till half past eight. It's very well used – we average about .. six hundred people a week through the door.

SC: So you have ways of getting to the community, finding out what they want .. but you don't live locally?

C/VR: No, but I've been working in the voluntary sector for now .. goin' on twenty one years, and I've worked in Urban Aid regenerations, APT areas, regeneration and SIPs. I've worked in er/ma background in fact/I've actually worked in Ferguslie Park, I worked in four groups, I've worked in Govan, I've worked in the Gorbals, I've worked in Great Easterhouse and I've worked in Castlemilk. So I've worked in all the kinda areas where ... people who .. were at disadvantage, living in a poverty trap. So I've seen it at first hand, experienced a lot o that sort of thing, d'y'know, wi' drug an' alcohol abuse .. er .. poor housing, massive unemployment. Just the social problems of livin' in the west of Scotland.

Participants spoke approvingly of the Scottish Executive's perceived condemnation of the SIP's non-involvement of community-based organisations. One participant had met an official from the Area Regeneration Division and been encouraged to lobby the SIP on this issue: she felt confident that the community had a champion in the Executive, who would be '*keeping a close eye*' on the SIP's activities. Conversely, the agencies that make up the SIP were seen as remote from the reality of life in the area. Another argued that local workers in the community sector are better placed to understand and respond to people's expressed needs than those who just '*sit round a table*', emphasising her own project's close connection to the community and thus her own legitimate and authentic status in speaking for the community:

C/VR: They don't really know what's goin' on. But we have tae mix wi' people every day, we have tae rub shoulders wi' the poverty every day. So ... they're the people that are sufferin' and they're the people that are sayin', "yes, we know ye're workin' in the community – why can't ye get that done?" An' I'm sick o'sayin' that tae the chief exec [of the council]. What we put here is not what/we don't sit round the tables sayin' "well I think that'd be quite a good wee idea". You put/the idea comes from the people. The people say, "we've nowhere tae go" ... I mean, I've had lassies sayin' "I've got a child under three, we've got nowhere tae go wi' this child" – couldn't get intae a nursery place, or they get sent in another area an' they haven't got the money tae travel. So they came tae me an' I come up wi' the idea that, right, we'll have a nought tae three creche or somethin' for these girls

tae come in. An' these people sittin' at their table, they're not listenin' tae us, they're not listenin' tae people in the community, they're sittin' round a table and they're comin' up wi' it.

7.2.7 Resisting external dominance

All interviewees spoke of a local history of competitive relations between the community/voluntary and the statutory sector. Some stated that if a project was perceived as successful, the Council would '*step in and take over*' and cited a number of examples of this happening. Close involvement with any influential Council official was therefore viewed with extreme wariness, if not actively resisted. They spoke of what seemed a paradoxical position: of community/voluntary sector organisations striving to obtain funding from the Local Authority by re-badging their own work in suitable ways, whilst simultaneously keeping the funder at arm's length in order to continue working in ways appropriate to the local context. (Very similar perceptions were articulated during my interviews with voluntary and community sector workers across Scotland, during the period of fieldwork around case selection). One interviewee spoke of the marginalisation of local community workers by powerful statutory sector agencies in favour of workers with paper qualifications:

C/VR: Folk got took in who had a wee bit o' paper that they'd been at a Uni an' had paper experience, an' get paid fer it. Whereas them who had worked in the place for years an' built up a reputation fer it ... fer nothin'... got the elbow, the big E, and not even a thank you. So ... I think it's/once they had a piece of paper that says "I am clever", then that was them. "Oh well", the higher-up people went "oh well, they must know what they're doin' then. We'll go tae them – have a talk tae them. No point goin' tae Mr [-] – he's just Mr Joe Bloggs off the street".

The context of this comment was that a Council employee had been assigned to help develop the project with which this speaker was involved: this was seen as the first step in a slow process of take-over. This project was not funded by the SIP, but other interview participants who were so funded told me that this process was also occurring in their own projects. For example, one project had been told by the SIP Chair that their management capacity was inadequate and they would therefore be partially managed by the Council in future. Representatives of those projects whose future funding appeared precarious particularly questioned the legitimacy of leadership of the SIP by Council officials, and their views need to be understood in the light of this context. The group of workers I spoke to perceived the dominance of the Council to be a barrier between local community and voluntary organisations and other agencies within the Partnership:

Worker: I think/I think that hinders a lot, because all the meetin's that we've had were with SIP people, right, regardin' any fundin' that we're gettin'. Two chief exec officers who are our own chief exec officers frae our last fundin' for regeneration Now obviously we feel that this isn't come/it's not council money, right, it's Scottish Office money, an' that we haven't had a chance as a group .. they could have come an' seen us, we could have spoken to them .. but it was two Riverbrae officials that have come an' sat round the table, there's not been any other members of the SIP management group that have come an' seen this group, an fer us to put proposals tae them. An' there's a barrier here, that's Riverbrae Council workers...

This concern with the perceived dominance of a small number of powerful, but unrepresentative, individuals was echoed during a separate interview:

C/VR: we met with the two... members of the Council, and I said tae them "why? Why are these the reps? Why are we not meetin' somebody from the Health Board or somebody from Scottish Homes? Why is it council led?" The council are the/the/the bankers – so mebbe that's why. I've heard people again sayin', "we need a wider representation". Mebbe one of the council members, mebbe somebody from the Health Board or mebbe from Scottish Homes or somebody from whoever, not just these same two people. It really concerns me.

7.2.8 A Partisan Partnership

The SIP was viewed as unaccountable to the local community: for example, all interview participants were aware that much of the budget had already been committed, with no participation from the community or voluntary sector in such decision making. The allocation of funds by the SIP was a particularly sore point for all interviewees. One interviewee told me that local community workers knew the money was already spent and contested the ways in which this had been done:

SC: Where are you hearing these things – what are your sources?

C/VR: Discussin' with other projects – "did you not know..?" "I didn't." "An' this has been spent." Mebbe the health promotion department is sayin', "ah but it's fer the next round of the smoking cessation programme, which was a success". From what I knew of the kinda workins' of it, there was a success rate. But why are we givin' money tae funded projects, why has it not gone tae the community and voluntary sector?

In the group interview, similar suspicions of partisanship *within* the Partnership were articulated:

Worker1: They're a' wee pals, it's a' pals.

SC: How d'you mean, pals?

C/VR: It is all pals together, it is. It's very much so, ye see it in which projects get funded and which have tae struggle.

These participants also spoke of internal partisanship in the allocation of funds to the larger statutory agencies, of illegitimate and wasteful funding decisions, and of being kept in the dark as far as their own funding position was concerned in the following, fairly lengthy extract:

Worker1: I always feel what's happenin' in the SIPs is all the money's gettin' channelled out tae the health board/

Worker2: /an' the local authority.

SC: OK. So what's wrong with this?

Worker3: It just doesn't seem right that the people makin' the decisions for the SIP should be able tae take some of that money and use it for initiatives that should be funded anyway.

C/VR: I think, because it's still early days, people are quite hopeful but I can't really see how, on the one hand it's gonnae work for us, funding-wise. On the one hand we'll wait and gie it a chance and see if it works, but ye're left a wee bit worried because o' what's happened up tae now, y'know, that money has went tae a lot o' areas. An' they're only now gettin' the community representatives involved ... which ... all their people were in place right away, an' they began tae dish out a lot o'money.

Worker3: And then they come up with something like the dietician. You know, three hundred thousand pounds and she spoke about bringing in some dietician. An' my sister said, "actually, why don't you go back tae the people in the community? You know, there's lots of people in the community that have mebbe brought up families. Great groups that can do a' that kind of stuff, y'know, all of it. And really save an awful lot of money that way." You know, because they seem tae .. spend an awfu' lot o'money on a lot o' frivel things.

Worker2: I mean, ye see it when ye look at how they've spent the SIP money – they've spent twenty thousand pound on the [initiative] but that twenty thousand pounds would keep us goin'. This is what/y'know, we're fightin' for wee bits of money that would make so much a difference, an' ye see all this round about ye that's gettin' wasted and squandered an' goin' tae consultants. An' payin' consultants thousands o' pounds tae go an' speak to a pensioner, a poor pensioner. When they don't have a clue what we're talkin' about. Twenty thousand pounds could change this, make a difference here phenomenally. You could go to any other funder, the lottery or whoever else – you put in your application, it's scored or wha'ever, they come out, they speak to ye personally, an' if you don't get it y'know it's a lack of funds or wha'ever or ... but SIP is a funder, an' to see what a' this money's gettin' spent on... Now we've been told the decision for us will be made on 29th March – how d'ye make any provision for what's happenin' on 1st April? Get budgets organised an' get things done...

C/VR: It just seems very cloak an' dagger tae me.

7.2.9 Representing 'the community'?

The intrinsic problem of representing a number of localities was mentioned by all interview participants. When I asked how the SIP would be able to work with the ten neighbourhoods, one participant spoke of the differences in opportunities for participation across the area that now existed but recognised that there were no easy answers to the complex problems of representing multiple interests, groups and neighbourhoods:

C/VR: I don't know how .. they've only got five community reps, they've no' got a youth rep as yet. How we're gonnae be fully representative of East Kirkland ... community involvement is strong in Wellbank, we've got a tenants' group, we've got a very good management committee, we've got a project providin' a service. The [-] project is pretty close, slightly different catchment area er... we provide information tae our local users and wider/wider community. But the likes of St Colmes and Southmuir, where there's no real representation, it's gonnae be very very hard tae be representative, tae take back information from SIPs. What these people want and need. I don't know how they're ever gonnae do that.

SC: Do you think every neighbourhood in East Kirkland needed their own rep?

C/VR: I don't know if that would work ... in practice there'd be a representative of each area, of ten areas. Or did we look at the focus groups, was it a rep tae deal with poverty, was it a rep tae deal with employment trainin', was it a rep tae deal with youth, was it a rep for the old age pensioners, was it a rep tae deal with community policin', was it a rep tae do with housin'? An' I don't know the answer. I know they've tried tae take some lessons from the Dunloan SIP, but what I know of that, that's a **shambles**. An' I don't know if East Kirkland is gonnae get any better. I'm hopin' it'll be more about poor housin' an' poverty.

Another interviewee saw the issue of neighbourhood loyalty and pressure towards partisanship as something to be resisted in the interests of the benefit of all:

C/VR: Whoever it is is gonnae get an awfu' lot o' pressure frae their areas. I mean, if this place was er had somebody on it, I know that folk would be comin' – yer door would be gettin' chapped twenty four hours a day: "you remember, we need tae get this and we need tae do tha', and you fight fer us cause you're in tha' place, an' we'll be behind ye, an' don't ye worry. Forget about the rest o' it as long as you get us this". I mean, I know, I've seen it, I've heard it a'. It's just a case, ye've gottae be strong enough tae be able tae say, "aye, nae problem" an' then go an' do what ye've tae do. An' I really think that we'd be an awfu' lot better off if we could a' get together in somethin' like this, an' get the benefit fer a' the areas rather than just fightin' fer one. If we get it/if one area gets it, all areas should get it. But so far, I mean, we've been fightin' one another, an' now if we could get together an' fight together fer somethin', I think we'd stand a better chance.

7.3 Contested Processes/Ambiguous Status

I was not surprised to find that some of the most stringent criticism expressed during the interviews was directed at the process of nominating/electing community representatives onto the SIP: *'the election that was a nightmare'*, as one participant put it. The one word consistently used to describe the event by all interviewees was *'shambles'*:

C/VR: The way they went about it ... that day, tae get people on it, was ... disgraceful. An' I thought they would be/bein' the organisation that they are, I thought they would hae been better .. organised in that regard. It was a shambles! It was a shambles – as soon as tha' votin' went ... it was a total shambles. Right at the very beginnin', when they says right, we're gonnae take in/this is the names of .. an' I sat an' I says, "what a way tae get a vote". An' that's why I put ma hand up – I says, "do we not get tae hear a wee spiel frae each o' them, sae tha' we know why they're standin' an' wha' their attitude is?" I mean, how can you vote fer somebody off pat, when ye don't know them? Ye don't know what their views are or anythin'. Ye need tae know wee bits like this. An' that wasnae forthcomin' until that was brought forward tae them. An' that's when they allowed them tae say who they were, an' what they were doin'. Cause I think it was just totally out ae order. I definitely think it was totally out ae order. An' I went home ... **fizzin'**.

Another representative argued that the nomination/automatic election process undermined the legitimacy of those who had become members of the Partnership via this route and effectively excluded the community's voice. Moreover, expertise in such processes existed already within the community, but was ignored:

C/VR: The three people who nominated themselves, they're no asked tae stand up on the night and tell the hall, "this is me – I'm doin' this, that, whatever". I felt it should have been only fair if they'd said, "there is three elected members already unopposed now – could you please mebbe give a five minute profile on who ye are an' why ye want tae do it?"

SC: So from what you're saying, there might be some ill-feeling about the elected-unopposed status of three of you?

C/VR: That's right. Three elected and unopposed, tae the SIP management group. I had a proposal form, I was nominated and seconded by my chair and vice chair, right? There was no other form of election. So the SIP's management group must have said, 'we'll take these three'.

SC: Yes, 'cause there were only those three nominations.

C/VR: But the problem is, the votin' was tae come from the local community. They were tae have the opportunity tae vote us on. Now there's two people representin' Borrowdale! Although we'll be sayin', "we represent East Kirkland", again the question is, how can we represent East Kirkland? We're active, but ... When they come down tae the nomination about one vote ... achhh [sound plus facial expression indicating disgust and exasperation]... an' I don't think certain individuals who were kinda chairin' up at the top table did themselves any justice in the eyes of the body of the hall. And these people are responsible for managing a

budget of seven hundred thousand pound! In light of how the body of the hall was reactin' tae the night, it does not take any great genius tae say that a SIP should include everybody. What most people were sayin' was, "there's three nominations: there's yer white card, write on the two ye want" – that would have sorted that process and kept every individual happy, that's what the body of the hall was wantin'. But they didnae want tae change that, it just was nae democratically done. There isnae actually a trade union in Britain would have operated like that on that night. There was quite a few trade union members there and I feel the benefit of that was to clarify and point them, direct them the way to do it right, democratically. They didnae listen. They didnae listen. Probably most of the people left that hall feelin' very disillusioned and neglected.

7.3.1 Unequal Partners

Their status as new partners was unclear to participants, with more than one suggesting that their SIP membership was more a matter of tokenism than a genuine desire by the SIP Board to establish a voice for community representation:

C/VR: I don't know if the voluntary and community reps are going tae be real partners, which is one of my concerns. A lot of decisions are made ahead of this financial year, which the community and voluntary reps are not involved in. I'm thinkin' of givin' Moira Carruthers a phone, tae say "Moira, this information we're getting' is quite disturbin' – what's happenin'?' Can we be informed?" I mean, after all, I am now an elected member and I would like tae be informed, and the community, if there's a SIP meetin' takin' place, tae see the decisions bein' made. There are things ye want tae take tae the table, as I've been tellin' you. So there is tokenism and lip service, no doubt.

For the community and voluntary sector representatives, the issues of financial dependence and perceived attempts at external control of their own project activities clearly undermined the concept of an equal partnership. Their late involvement, combined with the fact that the SIP funds appeared to have already been allocated, suggested to them that they were merely tokens on the SIP management board and the flawed election processes had probably undermined their own legitimacy and capacity for community advocacy.

7.4 Working with Uncertainty

The SIP Manager, Moira Carruthers, had suggested to me during the December training event that the IMG had some uncertainties about their work. The uncertain nature of the SIP, its purpose and themes, was more fully elaborated during the SIP Support Team away day, held on May 14th 2001. By this month, Moira had finally found and furnished town centre office accommodation for her newly recruited team. The SIP leaders believed this had to be in the centre of Kirklands, as to site the SIP

office in any of the ten neighbourhoods might produce allegations of partisanship and undue influence over SIP resources. The Support Team was made up of the Manager, a research officer responsible for establishing base-line health data in the SIP area, a nutritionist (who also covered the Dunloan SIP) and a half-time health promotion specialist, Sheena Munro, who had formerly sat on the SIP Board. This meant that the SIP Board now lacked any professionally qualified health promotion or public health input, as the health promotion policy director was from a different disciplinary background and the public health consultant had given up his seat on the Board in the March restructuring¹. The latest appointment to the team was David Sinclair, as Partnership Development Officer (Community Capacity). This post had been discussed at SIP Board meetings, but it was unclear what, if any, involvement the post holder would have with the community representatives and this was to be the source of considerable future contention between the SIP Chair and community/voluntary sector representatives.

Moira had organised a planning day for this new team, and had readily agreed for me to attend. The offices were located in an old stone building belonging to the local Primary Care Trust, in a square off the main street of the town. The away day was held in the newly decorated and furnished conference room shared by both SIP and Trust. Moira had arranged for the day to be facilitated by an experienced SIP manager from the West of Scotland but with some familiarity with the local area, having worked as a consultant for Riverbrae Council Community Services Department in the past. Although my fundamental aim in attending SIP events was to learn, I believed that for this day my role could be as much that of participant as observer. This was partly because the tenor of the day was to be informal. I also felt that I might know as much as the new team about the SIP and believed that I could contribute something to their discussions, though making notes was my priority. I had wanted to attend to find out more about the role of this team in relation to both the main agencies of the SIP and to the newly appointed community and voluntary sector representatives. The event proved more useful than I would have predicted, in that a number of observations I believed to be significant were validated and some puzzling issues clarified.

¹ However, the Public Health Consultant remained involved through having commissioned, with SIP funds, a University-led research project into risk-taking behaviour in young people in two particularly disadvantaged SIP neighbourhoods. The findings of this project led directly to the initiation of a breakfast club to serve the two primary schools, again through the Health Board, with SIP funding.

The description below is obviously a highly condensed and selective version of the whole day. In order for her new team to understand their role and tasks, the SIP Manager had to speak a good deal more freely than had appeared to be the norm either at Partnership meetings or with community representatives. The dominant voices in this insider account are therefore those of the SIP Manager and the facilitator, with the members of the Support Team playing a lesser role. Although such data should not be taken at face value or as valid in their own right, the explanations and comments offered by the former two individuals both revealed their perspectives on some key matters, and helped me to confirm some tentative analytical conclusions and make sense of some otherwise perplexing issues.

7.4.1 Setting the SIP Agenda?

Moira laid out the purpose of the day for the team. She told them that, up to now, there had been no one to '*pull SIP activities together*'. Over forty individual pieces of work had been carried out, some of which were related and some not, so a greater degree of co-ordinated action was required. Moreover, as the money was practically all spent, there was now an opportunity for the partnership to develop as a group and time to reflect on the SIP's purpose and themes. The latter was to be the team's task. The agencies around the partnership table did not have the time: '*we set the agenda*'. After the group had performed the usual round of introducing themselves, the facilitator began the day by talking (as Sheena Munro had done in our earlier interview) about a background of '*forced partnerships*' being driven by Scottish Executive funding, and the complex history and various tensions existing around this. One of the purposes of the day was to address the SIP's priority themes: '*do they make sense, and how do you explain them? If someone asks you in a pub what the SIP is about, what would you say?*' Team members clearly found this a little hard to formulate though the research officer spoke of '*trying to inform an uninformed community*' and '*only being able to affect long term health by affecting behaviour*'.

The facilitator spoke of the SIP's purpose as a strategic partnership with responsibility for bending resources: he warned them that if this did not happen then the SIP could become a mechanism to cut funding. Or it could remain '*static*' and continue to allocate the same sums of money for the remainder of the funding period. Moira concurred with him, saying '*the council perspective is that the SIP will deal with East Kirkland, so we don't need to*'. (This point clarified for me part of the

basis for the SIP leaders' apparent reluctance to continue to fund community-based projects: they apparently did not want to facilitate powerful service providers in the process of absolving themselves from responsibility for the area.) The facilitator emphasised that £750,000 a year was inadequate to improve health in the area, and could only be regarded as pilot funding. Given the new role of the SIP Team in '*driving the SIP agenda*', he said there was some danger that those in the team could become the '*fall-guys*' in the event of failure to bend resources. The research officer responded that local community and voluntary organisations have limited funding and that the SIP had failed them: '*the grass roots view of bending is, "that's crap - and you've spent a fortune on it"*'.

Moira spoke of the difficulty caused by some of the partners not taking the SIP agenda back to their home agency, thus unwittingly contradicting the more polished account given to me months ago by the SIP Chair, of much SIP work being conducted away from the table by active agency champions (it is not, of course, unusual for interviewees to give moral accounts, seeking to present themselves or their actions in a good light). In this context, Moira was raising the question of what agency representatives actually did. With the exception of the Health Board and LHCC representatives I judged that the answer apparently was, not much beyond sitting at the partnership table. The reasons for such relative lack of involvement became clearer at a later stage.

7.4.2 Community management or community influence?

The facilitator told them that the chosen focus on young people was '*difficult to sell*' to an older audience, and that the focus on health was even more difficult to sell '*through the cloud of smoke that makes up most of the local audience*'. Nevertheless, the original bid had claimed that the SIP would be '*a fully community-managed health initiative*'. This point was news to me, but showed why the Scottish Executive had had to fund this SIP, given the contemporary policy emphasis on community involvement in action to improve health and prevent disease (Scottish Office Department of Health 1998). However, I felt that this original aim had disappeared from view - it was certainly not visible in anything I had seen, heard or read in the course of fieldwork to date. David Sinclair questioned the delayed attempts to involve the community, saying that this should have happened when the SIP was initiated: the community representatives' jobs had been made more difficult through this approach - '*plucking community activists from thin air*'. Moira

responded by saying that some of the main health partners would not have consented to take part, had this been the case, and that agencies needed to learn together first. David pursued his point: *'but the blurb says the community is central'*, and spoke again about the original bid. Moira said that, to her, *'community management means community influence and involvement'*. This comment, like those made by the Chair during our earlier discussions, is an indication of the meanings key individuals attribute to such terms, meanings which arise in the context of delivering complex public services but which may differ significantly from those held by both policy makers and community members. It also arguably acts as legitimisation for continuity of centralised control of resources, thereby restricting community capacity for action.

7.4.3 (Not) re-thinking the themes

The afternoon session was devoted to the issue of priority themes for the SIP: the team was asked to consider if the themes related to the activities funded so far. Moira told them that this was an important issue - the themes had *'only ever been half discussed by the management group - and eventually it became a matter of just writing something down'*. She told them that the written themes had been presented to the IMG, but little attention paid. These themes had never been part of the original bid to the Scottish Executive: original themes had been around information and consultation. (That the themes had never been subject to consultation with or feedback from the community remained unsaid.) She felt that they now needed a more explicit formulation. The group did not respond immediately - team members seemed surprised to learn that the SIP's themes and priorities were unsubstantiated and, in David's words, still *'tentative'* after eighteen months of operation. Moira spoke of the need to have a *'manageable area'* as at present they had only *'disparate and unconnected activities'* - and the new team had been landed with responsibility for dealing with this problem. Only the lifestyle theme was relatively straightforward, with the Health Board (health promotion department and LHCC) taking responsibility for this area of partnership work. Moira described the SIP's themes as *'as wide as the Clyde'* but reminded the team that the focus was on young people. The group continued to debate and worry at the themes for some time, with the facilitator and some participants suggesting minor changes of wording. Some were reluctant to exclude older age groups and they found it impossible to agree on a reworking of the main aims. No decision or consensus was reached and the debate became circular: the facilitator eventually suggested that perhaps - given the group's earlier difficulty in articulating what the SIP was about - the themes should clarify

what the SIP was *not* about. This got them no further and the issue was finally abandoned.

7.4.4 Partnership weak spots

Perceived weaknesses of the SIP, by this group, included how the community viewed the SIP, in that there was a *'lack of visibility of what SIP has done'*. The health promotion specialist (who had had to leave the meeting shortly after it started, returning much later) said that many people in the community had contact with the early, successful pilot health promotion initiative led by the Health Board's health promotion department. But Moira told her that few would connect this initiative with the SIP - it was attributed either to the Health Board or the Council. She believed that the community mainly saw the SIP as indistinguishable from the Council (an interpretation borne out by interview comments made by the community/voluntary sector representatives). Related to this, she said SIP work was not being *'branded'* as such by local projects that had benefited from funding (a category that included the projects of the new community representatives), and despite being a pilot, it was now raising community expectations through its work². They also discussed the problem of community representatives' disenchantment with the Board, agreeing that they *'can't be in the management group then sling stones from outside'*. Some members of the group spoke of the need to defend the statutory sector against the Scottish Executive perception that *'voluntary sector equals good, statutory sector equals bad'*, arguing that good statutory sector work is seldom recognised in the contemporary policy climate.

They moved onto discuss how best to engage with the community: various (with hindsight, optimistic) suggestions were made for a possible re-branding of the SIP with a re-launch to accompany this. The closest perceived goal was to produce a leaflet or newsletter for community information, and a directory of services available in the area, for agency information. The day ended with the facilitator noting *'priority actions'* for the team: to define a focus for the SIP; to create a clear, timetabled action plan; and to develop a community and marketing strategy.

² An important example of this is the hard-hitting findings of the commissioned research project on risk-taking behaviour in two of the SIP's neighbourhoods, referred to in an earlier footnote. Using an ethnographic approach, this work had amended its original commission to examine 'unhealthy behaviour' to focus instead on concerns about 'community safety'. The work had generated considerable local interest and calls for action.

However, when I left the field nine months later, the work of dealing with such uncertainties was still very much in process.

7.5 Board Work

This section covers a period that encompassed three full Board meetings (3rd May, 21st June and 23rd August 2001), a weekend training event for the community representatives (1st/2nd June) and a second Working together/Learning together event for all SIPs in the region (5th/6th June). This period enabled me to observe the induction of the new partners, the discussions of most of the Partnership around the topic of health inequalities during the time-out training sessions, and the interaction of all SIP members as they engaged in the committee-type work characteristic of the former IMG. As on other occasions, my role varied between observer and participant according to context, and frequent informal conversations with other participants provided useful additional insight.

7.5.1 Cultivating the 'New' Partners/Confronting the 'Old'

The first full partnership board meeting was held in early May 2001, in a committee room of the Riverbrae Council offices. All the new voluntary/community sector representatives attended, except for Jim Cross - a matter of some surprise to me as he had shared his colleagues' concerns about their seeming exclusion from the SIP. However, I learned that the SIP Manager had met the community representatives the week before in order to brief them on forthcoming agenda items, and I suspected that these contained little of importance or relevance from Jim's point of view. As with all of the community representatives, he also had multiple commitments elsewhere. Building work below the room and a noisy meeting of councillors next door made it somewhat difficult for participants to hear each other. The format of the meeting followed the habitual committee business configuration but the tone was markedly more formal than that of the now-defunct IMG: this first formal encounter of new with established partners is best described as wary on both sides.

Some of the new representatives proved willing to challenge the most vocal partners, i.e. the SIP leaders (Chair and Manager) on a number of issues. For example, on being told that their forthcoming training weekend would be held at a Hilton Hotel, one asked if the programme could not have been held in a local venue, given that the SIP area was one of great poverty. She spoke of the impact of using a '*fancy hotel*'

in terms of how the SIP would be perceived by the community. Later in the meeting, the Manager informed them that the new SIP support team would be reviewing the SIP's themes and developing a three year plan. After one of the established partners had endorsed this proposal, one of the new partners commented that they needed to ask '*what have you achieved in two years?*' as they '*didn't seem to be very committed*' in what they were doing. Later again, when asked to agree funding for signposting for health walks around Kirklands, another new partner questioned the SIP's decision to commission an organisation external to the area when walking groups existed in the town. One of the newly elected community representative asked for more information about the bases on which projects had been funded up to now, as she had only been given '*one tiny paragraph*' on each which made funding decisions impossible to evaluate.

In short, this meeting involved a series of oblique challenges on nearly every agenda item from some of the community representatives to the SIP leaders and, by extension, the established partners. I do not believe that this was done simply in the spirit of trivial needling: my interpretation was that these community representatives took every opportunity to point up their differences of opinion with some of the decisions made, and the bases for these differences. In so doing, they were contesting the legitimacy of most of the funding decisions actioned by the SIP prior to their own involvement. This encounter thus marked a clash between very different social worlds.

There was one noticeable exception to this pattern of critical evaluation - a negative case, in analytical terms. The first report of the research project into risk-taking behaviour in young people had been distributed prior to this meeting and, although no time was allotted for its discussion during the meeting, the work was spontaneously described as '*excellent*' by some of the community representatives present. I found later that their approval of this research derived from its marked differences to most SIP initiatives. Firstly, the work had been conducted in such a way as to be responsive to community priorities: although health issues were not neglected, the researchers involved had primarily painted a grim picture of the lives of young people in under-resourced, internally divided and apparently dangerous neighbourhoods - areas described by the main researcher as '*going under*'. Secondly, and related to this, the academic authors were highly critical of the perceived unresponsiveness of some of the larger public sector service providers in

the area. The research thus corresponded with their own perceptions of community problems and priorities and critique of public service provider inaction.

7.5.1.1 Post mortem

After the meeting ended, I joined this group to chat to them as they gathered for a smoke in a seating area beyond the committee rooms. I give below an extract from the notes I made immediately following this but omit participants' names, as this is an example of an *ad hoc* conversation where the group may well have forgotten my observing/recording role:

One representative talked to me about the money being spent. Most seemed to feel their involvement is still tokenistic, though one said little. Another pointed out that Helen Cameron had used the different terms 'partners' and 'community reps', which indicates to her that the latter aren't yet seen as partners. I hadn't noticed this. She said 'millions have been spent already, and no-one seems accountable'. They seemed to feel excluded – talked crossly about being involved in decisions about the allocation of small sums of money – '*patronising*' and '*condescending*' were the words they use. They're also not happy that they're not involved in the support team away day, when priorities will be drawn up. I didn't point out that agencies won't be involved either – don't want to appear as an apologist for the SIP IMG. I feel awkward that, unlike them, I've had easy access to the SIP: it's not easy to decide what to say to them in this context. We wandered downstairs, they were still talking heatedly, with one of them planning for the group to meet up separately from the SIP and to consult Dunloan SIP reps on their experience. (Fieldnotes of SIP meeting, Riverbrae Council Committee Room, 3.5.01)

7.5.2 Towards integration

The critical views of the new partners underwent something of a transformation over the course of the training weekend held at the beginning of the following month, in a meeting room of the nearest Hilton Hotel. All were present, except for Stewart Orr, whose transport to the venue did not arrive. The first day ended with dinner for the entire partnership, although not all stayed for this. Only new partners, Chair and Manager were expected to stay overnight, as the Chair believed this would enable the building of relationships between them. As Jim Cross did not stay and as Stewart Orr had not attended the session, only women were present at the highly informal evening session. There was little evidence of male dominance in any sphere of this SIP at this event or any other. The leadership was mainly female and, of the new partners, the women attended a greater number of events, contributed more in verbal terms than their male colleagues and - over time - proved most willing to openly challenge partnership decisions.

A rare attendee at the daytime part of the event was the local Councillor, whom I interviewed informally at the first opportunity, as elected members are important elements of Social Inclusion Partnerships. This individual was one of the earliest arrivals, coming straight to the meeting room whilst most of the community representatives gathered in the hotel bar to smoke. The Councillor questioned the SIP Manager about the Scottish Executive's criteria for areas to gain SIP status, commenting that many disadvantaged areas were being excluded, and seemed unconvinced by her replies justifying the focus on East Kirkland. When I got the chance to speak privately with the Councillor, this informant proved critical both of social inclusion partnerships in general and the East Kirkland SIP in particular - comments that, as I found later, agreed with observations made by officers from other SIPs (during the 'Working together/Learning together' session held during the following week) about their experience of some opposition from elected members - ostensibly key members of their partnerships.

My discussion was curtailed by the return of the SIP Chair with the new partners, whom she had gathered up from the smoking area. The atmosphere was informal and relatively friendly as the SIP Chair introduced the purpose of the day. She told the five representatives present that the Scottish Executive had provided ring-fenced money to every SIP to facilitate community involvement (£60,000 per annum) but this money was not solely intended for community representative support: she emphasised the need for community involvement beyond the community representatives present. One of the new partners mentioned representatives' fears of being thought '*outspoken*' but the Chair emphasised that it was '*OK to speak out*'. Another community representative echoed this, saying that '*speaking out should not affect working relationships*'. The following brief extract from my fieldnotes illustrates the scene setting provided by Moira Carruthers, the SIP Manager, who emphasised the difficulties and constraints of responding to national policy imperatives. The extract also indicates the local Councillor's concerns about the type of community representation that he discerned in SIP work:

Moira goes to the OHP - she has a whole pile of acetates plus handouts. She kicks off by telling them that the Scottish Executive is 'not good at joined up thinking', that social justice and social inclusion are only two of their priorities and that both these and others are often in competition with, for example, health policies. In practice, they're experienced as 'disjointed - a nightmare'. She says new definitions of social exclusion are not new - just deprivation re-named. She tells them about the preferred focus on social inclusion in Scotland - a matter of 'terminological differences', but says social inclusion came before social justice. Talks about Priority Partnership Areas being designated under Tory government but current

focus on 'activities' is broader than former Urban Programme emphasis on 'projects'. Says it's now crucial to integrate and bend mainstream budgets but this is 'the hardest target'. Says East Kirkland is both thematic and area based – the SIP is about filling gaps in services, not about duplication. 10 years of funding is small in terms of impact on peoples' lives. The ultimate aim is for the SIP not to be needed. Helen then speaks about the need to build up evidence to change services e.g. using the risk-taking research report. Councillor [-] challenges this, saying they 'need to be careful who they talk to – addicts only make up 5% of the population and if you give them what they want, then you end up excluding the other 95%'. The Chair responds by talking about using the research to impact on children's services, with the longer term aim of reducing crime. 'We need to change the way we spend money', she says. Nancy and Margaret nod in apparent agreement with this comment. (Voluntary/Community Sector Representatives' Training Weekend, [-] Hilton Hotel, 1st/2nd June 2001, a.m. session).

After lunch, the other agency partners arrived: during the course of the afternoon each presented a brief overview of the workings and priorities of their organisation and of their own role and involvement with the SIP. The new partners questioned all of them on specific issues. A civil servant from the Area Regeneration Division of the Scottish Executive was also present to give the Minister's perspective, summed up in the words: '*the Scottish Executive is not a partner – SIPs **have** to deliver what the Minister wants in the way of targets*'. I found, during later conversations, that the SIP leaders viewed this statement as an indication of policy makers' inflexibility and unresponsiveness to local context.

7.5.3 Talking (briefly) about health

The ostensible focus of the SIP on tackling health inequalities received virtually no explicit mention during the day, with two exceptions. During the morning session, two of the community representatives challenged the SIP's decision not to fund community projects wishing to organise excursions, arguing that such '*outings*' should be part of a community health improvement agenda, particularly for children. The Chair responded that, had the SIP not taken this decision, the budget could easily have been spent solely on this type of activity. She also suggested that the community representatives should consult the community to check local attitudes on the topic - thus arguably defusing their challenge by throwing some doubt over the validity and authenticity of their views on this issue. Some of the difficulties involved in addressing health inequalities were raised during Graham Hamilton's presentation on the Health Board's involvement in health promotion:

Graham Hamilton speaks about the public health and health promoting role of the Health Board: he says 'the agenda for health promotion means that we have to involve communities'. He tells them that the Board also has to do a needs

assessment – ‘a difficult area because of how needs are defined: a need is something you can treat’. He says the Health Improvement Programme is about meeting needs, in theory, but resources still get sucked into the secondary/tertiary sectors. He tells them that this is a reflection both of politicians’ priorities and ‘what people in the community say. But new hospitals don’t necessarily improve health.’ The crucial difference in a health promotion approach is ‘helping people live healthier lives, longer. Once you’ve got cancer or heart disease, you’ve got it – so it’s important to prevent it’. One community representative comments, ‘people with cancer won’t see it that way’. Cllr says that ‘it’s about prevention rather than cure’. Another community representative says, ‘but early diagnosis can improve outcomes’. Graham goes on to talk about ‘the battle to change practice’ – tells them that the health promotion evidence base gets ignored. The LHCC representative takes up his earlier point about the tensions between wants/needs, saying bluntly that ‘lots of disease is self-inflicted: people must take advice, stop smoking and get screened’. (Community/Voluntary Sector Representatives’ Training Weekend, [-] Hilton hotel, 1st/2nd June 2001, p.m. session)

In the above extract, the policy director’s arguments in favour of health promotion/prevention and critique of some aspects of health policy were contested by the community representatives’ references to the need for formal health services and by the individualistic and medicalised formulation of his LHCC colleague. This went unchallenged by the community representatives, although those whom I had interviewed had utilised a more social discourse of health inequalities. It may be that individualised explanations for poorer health are intrinsically harder to dispute because of the wealth of evidence available, evidence that community representatives themselves had referred to at interview.

7.5.4 Establishing a role for the ‘new’ partners

The second day was attended by the new partners only - an opportunity for them to have time with the SIP Manager and an external facilitator to think about their own roles and training needs. The Chair was not present. It became clear during this event that there were few fora for community consultation or involvement in East Kirkland. The community representatives spoke of informing the communities about the work of the SIP *via* churches, schools and other local organisations but as the facilitator pointed out, this would hardly enable them to contact more excluded members of the communities, particularly young people. Organising local fun days seemed a potential option. The group agreed that they would need administrative support and some training needs were identified. Suggestions made by facilitator and SIP Manager that they establish a specific forum for community consultation and feedback were not taken up.

The weekend ended on a positive note, with all the community/voluntary sector representatives present expressing feelings of greater confidence about their future involvement in the work of the SIP and the willingness of the longer-established partners to listen to and work with them. However, there was some potential for rivalry and poor relationships within that group because of overlapping spheres of activity: for example, two of the representatives were potentially in competition to represent youth in the area. I felt that these projects' futures could be vulnerable as they provided a service within particular neighbourhoods rather than across the whole SIP area. This would probably have mattered less if, like some of the smaller projects referred to above, their funding applications had been for small amounts. As it was, these projects received both core and sessional funding from the SIP - averaging sums of around £100,000 per annum each, a substantial proportion of the entire SIP budget.

7.5.5 Discussing health and inequality - inconclusively

The Working together/Learning together session held shortly after the community representatives' training weekend was located at the same (highly popular) football ground venue as the December session. The facilitators formerly assigned to the East Kirkland SIP had been replaced, probably because of criticisms made of the handling of that earlier event. This conference/workshop event provided further momentum for the partnership building work already begun although, as a number of new faces from the statutory sector agencies were present, replacing colleagues who could not attend, there was some degree of disruption to continuity. I was also surprised to find that neither Jim Cross nor Nancy Robertson came to this training session, given the community representatives' critique of the SIP as an exclusionary organisation. The event provided SIP members with time, otherwise rarely available, to discuss their approach to the ostensible purpose of the SIP in tackling health inequalities, although this topic had to compete during the event with other interests pursued by various members within the group. This section contains several lengthy extracts from fieldnotes (though these inevitably represent only a small part of the whole note of the event), in order for the reader to evaluate subsequent interpretations and analysis.

7.5.5.1 Questioning decisions

During the first of three whole-SIP sessions, East Kirkland's facilitator conducted an anonymised post-it note exercise with the group (in which I participated) focusing on what aspects of the SIP to keep, and what to change. This exercise produced two main issues for change: community perceptions of the SIP, and the conduct and format of the monthly committee-style meetings. The facilitator then split participants into two groups - I was assigned to a group containing the SIP Manager and two female community representatives, amongst others. Although this group briefly addressed the issues raised during the exercise, the community representatives used the task as an opportunity to steer the discussion firmly in the direction of a number of issues concerning them. Principally, these were the unforeseen amount of paperwork involved for them and the bases for SIP decisions about funding allocations:

They discuss suitability of SIP meeting venue, problematic continuity of personnel, and the questionable voting capacity of irregular attendees. They agree that 'structure is needed but not stiffness' and that the meeting venue should be more community based. Elizabeth then queries the basis of decisions taken by the Board up to now and Moira tells her that there's been no reasoned case to reject any funding request until recently. Margaret comments on the amount of paper she has to read and asks, 'can important bits be flagged instead?' Says she has two suitcases full. Moira explains that the SIP agenda is divided into issues needing decisions and those needing discussion - says there's lots of stuff from the SE that community reps 'simply must see and can't be withheld'. She asks them how they found their first pre-SIP briefing meeting: Margaret says she liked it, Elizabeth says it was just duplication and a waste of time. Moira points out that they may need time to develop a different view from that of the agency partners and that the briefing gives them the opportunity to think through a response. She goes on to say that there should really be more discussion at the Board meetings - Margaret and Elizabeth agree with this, saying it's just Helen Cameron talking (which they'd also said to me privately). Moira tells them that the last meeting was similar to all others - nobody normally talks much apart from her and the Chair. They move on to discuss 'clarity around decision making', as Elizabeth puts it. She asks how funding decisions are made - 'do partners get copies of funding applications?' Moira tells her that proposals are looked at by the management group and either accepted or not. But for the small grants fund, a sub-group examines and makes recommendations to the Board. No sub group is in existence at the moment. She says the whole management group will have to discuss representation on this and warns them it'll be one more meeting to attend, if they want to be involved.

Margaret asks her if a sub group was involved in the applications that were questioned and more information sought (her own project submitted one such application). Yes, says Moira, and recommendations were then taken to the whole management group. Margaret then says, 'but if people went down the sheet' (she's talking about the brief summary of funding allocations she was given during the training weekend - an issue she's told me she's very dissatisfied with) 'could they know why groups got funding, just from one tiny paragraph?' Moira responds that 'most agencies know the projects, especially the big ones, but there was discussion round the table just the same.' Margaret tells her that the community sees SIP money as the same as urban aid, urban regeneration etc, so why are projects from

Riverbrae being taken on by East Kirkland? Moira gives her a lengthy explanation of the history of regeneration initiatives. (Working together/Learning together training event, 5th/6th June 2001, East Kirkland Session 1, 5th June, p.m.)

7.5.5.2 Improving Community or Individual Health?

The other group, which was led by the health board policy director and contained community representatives evidently less ready to question the SIP leaders, had had quite different discussions. They had focused on the issues of raising awareness of the SIP in the local community and the task of improving health for local people. However, this second point was formulated in individualised terms, as the dominant figure in the group had suggested that the concept of community was illusory in the local context:

Graham Hamilton feeds back for his group – his detailed flipchart diagrams aren't easy to understand - others joke about his well-known tendency to do this. He says 'some people in the SIP are not clear what the SIP is about and this is important, as the SIP can't communicate with the community unless we are clear.' Says they 'have to get across that this is a community initiative'. Says the SIP is *for* the community – improving health, wellbeing, social fabric, poor health statistics - and the only way to do this is to empower individuals. His eloquence calls forth wry remarks from his group, that they understand it much better now than when they were discussing it a few minutes ago – and were they all in the same group? Undeterred, GH says it's about 'getting behind what causes people's problems and maybe leads to pathological behaviour'. He tells them that information that health services and other major agencies have 'doesn't tell the right story' – he talks about the importance of context, of knowing how illness and disease fit into lives of hardship. Says that the community doesn't recognise the SIP and has 'wild ideas' of what it's about. People in the community 'have to want to know, and not just be passive recipients'. He stresses that their work in the SIP is about improving individual health – he says 'community' is an illusion: 'there are communities of conflict rather than communities of interest in the East Kirkland area' – mentions conflict of neighbourhood and age and religion. (Working together/Learning together training event, 5th/6th June, East Kirkland Session 1, 5th June 2001, p.m.)

After re-joining, the whole group resolved to continue discussing these issues during the following day, agreeing that these were '*fundamental*' to the work of the SIP. One community representative commented that she felt that both her own group and the other partners were '*going along the same lines*' and that they shared similar priorities. When they gathered for the next morning's whole-SIP session, Elizabeth passed a gift-wrapped item to Graham Hamilton, which turned out to be a set of child's watercolour paints in celebration of his artistic talent. The group joked about him having to declare the gift to the SIP and their discussions began on this genial note. They took up the still problematic thread of knowing and being clear about '*what the SIP is for*' and the requirement to '*follow the official line*' in bringing East

Kirkland into line with the rest of Scotland's admittedly still poor health record. Problems of measuring the impact of the SIP loom large and the still tentative nature and purpose of the SIP is indicated towards the end of the extract by the Manager:

Margaret says she needs to be clear what this SIP is before she goes out into the community – it's entirely different from what she'd thought – which was, just a new name for urban regeneration. Says this SIP now has a specific target. Facilitator asks, 'what *is* that?' She falls silent, but Elizabeth responds that it's more community focused and is supposed to be bottom up. This does not appear to be what he was asking (though it arguably reflects her own ideas of what the SIP should be) so he says 'can I put it another way? The SIP has a life of 8 years: what do you hope to achieve during this time?' Wilma Edwards says 'it's about a healthy community, the whole quality of life, opportunity, choices'. Says 'people don't *have* to participate if they don't want to'. Margaret talks about the need for SIP work to become part of 'normal funding'. Elizabeth says, 'but how do you measure health impact in 8 years? We need 30 years to make a difference!' Moira agrees, suggests that they won't have any impact on the health statistics for 20 years. Graham says 'a lot of health stuff can be measured – such as young people stopping smoking as a proxy measure'. He talks about the 'official line – trying to achieve normality, normal health and wellbeing.' But the 'sad reality – which doesn't sound that great, is to just give local kids the same chances as the rest of Scotland – which still isn't as good as it would be in England.' Moira talks about using 'individual portraits' as a qualitative outcome, looking at the impact of interventions in peoples' lives. The problem for them is that the Scottish Executive prefers 'hard' indicators and quantitative outcomes. The facilitator asks, 'do you have a strategy?' Moira says 'there's a draft' and that they also have some objectives from the original plan - a focus on children and young people. (Working together/Learning together training event, 5th/6th June 2001, East Kirkland Session 2, a.m.)

The SIP leaders present then described to the rest of the group how their experiences with a similar but earlier-established SIP had forewarned them of the difficulties facing East Kirkland. In the extract below, a challenge mounted by a community representative to the legitimacy of the SIP's health promoting approach (older people are excluded from nicotine replacement initiatives) is neatly countered by the health promotion policy director, who suggests that community representatives should counter what he calls the '*wild stories*' circulating about the SIP: though he does not specify what these are, he seems to be referring to the complaint just raised. The Manager speaks of benefiting the community, not individuals - thus completely contradicting one of the arguably key statements made by the health promotion policy director the previous day:

Graham Hamilton says Dunloan SIP members found themselves faced with a flood of expectations and submissions, all of which said they would help achieve targets. So they 'had to sit down and think about our hierarchy of priorities in terms of building blocks. Education is the first step.' He tells them that this took a long time within the Dunloan partnership – 'we're steeped in it, we've had it for years and years', 'whereas folk coming from the community are new to this'. Moira says that Dunloan started as an area-based SIP, aiming to improve all lives in the area but

they 'gradually became aware that we can't do all this' and they had to decide on priorities. That SIP had also chosen to focus on young people for the same reasons – seeing the potential for the biggest impact on this group, and on families too. However, Moira told them 'our focus on health doesn't mean that we ignore unemployment'. Graham agrees, saying that money spent on other issues will still impact on health and wellbeing. Margaret says, 'feedback from the streets is, it's all very well focusing on smoking and health but old people can't get nicotine patches - £750K can't target everyone'. Graham responds by talking about 'urban myths' and 'wild stories' around the SIP and says that the community reps need to tackle such issues within the communities as 'they won't listen to us'. Moira admits that community representatives are in a *more* difficult situation than the agencies, as many individuals in their communities won't see any benefit to them from the SIP. She stresses that their focus is on 'benefiting the community, not just individuals'. (Working together/Learning together training event 5th/6th June 2001, East Kirkland Session 2, a.m.)

7.5.5.3 An emergent discourse of good life promotion

The facilitators divided up the SIP for the next discussion session: they wanted to place two particular participants in the same group, as these were articulate individuals who seemed to get on well together but who, separately, tended to dominate any group in which they participated. This would provide an opportunity for a vocal community representative to engage in debate with an equally vocal SIP leader and agency champion - and hopefully to provoke debate amongst some other, less active members of the SIP. The direction of the subsequent discussion was, however, shaped mainly by Graham Hamilton - perhaps because of his confident display of knowledge on the subject of health inequalities and contemporary policy:

The facilitator says that their task is 'to consider what they want to achieve in terms of children and young people, and to remember the category of excluded youth'. One group moves off a little way: the facilitator brings flipchart paper over and sits with them for most of the time, making occasional contributions to help them along or challenge their assumptions. I 'flit' between both groups. Graham asks the group, 'what do we want for kids?' Elizabeth suggests 'access to employment.' 'And before that?', asks Graham, 'services to compensate for deficits in family situations? Nursery support? How do we support families, mothers, parents?' Andy says, 'and further back, what do we want to change?' The group pauses. Facilitator says 'it's useful to start off by thinking who it is and what you want as outcomes'. Graham says, 'all children'. Sheena says 'nought to twelve and under twenty fives'. Graham tells them about research on antenatal influences - low birthweight babies being born into deprived families - and says that they need to develop a model to take account of the different life stages. Andy suggests they 'tackle babies and children'. Graham says, 'start with conception and pregnancy'. Elizabeth asks, 'where to start then, if you're involving adults?' Graham says this illustrates the difficulties of the whole process. Wilma agrees that 'it's about the whole life cycle'. Sheena says 'it's about improving overall health'. Elizabeth responds that this is too broad. Graham says they have to fit into social inclusion policy priorities around teen pregnancy, under-age smoking and nursery school groups. He talks about 'compensating for deprivation' by providing more services to poorer areas than to better off areas. They agree that the SIP needs to take a life stage approach. Facilitator asks, 'are you about changing people's behaviour patterns?' 'Yes', says Graham

unhesitatingly. A lengthy discussion follows about individual responsibility for behaviour. The facilitator asks, 'but how will the partnership influence all this?' He points out that they don't know how they'll achieve what they've recorded. Graham talks about 'wanting people to aspire to be investment bankers, not plumbers'. The facilitator responds by saying that 'one of the problems is with society valuing bankers but not plumbers' and he suggests that this may not necessarily be the right approach. (Working together/Learning together training event, 5th/6th June 2001, EK Session 3, 6th June, p.m.)

The extract reflects the discourse of redistribution frequently employed by the SIP leaders, in conjunction with aspects of a discourse of social integration implied by fitting in to social inclusion policy priorities. This health promotion representative also spoke in terms of individualised responsibility for behavioural change, drawing on a discourse based on identifiably middle-class occupational values. The latter approach has been categorised by Seedhouse (1997) as a form of good life promotion i.e. an explicitly value-driven discourse wherein influential groups seek hegemony of their own conceptualisations of what constitutes a good life. Although this imposition of values appeared to be challenged as illegitimate by the facilitator, this aspirational, good life-type discourse echoed comments made by the SIP Chair in my interview with her during the previous year. She had condemned as inadequate the training and qualifications offered by the local enterprise company as these provided entry to lower-grade employment. The SIP wanted such organisations to offer funding for local people to achieve University degrees instead.

7.5.5.4 Risk and Responsibility

The other group, which contained representatives from the Police and the Benefits Agency as well as the SIP Manager, had taken a somewhat different approach in that they discussed specific groups of excluded young people, i.e. care leavers, young carers, young homeless people, and those in contact with the criminal justice system. This appeared incompatible with their focus on specific diseases normally associated with older age groups, but probably reflects a widespread awareness of the policy emphasis on the 'Big 3'. This group articulated a MUD-type discourse of '*taking personal responsibility for risk*', whereby '*people*' would understand the impact of their (bad) behaviour on others in the community, and on the health service:

Their feedback indicated that discussions had been about 'wanting to achieve equal access, equal opportunities and employment training for local people: broadly speaking, better health and specific outcomes, for example, reduction in CHD, strokes, health issues that affect people in East Kirkland', as one participant put it. Another suggests that they want to 'provide information for making choices and for minimising risk'. Moira comments that 'people can still make choices with risk but

they'll understand the impact that risk has on the whole community'. She speaks about increasing the public's understanding of the health services and the impact on such services of people's health choices and behaviour. The whole group then comes together to feed back, before moving on to talk about the 'chaotic lifestyles' of people in the East Kirkland area. (Working together/Learning together training event, 5th/6th June 2001, East Kirkland Session 3, p.m.)

Notwithstanding the extracts given above, it was noticeable that members of the SIP *as a group* spent relatively little time talking about health inequality to the exclusion of other issues, even during dedicated discussion time. When they did focus on the problem they tended to emphasise personal responsibility for health, without discounting the probable impact of social disadvantage. The event ended with the SIP Manager promising to use the group's discussions to inform the SIP development plan, which she was writing.

7.5.6 Getting down to business

The final two SIP meetings of this period took place in June and August 2001, July being a holiday month for many people. Although the June meeting was held in the Riverbrae offices, a number of miles from Kirklands and relatively inaccessible for community representatives who did not own a car, by August the venue had been changed to the local council offices in Kirklands itself. Elizabeth McArdle and Nancy Robertson did not attend the June meeting, and Stewart Orr was not present at the August meeting. (With the exception of the permanently absent partner (i.e. a representative of the CHC), statutory sector agency representatives invariably sent a substitute if they could not attend in person.) In comparison with the May meeting, these events were less formal in tone and more discursive in format.

The main agenda items for these events (such as the budget statements, the Annual Report to the Scottish Executive, and the three-year Development Plan) were relatively uncontentious: the latter two documents remained undiscussed on both occasions, although the agenda had been intentionally restricted by the Manager to facilitate their consideration. The latest versions of the Development Plan had been amended to incorporate comments made by particular Partners: for example, new priorities included addressing community safety, older age groups, and housing in the area. The lack of verbal response to these key documents from members of the Partnership may partly have been caused by their daunting size and complexity. However, the meetings did expose some areas of particular dispute between

community/voluntary sector and statutory sector partners that used up considerable committee time, as described below.

7.5.6.1 A Continuing Clash of Social Worlds

Prior to the June meeting the representatives had held their own discussion to air a number of issues of concern to them: I had not attended this, but had requested and received a copy of their confidential minutes. I discovered that this group had chosen to elect their own Chair (Elizabeth McArdle) and Secretary (Wilma Edwards) - perhaps an indication of their felt need for some formal structure. Wilma's position as voluntary sector representative seemed to enable her to occupy an intermediary position between statutory and community sector representatives, and she spoke for the group at the June meeting, briefing the established partners about the concerns of the new group under 'any other business'. She raised such issues at this meeting with obvious hesitancy, choosing her words with care in order to reflect her colleagues' concerns without alienating others at the table. She was only partially successful.

The first issue concerned the community representatives' training weekend at the Hilton Hotel: *'had the funding for this come from money that should have gone to community projects?'* Those present at the June meeting informed their longer-established partners that this had been viewed as a *'junket'* by members of the community and that they had been soundly criticised for taking part, one saying *'I got ripped to shreds!'* The Chair defended the decision on the grounds that SIPs are encouraged by the Scottish Executive to do partnership training; that it was normal for the larger agencies to hold away-days in pleasant surroundings; that the funding had been allocated to community support by the Executive; and that the evening session of the event had *'made a difference'* in terms of building relationships. Both the SIP leaders and statutory sector representatives expressed concern that the community representatives should have been the target of such *'flak'*, as criticism should have been directed to the Partnership rather than at exposed individuals. In the SIP Chair's words, *'we don't want people getting a sore face in the community about spending money on junkets'*.

The second issue was more contentious. Wilma told the group that her colleagues wanted to know why a particular local school-based sports project had been funded to provide fruit to children attending the scheme. I was interested in their choice of

this target for critique: the project referred to was run on a voluntary basis in the community by a former member of the Community Sub Group not able to seek election to the SIP because employed by a statutory sector organisation. This individual had appeared to be 'cold shouldered' within that group, his involvement resented and his suggestions frequently vetoed. It now appeared that the basis for their present concerns was that this project might benefit children not living within the East Kirkland area, and some personal criticisms were made of the project leader. (Interestingly, some of the community representatives later visited this project's Open Day, after which they underwent a complete reversal of attitude, openly admitting that they had been wrong to condemn it, and praising the project leader for his work.) The Chair responded, with evident exasperation, that the project had been funded simply because it had applied, and because it appeared to conform to SIP objectives. She also said that although she understood their point about people not living in the area being able to access such services, the view of most partners round the table had been to

'use common sense and go with the best fit. We're no' gonnae greet if a young person not living in the SIP area gets a free apple!'

Her point was endorsed by other statutory sector partners, who explained to the community representatives that, although they had received SIP funding for initiatives covering the whole of Kirklands, they viewed this as acceptable as long as the bulk of funding and activity was focused on the neighbourhoods of East Kirkland. The Chair added,

'We have to trust people if they say that they're working in East Kirkland, and accept that the bulk of the money will be spent there. If this is going to be an issue, how are we going to police it? People will lie. We'll end up asking for birth certificates and standing outside projects.'

She stressed that all projects were reviewed and evaluated and closely monitored financially, adding slowly and with emphasis,

'I think people need to be clear that every single application that comes in is considered. There has never been an occasion where anyone has said, "that's a load of rubbish". Any application is valid if it's operating in East Kirkland.'

The next issue was the post of Community Engagement Officer held by David Sinclair: '*who was he supporting?*' asked Wilma, as the wording of the job description suggested this was the community representatives, but they had been told

(by the Chair and Manager) that this was not his role. The Chair explained that this post was for the strategic development of community capacity across the SIP area, rather than a community development role. Asking the secretary not to minute the next item, she went on to suggest to them, as she had done on previous occasions, that they draw up plans to use the extra £60,000 available from the Scottish Executive, to employ their own support worker. She told them that she would arrange separate discussions with them on the issue.

Wilma's last question (*'this is difficult to ask...'*) concerned the continuity of funding awarded to the larger community projects i.e. those represented by a number of the 'new' partners round the time. By this stage the Chair was clearly still more exasperated at the prolonged interrogation (which had taken up most of the meeting time) and said as much. She gave a long and detailed explanation of each funding decisions from memory (*'an' see, if we're gonnae have this in future, I need warning so I can come with papers!*). She then told them that they needed to be *'very careful'* in discussing such issues publicly:

'Some of the projects are represented round this table and I'm trying not to say names. Don't bring this type of thing to the management committee - take it to Moira and set up ground rules between yourselves for discussing confidential issues like this. We can't spend every meeting talking about your own projects.'

Several of the community representatives agreed that they had *'to come to this table with no hat on'*. The Chair then warned them that the minutes were available for public scrutiny and that these discussions could be interpreted as community representatives seeking *'inside information'* in a context where they should not be actively involved. Another partner spoke in agreement with the Chair, saying *'I'm uncomfortable listening to this'*. I believed that the community representatives were not just seeking answers but were also, as on other occasions, implying their disagreement with previous funding decisions. It is possible that they were also using this public interrogation as a means to bypass the perceived barrier of the SIP leadership in order to air their concerns before the other partners, with whom they otherwise had little contact. However, the evident discomfort of other, less involved participants in witnessing these public discussions seemed to indicate that the community representatives were also breaching unwritten committee decorum and exposing themselves to accusations of improper behaviour and self-interest.

The August SIP meeting should have been preceded by a separate community representatives meeting, but this had been cancelled as not every member of this group could attend, causing the Manager to worry that the representatives were not taking the time to brief themselves fully. I learned during this third full Partnership meeting that a sub-group had been set up within the SIP to examine funding applications and make recommendations to the Board, and assumed that this was probably in response to the contentious issues raised in June. The new working group was made up of the SIP Manager, a community representative and a statutory sector partner. The process was not entirely open, however: the Manager's role was to scan applications according to pre-decided criteria and those which passed this stage then went to the rest of the sub-group.

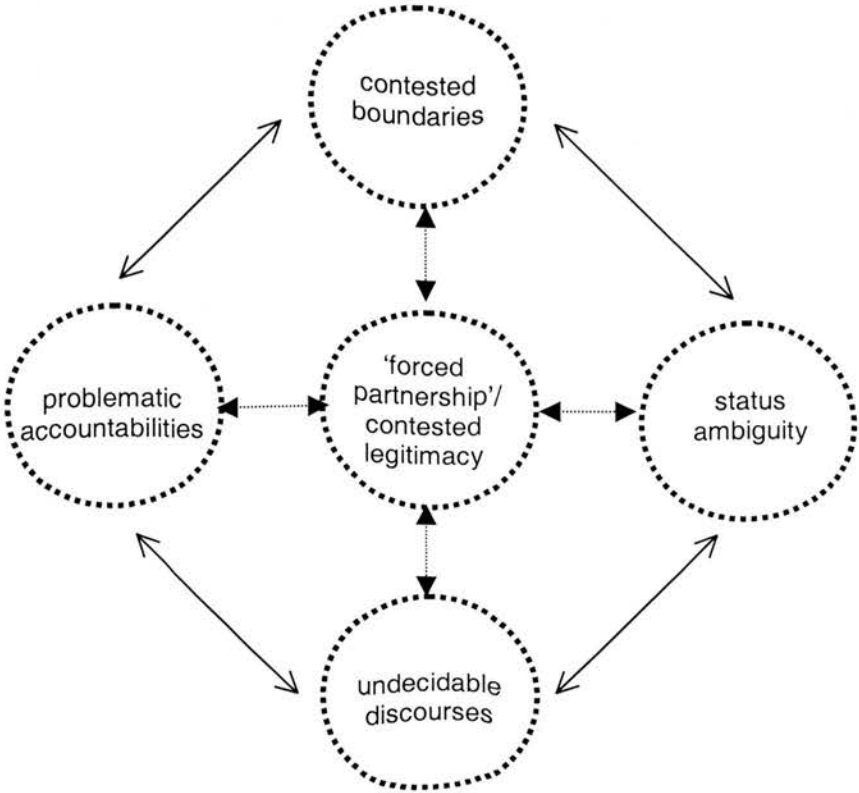
At this meeting the Chair told the Board that the larger community projects had been asked for a report on their work up to now: this would be discussed at the September meeting. She reminded them that one project had failed in its application to the New Opportunities Fund and another had been taken into joint management with Riverbrae Council. She asked if a small group of people was needed to concentrate on the decisions to be made around just these projects, warning that those community representatives involved should not participate and should in fact leave the room whenever their projects were under discussion. The community representatives at whom her remarks were obviously targeted (Jim Cross and Nancy Robertson) agreed with this. Two of the established partners, from Scottish Homes and the local enterprise company, also volunteered to work on this sub group, as did Elizabeth McArdle. However, I later learned that her offer was not taken up: Margaret Kinnaird took this place, probably because she had recently terminated her involvement with a large project seeking SIP funding, and thus possessed apparently 'neutral' status. The unforeseen consequences of this are examined in the following Chapter, which unpacks the implications of differential involvement in decision making for the community representatives group. Before recounting the final episode of fieldwork, however, I want to close this chapter by considering some of the persistent paradoxes that appeared to beset this Partnership, and - potentially - hindered their work on tackling the poor local health record.

7.6 Partnership Paradoxes

This section delineates an explanatory framework, grounded in the data generated during fieldwork and developed during the process of analysis. This is

conceptualised in terms of a sequence of linked paradoxes, illustrated in *Figure 3* below, clustered around the central paradox of '*forced partnership*'. Whilst the concept of forced partnerships does not necessarily connote reluctance to work in this way, it emphasises that for many working in the contemporary public sector this is no longer a matter of choice but a fundamental compulsion or imperative. The mutual attribution of negative characteristics conveyed to me by the different types of participant in the partnership (i.e. former Interim Management Group [now established partners]; former Community Representatives Sub Group [now new partners]; and SIP Support Team) may be characteristic of '*forced partnerships*' marked by gross inequalities of power, influence and resources. However, this element of participants' interactions may well be mutable and capable of change and improvement during the life of a partnership. Other problems appear more difficult - perhaps impossible - to resolve. I suggest that the partnership imperative operates in parallel with the concept of '*contested legitimacy*'.

Figure 3
Persistent Paradoxes in the East Kirkland SIP



I have used this concept to explain the ways in which claims are made, by different categories of partner in the SIP, to represent and to speak for community interests. The remaining concepts displayed below would, I believe, also be recognisable to research participants although the terms in which they are couched here would not necessarily be those used by participants themselves. The concepts are inter-related and represent some of the key uncertainties confronting the partnership in terms of contested boundaries, status ambiguity, problematic accountabilities, and the inherent undecidability of the multiple discourses around health inequalities. I describe below how this analytical framework illustrates the complex relationship between national policy context and local implementation explored in this case study.

7.6.1 Contested boundaries

The physical/geographic boundaries of the SIP constitute an immediately noticeable paradox: East Kirkland is an administrative/bureaucratic construct not recognisable to the community with whom it must engage and whose health it purports to improve. The SIP's boundaries are contested by those who point to other local areas of deprivation, excluded from this initiative. Conversely, in the context of East Kirkland, community is also a misleading term: local people identify strongly with their neighbourhood, with young people in particular identifying this as their territory (evidence of this was to be found in the Risk Taking Research Report). Sharp divisions between age and sectarian groups, and the hostile attitudes of some people to others *within* their own neighbourhood, are hardly captured by utilising the bland term, communities of interest (again, I found evidence of this in the research report referred to above). Boundaries other than the spatial are also problematic and contested. The difficulty of bounding and legitimising SIP themes and priorities has been referred to above. As these were '*just written down*' by SIP leaders and rubber-stamped by the Interim Management Group, but unseen by either the Scottish Executive or members of the community, they possessed neither top-down nor bottom-up legitimacy. There is also the question of their appropriateness: if the themes are too broad ('*as wide as the Clyde*'), the SIP risks achieving little in concrete terms; if too narrow in their focus (ostensibly on young people), they risk the exclusion of other community elements/groups. I suggest that one of the central paradoxes of a social inclusion partnership is that the requirement to choose a focus and establish boundaries may, ironically, work as a process of exclusion.

7.6.2 Status ambiguity

I suggest that there are a number of status ambiguities intrinsic to this, and perhaps other, such partnerships. For example, East Kirkland's status as deprived renders it eligible for social inclusion funding: however, such funding runs the paradoxical risk of improving the area, which would then fall below the necessary deprivation level, thus depriving the communities of their beneficial SIP status. However, the attainment of SIP status generates dissatisfaction from within other local areas not so designated. The SIP's status is also ambiguous in that it is a potentially radical organisation and a threat to the status quo of the main service deliverers: it would be a mechanism for change and development if successful in mainstream budget bending. However, it is also potentially conservative and a threat to change and development: it becomes a mechanism for preservation of the status quo if it continues to fund existing projects. Although cast as a social inclusion partnership, a further paradox is that gaining SIP status initiates the process of exclusion referred to above: *'what it's not about'*.

There is some ambiguity in the status of the established partners, who were originally intended to be champions of the SIP cause within their parent agencies, but who seem to have found this difficult or inappropriate. There is also uncertainty about the status of the Scottish Executive in that it acts as supporter and funder of the SIPs but also as monitor and regulator, with the potential to withdraw funding. Finally, there is the ambiguous status of the voluntary and community sector representatives: although in theory their role is that of champions for the broader community, they may also be viewed as territorial agents driven by self-interest.

7.6.3 Problematic accountabilities

Both SIP leaders and community representatives made frequent references to accountability - the former in relation to their obligations of probity in spending public money, the latter in relation to the alleged unaccountability of service providers so funded. From the perspective of the established partners, and particularly the leadership group, the SIP is held accountable for compliance with the policy directives of the Scottish Executive, but should also be responsive to community needs and priorities. Yet there are undoubtedly problems in the accountability of the SIP Board to the community for their plans and spending decisions. Although I do not espouse conspiracy theories of statutory sector partisanship, there are no local mechanisms for consulting the community, other than

a one-off, possibly discredited Citizens' Jury. There is also the related question of the problematic accountability of the community sector representatives themselves, to their neighbourhoods and to the wider community, given the absence of formal structures or mechanisms to facilitate this. On the other hand, there is also the issue of the problematic accountability of key public sector agencies, over whom the SIP has little control, for the way in which they deliver services to the East Kirkland area in response to the SIP agenda. Finally, there is issue of the unclear accountability of the SIP Support Team, particularly the post of the Community Engagement Officer. From the perspective of the community representatives, this post, accountable through line management only to the SIP Manager and Chair, had the potential to transgress the boundary between the SIP and themselves, as authentic spokespersons and intermediaries for the community.

7.6.4 Undecidable discourses

A final paradox for this (and perhaps other) Partnership(s) is the tension between policy makers' need to devise concrete policies and the difficulties around tackling health inequalities, given the multiple discourses attached to this problem, which render uncertain the bases for decision and action on the problem. Local service providers (from the statutory, voluntary and community sectors) are obliged to comply with concrete policy requirements as a condition of funding but a degree of indeterminacy percolates down to this level. This is evident in SIP members' shifting usage of both individualised and social accounts of inequality in health, and in their ongoing struggles to decide on an appropriate starting point for action. Despite various attempts to devise coherent strategies, results seemed akin to herding cats. Given the knowledge within the entire group about the degree of poverty and deprivation experienced by the communities of East Kirkland, a paradoxical degree of censure towards irresponsible attitudes and behaviour pervaded some of their discussions. Pejorative accusations of '*chaotic lifestyles*' and '*pathological behaviour*' made during the time out sessions are reminiscent of Levitas's MUD-type discourse. However, participants also utilised an alternative explanatory discourse of social disadvantage, unfulfilled entitlement and unequal opportunities and life chances. This is not a matter of the more powerful partners dominating discussions with victim-blaming discourses. Arguments for redistribution were employed by community representatives but also by the SIP leaders, with both Chair and vice-chair arguing that people living in disadvantaged areas need more services and facilities than better-off areas. The group's tendency to focus on lifestyle issues may

be because these factors appear more amenable to modification than the daunting alternative - attempting to change an unequal and divisive social structure. However, no one type of discourse conclusively and consistently dominated group discussions and SIP members deployed alternative discursive emphases in different contexts.

A second type of undecidability is apparent in the Partnership's consensus on the importance of a life course approach, which raised the problem of where to start in order to have the greatest impact on those perceived to be at risk. Should they start with adults, families, children, young people, infants or pregnant women? With sub-categories of such groups, such as excluded young people? Or with specific health and social problems such as drug and alcohol misuse? All can be justified as legitimate targets for action, but such blanket coverage is scarcely feasible in a context of limited resources and timescales. Elements of indeterminacy and uncertainty around how best to address the problem of health inequalities also underpinned the bewildering array of initiatives funded by the SIP. These ranged from traditional health promotion initiatives such as smoking cessation, healthy eating, exercise and stress busting sessions, to community fun days, and an array of special projects providing help ranging from debt counselling to appropriate clothing for interviews and work. The observable parallels between national and local approaches, in terms of throw everything at the problem and see what works, may well improve the health of disadvantaged communities over the long term but may also lead to problems in the causal attribution of improvement.

7.7 Summary

In this Chapter I have interwoven narrative account with analysis, contingent in the sense that different interpretations and different perspectives are possible. In trying to make sense of the data, I suggest that this Partnership can be analysed and understood in terms of the intersection of a number of very different social worlds (Strauss 1978, 1982). These are represented by the community and voluntary sector; local government; the strategic and operational arms of the Health Board; and other, less centrally involved statutory sector agencies. This intersection between worlds forms the Partnership arena wherein claims for authenticity, legitimacy and representation are made, challenged, repudiated or substantiated. My role as analyst is to show how the cultural map of this arena is established and re-established as the antagonistic groups at the heart of the SIP engage in episodic negotiations and conflicts over what constitutes authentic accounts of community needs, and who merits the status of legitimate representative. Participants in forced partnerships are

likely to be drawn from widely different social worlds and partners are obliged to deploy a strategy of legitimating their own position as authentic representatives with an entitlement to be involved in decision-making. By implication and logical extension, this may lead to a complementary strategy of contesting and delegitimizing the position and entitlement of other groups or members. The goal of improving public services in order to ameliorate local disadvantage and improve health was shared by all categories of partner in the SIP. However, whilst community representatives may claim to know their communities best, statutory sector representatives may lay the alternative and competing claim that they know what is best for such communities in terms of service provision and delivery.

CHAPTER EIGHT

THE RISKY BUSINESS OF PARTNERSHIP WORK

8.1 Introduction

I suggested in Chapter Seven that the forced partnership described in this case study is beset by a number of paradoxes, some of which might act as fundamental barriers to the SIP's stated aims of working with multiple sectors and groups (including those perceived as excluded) in order to address the problem of inequalities in health within the local area. I also argued that the encounters between different types of partner on the SIP can be understood in terms of contested legitimacy between representatives of different social worlds. The analytical focus on the practices and strategies of different world members is pursued here, as participants continued to compete within this arena over the nature and purpose of the Partnership. Although the worlds represented by the different partners may, as described in previous chapters, intersect and overlap within the partnership arena, it seems clear that they do not necessarily compete on equal terms. Not only do they have different histories and exert different influences within that arena, but the risks attached to participation also differ, as will be seen below.

It may appear, as with the previous two chapters, that the narrative appears to meander off course at times, incorporating seemingly tangential details or data out of the chronological order that structures the ethnography. However, it is largely in the recording and analysis of such minutiae that insight is gained into the micro-level processes at work within this partnership, and that the substantial difficulties of implementing current health and social policies at the local level become apparent. This chapter is analogous to Chapter Seven in structure, in that the first section presents data from a tranche of interviews, combined with notes taken from numerous informal short conversations held on different occasions and in a variety of settings. The second section of the chapter is based on continuing fieldwork and returns to the chronological narrative of partnership work. The interwoven descriptive detail and analytical comment are summarised in the last section, in terms of a discussion of some of the risks of participating in multi-sectoral partnerships that have emerged during this research. Although important in enhancing our understanding of the complex social processes involved in policy-responsive, health-

oriented partnership work, the risky elements of participation are rarely explored in detail in the partnership literature or admitted to in relevant policy documents.

8.2 Experiencing Partnership

'One thing I've learned about partnership work. It's about relationships between people, not the organisations they represent. And it's time consuming'. (SIP Manager)

During August, September and October 2001 I conducted in-depth interviews with the remaining three community representatives - Stewart Orr, Margaret Kinnaird and Elizabeth McArdle (the Chair of the community representatives group). I also interviewed Gillian Stainton, the LHCC representative on the SIP, because of her relatively greater involvement in the work of the SIP compared to some statutory sector representatives. I spoke to these other representatives about their experience of partnership on a more *ad hoc* basis over the months of fieldwork, both at SIP meetings and other SIP-specific events such as a social marketing workshop and a 'health campus' workshop. As noted earlier, such insider accounts provide information about events and are useful for revealing the discursive practices of those who produce them. These accounts arguably reveal participants' hidden constructions: in the private context of the one-to-one conversation they disclosed critical or contentious opinions that normally remained unspoken in other, more public contexts - such as SIP Board meetings. (An exception to this is described in Section 8.3.3, where critical comments about SIP processes were openly made in a Board meeting by a statutory sector partner who had, shortly before, voiced such comments privately to me. I believed our conversation to have been an additional spur for this participant to speak out.) As with the first tranche of interviews, the issue of confidentiality loomed large for participants from all sectors. Although some were critical of SIP structures and processes, having such criticism voiced and attributed *via* this research was not seen as acceptable. In the words of one of the statutory agency partners,

We have been getting money out of SIP so there are elements of that – not rocking the boat. I think it would be safe to say that, politically, we have to be careful not to hang ourselves.

This required assurances of non-attributability to be given. In the extracts given below I therefore anonymise participants' comments, distinguishing between the two

types of SIP partner by assigning numbered labels: SSR for statutory sector representative and C/VR for community/voluntary sector representative. There may perhaps be some risk of misleadingly homogenising the different types of partner by this labelling technique, as some differences of perspective existed within the groups and I try to point this out where possible. However, this seemed to me to be a lesser danger than that of causing damage to existing, but fragile relationships, which was a matter of concern to some of the statutory sector partners. Indeed, it is highly unlikely that they would have spoken frankly had I not promised to preserve their anonymity. For this reason I do not differentiate below between data produced from informal conversations with established partners and that produced *via* interview.

Several themes noted during the first set of interviews with the community representatives were repeated during this second series and will not be re-rehearsed in great depth here (e.g. suspicions of partisan allocation of funds within the agencies that made up the SIP; the long history of distrust between local government and the community; and the strong sense of being unequal partners.) Extracts from interviews and conversations with SIP members are frequently lengthy but fulfil a dual purpose: enabling different voices, apart from the author, to be heard; and providing the evidence and ground for analytical conclusions and claims.

8.2.1 Rhetoric and realities in partnership working

Given the limited participation of the statutory sector partners that I had observed over the previous months, I was particularly interested to ask them about their views and experiences of the SIP. Some discrepancy between the rhetoric of partnership and a more problematic reality emerged. All the representatives of the statutory sector to whom I spoke endorsed multi-agency and multi-sectoral partnership work when tackling problems as complex and multi-layered as inequalities in health and social exclusion. They argued that individual organisations would never achieve sustainable change:

SSR: SIP has an influence that we don't have - you need these strategic people sitting from all the organisations. People on the ground floor can batter their heads till they're bleeding, working hard doing small pieces of work, but they'll never change or make sustainable change in the health of the population of Kirklands without real partnership working.

SSR: You have to be targeted, which is what SIP is trying to do and I applaud the kind of underlying principles of SIP in that they're trying to tackle employment as well as education, and information as well as housing and benefits.

You can't do one without doing all of them. If we don't get our act together and really make policy makers and strategy makers within Kirklands – because we can only do it within this wee area just now – really have a co-ordinated partnership approach, how do we move forward in tackling employment, in boosting people's self esteem? We need all these structural things in place to assist people.

SSR: We're trying to pull together because we recognise that everybody's working hard on the ground, all doing our own wee bits of work. We are all probably duplicating bits of work so we're not targeting effectively and efficiently. Therefore wasting a resource.

SSR: We are learning to use SIP to our own advantage because we recognise that although we're a big organisation, we are still only one organisation within Kirklands and we have no sway with Local Authority and other groups. We can't force people to do things – we can only ask them to our table and assist us to take forward pieces of work.

However, although participants deployed the rhetoric of partnership working, they also spoke feelingly of its practical impact on their other working lives generally and of more specific problems, such as working with boundaries that differed from those of their own organisations. For participants working at the most senior management levels in their organisation, partnership work was welcomed and seemed to be a positive experience, whereas those in somewhat less senior positions spoke of it as a '*grind*': attending other people's tables was an additional commitment to their normal workload. This may reflect participants' differing capacities to structure and organise their own professional roles. The extracts given below emphasise the extra work involved in partnership:

SSR: This is an artificial divide for us. Working in partnership with the SIP exclusively isn't natural, because all the services in the SIP area cover the whole of Kirklands. I think we have to force people to work in partnership but one of the major drawbacks to partnership working is the amount of paper that comes across your desk every day in report form. There's reports sitting waiting to be read. You prioritise the bits of paper you need to read and sometimes the SIP ones go to the bottom of my pile.

SSR: I actually had forgotten the meetin' was on this afternoon an' I left the papers at home, because at quarter past twelve last night I thought "no, I'm not doing any more now – I'll leave them for tomorrow"...

SSR: We suffer like other organisations from the work agenda, the basic core work agenda that hits everybody as it comes in. There's not a day goes past that you've not got a massive amount of documents coming in. And then we've got however many hundred staff out there who we are responsible for line managing, and professional responsibility as well. And there's money coming from *everywhere* but we're saying, "look let's get our core work right, let's make sure we have all our standards in place, that we are sound and giving the best practice and service possible to people". But we don't get money for that - we only get money for fancy stuff and new stuff.

One respondent explained how the requirement for the partnership to be seen to take immediate action on health inequalities, once funding was received, is in conflict with the necessity to involve those who are targeted for help and the length of time needed to make any real impact on health:

SSR: I was saying, “why are there no public reps on this group?” I couldn’t understand why that was, and it took me a while to work that one out.

SC: Do you know why now?

SSR: ...I can understand that the agenda is huge and you tend to get money thrown at/I mean, you don’t get a planning period without money. Or just a little money to allow you to set up the process. You know, you’re slap-bang into full budget – get things up and running, we need to have outcomes for this, this and this. And these are your dates – y’know? And you’re kind of forced into/it happens all of the time. And mainly it’s from the Scottish Office – you’re having to report back very quickly. Now the finance cycle doesn’t assist you to do that, in that by the time projects were being discussed, the biggest majority of the year had gone. I mean, we got money for two projects at the end of the year, it was January before the money got into our banks and we had to spend that by March. So systems are not well enough set up. This is a yearly cycle of funding that doesn’t assist the process of being inclusive of people. Because we almost have to start, “bang-bang-bang, spend this money”. Get a project up and running – show that we’re doing something to make a difference. Now, health has been deteriorating for [laughs] how many years? People have been killin’ themselves through smoking, eating and all the rest of it. To try and start/to make planning part of/including people to be part of .. because you will never improve people’s health unless you include them in the whole process .. and here we were, embarked on a process that/it was all very official people. There was all people from strategy levels that were sitting round the table having discussions. And here we are, being told we have to make differences to the health of the population of Kirklands in five minutes, although it’s a nine year project. I mean, the health determinants – we’re hardly likely to see massive changes in nine years.

All of the statutory sector partners agreed that some degree of community involvement was vital to partnerships aiming to tackle health problems and social exclusion. They admitted that their own organisations were inexperienced at and poorly adapted to seeking and gaining community feedback on their own services. However, some believed that small community/voluntary sector groups worked in isolation, duplicating services unnecessarily, and that large organisations such as their own could make better use of funding through economies of scale - though such opinions were never explicitly voiced in SIP meetings. They spoke of understanding the difficulties of taking on a community representative role in a partnership, whilst expressing some scepticism about the representative status of their new partners.

SSR: I think they’ll have a major uphill battle. I think they have a very difficult job on – having to report back to the community. I’m not sure how representative they

are. I think, y'know, bringing people onto/it's a poisoned chalice. I don't think I would like [laughs] I couldn't be a rep.

One participant also acknowledged a more subtle difficulty facing the new partners: a lack of experience and knowledge of how the larger agencies work:

SSR: I think they do a good job in challenging us as decision-makers. I think they could do it better by asking a lot more questions because I think things still zip past them. They're not well enough in the know to question a lot of things that are coming before them.

This perspective was echoed by community representatives, who had made persistent efforts to question their established partners and so become 'in the know', as described in Chapter Seven. During our interviews this group expressed frustration with the practical realities of partnership work. They spoke of the lack of any obvious progress beyond sitting at the partnership table '*discussing policy*' - an activity that they believed would fail to impress their own constituency of the community. They spoke at length about the ongoing uncertainties around the unclear nature of their own role. The three extracts given below illustrate their perceived degree of powerlessness to change the situation. It should be borne in mind, however, that some of this group had not taken up the SIP Manager's suggestion of establishing a formal mechanism for community involvement, made during their first training session.

C/VR: This is us now, havin' these meetin's an' the next one will be October. And the year'll be gone and people'll be sayin', how far have we come and what have we learnt and what is the feedback, how many youth organisations have we got involved, are we gettin' feedback how the older people feel about it? And these are things we think the council hasn't tackled. We're involved in meetin's, discussin' policy, an' ye come away sayin', "well, I said that and I feel good". But then what are ye gonnae work at when ye go home and it's still there for the next month? Without goin' out intae the community?

C/VR: A year has went by now and we still don't know wer roles, how Although we represent the community an' the like, when we seen the grants that are put out, the no smoking sensation etcetera an' that, an' the breakfast club an' that - we're speakin' tae people an' ask them what they think about it, but that's just ... they're no' structurin' it. I have no way, no project and group that I could tell about SIP. We've been doin' a load ae talkin' about... what we need tae dae is get more publicity. What else can ye do?

C/VR: I don't want tae sit at an open meetin' in another year's time, an' have people say tae me, "you're a rep, what have you done? A waste of time. What are you's daein? You's are as bad as the ones that you're talkin' about", that the SIP's been doin' nothin'. And then we've all been elected, or nominated, to take part in this because we were quite active .. citizens, or as you say, community activists fer want ae a better word. And we're sittin' there an' we're as bad as them cause we're not doin' nothin'. We're no' allowed tae be doin' anythin. We don't know what/we've

aw got/I think we should have ...see for ma volunteers and fer ma staff, I've got a job description. It defines ma role, ma job description defines what I'm supposed tae dae. An' we don't have that.

Although most of the community representatives were sceptical about the contemporary ethos of partnership work mainly in relation to their own partnership, one expressed scepticism about chances of success because of the context of competitive party politics. This participant articulated a *realpolitik* wherein local politicians would have little to gain from supporting long-term partnership work to benefit the local community, as they might not be in office at the appropriate time in the future to claim the credit:

C/VR: It could be a success but maybe it'll be a Labour council in ten years, or it might be Liberal Democrats runnin' it. Or the SNP. And I think politicians think that's a big problem - ten years o' someone else runnin' it. They have their own agenda, a political party agenda. I don't think that politicians really look ten years down the line, "how can we change things?", because it might mean that they'll suffer politically. Y'know, we're talking about social inclusion but they're talking about political power.

8.2.2 At the centre or on the margins?

My perception of the SIP structure was that of a small core of leaders surrounded by a ring of relatively passive, satellite partners. During a number of conversations I found that this view of central and marginal partner status was shared by a number of the established partners (the SIP leaders also shared this view, but the meaning they gave to it was quite different: see, for example, section 8.3.4.) Despite the lengthier involvement of this group in the SIP they, like the community/voluntary sector representatives, spoke of feeling excluded but perceived this to be less the outcome of deliberate strategy and more as a result of the way the SIP seemed to be led - structured and organised around specific interests. They appeared to endorse my own perception that, although the structures of the SIP were open (SIP Minutes, for example, being available for public scrutiny), the processes of agency were oddly obscure:

SSR: The people who are around are Helen, Moira and Graham. So you're never actually in at the *origins* of things. That's a kind of general theme that has gone through SIP. There's always been that kind of feeling that there's other people's agendas in there.

These representatives explained their apparent passivity in terms of an ongoing uncertainty and occasional bewilderment that prevented meaningful participation, as in the following extracts:

SSR: The meetings – and you’ve been part of these meetings so you know what I mean – they don’t make a lot of sense to you.

SC: I’m actually quite relieved to hear you say that.

SSR: I mean, I’ve sat at these meetings for months. Very much driven by the Local Authority. And that’s not something that I haven’t shared with them. But it’s a feeling that I sit outside the whole process of SIP.

SC: D’you think the other partners feel this?

SSR: Yes, I’ve spoken to them - it’s as though there’s a core group of people that meet outwith this big meeting ... and the agenda is set round about that. You always get the feeling that things have happened and you haven’t been there or “is it just in my own head?” (laughs) “Why don’t I understand that? Why?” An’ the meetin’s go so quickly – and the papers! The papers for the SIP meeting, I got them yesterday for this meetin’ today. An’ they’re that high (indicates size of pile of papers).

The sense of not really understanding what was going on during the SIP meetings, despite being an insider, was shared by other agency partners, as shown in the three extracts below:

SSR: The amount of *business* that we’re expected to take in, work through and make a decision on is .. a lot of things get pushed through without mebbe any great thought but you just feel that, “other people know about this and are agreeing to it so I will too”. There is a sense of that.

SC: It’s hard to put your hand up and say, “stop”. I’m certainly not able to do that because I’m a complete outsider.

SSR: It’s very hard even for an insider! I can do it now, and I don’t know whether you notice – I do speak out more than I used to. And I’m not somebody that hangs back, but I just feel so out of the whole circle.

SSR: People do feel excluded at times. And I think it takes a long time for people to feel comfortable at this forum because the local authority are so *steeped* in it and they work so quickly in that. I mean, we have our own planning forum which brought in our own strategies, which are probably as much of a mystery to local authority, and I am more comfortable in that sort of area and maybe we’d work too fast for the local authority. I’ve had a number of discussions with Moira, because Moira sits out, you know, at another level, and we discuss these things and I hope Moira takes these back because she’s the link with SIP. And we’ve all said, “you do work too fast”, and I’ve said to her, “d’y’know, I always get the feeling that I’ve missed out on something, Moira. That you’re part of another process that actually is SIP, that some of us sittin’ round the table actually aren’t part of.” And she said, “oh well you know that Helen and I have to work together – we work on other things at other times.” And I said, “yes, that’s fine, that’s legitimate, but if you’re discussing

business and you're ahead of us, you have to be aware that you're leaving us/a lot of us well behind". And I don't think they can afford to do that.

SSR: Take the Health Campus, for example. No problem with the principles, with having a resource for the people of East Kirkland based in East Kirkland. But this has to be grown, y'know, with people who are working in the area, who are living in the area. And that hasn't happened. That partnership bit/that has not been a wonderful project. And I don't care if I'll be ostracised, I'm not going to sit in a process where my time is being wasted along with other people, and then it's being sold as a good process. None of us knew what was going on. And that's a kind of general theme that has gone through SIP. There's always been that kind of feeling that there's other people's agendas in there.

The obstacles to challenging perceived exclusion expressed by statutory sector participants were apparently small, but sufficiently significant to deter them. As noted above, one participant commented on a certain sheep-like tendency to simply fall in with events, whilst another said:

SSR: You don't want to seem petty. And I have enough daily hassle just trying to keep my head above the water back in work, without getting embroiled in a million other wee niggly bits here that I can well do without.

During the first series of interviews with community representatives originally drawn from the sub-group, they had constructed their limited involvement in the SIP as marginal and tokenistic (see Sections 7.2.2 and 7.2.3). Having gained entry to the Board, feelings of exclusion were still being expressed by their three colleagues, as in the example below:

C/VR: See at that partnership meeting, there's no' much ae an opportunity tae take part in that meetin'. That meetin's very focused – Helen talks, Moira talks an' that's it. Naebody takes any part in it.

The leadership composition of the SIP was constructed slightly differently by some of the community representatives, who named Helen Cameron, Moira Carruthers and David Sinclair, Community Engagement Officer with the SIP Team - in other words, the three Local Authority employees. Members of this group were believed to exert undue control over partnership activities. In the following extract, for example, a community representative is complaining to me that decisions are being made for them:

C/VR: That was something I brought up that I wasnae happy about an' I mentioned that I wasnae happy because we never get invited to the youth thing at night. Sometimes people think I'm being a bit nick-picky but/an' I know David [Sinclair] had mentioned, or somebody had mentioned, "what, d'you want us to invite you to every

single thing?" Well I'm quite clear that it's up to us to make the decision whether/ between us, whether we think/who should attend. See, that's the type o' thing. I don't think that Moira and David in that office should make that decision. I think if there's things happenin' in the community, OK, I suppose in some respects its up tae us tae find oot this but ye cannae always find out what's happening everywhere. An' if they're getting that kindae information, they should pass it to the community reps and say, OK, if there's a cost involved tae go to tae things, it's not as if the whole six of are gonnae want tae go. I mean, we're no' *daft*. We can decide between werselves who's gonnae go tae represent ... but if there's a thing happening locally, that in our view it would be worthwhile to attend – it's up tae us to make that decision.

Conversely, this group saw similarities between their own marginal status and that of the other established partners.

C/VR: See, since the time that I've come on there, it's no' the rest o' the agencies that's a problem. If any of them are quite, like, defensive, it's the council – it's Helen Cameron, Moira Carruthers and David Sinclair – but mebbe it's because they hold the purse strings. And I actually think – I'm no saying "like", cause that's no' the right word - but I can actually relate tae a lot o' the other agencies sittin' round that table, that they're in the same sort of position as us. Whereas it's the council that have got the power...

Some had also discovered unexpected bases for agreement with the health representatives:

C/VR: I think there were aw these sortae values set up at the start. We didn't like any of yous sittin' round the table an' it was, "we shouldae been involved from the start and aw these people are doin' things underhand an' we're only in here because they had tae get us here" an' aw that type o' thing. But when you sit and listen tae some of the things that they're sayin', like Graham Hamilton, I think, "aye, I like what he's saying. I like where he's coming frae", y'know, type o' thing.

C/VR: I have tae admit, I'm along the likes o' Gillian [LHCC representative]. I agree wi' a lot ae what she's sayin'.

Notwithstanding this evidence of common interests, interviews with some community representatives revealed their continuing sense of grievance about being excluded from funding decision-making and their determination to have a say, as illustrated in the following interview extract:

C/VR: The SIP's still Riverbrae, it's through who you know, what you know, what group you're in. It wouldn't matter if ye had a strong voice at that table – if Helen Cameron/if you're not one of her favourites, you're not gonnae get yer money – simple as that. That's the view of the public. They know through the local paper that comes through the door and through the local advertiser, they know that this/this group got seven hundred thousand pounds. It was supposed tae be for/what they thought was for projects. And this is still the public view. And I'm talking about the public view **and** voluntary organisations'... views. I'm gonnae be up front an' tell you

this – their view is, this is extra money supposed tae be fer the SIP area. Tae help health. And what has happened is, all the grants that's ever come intae Riverbrae, it was always either the councillors or .. people like Helen Cameron who said who got what. Now we were/we were determined tae change this/

SC: When you say “we”, who d’you mean?

C/VR: The public.

SC: People that you know, your friends, neighbours...?

C/VR: Friends, community groups, voluntary organisations, even some of the projects that were funded. And what happened – and it’s still happening, if you look, if you look quite closely at it, ye’ve only five or six projects which got money. The rest went tae agencies. The bulk o’ the money went back intae what we call the government. Y’know, the government gave us this but they took it all back, that’s the way we look at it. ‘Cause we don’t know how agencies work their budgets or anythin’ like that. But so far as we were concerned, we were told that we were gettin’ this X amount of money tae go intae the community. Yet, if you look at the grants that were given out, and again the word was - and it’s got proved right **again** – even if this money did come, it was mostly the agencies got the money. So that put oor back up against the agencies straight away.

SC: Because they awarded the funds to themselves...

C/VR: But it’s not even the agencies that are decidin’ that they’ve got this money – it’s Helen Cameron and Moira. It’s their ain people. And we said, “we’re gonnae get on this, so that the next time, when the money comes out we’ll have a better say. We weren’t there for the first time – it was awready spent. But even although it was awready spent, as ye can see, the other agencies aren’t gettin’ put up for “in principle” fundin’ – it’s only projects. So that’s got wer backs up again, y’know, why is it that projects are gettin’ a sub-committee tae look at their grants, tae see if they’re gettin’ their second and third year funding? What happened tae the five hundred thousand plus that went tae the agencies? I’m on it now and I want/ma number one priority is the projects an’ the groups here an’ there.... Y’know, it’s not a fair table tae sit at.

However, one community representative constructed the situation rather differently and presented an account discrepant with that of others in this group. This participant implied that the continued marginal status of this group was perhaps in part their own responsibility because of their continuing focus on ‘petty’ and ‘partisan’ issues rather than partnership business:

C/VR: At SIP among the volunteers you hear what someone else is getting and what someone else is doing and there seems to be a lot of petty jealousy, to be honest. Which goes against the whole inclusiveness, which is what I’m trying to get out of this. It’s “why are they gettin’ that money when they shouldn’t be gettin’ that money?” Then you had the pettiness about saying that “he’s misusing the money and people are coming not from his area but from other areas - are they gettin’ anythin’ out of it?” As if, y’know, that mattered. It’s all kindae partisan. A lot of petty jealousy - it’s just about people puttin’ in fer grants tae run their own wee organisation.

8.2.3 Tackling health inequalities/practising health promotion

The community representatives interviewed at this stage now had some months' experience of the approach the SIP was taking to tackling health inequalities and, given the importance allotted to community participation in such issues by central government policy, I was interested to discern their perspectives. One community representative spoke of those excluded by the SIP's choice of priorities for action on health and rejected as artificial the separation in policy priorities between major diseases and other health issues:

C/VR: There's a lot of older men with families, who can't get jobs. A lot of unemployed people have got mental health problems. Is the SIP aware of all these kinds of issues? It doesn't seem so.

SC: Well, government priorities are cancer, heart disease, and stroke. But sexual health of young people, reducing unwanted pregnancies, HIV and AIDS, dental health, and mental health are in there too.

C/VR: Well the thing about heart disease - it's not brought on by diet, it's brought on by stress. And I would say that stress also accounts for/there's stressful effects on mental health and it affects their/there's problems in the family if someone's got mental health problems. They just highlight the Big 3 as separate, but it's all entwined.

Although this representative had highlighted the marginalisation of older age groups by the SIP, its apparent failure to engage its priority group - young people - was also mentioned. The extract below reflects this participant's perception of flaws in the SIP's methodological and ethical approach to engaging excluded young people, based on experience of one of the health campus workshops (*'that thing at the Greystanes Hotel'*) that the SIP had funded. The initiative had been led by the health promotion policy director and some workshops had been attended by a number of partners from both statutory and community/voluntary sectors. I had also been present at the particular event referred to here. I was interested to note that the judgements made by this participant were not only shared by other community representatives but also mirrored comments made to me by some of the statutory sector partners.

C/VR: The problem that I think we'll find is, since it's about young people, what kind of input are we going to have from young people? I don't even think yet ... we have a youth rep. And ... I think there's always/you're going to find the problem of older people talking down to younger people. Which they don't like. If that's what we're going to be doing over the years in Kirklands, then there has to be a greater involvement of young people. I don't know if you can expand the management committee. But I think you're gonnae have to have a lot of under twenty fives on it, because ye can't just make decisions *for* young people, they've got to be *with* young people - they know the problems - and talk about diet, talk about drugs, problems

with alcohol, problems with unemployment. At the moment it's older people running it for younger people. It's telling young people about drugs, but you'll find that young people know mair about drugs than any older person. It's tellin' them about health, but they know the things they're doin'. We make decisions for other people and so far as I can see, everyone on the SIP's well over thirty five! That's a major problem, something you have to tackle. It's supposed to be a social *inclusion* partnership. Well where does the inclusion come in? A partnership of so many older people. The problem I think in the SIP is, we have this meetin' on a monthly basis and we discuss things, then we go away again - and where's the link? I find that young people don't seem tae be involved in a/in a policy that's supposed tae be/tae include them. I don't know where it's including them. And I don't think there's much hope that we get young people involved in this sortae thing. That thing at the Greystanes Hotel³ - there was two young people there but ... [sighs] I thought that was kindae patronisin'.

SC: Yes - there was only the two of them, and I found what we were supposed to be talking about hard to grasp. I've no idea how those young guys were coping.

C/VR: I felt it was a sortae token gesture. When those two young people wi' drug problems com in and were tellin' us about it, an' ye listen tae it ...I felt, this is no' right, it's no' right tae do this tae young people. You'd be better, say, sendin' two members of the SIP to a gang o'young people and say, "right, yous tell us" and record it, the way you're recordin' this, and take it back to SIPs and say, "well, that's what they say".

Notwithstanding such specific critique, this group's growing familiarity with and participation in the Partnership had led to some increase in their acceptance of the value of other SIP-funded health promoting initiatives. For example, one community representative who smoked spoke of the value of the smoking cessation project (which had provided free nicotine patches to smokers in the SIP neighbourhoods) and the school fruit project for people on low incomes:

C/VR: I mean, like this smokin' sensation thing - I thought they free patches was a *brilliant* idea because I always think that smokers get a raw deal. I really want tae stop smokin', I really do. But ye need to have your mind set on it. Cause you can see I still smoke although I gave up smoking for four or five years. But ye need tae be focused before ye take that/ye need tae make yer mind up prior tae daein' it. If somebody was giein' out the patches fer nothin', I would take them. But I'm no payin' fer them, cause then I'd be saying, "imagine payin' twenty odd pounds fer *them* when I could buy cigarettes!" I know that sounds terrible but that's the way I would see it. Erm ... I know it sounds silly if you were to start an' analyse it, you should still do it, try them and save yourself a lot o' money. But if I stayed in an area where patches were bein' given oot free, an' somebody said tae me, "gae tae your GP and get patches", I would gae the morrow. Because if I don't stick tae it, if I have a smoke, I won't feel sae bad because I haven't paid fer them, they've gie me them fer nothin. So they people that stay in East Kirkland that get patches, it's great for they people. And we know ourselves, the poorest people are the people that smoke. So giein' these patches out were brill! That's the type ae things that they should be daein'. Support and help people who need these things tae stop daein' whatever habit they are daein'. It's like giein' a piece o' fruit, OK it might just be a token thing,

³ Formal evaluation of the range of events, conducted by an external agency, was extremely positive: informal opinions that I gathered from a range of participants tended to be far more negative.

they might still be eatin' their chips and things that they shouldnae be eatin', but the fact is that there should be mair o' that.

Despite perceiving such initiatives as useful, even necessary, this respondent also criticised what she called the '*classist*' aspects of health promotion, i.e. its basis in identifiably middle-class values, suggesting that practising certain (bad) habits or possessing a particular (undesirable) body shape enabled people to be constructed by others as unthinking:

C/VR: It's also seen as a thing that people dae that come frae/I think that it's like a classist things, like if you smoke .. it's the same I think as if ye're overweight .. it's seen as if ye're not in control of your own body. In some/in some respects it's a/it's a ... that ye're stupid in some respects, that ye should know better and ye've not got enough erm y'know, not educated enough to know that y'don't smoke and y'don't overeat an' ... basically it's that y'don't *think*. Y'know, a kindae a classist thing.

Despite the clear statement by a senior health promotion specialist that '*the days of telling people what to do are long gone in health promotion*' (made to SIP members at the beginning of a social marketing workshop held in early October by the health promotion department of the Health Board), community representatives invariably associated this approach with the giving of narrow prescriptive advice that fails to take account of the broader social context of people's lives:

C/VR: I don't think health promotion can get through to a lot of people. Again, it's down to the economics. It's easy to say what people should buy but it depends what money people have and what they can afford. Y'know, it's alright sayin' "eat high fibre and eat protein and low fat", but people have to live with what they've got. There's a lot of unemployment so a lot of what people want, they can't afford. And the cheaper food's probably not the best diet, so that's a problem. The smoking problem ... again, a lot of young people smoke. A lot of the people smoke because ... it's a paradox - they have a lot of worries and the more they worry the more they smoke an' so forth. It's again .. they tend to say to people, "give up smoking and eat this". But it's economics – what sort of jobs/what sort of money are they bringin' in? I mean, talking about healthy lifestyle, changing lifestyle – but a lot of it, I think anyway, is about finances. What people can't afford. A lot of it is down to the economic environment of various places. Bad housing, unemployment, poverty. For this generation, the lack of basics in gettin' jobs - reading, writing, basic education.

C/VR: It's awright fer them round the table sayin' "fruit, that's healthy, an' cereals, that's healthy" an' that – but has any o' them ever *lived* wi' a hundred and ten pounds a week, y'know, tae feed three kids? An' clothe them? An' the electricity an aw' the rest ae it? Yes, again, don't get me wrong – it could be done. If that's aw ye were goin' tae do, y'know, an' the children didn't go out wi' their nice clothes on and aw the rest ae it.

However, having spoken of the difficulties of following ‘healthy’ advice for people on low incomes, this participant went on to throw doubts over the presumed relationship between a more adequate income and improved health. In the interview extract below, the community representative draws on local knowledge to argue that people would use extra money to augment their ‘*basic package*’ of familiar foodstuffs and to buy fashionable clothes, rather than switch to ‘*luxury*’ items, such as fruit:

C/VR: If they’ve got more money tae spend, in the SIP area, it won’t lead tae more healthy eatin’. There’d be more smokin’, more drinkin’ and more carry-outs. The benefit people, even the workin’ people, it used tae be, years ago, an’ it’s still the same, on a Friday it was the chip shop because it was pay-day or somethin’ like that. Nowadays, if people had more money, it’d be more business fer these shops, the carry-out shop or the Chinese. It would *not* lead tae healthy eatin’ I can assure you. I doubt it very, very much.

SC: What do you think this means for the SIP’s health messages about healthy eating? No smoking? Moderate drinking? Things like that?

C/VR: I think it’ll work fer a very small minority. You know, the likes o’ those people who are always goin’ on a diet – somethin’ like that. But not tae the main people, no. I can’t see it.

SC: A lot of the surveys done do suggest that people would make healthier choices, if they could afford it.

C/VR: Of course – they know the right thing tae say. They know fine well the people who they’re dealin’ wi’, that you don’t tick that ye go tae the Chinese or the chip shop. Ye tick what they want tae *hear* – and they want tae hear that ye’d spend it wisely on fruit. But that’s why we’ve got/we support the fruit club here – we know a lot o’ people/I mean, I’ve got a bowl of fruit on the table in here, but that’s only been mebbe fer the last few years. And only cause ma income rose and I could afford fruit on the table. Fruit is still a luxury tae people who are on benefits. And this is what people round the table don’t understand. People on benefits, if ye gave them more money they’d buy more fashionable clothes fer they or their kids – they would not put their money tae more healthy eatin’. I mean, gingerale, sweets, crisps an’ things like that – they’re now part ae yer basic package, know what I mean?

Apparently judging that I remained unconvinced by these arguments, this participant went on to explain further the reality of making choices on limited budget:

C/VR: Most o’ the people I know/in the thirteen⁴ SIPs [neighbourhoods] that we deal wi’, ninety per cent o’ them ... I’m thinking how tae say this ... ninety per cent o’ them use their money not tae buy healthy foods, it goes on the Stepic or the Provident fer wide screen televisions. I mean most o’ the people who are on benefits - or not even on benefits – the ones that are on the low wage an’ that, these are the main companies that they use. Now these people mostly come tae yer door fer their money. So if it was a choice between food and the Provident, I’d pay the Provident. I know hundreds, *hundreds* of families would pay out twenty five pounds

⁴ There were only ten neighbourhoods in the SIP.

a week because they'd be ashamed of not havin' basic things. I mean, can you imagine goin' intae a house nowadays and nobody's got a television or a video or a washin' machine? But what it aw boils down tae, no matter if you're talkin' about health inequalities, it all boils down tae finance. An' we're gettin' this extra money tae encourage healthy eatin', and we're supposed tae go out in the community fire-fightin' this an' that – I'm sorry tae say, the more you give tae people – people like us, lower/not lower/working class, yes, mebbe ye'd buy a bit o' steak instead o' mince, which has got less fat, but I think .. eighty per cent .. would be buyin' an extra sausage supper.

The community representatives thus expressed doubts about the validity of some of the particular health promotion approaches espoused by the SIP as a way of tackling health inequalities. One respondent suggested that the priority for *all* sectors involved in the SIP was to gain access to SIP funds: this, rather than any clear idea of how to tackle poor health, drove partners to comply with the health focus, regardless of the nature of their core activity:

C/VR: I think it's aw done too haphazardly. I think it's aw done without thought, type ae thing. OK, I know that the erm Moira's group are puttin' together a development plan. It's OK writing in a couple of sentences, "we intend to do blah blah blah" ... but the actual practicalities of this... Everything that they've started, I know that they were goin' ahead wi' before we came on board, and I don't think they've co-ordinated it. It's just like, "OK, we'll dae this, and that relates to health". Even projects like werselves, it's "how can we get money out of this? How can we relate what we're doin' tae health?" Cause I know, I've had tae put it on the proposal forms, how ma service relates to health. And I think there's an awful lot ae people doin' that, no' just the voluntary sector. It's the agencies as well. It's like ... there's a pot ae money here, an' I don't think that they're actually really interested in other people in East Kirkland. I think they/they're interested/their focus is on the money. A'bodys daein it. Their focus is on the money.

Another participant spoke of funding to tackle social exclusion and poor health as just a '*new bandwagon*' - a labelling device that poorly concealed its substitution by central and local government for previous regeneration funds. In other words, despite government assertions, this participant suggested that the community dismissed claims that such funds constituted extra help and new money for disadvantaged communities. Moreover, the shift of purpose and the emphasis on eventual self-sustainability of funded initiatives was perceived as a threat to established community projects:

C/VR: The government's gave money tae take it back intae their own projects. And the five projects who are gettin' funded through the health initiative, yes, they are doing healthy things etcetera. But it's only because they took urban aid money away, our regeneration money away. So...it's just a new bandwagon. The SIP's not new money.

SC: You think it's a substitute for the old urban aid progamme?

C/VR: Aye. It's just a substitute, cause y'see, even groups who used tae get regeneration money, had nothin' tae do wi' health – it's the same groups on this bandwagon.

SC: I s'pose they'd say that they have got something to do with health – like providing services to mothers and toddlers in areas that have very little ...

C/VR: Oh, aye, don't get me wrong – I agree entirely that, yes, they should be getting it in the health SIPs, they are doing health-related issues. But the point being, that's just a new name for the old stuff. And when ye look at it, if ye look at all those who used tae be funded by Riverbrae, by regeneration money, it's "no, we're no longer fundin' ye". "Where do we get the money from then?" And all of a sudden this nice new SIP come in. I think they're tryin' tae say "this is new money for health". It's *not* new money – it's *old* money and we're still tacklin' the old issues. If the government was givin' us wer new money, on top of still funding the groups that need tae be funded, *then* we would maybe start tae make a difference. All they've done is, they've gave the *extra* money that did come through tae agencies, so the agencies could get more clinics and more smoking sensations because they've not enough in their budget tae do these things. So the local authorities who got this money tae give tae people fer health, instead, what they done was, when they got this money, they went, "see aw these people we used tae fund? We'll move them over intae this wee pot now. And that'll bring us this money back in, that we used tae fund them and we'll give them it from that budget." All they've done is change budgets or whatever way they do it technically...

(lights up another cigarette)

One o' the main reasons I got involved wi' SIP wasn't because it was health. It was tae get involved in finance. Because it was always the councillors that sat on these groups. It always is still the councillors. It depends who ye know, who ye don't know. It doesn't depend on, "that's a great project – that will help the area". That's not the way it's done. People are askin' us what SIPs is. We're tellin' them that, basically, there's some monies there tae improve the health o' Kirklands. "Ohh. What's the criteria?" Ye tell them the criteria: "it's got tae be health related". "Well why is the agencies gettin' aw that money? Should they not be fundin' that theirselves?" And then when we did ask the question, we were told that the agencies are kindae bein' funded the now, but that they're gonnae put their ain money intae the SIPs .. eventually. To finance their projects. But the community projects are not gonnae be financed because we're wantin' them tae fund theirselves. How can they fund theirselves? Ninety per cent o' the people that go tae they projects are on income support. Again, we're back down tae finance. It's just one long paper trail.

8.3 Conflict and 'Crunch Point'

This section covers the final fieldwork period from August 2001 to February 2002. As with the section above, some of the fieldnote extracts from these events given below are extensive. My intention is not for these data to speak for themselves and thus eliminate the necessity for analytical thought: their purpose here is to provide sufficient evidence for my interpretations. Participants are not always anonymised (except through the use of pseudonyms), partly because it is not feasible to conceal identities when using fieldnote extracts. I also believe that events cannot be

understood without some sense of the individuality of participants and the different backgrounds and perspectives they brought to the partnership table, and of the heterogeneity of the different groups involved. There is thus a careful balancing act involved between including sufficient data to underpin subsequent explanations and provide an adequate account, and avoiding revelations that would cause harm. I have found this issue to be the most troubling element of the case study but believe it to an inherent, perhaps inevitably non-resolvable, risk of ethnographic work.

During this period I continued to attend SIP Board meetings, held in August, October, November, December, January and February. I also attended the health campus and social marketing workshops referred to above. The community representatives held a series of meetings outwith Board meetings, some of which involved Moira Carruthers and/or David Sinclair from the SIP Support Team. These separate meetings were established in order for them to develop as a group and to discuss specific issues of interest. They were initiated and encouraged by the SIP Chair and Manager, who had told me that they believed this group needed to foster their own relationships in order to function well within the larger Partnership. The SIP Manager had also set up briefing meetings with the community representatives before each full Board meeting, which she normally attended and led. All meetings were held in the SIP offices, and lunch provided for the participants. I attended most of these, together with the specially convened meetings with the SIP Chair that were organised following the most fraught of the SIP Board meetings. Despite reservations expressed by the community representatives about the SIP leadership, working relationships between the two groups were, for most of the time, seemingly amicable. (As one community representative pointed out, *'you don't always have to like people to work with them.'*) Points of rupture in the relationships within and between such groups are therefore particularly revealing from an analytical perspective.

8.3.1 Going backstage with the 'united front'

The meetings of the community representatives during October and November 2001 are reported and discussed here separately from the SIP Board meetings they were designed to precede, and slightly out of chronological order in that they were separated by one such Board meeting. There are a number of reasons for this. Primarily, the two meetings are joined by continuity of the topics discussed. The meetings provided the grounds for the growing suspicion, in some, of

'*underhandedness*' on the part of the SIP leadership. However, they also provided part of the basis for emerging differences, even dispute, *within* the group that was at odds with their stated intent of presenting a '*united front*' to their more established partners. Finally, it was the seemingly innocuous resolution to hold a team building session, developed during these meetings, that was to lead to some unease amongst other partners and open confrontation with the SIP Chair. That episode cannot be understood in isolation from the pattern of shifting alliances emerging within the group and the Partnership.

8.3.1.1 Dissent over support structures

Two meetings that I had not known about and therefore did not attend were held in September 2001 between the community representatives group and David Sinclair, the SIP officer responsible for developing a strategy for community capacity/engagement. The original purpose of these meetings was to agree a role for community representatives, both as individuals and as a group (the voluntary sector representative was part of the group but her role on the SIP Board was generally agreed to be clearer than that of her colleagues and was therefore never a topic for discussion). However, the bulleted summary of the meetings that David sent me indicated that the issue of representatives' roles was not covered, as they had chosen to discuss how to spend the ring-fenced £60,000 provided by the Scottish Executive to the SIP to facilitate community involvement. Spending this money was also the central topic of the group's pre-SIP briefing meeting on 6th October 2001, attended by Moira Carruthers and David Sinclair, with each of them facilitating half of the meeting. Neither Jim Cross nor Nancy Robertson was present at this event.

Moira and David had drafted a job description for a Community Support Officer. Two of the community representatives objected to this draft for a number of reasons. They said that the grade and pay scale were far too high for the tasks involved (A/P5, roughly £25k p.a.). They also objected to wording that suggested that 'their' support officer would also provide some support to David Sinclair in his role of engaging with the community. One representative was reluctant for the post to be a council employee, based within the SIP team and line-managed by Moira, on the grounds that there would be no independence from the council. She appeared to believe that 'a fast one' was being pulled, saying '*we've been stung too many times*', although her colleague responded, '*no, the way it's been done has made us think that, but not once it's been clarified*'. The other representative told David that he was '*an*

insider', and that his own appointment had been '*a closed shop - nobody was consulted*'. Clearly taken aback by this statement, he responded that he presumed his post had been discussed at the management group. I told them that it had - briefly - although this had been before the community representatives had taken their place on the Board (during the IMG meeting held on 1 March 2001). The issues around the support post were not resolved and the group could not agree amongst themselves as to which aspects of the job description were most unacceptable.

They returned to the subject again at their next meeting on 8th November. On this occasion, Nancy Robertson was present, though Jim Cross remained absent because of illness. Though not known for her support of the SIP on most occasions (see, for example, Section 8.3.2 below, which recounts an incident involving Nancy that arose during the SIP Board meeting held in October, the month before the community representatives' meeting under discussion here), Nancy nevertheless backed Moira, saying that the pay scale for a Community Support Officer was not excessive for the demands of the post, and that there were more such posts available than people with the requisite skills and experience to fill them. One of her colleagues remained unconvinced, and expressed anxiety about being held accountable by the community for spending so large a sum of money and about establishing working relationships with - from her perspective - an over-qualified member of staff:

It seems as if we're milking it. I want a wee Tracy⁵ the now, no' a graduate. This money's fer a graduate. We don't know wer roles, so how can she support us? If ye employ someone at that rate, they'll be tellin' us, not us tellin' them. I've got tae go back tae the community - I'd like tae be able tae explain how we spent sixty thousand pounds. I'd rather resign than do that!

Another agreed that '*we just want someone in an admin role to support us*', and objected that, on the agenda for the next SIP meeting, this post was ticked as '*for decision*', whereas it should have been '*for discussion*'. Conversely, Nancy and Stewart stressed that they needed a support officer '*this side of the financial year*', and that '*if you ask a lower rate, you don't get the standard of worker*'. The group seemed to agree to the post being a council employee but it was clear that some were far from happy with the job description as it stood. After the meeting ended, two of the group told me that they saw this drafted job description - with which they had had no involvement - as providing additional support for David Sinclair and the SIP team. They did not appear to judge this an appropriate way to spend money

⁵ Secretary to the SIP Board.

allocated by the Scottish Engagement for community support. As one community representative commented,

I know it sounds terrible that we keep thinkin' that these people are daein' things underhand, but we're aw sittin' roond the table and every one ae us, every single community rep, thinks it.

In short, the general suspicions which some of the representatives had expressed regarding the control of power within the SIP, crystallised around the topic of how best to spend the community support money. The contested ownership of the new post also provided a focus for their energy. Dissent within the group can perhaps be partly explained in terms of some members' concerns over an unequal financial status between themselves and their proposed worker, and partly in terms of their own differential experience of managing such posts.

8.3.1.2 Team building plans

During the October meeting Elizabeth, as Chair of the community representatives, had asked Moira if they could have a team-building session, funded from the community support monies and to be held locally and externally facilitated. She said they felt that they were not yet a team, hardly ever met up with each other, and that people still brought up '*old issues*'. Moira had agreed that they needed their own discussions '*behind closed doors*' to sort out their relationships, that sufficient money was available, but that it was an issue for the whole Management Board to agree. She suggested they also give some thought to setting up an annual community conference or other event, as there was some danger of them being accused of having done little, so they needed to be seen doing something. Those present had readily agreed with this - an issue they frequently expressed anxiety about. Shortly before their second meeting on 8th November, the group had attended the annual SCVO conference and workshops for community and voluntary sector representatives on all SIPs across Scotland. They told me that they had chosen to sit in the particular corner of the conference hall reserved for those feeling '*Very Negative*' about their SIP for the whole of the weekend. Nevertheless, following contact with longer-established partnership representatives they came away having firmly decided to become '*empowered*', as one of their group told me, albeit somewhat tongue-in-cheek. Arranging team building was an important first step and considerable time was spent during their November meeting discussing this.

For the C/VR Chair, arranging a team-building event raised a number of issues. Firstly, she believed she had to tread carefully with her colleagues and involve them fully in all arrangements, given the problems associated with the venue of their first away day and the somewhat volatile nature of the group. Secondly, arranging the day raised a boundary issue with the SIP itself - was she allowed to organise such an event without formal permission from the SIP? Having been given apparent clearance to go ahead, the group appointed a facilitator and booked a country house hotel as venue for an event in late November (although the projected costs for this event exceeded those of their first session at the Hilton Hotel and one member of the group asked me to attend, to write an evaluation report, in order to justify the expense to other SIP partners.) This event never took place, for reasons that will be explained in section 8.3.4 below. Firstly, however, brief accounts are needed of the SIP's October and November Board meetings, both of which were ruptured by the emergence of specific areas of conflict.

8.3.2 The Murraybank focus group incident

The October 2001 Board meeting was held a few days after the first of the community representatives' meetings described above. Two academic visitors were present - a well-known sociologist who had led the risk-taking behaviour research project and was present to talk about his team's work, and a researcher from a policy studies unit, who had been appointed to evaluate the Health Campus project. The usual, efficient committee processes followed: apologies for absence, approval and seconding of the Minutes and listening in silence to budget updates by the SIP Manager. (Approval and seconding of Minutes was normally offered by members of the community representatives' group, perhaps as a way of demonstrating their active involvement and voice: I learned that they did not always perceive the Minutes as an accurate record but felt it would be petty or nit-picking to challenge these - echoing very similar comments made to me by statutory sector partners.) When they came to discussing the proposed community support worker post, one of the statutory sector agency partners commented that they had not had enough time to look through all the relevant papers, but they supported the post in principle. However, on the issue of team building for the community representatives, this partner spoke of the '*danger*' of those partners becoming a cohesive group, whereas '*the other partners just flit in and out*'. The Chair responded that the Scottish Executive wanted community representatives to be fully informed, but the other partner countered with, '*agency reps aren't up to speed either! You come along to meetings and feel things*

have happened elsewhere'. Given that I had spoken to that partner on just this issue before the start of the meeting, I believed it probable that this public critique might have been inspired by our conversation. I learned later that this minor altercation had been received with silent delight by the community representatives. The exchange was curtailed by Graham Hamilton's diplomatic suggestion that the order of the agenda should be changed at this point, as the 'guests' present might be getting bored.

The sociologist provided the Board with an informal account of his team's methodology and findings, but he did not have any copies of their report with him. He described two extremely disadvantaged communities currently in the process of 'going under', ill-served by formal service providers outside the area, and internally divided by conflict of age, religious beliefs and 'territorial' issues, particularly for young people. He warned them that help for young drug users would not be welcomed by all in the community and stressed that the main research findings had been the '*surprising lack of felt safety within the two communities*' and the apparent lack of response to such concerns by the Police. Not surprisingly, Superintendent McDonald, the Police representative present, defended his agency against such allegations. He said the young researchers had been '*needlessly afraid as nothing had happened to them*', that communities have become '*less tolerant of certain elements*' over the years, and that demands on the Police force could not be met. This was not simply a matter of resources - demand was '*infinite*'. Moreover, there was '*too much concentration on the negative side and poor health of Kirklands and not enough on the positives*'.

Following the researcher's departure from the meeting, Superintendent McDonald went on to contrast local people's '*beliefs*' about dangerous communities with the '*facts*' of police statistics which showed a drop in '*serious crime*' in these neighbourhoods over the years. (I understood perfectly at this point what other participants meant when they spoke of '*dying to say something but biting your tongue*'.) He explained that '*young people hanging about*' was not a problem for the police, though the community might well feel it to be so. Nancy Robertson commented that, from her knowledge and experience of the area, the findings of the research team were likely to apply in other neighbourhoods as well, all of which would follow the decline of St Colmes and Southmuir unless action was taken soon. For other members of the Board, ownership of the research and confidentiality of the findings presented a problem. They appeared to feel that because the Partnership had

funded the research they also owned the findings and could control dissemination: the report had the potential to embarrass a number of agencies and they wanted to be able to manage distribution. At the same time, they wanted the SIP to be credited for funding a piece of rigorous academic work that had been well received (almost) universally. I felt I had to point out the incompatibility of these two aims, and told the Board that the academic team might view responsibility for dissemination rather differently so they needed to talk this through with the researchers.

After some discussion of the thorny issue of intellectual copyright, the Chair asked Superintendent McDonald to tell the rest of the Board about a SIP project that the two of them had been involved with, in Murraybank. (Murraybank lies within Kirklands town but outside the ten SIP neighbourhoods: it is generally perceived as one of the better areas). He told them that the local police had received numerous complaints from the Neighbourhood Watch in the Murraybank area, reporting '*nuisance behaviour*' from local gangs of young people⁶. Despite spending £35,000 of police resources, nothing had been achieved. So he and the SIP Chair had formed a discussion group of six of the best-known local '*neds*' (?young men perceived as troublemakers/minor criminals) and five Neighbourhood Watch members. He described this approach as '*draining the pool rather than shooting the alligators*'. The Chair spoke of how '*embarrassing*' the Council had found some of the issues raised by the young people. This group had been refused admission to a Council-run community education centre because they were not interested in the health education on offer, and there were no other local facilities for them. Following the meetings of this focus group, complaints to the Police had reduced and community representative Jim Cross had begun working with the young people. However, Nancy Robertson was clearly irritated by this presentation. The following extract from my fieldnotes shows the fairly dramatic nature of her confrontation with some of the other Partners:

Nancy comments that Murraybank is a quiet area in comparison with her own (i.e. she seems to be questioning why they initiated any activity here). SuperMcD says they get most calls/complaints from this area, from Neighbourhood Watch members (this reminds me of his presentation in June about the various types of police approach – mostly reactive. So it seems that the police take action in response to large numbers of complaints, although an area itself may be more well off.) The others discuss the usefulness of the focus group model and potential of rolling it out to other areas. SuperMcD says it only cost £200 for 2 days – which Nancy does not seem to think a small amount, judging by her body language. She says, 'so if communities are having problems during the day, do they get help?' (I know she's referring obliquely here to her own play park project, which was recently vandalised.

⁶ Complaints had been made of drunkenness and swearing by the young people congregating in the area, and of them having sex in the back alleys, in full view of the windows of older neighbours.

She had told me that she had to 'take her life in her hands' in confronting the very large gang of young men responsible.) Helen says 'the exercise was about testing out a way of addressing young-older person problems – a method to add to the SIP's basket of techniques of how to talk to people'. She says it's seen as a way of enabling debate: the same applies to the methods used in research project on drugs.

Helen then says, 'we paid the kids to be there'. The sum of £10 payment for participants is mentioned. Nancy asks, 'would you get them there if you didn't'? Helen responds that this didn't matter. SuperMcD says 'there's a whole issue about paying volunteers'. Nancy bursts out, 'that's wrong! And you're paying older people? You've lost the plot there! That's wrong! Jesus Christ!' Visibly angered and upset, she puts her head in her hands – then talks about her unpaid young volunteers and how unfair it is. She refers to her vandalised play scheme, but SuperMcD seems to imply that the vandals came from her own project. She gets her coat on, puts her papers together and seems about to leave. Helen asks what difference there is between paying research companies and paying local people? Nancy is still incensed: 'we don't take *nothing*. It's disgusting to pay ten pounds. I have kids coming along, giving their time for free.' Helen says 'these are *not* volunteers – they're people we've asked to come along. People who volunteer are different – they just get travel expenses'. Wilma Edwards says, 'it's kids we wouldn't normally access – we need to provide an incentive'. Margaret, sitting right next to Nancy, echoes Helen – says that the kids were taking part in some local research, not volunteering. Nancy is clearly unconvinced and the atmosphere remains very uncomfortable. Helen says a report will be brought to the next meeting about this⁷. Silence follows.

(Fieldnote extract, SIP Board meeting, 11th October 2001, Boardroom, Riverbrae Health Board)

Nancy was not making a uniquely personal objection here. During the first Working together/Learning together training session in December 2000, several of the former Community Representatives Sub Group had been extremely critical of another SIP who had collaborated with Oxfam and paid excluded young people to participate in workshops. Paying volunteers was an extremely sensitive topic for some participants from this sector: it almost seemed to be perceived as akin to corruption. However, this episode seemed to confirm Nancy's role as most outspoken critic of the SIP, ready to challenge the Chair openly. Others had told me that they respected her knowledge, experience and passionate commitment to her work, but feared that she risked marginalisation through the statutory sector partners' interpreting all her comments solely in relation to her own project. The incident was also the first example of public disagreement between members of this group.

Nor did the meeting conclude smoothly. Graham Hamilton's presentation of the Health Campus project, and the short evaluation given by the second academic present, was extensively challenged by a statutory sector partner who had

⁷ This report never materialised.

participated in a number of the project's workshops but not been impressed, concluding that

'if this is how we're spending the public's money, we should be shot.'

The community representatives were packing up as this Partner spoke - their usual way of indicating that they felt the meeting had gone on long enough.

8.3.3 Efficient structures/divisive processes?

The SIP leaders had taken note of the new partners' objections to the way earlier decisions about the allocation of funds had been made, and a funding sub-group had been established earlier in the year, with Jim Cross representing the other community representatives. (I had found that this did not meet with their universal approval, as some of the community representatives were wary of allowing one person to speak for all. They also objected to one of their group being selected for such participation by the SIP leaders, rather than volunteered by the group as a whole.) At the SIP Board meeting held in November the Chair announced that another new funding sub-group had been set up and was now in operation. The purpose of this group was to review the applications for continued financial support by the 'SIP Projects' (i.e., those inherited from previous urban regeneration funding, two of which involved SIP members) and to bring their deliberations back to the Board for decision. The sub-group was made up of the Chair, the representatives of Scottish Homes and Scottish Enterprise, and Margaret Kinnaird as community representative. With hindsight, the risks involved in this strategy are clear. On the one hand, the sub-group structure was an efficient - if somewhat exclusive - way to conduct SIP business and the community representatives had a voice in deciding what recommendations to take to the whole Board. On the other hand, the selected representative was clearly placed in an ambiguous position. She was obliged to support her own colleagues as a matter of general principle, yet also needed to be seen by other Partners as warranting a legitimate place in decision-making by bringing a non-partisan perspective to funding applications from the voluntary/community sector.

During the November meeting, Jim Cross and Nancy Robertson were asked by the Chair to leave the room whilst their future funding was discussed, and a paper was tabled summarising the debates of the funding sub-group. The discussion which then took place revealed that the other community representatives present were quite

capable of taking a critical look at their absent colleagues' projects and the '*united front*' seemed in abeyance. Little of what was said at this time could have been voiced had the two other representatives been present. The Board agreed that these representatives and their projects, though presently in competition because of their close proximity, needed to work together for the benefit of the whole SIP area as it was '*not sensible to have this level of resources*' for just one part of the SIP. They also agreed that the projects needed to develop more of a focus on health. Margaret told the Board that her sub-group had agreed on the core funding for the two projects, but was contradicted by the Chair who said, '*no, we didn't get that far*'. Some community representatives expressed a degree of discomfort with their position before their colleagues' returned to the Boardroom, with one asking the Chair in evident apprehension, '*what will we say if they ask us about it on the way home?*' (one of this group owned a large MPV or 'people-carrier' and often transported others who lacked a car.) Helen responded that their discussions were not intended to be secret, but that she would summarise them for the others. She did so, and the two representatives received the information without comment. It would, I think, be reasonable to say that this was unexpected, and something of a relief to everyone else around the table. The open conflict that arose later in the same meeting derived from a quite different source.

8.3.4 The display of power

The issue of allocating the £60,000 of community support monies had been raised early in the meeting during discussions of the currently underspent budget, and community representatives' objections around this issue were deferred until later in the agenda. The following is a lengthy fieldnote extract of that part of the event. I believe this to be justified in terms of the impact on the Partnership and the community representatives' group in particular. In this passage the Chair displays her authority in the Partnership, and in doing so doing undermines the authenticity of the arguments made by some members of the community representatives' group. There is, however, evidently some sympathy for what this group is saying from some of the larger agency partners. However, the group's hopes of presenting a '*united front*' fall apart, irrecoverably as it turned out.

The Chair suggests they move onto the reps' disagreements with the post, saying 'I don't think anyone can disagree with the activities outlined', as these conform to the areas of expertise outlined by the Scottish Executive. She says this might all change later, but they need to get issues out now and have a partnership discussion. (I note some reluctance to speak out in this forum from the vol/comreps, whereas there was

no such hesitation with Moira and David on Tuesday – that had been a less formal meeting, the weight of numbers had been on their side, and the sense of injustice very fresh.) Elizabeth says the grade is too high for the post and part of the job description stated that the worker should support David. Helen says, ‘there’s been talk about ‘your’ and ‘our’ money [earlier in the meeting]. It’s for community support. It’s not yours or ours – it’s partnership money. You’ve got first call – you’ve had several discussions, but it needs to come back to the partnership. The person needs to be part of the SIP *team*, not stuck out somewhere’. Elizabeth responds, ‘but we don’t know what the SIP team’s role is – we never sat and had a full discussion about the kind of support we need’. Helen asks if all the vol/com reps feel this? There’s no immediate answer, and I’m a little surprised at Elizabeth’s statement, as the group has had a number of planned opportunities for this discussion. Wilma says they’re clear they hadn’t *agreed* the content of the job description. Helen returns many times during the ensuing discussion to what she clearly sees as a point that needs clarification – the reps not being given enough time to consider the issues.

Nancy talks about the need for a good standard of appointment (she doesn’t agree with Margaret or Elizabeth on this issue.) Elizabeth says they haven’t had the opportunity to discuss this, that David Sinclair took the initiative to draft a job description and allocate the money, and that it would have been better if the reps had had the opportunity to discuss grades etc. Graham H then says, ‘I find it strange you’re saying you’ve never had an opportunity. It sounds as if you think you need permission to go away and talk’. Elizabeth says again, ‘we’re not clear what we can’t do’ and Margaret agrees - ‘we’re not clear about our role’. Elizabeth tells them about her hesitation to book the training event. Helen says ‘I’m disappointed that you feel this – that you’re not clear in your roles’ and that she thought they’d begun to develop this, from the discussions they’d had. Talking about the grade of the post, she says ‘if you’re looking for someone with experience of complex issues, you have to pay a decent salary. I think it’s the job description not the grade that we can change.’ She calls for a ‘reality check’ – talks of the danger of missing committee cycles and not having anyone in post until April. She speaks of the current market for people with such skills – says it’s hard to fill vacant posts. Says ‘there’s a need for a couple of us to get together with the community reps quickly’. Says, in terms of their 2/3 away days, ‘it’s crucial that some of us should be there – thrash out issues, roles, responsibilities, the way the partnership works – you need someone there’. Asks if maybe there’s a need for the whole partnership to go away? She tells them that they ‘can’t go and decide on things other partners may not agree with – this needs sorting, on an away-day or elsewhere, or we’ll get in a mess’.

The atmosphere during the exchanges between Chair and two of the reps is distinctly tense, with their interaction bordering on hostility. Margaret says, ‘I’m taking offence here’ (and she sounds it). ‘We go through papers for every meeting, so please don’t be ‘disappointed’. Maybe we do need a full day away to clarify our roles. I’m not clear in my role, and I’m not ashamed to say it’. Elizabeth thanks Margaret for supporting her – quite quietly, but perhaps she intends the others (who didn’t do so) to hear? Helen is clearly annoyed and the two representatives who have been doing most of the talking appear both defensive and cross. My notes don’t capture by any means all that is being said here. Graham H suggests using some of the money to get a consultant to bring the group up to speed. Wilma, however, says it’s not a problem that they’re all not clear about – ‘some of us are at different levels’. This seems to annoy Margaret, who asks ‘do all the others know their roles?’ Graham says yes. Fiona Sands (Scottish Enterprise representative) says the reps came on the board at different times and they’re making an important point.

Helen says, 'none of us are dead clear, we're making it up as we go along to a large extent'. Margaret says guidelines would be helpful. Helen says much the same debates were held in Dunloan SIP. Graham H says they've got a big opportunity to carve out their roles. Helen says it would be a big part of their support worker's job to put structures into place. Says that this isn't just the responsibility of the community reps – 'they're *our* structures as a partnership'. Stewart speaks up, says 'that's a problem – there's a "them and us" mentality. We don't quite realise we're a partnership'. Helen says that she's very clear that they are. Talks about money coming into the partnership for specific allocations which is 'not your or our money. All discussions about spend happens here – at the partnership'. Elizabeth asks, 'should we not have an input to how the money's spent?' Helen says, 'you should have an input into *all* decisions'. She says she thought this was all sorted out in June.

Wilma says they intended to do more training needs analysis at the away weekend. Nancy says they need team building, good training, and a good facilitator. Fiona says, 'if we're not clear about our roles, it's an issue for all of us'. Nancy checks that Helen thinks it'd be a good idea if someone from the SIP came to the weekend. Helen says yes, 'and we need an agenda'. She says she's concerned that the reps may be talking about things they don't know enough about, things that won't be connected to the SIP. She says she's worried about conflict and tensions building up in this way. Says they 'mustn't go off and talk about things that are factually wrong. I don't know your programme, but you could give a slot for someone to come along'. Elizabeth is talking to Margaret, saying 'this is about control'. If I can hear this, others must also be able to. Elizabeth says, 'we get asked what we're doing, on the ground' (i.e. by the community – and the reps feel they're doing nothing). Margaret says 'this training is about team building – you've done this and we haven't. Graham H responds, 'we haven't'. Fiona says there's a clear message of disagreement from the community reps about how the money's being spent in the SIP (certainly accurate). Helen says 'time is short, there's an offer on the table to give you factually correct stuff.' Suggests they get their facilitator to 'write down issues/a menu to work through'.

Nancy says she's worried about the danger of team building without tackling other issues. Elizabeth counters with, 'the two days are about issues we have with one another, not with the partnership'. Helen urges them to 'talk about real things' and to use 'SIP business' as the mainstay of their programme. Jim, who hasn't spoken at all up to now, says 'we still don't know why we're sitting here'. He talks about the danger of wasting money again on team building – says 'we need to take up the offer' (of Helen talking to them). Nancy agrees. Helen suggests they go away and talk about it, and agree on something. Nancy and Elizabeth are still discussing this when Helen moves onto the next item.
(Fieldnote extract, SIP Board meeting 8th November 2001, Committee Room 2, Riverbrae Council)

The rest of the meeting passed without incident so at the end, although I felt the timing was far from perfect, I took the opportunity to call their attention to the future dissemination of research findings based on my time with them. I warned them that they were highly identifiable as a group and that it might not be possible to maintain anonymity. They agreed with this, but did not view identification as a problem - they were well aware of the interest many other groups had in their work. I then pointed out that certain individuals within the SIP would also be identifiable and that the nature of my research involved describing and explaining processes and interactions

within the group, and that this might look very different to them when in hard print. They suggested that I follow whatever was considered '*best practice*' within the research community and seemed to trust, probably based on the friendly relationships built up over time, that I would not reveal anything too damaging. I asked Moira to give me a space in the SIP agenda at some time in the near future so that I could give the group some idea of how I would be speaking publicly about them to others. I remained concerned about adequately conveying to them the potential dangers of allowing a researcher such unrestricted and sustained access.

After the meeting ended I was interested to get the Chair's reactions to the earlier fraught episode so hung around whilst she and Moira spoke to departing partners. Helen then asked if I wanted to go through to her office '*for a chat*'. Moira and Graham were also present. I was unable to take notes during this gloomy post mortem of the meeting: this had to wait till afterwards. The good working relationship between the three SIP leaders was evident but the Chair was clearly somewhat downhearted, saying '*I'm fed up with constantly being seen as the enemy.*' I took the opportunity of giving them some feedback from the research perspective, telling them that I viewed them as the core of the partnership, influencing if not shaping all the major decisions. I said that this produced a trade-off between the efficient and rapid functioning of the SIP committee and the less desirable result of other participants feeling excluded. On reflection, this was an honest if hardly tactful contribution, given the context, but I believed they needed to hear this and detected no significant impact of such feedback, either positive or negative on this occasion or subsequently. However, on a more positive note, I also told them that the Chair's suggestion of a whole-SIP meeting would be useful, as I had observed that relationships appeared to improve on every occasion when the partners had time to talk to each other and debate issues.

Before I left, the secretary called the Chair away briefly, to speak to Nancy Robertson. When she returned she told us that the community representatives had decided to cancel their weekend and that there were obvious signs of disagreement within the group, but that they were planning another meeting for the following week and had asked her to attend. She appeared surprised and encouraged at evidence of accord from this perhaps least-expected source. On leaving I found the community representatives still sitting outside in the smoking area, engaged in vigorous debate, and I felt distinctly uncomfortable in being seen '*consorting with the enemy*'. Moira

asked me if I'd be '*around the next week*', from which I gathered that the SIP leaders would like me to attend the forthcoming meeting and of course I agreed.

8.3.5 Resignation, rescue strategies and restructuring

This section pursues the emerging processes of fragmentation amongst the community representatives' group and the rescue strategies implemented by the SIP Chair and her officers, aimed at reducing their disaffection from the rest of the SIP. During this period the Chair and Manager were also involved in a simultaneous process of planning the re-structuring of the three Riverbrae SIPs. This section covers two meetings between the SIP Chair and members of the community representatives' group, the SIP Board meetings of December, January and February and - briefly - the community representatives' separate working meetings with David Sinclair. It ends with an account of my withdrawal from the field.

8.3.5.1 Resignation and fragmentation

The first post-crisis meeting had been scheduled for Friday 17th November 2001 and I checked with Wilma, as secretary to the community representatives group, that they consented for me to attend. She foresaw no problem with this, as my presence at their meetings was well-established. She warned me that one representative would not be there, but preferred not to say who this was. The meeting was held in the committee room at her offices, as reasonably neutral territory. The representatives had agreed to meet in advance of the SIP Chair's arrival so that they could list the issues they wanted to discuss with her. In other words, they did not envision this as a passive event where they received '*factually correct stuff*'. My note-taking was sporadic during this event, both because I normally participated in informal meetings and because obvious recording would have felt - and been perceived as - insensitive behaviour. Nevertheless, I was able to capture a reasonable record of the event.

The meeting got off to a rocky start. Elizabeth was absent and Margaret said that this was because she had resigned. Wilma said Elizabeth was considering doing so. Margaret was clearly still angry about not being allowed their away day but others in the group countered this interpretation. She appeared to feel betrayed by the group's lack of support for their original decision not to include the other partners. Her colleagues responded that the last SIP meeting had raised issues for them that only Helen could deal with. Jim Cross appeared disenchanted with the group's internal

disagreements and with the apparent lack of influence of the representatives on the Board. He stated his intention to leave the meeting before Helen's arrival and Margaret followed suit. After considerable effort, Wilma eventually managed to persuade them to stay. Nancy commented that she often fought with Helen (she and Jim laughed at the undeniable truth of this) but that she'd always go back to the table and work with her. Both Nancy and Jim reminded others in the group that the SIP leaders had urged them to set up contact with and learn from community representatives on other SIPs, outside the annual SCVO forum but that they had never taken up the suggestion. Jim spoke of how conflict moved round the table, an apparent reference to the shifts in alliances and discord within the group over time.

They then turned to a lively discussion of the issues they wanted to raise with Helen, Wilma acting as facilitator and recorder. Their main points were: the contested job description; the issue of who controlled the SIP agenda; and the (un)equal nature of the partnership. On Helen's arrival, the atmosphere of the meeting became initially more formal but gradually thawed. She began by asking that their discussions remain confidential (I found this an effective deterrent to note-taking, which became even more cautious and sporadic). She explained the difficulties of her own role: '*wearing two hats - protecting public money and then sitting round the table as Mrs Partnership*'. She agreed that they as a group needed to meet separately from the other Partners but stressed that such meetings should be partnership-focused. They pointed out their bulleted discussion list on the flip chart and asked for her comments. With regard to the contested job description, she said that this was not a *fait accompli*, but a proposal put together by Moira and David, for submission to the Policy and Resources Committee, who had to approve all SIP expenditure decisions. Most of the group seemed to accept this interpretation. She said that an agenda was necessary for Partnership business meetings to function and that this was normally agreed between her and Moira '*at seven a.m. in the morning*'. She stressed that there were no meetings behind closed doors. Whilst she was trying to talk to the group she had to leave the room several times to answer urgent calls to her mobile phone from the Council's Chief Executive: this gave the group the opportunity to debate her comments.

8.3.5.2 Rescue strategies

Helen then proposed a '*simple, practical remedy*' for tackling the group's concerns and suggested that, until the Community Support Officer was appointed, David

Sinclair should work more closely with them in developing the job description, their own roles, and ways of communicating with the community. She urged them to involve her and Graham Hamilton in drawing up the job description because of their experience, and asked them to recognise when they needed to meet by themselves and when they needed to involve others. Margaret said, yet again, that the group needed to present a united front once they had made a decision. Helen responded, *'you need to agree as best you can, but you can't agree all the time'*. The group consented to her suggestions and the meeting seemed to end on a far more positive note, with a further meeting planned to continue their discussions.

I was invited to the next meeting by a letter from David Sinclair, in which he referred to it as an *'opportunity to put some of the past behind us and look to a fresh start for all'*. At this meeting I learned that Elizabeth had definitely resigned but relationships within the remaining group and between the group and the SIP officers seemed amicable enough. Helen said that the purpose of the meeting was to help the community representatives think through certain key questions: *'what kind of structures do you need locally to help you carry out your roles? How do you talk to and get feedback from local people?'* The various participants put forward a number of suggestions, such as a newsletter, a website, or a relatively permanent forum such as a community panel. Eventually, following a suggestion made by the Chair, they agreed that a series of local fun days, involving the whole partnership, would probably be most likely to trigger interest and participation from the community. However, Helen also remarked that such events would be unlikely to reach excluded people in the communities. It seemed to me that, as with much other SIP work, their practical working priority of raising the profile of the SIP amongst the wider community was hardly compatible with their broader aims of improving the lives of hard to reach/excluded individuals (who had, in any case, not been clearly defined). The group, however, appeared enthusiastic about their role in staging such events. Helen suggested that they use the process of organising the fun-days as a team-building exercise, and that they could be supported and assisted by David Sinclair.

They then moved onto the vexed topic of the job description. The Chair told them that experience and a good standard of education was essential for this post, and a university degree was also desirable. She asked them whether they felt that community health experience or knowledge was an essential feature of the post, but they said it was not - *'it's more about local issues'*. They agreed that the post holder

would be part of the SIP team and could work with David Sinclair, although Margaret said she was *'still struggling with the grade'*. Nancy, Wilma and Helen jointly attempted to justify this grade to her and she finally agreed.

8.3.5.3 Restructuring - and other matters

The sixth SIP Board meeting was held shortly after this, and Elizabeth's letter of resignation was on the agenda for discussion. This agenda was short as the meeting was partly a pre-Christmas social gathering and lunch. Few of the statutory sector partners attended but those who did were horrified to learn from one of their number that the risk-taking research report was already being widely disseminated *via* the Health Board. Worse, the research team was making copies available to anyone who wanted one at a cost of £10.00 each. It hardly needs saying that the standing of the research community reached a low point with the Board here. I felt, if not quite tarred by association with (to this group) apparently disreputable and unprofessional research behaviour, then certainly obliged to be especially vigilant around the ethics of disseminating my own work. The Chair suggested that they summon the individual responsible⁸ (or at least, the only one whom they could effectively hold to account) to the next Board meeting. Helen then updated the other partners on her meetings with the community representatives, and suggested that the conflict had arisen because of the representatives *'not understanding issues of accountability and responsibility'*. Though not a particularly tactful statement, this went unchallenged by those she was referring to. She went on to say that arrangements would be made for the management group to spend more time with the community representatives, and for that group to have a greater involvement with the SIP team. All agreed that this would help build relationships.

The agenda moved on to Moira's presentation of what she referred to as, *'the latest version of the development of the development of the Development Plan'*. As usual, members of the Board were asked by the Chair to read the document at their leisure and provide Moira with feedback. One of the issues raised in the Development Plan was the proposed restructuring of all the Riverbrae SIPs⁹. Although staffing in these organisations was particularly *'lean'* compared to other SIPs, some posts were

⁸ The public health physician who had formerly been a member of the SIP Board and who had been instrumental in commissioning the risk-taking research work.

⁹ The Chair's paper on SIP restructuring was to have been presented to the Board at the previous meeting, but she had taken it with her on holiday to Greece, where it had been stolen (obviously as part of other rather more attractive items).

duplicated - for example, the SIP Manager and various posts in the three SIP teams. The new, centralised structure would enable individual SIPs to retain their identities - and the role of community representatives would remain unaffected - but duplication of effort would be avoided and new, additional posts would be created. One partnership manager would oversee all the SIPs and the development staff, and Moira was free to apply if she wished. More operational staff were to be included, from departments such as Social Work, as the SIP had found it extremely difficult to influence this level of work. Helen told them that she would remain as Chair for a further year to provide some continuity and would then restrict her role to chairing the Dunloan SIP. Graham Hamilton would take over East Kirkland. Jim Cross asked how voluntary and community organisations would be supported under the new structure, and was told that the re-structured SIP team would have a post dedicated to levering in additional funding, and that this post-holder would assist such organisations in obtaining financial support. They discussed the possibility of getting a whole package of job descriptions drawn up and approved by the Policy and Resources Committee, then prominently advertised in the local and national press. Moira also told the group that '*a bigger funding pot*' would become available in 2003/2004, which would enable the SIP to '*move off just continued support for existing projects*'.

After lengthy discussions of the above issue, the Chair broached the subject of Elizabeth's resignation letter. She told the group that this was in two parts, the first of which set out four specific reasons for her resignation, and the second being a complaint about the SIP Chair herself. Helen confessed that she did not really know how best to deal with this (she certainly looked uncomfortable) and that had Graham Hamilton not been on leave she would have asked him to chair this meeting so that the Board could discuss the issue. She promised to circulate the letter and told the group that they could discuss the issue at the next SIP meeting, when she would be on leave. She asked Moira to write to Elizabeth, thanking her for contribution to the SIP and promising a fuller response to her letter once the issues had been discussed. The Board met again in early January, greeting each other sociably. A copy of Elizabeth McArdle's resignation letter had been sent to all participants with the agenda and papers for this meeting, which Graham Hamilton chaired. As he went through the Minutes of the last previous meeting, Margaret said that had not realised that Elizabeth's resignation had been accepted as

'we didn't spend a minute discussing it. I thought that when you read her resignation you wouldn't accept it, or maybe it would raise concerns so that you'd go into more detail about why she's resigned.'

Some seemed surprised by her objections and Graham asked, hesitantly what she meant: *'if she resigns, we can't refuse to accept it'*. Others agreed that discussion had been minimal and that the issues should be aired during this meeting. Firstly, though, they dealt with the perennial budget/funding situation. Before the discussion began, Moira asked Wilma and Nancy to leave the room (Jim Cross was absent for a family funeral) and the secretary tabled additional documents relating to funding proposals. One of the proposals was for additional funding for the SIP team, which prompted Margaret to ask, *'is this on top of the money we already give - fifty thousand to David etcetera?'* Moira said yes, and gave a technical explanation of the split of costings across posts. A further proposal was for the core costs of the two SIP projects (those represented by Jim and Nancy). Moira told participants that the joint plan submitted by the two projects, as requested by the SIP, had not covered all the required areas and further discussions were needed. Their applications for sessional costs had not been agreed (of these, the claim by Nancy's project was the larger of the two). However, the funding sub-group (of which Margaret Kinnaird was a member) had agreed on core costs (of these, the application from Jim's project was by far the larger of the two). The funding would now be conditional on their accepting an annual Service Level Agreement (SLA), with agreed targets. Graham asked the Board if they were happy to make a decision on this. Before this, however, Margaret asked that the whole committee made it clear to the representatives of these projects why there was so noticeable a difference between their funding. She says, *'alarm bells are already ringing'*, talking about Nancy's response to the document, though it was unclear how Nancy could have known about this.

The absent representatives returned to the room as the public health physician, Dr Cruickshank arrived. He had been summoned to explain to the Board how the risk-taking report had come to be disseminated without their approval - or to be *'rapped over the knuckles by Moira for hawking it round the streets'*, as he jovially put it. He described the background to this work and assured them that he had not been aware that they had not had the opportunity to consider it and that he had assumed they had received copies as soon as these became available. He had brought a single copy with him. He believed the work flagged up many issues that the SIP and Health Board had to respond to, and he had also drawn it to the attention of the Scottish

Executive. He praised the *'novel'* methodology¹⁰, which was similarly commended by community representatives present for its *'grass-roots'* approach. Nancy Robertson said, *'how many people round this table really know what those people's lives are like?'* Graham Hamilton responded, *'it's about having a job to do on children - resocialising people, trying to change their beliefs of what's right and what's wrong'*. His LHCC colleague added, *'we've a job to do on the parents as well'*. (This brief exchange perhaps best sums up the gulf between the perceptions of some community representatives and their health sector partners.) Dr Cruickshank said, more than once, *'we can't walk away from this - we have to be accountable.'* The LHCC representative agreed that this report would *'force organisations to work together'*. Graham Hamilton objected to the use of the word force (he invariably spoke of partnership work as freely and voluntarily undertaken) but she reiterated her belief that *'it's about forcing people to work together'*. Moira suggested a separate meeting be scheduled for March to *'look at the report and take it forward'*, and Dr Cruickshank departed.

They then came to the matter of Elizabeth's resignation, which Fiona Sands described as a *'crunch point for the Partnership'*. The four issues listed were: tokenism; lack of equality; lack of monitoring of agencies; and decisions being made before coming to the table. Graham admitted *'I don't know how to respond'*, and asked for the views of others present. A lengthy discussion of all the points followed, in which the statutory sector partners realised that at least one of the community representatives shared the perceptions outlined in the first part of the letter. The matter of the complaint against the Chair was discussed as a separate issue and it was finally agreed that Graham Hamilton would approach Elizabeth with a proposal for an informal meeting to discuss this. Gillian Stainton from the LHCC and Fiona Sands from Scottish Enterprise would also be involved.

Moira then told them that their third Working together/Learning together training event had been re-scheduled from late January, given the ongoing work on restructuring the SIP, to April, when it was hoped that additional members of the SIP Board would be in post. As the meeting ended, the representative of the Benefits Agency issued an invitation to the community representatives to visit the local job centres to find out what initiatives were currently taking place that related to SIP

¹⁰ Participant observation as a research method was established in the early 20th Century, largely by anthropologists, but may well still appear to be an unusual approach to contemporary health professionals more familiar with experimental and survey-based research.

work, and they agreed a date. I was talking to Fiona about the problems of partnership work when Margaret approached her and asked, in a whisper, what she should tell Nancy about the decisions relating to her project. Fiona responded, as the SIP Chair had done on a previous occasion, that this was not a secret, but they were unable to discuss the issue further as Nancy came over at that moment. Fiona shifted fluently into talking neutrally and Nancy and Margaret left the room together. Fiona then approached Moira to tell her what had just happened: I judged that she wanted this to be a private conversation, so I left them to it

8.5.3.4 Finding a role for the community representatives

Between this meeting and the February Board meeting that marked the end of my fieldwork, I also attended three fun day planning meetings between David Sinclair and the community representatives. I learned from some of the latter group that, although they had appreciated the SIP chair's frankness (and some of the group had accepted her explanations for their apparent difficulties), their attitudes to the Partnership and its leaders remained largely unchanged. One spoke of '*feeling involved and feeling used*', referring to participation in the funding sub-group. Another spoke of their dislike of being required to leave the partnership table whenever their project was under discussion:

'Don't say that ma project's rubbish behind ma back. Speak yer mind - say it tae ma face.'

The first fun-day meeting was largely taken up by some members of this group rehearsing a number of their grievances to David Sinclair, who suggested that they raise these issues with the SIP Manager. As the agenda for the meetings seemed in danger of being ignored, he suggested that they adopt a main group/sub-group structure. David, Nancy and Jim made up the sub-group, planning the family-oriented events and feeding back arrangements to their colleagues. Although an efficient way to work, this prevented the meetings becoming the '*team building exercise*' envisioned by the SIP Chair. Numerous activities were planned and organised in the sub-group, such as a bouncy castle, face-painting, hair-braiding, story-telling, a drama group and circus skills, as well as more obviously health-related activities, such as sports activities, fitness testing, making fruit 'smoothies', stress-relieving techniques, information about smoking cessation and other related projects in the areas. Although one senior health promotion specialist was available for advice and assistance, others in the local health promotion team were unable to

provide much help, as a surprising number were on extended sickness absence (due, I was told, to stress – ironically enough).

David told the sub-group that the SIP team had agreed on a budget of £3,000 for the three events. Nancy and Jim seemed astounded at this sum - both spoke of their experience of organising similar events for less than £200, and viewed this as evidence of *'how good the community sector can be'*. They debated where the first fun-day should be held. Nancy and Jim reported hearing from various members of the community that *'two projects are getting all the SIP money'* (i.e. their own areas). I reminded them that the neighbourhoods of St Colmes and Southmuir would probably still feel aggrieved at their exclusion, so the group agreed that the first event would take place there. The venue would be the two adjacent primary schools (one Catholic, one Protestant, not previously known for their interaction). The community representatives expressed some scepticism about the 'health' aspects of the event, with one saying:

'Aye, we're gonnae gie ye five pieces o' fruit, but ye can sit in yer house an' be terrified tae go out.'

Another also agreed that there would be community resistance to *'healthy eating messages'* from the SIP and said, *'just let people have fun and get away fae their problems fer aince'*. The group agreed that it was essential to listen to what the community itself identified as their problems. Between the SIP Chair's December meeting with the group and the February Board meeting, the purpose of the fun-days shifted subtly from being a partnership event to being seen as something of a showcase, enabling the community representatives to demonstrate their roles and involvement to their own constituency.

8.4 Leaving the field

The eighth SIP meeting was held on 28th February 2002 and was particularly sparsely attended, with only three community representatives and two statutory sector partners attending, not counting the Chair (Graham Hamilton on this occasion) and the SIP Manager. This was regrettable as I had been given a place on the agenda of this meeting for a research presentation to the Board, with the opportunity for feedback from them. The representative from the Scottish Executive whom I had first met at an IMG meeting over a year ago was also unexpectedly present. Her presence produced a more formal atmosphere and more subdued interactions than was usual

(and forced me to do a swift mental re-evaluation of whether my presentation might be received as overly critical). I provide below a brief description of the meeting, before giving an account of my presentation and the group's response. This was an opportunity to enable the group to reflect on a relative outsider's perspective on their partnership, and therefore an opportunity for further data generation.

Moira explained that Scottish Homes was now no longer a partner within the East Kirkland SIP and, in its restructured form of Communities Scotland, now managed all the SIPs across Scotland. She also told them that a new sub-group would be set up to consider and respond to the risk-taking research report, as the Board was '*not the place for this*'. After Moira had talked to the budget papers, the civil servant told the Board that only 75% of any under-spend would ever be returned by Communities Scotland: the remaining 25% would be retained as '*an incentive to spend the whole budget in future*'. Graham then told the group that despite having made a number of efforts to contact Elizabeth McArdle, she had not responded. Participants appeared to feel that they could do no more. Jim Cross then updated the Board on the planned fun-days.

When the time came for my feedback, I told them that my presentation had three purposes: to feed back to them my research findings; to indicate how I would be speaking about them to other groups; and to gain their responses to both of these issues. I told them that some of my findings might be unique to this SIP, but that some aspects of the research might be more generally applicable to other such partnerships. I summed up my research with the East Kirkland Partnership in terms of three main themes: participation, partisanship and power. I then briefly outlined the most well known explanations around inequalities in health, pointed out where I believed their aims and work fitted into these and some of the difficulties surrounding the various approaches, including theirs. I went on to explain that I saw the SIP as multi-sided and - perhaps inevitably - unequal and briefly outlined some of the different perspectives I had gathered from my observations and interaction with different members of the Board. I detailed how I would describe the fraught events of the election process for community representatives. I described the Partnership as: statutory service-centred; task-oriented; efficiency-focused; accountability-driven; and minimally discursive. I went on to outline the paradoxes described above, in the last section of Chapter Seven. Finally, I described what I saw as the risks of participation for community representatives.

Graham Hamilton commented that he felt '*reasonably comfortable*' with the approach I was taking, and that the SIP would only feel justified in intervening if my research produced findings that were inaccurate. He said that my perspectives and interpretations did not necessarily accord with that of others in the Partnership, but that he accepted this. He asked that my references to the election processes explicitly incorporate the SIP leaders' perspective that they were trying to counter the undemocratic actions of a small group: I promised to do so. My presentation prompted a number of reflections from other participants. Moira remarked on the '*schizophrenia*' of partnership that I had seemed to uncover - the '*tensions between inclusiveness and direction*'. One of the other statutory sector partners commented that she sometimes felt like a community representative and asked, '*where did that come from?*' She went on to say that agencies are '*staffed for traditional work*' but were now having to '*do joined up stuff and multiple group involvement*'. Moira said that the problems they experienced were '*not a matter of willingness, but a matter of capacity*'. She remarked that the Primary Care Trust, Scottish Enterprise and Scottish Homes had all undergone restructuring processes over the time of the research. Graham emphasised that, although I had used the term '*agency*' throughout the presentation, these were in fact not a homogeneous group: differences of structure and culture existed. I agreed that this was more of a convenient shorthand term for a large group than an accurate description, but told the group that this was the word that all members of the Board invariably used to describe the various different partners from the statutory sector agencies round the table.

The most obvious gap in feedback was any substantial comment from the community representatives group. Two had been unable to stay for the end of the meeting, leaving before my presentation was over, and the remaining member made no response other than that it was '*very interesting*' - almost the last thing any researcher wants to hear when seeking critical feedback. This aspect of the event was therefore less than satisfactory. Finally, the Chair asked for sight of any papers prior to future publication, to which I readily agreed. He suggested that I return in a year's time as the situation would by then undoubtedly have improved as a result of the current restructuring processes. Whether the latter point is an accurate forecast or not I left the Partnership with a strong sense of regret for unfinished business, as they were embarking on yet another stage of development that I would gladly have stayed to trace.

8.5 The Risks of Participation

'We venture to generalise that one of the most prominent themes of recent social science is that all people in advantaged social categories are bad guys and all people in disadvantaged ones are good guys' (Lofland and Lofland 1995 p172)

Although Lofland and Lofland may be over-generalising and over-simplifying here, there is nevertheless a well-established and understandable (but not universal) tendency in social science research towards championing 'the underdog', given that such research often focuses on disadvantaged rather than elite social groups. The East Kirkland SIP arguably brings representatives of both groups together (albeit not from the extreme ends of the social hierarchy). As I hope to have shown in this ethnographic account, neither group can simply be assigned to the fixed categories of good guy or bad guy. We have instead a picture of complex, shifting social relationships, oscillating between co-operation and conflict depending on context. There seems little reason to believe that the relationships depicted here are unique to one Partnership, and it may be that such micro-level processes are to be found elsewhere, particularly in the case of forced partnerships with relatively clear factions. This final section of the chapter turns to analysis of a previously neglected aspect: the different (unequal) risks of partnership work experienced by different types of partners.

8.5.1 Exploring the unequal risks of participation

Inequality within the partnership was a recurrent theme during my research. This section turns to the issue of the unequal risks of partnership work for the two groups of leaders and community representatives. This is not meant to imply that participation for other types of partners is risk-free. Partners representing the statutory sector services ran the clear risk of being perceived as passive and disinterested, whereas their own interpretations of this - as illustrated above - are rather different. However, my research suggests that the most marked risks of participation are experienced by those responsible for representing the community, and those in leadership roles. It may be that such risks are mainly confined to *'forced partnerships'*, where involvement is both voluntary (in that participants believe in the inherent value of partnership work) *and* coerced (in that participation is required by organisational or national policy makers).

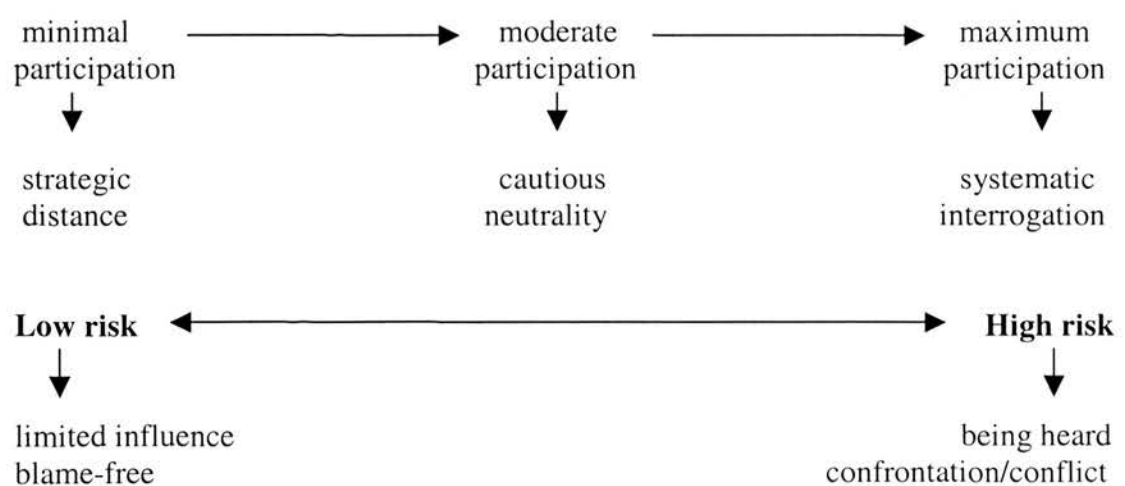
8.5.1.1 Participation and risk for community representatives

I find it difficult to control myself in the meetin's. I try, but it's hard to be positive an' civil. I look at these people an' I think, "they don't know an' don't care what's happenin' in the community." An' I lose it! (Community Representative)

I have conceptualised the relationship between different degrees of involvement and participation by the community representatives in terms of different types of risk. I do not suggest that the community representatives on the East Kirklands SIP adopted the positions outlined below as a matter of conscious choice on every occasion, nor that such positions once taken are permanent. On the contrary, it seemed to me that they shifted between different stances, varying between neutrality and engagement, depending on context and on how important to them the particular issue under discussion. In *Figure 4* below I suggest that minimal participation is consistent with a position of maintaining a strategic distance from other partners and from active involvement in decision-making. Moderate participation seems compatible with cautious neutrality towards other partners. The desire for maximum participation seems to be accompanied by a strategy of systematic interrogation of fellow participants and the bases for the decisions they make. Whilst the first of these positions seems to be low risk, in that adopting such a strategy implies limited influence but also limited accountability (or blame), seeking maximum participation seems to a high-risk strategy, enabling one's voice to be heard but involving the danger of encountering damaging confrontation, even conflict. Moreover, dealing with confrontation may require political skills of diplomacy that are not always valued by representatives of this sector, who prefer to speak their minds and expect the same of other partners.

Figure 4

Participation and risk for community representatives



'Losing it' can be particularly risky. From the perspective of my research findings, it seems that if the outcome of such confrontation is unsuccessful, the community representative may experience not just shame and loss of face but also loss of perceived authenticity as a member of the group with a legitimate right to be heard. However, within partnerships that have discernible factions, maximum engagement *without* conflict may mean that community-based participants run an increased risk of being accused of divided loyalties and thus betrayal of their own group's interests.

8.5.1.2 Becoming 'the enemy'

Thank God, at some time in the future I'll either be in a different job - or dead!
(SIP Chair, SIP Board meeting, Riverbrae Council Offices, 20.12.01)

There are obviously good reasons for focusing on the dangers of participation for community and voluntary sector representatives, who occupy the difficult middle ground between the larger service providers and the community. However, my research suggests that there are also costs associated with being in the position of leading such partnerships, both personal and political, which should not be ignored. In their capacity as well-paid, influential officials of a major public sector service-providing agency it may be that their particular plight attracts little sympathy, in comparison with the very different positions of their colleagues in the community and voluntary sectors. Nevertheless, we should bear in mind that those in advantaged positions cannot always be simply consigned to such categories as '*power-crazed barmpots*' (to use the colourful phrase employed by one participant).

The Chair, unofficial vice-Chair and Manager believed that they bore an unequal burden of work within the Partnership. From the perspective of their partners, this was interpreted as the desire to remain in control of direction and resources. The SIP Chair had spoken of her experience of incompatibility between professional accountability for spending public money and '*playing Mrs Partnership*' and, later, of being tired of being seen as the enemy. From the perspective of the community representatives, as a senior officer in the Council she and the Manager simply exercised too much power. In all the discussions of the community representatives above, those at the centre of the SIP, and particularly the Chair, ran the risk of being demonised as representatives of powerful and sometimes unpopular organisations.

In summary, this chapter has emphasised the essential separateness of the core players within the SIP and the differentially successful strategies of these social world members to gain epistemic authority and to obtain/maintain control of resources. I have also illustrated the potential for marginalisation and experienced non-authenticity amongst those with least power and influence in this arena and, conversely, that although the literature on partnership working invariably states that strong leadership is needed, the wielding of such power and influence is not without penalty.

PART V

CHAPTER NINE

DISCUSSION AND CONCLUSIONS

'Although the words may have changed over the past 20 years, the rhetoric remains the same: whether in health services, social policy or urban renewal, working together is a good thing. It will produce more efficient, effective and appropriate responses to individual and population need – or so we are told.' (Popay and Williams 1998 p410)

9.1 Introduction

The aim of the East Kirkland Social Inclusion Partnership was to reduce local health inequalities (i.e. in comparison with the rest of Riverbrae and Scotland) in ten deprived communities by using a broadly conceptualised health promotion approach. No other in-depth study of this type of SIP has as yet been conducted. The East Kirkland SIP is currently less than three years old, rendering it hazardous for anyone to predict the degree of health improvement or positive impact on the lives of people living in its disadvantaged communities that may result from its activities. I withdrew from this field after its traumatic earliest phases, at a time when the SIP was about to re-organise and develop further. Conclusions based on this restricted period of fieldwork should therefore be regarded with some caution. Whilst in the central chapters of this thesis other voices were heard, in this chapter, the authorial voice is foregrounded in drawing together interpretations of the data and mounting arguments for what this study might mean. The discussion in this chapter is not intended to be politically neutral, but strives for an essentially even-handed critique, one that has been developed over the course of the whole studentship through the reflexive process of reflecting on the multiple relevant literatures and my own empirical work. This leads me to echo Popay's and Williams' cautious scepticism about the presumed benefits of working together in tackling the deep-seated problems resulting from profound social inequality: my research findings lead to some rather pessimistic conclusions. Building on a critical but inevitably partial literature review, I have argued that the relationship between health promotion (broadly conceptualised) and health and social policy, with regard to health inequalities and social exclusion, is one of increasing convergence. Both health promotion and contemporary policies focus on the principles of localised action, multi-sectoral partnership working and

community engagement as appropriate ways of tackling such problems. These themes were exemplified and problematised in my empirical study of a community-based health partnership, the findings from which confirm many found in the broader literature. The first of the following sections briefly summarise the disparate literatures that provided the theoretical framework for the empirical work. I then review my own research procedures, the processes of fieldwork and analysis, and the ontological and epistemological claims made for this work. Final sections consider the relevance of and contribution made by the research to the fields of health promotion, medical sociology and to the broader policy context.

9.1.1 Summarising the literature(s)

The literature review in Part II provided the ground for a critical understanding of the fields relevant to the case study elaborated in Part IV of this thesis. In reviewing the extensive but incomplete and potentially competing forms of knowledge and evidence that constitute the multi-disciplinary research field of health inequalities, I concluded that whilst most explanations and proposed solutions discussed recognise the role of broader social inequalities, their focus for action differs, reflecting the political and politicised nature of the field. Whether the different types of explanation are viewed as conflicting or complementary, I suggest that the diversity of this field provides policy makers with considerable room for political manoeuvre in deciding on remedial action. The concept of discourse was introduced as a way of understanding the linkages in the contemporary policy agenda between explanations for health inequalities and social exclusion, and of exploring the discursive shifts that invoke contradictory responses (Levitas 1998, Hastings 1998). I argued that the relationship between social structure and human agency still remains poorly understood: in much epidemiological research, agency is presented as determined by structure; in policy documents, as overly voluntaristic. I suggested that, whilst the impact of poverty and deprivation on health is widely accepted (even if the mechanisms by which these operate remain incompletely understood), a degree of personal responsibility for poor health is never discounted.

I then argued that health promotion, when conceptualised as both process and activity, has escaped disciplinary boundaries. As a process, on the one hand, it provides a relatively new form of social regulation and governance through surveillance (O'Brien 1997, Nettleton and Bunton 1999). The surveillance critique of health promotion argues that the intersection of social and cultural pressures around

actual or potential health and illness leads to a situation whereby people come to feel responsible for their own health status (Fitzpatrick 2001). In the name of health promotion, economic and political interests and priorities become embedded in the regulation of multiple aspects of people's lives (O'Brien 1997 p253). On the other hand, as an activity, health promotion provides an elastic canopy capable of incorporating diverse social/political values, organisations and practitioners. Health promotion's flexible and polysemic nature thus has particular utility for public health and social welfare policy makers, but contains marked tensions for practitioners, incorporating as it does both radical *and* conservative biases. I drew attention to the near-ubiquitous emphasis in contemporary policy on partnership working and community engagement as a response to the problems of poor health and social exclusion - an emphasis shared by health promotion. The participatory and partnership turn is subject to both praise and extensive critique by researchers in the field, whose work finds both positive and negative aspects. This diverse literature base thus provided the conceptual foundations for my empirical work, which found an appropriate focus in the East Kirkland Social Inclusion Partnership. This selection of the case led to an expansion of the relevant literatures in order to incorporate the concept and practice of regeneration, outlined below as a dominant influence on government policy and practice around poverty and poor health.

9.2 Evaluating the Ethnographic Approach

In considering ways in which qualitative research can be 'written up better', Wolcott argues that the case study is best regarded as the preferred form of reporting participant observation, rather than as a strategy for conducting research (Wolcott 2002). He also suggests that, as a label, case study is woefully inadequate if used without further explanation of research thinking and process. Whether one agrees with his first point or not (and I think it debateable), the second point is surely unexceptionable. I chose the East Kirkland SIP primarily as an instrumental case but one that also contained elements of strong intrinsic interest (Stake 1994). I explained the appropriateness of utilising an ethnographic approach to this case, principally in terms of its capacity to capture micro-level social interaction and processes and interweave these with participant accounts, thus providing firmly grounded data from multiple perspectives (Lofland and Lofland 1995). My choice of ethnographic method underscores both the everyday nature of the data and the everyday nature of the ways in which such data were collected and made accessible *via* this thesis. As Wolcott argues, '*it is impossible to shroud in mystery or esoteric explanation an*

approach that can be encapsulated by the term participant observation' (Wolcott 2002 p102). I highlighted the inseparability of data generation and analytical procedures (Hammersley and Atkinson 1993) and noted the tensions between ethnography as sole-authored product and ethnography as process, which involves the reflexive complicity of researcher and researched (Marcus 2001). I discussed the ethical and political problems of researching a potentially identifiable case, particularly the troubling issue of balancing anonymity and confidentiality with research integrity (Punch 1994). I outlined the analytical procedures undertaken, including the key process of creating the text from the field (Denzin 1994, Hammersley 1998, Silverman 1997, 2000).

9.2.1 Research process/data status

Studying an organisation that takes the form of a committee provides ample opportunity for observing and recording utterances and behaviour, and the subtleties of human reaction and interaction encapsulated in the term body language. Over a period of some seventeen months data were generated through periods of (variable) participant observation, interviews and shorter conversations. These were integrated in a process of reflexive analysis and represented as a temporally situated narrative account. In the methodological section of this thesis I depicted my own epistemological position as one of subtle realism, recognising that this approach provides no easy answers to ontological questions but eschews the political perils of extreme relativism (Hammersley 1998). I take my interview data to be accounts provided by social actors, knowledgeable in their different fields and speaking from specific contexts of professional and biographical experience. This approach pays serious attention to the lived experience of research participants and their constructions of the world, without assuming that such data must be taken at face value. From this perspective, these interview data are the interpretative, negotiated product of situated accounts, rather than embodying unmediated access to an unproblematic and singular reality (Hammersley 1998). However, whilst it would be naïve to view data generated in this way as representative in a generalised sense (e.g. claiming that what one community activist says reflects the experience of all others - and there are epistemological problems in assuming that accounts automatically give access to experience [Silverman 2000]), there are continuities between themes arising from my interview data, common sense views of the world and the wider bodies of relevant research literature. We are surely not surprised to learn of the impact of national-level policy on public sector organisational structure and function,

or that territorial claims arise between public and voluntary sector in the context of politicised partnership work. There is a sense then that such data do refer to a shared reality beyond that constructed through the interaction of researcher and respondent.

The generation of data based on participant observation is less obviously a joint construct: the particular interests of the researcher provide the main framework and focus (Peacock 1992). Even the most detailed ethnography thus results in only a partial account: partly because one researcher is unable to capture any social phenomenon in its entirety, and partly because purposeful selection from the myriad of potential detail is essential if the account is to be intelligible to anyone other than the researcher (Clifford and Marcus 1986). There are gaps in the data as a consequence both of the existing boundaries of the case and those I established. With regard to the former, for example, it is evident that much SIP work was conducted by the core leadership group away from the table (if not quite in the sense of behind closed doors that I originally suspected). Key participants routinely encountered each other in quite different fora not accessible to me – in other committees such as the local Child Care Partnership, or in local Labour Party meetings, for example. It has therefore not been possible to provide a complete representation of the complexity and interwoven nature of local organisations and personal/professional relationships. Other boundaries were of my own choosing, in the interests of maintaining the manageability of the data and ensuring a focus for the research. An equally important boundary is that of deciding what to include in the formal process of writing up the work, not least given the word limit regulation of thesis production (and notwithstanding the extension to this granted by the University). Inevitably, some things have to be omitted that ideally should have been included. For example, I have only made brief reference to the large number of health promoting initiatives funded by the SIP, rather than describe these in detail. Nor have I presented a detailed analysis of the proportion of the funding allocated to the statutory sector and how this compared with that granted to the voluntary/community sectors (roughly 2:1), although this was a matter of great concern to the representatives of the latter groups.

9.2.2 The question of generalisability

The question of how one may generalise from the single case study needs to be addressed (Denscombe 1998). Case study is not an exclusively comparative method: some researcher-practitioners argue that comparison may fix attention upon the few

attributes being compared and obscure other knowledge about the case (Stake 1994). From this perspective, comparison is the opposite of thick description and generalisations from differences between any two (or more) cases are much less to be trusted than generalisations from one. Yet the comparative method involves more than the simple comparison of attributes between cases (Glaser and Strauss 1967). My ethnographic account of the East Kirkland SIP contains multiple, implicit, internal comparisons – for example, in specifying and elaborating the different perspectives and degrees of power and influence of the different types of participants and how these shifted (or failed to) over time. This suggests that thick description and comparison are not mutually exclusive and can be used in complementary ways.

Although a single case is in some respects unique, it is also an example of a broader class of things (Denscombe 1998). We may be able to generalise findings from the case study to other examples in its class, depending on how similar the case study is to others of its type. Although the configuration of the East Kirkland SIP is unique in some respects – particularly in its primary focus on health inequality - some of the themes that emerged were found in other contexts. For example, community representatives' perceptions of exclusion and concerns about accountability in this relatively new SIP were also articulated by their more experienced fellows at both the Big Issue conference on community-based responses to SIPs¹¹, and during the multi-SIP Working together/Learning together events¹². Conversely, the experience of officers in other SIPs of interference and hostility from elected members was far less of an issue in East Kirkland. Although the broader findings of this case are not dissimilar to the problems identified in, for example, much of the literature on health/regeneration partnerships, such literature tends to operate at a level of generality (e.g. Scottish Executive Central Research Unit 2001, Kings Fund 2001). Multiple cases certainly have much to offer, but more is not necessarily better. The specificity of the single case approach enables the recording and analysis of micro-level social processes scarcely obtainable via any other research method. It is in such minutiae that the substantial difficulties of implementing current health and social policies at the local level become apparent.

In addition to straightforward comparison, case studies can also be used for theoretical generalisation, enabling the transferability of understanding (Denzin 1994). Stake argues that case study is a particularly useful research tool because of

¹¹ May 2000 conference in Glasgow.

¹² December 2000 and June 2001.

its capacity to provide concrete and contextualised illustrations of how groups or organisations understand and seek to implement otherwise abstract theoretical and/or policy concepts (Stake 1994). A key function of the case study is therefore its role in informing/applying interventions because of its capacity to extend the experience of both practitioners and policy makers. The contribution of this case study lies in its critical description and explanation of a particular form of partnership for health, highlighting the paradoxes involved in tackling complex social problems within a technical-rational policy framework that emphasises agency at the expense of structure, obscures dissent, and neglects the role played by the meanings that participants bring to the partnership table. My account highlights the different experiences, understandings and meanings of such participants and sets these within a local context of industrial and economic decline, hard-pressed public services, sustained under-investment in voluntary and community sector organisations, and sectarian, territorial and other divisions within 'dangerous' neighbourhoods. The East Kirkland SIP is just one of many Government-funded partnerships between statutory public sector agencies and representatives of the community across Scotland: however, the town of Kirklands is not unique within Scotland and may have much in common with similar communities in other parts of Britain.

9.2.3 Summary: harsh light, soft focus

Ethnographic research is never a neutral process providing unmediated access to a social world (Marcus and Fischer 1986). An author stands behind every text, and the actively constructive role of the researcher/author in creating such a text is foregrounded when using this approach (Rosaldo 1994, Richardson 1994, Moring 2001). As Peacock explains, anthropologists strive to use the seemingly opposed ways of perceiving summed up in the phrase 'harsh light/soft focus', simultaneously endeavouring to capture foreground, background and self within the research process and context (Peacock 1992). Trying to capture so wide a field necessarily sacrifices some precision of focus for breadth of vision (Whyte 1991). In reporting my empirical work I have tried to incorporate sufficient ethnographic data to enable an audience to evaluate the bases on which analytical statements and ontological claims are made. I have striven to achieve an adequate balance between personal engagement and analytical distance, between representing multiple voices/perspectives and maintaining a coherent authorial narrative, and between data presentation and analytical elaboration (Lofland and Lofland 1995). I believe the result is an enlightening and relevant account of complex social processes, embedded

in their local context but relevant to the broader policy context and to a number of different disciplines and sectors. Nevertheless, a difference of focus (or of researcher) could have produced a different story: the 'truth' status of this account should therefore be considered contingent - different interpretations are possible. As Wolcott reminds us, readers of qualitative research work need to be reasonably confident that the researcher is secure in her/his perspective, that the choice of perspective is reasonable and reasoned, and suited to the researcher's purpose and talents (Wolcott 2002). I suggest that this work builds on and extends our understanding of the difficulties of achieving community participation in health promotion, the complexities of partnership processes in particular socio-economic and cultural contexts, and of how health promotion and government policy are interpreted and contested by different vested interests, all of which shapes implementation at the local level. Although neither evaluation nor action-research oriented, I believe that this case study report contributes to the inter-disciplinary science of health inequalities called for by Graham (Graham 2001), in presenting an informed, grounded critique of government policy and health promotion theory and practice in addressing health inequalities.

9.3 Reviewing the Findings

This study does not fall readily under the rubric of any one discipline or theoretical perspective and the narrative, context-bound and highly specific detail provided by the ethnographic approach hinders easy placement of this type of empirical work within any one body of literature. This means that in reviewing some of the key findings, reference to a broader framework is required, particularly that constituted by contemporary health and social policy. The first part of this section sets out this context and is followed by a critique of the partnership approaches developed within this, focusing on the example of the East Kirkland SIP.

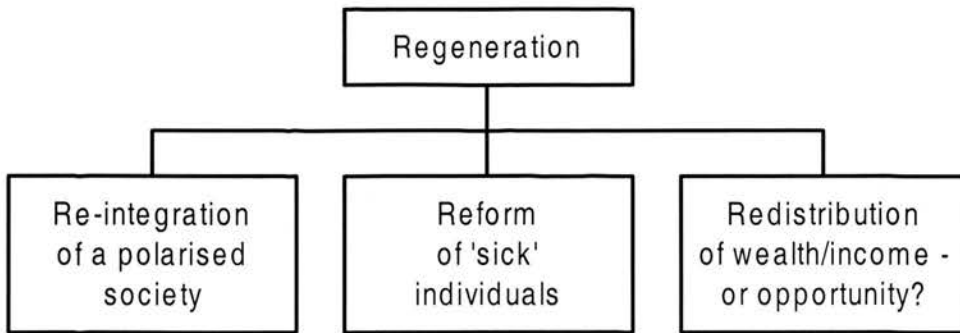
9.3.1 Regenerating communities, re-integrating society and reforming individuals

Forbes has claimed that health inequalities constitute a controversial and unstructured policy problem (Forbes 2000). 'Controversial', because conflicts of values as well as facts are interwoven in debates around the problem. 'Unstructured', because the boundaries of the problem are diffuse and hardly separable from other, related problems, leading to different types of causal explanations and proposals for

solution. There is also uncertainty as to which specialisms or disciplines should be involved. Forbes suggests that policy problems with unstructured characteristics are unlikely to be amenable to technical problem-solving methods or economic reasoning, although such processes arguably dominate current social policy (Forbes 2000). This poses particular challenges for policy makers working within the technical-rational framework suggested by policy documents such as the Scottish White Paper on public health (Scottish Office Department of Health 1998). Although the causes of poor health are admitted in government policy documents to be largely beyond the control of the NHS, the causes of poverty and social exclusion are *not* deemed to be beyond the influence of local government and communities (Scottish Executive 1999a and 2002b). Across the UK, contemporary policy initiatives involve two key aspects: provision of equality of opportunity for individuals; and regeneration/renewal of ‘bad’ areas, communities or neighbourhoods. National and local attempts to reduce inequalities in health are thus shaped by discourses in which attention is directed downward to the problems of (potentially) sick individuals and (allegedly) sick communities.

I drew on Levitas’s discourse model of RED, SID and MUD in earlier chapters of this thesis to explore the strong policy links being made between social exclusion and health inequalities. This framework needs amending to take into account the current policy emphasis on neighbourhood regeneration (which always involves partnership working) as an effective way of tackling the problems of poor health and poor communities (Lund 1999, Social Exclusion Unit 2001, Scottish Executive 2002a). I suggest that the discursive framework outlined in *Figure 5* below can be applied to contemporary policy makers’ concerns for joined-up health and social policy. Under an overarching discourse of the need for regeneration of ‘bad’ areas are subsumed the lesser discourses of redistribution of resources, re-integration of ‘excluded’ elements into society, and reform of those who espouse ‘unhealthy’, workless or criminal lifestyles. These discourses are not of solely linguistic interest as they exert material effects: discourses both construct problems in particular ways and provide the bounded horizons for their solution via specific initiatives. Discourse thus invokes practice in a way that the term ideology does not. Social Inclusion Partnerships are a useful exemplar of discursive practices around regeneration, re-integration and reform.

Figure 5
Health and social policy discourses



Despite the occasional use of the ‘once banned r-word’ (redistribution) by the current Prime Minister, a number of commentators argue that redistribution of income and other resources in society has been minor and conducted by stealth under the new administration, in order to avoid causing alarm to certain sections within the voting population (White 2002). Redistribution as we now know it involves providing for equality of opportunity, not outcome (Walker 2000). This more modest aim has recently been conceptualised in arguably even more conservative terms in Scotland as ‘closing the opportunity gap’, where the Executive argue that ‘promoting more sustainable and healthier lifestyles’ is the appropriate solution to health inequalities:

‘The most disadvantaged in Scotland’s communities are those with the most unhealthy lifestyles and the poorest health, hampering their efforts to improve their own situation.’ (Scottish Executive 2002a p4)

Redistribution of wealth/income thus seems to have been relegated to the status of a scarcely relevant concept in contemporary policy, in marked contrast with the evangelical fervour that accompanies regeneration – a concept which, as Furbey points out, is also a powerful, semi-spiritual metaphor signifying rebirth and renewal (Furbey 2001). Regeneration interventions require joined-up policies at the local level, simultaneously tackling issues such as health promotion and poor employment, education and transport services. Regeneration is invariably characterised by area- and partnership-based interventions. Although such partnerships seek consensus and a shared vision, it has been suggested that they are fed by conflicting ideologies: collectivist ideals of empowered and reborn communities versus individualist ideals of self-actualisation and active citizenship (Furbey 2001). There is a strong

association between regeneration and broader contemporary concerns with individual transformation and improvement, conceptualised in *Figure 5* as the reform of individuals. Notable amongst those included in area-based regeneration initiatives are the objects of the New Deal and Welfare to Work strategies – young people, long-term unemployed people, lone parents, and people on incapacity benefit. We may conceptualise such groups as excluded, or, alternatively, as stigmatised under current neo-liberal welfare policy regimes. Regeneration policies are connected to government's wider welfare strategies, including the moral regeneration and reform of the poor and unfit.

Although many writers in the field of health inequalities have welcomed the prioritisation of this topic under New Labour, social policy writers have tended to be far more critical of the Third Way, with some arguing that the welfare state is being undermined and steadily replaced by an encroaching discourse of the workfare state (Lund 1999, Scambler 2002, Stepney *et al* 1999). Re-integration of 'the excluded' into the social body and the body politic is to be achieved through the acceptance of rights-with-responsibilities (Giddens 1998), disciplinary strategies of compulsion to work, restricted entitlement to welfare benefits and self-governance in terms of moderation of lifestyle. As Scambler has argued, structural/material factors are thus being individualised in current government thinking: there is a functional equivalence of neo-liberalism and the pejorative logic that accompanies some contemporary Third Way politics (Scambler 2002 p108). Despite being at the beginning of a new century, critical sociologists like Scambler suggest that we are instead returning to Victorian values of worth (Holden 1999). The new regeneration aims to tackle not just the degradation of the built environment, but to achieve the reform and reclamation of people and the reintegration of a now fragmented, polarised society. The connections between low social status, worklessness, criminality and the experience of poor health are being made increasingly explicit. Current thinking appears to be that whilst ill health may not spill over from the poorest to the wealthier, criminality and other forms of social disorder might (Wainwright 1996): the reintegration of society and the reform of individuals are therefore high policy priorities. This policy critique provides a framework against which to set my research within the East Kirkland SIP, and the critical conclusions this leads me to draw.

9.3.2 Partnership approaches to health inequalities/social exclusion

In Scotland, in accordance with the modernisation agenda of both Westminster and Holyrood governments and the emphasis on joined-up thinking/working, Health Boards and Local Authorities are obliged to collaborate more closely together than ever before. However, policy imperatives still differ: for Health Boards there is the requirement to construct a local Health Improvement Plan addressing public health amongst other needs: for Local Authorities, the Social Justice agenda dominates. This aims to deliver change through such mechanisms as Social Inclusion Partnerships and Community Planning. Local Authority-led, the aims of SIPs differ from the traditional regeneration focus on the built environment by focusing on people rather than places – the new regeneration. This is the case whether they are area-based or thematic: the main focus is on communities, groups and individuals presumed excluded from the wider society. The literature suggests that the agenda for change in ostensibly community-led projects may be determined to a considerable extent by these larger agencies through the initial process of bidding for funding from central government, in accordance with government-determined guidelines (e.g. Mayo and Taylor 2001). The East Kirkland SIP's origins confirm this argument, but arguably reflect the pressures on large public sector agencies to respond *rapidly* to policy initiatives in order to lever in additional funding for areas perceived as particularly deprived.

Consulting with and involving local communities is mandatory for the key public sector agencies of health services and local government, and the source of a burgeoning body of literature. However, though agencies may be criticised for any delay in public participation, as this case study amply demonstrates, gaining community participation or representation is an inherently complex, convoluted and contestable process. Rooted in the rhetoric of community participation/development, the pragmatic reality in the East Kirkland SIP was nevertheless that of expert-led prescription – a finding consonant with much of the critical literature on community involvement in health (e.g. Crawshaw *et al* 2003, Jewkes and Murcott 1996). This suggests that strategic partnerships lacking expertise in bottom-up types of community development and the empowering aspects of health promotion may face serious difficulties in facilitating genuine, rather than tokenistic, community engagement. Given the scale of the SIP's aims and the size of the population covered, it is difficult to see how anything other than partial engagement – in terms of representation - could have been achieved. The SIP did not seem to lack a strategic approach to community participation (a shortcoming frequently suggested

in the literature): rather, participants became engaged in divisive, and perhaps ultimately irresolvable, contests for legitimacy. Although some values and goals were shared (such as the desire to improve public services for the community), mutual respect seemed elusive and the profound differences in worldview displayed by different types of participant unlikely to be readily solvable.

9.3.2.1 The meanings of health inequality

Although intellectual argument is in the very nature of academic work, this is not the case for grass-roots level, multi-sectoral organisations: the work of the SIP was remote from the complex field of research debates on health inequalities. With hindsight, my initial surprise at the comparative absence of ‘talking about health inequalities’ in the committee meetings may be judged naïve. During the course of fieldwork it became apparent that spending the money was the real business of this, and perhaps many other such, partnership(s). Having gained access to government funding, the question becomes that of how best to spend it – an issue understandably subject to contested claims (Taylor 2000). Talking about health inequalities largely took place in time out sessions, but was still a relatively marginal issue. Yet it is clearly important for both policy makers and disciplines such as health promotion to understand how members of such Partnerships, in the absence of sustained specialist health promotion input, conceptualise health inequalities. There was certainly some awareness of the main findings of health inequalities research within the SIP, most obviously articulated by the health representatives but also shared by the local authority representatives. Community representatives too, were aware of the Scottish reputation for poor diet, over-indulgence in alcohol and under-indulgence in exercise, area differences in mortality, Glasgow’s unenviable reputation as the ‘heart disease capital’ of the developed world, and the links between poverty/deprivation and smoking. It was noticeable that members of the SIP *as a group* spent relatively little time talking about health inequality to the exclusion of other issues, even during dedicated discussion time. When they did focus on the problem they tended to emphasise personal responsibility for health, without discounting the probable impact of social disadvantage. In the debates of the whole SIP, a range of understandings were apparent, including both medical and social approaches to health promotion, utilising apparently incompatible discourses of social *and* individualised responsibility – thus arguably mirroring some of the debates found in research and policy (e.g. Blaxter 1997). There were clear indications of tensions

between the emphasis on lifestyle choices and the acknowledgement of the structural determinants of health articulated by all partners.

The main health promotion representative spoke in terms of individualised responsibility for behavioural change, drawing on identifiably middle-class occupational values. The latter approach has been categorised by Seedhouse (1997) as a form of good life promotion i.e. an explicitly value-driven discourse wherein influential groups seek hegemony of their own conceptualisations of what constitutes a good life. The individualistic and medicalised formulation of health inequalities utilised by some of the health representatives went largely unchallenged in public fora by the community representatives, although those whom I had interviewed had utilised more 'social' explanations for health inequalities. It may be that individualised explanations for poorer health are intrinsically harder to dispute because of the wealth of evidence available, evidence that community representatives themselves had referred to at interview. A reform-orientated, individualised discourse of taking personal responsibility for risk was also articulated in whole-SIP meetings, where it was suggested that people should be educated to understand the impact of their (bad) behaviour on others in the community, and on the health services. Given the knowledge within the entire group about the degree of poverty and deprivation experienced by the communities of East Kirkland, a paradoxical degree of censure towards irresponsible attitudes and behaviour pervaded some of their discussions. Pejorative accusations of '*chaotic lifestyles*' and '*pathological behaviour*' made during the 'time out' sessions are reminiscent of Levitas's MUD-type discourse, as was the startlingly patronising, reformist perception that the SIP had '*a job to do in resocialising people*'. The group's tendency to focus on lifestyle issues may be because these factors appear more amenable to modification than the daunting alternative - attempting to change an unequal and divisive social structure.

However, some participants also drew on an alternative explanatory discourse of social disadvantage, unfulfilled entitlement and unequal opportunities and life chances. This was not a matter of the more powerful partners dominating discussions with victim-blaming discourses: arguments for redistribution were employed by community representatives but also by the SIP leaders, with both Chair and vice-chair arguing that people living in disadvantaged areas need more services and facilities than better-off areas. Arguments for redistribution were frequently employed in conjunction with aspects of the discourse of re-integration implied by fitting in to social inclusion policy priorities. However, no one type of discourse

conclusively and consistently dominated group discussions and SIP members deployed alternative discursive emphases in different contexts. The inherent indeterminacy of explanations for inequalities in health and of potential solutions, apparent in both research findings and policy making, appears to percolate down to this level of local implementation. This is evident in SIP members' shifting usage of both individualised and social accounts of inequality in health, and in their ongoing struggles to decide on an appropriate starting point for action in the lifecourse.

Blaxter's observations around the difficulties inherent in getting lay people to talk about inequalities in health are apposite in this research (Blaxter 1997). Community representatives found the subject difficult to talk about at length or in depth. Their constructions of health inequalities shifted across contexts. Nor were such constructions necessarily stable even during the *same* context, which perhaps reflects the intrinsic difficulty of finding and holding a fixed position on this complex subject. Not surprisingly perhaps, most community representatives equated inequality in health with inequality in provision of or access to health services or health-related welfare benefits. Talking about health rather than health inequality proved easier, but a focus on general social inequality and inequity formed a significant part of their responses: poor health was seen as only one consequence of a broader-based structural inequality. The links between health, poverty, deprivation, inadequate housing, lack of educational qualifications and unemployment, were noted by all these respondents at interview, demonstrating their sophisticated understanding of the broader social determinants of health and inequality.

Explanations given to account for the apparent disinterest of local people in the work of the SIP were couched in terms of '*community apathy*' or '*lack of community confidence*' by community representatives and other partners – the latter phrase being found in much of the partnership literature. This may be a strategy of self-legitimation and justification on the part of those who do seek to act in this arena, but it may also render questionable policy makers' explicit assumptions that communities are ready and eager to engage in partnership with service deliverers. Epistemological claims are apparent in the distinction made by community/voluntary sector representatives between the knowledge of health inequality that ordinary people in the community were likely to have and that possessed by those who, like themselves, were active within the community and in contact with knowledgeable others. This suggests that the traditional opposition of lay-expert knowledge found in much medical sociology requires some reworking in order to recognise that

competing claims to knowledge may be mounted by confident, vigorous and articulate representatives of the community. Such individuals may better be conceptualised as alternative experts who locate lay knowledge, views and apathy within non-involved people.

9.3.2.2 Using a health promotion approach

The problems of initiating healthy policies within community projects and of encouraging healthy lifestyles for individuals were noted by all the community representatives, together with their doubts about the prescriptive philosophy underpinning traditional health promotion. Participants drew attention to what they perceived as greater priorities for the community *and* to the fact that poor health is, in some sense, ‘normal’ in a deprived area and therefore a less urgent issue than living on an inadequate income. Also acknowledged in the broader literature on community participation, this finding nevertheless has implications for both health promotion and policy, if community needs are to be adequately addressed. Community representatives spoke of formal health services having a greater priority locally than attempts at disease/illness prevention. They invariably associated the health promotion approach with the giving of narrow prescriptive advice that fails to take account of the broader social context of people’s lives. Despite perceiving some of the health promoting projects funded and initiated by the SIP as useful, even necessary, one respondent explicitly criticised what she called the ‘*classist*’ aspects of health promotion, i.e. its basis in identifiably – and arguably pejorative - middle-class values.

These perceptions perhaps reflect the fact that public understanding is slow to change and does not yet reflect contemporary aspects of the discipline. Whether this is the case or not, community representatives expressed many doubts about the capacity for health promoting messages to have any effect in a context of profound structural inequality: problems of poverty and fear of crime, rather than poor health/health improvement, were seen as the main issues for local people. From their perspective, ‘real’ knowledge of community needs was only to be found at the level of the community itself: some professional/policy/research-based discourses were rejected as inappropriate and remote. However, there was an undeniable congruence between policy makers and community in their shared concern with the problems of social disorder in deprived areas – with the latter group sometimes couching their views in bluntly stigmatising terms (*‘hang all the junkies’* was one community response to the

problems of drug use recorded by the researchers in the SIP-commissioned research project). Health promotion recognises that people need to be actively involved in programmes designed to get them to change (Gillies 1998, Ewles 1998). This suggests a need for community development principles and action. However, in organisations such as the SIP, which covered a population of 20,000 people, this becomes problematic. The discursive shift involved in the SIP leaders' translation of '*community management*' into '*community influence and involvement*' is an instructive indication of the meanings key individuals may attribute to such terms. These meanings arise in the context of delivering complex public services but arguably differ significantly from those held by both policy makers and community members. Such a shift also acts as legitimisation for continuity of centralised control of resources, thereby restricting community capacity for action. Community engagement seems to mean community co-option, even coercion (Farrant 1991). Despite the policy emphasis on community involvement, the potential for community-led prioritising of action – though raised during interviews with community representatives – was rarely articulated in any whole-SIP discussion. This may perhaps be because SIP leaders were well aware that health promotion and health inequalities were not likely to be on the local list of priorities for action, but that the Partnership was constrained by government policy imperatives.

9.3.2.3 (Not) working together

Ewles has written of the provocations, frustrations and rewards of partnership working from the perspective of an 'insider', noting that few accounts of '*falling-outs and fizzling-outs*' tend to get reported outside the academic literature, and failures never get into print at all (Ewles 1998 p196). Ethnographic case studies remain rare. In this account I have suggested that the arena of the East Kirklands SIP constitutes a clash of social worlds wherein we find the paradox of forced partnership, contests for legitimacy and risky participatory positions. Aside from the leadership of the Partnership, other participants spoke of feeling strangely marginal, even whilst taking part in active decision-making – '*feeling involved and feeling used*'. It may be that marginality is a common experience in business-oriented organisations like the SIP and that some degree of trade-off between efficiency and inclusiveness is inevitable. The SIP was not a talking shop. Its main characteristics can be summarised as: statutory sector led; task driven; efficiency focused; accountability oriented; and minimally discursive. The cosy rhetoric of working together employed in policy documents and espoused by health promotion is clearly

at odds with the struggles of participants outside the SIP core to understand and engage effectively with the goals of the SIP in the limited time available in monthly meetings. Yet there was little space in the increasingly busy lives of public sector professionals and practitioners for more extensive involvement and any further encroachment on their time would probably also have been resented by the voluntary/community sector representatives.

The partnership literature is replete with references to power imbalances between partners and sectors (e.g. Balloch and Taylor 2001, Pickin *et al* 2002). In the East Kirkland SIP, power imbalances applied not only to relationships between different types of partner (from the statutory, voluntary and community sectors) but also to relations within the less powerful groupings – between one community organisation and another, and between individuals purporting to represent different elements/areas of the community. I suggest that, whilst policy makers recognise that communities such as those making up East Kirkland may be excluded from participation in the benefits enjoyed by the wider society (hence the focus on re-integration), they seem reluctant to incorporate within policy documents any explicit acknowledgement that a community may be divided within itself. Local service providers may therefore find themselves obliged to adjudicate and arbitrate between pre-existing, competing community interests, perhaps satisfying neither service users nor national government in the process. Moreover, government funding ostensibly aimed at tackling deprivation and health inequality introduces yet more competition into the local context, leading to the conclusion that social inclusion partnerships may unintentionally be mechanisms for exclusion.

There is another point to be made that as yet remains absent from the burgeoning literature on partnership. I suggested in Chapter Eight that there are risky aspects of partnership interaction. Wilkinson's hypothesis of the harmful effects of perceiving oneself to have low status in a social hierarchy carries additional implications of risk, and would bear further investigation (Wilkinson 1997b, 1998a). If he is correct, then the experience of participating in a partnership where social inequality is made visible (e.g. through lack of professional status, formal education and adequate income) may be more harmful to the individual than previously suspected. For example, the requirement to spend a weekend in a Hilton Hotel for training purposes was not only a cause for resentment from the community, but arguably a source of stressful self-presentation for some community representatives.

9.4 Conclusions

The difficulties of achieving democratic participation are well known: from the perspective of this research, it seems likely that SIPs may face considerable difficulties in working to empower communities or their representatives. It may be that they are more likely to ensure continuity of insecurity for community-led initiatives. My research found local organisations forced to compete with each other for vital resources. Competition for funding is not, of course, alien to the larger agencies of the statutory sector, but such funding is not normally a matter of basic survival. SIPs are paradoxically able to practice the strategy of short-term piloting of (mainly statutory sector) initiatives whilst simultaneously preaching the contemporary policy ethos of sustainability to those local voluntary and community sector organisations that look to Partnerships for funding. I do not suggest that this is necessarily an enjoyable position for statutory sector workers, as some of the major agency representatives I spoke to were clearly embarrassed by their role in constructing a '*voluntary sector dogfight*'. Given a context where public (statutory, voluntary and community) sector organisations are dominated by the constant competition for funds to improve service delivery, this research suggests that tackling health inequalities at the local level may be in danger of becoming a politically expedient label for existing activity.

Although SIPs are aimed at supporting and developing innovative ways of tackling social exclusion, some may inherit existing local programmes that were funded under previous regeneration schemes and left with no other obvious source of financial support. In such cases, the metaphor of 'old wine in new bottles' seems more apposite than policy makers' claims to be providing new money. As East Kirkland shows, problems arise where support cannot easily be obtained from other funding bodies but the aims and purposes of community-based programmes do not fit into the aims and purposes of the new initiatives. This suggests the potential for fundamental conflicts of interest between national policy imperatives aimed at reducing health inequalities and social exclusion, and local priorities around specific issues such as unemployment, housing, community safety, and facilities for young people. As Furbey has observed, the central characteristic of regeneration initiatives is tight central control of local competition for resources – an imposed agenda of consensus that suppresses local dissent (Furbey 2001). The complexities of local context and the conflict-ridden social processes described and analysed in this case study are presented in the literatures on community participation and partnership, but are too rarely acknowledged in policy documents: that communities may encompass

competing interests that undermine or actively resist policy intent still remains largely inadmissible. As my respondents indicated, for people living on a low income, living healthily implies diverting scarce resources from other essentials of contemporary social life, such as consumer goods or fashionable clothing – all of which act as non-trivial markers of inclusion in our profoundly consumption-oriented society. Other community aspirations seemed modest – freedom from the fear and experience of crime, and safe places for children to play.

I suggested above that the lack of consensus inherent in the discourses surrounding health inequalities provides the flexibility and ambiguity required by policy makers. Such ambiguity facilitates claims of leadership in tackling the issue through the publication of consultation and policy documents, whilst avoiding dramatic action at the level of the social structure. At the same time, the increasing popularity of partnership and community development initiatives enables Government to devolve responsibility for action to the community and individual level. Although critics have pointed out that area-based initiatives will always exclude the majority of poorer people and those with the worst health (e.g. McLoone 2001, Pantazis and Gordon 2000), such distancing tactics fit well within the enlightenment and political models of social policy making referred to above. Awareness of health inequalities is now central to contemporary political debates but responsibility for any failure to reduce the health divide may well fall on the many partnerships trying to make a practical difference. Although the research literature focuses on the importance of strong leadership in such partnerships, the case of East Kirkland demonstrates that providing such leadership is not without risk.

The case study described in this thesis clearly shows the complexity of implementing, at the local level, policies aimed at engaging ‘the community’ or its representatives in health and social improvement initiatives. It implies that the apparently benign move towards joined up policy imperatives also works towards privileging agency over structure in terms of what needs to be changed. Both health promotion and the contemporary policy context assume a voluntaristic construction of human agency. However, this is a type of agency that is constrained to work within prescriptive structures. This suggests that researchers, health promoters and policy makers need to make greater efforts to connect broader social/policy problems with local perceptions. It may be that action research holds some promise as an egalitarian rather than extractive model of research that seeks to involve participants

in problem construction and solution (Pickin *et al* 2002). Yet there are no easy answers here.

Although devolution has arguably provided for closer working relationships between policy makers, academics and practitioners, it may also have had the effect of muting critique: partly because of the inherent difficulty of ‘biting the hand that feeds’, and partly because of conviction that those in positions of power and influence are genuinely making an effort to tackle the problems. I have argued that the contemporary rhetoric of partnership and community involvement, as a key strategy in tackling ‘wicked issues’ such as health inequalities and social exclusion, is fed by conflicting ideologies and involves deep ambiguities of policy and practice. In particular, unresolved and undiminished tensions between professional prescription and lay empowerment still exist: within health promotion; at the level of policy making; and at the level of local implementation. Although disadvantaged communities may welcome external funding and additional services, my research suggests that for representatives of dissimilar social worlds to learn to work together may take years, that learning to listen to communities remains a significant challenge, and that local conflicts of interest and disparities of power and influence may thwart policy intent and make participation in partnerships a risky business. A broader conclusion is that, whilst some success may be achieved by committed people working at the local level, inequalities in health and social exclusion remain deeply embedded within the unequal structures of society and are unlikely to be dramatically affected. Attempts to tackle them may not be resolvable within a contemporary policy paradigm that prescribes both problem and solution. At worst, local initiatives may, unintentionally, have been set up to fail.

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Appendix 1a) and 1b)

Health promotion, advocacy and health inequalities: a conceptual framework

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SUMMARY

Advocacy has often been described as a key strategy for the achievement of health promotion aims, but multiple and conflicting definitions and usages exist. The concept itself may be unnecessarily intimidating. Advocacy work can take place at the level of both 'cases' and 'causes'. Two main goals underpin health advocacy—protection of the vulnerable (representational advocacy) and empowerment of the disadvantaged (facilitational advocacy). This paper attempts to integrate existing models and definitions into a conceptual framework for considering the role of advocacy

in addressing health inequalities. It argues that we need to pay some attention to the diversity of values and goals of health promotion if we are to understand which models and approaches to health advocacy apply and in what context. This paper concludes that advocacy for health fulfils two functions: as a form of practice and as a useful strategy for a discipline which has to be self-promoting as well as health-promoting in order to survive in the competitive political environment of contemporary health work.

Key words: advocacy; health inequalities

Traditionally, the ethic of the health worker is to be the protector and advocate of the patient. Today, advocates for the wellbeing of whole populations are needed (International Union for Health Education, 1992).

INTRODUCTION

As the above quotation implies, health promotion is arguably one of the most ambitious health-related enterprises of the 20th century, and advocacy is seen as one of its key strategies. Health promotion has been described, from a global perspective, as a necessary and timely reconsideration of public health rather than a new and separate discipline (Kickbusch, 1986), but in practice the two may differ at the practitioner level. Health promotion practitioners are to be found working in a wide range of agencies and sectors: their efforts

can be directed towards improving the health of entire populations, defined communities or groups, and single individuals (Mechanic, 1999). In recent years, health promotion has increasingly sought a role in the development and implementation of healthy public policy at the local, national and global level (WHO, 1988). This has been, in part, a response to the perceived over-emphasis on curative medicine and the behavioural approach to disease prevention that has characterized much health policy development (Kickbusch *et al.*, 1990). Health promotion is therefore a multi-level, multi-sectoral and multi-disciplinary activity. It also evinces characteristics of a visionary movement, concerned with equity and justice in society as well as environmental protection on a global scale (WHO, 1991; WHO, 1997).

Although it seems that few areas of contemporary life lack the potential for health promotion

activity, the breadth of vision, arena and practice within the discipline raises questions of control and power that are not always addressed explicitly (Adams and Pintus, 1994). Seedhouse, for example, points out that while health promotion may be done on request, it may also be carried out without the intended recipient or recipients asking for it (Seedhouse, 1997). We therefore need to pay some attention to the underpinning values and contexts within which models and approaches to health promotion advocacy are applied.

Advocacy has been recognized as one of three major strategies for achieving health promotion goals, the others being enablement and mediation (WHO, 1986). The World Health Organization (WHO, 1995) describes advocacy for health as a 'combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or programme'. Such action may be taken by or on behalf of individuals and groups to create living conditions conducive to health and the achievement of healthy lifestyles (Nutbeam, 1998). Two main goals underpin health advocacy: that of protecting people who are vulnerable or discriminated against; and that of empowering people who need a stronger voice by enabling them to express their needs and make their own decisions (Scottish Health Service Advisory Group, 1997). The potential for advocacy as a way of tackling health inequalities seems obvious, but the concept is not universally accepted. Critics of advocacy perceive a sharp contrast between health promotion rhetoric of community participation and co-operation, and the paternalistic role of advocacy in constructing people as uninformed, ill-educated and in need of the services of interventionists who claim to know better (Wenzel, 1999). Given the scope of health promotion practice, it is perhaps not surprising that multiple meanings are attached to the term 'advocacy' throughout the literature. Such contrasting usages are explored below in an attempt to conceptualize the field, mapping such complexities as the diversity of advocacy goals and ideologies or philosophies of practice, the range of levels at which practitioners work and how these disparate elements relate to the issues surrounding health inequalities.

In Britain, after years of official neglect, reducing inequalities in health is now a matter of urgent public policy concern (Department of Health, 1998a; Scottish Office Department

of Health, 1998). The priority attached to this matter by the current government was signalled by the commissioning of an independent inquiry (Department of Health, 1998b). Despite a lengthy research tradition in this area (which in itself is an important component of advocacy for health), existing accounts for health inequalities are not yet fully developed, and much remains to be discovered about the mechanisms that create and sustain them (HEA, 1999). Structural, material and psycho-social explanations and interpretations have all contributed to a rich and steadily expanding body of knowledge, a full discussion of which is beyond the scope of this paper. Arguments for the causes (and effects) of inequalities in health may be located mainly within the social structure/environment or mainly within the individual, although the links between the two are not in doubt. Individualistic explanations of health inequalities, in terms of unhealthy lifestyles and choices, still exist, although epidemiology and the social sciences have produced extensive evidence of the harmful impact on health of poverty, deprivation and social exclusion at both individual and population levels (Wilkinson, 1996; McIntyre and Hunt, 1997; Bartley *et al.*, 1998; Popay *et al.*, 1998; Townsend, 1998; Davey Smith *et al.*, 1999). This paper offers a conceptual framework that could be used to reflect on the polysemic role of advocacy in health promotion and its potential for addressing health inequalities.

DEFINITIONS AND MODELS

At its simplest, advocacy may be defined in terms of the activities it encompasses: for example, the representation of under-privileged groups, such as those who are disadvantaged or sick, with the aim of promoting their rights and/or redressing imbalances in power. This has been characterized as 'case' advocacy (Rees, 1991). Advocacy is also seen as a lobbying activity within public health and as such has a long history. In recent years this usage has become increasingly common within the health promotion literature. This approach acknowledges that barriers to health can lie beyond the control of individuals, and that structural factors need to be addressed if health inequalities are to be reduced. This has been characterized as 'cause' advocacy (Rees, 1991). Both types can be categorized as representational advocacy. However, health promotion explicitly

espouses values of democratic participation, community development and empowerment, wherein disadvantaged individuals or groups are enabled to represent themselves and lobby for their own health needs. The role of advocacy here is best categorized as facilitational rather than representational—providing individuals and communities with the skills to tackle and redress inequalities in health.

Other definitions and models of advocacy within health promotion exist. For example, advocacy may be seen as a confrontational activity, challenging powerful anti-health interests such as the tobacco lobby (Wallack *et al.*, 1993; Altman *et al.*, 1994; Chapman and Lupton, 1994; Wallack and Dorfman, 1996). Alternatively, advocacy may operate as a conduit or channel, mediating and negotiating between opposing forces in the interests of positive health, abandoning adversarial positions in order to develop a common agenda and find mutually achievable goals (Nutbeam, 1993). Advocacy may also have a capacity building function, providing support for disadvantaged individuals and/or communities to gain control over and improve their own health by becoming effective policy advocates (Schwartz *et al.*, 1995). Kickbusch argues that the aim of public health is to improve the health of communities through employing all three: advocating for healthy public policies and supportive environments; mediating between different interests in society to benefit health; and enabling communities and individuals to achieve their full potential (Kickbusch, 1995).

A CONCEPTUAL FRAMEWORK FOR ADVOCACY ON HEALTH INEQUALITIES

Defining health advocacy solely in terms of activity neglects to make explicit a number of key elements mentioned earlier, for example, the way practice is shaped by the different domains and levels at which advocacy can operate (individual/group or policy/social structure), potential tensions in the goals of advocacy (representation or facilitation) and how such goals are related to the practitioner's own philosophy of practice. It also neglects to make explicit which particular explanatory models of health inequalities are being used. The distinction Seedhouse makes between medical and social health promotion can be used, albeit somewhat simplistically, as

a basis for considering practitioners' work on health inequalities (Seedhouse, 1997). For the sake of simplicity, Seedhouse's additional conceptual models of 'good life promotion', 'go for it health promotion' and 'mix'n'match health promotion' will not be considered here. 'Medical health promotion' seeks to prevent or ameliorate disease, illness and injury, drawing on 'objective' evidence (the benefits of not smoking, eating less fat/drinking less alcohol, taking regular exercise) to prevent clinically defined conditions. 'Social health promotion' seeks to change the world and challenge the injustices that cause ill health by improving the lives of the least well-off members of society. In a paper with considerable significance for health promotion practice, Lomas (Lomas, 1998) argues that public health as a discipline has been 'colonized' by the individualist ethics of medicine and economics. He believes that the emphasis on screening, immunization, lifestyle change and risk factor modification obscures the need to '(wo)man the barricades in the name of radical social system change for health'. This suggests that 'medical health promotion' may therefore be the dominant model, which has implications for the ways in which practitioners will seek to tackle health inequalities.

Figure 1 seeks to integrate such elements within a conceptual framework that provides a more explicit way of locating advocacy practice in health promotion. Four different types of advocacy are identified. It is suggested that these are shaped by the domain within which health promotion advocacy takes place (case or cause); the goals and philosophy of the practitioner; and the freedoms and constraints associated with their professional role. Advocacy work will also be influenced by the particular conceptualization of health inequalities being used. The axes of the matrix are best regarded as continua along which practice can be located, rather than mutually exclusive and oppositional poles: depending on context, it is possible that one form of practice may shade into another. The right-hand half of the matrix relates to representational types of advocacy: the left to facilitational types.

Representation

Straightforward representational advocacy operates at the level of cases rather than causes, and individual health promoters are likely to practise this type frequently. The goals of the health promoter may be traditionally prescriptive, in

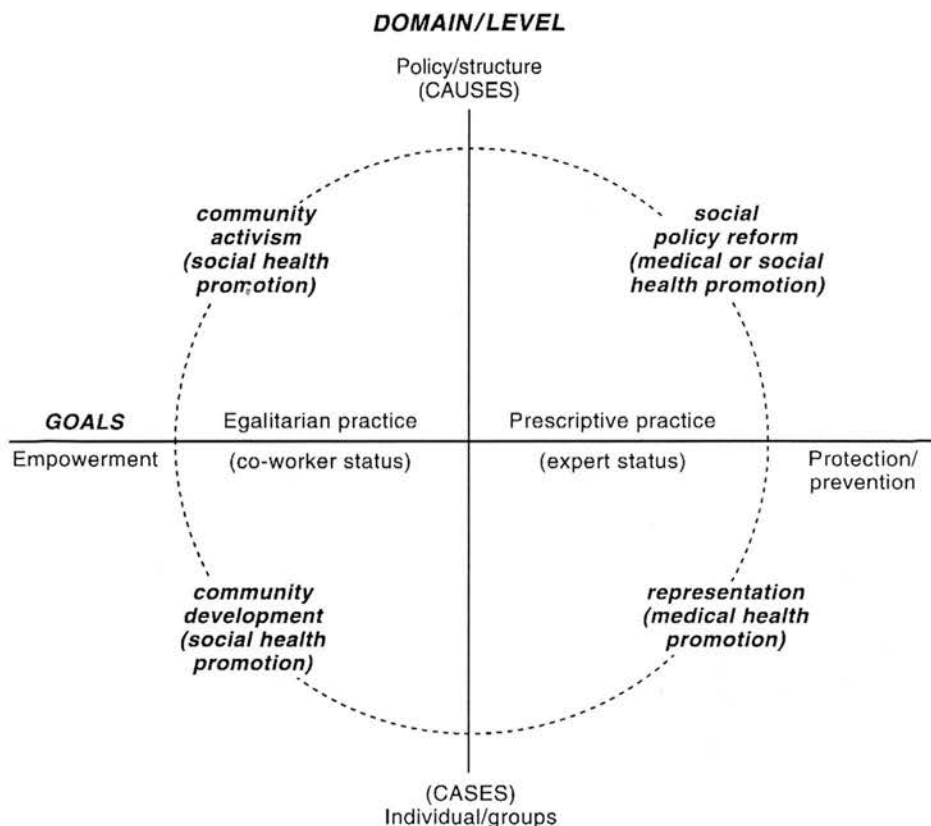


Fig. 1: A conceptual framework for advocacy in health promotion.

advocating for education and behaviour change to improve the health of individuals and groups and thus reduce health inequalities through a lifestyle approach (medical health promotion). Alternatively, the main concern may be to represent the rights and health needs of those unable to speak or act for themselves to agencies and service providers (social health promotion). Most advocacy in the fields of mental health and learning disabilities is of this type and is covered by an extensive literature. In both cases, the status of the health advocate is likely to be that of an 'expert'. Baric, for example, has traced the rise of the advocate planner, possessing expert knowledge and concerned with promoting the interests of threatened or deprived groups or communities (Baric, 1988). This type of representational/authoritarian advocacy is driven by the perceived need to protect or defend such interests. Baric suggests that this may be necessary when the increasing sophistication of planning techniques

means that individuals and communities are unable to participate effectively in planning processes for health, even if given the opportunity. Depending on the context within which they work and their professional background, health promoters may also seek opportunities to move from such traditional advocacy to more facilitational forms. Protective, representational advocacy may therefore draw on either medical or social health promotion approaches to health inequalities.

Community development

In this type of health advocacy, the goals of health promotion are enablement rather than protection/prevention. The practitioner's status is likely to be that of a facilitative co-worker employing an egalitarian philosophy of practice. Advocacy activities are orientated towards 'case' level work with individuals and groups, identifying their needs and seeking to address these

at the local level (Jones, 1999). An extensive and growing literature exists as testimony to the popularity of community development. This approach seeks participation and empowerment, which suggests that this type of advocacy would use a social health promotion approach to health inequalities. This is not necessarily the case. Farrant documented the increasing use of community development work, together with its underlying contradictions and tensions (Farrant, 1991). She drew attention to the historical roots of community development in colonialism where, far from being inherently radical, it was employed to safeguard and further the interests of the ruling class and reduce the burden on colonial administrators. From this perspective, the drive for community participation can be viewed as part of a medically driven, professional prescription for community manipulation. Working with communities may in practice translate as working *on* communities—advocating for change at the grass roots level but the change agenda is decided by professional interest, not the community 'voice' (i.e. medical health promotion). Facilitating community definitions of health and health problems is therefore a key role for the advocate who wishes to practice social health promotion. Health promotion work on community development may evolve into empowerment for action, which for some is the ultimate goal of practice (Wallerstein, 1992; Wallerstein, 1993).

Community activism

This type of advocacy moves beyond facilitating community definitions of need to enabling communities to challenge the causes of poor health more directly at the policy-making and structural level—i.e. social health promotion. Although the advocate operates at the level of 'causes', his or her goals remain facilitative and empowering. This model of advocacy seeks to provide communities with political advocacy skills (Schwartz *et al.*, 1995) rather than individualistic skills to make 'better choices'. Gillies argues that greater levels of local community involvement in setting agendas for action, and in the practice of health promotion, result in greater impacts on that community (Gillies, 1998). The rise of citizens juries are a recent example of how representative community participation can make decisions about health-related policy (Macdonald, 1998), although lack of congruence between national and local policy concerns may undermine the legitimacy

of healthy public policy-making at local level. Advocacy for health inequalities within this model therefore needs to incorporate coalition-building activities, forming links with other communities and with organizations at local and national levels—acting locally but thinking globally (Hancock, 1990). Alliance building across sectors (Milio, 1987) to promote health and tackle inequality is a necessary component of this type of social health promotion advocacy. de Leeuw has characterized such advocates as social entrepreneurs in health promotion (de Leeuw, 1999): work at this level of practice requires them to act outside their own organization or in individual roles rather than as organizational representatives. This requires a freedom of action and decision making not constrained by the need for political acceptability and sensitivity.

Social policy reform

Health promotion work that seeks to redress health inequalities at the level of the social structure and to influence policy making can be categorized as health advocacy for (social) policy reform. From this perspective, health inequalities are the outcome of 'causal chains' that run to and from the basic structure of society (Department of Health, 1998b). This type of advocacy is likely to require knowledge of local and national political systems and other complex mechanisms. Work at this level demands that the advocate practitioner possesses a degree of 'expert' knowledge and authority in order to have credibility. Examples of this type of prescriptive advocacy may focus on legislative reform relating to the availability of products perceived as antithetical to health such as tobacco, alcohol or illegal drugs, or on the prevention of environmental hazards and pollution, etc. The 'champions' of this type of social change in the interests of public health are unlikely to be lone health promotion specialists working within local health or social services, but are clearly drawing on a medically orientated view of health promotion [e.g. (Altman *et al.*, 1994)]. Although inherently 'top down', this type of practice is not incompatible with radical change models, as the targets for health advocacy are often the powerful vested interests of multinational corporations more interested in profit making than population health, and the governments that support them.

Alternatively, advocacy at this level may take a broader social perspective on health inequalities.

Much of the literature detailing the role of poverty and deprivation in structuring health inequalities within society draws on the theme of social transformation through policy change as the most effective way to tackle such issues (Wilkinson, 1996; Alcock, 1997). Only interventions at the level of the social structure are believed capable of reducing social and economic inequalities: the issue of health inequalities is fundamentally a matter of social justice (Department of Health, 1998b). Labonte suggests that this type of advocacy may be the solution to the limitations of community organizing, as it targets policies and policy makers in order to achieve radical social change (Labonte, 1997). Well known for his work in the field of community empowerment, Labonte makes the case for structural and policy-level health promotion advocacy [(Labonte, 1999), p. 172] when he says:

If we can prescribe blithely on health-promoting behaviours, we should not shuck such prescriptions when it comes to health-promoting economic or environmental conditions.

The strategic influencing of governments and large organizations to reduce health inequalities through changing their policies and practices demands considerable capacity and freedom of action unconstrained by the need for political acceptability. Health promotion advocacy at this level is likely to require cross-sectoral alliances.

DISCUSSION

The literature suggests that advocacy to reduce health inequalities is likely to draw on either medical or social conceptualizations of health promotion work, although there may well be some blurring of boundaries. It is not possible to state categorically that (x) type of practice will always occur in (y) type of context. Whilst facilitational advocacy seems more likely to draw on social models of health promotion, this does not exclude the possibility of the individualistic influence of medicine. Representational advocacy may draw on either social or medical conceptualizations of health promotion, although this is rarely made explicit in the literature. The framework in Figure 1 aims to make clear the continuum from conservative to radical politics and practice that characterize the discipline and shape advocacy for health.

Carlisle suggests that advocacy has the capacity to bridge different political–philosophical positions as well as the gap between the world of policy makers and the lives and experiences of health promotion’s ‘clients’ (Carlisle, 1998). This may be the case, but there remain a number of factors that limit the potential of health promotion advocacy for tackling inequalities in health. Firstly, while it is now beyond doubt that social and structural factors are instrumental sources of health inequalities, it will probably be difficult for some health promoters to escape the traditional individualistic imperatives of the discipline. Work at ‘higher’ political levels may be beyond their individual and organizational remit. Secondly, community organization, development and activism are valued for their grass roots nature but are limited in scope. Critics of the approach have pointed out that, by locating the potential for tackling health inequalities within communities, governments are attempting to solve their own pressing problems with regard to the increasing costs of the welfare state (Wainwright, 1996). Community development and action thus risk becoming a misdirected panacea for inequities at national and global level. However, although more radical proposals for redressing health inequalities at the level of social policy may appear to have greater potential for social change, they run the risk of rejection as unacceptably top-down. Depending on their content, such proposals may be interpreted as left-wing attempts at prescriptive social engineering, or as right-wing, anti-democratic medical authoritarianism.

Although the literature indicates a multiplicity of meanings, plurality of practice, diversity of practitioners and conflicting ideological underpinnings, the model in Figure 1 suggests that there is no one ‘right’ type of health advocacy. The tendency to assume that ‘bottom up’ types of practice are inherently preferable to ‘top down’ initiatives is open to question. Such arguments can unwittingly run counter to advocacy for social change in the interests of social justice and greater equality in health. The framework outlined in Figure 1 suggests that both (social) empowerment and (medical) expertise models are needed—‘upstream’ and ‘downstream’ advocacy for redressing health inequalities. Advocacy is not value neutral at any level or in any arena of health promotion although, in practice, it is not always apparent that the values in question may be contradictory at the different levels. Health

promoters therefore need to be explicit about the explanatory frameworks of health inequalities they utilize and how these affect the type of advocacy they choose—or are expected—to practice. Practice is located within the specific context of perceived needs of communities and capacities of health promoters. The above framework does not seek to suggest that health advocacy practice is necessarily fixed: if advocacy is to be effective, the boundaries between different types of practice need to be mutable to allow for changing contexts. Given sufficient room for manoeuvre, representation can shift towards empowerment; individual and community-based initiatives geared towards skill development can lead to communities expressing their own needs and working to achieve change. Coalitions and alliances between groups and communities can be supported to engineer a critical mass with the power and will to lobby for policy change.

Finally, although advocacy for health is clearly a major contemporary issue contributing to the development of health promotion practice, it is also enmeshed within the project of advocacy for health promotion as a discipline. As advocacy is always associated with the pursuit of justice, it provides a powerful legitimizing rhetoric for a still youthful discipline with—perhaps—ambitions of becoming a profession (Oakley, 1998). It also provides an emancipatory framework with which to challenge the restrictive definitions of health employed by biomedicine. The role of health advocacy is to influence governments and national/international agencies in beneficent and health-promoting ways, and to raise the profile of health-promoting organizations, ensuring that their voices are heard and taken note of (IUHPE, 1999). Both health promotion and public health are currently involved in a form of self-advocacy, obliged to re-invent themselves as 'investments' in times of tough global competition for finite resources (Labonte, 1999; WHO, 1999). Ironically, the lack of concrete and universally accepted definitions for the terms 'health' and 'health promotion' that so irritates critics is probably the factor which provides sufficient flexibility and scope for such reinvention. Advocacy for health therefore fulfils two functions: it is both a form of practice and a useful strategic tool for a discipline which has to be self-promoting as well as health-promoting in order to survive in the demanding contemporary environment of national and international health work.

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Inequalities in health: contested explanations, shifting discourses and ambiguous policies

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ABSTRACT *The research field of health inequalities is unavoidably politicized: through the ideological context in which such research is conducted, through the explanatory frameworks advanced, and through the linked discourses that propose or imply particular solutions to the problem. After years of official neglect, reducing inequalities in health is now an established part of UK Government policy. However, the research evidence has become increasingly complex in past decades and a number of different explanatory discourses have developed. This discussion paper presents a brief overview of three identifiable but contested explanations (poverty/deprivation; psychosocial stress; individual deficit) and adopts an existing discourse model (Levitas's RED, MUD and SID) to conceptualize the links between such explanations and potential policy solutions. A 'political' model of the research-policy relationship is used to suggest that the uncertainty surrounding competing explanations and solutions to the problem of health inequalities enables flexibility of interpretation and political manoeuvring at the policy-making level. The capacity for shifts in discourse enables the UK Government to claim leadership in tackling the issue whilst simultaneously assigning responsibility for action to the community and individual level.*

It is one thing to analyse society's problems, quite another to suggest remedies which should be embedded in legislation. (Thomas, 1983, p. 117)

Introduction

The political context of health inequalities research

Natural scientific disciplines such as public health and epidemiology have their roots in the presumptions of modernism and the Enlightenment—notably the existence of externally verifiable realities that can be uncovered through rational thought and scientific study (Watson, 2000). Although such assumptions may be challenged by social scientists espousing less positivist perspectives (Popay *et al.*, 1998), scientific

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research is seldom explicitly aligned with political issues. The value of research findings is linked to their neutral status and presentation of the facts observed and hypotheses verified (D'Andrade, 1995). Yet political ideology has a crucial role in shaping the commissioning of research, the type of evidence that gets accepted and subsequent policy action. The UK Working Group on Health Inequalities (widely known as the Black Report) provides a well-known exemplar: originally commissioned under a Labour administration, the Report (DHSS, 1980) encountered a hostile reception from an incoming Conservative administration. The fiscal implications of the structuralist-materialist explanations for health inequalities supported by the report's findings led to their outright rejection by a new government committed to an ideology of reduction in public spending. The research community responded by defending the field of social inequalities in health against charges that they did not exist, or were not increasing. Macintyre (1997) suggests that much research energy was thus spent in (successfully) keeping health inequalities on the political agenda, rather than on investigation of the processes by which such inequalities are generated and maintained, and that less attention has been paid to specific recommendations for much the same reason. This paper argues that the field of inequalities in health research is unavoidably politicized—through the political context in which such research is conducted, through the competing explanatory frameworks advanced, and through the linked discourses that propose or imply particular solutions to the problem.

The health inequalities debate

There is a lengthy tradition in the UK of contested explanations for inequalities in health. Macintyre (1997) has suggested that, in the latter part of the nineteenth and early part of the twentieth centuries, debates about the causes of inequalities in health were shaped by three different explanatory discourses. Hereditarian explanations for class variations in disease argued that people's social position depended on biologically determined natural capacity. Variations in health were therefore inevitable and little could be done about them. Behavioural explanations viewed the high infant mortality rate found in the labouring classes and bad health of poorer sections of the population as a consequence of working-class maternal ignorance and generally unhealthy or feckless ways of living. Education was seen as the appropriate measure to improve health. Environmental explanations regarded the widespread poverty and material conditions of urban industrial life as central to the social distribution of disease and premature death. From this perspective, social reform was urgently needed.

In their review of the contemporary research field, Popay *et al.* (1998) have argued that two main constructions continue to dominate research on health inequalities: first, the view that individual behaviours and lifestyles are principally responsible (e.g. Hattersley, 1999); second, the view that inequalities in health are a mirror for wider social inequalities and injustice (e.g. Bartley, 1994; Davey Smith, 1996; Wilkinson, 1997a, 1997b, 1998a, 1998b). There is thus a historical continuity

between nineteenth-century environmental explanations and contemporary models based on poverty and deprivation. There are also elements of continuity between behavioural/hereditarian models and contemporary explanations that posit the pathology of lifestyles and 'cultures', the determining impact of biological factors, or the endemic nature of inequality in all societies. There are apparent differences in the social values and political ideology underpinning these different explanatory discourses, all of which have implications for a policy response.

Contemporary models

From the perspective of the twenty-first century, the evidence for continuing inequalities in the social patterning of health is beyond doubt and the research literature is now vast. It has been estimated that about 800 empirical and conceptual papers have been devoted to this topic over the last two decades in Britain alone (Macintyre, 1997). The explanatory models¹ briefly outlined below are thus inevitably an over-simplification of a highly complex and constantly developing research field. They do *not* constitute an adequate review of this field: rather, it is suggested that they are broadly indicative of three influential contemporary discourses around poverty/deprivation; psychosocial stress; and individual deficits. There are obviously some conceptual overlaps between these three broad-brush explanatory types.

Poverty/deprivation

Townsend (1998) draws a conceptual distinction between deprivation and poverty. Deprivation refers to the material and social conditions, independent of income or resources, which are experienced increasingly in descending the social hierarchy. Poverty refers to the lack of income and other equivalent resources that makes those conditions highly likely. The poverty/deprivation model unhesitatingly pinpoints an inequitable and divisive social structure as the causal mechanism for health inequalities. Although life expectancy rose overall for men and women in the UK throughout the twentieth century, such improvement has been inequitably distributed throughout society (Shaw *et al.*, 2000). At the end of the 1990s, Davey Smith *et al.* (1999) argued that poverty and inequality of income were greater than at any time since the 1930s. They suggest that, as a result of successive Conservative government economic and social policies, inequality and poverty increased faster in Britain over the last two decades of the twentieth century than in almost any other country. By 1990, 20% (11 million people) of households in Britain were living in poverty. In short, the widest (and growing) health gap since 1921, when the Government first reported figures this way, was being reported.

Psychosocial stress

Despite the strength of the evidence, the deprivation model is viewed as incomplete. A number of critics point to 'the challenge of the gradient': health inequalities are not confined to the poorer sections of society but follow social class gradients (Marmot *et al.*, 1991). Material differences alone cannot explain this. The psychosocial stress model is partly a result of scepticism about the explanatory power of material perspectives, although it draws heavily on the concept of structural inequality in acknowledging the salience of relative deprivation. The model theorizes an aetiological basis in the health-damaging potential of psychosocial stress, arguing that this has both a direct effect on disease development (experiences transmitted through the central nervous system provoke harmful changes in other human organs) and an indirect effect, as stress may be expressed through 'unhealthy' behaviour (Elstad, 1998). The foremost exponent of the psychosocial stress type of explanation is probably Richard Wilkinson, who has argued for the effect of income inequality within countries, rather than average income, on national mortality and morbidity statistics (Wilkinson, 1998a, 1998b). Sociobiological arguments have been used to draw parallels between primate and human stress responses to such social positioning (Wilkinson, 1998a). The psychosocial stress model recognizes that the effect of social inequalities goes beyond income inequalities to involve the concept of relative deprivation, wherein people's health will vary inversely to their position in society's hierarchical order (Elstad, 1998). The social stress approach suggests that stressors are unevenly distributed in society, basically in line with its structural inequalities, leading to chronic stress, particularly in those who lack 'buffering' resources (Marmot & Wilkinson, 2000).

Individual deficits

Critics of the deprivation and social stress models argue that health and social inequalities exist in all societies. From the perspective of evolutionary psychology, Charlton (1997) argues that modern humans have inherited egalitarian instincts that are activated when inequalities are encountered but that such inequalities are an inevitable by-product of modern economies. Because of the instinctual component, amelioration of differentials that fall short of full equality would not necessarily diminish perceived injustice at the individual level, which is where action is required. Charlton and White (1995) suggest the concept of a 'margin of resources' as the underlying explanatory variable: this is the gap between socially determined needs and available resources. There is thus some continuity with the sociobiological aspects of psychosocial stress-type explanations. Located within the individual deficit model we find the (widely contested but still extant) belief that lower socioeconomic groups share and reproduce an unhealthy, underclass 'culture'—a 'cycle of deprivation' that is transmitted from each generation to the next (Sir Keith Joseph, quoted in Alcock 1997, p. 30).

Overlaps and discontinuities

The psychosocial stress model acknowledges the problem of an inequitable social structure but sees the generative mechanism for health inequalities in the relationship between social structure and individual psyche. The individual deficit model similarly acknowledges social inequity but is less focused on restructuring society than on tackling the problem at the level of individuals and their 'culture'. The boundaries between types of explanation tend to be fluid rather than clear cut, explanations remain incomplete and contested, and theoretical diversity stimulates the ongoing debate (Health Education Authority, 1999). Although such diversity facilitates increasingly sophisticated theoretical and methodological development² and refinement within the multidisciplinary research community concerned with the issue of health inequalities, it also seems to provide policy makers with a dauntingly complex field from which to construct remedial action. Does this matter? In order to address this question we first need to consider the types of discourses that are deployed around potential solutions.

Discourses of inequality

The term discourse draws attention to the importance of understanding how language is used to construct the social world in various ways. In discussing the language of politics, Levitas (1998) argues that a discourse constitutes ways of acting in the world, as well as a description of it: a discourse both opens up and closes down possibilities of action (Levitas, 1998, p. 3). From this perspective, discourse analysis:

. . . underlines the fact that the matrix of concepts through which we understand the world and act in it profoundly affects those actions and thus the world itself, *without denying the material character of social relations*. (Levitas, 1998, p. 3, emphasis added)

The discourse model outlined below was originally developed by Levitas (1998, 1999) to tease out the various meanings of social exclusion embedded within current political debate. She identifies three different discourses around social exclusion: RED (a redistributionist discourse); MUD (a 'moral underclass' discourse related to 'pathological' culture/behaviour); and SID (a social integrationist discourse); the latter overwhelmingly associates social inclusion with being in paid work. Although developed for a different context, Levitas's discourse model is a useful conceptual tool for considering the debates around inequalities in health, which involve both the language of research and the language of politics, and which are closely intertwined in any case with debates around social exclusion. Levitas's RED, MUD and SID model is applied in the following section as a way of exploring a number of approaches to tackling health inequalities and some of their limitations.

Redistributionist Discourse (RED)

The RED approach to health inequalities is unmistakably linked to the poverty/deprivation explanatory model. From this perspective (normally located amongst writers on the political 'left') a more equitable distribution of resources in society and the restructuring of socioeconomic policy is required (Bartley, 1994; Townsend, 1998; Wilkinson 1998b; Davey Smith *et al.*, 1999):

There is *one central and fundamental* policy that should be pursued: the reduction of income inequality and consequently the elimination of poverty. Ending poverty is the key to ending inequalities in health. (Davey Smith *et al.*, 1999, p. 163, emphasis in original)

The redistributionist discourse frames the problem as one of wealth, as well as poverty. It acknowledges the role of relative inequality in its focus on 'downward' redistribution through reformed welfare policies. It rejects welfare dependency arguments and argues for the strengthening rather than the reduction of the welfare state (e.g. Bartley *et al.*, 1997). This perspective is also found in the report of the Independent Inquiry into Inequalities in Health (the Acheson Inquiry), which states that:

We consider that without a shift of resources to the less well off, both in and out of work, little will be accomplished in terms of a reduction of health inequalities by interventions addressing particular 'downstream' influences. (Department of Health, 1998a)

One problem with the deprivation/redistributionist approach is the related belief (particularly in some of the debates around health promotion and health education) that increases in income will be accompanied by an increase in 'healthy' types of expenditure. Poverty as a determining factor for health-related behaviour and expenditure is challenged by the social anthropological conceptualization of the class-related 'habitus' (Bourdieu, 1984). Bourdieu argues that the tastes, behaviours and preferences of any socioeconomic group are not only shared, but become internalized as 'natural'. We cannot predict that increases in income will lead automatically to 'healthy' tastes and behaviour because preferences in such things as diet or physical activity cannot be simply mapped onto a simple healthy/unhealthy dichotomy. They carry social meanings that need to be understood and related to the physical, social, economic and cultural context within which they occur.

Moral Underclass Discourse (MUD)

This type of discourse may be deployed as part of a neo-liberal or new right political discourse.

The concept of a 'moral underclass' resonates with explanations of health inequalities that focus on individual (ir)responsibility for health, given the profound associations between perceived moral turpitude and illness in contemporary society (Blaxter, 1997). MUD-type approaches believe the solution to lie with individuals themselves, who should change their reprehensible behaviour and accept responsibility for their own health. From the MUD perspective, social and health inequalities are endemic in all societies; recommendations for action therefore tend to be cast in terms of individual adaptation to inevitability rather than social change. This type of discourse is related to the individual deficit model of health inequalities outlined above. The solution is to increase the margin of resources at individual or community levels by increasing resources or reducing needs. One way of achieving this is through a conventional health promotion/empowerment approach, providing adaptive skills and reducing needs through increasing lower socioeconomic groups' understanding of and resistance to advertising techniques and peer pressure (Charlton & White, 1995). A community development approach to the creation of mutual help networks, for example food co-ops and credit unions, would have the additional benefit of leaving financial input virtually unchanged (Charlton & White 1995).

From the egalitarian instincts perspective of evolutionary psychology, macro-scale action fails to tackle the real problem (Charlton, 1997). Policy goals should therefore address the subjective experience of inequality at the level of individuals, which is where its effects are felt. A pragmatic, if admittedly second-best solution is to create a 'step-like inequality'—a stratification of classes, with egalitarianism within strata. This type of encapsulation would provide a protective insulation from invidious comparisons with more advantaged social groups as differentials between strata may be compatible with equality within strata:

If resource differentials are indeed a reliable consequence of a delayed-return, surplus economy, then inequality might be regarded as an endemic injustice which cannot be eradicated but must nevertheless be negotiated . . . the inequity of inequality therefore requires containment, compensation and compromise at the 'capillary' social level—the family, the workplace and the community. (Charlton, 1997, p. 422)

The casualty approach implied by an individualistic discourse fails to acknowledge the role of structural inequalities in facilitating or preventing access to basic components of health such as adequate housing, decent food, education, transport, income and employment. It also carries unacceptably stigmatizing undertones of personal social, economic and moral failure.

Social Integrationist Discourse (SID)

A social integrationist discourse dominates the New Labour approach to social problems (Levitas, 1998). SID approaches in response to explanations for health

inequalities claim the causal effects of social polarization, social exclusion and resultant psychosocial inequalities. There are parallels with the psychosocial stress model. Social integrationist discourse around health inequalities is closely related to the perceived relevance of social capital and social cohesion to health. Social capital sees the community rather than the individual or the social structure as the unit of analysis. It has been defined variously in terms of the existence of trust in one's fellow human beings, active community networks, participation in civic activities, and shared objectives (Gillies, 1998). Some argue that low social capital is a key causal factor in health inequality and that income inequality only exerts its effect through this variable (Lomas, 1998). Building social capital has been seen as a relatively inexpensive means of tackling the structural determinants of health and disease and offsetting the most abrasive effects of health inequalities (Gillies, 1998). SID-type solutions suggest that creating and sustaining social cohesion or social capital at the community level is the most appropriate way to tackle the problem.

Despite its obvious appeal, Muntaner *et al.* (2000) argue that social capital is being conceptualized in unsophisticated ways and that care needs to be exercised in making such claims. They suggest that the concept is being used as an alternative to materialist-structural explanations for inequalities and invokes a romanticized view of communities. SID-type solutions tend to assume that material circumstances are without significant influence after certain threshold levels are passed but this remains doubtful; Elstad (1998) reminds us that the evidence for relative inequality still does not explain why individual or household income is closely related to mortality risk within most present-day affluent societies.

Table 1 presents a simple heuristic framework, encapsulating the different perspectives on problems, solutions and action found within the RED, MUD

TABLE 1. Problems, causes, solutions and action

Discourse level	Source of problem	Explanatory level	Causal mechanism	Solution	Action level
Redistribution (RED)	Concentration of resources in higher socioeconomic groups	Social structure	Inequitable social distribution of resources	Relieve poverty by redistributing resources downwards	Socioeconomic policy
Social integration (SID)	Social polarization of socioeconomic groups	Interaction between individual and social structure	Relative inequality and social stress in disadvantaged groups	Reduce gap and increase social integration	Community
Moral underclass (MUD)	Lower socioeconomic groups	Individual experience and action	Narrow resource margins	Help poor people develop coping strategies	Individual

and SID discourses on health inequalities. The explanations and proposed solutions to health inequalities delineated here all recognize the role of broader social inequalities: the key point is that their focus for action differs.

From contested research . . .

Given the diverse nature of the field of health inequalities, it is unsurprising that no one discipline or research method has been able to provide unitary or definitive accounts of the cause of inequalities in health on which policy could be based. In this respect, Weiss (1986) has cogently argued that:

(a)s more studies are done, they often elaborate rather than simplify. They generate complex, varied and even contradictory views of the social phenomena under study, rather than cumulating into sharper and more coherent explanation. The effect may be to widen and enrich our understanding of the multiple facets of reality, but the implications for policy are *less* simple and clear cut. When the diverse research conclusions enter the policy arena, the direction they provide for policy is confused. Advocates of almost any policy prescription are likely to find some research generalizations in circulation to support their point of view. (Weiss, 1986, p. 39)

From an even less sanguine view of the effect of research findings on policy, the problem is not just that even complementary (rather than obviously contradictory) research findings are open to multiple interpretations. A sceptical view suggests that research which bears out the predilections of administrators or their Ministers is far more likely to be used than research which runs counter to them, and that large social issues are usually resolved on the basis of party politics (Thomas, 1983).

. . . to ambiguous policies . . .

Although the perennial response of the academic community is inevitably that more research is needed for clarification and greater certainty, Nazroo (1998) points out that the continued search for causal mechanisms in health inequalities obscures wider social inequalities, and difficult and dramatic interventions can continue to be avoided. Inequalities in health thus become 'a problem requiring technical interventions tailored to individual diseases and individual circumstances rather than a reflection of social malaise' requiring political action (Nazroo, 1998). Booth (1988) suggests that the assumption that more information makes for better decisions is probably mistaken, and that the real question for policy makers may be, how to choose what to safely ignore? He argues that the 'view from the frontline' of policy making is that it is more rational to accept ignorance as a condition for action than to strive for certainty or to rely too much on the help which research can give.

Research casts events in a fundamentally different light from policy and rarely provides the breadth of vision that policy makers require. Epidemiological research, for example, abstracts a number of variables from the wider context and examines them in a controlled and systematic way that bears little resemblance to the 'real world' of policy making.

In order to reflect on the political implications of the multiple discourses in research around inequalities in health we need to consider some general models of how research findings relate to social policy-making processes. Booth (1988) discerns four models of the relationship between research utilization and policy. The 'purist' model (research generates knowledge that impels action) and the 'problem-solving/engineering' model (policy requirements drive research) are both rejected for their overly narrow view of the functions of research, simplistic view of the workings of the policy process, and inapplicability to the field of social policy (Booth, 1988). Two more relevant models are the enlightenment and political models. The enlightenment model suggests that research creeps into policy in diffuse ways by a slow process of osmosis, helping to shape policy makers' perceptions of reality and their understanding of possibilities for action. Research is used for ideas as much as data, subtly altering the parameters of the debate. In this model, the reality of the fragmentation of power and responsibility means that many are involved in a slow, cumbersome process of policy decision making. In short, policy decisions are not made—they accrete. From this perspective, the enlightenment model is pertinent to the utilization of research that merges with other forms of knowledge (including 'common sense') in shaping policy. The evidence for continued social inequalities in health has accumulated for over a century in Britain, and contemporary social policies reflect this filtering effect. One example is the shift from seeing socially stratified differentials in health as 'variations' under Conservative administrations to their explicit acknowledgement as 'inequalities' under the present Labour government. However, although more sophisticated than purist or problem-solving models, the enlightenment model neglects to take account of how political ideology shapes the relationship between research and policy—in particular, what type of evidence is accepted.

Booth's (1988) 'political' model argues that research is a political activity in an adversarial system of policy making. Different groups, different interests and different ends are all involved in the policy process. In this model, research can fulfil multiple purposes for policy makers: it can legitimize policy, vindicate policy makers' actions, function as a mechanism of control, have symbolic value or decorative effect, or 'lace policy making with the appearance of rationality' (Booth, 1988, p. 289). Research can also be used as political positioning, as a tactical ploy to head off criticism, delay action, or as a source of ammunition for fighting political wars. Within this model, research information is partisan—promoting some interests and undermining others. The health inequalities debate has arguably fulfilled most of these functions for all political parties in the UK. Given the diversity of interpretations surrounding inequalities in health, the political model is particularly apposite: competing explanatory discourses are frequently used to invoke solutions of differing political significance and economic cost. Booth (1988) suggests that

such ambiguity is essential (from the policy makers' perspective), as it leaves policies open to a variety of interpretations compatible with many interests and allows flexibility in dealing with problems arising from implementation.

. . . and shifting discourses

The contested nature of the various explanations around health inequalities facilitates such flexibility and is compatible with complex ideological shifts between different types of discourse. One result of this is ambiguous policy initiatives that place responsibility for action at the community and/or individual level, rather than at that of national government strategy. The majority of workers in the fields of health services and community development would justifiably reject suggestions that they knowingly utilize a 'moral underclass discourse'. Nevertheless, government initiatives based on 'empowering' types of health promotion and community development activities can unwittingly be a thinly disguised veneer for the classic victim-blaming approach and the social marginalization of the problems of poverty, relative deprivation and poor health. Work on developing social integration and cohesion at the community level and combating social exclusion is currently being undertaken in many communities as 'bottom-up', grass-roots initiatives have experienced a steady rise in popularity over the last couple of decades. However, promoting social citizenship as one of the principle responses to inequalities and other difficulties in society is unsustainable without adequate social welfare safety nets (Hutton, 1996; Bartley *et al.*, 1997). Critics have also pointed out that encouraging communities to develop their own strategies for combating social problems is a less than admirable way for the Government to solve pressing problems with regard to social order³ and the increasing costs of the welfare state (Wainwright, 1996). Farrant (1991) has documented the underlying contradictions and tensions of community development work, drawing attention to the historical roots of community development in colonialism where, far from being inherently radical, it was employed to safeguard and further the interests of the ruling class and reduce the burden on colonial administrators. From this perspective, the drive for social integration can be viewed as part of a political prescription for community manipulation.

The identification of discourses is both an analytical device and a means of empirical description (Levitas, 1998). RED, MUD and SID provide three potential strategic approaches but they remain partial, like the contested explanatory frameworks on which they are based. In the UK, government policy documents have stressed the importance of individual health behaviours and lifestyles, based on the assumption that individuals control their own lifestyles and that approved changes will improve health outcomes (Department of Health, 1992). More recent policy documents have begun to acknowledge the role of poverty and social inequality in shaping life circumstances and impacting on health (Department of Health, 1998b; Department of Health, 1999). There are similarities between redistributionist and social integrationist approaches in seeking to narrow the gap

between rich and poor, but the latter type of discourse is arguably dominant in contemporary social policy. Utilizing RED-type solutions aimed at poverty elimination is undoubtedly an uphill task as this approach requires political will to action that extends beyond the life of any one parliament. Such policies are likely to meet with considerable resistance on both ideological grounds (e.g. accusations of nanny state-cum-social engineering tactics) and pragmatic grounds (e.g. unpopularity with certain sectors of the voting population).

Contemporary initiatives include an emphasis on reducing 'pathological' lifestyles, e.g. by eating a better diet, quitting smoking and increasing physical activity; these can be categorized as a MUD-type solution. Although most UK policy documents now acknowledge the impact of poverty and deprivation on health, a redistributionist discourse is rarely explicit and many policy initiatives aimed at tackling health inequalities provide a better fit with a social integrationist discourse model. A plethora of community-based initiatives are founded on the explicit assumption that multi-level, multi-sectoral partnership working at community level, e.g. through Healthy Living Centres and Health Action Zones, is the best way to tackle the problem (a SID-type solution). In particular, work is seen as the best route into a healthier life, principally through the New Deal and Welfare to Work initiatives, even though being in paid employment guarantees neither freedom from ill health and poverty for the individual nor cohesion for the community. Although the weight of evidence indicates that inequalities in health can only effectively be tackled by policies that reduce poverty and income inequality (Shaw *et al.*, 2000), individualistic explanations and solutions to health inequalities will probably continue to be highly acceptable to any government. Such approaches are inevitably less costly (in economic and political terms) than redistribution of resources through increased welfare benefits for the poor and progressive taxation for the wealthy.

In summary, it seems likely that the complexity and lack of consensus inherent in the discourses surrounding health inequalities provides the flexibility and ambiguity cherished by policy makers. Ambiguity facilitates claims of government leadership in tackling the issue through the publication of consultation and policy documents, whilst simultaneously avoiding dramatic action at the level of the social structure. At the same time, the increasing popularity of community development initiatives, and political emphasis on social integration rather than equality, enables the government to devolve responsibility for action to the community and individual level. Awareness of health inequalities is now central to contemporary political debates but responsibility for any failure to reduce the health divide will be shared by many throughout society.

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all their points and remaining flaws are my own responsibility. Thanks are also due to Dr Sarah Cunningham-Burley and Dr Amanda Amos, of Public Health Sciences at Edinburgh University, for their helpful comments.

Notes

- ¹ The term model is used here in its Weberian meaning of 'ideal-type', in the sense of an heuristic tool rather than claiming a correspondence with reality.
- ² It should also be noted, however, that developments in statistical manipulation fail to compensate for the wider failure to address problems of the relationship between structure and agency (Thomas, 1999; Rogers *et al.*, 1997).
- ³ For example, it is suggested that increasing social capital and social inclusion at the community level will reduce crime and social disorder (Kawachi *et al.*, 1999).

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Research Outline: Health Promotion, Advocacy and Health Inequalities

Background

Although a vast research literature on the social patterning of inequalities in health has emerged during the last 20 years, there has been almost no British research on health advocacy apart from more narrowly conceptualized patient advocacy studies. The main aims of this studentship are:

- to provide a clear conceptual framework for health promotion advocacy that will be useful to a range of institutions and groups concerned with health inequalities.
- through a case study approach, to offer an informed critique of health promotion practice, highlighting the potential for and barriers to effective advocacy.
- to contribute to the understanding of social exclusion in relation to inequalities in health, public involvement in health policy, and new ways of working in health promotion, including multi-sectoral activity.

This research project will be the first of its kind within the UK and will contribute to new knowledge in this developing dynamic area. The studentship is funded for three years by the Economic & Social Research Council and HEBS and will be carried out by Sandra Carlisle, a PhD student in Public Health Sciences at the University of Edinburgh.

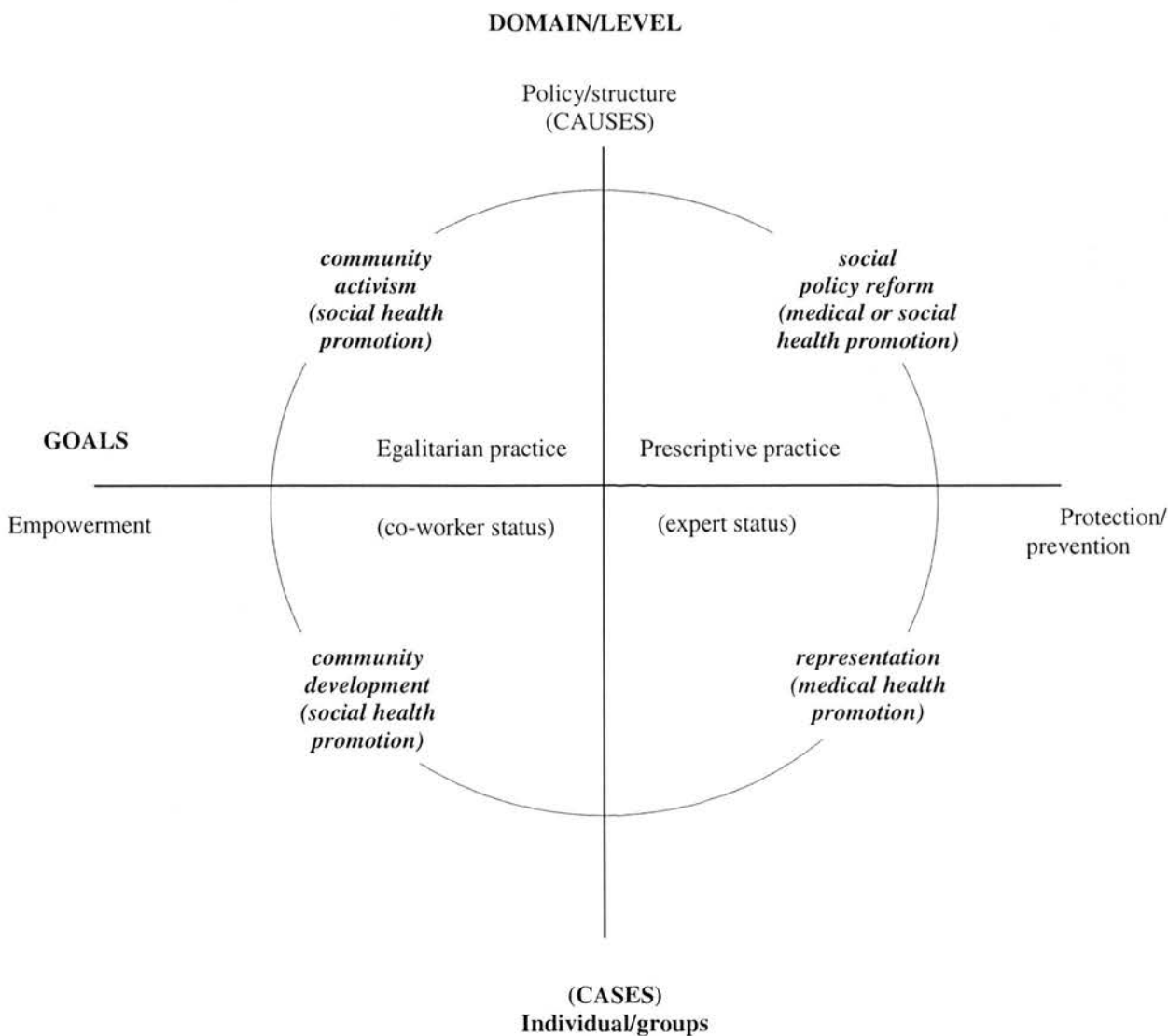
The case study

A wide range of structural factors (including economic, social, cultural and environmental influences) act as barriers to health and need to be addressed if health promoting goals such as reducing health inequalities are to be achieved. Although a focus on 'health promotion' is central to the studentship, it should be recognized that not all health promotion activity takes place within health promotion departments or Health Boards. The researcher has therefore drawn a distinction between health promotion *practice* (as the fairly narrow preserve of professional specialists) and health promotion *work* (which incorporates specialist practice but also acknowledges the important role of other sectors, such as local authorities and voluntary organizations). This approach helps to anchor the research within the broader social context of efforts to tackle health inequalities.

The public health White Paper, 'Towards a Healthier Scotland', has implications for many service providers and it is obvious that numerous organizations and groups are involved in tackling health inequalities around Scotland, whether explicitly or implicitly. Identifying a suitable 'case' to study has therefore been a major research task. Preliminary work led the researcher to conclude that Social Inclusion Partnerships (SIPs)

have particular potential. There are, of course, other area-based health alliances around Scotland but SIPs seem likely to have the capacity to cross the boundaries between different types of advocacy, to shape policy at the local level, and influence policy at the national level. The [-] SIP is especially interesting because of its specific focus on tackling health inequalities through working at individual, community, partnership and policy levels – in effect, at all levels of advocacy identified in the framework below.

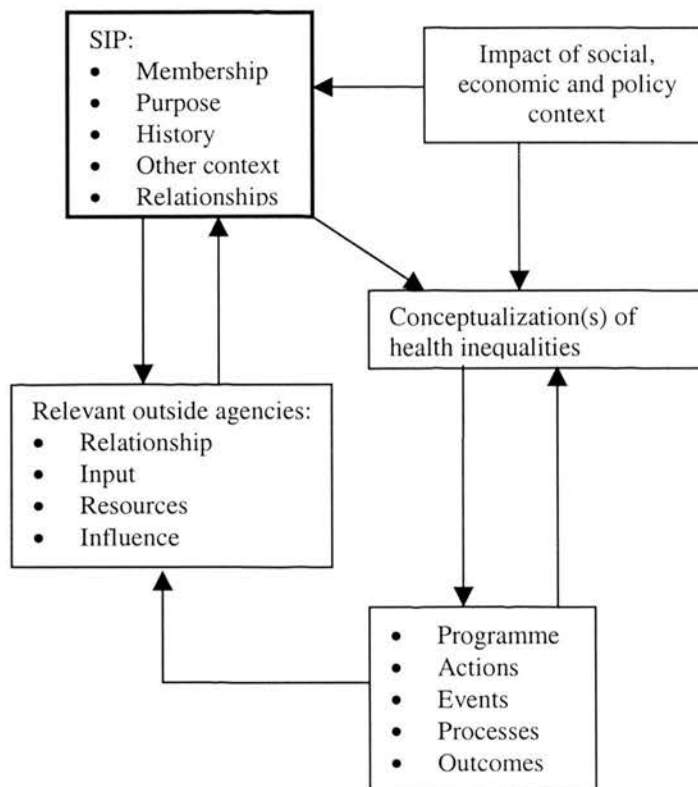
A conceptual framework for advocacy in health promotion



Research methods and questions

Within the case study approach, design is an ongoing process during the research and will involve multiple qualitative research methods. For example, key workers in the institutions, groups and community will be interviewed to gain their perspectives. Relevant SIP activities will be observed (e.g. meetings of the management board, community meetings/conferences) and documents will be analyzed (e.g. policy papers, discussion documents, minutes of meetings). Broad research questions are: how can advocacy for health be used to tackle inequalities in health? What is the potential of a health advocacy approach to undertaking work on health inequalities? These questions will be refined within the specific context of the [-] SIP. Given below is a diagrammatic framework of the key relationships and other contextual factors to be considered in the case study:

Case study framework



Researcher access and ethics

I recognise that ongoing negotiation will be required throughout the life of the project in order to obtain access to the field of research, and consent from the key players to be observed/interviewed: no one person or organization is in a position to grant this 'up front'. All research may exploit its participants, knowingly or not, so ethical agreements are important. The following criteria are suggested:

- Codes for protection of research participants (and their data) should be heeded.
- Limits of accessibility should be agreed with participants.
- Issues of observation and reportage should be discussed in advance.
- Participants should receive drafts of how they are presented, quoted, or interpreted.
- Levels of confidentiality or anonymity need to be agreed.
- The researcher should avoid low-priority probing of sensitive issues.

I have an academic background in medical sociology and anthropology and several years' experience of using qualitative methods of research and evaluation in primary and community care. As a contract researcher based variously within university departments of general practice, postgraduate medical education, and the voluntary sector, I have undertaken a number of projects. These include research on GP home visits to elderly people (on Tayside), informal community support for family carers (across Highland), and the evaluation of various initiatives relating to continuing professional development in primary care (for the National Assembly of Wales). She is now based in Public Health Sciences at the University of Edinburgh as a PhD student. The studentship began in October 1999 and will finish in September 2002.

Sandra Carlisle
December 2000

Interview Topic Guide

**East Kirklands Social Inclusion Partnership
(Interim Management Group, Interim Sub-Group and formally elected
Community Representatives)**

First I'd like to get a bit of background information about you, before moving on to talk about East Kirklands generally. (where appropriate, explore: age; residence in East Kirklands area - which neighbourhood? for how long? any other family members? friendship networks? nature/extent of involvement with any local community organisations? work base in East Kirklands? work base elsewhere? in statutory/ voluntary sector/other? If connected with local community, name of organisation? role/job title? remit/responsibility? length of employment?)

Can you tell me what it's like to live/work in the East Kirklands area? (explore positive/negative aspects plus, if appropriate to the research participant, information about local history; social environment/culture; physical environment/housing stock/leisure facilities; local economy/unemployment levels; schools and other educational facilities; age distribution of population; religious/political characteristics/potential conflict; awareness of illness/disability levels; crime levels; history and quality of working relationships between statutory and voluntary organisations; between statutory organisations and community; between voluntary organisations and community) **(also explore whether the participant thinks other community members might offer different accounts, and how these might differ)**

A lot is talked about health inequalities - can you tell me what 'health inequalities' means to you? Do you think other members of the community would agree with your meaning, and if not, how might they differ? Reducing inequalities in health is a national policy priority for the Scottish Executive and at Westminster - do you think 'health inequalities' are a local priority? What else do you think is important to local people? What do you think would be the best way of improving health in the local community? Do you think other local people share your views about these issues? Who might hold different views? How might they differ?

How did you get involved with the East Kirklands SIP? (check out: background to involvement - personal interest/professional nomination; nature of involvement - role, responsibilities; perceived status within partnership both as individual and organisational representative; degree of influence within partnership; frequency of attendance at meetings)

What do you think the East Kirklands SIP trying to do? (areas to explore where appropriate and if not spontaneously mentioned: improving 'community' health; improving individuals' health; reduce health inequalities; reduce social exclusion; promote social inclusion; stimulate urban regeneration; improve working relationships amongst service providers; deliver better services/more efficient expenditure; influence policy making; stimulate community development; stimulate voluntary sector development) **(in every case, check out what these concepts mean to the research participant and which individuals/groups in the community s/he believes they apply to)**

I'd like to talk to you about working in partnership for health improvement, about its potential, the problems and benefits of this approach. (possible areas to explore: are any key players not represented in the SIP partnership? has the SIP achieved a shared health improvement agenda or do multiple views exist? what, if any, are the areas of disagreement? who are the key players in terms of leadership, decision-making, agenda-setting, expenditure influencing? who has least influence, and why? what kind of influence, if any, does the SIP have on local people's lives?)

What do you think is the best way of getting the community involved in the work of the SIP? (areas to check out: perceptions of the two community conferences and the nomination/election procedures; what community involvement means to the research participant and whether s/he thinks others would agree; who tends to get involved and why; what are the difficulties around community involvement – for example, in differing local priorities, potential areas of disagreement, local politics, reaching people who don't normally get involved?)