Participation for Health Equity

A comparison of citizens' juries and health impact assessment

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LAY SUMMARY

This doctoral thesis examines how public participation techniques might create healthier and more equitable public policies. We know that social, environmental, political, and cultural factors are the primary causes of health, yet policy efforts to improve these have largely failed to reduce inequities. One way to create 'healthier' policies is by including public perspectives in policy design. Different forms of participation have been developed and used to do this. Yet we still don't know exactly how public participation can improve health equity. This research addresses this gap by examining how two kinds of participatory processes might affect health equity, by empowering participants and making better policies.

I used qualitative methods to compare four case studies of participatory processes – called citizens' juries and health impact assessment – in the United Kingdom and Australia. A key finding of this research is that the context and individual characteristics of participants made a big difference in what outcomes the process produced. Different forms of power were apparent within the processes. These influenced how they were implemented, experienced, and produced different outcomes that support health equity.

Some forms of public participation can help improve health equity but rely on citizens with the capacity and power to participate. Public health theories have begun to focus on power as a 'fundamental determinant' of health inequities. This research adds to our understanding of this by demonstrating that power dynamics in participatory spaces make a huge difference in whether they can achieve their intended benefits.

ABSTRACT

Despite research demonstrating that the social determinants of health are the primary cause of health inequities, policy efforts in high-income countries have largely failed to produce more equitable health outcomes. Recent initiatives have aimed to create 'healthier' policies by incorporating public perspectives into their design, and scholarship has focused on improving participatory technologies. Yet how participation can improve health equity through policymaking for the social determinants of health remains unclear. The thesis addresses this gap by examining how two examples of participatory technologies implemented in Australia and the UK -- citizens' juries and health impact assessment -- affected health equity. I found that the intersection between context, positionality and process generated a range of direct and distal outcomes for health equity.

I conducted a qualitative comparative analysis of four case studies of participatory processes, including interviews and document analysis. In doing so, I examine how processes were contextually designed and delivered, personally experienced, and how their adaptive and interpretive nature produced outcomes relevant to health equity.

Though participatory technologies were often designed and promoted as uniform tools, the context in which they were employed profoundly affected their implementation. Processes were embedded within different participatory ecologies -- histories, spaces and practices – that shaped their aims, design and delivery. Similarly, individual characteristics of participants (especially their positionality) affected how they interpreted the process: what the process could achieve and how they should participate. In turn, participants' experiences resulted from (in)congruence between their expectations and outcomes.

The participatory experience led to various personal outcomes, including civic skills, social capital and empowerment, which can benefit health equity. 'Having a say' was often described as the vital ingredient for why participants experienced empowerment. Yet what mattered most for generating this outcome was whether or not participants 'felt heard.' This dialogic process between participants 'voicing' and decision-makers 'listening' was core to the experience of empowerment.

The processes also led to governance outcomes. The level of impact on the intended decision ranged, with some processes creating direct effects, but more commonly, by being situated in participatory ecologies, the processes affected change through non-linear or diffuse channels. Though public participation is often structured to achieve a technocratic goal, the processes accomplished other participatory, epistemic and institutional aims. These non-technocratic outcomes, combined with decision-making changes, could improve governance for the social determinants of health.

Power acted as a mechanism that underpinned other elements of the processes. Public health theories have begun to focus on the role of power as a fundamental determinant of health inequities, and this thesis contributes to this emerging body of evidence by examining how instrumental, structural and discursive forms of power were enacted and influenced how processes were implemented, experienced, and what outcomes they produced.

By examining not just *what* outcomes occurred but *how* they arose, this research develops a better understanding of the underlying mechanisms that generate outcomes. This shifts evidence from 'perfecting the form' toward building an understanding of how to utilise participatory approaches within specific contexts to achieve health equity benefits. The thesis highlights the need for greater consideration of context, positionality and variability of experiences in public participation. If participatory processes seek to achieve specific outcomes (healthy public policy and empowerment) that improve health equity, then consideration must be given to the mechanisms that can produce these effects.

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50K	50,000 Affordable Homes
AB	Airds Bradbury
CBPR	Community-based participatory research
CJ	Citizens' Jury
CSP	Community Solutions Panel
CRC	Critical realist comparison
CSO	Civil society organisation
HIA	Health Impact Assessment
HiAP	Health in all policies
MTM	Measuring the Mountain
PAR	Participatory action research
PB	Participatory budgeting
SDOH	Social determinants of health
WG	Welsh Government
WHO	World Health Organization

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CHAPTER 1 STRATEGIES FOR HEALTH EQUITY: THE ROLE OF PUBLIC PARTICIPATION

1.1 Towards an understanding of the causes of the causes

This thesis is not just the culmination of five years of painstaking doctoral research; it is an attempt to answer a question that has been forming in my mind over 15 years of professional work and experience. I recently looked back at an essay I had written for entrance to my graduate programme in public health at the University of Michigan. At the core of my argumentation about why I should be accepted to the programme was a rejection of conventional approaches to health (which in the US is primarily based on healthcare access). Whether or not people get sick or stay well is an issue of social justice. This perspective reflected academic training (my undergraduate degree was in social relations) and significant personal experiences. My first job post-graduation was determining the eligibility of people applying for social services in Michigan. I had the unfortunate job of (sometimes) accepting and (more commonly) rejecting applications for state-funded health care (Medicare/Medicaid). I recall sitting with a man who looked just like my father to discuss his application. He had coronary heart disease leading to an inability to work, thereby losing his medical insurance to care for his heart condition. As a single, middle-aged man, the state provided no alternative healthcare insurance[1]. Commonly, my clients weren't just sick; they were also poor. Clearly, health and wealth were related, and this issue required state-supported social change, not personal remedies. This began my quest for health equity.

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[1] This was prior to the implementation of the Affordable Care Act (2010). The ACA, in theory, opened up access to health insurance that had previously precluded access for people like my client. In practice, healthcare access in the US remains a critical issue reflective of deep social injustices (Gaffney & McCormick, 2017).

In the years that followed, I pursued whatever path I believed would lead me to the solution. This took me through completing a master's degree in public health, in which I increasingly focused on health equity and the social determinants of health. I then took on a position post-graduation, working on expanding the use of health impact assessment (HIA) in the US. This two-year position would serve as an opportunity to cut my teeth on 'doing' HIA and launch a ten-year career working in the HIA field in Australia and the UK. Yet throughout my career, this searching for the 'cause of the cause' of health inequity has remained with me.

Health impact assessment is a valuable tool for integrating the consideration of health impacts into decisions that affect the social determinants of health. I am an HIA practitioner and former President of the Society of Practitioners of HIA and have spent a good portion of my career advocating for its use. Yet I remain aware that there are limitations and things we still do not understand about how to apply this tool best to improve health equity. Acknowledging these gaps in my knowledge and observing that despite the abundance of research in this area, there remain pernicious health inequities prompted me to ask, 'what don't we understand?'

This thesis is an interrogation of the academic body of evidence and my professional understanding of what causes health inequities. It is embedded in the public health literature but expands upon this, linking to the fields of public participation and deliberative democracy to search for better, more inclusive explanations. This research is also situated in a critical realist paradigm (Danermark et al., 2002) – I believe that there are fundamental explanations for how the world works (reality), even if they are not always apparent. Critical realism also informs an axiological position or the values that inform my research. As critical realism is based on an understanding of the world in which reality is emergent (created through generative mechanisms), there is an understanding that the world doesn't need to be the way it is, and research should consider how to change things to improve it (DeForge & Shaw, 2012). As Flyvberg (1998, p. 5) states: "After all, we tell stories in order to do things differently." In essence,

this research is a story rooted in a belief that society can be 'done differently' to be more equitable.

In this chapter, I provide the conceptual background for the problem: why do health inequities persist, and what strategies have been used to address them? I then examine the role of public participation as a mechanism for improving health equity based on concepts of power and the social determinants of health. I discuss how public participation has been theorised as a strategy within the academic literature and implemented through policy contexts in the UK and Australia (where most of my professional experience has taken place). Based on the conceptual background, I state the research problem and provide the research questions that best address the problem. Finally, the research design is summarised, and an overview of the thesis structure is provided.

1.2 The problem of health inequity

It is well recognised that health and well-being are generated through more than just individual, genetic, or behavioural factors but are caused by broader social, political, economic and environmental conditions. These conditions, called the social determinants of health (SDOH), are responsible for the majority of variations in health outcomes (Marmot et al., 2008). Figure 1 shows the connection between the unequal distribution of health and socio-material circumstances, social position, and socioeconomic and political determinants. Public policies, macroeconomic conditions and societal norms are considered the 'causes of the causes' as they determine the distribution of other resources necessary for achieving health across the population.

Figure 1 Conceptual Framework for the Social Determinants of Health, (Solar & Irwin, 2010)
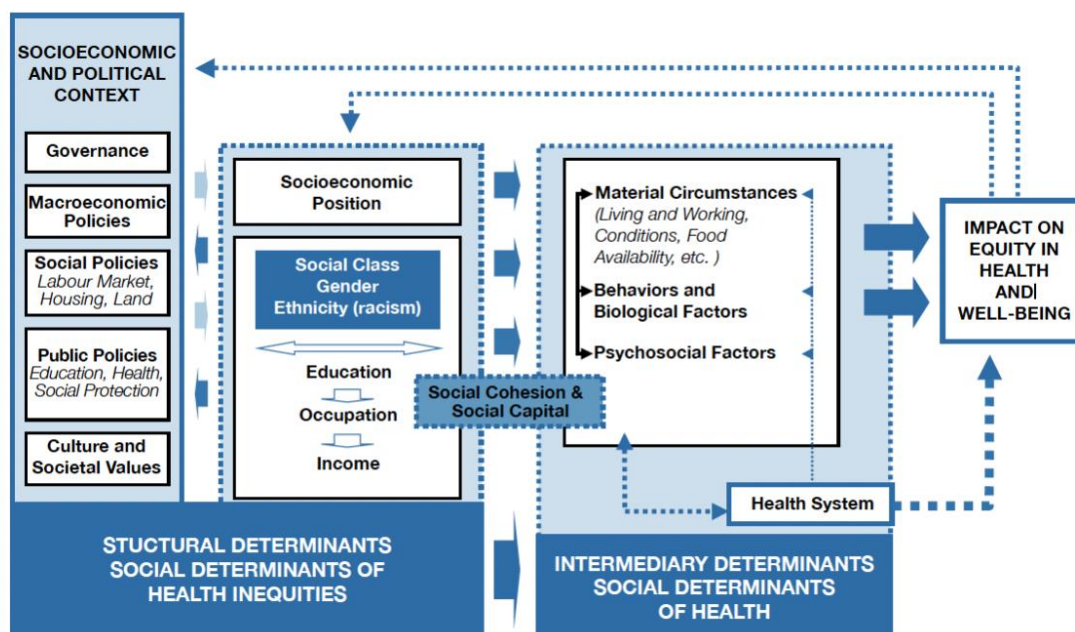
Differences in health outcomes that are both avoidable and unfair are considered health inequities (Whitehead, 1991). I use the term 'inequities' rather than 'inequalities' intentionally. There is a lack of consistency in the field regarding the use of these terms, with both 'inequity' and 'inequality' being used interchangeably (Braveman et al., 2011), with different meanings depending on the country and policy context. 'Inequality' refers to any difference in health status, whereas 'inequity' refers to a difference in health status that is both avoidable and unfair (Whitehead, 1991). In this document, I used the term health in/equity thereby framing my research around perceptions of fairness and rights, rather than measurable differences in health status (for more on framings of health equity language see (Freeman, 2006)). The term 'health equity' fits within my stated research axiology – that variances in health do not need to be the way they are. If differences in health are unnatural and unfair rather than inherent disparities, then we can look for strategies to address them.

It has been argued that effective strategies to tackle health inequities must address multiple determinants of health (Arcaya et al., 2015) across multiple levels of intervention (Whitehead, 2007). Despite the growing evidence base to support this multi-tiered approach, policy interventions aimed at improving health inequities have largely failed to produce more equitable health outcomes (Cairney et al., 2022a; Hunter et al., 2010; Mackenbach, 2010; Mackenbach, 2019) and most policy responses have been centred in the health sector, focusing on more efficient care (Baum & Laris, 2010). While 'prevention' as a policy priority gains traction (Boswell et al., 2019a), in practice, these initiatives are commonly sidelined by competing priorities and policymaking constraints (Cairney & St Denny, 2020) (as was the case for prevention strategies during the Covid-19 pandemic (Cairney et al., 2022b)). Tackling 'wicked problems' like health inequities (Petticrew et al., 2009) requires looking beyond the health sector for interdisciplinary approaches that employ different thinking and strategies than those used in the past (De Andrade, 2018). After all, if health inequities are formed through social, environmental and political conditions, then looking to these fields for answers should be apparent (if not commonly practised).

In recognition of the need for different approaches, there has been growing support for using public participation as a strategy to address health equity. The WHO framework for tackling social determinants of health inequities (Figure 2) shows the connection between intersectoral action, participation, empowerment and health equity (Solar & Irwin, 2010). Policy action is required to affect macro (societal), mesa (community) and micro (individual) level health determinants. Intersectoral action, social participation and empowerment crosscut the different levels of health determinants through shaping public policies that reduce the unequal distribution of determinants, unequal exposures and vulnerabilities for disadvantaged people, and unequal consequences of illness. This research seeks to understand how public participation can be utilised as a strategy for intersectoral action and empowerment toward achieving greater health equity.

Figure 2 WHO Commission on SDOH framework for tackling social determinants of health inequities (Solar & Irwin, 2010)
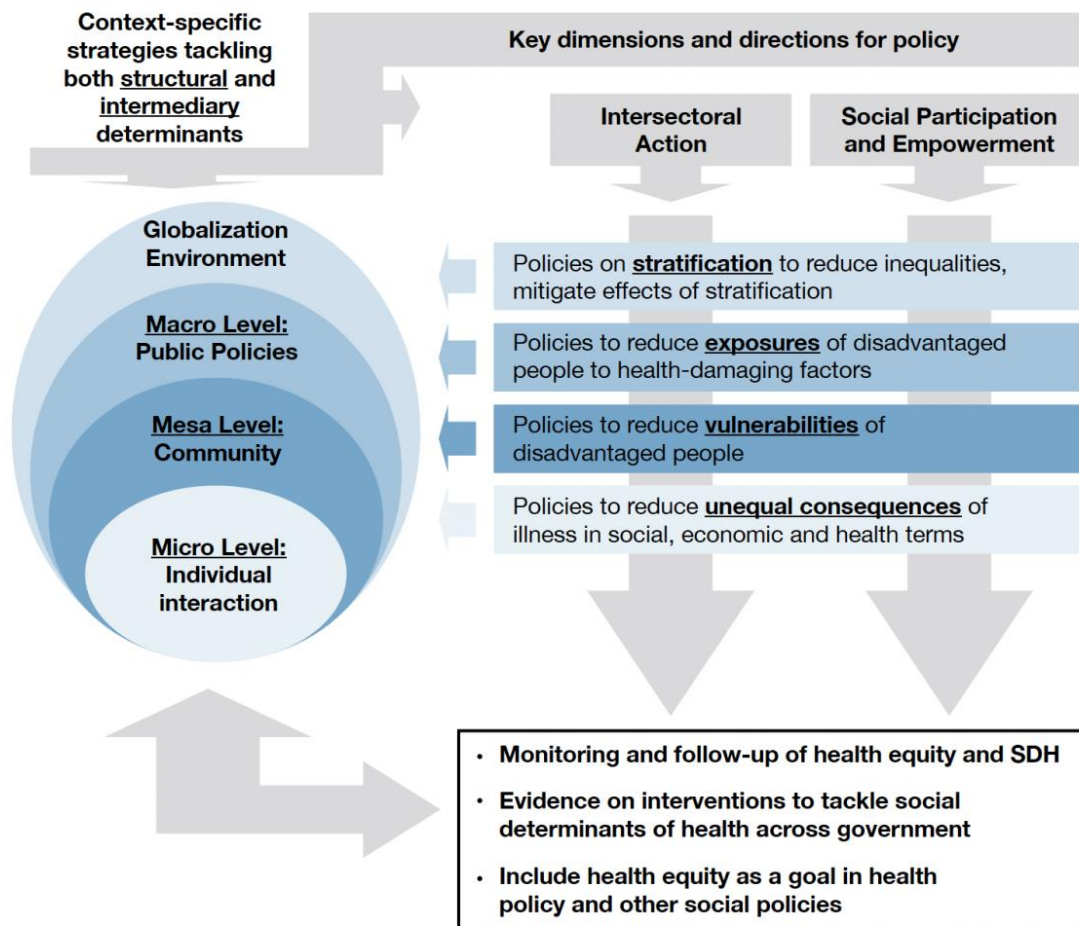
Participation is envisioned as improving health equity through public involvement in four key ways, which I will discuss: healthcare decision-making, developing 'healthy' public policies, empowerment and directly improving health status. While patient and public involvement (PPI) in healthcare are important, as I have established, health equity is mainly created through conditions outside healthcare settings – the social determinants

of health inequities. What is needed is an examination of participation within broader policy contexts. Therefore, this thesis does not focus on PPI as a strategy for health equity. Rather, it examines public participation through the remaining three pathways: developing 'healthy' public policies through intersectoral action, empowerment and directly improving health status.

There is growing recognition that people who are experiencing health inequities are well positioned to inform policy development that addresses fundamental causes (Blencowe et al., 2015; Popay et al., 2003). Yet this is complicated by conflicting research demonstrating that lay understandings of health sometimes consider fundamental causes (Smith & Anderson, 2018) but may also prioritise proximal determinants (Putland et al., 2011). Public participation can be viewed as both an asset and a barrier to health policy development, research and service delivery (Pickersgill et al., 2019). Furthermore, there are challenges in identifying who 'the public' is, along with a lack of clarity around which practice of public input best captures the 'public voice' (Boswell, 2018). This incongruence between community understandings and public health strategies (De Leeuw, 2016) poses an interesting quandary: how best can citizens inform policy formation on the social determinants of health?

A second strategy for public participation is involving people in decisions that affect the social determinants of health to create 'healthier public policies' (World Health Organization, 1986, 1988). Integrating consideration for health across all public policies, known as health in all policies (HiAP), has been shown to promote health equity (Hall & Jacobson, 2018). Involving citizens in the development of public policies has been supported as a strategy to enhance the effectiveness of the formation of healthy public policies (World Health Organization & Ministry of Social Affairs and Health Finland, 2013). Some of the formal engagement tools promoted by the WHO to achieve HiAP include citizens' juries (CJs), health assemblies, deliberative meetings, community town hall discussions, or online and social media forums. The rationale underpinning these recommended approaches is that public participation can lead to better integration of

public perspectives, priorities, and concerns, which can improve the creation of health-promoting policies (particularly those that support the SDOH).

Thirdly, participation is also supported as an approach to improve health equity through enhancing empowerment (De Andrade, 2016; Milton et al., 2012; Zimmerman & Rappaport, 1988). Empowerment is seen as improving health equity through increasing individual, organisational and community control. At the individual level, empowerment strategies like public participation develop self-efficacy, social capital, critical consciousness and political efficacy (Wallerstein, 2006) that can lead to individual well-being and contribute towards collective efforts to improve people's lives (Zimmerman & Rappaport, 1988). At the organisational level, empowered organisations more equitably distribute resources, are culturally appropriate, and enhance social capital (Wallerstein, 2006). At the community level, empowerment efforts can support communities in developing capabilities needed to enact control over decisions and actions that affect the social determinants of health (Popay et al., 2021).

Theorising empowerment as a strategy to improve the social determinants of health has important implications for policy, action, and research, but it is a contested concept. Empowerment can be conceptualised in different and often incompatible ways (Solar & Irwin, 2010) and can lead to an over-emphasis on individual empowerment approaches without consideration for changes to other power dynamics. Action on empowerment requires more transparent ontological positions and clearer conceptualisation (Weber & Castellow, 2011) to ensure that empowerment strategies achieve their intended aims. Additionally, actions that seek to enhance empowerment require better evaluation to determine the actual effects on individual and community empowerment (Evans et al., 2010). A better understanding of the outcomes of empowerment strategies can ensure that they are fit for purpose but may also highlight ways in which empowerment strategies are insufficient for improving health equity.

Interestingly, the WHO framework combines empowerment and public participation into one strategy. This reflects how public participation and empowerment are often conflated

as the same thing: 'empowerment projects' invite people into decision-making using the 'mantra of empowerment talk' (Eliasoph, 2016), and the ultimate aim of participation as a means to an end (Nikkhah & Redzuan, 2009) is to empower (Arnstein, 1969). My thesis diverges from this normative viewpoint to view public participation as a complex, contested structure with myriad aims and outcomes. I examine how public participation can be an empowerment strategy but may also support action on the social determinants of health or directly affect health equity.

Lastly, there is evidence that public participation can produce outcomes that directly ameliorate health inequities. A systematic review found that community engagement initiatives could improve conditions in the social determinants of health, such as housing, crime, social capital and social cohesion; environmental and socio-economic indicators such as employment, education and income; and direct health benefits, including physical and mental health and quality of life (Popay et al., 2007). A recent review found positive impacts on social determinants (housing, crime, social capital) but no evidence of improvements in population health (Milton et al., 2012). Health benefits from participation are often demonstrated through intermediate determinants, like housing or social capital, and there is a need for better evidence to understand these health pathways. Furthermore, there is growing recognition that the determinants of health are not the same determinants of health inequities. While the SDOH include the conditions in which people live, learn, work and play, the social determinants of health inequities are the factors that produce the distribution of living and working conditions (e.g. political power) (Marmot, 2005). This brings into question whether participation affects health equity through direct health effects (for example, through decreasing stress), through intermediate benefits (social capital, empowerment, etc.), or through affecting governance for the social determinants of health (or some combination of all three).

Therefore, public participation remains a central strategy in the arsenal of approaches to improve health inequities. The potential to improve public policy creation, enhance empowerment, and directly affect the social determinants of health (the three strategies for health equity) have enticed the expansion of participatory technologies and

contributed to the institutionalisation of public participation by governing bodies (a move towards what Lee and McQuarrie (2015) call 'the public engagement industry'). In the UK, a proliferation of recent deliberative innovations, described as the 'deliberative wave' in British policymaking, has shifted the debate about democracy (Tyers et al., 2020). Efforts by institutions to more broadly implement participatory practices can be seen as an approach to moving away from bureaucratic government toward community-led governance (Newman et al., 2004). On the face of it, such an approach implies a shift away from powerful institutions towards more community control. Yet, some have questioned this approach, highlighting the ways that policies which ostensibly liberate communities may engender greater social control through surreptitiously influencing the behaviour of citizens (Rolfe, 2018). There is also the concern that participation that focuses on enhancing empowerment and community control (a key strategy of asset-based health promotion) can shift the responsibility to communities for structural issues that remain outside their control (De Andrade, 2016; Popay et al., 2021).

To understand the institutionalisation of public participation (Bussu et al., 2022; Dean et al., 2020), it is essential to examine the policy drivers for participation within specific contexts. As a public health practitioner, most of my work has been focused on UK and Australian contexts. Consequently, it made sense to focus my doctoral research on participatory processes that have been conducted in these places (I discuss how this informed my research methodology and case selection in Chapter 3). Therefore, I will now examine how public participation has been institutionalised in the UK and Australia.

In the UK, devolution, policy divergence (Rolfe, 2016), and differences in political actors (Escobar, 2022) have led to varied approaches to institutionalising public participation. In Scotland, drivers for public participation have been centred around key legislation aimed at institutionalising participatory governance. The *2015 Community Empowerment Act* enables greater citizen access to institutional decision-making, such as through existing Community Planning Partnerships and the introduction of Participation Requests (Scottish Parliament, 2015). As the name implies, the emphasis is on empowering citizens, granting greater power to participate in service improvement and extending

rights to control and ownership of assets, with a focus on tackling inequalities and socio-economic disadvantage. This approach reflects the political agenda of the Scottish National Party (in government since 2007), growing recognition of the need to tackle community issues through empowerment (see, e.g. Scottish Government and COSLA, 2009), and policy focus on community assets and co-production (see, e.g. Public Services Commission, 2011) (Escobar, 2022; Rolfe, 2018).

In comparison, England and Wales have different rationales for participation focused more on involvement in shared decision-making. The 'duty to involve' came into effect in both nations in 2009 and explicitly requires local authorities to 'embed a culture of engagement and empowerment' through consultation and participation of communities across local authority activities (Johnson, 2015). In Wales, changes to co-productive models of service delivery which emphasise empowering service users and shared decision-making (Phillip & Morgan, 2014) (as espoused in the *Social Services and Well-being (Wales) Act (2014)*) reflect a move toward prioritising individual choice and control. These calls for participation have been linked to a sense of democratic responsibility and an opportunity for community empowerment (Davies et al., 2006). Yet, the rise in public participation in the UK coincides with a shift from public investment to various forms of public-private partnership. Newman and Clarke (2009) argue that this decentering of the public sphere has provided the vacuum for public participation to flourish, yet it serves as a weak counterbalance to the withdrawal of state services and dwindling accountability structures.

In Australia, there has been a similar shift towards citizen involvement in public policymaking. Over the past 30 years, Australian national policy has shifted away from viewing the public as 'consumers' towards approaching the public as 'citizens' who should be involved in the co-production of policymaking (Holmes, 2011). This included the *2010 Declaration of Open Government,* which called for citizen collaboration in policy and service delivery design, strengthening citizen access to information, and making government more participative (Tanner, 2010). Different States and Territories have integrated this approach to varying degrees. Most recently, the *Victorian Local*

Government Act 2020 requires all 79 local government authorities in Victoria to conduct 'deliberative engagement' in their strategic planning (Local Government Victoria, 2020). The act is principles-based, meaning it does not legislate on how, precisely, deliberative engagement should be performed. The *Victorian Local Government Act 2020* and the *Scotland Community Empowerment Act 2015* are two of only a handful of regulatory frameworks that institutionalise deliberative democratic innovations worldwide (OECD, 2020b). Despite its similarities with the Scottish Act, the Victorian Act places responsibility for institutionalising democratic innovation with local authorities, an approach perhaps more similar to England and Wales. Conversely, in New South Wales, policy initiatives for public engagement are more focused on involvement (NSW Office of Local Government, 2022) and consultation (Christensen, 2018) rather than empowerment.

Policy initiatives in the UK and Australia reflect the increased mainstreaming of participation (Davies et al., 2024; Newman & Clarke, 2009) and the rationale for using participation as a mechanism to achieve empowerment and other democratic goals. There is a plethora of different approaches to participation (Participedia, 2013) and often conflicting (Barnes et al., 2007) rationales for their use (Bowen et al., 2010; Jolley et al., 2008; Roussos & Fawcett, 2000), and it is hard to know which approach is best utilised in each specific context and decision-making process (Mitton et al., 2009; Rowe & Frewer, 2005; Stewart et al., 2015). Additionally, there are many challenges in conducting public participation, including reaching appropriate publics, particularly the so-called 'hard-to-reach' (Lightbody et al., 2017); ensuring appropriate integration of citizens into various processes (Stewart, 2014); micro-dynamics of deliberation (Barnes et al., 2007); and the legitimacy of claims made within processes and the response to these by decision-makers (Cornwall & Coelho, 2007). The concept of participation[2] is also ill-defined and

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[2] There is a multitude of terms used to describe participation, including engagement, deliberation, co-production, collaboration, consultation, involvement; and also various concepts of audiences, such as citizens, communities, consumers, patients, participants, service-users, publics, and stakeholders. The convolution of these terms has led to a lack of conceptualization of each precise practice and differences between each process and public. For clarification in

misunderstood (Degeling et al., 2015), leading to practices that do not always best integrate public involvement (Stewart, 2013), that may intentionally manipulate populations (Cooke & Kothari, 2001) or create inequitable resource allocation (Matthews & Hastings, 2013). The focus on perfecting the form without considering context, and producing 'neutral' spaces of deliberation, ignores the "transformative potential of public participation…conditioned by the way in which a series of political and policy tensions are negotiated" (Newman & Clarke, 2009, p. 17). Additionally, relative to the multitude of engagement practices that take place each year, evaluation efforts are minimal, making it challenging to identify efficacy and best practices (Mitton et al., 2009; Nabatchi, 2013). While many participatory processes aim to achieve empowerment, participation alone may be insufficient to build the capacity of individuals, organisations and communities to effectively engage in political advocacy. Therefore, while there is increasing institutionalisation of public participation, there remains a lack of understanding about how it should be employed and to what end.

Assumptions about the empowering effect of public participation have also been called into question (Lee & McQuarrie, 2015). 'Empowerment projects' have been used to supplant state-funded support, shifting the burden for delivery of services to communities under the guise of autonomy, capacity-building and empowerment (Eliasoph, 2016). The focus on empowerment as individual choice may also conceal real economic and political power (e.g. privatisation of public resources may limit the choices of disadvantaged communities regardless of their 'empowerment') (Newman & Clarke, 2009). Furthermore, empowerment strategies shift the responsibility of welfare to communities and "provid[e] yet another example of neo-liberal 'unloading' of public services onto empowered and 'responsibilised' selves and communities who…are thereby made complicit in the contemporary workings of power and governance" (Sharma & Gupta, 2006, p. 21). These concerns reflect Cruikshank's (2019, p. 69) warning that "'empowerment' in and of itself

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this paper, the terms 'participation' and 'public participation' will be used to refer to all forms of participation.

is a power relationship and one deserving of careful scrutiny." Rather than merely seeking to empower, we need to ask what we are empowering people for.

As policy drivers for public participation grow, community developers, researchers, and government agencies have shifted to viewing engagement as a required rather than an optional activity (Lee & McQuarrie, 2015). In settings where there is no long-standing relationship with the community, this has led to engagement efforts that dip in and out, leaving community members with distrust and the belief that engagement efforts are tokenistic (De Andrade, 2016). This is particularly true for marginalised communities that have been bombarded with policymakers, practitioners and researchers seeking to "do participation" rather than cultivating the long-term relationships and trust required to effectively engage with such populations (De Andrade, 2016). Furthermore, there is recognition of the risk that innovations in participatory governance can exacerbate power inequalities through empowering already powerful communities (e.g., those with high SES or social capital) (Escobar, 2022). This has led some to claim that community participation policies can be regressive – placing greater responsibilities on and higher risk to disadvantaged communities who receive fewer of the benefits (Rolfe, 2018). The risks of public participation 'empowering the powerful' are even greater under the constraints of austerity measures (Hastings & Matthews, 2015). Newman and Clarke (2009, p. 18) warn that when publics are the focus of transformation (rather than institutions), there are always risks to participants:

> *Those invited to encounters with power in its many forms may go away disheartened – perhaps power did not listen, or listened but took no notice, or took notice but failed to tell citizens what they had done (or not) as a result. Or perhaps citizens misunderstood the nature and extent of the power being offered to them.*

Despite institutional support for the inclusion of participation in policymaking and wide acceptance of the role of participation in increasing empowerment, there is a dearth of evidence as to how, precisely, participation can lead to improved decision-making and empowerment and how in turn, this can lead to improved health equity. Given the

considerable risks and harms of poor public participation and paucity of evidence on how best to achieve their potential benefits, there is a clear need to better understand how public participation can generate the positive outcomes it promises to deliver for health equity. This research seeks to address this knowledge gap by examining how participatory processes affect health equity.

1.3 The research aim

Articulating the effects of public participation is complicated due to the myriad activities that constitute 'participation,' the diverse actors who commission and run processes, and the contexts in which these activities are implemented – contexts in which there are obvious power imbalances between those who seek to empower and the publics who are the supposed recipients of such efforts (Patel & Yeo, 2021). Yet, examining participation within different contexts helps to elucidate the 'political and policy tensions' (Newman & Clarke, 2009) that inform their conception, design, delivery and outcomes. Comparing different participatory processes provides contextual narratives that enhance the understanding of diverse participatory arrangements and identify similarities and differences that may be relevant for understanding the outcomes of these processes (Esser & Vliegenthart, 2017). Most importantly for this research, case study comparison can allow for an explanation of the mechanisms that occur within processes (Easton, 2010), helping to better understand how, if at all, participation affects health equity.

Therefore, this research seeks to empirically examine, through case study comparison, the relationship between participation and health equity. As demonstrated by the research logic in Figure 3, this research examines how, if at all, participation affects decision-making for the social determinants of health, empowerment, or health outcomes, and how these changes can affect health equity. This will be empirically examined through a comparison of citizens' juries and health impact assessment (further explanation for the selection of these processes is provided in Chapter 3). I have established that there is a well-recognised relationship between health equity, empowerment and the social determinants of health. Public participation can support decision-making for the social determinants of health and empowerment, yet what is not well understood is precisely

how outcomes are produced, given the varying contexts in which these processes occur. Therefore, this research seeks to move beyond existing evidence on public participation to examine the mechanisms through which participatory processes affect health equity.

Figure 3 Research logic for the thesis
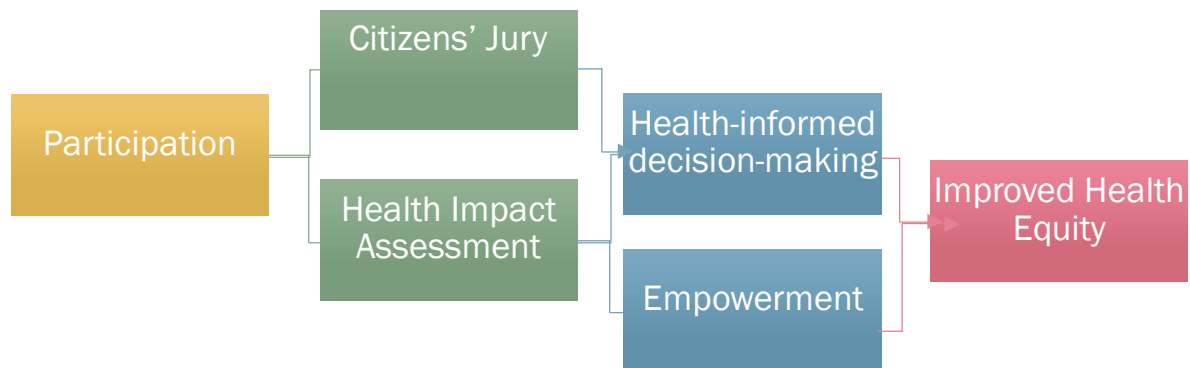
This research seeks to make a scholarly contribution to the fields of public participation and health equity in the following ways. First, understanding how processes are conceived within varying contexts (their aims and rationales) and how participants experience and create meaning through their participation can provide better evidence on how and why different outcomes occur. This research thereby contributes to participation studies by examining the context-driven, and interpretive ways processes are designed, delivered and experienced. Second, this research examines how participatory processes generate interpersonal and governance outcomes and how power is enacted through the processes to generate these outcomes. This research, therefore, contributes to the field of public health by demonstrating how public participation can improve health equity.

In order to make this research contribution, the following main research question will be addressed:

> *How, if at all, do participatory processes, through health-informed*
> *decision-making and empowerment, contribute towards health*
> *equity?*

This research question will be explored through an empirical examination of how participatory processes affect decision-making for the social determinants of health and empowerment. In Figure 4, I provide research questions designed to address the multiple elements of the leading research question. First, the main research question asks how participatory processes enable the consideration of health and health equity in decision-making. To answer this, I will examine how processes are designed and implemented; how they are perceived and how the context of the process affects their perception; what outcomes they produce; and how they contribute toward shared decision-making more broadly. Second, the main research question asks how participatory processes affect empowerment. To address this, I examine how the processes can be empowering (as an outcome) and how power is enacted (as part of the process and as an outcome). Therefore, by exploring how participatory processes enable the consideration of health within decision-making and affect empowerment, this thesis contributes to understanding how participatory processes can affect health equity.

How, if at all, do participatory processes enable consideration of health and health equity in decision-making?

I. **Design and implementation:** How do the approaches differ in their design? How was the approach designed and implemented? What were the aims of the approach (implicit and explicit)? How did it seek to inform decision-making? How were results communicated to decision-makers?

II. **Context and perception:** How do decision-makers and participants perceive the recommendations of the process (in terms of validity, usefulness for policy making, uptake, etc.)? Did the process introduce new issues or solutions (particularly health issues) that were not originally on the decision-makers agenda? Did the political context impact the process or how decision-makers perceived or responded to the recommendations? Did participants perceive the recommendations as informing the decision-making process?

III. **Outcomes:** How, if at all, did the process affect the decision(s)? Were findings from these processes (i.e., issues, solutions) incorporated into public policies? How did participants perceive the outcome affecting their or the community's health? Were there any other outcomes (negative or positive) from the processes?

IV. **Shared decision-making:** How, if at all, do participants and decision-makers perceive the process affecting engagement between decision-makers and community members? Did this engagement extend beyond the scope of the process?

How, if at all, do participatory processes affect empowerment?

V. **Empowerment:** How, if at all, did the process empower participants? Did it change perceptions of individual capacity to exercise power? Did changes in empowerment extend beyond the scope of the process? Were these perceptions sustained beyond the time of involvement?

VI. **Power:** How, if at all, did participants and decision-makers perceive the process as changing dynamics, power, and relationships between decision-makers and participants?

1.4 Situating the thesis

The previous sections examined the gap in the evidence on public participation, which this thesis seeks to address, and how this will be examined through the empirical research questions. In this section, I provide the theoretical basis for this research, examining how it has been theorised that power is a social determinant of health inequities and how public participation can affect power and health equity.

Power and the social determinants of health

To understand theoretically how participation can lead to health equity, it is essential first to understand power and its effect on the social determinants of health. Power is a contested subject that has been conceptualised in many different ways. Importantly, it is not just a unilateral situation in which one person has power over another to get someone to do something they usually would not (Dahl, 1957) or to prevent them from acting altogether (Bachrach & Baratz, 1994). Lukes' (1974) third dimension of power theorises that power can be used to influence the thoughts, perceptions, and desires of those with less power. These theories view power as a form of domination (Dahl, 1957). Yet, more emancipatory conceptualisations of power conceive of it as a form of collective action (Arendt, 1970), and others have viewed power as taking multiple forms (Fuchs & Lederer, 2007). Therefore, actions that increase power (empowerment) are not just unilateral in the sense of giving one individual more power; they may also affect thoughts, behaviour, control and action of individuals, groups, and institutions.

Because power has such an essential role in affecting people's actions, thoughts, perceptions and desires, it can be viewed as a fundamental determinant of health inequities. Recent theories (Friel et al., 2021; McCartney et al., 2021; Milsom et al., 2021) have considered the role of power in determining access to other social, economic, environmental and political determinants of health. In their conceptual framework, McCartney et al. (2021) identify sources (e.g. economic, culture, knowledge), spaces (e.g. political parties, academia, workplaces), positions (e.g. religious leaders, civil service) and forms of power (e.g. framing, agenda setting, influence). While this framework provides a heuristic for identifying aspects of power, it does not offer any mechanisms by which

power may be analysed in the identified domains. Using a realist synthesis of existing models of power, Milsom et al. (2021) address this gap through their conceptual framework for analysing power in public health policymaking (see Figure 5). The model builds on three fundamental forms of power set out previously (Fuchs & Lederer, 2007; Lukes, 1974) to examine how power in its various forms (e.g. instrumental, structural, discursive), mechanisms (e.g. rules, ideology), and dimensions (e.g. levels and spaces) leads to specific policy and non-policy decisions. This model is helpful in analysing the interrelationship between the different forms, mechanisms and spaces of power to demonstrate how policy non-decisions persist (particularly for non-communicable diseases, which the authors examine in relation to trade-making).

Figure 5 Milsom et al. (2021) Conceptual framework for analysing power in public health policymaking
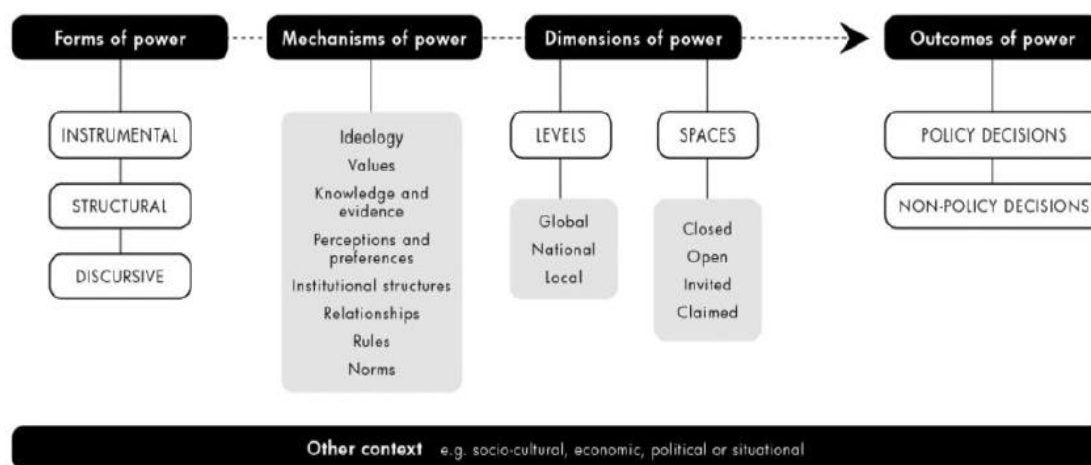
Friel et al.'s (2021) more expansive health equity power framework (see Figure 6) incorporates more than the three forms of power set out by Milsom et al. The framework draws on Moon's (2019) typology of power and Gaventa's (2006) power cube to describe the various types (e.g. structural, physical, discursive), forms (e.g. visible, hidden), actors

(e.g. state, market, civil), spaces (e.g. closed, invited, claimed), and levels (e.g. global, national, local) that produce power inequities that inform public policies which shape health inequities. This model allows for a systematic approach to assessing power dynamics across policy systems, taking into consideration the actors, forms, spaces and structures that (re)produce health inequities.

Figure 6 Friel et al. (2021) Health equity power framework
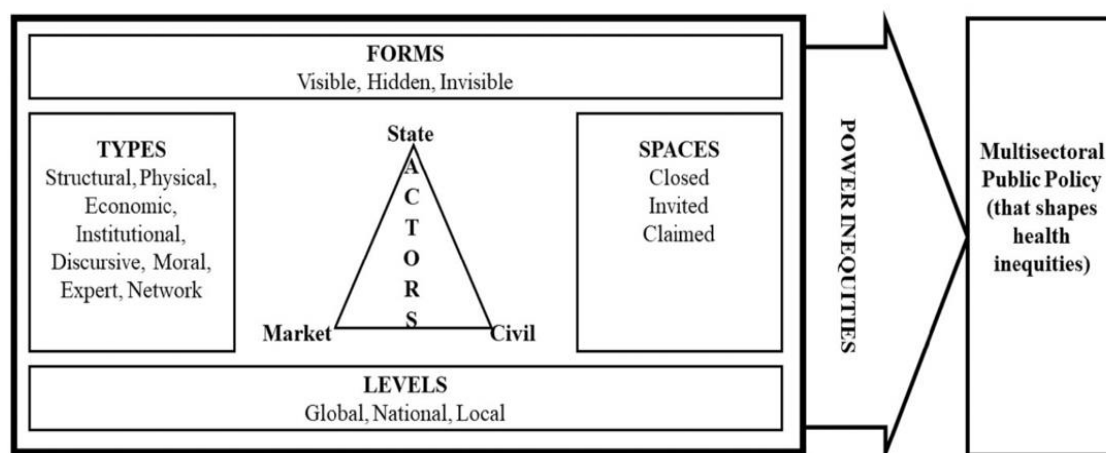
Note. Reprinted from Friel, S., Townsend, B., Fisher, M., Harris, P., Freeman, T., & Baum, F. (2021). Power and the people's health. *Social Science & Medicine 282*, 114173. Copyright 2021 Elsevier Ltd.

Individual and group power influences how other social, economic, and environmental determinants are distributed in society. Conceptualisations of power have implications for policy and practice, and particularly for processes of engagement. In the academic discourse on democratic theory, power has been examined as a means through which citizens mobilise to enact their interests. Contemporary models of democracy—representative, participatory and deliberative—articulate power in different ways. Through representative democracy, citizens enact power to express their interests and preferences through elected representatives who protect their interests (Schumpeter & Stiglitz, 2010). While this remains the dominant form of democracy, other approaches emphasise the role and capabilities of citizens to act as powerholders – enacting more direct and participatory approaches to policymaking. Public participation and collaborative

governance have been presented as potential approaches to incorporating citizens in the policymaking (Ansell & Gash, 2007). Participatory democracy is envisioned as a form of participation in which citizens are gathered as collective publics to directly engage in decision-making (Escobar, 2017), placing power directly with the people. Deliberative approaches build on ideals of participatory democracy to emphasise 'talk-centric' rather than 'voter-centric' approaches to decision-making (Elstub & McLaverty, 2014). Such approaches shift away from 'the weight of numbers or the power of interests' (Parkinson & Mansbridge, 2012) to increase the spaces in which power operates, rendering it more visible (McCartney et al., 2021). Therefore, public participation can be a site of enactment of power.

Public participation and health equity

Public participation is a widely used yet contested construct. Research on the topic spans multiple disciplines, including development studies, political science, public policy and public health (to name a few). Further complexity is added through the use of different terms (i.e. community engagement, patient and public involvement, citizen participation), definitional differences within these terms and the diversity of practices and evaluation approaches. A mere glance at the range of reported approaches on the Participedia website (Participedia, 2013), a user-generated database of participatory practices employed worldwide, gives an idea of the scale of usage and contestation of public participation. This breadth of approaches, topics and aims makes it challenging to assess the overall effectiveness of public participation (for one notable exception, see (Patel & Yeo, 2021). Furthermore, a lack of high-quality studies that empirically assess the outcomes of such processes make comparing the relative effectiveness of different methods difficult, if not impossible (Popay et al., 2007).

There are various ways in which public participation is conceived of as affecting health equity. Popay et al. (2007) provide a conceptual model demonstrating how outcomes arise in proportion to increasing community participation, empowerment and control (see Figure 7). Their model envisions different types of outcomes – service outcomes (e.g. more appropriate health services) and social outcomes (e.g. social capital, community

empowerment, and improved material conditions) – which impact upon improvements in health status and reduce inequities. Participatory strategies that emphasise greater citizen power and control can improve the design, development and implementation of activities that improve people's lives and improve community health. Evidence on community involvement in decision-making and governance of services suggests that these approaches can improve health (Gillies, 1998). Some theories also posit that increased community power, exercised through participation in decision-making and governance, can improve individual and community conditions, leading to increased health and well-being (Pennington et al., 2018).

Figure 7 Popay et al. (2007) Pathways from community participation, empowerment and control to health improvement
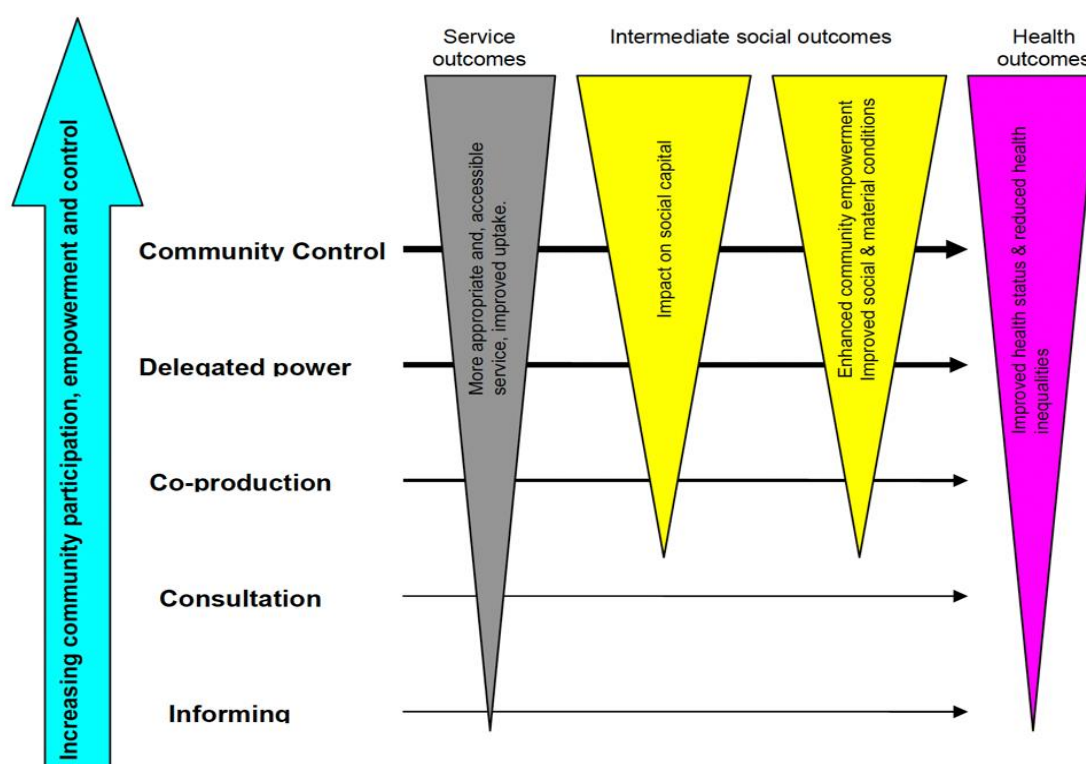
Haldane et al. (2019) build on this model to provide an outcomes framework which demonstrates the hierarchical nature of outcomes (see Figure 8). Their framework suggests that health outcomes arise through the provision of sustainable organisational structures and community involvement. Process outcomes, such as collaboration and clear role definition, are prerequisites to the formation of community outcomes. Community outcomes, such as increased knowledge, self-efficacy, and confidence, are required for the formation of health outcomes. Parallel to this hierarchy is participants' perceptions, which are shaped by social and cultural contexts, and empowerment. We can assume that perceptions and empowerment inform the other levels of outcomes, but the authors do not explicate in the conceptual framework the mechanisms by which these concepts affect the development of health outcomes.

Figure 8 Haldane et al. (2019) Community participation outcomes framework
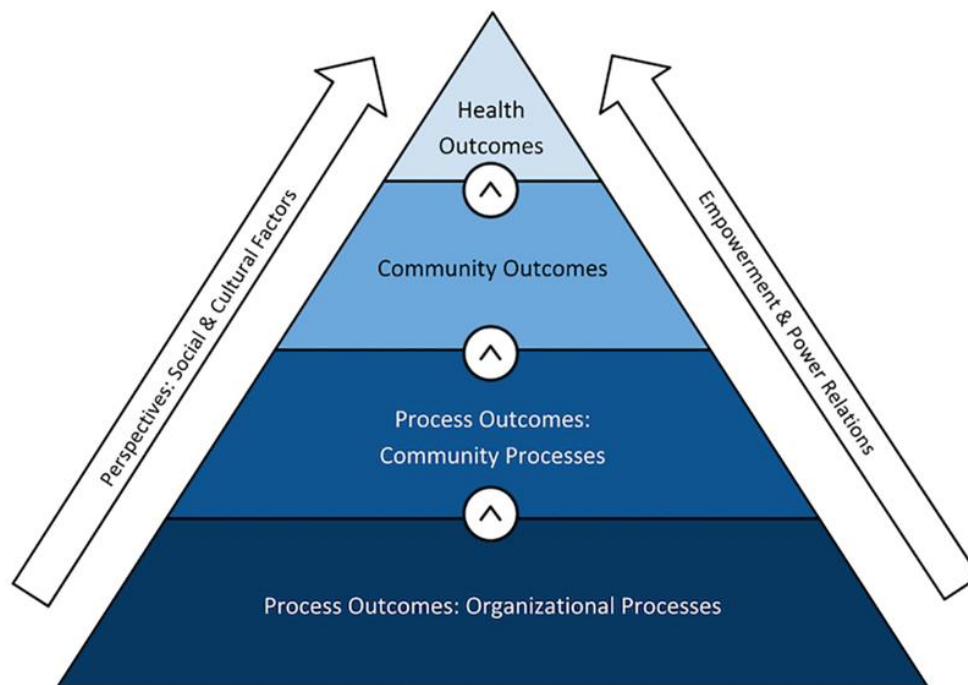
Note. Reprinted from Haldane, V., Chuah, F. L. H., Srivastava, A., Singh, S. R., Koh, G. C. H., Seng, C. K., & Legido-Quigley, H. (2019). Community participation in health services development, implementation, and evaluation: A systematic review of empowerment, health, community, and process outcomes. *PloS one,* 14(5), e0216112-e0216112. CC BY-NC.

In their systematic review, Milton et al. (2012) found that community engagement in the UK had a positive impact on housing management, crime perception and neighbourhood safety, service provision, social capital, involvement, and empowerment (specifically skills, knowledge, confidence and political efficacy), but did not find evidence of primary, direct effects on health outcomes. Their findings suggest that community engagement may be beneficial for enhancing social determinants of health and protective factors for mental well-being, that in turn may produce improvements in health and health equity but are less well suited to do so directly (or that different methodological approaches are required that can assess the evidence of direct population health effects). Similarly, a systematic review found that community participation may positively affect health through decreased hospital admissions, reduced clinical symptoms, improved behavioural risk factors like exercise, improved quality of life, and decreased mortality over time (Haldane et al., 2019). Yet, the authors also identified studies in which there was no significant effect on health outcomes, bringing into question the efficacy of different participation approaches as a health promotion strategy. Despite the theorised benefits for health equity, there is also evidence of the dis-benefits of public participation. A systematic review found evidence to suggest that community engagement may have dis-benefits including physical, emotional and mental health costs and consultation fatigue (Popay et al., 2007).

This evidence suggests that power is a fundamental determinant of health inequalities, and public participation can be a strategy for changing power (empowerment). Furthermore, reviews of evidence on public participation demonstrate that participatory processes have the potential to affect the social determinants of health, though there is less evidence of a direct effect on health outcomes. The evidence further suggests that participation can produce a lack of effect or even dis-benefits for participants. Therefore, despite the theoretical opportunity for public participation to affect power and the social determinants of health, improving health equity, it is unknown how to achieve such effects. This research seeks to contribute to this understanding by empirically examining how participatory processes affect decision-making, empowerment, and health equity.

1.5 Case studies

Four participatory processes were examined in this research (see Figure 9). Two cases – 50,000 Affordable Homes Health Impact Assessment (50K) and Measuring the Mountain (MTM) – took place in the UK. The other two – Airds Bradbury Health Impact Assessment (AB) and Byron Shire Community Solutions Panel (CSP) – occurred in Australia. Two processes were health impact assessments (HIA), and the other two were citizens' juries (CJ). In Chapter 3, I provide a complete rationale and description of the case selection process. Below, I briefly describe the two types of processes examined.

Figure 9 Diagram of the four case study participatory processes
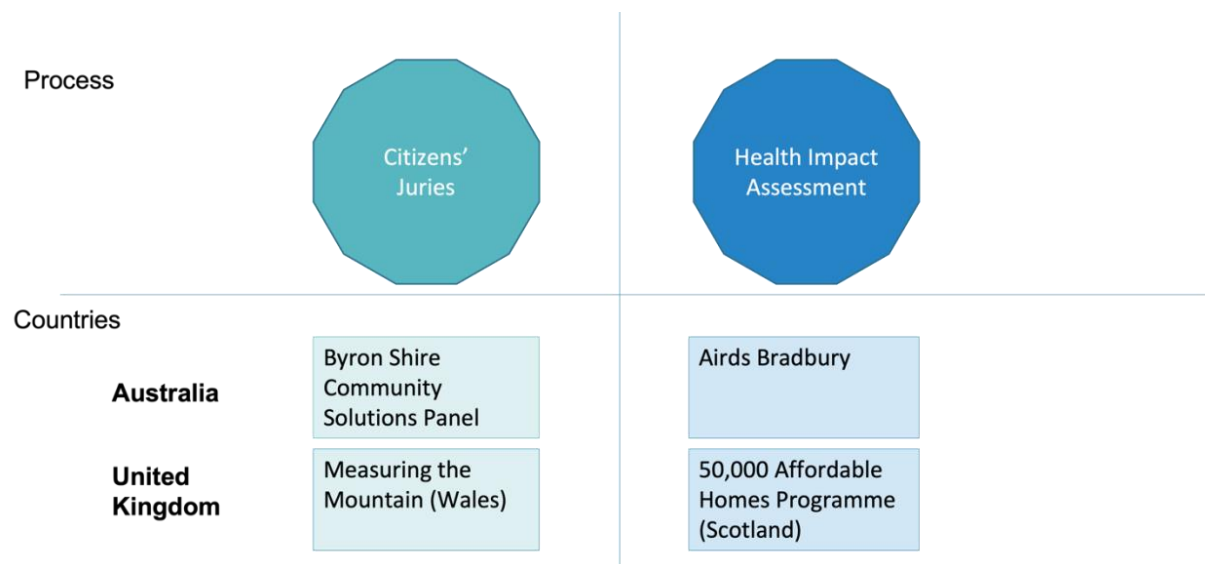
HIA is a systematic process that examines a future plan, policy, programme, or project to identify potential health impacts and the distribution of impacts within a population (WHO European Centre for Health Policy, 1999). HIA offers recommendations to mitigate any identified negative impacts and enhance potential positive effects. HIA follows a standard step-wise process: screening, scoping, assessment, recommendations, reporting, and monitoring and evaluation (Scott-Samuel et al., 2001). The amount of time required to conduct an HIA varies depending on the scope of impacts considered (breadth) and the amount of data collected (depth). They can range from desktop HIAs which may examine only a few key impacts and use only existing data, to comprehensive HIAs, which examine

a wide array of impacts and may conduct primary data collection (Harris et al., 2007). HIA is generally considered a key strategy for health in all policies (American Public Health Association, 2012; Delany et al., 2014; Kemm, 2001) and a practical way to improve policymaking for the social determinants of health (Sohn et al., 2018)

Participation within an HIA by key stakeholders and community members is supported by best practice guidance (Bever et al., 2022; Bhatia et al., 2014; Charbonneau et al., 2015; Den Broeder et al., 2017; Group Health Research Institute & Human Impact Partners, 2014; Harris et al., 2012; National Collaborating Centre for Healthy Public Policy, 2012). However, it is not considered an essential element of an HIA and can be challenging to conduct (Parry & Wright, 2003). Consequently, many HIAs have no stakeholder participation. Therefore, the level and type of participation offered through an HIA are variable and usually determined by the person, team, or agency conducting (or commissioning) the HIA.

A citizens' jury is a form of 'mini-public,' a democratic innovation designed to enable more direct participation in public deliberation (Elstub & Escobar, 2019). Mini-publics are usually made of quasi-randomly selected citizens that aim to be demographically representative of a cross-section of the larger population (Escobar & Elstub, 2017). Most are intended to convene and deliberate on a specific issue and dissolve thereafter. CJs are loosely modelled after a legal jury in which jurors are presented with the evidence on a topic, are provided time to deliberate, and conclude with a recommendation or 'verdict'. They can be designed so that the jurors have some control over the process design, including choice of key witnesses and evidence provided to them (Escobar & Elstub, 2017). The amount of time provided to conduct a CJ can vary but typically will run over multiple days spread out over weeks or months.

A central feature of mini-publics is deliberation – where participants seek some level of consensus through articulation and exchange of reasoned arguments (Grölund et al., 2014). CJs have been used to integrate citizen perspectives into health policymaking (Davies et al., 2006; Degeling et al., 2017; Street et al., 2014) and are a strategy promoted

by the WHO to achieve HiAP (World Health Organization & Ministry of Social Affairs and Health Finland, 2014). Therefore, HIAs and CJs can be considered participatory technologies that can be used to address health equity.

Below I provide a summary of each of the cases. A more comprehensive description of the cases is provided in Appendix A. In Chapters 4-8 of this thesis, I examine how and why the processes were conceived, how participants experienced the process, and finally, what outcomes the process helped to produce.

50,000 Affordable Homes Health Impact Assessment

In 2016-17, members of the Scottish Health and Inequalities Impact Assessment Network (SHIIAN) conducted a health impact assessment (HIA) on the Scottish Government's 50,000 Affordable Homes programme. The HIA involved members of NHS Health Scotland, Scottish Public Health Network, SHIIAN and the Association of Local Authority Chief Housing Officers. Given that the HIA was being conducted after the 50,000 homes programme had already been decided and was into implementation, the aim was less about influencing policy design and more about informing implementation at later stages or other sub-decisions that would need to be taken by local authorities. The HIA produced a report, and findings were communicated to the Scottish Government and other relevant stakeholders.

Airds Bradbury Health Impact Assessment

The Airds Bradbury Health Impact Assessment (HIA) aimed to identify the potential health impacts of the town centre redevelopment of the Airds community. The HIA was conducted in 2015-16, led by staff from local housing and health agencies and research institutes, and included members of the local Airds and Bradbury communities. Additionally, community stakeholders participated in various stages of the HIA. The findings of the HIA were communicated to relevant decision-makers, including the developers and the local Council.

Byron Shire Community Solutions Panel

In 2018, Byron Shire Council, with support from newDemocracy Foundation, ran a citizens' jury ("community solutions panel") on infrastructure spending prioritisation. The community solutions panel (CSP) aimed to inform infrastructure spending and trial a new approach to community engagement in Byron. Thirty-two residents were randomly selected to participate, and through the process, they produced a report with values-based recommendations for Council. These recommendations were formally adopted by Council and have since been integrated into various Council strategies and approaches, including the 2018-19 Delivery Programme.

Measuring the Mountain Citizens' Jury

The Measuring the Mountain Citizens' Jury (MTM) was held in 2018 as part of a co-productive approach to evaluate the Social Services and Well-being (Wales) Act. MTM was funded by the Welsh Government and run by a steering committee composed of academic, health and social care professionals. The citizen's jury comprised 14 people who had direct experience in social care and culminated in a final report with a set of recommendations for the Welsh Government on how to improve the Act. Though there was no up-front commitment from Welsh Government to respond to the findings of the jury, they have since provided a written response to the recommendations.

1.6 Overview of the thesis chapters

This chapter has introduced the problem that this research seeks to address: public participation is theorised to affect power, the social determinants of health, and in turn, health equity, but it is unclear *how* these potential outcomes arise. This research aim was then positioned in relation to existing theories and evidence on public participation, power and health equity.

Chapter 2 expands on this evidence by systematically examining the literature on public participation and health equity. I conducted a scoping review to better understand how health equity is affected through public participation when this is the goal of the process.

The methods for this evidence review and a descriptive and content analysis of the evidence are provided.

Chapter 3 gives a detailed description of the methodology for the empirical research. This research employs a comparative methodology using an interpretive approach rooted in a critical realist ontology. In order to best understand *how* outcomes are generated, I conducted a critical realist comparison to analyse the findings. This approach and other methodological choices are explained in this chapter, providing a theoretical and methodological foundation for the empirical findings.

In Chapters 4-8, I analyse the empirical evidence, examining how processes are conceived, experienced and what outcomes they produce. I begin in Chapter 4 with an exploration of the context in which participatory processes are conceived. What a process is envisioned to achieve and how it is designed to accomplish that goal is inextricably linked to the context in which the process takes place. This is examined by comparing the different participatory contexts – histories, spaces, and cultures – of the different processes. These 'ecologies of participation' greatly influenced the level of control that participants enacted within the participatory spaces.

How the different processes were designed and implemented profoundly affected the experience for participants. The positionality of participants, their expectations and interpretation of the process are explored in Chapter 5. While context acted as a catalyst for how a process was conceived, the expectations and positionality of participants shaped their actual experience. How and why people participated was influenced by positionality – their identity, role, and relative power. Although participants are often treated uniformly (as a 'participant' or a 'juror'), their unique positionality influenced whether and how they participated in the process and shaped their expectations of the process. Different expectations about what the process should achieve and what they wanted to get out of it created different experiences. What participants thought the process could achieve was based upon how they thought it was framed – as a democratic, technocratic, judicial, or normative process. These expectations then served as a

backdrop from which participants interpreted their experience. This variety of experiences sets the stage for understanding how and why different outcomes arose.

I examine outcomes by first looking at the outcomes for participants in Chapter 6. Participants described a range of outcomes arising from their involvement – many of which were positive and aligned with the aims of the process, but others were negative. How participants experienced the process overall was often a reflection of their expectations of the process, what they thought it could achieve, and whether or not that goal was realised. Alignment between expectations and outcomes resulted in more positive experiences. Negative experiences arose when the processes failed to meet the participants' expectations but could also result from how participants engaged in the process, such as the level of control they were able to exercise. Importantly, participants described ways that the process had been empowering or not. Participants' expectations and previous experiences shaped empowerment. A critical component to this experience of empowerment, described by participants, was 'feeling heard' through the process. As I examine, what seemed to matter most was not just that participants had an opportunity to voice their thoughts and feelings, but whether this information was 'heard' by decision-makers. This dialogic process between decision-makers and participants was core to the experience of empowerment.

Chapter 7 provides an understanding of what effect the processes had on their intended decision. Whilst most processes were envisioned as directly feeding into a decision-making process, the actual effect was often non-linear or produced more distal outcomes. By being situated in different participatory ecologies, the processes commonly led to other unintended follow-on outcomes. Though public participation is often structured to achieve a technocratic goal, the processes accomplished other participatory, epistemic and institutional aims.

Lastly, Chapter 8 reflects on outcomes for participants, including empowerment and changes to decision-making, to understand what effect, if any, the processes had (or could be theorised to have) on health equity. Participants described interpersonal

outcomes such as developing civic skills, social capital and empowerment, and I examine how these interpersonal outcomes can enhance health equity. Additionally, the processes produced variable changes to decision-making contexts and how these changes could produce health equity outcomes is examined with consideration for theories on the social determinants of health.

Chapter 9 then engages with conceptual frameworks of power and health to identify how the empirical evidence demonstrates the enactment of power within participatory processes. Public health theories have begun to focus on the role of power as a fundamental determinant of health inequities. Examining how the processes were framed, interpreted, and experienced demonstrates public participation's dynamic and contested nature. Instrumental, structural and discursive forms of power were enacted within the processes and influenced how the processes were implemented, experienced, and what outcomes they produced. Empirical findings, such as 'having a say' and 'feeling heard', reflect instrumental, structural and discursive forms of power. The ability to impose ideas about what the process could achieve and how it should be run reflect ideational power. What influence the process had on decision-making was informed by larger structural dimensions of power. Examining how these dimensions of power played out within the processes helps to explain *how* the different outcomes arose. I conclude the chapter by considering how examining power in public participation is essential for ensuring processes produce outcomes that support health equity.

The final chapter of the thesis summarises the empirical contribution and reflects on how this improves our understanding of public participation as a mechanism for health equity. I conclude with what this implies for public participation practice and policymaking for health equity.

1.7 Conclusion

Despite growing support for public participation in policymaking, there is a lack of evidence to demonstrate how different approaches can accomplish the outcomes they promise to achieve. As participation is a strategy supported in various countries and by

international bodies like the WHO, understanding these processes is critical to expand beyond descriptive outcomes of individual cases to a broader understanding of how processes lead to intended outcomes. For this reason, comparative interpretive research is an appropriate strategy for providing an understanding of these processes. It is the hope that this research will provide a scholarly contribution to the fields of health equity and public participation and evidence that is useful to policymakers to better inform the implementation of participatory practices to improve health equity.

CHAPTER 2   LITERATURE REVIEW

2.1 What do we know about public participation and health equity?

With growing support for public participation from governments at the local, national (NHS Health Development Agency, 1998; Scottish Parliament, 2015) and international levels (World Health Organization, 1978), there is a need for a comprehensive understanding of the potential impacts of participation. Many systematic reviews have examined the impacts on health and health equity through, for example, engagement in healthcare decision-making (Durand et al., 2014; Murphy, 2005), engagement in school-based interventions (Krishnaswami et al., 2012), community-based participatory research (Salimi et al., 2012), marginalised perspectives in policymaking (Siddiqui, 2014), and health promotion (Marent et al., 2012). Several systematic reviews on community engagement have found positive impacts on individual and community health (Attree et al., 2011; Cyril et al., 2015; Milton et al., 2012; Popay et al., 2007). A systematic review focused on the impacts on individuals from community engagement approaches to address the social determinants of health found positive impacts on physical and emotional health, confidence, self-esteem, relationships, and empowerment (Attree et al., 2011). Another study reported on individual health outcomes, such as improved mental well-being and reduction in neonatal mortality, community-level changes, including community empowerment, public health planning and community health initiatives (Cyril et al., 2015). While many studies have looked at the overall benefits of engagement, some have found that participation did not improve health (Daniel et al., 1999; Faridi et al., 2009), and others have pointed to the potential harms of engagement, such as a loss of control or demobilisation (Katz et al., 2015). Therefore, developing effective public participation to address health equity requires a greater understanding of the potential benefits and harms of such processes.

In other systematic reviews, health equity was sometimes identified as an outcome of participatory processes designed to achieve other goals (e.g. healthcare decision-making). What is missing from the evidence base is a comprehensive understanding of how health equity is affected through public participation when this is the goal of the process. This review, therefore, aims to fill this gap by examining what is claimed by the literature about whether and how participatory processes designed to decrease inequities achieve this goal. In the previous chapter, I provided a conceptual framework for the thesis situated in public participation and health equity scholarship. The literature review provided in this chapter contributes to the thesis by systematically examining the breadth of what is known about how public participation affects health equity. The thesis draws on this evidence base to examine the connection between participatory processes and health equity.

2.2 Methods

I chose to conduct a scoping review as the method for this literature review. Building on the literature discussed in Chapter 1, a scoping review comprehensively identifies evidence, catching what could have been missed through a selective literature review. This approach also helps to systematically identify the range of studies on this topic, particularly those that exist outside of expected fields of study (e.g. public health, political science). Lastly, conducting a scoping review allows other researchers to understand how I have identified evidence and can allow others to replicate or build on my work.

Compared with a systematic review which endeavours to synthesise evidence towards achieving best practice or policy (Munn et al., 2018), a scoping review seeks to map key concepts and sources of evidence in a research area (Arksey & O'Malley, 2005). Scoping reviews are helpful for identifying knowledge gaps, setting research agendas and highlighting implications for policymaking (Tricco et al., 2016). Furthermore, scoping studies contextualise knowledge (Anderson et al., 2008) and provide greater conceptual clarity about a topic or field of evidence (Davis et al., 2009). Rather than seeking to synthesise the evidence base into best practice, a scoping review allows for consideration of the breadth of literature, approaches, outcomes, and theories employed

to affect health equity. This type of literature review, therefore, better foregrounds the thesis and answers key initial questions (see Figure 10) before conducting the empirical research.

Figure 10 Scoping literature review questions

What is claimed in the existing literature about whether and how participatory processes affect health equity?

Sub questions:

  i.   Are the goals of the participatory process explicit, and if so, what are they? Do they seek to increase empowerment, to inform decision-making, to explicitly improve health equity, or something else? Is there a sense of prioritisation if there is more than one goal?

  ii. What are the outcomes of each process? Are these made explicit?

  iii. How, if at all, do the authors claim the process affected empowerment or health equity?

  iv. Are any claims made about how participation affected empowerment or health equity supported by a theoretical model? If so, how are these models employed and what do they suggest about the links between participation and empowerment and/or health equity?

  v.   What participatory approaches have been used to affect health equity and/or empowerment?

  vi. Do the claims of how participation affects health equity vary according to the approach used?

2.3 Search strategy

This scoping review was conducted with reference to the Preferred Reporting Items for Systematic Review and Meta-Analyses (PRISMA) guidelines (Moher et al., 2009). A literature search was conducted in May 2018 in five electronic databases: Applied Social Science Index of Abstracts (ASSIA); Cumulative Index of Nursing and Allied Health Literature (CINAHL); Web of Science Core Collection; Scopus; and International

Bibliography of the Social Sciences (IBSS). Additional studies were identified by reading the reference lists of included studies. Given the number of references generated through these electronic databases, and the time limitations of this project, I have not included any grey literature.

A Boolean search strategy was designed with assistance from a reference librarian to capture the range of terms used to describe various forms of participation and the types of potential outcomes relevant to health equity (see Figure 11). When possible, subject headings were included in this search strategy.

Figure 11 Search Terms and Boolean Strategy

Population (any term included using 'OR')	citizen*, communit*, consumer, participant*, patient*, public, users, stakeholder*, client*
AND	
Process (any term included using 'OR')	"action research", citizen science, citizen jur*, co-governance, co-production, collaborat*, community building, organi?ing, "community consultation", "public consultation", "citizen consultation", "consumer consultation", "user consultation", "stakeholder consultation", "client consultation", deliberat*, democrac*, dialogue, engag*, forum, "health impact assessment", involv*, participat*, "participatory budgeting", Partnership, prioriti?ation, "shared governance"
AND	
Health Equity Outcome (any term included using 'OR')	"health disparit*", "health equ*", "health inequ*"
AND	
Governance or Empowerment Outcome (any term included using 'OR')	"capacity building", "decision-making", Empowerment, "social justice", Legislation, policy, "government regulation", "social capital", "social exclusion", "social inclusion"

2.4 Inclusion and exclusion criteria

I included studies in this review if they met the following criteria:

1. Study reports research on a participatory process that was implemented (thereby excluding studies that examine theoretical models of participation).
2. Study reports research in which one of the goals of the process is to enable participation (thereby excluding studies in which people were involved, e.g. on a steering committee, but the overall aim of the process was not public participation).
3. Study reports research in which the process directly engaged lay individuals (thereby focusing on impacts to individuals).
4. Study reports research in which an empirically measured outcome was one or more of the following:
   a. health equity
   b. empowerment
   c. social support (social capital, social inclusion, resilience)
   d. decision-making or decision support related to health, health equity, or social determinants of health
   e. A failure to achieve one or more of the above.
5. Study published any time up to May 2018.

I excluded studies if they focused on a participatory process without studying the outcome of that process. Given that this review seeks to understand not just *what* outcomes arose but *how* they arose, included studies needed to provide some description of outcomes of a process and how they assessed outcomes (i.e. a methods section). I also excluded studies if they did not clearly describe the participatory process. For example, some studies said that public participation was conducted without descriptions of what type or how it was conducted. Studies were also excluded if they insufficiently focused on a participatory process. For example, many community-based participatory research (CBPR) studies included some form of participation, but the process focus was on research. I also excluded studies that identified impacts unrelated to this study (e.g. impacts to health services) or were not peer-reviewed. Only articles written in English or

Spanish were considered (based on the language limitations of the reviewer). There were studies identified from the search strategy that provided interesting findings but did not fit the inclusion/exclusion criteria (e.g. descriptive case studies, literature reviews). These studies have been considered and used in the thesis where appropriate.

The scoping review was conducted in 2018 and does not include studies published after this time. I decided not to update the literature review up to the year of the thesis submission (2022) for several reasons. First, the review was intended to ground the thesis in the literature and to reflect on what was known about how participatory processes affect health equity. As my analysis progressed, my understanding of the research topic shifted, leading me to other literature, for example, on deliberative democracy and power. I, therefore, did not believe it would substantively add to the thesis (nor would it be a good use of time) to update the literature review[3].

2.5 Data extraction and evidence review

I conducted data extraction through a three-step process with articles excluded through review by title, abstract and full text (see Figure 12). I cross-checked articles with additional reviewers (i.e. my supervisors) when necessary. Following guidance on conducting a scoping review (Levac et al., 2010), I extracted data on the characteristics of each study, including: geographical location, form of engagement, substantive topic, population targeted for engagement and population actually engaged, number of participants, and length of process. I conducted content analysis (Levac et al., 2010) with regard to five main research questions (see Figure 10). In order to understand not just *what* outcomes are produced through each process but also *how* they are produced, I extracted data on mechanisms, barriers, and enablers of participation (Pawson & Tilley, 1997). Furthermore, definitions, frameworks and theories were extracted when included by the study authors to further explicate how participatory processes led to outcomes.

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[3] Though this might be a useful endeavor for publication of the literature review in the future.

Figure 12 Elaboration of the literature screening process using a PRISMA diagram

Identification

Records from ASSIA (N=196)	Records from CINAHL (N=398)	Records from IBSS (N=95)	Records from Scopus (N=1195)	Records from Web of Science (N=1446)

Records identified through database searching (N=3330)

Duplicates removed (N=297)

Screening

Records screened by title (N=3033)

Records excluded (N=2823): not a participatory process; process didn't involve lay participants; outcome not relevant to health equity

Records screened by abstract (N=210)

Records excluded (N=134): not full paper (conference abstract only); not a participatory process; process didn't involve lay participants; outcome not relevant to health equity

Eligibility

Articles assessed for eligibility (N=76)

Records excluded (N=56): literature reviews (N=8); not empirically assessed (N=21); insufficiently focused on participatory process (N=14); focussed on outcomes not relevant to this research (N=12); full text articles could not be found (N=7)

Articles included after reviewing references from retreived articles (N=2)

Included

Articles included in qualitative synthesis (N=16)

2.6 Results

The search resulted in 3330 articles; following removal of duplicates, there remained 3033 articles, from which 2957 were excluded after screening for title and abstract. The remaining 76 articles were read for eligibility. Of these, 56 articles have been excluded according to the inclusion criteria of this review. A further 2 articles were added through reference mining from the included studies. Sixteen articles were included in the analysis. This distilling of the literature (from 3330 articles to 16) highlights the relative scarcity of evidence on the intersection of participation and health equity.

2.7 Descriptive analysis

The studies included a range of participatory approaches focused on various topics. The type of process was usually described, though there was often conceptual ambiguity about what a process was (for example, 'community development or 'health promotion activities' can mean very different things) and what a process does (studies did not always report on how the process was conducted). Nine different types of processes were reported in the studies (see Figure 13): five studies using community-based participatory research (CBPR)/participatory action research (PAR)[4]; one study using photovoice; two studies conducting health impact assessment (HIA); one study on health in all policies (HiAP); two studies conducting community development; one study on a social inclusion partnership; one study of a citizens' jury; one participatory budgeting (PB) study; and two studies using various health promotion activities combined under a 'community participation' banner (including, e.g. training programme on health and health services; diabetes awareness project, first aid courses, exercise classes). The studies focused on various substantive topics, with the majority focusing on health equity (n=5) (see Figure 14). The range of types of processes and topics included in the review highlights the diversity of applications and conceptual understanding of public participation.

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[4] Community-based participatory research and participatory action research processes in the included studies shared the same characteristics. The difference in name seemed to be mostly a geographic difference, with CBPR being the favored term in the US. I have therefore grouped these two types of processes together.

Figure 13 Types of Participatory Processes
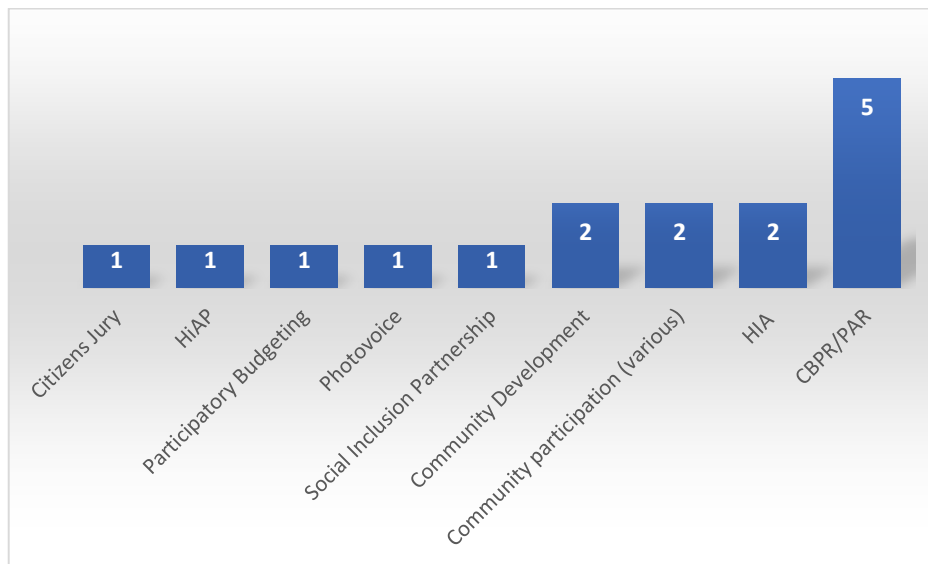
Figure 14 Substantive topics of processes
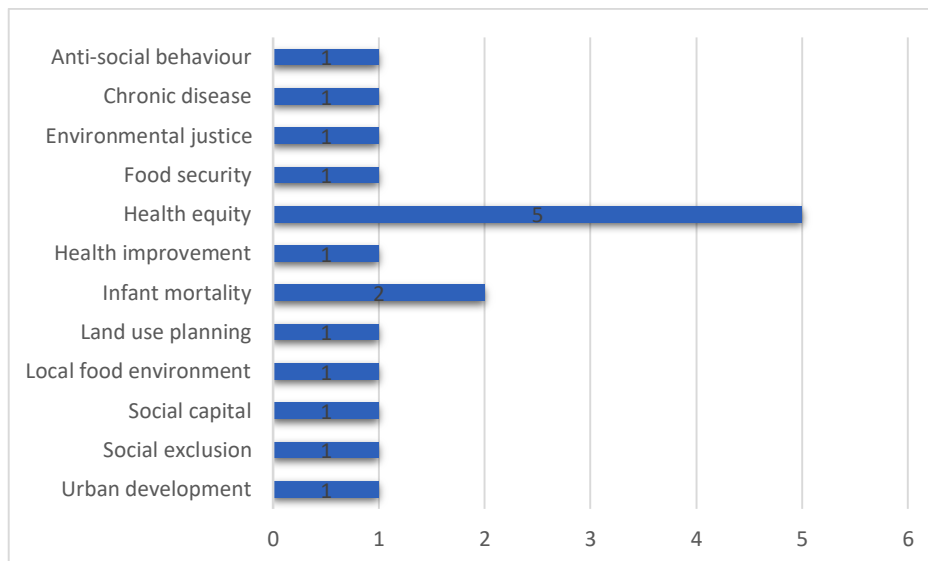
The included studies reported on change (or a lack of change) to empowerment, health equity, policymaking and social capital, with some studies reporting multiple outcomes. Eight studies reported improvement in policymaking and empowerment, seven reported

improvement in health equity, and three reported improvement in social capital (see Figure 15). Some studies also reported when the process had failed to achieve an intended outcome. Two studies reported a lack of improvement in social capital and empowerment, one study reported a lack of improvement in health equity, and one study reported a lack of improvement in policymaking (see Figure 15). The tendency for studies to report positive outcomes rather than adverse outcomes or a lack of change may reflect a reporting bias from the authors (reporting on what the authors expected the process to achieve rather than the perspective of participants) and a tendency for authors to publish papers with positive findings (i.e. positive outcome bias (Fanelli, 2012)).

Figure 15 Reported outcomes in the included studies
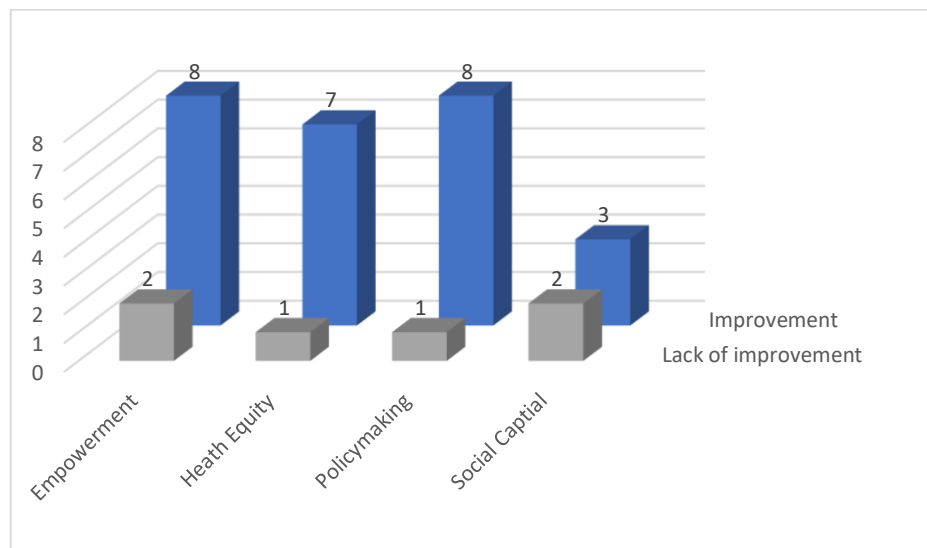
The processes included in this study took place between 2002 and 2018 (see Figure 16). The majority of the included studies occurred in high-income countries (except Brazil (n=1)), including the USA (n=6); UK (n=3); Canada (n=2); Australia (n=1); France (n=1); Ireland (n=1); and Spain (n=1). This tendency towards processes occurring in high-income countries is likely to reflect the search strategy, which excluded most non-English papers (Spanish was included). Furthermore, it should be noted that several of the included studies reported on various outcomes of one process (a CBPR project in Detroit, USA). This might explain why there are more studies in one location (USA). Conversely,

the one study in Brazil was a large N analysis of participatory budgeting that included 253 processes. Therefore, the reported papers may not necessarily reflect the full scale of processes.

Figure 16 Timeline of Processes
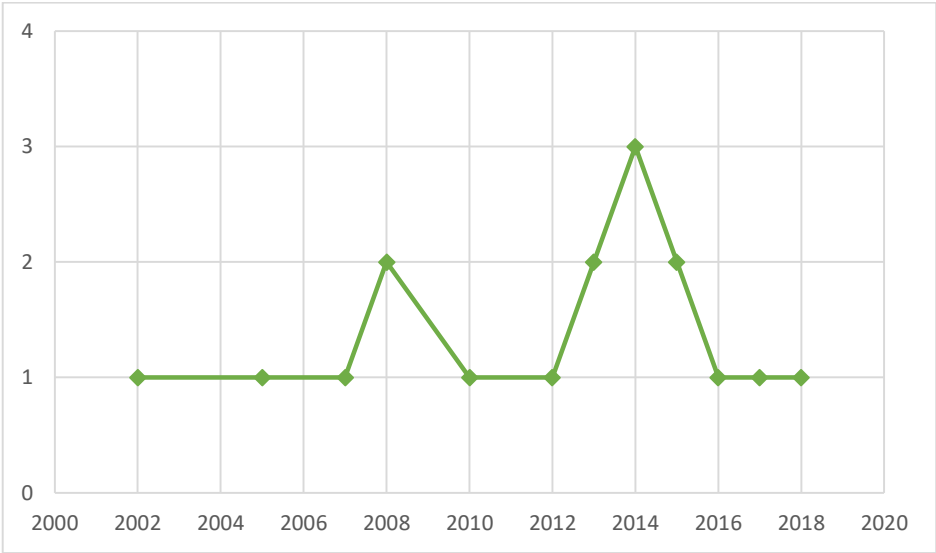
Nine studies included a definition of participation, empowerment, social capital or health equity (Table 1). There was no consistent use of the term or definition of 'participation'. Participation was described as either 'civic engagement', 'democratic participation', 'community engagement', 'grounded consultation' or 'participation'.

Table 1 Definitions included in studies

Definition	Study
Empowerment	
Relates to a change in self-perception in terms of the perceived levels of control one has over different areas of life. It can also encompass a change in access to and use of resources, and the formation of social relations and networks.	(Budig et al., 2018)
Enables people to have a greater say and control over their own lives and local health care decisions.	(Bandesha & Litva, 2005)

The development of, understanding, and influence over personal, social, economic and political forces impacting life situations.	(Cheezum et al., 2013)
A process through which people gain greater control over decisions and actions affecting their health.	(Johnson et al., 2015)
"Process through which individuals and communities take control over their lives and their environment" (Rappaport, 1984)	(Minkler et al., 2002)
"Individuals, organizations and communities gain mastery over their lives in the contest of changing their social and political environment to improve equity and quality of life" (Wallerstein, 1992)	(Minkler et al., 2002)
"Community empowerment is considered central to the process of participation, enabling people to have a greater say and more control over their own lives and local health care decisions."	(Bandesha & Litva, 2005)
Health Equity	
The absence of systematic disparities in health among groups with different levels of wealth, income, power, or prestige.	(Cacari-Stone et al., 2014)
Promotes distributive and procedural justice, that is, directing resources to reduce social inequalities and ensuring openness and fairness in the political processes involved in decisions about allocating public resources.	(Corburn et al., 2014)
'Health inequities' are health differences attributable to disparities in advantages, opportunities, or exposures in social, economic, political, cultural and environmental dimensions.	(Cahuas et al., 2015)
Participation	
'Civic engagement' is the individual and collective actions designed to identify and address issues of public concern. 'Political participation' is the collective actions of community members at the local, state or national level that support or oppose government authorities or decisions to allocate or re-allocate public goods.	(Cacari-Stone et al., 2014)
'Participation' is full and open debate of issues and decentred processes of decision-making, allowing for a broad base of citizen involvement in a range of actives. It is also an enabling, citizenship-building process where people learn democratic skills and values.	(Cahuas et al., 2015)
Social Capital	
The connections, trust, and reciprocity between individuals and within communities, and the resources that can arise from these connections.	(Putland et al., 2013)

The papers varied greatly regarding the quality of reporting about the participatory process. All studies reported intending to engage with some form of the 'community', although studies rarely defined who or what 'the community' was. Only one study (Cahuas et al., 2015, p. 368), defined community as: "…social groupings, networks or place-oriented processes that express a shared sense of identity". Nine of the studies reported who participated. In the papers where this was reported, the group who participated was the same as the group that had been targeted for participation.

There were differences in the number of participants and the process length. The smallest number of participants reported was 6, and the largest was 228. There were also inconsistencies with this reporting, with only six studies reporting the number of participants. The length of the process was variably reported. In the nine studies where this was reported, participation ranged from 4 days to 2 years. In the remaining cases, it was unclear how long the participatory process took. In one extreme, a process was said to have lasted 10 years, but it was unclear if participation lasted throughout (Carlisle, 2010). Some studies also reported that their process was ongoing at the time of reporting (n=2).

The majority of the studies used qualitative methods to assess outcomes, except for one study that also assed changes reported in population health surveys (Corburn et al., 2014) and one large N comparative study that conducted multivariate regression using a constructed dataset (Touchton & Wampler, 2014). The studies mostly used interviews and focus groups, with some studies also conducting document reviews and ethnographic fieldwork.

2.8 Content analysis

The studies showed four main positive outcomes of participation: empowerment; improved decision-making; improved participation; and improved health equity. Empowerment is a term that is loosely defined and often poorly measured, and there were inconsistencies in the definition of the studies included (see Table 1). Research on

empowerment has focused on it as an outcome and an intermediate step towards health promotion (Wallerstein, 2006). This ambiguity in definition reflects the diversity of domains in which empowerment interventions have been applied: psychological, organisational, familial and community-level. Whilst definitions of empowerment reflect these various domains, McWhirter's (1991) definition, stemming from the field of psychological empowerment, is helpful for interrogating the evidence due to the conceptualisation of empowerment as a transformation that can be individual or collective, ongoing, context-specific, and relevant to the individual. McWhirter (1991, p. 224) defines empowerment as: "the process by which people, organisations, or groups who are powerless (a) become aware of the power dynamics at work in their life context, (b) develop the skills and capacity for gaining some reasonable control over their lives, (c) exercise this control without infringing upon the rights of others, and (d) support the empowerment of others in the community." This definition provides four main elements of empowerment: awareness of power; skills and capacity development; exercising control; and supporting empowerment in others (what I interpret as a form of social capital development) (see Figure 17). Ten studies reported outcomes related to an element of empowerment (Budig et al., 2018; Cahuas et al., 2015; Carlisle, 2010; Cheezum et al., 2013; Haigh & Scott-Samuel, 2008; Israel et al., 2010; Johnson et al., 2015; Minkler et al., 2002; Pursell & Kearns, 2013; Touchton & Wampler, 2014). Using McWhirter's (1991) definition, I will first examine how these studies reflect dimensions of empowerment before examining the other reported outcomes relevant to this review.
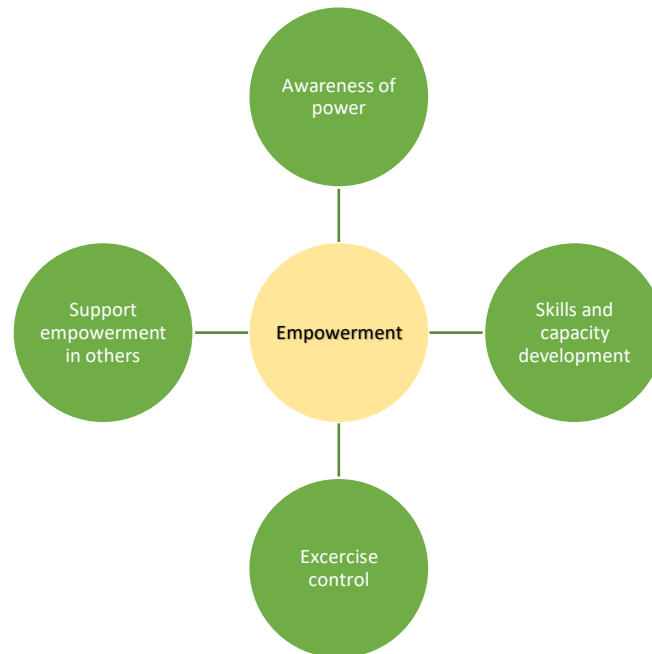
Awareness

Awareness development can refer to the process of understanding power dynamics (why some people have power and others do not), and the effect these have on people's lives and other elements of society (McWhirter, 1991). Four studies reported an increase in the critical awareness of participants (Budig et al., 2018; Israel et al., 2010; Johnson et al., 2015; Minkler et al., 2002). In a Photovoice project on the local food environment in two communities in Madrid (Spain), study authors reported that taking photos and group discussion allowed participants to develop an understanding and awareness of the local food environment (Budig et al., 2018). Participants reported becoming more conscious of their surroundings, being sensitised to others' perspectives and developing more critical, attentive and empathetic views of their local environments. Another project on food insecurity in Nova Scotia (Canada) reported that the PAR approach enabled participants to identify the underlying causes of food insecurity (Johnson et al., 2015). A CBPR policy advocacy training focused on power in one of the training sessions (Israel et al., 2010). This discussion included a power mapping exercise to examine who has power and how it can be mobilised. The majority of participants in this process agreed (87%) that they

would use what they had learned to bring about change. Lastly, a community engagement project on infant mortality in the US sought to increase the awareness of the community by identifying root causes of infant mortality (Minkler et al., 2002). Enabling residents to identify local needs (i.e. awareness development) while increasing their competency to problem solve was seen as a critical strategy for community empowerment.

Skills and capacity development

Skills and capacity development are considered essential for empowerment as they enhance the individual's sense of control and autonomy (McWhirter, 1991). In addition to building awareness of issues in their community, seven studies reported that participants were able to develop skills, knowledge, confidence and capacity (Bandesha & Litva, 2005; Budig et al., 2018; Cheezum et al., 2013; Haigh & Scott-Samuel, 2008; Johnson et al., 2015; Minkler et al., 2002; Pursell & Kearns, 2013). Participants in various health promotion activities in Greater Manchester (England) reported having new knowledge and skills, which led to higher levels of confidence (Bandesha & Litva, 2005). Participants in the PAR project in Nova Scotia described that they had built skills, learned and applied lessons learned, gained the confidence to speak out, and could apply previous skills to the project (Johnson et al., 2015). A study of a citizen's jury in England reported that participants had gained a better understanding of city council and public services and how to better access services (Haigh & Scott-Samuel, 2008).

Many studies focused on individual and community-wide capacity building as positive outcomes of the participatory process. Several individual empowerment components, such as increased knowledge, skills, and leadership, were attributed to increasing confidence and community capacity. For example, participants in a CBPR policy advocacy training in Detroit (Michigan, USA) reported enhanced community capacity via increased participation, inter-organisational networking, improved skills, and leadership (Cheezum et al., 2013). Study authors reported that a community participation campaign aimed at reducing infant mortality across various sites in the USA led to new skills in participants (such as infant resuscitation), leadership development (which led to career advancement or return to school for some participants), and enhanced civic engagement

(Minkler et al., 2002). The study authors described how these new skills and capacities helped the community to design local solutions to address infant mortality. Similarly, one study reported that training provided to residents on a local action group (formed as part of an HIA on urban development in disadvantaged communities in Ireland) increased skills and expertise that led to a better understanding of and confidence to participate in policymaking (Pursell & Kearns, 2013). Essential to this was residents developing a better understanding of various agency work, service planning, and awareness of transport and health issues.

One study focused on the development of new social networks and resources as a way to develop capacity. The study reported that the photovoice process on the local food environment enabled participants to access social networks that were usually hard to reach, such as local decision-makers and public health practitioners (Budig et al., 2018).

Control

Several studies reported that exercising control, or having the ability to influence circumstances in one's surroundings (McWhirter, 1991), was an element of empowerment. Six studies acknowledged that the process had given participants the ability to voice their concerns and influence policymaking that affected their community (Budig et al., 2018; Cacari-Stone et al., 2014; Cahuas et al., 2015; Cheezum et al., 2013; Corburn et al., 2014; Pursell & Kearns, 2013). Some studies reported that the process had led to an increase in resources that supported the community. For example, one study reported that the partnerships developed through a CBPR process on environmental justice projects in California led to broad intersectoral collaboration in which each partner applied for and received new funding or leveraged existing resources to strengthen policy advocacy efforts (Cacari-Stone et al., 2014). Israel et al. (2010) reported that CBPR policy advocacy training helped build participants' self-efficacy. Self-efficacy is a belief in one's ability to accomplish a task or behaviour (McWhirter, 1991). Within this study, 40% of participants had worked towards a policy change since their participation, demonstrating an increase in self-efficacy. Participants in an HIA on urban

regeneration in Ireland stated that the HIA could be an advocacy tool and route through which their voices could be heard in decision-making (Pursell & Kearns, 2013).

Social support

Studies also reported that participants gained social relations, networks and support that were instrumental for their own empowerment and community support. Networks of access and capabilities for interaction are considered core dimensions of social capital (Claridge, 2018). Five studies reported an outcome that reflected social support or social capital (Budig et al., 2018; Cheezum et al., 2013; Haigh & Scott-Samuel, 2008; Johnson et al., 2015; Touchton & Wampler, 2014). In the Spanish Photovoice process, participants reported that it helped them develop friendships with other participants and be acknowledged for their work by their communities and local decision-makers (Budig et al., 2018). Participants in the Detroit CBPR project reported that the process brought together a variety of groups which enabled them to engage with a diversity of constituents and bring in a variety of resources to influence policymaking (Cheezum et al., 2013). Participants in an HIA on a citizen's jury on anti-social behaviour reported feeling better able to support other community members (Haigh & Scott-Samuel, 2008). The HIA also found that involvement in the CJ could increase feelings of control, increased community participation and feelings of inclusion.

Two studies concluded that developing social capital was essential to the generation of long-term health outcomes. The PAR project on food insecurity in Nova Scotia reported that the process had led to greater links among food security projects across the province and with external networks such as nutrition professionals and universities (Johnson et al., 2015). The study authors concluded that connections to broader institutions and systems support the idea that capacity building can lead to health gains beyond immediate outcomes. Touchton and Wampler (2014) found that PB programmes in Brazil incentivised the creation of civil society organisations (CSOs). These CSOs enabled ongoing participation in policymaking and the formation of social capital within communities. The study also reported that positive outcomes of PB (such as decreased infant mortality) were more significant over time, meaning that PB leads to long-term

institutions and political change, not just short-term shifts in spending priorities. The study concluded that long-term changes were due to the influence and integration of CSOs, who were best positioned to advocate for changes that benefit health and well-being.

Improved decision-making

In addition to reporting outcomes relevant to empowerment, studies reported improved decision-making, increased participation and changes to health equity. Seven studies reported that the participatory process had led to an improvement in decision-making related to health or health equity (Budig et al., 2018; Cacari-Stone et al., 2014; Cahuas et al., 2015; Cheezum et al., 2013; Corburn et al., 2014; Minkler et al., 2002; Pursell & Kearns, 2013). This was often achieved through participants directly engaging in policymaking processes or advocacy. Several of the studies reported that participants used the data generated through the process to report directly to decision-makers through public testimonies, meeting with policymakers, or developing neighbourhood plans that were endorsed by Council (Budig et al., 2018; Cacari-Stone et al., 2014; Cahuas et al., 2015). In other processes, study authors reported that participants developed advocacy skills that were then applied to influencing decision-making (Cheezum et al., 2013; Israel et al., 2010; Johnson et al., 2015). An HIA on urban redevelopment in Ireland developed recommendations that could improve the decision (Pursell & Kearns, 2013). Notably, the project also developed a multi-sectoral local action group (including agency stakeholders and residents) that was responsible for overseeing the implementation of these recommendations.

Studies reported that the impacts of participants' engagement in decision-making were beneficial to health and health equity through improving conditions of the social determinants of health. One study on CBPR projects in California reported that participant involvement in decision-making played a significant role in the passage of an ordinance to phase out polluting industries and requiring that health impacts and community input be included in all further city decision-making (Cacari-Stone et al., 2014). In a HiAP project in Richmond, California, study authors reported that healthy community development work was responsible for a value shift, making health equity important to

local decision-makers. The study authors described how this led to a new government-community coalition focused on health equity and increased investment in health equity related activities (Corburn et al., 2014). One study of a CBPR project in Detroit reported that participants' actions led to tangible successes such as re-opening a neighbourhood police station, demolishing abandoned houses, and improved relationships with Immigration and Customs Enforcement (Cheezum et al., 2013). Authors of a project study aimed at reducing infant mortality reported that participants developed leadership skills that they applied towards improving community health issues (Minkler et al., 2002). This led to political leaders seeking out the input of these community leaders. The authors reported that this groundwork helped to improve policies and expand health services that could reduce infant mortality rates.

Participation

Participatory processes also created opportunities for participants to remain involved in community engagement, even after the end of the initial process. Five studies reported new or sustained participation opportunities (Cacari-Stone et al., 2014; Cahuas et al., 2015; Cheezum et al., 2013; Roue-Le Gall & Jabot, 2017; Touchton & Wampler, 2014). For example, a study of the environmental justice CBPR projects in California reported that enhanced community engagement in implementing an action plan, which led to the involvement of community members in Council meetings, increased youth interest in advocacy work, and even led to the election of a former participant to city council and appointment as vice mayor (Cacari-Stone et al., 2014). Participants in the CBPR policy advocacy training in Detroit remained engaged in various advocacy strategies and were involved in raising awareness in their communities (Cheezum et al., 2013). Touchton & Wampler (2014) reported that participatory budgeting programmes produced new forms of governance that could incorporate long-term citizen participation. This was mainly achieved through the formation of CSOs. The study authors conclude that citizens' direct participation empowers them (through gaining technical skills and political knowledge) to make decisions that benefit local communities and maintain oversight of state services. An evaluation of multiple HIAs on land use planning in France found that community involvement in the HIA process added an opportunity for residents' involvement beyond

standard consultation (Roue-Le Gall & Jabot, 2017). However, the authors reported that the level of dialogue and 'co-construction' with community members depended upon the level of understanding of public representatives of the HIA and what it could contribute to the decision-making process.

Health equity

One study reported direct impacts on health equity (Corburn et al., 2014). Study authors described how healthy community development work as part of an HiAP approach led to new community initiatives focused on improving health equity. Using a county health survey, the study authors reported that a greater percentage of people in neighbourhoods targeted for healthy community development rated their health as good or excellent compared to those not targeted.

Six studies reported on indirect improvements to health and health equity through improvements to the social determinants of health (Cacari-Stone et al., 2014; Cahuas et al., 2015; Cheezum et al., 2013; Minkler et al., 2002; Schultz et al., 2009; Touchton & Wampler, 2014). An HIA conducted on a citizen's jury found that the recommendations proposed by the jury could reduce stress and anxiety and improve access to services and resources (Haigh & Scott-Samuel, 2008). Significantly, these improvements would benefit vulnerable people the most and contribute towards reducing health inequalities. Similarly, a community engagement project aimed at reducing infant mortality centred upon racial and ethnic minority populations in the US (Minkler et al., 2002). The study authors asserted that community participation lays the groundwork for intermediate changes (behaviour, self-esteem, local infrastructure, new policies) that can lead to health equity benefits (i.e. reduced infant mortality in racial/ethnic minority populations). A CBPR project focused on chronic disease in African American, and Latino communities in Kansas (USA) found that most of the documented changes were for health protective factors (e.g. physical activity and healthy eating) with fewer policy changes (Schultz et al., 2009). The study authors asserted that community changes brought through the CBPR process were beneficial for health protection. Most of these events focused on learning (e.g. providing information, enhancing skills) with fewer aimed at modifying

access, barriers and opportunities for services. Furthermore, most activities targeted African American communities. The study authors reported that community changes were insufficient within Latino communities to improve population health outcomes. In their study of participatory budgeting programmes in Brazil, Touchton & Wampler (2014) reported that municipalities conducting PB had increased spending on health care and sanitation (up to 23%). These municipalities also had a reduction in infant mortality (up to 19% reduction). Participatory budgeting programmes are designed to allocate resources to the poor (via preferential voting) and to allocate health and social services spending that most greatly benefits the poor, therefore positively affecting health equity.

2.9 Failures

Not all of the reported outcomes were positive. Two studies reported on the processes' failures to improve health equity, social cohesion, participation, or policymaking (Bandesha & Litva, 2005; Carlisle, 2010). Studies reported that various community engagement initiatives focused on health promotion in Greater Manchester, England, increased participants' knowledge and skills but did not increase health equity or social cohesion (Bandesha & Litva, 2005). Health professionals who had led the project were optimistic that the project had changed health behaviours. However, participants did not make a link between improved health knowledge and lifestyle changes.

Similarly, study authors reported that the project failed to increase social cohesion. The project was not considered a priority to the community; therefore not all groups participated. The most deprived group participated the least, which some saw as widening inequity in the local South Asian population. A study of a Social Inclusion Partnership in Scotland reported that the process led to conflict rather than collaboration (Carlisle, 2010). There was insufficient time allocated for different partners to learn to work together, and local conflicts of interest and power disparities thwarted the policy intent and made participation difficult. The study reported that participants identified issues that were more significant priorities to the community other than health and social exclusion, but the institutional goal of the project did not change. Furthermore, the study reported that

participants saw social exclusion and health as new labels to mask the local governments' ongoing work.

2.10 Mechanisms

In a critical realist approach, mechanisms are seen as context-specific generative factors that produce effects (Pawson & Tilley, 1997). Unlike context and outcomes, mechanisms are usually hidden (Astbury & Leeuw, 2010) and help explain *how* certain outcomes arise (Lacouture et al., 2015). I examined the included articles for explanations of how the stated outcomes arose. Below I provide a summary of the mechanisms identified in the literature.

Studies reported various mechanisms that enabled participatory processes to lead to positive outcomes or were missing in cases where processes failed to achieve intended benefits. The reported mechanisms were: changes in individual participants; equal power dynamics; and development of trust. According to studies, these mechanisms enabled empowerment through developing individual components of empowerment, or towards health equity through developing beneficial conditions for health equity via changes to decision-making. As one study concluded, "...an existing relationship of trust between the partners, use of multiple forms of evidence, advocacy of community members, and alliances with supportive policymakers became the catalyst for creating an environment of....policy-oriented learning" (Cacari-Stone et al., 2014, p. 1621).

Changes to participants

Studies reported that changes to empowerment were achieved through addressing various aspects of empowerment, including developing awareness of power; building skills, knowledge, and confidence; enabling participants to exercise self-efficacy and control; and facilitating social support and social capital through developing networks and partnerships. For example, in an asset-based community development approach, community developers acted as liaisons between the community and various social actors to relay information, build connections across community and government actors

and develop strategies to mediate differences (Cahuas et al., 2015). In the PAR project on food insecurity, the process organisers sought to increase empowerment through the combined effort of allowing participants to recognise the root causes of food insecurity, increase their sense of ownership over such problems, and build evidence to support social change (Johnson et al., 2015). Similarly, study authors reported that policy advocacy training developed participants' skills, knowledge and self-efficacy to enact policy changes in their local communities (Israel et al., 2010).

Studies reported that another critical component that enabled positive outcomes was the development of leadership capabilities within participants. The study authors of the CBPR policy advocacy training reported that leadership development was vital for recruiting new people, keeping members engaged, and sharing skills and knowledge (Cheezum et al., 2013). Through the food insecurity PAR project, participants developed leadership skills, including assuming leadership roles in organising project activities related to food insecurity (Johnson et al., 2015). Study authors of a project on infant mortality reported that the project developed leadership skills in community members (Minkler et al., 2002). The study reported that this led to greater mobilisation of the community around infant mortality, and many of these leaders were sought after by politicians to inform community health issues.

Equal power dynamics

There were several ways shifts in power dynamics between participants and other powerholders helped to enable positive outcomes. One of the critical ways that power was shared equally was between participants and process organisers. In the Spanish Photovoice project, study authors reported that the process was built around mutual collaboration between participants and organisers (Budig et al., 2018). Conversely, another study reported that participants in the health promotion initiatives in Manchester did not feel like partners in the project, even though facilitators reported seeing them that way (Bandesha & Litva, 2005). Bandesha and Litva (2005) conclude that the 'I plan you participate' philosophy may have led to unequal distribution of power in the project's

design, preventing some from participating and leading others to feel they had no control over the project.

Another way that power dynamics were improved was through mediation between participants and community powerholders. One of the aims of the asset-based community development project was to change power dynamics by building relationships, working with communities to identify shared issues, and facilitating opportunities for collective action (Cahuas et al., 2015). They attempted to negotiate power between residents and policymakers by refocusing the attention on objectives laid out in residents' neighbourhood plans and creating alternative decision-making processes that brought back power and decisions to communities instead of the city. Similarly, a policy advocacy training included a discussion session with invited state and local policymakers giving participants the chance to discuss policy issues in their communities (Israel et al., 2010). One of the reasons why the study authors described the Social Inclusion Partnership as not working was local conflicts of interest and power dynamics that thwarted any policy attempts (Carlisle, 2010). Bandesha and Litva (2005, p. 244) further added: "Partnership models in some community initiatives may represent mediation of continued disadvantage, because they tend to be based on relationships of unequal power and allow statutory organisations to assume that projects will manage minority ethnic issues without any need for internal change themselves." In their study on participatory budgeting in Brazil, Touchton and Wampler (2014) found that PB was successful at allocating resources for the poor due to the power of public authority and the resources behind it. Governments are forced to implement the decisions of the PB because a certain percentage of the municipal budget is required to be allocated through the PB.

Trust

Studies reported that a critical component of success for many processes was the development of trust. Cacari-Stone et al. (2014) attribute some of the projects' success to the partnership between community members and other stakeholders built over decades of intersectoral collaboration that provided a foundation of trust. Similarly, in the

HiAP project, study authors reported that a bottom-up approach that engaged local government enabled the city and community partners to develop trust, learn together how to implement community development and encouraged new partnership (Corburn et al., 2014). The asset-based community development project in Nova Scotia invested initial time and energy to develop relationships and trust with the community (Cahuas et al., 2015). A CBPR project in Kansas reported that embedding the project in the African American community (such as working with well-established organisations; being physically located in one community) helped to develop trust with this community and, in turn, led to greater community participation (Schultz et al., 2009). Conversely, the project was less successful at engaging the Latino community because of multiple barriers (including a lack of bilingual staff and less cultural awareness) that inhibited trust with this community.

2.11 Enablers and Barriers

In addition to identifying the underlying mechanisms that generated reported outcomes, the articles identified various enablers and barriers that explained the magnitude of a process's success (or failure) in achieving its intended outcome. In addition to changes in participants, equal power dynamics, and development of trust, which acted as mechanisms for obtaining favourable outcomes, there were also specific enablers and barriers to each process.

Enablers

The included studies emphasised various enablers for process success. In particular, there were four consistent enablers across the included studies: strong community identification; being socially active; experiential learning approaches; and support for participation.

Budig et al. (2018) found that a strong identification of participants to their community was a critical enabler. Participants strongly identified with their local neighbourhoods, making them more invested in the project's outcomes. Budig et al. (2018) also found that being

socially active enabled participants to gain benefits from the process. The social engagement of participants prior to joining the process was a 'backbone' of their empowerment approaches. A CBPR project in Kansas found that participation of the African American community was enabled through mobilising organisations that were deeply embedded in that community. They did this by partnering with organisations with a history of working with that community (e.g. faith organisations) and creating a physical presence by locating the project in a well-known location in an African American neighbourhood. This embeddedness helped ensure high representation of African Americans on the steering committee, which helped spur more community involvement.

Several studies found that experiential learning was a valuable component of their process. The CBPR policy advocacy training used an experiential learning design which helped participants to meet each other, share ideas, and provide opportunities for networking from different communities (Cheezum et al., 2013; Israel et al., 2010). The HiAP process used a learning-by-doing approach to build new partnerships and coalitions (Corburn et al., 2014). Similarly, small place-based pilot projects conducted at the start of the HiAP process helped engage residents and deliver tangible community improvements.

Enabling participant involvement was also a key enabler to gaining benefits. Project facilitators of the food insecurity PAR process used internal resources to facilitate the participation of women with first-hand experience of food insecurity (Johnson et al., 2015). These women often face significant barriers to participation.

The study authors of an infant mortality project found that addressing racial/ethnic tensions with the community was essential for achieving other outcomes (Minkler et al., 2002). The project addressed these barriers by increasing providers' cultural competence and removing barriers to accessing healthcare.

Minkler et al. (2002) also identified enablers: flexibility in programme structure, strong identification with the programme's mission, providing incentives for participation,

adequate resources, including fiscal support and personnel, and community and institutional support. Putland et al. (2013) similarly found that in social capital projects in Australia, success was supported by a flexible approach that could respond to the community's expressed needs and a long-term commitment to sustained engagement. Most importantly, the study authors concluded that approaches have more potential to be sustained and effective and therefore contribute more to health equity if they are supported at all levels of government and programme management.

Barriers

The study authors also identified several barriers to the processes: competing demands; bureaucracy; artificial constructions of the community; top-down approaches; and power differentials.

Competing demands

Budig et al. (2018) found that competing demands on participants (such as caregiving) and the time-intensive nature of the photovoice process were barriers to participation, particularly for women. Similarly, participants in the HiAP process were reluctant to be involved because they saw the process as adding time and cost to their work (Corburn et al., 2014). Participants in the Detroit CBPR project reported that policy advocacy was labour-intensive, leaving many participants feeling burnt out (Cheezum et al., 2013).

Bureaucracy

Several studies cited governmental or organisational bureaucracy as a barrier to participation. Cauhaus et al. (2015) found that municipal policies lack the transparency or flexibility to be helpful to residents, and bureaucracy often sparked frustration. Additionally, the focus of community development identified by the local government was not always the same priority for the community (Cahuas et al., 2015; Carlisle, 2010). Government staff were also not always willing to do the hands-on work to develop trust and relationships with communities (Cahuas et al., 2015). Government processes are often designed in ways that lack transparency and make it difficult for communities to

engage (Carlisle, 2010). For example, Cauhaus et al. (2015) found that while the government provided funding to resident projects, the timelines for submitting applications to receive funding did not correspond with the timelines of resident initiatives. Whilst some public representatives supported community involvement in land use planning HIAs in France, others saw it as a threat as it could move the discourse on community planning out of their control (Roue-Le Gall & Jabot, 2017). Furthermore, a barrier to including residents in the HIAs was that officials could regard their involvement as redundant to existing consultation activities or undermining local authority. Despite this, the study authors concluded that public participation in HIA can help articulate the link between projects and their well-being impacts and serve the needs of small towns that do not have the resources to set up their own consultations.

Artificial constructions of community

There were also barriers to participation based on how "the community" was constructed. In the Social Inclusion Partnership, the areas of designation from which participants were selected were constructed in bureaucratic terms with little meaning to the community (Carlisle, 2010). Most people identified with their local neighbourhoods rather than the broader constructed areas and some highly deprived areas were left out of the process due to this construction. Similarly, Bandesha and Litva (2005) found that oversimplification of the community was problematic. By designing the initiative to be targeted to 'South Asians' in Manchester, it ignored the heterogeneity within that population and the different constructs of community that the various participants might use. Similarly, a CBPR project in Kansas ignored heterogeneity within the Latino populations (Schultz et al., 2009). Treating all Latino communities as the same meant that the project overlooked cultural differences and unique challenges (such as the barriers for undocumented Latinos in accessing services). This led to minimal engagement with Latino communities.

Top-down approaches

Top-down approaches to engagement were also seen as a barrier. In the Social Inclusion Partnership, the process organisers chose the topic and agenda prior to engagement with

residents (Carlisle, 2010). This approach disregarded topics that were of higher priority to the community. Similarly, Bandesha and Litva (2005) found that the top-down nature of the process led to focusing on a topic that was not a priority to the community and oversimplified the cultural commonalities of the targeted groups for engagement. This led to some participants feeling stereotyped by health professionals.

Power differentials

Several study authors reported that outside actors with more power could thwart a participatory process. Involvement of multiple actors in asset-based community development projects, often those with more power or resources, could sideline community priorities (Cahuas et al., 2015). Participants in the policy advocacy training CBPR project in Detroit reported feeling that they had limited power or that policymakers prioritised the needs of more powerful actors over those of the community (Cheezum et al., 2013). Community residents on a local action group (formed as part of the HIA process) lacked the skills and confidence to interact with agency representatives in the group (Pursell & Kearns, 2013). Furthermore, the two groups of participants (agency stakeholders and residents) had contrasting cultures and ways of working (top-down vs bottom-up) and different languages and discourses. The study authors identified this barrier and provided training for resident participants to enhance their skills to engage with stakeholders. Yet, they recognised that this did not fundamentally change the power imbalance in the group. They highlight that, for example, service providers were not similarly trained on how to work more collaboratively with the community. Touchton and Wampler (2014) also found that poor citizens often have more hurdles to participate and fewer political networks to secure public goods for their communities. However, participatory budgeting enhances participants' political capabilities, enabling citizens to better advocate for the use of public resources.

Lack of follow-up

The level of follow-up with participants also influenced the positive outcomes of a process. For example, a study of a citizen's jury on anti-social behaviour reported that participants did not know if their recommendations had been implemented by the city council (Haigh

& Scott-Samuel, 2008). The authors reported that this led participants to feel frustration, disappointment and a lack of control and influence over the decision. Furthermore, there was a low level of awareness of the citizen's jury by the wider community, leading participants to feel that the overall benefit to the community was diminished.

2.12 Theoretical frameworks

The studies used various frameworks and theories to conceptualise how the process could lead to empowerment or health equity. Several studies theorised participation as a mechanism to equalise power which could change policies that affect the social determinants of health (as an intermediate step to improving health equity). Study authors of CBPR projects conceptualised CBPR as a tool for addressing health equity through power sharing, action and research (Cacari-Stone et al., 2014; Cheezum et al., 2013; Israel et al., 2010). Cacari-Stone et al. (2014, p. 1617) described CBPR as a framework linking participatory research, policymaking and health equity: "the interaction between evidence and civic engagement to shift political power, with a targeted focus on policy outcomes as an intermediate step toward health equity". Several studies also saw the process as affecting health equity by promoting distributive justice (fair allocation of burdens and resources) and procedural justice (fairness in decision-making with the inclusion of marginalised populations) (Cacari-Stone et al., 2014; Corburn et al., 2014).

Two studies linked participation to empowerment through the production of critical consciousness (Budig et al., 2018; Johnson et al., 2015). Critical consciousness or 'conscientizaçaõ', is a concept developed by Freire (1972) as part of an empowerment education model that theorises that the collective awareness of the reality of disempowered groups can lead to action to improve their lives. It is strongly connected to participatory action research frameworks and feminist theory, which emphasises that local expertise cannot be uncovered from the outside (Tanesini, 1999).

Participation was also seen as a mechanism of co-production of assets and interventions, which can lead directly to health equity. This framework was used within the asset-based community development approach, which involves tapping into community strengths and

assets to improve local issues from the bottom-up (Cahuas et al., 2015). Similarly, increasing community capacity to identify local issues and solve problems was seen as a critical step in achieving health equity (Minkler et al., 2002). In one study, the authors regarded 'community HIA' as an empowering and educational tool that places affected populations in the centre of decision-making (Pursell & Kearns, 2013). They emphasise that incorporating local people into decision-making can bring about desired changes for community well-being.

Participation as a mechanism to build capacity was seen as leading to health outcomes in one of two ways. In the CBPR approach from Cheezum et al. (2013), the policy advocacy training was a vehicle for improving participants' skills, knowledge and capacity to change policies that impact health equity (usually through intervening in the social determinants of health). The policy advocacy training could also mobilise community members to advocate for a change to these policies (Israel et al., 2010). Increases in capacity (education and action) via participation were also viewed as an approach to empowerment by which collective power could be used to develop strategies to improve health equity (Johnson et al., 2015).

A few studies examined how community-based initiatives could contribute towards a reduction in health inequities through the development of social capital (Budig et al., 2018; Putland et al., 2013; Touchton & Wampler, 2014). Touchton and Wampler (2014) examined how participatory budgeting programmes in Brazil led to an increase in the development of civil society organisations (an indicator of increased social capital) that worked to increase spending on healthcare and contributed towards a reduction in infant mortality. They posit that well-being is generated, especially for the poor, through the mobilisation of CSOs (via the participatory budgeting process). Putland et al. (2013) acknowledged that while it is theoretically accepted that social capital has benefits for health and well-being, practitioners in their case studies in Australia lacked precise means to link elements of social capital to health outcomes within their evaluation efforts.

The authors of the studies in which participation did not lead to positive outcomes provided frameworks of unsuccessful models. Participation which was intended to improve government-led interventions and policies did not lead to health equity (Carlisle, 2010). Similarly, participation as a mechanism for achieving coverage, efficiency, effectiveness, equity and self-reliance (the WHO summary of benefits of participation (World Health Organization, 1991) did not lead to positive health outcomes (Bandesha & Litva, 2005).

2.13 Discussion

This literature review highlights several key characteristics of the evidence base on participatory processes. First, the goals, mechanisms, and outcomes of participatory processes vary widely. Though all of the included studies had an explicit focus on health equity, and several studies reported on outcomes to the social determinants of health, only one study demonstrated a tangible impact on health equity (Corburn et al., 2014). Most studies theorised that participation could impact on health equity through changes to empowerment or by affecting the social determinants of health, usually through a policy change.

Though many of the included studies found positive impacts to participants, the variations in design that led to these outcomes highlights an important finding of this review. Multiple approaches were able to achieve impacts on empowerment and health determinants. Diverse participatory approaches may lead to the same outcome, highlighting that potential outcomes are highly contingent upon the design and implementation of the process. While much evidence theorises participation as having an impact on health equity, this review finds that positive impacts of participation are achieved principally when processes are carefully developed to increase empowerment and capacity in participants, with equal power dynamics between organisers and participants, and enable the development of trust. It would therefore seem that the specific approach used is less relevant than these mechanisms, which could be integrated into several types of approaches. Approaches in which these mechanisms are built into the rationale and design of the process (e.g. CBPR, Photovoice) would therefore be well suited to

addressing empowerment. However, these types of processes may not always fit in standard decision-making windows, making it difficult to affect policymaking.

Secondly, although some reviews have examined the correlation between participation and health equity (Cyril et al., 2015; Durand et al., 2014), this relationship is not commonly assessed empirically in the literature. The majority of studies identified through this search either did not adequately describe the participatory process to understand how a process could lead to expected outcomes or were descriptive case studies that did not empirically determine the process's impacts. This lack of evidence highlights the need for more robust research methods to determine not only *what* are the impacts of participatory processes but also *how* such processes lead to potential outcomes. Additionally, despite substantial evidence linking empowerment to health equity (Laverack, 2006), none of the included studies assessed both of these impacts. This might suggest that a process appropriate for enhancing empowerment may not be the same process required to affect health equity or that enhancing empowerment alone is not sufficient for health equity.

The lack of empirical assessment of many participatory studies, and descriptive analysis of outcomes, may lead to a tendency for authors to report the positive impacts that they perceive rather than assessing for the potentially negative or missing impacts experienced by participants. Professionals often thought the project had benefits not perceived equally by participants. For example, professionals in a health promotion community engagement project (Bandesha & Litva, 2005) saw the process as being empowering, that there was an equal partnership, and had led to social cohesion. On the other hand, study authors reported that participants did not feel like partners in the project, did not perceive the same benefits to social cohesion, and even felt frustrated by the lack of cultural awareness and sensitivity. This emphasises the need for more transparent methodological approaches for assessing the impacts of participatory processes.

Finally, not all studies supported their findings by linking to existing theories or frameworks. In the studies linking to theory, empowerment theories or CBPR/PAR

frameworks were the most commonly used. The lack of a consistent model that can be applied across various participatory approaches highlights the diversity of goals and approaches used to link participation to health equity.

2.14 Limitations

While this review was designed to gather evidence on all types of participation impacts, it is possible that processes with negative or no impacts were underreported, generally reflecting the tendency for higher acceptance of publication of positive research outcomes (Callaham et al., 1998). Additionally, this review did not include any studies that documented potential participation harms as reported elsewhere (Katz et al., 2015). The lack of inclusion of studies that reported null or negative impacts of participation may have unintentionally excluded other important mechanisms.

2.15 Conclusion

While there is broad support for the use of participatory processes to increase health equity from policymakers and the public, there is a dearth in the evidence base to demonstrate how such processes can lead to posited outcomes. This review seeks to narrow this gap by detailing the types of processes that have been used and how they have led to impacts on health equity. There is evidence to support the use of participation as a mechanism to improve health equity but to better understand how approaches lead to outcomes, there is a need for better assessment of findings and reporting of outcomes. Ideally, a more transparent and reflexive evidence base can help to ensure that participatory processes are conducted in ways that can improve health equity as they are intended.

CHAPTER 3 METHODOLOGY

> People are always knowledgeable about the reasons for their
> conduct but in a way which can never carry total awareness of the
> entire set of structural conditions which prompt an action, nor the
> full set of consequences of that action…In attempting to construct
> explanations for the patterning of social activity, the researcher is
> thus trying to develop an understanding which includes hypotheses
> about their subjects' reasons within a wider model of their causes
> and consequences. *(Pawson & Tilley, 1997, pp. 162-163)*

3.1 The research question

Public participation is a widely-supported strategy to improve health equity, yet it is unclear how participatory processes can generate their purported benefits. As discussed in the previous chapter, participation is theorised to support health equity through improving public policymaking, enhancing empowerment and direct benefits to health and the social determinants of health. This research contributes to this evidence base by empirically examining how such outcomes can arise. The main research question that this research seeks to answer is:

How, if at all, do participatory processes, through health-informed
decision-making and empowerment, contribute towards health
equity?

Given the existing evidence that supports the use of participation as a strategy for improving decision-making and empowerment, the following additional research questions will also be addressed (the sub-questions are provided in section 1.3, Figure 4):

How, if at all, do participatory processes enable consideration of health and health equity in decision-making?

How, if at all, do participatory processes affect empowerment?

This chapter provides a methodological explanation for how these research questions will be addressed. An intellectual grounding for the research methodology is provided before detailing the research design, methods and analysis. The chapter concludes with consideration of the limitations of this approach.

3.2 Intellectual grounding

This research employs a qualitative methodology, supported by a scoping literature review, to answer the research questions. This approach is structured around two key methodological choices -- interpretation and comparison -- rooted in a critical realist ontology. Below I explain these concepts and how these choices are best suited to address the research questions.

As described in Chapter 1, this research focuses on understanding how participatory processes can affect health equity. In addition to analysing the types of outcomes that arise through public participation, I wanted to better understand the context and mechanisms through which they occur. My approach to this research relied upon a critical realist ontology. Critical realism purports that reality exists outside our experience (Sayer, 1992). It can be approached but never fully understood. While positivism purports that reality can only be understood through what can be observed and constructivists view reality as potentially unknowable outside human experience,[5] critical realists believe that

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[5] I acknowledge that these are oversimplified summaries of positivist or constructivist ontologies, but my point is to convey their ontological propositions compared to those of critical realism. Bhaskar (2008, p. 4) argues that other scientific approaches commit an 'epistemic fallacy' when reducing things into thoughts or ontology into epistemology: "the chief metaphilosophical error in prevailing accounts of science is the analysis, definition or explication of statements about being in terms of statements about our knowledge of being". It should be noted, however, that many

there is an external reality but that our interpretation of that reality is filtered through lived experiences (Danermark et al., 2002). Critical realists seek to understand reality through the examination of mechanisms that drive social phenomena (Fletcher, 2016) and to "investigate and identify relationships and non-relationships, respectively, between what we experience, what actually happens, and the underlying mechanisms that produce the events in the world" (Danermark et al., 2002, p. 21).

According to Danermark et al. (2002), critical realism stratifies reality into three levels. The *empirical* level is the level at which we experience reality. This reality is mediated by human interpretation. Below is the *actual* level, or the point at which reality exists without human interpretation. Underlying both of these is the *real* level. These are the "inherent properties…that act as causal forces to produce events" (Fletcher, 2017, p.183). We experience events at the *empirical* level, but the manifestation of events occurs at the *real* level. An important distinction from constructivism is that critical realism treats "the ideas and meanings held by individuals – their concepts, beliefs, feelings, intentions, and so on –as equally real to physical objects and processes" (Maxwell, 2012, p. viii). From a practical standpoint, critical realists treat unobserved data as real - meaning that data produced by people (feelings, beliefs, etc.) can be treated as evidence of phenomena rather than an interpretation of something unobservable.

This approach is useful for this study for several reasons. First, health and participation can be both observable and interpreted experiences. Health can be empirically measured from a population standpoint, but the experience of illness and wellness is personally and socially interpreted (Kerr et al., 2018). Furthermore, wellness is created through 'unseen social generative mechanisms' (Alderson, 2021, p. 50). These mechanisms are multiple and interactive, making them 'determining but not determinist.' (Alderson, 2021, p. 50). Understanding how participation affects health requires treating these events as

social constructivists would contest that constructivism is inherently relativist or that it treats being as a reflection of knowing. Boswell et al. (2019), for example, provide an interpretivist approach -- one that I employ in this research -- that challenges Bhaskar's assertion.

interpreted experiences that generate real outcomes through causal mechanisms that may or may not be observable. Critical realism recognises that people's experiences, motivations, decisions and intentions can be causal influences with real effects and outcomes (Alderson, 2021).

Based on this ontological position, I can make several assertions for this research. First, this research generates evidence that considers the context (i.e. structures, systems) in which mechanisms are contained and enacted. Second, this research treats the experience of participation as real – both as a causal mechanism and as an outcome in itself. Third, this research identifies explanatory (necessary and contingent) conditions that exist at the *real* level of reality. Finally, this research develops plausible conjectures that explain the relationship between participation and health equity. These plausible conjectures do not need to be absolute or present in every case, rather, they act as a "best explanation for the puzzle" (Boswell et al., 2019b, p. 29).

Two critical methodological approaches were chosen to generate the evidence necessary to answer the empirical research question: comparison and interpretation. I have chosen to carry out a case study comparison for several reasons. First, as identified by the literature review, there is an abundance of participatory processes that have been conducted worldwide, and a subset of processes that have been used to address health equity. In-depth case study of a particular process can identify potential outcomes that arise within a real-world context (Stake, 2005). Second, comparison is helpful for providing a deeper understanding of social phenomena (Weber, 2017). In particular, it can be used to explain the mechanisms through which social phenomena arise (Creswell, 2017), focusing on mechanisms of change rather than cause and effect (Blaikie, 2009). 'Thick description' (Denzin, 1989; Geertz, 1973) elicited through case study examination can illuminate 'plausible conjectures of broad theoretical applicability' (Boswell et al., 2019b, p. 55). A comparative analysis of two types of processes can illuminate the mechanisms by which outcomes arise. A critical realist approach to case study allows for the consideration of context, entities and events to understand "what caused those events to happen" (Easton, 2010, p. 121). Therefore, comparative case research can provide an

understanding of how characteristic factors of the contextual environment (Esser & Vliegenthart, 2017) shape how participatory processes contribute towards health equity in different settings.

Furthermore, this research employs an interpretive methodology. I have taken up Boswell et al.'s (2019b, p. 5) "…call to arms for interpretivists to embrace creatively comparative work that uses the dilemmas of situated agents as its empirical starting point to develop plausible conjectures". Though, as I describe above, this research is embedded in a critical realist ontology, it does not exclude the use of an interpretive approach. In particular, interpretivism allows for abduction – an iterative movement between plausible explanations for a phenomenon and observation of the phenomenon (Schwartz-Shea & Yanow, 2020). It is the sensemaking process of the 'misfit between experience and expectation' (Boswell et al., 2019b). For this research, I started with a plausible conjecture that participation could affect health equity through changes in health-informed decision-making and empowerment. This conjecture enabled me to design the research to study these (possible) occurrences but allowed for the emergence of other explanatory mechanisms.

Furthermore, interpretivism enables the consideration of multiple accounts of a single phenomenon, allowing for context, culture and beliefs in its creation. The study of the 'narrative' of an event takes into consideration people's contingent beliefs and practices and seeks to identify recurrent patterns of actions and practices (Bevir, 2007). Applying an interpretivist lens to comparison allows for a broader understanding of the social construction of participation. It treats critical concepts of this research – participation, power, health – as being socially constructed and individually interpreted, yet through comparison and "abductively moving back and forth between the meaning and beliefs of actors and our sensemaking of their practices…we provide an interpretation of their interpretations" (Boswell et al., 2019b, p. 5). As the interpreter of research participants' interpretations, I can seek to identify plausible conjectures that explain how and why certain outcomes arise through the experience of a participatory process.

Overall this project is based on critical realist constructions of truth (ontology) and interpretivist assertions of how to generate knowledge (epistemology) (Carter & Little, 2007). Consequently, this project seeks to explain how public participation affects health equity by examining the experience of participatory processes as social phenomena embedded in particular contexts, cultures, and webs of meaning (Boswell et al., 2019b). The methodological choices described in the remainder of this chapter are guided by and are best suited to addressing the research questions with these orientations in mind.

3.3 Research design

The research, including data collection and methods of analysis, was designed to achieve the methodological choices described above. Below I provide a detailed description of these choices, including the development of what I refer to as critical realist comparison (CRC).

3.4 Casing

Boswell et al. (2019b) suggest moving beyond traditional approaches to case study comparison (dominated by variations of John Stuart Mills' 'method of difference') in favour of an interpretive approach which relies on a process of abductive reasoning. With such an orientation, the task is to work out what a study is a case of rather than deciding this a priori. However, for practical reasons, I needed to begin somewhere with designing the project (including offering my first-year board examiners a relatively cohesive research plan), and it was easier to search for cases that met certain a priori criteria than to let this emerge on its own.

To determine the types of cases I would use for this research, I began by first exploring the breadth of forms of participation used for health-related topics. The scoping literature review in Chapter 2 sought to identify the various forms of participation used to address health equity (see literature review for details on search strategy). The following processes were identified:
- Community-based participatory research (CBPR)
- Photovoice

- Health impact assessment (HIA)

- Health in all policies (HiAP)

- Community development

- Social Inclusion Partnership

- Participatory Action Research (PAR)

- Citizens Juries (CJ)

- Participatory budgeting

- Various health promotion activities combined under a 'community participation' banner.

In order to ensure that I had not overlooked any process not included in the peer-reviewed literature, I consulted an online database: Participedia.net. Participedia generates data through the input of public participation practitioners and researchers, so it is by no means fully representative of the full range of processes that have been used. However, it offers the ability to see the variety of processes that have been reported globally. I screened the Participedia database to see what types of processes had been applied to a health-related topic (broadly speaking, including social determinants of health and health equity). I encountered 156 examples of processes that had been reported, representing 48 different types of processes. Interestingly, this publicly-generated dataset did not include all the same processes identified in the literature review. This might be due to discrepancies in language across different fields (i.e. calling the same process by different names) or a tendency for more research-focused processes to be reported in the literature and more practice-focused processes to be reported in crowdsourced open databases.

Next, having established the breadth of possible cases, I wanted to ensure that the processes I selected were adequately comparable to enable depth of analysis. To do this, I established a set of criteria that include common features that each process should contain based on plausible conjectures and pragmatic considerations:

1. *The process is intended to inform decision-making.* Given that this research seeks to understand how, if at all, participatory processes influence decision-making, I

narrowed the scope of potential cases to only include processes that have been used to inform decision-making. This would exclude cases conducted primarily for research purposes (e.g. many CBPR and PAR processes, Photovoice) and processes designed for other purposes (e.g. health promotion activities).

2. *It is a discrete process.* Many forms of participation take place on an ongoing basis. These types of processes can inform a decision at various stages in the process, but I felt that cases would be more comparable (and importantly, would be pragmatically easier to collect data on) if they had occurred within a discrete timeframe. This would exclude many long-form types of participation (e.g. social inclusion partnerships, community development initiatives, some forms of participatory budgeting and some health in all policies initiatives).

After applying these additional criteria, two types of participatory processes stood out as explicitly intended to inform decision-making and conducted within discrete timeframes: Health Impact Assessment and Citizens' Juries. HIA is a systematic process that examines a future decision to identify potential health and health equity impacts and offers recommendations for decision-making to avoid harms and enhance benefits (WHO European Centre for Health Policy, 1999). Community and stakeholder participation can occur at different stages or throughout the HIA (Baker et al., 2012). The length of an HIA ranges depending on the scope and depth of analysis, ranging from a few weeks or months for a desktop HIA (one conducted with only secondary data) to several years for a comprehensive HIA (Harris et al., 2007). A citizens' jury is a form of 'mini-public,' a democratic innovation designed to enable a more deliberative form of public participation (Elstub & Escobar, 2019). Mini-publics are made of citizens selected through random sampling with the aim of representing a cross-section of the larger population (Escobar & Elstub, 2017). Most are intended to convene and deliberate on a specific issue and provide recommendations that are fed back into governance processes and are dissolved thereafter.

Boswell et al. (2019b) suggest that conjectures about whether cases are comparable are less about objective assessments of what is 'typical' or 'deviant' and more based on

hunches and assumptions built upon the researcher's personal normative preferences. In this regard I should like to make explicit my own positionality upon undertaking this research. First, as I explained at the beginning of the thesis, I am a health impact assessment practitioner. I have spent the past 10 years of my career conducting HIA, researching it as a practice, advocating for its use, and training others on how to do it. It goes without saying that I see HIA as a valuable tool. However, what I felt was missing from the field of practice was greater consideration for and integration of public participation in the HIA process. Therefore including HIA as one of the case studies could provide practical evidence that would be useful to me from a professional standpoint. This research could have been designed to only include cases with some form of representative participation, thereby excluding HIA. This would have also addressed the research questions but would not have met my personal, pragmatic requirements.

Second, underlying this research is a normative assumption that participation is a good thing. One of the greatest motivators for pursuing my research topic was an HIA I conducted in 2017 on the development of Sydney's second airport. The airport approval process had been conducted with standard community engagement practices, which had left local communities confused, angry and oppositional to its continued development (there were, for example, anti-airport advocacy groups in the Blue Mountains region of New South Wales, an area that would sit below the flight paths to the new airport). A team of researchers and I decided that it could add value to the decision-making process to conduct an HIA on the airport community engagement strategy (Hirono et al., 2017), considering that engagement would be ongoing for the duration of its development and operations. Conducting research on this topic and engaging with hundreds of local community members affirmed to me the value of conducting (good) public participation. At my core, I am an advocate for public participation. Rather than seeing these normative and practical preferences as potentially compromising the validity of my findings, I make them transparent with the belief that they can "enliven and enrich the research we do" (Boswell et al., 2019b, p. 61).

3.5 Case selection

In order to select appropriate cases from within this design, I developed an initial set of selection criteria.

1. *Process deals with a topic that is relevant to health equity.* In order to understand how participation may function as an approach to achieving health equity, it was essential to examine processes in which the topic of the decision is relevant to health equity. This was considered within a social determinants of health framework and therefore included any decision impacting on social, economic, political, environmental or other structural determinants of health.

2. *The process involves lay publics.* As part of this research seeks to examine how participatory processes may affect empowerment (with empowerment serving as a theoretical component of health equity), I decided to impose an inclusion criterium that the cases under consideration must include members of the general public (for example, not being a process where only organised stakeholders were involved).

3. *The process was conducted according to best practices.* 'Ideal type' is a hypothesis about what something is (Gerhardt, 1994). Given the critical realist orientation of this research, 'the ideal' is seen as something that is constructed as a representation or generalisation of reality but which will never be identical to reality (Stapley et al., 2022). For the processes to serve as ideal types for comparison, it was important to establish that they met some criteria of what it means to be 'ideal.' I searched for cases that followed best practices according to specific criteria to establish ideal types. For HIAs, there is existing guidance on best practices for participation (Baker et al., 2012). I read through the HIA reports of potential cases and completed a best practice checklist to ensure that the case met most of the criteria (for an example, see Appendix B). At the time of case selection, I could not find any best practice guidance for citizens' juries, but I was,

however, able to consult with two leading experts[6] in mini-publics to determine a set of criteria (see Appendix C).

4. *The process was completed in the past 3 years.* Cases were culled only to include those that had occurred in the past three years (not older than 2015). This was intended to enable enough time to determine how the process affected the decision while also being recent enough to assist with participant recall.

5. *The case had potential to impact on the decision.* I have selected cases in which there was potential for the process to have some sort of impact on the decision. Impact refers to any effect (positive or negative; intended or unintended) resulting from the participatory process (immediately or long-term) (Stern, 2015).[7] This would include cases in which a decision exists in the realm of possibility rather than theoretically. For example, a citizen's jury that examined the type of mitigation strategies that citizens would like to adopt to address climate change would be excluded if there was no actual decision point that this information was intended to inform. Processes used exclusively for research were also excluded for this reason. This allows for comparison using 'theoretical replication,' meaning that the cases can have contrasting impacts so long as the logic of the cases can be expected to have similar results (i.e. an impact) *(Yin, 2013).*

I developed a list of potential cases by consulting with various HIA and CJ practitioners, reviewing online repositories such as Participedia.net, and conducting web searches. Once a list of potential cases was developed, I applied a checklist (see Figure 18) to each case to ensure it met all the inclusion criteria. Of course, the reality of cases was quite

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[6] I consulted with Claudia Chwalisz and Oliver Escobar (before he joined the supervision team) to inform my list of best practice criteria. Recently, guidance has been published by the OECD on good practice for deliberative processes: (OECD, 2020a).

[7] I acknowledge the contested nature of defining and measuring impact (see for example:Bandola-Gill & Smith, 2021). Using an interpretive approach allowed for conceptual openness – meaning that I did not define what an impact was a-priori, rather, I allowed for this emergence through the narratives of the case studies.

different from my idealised criteria. Many of these criteria were ultimately changed to progress the research, as I will explain below.

3.6 The reality of case selection

No other stage of this research was as difficult, daunting or disheartening as the case selection process. As I have detailed above, I set out to find cases with inclusion criteria focused enough to enable comparative analytical rigour but broad enough to include a wide range of cases (or so I thought). The initial list of cases I generated through the search strategy included a range of HIAs and CJs in the UK, Australia, Canada, South Africa and the USA. I narrowed the search to cases in the UK and Australia for two reasons. First, the policymaking context of parliamentarian governments is similar in the UK, Australia and Canada. Selecting cases from within proximately similar policymaking contexts would allow for more robust comparison, especially given similar drives for public participation in the UK and Australia (as discussed in Chapter 1). This ruled out cases in the US. Second, as I had spent the past four years working in Australia, I had a solid professional network which I could draw upon to access cases. I similarly had professional contacts in the UK and could draw on the networks of my supervisory team. This narrowed the cases to only those in the UK and Australia.

Where contact details were available, I contacted the process organiser. If I had a professional contact available, I would ask them to introduce me rather than contacting them blindly. I emailed the contact a brief description of my research and a request to schedule a phone conversation. Usually, these contacts were happy to set up a time to discuss my research though the time delay for scheduling that conversation could be weeks and sometimes months. During the phone call, I again described my research and explained that I would be seeking to interview participants, organisers and decision-makers. It was at this point that the case selection process usually stalled.

In some cases, the organisers were happy to be involved, but did not have adequate access to participants. For example, in one HIA, they had run several community workshops but had not recorded participants' contact details. In another HIA, most of the

participants in the HIA had moved on from their professional work (one person had retired, one person was on secondment during the HIA, and one person had left the organisation,) and the organiser did not have follow-on contact information for them.

In other cases, there was pushback or hesitancy from the organiser or decision-makers about being involved in the research. In one HIA of maternity services, the decision-maker declined to be involved. The organiser confessed that the HIA had been done because the health service had not conducted sufficient engagement at the start. She speculated that my research findings would therefore "make them look bad." In another case, there were personal tensions between the person who had conducted the HIA and the current decision-makers. My contact told me that interviewing decision-makers about the HIA was likely to 'stir the pot', and therefore they could not approve my research. In one case, the organisers had already commissioned an evaluation to be conducted on the CJ, and felt that my research would be over-taxing to participants (who would also participate in the evaluation).

Lastly, in some cases, it was unclear whether there had been any impact on the decision. Several HIAs had been conducted on a decision that was still ongoing. For example, an HIA on a land use planning policy in Wales had been conducted recently, and the final decision about the preferred strategy for the planning policy had not yet been selected. The process organisers felt (and I agreed) that it would be challenging to examine how the HIA affected the decision when it was still in flux. In total, I screened and contacted over sixteen potential cases. This (infuriating) process of searching for cases, finding fits, and then not being able to progress the research for reasons explained above lasted from early 2018 (when I began looking for cases) to early 2020 (when I confirmed the final case).

The difficulties I encountered finding appropriate cases reflect the broader sensitivities and organisational politics of how participatory technologies operate within broader administrative processes. Because I am seeking to understand how these processes can affect health equity, it was imperative that I find cases that were linked to decision-making

contexts relevant to the social determinants of health. Yet it was precisely these contexts that created the greatest barriers to conducting the research. Though frustrating, this experience highlighted for me the importance of understanding the context for implementing participatory processes, rather than examining processes as technologies that can be easily adapted and implemented regardless of the context (as they are often treated in the literature). This critical consideration helped spur my own analysis, and the following chapter reflects this thinking.

Luckily, in some cases, organisers were keen to be involved in the research. Some organisations, such as newDemocracy Foundation, had conducted several citizens' juries. A contact from the organisation suggested I look through their online repository to identify which processes might serve as a case. We followed up over email and a subsequent phone conversation to confirm that the Byron Bay Community Solutions Panel fit my research criteria best. Similarly, I had been involved in the HIA training programme for which the Airds Bradbury HIA was conducted. In this case, I knew the process organisers well and contacted them directly. The process organiser confirmed that she still had access to the HIA participants and was happy to support the research.

In the UK, I identified the Measuring the Mountain Citizens' Jury as a potential case. I contacted the process organisers, who confirmed that they were happy to be involved and to contact participants on my behalf. The selection of the final case proved difficult. As I described above, I encountered numerous barriers to selecting a UK HIA despite an abundance of options. A professional contact of mine had worked on the 50,000 Affordable Homes HIA, and she suggested that participants would be willing to be involved in my research. This case had initially been disregarded because it relied on professional stakeholders, not lay participants (one of the original selection criteria). However, the case used a participatory process that met best practice criteria. I, therefore, decided to amend my inclusion criteria to allow for the inclusion of this case. The final inclusion criteria (see Figure 18) included essential criteria that would enable suitable comparison across the cases, in addition to additional criteria that would be helpful for my research (such as the inclusion of disadvantaged populations) but would not detract from

the comparability of the research if not met. This iterative approach to case selection fits within an abductive approach to comparative research (Boswell et al., 2019b).

Figure 18 Case study selection criteria

Essential Criteria	Yes/No	Additional Criteria	Yes/No
Deals with a topic that is relevant to health equity		The participatory process aligns with best practice guidance.	
The HIA/CJ used a participatory process		The recommendations of the HIA/CJ were used by decision-makers	
Conducted within the last 3 years		Participation included disadvantaged populations	

In all the selected cases having a supportive 'gatekeeper'– someone who had been involved directly in the process – was critical (Crowhurst & Kennedy-Macfoy, 2013). These people contacted research participants on my behalf (to preserve the anonymity of participants who did not want to participate in the research), provided access to key documents and other outputs, and invited me to observe other relevant meetings or subsequent processes. My professional contacts for AB even invited me to use their office as a workspace while I was conducting fieldwork in Australia. Having an introduction to the research come from someone known to participants also seemed to generate good engagement in my research – participants were happy and enthusiastic to participate.

3.7 Data collection and fieldwork

Before conducting fieldwork, this research (including interview protocols) was submitted for ethics review and approved by the University of Edinburgh School of Social and Political Science ethics committee. Fortuitously I was able to confirm cases in Australia first. I, therefore, conducted fieldwork in New South Wales (Sydney and Byron Bay) between February and March 2019. Confirmation of the UK cases came later, and I conducted fieldwork in Cardiff, Wales, in November 2019. Fieldwork in Edinburgh, Scotland, began in March 2020 but was interrupted due to the Covid-19 global pandemic

and subsequent lockdown in the UK. Several people I had planned to interview worked in public health and were, therefore, unavailable to participate in this research due to time constraints. Likewise, the decision-makers of that case study were policy advisors for the Scottish Government, who faced similar time/prioritisation constraints. Luckily all the remaining interviewees were willing and able to complete interviews in September 2020.

In total, I carried out 44 interviews from four case studies (see Table 2). Participants, organisers, and decision-makers were invited to participate in an interview. Potential interviewees were contacted via email by the process organiser on my behalf (or were contacted by phone). Twenty-four people were contacted for AB. Of those contacted, 11 people participated in an interview (46% response rate). For the CSP, 34 people were contacted for interviews of which 13 participated (38% response rate). There were 36 people invited to interview from MTM, of which 12 people participated (33% response rate). From 50K, 17 people were contacted, of which 8 people participated in an interview (47% response rate). A breakdown of the number and types of participants is provided in Table 2. It should be noted, however, that some of these categories overlap. For example, in the HIAs, people could participate in the process while also being an organiser or decision-maker. In cases where a person had multiple roles, I have included them in a non-participant category (to show the breadth of types of interviewees).

Table 2 Number and Type of Interviewees in each Case

Case	Airds Bradbury	Community Solutions Panel	Measuring the Mountain	50,000 Affordable Homes
Participant	5	9	8	4
Organiser	3	3	3	1
Decision-maker	3	1	1	3
Total interviewed	*11*	*13*	*12*	*8*

3.8 Interviews

Conducting interviews seemed an obvious method for this research. Qualitative interviews allow in-depth examination of an experience (Brinkmann, 2020). This focus on experience complements a phenomenological approach to qualitative research (rather than, say, a discourse orientation)[8]. I sought to understand what had happened but also how people interpreted what had happened. In critical realism, people's interpretations of the event are as causally powerful as the event itself (Maxwell, 2012). Interviewing allows for constructing meaning through the interview process while also elucidating context, social relations and structures that affect action (aspects central to a critical realist approach) (Elger & Smith, 2014). Interviewing different people involved in the process, not just participants, enables the development of a thick description of the cases (Ponterotto, 2006), which helps to uncover structural conditions and mechanisms as well as a broad examination of outcomes. I also chose to conduct semi-structured interviewing as this allows for a dialogic approach to knowledge production (allowing me to follow unexpected lines of inquiry) and makes the researcher more apparent as a knowledge-producing participant (Brinkmann, 2020; Elger & Smith, 2014).

I developed an initial protocol for conducting semi-structured interviews. The questions were based on my theory-led conjectures about how a process might affect health equity. Therefore I asked participants about how the process was run and the results for decision-making and themselves. This is similar to Pawson and Tilley's (1997) theory-driven approach to interviews, in which the subject matter of the interview is based on the researchers' theory and the expertise of the interviewee is seen to be greatest in relation to explanatory mechanisms (e.g. choices, reasoning, motivations). Some questions were

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[8] In describing this research a 'phenomenological' I am referring to the concept first theorized by Husserl which posits that meaning can be generated through the interpreted experience of a phenomena (Husserl, 2013). As opposed to discourse analysis which aims to interpret how humans make sense of the world through their social constructions of it (e.g. texts, words)(Mogashoa, 2014), phenomenology allows for interviewees descriptions of the event to serve as interpretations of that experience.

left open-ended, such as asking what, if any, were the outcomes of the process. However, I did want to ensure that I at least prompted interviewees to answer some questions relevant to my conjectures. Therefore, I asked specific questions about, for example, whether or not they felt any empowerment had occurred. Semi-structured interviewing allows for both types of questions – it is flexible enough to enable interviewees to raise topics from their perspective and in their own words (Brinkmann, 2020, p. 436) – and this seemed the most appropriate strategy given the interpretive approach of this research. Given their different perspectives on the process, I wanted to elicit an understanding of the process aims, design and outcomes according to participants, organisers and decision-makers. Therefore, I created three separate protocols for the different types of participants, including some slightly different questions for each type (see Appendix D for an example protocol).

I carried out two pilot interviews to trial the interview protocol. I conducted one with a community resident and one with a team member of the AB HIA. I had worked with both of these people in my previous job in Australia and therefore felt comfortable trialing the process with them and receiving their input. A former colleague who specialises in critical realism also offered to review the protocol. Based on the feedback from these interviews and my colleague, I modified the protocol to allow a more realist approach which would help to elucidate the mechanisms that enabled the stated outcomes.

I carried out interviews at either the home, workplace, or public space (shopping centre, library, etc.) that was convenient to the interviewee. Some interviews were carried out in the offices I was working at in Sydney, and a colleague at Public Health Wales also offered meeting space within their offices in Cardiff for me to conduct interviews. I tried to be flexible about where the meeting took place to accommodate the interviewee. This had benefits and drawbacks. The benefit of this approach was that interviewees often selected places to meet where they felt comfortable (their homes, a familiar cafe, etc.), and by meeting in these familiar places, interviewees were comfortable speaking freely about the process. The drawback of this was that interviews were occasionally interrupted (e.g. by a waiter), and the sound quality of the recording could be poor. In a few cases,

participants could not meet in person (n=9)[9]. Therefore, I scheduled a remote interview through Microsoft Teams, Skype, or over the phone. In two cases, due to time constraints, the decision-makers could not meet for individual interviews. I, therefore, conducted group interviews with two (AB) and three (50K) participants at one time.

At the outset of each interview, I provided the participant(s) with a description of the research (see Appendix E) and requested their consent to participate (see Appendix F). Signed consent forms have been kept securely according to the University of Edinburgh ethics guidance. I also asked for verbal permission to record the interview, and all interviews were recorded.[10] I informed participants that I would ensure their anonymity in any further discussions or outputs of the research. I took notes during the interview and then commonly wrote additional notes after the interview had concluded. Given that I was conducting all fieldwork within short periods of time (sometimes over 4-5 days), some interviews had to be scheduled back-to-back, and I was not always able to take notes following an interview. I did, however, write a summary of my overall impressions of the data collection upon completing fieldwork for each case. I transcribed the audio recordings of all interviews with the assistance of Otter.ai software. One interview was sent for professional transcription due to poor audio recording.

3.9 Participant observation

In addition to conducting interviews, I had the opportunity to conduct some participant observation. Participant observation allows the researcher to study behaviours and beliefs that an interviewee might ignore in an interview, either because they do not see the importance of it or because they are so culturally embedded that a person is not

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[9] The majority of these remote interviews (n=6) were for 50K participants due to social distancing rules associated with the Covid-19 pandemic.

[10] For one interview the audio recorder stopped working about 15 minutes into the interview. Luckily I had checked the recording immediately after conducting the interview and realized this issue. I therefore wrote detailed notes following the interview in order to capture what had been lost from the recording as best as I could.

critically aware of them (Harrison, 2020, p. 345). These opportunities for participant observation allowed me to iteratively engage in the cases – exploring the journey of the case beyond the initial process – and observe cases in progress rather than through the narrative lens of interviewees.

While I was conducting fieldwork in Byron Bay, newDemocracy Foundation was running a session for a new Citizens' Jury they were conducting for Byron Shire Council. The CJ was taking place as a consequence of the CSP and was therefore being run in the same style as the CSP. Therefore, this was a great opportunity to observe how the process was run in action. I attended a full-day session on 9 March 2019 and observed the various activities and discussions occurring as part of the CJ process. I took extensive field notes and some photographs from that day. Participants were made aware of my attendance and the aim of my research before the observation began. While back in Sydney, I also had a follow-up conversation with the facilitator. He had not facilitated the CSP, so I did not interview him as part of this research, but it was helpful to have a conversation with him about the current CJ and ask him some questions about facilitation.

I was also invited to attend an Airds Bradbury community residents group (CRG) meeting. The CRG is an ongoing convening of community residents, estate managers, agency stakeholders and representatives of City Council. Given that the HIA is a standing agenda item for the CRG, the process organiser thought it would be helpful for me to attend. I observed the meeting on 11 February 2019 and took notes about the discussion on the HIA and the redevelopment. One of the community residents also introduced me and my research and suggested that members of the group volunteer to be interviewed for my research.

Lastly, one of the interviewees for 50K knew of a joint stakeholders meeting that would take place in a few days following our interview. He felt it would be relevant for me to attend, given that the meeting is centred around health and housing work (which was the topic of the HIA). He confirmed that it would be appropriate for me to attend as an observer. I attended the local housing strategies and health roundtable discussion on 9

March 2020. The meeting convened stakeholders from Health (NHS and Public Health Scotland), Council/local government members, and a few people from non-profit/third sector agencies. I observed the discussion that transpired and took notes during the meeting.

3.10 Document analysis

The final method I employed for this research was document analysis. Documents not only communicate information about the process; they act as a site of social practice, conveying certain behaviours, priorities and norms (Freeman, 2006). I analysed written outputs from the cases, including the final reports, peer-reviewed publications, evidence summaries, and briefing books used during the process. I also examined other relevant documents, such as policy statements, newspaper articles, and meeting agendas relevant to the broader decision-making context. Lastly, in some cases, participants shared ways that the process had follow-on effects on other pieces of work. I reviewed these (research documents, funding proposals, policy statements, operational plans, etc.) as part of the examination of the impact of the case studies. In examining documents, I sought to understand the narratives and framings of the processes (Freeman, 2006) and how the documents performed certain functions as an actor in the process (Prior et al., 2020). Rather than conducting a discourse analysis of the documents, I used them to expound themes that had emerged from the interviews. For example, I looked to see if the documents reflected the same goals, process and outcomes that participants described. This (in)congruence helped to shed light on the diversity of experiences and interpretations of the processes (a topic I examine in more detail in Chapter 5).

The use of three types of methods allowed me to create a comprehensive understanding of the cases. I used multiple data sources to 'triangulate' the data in terms of increasing validity (Bryman, 2016), for example, to verify the outcomes of the process. Yet, more commonly, combining interviews with documents allowed for 'intertextuality' (Schwartz-Shea, 2013) – expanding the interpretive analysis to capture the multidimensionality of perspectives and experiences. This allowed for corroboration but also shed light on inconsistencies that challenged my conjectures or highlighted points of contestation

(Schwartz-Shea, 2013). Furthermore, the 'trustworthiness' (Schwartz-Shea, 2013) of this research is supported by my reflexivity. Reflexivity is a form of reflection on the production of knowledge conducted by the researcher throughout the process (Gray, 2008; Pillow, 2003) and requires an awareness of the researcher's positionality within the research process (Doucet, 2008). As part of my note-taking process, I documented my feelings, thoughts and experiences of conducting this research. Furthermore, I took detailed memos during the analysis to capture my thoughts and reflections on the research. These memos were integral to the analysis – often serving as a starting point for interrogating the data (such as providing an initial coding framework).

3.11 Analysis

I employed a novel analytical approach for this research, building on existing (but hitherto uncombined) critical realist, comparative and interpretive methods; synthesised into what I call a critical realist comparison (CRC). This expands on the interpretive comparison designed by Boswell et al. (2019b) to integrate a critical realist epistemology. According to Roberts (2014), a realist approach to qualitative research offers the opportunity to investigate causal relationships through movement from the concrete to the abstract and back to the concrete. Similar to interpretive comparison, the objective is not to deduce generalisations but to infer plausible conjectures for why the world is the way it is (Boswell et al., 2019b). The comparative analysis seeks to understand the contextual conditions of a social phenomenon (Stake, 2005), and case study in qualitative research allows for the interpretation of findings within the context of each case (Roberts, 2014). In this sense, CRC is an analytical approach that investigates a social phenomenon's underlying mechanisms and causal relationships with consideration for contextual conditions. As Easton (2010, p. 128) states:

> *Generalisation to theory via case research carried out under*
> *critical realist conventions occurs by virtue of clarifying the*
> *theoretical nature of the entities involved, the ways in which they*
> *act and the nature and variety of mechanisms through which they*
> *exert their powers or are acted upon by other entities.*

Therefore, the aim of comparison in critical realism is to strengthen the validity of knowledge gained about mechanisms of observed phenomena through in-depth analysis of a few chosen cases (Bergene, 2007). Furthermore, comparison enables the researcher to identify necessary conditions rather than contingent ones and explore how common factors manifest in different contexts (Bergene, 2007).

It is the goal of critical realism to explain reality through the examination of causal mechanisms. For this reason, retroduction is an instrumental approach for CRC. Abduction is a process of inference in which a phenomenon is interpreted through a set of concepts (Danermark et al., 2002). Retroduction builds upon abduction, so that theories are used to identify mechanisms that may explain events (Douven, 2021). In retroduction, phenomena are then probed to identify the necessary and sufficient conditions fundamental to these phenomena (Sayer, 1992). Paolucci (2007) provides qualitative research questions that can assist retroductive analysis (see Box 1).

Box 1 Summary of research questions for retroductive analysis from (Paolucci, 2007)

1. What are the ongoing empirical regularities within the context in question?
2. What are the essential structural relations in this context?
3. What structural relations account for specific empirical regularities?
4. What historical events account for the rise of this or that set of relations?
5. How have these empirical regularities and structural relations changed over time?
6. What are the primary causal forces of this change?

Fletcher (2017) developed a method for applying a critical realist paradigm to qualitative research. Her approach involves three key steps: identification of demi-regularities, abduction, and retroduction. 'Demi-regularities' are the tendencies observed in how people and social systems act or interact, for example, participants' perceptions that the participatory process gave them 'a voice' (i.e. codes). Fletcher's (2017) method begins by identifying demi-regularities through data coding. This is similar to what might be

identified through thematic analysis (Guest et al., 2011). Next, abduction allows the researcher to examine the research through the lens of existing theories, which help to explain the observed demi-regularities, or what Boswell et al. (2019b) call plausible conjectures. Lastly, Fletcher's (2017) approach calls for retroduction, which strives to identify the necessary conditions for a causal mechanism to occur in order to achieve the empirical trends observed. What is deemed 'necessary' is specific to each case under examination and should not be treated as universal laws or causalities (Bergene, 2007).

Fletcher's (2017) method can be described through a stepwise process:

1. Identification of demi-regularities - trends or broken patterns in empirical data; identified through data coding
2. Abduction - data is re-described through theoretical constructs
3. Retroduction - identify the necessary contextual conditions for a particular causal mechanism to take effect and result in the observed empirical trends. This will require an explication of the contextual conditions of each case.

Critical realist comparison aims to understand causal relationships through in-depth analysis and how these relationships function within the cases chosen, but not to test whether they are generalisable to other contexts (Bergene, 2007). Bergene (2007) provides a method for applying critical realist ontology to comparative methodology. First, 'analytic comparison' identifies the demi-regularities between or among cases and can explain how they manifest in different contexts (Bergene, 2007). Next, theoretical comparison examines how the cases relate to theories applicable to all of them and how the theories manifest within each case. Bergene's (2007) process of critical realist comparison can be built upon using Fletcher's (2017) stepwise approach by adding stages of comparative analysis (see Box 2).

1. Cases are selected on "the basis of a belief that they exhibit the operation of the structures and mechanisms delineated by the theoretical perspective chosen as the framework" (Bergene 2007, p.22).
2. Cases are analysed according to their similarities and dissimilarities with other cases.
3. Each case is compared in relation to the theoretical framework. "By applying the theories to different contexts, the research is, in that process, forced to adapt them to each specific case, but with a view to discerning, in the end, the general as distinct from the contingent….a general theory might be applicable to several cases, but the mechanisms it depicts may play out different in different contexts" (Bergene 2007, p.22).
4. Examine the interconnections between the demi-regularities identified across the cases, and structures and mechanisms found in each case, through within case analysis, with the aim of reformulating the theoretical framework chosen at the start. (This can be achieved through the critical realist approach for qualitative research provided by Fletcher (2017)).
5. Use theoretical frameworks to inform how to interrogate the data (such as in a coding framework) within cases. Employ a theoretical framework across cases to understand demi-regularities.
6. Delineate structures and mechanisms common across cases and unique to individual cases.

Using Bergene's (2007) and Fletcher's (2017) methods, I developed a multi-case study procedure for critical realist comparison using Yin's (2013) original design (see Figure 21). The boxes in blue indicate where additional steps have been added to Yin's model to achieve a critical realist analysis.

Figure 19 Elaboration of a critical realist comparison (CRC), based on (Yin, 2013), (Fletcher, 2017) and (Bergene, 2007)

Following this design, I began my research by selecting cases that reflected theory-informed plausible conjectures about the mechanisms (healthy policymaking and empowerment) that could connect public participation to health equity. For the analysis, all data were compiled in NVivo software, and I began with coding each case[11]. I developed an initial coding tree based on my research design (coding for process design, context, expectations, and outcomes) but allowed for inductive theoretical coding. As I completed analysis for the first case, I started to play with creating maps of the data (a technique suggested by Bazeley (2020)). I reorganised the coding tree into three

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[11] Jackson and Bazeley (2019) offer excellent guidance on conducting data analysis with NVivo. I consulted this guidance frequently during my analysis.

categories: input, moderators and outcomes. However, as I began coding the second case, I quickly realised that this linear categorisation did not encompass the processes' flexible, adaptive, and non-linear experience. Therefore, I removed the coding structure I had created in NVivo and allowed for non-structured inductive coding. I continued with this coding approach for the remaining cases. This resulted in 198 codes.

At this point, I knew I needed to move from this inductive approach to an abductive reorganisation of the data. To achieve this, I reorganised the nodes into a coding tree with parent nodes that reflected theoretical constructs (e.g. power, control, legitimacy). I used this coding structure to write individual reports for each case. This stage of the analysis was critical in allowing me to 'tell the story' of each case using thick descriptions. I shared these case summaries with all research participants and offered them the opportunity to comment on my initial findings.

As part of the interpretive tradition, other authors have espoused the value of incorporating participants into the analysis (Braa et al., 2004; Ospina & Dodge, 2005; Wagenaar, 2012), particularly in comparative analysis (Boswell et al., 2019b). Participants can provide insights, contextual clarification, or highlight misperceptions and omissions that strengthen the analysis (Israel et al., 1998). Engaging research participants in knowledge production also allows for incorporating a wider range of epistemic points of view (Erikainen et al., 2021, p. 8). For me, this was an incredibly valuable step to sense-check my interpretation of the participants' interpretations of the process. On the whole, the feedback I received on the case summaries was supportive of my findings. However, one participant highlighted two critical issues with the research. First, she felt that I had misrepresented her description of the impact of the case, and secondly, the way that she had been quoted and attributed in the research was potentially identifying. Without insider awareness of her organisation and its relationship to the process, I would not have known that the quotes I had used from her could lead to her identification. Therefore, this step was crucial for helping me ensure interviewees' anonymity.

Lastly, interpretive research acknowledges the researcher as inextricable from the research subject, and this became apparent to me during this stage of the analysis. Many of the process participants were unaware of the impact of the process on the decision. In sharing my findings with research participants, I was essentially helping to close the feedback loop for participants. Additionally, and unexpectedly, interviewees also shared how this research impacted their work. One process organiser shared: "I think the main thing I take away from this is the need to take a different approach to the response from government: away from a 'single point in time' to something with 2-3 check-in points, so people are more easily able to track what was actually implemented." The fact that the initial findings of the research were already proving useful was an affirmation that I was on the right track with my analysis.

I used the individual case reports to identify over-arching themes that informed the next stage of the comparative analysis. Through the process of writing (Yanow, 2000a), I analysed across cases to identify the causal mechanisms that helped explain the demi-regularities apparent within the cases. This is not to say that these mechanisms were consistent across all cases. Part of my analysis was unpicking where there were commonalities or inconsistencies in the cases and interrogating these (ir)regularities to understand why. This is similar to Fletcher's (2017) critical realist analysis, in which interconnections are explained using theory before delineating structures and mechanisms that are common across cases or unique to individual cases. The final stage of the analysis was a process of retroduction in which the empirical evidence was probed to identify the 'necessary and sufficient conditions' that explain the phenomena (Sayer, 1992). My discussion on power in Chapter 9 reflects this retroductive thinking.

3.12 Limitations

This chapter has described the research design, data collection and critical realist comparative analysis of this PhD project. While the choices made for this research have been based on clear ontological and epistemological positions, they are still choices, and this project could have been designed using other approaches that still answered the

research questions. These choices have resulted in limitations to the research, which I will examine in this section.

The case study comparative design of this research inherently limited the scope of the research. The research focused on only two types of participatory processes that took place in specific contexts that profoundly affected their implementation (the focus of Chapter 4). The findings from the cases are not transferable to public participation in general, however, as I have explained, the critical realist/interpretive focus on generating plausible conjectures rather than generalisability means that the underlying mechanisms within these cases and contexts could be more broadly relevant.

Given that this research sought to understand the processes' outcomes, all cases had been completed. While this was useful for addressing the research question, it excluded evidence that might have been elucidated through a more longitudinal design. Examining processes in action might tell a different story about how outcomes are produced, such as through the ways in which participants interact with each other, the space, the facilitator and the organisers. Many process evaluations of participatory processes focus on process rather than outcomes (Elstub et al., 2019). Focusing on outcomes in this project helped to examine a lesser-researched area of interest.

The focus of this research on policy outcomes was also limited. Policymaking is inherently complicated and influenced by a multitude of factors (Colebatch, 2009). As I will discuss in Chapter 8, decision-making outcomes were generated through diffuse, non-linear channels. Greater examination of the broader policymaking context for the cases could have garnered a better understanding of the process but would require time and resources beyond the scope of a PhD project. Furthermore, this research focused on just two theoretical connections between public participation and healthy equity (policymaking and empowerment). There is a multitude of plausible conjectures for this connection that are beyond the scope of this project. Examining other theoretical explanations for how public participation affects health equity is a potential area of future research.

The fact that this research relied primarily on participant interviews for the empirical evidence was both a strength (discussed above) and a limitation. People responded to an invitation to participate; therefore who participated in this research was filtered through a self-selection process. Potentially, people who had stronger experiences (good or bad) might have agreed to an interview rather than those who were ambivalent. However, through interviews I found that participants had a range of experiences from good to bad and many in-between (I examine the participant experience in depth in Chapter 5). The range of interviewee experiences captured would suggest that the threat of selection bias is minimal. Participants who agreed to be interviewed might also have the skills, confidence and capacity to do so. These characteristics might have influenced why people participated and their experience of participation (discussed in Chapter 5). Therefore it should be noted that this research does not represent the full experience of every participant, only those that chose to be interviewed. I also chose cases that were recent enough (less than three years old) for participants to have adequate recall. While interviewees did describe the cases in sufficient detail, there were several times when there were details that the interviewee had forgotten or in some cases, I received conflicting information (for example, about who had done what). However, by interviewing a wide range of people (participants, organisers, decision-makers) and examining documents associated with the process, I gained an overall understanding of the process, minimising any issues from a lack of recall from one particular interviewee.

Lastly, the focus of this research on the interconnection of public participation and public health made this project inherently interdisciplinary. While this remains a strength overall, it is also a limitation. Situating this research in one discipline could have enabled examination in more detail of issues relevant to that field of research. For example, a stronger emphasis on process design and implementation, such as representativeness, facilitation, legitimacy and authority, might have made this research particularly relevant to the field of deliberative democracy. However, focusing on these elements would have come at the expense of examining broader causal mechanisms that connect public participation to health equity and limited the broader application of this research. Given that there is growing recognition of the complex nature of how health equity is created

(Pedrana et al., 2016; Solar & Irwin, 2010), it remains a strength of this research to have taken an interdisciplinary approach.

3.13 Conclusion

In this chapter, I have described the methodological choices I have taken in order to best address the research questions. I have conducted an interpretive case study comparison, rooted in a critical realist approach, to elucidate the mechanisms by which the processes generated various outcomes for health equity. The following chapters (Chapters 4-8) describe the empirical findings gleaned from this methodology. Given that the empirical chapters reference the case studies, I provide below (Figure 22) a table summarising the four cases. A more comprehensive summary of the cases can be found in Appendix A.

Figure 20 Summary of thesis case studies

50,000 Affordable Homes Health Impact Assessment (50K) [UK, HIA] In 2016-17, members of the Scottish Health and Inequalities Impact Assessment Network (SHIIAN) conducted a health impact assessment (HIA) on the Scottish Government's 50,000 Affordable Homes programme. The HIA involved members of NHS Health Scotland, Scottish Public Health Network, SHIIAN and the Association of Local Authority Chief Housing Officers. A final HIA report was produced and included recommendations on improving the programme's implementation.	**Airds Bradbury Health Impact Assessment (AB)** [Australia, HIA] Conducted in 2015-16, Airds Bradbury Health Impact Assessment aimed to identify the potential health effects of the Airds town centre redevelopment. The HIA was led by staff from local housing and health agencies and research institutes, with members of the Airds and Bradbury communities. Community stakeholders also participated. The findings of the HIA were communicated to relevant decision-makers including the developers and local Council.
Measuring the Mountain Citizens' Jury (MTM) [UK, CJ] Measuring the Mountain Citizens' Jury was held in 2018 as part of a co-productive approach to evaluate the Social Services and Well-being (Wales) Act. The citizen's jury was comprised of 14 people who had direct experience of social care and culminated in a final report with a set of recommendations for Welsh Government on how to improve the Act.	**Byron Shire Community Solutions Panel (CSP)** [Australia, CJ] In 2018, Byron Shire Council, with support from newDemocracy Foundation, ran a citizen's jury ("community solutions panel") on infrastructure spending prioritisation. Thirty-two local residents were randomly selected to participate and through the process, produced a report with values-based recommendations for Council. These recommendations were formally adopted by Council.

CHAPTER 4   TAKING ROOT: HOW PROCESS CONCEPTION AND DESIGN IS ROOTED IN ITS CONTEXT

4.1 Policy contexts and aims for public participation

Public participation has been described as being able to achieve a range of goals, including instrumental aims (e.g. decision-making impacts), process-oriented goals such as improving the legitimacy of decision-making or increasing participants' knowledge and capacity (Abelson et al., 2007). In some contexts, requirements for public participation have been integrated into mainstream policy, with countries including Scotland requiring participation in various circumstances (Escobar, 2022; Scottish Parliament, 2015). Policymakers within local and national institutions have also increasingly commissioned participatory processes to help shape policy (for example, through climate assemblies (Boswell et al., 2022)). As I described in Chapter 1, the UK and Australia have policy drivers for public participation. However, in many contexts, public participation is optional and may be undertaken by 'outside' actors to pursue policy (or other non-instrumental) outcomes or goals. Public participation as a mandated activity is often categorised as invited, whereas 'optional' participation may take the form of an uninvited activity (e.g., protests) but also includes a multitude of invited processes (e.g. focus groups). Abelson (2001) compares 'routine, solicited participation' with 'unsolicited, issue-driven participation' yet this dichotomy often overlooks how systems shape invited participation and individuals carve out their interactions with systems through both invited and uninvited activities. In her research on citizen participation in health settings, Stewart (2016, p. 14) frames research around publics, which "directs our attention towards a wider range of engagements between citizens and system." By shifting the focus beyond the form to the myriad ways that citizens engage with the health system, Stewart (2016) shows how the context of engagement (that of the healthcare organisation) is essential for understanding the various forms of participation. Similarly, this chapter will explore

how the context for participation in the case studies fundamentally shaped the form of the process.

Public participation can be designed to achieve different aims. The International Association of Public Participation (IAP2) describes participation as occurring on a spectrum with different levels of power-sharing between actors (Figure 23) (International Association of Public Participation (IAP2), 2018). Whilst some authors have questioned the usefulness of using the IAP2 spectrum to evaluate outcomes of public participation strategies (as it focuses more on *how* processes are run rather than *why* (Davis & Andrew, 2017)), the spectrum can be used as a heuristic to understand the different goals of the processes examined. The aims (implicit and explicit) with which processes are conceived have consequences both for how they are designed and how participants experience them.

Figure 21 Reproduction of the IAP2 Spectrum of Participation Aims (International Association of Public Participation (IAP2), 2018)
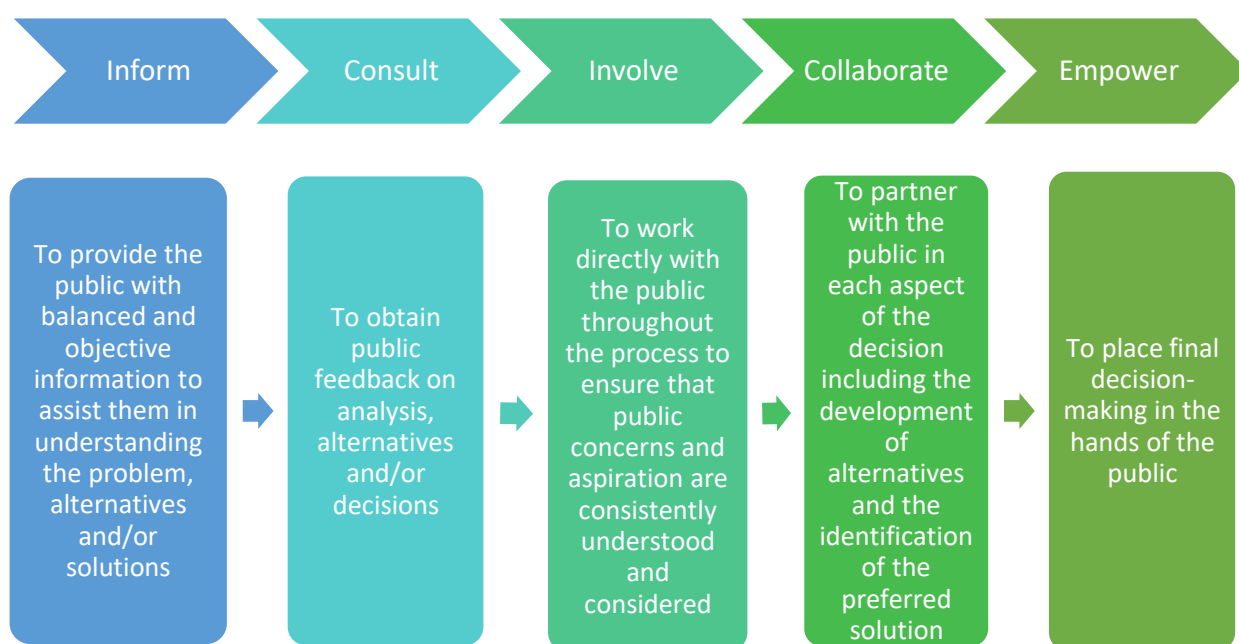
Note. Adapted from International Association of Public Participation (IAP2). (2018). IAP2 Spectrum of Public Participation.Retrieved from https://cdn.ymaws.com/www.iap2.org/resource/resmgr/pillars/Spectrum_8.5x11_Print.pdf
Copyright 2018 IAP2 International Federation.

Though the case studies were not selected with the intention of aligning across the IAP2 spectrum of participation, the way interviewees described the process's goal demonstrates alignment with the spectrum. 50K did not involve community members, instead relying on the involvement of relevant stakeholders. The aim of the process was often described as 'informing' other stakeholders about health impacts. MTM sought to 'involve' a selective group of citizens in evaluating the Act. Whilst there was a commitment to feed this information back to the Welsh Government as part of the evaluation, there was no clear explanation of how this information would be incorporated into the Act. Participants in AB often described the HIA as a way to 'collaborate' with the community and give them some ownership over the final decision. The CSP was the only process explicitly describing its aim as 'empowering,' with a clear goal of participants having total control over the final decision and Council providing an upfront commitment to implement their recommendations.

Several authors have criticised the use of typologies of participation as it "neglects documenting practice in favor of forming a summative judgement" (Stewart, 2016, p.11). Indeed, categorising the cases into the IAP2 Spectrum does little to tell us what occurred due to the process (versus what was intended). Whether or not the process achieved its goal was influenced by meaning-making and individual experiences of the process and will be part of my attempt "to produce fuller understandings of the practice and consequences of participation" (Stewart, 2016, p.12) in the following empirical chapters.

The aims of the processes are reflections of the greater context of participation. Comparing processes within the systems in which they occur better elucidates why and how they "emerge, flourish, interact, shift or fail" (Boswell & Corbett, 2017, pp. 816-817). While my case studies focused on single processes, this research strives to understand them within participatory systems that enable and constrain particular approaches. Examination of context helps to explain how processes emerged the way they did, why they were run in a given way, and why specific outcomes materialised (and not others). As Parkinson and Mansbridge (2012, p. 25) say of deliberative systems: "none of these

deliberative processes can be studied adequately in isolation, apart from their broader, systemic context". In this chapter, I will examine how the context of the participatory process shaped the process, mediating its aim and design.

4.2 Ecologies of participation

In the natural sciences, ecology refers to the relationship between living things and their environment, including the movement of biological materials through the life cycle, the adaptation and interaction of living things within their environment, and the effect of living things on the natural environment. Chilvers et al. (2018) introduced the concept of 'ecologies of participation' in their work on energy systems transition. They define ecologies of participation as "the dynamics of diverse interrelating collectives and spaces of participation and their interactions with wider systems and political cultures" (Chilvers et al., 2018, p. 200).

In their analysis of 30 cases of energy participation, they examine the ways that processes are contextually situated and interact with each other to produce dominant participatory collectives: "i.e. the relational dynamics of diverse interrelating collective practices and spaces of participation which intermingle and are co-produced with(in) wider systems and political cultures" (Chilvers et al., 2018, p. 202). They argue that it is not possible to understand one participatory collective without understanding its relationship to other participatory collectives, technologies, spaces and political cultures. Whilst my research looked at disparate processes and therefore does not allow for the same breadth of analysis, I believe there are valuable elements of an ecological approach to participation that can be applied to this research.

In this research, the processes reflect a relationship between those 'doing' participation and the environment (political and cultural) in which the process occurs. Ideas, like biological materials, circulate and materialise across various participatory landscapes. Processes reflect the environment from which they sprout. Some processes emerge within lush participatory landscapes, whilst others struggle to take root in more arid conditions. The effect of the process, whether it yields abundant 'fruit', is mitigated by the

ecology of participation from which it grows. The contexts of the cases seemed to fit into two participatory landscapes: regulatory and nonregulatory. I will examine how these two landscapes laid the groundwork for what the process was envisioned as being able to achieve.

4.3 Participatory landscapes

Public participation can be a required activity which seeks to address a particular policymaking goal (consulting on a policy option, seeking feedback on new regulations, spending prioritisation, etc.) These processes are conceived to meet an existing policy goal -- sort of like roses grown in a greenhouse for a particular purpose. Two cases I researched, MTM and 50K, took place within this context. MTM was commissioned to be part of the evaluation the Welsh Government was conducting on the Social Care Act, and 50K was conducted during the implementation of Scotland's new housing strategy. In these cases, the participatory process was not mandated, but it took place in the context of policymaking in which public participation is a mandated activity. In this context, processes were conceived of as needing to meet a particular policy goal and complement existing (mandatory) public participation.

Conversely, some of the processes took place in a context where there was no mandate for public participation. Like wildflowers that grow for no prescribed purpose, the goal was not to fit into existing regulatory frameworks. Instead, the process was conceived of as being inherently participatory. The CSP and AB took place within this context. Byron Shire Council commissioned the CSP as a means of engaging with the community and the topic of infrastructure spending was selected to serve the process. AB was conducted as part of a training course on HIA, with the lead process organiser selecting this tool as a strategy for participation.

One might think of public participation in a regulatory context as the more arid of participatory climates because the process was confined to more structured conditions, like roses grown in a greenhouse. Whereas it would be easy to assume that processes that grew from less structured contexts simply emerged, they too required some level of

tending; akin to growing wildflowers -- more likely to flourish on their own, but they also relied on planted seeds. The way the process was conceived, including its aims and design, was influenced by the context (or Chilvers et al. (2018) would say, 'technologies, spaces and political cultures') from which it grew. Below I will examine how the two sets of cases – those that grew in regulatory landscapes (i.e., roses) and those that emerged in non-regulatory landscapes (i.e. wildflowers) – were shaped by their environment and, in turn set a path for their design and implementation. How participants experienced the processes that grew out of these contexts was influenced by the aim, design and other factors, which I will explore in the following chapter.

4.4 'Roses'

Wild roses require heat and direct sunlight, typically blooming once in the summer. However, when grown in the controlled environment of a greenhouse, they can bloom all year. Being the popular choice for celebratory events, greenhouse roses are meticulously sown, watered, pruned and finally cut to be the exact colour, height and bloom that the paying customer desires. Two of the cases I researched, 50K and MTM, were similarly conceived, designed and implemented to deliver a final product that would meet the desires of a regulatory body (i.e., 'the customer').

To understand why these processes were designed in such a way, we must first look at the soil in which they take root. Public participation, in these contexts, is viewed as a legally required activity that achieves a particular policy goal. For MTM and 50K, the process was not mandated, yet it took place within the context of overarching policy issues in which public participation is mandatory. For example, for 50K and MTM, the participatory process examined a component of a much larger policy (affordable housing in Scotland and social care in Wales). In both of these cases, there was ongoing, legally mandated public participation related to the policy. For example, the Social Care Wales Act legally requires local authorities to provide citizen and service provider engagement, including creating regional partnership boards (Welsh Government, 2014). These regional partnership boards stipulate the inclusion of people receiving care. Similarly, Scottish Government housing delivery frameworks, such as the 50,000 Affordable Homes

Programme, require 'consultation and engagement with communities' (Scottish Government, nd) at the national planning level and within local housing strategies. In both these cases, existing policy drivers provided a rationale for conducting the participatory process. MTM, for example, was conceived of as meeting part of the legally required mandate for evaluation of the Act:

> *The Phase 3 evaluation would give an unbiased assessment of the Act's implementation and impact, and provide valuable information as to how, if needed, further implementation of policy and legislation could be improved… Understanding the experiences of Welsh citizens in relation to social care was fundamental to the evaluation of the Act. Having identified that capturing people's voices as part of more formal processes can be challenging, and that early insight into these experiences would be beneficial, Welsh Government commissioned the Measuring the Mountain (MtM) project (Cooke & Iredale, 2019, pp. 5-6).*

In this case, MTM was situated within a landscape in which a plethora of required participatory activities was taking place (e.g. regional partnership boards). However, the process organisers identified a gap within existing activities ('capturing people's voices' and 'insight into these experiences'), and therefore one of the main rationales for running the process was to fill this gap and feed it back into existing policy formation (i.e. the evaluation of the Act). Similarly, with 50K, the process emerged as a way to address a knowledge gap within the policy development of affordable housing in Scotland. As Linney, one of the 50K organisers, explained: "there were some potential pitfalls in the whole building programme that we felt were useful to highlight in a health impact assessment." This rootedness of MTM within the Act's evaluation (a legally required and highly regulated piece of work) and 50K within "one of the Scottish Government's flagship policies" affected the aim, design and implementation of the processes, which I will discuss below.

4.5 Participation as epistemic stopgap

Being situated in a context where the participatory process was seen as needing to serve a policy goal, the aim of both 50K and MTM was to offer knowledge that was missing from the policy evaluation/implementation. Participants in 50K asserted that there had been ongoing engagement amongst policy stakeholders in health and housing outside any formal participatory process. For example, a health and housing working group was discussing the potential health impacts of affordable housing for some time. However, these conversations, though useful for other reasons, had not culminated in concrete recommendations that could feed into the formal housing policy development. The HIA was seen as not just a tool by which health impacts could be identified but as a mechanism through which the knowledge culminating in existing partnerships could feed into the policy cycle. Linney, one of the process organisers, explained:

> *We're very conscious that actually the way homes are developed and built in Scotland is done in a way that certainly doesn't maximise potential impacts on health. So we saw a real gap. We saw the 50,000 homes is a real opportunity to do something a bit different and to really make a significant contribution to public health.*

50K was conducted at a point when the programme was already being implemented. Linney explained that they were aware that this would limit their ability to impact the policy, but they saw a rationale for doing the HIA anyway because it could provide evidence missing from the current implementation. Therefore, even though the HIA was intended to inform a decision point (i.e. the instrumental goal of the process), the primary aim of the process was epistemic.

Similarly, MTM was conducted as part of an ongoing evaluation of the Act. Process organisers described the CJ as a means by which lay knowledge could be better incorporated into the evaluation:

> *Significantly, the Citizens' Jury method offers an approach to bridging the gap between top-down consultation and bottom-up*

> *community participation; the former offering little public involvement*
> *and the latter being based primarily on lay knowledge and interests.*
> *When evaluating legislation and its impact on citizens, a means of*
> *drawing together the views and experiences of the policymakers,*
> *those that are delivering the policy, and those that are in receipt of*
> *services, is critical (Cooke & Iredale, 2019, p. 10).*

As illustrated by the above quote, process organisers saw the CJ as a way to bridge an epistemic gap between top-down understanding by policymakers and lived experiences of the policy by community members.

Whilst both MTM and 50K were designed to inform a decision point, the overarching rationale of the process was epistemic: knowledge transfer was seen as a way to achieve the instrumental goal (the decision point could be affected through enhanced knowledge). This aligns with Dean's (2017) 'participation as knowledge transfer' mode of participation. Based on this rationale, participation is enacted to achieve an epistemic imperative[12] to improve outcomes, not necessarily because of a right to participate. This perceived aim was different from the other processes, which viewed participation (as a goal in and of itself) as a mechanism for achieving an instrumental outcome, akin to Deans' (2017) 'participation as collective decision-making' mode of participation (see Figure 24). This epistemic aim then dictated how the process was designed and run.

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[12] Mazanderani et al. (2020) question the logics of involving lay people in policy decisions, describing the epistemic imperative as foregrounding lived experience as a source of knowledge; and the democratic imperative as involving the public precisely because they are not experts.

Figure 22 Process rationales based on Dean (2017)
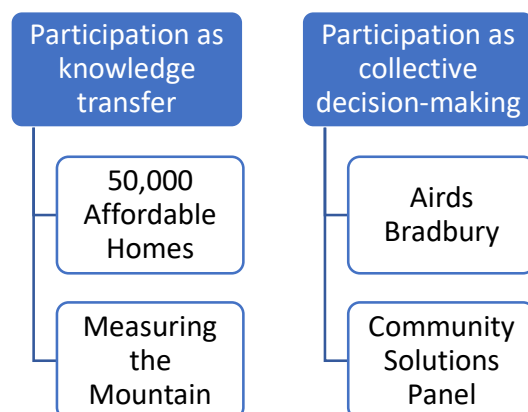
4.6 'Roses' process design

For 50K and MTM, given that these processes emerged within the context of formal policy frameworks, it is unsurprising that the participatory process was designed to fit into existing policy structures. Both processes viewed improved knowledge as a mechanism for achieving the instrumental outcome and this epistemic goal affected how the process was run.

50K was conducted by a small working group comprised of health and housing professionals. They ran a scoping workshop and consulted with other health or housing professionals and academics as part of the evidence gathering process. The types of people who participated in the HIA were all professional stakeholders, rather than community members. This served the purpose of bringing forward evidence, which was the primary rationale for the HIA as described above. Engaging with stakeholders also helped to build upon existing networks and discussions that had been ongoing prior to the HIA, importantly, linking the HIA back into the broader policy discussion.

The choice to involve stakeholders rather than the broader community was also due to the perceived challenges of engaging the community. Interviewees from the HIA team described a lack of capacity both in time and resources to be able to engage an appropriate sample of the community relative to the breath of the policy -- given that the

national programme would have affected all of Scotland, a representative sample (according to one interviewee) would have required representation from the entire Scottish population. Linney, a member of the HIA steering group, also described dilemmas in trying to engage community members about the policy. Given that there was already other (legally required) consultation taking place she asserted that the HIA could potentially be duplicative: "you don't want people to be confused about what we're doing versus the consultation that they're already having on the policy…". Additionally, she expressed concern that involving community members in an HIA focused on a national policy might be unethical because of the limited ability of the HIA to directly benefit them: "…you don't want to get involved a whole lot of people and use their time if it's not going to directly benefit them." This reflects public views in Scotland that 'public benefits' of health research should benefit individuals, specific (usually more vulnerable) groups, and society more broadly (Aitken et al., 2018). While participation can be viewed as a public service for the common good, the organisers did not express this rational for the process. Interviewees described the aim of the HIA as being mainly epistemic (rather than participatory), and therefore viewed any benefits to community members of participating as being limited. Therefore, the HIA was designed to engage stakeholders who could help generate knowledge on the housing programme rather than running a more inclusive participatory process (which, according to interviewees, was what the Scottish Government was already doing through their legally required consultations).

MTM similarly, was designed in a way to fit within an existing regulatory framework. Though MTM was intended to inform the evaluation of the Act, as process organisers described, it was also intended to be a 'process of inquiry' for understanding experiences of social care in Wales. Rather than structuring the CJ around a question which would require a definitive response from jurors, the question was open-ended and exploratory and reflected the epistemic aim of the process: *'What really matters in social care to individuals in Wales?'* Following on from this as an epistemic process, the types of witnesses that were selected to give testimony represented a broad swath of social care experience: direct users, advocates, and social care providers.

The process was also designed in a way to fit the expectations of both the process organisers and the policymakers who were funding it. Several of the organisers, including the project lead, had a background in criminal justice. What seemed to appeal to these organisers about the citizens' jury was its similarities to a legal process, and in keeping with this, many aspects of the process were designed to be like a trial. Witnesses were selected by the process organisers in advance and were 'prepped' with the types of questions jurors might ask. Jurors were given training at the onset on how to appropriately 'interrogate a witness.' Stakeholders were invited to observe the process but were given strict directions not to interact with the jurors, as Barbara, one of the process organisers described:

> And I've issued to observers, you know, little sheets of paper saying, 'Do not approach the witnesses. Do not approach the jurors.' If you're in a criminal trial, you wouldn't be allowed to talk to anybody if you were in the public gallery. The same sort of principle should technically apply I think, in the purest form of this method that you shouldn't be influencing in any way the people who are making the decision - who are coming up with the verdict. So we didn't do that.

In practice, interviewees told me that they did socialise with witnesses and observers and asked them questions during the breaks despite the edict from the organisers.

This emphasis on citizens' jury as a trial, whilst appealing to the process organisers, was an initial roadblock to the Welsh Government, who were both funding the process and would be recipients of the recommendations. The idea of a jury led civil servants to think that the Welsh Government would be on trial, as Barbara described: "It was just the notion of finding the government guilty the way you'd find somebody guilty in a jury, that was problematic in such a state." In fact, the civil servants had requested at one point to change the name of the process which created tension with the process organisers who felt that changing the name could threaten its integrity.

This perceived threat by the civil servants that the process could 'find the Welsh Government guilty' led to a hesitancy on their part to make any commitment to the findings of the CJ. Meghan, one of the process organisers explained:

> *And I think that there was a real hesitancy on the part of Welsh Government. That is the impression I've had. I mean, I consider them to be very risk adverse as an organisation anyway… I think for Welsh Government, that was quite an uncomfortable situation to be in. I feel like we had some conversations about what would happen after the jury and what would happen with the recommendations and my recollection is that there was just a general sort of hesitation from Welsh Government to commit to anything in terms of our findings and then acting on anything.*

This perceived risk of Welsh Government to be involved in the process played out in a bizarre dance with civil servants stepping forward and backward in their level of involvement in the process. For example, they agreed to fund the citizens' jury but then refused to allow process organisers to issue a press release calling it a citizens' jury. A key civil servant also spoke to the jury at the outset but refused to take any questions from the jurors. Meanwhile, the process organisers maneuvered around this hesitancy by implementing the jury in some similarly strange ways[13]. Rather than allowing jurors to decide what experts they wanted to speak with, they devised a very packed and rigid agenda with a range of speakers whom they thought were important. On the final day, they allowed jurors to put forward recommendations but did not provide time for them to deliberate or prioritse the recommendations, opting to do this culling process themselves. On the same note, the final report was written by the process organisers, not the jurors.

While the process organisers expressed some frustration at the hesitancy of decision-makers it seemed as if their approach to manage that hesitancy was to tightly control design of the process (such as writing the final report). This created a more rigid process

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[13] In comparison to good practice guidance (see, e.g. Escobar and Elstub (2017)).

than other citizens' juries (like the CSP, which allowed for a greater degree of participant autonomy, as I will discuss below).

4.7 'Wildflowers'

Planting a field of wildflowers is done to not produce one singular perfect bloom, but to create a landscape of variable colours. In essence, their purpose is a reflection of their inherent nature – to be wild. Similarly, two of the cases I researched, AB and CSP, were conducted as processes to be inherently participatory. Like a field of wildflowers that self-perpetuates by fertilising new seedlings, so too did these processes emerge from 'fertile soil' and contribute towards the onward growth of other participatory activities (which I will discuss in Chapter 7).

4.8 Participation for participation's sake

In the cases of AB and CSP, the processes took place within non-regulatory contexts. The topics of both processes were at a local community level rather than examining national policies; therefore, neither were intended to feed back into formal policy debates. The primary rationale for running both processes was as a tool for participation, not to inform a policy (though this was a secondary goal). For example, AB was conducted as part of a professional development course on HIA within the Local Health District. The topic of the HIA was selected as a result of the lead organiser (Denise) enrolling in the course and through consultation with the course instructors (I was one of those instructors). Though one of the goals of the HIA was to inform the redevelopment strategy, the initial rationale for the HIA was to train staff on how to conduct HIAs. The level of participation within the HIA was, therefore, entirely up to the process organisers – they could have conducted the HIA without any participation (what is called a 'desktop' HIA) and still have met the training course requirements. The choice of the process organisers to not only conduct a participatory HIA but to ensure that community members were included within the scope of participation is reflective of the participatory landscape of the Airds Bradbury community, which I will discuss further below.

Whilst all HIAs are intended to provide missing evidence on health impacts, unlike 50K, which relied on professional stakeholders to provide this epistemic stopgap, the focus of AB was on providing evidence that was reflective of the community. As Nicole, the HIA commissioner, stated, "I think that was the biggest objective, to have evidence to show and say, 'This is what we [the community] need. This is what…will be the best for our health.'" As is inherent to the type of process, both HIAs aimed to provide public health evidence, but AB also sought to involve community members in the process of generating that evidence. In fact, like 50K, public consultation had already been done at other stages in the redevelopment process. The process organisers, conscious that formal consultation had already taken place, did not want the HIA to serve as a similar consultation strategy. Pat, a member of the HIA team, explained: "So certainly [we] don't want to go and confuse the community with another round of consultation. So we're not changing the plan; we're just trying to see which part of the plan the community will have the most impact… the needs of those people also need to be incorporated." Unlike 50K, which viewed community participation in the HIA as potentially duplicative of other consultations, AB viewed the HIA as a mechanism by which the community's perceived needs could be elicited, bringing forward a perspective that was missing from existing consultations.

Although any HIA aims to generate evidence, for Denise, the lead process organiser (who instigated the HIA), the primary aim was to engage the community. As she describes:

> *To be perfectly honest, my priority was reengaging a community. Because the Airds Bradbury community had been engaged in consultation for the master plan in like 2010. And it was a very, it was an award-winning consultation process … So the community itself were very used to and expected to be consulted and part of decision-making and things like that. And we were always very proud of that.*

She explains that a history of community engagement in the area had been done with considerable quality (if award-winning can be an appropriate measure of quality).

Because of this, Denise wanted to continue engagement with the community in a way that would appropriately integrate their feedback into the design of the redevelopment. She saw the HIA as a mechanism that could, first and foremost, engage with the community and secondly, provide helpful evidence: "It wasn't like I've got this training opportunity to do, what will I choose to do it on? It was like, I've got this project that I need to progress, guess what, there's a training over here that will help me progress. So it was almost flipped." The overarching aim of the HIA was to use participation as a means to achieve the instrumental goal (i.e. informing the redevelopment). Unlike 50K, which viewed the HIA as serving a primarily epistemic aim, AB made participation the primary goal of the process.

The fact that the HIA was conducted to provide public participation reflects the environment within which it took place. Airds Bradbury is considered an area of high deprivation, and in response to this, local Health and Housing agencies had been working with the community on the redevelopment for many years. As Denise described above, Housing had previously conducted a consultation process for the redevelopment. In fact, during my interview with Susan, one of the residents, she often responded to my questions by discussing all the community activities taking place in Airds Bradbury rather than commenting on the HIA specifically:

> *Katie (interviewer): It sounds…like a lot of the benefits that you're describing are sort of about all of these things that have been going on [previously]… What was it about the HIA that you felt fit in with that or contributed to these overall benefits? Or is it not one thing in particular?*

> *Susan: I don't think it's one thing in particular. I think it fitted in beautifully because of the nature of it, in doing it and bringing to light a lot of people's concerns.*

To Susan, the HIA was not a stand-alone process; rather she viewed it within the context of the myriad participation activities already taking place in her community. Therefore, community residents experienced the HIA within the context of other ongoing activities or

a broader participatory ecology. It is difficult to unpack whether the outcomes of the HIA arose as a consequence of the process or whether they are a consequence of the HIA taking place in tandem with other community engagement.

The participatory ecology of AB shaped the HIA process. First, community members trusted the process organisers because they had established relationships with them. The current Housing team, in particular, had made efforts over the years to establish trust with the community, as Susan asserted:

> *I need to explain something that with public housing residents, there's a distrust of Housing. Has been for many years. I mean, we've been lied to over the years, we've been treated badly. So that distrust of them is valid. But then we had Denise's train come in… a community redevelopment team, and they came in with a different attitude. So residents got a chance to connect with them.*

Furthermore, Housing hosts a community reference group (CRG) that convenes residents and representatives of the Housing agency, Health agency, redevelopment agency (Landcom), local city council, and other local services (such as the local high school). The HIA is a standing item on the agenda, and, given this, I was invited to observe one of the CRG meetings while conducting my fieldwork. What stood out to me in this meeting was the cooperative attitude the agency representatives and residents had with each other. I have attended other public consultations on land use development which feel like a one-way conversation with the agency telling the community what will happen (whether the community likes it or not). The atmosphere of the CRG meeting felt completely different – more like a committee meeting – with coffee and tea available and all participants engaging in friendly conversation. In the CRG meeting, there was an update from the redevelopment agent, but it felt much more like dialogue and deliberation between residents and the agencies. For example, Landcom presented the potential disruptions due to upcoming construction. Residents asked questions directly of the redevelopment agents (for example, which roads would be closed) and voiced their concerns (for example, about seniors having to walk further to bus stops). The redevelopment agents

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seemed to take these concerns seriously and were willing to offer solutions when they were available. In one case, a resident was concerned about overgrown grass on vacant lots. She said it could take 3 months for a client service officer to respond to formal complaints about issues like this. A representative of Housing told the resident to contact her directly, and she would make sure the issue was fixed.

The HIA seemed to be a mechanism by which trust between agencies and the residents could be nurtured. In fact, according to Denise, one of the goals of the HIA was to enhance this trust:

> *So that was to hopefully get them, and to reinvigorate, trust that they should have had in the project. Because I think they were trusting at the start. We went to a lot of trouble to build the trust and to consult them. You know, it was a huge consultation exercise. And then there was, as I said before, there was a little bit of a hiatus. And then, so when you come back, you know when all these people are being moved, and new houses are being built, you want to see something for the whole community there. A sort of a focus. And this [HIA] was a perfect opportunity to do that.*

Organisers emphasised that one of the aims of the HIA was to collate the needs and desires of community residents and to share this back to decision-makers, with the intention of these community perspectives being incorporated into the final design of the town centre. Pat, a member of the HIA team, emphasised that the redevelopment needed to be done in a way that had a tangible community benefit: "because without a good way to integrate communities, you just have brick and mortars. It's not gonna function, you know, you'll have paths that no one use and community centres that are going to be empty halls with nobody." In order to ensure that the redevelopment benefited the community, it needed to reflect the desires of the community, and the HIA was a mechanism to ensure that local perspectives were collected and integrated into the planning process. Therefore, whilst the HIA sought to achieve the instrumental aim of informing the redevelopment, it did so through the overarching goal of conducting public participation.

Similarly, the CSP was commissioned through consultation between newDemocracy and Byron Shire Council as a strategy to conduct public participation. The instrumental topic of the process (infrastructure spending prioritisation) was secondary to the participatory goal. Having participation as the primary goal, with its intrinsic value, affected the process aim, design and implementation and is reflective of the unique context in which the process took place.

Byron Shire is an area of northern New South Wales renowned for its natural beauty and is a popular tourist destination, particularly Byron Bay. Part of the attraction for tourists and those who have relocated to the area is the community's unique character. Dating back to the 1960s, Byron Bay was a highly regarded surfing location, and in 1973 the Aquarius Festival, a counter-cultural arts and music festival similar to Woodstock, was hosted in Nimbin, an area of the Shire. The region continued to attract and espouse an alternative hippy culture that continues to this day (Byron Bay Historical Society, 2017).

Embedded in the fabric of the Byron community is an 'anti-establishment' culture. For example, Byron Bay has the lowest childhood vaccination rates in Australia (Elliott, 2019). There is an organised and outspoken grassroots section of the community that openly opposes many of the Council's decisions. John, one of the process organisers, explained:

> *Byron Bay is a great place to do this, because pretty much everyone in government would have a view about the difficulties of governing in Byron Bay. Even the councillors there across all different positions and perspectives would agree that they operate in a place with the most highly active community groups. There's a protest group about everything. I don't mean that in a negative way, it's just the nature of that community -- is a very, very active community. You could say this to anyone in Federal Parliament, 'Byron Shire Council' and they would go 'ho that's got to be tough.' …And the discussion we initially had with the Council was one of empathy to say, there's no decision you take that can be widely*

trusted. Just the nature of things -- you can announce free
chocolate bars for everyone and you'll hear from the lactose
intolerance association and get flogged.

As a community that was already civically active, vocal, and distrustful of authority, any attempts by Council to engage with them using traditional consultation methods were highly criticised by the community and did not achieve their intended goal. Furthermore, due to the highly engaged nature of the community, decision-making is often fraught, with citizens opposing Council decisions and decisions taking longer to be made. Carol, a participant, explained:

It's very hard in the Byron Shire, because to get any decision
made…they can't get the community to agree. It is terrible. I mean,
it's a wonderful community, it has a lot of say in the Council, but
getting it just to make a decision, and getting the groups together is
very, very difficult.

Therefore, the challenge for Council was to find a new way of engaging the community that would enable their involvement in decision-making (an expectation from the community) without eliciting criticism or a backlash. In 2019 Council ran a second community solutions panel to determine how citizens would like to be engaged in Council decision-making in general. As the process was run while I was conducting fieldwork in Byron, the process organisers invited me to observe one of the sessions. One of the conversations I witnessed was about the unique culture of Byron and how this has created challenges and opportunities for Council governance. Participants discussed how Byron was founded as an activist community focused on preserving the rainforest. It has now become the norm and expectation that citizens will protect the community "from the bastards" or the powers that be. Therefore, the challenge for Council was how to harness that level of activism in a productive way for community governance.

The rationale behind the first CSP was that the Council needed a better way to engage citizens in decision-making. Previous attempts by Council to involve citizens had led to engagement with very active individuals and groups and missed out on broader public

engagement. nDF suggested running a citizens' jury to involve the broader community. The focus on community infrastructure was later selected as the topic for the CSP because it was an ongoing, contentious issue and, therefore would be a helpful topic to trial this approach.

Similarly to AB, building trust with the community was one of the goals of the process. Council felt that there was a lack of faith in their decision-making, with strong community opposition to many of their decisions. The CSP was viewed as a mechanism by which a wider range of citizens could be engaged and in doing so, could build trust with Council. The welcome statement by the Acting General Manager in the briefing book further explains:

> *We also heard from community and acknowledge that there is a general lack of trust and faith in the Council and a desire for more community-led decision-making. We have taken this feedback on board and are committed to openness, building trust and increasing opportunities for community to be involved in and lead decision-making. That is why Council has asked newDemocracy Foundation (nDF) to design and run the Community Solutions Panel… (Byron Shire Council, 2018, p. 7).*

Unlike Airds Bradbury, in which the process emerged in an environment where there was existing trust between residents and Housing, the CSP was initiated to restore broken trust between the community and Council. Therefore, the aim of the CSP was participatory, first and foremost, with the instrumental goal of the process in service of this participatory goal. How the CSP was designed and implemented reflect this principal aim.

4.9 'Wildflowers' process design

The fact that both AB and CSP aimed to be participatory meant that organisers could design the process to achieve this goal. Unlike the other cases, which sought to provide evidence that could feed back into existing decision-making contexts, AB and CSP could be designed to achieve participation, in and of itself. This strongly influenced the design

of the process, though, as I will discuss below, this did not detract from the process seeking to achieve other instrumental goals.

Process organisers described AB as a 'community-grounded approach' to HIA (Jaques et al., 2017). Community-grounded HIA is described as being based on the values and worldviews of the populations they serve and is, therefore, more closely connected to the lived experiences of those communities (Jaques et al., 2017). This focus on grounding the HIA in lived community experiences[14] informed the design and delivery of the process.

The HIA was 'community grounded' through the direct involvement of community residents and stakeholders in the HIA, including participation in the working group, reference group, and in providing evidence. Community residents included people who lived in the Airds and Bradbury communities, including local high school students and a member of the local Aboriginal community. Community stakeholders included representatives of the local high school, police, and population health services.

Participation in the AB process centred around community residents voicing their thoughts and preferences on aspects of the redevelopment. Participants in the HIA working group also influenced the overall HIA process. For example, they could select health pathways to research that were more important to the community (during the screening and scoping stages of the HIA), and impacts that were more pertinent to the community were prioritised during the assessment stage. In this sense, community members were given some authority regarding how the process was run and, according to process organisers, had "ownership and power in the HIA process" (Jaques et al., 2017).

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[14] It should be noted that the concept of 'lived experience' is not without contestation, though this was not addressed by interviewees. For example, McIntosh and Wright (2019) critique the Anglo-centric usage of the broader term 'experience' and explore the use of lived experience in social policy research through the lens of phenomenology, feminist writing and ethnography.

The history of engagement between the process organisers and community members influenced the process's design. Alice, one of the process organisers, explained:

> *I think because they, Housing in particular, has a history of consulting with that particular Airds Bradbury community. And they've done a lot in the past. So it was kind of like automatic for them to want to have residents on there, but also that they wanted to consult the community, within the data collection, sort of in validating everything throughout the whole HIA process. Probably because they already had those established sort of working relations with the community.*

According to Alice, the design of the HIA was tied back to the context within which it was conducted. The lead organiser and her agency (Housing) had a history of engaging with the community, and community involvement seemed to be part of their normal mode of operation ("it was automatic for them"). This ongoing practice of community involvement had led to the relationships which process organisers used to involve community residents in the HIA. In fact, these relationships, and the trust that developed through a history of partnership, were why residents chose to engage in the process. Nora, one of the community residents, explained that the quality of engagement from Housing, and the people running those activities, led to residents feeling trust in them:

> *I think the trust was already there. We take time to trust them, we don't trust them automatically, because they come from Landcom or they come from Housing or they come from wherever. We had people for a long time, and then we've had kind of a turnover. And we assess the people as they come in and we tend to go to the ones that we trust. So if this person isn't working for us, we'll go to the ones that we know we can trust to follow through.*

This interviewee described how the existing trust that had already developed through a history of engagement between Housing and community residents was a reason why she felt comfortable participating in the HIA. In essence, trust was essential for the design of

the process. If we look at this from an ecological perspective, trust was like an essential mineral in the soil from which the process grew.

Given that involvement in the HIA was invited (rather than, for example, via representative sampling), a history of engagement and ensuing trust meant that community residents were willing to participate. Nicole, one of the process organisers, explained that the history of partnership meant that community members were willing to participate: "And so yeah, that is also a reason: In the past - of the partnership - having Denise - the community, how fertile and how ready they always are. They never, ever say no. We've done other things there and they're always ready." In the same way that wildflowers create fertile soil for more flowers to grow, Nicole explains that a history of community participation enabled AB to take place. Participants were willing to take part because they trusted the process organisers. The HIA was then conducted to enhance trust and therefore perpetuated future participation. Without these existing relationships, it is likely that the HIA would have been designed differently because the organisers would not have been able to rely on community involvement as a given. As Alice explains:

> *The success of it, yeah, I would say it's to do with Housing. So though [participation's] a concept within HIA, it was kind of like, well, we have that down put already. We know what to do. We have the connections. Whereas I think in other HIAs that I've been involved in, it's like you really struggled to engage communities, and you have even more of a feeling that I don't think we spoke to everyone that we could of. Whereas with this one, it's not as a major thing. Like they still spoke to a really broad range of people. And it was because of the relationships that were already there.*

Whilst 50K excluded community residents because of their fear that they would not be able to capture the entire community's perspective adequately, AB included them because of their existing engagement with the community and belief that because of this relationship, they could adequately and appropriately include them in the HIA.

Beyond engagement being standard practice, it also appeared that the community organisers placed a high value on the community's involvement, which might have materialised through a history of engagement with them. Denise explained her approach to engaging with communities:

> *Typically for our estates, I mean of course you can do HIAs lots of different places, and you know, topics. But you know, if you're going to expect to go into a vulnerable community, who are undergoing some pretty traumatic process already, then you need to do the lead up, otherwise they're not going to trust you, they're not going to talk to you at all. But that I mean, that's just my perspective.*

Although HIAs do not have to be participatory, in Denise's opinion, the only way to engage the community in a way that would yield a helpful output was to first establish trust with them. This belief in trust on a personal rather than institutional level ("but that I mean, that's just my perspective") set the foundation for how the HIA was designed. Alice, another one of the process organisers, explained: "But I think also that because Housing already had that established and historical thing of consulting the community already…although community engagement is part of HIA at its core, the actual undertaking of that [community engagement] was totally to do with Housing's existing relationships." Seen from Alice's perspective, the HIA was designed as a reflection of the practice of the lead organiser, Denise. However, this practice stems from Denise's belief system. So whilst HIAs can be undertaken to be participatory, and this is often regarded as best practice, the actual implementation and design of the HIA as a participatory process stemmed from the person leading the HIA --much like a gardener chooses which flowers to grow and how best to grow them. AB was conducted to be participatory because of a belief in the value of participation rather than a need to meet a regulated requirement.

As part of a team of 'like-minded gardeners', Denise was not the only process organiser who viewed participation as inherently valuable. The process organisers conveyed a

consistent attitude towards participation which valued collaboration, mutual respect, and a duty of care to the community. Nicole, one of the organisers, explained:

> *But when you've been there, and I had gone [and worked in this community] for a long time, I know these people quite well. You can understand that you would want to do good by them and they deserve to have...like be treated with respect because they live there, that's their community. Like, that's them that you're affecting every single day. And I think they make that known. And they should have a voice. You know, and I think that they, they need to replicate things like that everywhere. Because people do have a voice, I know that they're social housing…but they're vulnerable people, they're very, very vulnerable, disadvantaged people, and they do deserve a voice because they don't have a say in a lot, especially when they're told 'you've got to move, or this is happening around you'. It's not as if they can afford to just go 'well, I don't want to deal with these orders. I'll just buy my own house somewhere else,' you know?...And I think the fact that they were treated with respect and taken seriously. And they felt that we were taking them seriously doing an HIA with them, I think that just was fantastic.*

In this quote, Nicole conveys a sense of duty or obligation to the community. She explains that as a disadvantaged community, they are limited in their ability to enact change for themselves (to buy their own house) and are, therefore at the mercy of the agencies (and the individual agents) who manage their housing. Furthermore, Nicole explains that because of her experience working with these people, she felt a duty "to do good by them." Whether through this experience of working collaboratively with the community, witnessing their disadvantage, or something else, Nicole expressed that she felt that the community needed to be treated with respect. This attitude of respect for the community and a desire to provide opportunities for the community to "have a voice" seemed to be intrinsic motivators for making the HIA a participatory process.

The culture of process organisers and the decision-makers also contributed to the participatory approach of AB. Several process organisers described public participation as a normative value of their work. Alice, a member of the HIA team, asserted that "community engagement is part of HIA at its core." Though participation is generally considered best practice, it is not a required aspect of the HIA process. Therefore Alice's belief in participation as inherent to HIA reflects a more normative perspective of participation. Denise, another member of the HIA team, similarly asserted: "I mean, it was my job, but I don't think you do this work without a real heart in that sort of work." A personal belief in participation as a normative aim of their work was consistently voiced across many of the process organisers in AB.

Doug, one of the members of the HIA team, further explained that it was not just the belief of the individual organisers but the institutions as a whole that led to the HIA being conducted:

> *In my line of work it's like you find that different agencies and different offices will often have different cultures and different perspectives and also opinions held towards residents' attitudes…. But in this instance, I think there's been a good attitude, and good enough to be able to explore stuff like health impact assessment and maintaining a steering committee. And…using that as a sense of equity in terms of delivering the redevelopment.*

This belief in community participation as being a fundamental part of the redevelopment, as Doug highlights above, was reiterated in my conversations with decision-makers. Though the developers had a requirement to deliver whatever Council wanted, Harrison, one of the planners, expressed an understanding of the value of community input in designing the redevelopment.

> *I think from development side…we need to work with the community and work with those around the area as well. Because if you're constantly banging heads with the local community, some*

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> *of the project's not going to work too well. So it's good to have that*
> *working relationship with the community.*

Harrison explained that a positive relationship with the community was important to ensure that the project could move ahead. However, beyond this, he also expressed a sense of personal accountability to the community:

> *That's me personally. As to whether other developers feel the*
> *same way, they might just go 'Nice report. Thanks very much.' …I*
> *have to front up every month in front of those people. You know, I*
> *feel as though people keep asking me, so I've got to provide a*
> *response.*

The fact that Harrison had to meet with the CRG every month made him feel accountable to the community. However, the depth of his engagement with the community came down to personal beliefs. "I think you would anyway… even if we weren't technically required to, I think we'd still go [to the CRG]. That's just part of working in a community like that, I guess." He explains that working in a community like Airds Bradbury had led him to feel like he would want to engage with them regardless of the requirement to do so. This was similarly echoed by Nicole, one of the process organisers, who explained that the culture of the AB community was one in which "you would want to do right by them." Again, this highlights the importance of beliefs in spurring public participation outside regulatory contexts. The process was not a required activity; therefore the level of involvement of decision-makers was based on their own beliefs in the value of the participatory process.

Many interviewees described participation as a personal belief ("that's me personally"), yet when looking across the various actors, it is clear that these beliefs reflect a broader cultural practice. Although interviewees discussed how they personally felt committed to engaging the community, there was also institutional support in place to conduct community engagement. Chad, a Council representative (one of the decision-makers), explained that poor engagement with other communities in the past had caused Council to shift their approach:

…the previous General Manager had… earlier on in his career worked for Housing, in property. And he had a very strong connection with Housing. So when they and the redevelopment processes were sort of entangled with some reactions to, I wouldn't call them riots, but that's what they were called at the time, but social disturbances…because of his connections with housing… there was a responsibility for local government to be involved. So he was very strong about, 'okay, it's your job to know. It's your job to make sure that we're really well connected in these processes that are going to happen.' So there was a very strong, right from the top saying…for my team, it did mean probably 10 years of a lot of resources being directed into working with housing, education, whoever else in these cross-agency projects on public housing estates. So that change, probably very different from [other social housing estates] … they didn't have that extent of their resources, community development resources being channeled into with Housing.

Importantly, Chad explains in the quote above that previous negative experiences from a lack of engagement with the community had led senior management to channel resources into engagement with the AB community. This led to other engagement activities taking place prior to the HIA and helped to fertilise the soil from which the HIA could sprout. Although he did not state this in the interview, it is possible that this high-level commitment towards engagement played out across the institution (Housing, in particular) so that the individuals within those organisations internalised an institutional normative belief in participation.

For the CSP, a vital aim of the process was to enhance citizen authority, and in many ways, the process reflected this in its design. For example, John, one of the process organisers, explained that the CSP was designed to adhere to core principles for conducting citizens' juries, with the intention of enabling citizen authority: "Am I speaking to a random representative group? Am I getting to consider diverse sources of

information? Am I giving them adequate time to reflect rather than react? Do they have a clear level of authority? Am I posing them an open question, not selling them an answer?" Importantly within this set of principles is the directive for giving participants a level of authority. nDF offered authority over the project to participants by allowing them to select which evidence to consider (i.e., selecting witnesses, reviewing selective data from Council); determining how they wanted to tackle the problem (they decided on a values-based approach to infrastructure prioritisation); and producing the final product (the group voted on the final recommendations and wrote the report).

Above and beyond these design elements, process organisers and participants described a sense of authority sprouting from the commitment that Byron Shire Council had made up front to adopt the recommendations from the CSP. Sallyann, one of the process organisers, explained that this level of commitment from Council added a heightened sense of authority, and therefore responsibility, to the process:

> *I think they saw that [commitment] both as a huge amount of pressure, but also as a huge piece of power, more empowerment to use your word. I think they felt the weight of, you know, expectation around that. 'Okay, well, Council's actually going to do what we're telling them to do.' And we're talking millions of dollars here, like it wasn't a small thing. Like I felt the pressure. And I've done loads of these processes by then. So yeah, I think they saw it as a real genuine commitment from Council that they actually were taking the process seriously.*

As Sallyann described, the upfront commitment by Council to adopt the recommendations was unusual. More typically, a decision-maker might commit to consider the recommendations from a process (if even that), but rarely will they commit to full adoption. To better understand why Byron Shire Council was willing to make such a commitment, we need to look at the broader context in which the process took place.

As discussed above, part of the rationale for undertaking the CSP was to improve community trust in Council and how they take decisions. Unlike other governments that tend to be highly defensive or risk-adverse when faced with opposition, Byron Shire Council decided to conduct the CSP with a willingness to try something new. John, one of the process organisers, theorised that they were willing to fully support a new approach because Council was so used to getting criticised. The Councillors unanimously supported the project and agreed, upfront, to adopt the recommendations. John explained:

> *I think there's definitely something in the culture of Council of being up for it --both of the engagement team and knowing that implicitly their general manager and their Councillors are saying, 'swing for the fences', when a lot of engagement is defensive. It's mandated. So you've got to do it, but they don't want to do it. And you see the passive resistance drip through. So if I was to say what's the non-technical element: this was a Council of cultural openness. It's not a blowing smoke exercise. Partly because they've been through the wars since living memory. If there's anyone going to be open to doing something new, it's the person being whacked on the head a dozen times.*

John highlights in the above quote that the support councillors and the general manager committed to the process had a trickle-down effect on Council staff. The process was undertaken as an elective process, not because it was mandated through any regulatory mechanism. To John, this meant that there was a more authentic commitment of Council leadership and staff to the process and it not being 'a blowing smoke exercise.'

Other reasons for this high level of commitment were the political nature of the councillors and buy-in from key leadership. The majority of the councillors were Green Party members and, according to Cat, one of the process organisers, the general ethos of the Party is one of participation. Cat explained: "It's a Green Council mostly…So they do have

a, I think they have an awareness of the importance of bringing people along." Sallyann, another process organiser, added:

> *I think there's a degree of driving philosophy that dictates how they perceive it. Like there were a number of progressive Greens councillors who were probably more inclined to be supportive of something like this. Versus, you know, the more conservative councillors. But funnily enough, he was pretty supportive right from the get-go.*

Although organisers described the Green Party as having an ethos that lends itself to be supportive of processes like this, even the conservative members of Council were supportive of the process, reflecting the broader culture of Byron Council.

Key leadership also enabled the process by generating buy-in. The mayor, in particular, played a pivotal role in developing buy-in and enthusiasm for the process. The process organisers attributed this to his interest in trying new things and "genuin[e] commit[ment] to doing things that were pushing the envelope." The general manager (GM) also acted as a critical facilitator for the process. In contrast to the former GM, "who quite clearly just didn't get what this whole project was meant to be about", the new GM provided an environment that helped to maintain support for the process. Sallyann explained:

> *The GM was a quiet guy, quite unassuming, set back, and let us do our thing. And that was a really different kind of environment. So he created a space within the executive team where they were either vocally supportive, and quite demonstrably supportive, at best, or at worst, they were just quiet. Whereas I've worked with and around other Councils, where that certainly wasn't the case. It's very challenging for people within government, so on the bureaucratic side, to hand over power, essentially hand over their power to the community. And I've watched people in similar positions of leadership of councils either deliberately sabotage that kind of*

process, or just do it by not doing things… in quite sneaky underhanded ways really. These guys weren't like that.

Having senior leadership who supported the process helped to generate buy-in by Councillors and council staff. This interest in trying new things was partly explained by political party ethos and individual leadership characteristics but also by Byron's culture. Diane, a staff member of Council, explained that the activist culture in Byron lends itself to a general interest in trying new things. This meant that Councillors "want to do things differently than other traditional Council[s]", and senior leadership tended to be "pioneer[ing]." Therefore, the culture of the organisation initiating the process, and their normative belief in participation, was a determining factor in why and how the process was conducted.

All of the processes served to inform some decision, yet the instrumental goal was often secondary to other aims. For MTM and 50K, the principal aim of the process was epistemic, whereas AB and CSP sought to conduct participation for its own sake. How the process was conceived and designed to achieve these various aims was influenced by the context in which it occurred. A significant contributor to this contextual landscape was the regulatory environment of participation. Some of the processes (AB and CSP) occurred in contexts in which public participation was not required for the decision. In other cases (MTM and 50K), public participation was a required activity (though the process itself was not required); therefore, it needed to fit within existing mandates for participation. These contextual conditions influenced how participation was conceived, what the process sought to accomplish, and in turn, how it was designed. Whilst all of the processes were structured to produce outputs that could provide feedback into existing policymaking, for some cases (MTM, 50K), the overarching aim was epistemic. For others (CSP, AB), the goal of the process was to enable public participation. Given that the processes had different goals, it is unsurprising that they were designed differently to accomplish them. Due to these various goals, process designs, and contexts, the cases enabled different levels of control and power for participants.

4.10 Control

Given that 50K and MTM needed the process to fit back into existing policymaking contexts, process organisers described potential risks of giving more control to participants. For MTM, the logistics of running the jury meant that most design elements could not be left to chance. Barbara, one of the organisers, explained: "Technically, I would say if we were being really pure about it, we did a lot of consultation as opposed to saying to… a group of citizens, 'why don't you go off and devise our programme for us?' We just couldn't take that risk." The process had to produce an output that could feed back into the evaluation; therefore, organisers maintained tighter control over the process to ensure that it achieved this goal (at the expense of delegating control to participants). For example, they identified key witnesses, had witnesses submit their testimony in advance, and wrote the final report themselves.

Meghan, another process organiser, confirmed that Welsh Government (WG) had exerted pressure on the process organisers, which had heightened their sense of obligation to produce a 'useful' output from the CJ:

> *And then I went and had a meeting with Welsh Government that made me just want to pull my hair out because…they had been batting the report backwards and forwards with me and there was stuff that they didn't want to have put in there…And I went to this meeting and there were four of them there, two from research and two from policy….and thankfully, somebody from the research team was kind of like, 'Look, you can't get measuring the mountain to go and speak to people and ask them questions and listen to what they say, and pretend you're interested and then go, 'Ah, we don't like this bit that they said, and we don't like this bit that they said, and chop those things out.'*

As Meghan describes, not only did WG exert pressure on the process organisers to tailor the report, but there were tensions between the WG civil servants regarding how to use the information that came out of the process. As I previously described, there was

hesitancy from WG to conduct the process because of the risk of the Government being seen to have not done its job or being 'found guilty'[15]. Civil servants had to navigate the commitment of WG to conduct the citizens' jury whilst also avoiding any perceived culpability of the Government. This led to the civil servants approaching the process with varying levels of comfort to delegate control, such as the civil servant described in the quote above, who advocated for more direct inclusion of the input of jurors.

Both CSP and AB enabled a greater level of control to participants than MTM or 50K. The CSP assigned control to participants regarding how the process was designed and run. Participants could select data sources, including requesting which witnesses they wanted to hear from. They were also given autonomy to decide how to answer the question posed to the group, which led to the group generating a values-based prioritisation tool. Finally, the group generated recommendations and wrote the report, so the final output was in the words of the participants. In AB, community perspectives were prioritised during the scoping and assessment stages of the HIA. This meant that health impacts or pathways that the community felt were important were included in the HIA over ones that the research team or the literature might have deemed important. The involvement of community members on the HIA team also gave them control over how the process was run. This approach enabled direct contribution by community members to the final report. Having the direct involvement of participants in the final output of both processes was a critical way that process organisers delegated control to participants.

Unlike 50K and MTM, in which context was a barrier to participant control, in AB and CSP, context played a role in enabling the process organisers to relinquish control. The culture of both Airds Bradbury and Byron Shire created an environment supportive of public participation. This led to the process organisers and decision-makers also upholding

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[15] This fear is not wholly unfounded. Whitehall funding for CJs scaled back after juries ran in the early days of their practice often criticized government (quite publicly) (Wakeford, 2011). Dean et al. (2020) found similar reservations among organisers in the NHS Citizen initiative.

positive beliefs in the value of participation which influenced how the processes were conceived, designed and implemented.

A culture of support for participation may have created the overall climate for AB and CSP, but trust was the essential mineral in the soil from which the processes grew. In both cases, building trust with the community was one of the aims of the process. For AB, the HIA was intended to "reinvigorate trust that they should have had in the project", whilst for the CSP, the process was intended to reestablish trust with the community that had been broken. Both processes needed to establish trust with participants throughout the process, and they did this by delegating a high level of control to participants.

In both AB and CSP, the overarching aim of the process was to enable participation. However, this did not necessarily mean that process organisers were unconcerned with how the process would feed back into decision-making. The fact that Byron Shire Council had an upfront commitment to integrate the findings from the process meant that process organisers felt an added pressure to produce useful recommendations. However, unlike MTM in which pressure from the decision-maker led to organisers asserting more control over the process, organisers in the CSP included more participant ownership. This willingness to delegate control to participants, despite the pressure from decision-makers, was reflective of the culture of the organisers and Byron Shire Council.

As described previously, Byron Shire Council were generally a progressive Council that was willing to take risks or to be seen as trying something new. Furthermore, Council was used to getting criticised for any decision they made, so they had very little to lose by trying a new process like the citizens' jury. Conversely, Welsh Government, which has an arguably less contentious relationship with its constituents, might be less inclined to do something that threatens their relatively high support by the community.

Conducting the process as a mechanism to feed into existing policymaking meant that the policymaking context dictated how that process was run. Participants were given less control over the process in order to ensure that the process achieved a particular

instrumental goal. Whereas processes that occurred outside of regulatory contexts, participation was the primary aim. In these cases, the process sought to build or strengthen trust with the community and delegated control to participants to achieve this. While, in the cases for this thesis, greater control over the process seemed to be something participants wanted, in other studies, control over the agenda has been shown to be demanding on participants and does not necessarily lead to 'usable' outputs (Boswell, 2021).

4.11 Conclusion

Whilst many contextual elements played out across the case studies, affecting their aim and design, a few key aspects stood out as being more influential than others. The overall culture within which the process took place set the stage for many other elements. If the decision-maker was less risk-averse, then the process organisers were likelier to delegate control to participants throughout the process. Similarly, the history of a place and how this affected the current approach to participation in general also affected the process. Places where decision-makers had been 'burned' in the past by poor engagement – such as in Airds Bradbury or Byron Shire – meant that they were concerned with conducting participation well. Places where engagement was a means to an end – to inform a policy like 50K or inform an evaluation like MTM – meant that process organisers were more concerned with the output of the process than creating an inherently participatory process.

The greater policymaking context also affected how organisers conceived of the process and what goal they thought it could achieve. In these cases, processes in the UK were aimed at fitting into existing policymaking, whereas processes in Australia were designed to be inherently participatory. The UK has several policy drivers for public participation aimed at greater involvement and empowerment of people. The *Community Empowerment Act 2015 (Scotland)* and 'duty to involve' in Wales reflect a move towards institutionalising public participation that is tied to both a sense of democratic renewal and opportunities for community empowerment (Davies et al., 2006). However, as described in Chapter 1, this shift coincides with divestment in public spending, and the

institutionalisation of participation can be viewed as a way of filling this need in the public sphere (Newman & Clarke, 2009). In comparison, New South Wales (Australia) has also moved towards greater citizen involvement yet lacks institutionalisation of practice similar to what has been done in Victoria (with the *Victorian Local Government Act 2020*) or the UK. This lack of top-down policy drivers for participation means that processes emerged organically in contexts in which there was both the capacity to conduct participation and the 'goodwill' by stakeholders to commit to such processes. This provides an interesting conundrum, as the aim of processes in less institutionalised contexts was more focused on empowerment than those conducted in contexts with explicit empowerment policy rationales for participation. Whether and how these processes led to empowerment will be examined, along with other outcomes of the processes, in Chapters 6 and 7. In the following chapter, I examine how the different approaches to participation played out in the experience for participants.

CHAPTER 5   POSITIONALITY AND INTERPRETATION: THE PARTICIPATORY EXPERIENCE

Meanings are not just representations of people's beliefs and sentiments about political phenomena: they fashion these phenomena (Wagenaar, 2011, p. 3).

5.1 Individual experiences of participation

In the previous chapter, I examined how the context in which the process took place -- where participation was either regulatory or not -- helped to develop different ecologies of participation. These ecologies of participation – histories, cultures, and policymaking contexts – shaped how the process was conceived. This context drove the primary aim of each process and had follow-on effects on the process design and implementation. Although the processes were conceived of as uniform events, the individual experience of the process varied considerably between participants. While context was a catalyst for how the process was conceived and designed, participants' expectations and positionality shaped their experience.

Participatory processes are experiences. By 'experience', I mean that a process is a communal event, but it is interpreted through the individual lens of participants. McIntosh and Wright (2019, p. 459) describe lived experience as "the mediation between intersubjective experiences and specific historical/temporal locations." By focusing on lived experience, the goal is to describe the experience as something that can be both subjective and developed through commonalities (the historical and temporal features of the process). Furthermore, lived experience is not just the 'embodied subjectivity' (Kruks, 2014) of the process; rather, it encompasses how participants act within a process. In this way, experience is shaped by participants as they go through the process, but also the

process is shaped by the way that they embody being a participant, or as Kruks (2014, p. 84) describes: "experience from the point of view of a subject that is also constituted." By foregrounding experience within a broader narrative of context (as discussed in the previous chapter), we can examine how expectations that are embedded in context are interpreted by individual participants to create different subjective experiences. McIntosh and Wright (2019) caution that establishing empirical claims based on experience risks overlooking broader social constructs and narratives such as disadvantage or disempowerment. However, by examining these experiences, this chapter serves to uncover common mechanisms, including social constructs, that explain how processes led to different outcomes.

As discussed in the methods chapter, I selected cases with distinct beginnings and ends to better compare the experience of being part of a defined process. Though each process met the criteria for inclusion in this research (achieving minimum elements of being considered an HIA or CJ), Chapter 4 demonstrated that the processes varied widely in their aim and design. Participatory processes are much like the theatre in which stories are acted out. The 'staging' of a process leads to some level of performance – both by those who design the process (the directors) and the participants (the performers) who take on varying roles throughout its enactment. Sometimes the directors and performers read from the same script but often have different ideas about how a story (the process) should end (Escobar, 2015). These varying expectations about what the process should achieve created different participant experiences. How and why participants participated was influenced by their positionality and relative power.

The participatory processes in the case studies mimic epistemic exercises in that they are also practices of inquiry. All four cases began with a topic of inquiry: how to prioritise infrastructure spending; how to improve social care in Wales; what are the health impacts of a town centre redevelopment; and what are the health impacts of the Scottish housing programme. Participants progressed through a process of knowledge gathering (e.g., examination of the literature, interrogation of witnesses), deliberation, and knowledge synthesis to produce a final output (i.e., a written report). Although organisers often

treated participants uniformly (e.g., they are a 'juror'), participants' individuality influenced why and how they participated in the process.

Individuality can be examined through the concept of positionality. Positionality comprises three main factors – identity, role and power (Acevedo et al., 2015). Identity is formed through social categories such as race and gender, is intersectional and shaped throughout a lifetime (Crenshaw, 2017). Role is context specific and can be formal (organiser, juror, etc.) or informal (expert, novice, etc.). Power and privilege play out across social categories and roles, as some social categories and roles are considered more 'desirable' than others (Acevedo et al., 2015). This positionality, in turn, shapes people's experiences in the world. Though participatory processes often separate people into single categories (e.g. participant, juror), people engage through the intersectionality of multiple categories. Furthermore, people are often asked to participate through one particular lens, but in reality, they bring multiple forms of knowledge and identity (Newman & Clarke, 2009). In this chapter, I will examine how participants' identity, role, and relative power within and outside the participatory space shaped their expectations of the process and how they participated. I then examine how expectations and positionality affected how participants interpreted the process. In Chapter 6, I will then examine how this dynamic of expectations and experience led to different outcomes for participants.

5.2 Why do people participate?

Before turning to what participants expected to get out of the process, it is crucial to understand why they chose to participate in the first place. Though, as stated above, exposition of experience risks prioritising individuality at the expense of commonality, I have employed an interpretive analysis to look for commonalities of experience. There was, of course, no singular collective experience, and I address this divergence in the analysis below. However, it is essential to understand the common features that arose across the cases to explain why individuals chose to participate. Most participants had the capacity to be involved, were motivated to participate based on a belief in the value of the process and/or tended to have a history of being involved in other community activities. I explore each of these components below.

5.3 Capacity to participate

The processes took different approaches towards recruiting participants, but all relied on participants 'self-selecting' to participate to some extent (as do all forms of invited participation (Cornwall, 2002)). For example, the CSP had the most methodologically robust approach to selection, with letters of invitation sent to thousands of residents. However, even with this approach, respondents had to register their interest in participating on the nDF website before they were randomly chosen to participate (based on criteria for demographic diversity). In all cases, requiring that people self-select to participate (or agree to participate in the cases of AB and 50K) meant that participants wanted to be involved in the process.

Furthermore, self-selecting to participate also meant that participants had the capacity – e.g. time, resources, and skills – to do so. For the CSP, the selection process yielded an older and more highly educated group. Roger, a panellist on the CSP asserted:

> *There were only one or two, or maybe a few more, but not terribly many out of thirty, that fell outside that demographic. There weren't, to the best of my knowledge, any tradies [trades people] there for instance. There weren't a lot of unemployed there… People in that lower demographic are likely to be much more affected in terms of their health outcomes, than people, you know, the former academic...*

This lean towards a higher educated, higher-status occupation and higher income group is common across various forms of participation (Dalton, 2017). Roger also highlights in the quote above his concern that the people who might stand to gain more through their participation in the process – those with a lower social status and potentially "more affected in terms of their health outcomes" – were less likely to have participated. Therefore, those who did participate were likely to be in a different socio-economic position than those that did not.

Roger further explained: "We were still a select group - we had the time, we had the money, we had the interest. So we're still a select group. We weren't totally typical of the population." Participants had sufficient relative power to enable them to participate. Relative power, defined as "the ability people have to achieve their purposes, whatever these purposes happen to be" (Brodie et al., 2011, p. 40), includes practical resources (time, money); learnt resources (skills, experience); or felt resources (confidence, self-efficacy).

The individuals' capacity to participate reflected many of these sources of relative power. This was emphasised by participants in CSP and MTM (though interviewees also discussed it in AB and 50K). Several participants described attributes of relative power that made them more capable of participating (see Table 3), including their educational status (such as having a master's degree); acquired skills (such as being a toastmaster); professional experience (such as conducting inequalities assessment); and previous experience and skills that reflect confidence or self-efficacy. Access to practical, learnt and felt resources, including time, money, health, knowledge and experience are common enablers of participation more broadly (Brodie et al., 2011).

Table 3 Examples of participants' relative power as expressed through practical, learnt and felt resources

Practical, learnt and felt resources	Quote from Participant
Education	*I'm a graduate of the Australian National University, I have undergrad degrees in arts and science. I have a master's in Asian Pacific studies. I know what I'm talking about.* Harris, panellist on the CSP
Skills	*Keith: But yeah, it did surprise me, I guess another thing, I guess my skill, I'm already heavily skewed to that skill set.*

	Katie (interviewer): From doing what like, your law degree? *Keith: And from my work. I already had those skills necessary* Keith, panellist on CSP
	Oh, yeah, it was great. I mean, I used to do toastmasters, so I, you know, I don't mind public speaking and whatnot. Tiffany, panellist on CSP
Experience	*The previous role that I was in to now, from time previous, I had been part of the inequalities team. Within the inequalities team we had a particular focus on delivering a programme of work around health inequalities impact assessment. So slightly different processes, but the approach is very similar. Yeah so I was familiar with the idea of a health impact assessment and what the process of doing that was.* Louise, participant on 50K
	So I'm a member of the [redacted] citizens panel, which is the oversight panel for health and social care in this region,.... And I've been a member of that since it was introduced… about four years ago. Owen, juror on MTM
Confidence	*Yeah, look I probably knew all that sort of stuff from, so I worked in the council before I went to private practice. So reasonably familiar with the governance of systems and stuff.* Doug, panellist on CSP
	My situation is that I've been very involved all my life all the way through for over 40 years, been in volunteer and third sector campaigning… I know well what I'm looking for

	because I've done it as a chair and vice chair and so forth in the committee's I've been on, the boards I've been on. Geoff, juror on MTM
Self-Efficacy	*I mean we were in a position to be quite honest, cause A, I'm on the national partnership board with the decision-makers who make these decisions; B, I'm involved in measuring the mountain; C, I'm a citizen so I deal with voluntary [organisations].* Rhys, witness on MTM

These elements of relative power facilitated participants' involvement in the processes. Studies of representation and representativeness in public participation caution that socio-material conditions can enable or inhibit certain groups from participating, further exasperating these forms of exclusion (Barnes et al., 2003). Boswell (2021) also suggests that there is a difference between formal and informal inclusion. Engagement within the process (facilitated through rapport and mutual understanding) may be easier for people with existing capabilities (such as English language proficiency), potentially limiting the engagement of more marginalised populations. As I will explore below, many people who participated had a tendency to have done so in the past, demonstrating that relative power can be an enabler for sustained engagement.

5.4 History of engagement

As I discussed in the previous chapter, the processes emerged within different participatory ecologies where a history of previous engagement with the community had often occurred. Perhaps reflecting both the participatory ecology and the capacity of participants to be involved, many of the participants I interviewed also had a history of engagement. For example, Terry, a panellist on the CSP, discussed her involvement in civic activities: "I've been involved in quite a few local government things…" Several participants in MTM were actively involved in citizen panels or other advocacy groups for social care.

Some interviewees described how their engagement stemmed from a personal history of seeking to be involved. For example, Susan, a member of the AB HIA team, asserted that she continued to be sought after for various engagement activities because of her history of involvement:

> *I think I've lived here in the Airds Bradbury community for 36 years now. And been involved in different ways, volunteering in different projects. And I became involved with the community reference group [CRG], which is the main community group that we have here for information sharing. And I've been involved with that from the start, and that was, its gotta be 10 years now. And because I've been involved, because of my skills as a Toastmaster, I often get bumped in for things that I don't know anything about, which is normal. As somebody came up later, they named it 'voluntold' --I get told instead of volunteering.*

Susan described how, due to her long-standing involvement in the community, she became known to the community development team and was often asked (or as she calls it 'voluntold') to participate in various activities. However, I did not get the sense from our discussion that she resented this participation. Instead, she seemed to regard it as part of her obligation to the community as one of its long-standing residents, because of her qualifications (as a toastmaster), and because of her position in the community (as someone who had been on the CRG for 10 years).

Even in a professional capacity, many of the 50K participants had previous and ongoing experiences of participating in collaborative activities. For example, before conducting the HIA, the lead organiser had established a cross-sector working group that included professionals from public health, housing and local government. Several people who had been involved in the HIA had a history of engagement in this and other cross-sector groups.

For several participants, their engagement stemmed from existing participation in a core activity (Brodie et al., 2011), such as participation on the CRG, a citizens' panel, or a professional workgroup. For these participants, the opportunity to become involved in the process arose because of their existing engagement – they were either known by the process organisers already or were targeted for participation because of their current engagements. This was true for most cases – 50K, AB, MTM – which relied more heavily on convenience sampling or selective invitations to the process. The CSP was different in that it used randomised outreach (via telephone numbers) to select participants. Yet, even with this approach, some of the participants I interviewed had a history of involvement. Whilst several participants wanted to participate in the CSP to become involved for the first time, others chose to participate to continue their legacy of involvement (such as Terry, quoted above). This history of involvement reflects the beliefs and values of participants – those who believe in the value of participation are likely to have participated in the past and to continue to participate in the future (Brodie et al., 2011).

In some cases, a history of individual engagement was linked to the broader context in which participation occurred. As discussed in the previous chapter, the spaces in which processes occurred had unique histories in which public participation was (or was not) commonly practised. In Airds Bradbury, previous engagement activities had led to high levels of participation from the local community. Chad, one of the participants and a representative of Council, explained:

> …when it came to the actual participation in the design workshops
> for the new Airds, that was really well attended. I was surprised. I…
> expect agencies but I think the level of community participation was
> really good. So you have school kids, you had residents, you had
> seniors, and a whole range of people involved.

In the quote above, Chad expresses surprise at the level of participation that took place by a range of community stakeholders. One possible explanation for the high level of involvement in the HIA was that a history of engagement had led to an expectation of

residents to be involved in decision-making. Denise, one of the process organisers, explained: "So the community itself were very used to and expected to be consulted and part of decision-making and things like that." This expectation of community involvement was supported by Susan, one of the participants from Airds. She explained that her experience of being active in the community and witnessing varying approaches to engagement had led her to have certain expectations about how engagement for the town centre redevelopment should take place. She explained:

> *When it came to community development work…they'd be doing it the traditional way with the clipboard and the questions and going door to door. When they redeveloped Minto, which is another suburb here, they learned a lot of things from that, because residents became very vocal. And I know a lot of the residents there so there was connections between them and our community. So we were allowed to see what they were doing and learn from that. So we've been speaking out and saying different things -- we were awake. So when they came to redevelop Airds Bradbury, they decided they needed to do something different. And that's where the community development team stepped up and created a different way of doing it.*

In the quote above, Susan describes viewing different approaches to participation as a process of enlightenment or mobilisation ("we were awake"). She also implies that because she and this community group then knew about different approaches that can be used for community engagement, there was an expectation that the development team, and importantly, the developers, would enact a different approach.

The history of how public participation or community engagement was previously conducted acted as a determining factor for participation in the case studies. Participants who had been involved in activities in the past seemed to want to continue to be involved. In some ways, like for Susan, participation in past events provided a process of

mobilisation in which participants not only saw the value of their participation but came to expect how participation was to be conducted.

This might suggest that the processes tended to engage already active citizens (what has been called 'the usual suspects'[16]). Mini-publics, in particular, are usually designed with this in mind to enable a cross-section of the population to engage equally (Boswell, 2021). Public participation that uses some form of sampling, like the CSP, is more likely to also engage people who do not have a history of participation, and this was supported by interviewees who discussed joining the CSP as a way to get involved for the first time. Furthermore, processes can be designed to provide resources and build capacity for people who do not have the relative power to enable their participation (such as the CSP, which provided a cash incentive to participants).

However, it should be noted that a willingness to engage may have also affected who participated in this research. People who felt comfortable being interviewed might also be those who have the confidence, skills and capacity to do so – the same characteristics that might have led them to participate in the process. Therefore, it is possible that the processes engaged a wider range of participants (e.g. with no history of engagement) than this analysis suggests[17].

How the group of participants was constituted reflects organisers' views on what was considered legitimate representation and the relative power, beliefs and history of participants. Process organisers used varying strategies to convene people who, on the one hand, were 'ordinary' – representing the views and needs of the local population – while at the same time having characteristics of 'professionalism' – the knowledge, skills,

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[16] This term, though commonly used, can be stigmatising for participants who are committed to contributing to public life and can disregard the considerable labour that people contribute towards processes.

[17] A limitation of this research which is discussed in section 3.12.

and time to participate (Learmonth et al., 2009)[18]. Whilst deliberative spaces are intended to be inclusive, without explicit goals of inclusivity, they can reinforce differences in power based on gender, race, class, and other measures of difference (age, income, education, etc.) (Barnes et al., 2003). It is possible to view the cases as reinforcing these categories of (dis)advantage, but it is important to consider how identity is constituted through participation rather than serving as a space of dialogue for fixed identities (Squires, 1998). This would refute the idea that participants who had engaged in the past were merely 'the usual suspects'. Rather, they brought with them motivations, skills, beliefs and experience that they enacted in the participatory spaces, producing unique experiences and outcomes.

5.5 Motivation to participate

Motivation to participate stemmed from participants' expectations and values. Similarly to other studies on motivations for participation (Brodie et al., 2011), reasons why people said they wanted to participate included meeting people or expanding their network; to learn more about their community; to find out how something worked (e.g. local government); and to feel involved in their community. Though personal motivations varied across individuals, there were three fundamental values that participants consistently described: a sense of duty to the community; a perception that the process would make a difference; and that the process reflected a personal belief (such as in democracy or social justice). These expectations and personal values formed the basis for why many interviewees said they participated in the process (see Figure 26).

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[18] The notable exception to this was 50K which relied solely on professional stakeholders. In this capacity participants brought forward the viewpoint of their respective agencies, therefore providing some type of representativeness, though this is not considered representative of 'ordinary' populations.

Figure 23 Interviewee motivations for participation in the processes
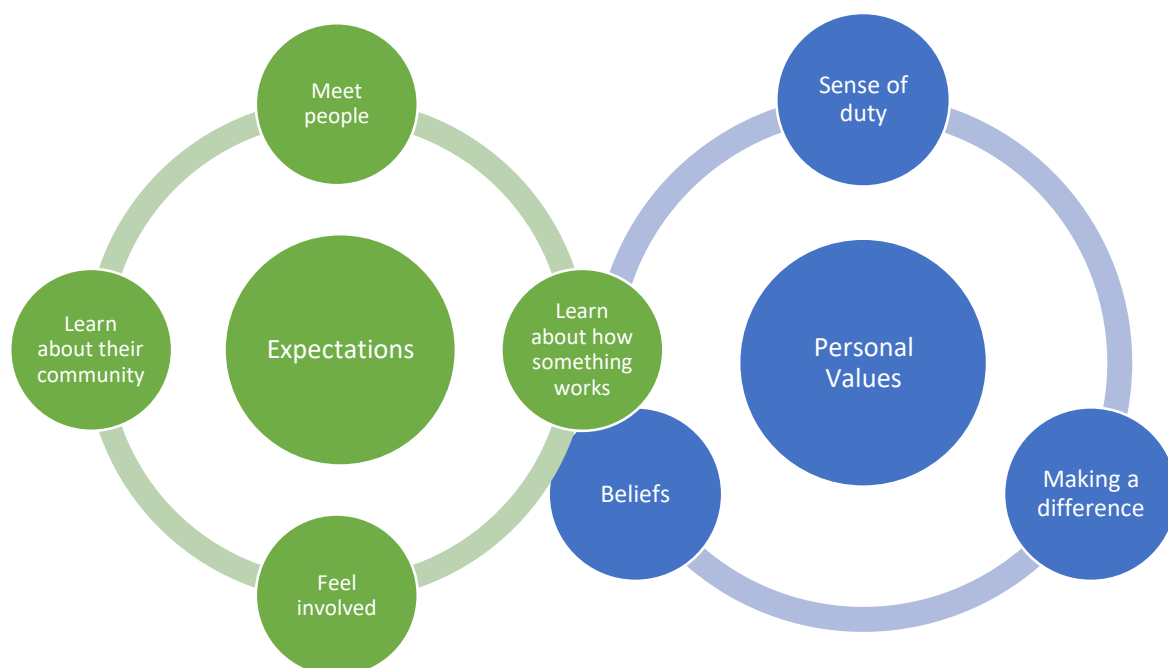
Expectations

Participants described a range of expectations from their involvement, including meeting new people, learning about their community or learning how something works (like council governance). Notably, most participants described wanting to feel involved. For some, wanting to be involved stemmed from a sense of duty to their community (more on this below), but for others, their involvement was tied to personal histories and experiences that reflected the participant's positionality.

In a few cases, participants said they had been looking for a way to be involved and had found the participatory process. For some, their involvement stemmed from personal characteristics. Doug, a panellist on the CSP, explained:

> *So I'm a town planner by profession, I'm, you know, sort of*
> *interested in decision-making and stuff like that… being, you*
> *know, sort of naturally inclined to look at, explore, think about that*
> *sort of thing, I signed up and I was lucky enough to come out of*

the hat. So yes, my involvement occurs as a consequence of not just professional interest but personal curiosity, and just watching new things and how they're emerging.

For Doug, his involvement was tied to his positionality – on a professional level as 'a town planner' and a personal level as someone with a natural curiosity about decision-making.

For Aife, a MTM juror, the process was the "outlet" she had been searching for after a very negative experience with social care. Aife explained that her father had recently died and managing his end-of-life care had been arduous. She had also lost her job in the process of becoming his full-time care provider, adding to the stress of the situation. Following on from this period of her life, she had been looking for a way to process and share her experience. She explained:

> *It's a bit feeling like I was…smart and knew all these things, and then it didn't make any difference. You know, there was no acknowledgment. And so my thing was even with the complaint system that I wanted them [the social care agency] to say, to kind of accept some failings or admit that they would make improvements. I didn't want to go through the formal complaint process. I didn't want to sue…I just wanted some acknowledgement really….*

> *…So it's like I was still looking for an avenue. And I found Measuring the Mountain. So it just was a perfect continuation then to take it a step further -- share my story. So without knowing it, deliberately, it was exactly what I was looking for.*

For Aife, the MTM process was an opportunity to talk about the negative encounter she had just experienced with social care in response to her father's death. This unique position of Aife -- being unemployed, grieving her father, and needing resolution for her experience with the care system – motivated her to engage in the process. Though not all participants were looking to get involved for the same reason as Aife, others

described individual motivations that reflected their positionality. In this case, the ability to self-select to participate benefited the participant and brought legitimate epistemic value to the process (Erikainen et al., 2021). This potentially refutes claims about the need for processes to always overcome self-selection or engage beyond the usual participants.

Sense of duty

Several participants expressed a sense of duty to improve their community. Roger, a CSP panellist, stated: "I mean, I got involved in it as a way of giving something back to the community." Reflecting on Roger's assertion that he wanted to participate to benefit the community, I was surprised that participants rarely described personal benefit as a motivation to participate. In the case of MTM, the self-selection process meant that all participants had direct social care experience in Wales. This direct (and often negative) experience with social care acted as a driver for many participants who saw the citizens' jury as an opportunity to make a difference not just individually but for all service users. Ruth, a MTM juror, asserted: "I just wanted to do it because I wanted to hopefully help. Didn't do it for me. I was hoping to do it to help others -- to help the bigger community."

Similarly, Nora, a participant in AB, explained that even though she would probably never experience the benefit of her participation (due to the length of time to complete the town centre redevelopment), she felt it was her duty to participate in order to ensure the best for future generations of people living in the community:

> Sometimes you come home from the CRG and 'what's the point?' [laughs]. But yeah you just have to do it. If you're interested in the community and you want things better, then you've got to do stuff. I may never see, Susan and I probably won't see the end of it, which is where the children at the high school come in, because it'll be their area, not ours…But yes, getting **their** ideas of what they want this suburb to look like for their children is what we're trying to do with them. …We've done our bit, what we wanted to achieve. Well

we haven't achieved it but still working towards it. Yes, but it won't
be our suburb any longer. It will be their suburb and what they see
for their children. [original emphasis]

Nora was motivated to participate not just because she saw it as a way to benefit the community but because she had a personal duty of care to the community ("if you're interested in the community and you want things better, then you've got to do stuff.") Importantly, this reflects a history of engagement discussed in the previous section. This motivation to improve the community had led Nora to be involved in activities in the past (e.g. the CRG), and based on that involvement, she had been invited to participate in the HIA. Just as there seemed to be overall ecologies of participation that enabled the processes to occur, it seemed that individual participants were tied to those participatory environments. Individuals who believed in helping their community sought activities to be involved. As they became more active, they were more likely to be invited to other activities, further perpetuating their involvement and strengthening their motivation to participate. In this way, participants were like perennial flowers that could 'bloom' (i.e. participate) year after year, so long as the garden (and gardeners) provided the right conditions.

Perception of impact

Importantly, motivation to participate was linked to a belief that participants' involvement would make a difference – sometimes for themselves but more importantly for their community. Nora also asserted that her desire to participate was based on the opportunity to have an impact. She explained: "I suppose as with any other consultation you are concerned about what actual impact it's going to have. I mean you do the work and you hope that it's going to have the impact that you want it to have. But you do the work anyway". Other studies have highlighted the importance of perceived impact (Brodie et al., 2011) or the contribution people seek to provide (Lehoux et al., 2012) as a motivation for participation. Importantly, as this quote demonstrates, what was important for some participants was not whether or not the process produced a specific outcome but that there was an opportunity to have some influence; as she says, "you do the work anyway."

Personal beliefs

In discussing their motivation, several participants also referenced a personal belief – for example, about direct democracy, a jury system, social justice, etc. – underpinning their desire to participate. Harris, a panellist on CSP, explained how his participation supported his belief in democracy:

> *Walter Burley Griffin wrote an essay called: Democracy and Architecture…His thesis or his beliefs…were that democracy is not just about who we vote for, but how and where we live. And I thought that that tied in with what Byron Shire Council [were] trying to do here because it's local government, and it's that kind of idea that we're all involved and not just politicians telling us what to do.*

For Harris, participating in the CSP was a way to reinforce his beliefs in a participatory and democratic system of government.

Similarly, Doug, a member of the AB HIA team, explained that the process provided a mechanism to examine the community redevelopment through his belief in social justice:

> *Yeah, I've got a keen sense of social justice. So I think I'm at a stage in my life now where I've got a pretty good idea of what that looks like, and what I'm comfortable with in terms of…how I would participate within all of that. Um, so, yeah, the HIA working group just provided an avenue to explore in the face of all of that.*

Doug explains that social justice is a belief that he values, and participation in the HIA was a way for him to explore the social justice of the redevelopment, thereby enacting his belief.

Perception of impact and sense of duty to the community are common motivators across various fora for participation (Brodie et al., 2011) and, along with personal beliefs, were

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key motivators in the case studies. Significantly, these motivators often outweighed facilitators used to increase participation, such as payment:

> *Katie (interviewer): I mean, so that's, it brings up an interesting question, because that it is a significant amount of time. I mean, you're getting compensated, but not like massively for it …*
>
> *Doug: I didn't take the money.*
>
> *Katie (interviewer): So then, what's your motivation for being involved in something like that?*
>
> *Doug: Two things, so professional interest and wanting to see the place get off and work.*

As Doug, one of the CSP panellists, highlights in the above quote, his motivation for being involved was based on his professional interest and a desire for the process to lead to a successful outcome. These desires outweighed any financial incentive. That Doug could forego the money reflects the fact that participants were likely to have capabilities (like financial status) to participate. Therefore, though personal motivation mattered for participants, it was not the only determining factor. Having the capability to participate was also a requirement for their involvement. Both capability and motivation stemmed from individual factors – experience, history, beliefs – and influenced whether or not someone participated.

5.6 How did people participate?

How participation is described (and who sets the terms, i.e. the organisers, commissioners) sets boundaries for engagement, "bounding the possibilities for inclusion as well as agency" (Cornwall, 2002, p. 8). How participants viewed their participation in the process was mainly based on how the rules and structures of the process were communicated to them (Landwehr, 2014). What participants thought was expected of them (their role) influenced what they thought they could contribute to the process. According to Cornwall (2002, p. 28), "…the identities people assume or are accorded in any given social or political space are not so much fixed as constituted and enacted

differently in different domains of discourse." This was a dynamic process in which participants interpreted what was expected of them and then acted upon this throughout the process, creating participation that varied in enactment.

The role of participants in each process had different levels of formality and structure. Dean's (2017) typology of participation distinguishes between 'prescribed participatory spaces' in which the design of the process is imposed upon participants and 'negotiated participatory space' in which participants influence the conditions for their involvement. Using this typology, both citizens' juries (MTM and CSP) could be categorised as prescribed participatory spaces. Participants were invited as 'jurors' (in MTM) or 'panellists' (in CSP), and there was a presentation at the start of the process in which participants were told what was expected of them in this role. In both cases, the organisers discussed trying to impress upon participants the need to be impartial and to participate in the process as a citizen rather than for their self-interest. Nathan, one of the MTM organisers, explained:

> *And I think there's a leap between that [self-interest] and being part of a deliberative democratic process. There's a real jump, I think getting people across that. So you're not here as Joe Bloggs or whatever. You're here as a citizen. Using your experience in this way is a different space. And I think they made that leap. I think for some it was a small step, for others, it was a challenging, uncomfortable experience.*

Nathan implies that the expectation was for participants to shift their identity within the process from individuality (self-interest) to commonality (communal interest). However, interviewees shared ways they expressed and drew upon their individuality within the process, flexibly moving between this and commonality.

Participants used their personal experiences to shape how they wanted to be involved and what they felt they could contribute to the experience. Rhys, a witness in MTM, explained:

See, the way I see my role in things -- role, I hate that word-- my involvement in things is to be a catalyst in a way; appear to link up all these different bits to improve matters. Not to be an activist or set up in a soapbox or whatever. But to make life better, to make it a more fairer society for everybody. And you can't look at yourself because it's very easy to be selfish in these matters, but sometimes you have to bring yourself in to be able to improve matters to show examples. So that's basically how I see myself.

Importantly, Rhys rejects the idea of having a particular role. Instead, he asserts that his involvement (perhaps more fluid than a prescribed role) is based on having lived experience he can draw upon to contribute. Rhys recognises the need for solidarity within the process ("you can't look at yourself"), but rather than adhering to the organisers' requests for complete adherence to commonality he asserts that participation in the process *requires* some individuality ("you have to bring yourself in") that can contribute towards communal goals ("fairer society for everybody").

In several instances, participants described how they had taken up responsibility for advocating for a certain perspective. For example, in MTM, several participants shared that they believed it was their role to provide a particular lived experience on a dimension of social care. Meghan, one of the organisers, described how this had led to a diversity of lived experiences being expressed within the jury:

Meghan: What I found really interesting was that the jurors had very particular things that they tended to focus on. And as the process developed, you knew who was gonna ask questions on which topic…they kind of really relaxed into that, because they knew that [Gareth] would ask something about regional partnership boards and [Aife] would ask something about carers, that [Owen] would ask something about relationships, that [Gail] would ask something related to neurological conditions or being housebound -- they all have particular things that they…

> *Katie (interviewer): like a role?*

> *Meghan: I think it's things that were of interest to them largely because of their personal experiences.*

Participants drew on their own experiences to follow particular lines of inquiry. In doing so they mediated the expectation of how they would participate (as communal citizens) with how they wanted to participate (as individuals). Some democratic theorists emphasise the need for self-interest, in addition to consideration for the common good, in deliberation (Habermas, 2018; Mansbridge et al., 2010a). The ability of participants to set aside personal interests has been called into question (Stewart et al., 2020), particularly with regard to different rationales for public participation which emphasise lived experience and empowerment rather than evidence and policy development (Dean, 2017).

In the HIAs, participants were involved in different working groups ('HIA team' (AB), 'HIA steering group' (50K)) and participants had undefined responsibilities within the group, more akin to Dean's (2017) 'negotiated participatory space'. In these undefined roles, participants brought to the process what they felt they could contribute from either a professional or personal capacity. As Jeremy, a member of the 50K HIA steering group, explained:

> *I suppose we didn't have specifically defined roles…And that said, my organisation does have a role to play around pulling together evidence for a range of different public health topics. So I was definitely able to contribute that. What I'm also then really heavily involved in is working closely with government policy leads…So that kind of broad context of policy understanding and an overview of the evidence really I suppose was my, I thought, my main contribution was.*

This lack of formality allowed participants to define how they thought they could contribute to the process. In the quote above, Jeremy explains how he drew upon his professional

skills and experience to contribute to the HIA process in a way that he saw as useful. Unlike the citizens' juries, in the HIAs, participants were encouraged to draw upon personal and professional experiences.

How participants believed they could contribute was shaped by how they were invited to participate and the dynamic nature in which they interpreted their role within the process. Participants in the HIAs expressed no reservations about drawing upon their personal experience, whereas participants in the CJs conveyed different experiences in expressing their individuality.

Some participants shared that they had been able to engage in the process beyond their self-interest. Terry, a panellist on the CSP, explained: "and getting people from all the different walks of life in one room together, I think made a lot of people realise that just viewing local issues or policy through their own lens can lead to a narrowness of understanding or being a bit myopic in how you think about things". Proponents of citizens' juries often view participant bias as a threat to the process (Landwehr, 2014) and highlight the ability of mini-publics to enable participants to move beyond self-interest to examining issues more generally (Escobar & Elstub, 2017). Terry supports this idea by explaining how the process helped participants to move beyond a "myopic" perspective.

However, other participants explained that they could not let go of their self-interest. Geoff, a juror on MTM, asserted:

> *How do we clear our minds and go in with a neutral perspective*
> *instead of becoming our agendas? I'm not the only one that had*
> *their agenda. You might have spoken to other people and they'd*
> *probably have said the same thing to you.. they used [their]*
> *agendas at their opportunity. So, you know, we're only human.*

Geoff explained that he had been unable to set aside his self-interest to assume a "neutral perspective." He expressed awareness that he had been expected to put aside his agenda in order to participate in the process but had 'failed' to do this. The fact that

participants like Geoff felt they needed to negotiate their self-interest reflects an inherent tension within the MTM process. Participants had been invited to participate because of their lived experience with social care. In this sense, organisers valued the epistemic imperative of participation by selecting participants with a lived experience (Mazanderani et al., 2020). Yet, they designed the process to achieve a democratic imperative in which participants would act as impartial citizens. This seeming contradiction meant that participants were left to negotiate their involvement, sometimes acting on self-interest and other times acting towards commonality.

Although organisers often structured involvement as either impartial or self-interested, participants moved fluidly between these two roles. For example, Doug, a member of the HIA team, explained:

> *So my role within the working group was as a community member. And so yeah, I'm a private housing resident. So I didn't exactly have a direct stake with the Airds Bradbury estate, other than having the community welfare background, knowing a lot about the local issues… I think that's why I received the invitation.*

Doug asserts that he did not use the process to serve his self-interest (he did not have a 'direct stake' in the redevelopment), yet he still interacted with the process through his worldview and interests (as a local resident; having a background in community welfare) rather than as an impartial citizen. This reflects the dynamic nature of participation. Participants could be self-interested and impartial at the same time. For some, contributing personal experience meant reflecting on individual experiences (e.g. experiences of social care) that aligned with their self-interest, but at other times it could help to represent communal beliefs which contributed towards the process. It is possible to both strive for the common good and to serve one's self-interest. Some deliberative democracy theorists have asserted that self-interest is essential for the recognition of diversity within the democratic ideal (Mansbridge et al., 2010b).

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This section examined how identity – expressed through capabilities, histories, and values – shaped participants' engagement in the process. Participants came into the processes with different histories, beliefs, motivations, and ideas about the role they would play. These individual positions coloured how participants viewed the process – what they thought it could accomplish and what they wanted to get out of it. The positionality of participants provided not just the motivation for why they wanted to participate but also their expectations of what the process could accomplish.

Interviewees across the four cases often had similar capabilities to participate, reflecting personal attributes of relative power (Brodie et al., 2011). Perhaps because of these personal characteristics, many of the participants I interviewed had a history of involvement in participatory activities. Previous engagement in participatory activities also helped to shape the expectation of what the process could achieve.

Interviewees also had varying motivations that stemmed from individual values, beliefs and experiences. These motivators for engagement can be viewed as articulating what participants hoped to get out of the process. For example, a strong motivator across all cases was the belief that their participation would 'make a difference' or impact the intended decision. This implies that participants expected their participation to lead to a worthwhile outcome. Reflecting on their own research, Brodie et al. (2011, p. 6) explain: "all participants are concerned about doing something that is worthwhile in their own terms and every participatory act has, and is intended to have, consequences." The next section examines how participants interpreted their experience of the process. How these experiences (mis)aligned with participants' expectations and how this created different outcomes for participants is the focus of the following chapter.

5.7 Expectations and interpretation

Interpretive policy analysis provides a valuable approach for examining how the process's design and implementation shaped participants' experiences. It is a useful method[19] because it examines (mis)alignment between expectation and experience. According to Yanow (2000a, p. 7), such differences reflect "different ways of seeing, understanding, and doing, based on different prior experiences". The meaning that people attach to certain phenomena is shaped through experience, feeling and understanding, bringing social structures, practices and institutions into being (Wagenaar, 2011). Furthermore, meaning-making in a social setting is an individual and collective experience. People who share a social setting contribute towards a mutual construction of that setting that entails a reality that is true for those actors at a particular time and place (Sugiman et al., 2008, p. 13). As such, the participatory processes can be seen as shared social settings in which meaning about that process is mutually constructed. Meaning-making is contrived of emotive (pathos), cognitive (logos) and moral (ethos) dimensions that correspond to feelings, values and beliefs (Gagliardi, 2011). Uncovering feelings, values and beliefs can be done by examining artefacts- specifically language, objects and acts – through which they are reified. In the previous section, I examined how participants' capacity, history, motivations and expectations manifested in why and how they participated. In this section, I will look at how artefacts of the processes – language, objects and acts – demonstrate the variable and contested ways the processes were interpreted.

5.8 Competing meanings

Yanow (2000a, p. 8) explains: "Interpretive policy analysis explores the contrasts between policy meanings as intended by policymakers — 'authored' texts — and the possibly variant and even incommensurable meanings — 'constructed' texts — made of them by other policy-relevant groups." Exploration of the language used to describe the processes

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[19] Though, Wagenaar (2011, p. 10) argues it is less method and more praxis: "… an actionable approach to judgment, understanding, and problem solving, which is only partly captured - as any practice - by recourse to an explicit method. The upshot is that interpretive policy analysis is as much an art as a craft."

helps to uncover the contested understandings about what the process was intended to do. This language was conveyed through authored texts, such as the process reports, and constructed texts, or the ways that interviewees described the process. In the section below, I examine the variable ways the process was interpreted through the language used to describe its aims and how it was framed.

5.9 Interpreted aims

As I discussed in the previous chapter, the processes were described by organisers as having different participatory aims, ranging from informing policymaking to empowering citizens. These reflected two overarching rationales for participation: participation as knowledge transfer (50K and MTM) and participation as collective decision-making (AB and CSP). How the process aim was communicated to participants, therefore, helped to shape the expectations that participants had of the process. The most comprehensive way that the process aim was communicated to participants took place in the CSP, in which panellists were provided with a 127-page briefing book at the outset which included the aim and design of the CSP. In all of the other cases, there was no distinct product that communicated the process aim to participants; instead, participants may have learned about the process through reading recruitment materials or conversing with the organisers. In many cases, participants described the aim of the process in a way that matched the organiser's description. Yet in others, participants conveyed very different notions of what they thought the process was intended to achieve. This mismatch of perceived aim across different actors (decision-makers, organisers and participants) occurred across all of the cases, even in the CSP, despite the upfront communication (see Figure 27 for a summary of the different ways that participants, organisers and decision-makers described the aims of the process in interviews).

Participants were likely to express that the process's aim was to inform a decision-making process or improve the decision (through identifying health impacts, integrating community concerns, etc.). This ties back to individual motivations for participation, in which participants expressed that they wanted to participate in order to make a difference or have some influence over the decision. However, process organisers commonly

described the process as making a case for a particular participatory technology or integrating community concerns ("voice") into decision-making without consideration for what difference that input would make. Similarly, decision-makers often viewed the process as a way of soliciting community perspectives. These variations in how the aim was interpreted could significantly affect how the overall process was experienced.

Figure 24 Summary of perceived aims of the case studies by different types of interviewees

	Participant Aims	Organiser Aims	Decision-maker Aims
Community Solutions Panel	– Improving community engagement – Identifying solutions to infrastructure spending prioritisation	– Improving democratic decision-making – Citizen empowerment – Making a case example in Byron	– Providing opportunity for shared decision-making with the community – Informing a "wicked problem" – More balanced community input
Airds Bradbury	– A new approach to community consultation – Community ownership and influence over the redevelopment – Demonstrating health impacts	– A new approach to community consultation – Integrating community needs into the redevelopment – Influencing the redevelopment – Demonstrating health impacts	– Integrating community preferences for the redevelopment – Ensuring positive health impacts
Measuring the Mountain	– Informing social care: information	– Informing social care: information	– Generating knowledge for

	generated through the jury would feed back into the Act – Piloting a citizens' jury	generated through the jury would feed back into the Act – Demonstrate the usefulness of a citizens' jury – Provide opportunity by which "people's voices [would be] heard." – Generate a conversation about improved social care	decision-making: gaining a deeper understanding of the lived experience of social care as well as generating ideas on how this could be improved.
50,000 Affordable Homes	– Demonstrating link between government programme and public health – Piloting an approach to HIA	– Identifying health impacts – Influencing the implementation of the programme	– Identifying health impacts – Influencing the implementation of the programme

What is important to note is that interviewees described these aims *after* the process had taken place. Therefore their perception of the aim of the process was shaped by their participation in it. For some participants, the way they expressed their interpretation of the aim reflects their experience of the process. Carol, a panellist on the CSP, explained:

> …I felt as though, right from the very minute it was directed towards an outcome, instead of it being just the question put, and then this lovely broad sort of thing. It was as though, 'look, we've only got this amount of time, so we've got to sort of steer it this way to get to here.' That's how it felt.

In stating that the process felt like it was being steered towards a particular outcome, Carol expresses how she *experienced* the process. This may help to explain why, even in cases with clear upfront communication, participants sometimes described different aims than the organisers: their perception of what the process was intended to achieve changed through their experience of participation. Whether the perceived aim was formed a priori or generated through participation in the process, the language used to describe the aim provides an essential perspective into what participants expected the process to accomplish. Whether these expectations materialised, and how that affected participants will be discussed in the following chapter.

5.10 Frames

How a process is framed – as research, as policy informing, etc. – also shapes the interpretation of the process. "Policy frames use language, especially metaphoric language, and in so doing shape perceptions and understandings" (Yanow, 2000a, p. 10). Through interviewees' descriptions of the process, I identified four ways that the processes were being framed: democratic process; technocratic process; judicial process; or normative process. How interviewees framed the process had implications for how they interpreted the rationale of the process, and in turn, what they thought the process could seek to achieve. Whether these frames were explicit or implicit, they shaped participants' expectations and, in turn, how they engaged in the process.

Democratic process

The way participants described the CSP seemed to imply a 'democratic rationale' for participation (Martin, 2009). The implication is that public participation can improve accountability between citizens and public institutions, thereby enhancing the legitimacy of such institutions. This frame was portrayed by participants in discussing what they thought the process was intended to achieve. Alan, a panellist on the CSP asserted:

> *So, we have plenty of people in our way to make decisions on our behalf and represent us. We've got loads of people representing us…However, in the real world, we know that actually, they may*

*well say they're representing us but they also have another whole
other set of interests that they're very focused on. So, I thought,
well, this could be a good opportunity to get involved in some
recommendations to make some decisions for my community. So,
it's generally believed on my part that this is a very proactive
process and I was quite excited.*

In the quote above, Alan compares the role of the process (as a deliberative democratic
process) versus a traditional representative democratic process. He describes
representative democracy as a process in which politicians say one thing to the public but
then act on their own interests. In comparison, he describes the CSP as a process that
enables 'involvement,' being 'proactive', and acting on behalf of 'my community.' Through
this frame, we can see how participation in the CSP can act as a bridge between public
institutions and citizens, enabling more direct participation in decision-making, what Dean
typifies as 'participation as collective decision-making' (Dean, 2017). The expectation of
the process is to enable participants to function as citizens acting for the common good,
and the efficacy of the process is measured by the extent to which people participate in
making decisions.

Technocratic process

In AB, the rationale for the process was framed around the idea that public involvement
can ensure better fit of service delivery. Alice, a member of the AB HIA team, asserted:

*I think it was to inform the plans of the redevelopment, so that they
would reflect community needs, and would be appropriate…but
also something that the community would use and would be not
something that's just put there without consulting the community.
To basically improve the redevelopment plans…like there was a lot
of discussion around, is it walkable? Are people going to be able to
go between the different aspects? Are the different aspects stuff
that people would use? How would they be used? And how [would]*

> *they be used not only in the short term, but in, say, 10 years' time*
> *when the community might be different than what it is currently?*

What Alice describes above – that service use can improve through the input of service users – is what Martin (2009) calls the 'technocratic rationale' for public participation. Providing community members with an opportunity to inform the planning of a service "is seen as a means of ensuring fit between what is provided and what is desired…" (Martin, 2009, p. 312). Seen through this frame, participants in AB are treated as the knowledgeable public who should have a "more proactive say" (Martin, 2009, p. 312). This language of 'having a say' was consistently used by organisers, participants and decision-makers when describing the process, particularly in AB:

> *I think they would probably feel that they were having a bit of a say,*
> *like, in things that were going to affect them.*

- Alice, member of the HIA team and process organiser

> *…when people here felt they own this community, they had a say*
> *and they were being heard.*

- Susan, member of the HIA team

> *…they felt like they were involved. And so they were having a say.*

- Nicole, process commissioner

> *Where residents feel like they have a say.*

- Doug, member of the HIA team

This approach to participation as 'having a say' embodies the typology of 'participation as knowledge transfer' and 'participation as collective decision-making' (Dean, 2017). The AB process was viewed as an opportunity to share lived experiences and community

preferences with decision-makers to improve the redevelopment. However, it was also an opportunity to have some control over the decision through collection decision-making. In this way, 'having a say' was a process of giving voice and being heard (a critical theme I examine in more detail in Chapter 6).

Judicial process

Frames are powerful because of their ability to evoke metaphors. Metaphors help to shape ideas and shared meanings. They can create "strategic portrayal for persuasion's sake, and ultimately for policy's sake" (Stone, 2002, p. 9). MTM was unique in how interviewees evoked metaphoric language to describe the process. The process was often described 'like a trial' by organisers and participants. The terminology of a citizens' *jury* seemed to appeal to a few of the process organisers who had professional backgrounds in law. As I discussed in the previous chapter, using this metaphor of 'participatory process as judicial process' meant that the organisers structured the process similarly (e.g. teaching participants how to interrogate a witness). This metaphor seemed to affect how participants then viewed the process, with several participants using similar legal language to describe their experience. Geoff, one of the jurors, used several legal metaphors to talk about his experience:

> *The people sitting in front of me, those that were, in my opinion, the*
> ***guilty folk****. The* ***defendants****… Right, the people that were doing*
> *the sitting* ***on trial****… [emphasis added]*

Viewing the process through this frame, the expectation is to reach a 'verdict' rather than having a say in policymaking or participating in direct democracy. This resembles Dean's typology of 'participation as arbitration and oversight[20]' in which the ultimate goal of

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[20] In his typology, Dean (2017) characterises this type as being highly impartial – with participants selected at random in order to avoid any vested interests. In comparison, MTM only recruited people with an experience of social care, therefore ensuring that the jurors would have

participation is to "improve the legitimacy of decisions and render them acceptable to all, primarily by demonstrating that decisions have been subject to a fair process that has not been dominated by one set of vested interests" (Dean, 2017, p. 225).

Normative process

In evoking a metaphor, the processes can imply 'good' and 'bad' or move from description to prescription, what Rein and Schon call the "normative leap" (1996). This 'normative leap' of the process exemplifying public participation was evidenced by the language interviewees used to describe the processes. Perhaps because MTM evoked one of the most potent metaphors in framing the process (a trial evokes strong visual images), participants in this process conveyed a stronger normative ideal than in other cases:

> *So I think it's a participative technology that we should be using a lot more often.*

- Nathan, MTM process organiser

> *Only in that I advocate for the jury, for the process.*

- Aife, MTM juror

> *I feel that it's a very good precept or concept. I think it's a brilliant idea. And I would like to see a few more of them gone up in different areas.*

- Geoff, MTM juror

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some vested interest in the outcome. This demonstrates that typologies of participation can be a useful heuristic but in reality there is much more fluidity in their design and implementation.

But I think it should be [done]. It's the only way you can get justified information.

- Rhys, MTM witness

However, it was not only MTM in which participants described the process as a normative ideal. In 50K, some participants described the HIA as a type of process that 'ought' to be done more often, as Hamish, a member of the HIA steering group, stated: "I guess, because it's a big programme. And it probably ought to be subject to some kind of health impact assessment." Through this lens, participation reflects an ideal of collective decision-making in which "participation in political, social, civic and economic decision-making is woven into the fabric of a citizen's everyday life" (Dean, 2017, p. 220). The fact that MTM and 50K more strongly emphasised this normative ideal might also be reflective of the participatory ecologies in which they took place, which were, as described in the previous chapter, settings in which public participation was expected to take place, and participatory practices had been institutionalised to meet this ideal.

In the previous chapter, I described the processes as conforming to two clear rationales for participation based on Dean's (2017) typology: knowledge transfer or collective decision-making. However, a more complex picture emerges when viewed through the frames of the participant's experience of the process. The processes could reflect multiple rationales for participation simultaneously, and these had implications for what participants might expect to achieve from their participation (see Figure 28). When the process was viewed through the frame of a democratic process, as in the CSP, the expectation was for people to participate in making decisions. This corresponded to Dean's (2017) 'participation as collective decision-making' rationale. When the process was framed as primarily technocratic, as in AB, the primary expectations were for participants to have a say and be heard. This aligned with Dean's (2017) 'participation as knowledge transfer' (i.e. 'having a say') and 'participation as collection decision-making' (i.e. 'being heard') rationales. The judicial framing of the MTM process created an expectation that the process should reach a fair verdict. This aligned with Dean's (2017) rationale for public participation as 'arbitration and oversight'. Lastly, a normative framing

of the process also enhanced the expectation that people should be involved in decision-making (Dean's (2017) 'collective decision-making' rationale). Whether or not these expectations were achieved is examined in Chapters 6 and 7.

Figure 25 Elaboration of frames, expectations and rationales (Dean, 2017) of the cases

Frame	Expectation of the process	Cases	Rationales for Participation (Dean, 2017)
Democratic process	People participate in making decisions	Community Solutions Panel	Participation as collective decision-making
Technocratic process	Having a say Being heard	Airds Bradbury	Participation as knowledge transfer Participation as collective decision-making
Judicial process	Reaching a fair verdict	Measuring the Mountain	Participation as arbitration and oversight
Normative process	People should be involved in making decisions	Measuring the Mountain 50,000 Affordable Homes	Participation as collective decision-making

5.11   Reports

Examining the process output (the final report) provides a useful mechanism for understanding participants' experiences because it embodies the remaining two artefacts of interpretive policy analysis: objects and acts. As a tangible output from the process, the report functions as an object which conveys meaning about the process (Freeman, 2006). At the same time, how the report was generated (who wrote it and who got the

final say in what was included) represents an act which imbues meaning in the process. This "interplay of text and audience through the strategic positioning of implicit meanings" (Wagenaar, 2011, p. 8) tells us more about the production of meaning than the examination of texts or interviews would alone. It is not just what the report says but who creates that meaning and how an audience interprets it. Here I seek to understand the interplay of texts and narratives to understand how this process of knowledge production reflects people's interpretations and contributes towards the production of meaning in the processes.

All of the processes produced a final report which summarised why and how the process had taken place and provided recommendations targeted at the decision that was the focus of the process. However, how the report was generated and, in particular, how it reflected the input of the participants involved, varied between cases. The construction of meaning via the report reflects the different rationales and varying levels of control within the processes.

Both of the HIAs produced a final report that met standard reporting criteria for health impact assessments (Fredsgaard et al., 2009), including a clear description of the evidence used, classification of health impacts, and a set of recommendations. However, they differed in their approach to representing participant input. The 50K report included a section in the evidence review with data from key informant interviews. Individual informants are not named, nor are individual quotes provided. Instead, the data provided by the informants are amalgamated and anonymised, referring to "informants" in general rather than specific individuals whose position (as a housing representative, as a public health professional, as an academic, etc.) is removed. The AB HIA report also distinguished between evidence from the literature and evidence "from the community." Similarly, the report amalgamates and anonymises the data referring to individual participants in general ("people have stated," "it has been noted by local residents,") or uses passive language to avoid ascription ("it was felt that"). In both cases, the amalgamation and anonymisation of individual participants serve a purpose. First, it adds weight to the evidence when the combined response of participants shows overall

agreement rather than demonstrating differences of individual opinion. Given that this evidence is used in the report to support a particular recommendation, it strengthens the argument to demonstrate solidarity rather than differences. By anonymising the data, the reports also imply impartiality. In both cases, the evidence of stakeholders is provided under the overarching section on evidence which includes health profile data and evidence from the literature. Positioning the stakeholder evidence within the larger section, and anonymising the stakeholder data, implies that the evidence is equal in merit and weight. Providing evidence from participants through the report also accomplishes the process rationale of 'participation as knowledge transfer' (Dean, 2017): unified public knowledge is transferred to decision-makers in order to improve outcomes.

While it is considered best practice to produce a written report for a citizens' jury, there are no guidance standards for what should be included, and reporting styles vary greatly (Street et al., 2014). The CSP produced a final report that included a decision-making tool that the panel designed along with recommendations. This decision-making tool relied on individual values. Panellists were asked to assign a weight to infrastructure categories based on a set of values agreed by the group (these were safety, community well-being, connectivity, equity, environmental consciousness, and excellence in design). The individual rankings were then amalgamated to determine the overall ranking of priority from the group. In addition to providing an overall group recommendation, the report lists anonymous recommendations from individual panel members. The report production was agreed through deliberation by the panellists and is reflective of 'participation as collective decision-making' (Dean, 2017) in that the output was negotiated rather than prescribed, and what is included was determined by participants, not the organisers. The report reflects not just the outcome of the process but the level of control that participants enacted within the process. In this sense, the report communicates the panellists' ideas but also acts as a 'nexus of social practice' (Freeman, 2006). As I described in the previous chapter, panellists in the CSP enacted control and ownership over the process in line with the overarching aim of the process. The fact that the report was created by the panellists and represented their consensus-building and deliberation reflects how participants interpreted the rationale for the process.

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In contrast, the MTM report exemplifies a lack of control of the jurors over the process. The MTM report is the only report that is not anonymous: participants are named in the report, and a photo of the jurors is included. However, the recommendations are amalgamated and written as a collective (e.g. "the Jury recommends") without including any individual recommendations from jurors (even though these had been provided on the final day of the process). As I described previously, the report was produced by two of the process organisers without input or approval from the jurors[21]. Unlike the CSP, this approach to report production reflects a more prescribed approach to participation. As described above, MTM typified 'participation as arbitration and oversight' with many elements, including report production, tightly controlled by the organisers. The production of the final report is a manifestation of the interpretation of this aim.

Each report reflects varying levels of participant control over the final output. Both of the HIA reports were written by members of the HIA team or steering group. As discussed in the previous chapter, membership of these groups reflected the overall participatory approach of the HIA, with AB including community members on the HIA team and 50K including professional stakeholders. The CSP was written exclusively by the panellists, and the language used in the report reflects this authority through the use of first-person pronouns (e.g. "the process we used"). Freeman (2006) suggests that the text and the group who produce it are mutually constitutive. But what happens when the connection between the text and the group is severed, such as in MTM? The text that was meant to represent the group becomes a reflection of the authors instead. Yanow (2000b, p. 15) explains that "…in producing a report, the analyst is engaged in interpretive acts. Whether reporting on observations, on interviews, or on documents, the analyst presents his interpretation of what he has seen, done, heard, and/or read". Through authoring the report, the process organisers took authority over the jury: defining the problems and recommendations and controlling how the audience interprets the process.

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[21] Interviewees told me that they had not been consulted in the report production and one of the report authors confirmed this.

Therefore, how participants interpreted the final report reflected the control and authority they experienced in its production. Participants described various ways the final report did or did not reflect their input. In the cases in which participants had greater control over report creation (CSP, AB, 50K), interviewees more commonly asserted that the report reflected their (and the community's) input:

> *Katie (interviewer): Did you feel like that final output and those recommendations reflected what you and other people from the community had provided, you know, like your thoughts, your feelings, your beliefs?*
>
> *Susan: Yes. It did, and it reflected everything, all the positive things that were said, and the negative things. So everything was put into the report… At the end of each section we did a summary of it, but everything was in the report. Because our attitude is, whatever a resident says is important. So everything went in, and then it was summarised at the end to make it easier to read.*

Susan, a member of the AB HIA team, explains that she not only felt that her individual viewpoint was represented in the report but also that of the community. She describes how the community perspective is expressly represented by having a dedicated summary in each section of the report. By summarising feedback from the community within the report, she asserts that this provided legitimacy to their input ("whatever a resident says is important"). In this way, the document helps to imbue authority not just to the report authors but to the community.

Several participants in the CSP asserted that even when the report did not represent their individual views, the deliberative nature of the process allowed them to support the collective view provided in the report. In contrast, several jurors in MTM expressed frustration at the lack of ownership over the final recommendations. Gail, one of the jurors, spoke at length about her frustration with the production of the final report:

I read it [the final report] very quickly. I think because I was so frustrated and I couldn't see anything in there that I mean, there were the odd little bullet points that they've taken some of these flicked up sentences and put a little bullet point in. But it wasn't [laughs incredulously]. I didn't feel that that was a report that we'd written, that we could have written.

For Gail, the fact that the process organisers had written the report meant that it did not represent what the participants would have wanted to be included. Representing participant input was reduced to "the odd little bullet points" rather than giving jurors ownership for writing the report. This lack of ownership over the final output led her to express disappointment in the process: "I think we walked out of there feeling frustrated that it didn't live up to what we expected it to."

The process of interpretation in the production of the final report meant that not all viewpoints were represented. For some participants, the process of authoring the final report meant they were satisfied with what was included. For other participants, like Gail, a lack of authority in the reports' production led to dissatisfaction with the process. Lack of ownership and control in the production of the report was a determining factor in satisfaction with the output and reflected elements of control and authority within the process overall. The following chapter will explore this interaction between interpretation, experience and outcomes.

5.12 Conclusion

Abelson et al. (2007, p. 40) state that "only when the purpose and goals for public involvement and accountability are clearly articulated can the questions of by whom, for what and how, be addressed". However, this research has demonstrated that the goals of a participatory process are often variable, contested and implicit. The form of the process can be determined first, with other instrumental aims being selected in service of the form (for example, making a case example for using citizens' juries). Abelson et al. (2007) suggest that consideration be given to how these goals compare with the

expectations of relevant stakeholders and publics. In this chapter, I have shown that these expectations are constituted through the positionality of participants. Understanding the variability of capacity, history and motivations helps to explain why and how people participate and creates different expectations of the process. Furthermore, these expectations create a backdrop against which the process is interpreted. Based on the different interpretations of the aims, processes were framed according to various rationales for participation: as knowledge transfer; as collective decision-making; or as arbitration and oversight. This interpretation is further expressed in the production of process outputs. Processes in which the rationale was collective decision-making provided greater authority and control to participants. The process in which arbitration and oversight was the predominant rationale lacked these characteristics. This created essential differences in how participants experienced the process.

Although public participation is often envisaged as achieving concrete, explicit process, instrumental, or knowledge and capacity goals (Abelson et al., 2007), in reality, the rationale for their conduct is much more fluid, implicit and variable. The rationale for a process is interpreted through prior experiences, and this interpretation contributes towards the constitution of the process as a social phenomenon (Wagenaar, 2011). Greater consideration for this iterative process of meaning-making in public participation can contribute towards not just clarity of purpose (after all, there can be multiple purposes) but more explicit expectations for those that participate. Next, I turn to ensuring expectations match experience and the important outcomes that arise from this (mis)match.

CHAPTER 6   BEARING FRUIT OR BARREN HARVEST: PARTICIPANT OUTCOMES

6.1 The fruits of participation

In the previous two chapters, I explored how participatory processes were conceived – based on their spaces, histories and cultures – and what aims they intended to achieve. I then looked at how these aims were interpreted and how participants experienced the process in relation to their positionality. I turn now to examining how process conception, expectation and interpretation led to different outcomes. In this first of three chapters examining outcomes, I look at the personal consequences for participants, focusing on how processes did (or did not) enhance empowerment. In Chapter 7, I look at how the overall process achieved its technocratic aim of informing a decision relevant to the social determinants of health. Lastly, in Chapter 8, I reflect on the processes' interpersonal and governance outcomes to examine how these outcomes affect health equity.

Reviews of public participation have highlighted the dearth of evidence on the relative experience of different approaches to engagement (Goodlad et al., 2005; Popay et al., 2007). Public participation is often envisioned as accomplishing process or instrumental goals without consideration for how these goals affect the experience for participants. In Chapter 4, I used a horticultural metaphor to demonstrate how variable ecologies of participation form the basis for different processes to arise. If we extend the metaphor, we can say that participatory processes are akin to gardening. Seeds are planted into the soil with the expectation that they will yield a particular crop. Like a gardener tilling, planting and weeding the garden, participants put their labours into a process with the expectation that they will see the benefits in the end. Yet not all gardens bear fruit. For some participants, the outcome was what they expected – the seeds they had planted yielded a successful harvest. But for others, the final bloom either didn't look as expected,

or there was a crop failure. Was it because the soil was bad – something had gone wrong in the process? Or was it because the seed was dormant – still waiting to sprout?

For some of these 'gardeners', what mattered was that they had planted the seed. They viewed the process as an investment in the future and did not expect to benefit from their participation. Participants who viewed the outcome as matching their expectations had a positive experience – often feeling empowered by the process and willing to plant more seeds (i.e. be more civically engaged). But for those that expected the process to yield a particular outcome, a failure of the process to 'bear fruit' led to feelings of frustration and disappointment.

Participants explained that part of their motivation for participating was the belief that their engagement would contribute towards the decision point. Implicit in the design of many of the processes was the intention that participants would receive some type of personal benefit from their participation (e.g. 'having a say,' becoming more informed). Participants described a range of personal outcomes from their engagement – many of these were positive and aligned with the aims of the process, but participants also described negative feelings about their involvement. The ways that participants experienced the process overall (i.e. the personal outcome of their involvement) was often a reflection of what opportunity their involvement had to influence the decision. In this chapter, I explore this alignment between expectation and outcome to identify what outcomes, both positive and negative, arose.

6.2 Positive and negative personal experiences

Participants described a range of personal outcomes arising from their involvement. Overall, participants described positive feelings associated with their experience (see Figure 29). They described *instrumental benefits* of their participation, such as acquiring new knowledge, skills or networks; *internal benefits,* such as pride, respect and self-esteem; and *external benefits*, such as making a difference or improving their community. However, several participants described feeling frustrated, dissatisfied, or disappointed in the process. For the individuals who described adverse outcomes from their

involvement, there was an apparent mismatch between what the participant had expected the process to accomplish and what manifested. Similarly, for participants who described a positive outcome, their experience mostly matched what they had expected to achieve through their involvement. Below I begin with first examining when the process 'bore fruit', that is, the outcome matched the expectation of participants. I explore this in relation to some of the central aims identified in the previous chapter. By way of comparison, I then explore cases in which participants described the process as being barren (the outcomes did not align with expectations) and how this affected their overall experience, including personal outcomes. Lastly, part of the logic for this research (see section 1.3, Figure 3) was an acknowledgment that empowerment can affect health equity, and participatory processes may have a role in empowering participants. Therefore, I conclude this chapter by examining the experience of empowerment. Who felt empowered and why? Empowerment was strongly related to the positionality of participants and reflects the dynamic relationship of 'having a say' within decision-making processes and 'feeling heard' in those contexts.

Figure 26 Summary of interviewee descriptions of positive personal experiences resulting from participation in the case studies
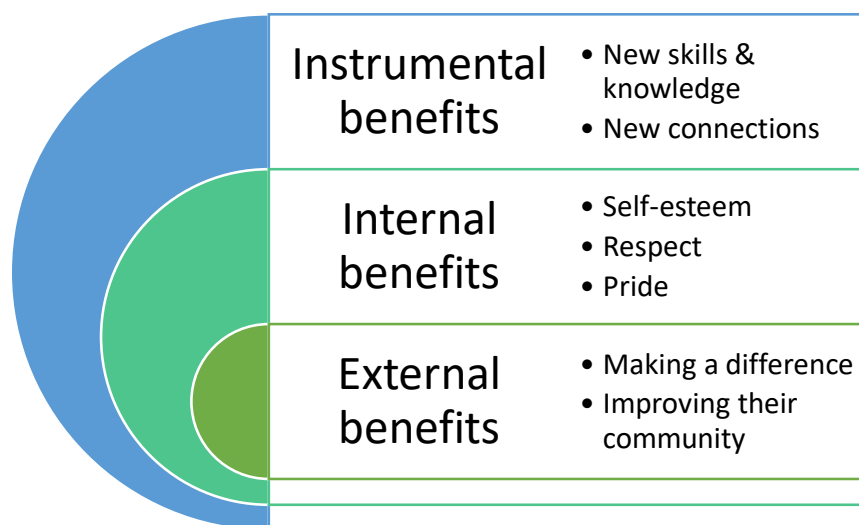
6.3 The seeds bear fruit

Several participants described positive feelings resulting from the process. The overall experience was positive for many participants because they viewed the process as a success. Participants described elements of a successful process in different ways. For some, what was important was that the process had been perceived as useful for decision-making. For others, success was measured by how well the process achieved another perceived aim of the process. Lastly, some participants described the process as successful if they felt they had contributed to it beneficially.

Process is perceived as being useful for decision-making

Success for many participants was measured by whether or not the process had achieved its policy aim. Doug, a participant in AB, explained how his perception of success had influenced his overall satisfaction with the process: "So it was a success, I believe in that it was adopted by the local steering committee that had a stake in the redevelopment with some participants of that committee also involved in the actual logistics of the redevelopment [the developers]." The HIA was a success because it had achieved what it had intended to achieve – to inform the redevelopment. He further explained that this sense of achievement was based upon the fact that the final output appeared to have been helpful for decision-making: "It's being applied and it's being - it's useful. And it's being recognised." The fact that the process had been awarded 'HIA of the year' also contributed to his perception that the process was being recognised as an important and useful piece of work. He went on to explain that because of this achievement, he felt a personal sense of satisfaction from the process: "The project itself, like I feel a sense of contentment that it was something positive." This positive experience was tied to an interpretation of the process 'reaping what it had sown'.

Even in cases where the process did not directly affect decision-making, the perception that the process had been useful led to overall satisfaction. Participants described ways that they thought the process had been helpful in other ways, such as raising awareness or informing advocacy about an issue. Linney, a participant in 50K, explained that even

though the HIA had not been used to make changes in the 50,000 Affordable Homes Programme, it had been used to inform a wide range of policy work taking place on health and housing:

> *And I did think it was worth it for the report that we were able to produce and you know how that was able to influence thinking. And like I say, I can't point to a decision and say that's the one we changed. It was much sort of more diffuse than that.*

The fact that the information generated through the HIA was being used in various ways to inform health and housing led Linney to view the process as worthwhile.

Outcomes meet another perceived aim

Participants in interviews also described positive experiences resulting from the process achieving another perceived aim. Interviewees described a range of non-policy outcomes beyond directly changing the decision, including shared decision-making, better understanding of health impacts, and a feeling that community needs had been voiced (see Figure 30). Several interviewees expressed that these other aims and non-policy outcomes had made the process successful.

Figure 27 Summary of interview participants' perceived aims and reported non-policy outcomes

	Participants' perceived aims	Non-policy outcomes
Community Solutions Panel	– Improving community engagement – Identifying solutions to infrastructure spending prioritisation	– Shared decision-making & community engagement – Improved understanding of and trust in Council
Airds Bradbury	– A new approach to community consultation – Community ownership and influence over the redevelopment – Demonstrating health impacts	– Improved community participation – Hearing/voicing community needs – Better understanding of health impacts – Improved relationship between community and decision-makers
Measuring the Mountain	– Informing social care: information generated through the jury would feed back into the Act – Piloting a Citizen's Jury	– New knowledge for decision-making – Demonstrated willingness to conduct participation
50,000 Affordable Homes	– Demonstrating link between government programme and public health – Piloting an approach to HIA	– Better understanding of health impacts

Participants were aware that the perceived success of the process was contingent upon what was expected by each participant. Ruth, a participant in MTM, explained:

> *Now other people might have wanted - And there were few people*
> *after more involvement in writing it up and things like that -- but we*
> *weren't there for that. We were there literally to be the jury. We were*

there to be given the evidence and to listen to what people were saying and through that to make recommendations. So for me personally, I felt that is exactly what we did.

Ruth explains that other participants wanted more out of the process than what they had been given (e.g. writing the report), which she believed was beyond the scope of the process. Her expectations of the process aligned with what was conducted, and she, therefore, felt satisfied with what had been achieved.

Similarly, Aife, a participant in MTM, described her experience as "a really positive, powerful experience." Aife explained that her experience was closely linked to what she had been looking to achieve through her involvement. As discussed in the previous chapter, Aife had been looking for an opportunity to make sense of her father's recent death and share her experience of being his caregiver. Her involvement in MTM, therefore, provided her with the experience she had been seeking. The outcome, in turn, was very positive for her: "… for me personally, I think it had like a healing, restorative effect. I think hugely." The MTM process fulfilled the aim of Aife's involvement. This achievement – providing her with a venue to share her experience – had the effect of being extremely 'positive', 'healing' and 'restorative'.

It did not seem to matter what the goal was: as I have discussed previously, the interpreted aims of the process varied widely. Instead, what generated a positive experience was that participants viewed the process as achieving whatever aim they thought it had. Bret, a panellist on the CSP, asserted: "I think that what the goal was, or whatever the community panel was, the goal was achieved: to make the community involved. Yes, it did." Bret believed that the process aimed to generate greater community involvement. His perception that this aim had been achieved led him to feel positive about the overall experience. Therefore, a positive experience was generated through congruence between perceived aims and outcomes.

For some participants, the perceived outcome did not need to be instrumental. The process could be perceived as intrinsically valuable, and by participating in the process,

participants viewed this goal (of doing something participatory) as being achieved. Terry, a panellist in the CSP, explained:

> *But I think on a whole it was positive. Even if, like I said before, the only thing that people got out of it was having to sit in a room with other people for a couple of days and hear other people's perspectives and get a deeper understanding of how these processes work. And being able to voice things that you find valuable for the community. Even if that was it, even if like nothing did change at all, I still think that's a positive outcome.*

For Terry, whether or not the process led to a change in the community did not diminish his perceived value of the process. For him, having the opportunity to engage in a deliberative process was a positive outcome in itself. Susan, a participant in AB, similarly shared that for her, the value of her involvement was tied to her participation, not the outcome:

> *Katie (interviewer): So, did you feel overall that the HIA process was useful for kind of informing that decision-making?*
>
> *Susan: I do. But I think it was more important showing residents that our input was valuable -- that they were listening and doing something. So I put the greater importance on the residents, proving to residents about the importance of our voice.*

For Susan, the principal aim of the process was to have a new approach to gathering information from the community. The fact that this aim had been achieved and that residents had an opportunity to have their say in the redevelopment was more important than how it affected the decision. For some participants, the primary rationale was process orientated, while for others, it was outcome orientated. Therefore, the perception that the process had been a success depended upon whether or not these process or outcome goals had been achieved. Some research has categorised participation into achieving either process-orientated goals or instrumental goals (Abelson et al., 2007), yet

this research demonstrates that the goals of the process, and perceived success, can vary from person to person.

Participants feel they have contributed

Lastly, some participants explained that the overall process had been positive because they felt their contribution had been beneficial. Ruth, one of the jurors in MTM, explained that she had put forward recommendations that had been used. The fact that she had been able to have some influence in the process led her to feel that the experience had been positive: "So I felt for my own experience, I had a positive, definitely had a positive influence." Similarly, Brett, a panellist in the CSP, explained that he was happy with the process because his contribution (a matrix) had been used: "I was very happy because they kind of use my matrix." As discussed in the previous chapter, participants were motivated to participate because they believed their involvement would make a difference. For some participants, like Ruth and Brett, they saw clearly how their contribution had benefitted the process, leading to a positive perception of the process.

6.4 A barren harvest

Unlike those participants who derived a positive experience from their involvement, a few interviewees described a negative overall experience. People who described a negative experience often did so because their expectations of the process were not fulfilled. The people who described a negative experience participated in either the CSP or MTM (both citizen's juries). This may reflect differences in the perception of legitimacy in process (the design and decision-making rules) and outcome (generating the anticipated result).

Dissatisfaction with the process

Some participants expressed dissatisfaction because the way the process was run did not match their expectations. As I discussed above, some participants felt that the process had intrinsic value and were satisfied due to their involvement regardless of the outcome. In those cases, the perceived process goal was achieved. Conversely, some

participants expressed frustration with how the process was implemented. Carol, a panellist in the CSP, explained how the process was a missed opportunity:

> *And I expected really great brainstorming because this is the Byron Shire, it's one of the most creative places in Australia. Yeah, you would have fantastic discussion. But it didn't really happen… And that there was such a chance and opportunity to make a difference and change. And that they just didn't take it up. Really, but that's what really upsets me. You know, that's when you've got the opportunity, and then you just run with all the old stuff. Because we need to change the whole world. If we could just change a little bit like that, it would have been good.*

For Carol, despite feeling that they had good facilitators, the design of the process was a source of considerable dissatisfaction. The focus of the question and the way the process was facilitated to answer that question, rather than being more open-ended, was a missed opportunity to capitalise on the creativity of people in her community. She had expected the process to enable equal participation from all participants, but this was not what she experienced:

> *It really upset me, Katie. Because I went through that sort of expectation that there would be fair, equal voice for people. And it came to my knowledge, as soon as we sat in the Council Chambers…And straight away, there were people who were going to have a great knowledge of the Councillors themselves and Councils dealing. And they just took over, and they stayed like that for the whole process… because I was so thrilled to be there. And I would have loved to have contributed. But I just couldn't.*

She explained that the design of the process favoured those who had experience with similar professional settings and could speak "the language", which enabled them to dominate the process. As opposed to participants who described feeling they had been able to contribute, Carol described being shut out and unable to participate in the way

she would have liked. Deliberative processes can be designed to enable input legitimacy (Harris, 2019), and facilitators work to maintain fullest possible inclusion in the group (Escobar, 2019), yet even in the best-designed processes, micropolitics within the process can challenge these design arrangements (Molinengo, 2022).

Participants in the CSP were given the opportunity to decide how they wanted to answer the question posed to the group. This diverged from the approaches of the other processes, which were much more prescriptive in their design. Evidence shows that allowing participants to determine how to structure deliberation enhances the legitimacy of the process (Harris, 2019). Despite this, Alan, one of the panellists, was frustrated by the group's approach (using a values-based matrix). He explained: "So that sense of frustration was born out of the inability to deliver what I felt was a really quality document. It wasn't a quality presentation wherever it was, so I was particularly frustrated by that." Even though the group had decided on this approach through consensus, Alan was frustrated that the group had taken an approach he would not have chosen.

Similarly, some participants in MTM were dissatisfied with elements of the process design. Chris, a juror in MTM, spoke at length about her dissatisfaction:

> I think we walked out of there feeling frustrated that it didn't live up to what we expected it to…

> I enjoyed the thought of it. I thought we were going to be able to go out and do something and make things better. And I'm a good volunteer, I volunteer for most things, but I did feel that that was four days of my life that I couldn't get back.

Chris explained that there were several elements to the process design that she didn't like. First, she had expected the group to be presented with information and then allowed the chance to choose what testimony they wanted to hear, rather than the organisers pre-selecting the witnesses. Secondly, the organisers wrote the final report, and Chris explained that this hadn't properly represented the group's input. Thirdly, the recommendations included in the report were not the ones she felt the group would have

selected. Many of these elements of the process design could have been delegated to the group (such as writing the report), but the process organisers chose to maintain control over the process (as discussed in Chapter 4). Mini-publics can be designed to share more agenda-setting and co-design, but organisers make these choices in light of other time and resource constraints (Roberts & Escobar, 2015). The fact that processes sought to achieve technocratic aims within limited policy windows may have resulted in top-down approaches that delegitimised the process to some participants (Harris, 2019).

As participants had little control over the process design, Chris asserted that the overall process felt tokenistic. She further explained:

> *And it was almost like, it sounds really condescending. It was almost like they were sort of patting us on the head and you're there, you're ticking a box. And, you know, now we're going to go away and write the report.*

There is always a concern that mini-publics can be used as tokenistic exercises where decision-makers cherry-pick recommendations to achieve politically suitable ends (Böker & Elstub, 2015). The legitimacy of a process is formed through micro-design aspects related to who participates, how they participate, and how recommendations are developed with both internal (voice) and external (representation) inclusion (Harris, 2019). The perception that the process design had failed to achieve one (or more) of these markers of legitimacy led participants to feel dissatisfied or disappointed with the process.

Lack of awareness of the outcome

The success of the process was also judged according to perceptions of outcome legitimacy – whether the outputs were being considered in decision-making. Several participants stated that they were unsure what impact the process had on the decision. For these participants, lack of knowledge of the outcome coloured their view of process success. Alan, a participant in the CSP, explained that even though Council had

committed up-front to adopting the recommendations, there was no evaluation plan in place to monitor their implementation. He asserted:

> *[There needs to be] some means of, some measurement system, keeping track of the work we did and measuring it against outcomes. Something that's ongoing. So, to me, I'm not sure whether it's just dropping into a black hole, just the report's gathering dust, or it's continued being reviewed by the Council, monitoring progress against what is recommended. I don't know.*

This lack of oversight and communication about how the CSP output would be used was a source of frustration for him. His lack of awareness about how Council would integrate the recommendations into their operations delegitimised the process to him (despite the commitment from Council) and limited the perceived success.

Similarly, Ruth, a juror in MTM, explained that she was unsure how the recommendations from the process were going to be used by policymakers. She explained:

> *So I think they got a lot of information it just needed to make sure that the people who are at the top actually listen. Cause the trouble with these things is people can say, 'Oh Yes, very nice. We've done that exercise.' That is my biggest concern is 'Oh well we've done this exercise.' A lot of people put a lot of effort into it. A lot of people told heart-wrenching stories and opened themselves up, and sometimes if people don't actually listen to what they've said, and it's all stony ground, it's just been a waste of time, effort and money.*

Without knowing how the CJ outputs would be incorporated into decision-making and having no evidence that this occurred, Ruth feared that the MTM process would be treated 'as an exercise' rather than as a legitimate approach to shared decision-making.

At the time of interview, Welsh Government had not published its response to the recommendations from MTM. Participants were, therefore, unaware that the report had

been presented to WG and that a response was forthcoming. As Chris, a MTM juror, explained, there was little evidence that the process had made any difference: "We'd hoped things would change for the better, that things would happen. And anything that wasn't working would be helped to work. [But] we didn't see any evidence of that." Some critiques of citizens' juries more broadly are based on the suspicion that they have been used as show trials to allow powerholders to avoid engaging in processes that would hold them to account with communities (Wakeford, 2011). The perceived inability of a process to achieve its intended aims has also led to a collaborative impasse (Molinengo, 2022).

Participants in the citizens' juries had variable knowledge of the process outcome. In both citizens' juries, a select number of participants had been invited to attend a dissemination event in which the process findings were presented to decision-makers. In the CSP, a few panellists presented the report at a Council meeting. In MTM, a few jurors attended a dissemination event at the Welsh Assembly, which the Deputy Minister for Health and Social Services attended. Compared to those participants that did not attend these events, these participants expressed a higher level of confidence that the process would affect decision-making. Bret, one of the participants in the CSP who presented to Councillors, explained:

> So by seeing [the Councillors] working, I felt much more confident about how they're going to use the report. And if they were going to use it and so on. It really helped. And that's where I felt like, Okay, this is legit. You know? This is a real way of trying to get the community more involved.

Several of the people who attended this meeting expressed greater trust that the Council would implement the recommendations of the CSP. Panellists had an opportunity to speak with Councillors about the final recommendations directly and to hear their feedback, which may have provided a greater perception of the legitimacy of the process. Similarly, Aife, who attended the MTM launch at Welsh Assembly, asserted: "I think all those little things added into a tapestry of feeling like that it's been ongoing and being kind of pulled forward."

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In comparison, participants in AB and 50K seemed to have a high level of awareness about the outcome of the HIA. This might reflect that most of the HIA participants had been directly involved in writing the final report and disseminating the findings. For example, participants in AB presented the findings of the HIA to the community reference group (CRG), which the decision-makers attended. Participants in 50K had also used the findings from the HIA in various meetings with Health and Housing agencies. Interestingly, none of the participants in the HIAs expressed dissatisfaction with the process design[22]. This demonstrates how input and throughput affect output legitimacy (Harris, 2019)—knowing what outcome the process had helped to legitimise the design as a means to achieve that end.

Whether or not the process was perceived as being successful reflected differences in the perception of its legitimacy. Other studies have found that participants may experience disillusionment with community engagement initiatives when their expectations of influencing decision-making are not realised (Bolam et al., 2006; Chau, 2007). One study of a citizens' assembly asserted that these types of processes might generate ideas and outputs unsuitable for traditional policymaking, and organisers should be more transparent about how processes fit into broader decision-making contexts (Boswell, 2021). How micro-design elements of the process aligned with participants' expectations enhanced or diminished participants' perception that the process was legitimate. Similarly, design choices about how to develop and disseminate the outputs of the process affected perceptions about the macro-political legitimacy of the process. Integrating these output activities into the design of the process to ensure all participants were included, as was done in the HIAs, seemed to enhance the perception that the process had achieved its policy aim.

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[22] Although it should be noted that not all participants from the processes were interviewed and it is possible that those who chose to be interviewed were more likely to have a positive or negative experience (rather than be ambivalent). Therefore, it is possible that some participants in the HIAs could also have had a negative experience but chose not to be interviewed.

Evaluations of citizens' juries generally do not establish whether the instrumental outputs of the process are used in decision-making (Street et al., 2014) and in practice, there is a legitimate concern from participants that the process may be a 'waste of time' (Boswell, 2021, p. 8). Conversely, evaluations of HIAs often examine the impact of the process on decision-making without examining the effect on participants (Dannenberg, 2016b). Street et al. (2014) claim that achieving instrumental aims is less critical than meeting goals related to empowerment, yet this research has shown that perception of aims (instrumental or otherwise) is key to the participant experience. For some participants, a positive experience occurred because the process had achieved perceived instrumental aims and non-policy goals or enabled participants to feel that they had contributed. However, for other participants, negative feelings occurred when the legitimacy of the process was challenged by not meeting expectations of how the process should be run or not knowing what outcome the process produced. Importantly, participants described ways that the processes were empowering. Like other participant experiences, empowerment was closely tied to expectations – especially around having a say and feeling heard – about the policy aim of the process. Next, I will explore how participants described empowerment in the processes and explore how this experience arose for some and not for others.

6.5 Empowerment

Participants described the process as empowering in many ways (see Figure 31), including: upskilling and capacity building; being heard; feeling involved; having a say; feeling confident; learning and knowledge; affirmation; being enabled; and making a difference. This range of ways to describe what felt empowering about the process reflects the breadth of how empowerment is interpreted (e.g. each individual might have a different understanding of empowerment) and the diversity of how empowerment is experienced.

Figure 28 Interviewee descriptions of empowering aspects of the processes
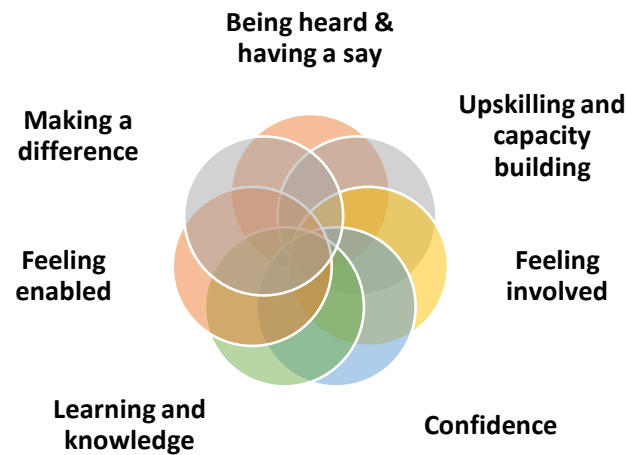
As discussed in Chapter 2, empowerment is a term that has been widely used yet loosely defined, making it a concept less easily assessed and more a matter of "I know it when I see it" (Burdett, 1991). Given the loose boundaries of what empowerment means, there is wide variation in how it is assessed, which further diffuses its definition (Bennett-Cattaneo & Goodman, 2015). Empowerment is a contested concept, and varying definitions reflect its application in various fields of study. Empowerment can be viewed as an individual experience. This form of empowerment, often referred to as psychological empowerment, has been defined as the "process by which individuals gain mastery or control over their own lives and democratic participation in the life of their community" (Zimmerman & Rappaport, 1988, p. 726). In contrast, empowerment can be viewed as a collective experience in which power is viewed as 'the capacity to implement and the type of power that makes up empowerment is one that is relational, a 'power with,' or "a process in which individuals and social systems mutually create each other" (Kreisberg, 1992, pp. 57, xi).

However, there are some consistencies across these contested definitions. Fundamentally, empowerment is considered an 'experience of power' (Bennett-Cattaneo & Goodman, 2015, p. 84). Empowerment is a *social process* through which there is a *change* in the *experience of power.* Central to this conceptualisation is the understanding

of power as a changeable experience (Kreisberg, 1992). Participants in the cases described empowerment as occurring individually and collectively. Not all participants experienced this, and some strongly rejected the idea that the process was empowering or that they needed to be empowered. This reflects the contested nature of empowerment and how it is experienced. Below I discuss for whom empowerment occurred and offer insights into why this happened for some participants and not others.

6.6 Individual empowerment

Participants discussed various ways that the process was personally empowering. Power has been described as "an ability to bring about significant effects, specifically by furthering their own interest" (Lukes, 1974, p. 65). For some participants, empowerment was a process through which they offered something to the process (for example, their insight or experience) and were able to see how their contribution could 'bring about significant effects'.

For some participants, the shared decision-making structure of the process (one of the instrumental goals) enabled them to feel that they had more 'voice' and 'power' in the decision. Aife described her experience:

> *For me personally it was still a great experience, and that you can only do what you can do and then you have to let it go anyway. The change doesn't come overnight anyway. And it's just it's maybe a small step into a bigger process, like a wave of change happening - getting voices and citizens involved in these kinds of juries and assemblies. So as a process, as a way of gathering community experience. Because that was the kind of message of it that you know, that we're the experts, that we're the people who should be asked about what's happening like on the front line, on the ground. So even hearing that, you know, that there's a slow shift really toward -- it's like a power and voice thing. Okay, isn't it? In who's representing what's happening.*

Regardless of the effect on the decision, Aife felt that the process had achieved its goal of embedding citizen voice into the evaluation of the Act. Having the opportunity to contribute towards this citizen representation ('getting voices and citizens involved') was a small change that could potentially lead to more considerable changes taking place over time. For her, being part of a process in which her voice is prioritised ('we're the people who should be asked about what's happening') contributed towards the process being an empowering experience. Research on jury deliberations found that allowing people to voice their opinion led to a sense of fairness in the process and legitimacy in the outcome, regardless of whether they agree with the outcome (Tyler, 2001; Tyler & Blader, 2013; Tyler, 1994). Reflecting back to the previous sections, this demonstrates that opportunities for participants to contribute ('voice', opinions, expertise, etc.) can increase legitimacy, enhancing the process's empowering potential.

This sense of fulfilment or satisfaction relates closely to conceptualisations of empowerment as individual control (Zimmerman, 2000). Importantly, as discussed in Chapter 5, many participants chose to engage in a process because they believed there would be an opportunity to affect a decision. Whether or not participants could have the impact they had anticipated was a major contributing factor to their experience of empowerment. For Aife, she expected that she would have the opportunity to contribute her experience ('gathering community experience,' 'power and voice'), not that the Act would necessarily change as a result of the process ('a small step into a bigger process'). These expectations were met, thereby leading to her empowerment.

For other participants, empowerment occurred because they gained something from the process (e.g. a new skill or confidence). Jeremy, a member of the 50K steering group, asserted that the HIA had empowered him to have different conversations with policymakers about the health impacts of housing policy and to "speak much more confidently about how housing policy in general impacts on health." This experience reflects enhanced capacity that was being used towards strengthening a collective process (i.e. better integrating health and housing).

Many participants described confidence-building as an essential aspect of what made the process empowering. Many described the process as allowing them to engage in different, professional spaces that "felt important" and in which they felt respected and valued. For some, this experience of feeling respected whilst learning new skills, and applying their knowledge in new ways, helped to build self-esteem and confidence.

Two participants shared that because of their experience, they had developed the confidence to pursue higher education. Doug, a member of the AB HIA team, explained that the HIA had given him the "affirmation" he needed to pursue a master's degree in public policy and governance. He asserted that the skills he had developed through conducting the HIA (for example, research skills) had affirmed his capability to pursue higher education. This feeling of being 'enabled' by the HIA was what he viewed as being the most empowering.

Several participants described empowerment as a personal experience in which they attained new skills, self-esteem, and confidence. One of the process organisers for the CSP, Cat, expanded upon this to explain how deliberative processes can develop these aspects in participants:

> *You know, I think people really think they're not as smart as they are. I think there's an incredible lack of confidence about people's ability to participate in decision-making, which for me, has always been like, thinking of it as an unused muscle that is just atrophied through lack of use. No one's ever asked them to participate in this. So why would they think that they were any good at? Which of course they are.*

Participants engaged in decision-making in ways commonly reserved for only elected officials or other professionals. By enabling participants to learn new skills and apply them to a decision, they developed new confidence in their abilities. For some participants, this confidence was described as empowering.

6.7 Having a say vs feeling heard

Participants also emphasised the importance of feeling like they were listened to as part of the experience of empowerment. They described 'having a say' as the opportunity to offer personal contributions (their thoughts, feelings, experiences, etc.) towards a decision. While participants sometimes used the phrase interchangeably with 'feeling heard', there is an essential distinction between the two. 'Having a say' was a one-way channel of communication in which participants made a personal contribution towards the decision-making process. 'Feeling heard' was instead a two-way channel in which a decision-maker acknowledged the participant's contribution or that participants understood how their input was being used (referred to as 'closing the feedback loop' by some practitioners). Cat elaborated upon how participatory processes, like the citizens' jury, enable the experience of feeling heard:

> *… that the personal experience is completely valued, you know, that your own experience of that community, of your street, of your everyday experience, is exactly what's needed in this circumstance. So, you don't need to be an expert, you don't need specialist knowledge, you just need to be an observing resident, you just need to notice what's going on in your community, and to communicate that to others… and that someone is actually going to value that. So all of their contributions should be valued. And when they are, I think it does build one's confidence, like, 'Oh, I had something to say, and people listen to me.'*

Cat highlights several vital factors in this process. First, the process values the everyday experience of participants and invites them to contribute in a way that is usually only given to people with authority ('expert[s]'). Secondly, it enables participants to share this knowledge (i.e. 'having a say') in a way in which their contribution is valued (i.e. 'feeling heard').

Whether or not their contribution ended up affecting the decision seemed to be less important to some participants than feeling that their contribution was valued and 'heard'.

Rhys, a witness for MTM, explained that for him, it didn't matter whether the process ended up affecting the decision. What mattered was that he was allowed to share his personal experience and that it was taken into consideration by the jury:

> *…I don't know what the outcome is going to be at the end of it. So you can't have preconceived ideas in it. All you can do is just tell your story...But as I said, I felt empowered by being able to say that. Because it's like the feeling that somebody's going to, that I'm being listened to.*

Rhys' perception was that the jury considered his personal story in their deliberations. He said he didn't have expectations about how that would affect the Act overall, but what was important to him was the feeling that his contribution was valued and he had been heard. This goes against orthodox critiques of public participation, which argue that participants are mainly concerned with the outcomes of a process (Brodie et al., 2011, p. 39).

Some of the process organisers acknowledged the importance of making participants aware of how their input had been used to ensure that they 'felt heard'. Alice, a member of the AB HIA team, explained her approach:

> *I think it made it more visible to people. It's something that they could see. And by knowing what we did in the HIA, the issues we discuss, the research that we did with that because it gets reported back to the community, they know even if they're not coming to a meeting and doing what, like what I do in a meeting, they know they're getting heard.*

The fact that the HIA was a standing item on the CRG agenda and that it continued to be regularly discussed was an essential factor for ensuring that participants saw how their contributions were being considered. In turn, ensuring that participants knew how their contributions would be used was essential for enabling them to feel heard.

Not only did participants need to understand how their input was used, but how it was received was important for how participants perceived the process. Aife explained that MTM had allowed her to share her personal experience in a way that was 'taken seriously', but also that was received with empathy and compassion:

> *So I know that my story and experience is taken serious, and it's about the empathy and compassion about your experience as well so that it matters. So my voice matters, my experience with Dad matters. So, therefore, then coming back to feeling empowered, to being valued. So what I have to say about it, so again, it's the difference between my experience with [inaudible] Council and feeling dismissed and that my experience isn't being valued or respected or honoured.*

As a carer for her father before he passed away, Aife's experience with social services had made her feel 'dismissed'. In contrast, her experience in MTM – organisers and other jurors had treated her with empathy and respect – and feeling that her experience was valued had led her to feel empowered by the process. Therefore, 'feeling heard' was not just a transactional process in which participants saw output from their input. It was also an emotional process. They needed to feel like their contribution was valued and that their personal experience was honoured. *How* a participant was 'heard' therefore, seemed to be an essential element for whether or not the process felt empowering.

6.8 Previous experiences shape empowerment

For those participants who said that they had been empowered, it appeared that whether this happened depended upon previous experiences of relative power and powerlessness. Some participants described themselves as already enacting power in their lives and therefore did not view the process as empowering. Ruth, a juror in MTM, disagreed that the process had provided her with any empowerment:

> *I'm not really bothered about being empowered. I don't really need somebody to pat me on the head and tell me I'm empowered. I'm quite empowered as it is… I don't really like empowered cause it*

> *makes you feel as though you literally got no voice. And I definitely*
> *have got a voice.*

Ruth is a carer to her son, and because of this, she is actively involved in the caring community. She described herself as very confident, as someone who can "just turn up at different meetings," and very involved: "just keep my ear to the ground, can open my mouth when I think it needed." Ruth explained that for her, the process helped provide new information rather than providing her empowerment. This reflects, as discussed in Chapter 5 that many participants had high levels of relative power, which enabled them to participate.

However, a few participants described disempowering experiences before engaging in the process. For these participants, the process enabled them to feel empowered because they came into it from a position of relative powerlessness rather than a position of relative power. In contrast to Ruth, who described herself and her caring responsibilities positively, Aife described how her experience of engaging with social services had made her feel dismissed and unvalued. Nathan, an organiser of MTM, explained how the way in which social services are structured (one is at the mercy of the provider) leads to an experience of powerlessness: "…the moment you become dependent upon services, you become voiceless. So your lack of independence, or to be able to control or manage yourself and suddenly your dependence on others made you lose your voice." Aife described how she had argued with social services to receive adequate care for her father, and this process had left her feeling powerless. Similarly, Harris, a participant in the CSP, was a carer for his father and the experience of engaging with the social service provider (Centrelink) stood out to him in contrast to his experience in the CSP:

> *So it was the antithesis of Centrelink. This was so much more.*
> *Whereas when you try to deal with the government through the*
> *agencies, it's just contradictory. It's hostile. It's demeaning. It's like*
> *there to put you in your place and teach you a lesson and make*
> *sure you get what's coming to you. But the Community Solutions*
> *Panel was totally the opposite. It was gob-smacking.*

Harris explained that he had been surprised at his engagement with members of Council. In contrast to his experience with Centrelink, another government agency, he was treated with respect by members of Council during the CSP. Whereas Centrelink felt 'authoritarian,' the CSP was a space where he could be 'vulnerable'. The fact that both Aife and Harris were starting their engagement from a place of powerlessness in one aspect of their lives meant that there was room for the process to enable empowerment – either through developing confidence and capabilities or giving them a sense of control over their lives. Similarly, Doug, who described how the process had enabled him to pursue higher education, had lacked confidence in a way the process could bolster. It seemed that the participants who felt most empowered by the process were those with deficits of power (confidence, abilities) that the process could fill.

6.9 Community empowerment

In some cases, empowerment was not just an experience of individual mastery or control; it was a collective change in capacity for the whole community. Participants in AB described how empowering individuals through the HIA could create empowerment more broadly for the Airds Bradbury community. Unlike MTM and 50K, which were informing national policies, and CSP, which looked at Council-level changes, AB focused on the town centre of a relatively small social housing development. The fact that the HIA was aimed at informing the redevelopment in this small community meant that some of the process participants viewed the HIA as having the potential to increase community-level empowerment. Pat, a team member of the HIA, explained:

> *You know, because Susan has been through the process. She's a terrific community leader, but she has been an influencer for many years with her involvement. Not everyone will be born like that. And I guess it's a skill that you keep building on. So once you know how it changed you, you're better placed in helping another person to them similarly. So in that sense, it's empowering for a whole community because one person goes through it, they pass on their skills, their insight to other people.*

Pat describes how the capacity building (empowerment) of one community member can lead to strengthening the whole community's capacity. Given that Susan (another member of the HIA team) is a community leader, her influence, skills and insight can be passed on to other community members. In fact, there was evidence that this was happening, as Susan was involved in follow-on activities such as a school civic works project, in which she confirmed that she was passing on the knowledge she had gained from the HIA to students (I discuss this in more detail in Chapter 7).

Similarly, Denise, another AB team member, explained how the HIA could build community empowerment:

> *You know, I think you look at the different stages of consultation and engagement, and empowerment is the last and ultimate goal. And as you said, it can mean lots of things to different people. The fact that the HIA was so community tilted, I think, did give empowerment to not only [community members who participated in the HIA] [but] by proxy also to the schools and sporting clubs. And just knowing that we're actually really interested in what they wanted to say. Having said that, if it's not reflected in what comes out, then you've lost empowerment, haven't you? So it's very fragile.*

Denise reiterated that by offering the opportunity to participate to the community at large, even if they did not all engage, others in the community could still be empowered. Viewed in this way, empowerment is less of an individual experience and more of a social process through which changes in power can strengthen the community's capacity. This reflects emancipatory constructions of empowerment as collective consciousness and action (Arendt, 1970; Freire, 1972). However, she emphasised that empowerment is contingent upon action. If the redevelopment did not reflect community input, the perception of enhanced community control could be lost.

Nicole, the AB HIA process commissioner, asserted that empowerment had happened because of how the process had enabled a shift in power between the residents and the decision-makers:

> *Like, they felt like they were involved. And so they were having a say. So they were empowered. Because they actually not just sat back and just let you know, these people come in, but they actually had a say. Because how they used to speak then to the planners, the developers, like it was almost like the balance was changed, you know, like that they were telling them what to do.*

The HIA provided a vehicle through which community members could articulate the possible impacts of the redevelopment and share what they felt was needed to improve it. This process of 'having a say' had given participants the ability to tell the decision-makers 'what to do.' It had therefore redistributed power over the redevelopment from the decision-makers to the community.

Empowerment emerged in the case studies as a contested, dynamic theme that participants subjectively experienced. For some participants, the process enabled new skills, confidence and control, which they interpreted as empowering. For others, this was not the case. Developing individual empowerment often depended on a dynamic process in which participants not only 'had a say' but also 'felt heard' in a way that honoured their individual experiences and contributions. Furthermore, although most participants began the process with some degree of relative power, some came into it from a position of greater powerlessness. This duality of having relative power on the one hand (time, skills, resources to participate) and being powerless on the other (e.g. in dealing with social services) reflects the multi-faceted nature of power. We all have power to some extent, but our ability to enact power in different situations can be constrained and mitigated by the power of others (a topic I return to in Chapter 9).

6.10 Conclusion

Through participating in deliberative processes, research has reported that citizens can become empowered, increase overall community social capital (Fishkin, 1997); enhance political self-efficacy; and increase their sense of community identity (Gastil, 1994, 2000). Participants in the cases described similar positive outcomes, such as *instrumental benefits* (acquiring new knowledge, skills or networks); *internal benefits* (pride, respect and self-esteem); and *external benefits* (making a difference); but this was not true for all. Several participants also discussed ways the process had been a negative experience leading to frustration or disappointment. These personal experiences often reflected the (in)congruence between expectations and outcomes. Processes in which the design and output were viewed as legitimate by the participant were more likely to align with their expectations. This alignment between expectation, legitimacy and outcomes varied between individuals rather than by cases, reflecting the positionality of participants and the very personal experience of participation.

Furthermore, positionality and expectation were critical markers for the experience of empowerment. The process empowered some participants, and this was often a result of having relative powerlessness coming into the process and the process providing positive experiences that matched expectations. Many participants described 'having a say' as their primary goal of participating, but this research has shown that, in fact, what was required is a dynamic relationship between 'having a say' and also 'feeling heard' within the process.

Having opportunities for communities to 'voice' does not necessarily translate to being heard by institutions. Drivers for community engagement can support opportunities for 'voicing' without institutional duties to listen, deliberate or act (Escobar, 2022). In the following Chapter, I explore how participants were 'heard' by decision-makers by examining the impact of the participatory process on decision-making. Following this, in Chapter 8, I will look at how changes to the decision point of the process and the positive personal outcomes discussed in this chapter (reframed as civic skills, social capital and empowerment) can affect health equity.

CHAPTER 7   NEAR, FAR, AND UNEXPECTED: DECISION-MAKING IMPACTS OF THE PROCESSES

7.1 Impact on the decision

As discussed in previous chapters, the processes were designed to feed into some type of decision-making: infrastructure spending prioritisation in Byron Bay, Australia; an affordable housing programme in Scotland; a town centre redevelopment in Airds Bradbury, Australia; and evaluation of the Welsh Social Care Act. Most cases achieved some level of input in the decision, yet this was commonly through an indirect route. All of the cases had the potential to affect health through changes to a social determinant of health, therefore, understanding the impact the process had on the overall decision-making context is vital for generating an understanding of the processes' contribution to health equity.

It is difficult to understand whether the processes affected the decision without a clear definition of 'impact.' Decision-makers gave examples of ways that the process had led to a change; sometimes that change was to a written policy, but more often, it reflected indirect or distal outcomes, such as changes in conceptual learning by the decision-makers (Haigh et al., 2013). In evaluations of HIA, success is often defined by "both their impacts on decisions and on the environments in which decisions are made" (Bourcier et al., 2015, p. 5). However, Haigh et al. (2013) highlight that what constitutes a desired change and how successfully that change is achieved is subject to interpretation. In their review of the evidence on individual and collective benefits of public deliberation and citizen engagement, Delli Carpini et al. (2004, p. 332) suggest that the impact of public deliberation "is complex and context dependent and does not assure either citizen satisfaction or government responsiveness."

Therefore, understanding whether and how the processes generated an impact requires examining changes that occurred as a result of the process, but also studying how these align with the context-driven aims of the processes. As was discussed in Chapter 5, interpretation of the aim of the process established different expectations for participants, organisers and decision-makers. Therefore, discussion of the outcomes of the process requires consideration of both who is describing that outcome and what they expected the process to achieve within the context in which it took place. In this chapter, I examine how the processes affected the intended decision point. I will then describe the various outcomes that materialised beyond the intended scope of the process and demonstrate how these intended and unintended outcomes reflect the variable aims of the processes.

The primary claim of deliberative democracy is that it can lead to legitimate and positive democratic outcomes (Barber, 2003; Benhabib, 1996; Bohman, 1999; Fishkin, 1997; Gutmann & Thompson, 1998; Mansbridge, 1983). Yet some analysts express concern that deliberative democracy is too disconnected from actual decision-making to make it useful or that it is just another form of "gated democracy", in which citizens already well endowed with social capital use their influence to support their preferences (Delli Carpini et al., 2004, p. 321). To determine what type of impacts the cases generated, I categorised them with an emerging typology using the impacts described by interviewees. A direct impact refers to a change made to the intended decision point that the interviewee attributed to the participatory process. An indirect impact refers to a 'distal' change (Haigh et al., 2013) within the decision-making context (such as changes to learning, engagement or influencing other activities). A null impact implies that no change was made to the decision-making process, either directly or indirectly. I then sense-checked these categories by applying them to the four cases, which helped to organise the findings and established some useful distinctions for the comparative analysis.

The cases ranged in the level of impact that the process had on the decision. In some cases, decision-makers described ways the process had been used to affect the decision. In other cases, there was a less clear direct effect, but even then, decision-makers discussed how the process had been used in often unintended ways. In many cases, the

process had unintended benefits that extended beyond the scope of the original decision point. Whether the process had a direct, indirect, or null impact and led to other follow-on effects varied across the four cases (see Figure 32).

Figure 29 Outcomes for decision-making in the cases

Byron Bay Infrastruture CJ
- Direct Impact
- Follow on effects

Airds Bradbury Town Centre HIA
- Indirect Impact
- Follow on effects

Wales Social Care CJ
- Indirect Impact
- No follow on effects

Scotland Affordable Housing HIA
- Null impact
- Follow on effects
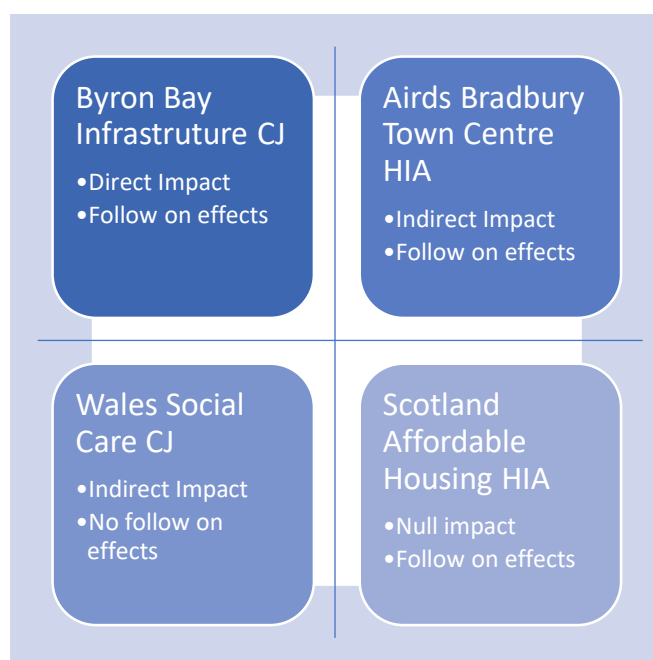
7.2 Direct impact

The case with the clearest evidence of a direct impact on the decision was the CSP. Before commencing the process, Byron Shire Council had committed to implementing the panel's recommendations in the Delivery Plan when it was adopted in June 2018. True to this commitment, the recommendations were integrated into the plan (for a full description, see the case summary in Appendix A3). Diane, a Council staff member, explained that they had applied the CSP recommendations to delivery objectives in the Plan that were more obvious, such as road network infrastructure, but also to broader objectives like Council operations and financial integrity.

Beyond this primary decision point, the recommendations had also unintentionally filtered out across Council. For example, the CSP listed safety as their number one priority and Council staff used this to prioritise their actions. Diane further explained:

> *And the criteria that the mayor actually brought up is, 'Well, you know if we're going to build whatever it was, let's say we're going to build a playground. Or we need to retrofit a community hall because it's got asbestos in it. The playground's really sexy; the asbestos is a safety and risk; we're putting that one [asbestos] as number one.'*

Beyond directly affecting the Delivery Plan, the findings of the CSP were being integrated into Council's decision-making prioritisation.

7.3 Indirect impact

In AB, decision-makers described ways that the evidence from the HIA had been considered, but there was no evidence of a direct impact on the redevelopment (there were no public documents that formally adopted the HIA recommendations such as there were in the CSP). Despite not being formally adopted, there was evidence that the HIA had been taken into consideration by some of the representatives of Infrastructure NSW (the agency responsible for the delivery of the stage 3 plan for the town centre redevelopment). Harrison and Tom, representatives of Infrastructure NSW, described ways they would incorporate the findings of the HIA into the concept plan: "And I'll actually go through, will consider those comments in their design". In addition to integrating the recommendations from the HIA, they asserted that the HIA had made them more aware of the health and equity impacts of the decision. Harrison explained:

> *Yeah, I suppose I probably don't put as much focus on the health side of things, in that you see this is embellishing open space areas and making it usable and pretty, and things like that. And probably focusing less on…and I suppose when I think health, I'm thinking the physical health because you're providing the open space and the walking trails, and things like that, but possibly you forget the mental health side of things as well. That these things can be areas*

for people just to mentally recuperate and provide benefits for their
mental health as well, I suppose you forget about that. Whereas I
suppose that this report brought it back into more forefront of the
mind to say, 'Oh, yes, it is; there is social benefits happening and
mental health benefits happening because of that.'

In addition to broadening his understanding of the physical and mental health impacts of the built environment, Harrison went on to describe ways that the evidence in the HIA helped him to translate what he understood conceptually into actions that could be tangibly beneficial for health:

Yeah, I would say that the health benefits of the sort of, ideological
level are [understood], and this [HIA] is trying to get that to a
tangible level. You know, I think that everybody in our game knows
that there's health impacts associated with public infrastructure and
open space. And this is just a way to make that a tangible thing.
And so this is, here's the ideological level, health is important, the
open space and infrastructure contributes to that, and here is how,
and this is the list of how. That's sort of how I view the document.

Although the developers did not provide examples of how they had directly integrated the HIA recommendations into the redevelopment plan, they described ways that their understanding of health and the built environment had improved because of the HIA. These indirect benefits of HIA, including conceptual learning (e.g. the relationship between land use and health), are believed to lead to long-term positive impacts (Dannenberg, 2016a; Haigh et al., 2013).

The developers, who arguably had less control over how the decision was implemented due to hierarchies of planning decisions and planning controls, were able to describe many ways that they'd been able to use the HIA. Chad, a representative of Council, who perhaps had more influence over the redevelopment (the Council was considered 'the client' to the developers), had less to say. Chad described the HIA as having a limited effect due to the shifting focus of Council priorities from housing to other areas:

I think it was useful for Housing. For Council, probably some missed opportunities more than anything else because after [the] health impact assessment, can't say exactly when, but our resources started to be pulled out of housing, the housing projects, and there was a lot of other things going on… I think we could have made a lot more of it if things had just kept going the way we were, but it was probably a bit of, you know, drawing away from that. Not through lack of interest, but just because the pressure was to do other things…But I think for Housing, it certainly gave them some perspective around what people wanted.

Interestingly, even though Council had more accountability to the broader population (as a democratically elected entity), the shift in their prioritisation meant that the HIA had received less consideration. Conversely, the developers, who had a stable and ongoing stake in the community redevelopment as a hired entity, were more interested in considering the recommendations from the HIA. The ability of the HIA to affect the decision was therefore mitigated by the level of interest and relative power of the different decision-makers (a topic I discuss in full detail in Chapter 9).

Similarly, in their formal response to MTM (Welsh Government, 2020), Welsh Government accepted, either wholly or in part, all fifteen of the recommendations from the citizens' jury. In response to each of the recommendations, they describe ways that they are currently working to achieve the aim of the recommendation, such as through current projects, initiatives, or new pieces of research. However, all of the examples provided are in reference to work that had already been committed or undertaken by Welsh Government. The response states: "This report and the supporting recommendations help to identify where additional work is needed and how we can ensure that, at a national level, all people in need of care and support and all carers who need support are able to improve their well-being outcomes" (Welsh Government, 2020, p.25). However, it is unclear what 'additional work' will be done to address the issues raised through the recommendations. The response concludes that WG will continue to work with key sector stakeholders to "explore these recommendations in more depth and

to explore what further actions are needed" (Welsh Government, 2020, p. 26). While this suggests that policy action is likely to be in keeping with the recommendations, it cannot be said that they spurred new thinking or action from Government.

Rather than discussing specific examples of policies that were changing in response to the recommendations, a representative from the Welsh Government talked about the report feeding into a journey of improvement: "But yeah, I hope that the findings from the jury will kind of feed into policy and then, you know, help that improvement journey." This idea of the recommendations being part of an ongoing improvement process (as indeed they were just one part of several for the Act evaluation) perhaps explains why the WG response to the recommendations was more focused on what they were already doing rather than identifying new ways of working. Additionally, in agreeing with existing policy action, the CJ might have served to reinforce the current course of action. Whilst participatory processes are often thought of as opportunities to change a decision point (as I have categorised it in my typology), it is possible that they can also serve to reinforce existing policy actions (Andrews et al., 2022, p. 15). Whether this policy coherence also represents a lack of impact is contestable and is an issue I turn to in describing the impact of the final case.

7.4 Null impact

Unlike the other cases, Scottish Government representatives from 50K did not describe the HIA as having contributed significantly to the 50,000 Affordable Homes programme. Overall, they expressed that the findings of the HIA reiterated what they already knew, and the recommendations in the HIA report were similar to what they were already doing. Unlike MTM, in which decision-makers described the process as having some influence on the decision point (such as reinforcing policy actions or feeding into the policy cycle), decision-makers for 50K described the HIA as having no apparent impact. Nevertheless, policymakers described ways that the HIA had reinforced their course of action, acted as a reference guide for ongoing work, and supported current policies. One of the Scottish Government representatives explained:

… within Housing, we've come under fire across sort of cabinet discussions about why is all this investment going to housing…We can point to the strong pieces of evidence and say, 'Well, you know, we are having this impact'… So pieces of documents like this [HIA] are hugely helpful in that respect to having done a lot of that unpacking for us. And giving us that independence and objectivity through that process. So, you know, I certainly wouldn't want our comments or my comments to be interpreted as the report isn't helpful. It is hugely helpful in that respect.

As this interviewee highlights, the HIA was helpful in demonstrating how existing policy action positively affected health. This was useful to the policy analysts for justifying their work and affirming their course of action through a process seen as 'independent' and 'objective.' Furthermore, there were ways that the HIA had generated other follow-on effects that were relevant for improving health and housing policy which I describe below. Therefore, impact is less of a binary outcome that processes did or did not achieve and is more of an interpreted, perceived outcome that exists along a spectrum with 'direct' impacts on one end and 'distal' or 'diffuse' impacts on the other. Furthermore, a lack of direct impact did not appear to make the process any less useful within the broader decision-making context.

7.5 Follow-on effects

In addition to impacts on the intended decision point, interviewees described many ways that the processes had follow-on or unintended effects. Similar to the concept in chaos theory in which the fluttering of a butterfly can create unintended and immeasurable consequences (Vernon, 2017), there was evidence from most cases that the process had created unpredicted, positive outcomes.

In AB, interviewees described outcomes that had happened as a follow-on effect of the HIA process. For example, following the HIA, Airds High School began a civil works project with students. Students were asked to develop a plan for how they would like to see the town centre developed (see, e.g. Image 1) and were given support from members of the community who participated in the HIA along with the developers and Council staff. Nora, a community participant, involved in both the HIA and the civil works project, described how the HIA continues to feed into the project: "But again, the HIA is involved in there because we don't direct the kids (the children), but we can suggest 'have you thought about this? Or that?' And so the HIA is still in your mind. Things have been said from that. And that's been suggested to the children." Nora explained that because she had been involved in the HIA, she was aware of how certain aspects of redevelopment can affect health and health equity. This knowledge then becomes transferred and dispersed onto other community projects, like the civil works project, because she applies

what she has learned from the HIA to these activities. The students, in turn, gain some of this knowledge through their engagement with Nora.

Denise, a member of the HIA team, also stated that there had been subsequent community projects on arts and sports in Airds that had been developed as a consequence of the HIA: "I think for the [Housing] team, I think it really informed where we should go with our community projects. So we had the sort of focus for us afterwards, and two of the three [projects] can be, I think, attributed [to] the HIA". Additionally, the HIA team was awarded 'HIA of the Year' by the University of New South Wales and a peer-reviewed article on the HIA was written and published by members of the HIA team. Lastly, because the HIA is a standing agenda item for the community reference group (CRG), Nora felt that there would be future opportunities to continue using the evidence gathered through the HIA process to inform the redevelopment.

Similarly, for the CSP, some recommendations from the report were being applied across Council, such as providing more opportunities for shared decision-making. In 2019, Council commissioned newDemocracy Foundation (the CJ organiser) to undertake another citizen's jury to examine models of shared decision-making in Byron. This 'Byron model' aimed to develop a process to embed deliberative community-led governance into Byron Shire Council's decision-making. The final report of this process was presented to Council in 2019, and Council provided a formal response offering ways that they would fulfil the recommendations of the process (Byron Shire Council, 2019).

Despite the perceived limited impact on the intended decision point, participants in 50K provided a multitude of ways that the HIA had influenced other policies and programmes related to health and housing. A representative of a public health agency provided examples of myriad ways that the evidence from the HIA was being used towards informing other decisions[23] (see Table 4).

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[23] I reviewed these documents to confirm.

Table 4 Strategies, resources, and reports informed by the 50,000 Affordable Homes HIA (identified by interviewee)

– A learning resource for primary care providers on the connection between housing, health and homelessness
– Local authority response to the Scottish Government policy on Housing to 2040
– Local authority response to Scottish Government on consultation for the National Planning Framework (NPF4)
– Research done in partnership between the local authority, Rural Island Housing Association and a charitable foundation on the social value of affordable housing
– Contributing towards the Edinburgh Council local development plan with regards to the proposal for 20-minute neighbourhoods
– Used as supporting evidence in a recommendation that was made to the Scottish Government by a local authority on the National Statutory Guidance to Local Authorities on local housing strategies

As evidenced by the documents listed in Table 4, the HIA did not directly impact a policy decision but was part of the evidence and broader conversations using that evidence that were used to inform other housing policies. Louise, a public health stakeholder, described how the 50K HIA had follow-on effects on other health and housing partnership work:

> *So the findings of the audit really paved the way for us to have the conversation about how to strengthen health and housing within local housing strategies. And now, the health impact assessment is one of the key references within that. So in terms of, I guess, influencing national government and their role in working with local governments, you can see that that's flowing through into the policy position.*

Although the HIA had been intended to inform a single decision point, it continued as a helpful resource that Louise saw flowing through into other policy work. Hamish, another 50K participant, further explained that the follow-on effects of the HIA had continued to facilitate discussions between the health and housing sectors. He asserted that

colleagues in health and housing were gaining knowledge about both sectors and were developing critical points of contact. This led to new collaborative work, such as a Health and Housing partnership meeting[24]. Finally, Linney, a member of the HIA steering group, explained that the strength of the HIA was not necessarily in its ability to inform the decision directly but in its ability to be used for raising awareness on the intersection of health and housing:

> *So for them, it was much more awareness raising and trying to sort of feed it in wherever you could, and, you know, taking it to things like the meeting of Chief Officers, and other sort of forums like that, just to raise awareness of 'these are the issues, this is the document, please get in touch so we can come and speak to you about it.' It wasn't linear in terms of trying to say, 'this is a meeting where there's going to be a decision'; it was much more, can we sort of raise awareness generally of these are the things to think about?*

The effectiveness of the HIA, therefore, was in its ability to be flexibly applied across a wide range of policy documents, contributing towards changes to the overall decision-making context in non-linear and diffuse ways. Notably, one participant pointed out that effective strategies for cross-sector collaboration need to occur in tandem with evidence gathering. As Linney explained, "…it was a kind of mix of using it, where you're in a position to build relationships, but also, you've got quite solid evidence, and you're able to justify the things that you're saying. So I think you probably do need both." For Linney, the HIA provided a mechanism to combine evidence-gathering with collaborative work between the health and housing sectors. Despite the lack of direct impact on the intended decision, interviewees described the HIA as having far-reaching and unintended effects on a multitude of decisions related to health and housing in Scotland.

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[24] I was invited to attend this meeting and observed the cross-sector collaboration at work through what was covered in the agenda of the meeting and the conversations that took place on the day.

The cases' influence on policymaking could be non-linear and diffuse. HIA evaluations (Dannenberg, 2016a; Haigh et al., 2013; Wismar et al., 2007) have demonstrated that the ability of HIA to have an ongoing effect, that spans across multiple policies and types of work (research, commentaries, etc.), can be more influential overall than affecting a single decision point. Bringing health into the broad range of policy areas, known as health in all policies (HiAP), has been widely supported to address health equity (World Health Organization & Ministry of Social Affairs and Health Finland, 2014). There is evidence that HiAP approaches have successfully brought health equity prominence as a policy concern (Hall & Jacobson, 2018). Making health equity a policy priority is essential, as focusing on the social determinants of health alone can overlook the structural determinants of inequities such as power, unequal distribution of resources and discrimination (Graham, 2004). However, policy ideas are often contested, in flux, and can rapidly change as they are interpreted by actors and institutions (Cairney, 2020). An evaluation of a five-year HiAP programme in South Australia found that while health equity gained policy prominence in the early years of the programme, it quickly lost ground to other hegemonic ideologies (i.e. neo-liberalism) and competing political agendas (Van Eyk et al., 2017). Therefore, the ability of participatory processes to achieve long-term, sustained influence on policymaking for health equity may be limited by broader political contexts and agendas.

7.6 Other aims and outcomes

The previous section examined the decision-making outcomes generated by the processes. As I have described, these instrumental outcomes occurred across a spectrum in which participants perceived the process as achieving some type of direct impact on the decision point on one end and generating more diffuse, indirect or follow-on outcomes on the other. Public involvement has been described as encompassing a range of goals beyond instrumental aims (Abelson et al., 2007). These include process-oriented goals, such as improving the legitimacy of decision-making or processes that aim to increase participants' knowledge and capacity.

How interviewees described the outcomes of the process was often a reflection of what they perceived the aim to be. Using Abelson et al.'s (2007) typology as a launching point, I categorised the types of aims described by participants. Beyond policy outcomes (i.e. informing a decision), participants, organisers and decision-makers described participatory goals (e.g. giving the community a say, improving shared decision-making); epistemic goals (i.e. developing knowledge on a subject); technocratic aims (e.g. making a case example of the process); or institutional ambitions (e.g. improving community trust). Figure 35 demonstrates how the perceived aims of the processes differed among the different roles of interviewees (participant, organiser, decision-maker) and how these compared to the perceived non-policy outcomes of the processes. Whether or not the process was perceived to have been successful depended upon what the interviewee thought the process would achieve and if this aligned with the non-policy outcomes of the process. Below I examine how these various non-policy goals were perceived as being accomplished through the process.

Figure 30 Summary of interviewee perceived aims of the processes and reported non-policy outcomes

	Participant aims	Organiser aims	Decision-maker aims	Non-policy outcomes
Community Solutions Panel	− Improving community engagement − Identifying solutions to infrastructure spending prioritisation	− Improving democratic decision-making − Citizen empowerment − Making a case example in Byron	− Providing opportunity for shared decision-making with the community − Informing a "wicked problem" − More balanced community input	− Shared decision-making & community engagement − Improved understanding of and trust in Council

Airds Bradbury	– A new approach to community consultation – Community ownership and influence over the redevelopment – Demonstrating health impacts	– A new approach to community consultation – Integrating community needs into the redevelopment – Influencing the redevelopment – Demonstrating health impacts	– Integrating community preferences for the redevelopment – Ensuring positive health impacts	– Improved community participation – Hearing/voicing community needs – Better understanding of health impacts – Improved relationship between community and decision-makers
Measuring the Mountain	– Informing social care: information generated through the jury would feed back into the Act – Piloting a Citizen's Jury	– Informing social care: information generated through the jury would feed back into the Act – Demonstrate the usefulness of a citizens' jury – Provide opportunity by which "people's	– Generating knowledge for decision-making: gaining a deeper understanding of the lived experience of social care as well as generating ideas on how this could be improved.	– New knowledge for decision-making – Demonstrated willingness to conduct participation

		– voices [would be] heard." – Generate a conversation about improved social care		
50,000 Affordable Homes	– Demonstrating link between government programme and public health – Piloting an approach to HIA	– Identifying health impacts – Influencing the implementation of the programme	– Identifying health impacts – Influencing the implementation of the programme	– Better understanding of health impacts

Participatory Goals

In several cases, interviewees described ways that the process helped to achieve a participatory aim, such as enhancing shared decision-making or providing an opportunity for community members to 'have a say' in the decision. For example, in AB, the developers stated that they saw the HIA as providing a venue for community consultation. A formal consultation process had not yet been conducted for this stage of the redevelopment because it was not finalised. But the developers saw the HIA as being able to provide community input into the formulation of the redevelopment planning. Harrison, one of the planners, explained the value of this process: "So they do have an opportunity to voice their opinion. And in my mind, that's what the HIA report does. It's part of that feedback to say, well, this is what the community is interested in".

Similarly, one of the stated aims of the CSP was to trial an approach for shared decision-making and community engagement in Byron. Many participants expressed in interviews

that the process had felt like a 'genuine effort' from Council to engage in more meaningful community engagement. Keith, one of the panellists, explained: "My early thoughts, I said going in, were one of slight pessimism. But yeah, I found that you know, that was wrong. In the end, that it was a genuine sort of effort by the Council to engage." Despite his initial perception that Council might be using the CSP to pay lip service to community engagement, his experience of the process was that it was a genuine effort to engage the community in shared decision-making.

Most interviewees felt that the CSP had improved co-working between Council and the community. Terry, one of the panellists, explained: "But I think by the end of that, they had seen the benefit, which we all had, of working together and being able to negotiate and synthesise our ideas and get to a common place of understanding which was good. And elected Councillors themselves were a lot more on board." Importantly, it was not just participants who had learned more about Council governance; the Councillors had also developed a common understanding with the community that could help to enhance shared decision-making. Harris, one of the panellists, further explained that the collaborative approach used in the CSP enabled a shared approach to decision-making between Council and the panellists:

> It wasn't 'shut up and do what you're told. Shut up. Listen to us. Get out of the way. You're wasting our time.' It wasn't that; it was, 'Okay. Come and tell us what you think. Oh, this is what we think. What do you think?' It's that collegiate, not necessarily cooperative, but collaborative, collaborative, and consultative. And it gave them another; it expanded their database because they were getting all this other information that was hidden from them. And us, too.

As Harris describes, shared decision-making was achieved not just from the Council learning about the needs of the community members but also through the panellists learning about the needs of Council. The final report of the CSP concludes with a similar assertion about the value of shared working:

> *The panel concludes with this observation: that communities thrive when they are given time and authority to develop their own assets. Community members are willing to own their community's problems and issues. Having accepted that it is a shared community problem, community members will be more likely to work together to develop a solution, and a solution is likely to be better than one provided solely by external experts (Byron Shire Community Solutions Panel, 2018, p. 14).*

The Council Delivery Programme and Operational Plan reflects this desire for more shared decision-making and makes explicit commitments to grow in this area. It also provides several actions to achieve shared decision-making in the Delivery Programme. Furthermore, Sallyann, one of the process organisers, explained that the process had the potential to lead to broader embeddedness of deliberative processes in Council:

> *… having come from working within councils and seeing what would often happen is, you know, you go through a project like this, it would finish, and then it would just be back to business as usual. Council of Byron was one of the few times that I actually saw that potentially that wouldn't happen. And I think it would have been really fascinating to watch as they go through this second project with nDF now, whether those commitments to deliberative processes internally have been embedded and whether the staff are now deeply engaging with them. My hope is that they probably are.*

Through conducting processes like the CSP, Sallyann asserts that there is greater potential to embed this type of shared decision-making and community engagement in Council.

Similarly, interviewees from AB described many ways that the HIA had achieved participatory aims, including bringing awareness of issues relevant to the community to decision-makers, facilitating conversations on some of the issues important to the

community and providing legitimacy to residents' concerns. Susan, a member of the HIA team, asserted that the HIA had increased the legitimacy of residents' views to decision-makers: "I think they [decision-makers] always did sort of listen, but I think it gave more of an impact of what we were saying. It gave us, I don't know the right word, the more, not validity, but more foundation of where we were coming from, if that makes sense". As a process that elicited input from the community, the HIA was used to provide an evidence base to explain to the developers what the community wanted for the redevelopment. In turn, by providing this evidence, some of the participants saw this as a way to make the redevelopment more responsive to the community's needs. Pat, one of the HIA team members, explained: "It's not about how attractive it looks or how good the Wi-Fi is, but it's about that it's there for me. To be used by me. That's the sort of ownership that people want". Through conducting the HIA and providing this information to decision-makers, Pat asserted that the redevelopment could be more appropriate for the community.

The decision-makers similarly echoed the value of the HIA process in providing a forum to hear from the community. Harrison, one of the planners, asserted: "So I think this stands out as something that really was able to get the community's voice heard early on." Decision-makers asserted that open communication and dialogue were essential elements in helping the community to feel that they had been heard and understand how their input had been taken into consideration. Harrison further explained:

> *Well, look, for me that's the important thing is the response. Means that someone's heard you and taken the time to respond. Okay, whether that response, we agree with everything or disagree, at least it's providing response to the community and saying, 'Yes, it was considered'. So even if we do disagree, it was considered, and here are the reasons why.*

As discussed in Chapter 6, for some participants, feeling 'heard' by decision-makers rather than just 'having a say' was a crucial step in the empowerment process. Harrison asserts that even though their feedback might not be formally adopted, the HIA provided a way for community feedback to be acknowledged and considered.

This opportunity to share community feedback was valuable to decision-makers and community members. Some participants expressed that the scope of the impact of the HIA could extend beyond the participants directly involved in HIA to the broader community. Susan, a member of the HIA team, explained:

> *I think it made it more visible to people. It's something that they could see. And by knowing what we did in the HIA, the issues we discuss, the research that we did with that because it gets reported back to the community, they know even if they're not coming to a meeting and doing what, like what I do in a meeting, they know they're getting heard.*

For Susan, the HIA process could enable not just those directly involved but the broader community to feel that they 'had a say' in the redevelopment.

Epistemic goals

Several interviewees described how the process generated new knowledge or insights. In particular, Laura, a representative from Welsh Government, explained that the report provided a mechanism for gaining initial insights into the lived experiences of social care users: "It was kind of a really good first step for us to look into what it was like for people." Furthermore, she explained that as an observer of the process, she had gained insight and knowledge about what was working and how social care delivery could be improved: "And the third day for me was quite inspiring to hear about ways people are working with it. So yeah, I guess that's something that was quite interesting as part of the process is that, you know, people are kind of doing what they can to kind of make things better for the people who are receiving care." The CJ provided a way for her, as a policy analyst, to gain insights into the lived experience of social care users, knowledge which would be helpful for her work on the evaluation of the Act.

For her personally, learning about the lived experience of social care and hearing examples of good practice had motivated her to continue improving the Act. "It probably

made me feel a little bit more passionate that we need to do something. We can't just let this carry on. I think that's probably true of the whole project, the stories and the jury. I think I didn't view any differently [her work], but what they were saying made me feel quite uncomfortable and that something needs to change." Though, as I described above, the CJ did not change any of the existing work being conducted by WG, Laura highlights how it still emphasised the value of improving the Act. Only two other people from her policy team had observed the process, and she commented that had more of the policy leads observed the citizens' jury, this might have had more of an effect: "I feel like if they were there to listen to the, you know, experiences and to listen to the witnesses and, you know, hear those recommendations firsthand, I think that would probably have more of an impact." Therefore, the value of the CJ was not just in the recommendations produced through the final report (as I have stated, these did little to change WG's actions), but in its ability to elicit deeper understandings of social care – knowledge that could continue to be useful beyond the scope of the Act evaluation. This reflects more nuanced understandings of policy formation in which policy actors' interpretations of the problem – based on past experiences, knowledge and emotional responses – form the basis of how they act (Barnes & Prior, 2009) (what Wagenaar and Cook (2003) refer to as 'situated judgements'). Therefore, by working towards an epistemic goal (understanding social care users), participatory processes can also affect, in diffuse ways, the policy decision.

In both HIAs, the evidence generated through the process was described by participants as being useful in several ways. The AB HIA compiled evidence on health impacts that decision-makers described as contributing towards their understanding of health and the built environment. In 50K, Jeremy, a member of the HIA steering group, explained that the knowledge he gained through doing the HIA was useful for supporting his work:

> *…it helped me crystallise in my mind how a significant housing programme such as this can impact on health, and you know, I hadn't considered all the various mechanisms. And so in that perspective, it's very useful for me in my organisation to be able to take that evidence back to my own organisation and affect other projects and programmes that we do.*

Similarly to Laura from WG, stakeholders involved in the 50K HIA could use the knowledge gained from the HIA process to support broader ongoing work on health and housing.

Technocratic aims

Several interviewees described how the process helped to make a case for a particular participatory approach. In MTM, the process organisers asserted that the CJ had been helpful in demonstrating the benefits of conducting citizens' juries as a type of participatory process. They hoped that demonstrating its usefulness would lead to more citizens' juries in the future. Similarly, participants from 50K asserted that the HIA had demonstrated the usefulness of conducting an HIA on large government programmes. Hamish, a member of the HIA steering group, explained: "I guess because it's a big programme and it probably ought to be subject to some kind of health impact assessment." By conducting the HIA, Hamish asserts that it helped to validate the normative position that HIAs should be conducted for policies and government programmes that have the potential to affect health.

Institutional ambitions

The aim of the CSP was not just to inform Council's spending on infrastructure but to improve the relationship and enhance trust between the community and Council. Interviewees stated that a significant outcome of the process had been a change in panellists' understanding of Council processes and challenges. Through learning about infrastructure spending and Council revenue, panellists gained a more nuanced and comprehensive understanding of the challenges of the Council. They therefore were more sympathetic to how they take decisions, leading some even to defend Council actions. Panellists expressed that through their interactions with Councillors, they were able to have more human and personable interactions and understanding of them. This change in their perception of Councillors then seemed to help participants feel more comfortable and confident in Council. According to one of the CSP organisers, Sallyann, the process was designed to provide a space to allow this shift in understanding to occur:

...they would go through one of these juries or panels where, you know, on day one they'd come in and there'd be a healthy degree of 'Council is full of shit, they don't know what they're doing, they're just a bunch of bureaucrats sitting in an office and I can fix this problem in the next half an hour', or some variant thereof. And watching them over the course of four or five, six sessions over many times, that they would come in, and they would learn about some of the issues that were facing with Council, they'd start to see it from the different perspective, they'd start to feel some empathy for the people in the Council. It'd start to shift and then you'd almost hear the language change, and you'd go from it being 'them' and 'they' to it being 'we' and 'us.'

Through engaging with the challenges of Council decision-making in a deliberative setting, it seems that participants broadened their perspective of Council governance. This in turn, led many participants to feel an enhanced sense of empathy for the decision-making process and with Councillors. As Alan, one of the panellists, explained: "I certainly have a very clear understanding of how the Council operates, and I have a lot more sympathy for the Councillors and the people who work on the Council than I had prior to getting involved."

Participants described how they had developed trust in decision-makers and Council more broadly through participating in the CSP. Keith, one of the panellists, explained that the CSP had led him to feel more trust for Council: "… all those Councillors do hold, you know, beliefs at heart that they want to do better things for the community. So I'm not sceptical of their intentions." Notably, a significant contributor to this trust in Council seemed to stem from the fact that Council was willing to take on the recommendations provided by the panellists. Doug, one of the panellists, asserted: "I definitely got the impression that the Councillors were fair dinkum [honest and trustworthy] when they said, we're going to get this, and we're going to implement what you say." This perception that Council would implement the CSP recommendations contributed towards a positive view

of the Council by participants, thereby helping to achieve an institutional goal of the process.

Interestingly, one of the benefits of the process described by a decision-maker for MTM was that the citizens' jury provided a platform by which Welsh Government looked like it was listening to people.

> *But it also, you know, shows people that Welsh Government are willing to invest money and invest time and listen to people who want to tell us about their experiences. So I think it was good for us. But also, hopefully, it kind of demonstrates that we do want to listen to people and we are kind of willing to engage with people in ways such as this.*

In this case, the institutional aim was symbolic and performative: not just to conduct the process but to demonstrate to people a willingness from Welsh Government to listen to feedback on the Act.

Interviewees from AB also discussed how the HIA had built positive relationships between the decision-makers and residents. Susan, a member of the HIA team, explained: "I think it deepened the relationship there, made it more...I don't know the word…substantial, I suppose. Because it showed the depth of commitment on our part, and how we were willing to work with them [decision-makers] with it." She asserts that the HIA demonstrated the willingness of members of the community to work with the decision-makers on the redevelopment. This enhanced their relationship because decision-makers better understood the community's needs and were willing to work with the community to address these needs. In turn, community members came to trust that the decision-makers would act on the information they provided. Susan further explained: "So I think it's more a case, they're paying more attention. And actually doing these things, putting them into practice, and with us. And that helps, it helps a great deal."

For Susan, the HIA helped to achieve collaborative working between the decision-makers and members of the community. However, this feeling was not shared by all interviewees. Nora, one of the participants, asserted that this had not been achieved partly because that was not the aim of the HIA. She explained:

> *No, because I don't think it was designed to do that. I don't think that was, I want to say, design, but that's not it. I don't think that's what it set out to do. It was to make them aware of how it was, how this process, the whole process was affecting people and how their decisions for the future of the area would affect the health of people, but not necessarily to improve any relationship we had with them.*

For Nora, the HIA process was not intended to change engagement between participants and decision-makers, and she did not see evidence of this having happened. Instead, the HIA had been useful for bringing forward information that had achieved other epistemic aims (knowledge about how the process would affect people's health). This demonstrates the versatility of interpretation by participants, organisers and decision-makers of the different aims and outcomes of the processes.

7.7 Conclusion

The participatory processes examined in this research generated impacts on decision points across a spectrum ranging from direct effects to distal, indirect and follow-on outcomes. Furthermore, the processes generated outcomes aligned with technocratic aims (which participatory technologies typically aim to achieve) and other epistemic, participatory and institutional goals. Though evidence on public participation often focuses on perfecting the form to achieve technocratic outcomes, this research found that processes can achieve myriad aims and goals that can contribute towards broader decision-making outcomes. Therefore, processes should focus less on getting the form right to achieve technocratic aims and more on ensuring that expectations align with outcomes. This calls for clearer articulation by participants, organisers and decision-makers about what they expect the process to achieve.

In the following chapter, the last of the chapters focused on outcomes, I examine how personal and governance outcomes can generate changes for health and health equity. Despite limited evidence of direct improvements to health via the decision point, changes associated with the other aims and goals of the processes may influence the social determinants of health and have the potential to improve health equity.

CHAPTER 8   HEALTHY PUBLIC POLICIES AND PERSONAL BENEFITS: THE HEALTH EQUITY OUTCOMES OF PARTICIPATION

8.1 The challenge of attributing health equity to participation

As discussed in Chapter 1, public participation has been supported as an approach to improve community health through intermediary changes such as empowerment, yet there remains limited evidence of the direct effect on health outcomes (Milton et al., 2012). An issue with attributing health improvements to public participation is that identifying changes in health status requires long-term monitoring and may not be measurable over a single participatory process. Furthermore, positive health outcomes are rarely attributable to a single non-medical intervention (Smith et al., 2014), and public participation is generally not designed as a linear, direct intervention but rather consists of a series of complex interactions (Milton et al., 2012). In line with these challenges, this research did not identify direct health changes resulting from the case studies. Participants generally did not attribute changes in their or the community's health to the process (with a few exceptions); rather they focused on how the process had produced changes to the intended decision and the personal benefits they derived through their engagement.

Many of the benefits participants described (see Chapter 6) reflect the types of benefits claimed to arise from deliberation, particularly the development of civic skills (Dahlgren, 2006; Fishkin, 1997; Gastil, 2000), and others embody dimensions of social capital or empowerment. Empowerment, civic skills and social capital are broad (and contested) concepts that have been studied through the lens of various disciplines, and there is evidence of the health benefits of increasing these dimensions through public participation (Haldane et al., 2019). Rather than seeking to demonstrate any direct effect of the case studies on individual or community health, in this chapter I explore the

capability of the processes to impact health through two main routes: changes to decision-making that align with the creation of healthy public policies (via the social determinants of health); and participant outcomes including civic skills, social capital and empowerment.

8.2 Healthy public policies

As discussed in Chapter 1, it is widely acknowledged that health and health equity are supported through equitable access to the social, environmental, economic and political determinants of health (Marmot et al., 2008). Actions to increase health equity, therefore, require consideration of how health is affected through public policies that span multiple sectors and levels of governance (World Health Organization, 1988), often referred to as health in all policies (HiAP) (World Health Organization & Government of South Australia, 2010; World Health Organization & Ministry of Social Affairs and Health Finland, 2013). Decision-making that integrates community needs and health equity impacts can benefit health (Marmot et al., 2008; Wise et al., 2009; World Health Organization & Government of South Australia, 2010). As discussed in Chapter 3, all cases were selected due to their relevance to the social determinants of health. Theoretically, each case had the potential to affect a change that could benefit a social determinant: affordable housing; public infrastructure spending; social care; and town centre redevelopment. As discussed in Chapter 7, there was not always a direct impact on decision-making, and this research did not evaluate whether a policy decision affected community health. Yet even in cases with an indirect or limited impact, there was still the potential to affect health through more distal changes, such as changing the way decision-makers think about health and health equity.

As described in Chapter 7, there was evidence of a direct change to the decision point in the CSP; an indirect effect in AB and MTM; and distal changes for 50K. Yet despite the lack of a direct change, interviewees in the cases provided examples of ways that they believed health and health equity could be affected through the process. This was achieved not just through changing the decision point (as this was only moderately achieved), but through changes brought about through other participatory, epistemic and

institutional aims of the processes. In the following section, I examine how health and health equity could be affected through changes in decision-making for each of the cases.

Airds Bradbury

Interviewees from AB asserted that providing the decision-makers with information about how to improve the redevelopment had the potential to improve health equity. Alice, a member of the HIA team, explained:

> *…if they were to consider even some of the recommendations and implement them within the implementation of the, or delivery of the redevelopment, I think that it definitely would have health and health equity considerations, and therefore, like outcomes: improved health and health equity.*

The final report of the HIA identified potential health benefits and risks associated with the redevelopment and offered recommendations to address these. Members of the HIA team believed that by providing this information, decision-makers could improve these aspects of the redevelopment and therefore improve health and health equity in the Airds Bradbury community.

Decision-makers from AB supported this by asserting that the HIA had helped them to better understand how the redevelopment affects health and health equity. Harrison and Tom, representatives from Infrastructure NSW, explained that the HIA had made them more aware of how changes in the built environment affect the local community's physical and mental health. They explained that beyond broadening their understanding of the social determinants of health, they would use that information to make decisions about the redevelopment. Additionally, Chad, a representative of Campbelltown Council, explained that the HIA could bring in a more explicit health perspective that had been previously missing from discussions about the redevelopment. He explained: "No, I don't think it was redundant because it brought in the health perspective. A lot of the work was around social health but wasn't necessarily defined as that. I think the Health Impact Assessment made that really explicit."

The fact that the HIA had identified health impacts and offered recommendations to address them helped to articulate health and health equity more explicitly than before. This helped the developers shift their thinking from health on an ideological level to being able to make more tangible decisions that could benefit health. Chad further asserted that participation in the HIA was essential for ensuring residents informed the redevelopment: "Yeah, from perspective of social determinants of health, just participation itself is a really important thing, in the sense that people have got some say about where the suburb's going to in the future."

Chad mentions the 'social determinants of health' as a rationale for including residents in the redevelopment design. Not all theories of the social determinants of health include participation as a social determinant, instead focusing on other fundamental causes, such as socioeconomic status (Phelan et al., 2010). Therefore, Chad's recognition of the HIA process as a route towards affecting the social determinants of health reflects his belief in the potential of the process to improve the redevelopment in a 'healthy' way. Similarly, a few participants, in this case, asserted that their participation, in and of itself, could have health benefits. Susan, a member of the HIA team, asserted: "I think there's a lot of benefits, because one of the things we've learned with being a voice in this and being heard, it reduces a lot of the stress and a lot of the health problems". Susan explained that having the opportunity to participate and have her concerns 'heard' by the decision-makers via the HIA helped to reduce stress related to the redevelopment (stress, perhaps, from the fear that the redevelopment would not provide the community what they needed) and through this would have health benefits to her.

Byron Shire Community Solutions Panel

The CSP had the most direct impact on the decision, with Council adopting the recommendations made by the panel. Though there was less recognition by the decision-maker about how this could affect health and health equity, the panellists acknowledged the relevance of infrastructure to community well-being in the final report. They stated:

"Infrastructure enables positive health outcomes for our community and visitors. Positive health includes physical, mental, emotional, spiritual and social components" (Byron Shire Community Solutions Panel, 2018, p. 8). While health and well-being were values that informed the overall approach to the Panel's deliberation, safety and risk were prioritised as critical considerations in their recommendations to Council. There was evidence that the prioritisation of safety as a health issue was being integrated into Council decision-making. Diane, a representative of the Council, explained:

> *The panel's number one criteria was safety and risk: that is something that has filtered across the organisation…. A couple of weeks ago, there was a landslip. Council have made decisions…by closing it. We've got a Geotech report that says there's a 50/50 chance of it failing, and Council said, 'That's it, safety is our number one priority', which it should be always, but I think that report from the solutions panel really emphasised that.*

The fact that the panel had made safety its number one priority meant that Council had additional leverage to support their decision-making on safety and risk issues, thereby improving community health. Strategies that affect health and well-being at a population level (rather than individual-level change) have been shown to be effective in improving health equity (Carey et al., 2015).

Measuring the Mountain

Given that the citizens' jury was part of an ongoing evaluation by the Welsh Government of the Social Services and Well-being Act, it is hard to judge what impact, if any, the recommendations had on health, well-being and equity. The overall aim of the Act is to improve the well-being of people who need care and carers. The Act defines well-being as "physical and mental health and emotional well-being" (Welsh Government, 2014, p. 5). Therefore, any contribution towards improving the Act could be viewed as beneficial for well-being. Doug, one of the process organisers, similarly expressed the view that activities that serve to empower communities, such as a citizens' jury, can serve the ultimate aim of improving community health:

> *I absolutely believe communities are able to deliver lots about themselves… if we supported communities to do things differently. So from a health perspective, you know, it's often been my position and often when I've talked to health leaders across the board, that if actually, we empowered our communities to become places where people grow their health, actually, we wouldn't need this constant provision of health services in the way in which we've delivered it.*

Doug asserts that the empowerment of communities can be a strategy to improve health and reduce reliance on care delivery. However, as discussed in Chapter 6, it was clear that not all participants felt empowered by the process, nor had the recommendations demonstrated a clear impact on the legislation. Furthermore, jurors and the representative from the Welsh Government asserted that the information provided by the citizens' jury wasn't necessarily new, rather, it supported existing actions being taken by the Government to improve the Act. Therefore, it is not clear to what extent, if any, the citizens' jury had made an impact on improving health and equity via the Act. Rather than producing health improvements via technocratic change, there is possibly more opportunity for change through process outcomes (i.e. benefits from participation), which I discuss further below.

50,000 Affordable Homes Programme

Given that the HIA appeared to have a limited impact on the 50,000 Affordable Homes Programme, it is unclear to what extent this might have more broadly affected health outcomes in Scotland. Even if there had been a more definitive impact on the programme, assigning causation of health outcomes to an HIA is extremely difficult to do and is generally not considered within standard HIA evaluations (given the complex and interconnected relationship of health determinants). However, as described in Chapter 7, participants highlighted how the HIA had contributed to other distal work and was being used to support ongoing consideration and integration of health and housing. Jeremy, a member of the HIA steering group, stated that the HIA was important for identifying the

relationship between health and housing and the relationship between housing and health inequalities:

> *So those are some of the things that we identified in the health impact assessment… things that we know are relevant to health inequality, such as, you know, housing affordability, or homelessness, or housing condition, or energy, or energy efficiency, etc. All of those are pretty fundamental to reducing health inequality. So it definitely helped, certainly helped me and my team to see and understand the connection between housing and health and between housing and health inequality...*

Calls for action on the social determinants of health (e.g. Marmot & Bell, 2012) expressly point to interventions in policy areas outside the health sector, such as housing. Similarly, a HiAP approach encourages the consideration of health across a range of policy areas that are influential to health, including housing. By increasing the understanding of the relationship between health, housing, and health inequalities, Jeremy is better informed to take action in these areas. And indeed, he elaborated that the evidence provided through the HIA had supported his ability to do this cross-sector work:

> *I suppose it's really helping us to understand the different facets of how housing impacts on people's health. To have been able to understand all of these different processes. And so being able to understand that then, you know, it makes it much clearer about where we need to intervene and where we need to focus some resources or maybe do things a wee bit differently.*

Similarly, several participants stated that the HIA contributed to growing cross-sector engagement between health and housing. Hamish, a member of the HIA steering group, explained how increased interaction between the public health and housing sectors was helping to strengthen relationships, develop a shared language and achieve shared agendas, all of which are key strategies of a HiAP approach (Greszczuk, 2019):

I think there's two aspects to that. One is just the simple proximity. You're seeing in front of you somebody who's just in a senior position in Public Health Scotland whose job is to talk about these things. No, they don't crop up day to day…So there's that kind of straightforward personal contact is absolutely critical. And the other side of it is in conversation, that development of shared agendas, all of a sudden, you start to understand that, not that nobody ever didn't understand it, but you're plugging away trying to do something about improving our housing supply or improving housing conditions. But there are other folk with interest in those outcomes too, other ways of looking at what you're achieving when you do that.

A key strategy of HiAP is cross-sector engagement and the development of 'win-wins' (Molnar et al., 2016). It is possible that developing these relationships and strengthening this collaboration through the HIA may be effective in the long term for achieving improvements in housing which in turn improves health equity.

Though none of the cases identified direct changes to individual or community health, there were clear opportunities for health improvement through changes to the social determinants of health and strengthening of health in all policies. Furthermore, interviewees highlighted the role that participation could play in improving health – enabling participants to 'have a say' therefore alleviating anxiety about a decision, or empowering participants. Below I will further examine the benefits that participants described arising from their participation and the potential health benefits of three primary outcomes: increased civic skills; enhanced social capital; and empowerment.

8.3 Personal benefits and health

Participants described personal benefits arising from their involvement in the case studies. These included new skills and knowledge; new connections; self-esteem; pride; and feeling like they were making a difference. These positive instrumental, internal and

external benefits are common outcomes of participatory processes, and a systematic review found positive health benefits associated with some of these outcomes (Popay et al., 2007). Below I examine how the development of civic skills, social capital and empowerment could lead to health and health equity benefits.

8.4 Civic skills

Participants in the cases expressed many ways that they had acquired civic skills. They described acquiring new knowledge and skills, as well as a variety of ways in which they became more engaged in civic activities. Although the particular knowledge or skill varied from case to case, participants consistently gave examples of how they acquired these through participation. Susan, a member of the AB HIA team, explained:

> *But even now, it's like that, I've learned something. And it's there. And I can't unlearn it. So it's now a part of my life type thing. And I think in some ways, I probably look at things a little differently because of that involvement, more in depth than having somebody else go do it.*

Susan asserted that she had learned not just about the HIA process and the various health impacts of the redevelopment but also new 'lingo' and 'education around health'. Participants in the other cases similarly gave examples of knowledge they had learned, such as how Council take decisions; how social care is delivered in different sectors in Wales; or how health and homelessness are connected. In addition to technical knowledge, participants described how they had acquired new skills. Participants described skills associated with deliberation, such as public speaking and getting "your point of view across."

Participants also described ways that they had learned from each other. This peer learning allowed them to draw on the other participants' various expertise and broadened their own understandings. Terry, a panellist in the CSP, explained:

> *And then other really good part is just having a very broad, diverse range of people from the community and hearing all the different*

perspectives, which again, enabled all the other people who hadn't considered those things… getting people from all the different walks of life in one room together, I think made a lot of people realise that just viewing local issues or policy through their own lens can lead to a narrowness of understanding or being a bit myopic in how you think about things. So definitely, that broadening of perspectives, I think, probably the best thing for the group as a whole, as individuals, to have gained from one another.

For Terry, the opportunity to broaden his perspective to understand different community members was the most valuable outcome of the whole process. Participants in MTM also reiterated the importance of this group learning. For several participants, a key outcome was learning that there were similarities in the experience of social care across Wales and using this to identify critical issues with the Act.

In addition to gaining new skills and knowledge, some participants described how they became more civically engaged. Bret, a panellist in the CSP, had become particularly involved in local politics after participating:

And so I thought, okay, well, why not try to give it a go getting interested in the politics and so on. And actually, I got a bit hooked, I got a bit hooked. So I've been starting to read the newspaper. And then even after participating to that community panel, I've been following different issue…so I'm getting more involved into the subject, which I wasn't really before. So yeah. I feel personally more involved in all this.

As part of this involvement, Bret had started writing letters to the local newspaper and Council, monitoring Council's decision-making, and advocating for local issues. He explained that the reason for his engagement was that he had learned that his actions could make a difference:

So for almost, especially for the politics, the Council, the infrastructure itself…and then I understood that actually, it was possible to change things. Because you can write letter you can write to the Council, you can call them, they're not that far, actually, if people wanted to get more involved. And the people just understood that a letter can actually make a quantum, like a big difference. Well, I think they'd write more. Because I've been writing more as well.

Bret was one of the panellists who presented the CSP findings to Councillors. He explained that the experience of participating in the CSP and speaking with Councillors helped him realise that Council decision-making was a much more open process with opportunities for citizens to inform their decisions. This new understanding of his ability to influence local decisions galvanised him to become more civically involved.

Similarly, Harris, another panellist on the CSP, explained how the process had led him to feel like an active citizen:

Just feels like you're being a citizen, and not just being harvested or not just being used. You feel like you're part of your government. Remember, in a democracy… a democracy means different things to different people. But I always liked Abraham Lincoln's Gettysburg Address, where he spoke about government, of the people, by the people, for the people. And that's what it felt like. I was of, by and for, whereas a lot of other democracy in Australia is very much about politicians and about vested interests. But it's not about the people.

The CSP allowed Harris to directly engage in Council decision-making. He was also one of the participants to present findings to Councillors, and it seems that this opportunity of engaging directly with them, like Bret, led him to feel like he had more ability to influence decision-making. Being more politically involved, in turn, led Harris to feel like an active citizen.

Jeremy, a participant in 50K, also discussed how the HIA process had enabled him to be more politically efficacious with his professional work:

> *But as I say, it also allowed me to be much more confident and*
> *explicit…with policy leads in government about how I thought they*
> *should be developing strategies --plans for the future around this--*
> *to have an impact on health, which is ultimately what my job is.*

Having the evidence that the HIA provided had given him increased confidence to discuss housing strategies with Scottish Government policy leads. This political efficacy could, in turn, advance his work focused on health and health inequalities.

Citizens juries have often been promoted as a way to enhance active citizenship (Smith & Wales, 2000), and an evaluation of HIAs found that they were effective at increasing skills, knowledge and relationships necessary for enhanced civic skills and collective civic agency (Charbonneau et al., 2015). Participants in the CSP gave more examples of ways they were politically active following the process than did participants in other cases. Although, as Jeremy in 50K demonstrated, participants in the other cases used their experience to enhance their political efficacy in other ways.

It has long been established that civic skills are essential for public and political participation (Verba et al., 1996). Individuals gain knowledge and skills such as leadership, public speaking, assertiveness, and negotiating through organisational membership (Green & Brock, 2005; Putnam, 1993; Skocpol, 1999), and organisational membership can increase interest in public affairs and prepare individuals for political participation and other civic activities (Green & Brock, 2005). The purported benefits of deliberative technologies include various civic, social and interpersonal outcomes. It is claimed that citizens become more active in civic affairs (Barber, 2003); tolerant of opposing views (Chambers, 2003; Gutmann & Thompson, 1998); better able to identify and justify their preferences (Chambers, 2018; Gutmann & Thompson, 1998); develop

faith in democratic processes (Fishkin, 1997); and raise participant's interest in politics and engagement in political activities (Gastil, 1994, 2000).

The development of civic skills can in turn improve health equity. Increased education, including skills, expertise, and reasoning abilities, has been linked to reductions in health inequities among low-income or racial and ethnic minority populations (Hahn & Truman, 2015). Democracy is theorised to be a determinant of health (Browne & Leckey, 2022) and civic agency is often construed as improving health through social capital (Kawachi, 1999). Enhanced civic engagement is viewed as a strategy for improving health equity by increasing the capacity of disadvantaged communities to advocate for policymaking that addresses their needs (Cacari-Stone et al., 2014) and improving civil rights (Hahn et al., 2018). Therefore, through increasing civic capacity, the participatory processes have the potential to reduce health inequities.

8.5 Social capital

There is strong evidence to demonstrate the health benefits of social capital (Kawachi, 1999). Trust, norms of reciprocity, and civic participation – elements of social capital – can enable coordination and cooperation of communities which in turn improve community health (Ehsan et al., 2019). Social capital has the ability to enhance collective control and empower communities to challenge unhealthy conditions (Whitehead et al., 2016). Social capital has been found to decrease community-level mortality rates (Choi et al., 2014), decrease illness (Hu et al., 2014) and is considered a protective factor for mental well-being (Almedom, 2005; De Silva et al., 2005; Ehsan & De Silva, 2015). The positive effects of social capital are also more pronounced in low socioeconomic and minority groups (Uphoff et al., 2013) making it an intervention supported for decreasing health inequities (Whitehead et al., 2016). Public participation has the ability to strengthen relationships and trust, what is known as 'bonding social capital' (Milton et al., 2012). Community engagement that increases social interaction (an element of bonding social capital) has been shown to improve community members' health and quality of life (Popay et al., 2007).

A common outcome for participants in the cases was feeling like they were more connected to their communities. Alan, a panellist in the CSP, explained how the process had given him the opportunity to become more involved:

> *So this has been really interesting though, to find out how the Council operates, what initiatives are in the pipeline and to meet another whole bunch of people in the community and get involved. Really get involved. And I've met some of the Councillors. Really, a wonderful opportunity to immerse myself more in the community.*

The CSP gave participants an opportunity to learn about Council governance and interact directly with some of the Councillors. This direct experience led Alan to feel like he was more involved and 'immersed' in his community. Similarly, the process of informing a local community decision led participants to feel more engaged. Kaylee, a community participant in AB, explained: "Yeah, cuz it makes them part of the community. Like it makes them… really felt like a sense of belonging in that they've actually given an opinion to what could happen down here [with the redevelopment]." Kaylee believed that reflecting on what the community needed and providing input into the redevelopment had enabled participants to feel a sense of belonging to their community.

Similarly, Susan, a long-standing and very active member of the Airds community, explained how the HIA had enhanced her connection to the community:

> *I think it helped connect me a bit more to the community in knowing more things about it. Because I've never been involved in a health assessment study before. And I mean, we were given bits of reports about, you know, different problems with health, you know, but they were just figures on paper. This put me in it, where I was living it for the time I was doing the course. So it became a more real thing if that makes sense.*

Susan explains that even though she was a resident in the community, there were still parts of the community, particularly health problems, of which she was unaware. The HIA

allowed her to connect public health evidence with her own lived experience and that of other community members. This process then made the health evidence "become a more real thing", and in turn, helped her to feel more connected to her community.

Participants also discussed how they had expanded their social networks and engaged with new people, another form of bonding social capital. Geoff, a juror on MTM, asserted:

> *And that's good networking, and that's where you learn more from your networking and also linking up…. I have met a couple of them since at a couple of Disability Wales meetings, a couple of the folks who were there.*

For some people, like Geoff, who was actively involved in other organisational membership, the process was an opportunity to expand their networks and continue to engage with people who were members of shared organisations. Having shared membership provided a forum to continue their new relationships. Evaluations on HIA have similarly examined their ability to strengthen relationships and connections between community members and decision-makers through inclusive community engagement in the HIA process (Chadderton et al., 2008).

For other people, however, relationships formed through the process ended when the process did. Tiffany, a panellist on the CSP, explained:

> *Well, I guess I expected to meet new friends when I decided to do that. I met one. Met one new friend. But you know what, at that moment, you think everybody is your best friend. Because you just spent four days together. Right? You're like, "oh Yeah, this is great! This is great. Yeah. Okay.' But yeah, only caught up with one person out of 32. And haven't really seen any of them since.*

Several participants in the citizens' juries talked about how the jury process had created an intensity that made them feel close to other jurors. However, without continued

opportunities to engage with other participants, it appeared that these relationships did not always last beyond the length of the process.

Some of the ways that participants had expanded their social networks and engaged in their community reflect structural social capital (Claridge, 2018). Structural social capital is the network of people whom a person can draw upon for support. People use their structural social capital to transfer knowledge, access opportunities or find peers with desired expertise. Some participants had formed new personal or professional relationships and continued to engage with people in other organisational settings. However, for many participants, these relationships did not last beyond the initial process, and it was not clear how participants were using these new networks, if at all.

Generalised trust is considered a marker of social capital (Putnam, 1993; Stolle, 1998, 2003) and is an element of bonding social capital (Milton et al., 2012). An evaluation found that participation in an HIA process helped to form ongoing partnerships after the conclusion of the HIA and created a foundation of trust which then enabled more opportunities for participation (Charbonneau et al., 2015). Trust can be both an outcome of social capital development and a requirement for it, what Putnam (1993) refers to as the "virtuous circle" of participation, social networks, and trust. Trusting people are more likely to be involved in their community (Putnam, 1993; Stolle, 1998), yet Uslaner (2002) calls into question whether group activity needs, or creates trust.

Some participants discussed how their involvement in the process had enhanced their trust in decision-makers or decision-making institutions. Keith, a panellist on the CSP, explained:

> *While I wouldn't probably trust right-wing governments to run with things that are for the good of the community, I feel that [the Mayor] and all those Councillors do hold, you know, beliefs at heart that they want to do better things for the community. So I'm not sceptical of their intentions.*

Through participating in the CSP and engaging more directly with Byron Shire Councillors, Keith felt that he could trust that they would want to take decisions that were for the good of the community. Other panellists explained that trust in Council had been developed through seeing their commitment to the process. Alan, a CSP panellist, explained: "So in a climate where you have no money, actually spending money on something that is only going to produce an idea at best…ticked a bit tick for their part." During the CSP, Councillors had come in to answer questions from panellists. The fact that these Councillors represented a wide political spectrum gave panellists trust that the process wasn't politically motivated. Furthermore, the fact that Council had been willing to run the process without expecting a particular outcome led to feelings that the overall process was trustworthy. Notably, a significant contributor to this trust in Council seemed to stem from the fact that Council was willing to take on the recommendations provided by the panellists. Because of this, most panellists felt that the process was trustworthy and in turn, several had increased their trust in Council.

Trust in the process seemed to be a major contributor to how participants experienced the overall process. Susan, a member of the AB HIA team, explained that her trust in the process stemmed from her trust in the process organiser. Similar to participants in the CSP, having personal interaction was a cornerstone for building trust. Susan had worked with the Housing lead and her team for several years and had seen that community residents were treated with respect and were willing to listen to residents' concerns. She asserted:

> *When people here felt they own this community, they had a say, and they were being heard. And that was a big thing that Housing had to learn how to do was to let it show us that we were being heard and being respected. So a lot of the negative started to decrease because a lot of that negativity was around the relationship in Housing, and the way we were treated by them…*

She explains that providing community residents with opportunities to provide input on community issues, like the redevelopment, had built respect and trust with the community.

The HIA had increased this trust because it was a process that had allowed community members to participate directly in it, as opposed to other health surveys which had been done on the community rather than with the community. These 'side effects' of the HIA – feeling respected and developing trust – are critical positive outcomes of the process and key components of social capital, and other studies have demonstrated how trust building, commitment and shared understanding are crucial for sustaining collaboration (Ansell & Gash, 2007).

It has been widely demonstrated that increased social capital can lead to positive health outcomes (Ehsan et al., 2019), and studies have shown how community participation initiatives can build social capital, social cohesion and community capacity (Clark et al., 2014; Popay et al., 2007; Sansiritaweesook & Kanato, 2015). In several case studies, the process strengthened relationships and enhanced trust, contributing to improved bonding social capital. Through strengthening social capital, it is possible that the participatory processes can improve health and health equity.

8.6 Empowerment

Empowerment is recognised as an outcome in and of itself and as a mechanism through which health equity can be improved. Within the first pathway, there are various forms of empowerment, including psychological, organisational, familial and community, which necessitate different interventions and have been used to inform different strategies for health promotion. Strategies to enhance empowerment have centred upon the use of participatory processes to build the capacity of communities and individuals to engage in decision-making and transfer power of decision-making authorities to participants (Wallerstein, 2006).

Empowerment has been shown to enhance community bonding measures like social capital, neighbourhood cohesion, sense of community and community capacity (Popay, 2021) – factors linked to health improvement, as discussed in the previous section. Evidence on the direct link between empowerment and health is more spurious though a systematic review on the effectiveness of empowerment strategies found that

empowerment predicted better self-reported health; improved self-regulated disease management for patients; increased HIV/AIDS prevention strategies; improved women's health; and created healthy public policies which led to improved health (Wallerstein, 2006). There is also strong evidence that the level of control an individual has over their material circumstances – an indicator of empowerment – is a significant determinant of health (Orton et al., 2019; Siegrist & Marmot, 2004).

Furthermore, empowerment strategies have been used to empower socially excluded populations and integrate the needs of disadvantaged communities, making it a valuable approach for improving health inequities (De Andrade, 2016). Collective control, or the ability of communities to address their needs, has been shown to support the social determinants of health inequalities (Milton et al., 2012; Pennington et al., 2018; Whitehead et al., 2016). However, Popay et al. (2021) caution that the 'inward gaze' on psycho-social capability enhancement of many empowerment interventions neglects the social and political transformation needed to sufficiently address the conditions that create health inequities.

My interpretivist approach to this research allowed participants to define and describe empowerment in their own terms. However, it should be noted that this makes for complex assessment of it as an outcome. Other authors have cautioned that without a robust definition of empowerment and measurement of impact, it may be difficult to attribute health outcomes to empowerment (Haldane et al., 2019). However, one participant from the AB HIA Team, Nora, described how she believed that empowerment from the process could improve health:

> *Well, I felt empowered because I felt listened to. And when you feel that you're being listened to, not just shooting the breeze, it empowers you, but it also makes you feel better in yourself. And so I would think that that would have affected my health in the way that if you're not doing anything, if you're not listened to, you don't feel you're worth anything. You tend to get depressed, and depression brings on a whole lot of other health problems, as well.*

Nora explained that the experience of 'being listened to' gave her a sense of 'worth' which she attributed towards improving her mental health. This feeling of worth reflects psycho-social constructions of empowerment as individual control (Zimmerman & Rappaport, 1988), and other studies have examined the role of empowerment in improving mental well-being, particularly in the context of urban regeneration (Baba et al., 2017).

Empowerment is produced and sustained through continued opportunities for participation. Participants who reported feeling empowered had often been involved in other participatory (empowering) processes. For example, Susan, a member of the AB HIA Team, described herself as already being empowered by the multitude of engagement activities that had been ongoing in her community for many years. Other participants described empowerment arising anew from their participation in the case study, such as Aife, who had been looking for an opportunity to become involved in social care improvement in Wales. Yet it remains to be seen for how long feelings of empowerment last. Without other social and political transformations, as Popay et al. (2021) caution, it is questionable whether empowerment from the processes will be sustained. For example, it is uncertain if Aife will continue to feel empowered as she navigates social services (or in other areas of her life) or if those positive feelings will fade without continued opportunities for participation and empowerment.

8.7 Conclusion

This research did not seek to establish whether direct improvements to health resulted from the decision; rather, through influencing the social determinants of health and creating 'healthier' public policies, this research found that processes had the potential to improve health equity. Though evidence on public participation often focuses on perfecting the form to achieve technocratic outcomes, this research found that processes can achieve broader outcomes, such as increasing civic skills, enhancing social capital and empowerment which contribute towards health and health equity outcomes.

Haldane et al.'s (2019) systematic review found that community engagement strategies which have specific goals upfront and are monitored over time have greater success in

achieving positive health outcomes. Similarly, as I discussed in the previous empirical chapters, clarifying the purposes of the participatory process and managing expectations of what the process can achieve may help to ensure more positive experiences for participants, potentially increasing health equity outcomes.

Studies on public participation have identified positive outcomes associated with improved health, such as increased confidence, self-esteem and personal empowerment (Popay et al., 2007). Interviewees of this research (with one exception) did not discuss substantive health benefits associated with any of the positive outcomes they described. Yet empowerment (Laverack, 2006), social capital (Abbott, 2010) and civic skills (Browne & Leckey, 2022) have been shown to be beneficial for health, and these personal benefits were apparent in all the cases. Furthermore, changing health inequities requires affecting the social determinants of health inequities – the structural factors that produce the distribution of living and working conditions. Though the processes did not affect decisions focused on distributive social policies (e.g. universal income), they did affect necessary conditions for the development of political power (social capital, civic skills and empowerment). Power is considered a fundamental determinant, meaning that it affects the distribution of all other health determinants (Friel et al., 2021; Harris et al., 2020; McCartney et al., 2021; Popay et al., 2021). Therefore, through the intermediate benefits of participation, the processes have the potential to affect health inequities. In the following chapter, I will examine how power was enacted within the different processes and what this implies for the role of public participation as a strategy for health equity.

CHAPTER 9   POWER IN PARTICIPATION

9.1 Rethinking power

This research has examined how the participatory processes in the case studies affected decision-making and interpersonal outcomes for participants. The empirical chapters have addressed the original research questions (see section 1.3, Figure 4), which sought to understand: how, if at all, participatory processes enable consideration of health and health equity in public policies; and how, if at all, participatory processes enable empowerment. While public participation, of the kind studied in this thesis, is often conceived and implemented as a uniform process that can be implemented broadly, in practice, they are adaptive, contested and context-driven spaces that enable a multitude of experiences. Process commissioners often envision these processes as informing particular decision points through linear channels, yet this research found that impact is much more diffuse, and more commonly, the processes generated changes to decision-making through more distal mechanisms, such as changes in the decision-maker's thinking. This research then considered how the processes led to changes in health equity and identified theoretical opportunities, such as through changes in the social determinants of health and interpersonal outcomes (civic skills, social capital and empowerment).

While the previous empirical chapters addressed the majority of the research questions, this chapter address two key questions which remain. First, I initially asked how, if at all, participants and decision-makers perceived the process as changing dynamics/power/relationships between decision-makers and participants. This question was structured around my understanding of 'power as domination' (Dahl, 1957; Lukes, 1974). I thought that deliberative invited processes could essentially move power away from powerholders into participants' hands in an almost commodified transfer. My foray into this research began through my previous work on a health impact assessment of the

community engagement process for a large infrastructure development (Hirono et al., 2017). Within much of the literature I referenced for that research, control and empowerment were treated as normative elements that could be enhanced through interventions for health promotion (Cooke et al., 2011). I brought these constructions of power with me in designing the original research questions for this doctoral research. Yet, I found that the empirical research challenged these understandings by demonstrating that power is more dynamic and diffuse than I had assumed. Furthermore, the definition of empowerment I used to examine the evidence in the scoping review (see Chapter 2) (McWhirter, 1991) asserted that some people are powerless, and power can be built through awareness, capacity building, social support and control. Yet this research found that everyone has power to some degree. It was enacted in various ways by participants, organisers and decision-makers throughout the process, making power a "dense and dynamic net of omnipresent relations" (Flyvberg, 1998, p. 5). Like Flyvberg's (1998, p. 6) study of Aalborg, which focuses on the "less visible mechanisms of the modus operandi of power", in this chapter, I will demonstrate that different forms of power were enacted within the processes and such enactment can help to address the fundamental causes of health inequities.

Secondly, recent conceptual frameworks have linked power imbalances to the creation of health inequities (Friel et al., 2021; McCartney et al., 2021; Milsom et al., 2021). Central to these theories is how power inequities shape public policies. During the course of this research, I identified the policy impacts of the processes, but for many participants, the final outcome was unknown at the time of the interview. As I discussed in Chapter 6, participants benefited from the process even when there was not a clear impact on the decision (or they did not know the impact), but they benefited less when they thought their participation had not made a difference. Therefore, this begs the question, do these processes need to inform a decision to affect health equity? Should participatory processes like the ones studied in this thesis be used to achieve technocratic aims, or are they more valuable for achieving process aims, such as civic skills and empowerment? Which of these outcomes better achieves health equity? In this chapter,

I will explore these remaining questions and offer suggestions for the future practice of public participation.

9.2 Power as a fundamental condition for health equity

As I discussed in Chapter 1, several public health studies have sought to analyse the fundamental conditions for health equity (Braveman et al., 2011; Lancet, 2008; Marmot, 2007; Marmot et al., 2008; Popay et al., 2021), and from this power has been acknowledged as a 'cause of the causes' of health inequities (Friel et al., 2021; Harris et al., 2020; Popay et al., 2021). Drawing on Milsom et al.'s (2021) conceptual framework (see Figure 5 below, also in section 1.4), I envision deliberative invited forms of public participation as enacting and challenging three forms of power: instrumental, structural and discursive. Instrumental power refers to one actor's ability to directly influence formal policy decisions or other policy actors. By providing opportunities for participants to inform policy decisions, participatory processes may help to challenge this form of power. Structural power refers to the ability of different actors or institutions to shape policy agendas. This includes who takes part in decision-making spaces and the scope of considered solutions. Less powerful actors are often excluded from such spaces, and certain policy ideas are not elevated because they are either inconceivable, unacceptable or challenge the status quo. Deliberative invited participatory processes challenge this power dynamic by seeking to incorporate broader actors (i.e. everyday citizens) into policy spaces (McCartney et al., 2021) and, in some cases, allowing participants to decide on their own solutions. Discursive power is the ability of powerful actors to shape the ideas and behaviours of other actors, limiting what is imagined to be possible. Whilst participatory processes may address instrumental or structural elements of power, they may be less able to counteract discursive power, which informs what solutions participants envision as possible. For example, participants in a citizens' jury are more likely to think of ways to improve existing systems than to overhaul more fundamental structural inequalities like neoliberalism (though this is not always the case (see e.g. Smith et al., 2021)).

Figure 5 Milsom et al. (2021) conceptual framework for analysing power in public health policymaking
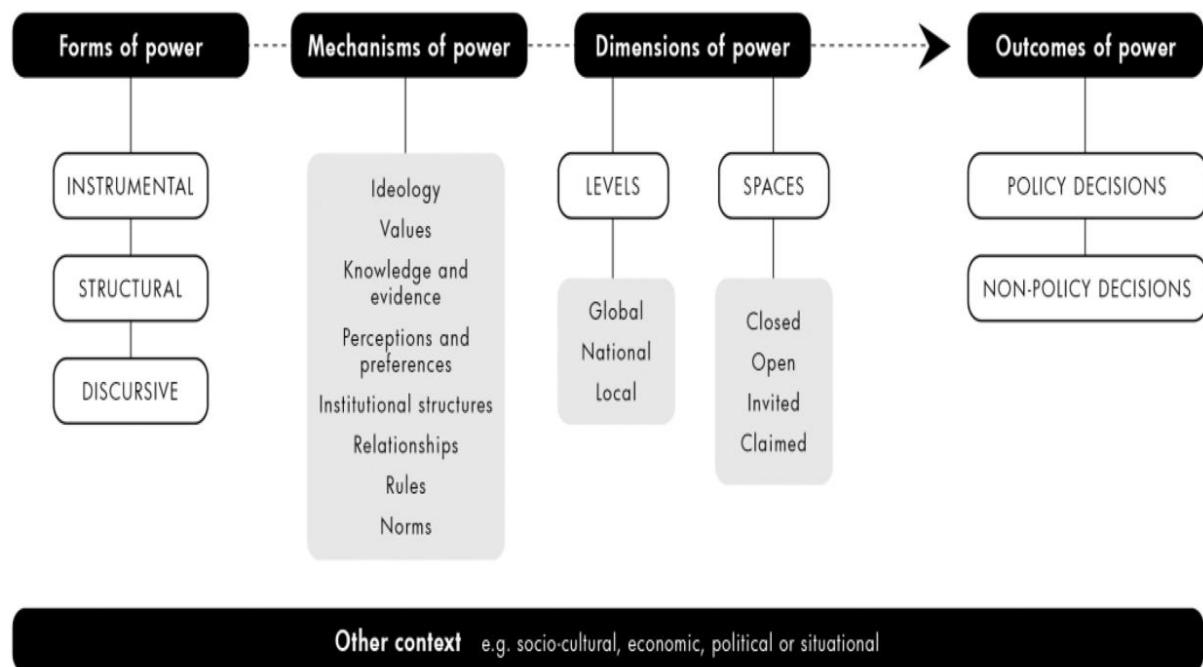
Within this research, different forms of power were apparent in the case studies in different ways. In this section, I will describe how different forms of power were evident across the case studies and argue that the enactment of instrumental, structural, and discursive power within these types of participatory processes can inform policy decisions that are beneficial for health equity.

9.3 The different forms of power in participation

A key finding of this research was the differential ability of the processes to enable participants to 'have a say'. As I examined in Chapter 6, having a say was an iterative process in which decision-makers also had to listen. This dynamic process of 'having a say' and 'being heard' reflect forms of instrumental and discursive power. Having a say was an expression of instrumental power: spaces that typically give greater weight to

policy actors with more existing power were carved out to enable citizens to voice their preferences. Participants enacted this instrumental power through the act of voicing ('having a say') but actually, 'being heard' by decision-makers was dependent upon discursive power. Whether or not the processes were 'heard' by decision-makers was influenced by the context of the process.

The history of engagement within the different participatory ecologies led to varying levels of interest of decision-makers to take on the recommendations. As I described in Chapter 4, Byron Shire Council was willing to commit upfront to the recommendations because of their history of poor engagement with the community (they were willing to try something new). On the other hand, policy analysts for Welsh Government were more cautious in their (lack of) commitment to the MTM recommendations because of their aversion to criticism. This level of comfort with committing to the recommendations reflects the different discourses used to frame the processes. The CSP was framed as a radical approach to collaborative decision-making, and Council members understood that by committing to run the CSP, they were buying into this (with some members of Council wanting to be seen as cutting-edge). In contrast, MTM was framed as a legal jury – meaning that a verdict on the quality of the Welsh Government's policy actions (i.e. the Act) would be reached. Inherent to this frame is the idea of guilt and innocence. Therefore, adopting any of the recommendations from MTM could be an admission that they had done something wrong (and therefore, something needed to be improved). Welsh Government, therefore, avoided any admission of guilt (or instead asserted their innocence) by not committing to the recommendations (or explaining what they were doing already to improve the Act). By framing the process, the organisers enacted discursive power, either expanding or limiting the impact the process could have on the decision. Even though participants enacted instrumental power by informing the policy decisions, the discursive power enacted by process organisers either limited or strengthened participants' other forms of power. This therefore demonstrates that there can be power hierarchies, with some forms of power superseding or influencing others.

Central to discursive power is the importance of ideas. Conceptions of power within political science often focus on the role of structures, agency, and ideas (Harris et al., 2020), with ideational power viewed as the capacity of actors to influence the ideas of other actors; impose certain ideas and resist others; and establish hegemony about what ideas are considered (Carstensen & Schmidt, 2016). Within the case studies, different ideas created frames about the process, influencing its aim and design, how participants and decision-makers perceived it, and what agency participants had within it. Different actors' ideas about what the process could achieve, and how the process was framed in response to this, reflect agentic power (Fuchs & Lederer, 2007). As coalitions of actors, the process organisers imposed hegemonic ideas that framed the process, bounding its conception and design.

Though the ideas of process organisers influenced decision-makers (in how the process was framed), they also acted as power holders and wielded this power in other ways. Underlying the processes were structural elements of power. Structuralist dimensions of power emphasise the overt or implicit social, institutional and macropolitical conditions that influence choice and agency (Fuchs & Lederer, 2007). The participatory processes were intended to inform policy decisions that took place within existing political or decision-making structures in which the power to make the decision was held and executed by certain actors. Broader macropolitical conditions about how decisions get made and who has the power to make those decisions influenced the overall structure of the decision. The division of decision-making for AB (described in Chapter 7), where day-to-day planning sat with a state-owned corporation, but primary responsibility sat with the Council, is an example of structural power. The decision-making structure established the 'rules of the game' (Arts & van Tatenhove, 2004), and any change proposed by the HIA had to fit within these established rules to be considered. The HIA recommended changes to the location and design of elements of the redevelopment but did not recommend, for example, better social welfare benefits which would have been outside the primary decision-maker's influence. They also did not advocate for an expansion of social housing – something that was in the power of Campbelltown Council to provide – but was outside the scope of the HIA. Therefore, the structure of the decision that the process sought to

inform bound what was considered possible to change. This reflects the notion of power as the ability to establish what is considered possible (Lukes, 1974).

Despite the agentic power of organisers to frame the process and the structural power of the decision-making contexts, participants enacted agency in the processes that reflect feminist constructions of power. Although deliberative invited participatory processes are treated as spaces separate from everyday life, participants in the process bring unique experiences and perspectives shaped through social and power relations (Cornwall, 2002). According to Lefebvre (1991), how a space is conceived and perceived is shaped through social experiences. Relations of power can play out within participatory processes and, in turn help to shape power dynamics.

> *People's experiences with officials are not simply going to be wiped clean when they encounter them at a meeting rather than in a clinic or across a counter, just as prevailing attitudes towards excluded groups are not magicked away by the use of a participatory technique or two (Cornwall, 2002, p. 7).*

Bourdieu argues that social interactions are so ingrained that they become continuously reinforced through their embodiment in different spaces – what he calls 'habitus' (Bourdieu, 1977). For example, structuring a community meeting where people sit in rows that face a central speaker (or, even worse, a stage) reinforces positions of power and subjugation. Yet Bourdieu (1977) also argues that power is constantly in flux through the interaction of agency and structures. Participants in the case studies embodied this flux through, at times, using their agency to activate power within the process (similar to Arendt's (1970) emancipatory concept of power as collective empowerment) and at others circumventing their potential subjugation within the process.

As discussed in Chapter 5, participants expressed many ways that they had relative power (e.g. skills, time, confidence). Participants with high relative power use this within participatory spaces, whereas participants without these may be less likely to participate, to begin with. Their involvement in the process was an extension of their position of power,

and participants described many ways that they utilised their relative power throughout the process. They contributed expertise – both professional and lay – towards the processes. They enacted roles of leadership, contributing towards essential decisions about the process design and implementation, such as deciding what evidence to consider (CSP), what evidence to collect (AB, 50K), and how to communicate their findings (i.e. producing the report – CSP, AB, 50K). This enactment of collective power by participants within the process reflects feminist theories of power as both capacity and empowerment (Allen, 2005).

According to Cornwall and Coelho (2007, p. 11), power is evident in public participation through certain discourses that determine what can be deliberated, the use of technical language and claims to authority, and the way groups are constructed and labelled (e.g. 'users' or 'community members'): "As 'invited spaces', the institutions of the participatory sphere are framed by those who create them, and infused with power relations and cultures of interaction carried into them from other spaces". Similarly, policy discourse seeks to construct citizen identities which embody particular ways of acting or forms of engagement within policymaking (Barnes & Prior, 2009). Yet, as Foucault (1980, p. 142) suggests "there are no relations of power without resistances". Participatory processes can provide spaces where power relations are tested, thereby allowing for the contestation of power and inviting acts of resistance.

In contrast to the other cases, participants in MTM had relatively less agency to enact power within the process. As I previously described, process organisers tightly controlled the process, deciding whom the jurors could hear from, whom they could speak to, and writing the final report. Yet despite this, the jurors carved out opportunities of resistance and power, as Barnes and Prior (2009, p. 22) assert, "citizens are not 'empty vessels' waiting to be filled with the attributes and potentialities prescribed for them by dominant discourses". Regardless of the edict from process organisers for jurors to act as 'impartial' citizens, they drew upon their personal experiences to pursue particular lines of inquiry or advocate for specific perspectives while questioning the witnesses. Participants fell into a pattern of relying on each other to pursue these lines of inquiry to capture the range of

perspectives the group wanted to hear. This reflects a more collaborative approach to power in which resources can be mobilised for collective action (Göhler, 2009). Although the organisers did not allocate time for jurors to speak with any of the process observers (they had explicitly forbidden this), jurors used lunch and other breaks to discuss or ask questions informally. Jurors wielded these small acts of resistance to assert some control over the process, a form of power as collective action and reciprocity between group members (Follett, 2004).

The processes as a whole also enacted certain types of power. Some processes were more effective than others in bringing new ideas to the policy landscape. Both HIAs brought forward health as a critical consideration that hadn't been strongly considered in the decision-making discourse. The CSP and MTM, rather than highlighting new issues, reiterated existing concerns (about the Act) or priorities (for infrastructure spending). Within the cases, HIA seemed to be particularly adept at bringing forward new discourses. HIA is designed to identify health impacts that are either unacknowledged or unintended. Decisions in which health is already a key consideration are more likely to be screened out as part of the HIA process.[25] Therefore, a strength of the HIA process is its ability to wield discursive power. Discursive power shapes the ideational boundaries of participation and informs what ideas, problems and solutions are brought to the decision-making table. Less powerful actors are often prevented from elevating policy issues and/or solutions because they are considered inconceivable or unacceptable by more powerful actors (Milsom et al., 2021). The HIA brought forward health as a legitimate concern in policy areas not traditionally associated with health. Furthermore, by engaging with community members and other stakeholders in the participatory process, the HIA

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[25] Though not always. There are times when health in a more narrow, clinical sense has been part of decision-making, but broader social determinants have not been considered. Similarly, some decisions may consider health impacts broadly but lack sufficient consideration for the health equity impacts of a decision. Equity-focused health impact assessment is one form of HIA used to examine the health equity impacts of health services decisions. (See Simpson et al. (2005)).

could highlight a diversity of needs, issues and solutions, therefore legitimising these actors within the policy space. As I discussed in Chapter 6, participants in AB described how the HIA had given them 'a voice' within the decision-making context, but also (perhaps more importantly) the decision-makers confirmed this by describing the obligation they felt to 'do right by the community.' This reinforces the evidence highlighted in Chapter 7 that the HIAs created non-linear or diffuse impacts. Rather than directly affecting the decision, the HIAs created changes in the dialogue surrounding a decision, highlighting health as a relevant policy concern. This discursive power was evident in the ongoing, distal impacts that the HIAs created, such as the multitude of ways the 50K HIA had been used to inform other policy decisions.

In contrast, the CJs, particularly the CSP, seemed more effective in supporting changes in structural power. A key element of structural power is the ability of certain actors to set the rules of the game (Milsom et al., 2021). CJs, unlike HIAs, aim to be representative of a cross-section of the larger population and therefore have the ability to broaden the field of participation, bringing citizens into decision-making contexts from which they would otherwise be excluded. This power is enhanced when decision-makers commit to implementing the decision made by the CJ, as was the case with CSP. This enactment of structural power could be enhanced by ensuring that processes are as representative as possible and that all kinds of citizens (especially marginalised or disadvantaged people) can participate.

9.4 Public participation as a site of power

In addition to examining how forms of power were enacted and interacted within the processes, power was required for the formation of the processes, to begin with. Cornwall (2002, p. 8) asserts: "To make sense of participation in any given space, then, we need also to make sense of the power relations that permeate and produce these and other spaces". As I described in Chapter 4, the processes emerged within different participatory ecologies. Some processes arose from regulatory landscapes in which public participation was required and regulated. In contrast, other cases were embedded in an ecology of participation in which enabling public participation was viewed as an inherent

aim and normal value. Yet despite these contextual differences, there were consistencies in what the processes achieved. They were able to accomplish some level of influence on decision-making (either proximate or distal), and all enabled some positive outcomes for participants. This reflects the political-economic contexts in which the processes took place, including the existing capacity of participants to engage; prior mobilisation of citizens; and institutional knowledge and interest of policy actors to listen.

Australia and the UK are stable democracies, and both have policy drivers for public participation (as discussed in Chapter 1). In these contexts, expanding opportunities for public participation may be less about expanding regulatory requirements for participation and more about enhancing the capacity of citizens to engage in participatory ecologies. As I discussed above, those who participated in the cases had relative power to do so. Therefore what may be required to expand public participation to disadvantaged populations -- those who could benefit the most from participation (both in creating healthy public policies and via empowerment) – is improved education, resources and mobilisation that enhances the skills and confidence of marginalised groups. Deliberative invited participatory processes can be spaces for creating citizenship and building civic skills that translate back into societal spaces (as discussed in Chapter 8) and can be 'schools of citizenship' that allow people to expand their understanding beyond their own immediate problems and biases (Cornwall & Coelho, 2007). Yet, in contexts with significant inequalities in power and knowledge, even processes with political commitment can fail to achieve these effects. This points to the need for societal spaces outside the participatory arena that build this capacity (Cornwall & Coelho, 2007). Public participation of the kind studied in this thesis can be a mechanism for enhancing health equity through the empowerment of participants, yet without more equal distribution of resources amongst citizens, these effects may be reserved only for those with the power to participate. Therefore, the remaining challenge is to strengthen the capacity of citizens to participate by addressing inequalities in knowledge and power. This could create a virtuous cycle (see Figure 37) in which citizens have the capacity to participate, which in turn creates better public policies that strengthen the capacity of citizens to participate, and so on.

Figure 31 Elaboration of a virtuous cycle of public participation for equitable public policy formation
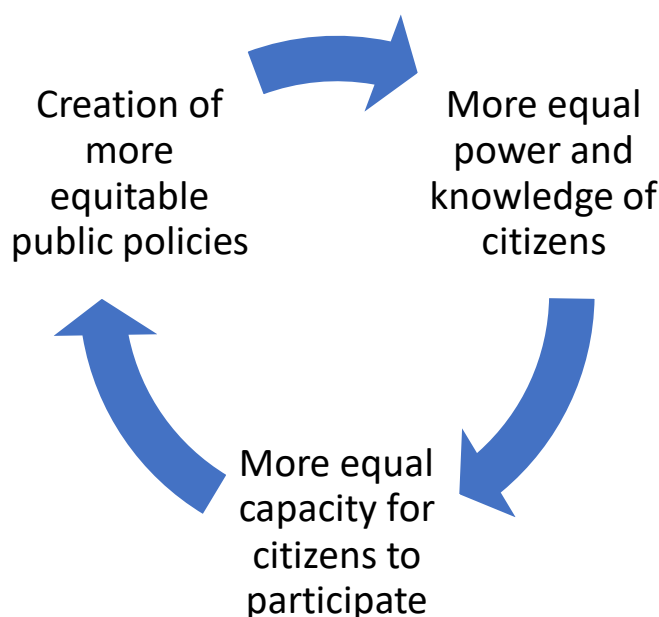
Given that knowledge and power are fundamental to creating health equity, such a virtuous cycle of public participation could also be essential for creating public policies that improve the social determinants of health inequities.

As I have described, the cases as forms of participatory processes enabled the variable enactment of instrumental, structural and discursive power. This enactment was done by participants, organisers and decision-makers in, at times, contested ways, with different forms of power superseding others. The processes, situated in different contexts, and the participants, also varied in their ability to enact structural or discursive power, thereby affecting their power to influence a decision. This reiterates that thinking about how power is expressed within these kinds of participatory processes is critical for realistic assessment of their value. Processes that enable greater instrumental, structural and discursive power, particularly by participants, are likely to be more effective at generating policy impacts that support health equity.

9.5 Empowerment as a mechanism for health equity

As I introduced at the start of the thesis, there are many conceptual models of health equity that take empowerment into account. Empowerment has been widely studied, but there remains limited evidence of the direct impact of empowerment on health outcomes. Empowerment is often construed through subjective experiences, making it difficult to define and assess. Furthermore, examining empowerment within the context of a bureaucratic process, like some forms of public participation, risks reducing empowerment, as a contested and dynamic concept, to a tangible indicator of power and influence. Indeed, my initial research questions erroneously conceptualised power as a commodity that could be moved from powerholders to participants through a process of 'empowerment'. I envisioned participatory processes providing community members with critical consciousness (or 'conscientização' (Freire, 1972)), which would spur collective action to improve health equity. Conceptual models of health equity tend to situate empowerment as a normative concept and, as I discussed in the scoping review in Chapter 3, there is a multitude of studies that measure empowerment as an outcome without so much as defining the concept, let alone considering the multiplicity of experiences of empowerment.

Whether and how we observe power as being enacted in the cases is perhaps less relevant than whether and how, participants felt that this had occurred. Foucault (2019, pp. 89-90) defines power as "not an institution nor a structure nor a certain capacity which some possess: it is the name which is given to a complex strategic situation by a certain society". Though Foucault's (2019) definition is criticised for denying the capability of human agency to intervene in social systems (Arts & van Tatenhove, 2004)[26], it helps to reflect how various forms of power are enacted in the complex social situations of public participation. Power is not only institutional, structural or agentic but all these things combined. Power within the processes may take emancipatory, agentic, structuralist or discursive forms, yet it will always be a complex and contested experience that may be

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[26] To be clear, I agree with Arts and van Tatenhove (2004) that people have agency, as I have discussed earlier in this chapter.

subjectively different for each participant. As I discussed in Chapter 6, participants described widely different experiences of empowerment. For some, the process provided skills development, learning new information, or feeling enabled, and participants described this as being empowering. Yet for others, this did not happen, either because they were 'already empowered to begin with' or because that was not (in their view) what the process was designed to achieve. This divergence of experience reflects the complexity of both power and empowerment.

Often, public participation is conceptualised as a homogenous experience and discourses on power and empowerment within public participation make normative assumptions about how power is enacted and what outcomes can materialise. This research has shown that power can be enacted in various ways, and empowerment may arise as an outcome, but there is no singular experience of participation. Furthermore, it may be futile to predict who, within a particular process, would end up feeling empowered. There were some consistencies amongst participants who described the process as empowering, such as building confidence, learning new skills or feeling involved (as I described in Chapter 6), but none of these could be described as an essential or contingent condition for empowerment to occur. This may be an opportunity for further research to examine these enabling factors. However, as this research has shown, I argue that empowerment does not have to be an outcome for the process to be a meaningful experience that produces valuable outcomes. Participatory processes like the kind studied in this thesis can, and should, be spaces in which participants enact power, but rather than seeking to empower all participants, it might be more critical to ensure the process is worthwhile by working towards achieving a meaningful outcome (of which participants are aware). This might shift these types of public participation to be less process-oriented and more outcomes focused.

Despite the multitude of studies demonstrating that public participation can strengthen civic skills and collective civic agency (Dahlgren, 2006; Fishkin, 1997; Gastil, 2000), there is less evidence as to how these skills enhance health. Democracy has been constructed as a determinant of health through community capacity and social capital, personal and

collective control, and citizen participation and power in decision-making (Browne & Leckey, 2022), and there is evidence of a population-level correlation between democracy and health outcomes (Wang et al., 2018), yet there is less evidence which shows how, and in which ways, democracy improves health and health equity for individuals. If a purported strength of deliberative invited forms of public participation is that it improves deliberation and active citizenship, then better evidence is needed to show how the personal/civic outcomes of participatory processes can improve health if these approaches are to be lifted up as strategies to address health equity.

Furthermore, public participation is often endorsed as a key strategy for community empowerment, and the case studies were no exception. Many of the process organisers discussed the ability of the process to empower citizens by 'giving them a say' in decision-making. Some authors have argued that instrumental goals are less important for public participation than goals related to empowering citizens (Street et al., 2014). However, this research has demonstrated that empowerment might arise only if policy goals are also achieved and if participants are made aware of what difference their involvement made. Separating process outcomes from the instrumental goals of participatory processes may not only undermine potential policymaking impacts, but it also has the potential to degrade the process. Participatory processes that seek to 'empower' must do so not just through how citizens are given control over the process; they must also provide opportunities for participants to influence policy decisions.

Popay et al. (2021) argue that empowerment strategies have focused on developing the capabilities communities need to exercise control but have neglected to consider the support required to activate collective control within social and political contexts. Empowerment initiatives run the risk of attempting to change individual factors without addressing structural conditions, thereby leaving existing structures of power and privilege intact (Friedli, 2013). This highlights an existing tension within the case studies. One rationale for the type of public participation studied in this thesis is that it can enhance empowerment, and this outcome is considered a worthy pursuit in and of itself. Yet, as I have discussed, there was variability in whether and how participants felt the process had

empowered them. Furthermore, it was unclear to what end their newly found empowerment served. Being politically engaged, forming new social networks and developing social support are supportive factors for health (as discussed in Chapter 8), but focusing on these outcomes without consideration of other social and political contexts in which participants live and work threatens to undermine any potential positive outcomes. Empowering participants through a participatory process may not address existing socio-material inequities, nor does it necessarily ensure that empowerment will last beyond the duration of the process. Processes that simultaneously achieved changes in these conditions through developing healthy public policies are more likely to affect changes that can support communities to enact their collective control. Given this, it is unsurprising that the processes that achieved greater changes to the decision point (notably CSP and AB) were the ones in which participants more commonly reported empowerment outcomes.

Political support for using public participation as an empowerment strategy has been driven by the rhetoric that such practices can enable communities to better self-govern. Beyond calling into question the authenticity of such approaches by policymakers (De Andrade, 2016), this shift in responsibility also places the onus on communities to solve their own problems, thereby ignoring the problems of social justice, power and privilege that create inequities. Rolfe (2018) argues that the level of community agency is shaped by a gradient of socioeconomic advantage. Imposing greater responsibility on disadvantaged communities in a context where they have lower levels of power can create regressive public participation. Essentialising public participation as building community capacity, therefore, risks decreasing actual community control, which may, in turn increase inequalities (Popay et al., 2021). The rationale for several of the cases was that the process could give participants the ability to 'have a say' over a particular decision, in essence providing participants with greater control over community decisions. Yet, the ability of the process to affect the decision was strongly influenced by broader contextual conditions, such as the level of agency of decision-makers and the overall decision-making context. These contextual conditions reflect the multiple forms of power as discussed above. Without consideration for the ways that power is enacted throughout

the decision-making process, participatory processes may oversell and underdeliver on their ability to empower communities. If the aim is for public participation to be empowering, then they not only require that the process seeks greater influence over decision-making but that they also address power differentials within these decision-making contexts. Popay et al.'s (2021) emancipatory power and limiting power frameworks are two possible strategies for examining power within participatory initiatives.

9.6 What are the implications of this for practice?

Public participation is a complex field of research. While there is extensive academic research looking at areas such as democratic innovation and deliberation, overall public participation remains a field of practitioners: those who commission, design, run and evaluate participatory processes. This focus on the act of running participatory processes has led to a plethora of research on how 'best' to do it while overlooking what actually happens (Cornwall, 2002) and a gap between macro-ideology in participation theory and lack of theory in participatory practice (Dean, 2018, p. 172). There is extensive research looking at design (Boswell et al., 2022; OECD, 2020a), representation (Barnes et al., 2003), inclusivity (de Freitas & Martin, 2015), deliberation (Davies et al., 2006), facilitation (Escobar, 2019), fairness and competence (Armour, 1995) and legitimacy (Harris, 2019) but less commonly are participatory processes evaluated for their impact to both participants and decision-making (Stewart, 2016).

This research found that deliberative invited participatory processes can lead to the inclusion of citizens in governance for the social determinants of health and other positive outcomes for participants. Yet these outcomes did not arise for every participant in every process in the same way, and this was primarily due to broader contextual factors. For example, despite the processes being very different, both the health impact assessment (AB) and citizen's jury (CSP) in Australia provided opportunities for informing health governance, and participants had diverse personal outcomes, such as pursuing further education, as a result of being involved in the process. In both cases, some participants described feeling connected to their community and developing trust through the process.

Underlying conditions such as trust, positive relationships, and a strong community seemed to be more consequential to whether or not positive outcomes of the process arose than the structure of the process.

This means that the process's form might be less important than initially thought. This research demonstrates that process design can be less critical than foundational enablers like trust and reciprocity. Moreover, this research shows that a formal process might be unnecessary in some cases. If trust, reciprocity, strong relationships, etc., can be facilitated through a range of activities – particularly those that are ongoing – then it may not be necessary to run short, high-resource processes. This matters because there continues to be investment in perfecting the form when scholarship and investment could be directed at supporting more of these underlying enablers of democracy (Hendriks et al., 2020).

Some authors have suggested that the effectiveness of public participation may be undermined when participants' expectations are too high or when there is a belief that the process will alleviate an intractable social problem (Barnes et al., 2004; Bauld et al., 2005). I argue that the benefits of public participation may also be diminished when processes are oversold as a cure-all for political disengagement, collective community action, empowerment, and healthy public policy creation. It is not to say that public participation cannot achieve one or several of these goals but a lack of conceptual clarity and communication about the goals of processes muddy the waters, potentially undermining such outcomes. Participants benefit from greater clarity about what the process is intended to achieve. Organisers would also benefit from understanding the expectations of participants and decision-makers, allowing for more focused strategies and considering the forms of power that play out across these participatory landscapes. Clarifying the intention of participatory processes could also help to avoid decision-makers and proponents of public participation espousing participation evangelism or (un)intentionally using participation as a front to achieve their own ends.

A further point of contention in public participation is the role of empowerment. There seemed to be a contradiction in this research in which some people felt that simply 'having a say' was sufficient to provide empowerment. But for other people, not knowing the impact of their participation diminished their experience of the process. Or for others, feeling like the process had not made a difference was also a significant source of frustration and disappointment.

Is 'having a say' really all that should be expected of participatory processes? The normative assumption of deliberative democracy is that involving citizens more directly in governance "makes for better citizens, better decisions and better government" (Cornwall & Coelho, 2007, p. 4). These improvements are purported to arise through more effective engagement between citizens and the state and are underlined by normative assumptions: that people want to and will share their views when given the opportunity and that bureaucrats will listen and respond (Cornwall & Coelho, 2007). This, of course, is not the reality of all participation. As I explored above, whether or not decision-makers were willing to listen and respond reflects various facets of instrumental, structural and discursive power. Many participants in the case studies described satisfaction from 'feeling heard,' without requiring that the process made a difference in a decision. As I explored in Chapter 7, informing a decision was often the explicit goal of a participatory process, but underlying, implicit aims often influenced (or sometimes superseded) these technocratic goals. It is possible that participants were satisfied with the processes because their expectations reflected the minimal ability of the process to make an impact on decision-making. But is that all they should expect from public participation? If participatory innovations seek to shift governance to the public and claim to offer mechanisms for enhanced empowerment – mechanisms of power which are theorised to improve policymaking for health equity – then we should expect that they achieve the changes in decision-making that they seek to inform. If rather, participatory processes are only truly effective at achieving process aims, then it may be time to reexamine their role within civil society and democratic reform. With governments advocating for increased use of public participation as a way to co-create public policies, consideration must be given to what real impact they can have, and reasonable expectations should be

communicated to participants. If the aim of participation is to give citizens an opportunity to 'feel heard', then by all means, they should continue as is (and the focus can remain on improving citizens' ability to participate), but if the goal is to achieve fundamental shifts in power, providing citizens with direct routes to policymaking that help to transform health inequities, then it may be time to prioritise more radical approaches.

9.7 Conclusion

In this chapter, I have discussed how instrumental, structural and discursive forms of power were enacted and influenced how processes were implemented, experienced, and produced governance and personal outcomes that support health equity. Deliberative invited forms of public participation can improve health equity by developing the power and capacity of participants but requires ensuring that all types of citizens have these preconditions to participate. Public health theories have begun to focus on power as a fundamental determinant of health inequities, and this research adds to the emerging body of evidence by demonstrating how power dynamics in participatory spaces profoundly affect their ability to achieve their theoretical benefits.

CHAPTER 10   CONCLUSION

10.1 Introduction

In the thesis, I have provided a narrative journey through the participatory case studies – from process conception and design through interpretation, experience and finally to their outcomes for health equity. The comparative case study design has provided a valuable methodology for explaining how outcomes arose the way they did. Flyvberg (1998, p. 4) asserts from his case study of the Aalborg Project in Denmark that: "…we will find that the most particular also reveals itself to be the most general". Similarly, through examining the 'particulars' of the case studies – how they were conceived, interpreted, experienced and what outcomes they produced – I have elucidated broader understandings of public participation and health equity.

In this final chapter of the thesis, I summarise the empirical contribution of the research. I discuss how the findings improve our understanding of how public participation can contribute toward health equity. Next, I discuss the strengths and limitations of this research and what the findings imply for policymaking for public health and public participation. Lastly, I provide implications for future research and some personal reflections on the contribution of this research to my personal journey as a public health practitioner.

10.2 Summary of empirical contribution

This research aimed to understand how, if at all, participatory processes can contribute toward health equity. Scholarship in public health suggests that health-informed decision-making and empowerment are two possible strategies for improving health equity. Existing evidence also suggests that public participation can improve healthy public policies and empowerment. Still, it was not clear how, if at all, these outcomes are achieved and whether they can improve health equity, as suggested. Through a case

study comparison, I have examined how participatory processes, with a focus on health impact assessment and citizens' juries, enhance health equity. Below I summarise the main empirical findings from this research.

Public participation is often considered an important element of public health interventions, but it has rarely been studied as a driver of health and health equity outcomes. This research sought to examine this gap in the evidence to better understand how public participation can improve health equity. I have found that participatory processes are far more complex than typically envisioned. Participatory processes of the kind studied in this thesis are often thought of as being uniform, yet they are embedded in rich contexts that profoundly influence why and how they are conceived. Beyond merely concluding that 'context matters,' in Chapter 4, I examined the cases' spaces, histories and cultures to understand how processes emerged and reflect particular participatory ecologies. This context acted as a driver for their conceptualisation, informing both the aims and design of the processes. In turn, the aims and design affected how participants could enact control over the process.

In Chapter 5, I then turned to unpack why and how people participated in the process. People who participated, by in large, did so because they had the capacity. The capacity to participate reflected elements of relative power – education, skills, experience, confidence and self-efficacy. Because participants had this relative power, they were often sought after and able to engage in other processes, which meant that they commonly had a history of involvement. Access to opportunities for engagement also reflected the participatory ecologies of the processes in which there were likely to be more past activities. Participants were also motivated to engage based on personal beliefs and a perception that their involvement would make a difference. Understandings of what the process could achieve varied between participants, organisers and decision-makers. What participants thought the process could achieve was based upon how they thought it was framed – as a democratic, technocratic, judicial, or normative process. These expectations then served as a backdrop from which participants compared their actual experiences.

In Chapter 6, I examined how expectations compared with experience and created different outcomes for participants. Participants who viewed the process as meeting their expectations more commonly interpreted it as a success. Participants who described how the process failed to achieve their expectations often had a more negative experience. This was frequently because the process did not achieve the impact the participant had expected, but it could also reflect how participants engaged in the process, such as the amount of control they were able to exercise through their participation. Based on these divergent experiences, there was a variety in the types of personal benefits that participants gained. 'Having a say' was often described as the vital ingredient for why and how participants experienced empowerment. Yet this research identified that what mattered most for empowerment was whether or not participants 'felt heard.' This dialogic process between decision-makers and participants was core to the experience of empowerment. Whether and how the intended decision was affected by the process is what I turned to in the following chapter.

In Chapter 7, I examined what impact the process had on the intended decision. Although there was some evidence of a direct effect on the decision point, more commonly, the processes achieved influence through less linear and more diffuse channels. Being situated within various participatory ecologies, they also often led to other unintended follow-on effects. Though deliberative invited forms of public participation are often enacted to achieve policy aims, this research identified that the processes accomplished other participatory, epistemic, technocratic and institutional goals.

Lastly, in Chapter 8, I looked at the personal outcomes and decision-making impacts to examine how the processes affected health and health equity. Participants described the benefits of their engagement – civic skills, social capital and empowerment – that have the potential to improve health equity. Furthermore, the decision points of the processes all reflected a social determinant of health. Greater integration of participant input in creating healthy public policies can improve decisions and make them better for the health of affected communities. As I described in Chapter 7, pathways of impact on the decision

points were also diffuse and often, the greatest change was in decision-makers' understandings of health, health equity, and community needs. These distal impacts also have the ability to improve community health beyond the scope of the participatory process.

In Chapter 9, I examined the role of power within the processes. Notably, power was pervasive across all the cases and was enacted in many ways. Instrumental, structural and discursive forms of power were apparent within the processes and influenced how the processes were implemented, experienced, and what outcomes they produced. Power acted as an explanatory mechanism for the other aspects of the processes. Participatory processes of the kind studied in this thesis can enhance capacity and power of participants, creating more equitable public policies that generate a more equal society. Enacting a virtuous cycle of participation is key to ensuring that these types of participatory processes achieve their intended benefits. Though deliberative scholarship often focuses on perfecting the form of participatory technologies, this research has identified that benefits (and drawbacks) were more closely linked to power within the processes than they were to form. This highlights the need for greater attention to providing opportunities for empowerment through public participation, regardless of the type of participatory technology employed.

In summary, tackling 'wicked problems' like health inequities requires interdisciplinary approaches that employ different thinking and strategies than those used in the past. In recognition of this, I have examined participation as means of improving health equity through empowerment and developing healthy public policies. Through the research, I have identified that participatory processes can contribute to health equity through personal benefits like empowerment and the formation of healthy public policies. However, whether and how beneficial outcomes arose was contingent upon underlying elements, such as participants' relative power and the process's context. Critically, power was pervasive across the processes and was enacted in ways that affected how the process was experienced and what outcomes it achieved. Therefore, greater

consideration must be given to power within participatory processes as a means to benefit health equity.

By examining not just *what* outcomes occurred but *how*, this research develops a better understanding of the underlying mechanisms that generate outcomes (power and control) and helps to shift evidence from 'perfecting the form' towards a greater understanding of how to utilise participatory approaches to achieve better outcomes for health equity. To that end, this research demonstrates that providing citizens with opportunities to affect health equity may require prioritising more radical approaches to participation.

10.3 How does this improve our understanding of public participation as a tool for health equity?

The comparative design of this project offers a unique contribution as it illuminates the mechanisms by which outcomes arise and provides an understanding of how characteristic factors of the contextual environment shape the outcomes of participatory processes in different settings. A contribution to the field of public health is made by analysing how participatory processes generate interpersonal and governance outcomes and how power is enacted through the processes to generate these outcomes. Theories on the social determinants of health posit that the fundamental cause of health inequities is the unequal distribution of health and socio-material circumstances, social position, and socioeconomic and political determinants (Marmot et al., 2008). Underpinning the unequal distribution of health determinants is power. More recently, conceptual frameworks have been developed to examine how forms of power produce public policies that shape health inequities (Friel et al., 2021; McCartney et al., 2021; Milsom et al., 2021). The thesis contributes to this emerging body of evidence by demonstrating how power is enacted within public participation. Similarly, it has been well established that empowerment and the creation of healthy public policies are helpful strategies for improving health equity (Wallerstein, 1992; World Health Organization, 1988). This research adds to the field of study by demonstrating that public participation can enhance health equity through empowerment and healthy public policies but requires that factors

often overlooked in existing research – context, positionality and power – must be considered for processes to achieve their intended outcomes.

This thesis also contributes to participation studies by examining the context-driven and interpretive ways processes are designed, delivered and experienced. An extensive body of evidence demonstrates that public participation, particularly deliberative democratic technologies, can enhance citizenship and provide social benefits (Haldane et al., 2019; Popay et al., 2007; Street et al., 2014). Much of the evidence in deliberative invited public participation has focused on form rather than looking at other contextual factors that affect the process. The thesis has provided a unique contribution to this scholarship by demonstrating how the benefits of participation (empowerment, social capital, and civic skills) contribute toward health equity and how other structural factors (e.g. power, capacity, control) are required to achieve the benefits. In doing so, this research demonstrates that public participation can improve health equity.

10.4 Strengths and limitations

I conducted this research as an interpretive case study comparison of two types of participatory processes (HIA and CJ) within different country contexts (the UK and Australia). The key strength of this approach is that it has enabled the identification of explanatory causes of the outcomes. This research aimed to understand not just *if* participatory processes can improve health equity but *how* those outcomes occur. Through comparison, this research has shown that positive outcomes that promote health equity (e.g. creation of healthy public policies and empowerment) occur when other necessary conditions are present within the process. The context and culture in which a process occurred provided a foundation upon which the process was structured (conceived, implemented and designed). The relative power of participants (their positionality) affected how and why people participated and what they expected to achieve from their participation. Processes could be interpreted in many ways, and this interpretation was often a reflection of both context and participants' positionality. Therefore, positionality and context can be seen as explanatory mechanisms for how a process is experienced and what outcomes they produce.

In a critical realist ontology, reality is stratified into three layers: empirical, actual, and real (Danermark et al., 2002). Fletcher (2017) compares the layers of reality to an iceberg – there are those events we can observe and experience, yet how events arise is caused by the other layers of reality (see Figure 38). The tip of the iceberg – the empirical level – is mediated by human experience, which is the level at which reality is observed. The empirical evidence in the thesis reflects this first level of reality: participants described myriad experiences and outcomes of participation based on their interpretation of events. However, as I have described above, the experience and outcomes of the process were mitigated by other explanatory mechanisms (positionality and context). Underlying that which is observed is the 'actual' level of reality. At this level, events occur that help to produce outcomes, whether or not they are observed. Positionality, context and the relative power of participants exist whether or not they produce observable events and influence the other levels of reality. Context was a driving force in how processes were conceived and delivered and the impact the process had on the decision. Context and positionality could therefore be described as generative mechanisms. These generative mechanisms exist in relation to other causal forces.
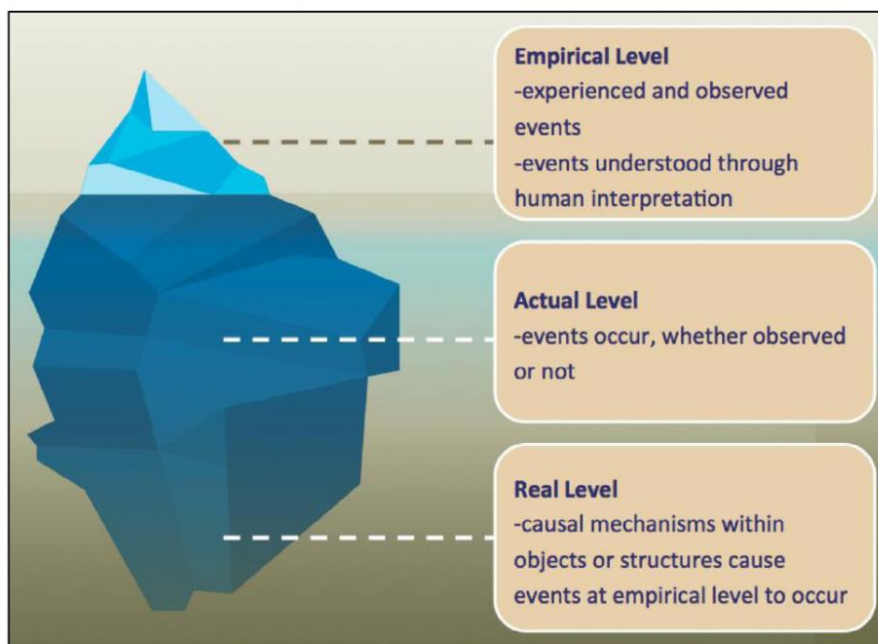
Underneath the other levels of reality are the causal mechanisms or structures which cause events to occur. These can be described as "the inherent properties…that act as causal forces to produce events" (Fletcher, 2017, p. 183) or the 'real' level of reality. Using a critical realist approach to this research has helped to add an additional level of explanation for the findings. While we experience events at the empirical level of reality, identifying the underlying causal factors that manifest these events helps to provide a deeper understanding of *how* events occurred. This research has identified power as a causal mechanism. Power is ubiquitous; we all have it to some extent, and how it was enacted within the different cases helps to explain how and why the different outcomes of the processes occurred. Interrogating the evidence to identify causal mechanisms is a strength of this research and enables a critical contribution to the fields of public health and public participation: If participatory processes seek to achieve specific outcomes (healthy public policy and empowerment) that improve health equity, then greater

consideration must be given for power as an underlying mechanism that helps to produce these outcomes. By identifying causal factors that explain how social phenomena arise (Creswell, 2017), this research provides some level of generalisability or what Boswell et al. (2019b, p. 55) refer to as "plausible conjectures of broad theoretical applicability". It is possible that power, context and positionality can act as explanatory mechanisms for how outcomes arise within a wide range of participatory processes, not just in the cases.

There are, of course, limitations to this research. I have identified the enactment of power as a plausible conjecture for how and why outcomes occurred. However, this only provides one piece to the puzzle of how public participation can enhance health equity. There are possibly other explanations and undoubtedly other underlying mechanisms that affected the processes that this research has overlooked. My own experiences and professional background as a public health practitioner have had an undeniable influence on how I have approached this research. My positionality perhaps influenced what conjectures I therefore felt were more 'plausible' than others. There are likely to be many other explanatory mechanisms for how outcomes are generated through public participation, and I believe this is an area that could be explored through future research.

10.5 Implications for future research

As I have stated above, the thesis provides many opportunities for future research. Bhaskar (1979) cautions that the 'real' level of reality is theory-laden, not theory-determined; therefore, explanations of reality can be fallible. The explanations I have provided in this research reflect public health theories of power as a social determinant of health. However, there are likely other explanations for how different outcomes arise through participatory processes like the ones examined in this research and how these types of public participation can support the development of health equity. To that end, drawing from this thesis, I have identified two substantial areas for future research.

First, this research identified that most of the impact on a decision was diffuse or non-linear. This reflects existing research, which has shown that the strength of HiAP approaches is in changing decision-makers' understanding of health equity and enabling

joint working (Delany et al., 2016; Haigh et al., 2013). Future research could expand on this to examine citizens' roles in changing policy debates on health equity. This could build upon the evidence developed in the thesis on power frameworks, for example, to examine how participants can enact discursive or structural power within policy debates for health equity.

Second, during data collection for this thesis, interviewees discussed many of the enablers and barriers to the perceived success of the process. Some of these enablers were discussed in the thesis, such as the development of trust or a history of previous participation, but others were not relevant to my analysis. Many of these enablers are related to the form of the process. While, as this research has identified, the form may be less critical than underlying issues of power, it could be helpful to compare how variety in the structure of processes can enhance or reduce power and empowerment. Future research could explore how other, perhaps less structured, forms of engagement enable empowerment and virtuous cycles of participation.

10.6 What are the implications of this for policymaking and public participation practice?

The evidence generated in the thesis provides clear implications for future policymaking for health equity and public participation practice. First, public participation can be a site of dynamic interaction between citizens, organisers and decision-makers and "…thus involve a negotiation of meanings and a sense of openness about potential outcomes" (Barnes & Prior, 2009, p. 22). Public participation of the kind studied in this thesis is commonly designed to achieve policy aims, but this research has demonstrated they may also address broader epistemic, participatory, technocratic or institutional goals. Processes can be interpreted as intending to achieve these broader aims; when they fail to do so, participants may miss out on the potential benefits. Therefore, greater recognition must be given to understanding the dynamic way processes are interpreted with greater transparency about their aims.

Secondly, while public participation can be used to support empowerment as an end in itself, it brings into question, 'what are people being empowered for?' Participants in the cases highlighted that they felt more empowered when they perceived that their input was being used towards a decision. Therefore, processes aimed at empowerment can be more successful if they are also used to affect a decision relevant to health equity. The focus of deliberative invited participation should be on making sure that processes inform a decision and that decision-makers are required to respond to the process (perhaps through upfront commitments, as was done in CSP). This could shift the focus away from perfecting the form of public participation toward more ongoing structures for citizen involvement in decision-making (perhaps akin to long-term participatory budgeting (Escobar, 2020)).

10.7 Personal reflections

I began the thesis by explaining why I had undertaken this research: I wanted to understand why health inequities persist and what can be done to improve them. I did this by exploring multiple cases of participatory processes aimed at improving a social determinant of health. The findings of this research reiterated some of my existing knowledge but also brought forward new and unexpected findings. I thought that participants would go through the process and acquire empowerment in an almost mechanistic fashion. I thought that decisions could be improved through the linear transmission of information from the process. I found that transformation processes (for participants and decisions) were much more nuanced than I expected. Context and participants' positionality were not just 'something you should think about when designing a process'; they were crucial for determining the overall outcomes of the process. Furthermore, 'success' was interpretive. What made a process successful in my mind was not always what made it successful for the participant. Most importantly, the thesis helped me examine power as a dynamic and contested structure with many forms.

I plan to continue my journey as a public health practitioner – perhaps continuing research on health equity but also likely through conducting health impact assessments on policy decisions. By increasing my understanding of public participation and health equity, I

believe I can better conduct strategies for health equity that consider context, positionality and power. In doing so, I hope to contribute in some way towards ameliorating inequities in health.

Bibliography

Abbott, S. (2010). Social capital and health: The role of participation. *Social Theory & Health, 8*(1), 51-65.

Abelson, J. (2001). Understanding the role of contextual influences on local health-care decision making: Case study results from Ontario, Canada. *Social Science & Medicine, 53*(6), 777-793.

Abelson, J., Giacomini, M., Lehoux, P., & Gauvin, F.-P. (2007). Bringing 'the public' into health technology assessment and coverage policy decisions: From principles to practice. *Health Policy, 82*(1), 37-50.

Acevedo, S. M., Aho, M., Cela, E., Chao, J.-C., Garcia-Gonzales, I., MacLeod, A., Moutray, C., & Olague, C. (2015). Positionality as knowledge: From pedagogy to praxis. *Integral review, 11*(1), 28-46.

Aitken, M., Porteous, C., Creamer, E., & Cunningham-Burley, S. (2018). Who benefits and how? Public expectations of public benefits from data-intensive health research. *Big Data & Society, 5*(2), 2053951718816724.

Alderson, P. (2021). *Critical realism for health and illness research: A practical introduction* (1 ed.*,* 10.2307/j.ctv1fcf8g0). Bristol: Bristol University Press.

Allen, A. (2005). Feminist perspectives on power. In E. N. Zalta (Ed.), *The Stanford Encyclopedia of Philosophy* (Vol. Winter 2021). Stanford: Stanford University.

Almedom, A. M. (2005). Social capital and mental health: An interdisciplinary review of primary evidence. *Social Science & Medicine 61*(5), 943-964.

American Public Health Association. (2012). Promoting health impact assessment to achieve health in all policies. Retrieved from https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/11/16/51/promoting-health-impact-assessment-to-achieve-health-in-all-policies

Anderson, S., Allen, P., Peckham, S., & Goodwin, N. (2008). Asking the right questions: Scoping studies in the commissioning of research on the organisation and delivery of health services. *Health Research Policy and Systems, 6*(1), 7-7.

Andrews, N., Elstub, S., McVean, S., & Sandie, G. (2022). *Scotland's climate assembly research report - process impact and assembly member experience*. Edinburgh: Scottish Government Research Retrieved from https://www.gov.scot/binaries/content/documents/govscot/publications/research-and-analysis/2022/03/scotlands-climate-assembly-research-report-process-impact-assembly-member-experience/documents/scotlands-climate-assembly-research-report-process-impact-assembly-member-experience/scotlands-climate-assembly-research-report-process-impact-assembly-member-experience/govscot%3Adocument/scotlands-climate-assembly-research-report-process-impact-assembly-member-experience.pdf

Ansell, C., & Gash, A. (2007). Collaborative governance in theory and practice. *Journal of public administration research and theory, 18*(4), 543-571.

Arcaya, M. C., Arcaya, A. L., & Subramanian, S. (2015). Inequalities in health: Definitions, concepts, and theories. *Global Health Action, 8*(1), 27106.

Arendt, H. (1970). *On violence*. London: Allen Lane.

Arksey, H., & O'Malley, L. (2005). Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology, 8*(1), 19-32.

Armour, A. (1995). The citizens' jury model of public participation: A critical evaluation. In O. Renn (Ed.), *Fairness and Competence in Citizen Participation* (pp. 175-187): Kluwer Academic Publishers.

Arnstein, S. R. (1969). A ladder of citizen participation. *Journal of the American Institute of planners, 35*(4), 216-224.

Arts, B. J. M., & van Tatenhove, J. P. M. (2004). Policy and power: A conceptual framework between the 'old' and 'new' policy idioms. *Policy sciences, 37*(3/4), 339-356.

Attree, P., French, B., Milton, B., Povall, S., Whitehead, M., & Popay, J. (2011). The experience of community engagement for individuals: A rapid review of evidence. *Health & Social Care in the Community, 19*(3), 250-260.

Baba, C., Kearns, A., McIntosh, E., Tannahill, C., & Lewsey, J. (2017). Is empowerment a route to improving mental health and wellbeing in an urban regeneration (UR) context? *Urban studies, 54*(7), 1619-1637.

Bachrach, P., & Baratz, M. (1994). Decisions and Nondecisions: An analytical framework. *Power: Critical Concepts, 2*, 95.

Baker, C., Gaydos, M., Gilhuly, K., Elardo, N. I., Malekafzali, S., Tamburrini, A.-L., Vonasek, K., & White, S. (2012). *Guidance and best practices for stakeholder participation in health impact assessments: Version 1*. Oakland, CA: Stakeholder participation working group of the 2010 HIA of the Americas Workshop Retrieved from https://hiasociety.org/resources/Documents/guide-for-stakeholder-participation.pdf

Bandesha, G., & Litva, A. (2005). Perceptions of community participation and health gain in a community project for the South Asian population: A qualitative study. *Journal of Public Health, 27*(3), 241-245.

Bandola-Gill, J., & Smith, K. E. (2021). Governing by narratives:REF impact case studies and restrictive storytelling in performance measurement.

Barber, B. R. (2003). *Strong democracy: Participatory politics for a new age* (20th anniversary ed. ed.). Berkeley, Calif.: University of California Press.

Barnes, M., Newman, J., Knops, A., & Sullivan, H. (2003). Constituting 'the public' in public participation. *Public administration (London), 81*(2), 379-399.

Barnes, M., Newman, J., & Sullivan, H. (2007). *Power, participation and political renewal: Case studies in public participation*. Bristol: Policy Press.

Barnes, M., & Prior, D. (2009). *Subversive citizens : Power, agency and resistance in public services*. Bristol, UNITED KINGDOM: Policy Press.

Barnes, M., Sullivan, H., & Matka, E. (2004). The development of collaborative capacity in health action zones: A final report from the national evaluation. In. Birmingham: The University of Birmingham.

Bauld, L., Judge, K., Barnes, M., Benzeval, M., Mackenzie, M., & Sullivan, H. (2005). Promoting social change: the experience of Health Action Zones in England. *Journal of Social Policy, 34*(3), 427-445.

Baum, F., & Laris, P. (2010). Improving health equity: action on social determinants of health through Health in All Policies. *Implementing Health in All Policies: Adelaide*, 25-38.

Bazeley, P. (2020). *Qualitative data analysis: Practical strategies*. London: SAGE Publications.

Benhabib, S. (1996). Toward a deliberative model of democratic legitimacy. *Democracy and difference: Contesting the boundaries of the political, 67*, 94.

Bennett-Cattaneo, L., & Goodman, L. (2015). What is empowerment anyway? A model for domestic violence practice, research, and evaluation. *Psychology of Violence, 5*(1), 84-94.

Bergene, A. (2007). Towards a critical realist comparative methodology: Context-sensitive theoretical comparison. *Journal of Critical Realism, 6*(1), 5-27.

Bever, E., Dills, J., Lindberg, R., & Whitehead, S. (2022). Minimum elements and practice standards for health impact assessment, Version 4. In: Society of Practitioners of Health Impact Assessment.

Bevir, M. (2007). The construction of governance. In M. Bevir & F. Trentmann (Eds.), *Governance, consumers and citizens: Agency and resistance in contemporary politics* (pp. 24-48). Basingstoke: Palgrave Macmillan.

Bhaskar, R. (1979). *The possibility of naturalism: A philosophical critique of the contemporary human sciences*. Atlantic Highlands, NJ: Humanities Press.

Bhaskar, R. (2008). *Dialectic: The pulse of freedom*. London: Routledge.

Bhatia, R., Farhang, L., Heller, J., Lee, M., Orenstein, M., Richardson, M., & Wernham, A. (2014). Minimum elements and practice standards for health impact assessment, version 3. Retrieved from https://hiasociety.org/resources/Documents/HIA-Practice-Standards-September-2014.pdf

Blaikie, N. (2009). *Designing social research: the logic of anticipation* (2nd ed.). Cambridge, UK: Polity Press.

Blencowe, C., Brigstocke, J., & Noorani, T. (2015). Theorising participatory practice and alienation in health research: A materialist approach. *Social Theory & Health, 13*(3-4), 397-417.

Bohman, J. (1999). Public deliberation: Pluralism, complexity, and democracy. *Political Theory, 27.6*, 857.

Böker, M., & Elstub, S. (2015). The possibility of critical mini-publics: Realpolitik and normative cycles in democratic theory. *Representation (McDougall Trust), 51*(1), 125-144.

Bolam, B., Mclean, C., Pennington, A., & Gillies, P. (2006). Using new media to build social capital for health: A qualitative process evaluation study of participation in the CityNet project. *Journal of Health Psychology, 11*(2), 297-308.

Boswell, J. (2018). The elusive search for the public voice in health policy: the case for 'systems thinking'. In (Vol. 23, pp. 4-5): SAGE Publications Sage UK: London, England.

Boswell, J. (2021). Seeing Like a Citizen: How Being a Participant in a Citizens' Assembly Changed Everything I Thought I Knew about Deliberative Minipublics. *Journal of Deliberative Democracy, 17*(2).

Boswell, J., Cairney, P., & St Denny, E. (2019a). The politics of institutionalizing preventive health. *Social Science & Medicine, 228*, 202-210.

Boswell, J., & Corbett, J. (2017). Why and how to compare deliberative systems. *European Journal of Political Research, 56*(4), 801-819.

Boswell, J., Corbett, J., & Rhodes, R. A. W. (2019b). *The art and craft of comparison*. Cambridge: Cambridge University Press.

Boswell, J., Dean, R., & Smith, G. (2022). Integrating citizen deliberation into climate governance: Lessons on robust design from six climate assemblies. *Public Administration*.

Bourcier, E., Charbonneau, D., Cahill, C., & Dannenberg, A. L. (2015). Peer reviewed: An evaluation of health impact assessments in the United States, 2011–2014. *Preventing Chronic Disease, 12*.

Bourdieu, P. (1977). *Outline of a theory of practice; translated [from the French] by Richard Nice*. Cambridge: Cambridge University Press.

Bowen, F., Newenham-Kahindi, A., & Herremans, I. (2010). When suits meet roots: The antecedents and consequences of community engagement strategy. *Journal of Business Ethics, 95*(2), 297-318.

Braa, J., Monteiro, E., & Sahay, S. (2004). Networks of action: Sustainable health information systems across developing countries. *MIS quarterly, 28*(3), 337-362.

Braveman, P. A., Kumanyika, S., Fielding, J., LaVeist, T., Borrell, L. N., Manderscheid, R., & Troutman, A. (2011). Health disparities and health equity: The issue is justice. *American Journal of Public Health, 101*(S1), S149-S155.

Brinkmann, S. (2020). Unstructured and semistructured interviewing. In P. Leavy (Ed.), *The Oxford handbook of qualitative research*. Oxford: Oxford University Press.

Brodie, E., Hughes, T., Jochum, V., Miller, S., Ockenden, N., & Warburton, D. (2011). Pathways through participation. In. London: NCVO, Involve, IVR.

Browne, G. R., & Leckey, M. (2022). Social cohesion and local democracy as determinants of health: Testing the liveability framework for health impact assessment of a major infrastructure. *Environmental Impact Assessment Review, 96*.

Bryman, A. (2016). *Social research methods* (Fifth edition. ed.). Oxford: Oxford University Press.

Budig, K., Diez, J., Conde, P., Sastre, M., Hernan, M., & Franco, M. (2018). Photovoice and empowerment: Evaluating the transformative potential of a participatory action research project. *BMC Public Health, 18*.

Burdett, J. (1991). What is empowerment anyway? *Journal of European Industrial Training, 15*(6), 23-31.

Bussu, S., Bua, A., Dean, R., & Smith, G. (2022). Introduction: Embedding participatory governance. *Critical Policy Studies, 16*(2), 133-145.

Byron Bay Historical Society. (2017). Byron Bay Grows. Retrieved from http://byronbayhistoricalsociety.org.au/development-of-byron-bay/byron-bay-grows/

Byron Shire Community Solutions Panel. (2018). Byron Shire community solutions panel: What infrastructure spending should we prioritise, and how should we fund these priorities if the rates alone are not enough? Final report. In.

Byron Shire Council. Byron Shire Population and Dwellings. Retrieved from https://profile.id.com.au/byron/population

Byron Shire Council. (2018). *Community solutions panel briefing book*. Retrieved from www.yoursaybyronshire.com.au

Byron Shire Council. (2019). The Byron model: Response to final recommendations. Retrieved from https://ehq-production-australia.s3.ap-southeast-2.amazonaws.com/843518c48dff345f810da5d0961a97069d36bcdf/documents/attachments/000/119/045/original/Byron_Model_Responses_prioritised.pdf?X-Amz-

Algorithm=AWS4-HMAC-SHA256&X-Amz-Credential=AKIAIBJCUKKD4ZO4WUUA%2F20220303%2Fap-southeast-2%2Fs3%2Faws4_request&X-Amz-Date=20220303T162253Z&X-Amz-Expires=300&X-Amz-SignedHeaders=host&X-Amz-Signature=e47a02fc8870d9bdf889d0cb9ca0b0102cc6af1d34aedeaa0f4353e7535cbbd5

Cacari-Stone, L., Wallerstein, N., Garcia, A. P., & Minkler, M. (2014). The Promise of Community-Based Participatory Research for Health Equity: A Conceptual Model for Bridging Evidence With Policy. *American Journal of Public Health, 104*(9), 1615-1623.

Cahuas, M. C., Wakefield, S., & Peng, Y. (2015). Social change or business as usual at city hall? Examining an urban municipal government's response to neighbourhood-level health inequities. *Social Science & Medicine, 133*, 366-373.

Cairney, P. (2020). *Understanding public policy: Theories and issues* (Second edition. ed.). London: Macmillan Education.

Cairney, P., Keating, M., Kippin, S., & St Denny, E. (2022a). *Public policy to reduce inequalities across Europe: Hope versus reality*: Oxford University Press.

Cairney, P., & St Denny, E. (2020). *Why isn't government policy more preventive?* : Oxford University Press.

Cairney, P., St. Denny, E., & Boswell, J. (2022b). Why is health improvement policy so difficult to secure? *Open Research Europe, 2*, 76.

Callaham, M. L., Wears, R. L., Weber, E. J., Barton, C., & Young, G. (1998). Positive-outcome bias and other limitations in the outcome of research abstracts submitted to a scientific meeting. *Jama, 280*(3), 254-257.

Carey, G., Crammond, B., & De Leeuw, E. (2015). Towards health equity: a framework for the application of proportionate universalism. *International journal for equity in health, 14*(1), 81.

Carlisle, S. (2010). Tackling health inequalities and social exclusion through partnership and community engagement? A reality check for policy and practice aspirations from a social inclusion partnership in Scotland. *Critical Public Health, 20*(1), 117-127.

Carstensen, M. B., & Schmidt, V. A. (2016). Power through, over and in ideas: Conceptualizing ideational power in discursive institutionalism. *Journal of European public policy, 23*(3), 318-337.

Carter, S. M., & Little, M. (2007). Justifying knowledge, justifying method, taking action: Epistemologies, methodologies, and methods in qualitative research. *Qualitative Health Research, 17*(10), 1316-1328.

Chadderton, C., Elliott, E., & Williams, G. H. (2008). *Involving the public in HIA: An evaluation of current practice in Wales*: Cardiff University.

Chambers, S. (2003). Deliberative democratic theory. *Annual review of political science, 6*(1), 307-326.

Chambers, S. (2018). *Reasonable democracy*. Ithaca, NY: Cornell University Press.

Charbonneau, D., Avey, H., Gilhuly, K., & Harris, L. (2015). Community participation in health impact assessments: A national evaluation. In. Seattle, WA: Centre for Community Health and Evaluation and Human Impact Parners.

Chau, R. C. (2007). The involvement of Chinese older people in policy and practice: Aspirations and expectations. In. York: Joseph Rowntree Foundation.

Cheezum, R. R., Coombe, C. M., Israel, B. A., McGranaghan, R. J., Burris, A. N., Grant-White, S., Weigl, A., & Anderson, M. (2013). Building community capacity to advocate for policy change: An outcome evaluation of the Neighborhoods Working in Partnership Project in Detroit. *Journal of Community Practice, 21*(3), 228-247.

Chilvers, J., Pallett, H., & Hargreaves, T. (2018). Ecologies of participation in socio-technical change: The case of energy system transitions. *Energy Research & Social Science, 42*, 199-210.

Choi, M., Mesa-frias, M., Nüesch, E., Hargreaves, J., Prieto-merino, D., Bowling, A., Smith, G. D., Ebrahim, S., Dale, C. E., & Casas, J. P. (2014). Social capital, mortality, cardiovascular events and cancer: A systematic review of prospective studies. *International journal of epidemiology, 43*(6), 1895-1920.

Christensen, H. (2018). Legislating community engagement at the Australian local government level. *Commonwealth Journal of Local Governance*(21), 1-30.

Claridge, T. (2018). Dimensions of social capital - structural, cognitive and relational. *Social Capital Research*.

Clark, N. M., Lachance, L., Doctor, L. J., Gilmore, L., Kelly, C., Krieger, J., Lara, M., Meurer, J., Friedman Milanovich, A., Nicholas, E., Rosenthal, M., Stoll, S. C., & Wilkin, M. (2014). Policy and system change and community coalitions: Outcomes from Allies Against Asthma. *American Journal of Public Health, 41*(5), 528-538.

Colebatch, H. K. (2009). *Policy* (Third edition. ed.). Maidenhead: Open University Press.

Cooke, A., Friedli, L., Coggins, T., Edmonds, N., Michaelson, J., O'Hara, K., Snowden, L., Stansfield, J., Steuer, N., & Scott-Samuel, A. (2011). Mental well-being impact assessment: A toolkit for well-being. In. London: National MWIA Collaborative.

Cooke, B., & Kothari, U. (2001). *Participation: The new tyranny?* London: Zed Books.

Cooke, K., & Iredale, R. (2019). Measuring the mountain: What really matters in social care to individuals in Wales? Report of a citizens' jury. Retrieved from http://mtm.wales/ckfinder/userfiles/files/MtM%20Citizens'%20Jury%20Report.pdf

Corburn, J., Curl, S., Arredondo, G., & Malagon, J. (2014). Health in all urban policy: City services through the prism of health. *Journal of Urban Health-Bulletin of the New York Academy of Medicine, 91*(4), 623-636.

Cornwall, A. (2002). Making spaces, changing places: Situating participation in development. *Institute of Development Studies, IDS Working Paper 170*.

Cornwall, A., & Coelho, V. S. P. (2007). *Spaces for change? The politics of citizen participation in new democratic arenas* London: Zed Books.

Crenshaw, K. W. (2017). *On intersectionality: Essential writings*. New York, NY: The New Press.

Creswell, J. W. (2017). About Research Questions and Hypotheses. In J. W. Creswell (Ed.), *Research design: Qualitative, quantitative, and mixed methods approaches*. Los Angeles, Calif.: Sage publications.

Crowhurst, I., & Kennedy-Macfoy, M. (2013). Troubling gatekeepers: Methodological considerations for social research. *International Journal of Social Research Methodology, 16*(6), 457-462.

Cruikshank, B. (2019). *The will to empower: Democratic citizens and other subjects* (10.7591/9781501733918). Ithaca, NY: Cornell University Press.

Cyril, S., Smith, B. J., Possamai-Inesedy, A., & Renzaho, A. M. N. (2015). Exploring the role of community engagement in improving the health of disadvantaged populations: A systematic review. *Global Health Action, 8*.

Dahl, R. A. (1957). The concept of power. *Behavioral Science, 2*(3), 201-215.

Dahlgren, P. (2006). Civic participation and practices: Beyond 'deliberative democracy'. In N. Carpenter, P. Pruulmann-Vengerfeldt, K. Nordenstreng, M. Hartmann, P. Vihalemm, & B. Cammaerts (Eds.), *Researching media, democracy and participation*: Tartu University Press.

Dalton, R. J. (2017). *The participation gap: Social status and political inequality* (First edition. ed.). Oxford: Oxford University Press.

Danermark, B., Ekström, M., Jakobsen, L., & Karlsson, J. (2002). *Explaining society: An introduction to critical realism in the social sciences*. London: Routledge.

Daniel, M., Green, L. W., Marion, S. A., Gamble, D., Herbert, C. P., Hertzman, C., & Sheps, S. B. (1999). Effectiveness of community-directed diabetes prevention and control in a rural Aboriginal population in British Columbia, Canada. *Social Science & Medicine, 48*(6), 815-832.

Dannenberg, A. L. (2016a). Effectiveness of health impact assessments: A synthesis of data from five impact evaluation reports. *Preventing Chronic Disease, 13*(E84).

Dannenberg, A. L. (2016b). Peer reviewed: Effectiveness of health impact assessments: A synthesis of data from five impact evaluation reports. *Preventing Chronic Disease, 13*.

Davies, C., Wetherell, M., & Barnett, E. (2006). *Citizens at the centre: Deliberative participation in healthcare decisions*: Bristol University Press.

Davies, C., Wetherell, M., & Barnett, E. (2024). *Citizens at the Centre : Deliberative Participation in Healthcare Decisions / Celia Davies, Margaret Wetherell, Elizabeth Barnett*.

Davis, A., & Andrew, J. (2017). *From rationalism to critical pragmatism: Revisiting Arnstein's ladder of public participation in co-creation and consultation*. Paper presented at the 8th State of Australian Cities National Conference, Adelaide, Australia. https://apo.org.au/node/178271

Davis, K., Drey, N., & Gould, D. (2009). What are scoping studies? A review of the nursing literature. *International Journal of Nursing Studies, 46*(10), 1386-1400.

De Andrade, M. (2016). Tackling health inequalities through asset-based approaches, co-production and empowerment: Ticking consultation boxes or meaningful engagement with diverse, disadvantaged communities? *The Journal of Poverty and Social Justice: research, policy, practice, 24*(2), 127-141.

De Andrade, M. (2018). A recipe for action: Using wider evidence for a healthier UK: A collection of essays exploring why we need trans-disciplinary approaches to improve the public's health. *The Health Foundation*, 18-23.

de Freitas, C., & Martin, G. (2015). Inclusive public participation in health: Policy, practice and theoretical contributions to promote the involvement of marginalised groups in healthcare. *Social Science & Medicine, 135*, 31-39.

De Leeuw, E. (2016). We need action on social determinants of health - but do we want it, too?: Comment on "Understanding the role of public administration in implementing action on the social determinants of health and health inequities". *International journal of health policy and management, 5*(6), 379-382.

De Silva, M. J., McKenzie, K., Harpham, T., & Huttly, S. R. A. (2005). Social capital and mental illness: A systematic review. *Journal of Epidemiology and Community Health, 59*(8), 619-627.

Dean, R. (2018). Control or influence? Conflict or solidarity? Understanding diversity in preferences for public participation in social policy decision making. *Social Policy & Administration, 53*(1), 170-187.

Dean, R., Boswell, J., & Smith, G. (2020). Designing democratic innovations as deliberative systems: The ambitious case of NHS Citizen. *Political Studies, 68*(3), 689-709.

Dean, R. J. (2017). Beyond radicalism and resignation: The competing logics for public participation in policy decisions. *Policy & Politics, 45*(2), 213-230.

DeForge, R., & Shaw, J. (2012). Back-and fore-grounding ontology: Exploring the linkages between critical realism, pragmatism, and methodologies in health & rehabilitation sciences. *Nursing inquiry, 19*(1), 83-95.

Degeling, C., Carter, S. M., & Rychetnik, L. (2015). Which public and why deliberate? – A scoping review of public deliberation in public health and health policy research. *Social Science & Medicine, 131*, 114-121.

Degeling, C., Rychetnik, L., Street, J., Thomas, R., & Carter, S. M. (2017). Influencing health policy through public deliberation: Lessons learned from two decades of citizens'/community juries. *Social Science & Medicine, 179*, 166-171.

Delany, T., Harris, P., Williams, C., Harris, E., Baum, F., Lawless, A., Wildgoose, D., Haigh, F., MacDougall, C., Broderick, D., & Kickbusch, I. (2014). Health impact assessment in New South Wales & health in all policies in South Australia: Differences, similarities and connections. *BMC Public Health, 14*, 699.

Delany, T., Lawless, A., Baum, F., Popay, J., Jones, L., McDermott, D., Harris, E., Broderick, D., & Marmot, M. (2016). Health in all policies in South Australia: Wshat has supported early implementation? *Health promotion international, 31*(4), 888-898.

Delli Carpini, M. X., Cook, F. L., & Jacobs, L. R. (2004). Public deliberation, discursive participation, and citizen engagement: A review of the empirical literature. *Annual review of political science, 7*, 315-344.

Den Broeder, L., Uiters, E., Ten Have, W., Wagemakers, A., & Schuit, A. J. (2017). Community participation in health impact assessment: A scoping review of the literature. *Environmental Impact Assessment Review, 66*, 33-42.

Denzin, N. K. (1989). *Interpretive interactionism*. Newbury Park, CA: Sage.

Doucet, A. (2008). "From her side of the gossamer wall(s)": Reflexivity and relational knowing. *Qualitative Sociology, 31*(1), 73-87.

Douven, I. (2021). Abduction. In E. N. Zalta (Ed.), *The Stanford Encyclopedia of Philosophy* (Vol. Summer 2021). https://plato.stanford.edu/archives/sum2021/entries/abduction/.

Durand, M. A., Carpenter, L., Dolan, H., Bravo, P., Mann, M., Bunn, F., & Elwyn, G. (2014). Do interventions designed to support shared decision-making reduce health inequalities? A systematic review and meta-analysis. *PloS one, 9*(4).

Easton, G. (2010). Critical realism in case study research. *Industrial marketing management, 39*(1), 118-128.

Ehsan, A., Klaas, H. S., Bastianen, A., & Spini, D. (2019). Social capital and health: A systematic review of systematic reviews. *SSM-population health, 8*, 100425.

Ehsan, A. M., & De Silva, M. J. (2015). Social capital and common mental disorder: A systematic review. *Journal of Epidemiology and Community Health, 69*(10), 1021-1028.

Elger, T., & Smith, C. (2014). Critical realism and interviewing subjects. In (10.1093/acprof:oso/9780199665525.003.0006). Oxford: Oxford University Press.

Eliasoph, N. (2016). The mantra of empowerment talk: An essay. *Journal of civil society, 12*(3), 247-265.

Elliott, T. (2019). How one hippie town became the anti-vaxxer capital of Australia. *The Sydney Morning Herald*. Retrieved from https://www.smh.com.au/lifestyle/health-and-wellness/how-one-hippie-town-became-the-anti-vaxxer-capital-of-australia-20190603-p51txe.html

Elstub, S., Carrick, J., & Khoban, Z. (2019). Evaluation of the Scottish parliament's citizens' jury on land management and the natural environment. In. Newcastle: Newcastle University.

Elstub, S., & Escobar, O. (2019). *Handbook of democratic innovation and governance*. Cheltenham, Gloucestershire: Edward Elgar Publishing Limited.

Elstub, S., & McLaverty, P. (2014). *Deliberative democracy: issues and cases*. Edinburgh: Edinburgh University Press Ltd.

Erikainen, S., Stewart, E., Filipe, A. M., Chan, S., Cunningham-Burley, S., Ilson, S., King, G., Porteous, C., Sinclair, S., & Webb, J. (2021). Towards a feminist philosophy of engagements in health-related research. *Wellcome Open Research, 6*.

Escobar, O. (2015). Scripting deliberative policy-making: Dramaturgic policy analysis and engagement know-how. *Journal of Comparative Policy Analysis: Research and Practice, 17*(3), 269-285.

Escobar, O. (2017). Pluralism and democratic participation: What kind of citizen are citizens invited to be? *Contemporary pragmatism, 14*(4), 416-438.

Escobar, O. (2019). Facilitators: the micropolitics of public participation and deliberation. In S. Elstub & O. Escobar (Eds.), *Handbook of democratic innovation and governance* (10.4337/9781786433862.00022pp. 178-195): Edward Elgar Publishing.

Escobar, O. (2020). Transforming lives, communities and systems? Co-production through participatory budgeting. In E. Loeffler & T. Bovaird (Eds.), *Handbook of co-production of public services and outcomes*: Palgrave Macmillan.

Escobar, O. (2022). Between radical aspirations and pragmatic challenges: Institutionalizing participatory governance in Scotland. *Critical Policy Studies,* 10.1080/19460171.2021.1993290, 1-16.

Escobar, O., & Elstub, S. (2017). Forms of Mini-publics: An introduction to deliberative innovations in democratic practice. In *Research and Development Note 4*: newDemocracy.

Esser, F., & Vliegenthart, R. (2017). Comparative research methods. In J. Matthes (Ed.), *The International Encyclopedia of Communication Research Methods*: John Wiley & Sons.

Evans, D., Pilkington, P., & McEachran, M. (2010). Rhetoric or reality? A systematic review of the impact of participatory approaches by UK public health units on health and social outcomes. *Journal of Public Health, 32*(3), 418-426.

Fanelli, D. (2012). Negative results are disappearing from most disciplines and countries. *Scientometrics, 90*(3), 891-904.

Faridi, Z., Shuval, K., Njike, V. Y., Katz, J. A., Jennings, G., Williams, M., & Katz, D. L. (2009). Partners reducing effects of diabetes (PREDICT): A diabetes prevention physical activity and dietary intervention through African-American churches. *Health education research, 25*(2), 306-315.

Fishkin, J. S. (1997). *The voice of the people: Public opinion and democracy*. New Haven: Yale university press.

Fletcher, A. J. (2017). Applying critical realism in qualitative research: Methodology meets method. *International Journal of Social Research Methodology, 20*(2), 181-194.

Flyvberg, B. (1998). *Rationality and power: Democracy in practice*. Chicago, London: University of Chicago Press.

Follers, D., Thorn, M., Rignold, J., Jaques, K., & Duong, T. (2016). Health impact assessment of stage 3 of the Airds Bradbury renewal project. In.

Follett, M. P. (2004). *Dynamic administration: The collected papers of Mary Parker Follett*. New York: Routledge.

Foucault, M. (2019). *The history of sexuality: Volume 1, The will to knowledge*. London: Penguin Books.

Foucault, M. (Ed.) (1980). *Power/knowledge: Selected interviews and other writings, 1972-1977*. New York: Pantheon.

Fredsgaard, M. W., Cave, B., & Bond, A. (2009). *A review package for health impact assessment reports of development projects*: Ben Cave Associates, Ltd.

Freeman, R. (2006). The work the document does: Research, policy, and equity in health. *Journal of health politics, policy and law, 31*(1), 51-70.

Freire, P. (1972). *Pedagogy of the oppressed*. London: Penguin Classics.

Friedli, L. (2013). "What we've tried, hasn't worked": The politics of assets based public health. *Critical Public Health, 23*(2), 131-145.

Friel, S., Townsend, B., Fisher, M., Harris, P., Freeman, T., & Baum, F. (2021). Power and the people's health. *Social Science & Medicine 282*, 114173.

Fuchs, D., & Lederer, M. M. (2007). The power of business. *Business and Politics, 9*(3), 1-17.

Gaffney, A., & McCormick, D. (2017). The affordable care act: Implications for health-care equity. *The Lancet, 389*(10077), 1442-1452.

Gagliardi, P. (2011). Artifacts as pathways and remains of organizational life. In P. Gagliardi (Ed.), *Symbols and artifacts: Views of the corporate landscape*. Boston: De Gruyter.

Gastil, J. W. (1994). *Democratic citizenship and the national issues forums. PhD thesis.* University of Wisconsin-Madison, Wisconsin.

Gastil, J. W. (2000). *By popular demand*. Berkeley: University California Press.

Gaventa, J. (2006). Finding the spaces for change: A power analysis. *IDS Bulletin 37*(6), 23-33.

Geertz, C. (1973). Thick description: Toward an interpretive theory of culture. In *The interpretation of cultures: selected essays*. New York: Basic Books.

Gerhardt, U. (1994). The use of Weberian ideal-type methodology in qualitative data interpretation: An outline for ideal-type analysis. *Bulletin of Sociological Methodology/Bulletin de Méthodologie Sociologique, 45*(1), 74-126.

Gillies, P. (1998). Effectiveness of alliances and partnerships for health promotion. *Health promotion international, 13*(2), 99-120.

Göhler, G. (2009). 'Power to' and 'Power over'. In *The Sage handbook of power* (Vol. 27, pp. 27-37). London: SAGE Publications Ltd.

Goodlad, R., Burton, P., & Croft, J. (2005). Effectiveness at what? The processes and impact of community involvement in area-based initiatives. *Environment and Planning C: Government and Policy, 23*(6), 923-938.

Graham, H. (2004). Tackling inequalities in health in England: Remedying health disadvantages, narrowing health gaps or reducing health gradients? *Journal of Social Policy, 33*(1), 115-131.

Gray, B. (2008). Putting emotion and reflexivity to work in researching migration. *Sociology, 42*(5), 935-952.

Green, M. C., & Brock, T. C. (2005). Organizational membership versus informal interaction: Contributions to skills and perceptions that build social capital. *Political Psychology, 26*(1), 1-25.

Greszczuk, C. (2019). *Implementing health in all policies*: Health Foundation.

Grölund, K., Bächtiger, A., & Setälä, M. (2014). *Deliberative mini-publics: Involving citizens in the democratic process*. Colchester: ECPR Press.

Group Health Research Institute, & Human Impact Partners. (2014). *Community participation in health impact assessments: National survey results*. Retrieved from https://humanimpact.org/hipprojects/community-participation-in-health-impact-assessments-a-national-evaluation/

Guest, G., MacQueen, K. M., & Namey, E. E. (2011). *Applied thematic analysis*. Los Angeles: Sage Publications.

Gutmann, A., & Thompson, D. F. (1998). *Democracy and disagreement*: Harvard University Press.

Habermas, J. (2018). Interview with Jürgen Habermas. In A. Bächtiger, J. S. Dryzek, J. Mansbridge, & M. Warren (Eds.), *The Oxford Handbook of Deliberative Democracy* (10.1093/oxfordhb/9780198747369.013.60pp. 871-882): Oxford University Press.

Hahn, R. A., & Truman, B. I. (2015). Education improves public health and promotes health wquity. *International journal of health services, 45*(4), 657-678.

Hahn, R. A., Truman, B. I., & Williams, D. R. (2018). Civil rights as determinants of public health and racial and ethnic health equity: Health care, education, employment, and housing in the United States. *SSM - Population Health, 4*, 17-24.

Haigh, F., Baum, F., Dannenberg, A., Harris, M., Harris-Roxas, B., Keleher, H., Kemp, L., Morgan, R., Chok, H. N., & Spickett, J. (2013). The effectiveness of health impact assessment in influencing decision-making in Australia and New Zealand 2005–2009. *BMC Public Health, 13*(1), 1188.

Haigh, F., & Scott-Samuel, A. (2008). Engaging communities to tackle anti-social behaviour: A health impact assessment of a citizens' jury. *Public health, 122*(11), 1191-1198.

Haldane, V., Chuah, F. L. H., Srivastava, A., Singh, S. R., Koh, G. C. H., Seng, C. K., & Legido-Quigley, H. (2019). Community participation in health services development, implementation, and evaluation: A systematic review of empowerment, health, community, and process outcomes. *PloS one, 14*(5), e0216112-e0216112.

Hall, R. L., & Jacobson, P. D. (2018). Examining whether the health-in-all-policies approach promotes health equity. *Health Affairs, 37*(3), 364-370.

Harris, C. (2019). Mini-publics: Design choices and legitimacy. In S. Elstub & O. Escobar (Eds.), *Handbook of democratic innovation and governance* (10.4337/9781786433862.00011pp. 45-59): Edward Elgar Publishing.

Harris, P., Baum, F., Friel, S., Mackean, T., Schram, A., & Townsend, B. (2020). A glossary of theories for understanding power and policy for health equity. *Journal of Epidemiology and Community Health, 74*(6), 548-552.

Harris, P., Harris-Roxas, B., Harris, E., & Kemp, L. (2007). *Health impact assessment: a practical guide*. Sydney, Australia: Centre for Health Equity Training, Research and Evaluation, Part of the UNSW Centre for Primary Health Care and Equity, UNSW Retrieved from http://hiaconnect.edu.au/wp-content/uploads/2012/05/Health_Impact_Assessment_A_Practical_Guide.pdf

Harris, P. J., Kemp, L. A., & Sainsbury, P. (2012). The essential elements of health impact assessment and healthy public policy: A qualitative study of practitioner perspectives. *BMJ open, 2*(6), e001245.

Harrison, A. K. (2020). Ethnography. In P. Leavy (Ed.), *The Oxford handbook of qualitative research*. Oxford: Oxford University Press.

Hastings, A., & Matthews, P. (2015). Bourdieu and the big society: Empowering the powerful in public service provision? *Policy and politics, 43*(4), 545-560.

Hendriks, C. M., Ercan, S. A., & Boswell, J. (2020). *Mending Democracy: Democratic Repair in Disconnected Times*(10.1093/oso/9780198843054.001.0001). doi:10.1093/oso/9780198843054.001.0001

Hirono, K., Haigh, F., Jaques, K., Fletcher-Larety, S., Millen, E., & Calalang, C. (2017). *Is anyone listening? Health impact assessment of the Western Sydney Airport community engagement process*. Sydney: Centre for Health Equity Training, Research and Evaluation, Part of the Centre for Primary Health Care and Equity, Faculty of Medicine, UNSW Sydney Retrieved from http://hiaconnect.edu.au/wp-content/uploads/2017/08/Is_Anyone_Listening_HIA_Report_Final.pdf

Holmes, B. (2011). *Citizens' engagement in policymaking and the design of public services*. Department of Parliamentary Services, Parliament of Australia Retrieved from https://parlinfo.aph.gov.au/parlInfo/download/library/prspub/942018/upload_binary/942018.pdf;fileType=application/pdf#search=%222010s%22

Hu, F., Hu, B., Chen, R., Ma, Y., Niu, L., Qin, X., & Hu, Z. (2014). A systematic review of social capital and chronic non-communicable diseases. *Bioscience trends, 8*(6), 290-296.

Hunter, D., Popay, J., Tannahill, C., & Whitehead, M. (2010). Getting to grips with health inequalities at last? *British Medical Journal, 340*, 323-324.

Husserl, E. (2013). Ideas: General introduction to pure phenomenology. In *Muirhead Library of Philosophy: 20th Century Philosophy* (10.4324/9781315823577). Abingdon: Routledge.

International Association of Public Participation (IAP2). (2018). IAP2 Spectrum of Public Participation. Retrieved from https://cdn.ymaws.com/www.iap2.org/resource/resmgr/pillars/Spectrum_8.5x11_Print.pdf

Israel, B., Schulz, A., Parker, E., & Becker, A. (1998). Review of community-based participatory research: Assessing partnership approaches to improve public health. *Annual review of public health*(19), 173-202.

Israel, B. A., Coombe, C. M., Cheezum, R. R., Schulz, A. J., McGranaghan, R. J., Lichtenstein, R., Reyes, A. G., Clement, J., & Burris, A. (2010). Community-based participatory research: A capacity-building approach for policy advocacy aimed at eliminating health disparities. *American Journal of Public Health, 100*(11), 2094-2102.

Jackson, K., & Bazeley, P. (2019). *Qualitative data analysis with NVivo*. London: Sage.

Jaques, K., Haigh, F., & Thorn, M. (2017). A community grounded HIA: The benefits of conducting a HIA during the Airds Bradbury estate redevelopment. *Chronicles of Health Impact Assessment, 2*(1), 49-61.

Johnson, C. (2015). Local civic participation and democratic legitimacy: Evidence from England and Wales. *Political Studies, 63*(4), 765-792.

Johnson, C. P., Williams, P. L., & Gillis, D. E. (2015). The capacity building experience of women engaged in determining the cost and affordability of healthy food in Nova Scotia, Canada. *Journal of Hunger and Environmental Nutrition, 10*(3), 356-378.

Jolley, G., Lawless, A., & Hurley, C. (2008). Framework and tools for planning and evaluating community participation, collaborative partnerships and equity in health promotion. *Health Promotion Journal of Australia, 19*(2), 152-157.

Katz, A. S., Cheff, R. M., & O'Campo, P. (2015). Bringing stakeholders together for urban health equity: Hallmarks of a compromised process. *International journal for equity in health, 14*(1).

Kawachi, I. (1999). Social capital and community effects on population and individual health. *Annals of the New York Academy of Sciences, 896*(1), 120-130.

Kemm, J. (2001). Health impact assessment: A tool for healthy public policy. *Health promotion international, 16*(1), 79-85.

Kerr, A., Ross, E., Jacques, G., & Cunningham-Burley, S. (2018). The sociology of cancer: A decade of research. *Sociology of health & illness, 40*(3), 552-576.

Kreisberg, S. (1992). *Transforming power: Domination, empowerment, and education*. Thousand Oaks: SUNY Press.

Krishnaswami, J., Martinson, M., Wakimoto, P., & Anglemeyer, A. (2012). Community-engaged interventions on diet, activity, and weight outcomes in U.S. schools: A systematic review. *American Journal of Preventive Medicine, 43*(1), 81-91.

Kruks, S. (2014). Women's 'lived experience': Feminism and phenomenology from Simone de Beauvoir to the present. In M. Evans, C. Hemmings, H. Marsha, H. Johnstone, S. Madhok, A. Plomien, & S. Wearing (Eds.), *The SAGE handbook of feminist theory* (pp. 92).

Lacouture, A., Breton, E., Guichard, A., & Ridde, V. (2015). The concept of mechanism from a realist approach: A scoping review to facilitate its operationalization in public health program evaluation. *Implementation science 10*(1), 153.

Lancet, T. (2008). Can health equity become a reality? *The Lancet, 372*(9650), 1607.

Landwehr, C. (2014). Facilitating deliberation: The role of impartial intermediaries in deliberative mini-publics. In K. Gönlund, A. Bächtiger, & M. Setälä (Eds.), *Delibeartive mini-publics: Involving citizens in the democratic process*. Colchester, UK: ECPR Press.

Laverack, G. (2006). Improving health outcomes through community empowerment: A review of the literature. *Journal of Health, Population and Nutrition*, 113-120.

Learmonth, M., Martin, G. P., & Warwick, P. (2009). Ordinary and effective: The catch-22 in managing the public voice in health care? *Health Expectations, 12*(1), 106-115.

Lee, C. W., & McQuarrie, M. (2015). *Democratizing inequalities: Dilemmas of the new public participation*. New York: NYU Press.

Lefebvre, H. (1991). *The production of space* (Fourth ed.). London: Verso.

Lehoux, P., Daudelin, G., & Abelson, J. (2012). The unbearable lightness of citizens within public deliberation processes. *Social Science & Medicine, 74*(12), 1843-1850.

Levac, D., Colquhoun, H., & O'Brien, K. K. (2010). Scoping studies: Advancing the methodology. *Implementation science 5*(1), 69.

Lightbody, R., Escobar, O., Morton, S., & Seditas, K. (2017). *'Hard to reach' or 'easy to ignore'? Promoting equality in community engagement*. What Works Scotland Retrieved from http://whatworksscotland.ac.uk/wp-content/uploads/2017/12/WWSHardToReachOrEasyToIgnoreEvidenceReview.pdf

Local Government Victoria. (2020). *Local Government Act (2020)*. Department fof Jobs Precincts and Regions Retrieved from https://www.localgovernment.vic.gov.au/council-governance/local-government-act-2020

Lukes, S. (1974). *Power: A radical view*. Basingstoke: Macmillan.

Mackenbach, J. (2010). Has the English strategy to reduce health inequalities failed? *Social Science & Medicine, 71*(7), 1249-1253.

Mackenbach, J. P. (2019). *Health inequalitites: Persistence and change in European welfare states*. Oxford: Oxford University Press.

Mansbridge, J. (1983). *Beyond adversary democracy*: University of Chicago Press.

Mansbridge, J., Bohman, J., Chambers, S., Estlund, D., Føllesdal, A., Fung, A., Lafond, C., Manin, B., & Martí, J. (2010a). The place of self-interest and the role of power in deliberative democracy. *Journal of Political Philosophy, 18*, 64-100.

Mansbridge, J., Bohman, J., Chambers, S., Estlund, D., Føllesdal, A., Fung, A., Lafont, C., Manin, B., & Martí, J. l. (2010b). The place of self-interest and the role of power in deliberative democracy. *The journal of political philosophy, 18*(1), 64-100.

Marent, B., Forster, R., & Nowak, P. (2012). Theorizing participation in health promotion: A literature review. *Social Theory & Health, 10*.

Marmot, M. (2005). Social determinants of health inequalities. *The Lancet, 365*(9464), 1099-1104.

Marmot, M. (2007). Achieving health equity: From root causes to fair outcomes. *The Lancet, 370*(9593), 1153-1163.

Marmot, M., & Bell, R. (2012). Fair society, healthy lives. *Public health, 126*, S4-S10.

Marmot, M., Friel, S., Bell, R., Houweling, T. A., & Taylor, S. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. *The Lancet, 372*(9650), 1661-1669.

Martin, G. P. (2009). Public and user participation in public service delivery: Tensions in policy and practice. *Sociology compass, 3*(2), 310-326.

Matthews, P., & Hastings, A. (2013). Middle-class political activism and middle-class advantage in relation to public services: A realist synthesis of the evidence base. *Social Policy & Administration, 47*(1), 72-92.

Maxwell, J. A. (2012). *A realist approach for qualitative research* Los Angeles: Sage.

Mazanderani, F., Noorani, T., Dudhwala, F., & Kamwendo, Z. T. (2020). Knowledge, evidence, expertise? The epistemics of experience in contemporary healthcare. *Evidence & Policy, 16*(2), 267-284.

McCartney, G., Dickie, E., Escobar, O., & Collins, C. (2021). Health inequalities, fundamental causes and power: Towards the practice of good theory. *Sociology of health & illness, 43*(1), 20-39.

McIntosh, I., & Wright, S. (2019). Exploring what the notion of 'lived experience' offers for social policy analysis. *Journal of Social Policy, 48*(3), 449-467.

McWhirter, E. (1991). Empowerment in counselling. *Journal of Counselling and Development, 69*, 222-227.

Milsom, P., Smith, R., Baker, P., & Walls, H. (2021). Corporate power and the international trade regime preventing progressive policy action on non-communicable diseases: A realist review. *Health policy and planning, 36*(4), 493-508.

Milton, B., Attree, P., French, B., Povall, S., Whitehead, M., & Popay, J. (2012). The impact of community engagement on health and social outcomes: A systematic review. *Community development journal, 47*(3), 316-334.

Minkler, M., Thompson, M., Bell, J., Rose, K., & Redman, D. (2002). Using community involvement strategies in the fight against infant mortality: Lessons from a multisite study of the national healthy start experience. *Health Promotion Practice, 3*(2), 176-187.

Mitton, C., Smith, N., Peacock, S., Evoy, B., & Abelson, J. (2009). Public participation in health care priority setting: A scoping review. *Health Policy, 91*(3), 219-228.

Mogashoa, T. (2014). Understanding critical discourse analysis in qualitative research. *International Journal of Humanities Social Sciences and Education, 1*(7), 104-113.

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *Annals of internal medicine, 151*(4), 264-269.

Molinengo, G. (2022). Flows of power: An analytical framework for the study of collaboration. *Critical Policy Studies, ahead-of-print*(ahead-of-print), 1-22.

Molnar, A., Renahy, E., O'Campo, P., Muntaner, C., Freiler, A., & Shankardass, K. (2016). Using win-win strategies to implement health in all policies: A cross-case analysis. *PloS one, 11*(2), e0147003.

Moon, S. (2019). Power in global governance: An expanded typology from global health. *Globalization and health, 15*(1), 74-74.

Munn, Z., Peters, M. D. J., Stern, C., Tufanaru, C., McArthur, A., & Aromataris, E. (2018). Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach. *BMC medical research methodology, 18*(1), 143-143.

Murphy, N. J. (2005). Citizen deliberation in setting health-care priorities. *Health Expectations, 8*(2), 172-181.

Nabatchi, T. (2013). *Democracy in motion: Evaluating the practice and impact of deliberative civic engagement*. Oxford: Oxford University Press.

National Collaborating Centre for Healthy Public Policy. (2012). *Citizen participation in health impact assessment: Overview of issues*. Québec: Institut National de Santé Publique

Québecs Retrieved from https://www.ncchpp.ca/docs/EIS-HIA_ParticipationOverview_En.pdf

Newman, J., Barnes, M., Sullivan, H., & Knops, A. (2004). Public participation and collaborative governance. *Journal of Social Policy, 33*(2), 203-223.

Newman, J., & Clarke, J. (2009). *Publics, politics and power: Remaking the public in public services*. Los Angeles: Sage.

NHS Health Development Agency. (1998). Improving health through community participation: Concepts to committment. In *Proceedings of a Health Education Authority Workshop*.

Nikkhah, H. A., & Redzuan, M. (2009). Participation as a medium of empowerment in community development. *European Journal of Social Sciences, 11*(1), 170-176.

NSW Office of Local Government. (2022). Community Engagement. Retrieved from https://www.olg.nsw.gov.au/councils/integrated-planning-and-reporting/support-for-implementation-of-ipr-framework/community-engagement/

OECD. (2020a). Good practice principles for deliberative processes for public decision making. Retrieved from https://www.oecd.org/gov/open-government/good-practice-principles-for-deliberative-processes-for-public-decision-making.pdf

OECD. (2020b). Innovative citizen participation and new democratic institutions: Catching the deliberative wave. In (https://doi.org/10.1787/339306da-en). Paris: OECD Publishing.

Orton, L. C., Pennington, A., Nayak, S., Sowden, A., Petticrew, M., White, M., & Whitehead, M. (2019). What is the evidence that differences in 'control over destiny' lead to socioeconomic inequalities in health? A theory-led systematic review of high-quality longitudinal studies on pathways in the living environment. *Journal of Epidemiology & Community Health, 73*(10), 929-934.

Ospina, S. M., & Dodge, J. (2005). Narrative inquiry and the search for connectedness: Practitioners and academics developing public administration scholarship. *Public administration review, 65*(4), 409-423.

Paolucci, P. B. (2007). *Marx's scientific dialectics: A methodological treatise for a new century*. Boston: Brill.

Parkinson, J., & Mansbridge, J. (2012). *Deliberative systems: Deliberative democracy at the large scale* Cambridge: Cambridge University Press.

Parry, J., & Wright, J. (2003). Community participation in health impact assessments: Intuitively appealing but practically difficult. *Bulletin of the World Health Organization, 81*(6), 388-388.

Participedia. (2013). Participedia: Strengthen democracy through shared knowledge. Retrieved from https://participedia.net/en

Patel, R., & Yeo, S. (2021). What works? Developing a global evidence base for public engagement. Retrieved from https://onthinktanks.org/wp-content/uploads/2021/11/OTT-Consulting_PublicEngagementReporte_Final-2.pdf

Pawson, R., & Tilley, N. (1997). *Realistic evaluation*. London: Sage.

Pedrana, L., Pamponet, M., Walker, R., Costa, F., & Rasella, D. (2016). Scoping review: National monitoring frameworks for social determinants of health and health equity. *Global Health Action, 9*(1), 28831.

Pennington, A., Watkins, M., Bagnall, A.-M., South, J., & Corcoran, R. (2018). *A systematic review of evidence on the impacts of joint decision-making on commmunity wellbeing:*

Technical report. London: What Works Centre for Wellbeing Retrieved from https://whatworkswellbeing.org/wp-content/uploads/2020/01/full-report-joint-decision-making-wellbeing-November2018-1.pdf

Petticrew, M., Tugwell, P., Welch, V., Ueffing, E., Kristjansson, E., Armstrong, R., Doyle, J., & Waters, E. (2009). Better evidence about wicked issues in tackling health inequities. *Journal of Public Health, 31*(3), 453-456.

Phelan, J. C., Link, B. G., & Tehranifar, P. (2010). Social conditions as fundamental causes of health inequalities: Theory, evidence and policy implications. *Journal of Health and Social Behavior, 51*(S), S28-S40.

Phillip, A., & Morgan, G. (2014). Co-production within health and social care - the implications for Wales? *Quality in Ageing and Older Adults, 15*(1), 10-20.

Pickersgill, M., Chan, S., Gill Haddow, G. L., Sridhar, D., Sturdy, S., & Cunningham-Burley, S. (2019). Biomedicine, self and society: An agenda for collaboration and engagement. *Wellcome Open Research, 4*.

Pillow, W. (2003). Confession, catharsis, or cure? Rethinking the uses of reflexivity as methodological power in qualitative research. *International journal of qualitative studies in education, 16*(2), 175-196.

Ponterotto, J. G. (2006). Brief note on the origins, evolution, and meaning of the qualitative research concept thick description. *The qualitative report, 11*(3), 538-549.

Popay, J. (2021). Community empowerment and health equity. *Oxford Research Encyclopedia of Global Public Health*.

Popay, J., Attree, P., Hornby, D., Milton, B., Whitehead, M., French, B., Kowarzik, U., Simpson, N., & Povall, S. (2007). *Community engagement in initiatives addressing the wider social determinants of health: A rapid review of evidence on impact, experience and process*. Retrieved from http://healthimpactassessment.pbworks.com/f/Community+engagement+in+initiatives+addresses+the+wider+determinants+of+health+-+NICE+UK+-+2007.PDF

Popay, J., Bennett, S., Thomas, C., Williams, G., Gatrell, A., & Bostock, L. (2003). Beyond 'beer, fags, egg and chips'? Exploring lay understandings of social inequalities in health. *Sociology of health & illness, 25*(1), 1-23.

Popay, J., Whitehead, M., Ponsford, R., Egan, M., & Mead, R. (2021). Power, control, communities and health inequalities I: Theories, concepts and analytical frameworks. *Health promotion international, 36*(5), 1253-1263.

Prior, L., Atkinson, P., Delamont, S., Cernat, A., Sakshaug, J. W., & Williams, R. A. (2020). Documents in social research. In P. Atkinson, S. Delamont, A. Cernat, J. W. Sakshaug, & R. A. Williams (Eds.), *Institutional ethnography*. London: SAGE Publications Ltd.

Public Services Commission. (2011). *Commission on the Future Delivery of Public Services Report (The Christie Commission Report)*. Edinburgh: Public Services Commission Retrieved from https://www.gov.scot/publications/commission-future-delivery-public-services/

Pursell, L., & Kearns, N. (2013). Impacts of an HIA on inter-agency and inter-sectoral partnerships and community participation: Lessons from a local level HIA in the Republic of Ireland. *Health promotion international, 28*(4), 522-532.

Putland, C., Baum, F., Ziersch, A., Arthurson, K., & Pomagalska, D. (2013). Enabling pathways to health equity: Developing a framework for implementing social capital in practice. *BMC Public Health, 13*, 1-12.

Putland, C., Baum, F. E., & Ziersch, A. M. (2011). From causes to solutions - Insights from lay knowledge about health inequalities. *BMC Public Health, 11*(1), 1-11.

Putnam, R. (1993). *Making democracy work: Civic traditions in modern Italy*. Princeton: Princeton University Press.

Rappaport, J. (1984). Studies in empowerment: Introduction to the issue. *Prevention in human services, 3*(2-3), 1-7.

Rein, M., & Schön, D. (1996). Frame-critical policy analysis and frame-reflective policy practice. *Knowledge and Policy, 9*(1), 85-104.

Roberts, J., & Escobar, O. (2015). *Involving communities in deliberation: A study of 3 citizens' juries on onshore wind farms in Scotland*. Retrieved from https://www.climatexchange.org.uk/media/1438/citizens_juries_-_full_report.pdf

Roberts, J. M. (2014). Critical realism, dialectics, and qualitative research methods. *Journal for the theory of social behaviour, 44*(1), 1-23.

Rolfe, S. (2016). Divergence in community participation policy: Analysing localism and community empowerment using a theory of change approach. *Local government studies, 42*(1), 97-118.

Rolfe, S. (2018). Governance and governmentality in community participation: The shifting sands of power, responsibility and risk. *Social Policy and Society: A Journal of the Social Policy Association, 17*(4), 579-598.

Roue-Le Gall, A., & Jabot, F. (2017). Health impact assessment on urban development projects in France: Finding pathways to fit practice to context. *Global Health Promotion, 24*(2), 25-34.

Roussos, S. T., & Fawcett, S. B. (2000). A review of collaborative partnerships as a strategy for improving community health. *Annual review of public health, 21*(1), 369-402.

Rowe, G., & Frewer, L. J. (2005). A typology of public engagement mechanisms. *Science, Technology, & Human Values, 30*(2), 251-290.

Salimi, Y., Shahandeh, K., Malekafzali, H., Loori, N., Kheiltash, A., Jamshidi, E., Frouzan, A. S., & Majdzadeh, R. (2012). Is community-based participatory research (CBPR) useful? A systematic review on papers in a decade. *International Journal of Preventive Medicine, 3*(6), 386-393.

Sansiritaweesook, G., & Kanato, M. (2015). Development of the model for local drowning surveillance system in northeastern Thailand. *Journal of the Medical Association of Thailand - Chotmaihet Thangphaet, 98*, S1-9.

Sayer, R. A. (1992). *Method in social science: A realist approach* (Second ed.). London: Routledge.

Schultz, J., Collie-Akers, V., Fernandez, C., Fawcett, S., & Ronan, M. (2009). Implementing community-based participatory research with two ethnic minority communities in Kansas City, Missouri. *International Journal of Migration, Health and Social Care, 5*(1), 47-57.

Schumpeter, J. A., & Stiglitz, J. E. (2010). *Capitalism, socialism and democracy* (10.4324/9780203857090). London: Routledge.

Schwartz-Shea, P. (2013). Judging quality. In D. Yanow & P. Schwartz-Shea (Eds.), *Interpretation and Method: Empirical Research Methods and the Interpretive Turn* (second ed., 10.4324/9781315703275). London: Routledge.

Schwartz-Shea, P., & Yanow, D. (2020). Interpretivism. In *SAGE Research Methods Foundations*. London: SAGE Publications.

Scott-Samuel, A., Birley, M., & Ardern, K. (2001). *The Merseyside guidelines for health impact assessment*. Impact Liverpool Retrieved from http://www.precaution.org/lib/06/mersey_hia_guide_2nd_edn.010601.pdf

Scottish Government. (2018). Infrastructure Investment Plan 2015: Progress Report for 2017. Retrieved from https://www.gov.scot/binaries/content/documents/govscot/publications/progress-report/2018/04/infrastructure-investment-plan-2015-progress-report-2017/documents/00534921-pdf/00534921-pdf/govscot%3Adocument/00534921.pdf

Scottish Government. (nd). *More homes: Housing and planning delivery framework*. Retrieved from https://www.gov.scot/policies/more-homes/housing-and-planning-delivery-framework/

Scottish Government and COSLA. (2009). *Scottish community empowerment action plan - Celebrating success: Inspiring change*. Edinburgh: Scottish Government Retrieved from https://dtascommunityownership.org.uk/sites/default/files/Community%20Empowerment%20Action%20Plan.pdf

Community Empowerment (Scotland) Act, § 6 (2015) http://www.legislation.gov.uk/asp/2015/6.

Sharma, A., & Gupta, A. (2006). *The anthropology of the state: A reader*. Malden: Blackwell.

Siddiqui, F. R. (2014). Annotated bibliography on participatory consultations to help aid the inclusion of marginalized perspectives in setting policy agendas. *International journal for equity in health, 13*(1).

Siegrist, J., & Marmot, M. (2004). Health inequalities and the psychosocial environment—two scientific challenges. *Social Science & Medicine, 58*(8), 1463-1473.

Simpson, S., Mahoney, M., Harris, E., Aldrich, R., & Stewart-Williams, J. (2005). Equity-focused health impact assessment: A tool to assist policy makers in addressing health inequalities. *Environmental Impact Assessment Review, 25*(7-8), 772-782.

Skocpol, T. (1999). How Americans became civic. In T. Skocpol & M. Fiorina (Eds.), *Civic engagement in American democracy*. Washington: Brookings Institution Press.

Smith, G., & Wales, C. (2000). Citizens' juries and deliberative democracy. *Political Studies, 48*(1), 51-65.

Smith, G. R., King, K., & Sanders, E. (2014). Community grand rounds: Re-engineering community and academic partnerships in health education—A partnership and programmatic evaluation. *Progress in Community Health Partnerships, 8*(3), 375-385.

Smith, K., Macintyre, A., Weakley, S., Hill, S. E., Escobar, O., & Fergie, G. (2021). Public understandings of potential policy responses to health inequalities: Evidence from a UK national survey and citizens' juries in three UK cities. *Social Science & Medicine, 291*, 114458.

Smith, K. E., & Anderson, R. (2018). Understanding lay perspectives on socioeconomic health inequalities in Britain: A meta-ethnography. *Sociology of health & illness, 40*(1), 146-170.

Sohn, E., Stein, L., Wolpoff, A., Lindberg, R., Baum, A., McInnis-Simoncelli, A., & Pollack, K. (2018). Avenues of influence: The relationship between health impact assessment and determinants of health and health equity. *Journal of Urban Health, 95*(5), 754-764.

Solar, O., & Irwin, A. (2010). *A conceptual framework for action on the social determinants of health. Discussion paper.* Geneva: World Health Organization Retrieved from https://www.who.int/publications/i/item/9789241500852

Squires, J. (1998). In different voices: Deliberative democracy and aestheticist politics. In J. Good & I. Velody (Eds.), *The politics of postmodernity* (pp. 126-146). Cambridge: Cambridge University Press.

Stake, R. E. (2005). *Multiple case study analysis*. New York: Guilford Publications.

Stapley, E., O'Keeffe, S., & Midgley, N. (2022). Developing typologies in qualitative research: The use of ideal-type analysis. *International Journal of Qualitative Methods, 21*.

Stern, E. (2015). *Impact evaluation: A guide for commissioners and managers*. London: Bond for International Development Retrieved from https://www.gov.uk/research-for-development-outputs/impact-evaluation-a-guide-for-commissioners-and-managers

Stewart, E. (2013). What is the point of citizen participation in health care? *Journal of Health Services Research & Policy, 18*(2), 124-126.

Stewart, E. (2014). Seeking outsider perspectives in interpretive research: Young adults and citizen participation in health policy. *Critical Policy Studies, 9*(2), 198-215.

Stewart, E. (2016). *Publics and their health systems: Rethinking participation*. London: Springer.

Stewart, E., Greer, S., Wilson, I., & Donnelly, P. (2015). Power to the people? An international review of the democratizing effects of direct elections to healthcare organizations. *The International journal of health planning and management, 31*(2), e69-e85.

Stewart, E., Smith-Merry, J., Bandola-Gill, J., & Geddes, M. (2020). Opening up evidence-based policy: Exploring citizen and service user expertise. *Evidence and Policy, 16*(2), 199-208.

Stolle, D. (1998). Bowling together, bowling alone: The development of generalized trust in voluntary associations. *Political Psychology*, 497-525.

Stolle, D. (2003). 'Getting to trust': An analysis of the importance of institutions, families, personal experiences and group membership. In P. Dekker & E. Uslaner (Eds.), *Social capital and participation in everyday life*. London and New York: Routledge.

Stone, D. A. (2002). *Policy paradox: The art of political decision making*. New York: Norton.

Street, J., Duszynski, K., Krawczyk, S., & Braunack-Mayer, A. (2014). The use of citizens' juries in health policy decision-making: A systematic review. *Social Science & Medicine, 109*, 1-9.

Sugiman, T., Gergen, K., Wagner, W., & Yamada, Y. (2008). The social turn in the science of human action. In T. Sugiman, K. Gergen, W. Wagner, & Y. Yamada (Eds.), *Meaning in action: Constructions, narratives, and representations* Japan: Springer

Tanesini, A. (1999). *An introduction to feminist epistemologies*. Oxford: Blackwell.

Tanner, L. (2010). *Declaration of Open Government*. Minister for Finance (Australia) Retrieved from https://apo.org.au/node/62429

Touchton, M., & Wampler, B. (2014). Improving social well-being through new democratic institutions. *Comparative Political Studies, 47*(10), 1442-1469.

Tricco, A. C., Lillie, E., Zarin, W., O'Brien, K., Colquhoun, H., Kastner, M., Levac, D., Ng, C., Sharpe, J. P., Wilson, K., Kenny, M., Warren, R., Wilson, C., Stelfox, H. T., & Straus, S. E.

(2016). A scoping review on the conduct and reporting of scoping reviews. *BMC medical research methodology, 16*(1), 15-15.

Tweed E, McCann A, & Arnot J. (2017). Foundations for wellbeing: reconnecting public health and housing. A Practical Guide to Improving Health and Reducing Inequalities. In. Glasgow: ScotPHN.

Tyers, R., Huckins, J., & Boswell, J. (2020). *Assessing the #DelibWave in the UK: A report on the impact of citizens' assemblies in British government*. Southampton: Public policy at Southampton Retrieved from https://eprints.soton.ac.uk/445542/

Tyler, T. (2001). The psychology of public dissatisfaction with government. In J. Hibbing & E. Theiss-Morse (Eds.), *What is it about government that Americans dislike?* Cambridge: Cambridge University Press.

Tyler, T., & Blader, S. (2013). *Cooperation in groups: Procedural justice, social identity, and behavioral engagement*. New York: Routledge.

Tyler, T. R. (1994). Psychological models of the justice motive: Antecedents of distributive and procedural justice. *Journal of personality and social psychology, 67*(5), 850.

Uphoff, E. P., Pickett, K. E., Cabieses, B., Small, N., & Wright, J. (2013). A systematic review of the relationships between social capital and socioeconomic inequalities in health: A contribution to understanding the psychosocial pathway of health inequalities. *International journal for equity in health, 12*(1), 54-54.

Uslaner, E. M. (2002). *The moral foundations of trust*. Cambridge: Cambridge University Press.

Van Eyk, H., Harris, E., Baum, F., Delany-Crowe, T., Lawless, A., & MacDougall, C. (2017). Health in all policies in south Australia—did it promote and enact an equity perspective? *International Journal of Environmental Research and Public Health, 14*(11), 1288.

Verba, S., Schlozman, K. L., & Brady, H. E. (1996). Voice and equality: Civic voluntarism in American politics. *The Journal of Politics, 58*(4), 1219-1220.

Vernon, J. L. (2017). Understanding the butterfly effect. *American Scientist, 105*(3), 130.

Wagenaar, H. (2011). *Meaning in action: Interpretation and dialogue in policy analysis*. Armonk, NY: ME Sharpe, Inc.

Wagenaar, H. (2012). Dwellers on the threshold of practice: The interpretivism of Bevir and Rhodes. *Critical Policy Studies, 6*(1), 85-99.

Wagenaar, H., & Cook, S. (2003). Understanding policy practices: Action, dialectic and deliberation in policy analysis. In M. Hajer & H. Wagenaar (Eds.), *Deliberative policy analysis: Understanding governance in the network society* (pp. 139-171). Cambridge: Cambridge University Press.

Wakeford, T. (2011). Citizens juries: a radical alternative for social research. In A. Cornwall (Ed.), *The paticipation reader*. London: Zed Books.

Wallerstein, N. (1992). Powerlessness, empowerment, and health: Implications for health promotion programs. *American journal of health promotion, 6*(3), 197-205.

Wallerstein, N. (2006). *What is the evidence on effectiveness of empowerment to improve health?* Copenhagen: WHO Regional Office for Europe (Health Evidence Network report) Retrieved from https://www.euro.who.int/__data/assets/pdf_file/0010/74656/E88086.pdf

Wang, Y.-t., Mechkova, V., & Andersson, F. (2018). Does democracy enhance health? New empirical evidence 1900–2012. *Political Research Quarterly, 72*(3), 554-569.

Weber, L., & Castellow, J. (2011). Feminist research and activism to promote health equity. *Handbook of feminist research: Theory and praxis*(2), 434-454.

Weber, M. (2017). *Methodology of social sciences*: Routledge.

Social Services and Well-being (Wales) Act 2014, § 4 (2014) https://www.legislation.gov.uk/anaw/2014/4/contents.

Welsh Government. (2020). Measuring the mountain: Response to phase one recommendations. Retrieved from https://gov.wales/sites/default/files/publications/2020-02/measuring-the-mountain-response-to-phase-one-recommendations.pdf

Whitehead, M. (1991). The concepts and principles of equity and health. *Health promotion international, 6*(3), 217-228.

Whitehead, M. (2007). A typology of actions to tackle social inequalities in health. *Journal of Epidemiology & Community Health, 61*(6), 473-478.

Whitehead, M., Pennington, A., Orton, L., Nayak, S., Petticrew, M., Sowden, A., & White, M. (2016). How could differences in 'control over destiny' lead to socio-economic inequalities in health? A synthesis of theories and pathways in the living environment. *Health & place, 39*, 51-61.

WHO European Centre for Health Policy. (1999). *Health impact assessment: Main concepts and suggested approach. The Gothenburg Consensus Paper.* Brussels: WHO Regional Office for Europe, Retrieved from http://www.impactsante.ch/pdf/HIA_Gothenburg_consensus_paper_1999

Wise, M., Harris, P., Harris-Roxas, B., & Harris, E. (2009). The role of health impact assessment in promoting population health and health equity. *Health Promotion Journal of Australia, 20*(3), 172-179.

Wismar, M., Blau, J., Ernst, K., & Figueras, J. (2007). *The effectiveness of health impact assessment: scope and limitations of supporting decision-making in Europe*. Brussels: European Observatory on Health Systems and Policies Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0003/98283/E90794.pdf

World Health Organization. (1978). *The Declaration of Alma Ata*. International Conference on Primary Health Care Retrieved from https://cdn.who.int/media/docs/default-source/documents/almaata-declaration-en.pdf?sfvrsn=7b3c2167_2

World Health Organization. (1986). *The Ottawa charter for health promotion: First international conference on health promotion*. Ottawa: WHO Retrieved from http://www.who.int/healthpromotion/conferences/previous/ottawa/en/

World Health Organization. (1988). *Adelaide Recommendations on Healthy Public Policy*. Adelaide, South Australia: Second International Conference on Health Promotion Retrieved from http://www.who.int/healthpromotion/milestones_ch2_20090916_en.pdf

World Health Organization. (1991). *Community involvement in health development: Challenging health services*. Geneva: WHO Retrieved from https://apps.who.int/iris/handle/10665/40624

World Health Organization, & Government of South Australia. (2010). *The Adelaide Statement on Health in All Policies*. Adelaide: WHO Retrieved from https://www.who.int/publications/i/item/adelaide-statement-ii-on-health-in-all-policies

World Health Organization, & Ministry of Social Affairs and Health Finland. (2013). *The Helsinki Statement on Health in all Policies*. Helsinki, Finland: The 8th Global Conference on Health Promotion Retrieved from http://www.who.int/healthpromotion/conferences/8gchp/8gchp_helsinki_statement.pdf?ua=1

World Health Organization, & Ministry of Social Affairs and Health Finland. (2014). *Health in all Policies Helsinki Statement: Framework for Country Action*. Helsinki, Finland: The 8th Global Conference on Health Promotion Retrieved from https://apps.who.int/iris/bitstream/handle/10665/112636/9789241506908_eng.pdf

Yanow, D. (2000a). *Conducting interpretive policy analysis*. Thousand Oaks: Sage.

Yanow, D. (2000b). Underlying assumptions of an interpretive approach: The importance of local knowledge. *Conducting interpretive policy analysis*, 1-27.

Yin, R. K. (2013). Validity and generalization in future case study evaluations. *Evaluation 19*(3), 321-332.

Zimmerman, M. A. (2000). Empowerment theory. In J. Rappaport & E. Seidman (Eds.), *Handbook of community psychology* (pp. 43-63). New York: Kluwer Academic/Plenum Publishers.

Zimmerman, M. A., & Rappaport, J. (1988). Citizen participation, perceived control, and psychological empowerment. *American Journal of community psychology, 16*(5), 725-750.

Appendix A.   Summary of the cases

1.   *50,000 Affordable Homes Health Impact Assessment*

In 2016 the Scottish Government committed to deliver more than 50,000 affordable homes during the 2016-21 Parliamentary term (Scottish Government, 2018). Of these, 35,000 were allocated for social rent and the remaining 15,000 may be a mix of other models including mid-market rent and low cost home ownership. An initial £3 billion investment was committed for delivery of the programme which may be used to grant fund Local Authorities and Registered Social Landlords to build the new homes.

Prior to the commitment of the Scottish Government for the 50,000 Affordable Homes programme, there had been a growing body of evidence to support the relationship between housing and health. In 2017, the Scottish Public Health Network (ScotPHN) published a practical guide for joint work between public health and housing colleagues (Tweed E et al., 2017). Within the guidance it was recommended that a health impact assessment be conducted on the new 50,000 Affordable Homes programme. In response to this recommendation, members of the Health and Housing Advisory Group (part of ScotPHN) conducted a scoping exercise to identify potential health impacts of the housing programme, and then commissioned members of the Scottish Health and Inequalities Impact Assessment Network (SHIIAN) to conduct the full HIA.

The 50,000 Homes HIA followed a standard HIA process and included the participation of key stakeholders in various stages. A steering group composed of members of NHS Health Scotland, ScotPHN, SHIIAN and the Association of Local Authority Chief Housing Officers led the HIA. The steering group was responsible for overseeing the process aims and design, determining evidence to be collected, discussing findings, agreeing recommendations and producing the report. Recommendations were generated through deliberation and consensus by the steering group.

Most participants described the aim of the process as identifying the links between health and housing through a systematic examination of the health impacts of the

housing policy. Given that the HIA was being conducted after the 50,000 homes programme had already been decided, and was into implementation, the aim was less about influencing policy design and more about informing implementation at later stages or other sub-decisions that would need to be taken by local authorities.

How was the process run?

In 2016 a scoping exercise (one of the first steps of an HIA) was conducted with members of the ScotPHN Health and Housing Advisory Group. Of the 26 members on the Housing Advisory Group – composed of a mix of public health and housing professionals (see Table 1) – approximately ten people attended the scoping workshop. This exercise helped to identify the populations and potential health impacts likely to be affected by the 50,000 homes programme. These impacts were used to identify research questions to be answered through the HIA. Evidence was generated through routine data on housing and homelessness in Scotland, through a literature review, and interviews with key informants. A summary of the scoping meeting was circulated to all members of the health and housing advisory group and several of the members sent comments.

Representation on the ScotPHN Health and Housing Advisory Group	
Public health representatives from various national organisations and local boards	Architect
Scottish Housing Network	Local Authority Housing Officer
Housing Options Scotland	Association of Local Authority Chief Housing Officers
Shelter Scotland	Scottish Government Housing Policy
Scottish Federation of Housing Associations	Voluntary Health Scotland
Chartered Institute of Housing	Convention of Scottish Local Authorities

Sixteen people were interviewed as key informants. Key informants were selected based on their knowledge of the policy and its implementation, and/or understanding of the links between health and housing. An initial list of participants were identified by the steering group, and others were suggested through a 'snowball' sampling approach

used during the interviews. Key informants included: Scottish Government policy makers responsible for implementation of the programme and policy leads for wider housing policy; academics with expertise in housing and/or public health; Local Authority Heads of Housing; Housing Authority representatives; Convention of Scottish Local Authorities (COSLA); Chartered Institute of Housing; and Homes for Scotland.

Approximately five meetings of the steering group were convened over the course of the HIA in addition to the scoping meeting. They were conducted via teleconference and the group communicated by email in between meetings. Additional informal conversations were had with members of the Scottish Government and COSLA as well throughout the process. For example, a Scottish Government representative provided access to data and contributed to early drafts of the report (though later withdrew from the process as they felt it was inappropriate to contribute towards recommendations aimed at Scottish Government).

Participants on the steering group contributed by attending teleconferences; having discussions with the process organisers; "pulling together evidence for a range of different public health topics"; participating in the scoping workshop (in which a range of public health areas and populations are considered against the policy to determine likely impacts); commenting on drafts documents; and disseminating the findings from the final report. A PowerPoint slide deck was created after the HIA report was completed, which included an infographic that summarised the impact of housing on health. One participant stated that he used these slides to present on the benefits of affordable housing. Some participants were more involved in the production of the final report by contributing to recommendations and writing the report.

Professional stakeholders were invited to participate in the HIA via membership to the steering group, participation at the scoping workshop, participation in key informant interviews, and through additional consultation with select stakeholders (such as a representative from the Scottish Government).

Participation from non-professional stakeholders, such as lay persons or community representatives, was not invited. In interviews with the process organisers I was told that they chose not to invite community stakeholders for a few key reasons. First, the programme under examination was a national programme, therefore appropriate community engagement would require participation of people across all of Scotland. Secondly, and partially due to this first point, the HIA steering group did not feel they had the time or resources to conduct appropriate community engagement.

The HIA was conducted between 2016-17 and the report was published in June 2017. I conducted interviews for this research in 2020.

2.   Airds Bradbury Health Impact Assessment

Airds Bradbury is a social housing estate located in Campbelltown City Council, approximately 50km southwest of Sydney CBD. The suburb has a population of approximately 3,500 residents (as of 2016). It is a culturally diverse community with Aboriginal and Torres Strait Islander people composing approximately 15% of the total Airds population along with a high percentage of residents born in Samoa, New Zealand, Fiji and Lebanon. Airds has high unemployment rates (26.8%) and the area is considered one of the most socioeconomically disadvantaged suburbs in New South Wales (Follers et al., 2016).

Since 2009, Airds Bradbury has been undergoing renewal. The objective of the Renewal Project, first set out by Housing New South Wales, and further approved by Campbelltown City Council in the 2012 Concept Plan, is to change the composition of the estate by moving it to a 30% social housing, 70% private housing mix. This has involved moving existing residents to new houses, relocating residents to other estates, building new roads and connections, and updating community facilities. The New South Wales Land and Housing Corporation (Housing), part of the NSW Department of Family and Community Services (FACS), is responsible for leading the project and Urban

Growth NSW Development Corporation (now Infrastructure NSW) is responsible for project delivery.

As part of the renewal project there have been many community consultation exercises run by FACS in the past. This included an award-winning consultation process called 'Airds Out Loud' that was run prior to 2010.

In 2015-16, a health impact assessment (HIA), led by Housing, was conducted on part of the Airds Bradbury Renewal Project. The focus of the HIA was on Stage 3 of the Concept Plan which sets out redevelopment of the town centre, including the multipurpose centre, manmade Airds pond, and new playing fields. The HIA team (those who led the HIA) was composed of members of FACS, residents of Airds and Bradbury suburbs, and a researcher from the Centre for Health Equity Training, Research and Evaluation (an academic unit within the University of New South Wales that is also part of the Local Health District). The HIA was conducted as part of a learning-by-doing training that was run by CHETRE (for which I was a trainer) with funding from the Population Health Unit of the South Western Sydney Local Health District.

According to members of the HIA team, the primary aim of the HIA was to provide an avenue through which the needs of the community could be incorporated into the stage 3 plan. Some HIA team members stated that providing the community with the opportunity to inform the decision, through which it would more greatly reflect the needs of the community, would in turn would lead to greater community ownership of the redeveloped areas. "For them to be the owners of where it was going to go" (Kaylee, community participant).

Some interviewees also described it as a 'new' approach to doing community consultation. There were concerns from community residents that the community had been "surveyed to death" and concern from Housing representatives that a formal consultation would imply that the redevelopment would be happening soon (they didn't

want to make false promises). The HIA was used as a way for Housing to enable input from local residents without launching a formal consultation.

Several interviewees stated that they saw the HIA as also providing a way for residents to have the evidence to demonstrate how the proposed redevelopment may affect the health of the community, and to share this information with decision-makers in order to improve the redevelopment. "I think that was the biggest objective: to have evidence to show and say, 'This is what we need. This is what will be the best for our health'" (Nicole, HIA Commissioner).

How was the process run?

The HIA team took a 'community grounded' approach to the design and delivery of the HIA process (Jaques et al., 2017). This involved community members providing evidence and through community participation on the HIA team and reference group. Being part of the HIA team meant that the involved community residents had influence over how the HIA was conducted (such as where data should be collected and who to involve) and were directly involved in collecting data from other community members. The HIA team also "prioritised community views and experience" in the scoping and assessment stages of the HIA (Jaques et al., 2017).

There were two key events at which community residents and stakeholders provided input and evidence for the HIA. These were the scoping and assessment workshops:

The scoping workshop included members of the Airds Bradbury Community Reference Group (CRG), local school administrators and high school students. The health pathways designed at this stage later received input from a member of the local Aboriginal community.

The assessment workshop included community residents, service providers, high school administrators and students, police, Council staff, Housing staff, and the developers. The assessment findings and recommendations were shared with a

member of the local Aboriginal community who shared them with members of the local Aboriginal men's group and brought this feedback back to the HIA team.

The community residents who were invited to be part of the HIA working group were selected due to their existing involvement in Airds Bradbury (they were well known by the lead Housing staff member). All community residents on the HIA team participated in a voluntary capacity and no compensation was provided to attendees of the two workshops.

The HIA was also established as a standing agenda item for the Community Reference Group (CRG) monthly meetings, at which draft outputs (findings and recommendations) were presented for comment from the group. This began during the HIA process in 2016 and has continued as a standing agenda item (as of 2019).

The final HIA report was presented to the CRG and submitted to Infrastructure NSW, the Housing Development Director, and Campbelltown City Council in December 2016. I conducted interviews for this research in 2019.

3.   *Byron Shire Community Solutions Panel*

Byron Shire is an area of northern New South Wales renowned for its natural beauty and is a popular tourist destination, particularly Byron Bay. Part of the attraction for both tourists and those who have relocated to the area is both the natural environment and unique character of the Shire. Byron has a large percentage of foreign-born residents (17.8%), which is higher than the regional NSW average (11.2%)(Byron Shire Council). The Bundjalung Nation of Byron Bay including the Akrawal people, Minjungbal people and the Widjabul people are the traditional custodians of the land. Aboriginal and Torres Strait Islander peoples represent 1.8% of the population (Byron Shire Council).

The local government area has approximately 35,000 residents, but as many as 2 million visitors annually. This massive influx of tourists each year boosts income for

local businesses, but does not increase revenue for Council, despite the considerable strain this puts on infrastructure. In 2017 Byron Shire Council (Council) approved a rate increase of 7.5% over 4 years to be invested into infrastructure. Community engagement prior to the CSP demonstrated that infrastructure was a key area of concern and there was a desire for community-led decision-making with Council in general.

Around this time, newDemocracy Foundation (nDF) had been in conversation with Council about opportunities to strengthen participation of residents in Council decision-making. Council staff had expressed a view that that their typical models of engagement, in which residents respond to Council decisions, was leading to frustration and a lack of trust from the community. nDF suggested that a citizen's jury could enable Council to share in the decision-making process, particularly for complex community issues or 'wicked problems.' Council had convened a citizen's jury in the past on tourist management and several of the Councillors were familiar with and supportive of this approach, including the Mayor.

In 2018, Council, with support from nDF, undertook a citizen's jury (what they called a Community Solutions Panel or CSP) to address prioritisation of spending for infrastructure. The remit of the CSP was to address this question:

> *"How should the money generated through the rate increase and earmarked for expenditure on infrastructure be prioritised, and how should those priorities be funded if rates alone are not enough?"*

This question was designed to be open-ended and non-partisan so as to avoid influence by decision-makers to take a certain decision. Furthermore, Council agreed in advance to adopt the recommendations generated through the process.

How was the process run?

The CSP comprised of 32 participants who were randomly selected using Council's database. Of the several thousand people contacted initially through the database, over 400 responded with interest in participating, and of those, 32 were selected to participate based on their demographics in order to reflect a cross-section of the local population. Thirty-one people completed the process.

Panellists met for 4 sessions over the month (approximately 27 hours) which is slightly shorter than nDF's typical model (35-40 hours). Panellists were offered an honorarium of AU$300 for their work, which is customary in mini-publics as a measure to reduce barriers to participation.

The process was run by nDF and moderated by an external facilitator who was trained in facilitating citizen's juries. Panellists were provided with a briefing book prior to commencing. This 127-page document covered the aim and process of the CSP but also provided panellists with extensive background information on Council infrastructure, spending, revenue and other processes (e.g. community engagement strategies, monitoring process). The information provided in the briefing book was compiled by Council staff. During the CSP, Council staff and elected representatives from across the political spectrum provided expert testimony.

Given the considerable community interest on this topic, Council invited community members to make submissions which would be provided to the panellists. Forty-nine submissions were received[27]. Furthermore the local media was briefed about the CSP in advance and a member of the press was invited to attend several meetings. Given the comprehensive and accessible information it provided, the briefing book was also made available to members of the public.

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[27] Although interestingly, the panellists voted not to consider these submissions as part of their deliberation.

The final report with the recommendations of the panel was produced during the final session of the CSP on 25 March 2018. I conducted interviews for this case study in March 2019.

4. ***Measuring the Mountain Citizens' Jury***

In 2016 the Social Services and Well-being (Wales) Act 2014 came into force. The Act was designed to transform the delivery of social care across Wales through improvement in five key areas: voice and control for social care users; prevention and early intervention; support for carers; and co-production. As part of the implementation of the Act, Welsh Government committed to a multi-stage collaborative evaluation which relied on citizen engagement.

Measuring the Mountain (MtM) was proposed by a steering group composed of academics, health, and social care professionals to Welsh Government as a co-productive approach to the evaluation. MtM is composed of two main streams of work: an ethnographic approach to story gathering from users of social care, called Sensemaker; and a citizens' jury which explores a key question arising from the collected stories. This multi approach was intended to provide Welsh Government with a better understanding of the experiences of social care users in relation to the Act. With this in mind, Welsh Government funded MtM with the first stage of the project beginning in January 2018.

The question posed to the Jury was: "What really matters in social care to individuals in Wales?" The steering group selected this question after key themes arising from the Sensemaker project demonstrated considerable variety in people's experiences of and priorities in social care.

How was the process run?

The MtM final jury was comprised of 14 Welsh residents. The CJ was advertised online and was included in the information provided to anyone who participated in the Sensemaker project. This approach yielded 42 registrants, which was later reduced to

21 people after discussion of the process expectations. From these 21 people, the final 14 were selected based on a random selection method intended to reflect a cross-section of the local population. Given that the initial registration of interest was generated through self-selection, most of the jurors had considerable knowledge and experience with the social care sector, either as recipients of social care or as carers. Jurors were also mostly older (over 45), highly educated, not employed, and resided in the south of Wales.

The MtM CJ took place over 4 consecutive days in September 2019 in addition to an initial half-day preparation session. The first three days were a structured programme designed by the process organisers to cover key areas of social care relevant to the Act. The programme was structured around sessions in which pre-selected witnesses provided testimony, either on their professional work or lived experience, along with time for the jurors to ask questions. A half hour of time for jury discussion and deliberation proceeded each of these sessions. The final half-day was a facilitated session for jurors to discuss the testimony and generate recommendations.

The witnesses were selected by the steering group to address the key themes of the programme. They were selected based on convenience sampling in which members of the steering group identified potential witnesses through their existing professional networks and then selected people based on scheduling and availability. Witnesses provided a summary statement of what they were planning to provide as testimony in advance to the jurors to allow them to anticipate the discussion and develop initial questions.

The process was run by the MtM Steering Group and was facilitated by an external facilitator with experience working with the third sector. It is generally considered best practice to pay jurors an honorarium for their time in order to reduce barriers to participation. For this project jurors and witnesses participated on a voluntary unpaid basis, however they were provided with hotel accommodation and travel expenses.

In addition to the jurors and witnesses, observers were allowed to attend the jury. Observers were representatives of interested organisations, including representatives from Welsh Government, and members of the MtM steering group including the process organisers. Observers had been informed prior to the commencement of the jury that they were not allowed to approach the jurors or witnesses so as to avoid any undue influence on the process. However, jurors were free to mingle with the witnesses and observers during break times and several jurors said that they had used that unstructured time to engage with the people in attendance. No witnesses or observers (with the exception of the process organisers) were allowed to attend the final half day of discussion and recommendations.

The final report of the CJ was written by the process organisers, not the jurors. It was published approximately 4 months after completion of the jury. The final half day session of the jury was structured to allow the jurors to develop recommendations based on the evidence they had been provided over the previous three days. Using e-tablets, jurors submitted a list of individual recommendations, rather than an agreed set of group recommendations. This approach was used due to the limited time available on the final day. The process organisers then looked for common themes across the individual recommendations and developed a final list of 15 recommendations which they felt reflected the recommendations of the group. A draft of the final report was circulated to the jurors for comment and the final report was submitted to Welsh Government in January 2019.

The MtM Citizens' Jury (CJ) was run in September 2018. The final report of the CJ was published in January, 2019, by the organisers (Cooke & Iredale, 2019). Interviews for this case study were conducted in November 2019 and included jurors, witnesses, process organisers and decision-makers.

Appendix B.   Sample HIA Stakeholder Engagement Checklist (Airds Bradbury)

Airds Bradbury HIA

Table 3: North American HIA Practice Standards Relating to Stakeholder Participation by HIA Stage[8]

	HIA Standards for Practitioners	Section
Process Oversight:	*Intended to be used throughout all the stages of the HIA*	
Essential	• Accept and utilize diverse stakeholder input.	1.5
Recommended	• Have a specific engagement and participation approach that utilizes available participatory or *deliberative methods* suitable to the needs of stakeholders and context	1.6
Screening Stage:	*Deciding whether an HIA is needed, feasible, and relevant*	
Essential	• Understand stakeholder concerns in order to determine potential health effects. • Identify and notify stakeholders of decision to conduct a HIA.	2.2.3 2.3
Recommended	• Identify stakeholders to potentially partner with a HIA. • Seek diverse stakeholder participation in screening the target policy or HIA plan.	
Scoping Stage:	*Deciding which health impacts to evaluate and evaluation methodology*	
Essential	• Use input from multiple perspectives to inform *pathways* (between the policy, plan or project and key health outcomes). Use multiple avenues to solicit input (from stakeholders, affected communities, decision makers). • Ensure a mechanism to incorporate new feedback from stakeholders on the scope of the HIA.	3.1 3.7
Recommended	• Work with diverse stakeholders to prioritize key elements of analysis. • Seek feedback from stakeholders on HIA scope.	
Assessment Stage:	*Using data, research, and analysis to determine the magnitude and direction of potential health impacts*	
Essential	• Use local knowledge as part of the evidence base.	4.2.1 4.2.4
Recommended	• Work to engage all stakeholders in data collection. • Seek feedback from stakeholders on draft findings.	
Recommendations:	*Providing recommendations to manage the identified health impacts and improve health conditions*	
Essential	• Use expert guidance to ensure recommendations reflect effective practices.	5.2
Recommended	• Work with community and other stakeholders to identify and prioritize recommendations. • Seek input on recommendations.	
Reporting & Communication:	*Sharing the results, recommendations*	
Essential	• Summarize primary findings and recommendations to allow for stakeholder understanding, evaluation, and response. • Document stakeholder participation in the full report. • Make an inclusive accounting of stakeholder values when determining recommendations. • Allow for, and formally respond to, critical review from stakeholders, and make the report publicly accessible.	6.2 6.3 6.5 6.6-7
Recommended	• Seek diverse input on draft final report. • Work with stakeholders to build their capacity to understand and articulate the findings of the HIA.	
Monitoring:	*Tracking how the HIA affects the decision and its outcomes*	
Essential	• Plan should address reporting outcomes to decision makers. • Monitoring methods and results should be made available to the public.	7.2 7.4
Recommended	• Involve interested stakeholders in monitoring outcomes.	

(Handwritten annotations: "HIA team included community Representative" next to Screening Stage; "Stakeholder Workshop" next to Scoping Stage Recommended; checkmarks in right margin throughout.)

Best Practices for Stakeholder Participation in Health Impact Assessments – March 2012
Stakeholder Participation Working Group of the 2010 HIA in the Americas Workshop

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Appendix C.   Mini-publics Criteria Checklist

Criteria	Yes/No
Focuses on a specific, tangible problem	
(quasi) Random sampling of the population - ordinary people affected by these problems	
Participants receive compensation	
Contains an education phase that allows participants to learn, form and articulate opinions	
Provides participatory (deliberative) problem-solving collaboration	
Seeks to incorporate recommendations of citizens directly into decision making	
Process is designed and facilitated by independent facilitators	

Appendix D. Research Interview Protocol (Participants)

1. Tell me the story of your involvement in the [CJ/HIA].
Prompts:
Can you tell me a little bit about the process?
What was your role in the process?
When and how did you become involved?
Whose idea was it for this process to take place?
What was the original impetus to undertake this process?
Who was pushing for this and why? How was it resourced?
What was the final output?

2. What do you think was the aim of the process and who decided that?
Prompts:
Were there multiple goals? If yes, do you feel the multiple goals sat well together or were there any tensions.
Do you think these goals were achieved? How so?

`Often the goal of an [HIA/CJ] is to inform a specific decision. How do you think the process was supposed to be used to inform decision making, if at all?
Prompts:
Is this what happened?
Do you think the process affected any subsequent decisions? How so?

3. What do you feel were the outcomes of doing the [CJ/HIA]?
Prompts:
Were there any benefits?
Where they any negative outcomes of the process?
Were there any outcomes that surprised you?
Do you feel that the process was able to bring forward new issues or solutions that were not originally on the decision makers agenda?
Do you feel that the outcome had an impact on your health or the health of your community?
Do you think that the whole community was affected by these outcomes or just some select groups? Was who was affected fair?

4. Whom do you feel you are representing by participating in the HIA? For example, did you see your role in the HIA as representing a group/organisation/community?
Prompts:
What does that mean in practice? What helps you to represent them here? (e.g. you are a member of that group, you have lived experience of a topic, you have professional/educational training on a topic)?

5. These kinds of processes are often underpinned by an implicit goal of 'empowering' participants. How, if at all, do you feel that the process accomplished this?

Prompts:

Do you feel like the process gave you more power or say in the decision-making process? Did it change your ability to have more control over the decision, or to influence the decision?

Did it change your awareness of the decision or how health is affected by a decision?

Did you gain any skills or capacity (to engage with decision makers, to write a technical report, leadership)?

Did you gain new social networks or social support?

Do you feel like the process changed how decisionmakers perceived you or your input?

Do you feel like these changes lasted beyond the process (e.g. with becoming more politically active or more engaged in other ways)?

If no, what would be a situation in which you would feel empowered?

6. Have you made any changes in your life as a result of this process?

Prompts:

e.g. Lifestyle changes, health changes, being more politically active, being more active in your community?

Have you become involved in any other types of processes (i.e. healthcare consumer panels, other citizens juries or HIAs?)

When did you make those changes? Did you make these changes during the process or after? Have those changes lasted?

Why have you made these changes? Was it a result of feeling empowered, or something else?

7. What was it about the process that allowed those outcomes to happen?

Prompts:

What were the features of this that made the process useful/not useful? Empowering/not empowering?

Was there something about the technical process that enabled these outcomes (e.g. gathering evidence)? Or was it the way the process was facilitated (i.e. through engaging with residents, involving decision makers, etc.)? Or something else entirely?

Was it a change in capacity, knowledge, thinking? What was it about the process that facilitated these changes?

8. How did you feel about the process immediately after it ended? Do you feel the same or different about it now (x amount of time later)? How so?

9. Tell me about how the information that you and other participants provided during the CJ/HIA (e.g. your thoughts, opinions, data) were used?

Prompts:

Have you been able to find out how the results of the process were used? E.g. was it communicated directly to decision makers?

What was your involvement in the process of engaging with decision makers?

10. Do you feel that the [CJ/HIA] process provided useful recommendations? How so?

Prompts:

Do you feel that the recommendations were useful for the decision-making process? Why or why not?

Did the recommendations reflect your input (thoughts, opinions, data)?

11. One of the findings from evaluations of participatory processes [e.g. CJ/HIA] is that the process enables community members to engage with decision makers. Was that your experience?

Prompts:

Are you engaged with policymakers now or have you been on any other topics?

Has your engagement with policymakers lasted beyond the process?

12. What was it about the process that enabled you (or inhibited you) from engaging with decision makers?

Prompts:

Or that made you feel that there was a shift in power?

13. How, if at all, do you feel that the process (outputs and recommendations) made decision makers any more aware of how health and health equity are affected by the decision?

Prompts:

Do you feel that the process was able to bring forward health concerns or solutions that were not originally on the decision-making agenda?

Do you feel that health and health equity were considered in the final decision?

What to you is 'health equity?'

Do you feel that the political and policymaking context affected how decision makers perceived or responded to the recommendations?

14. Did you have any concerns about the process? If so, what?

Prompts:

For example, concerns about who was involved in the process (representativeness of participants) or how decision makers were engaged?

15. If this kind of process was being undertaken again for a similar issue, would you like to see any changes being made?

16. Would you like to see this kind of process being used more regularly to inform other policy decisions?

Prompts:

Do you feel it could be used very broadly or is it only suited to particular kinds of issues/decision?

Appendix E.   Participant Information Statement

THE UNIVERSITY OF EDINBURGH

Approval number 256541

PARTICIPANT INFORMATION STATEMENT

Participation as an approach to health equity: A comparison of citizen's juries and health impact assessment

You are being invited to take part in research on how participatory processes affect health equity. Katie Hirono, a PhD candidate at the University of Edinburgh is leading this research. Before you decide to take part it is important you understand why the research is being conducted and what it will involve. Please take time to read the following information carefully.

WHAT IS THE PURPOSE OF THE STUDY?
The purpose of the study is to explore perceptions of how a participatory process such as a citizens' jury or health impact assessment may affect health and health equity. This research will be used for a PhD dissertation.

WHY HAVE I BEEN INVITED TO TAKE PART?
You were selected as a possible participant in this study because of your former participation in [insert the name of the process for each case study]. If you decide to participate, you will form part of a group of participants who will be asked questions concerning your experience with the [insert the name of the process].

DO I HAVE TO TAKE PART?
No – it is entirely up to you. If you do decide to take part, please keep this Information Sheet and complete the Informed Consent Form to show that you understand your rights in relation to the research, and that you are happy to participate. If you do decide to take part you are still free to withdraw at any time and without giving a reason. Please note down your participant number (which is on the Consent Form) and provide this to the lead researcher if you seek to withdraw from the study at a later date. Your decision whether or not to participate will not prejudice your future relations with the University of Edinburgh or the researcher. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without prejudice.

WHAT WILL HAPPEN IF I DECIDE TO TAKE PART?
You will be asked a number of questions regarding your experience in [name of the process] and the outcomes of that process. The interview will take place in a safe environment at a time that is convenient to you. Ideally, we would like to audio record your responses so the location should be in a fairly quiet area. You can decide whether or not you want the interview to be recorded at the time of the interview. The interview should take no longer than one hour.

WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART?
By sharing your experiences with us, you will be helping the researcher and the University to better understand the ways in which participation in decision making processes can affect health equity.

ARE THERE ANY RISKS ASSOCIATED WITH TAKING PART?
There are no significant risks associated with participation. If there are any questions that you would prefer not to answer or any discussion topics that are uncomfortable, you are free not to answer, change the topic, or end the interview.

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WHAT IF I WANT TO WITHDRAW FROM THE STUDY?

Agreeing to participate in this project does not oblige you to remain in the study nor have any further obligation to this study. If, at any stage, you no longer want to be part of the study, please inform the project administrator Katie Hirono, tel: +61 0401205233 (Aus), +44 7412556405 (UK); Email: katie.hirono@ed.ac.uk. You should note that your data may be used in the production of formal research outputs (e.g. journal articles, conference papers, theses and reports) prior to your withdrawal and so you are advised to contact the research team at the earliest opportunity should you wish to withdraw from the study. On specific request we will destroy all your identifiable answers, but we will need to maintain our records of your consenting participation.

DATA PROTECTION AND CONFIDENTIALITY

Your data will be processed in accordance with Data Protection Law. All information collected about you will be kept strictly confidential. Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission, except as required by law. Any information that you disclose during the interview that could potentially identify you will be redacted from the transcription and any subsequent publications. If you consent to being audio recorded, all recordings will be destroyed once they have been transcribed. Your data will only be viewed by the researcher and her supervisors. All electronic data will be stored on a password-protected computer file on a secure server and all paper records will be stored in a locked filing cabinet. Your consent information will be kept separately from your responses in order to minimise risk.

INTERNATIONAL DATA TRANSFERS

Your data may be stored and processed in Australia. Please note countries outside of the European Economic Area may not offer the same level of data privacy protection as in the UK.

WHAT WILL HAPPEN WITH THE RESULTS OF THIS STUDY?

If you give your permission by signing the consent form, information provided in this interview will be used towards a PhD dissertation. The results of this study may be summarised in published articles, reports and presentations. Quotes or key findings will always be made anonymous in any formal outputs unless we have your prior and explicit written permission to attribute them to you by name. In any publication, information will be provided in such a way that you cannot be identified. Information may also be kept for future research.

WHO CAN I CONTACT?

If you have any further questions about the study, please contact the lead researcher, Katie Hirono:
tel: +61 0401205233 (Aus), +44 7412556405 (UK); Email: katie.hirono@ed.ac.uk.

If you wish to make a complaint about the study, please contact: Dr Katherine Smith, Katherine.smith@ed.ac.uk. In your communication, please provide the study title and detail the nature of your complaint.

You can get this document on tape, in Braille, large print and various computer formats if you ask us. Please contact the data protection officer (details below) and quote reference number 256541. For general information about how we use your data go to: https://www.ed.ac.uk/records-management/privacy-notice-research.

University of Edinburgh Data Protection Officer
Governance and Strategic Planning
University of Edinburgh
Old College
Edinburgh EH8 9YL
Tel: 0131 651 4114 dpo@ed.ac.uk

Appendix F.　　Participant Consent Form

PARTICIPANT CONSENT FORM

Study Title: Participation as an approach to health equity: A comparison of citizen's juries and health impact assessment

Participant Number: _____

Please initial box

1. I confirm that I have read and understood the Participant Information Sheet for the above study.

2. I have been given the opportunity to consider the information provided, ask questions and have had these questions answered to my satisfaction.

3. I understand that my participation is voluntary and that I can ask to withdraw at any time without giving a reason and without my relationship with the University of Edinburgh or the researcher being affected.

4. I understand that my anonymised data will be stored for a minimum of 5 years and may be used in future ethically approved research.

5. I agree to take part in this study.

Name of person giving consent　　　Date　　　Signature

_____　　　_____　　　_____

Name of person taking consent　　　Date　　　Signature

_____　　　_____　　　_____