Putting partnership into practice: participatory wellbeing assessment on a south London housing estate

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Abstract

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Accepted for publication

28 August 2002

Keywords: community development,
participation, participatory assessment

Purpose Bridging the gap between professionals and communities and establishing new forms of partnership is essential if service provision is to be made more responsive and accountable. This article describes an innovative approach to creating the basis for partnerships to address community wellbeing on an estate in south London.

Methods Drawing on participatory appraisal and action planning methods, and drawing together residents and professionals within and beyond the health service, a participatory wellbeing assessment exercise was carried out on a housing estate with a population of around 6000 people, involving just under 10% of residents.

Results The participatory wellbeing assessment exercise served as a means of seeking to bridge different perceptions, priorities and perspectives on wellbeing and forge new relationships, alliances and partnerships for change. Creating this vehicle for change also created opportunities for local people to participate in community wellbeing issues. This, in turn, strengthened connections between health policy, provision and grassroots community health development, broadening opportunities for service responsiveness and citizen involvement.

Conclusion Broadening involvement in assessing and determining priorities for improving wellbeing can serve to do more than enable citizens to engage more directly in making and shaping the policies that affect their lives. It can also serve as a way of establishing new kinds of partnerships across and within the statutory and non-statutory services, opening up space for new, more 'joined up' forms of work that help to bridge the gap between citizens and services.

Introduction

In recent years, new spaces have opened up in the UK for the democratization of decision-

making over policies, priorities and provisioning in the health sector. A wave of consultation has washed over some of the poorest areas of the country. With these moves, potent challenges

have surfaced for participation.^{1,2} Participatory approaches have been used for decades to enable local people to empower themselves, demand changes in service provision and engage more actively in bringing about some of these changes themselves.^{4,5,6} Informed, aware and active citizens are clearly in a better position to mobilize around demands for change. But bringing about better service responsiveness and a closer fit of policies to local priorities depends on more than strengthening citizen voice.^{1,5} The tokenism and manipulation that Arnstein³ drew attention to 30 years ago is just as alive in many of today's efforts to engage public involvement, and is manifest in the use of the instruments of participation to rubber-stamp existing projects and proposals. Communities complain of being 'consulted to death', or, as one London resident put it, remaining victims of the 'mushroom syndrome': 'keep us in the dark and feed us on sh*t'.

Moving beyond lip-service about public involvement calls for processes that can engage, and seek to transform, those who are responsible for deciding about and delivering health services. This, in turn, requires renewed efforts to change professional practice and to forge new kinds of relationships between professionals and community members. Our focus in this article is on these relationships, and on the opportunities that participatory processes open up for enhancing understanding, as well as for enabling citizens to have more of a voice in determining the decisions that affect their lives. We reflect on a participatory wellbeing assessment process that sought to open up space for greater engagement of community members with the professionals who work closely with them in setting a new agenda for local health and social development in a low-income housing estate in south London.

The participatory wellbeing assessment process aimed to put ideas about partnership and participation into practice. It sought to combine finding out about people's views and experiences with bringing about changes in relationships, attitudes and behaviour – as well as in the services people felt they needed. Adapting an

approach to broadening public involvement that grew out of innovative practice in Africa and Asia, Participatory Rural Appraisal (PRA), known in the UK as Participatory Appraisal (see Box 1), we sought to draw on lessons learned from applications in policy research and institutional change in developing countries, and to complement participatory appraisal with participatory action planning.^{7,8} Told from our different perspectives as resident, health promotion manager, community health development worker and consultant-facilitator, the stories of challenge and change that we narrate here offer lessons that may be applicable more widely. Five years have passed since we began work on this estate. With the passage of time, we are able to reflect on the kinds of changes that have taken years, rather than weeks or months, to come to fruition and the seeds sown by this work that have taken root in work on the estate and within the authorities.

Box 1 Participatory wellbeing assessment: principles and practice

- Guided by local people's perceptions of wellbeing and their definitions of 'need';
- involves local people in setting the agenda for action;
- emphasises multi-agency, multi-disciplinary teamwork;
- professionals spend time in the community, as listeners and learners;
- uses simple visualization methods, stresses iterative 'learning as you go';
- achieves wide community representation through work with community institutions, opportunistic encounters in public spaces and local people's social networks;
- emphasizes changing the attitudes and behaviour of professionals, valuing local people's knowledge and creativity, enhancing local capacity for problem-solving and planning, building partnerships for longer-term engagement;
- uses triangulation as a means to verify findings and ensure their reliability and
- uses complementary analysis of existing secondary quantitative and qualitative data.

Taking a participatory approach: benefits and side-effects

Debates on participatory research within health circles in the UK, US and other northern countries have largely turned on contributions that lay perspectives and community involvement can make to improving the impact of health interventions, the fit of policies and health equity.^{5,9,10,11,12} In some of this work, the contribution participatory or community-based research can make to building and sustaining partnerships for public health has been highlighted.^{9,11,13} Others have drawn attention to the value of a more qualitative approach in 'reaching the parts others methods can't reach'.¹⁴ The participatory development literature focuses both on the benefits of community participation to efficiency and effectiveness, and on the transformative effects it can have on community members and the relationship between them and the professionals who are supposed to serve them.^{5,6,15}

In both the participatory research and participatory development literature, a primary emphasis has been placed on lay or local knowledge, on listening to local voices and on strategies to democratize otherwise hierarchical interactions and encounters.^{4,5,6,9} Professionals are often positioned in this literature in a rather monolithic way and accorded a great deal of potency. Empowerment through participation is presented as a zero-sum game in which professionals cede power to communities. Yet some professionals may be as 'done to' as residents often feel they are. Recognizing this is important. Getting the authorities to listen and respond to local concerns may be an uphill struggle for front-line health workers, such as community development health workers and health visitors, who may have little influence on those 'above' them. While they may make alliances with other front-line workers, shaping policy from below, the opportunities open to them to engage more directly in the policy process are often as limited as those they work with and for. Those who make policy and exercise decision-making powers often have little direct experience of the realities of those whom their decisions affect.

Sitting in their offices, going from one meeting to another, opportunities for them to listen to and learn from recipients of health services, or even from the front-line workers who deal with everyday service delivery, may be very limited.

The impact of direct engagement in participatory processes on the attitudes and practices of policy makers, managers and providers has received considerable attention in writing on PRA.^{6,7,8} Robert Chambers, one of the best known advocates of this approach, highlights the importance of being there, taking part, seeing for oneself, learning at first hand. Bringing together those ranged along the 'vertical slice' of professional hierarchies and scattered across different sectoral departments or organizations with community members, to learn together, is not only a common-sense approach to 'joined up' service provision. It may also have transformative 'side-effects' that go beyond informing decision-making and action.

Finding ways of bringing policy-makers, front-line professionals and community members together in this way to learn from each other and develop solutions together makes a lot of sense. But doing so is more easily said than done. Few professionals have much time to spend on these kinds of activities, even if they would pay important dividends in their work. Research is often mystified as something done by 'experts'. Professionals might commission or use research carried out by others to inform their work, but rarely contribute to such studies themselves. Professional boundaries commonly limit the sense of competence many feel when it comes to learning from and about those for and with whom they work. Prejudices about the contributions of lay people and colleagues who lack technical 'expertise' may create other barriers, to taking part at all as well as to listening and learning.^{6,16}

One of the attractions of PRA in international development work has been its accessibility and the speed with which a team of people without professional research skills could tune into local realities, build rapport and begin to understand people's needs and priorities.⁶ Using visual methods that are simple, fun and engaging,

going to the places people gather rather than expecting them to turn up to public meetings, and involving them in analysing their own needs and seeking solutions, PRA would seem to offer a common-sense solution to these problems. It is not, however, without limitations. Prejudices can be reproduced, unquestioned, in the ways issues are framed and questions are asked. Selective listening and closure of certain issues or possibilities by powerful actors in the team can limit its democratizing potential. Used alone, PRA processes may open up Pandora's box of expectations, then leave people hanging for lack of follow-through and action-planning methodologies that turn good ideas into concrete proposals.

Recent research on PRA in developing countries has shown that it may be most effective in catalysing longer-term change where it is combined with methodologies for community development and empowerment.^{17,18,19} Reflection on the use of PRA in policy research suggests that the data that is generated may be less significant than the public visibility of these processes, the involvement of policy actors and service providers, and the networks and alliances they can create.²⁰ Where these approaches have been used by organizations, some of their most powerful 'side-effects' have been on interpersonal relationships, management styles and the attitudes of those within the organization, as well as on the strength and depth of partnerships outside them.⁶

As well as enabling those on the receiving end of services to express voices and views, then, a participatory approach can have important effects on the professionals who take part. Enabling health and local authority workers as well as community members to play a more active role in priority setting, bringing their perspectives and experience to bear on shaping strategies for enhancing service provision, can help to give greater substance and meaning to the current rhetoric about partnership. In the following sections, we describe in some detail a process that sought to put some of these ideas into practice, and from which insights into the benefits and 'side-effects' of participation were gained.

Inviting participation

As part of the bid for regeneration funding for a densely populated social housing estate of around 6000 people on the edge of London, health, social services and housing professionals on the local health alliance were asked to prepare a health needs assessment. They gathered existing statistical data, piecing together a picture of ill health from hospital admissions, standardized mortality ratios and notifications of serious diseases. To this, they added their analysis of the causal factors: deprivation, poor nutrition, poor heating and ventilation systems. This told a story of ill health on the estate. But the health promotion team felt that an important part of that story was missing: residents' perspectives on what was wrong and what might be done to improve their wellbeing. The alliance was persuaded that they needed to find out more. A tender went out, supported with the promise of funding for follow-up activities. Among the proposals was one that suggested training a team of residents and professionals to work together to engage residents in analysing their situation and coming up with solutions. This was a new departure and an exciting opportunity.

Putting what seemed like a good idea into practice proved more difficult. The facilitator began as any community development worker would do: getting to know people, finding out about social networks and institutions on the estate, listening to people's concerns. Coming into the estate in her car, she seemed like any other professional. People were polite, and barely even curious. When she found somewhere to live on the estate, relationships changed. As one resident was later to say, 'we used to tell them "you don't know anything about us, you don't live here"'. Well we can't say that to you, can we? But getting to know people was not enough. No one seemed to want to get involved.

An obvious point of entry seemed to be to work with established community representatives. But they were busy waging other battles with the authorities over plans for rebuilding the estate and had little interest in being involved in

another time-consuming and potentially cosmetic exercise. Some residents suggested that these representatives enjoyed the power of playing a gatekeeper role, mediating relations between the estate and the authorities: they were not given to consulting with people on the estate, or sharing information with them, and were not about to start now. The representatives were aware that people thought they were complicit with the authorities, but they had worked hard on strategies to get their voices heard by officials and acquired a grasp of the language and procedures of government that 'ordinary' residents lacked. Whatever the case was, it was significant that the space created by a participatory process such as this was neither taken up nor controlled by many of the most powerful actors on the estate. They chose to more or less ignore it, at least until things started to happen.

Others on the estate were equally disinterested. For some, as for some of the representatives, it was a matter of time and juggling their other commitments – an issue that was particularly acute for single mothers. For others, the prospect of working together with professionals in a team raised issues of confidence in their own capabilities: they did not feel they would be able to contribute anything, they were not educated like these professionals, they did not know anything about health. All the assurances in the world could not compensate for their lived experience of being made to feel ignorant and inferior. Eventually, two residents came forward. Both had previous experience in social or community-related work.

Getting professionals involved in the team required the contacts and clout to persuade those in the higher echelons of authority to take part in the exercise or release their staff. A 'champion' within the authorities was needed. The health promotion manager stepped into that role, enthusiastically drumming up commitment and support from within the health authority and across other services. Six weeks later, a team of 30 people assembled. It included residents, health authority officials (a commissioner for GP services, an information manager), a senior environmental health offi-

cial, public health registrars and researchers, health providers (school and district nurses, health visitors), health promotion staff, youth and housing workers, voluntary workers and students.

Training in PRA and facilitation skills was spaced over a series of sessions, to enable people with hectic schedules to take part. Six groups were formed, bringing together as wide a mix of people as possible. Five set out to work with different age groups, from children to older people, to make sure there was as wide as possible representation. The sixth focused on asthma, as a health issue about which residents and health professionals alike had expressed considerable concern, borne out by above average incidence amongst this population. Each group reflected on what 'health' meant to them, then generated a series of themes to find out about. Coming together to pool ideas, groups drew on issues that other groups had come up with that had not occurred to them. Work plans were developed that took into account the availability of each team member and times were set for 1–2 hour sessions on the estate that at least two or three of the team would be able to attend.

Broadening resident involvement, building partnerships

The next hurdle was how to make sure a range of resident views were listened to, reaching out to parts of the community that the usual round of consultative meetings rarely touched. Like many communities, the estate has its share of local institutions and community representatives, the usual entry point for PRA. But it quickly became evident that many residents did not feel part of these institutions – either because they catered to a specific age group, or were perceived to be 'clique-ish'. In some developing countries, PRA practitioners use exercises like mapping in community spaces to draw large numbers of participants, who are then invited to participate in other activities. In others, PRA teams invite themselves into gatherings of people, in compounds or public spaces. In the midst of winter, there were few residents to be found gathered in

open-air public spaces. Knocking on doors might yield at the most a surprised – or suspicious – family, busy with other things. And while turning up to bingo, lunches or youth club sessions offered the chance to interact with some residents, they hardly provided much of a chance to interact with the diversity of the population.

It was the team and their own social connections that made a difference in broadening involvement. The residents on the team were able to bring together people from their social networks. By living on the estate, the facilitator got to know a wide range of people and was able to mobilize contacts and neighbours. Local health, youth and housing workers were able to make the most of their own professional connections to involve people in sessions in community spaces, or to run sessions in places like the clinic, schools and the youth club. Other kinds of activities were designed to reach out to the general public. Displays of a problem wall and solution tree in the library and at a local school, where children were given a 'leaf' and a 'brick' to take home, discuss with their parents and bring back, were a rich source of ideas. In this way, the team was able to go beyond those who might turn up at a community meeting and the restricted range of people who are part of local institutions. Overall, around 500 residents took part (Box 2).

In designing a process that would work not just to generate knowledge and understanding but to build partnerships, it was as important to understand where the professionals on the team were coming from as it was to appreciate the perspectives of the residents. The principles of PRA emphasize 'reversals' in normal professional behaviour.⁶ Professionals are enjoined to listen, learn and keep quiet; and to facilitate local people to do their own research, analysis and planning. The shifts in attitude and behaviour this involves are a crucial part of the process. But effective partnership depends not on a complete reversal – one that would effectively place professionals in a position where their only contribution is to facilitate – but on making the most of everyone's contributions and creating new working relationships. Professionals have

Box 2 Participatory methods used on Roundshaw

Social mapping: maps drawn by residents to indicate social institutions and positive and negative features of the area.

Body mapping: pictures of the body to explore people's understanding of bodily processes and of anatomy.

Timelines: line diagrams mapping important events in the community over time.

Time trends analysis: simple line diagrams to illustrate changes over time in aspects of life regarded as important to people.

Seasonal calendars: a chart of activities and changes over the period of a year (i.e. in illness, sociability, labour demands etc.).

Weekly calendars: a chart of activities over the week, by type and time of day.

Daily activity routines: a chart of activities over a day, indicating time spent on each.

Venn diagrams: diagrams using circles of different sizes to represent the relative importance and inter-relationships of social institutions or issues.

Spider diagrams: diagrams using a central term or issue, such as 'regeneration', to explore associations, meanings, solutions.

Matrix ranking and scoring: matrices used to explore values and priorities by ranking or scoring types of thing (i.e. health providers) against criteria for choice (i.e. quality of care).

Impact flow diagrams: diagrams exploring the impact of particular events, policies or projects by setting out linkages and perceived consequences.

Card sorting: the use of cards with issues or objects written or drawn on them to sort into categories using people's own criteria.

Problem wall: used to generate a thought-shower of perceived problems, on 'bricks' that are then stuck on a wall or sheet of paper.

Solution tree: similar to problem wall, but with solutions written on 'leaves'.

Proportional piling: using a pile of anything that comes to hand to allocate relative proportions (of income, expenditure, people with particular sicknesses), drawn as a pie chart.

knowledge, such as of how the authorities they work for function, and skills to contribute; they may also have access to useful information on innovative schemes that have worked elsewhere.

By separating residents' recommendations from those the teams arrived at through their own process of learning and analysis, and by making spaces for professionals to explore ideas from successful projects elsewhere with residents, we sought to acknowledge the contributions that everyone could make to improving wellbeing.

From assessment to action planning

Over the course of a month, teams spent as much time as they could on the estate while carrying on with their jobs. To make the most of limited time and of the richness of interactions, every team used colour-coded cards to note down issues, challenges and opportunities for change identified by residents in each session. This reduced the pressure to spend further time writing up, and had the advantage of offering transparency about what was being recorded. By recording quotes as well as by capturing good ideas, these cards were a wonderful resource for report writing. Later, these cards were collated – giving an immediate and direct sense of key issues and concerns – pasted onto newsprint for a feedback session to which all residents were invited, and used in action planning.

Regular team meetings kept the process on track and enabled groups to get a sense of the issues others were raising. Health alliance meetings served as a forum to bring members up-to-date. One of these meetings signalled the beginning of a wave that promised to bring other changes. As preliminary findings were presented, a senior official suddenly said the process had gone far enough and should be brought to a close. Health workers on the estate had borne witness to some of the concerns residents were expressing, but had felt too disempowered within the medical hierarchy to do anything. Suddenly, everything was coming right out into the open. If a single individual had raised these issues, it would have been easier to silence them. But almost everyone present, including the official, was part of the team. They had all heard these complaints directly from residents. Around the room, people spoke of the

need to live up to the initial commitment made to residents that their voices would be heard. They could no longer be disregarded.

As the wellbeing assessment drew to a close, a community feedback event was held at the community centre, to coincide with a Christmas party for children organized by the tenants' association. All the materials from the assessment were put on display. Several hundred residents took part. Various other interested parties from local authorities, civic and voluntary associations also participated, including local elected representatives. The feedback event not only served to present back outcomes of the wellbeing assessment for verification by those who had been involved in generating them, but also to invite those who had not taken part to deliberate on, amplify and analyse the emerging issues, and to make their own suggestions (Box 3).

At this point, residents' perceptions and suggestions might have been put together into a report and handed to the authorities to act on; in the absence of strong resident organization to pressure for action, little might have come out of it. The involvement of managers and providers in the process meant that negotiations had already begun within the authorities on what could be done to respond to residents' concerns. This paved the way for the authorities to prepare their responses, rather than be surprised with on-the-spot demands. It also meant that firmer commitments could be sought than the promise to look into concerns that residents had raised. What was needed now was to complement the wish to respond with tangible commitments to specific actions.

Some applications of PRA in developing countries end with a community action-planning event, in which priorities for action are fleshed out into plans. In many cases, such plans are built around the assumption that communities should do as much as possible for themselves. On the estate, people were more used to complaining about service delivery and seeing no results than they were about thinking of what they could do themselves. And many of the issues that were raised were not something

Box 3 Summary of issues and major recommendations**Social dimensions of well-being**

Problems: lack of social activities; lack of child care; lack of safe, supervised play areas for young children; lack of support for parents; lack of activities for older people; nothing for teenagers to do and little support for mental health
Solutions: a drop in where people who are feeling down can go; a community cafe; improved child care provision, more clubs for children; more support for parents, especially fathers; somewhere for teenagers to go that they regard as 'theirs' and better information on services for older people

Health and well-being

Problems: poverty is the main problem, causing a lot of stress; asthma in children; local doctors perceived to be poor; health centre caters only to families; attitudes and behaviour of medical staff.

Solutions: revitalize the health centre and make it somewhere people can meet; improve services to meet needs of whole community; recruit a female doctor, new doctors, a dentist; provide information on complementary medicine, especially for treating stress; set up a group to monitor the doctors; start a 'cook and eat' club to help with healthy, low-cost eating and encourage recovered smokers and drinkers to help each other.

Environment

Problems: dog mess everywhere; litter, broken glass, vandalism, graffiti; noise pollution; air pollution and not enough bins

Solutions: zone the park to have a 'dog-free' area; work with kids on issues around dog mess and litter, use them to influence families and more bins

Community participation

Problems: cynicism; apathy; untapped potential and unrealized strengths; competition; leadership issues; historical experience with the authorities

Solutions: use what is already there to do more; small, catalytic projects for maximum visibility, bring others in this way; changing the culture of involvement by building people's confidence in their contribution; using 'community spirit' as a force for change, building on local social institutions; focus on making the most of existing skills and talents; skills audit and skills sharing; give people a chance to do what they like doing and are good at; give people responsibilities, let them decide about and run institutions for themselves.

residents could tackle for themselves: people felt they had a right to a better quality of care from health providers, better environmental services, better treatment from housing officials.

Presenting the authorities with a list of demands, however, was not necessarily the best way to build partnerships for change. It would simply place community members back in the position of being passive beneficiaries of the whims of bureaucrats. Instead, we devised a visioning and action planning process that would seek to draw on the best thinking of both community members and professionals and create spaces for them to come together to plan the implementation of solutions they decided on as the most feasible and desirable. We did so, however, making sure that community members continued to have the opportunity to set the agenda.

A day-long analysis and action planning session was held. Materials from the wellbeing assessment were plastered all over the walls of the community centre. In the morning, residents gathered to take stock and assess over a hundred solution cards. A wall was covered with sticky fabric on which a matrix was placed with boxes divided according to cost, to appeal to budget-wielding officials (better use of existing resources/low cost, some additional resources, major cost implications), and responsibility (for us, with us, by us). With some debate, residents allocated cards to boxes and then 'voted' with stickers on their top three priorities, and one solution they thought was a waste of time. During lunch, their stickers were moved onto the back of the cards, which were then replaced on the wall (Box 4).

In the afternoon residents were joined by professionals from a range of services, from the Director of Public Health to the local vicar. They were invited to view the display, then to vote. Residents noted the professionals' hesitance when it came to voting, interpreting this as reluctance to commit themselves to anything. After an anxious silence, people slowly came forward. The 'votes' on the front and back of the solution cards were then compared. There was more convergence than anyone expected.

Box 4 Action planning matrix

	Low cost (make use of existing resources or facilities)	Medium cost (extend existing facilities, some new resources)	High cost (new staff, new facilities, new resources)
By us	e.g. 'clean up Roundshaw' day	e.g. dance classes for older people	
With us	e.g. set up a 'cook and eat' club to improve nutrition	e.g. domestic violence support on the estate	e.g. more places on the estate for community use
For us	e.g. stagger health visitors' visits so one is available all day	e.g. asthma clinic at local health centre	e.g. dentist on the estate

Reaching consensus on a list of starting priorities was quick and easy. For each priority, a 'champion' was enlisted and people were asked to sit with them to flesh out plans for action. The room came to life as residents and professionals clustered together in animated discussion.

In a report collating the findings from the wellbeing assessment, residents' recommendations accompanied every section and the action plans from the final meeting were set in print.²¹ This 'book', as residents came to refer to it, served another purpose: it could be used with newcomers to service delivery on the estate, as by residents themselves, to look back and see what commitments had been made and what solutions had been identified. Ideally, the residents themselves would have written it. But an authoritatively written report, produced by a professional researcher, gave the 'book' a credibility that residents felt they would have lacked. Its effectiveness emerged in two later incidents. A senior official who had poured scorn on the process – regarding it as a waste of resources – phoned up, shortly after its circulation as a draft, to point out that one recommendation made by residents had been inadvertently left out of the summary. He needed it to be in print to be able to mobilize resources. A community worker from another estate later raised residents' request for a similar 'book': they did not need research, they argued, they knew what they wanted and needed something like this to make the authorities take notice.

Learning and change

At the end of the process, the team had gained an enormous amount. What mattered more than *what* was known, however, was *who* had found it out and *how* they had done so. A community psychiatric nurse glowed with pride at the research she had done and talked of how it had given her a whole new perspective on her work. A commissioner for general physician (GP) services who had previously simply driven into and through the estate for meetings sat in residents' homes drinking tea and listened to the concerns they had about GP provision to the estate, and the stories they had to tell. Health visitors heard suggestions for improvements from a group of mothers that had never been voiced in interactions with them as providers. One health authority official was moved to the complaints division shortly after the assessment finished and talked of how she appreciated more than ever what people were saying to her, being able to understand in a way that she simply could not have done before.

Even if the priorities for change were no surprise to many residents, there were other important lessons. As one resident noted, prior to the wellbeing assessment residents would see professionals driving onto the estate in their cars to go to meetings. They did not attend those meetings, did not know who these people were or what they did. All that began to change as they began to interact with each other. Other residents talked of how at first they had not believed that

they would be listened to, how much they had enjoyed the interactions with the team, how they had never realized how much they knew. They recalled initiatives that had worked, that had been lost in the past, that might be worth reviving and came up with a wealth of creative ideas for changes that would make a difference to their wellbeing. All this served to spur enthusiasm and energy for change.

Looking back at the wellbeing assessment prepared by the health alliance, differences with residents' perceptions of problems on the estate are striking – if not unsurprising (Box 5). Tackling residents' concerns has required a shift in approach that bridges these gaps in perception and focus, one that is entirely consistent with a community development perspective. This much, community development specialists might argue, is nothing new. But what is most significant here is not *what* emerged in the way of possible responses or solutions, but *who* was involved in the process of seeking action on solutions. The community development worker for health who was appointed after the wellbeing assessment not only had a mandate from the community for changes they wanted to see happen. There was also a degree of understanding and support from within the authorities that could serve as a lever for changes in provision that might otherwise be difficult to secure.

Box 5 Different perceptions of the problem

<p>According to health workers</p> <ul style="list-style-type: none"> Higher than average incidence of cancers (lung, breast), asthma and mental illness High fertility rate Poor nutrition Higher than average accident rate Deprivation <p>According to residents</p> <ul style="list-style-type: none"> Poorly performing doctors No dentist Asthma from the heating system No money No jobs Nowhere to go Nothing to do Isolation
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'Champions' for changes within the services have continued over the last few years to have an influence on opening spaces within and with them pathways to change that might have remained entirely out of a community development worker or community representatives' reach.

We surveyed the team a year after the wellbeing assessment finished and found that 87.5% of them felt that their experience had changed the way they viewed their work. This was borne out in our experiences of the new kinds of interactions that began to take place between residents and statutory workers on the estate in the years that followed, leading to and deepening a more active resident involvement in the health alliance and other community development work. For the authorities, and especially the health promotion unit, this new way of engaging with communities came to shape practices in other areas and led to the institutionalization of a participatory approach to wellbeing assessment in estates across the three London boroughs in which the health authority worked.

As with other areas of human resource development, sustaining a change is contingent on retaining staff who have been trained or exposed to new practices. Four years down the line, just under half of those who took part were still working for the same state agencies; one-third of them had been promoted to positions of greater responsibility. Of those no longer in their jobs, almost two-thirds moved on to related jobs within the statutory sector and work for other health authorities or councils. This holds the prospect of spreading changes in practice to other areas, although individuals can feel isolated in the absence of an enabling environment. One strategy that has been successfully pursued in other areas, most notably the Humberside region, is the formation of networks of residents as well as statutory and non-statutory workers to support individuals and provide a forum for ongoing sharing and learning. In time, this kind of horizontal networking might be something that could further strengthen and deepen partnerships at every level.

From commitment to action

Perhaps the most obvious indicator of change is the extent to which suggestions for change have been acted on. Action in itself requires new kinds of partnerships, rather than simply a 'doing to or for' response on the part of particular authorities. And in this context, it was only action that could prove to residents that this would be more than one of those 'ask questions and then nothing happens' exercises. Levering resources from government schemes, making better use of existing resources and building on links between services that were strengthened as a result of working together as part of the team have all led to positive changes in service provision.

One of the key priorities signalled by residents was also one that was perhaps the hardest, and most costly, to tackle. People on the estate had been grumbling about the local GPs for years; their complaints came to dominate the wellbeing assessment. The local Community Health Council was all too aware of the problem, but unable to do anything about it in the absence of complainants who were willing to take their cases forward in public. The high visibility of the wellbeing assessment provided an impetus for action. The health authority's response restored confidence in their willingness to listen: a new GP was appointed to the health centre, from which the existing GPs had moved some years ago, and the older GPs were given communication training. The health alliance had previously lacked a GP presence; with the new GP this was restored. Another concern that required significant resources to address was the lack of dental services on the estate. As one of the residents was later to joke, his two new fillings from the newly appointed dentist were proof that the wellbeing assessment had met with a response. But non-attendance by other residents left the service financially unviable. A community dental service is now available, two mornings a week.

Innovative solutions were found to other wellbeing-related recommendations that were potentially beyond the pockets of residents and the authorities alike. In response to a call for the

provision of aromatherapy at a reasonable cost, students from a local Aromatherapy Training College were enlisted in providing a series of sessions for £1. Residents are now being offered training on aromatherapy, supported by creche provision at 50p a session. A range of low-cost health and leisure activities for people over 50 is available, from keep fit and line dancing to yoga and Tai Chi.

In other areas of concern, residents and professionals have been able to take advantage of government training schemes and further education. Child care and family support has been a key area for the expansion of current provision, responding to felt needs of residents as well as those perceived by professionals. Taking the initiative, health visitors sought new training in parenting skills and run classes for parents; residents are now able to take a General National Vocational Qualification (GNVQ) in child care to become more actively involved in child care provision, supported by a government scheme. A new family support drop in has been established, and the Family Centre has embarked on an initiative to support children in transition from junior to secondary schools. Connections between the health, youth and social services have been strengthened as a result of working together on the wellbeing assessment, which has in turn helped support further linkages between schemes and initiatives.

Support for domestic violence, alcohol and drug abuse and mental health problems emerged as another of the priorities identified by the wellbeing assessment. Responses have come from the statutory and non-statutory sector, from holding drop in sessions on domestic violence and drugs, to working with schools. Response from the community, however, has been limited. The community health development worker and a resident volunteer worked together to revive a mental health drop in that had been successful many years ago, which fizzled out because of lack of interest. and the weekly sessions held by the Community Drugs Line in the new community space established as a result of the wellbeing assessment met with little attendance.

One of the initiatives that emerged from a convergence of residents' ideas with innovative models from previous health promotion work has been a 'cook and eat club'. Based on the principle of having fun and socializing while learning how to cook cheap and healthy food, 'cook and eat' clubs had been successfully established elsewhere by the health promotion team. The Roundshaw club meets weekly in the new community space, and has a creche; 22 residents now hold a certificate in Food and Hygiene. Driven in part by the enthusiasm for this initiative, a three bedroom empty property on the estate was converted for community use. It now provides a venue for other activities, including as a resource for advice and information provision.

An issue that was repeatedly raised by residents as a source of concern was dog mess. Dog mess is more than an everyday nuisance. It is in some respects an indicator of social exclusion, manifest in residents' complaints of middle-class house-owning neighbours 'using our park as a dog toilet', as of social connectedness and a concomitant sense of communal responsibility. The presence on the team of a senior professional from the environmental services meant that solutions were already brewing as the wellbeing assessment took place and his active role in taking ideas forward made a real difference. A dog mess working party was set up, bringing together residents, council and housing officials. Children's concerns about dog mess were powerfully expressed in 'problem walls' and 'solutions trees' created during the wellbeing assessment; working with them was a natural starting point for bringing about changes in attitude. Colouring and poster competitions in schools, visits from animal wardens to school assemblies and the presentation of prizes by the mayor, sparked off a local campaign in which posters from the competitions are to be used around the estate.

Some of the suggestions made by residents required nothing more than better use of existing resources and more effective service delivery. For example, older residents called for wardens to do their jobs properly and make sure they

visited older members of the community regularly; others highlighted the need for improved responsiveness from housing and environmental services to deal with issues like broken street lights or piles of discarded junk. Others called for a change in attitude: rather than talking down to residents, and treating them with disrespect, they wanted to feel cared for and valued by those who were supposed to serve them. It is these 'small changes' that can make all the difference. Incentives, directives and even training courses in client-focused service delivery may do less to change attitude and behaviour than the simplest forms of direct engagement. The 'added value' of processes such as this participatory wellbeing assessment lies in precisely the kinds of personal and interpersonal changes that it can help facilitate, as much as in any outcomes in the forms of projects or interventions.

Partnerships for change

The wellbeing assessment was widely distributed and became an ideal vehicle through which these new links could be forged with departments and other agencies, bringing them together under a project title or common objective. It also provided a mechanism through which professionals could remain in direct contact with members of the local community – and vice versa – to discuss issues and solutions. This in itself served to change the attitudes of some of those who had not been part of the participatory process. After one such meeting, for example, a professional commented on how good the ideas were that a resident had raised, really making him think about the issues they were discussing. Small as this change may seem, it is this kind of shift in attitude that is such an important move in the right direction.

Longer-range community health projects have been set in train and supported by the community health development worker, recruited with the remit of taking the recommendations forward by working with the local community and other agencies to establish appropriate projects. Many of those who became involved were not formal community representatives, but

interested residents who were willing to participate in projects that appealed to them. Engaging these individuals could only be achieved through community development, as time was required to meet and support such people in coming forward and participating. Once involved, many residents felt a sense of contributing to the community and doing some good. However, it was not an easy task to engage and 'persuade' people to give up their time for free and become involved in projects. Residents often politely reminded the community development health worker that *she* was paid for her time!

The role of community health development worker gradually evolved into working both at a local and strategic level, and bridging the gap between local people and agencies by either representing them or/and engaging them directly. The post itself was based within local authority, but from the onset, recruitment and management of the post involved different partners: the health authority, the local authority and the local community. This provided an ideal platform for joint working across departments and agencies with real opportunities to engage local people within this process, as those involved from these agencies were a pivotal source of support.

The participatory wellbeing assessment paved the way for the community development health worker to work closely with departments within local authority and health authority to such an extent that the traditional boundaries between the two became more fluid. This meant greater awareness of local and national policies, strategies and politics on both sides. It meant access to training, resources and support from both sides, and it translated into the ability to influence and input into local strategy, by feeding issues from the ground level up, as well as to raise awareness of health and well-being issues within local authority. It lent opportunities to attend meetings at which it was possible to meet key people within statutory and non-statutory organizations and highlight the needs of local people, discuss work and projects being developed and how the work fits into local and national policy frameworks. It also offered the

chance to provide ideas on how issues could be progressed from an implementer's perspective and for those who might ordinarily never have met to meet each other, and for faces to be put to names. Such meetings paved the way for work with the Director of Social Services to prepare and present current work in partnership with a local resident and health authority manager at a national conference.

Making a difference

While the initial promise of Participatory Appraisal is the generation of a vast amount of information, the other dimensions of participatory processes may be just as if not more important. As we suggest here, participatory wellbeing assessment can lead to a number of outcomes. One of the most significant dimensions of this process was the opportunities it afforded for making connections: connecting people between agencies, local people and agencies; participation in internal working groups; and developing innovative holistic programmes which addressed a number of health and well-being issues at once through working in partnership. This made not only for a more effective use of resources. It also helped build new kinds of relationships, ones marked by greater respect, empathy and responsiveness to residents' perspectives and priorities.

Community development work remains a long, intensive and slow process. Participatory assessments, such as these, are no substitute for the kinds of processes of engagement that are needed to build confidence and capacity within communities. But they can serve as a valuable complement, stimulating an impetus for change, building a sense of commitment and understanding amongst the authorities who might rarely otherwise come into direct contact with residents, and opening avenues for influence and channels for communication within the authorities. As highly visible events taking place in public space and engaging residents, providers and commissioners in learning and deliberation, these kinds of processes can provide new ways of putting partnerships into practice.

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