

## **Leading Community Development for Health Improvement**

A project submitted to Middlesex University in partial fulfilment of the requirements for the degree of Doctor of Professional Studies

**Name:** Mike Grady  
C.Q.S.W.  
MA Social and Community Work: D.M.S

**Student Number:** 2336536

**Submission Date:** August 2009.

**Module Number:** IPH 5180

**University of Middlesex  
School of Health and Social Sciences**

## Contents

|  | <b>Page Nos</b> |
|--|-----------------|
| 1. Tables and Figures:.....  | ii/iii          |
| 2. Abstract: .....   | iv              |
| 3. Acknowledgements: .....   | v               |
| 4. Chapter 1: Introduction: .....  | 1               |
| 5. Chapter 2: Terms of Reference and Literature Review: 1 .....  | 13              |
| 6. Chapter 3: Study design and Methodology:.....   | 36              |
| 7. Chapter 4: Activity: .....  | 62              |
| 8. Chapter 5: Discussion and Findings: .....   | 101             |
| 9. Chapter 6 - Conclusions and Recommendations: .....  | 115             |
| 10. References: .....  | 120             |
| 11. Appendices:  |                 |
| Appendix 1: Research Approvals:<br>Wakefield NHS Ethics Committee<br>West Yorkshire Research Governance Unit<br>Programme Approval Panel Research Approval<br>Academic Supervisor Declaration. |                 |
| Appendix 2: Community Development Workshop Attendance  |                 |
| Appendix 3: Community Development Workshop Evaluation.   |                 |
| Appendix 4: Community Project Analysis.  |                 |
| Appendix 5: Interview Framework.   |                 |
| Appendix 6: A Guide to Interviewing.   |                 |
| Appendix 7: Information and Informed Consent Forms.  |                 |
| Appendix 8: Thematic Analysis Specification.   |                 |
| Appendix 9: N Vivo Coding Summary.   |                 |
| Appendix 10: User Participant Analysis.  |                 |
| Appendix 11: User Participant Thematic Analysis 2.   |                 |

Appendix 12: Over view of Doctorate Programme.

12. Tables:

|  |    |
|--|----|
| Table i: Population of Wakefield Metropolitan District 2001 .....        | 3  |
| Table ii: Unemployment in Eastern Wakefield by Electoral Ward 1997 ..... | 6  |
| Table iii: Community Development Workers Analysis .....                  | 52 |

13. Figures:

|  |    |
|--|----|
| Figure i: Map of Wakefield District .....  | 4  |
| Figure ii: Multiple Deprivation Wakefield Metropolitan District 2000 ..                            | 7  |
| Figure iii: Eastern Wakefield PCT Organisational Chart 2001 .....                                  | 17 |
| Figure iv: Definitions of Community Generated by Health Professionals .....                        | 19 |
| Figure v: A Continuum from Community Defined by Non-Members to Communities Defined by Members..... | 20 |
| Figure vi: Arnstein's Ladder of Participation .....  | 21 |
| Figure vii: Community Development Outcomes.....  | 33 |
| Figure viii: Research Study Processes .....  | 56 |
| Figure ix: Community Development Processes .....   | 60 |
| Figure x: Summary of Emergent Analysis –Community Need .....                                       | 75 |
| Figure xi: Summary of Emergent Analysis – Personal Involvement and More Generalised Outcomes.....  | 90 |
| Figure xii: Typologies for Identifying Community Involvement.....                                  | 92 |

## **Abstract**

There has been increasing interest in participatory approaches to health promotion. However, there is a lack of consensus on key definitions and limited evidence of the effectiveness of community development in contributing to health and wellbeing.

This study evaluates from the perspective of user participants involved in community development projects in a deprived metropolitan area, the impact of that participation on overall health and wellbeing.

The study highlights the impact of stress, depression, social isolation and the abrasive effects of multiple deprivation on the lives of the user participants.

The main findings showed that a robust Community Development Strategy had been agreed by the partner agencies and this aligned with individual community development projects to address social cohesion and health inequality.

The user participants self-reported being healthier and happier as a consequence of their participation. Participation had a positive psycho-social impact on service users increasing confidence, competence and self-esteem and created a wider social network and a greater social cohesion. For some participants, the additional support offered by involvement promoted better individual functioning. Others adopted a more activist role looking beyond individual needs, taking action to identify and address community needs.

The study recommends action at a national level to promote a co-ordinated response to address the social determinants of health and at a local level for Local Strategic Partnerships to promote sustainable funded community development to address health inequalities and multiple deprivation focused on the wider determinants of health.

## **Acknowledgements**

I must thank Dr Lesley Vernon and Dr Gordon Weller, my academic advisors and Dr Nick Emmel, my academic consultant. Their encouragement, cajoling and prompting was especially important at those points where you don't believe you have the strength or the will to carry on.

I want to especially thank my Directors and Staff at the Eastern Wakefield Primary Care Trust for their patience, friendship and loyalty: all critical elements in completing my Doctorate.

Above all, I want to thank the Service User participants. I can only hope I have done justice to your efforts and made your voices loudly heard as they should be.

My thanks to Val Barker, Sue Perry and the Team who contributed so much to the PCT and to our communities.

A special tribute to Sue Holden who got me into this in the first place but who has supported me as a good friend to the bitter end!

Finally, my thanks to Wendy Spink for all the effort and support with my study.

Mike Grady

## Chapter 1 - Introduction

In 2001, I was appointed as Chief Executive of Eastern Wakefield Primary Care Trust (PCT). The timing of my appointment coincided with the establishment of Primary Care Trusts (PCTs). These were new NHS organisations with a remit to commission and provide health care but also to lead the NHS in addressing health improvement and health inequalities. The backdrop for this shift had been set out earlier in the NHS Plan (Department of Health 2000) (2) with an emphasis on tackling health inequalities alongside improving health services. Guidance in 2001 (Department of Health 2001) (1), further expanded the role of PCTs in commissioning Health Services but, more importantly, stressed their role in improving the health of their populations by encouraging participation of individuals and communities and working in partnership with other key statutory, private and voluntary organisations to address health inequalities.

The issue of health inequality has been a constant, if politically sensitive, issue in the UK with concerns about a widening gap between the 'haves' and the 'have nots' (Brandt and Rozin 1997). An important contribution was made to this debate in 1998 with the publication of the Acheson Report (Acheson 1998). Acheson marked a shift in policy, adopting a socio-economic model including both structural and material factors in determining inequality, as well as behavioural approaches. Poverty was identified as a cause of ill-health which required a move beyond changing individual behaviours, to addressing the influence of wider social determinants of health inequalities. The report informed subsequent policy guidance from the Department of Health "Our Healthier Nation: A Contract for Health" (DOH 1998) and subsequently "Saving Lives: Our Healthier Nation" (DOH 1999): the "Reducing Health Inequalities Action Report" (DOH 2003) and more recently the "Choosing Health White Paper" (DOH 2004) (1).

All these policy initiatives looked to changes in poverty, income, tax benefits, housing environment, nutrition and the like. The overall aim was to evaluate policies in terms of health impact and health inequalities and improve living

standards for the worst off, especially children and families, and reduce life expectancy gaps (Acheson 1998).

In response to the high levels of deprivation and health inequalities, Eastern Wakefield PCT developed a Community Development Strategy with key partners aimed at increasing participation by local people, groups and communities and improving the health and wellbeing of its local population.

### **The Local Context : Wakefield District**

Wakefield is one of the most deprived areas in the UK with high levels of unemployment, poor housing and high levels of long-term illness (DOH 2000) (1).

The Wakefield District Metropolitan District Council area was established in the 1974 Local Government reorganisation. It covers approximately 350 square kilometres and has a population of approximately 321,200. It is made up of a range of city, town, village and rural communities. To the west, there was the City of Wakefield, long an important administrative centre for Yorkshire surrounded by the towns of Ossett, Horbury, Wrenthorpe, Stanley and Altofts. To the east, there were the Five Towns area made up of Normanton, Castleford, Pontefract, Knottingley and Featherstone with a number of smaller villages interspersed. To the south east lie the towns of Hemsworth, South Elmsall and South Kirkby. Eastern Wakefield Primary Care Trust served the communities to the east of Wakefield.

The population profile is set out in Table i:

**Table i: Population Wakefield Metropolitan District 2001**

| <b>Demography</b>                     | <b>Wakefield</b> | <b>%</b>    | <b>Yorkshire and the Humber %</b> | <b>England %</b> |
|---------------------------------------|------------------|-------------|-----------------------------------|------------------|
| <b>Males</b>                          | <b>153,210</b>   | <b>48.6</b> | <b>48.6</b>                       | <b>48.7</b>      |
| <b>Females</b>                        | <b>161,962</b>   | <b>51.4</b> | <b>51.4</b>                       | <b>51.3</b>      |
| <b>Aged 0-4</b>                       | <b>18,097</b>    | <b>5.7</b>  | <b>5.9</b>                        | <b>6.0</b>       |
| <b>5-15</b>                           | <b>46,667</b>    | <b>14.8</b> | <b>14.6</b>                       | <b>14.2</b>      |
| <b>16-74</b>                          | <b>228,151</b>   | <b>72.4</b> | <b>72.0</b>                       | <b>72.3</b>      |
| <b>75+</b>                            | <b>22,257</b>    | <b>7.1</b>  | <b>7.6</b>                        | <b>7.5</b>       |
| <b>Ethnic Group</b>                   | <b>308,050</b>   | <b>97.7</b> | <b>93.5</b>                       |                  |
| <b>White</b>                          | <b>7,122</b>     | <b>2.9</b>  | <b>6.5</b>                        | <b>90.9</b>      |
| <b>Other ethnic group</b>             |                  |             |                                   | <b>9.1</b>       |
| <b>HEALTH</b>                         |                  |             |                                   |                  |
| <b>Total population:</b>              | <b>315,172</b>   |             |                                   |                  |
| <b>Limiting long-term illness</b>     | <b>70,697</b>    | <b>22.4</b> | <b>19.5</b>                       | <b>17.0</b>      |
| <b>General Health not good</b>        | <b>38,701</b>    | <b>12.3</b> | <b>10.3</b>                       | <b>9.0</b>       |
| <b>People providing unpaid care</b>   | <b>35,076</b>    | <b>11.1</b> | <b>10.4</b>                       | <b>9.9</b>       |
| <b>Unpaid care 50+ hours per week</b> | <b>8597</b>      | <b>2.7</b>  | <b>2.3</b>                        | <b>2.0</b>       |

**Source: Census 2001; Crown copyright 2001**

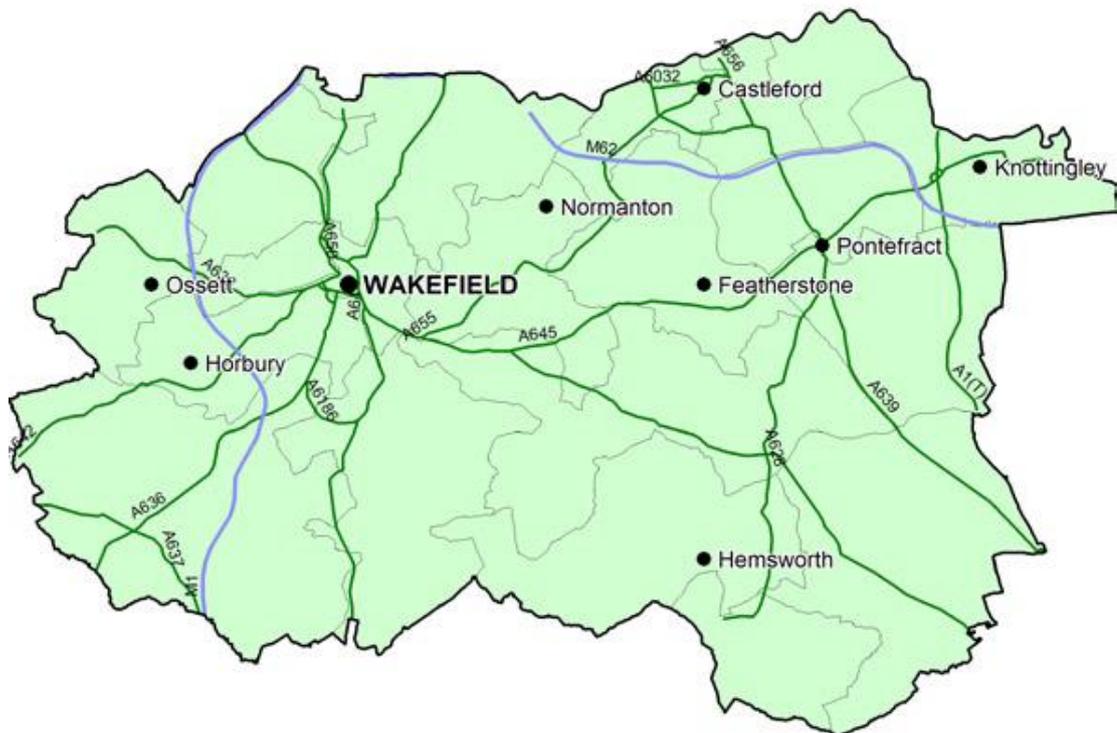
Table i. evidenced a relatively stable population with a profile broadly comparable with both Yorkshire and the Humber and England. Differences were the numbers of BME residents which was significantly lower for the district overall. Most BME communities were located within Wakefield City

and the levels of BME residents to the east of the district were lower still. However, the health profile of the district demonstrated high levels of limiting long-term illness, generally poor health and higher levels of people involved in providing unpaid care.

Most of the towns and villages to the east were 'pit' towns and villages. These former mining communities retain a pride and nostalgic memory for coal mining, the community spirit surrounding the 'pit' and what is perceived as a gallant struggle against the Conservative Government of Mrs Thatcher to save the industry and avoid pit closures. The miners' strike of 1984/5 was bitter and there were numerous demonstrations and disturbances on the picket lines and in the coal mines across the area (Jones 2004). These remain in folklore memory and underpin a sense of heroic failure and lament at the collapse of the coal industry and the community's dependent upon the industry.

A map of the district is set out in Figure i. to help in identifying the features.

**North**



**South**

**Figure i: Map of Wakefield Metropolitan District**

The aftermath saw a succession of pit closures over the period 1984 to 2004. Collectively these communities made up a significant part of the mining communities of Yorkshire with 15 of the 56 collieries situated in the district (20%), the largest number in any of the coalmining areas (Jackson 2008). In 1984, there were approximately 56 pits in Yorkshire employing 200,000. By the end of 2003, there were only 15 pits left. Frickley Colliery at South Elmsall was one of the largest pits in the country. It closed in 1993 following on the closure of other local coalmines – Ferrymoor (1985) Kinsley (1986) South Kirkby (1998) and Grimethorpe (1992). The final pit closure was the Prince of Wales Colliery in 2004. The impact of the loss of the coal industry was devastating, especially in the communities to the east of Wakefield - the Five Towns and the towns and villages to the south east. Nine of the twelve Local Authority wards in this area were in the top 20% of the most deprived wards in England and Wales (DOH 2000) (1).

In the period 1984 – 1998, the area moved rapidly from being economically stable and prosperous to being one of the most deprived and depressed areas in the UK as evidenced in the 1989 study of baseline disadvantage on Priority 5 Areas of the Wakefield District undertaken by the Policy Research Institute (Baldwin S et al 1989) and subsequently the Indices of Deprivation Reports (Office of the Deputy Prime Minister (2000) (1)) and (ODPM 2004) as well as the Health Profile for Wakefield (DOH 2006).

The structure of employment in the District changed significantly as well as the income of households used to the relatively high earnings of miners. During the period 1984 -1998, 15,000 jobs were lost in the mining industry with more job losses in the allied manufacturing industry. Overall male full-time employment declined by 23% with a mismatch between employee skills and experience and employer requirements (Baldwin et al 1998). This loss was offset to only a limited extent by an increase in part-time female employment primarily in the service sector. In October 1997, the claimant unemployment count for Wakefield was 5.3% compared with a national rate of 5% for the UK. However, the district rate masked considerable variation in the rates at sub-

district level. This was especially the case in the wards to the east of the district which shows a higher rate for eastern wards over the Wakefield average. This was highlighted in Table ii.

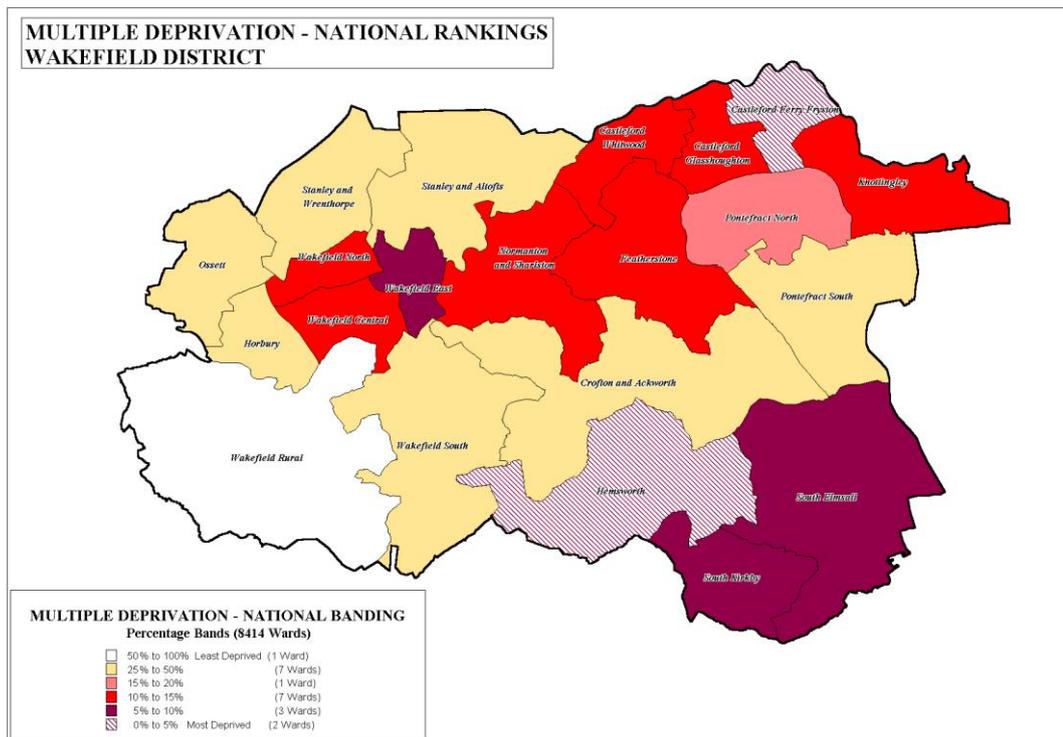
**Table ii: Unemployment Eastern Wakefield by Electoral Ward: October 1997**

| <b>Ward</b>              | <b>Male Unemployment</b> | <b>%</b> | <b>Female Unemployment</b> | <b>%</b> | <b>Total %</b> |
|--------------------------|--------------------------|----------|----------------------------|----------|----------------|
| Overall Wakefield        | 6140                     | 7.2      | 1750                       | 2.8      | 5.3            |
| Normanton                | 340                      | 8.2      | 88                         | 2.8      | 5.9            |
| Castleford Whitwood      | 282                      | 8.6      | 65                         | 2.6      | 6.0            |
| Glasshoughton            | 252                      | 6.7      | 87                         | 3.1      | 5.2            |
| Castleford Ferry Fryston | 303                      | 8.9      | 91                         | 3.9      | 6.9            |
| Knottingley              | 283                      | 6.9      | 78                         | 2.7      | 5.2            |
| Featherstone             | 256                      | 6.9      | 65                         | 2.4      | 5.0            |
| Pontefract North         | 328                      | 7.9      | 77                         | 2.5      | 5.6            |
| Pontefract South         | 215                      | 5.4      | 54                         | 1.9      | 4.0            |
| South Kirkby             | 379                      | 11.0     | 86                         | 3.5      | 7.8            |
| Hemsworth                | 333                      | 8.5      | 88                         | 3.3      | 6.4            |
| Ackworth                 | 204                      | 4.8      | 69                         | 2.1      | 3.7            |

**Source : Official Labour Market Statistics (Office for National Statistics) Wakefield Metropolitan District Council 1997**

Nor was deprivation solely focused on issues of income and unemployment. The Indices of Deprivation 2000 (DOH 2000) (1) measures deprivation for every ward and Local Authority area in England. They combine into a single score for each area with a number of indicators of deprivation – income, employment, health deprivation and disability, education skills and training, housing and geographic access to services. This allowed a nationwide picture of deprivation to be built up and has a major advantage over previous models of focussing that disadvantage at ward levels which had not been possible earlier.

The profile for Wakefield District is set out in table ii.



**Figure ii: Multiple Deprivation in Wakefield Metropolitan District**

**Source: Department of Health Indices of Deprivation 2000 (1) HMSO London**

As set out above, using this measure Wakefield District fell within the top 7% of the most income deprived districts in England and in the top 4% of the most employment deprived districts. Two wards were in the top 5% of the most deprived wards, namely, Hemsworth and Castleford Ferry Fryston. Wards in the top 10% also included the above plus South Kirkby and South Elmsall: all wards within Eastern Wakefield PCT's catchment area.

The Health and Disability domain of the IOD was particularly relevant to my study. Ten wards fell within the top 10% of health deprived wards nationally. The most health deprived wards in the district were Hemsworth and South Kirkby. Of the 12 wards served by the PCT, only two were outside the top three bands for health deprivation as measured by the IOD (DOH 2000) (1).

Lifestyle risk factors such as smoking, alcohol consumption, poor diet, drug misuse and physical inactivity impact detrimentally on health and wellbeing.

The Household Survey for Yorkshire (Policy Research Institute 1998) reported that 27.5% males and 34% females in Wakefield were smokers in comparison to 24% men and 27% of women nationally. Similar indicators were highlighted in the Annual Report of the Director for Public Health for Wakefield (Pollock 2002).

Comparative data from the Yorkshire Household Survey (Policy Research Institute 1998): the General Households Survey (Office for National Statistics 1999) and the 1999 Wakefield PCG Survey identified higher levels of alcohol consumption in Wakefield beyond the norm of 21 units for men and 14 units for women (Pollock 2002).

Lack of education, skills and training had a significant impact on health and social wellbeing, as well as extending or limiting employment prospects. Wakefield-wide averages had disguised substantial sub-district variation. Five wards within the PCT area Normanton, Knottingley, Castleford Ferry Fryston, South Kirkby and Hemsworth were in the top 15% of deprived wards nationally. Indeed Castleford Ferry Fryston was the most deprived in the district. Only 5% of students in this ward successfully applied to go to University compared to a district average of 11.3% (Baldwin et al 1989).

### **Action to address Health Inequalities**

This pattern of deprivation led to Wakefield being designated a Health Action Zone in 1999 and numerous projects and initiatives were put in place to shift health inequalities and with some success. However, the task of addressing health inequalities was longstanding and intransigent. In the 2004 Indices of Deprivation (ODPM 2004), Wakefield was ranked the 54th most deprived local authority area out of 345 and 34 % of the district's population lived in areas that were amongst the top 10% most deprived areas in the country. The indices demonstrated that higher levels of deprivation were centred on the former coal mining areas to the east. This profile is confirmed again in the Department of Health Profile for Wakefield 2006 (DOH 2006). Most of the wards in eastern Wakefield remained in the most deprived quartile nationally.

Air quality was poor even by the standards of the 'Manufacturing Towns' cluster to which Wakefield belonged (Wakefield District Partnership 2005). A higher than average proportion of Wakefield residents described their health as not good or were registered as having diabetes, or were undergoing treatment for drug misuse or severe mental health problems (Census 2001).

Overall, Wakefield District was identified as having the 29<sup>th</sup> most deprived wards in terms of poverty and income in the 2004 Index of Deprivation and this position was further evidenced in the Department of Health (2006) Community Health Profile which showed the majority of local wards were in the most deprived quartile nationally. Eastern Wakefield PCT's area was designated as one of the 88 Spearhead PCTs (DOH 2004) (2) and given extra resources and targets aimed at tackling health inequalities and improving the health of the population in highly disadvantaged areas.

Eastern Wakefield PCT responded by developing strategies to improve and modernise health services and to improve the health and wellbeing of the local population. Initiatives to address the latter included the design and implementation of a Community Development Strategy. This was agreed with key Partner Agencies and aimed to increase engagement and participation of socially excluded local people and groups living in disadvantaged communities.

There are a variety of approaches to increasing individual and community participation. Rifkin (2000) developed a model to describe a number of approaches:-

- A medical approach which sought to apply the application of medical science and technology as a way of increasing participation;  
and
- A health planning model in which the community participates in decisions about the delivery and type of health care provided.

Both these were seen as 'top down' approaches. Both were used by the PCT in meeting NHS Plan targets and best practice requirements. Evaluations of these approaches took place within various inspections and assessments by the Health Care Commission and Annual Performance Management by the West Yorkshire Strategic Health Authority.

Rifkin (2000) further proposed a 'bottom up approach' of community development which identified participation in terms of individual and community empowerment. This fitted well with the values of the Trust and was adopted by Eastern Wakefield PCT (Crowley 2003). The PCT invested in community development and community development projects in the most deprived communities of its catchment area, seeking to increase community participation and improve the health and wellbeing of the local communities.

### **Delivering Community Development**

The strategy was delivered by a range of projects. In total 48 project groups were supported. These included self-help groups, community projects, geographically based groups and communities of interest groups. Overall approximately 600 adults and children were contacted through the various projects supported by six operational Community Development Workers. Details are set out in Appendix 4.

Each group had specific aims and a linked Community Development Worker usually employed by one of the statutory partners and supported by a variety of Health and Social Care professionals. The PCT employed a team of Community Development Workers with a Team Leader and a Head of Community Development reporting directly to the Director of Public Health.

Funding for the projects was provided by a variety of sources including Neighbourhood Renewal Funds, Millennium Awards, Health Transport Fund, Wakefield Council Strategic Reserve, Scarman Trust, Single Regeneration Budget Programme 5, Health Action Zone Funding, Mental Health Trust, WMDC Adult and Community Education Service, West Yorkshire Police,

Wakefield District Learning Partnership, English Partnerships, Wakefield Drug Action Team, The Environment Agency, West Yorkshire Community Safety Partnership, Coalfield Regeneration Trust, Rank Foundation, VOX (Voluntary Action Wakefield) Eastern Wakefield PCT and Self Funding. The list was extensive and represented the breadth and complexity of the partnership needed to deliver community development projects but also the ad hoc nature of much of the funding which was not mainstream revenue funding.

This research project evaluated from the perspective of service user participants, their views on the impact of a series of targeted community development projects. The aim was to consider whether individuals and groups involved had benefited through improvement in health and wellbeing. This formed an important ethical consideration about the role of the PCT in addressing health inequalities and health improvement and providing strategies and approaches which were compatible with statutory duties, effective in delivering to patients, the public and community and delivering added value and value for money for the taxpayer. I reached a view that it was important to evaluate the effectiveness of the Community Development Strategy and individual projects to ensure the public and individual participants were provided with a sound, cost effective service which delivered the PCT's objectives.

Such considerations were at the forefront of my thinking when I decided to undertake this research study. I was aware of the difficulties involved in evaluating community level interventions for health improvement (Hills 2004) but the project presented a real opportunity to investigate the approach and contribute to the national evidence base relating to community approaches to health improvement.

## **Summary**

This introduction has set out the local context within which my research study was undertaken. I have documented the multiple deprivation and its 'toxic' impact on individuals and local communities served by the Primary Care Trust

(WHO 2008). The rationale for design and implementation of a Community Development Strategy focused on participation and empowerment of participants involved in the various community projects. This exercise of community leadership by the Primary Care Trust and local Partner Agencies promoted a new relationship between services and the local communities based on citizenship and democratic renewal (Clarke and Stewart 1996). I consider the implications of this for leadership and followership in the public sector in Chapter 5.

My study now moved on, firstly explicitly stating my research question and then, undertaking a critical review of literature exploring definitions of Community: Participation and Empowerment: Health and Wellbeing, Health Inequalities and finally Community Development and Health. The outcome is set out in Chapter 2.

## **Chapter 2 – Terms of Reference and Literature Review**

My doctorate programme provided an opportunity to reflect upon and consolidate learning and my understanding of leadership in a newly established and emerging public service orientated organisation. Eastern Wakefield PCT was established on 1 April 2001. Its remit was to commission and provide health services to the local population and to lead the local NHS, in partnership with other stakeholders, to improve the health of local communities reducing health inequalities (DOH 2001) (1). This was a new and radical role involving the exercise of community leadership by a public service organisation to engage and empower local people and communities in participation to improve health and wellbeing.

In summary, the overarching aim of this research project was to evaluate from the perspective of User Participants involved in local community development projects whether their participation contributed to their health and wellbeing.

The approach taken included:

- Engaging the Community Development Team in Eastern Wakefield PCT in improving practice by developing an evaluation process which captures the perspectives of the participating citizens and synthesises those perspectives with best practice;
- Creating a research study which actively engaged service users / citizens involved in the Community Development projects delivered in the Eastern Wakefield PCT area to give them a voice in evaluating the impact of such initiatives on their health and wellbeing;
- Evaluate from the perspective of individual participants the impact of involvement in a range of community projects on their health and wellbeing;

- Dissemination of the work widely across key stakeholders, as a case example, in evaluating community developments contributions to community engagement and health improvement.

As a leader in Health and Social Care Services, I was aware that despite increases in prosperity and reductions in morbidity in the UK, health inequalities persisted between deprived areas and the rest of England and Wales: between Men and Women and between different Ethnic Groups. Many of those gaps in inequalities were large and in some cases the gap had increased since the 1980s (ODPM 2000). In Wakefield, the standardised mortality ratios for deaths from Coronary Heart Disease was significantly higher than the England and Wales average and even within Wakefield District itself rates were significantly higher in the wards to the east rather than west Wakefield (Pollock 2002).

The Independent Inquiry into Inequalities in Health (Acheson 1998) was instrumental in fostering a widespread recognition that the wider determinants of Health – Poverty, Unemployment, Education, Sanitation, and Housing were crucial (Rowntree 2003). The Acheson Report (1998) also provided a context for the national Public Health Strategy for England – Saving Lives: Our Healthier Nation (DOH 1999).

Initially, the New Labour Government implemented a disparate range of initiatives and policies to address health inequalities and to deliver on a long standing commitment to a fairer society (Keen et al 2007). This included new duties on Local Authorities to promote the Economic, Environmental, Health and Social Wellbeing of their local communities set out in the Local Government Act 2000. The following year, PCTs became the new NHS bodies with a lead to work in partnership with those councils to deliver better health for all. The vehicle to deliver this was a Local Strategic Partnership (DETR 2000) and the Neighbourhood Renewal Strategy (Cabinet Office 2001). Such initiatives were consolidated into policy with new Public Service Agreements arising from the 2002 Public Spending Review: the Department of Health consultation on a Plan for Delivery (2002): and the Treasury's

Crosscutting Spending Review on Health Inequalities (2002). Later, further policy frameworks would be set out in Choosing Health (DOH 2004) (1) and 'Securing Good Health for the Whole Population' (Wanless 2004). Overall, the view emerged that NHS interventions such as smoking cessation might deliver the short-term targets but addressing social determinants were crucial if long-term, sustainable reductions in health inequalities were to be secured (DOH 2009). Together, these set the wider political and service context for my choice of topic and research study.

The nature of the health inequalities challenge facing the statutory agencies and other partners meant that more traditional bureaucratic responses would not be able to address this major issue. Operating on a seemingly intractable problem within a complex adaptive system demanded different ways of working and intervention especially, where outcomes are unpredictable (Malby and Fisher 2006). Partnership working with network based approaches and common governance frameworks offered potential tools for change in an uncertain world albeit the evidence base for this approach is limited (Keen et al 2006).

In Wakefield, the Local Strategic Partnership was known as the Wakefield Partnership. In 2002, the Wakefield Partnership adopted a Community Development Strategy alongside its broader Community Strategy, aimed at delivering the new statutory duties to secure health and social wellbeing for local citizens. This Community Development Strategy defined community development as being about building active and sustainable communities based on social justice and mutual respect through participation. (Green 1986). The focus was on changing power structures to remove barriers to local participation by individuals and communities (Perry 2002). The strategy would be evaluated in accord with the values and commitments of community development as an empowering experience, with all those involved having a say. This strategic framework was adopted by both the Wakefield Strategic Partnership and Eastern Wakefield PCT's Trust Board and set a clear framework for my research project based on participation and empowerment of citizens and communities, as the PCT sought to provide opportunities for

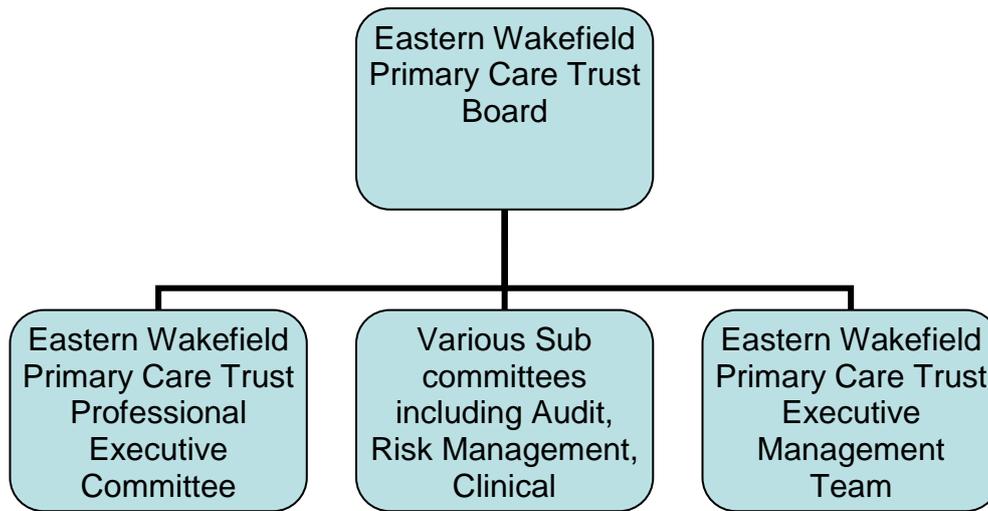
engagement in health improvement. This Community Development Strategy is considered more fully in Chapter 3.

As Chief Executive and the 'Accountable Officer' for the PCT, I had a statutory duty to demonstrate that services provided by the PCT were effective, relevant and provided value for money. This was one of many service reviews undertaken. Other reviews occurred through the normal managerial processes within the NHS. The community development approach was not included and a different mechanism was required to review this aspect of the PCT activity and investment.

Personally, this review was important because it allowed me the opportunity for critical reflection on leadership and consideration of my contribution and performance as a key community leader. I had set out to establish a new NHS Trust with a value driven and community focused culture in which the PCT placed greater emphasis on health improvement as well as the modernisation of health care. The project was intended to see just how far the PCT had progressed in this objective from the perspective of service participants and citizens living in deprived communities to the east, consistent with the evaluation framework set out in the strategy (Perry 2002).

The review was also important to the PCT as an organisation and strategic partner in that, it created a new learning resource for the Board, the Professional Executive Committee and the Senior Management Team in meeting the challenges of being a key stakeholder in leading the local NHS in addressing health improvement and health inequalities. Primary Care Trusts have unique governance structures in the NHS having the usual Board of Non-Executives Directors and Executive Directors and also a Professional Executive Committee made up of Clinicians and Managers.

This is set out at Figure iii.



**Figure iii: Eastern Wakefield PCT Organisational Structure 2001.**

The research also provided the PCT and its staff with a robust and validated evaluation methodology for reviewing community development approaches to health improvement. The aim was to provide a case study to support, not only Eastern Wakefield PCT, but PCTs nationally. As such, it added value to professional practice and provided cutting edge research for understanding how the new form of NHS organisations could exercise community leadership and deliver health improvement.

The study involved interviews conducted with participants in various community development projects. Similar evaluation of a community development approach to health promotion includes the work of Robinson and Elliott (2000). Additionally, there are a number of studies which support a view that community development and bringing people together into social networks has a beneficial impact on their health and wellbeing. This includes Berkman (1992), Berkman and Glass (2000) and Putman (2001).

My study was primarily qualitative in nature and sought to 'put people first' through establishing their ideas and stories as the most important data source (Cernea 1991). A variety of topic areas had been designed and agreed between the Community Development Team and myself as the Research

Project Director (Appendix 3). These included user perceptions of success or failure of the particular community development project in which they participated and the identification factors which facilitated or impeded collaboration and their self-reported health and wellbeing. The participation of the team in the study design was aimed at securing maximum ownership and enabling the team to think systematically about practice in what Bawden and Packham (1993) called “systematic praxis” (p7).

## **Review of Literature**

I have attempted to undertake a critical review of the literature relevant to my research question.

There has been an increasing interest over the past decade in participatory approaches in health promotion and health planning (Draper and Hawdon 1998).

I commenced with a review of definitions beginning with an exploration of an understanding of communities and subsequently concepts of empowerment and participation. I then addressed questions of health and wellbeing and health and inequalities before finally exploring models of community development and health.

## **Understanding Communities**

‘Community’ is a highly contested term. Hillery (1955) for example gives 55 differing definitions of ‘Community’. Oakley (1991) concurred stating that community and community participation have a proliferation of meanings with no universal definitions in sight. Jewkes and Murcott (1996) commenced with a common sense notion based on the Oxford dictionary – community could be considered as a geographic area with shared interests but equally reached a view that there is a singular lack of agreement.

If there is little agreement on the definition of what constitutes a community, it begs significant questions about who should be involved and who should not and who decides and what approach should be taken, to what end. Jewkes

and Murcott (1996) set out definitions of community generated by a range of health professionals (Figure iv).

| <b>Definitions of Community Generated by Health Professionals</b> |  |
|---|--|
| Definition of Community   | Examples                                       |
| Geographically  | A particular and clearly demarcated population |
| Shared Characteristics  | Young unemployed men, single mothers           |
| Communities of Interest   | Ethnic minorities / mental health users        |
| A numerically defined community                                   | A census aggregate                             |
| An administrative area  | PCT Population or Council Ward                 |
| An at risk group  | Males who smoke and have high cholesterol      |
| A GP List   | A practice population                          |
| Tautology   | The community with whom we work                |

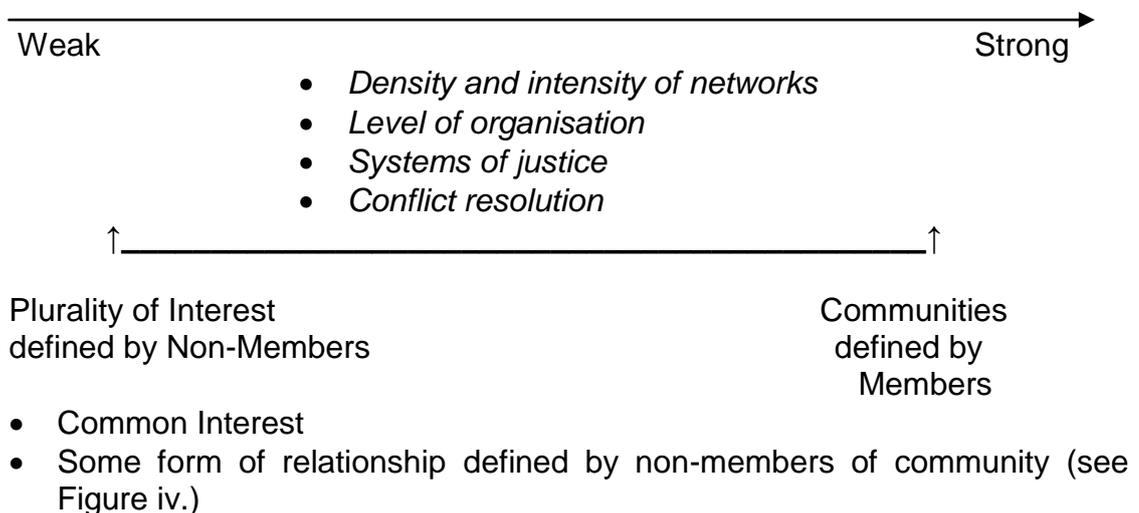
**Figure iv: Definitions of Community Generated by Professionals**

Source: Tewkes and Murdoch (1996) cited in Emmel and Conn (2004) (1) p.5

There are no doubt advantages for health professionals - Doctors, Nurses, NHS Trusts and Local Government in adopting an ordered approach. As Emmel and Conn (2004) (1) highlighted, such advantages include facilitation of resource allocations and service outcome measures which provide a structure platform for agency planning and budgets. However, definitions generated by professionals don't always correspond with community identity that lay people recognise (Emmel and Conn) (2004) (1). Indeed the imposition of such definitions may hinder progress by excluding disadvantaged groups and especially minority groups within specific geographical areas. Inequality and social exclusion are multi-faceted with different forms of social and

economic disadvantage typically linked together and mutually reinforcing deprivation (Baldwin et al 1998). Such factors impact disproportionately on specific groups eg Long-term unemployed, Women, Ethnic Minorities, and People with Learning Disabilities and exacerbate disadvantage. The needs of these groups can be marginalised when definitions of ‘community’ are generated externally (Jewkes and Murcott 1996). Definitions of community have then an important role in scoping and framing community involvement strategies.

Hahn (2002) proposed a continuum for community defined by non-members to communities defined by members.



**Figure v: A continuum from community defined by Non-Members to Community defined by Members**

Source: Hahn R.A. (2002) cited in Emmel and Conn (2004) (1) p6

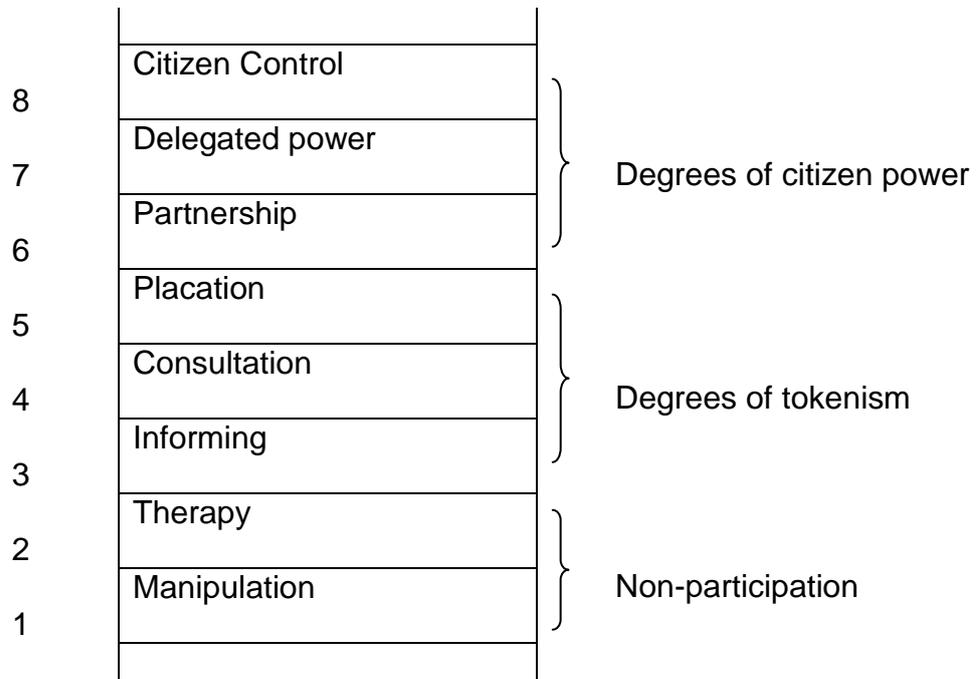
This highlighted the differences and clarified the definition of community with strong communities having higher levels of cohesion and weaker communities disadvantaged. Emmel and Conn (2004) (2) argued that as a consequence, stronger communities are more able to address conflict and to express demands than their counterparts. Furthermore, they indicated that a failure to be clear about definitions of community and to understand their status explained why so many community involvement projects fail to meet expectations. This perspective was supported by Jewkes and Murcott (1996)

who highlighted the lack of specificity in agreeing who communities are and whose participation is seen as crucial (p588).

### Participation and Empowerment

The literature seeking definitions of community participation is extensive. The definitions are influenced by historical contexts, views of social theory and political perspective (Rifkin et al 2000). As a consequence, participation can therefore mean many different things on a continuum from influencing people through to empowerment of participants.

Arnstein (1969) proposed a helpful eight rung ladder of citizen participation. This is illustrated below:



**Figure vi: Arnstein’s Ladder of Participation**

Source Arnstein S R (1969) p220

Arnstein’s ladder ranked different degrees of citizen participation, placing citizen control at the pinnacle of involvement. User involvement was perceived as a contest between parties wrestling for control over finite amounts of power. This perspective linked with concepts concerning the role of citizen’s involvement in decision-making processes about what services should be funded and provided by the State.

Tritter and McCallum (2006) rejected this model on the grounds that it was too overtly adversarial and underestimates the importance of alliances, collaboration and partnerships. Their focus was on deliberative processes and the difficulties in securing common ground and consensus. A truly empowering system would provide space for dissenting views and a reshaping of relationships between users, public service professionals and the public in a new contract for public service (Clarke and Stewart 1996). This would involve service users and the public in both defining problems and contributing to solutions to those problems. Arguably this element was missing from Arnstein's linear and hierarchic model. Instead Tritter and McCallum (2006) proposed a scaffold model in which multiple interests and types of expertise were represented in varying relationships.

Illich (1973) explored issues relating to what he called "conviviality" which he defined as individual freedom of people realised in interdependence with others and which he saw as an intrinsic ethical value (p168).

In further considering issues of participation, Muller (1983) expands this concept where he differentiated between *direct participation* which involves implementation of projects through community resources and *social participation* where communities decide and take control over factors that control health.

An expanded continuum of participation identified from practice is proposed by Oakley (1989) who suggested:

- Participation ...means in its broadest sense to sensitize people and thus to increase the receptivity and ability of people to respond to development programmes as well as to encourage local initiatives;
- With regard to development participation ... includes people's involvement in decision-making processes, in implementing programmes, their sharing in the benefits of development programmes and their involvement in efforts to evaluate such programmes;

- Participation involves organised efforts to increase control over resources and regulative institutions in given social situations on the part of groups or movements of those hitherto excluded from control (Oakley 1989 p9);

This leads him to definitions of three types of participation – marginal, substantive and structural (Oakley 1989).

The latter two enhance participation and empowerment to become:

*“A social action process in which people and communities gain mastery and control over their own lives” (Wallerstein 1993 p219).*

Such empowerment conveys an important sense of personal psychological control which enhances self-esteem and wellbeing underpinned by the ability to actually influence (Rapoport 1987). As such, this fits with the work of Friere (1973) who focused on education as the political and social means of changing power relationships. In this context, participation in its broadest sense has come to mean people gaining control over their own lives through participating with each other to change social and political realities (Wallerstein 1993). This was especially important within the context of individuals and communities suffering long term multiple deprivation where the cumulative impact of multiple deprivation was identified as significant. (Cantle 2005) in undermining social capital and trust. (Balanda and Wilde 2003).

Cooke and Kothari (2001) argued that whilst participatory development has been conventionally represented as emerging out of recognition of the shortcomings of top down approaches, there were dangers that the rhetoric of such participation simply masks continued centralisation of power in the name of empowerment. They pointed to the tyranny of participation where participatory projects over-ride existing and legitimate decision-making processes and were;

*“group dynamics lead to participatory decisions that reinforce the interests of the already powerful” (p8).*

This position was supported by Mosse (1994), Stirrat (1997) and Biggs and Smith (1998).

Participation and empowerment of communities was also a central theme in notions of communitarianism (Etzioni 1993 and McMurray 1995). Rejecting liberal society, communitarianism claimed to be a

*“social movement aimed at shoring up the moral, social and political environment”* (Etzioni 1993 p249).

Current society was seen as fragmented and morally decayed. Appealing to a nostalgic notion of lost communities, he proposed the establishment of a new contract of participation. In this new contract, individual rights are matched and rebalanced against civic responsibilities in a new moral order built on overarching values. The goal was a renewed moral community incorporating social order and bounded autonomy, leading to individuals doing the ‘right thing’ and achieving a dynamic new balance between the state, market and community (Etzioni 2000). This third way recognised that good societies combine respect for individuals and their right to fulfilment of basic human needs and the expectation of participation in picking up responsibilities for themselves, their families and the community at large. A good person, a member of a good society participates and contributes to the common good. No one was exempt (Etzioni 1993 p17). A supportive and empowering framework was, in this model, conditional on self-help and communal participation. The emphasis was on reciprocity; with individual rights of participation and empowerment balanced alongside civic duties and responsibilities. These concepts can be identified as drivers in New Labour welfare and social policies although it has been argued that implementation has seen a shift toward individual blame and authoritarian approaches (Heron and Dwyer 1999).

Issues of power and influence can often be controlled by professional groups and institutions (Emmel and Conn 2004) (2). This notion of complicitness

within power relations was explored by Foucault (1984). Whereas Marx had focused on the exercise of power by the dominant class in controlling the means of production, Foucault argued that this paid insufficient attention to disciplinary and normalising power with society and in local context (Foucault 2004). Whilst power can be exercised in a repressive way, power can also be exercised in a productive way in everyday life in subtle and diverse ways. In this model of power subjects become both victims and active participants within networks of power. Marginalised groups are created by making compliant obedient to authority through social control. The marginal groups come to be seen as pathologically dangerous in an otherwise healthy society and obedience is reinforced (Kumar 2007). In this sense

*'the dominated become as much of the network of power relations and particular social matrix as the dominating'*  
(Hoy1986).

Consequently, a strong message from the literature is the importance of explicitly articulating definitions of participation, power relations and empowerment in answering the key questions about community development, namely:

- Who is defining community and to what end?
- Is participation a means or an end in itself?
- Who decides on priorities, action and evaluation?
- What is the balance of individual rights and community responsibility?  
(Adapted from Rifkin et al 2000 p16).

The above highlights the complex nature of power relationships within community participation and development work. In attempting to adopt a shared and collaborative approach for the project, we were mindful of the need to develop and secure partnership with service users by developing their skills to facilitate participation and self determination. (O'Keefe et al 1999). This included membership of the Steering Group and the design of semi-structured interviews aimed at enabling participants to tell their stories in their own way. In this way, as the study progressed this created a form of social learning with

increased involvement, empowerment and control by both community development staff and participants. (Kreuter et al 1998).

The positive impact of participation and skill development is evidenced in a number of studies. Aldridge and Lavender (2000) highlighted the gains in self esteem and confidence from participation and this is echoed in the work of Feinstein et al (2003): Bynner and Parsons (2006) and Higgins et al (2009). As such a focus on creating social capital and social networks was identified as creating positive gains(ONS 2003) underpinning more effective personal functioning (Ley 1998) and the creation of positive affect impacting on health and wellbeing.(Pressman and Cohen 2005).

### **Health and wellbeing.**

Defining 'health brought it's own challenges and ambiguities. (Kelman 1975). Most definitions of health frequently commence with the World Health Organisation who stated:

“Health is a state of complete physical, psychological and social wellbeing not simply the absence of disease or infirmity” (WHO 1948 p100).

This definition has been criticised as being too 'utopian' but never the less provides a useful starting point (Calman 1998). As with all definitions, it may well conceal an unacknowledged value base but it is multi-dimensional, underpinned by concepts of equality and social justice and suggested health as a relative state capable of maintenance and improvement individually and collectively.

The WHO definition also importantly links health and wellbeing and increasingly wellbeing has been identified as an important public health indicator. (DOH 2001). Definitions of wellbeing vary but a broad definition would include self reported life satisfaction, happiness, social welfare and life quality. This would form a multidimensional approach which uses both

subjective and objective aspects to be utilised in assessing wellbeing as highlighted in 'Choosing Health' (DOH 2004) and DEFRA's National Environmental Policy(2007). THE Warwick and Edinburgh Mental Wellbeing scale has been validated in the UK for measuring positive mental health (Parkinson 2006)

This linkage of health and wellbeing is also evidenced in the literature with health identified as a strong driver of wellbeing (Clarke and Oswald 2002). This association is strengthened by considering the socioeconomic differences in wellbeing. There is considerable evidence that above a certain level of economic growth, that increasing wealth does not result in growth of life satisfaction or wellbeing (Layard 2005). However, there are significant differences on the impact on wellbeing and mental health of social status as set out by Curtis (2008). Levels of mental health problems were significantly higher for manual rather than non manual groups (Office of National Statistics 2003). Further evidence was offered in the work of Dunnell (2008) who highlighted that in the late 1990s and early 2000, suicide rates in England and Wales were double the rate in areas of multiple deprivation within an overall context of a rise in depression throughout the UK. (Collishaw et al 2004). In this way, mental health and wellbeing can be seen as an indicator of social inequalities (Friedli 2009).

Wellbeing is then shaped by many factors – gender, ethnicity, physical health, locality, social status and social inclusion. However, the fundamental linkage between wellbeing and health means that a consideration of one compels an exploration of the other.

### **Health and health inequalities**

Health inequalities have been a concern of successive UK Governments. That there are health inequalities, no longer seems to be a contentious debate. Numerous research studies, conceptual papers and public reports have taken the evidence beyond that point. Through the Acheson Report (1989) in particular, inequalities in health became an embedded plank of

public policy. However, what was also clear is that there are a number of contested, conflicting and complex issues on explanations of health inequalities.

Popay et al (1998) argued that two main perspectives dominate the debate. Firstly, there was a view that individual lifestyle and personal choices are responsible for health outcomes and that is often linked to a view of an underclass culture which transmits a cycle of deprivation between successive generations (Alcock 1997). An alternative view is that health inequalities were a mirror for wider social inequalities and injustice (World Health Organisation 2008). Evidence for this approach was that health inequalities follow the social class gradient. (Stansfield et al 2003). Clearly what might be done about equalities depends on the preferred explanation, each embedded with political values.

Townsend (1998) saw poverty and deprivation as critical sources of inequality stemming from an inequitable distribution of income where even though overall morbidity fell and life expectancy increased, this was not equally distributed across society. This is often referred to as a materialist / structuralist explanation: a redistributionist discourse in which the eradication of poverty is the precursor to the reduction in health inequalities (Carlisle 2001). However, it has been suggested that this approach has been shown to have limitations (Oliver 2008). The debate on health inequalities acknowledges that whilst the UK has a relatively high standard of living compared with other countries, the gap between the rich and poor has grown, impacting on income but also health inequalities (Johnson 2008).

Wilkinson (1996) offered a more social integrationist model. He argued that relative not absolute income was the critical factor with those countries that are more egalitarian enjoying the best health and secondly health was damaged not just by material deprivation but also by the social context where social relations and social justice were prime determinants of health and social wellbeing.

*“To feel depressed, cheated, bitter, desperate, vulnerable, frightened, angry, worried about debts or job or housing insecurity, to feel devalued, useless, helpless, uncared for, hopeless, isolated, anxious and a failure: these feelings dominate people’s whole experience of life” (Wilkinson 1996 p215).*

He argued that reducing inequalities leads to greater social cohesion - defined by Putman (1995) as features of social life – social networks, norms and trust that enable participants to act together more effectively to pursue shared objectives. In short, people with more social contacts and friends, better local social networks, involved in local activities and able to influence the world around them, enjoy better health. This underlined the importance of community self determination and the building of community capital in promoting health and wellbeing. (Robinson and Elliott 2000).

A redistributionist discourse emerged where health inequalities are inextricably linked to income inequality and poverty. (Kawachi and Kennedy 2002).). From this viewpoint, the focus should be on downward redistribution of resources. The belief was that increased income will be accompanied by an increase in health. This was challenged because it is not possible to predict that increased income leads to healthier behaviours on the basis that behaviours relate to a specific cultural context and carry social meanings (Bourdieu 1984).

The World Health Organisation launched a commission on the Social Determinants of Health in 2005 (Marmot 2005). The aim was to review existing knowledge and to seek ways of reducing health inequalities within and between countries. This resulted in the publication of The Solid Facts (Wilkinson and Marmot 2005). It identified 10 key messages on the social determinants of health based on social gradient, stress, early life chances, social exclusion, work, unemployment, social support, addiction, food and transport (p1102). The range of the social determinants that impact adversely on individuals and communities was evident. Unemployment was identified as carrying significant consequences for long term illness (Bartley and Plewis 2002) and (Bartley 2004) and also for increased morbidity (Bethane 1997). Some studies link the absence of social capital with inequality and increased

morbidity. (Kawachi et al 1997). The spatial dimension of inequality was also evident, especially the impact of non decent housing on mental health (Blackman 2001) and on self esteem and health in childhood. (Hume et al 2005) and (Dyson 2009).

In rich and developed countries like the UK with lower levels of material deprivation, the social gradient of deprivation and health inequality makes the issue a relative rather than an absolute concept. What the evidence showed was that in countries with more equitable policies, people are healthier. Equally the lower a person's socio-economic position in unequal societies the worse their health will be. Addressing this relative deprivation means action to address the problem must be multi-faceted with a framework for action at an individual, community, public policy and global level. Activity would include: improving daily living conditions: tackling the inequitable distribution of power, money and resources and measuring and understanding the problem as well as assessing the impact of action (WHO 2008).

This inevitably leads to a consideration of individual participation and empowerment as well as community development in regenerating communities and growing social capital to ensure better social cohesion and health. This approach was seen as the most appropriate way to tackle the structural determinants of health inequalities ameliorating the worst effects of health inequalities (Singh-Manoux and Marmot 2005) and targeted on those who at the bottom of the social class gradient (Gillies 1998) (2). Community development provided a model through which social capital could potentially be delivered. (Wenger 1998).

### **Community Development and Health**

Much of the writing in the UK had focused on a broad community development theory and practice rather than health and wellbeing specifically. Additionally, many of the studies were not published and remain as grey literature (Rifkin et al 2000). As such, further research in this area was both timely and relevant.

In the UK, community development has a chequered history often linking to tensions between community development and community activism with significant differences about how the approach should develop.

In the 1970s, Sanders (1970) identified community development as a method, a movement, a programme and a process. It was viewed as an alternate means through which local democracy could be expanded and public participation secured.

Politically, it was viewed with suspicion by the Conservative Right and the Municipal Labour Left because it was replacing what was seen as legitimate decision-making processes of local councils but also because there were tensions between community activists and elected members on such questions of legitimacy (Craig 1989). This was brought close to home in Wakefield as the Miners' strike brought forth a wave of militant union activism, flying pickets and increased political consciousness. There was an emphasis on informal education and self-help which found echoes in Friere's (1972) liberation theology and educational philosophy which sought to explore meaning and develop dialogue to promote the confidence of the marginalised and powerless and secure action for present and future influence.

A rather different definition was published by the AMA (1993) who defined community development as being about

*“the involvement of people in the issues which affect their lives”* (p9).

However, there was a differentiation between community work – enabling people to improve the quality of their lives and influences which affected them and community development which whilst building on the former was about developing more openness and accountability by local statutory, voluntary and private sector stakeholders.

This debate was, of course, taking place in a lengthy term of Conservative rule with the Government instituting quasi market reforms of the welfare state and

health service with the focus more on consumerism than empowerment (Kitchener and Whipp 1997).

A strategic framework for community development was published in 2001 (Standing Conference for Community Development 2001) (SCCD). It was endorsed by the Local Government Association, the Association of Local Authorities Northern Ireland and by the Community Development Foundation as an example of good practice. It proposed that community development is about

*“building active and sustainable communities based on social justice and mutual respect. It is about changing power structures to remove barriers that prevent people from participating in the issues that affect their lives. Community Workers support individuals, groups and organisations in this process” (p5).*

The values underpinning this framework and approach included social justice, participation, and equality, learning and mutual co-operation. The model sought empowerment of individuals and communities by not seeking to impose externally defined structures but by promoting the self-determination of participant citizens in defining problems, developing informal networks and collective skills to challenge existing power relationships. As with the Friere’s (1973) model previously discussed, informal education was viewed as a key to overcoming barriers which restricted participation, limit self-esteem and forestall participation. (James 2001).

The outcomes anticipated by the SCCD model (2001) are set out as:

|  |  |
|--|--|
| <p><b>Community Empowerment</b></p> <p><b>Process</b></p> <p><i>Personal empowerment</i><br/> <i>Positive action</i><br/> <i>Community organising and volunteer support</i><br/> <i>Participation and involvement</i></p>  | <p><b>Outcome</b></p> <p><i>A learning community</i><br/> <i>A just and fair community</i><br/> <i>An active and organised community</i><br/> <i>An influential community</i></p>      |
| <p>Quality of Life</p> <p>Process</p> <p><i>Community economic development</i><br/> <i>Social and service development</i><br/> <i>Community environmental action</i><br/> <i>Community arts and cultural development</i><br/> <i>Governance and development.</i></p> | <p>Outcome.</p> <p><i>A shared wealth</i><br/> <i>A caring community</i><br/> <i>A safe and healthy community</i><br/> <i>A creative community</i><br/> <i>A citizen community</i></p> |

**Figure vii: Community Development Outcomes**

Source Achieving Better Community Development  
 Barr A and Hashagans S (2000)

This framework looked at community development within a broad definition of health and focused on the promotion of active citizenship. Important messages include the need to acknowledge the history of community development and clarity of definitions about whom and what communities are: who participates and what enables rather than diminishes that participation and finally how can community development be sustained. This latter was identified as critical by Banks (2003).

The New Labour Government has sought to engage the public and to renew local democracy by a number of new policy initiatives since 1996. This includes Neighbourhood Renewal, Local Government Reform and Local Area Agreements (ODPM 2000) (2). The approach seems to fundamentally depend on community development although this is not explicitly presented and the profile was unclear. It has been argued that if community development was to impact, there needs to be a much clearer definition, linked to strategic

approaches nationally and locally (Cook 2009 and Hughes 2009) with sustainable funding and a systematic development of the workforce (Communities and Local Government 2006).

The review of literature had revealed a real gap in the knowledge of the impact of community development on health especially through bottom up approaches (Rifkin 2000). This informed decisions concerning my approach to the research study. The approach adopted incorporated perspectives of participation and empowerment explored in the literature review and was consistent with the framework of good practice proposed by Smithies and Hampson (1999) and SCCD (2001).

Alternative approaches could have included focus group interviews with Community Development Workers but this would need to be transparent in defining terms and would not have met the criteria for evaluation incorporated into the locally agreed Community Development Strategy (Perry 2002). It would have presented a missed opportunity for empowerment of service user participants and an evaluation of the cost effectiveness of these public services.

In conclusion, my research question sought to evaluate from the perspective of service user participants involved in a range of community development projects in Eastern Wakefield, the impact of their participation on health and wellbeing. The case study approach adopted sought to empower user participants and to give them a 'voice'. The literature review highlighted the requirement to be transparent in defining terms and explicit in relation to power and process within the community development projects and strategy. (Ledwith 2008).

The lack of consensus on definitions of key terms – community, empowerment and participation was apparent with definitions influenced by both historical context and views on social theory. There was potential conflict between professional views of the world and that of community members, calling for negotiation about the framework within which community development

projects focused on health with objectives being explicitly clarified at the outset.

The review also identified a number of different discourses on health inequalities. The conclusion reached may depend on what perspective is taken and on whether the view was predominantly single disciplinary focused or more holistically framed (Kelly et al 2009). Conclusions varied from lifestyle and underclass issues to a more social integrationist model focused on the social determinants of health and health inequality, and finally a redistributionist discourse focused on addressing income inequality. Clearly, the differences in these discourses could lead to very different responses (Gillies 1998) (1). For the former, recommendations for action would lie with the individuals themselves taking responsibility for themselves and their health: the latter two required structural change and reduction in social inequalities including income inequality based on redistribution and narrowing of the gap are necessary steps. (Glennister et al 2004). The lack of consensus leaves a vacuum where flexibility and ambiguity flourish and responses can be piecemeal and partial (Carlisle 2001).

## Chapter 3 - Study Design and Methodology

### Overview

This section sets out the theoretical underpinning for this collaborative research study. The approach developed iteratively as the research study progressed. This was to be expected, given that the research was a real world / real time study focused on a qualitative approach involving interviews with service participants in a critical inquiry. The aim was to provide them with a voice in evaluating the 'added value' of a community development approach to improving health and wellbeing.

The study is grounded within a social constructionist episteme. Crotty (1999) defines epistemology as

*“the theory of knowledge embedded in the theoretical perspective and thereby in the methodology”* (p3).

Further he posed a view that at this level, there is a distinction between objectivist / positivist research and constructionist or subjective research. My research question brought me to reflect on this perspective, where meanings are constructed as people engage with the world around them at a collective level and in which culture directs behaviours and organises experience. In that sense, the human world differs from the physical and natural world and as a consequence requires a different response (Guba and Lincoln 1989).

My theoretical perspective emerged from consideration of both critical inquiry and grounded theories, reflecting real life research can be complex and messy.

The foundations of critical inquiry are to be found in Marx (Feuer 1969) and significantly influenced the work of Friere (1973). He developed the term 'conscientisation' where engagement of users is emancipatory and empowering and the object is to raise consciousness enabling participants to

understand themselves and their world (Gomm 2004). This process leads to critical reflection which challenges the status quo and promotes social justice, equity and social inclusion. This moved the perspective beyond the acquiescent stance of interpretivism and promoted a research position which allowed for conflict and oppression and which sought to secure change and to empower participants which was at the heart of my approach (Lewin 1997).

Grounded theory was also relevant to my study. It was initially proposed by Glaser and Strauss (1967) and whilst it has been adopted and adapted, certain basic ideas remain constant. It is an approach focused on generating substantive theory rather than testing formal theories adopted from earlier work. Denscombe (2003) suggested it was particularly relevant to four kinds of research qualitative, exploratory, studies of human interaction and researching participant viewpoints (p113). This was pertinent to my research question looking at the interaction between participants and community development projects.

The grounded theory approach is considered appropriate because it personalised and humanised the study, fostered a flexible and open approach and provided a coherent and robust basis for the overall study of a complex phenomenon embedded within its cultural context. It allows real world real time research to be undertaken in a test bed situation which facilitates participation and self-evaluation and which can be reused in assessing approaches to community development.

Furthermore, the approach seeks to generate theory from a systematic analysis of the data to create a 'grounded' interpretation embedded in the evidence (Glaser and Strauss 1967).

This had the advantage of being adaptable, focused on professional practice and human interaction but allowing systematic thematic analysis and theory grounded in the data and reality (Denscombe 2003). As Silverman argued, the important issue in carrying out effective qualitative research is to select a model which makes sense to the study and delivers the desired outcomes

(Silverman 2000). Such action research is grounded in the realities of the research study leaving it as an emancipatory process with growing credibility (Reason and Bradbury 2006).

Whilst it is critical to commence with a clear research question for the study, I was open-minded and flexible in my approach wanting to engage the Community Development Team and participants. Designing the study to facilitate participants to tell their stories in their own way meant that any substantive theory would emerge from the data generated by the interviews and subsequent thematic analysis. The aim of my research study was to evaluate from the perspective of individual user participants the impact of their involvement in a range of community development projects on their health and well being. As such the research was intended to be user led, emancipatory and empowering (Barnes and Mercer 1997).

### **Activity**

The research project involved two phases starting with a consideration of the Community Development Strategy (Perry 2002) adopted by Eastern Wakefield PCT and its Partner Agencies and a description and brief analysis of the various projects implemented by the PCT in order to deliver improvements in health and wellbeing as part of that strategy. This involved visiting projects with the Head of Public Health Development and reviewing documentation on the community development projects to secure an overview of both strategy and implementation.

The core of the research was qualitative data generated in the form of interviews with project participants. These interviews were undertaken by members of the Community Development Team employed by the Primary Care Trust as a part of their normal work responsibilities. They took the form of participatory enquiry consistent with the values of community development as outlined by Shaw (1999). The aim was to ensure local people were involved and engaged in each stage, creating a dialogue between the User participants and the Community Development Team which validated local

views and knowledge and provided a voice on their experience and perception.

The research project was submitted to the Wakefield District Ethics Committee, West Yorkshire Research and Development Committee and Middlesex University School of Health and Social Science and given approvals (Appendix 1).

### **A Consideration of Insider Research issues**

“Insider” research can be defined as research conducted within an organisation or culture to which the researcher belongs. It presents specific problems and opportunities for the design and conduct of the study as well as the influence the worker / researchers may have through their connection with the organisation on results, interpretation and the dissemination strategies (Hewitt - Taylor 2002).

Coglan (2001) argued that insider action research has a differing dynamic to other action research because the researcher has both intimate and immediate knowledge of the phenomenon under study and a relationship with the host organisation as an employee. As a consequence, he poses three specific challenges to insider researchers: pre-understanding, role duality and organisational politics. Pre-understanding describes the researcher’s knowledge, insights and experience before they engage in the research study. For both managers and frontline workers, this includes intimate knowledge of the organisation, its cultural taboos and preoccupations. The advantage is the researcher is close to participants and the data and can both participate and observe from a position of relative trust, rather than initial suspicion, keying into informal networks. They are potentially aware of critical events and their timeline in organisational history; understand political and organisational culture and the way it works and organisational success and failures. They can use such professional insights and knowledge to influence design of research questions and obtain richer data as a consequence. It also prompts personal and professional reflection which fosters a questioning of taken for

granted implicit assumptions on the part of the researchers and illuminates practice as a consequence (Burke and Kirton 2006).

Winter (1989) argued that what he calls 'practitioner action research' is an extension of professional work in that it seeks to improve professional practice as well as increasing knowledge and understanding. He draws a distinction between traditional social science research and professional knowledge borne out of reflective practice. The latter can be viewed as a conversation between the participant and their everyday world (Schon 1987). This differentiation was supported by Reed and Procter (1995) who identify differing aims of research study between outsider research and insider research focused on service improvement.

For Winter (1989), the outsider researcher uses 'positivist' method while Practitioner action research

*"being in an important sense the study of a changing situation from the inside must ensure its methods do not depend on positivist assumptions" (p 27).*

What becomes important is the outcome of reflective practice emerging from professional interaction, developed alongside and within professional practice. This is not to de-value other methods but to reinforce action research as using different but valid and coherent principles in an action research cycle (Elliott 1982: Lewin 1997 Kemmis 1982 and Berwick 2005). This involved analysis and change validated through practice. Adopting this approach means, the data can be viewed and understood within the cultural context in which the study is located. The focus is on the everyday experience of the participant and the interaction between them and their environment (Wenger 1998). This is critical in informing and illuminating interpretation and analysis of the research data and ensuring a split between theoretical and practical understanding is avoided (Winter 1989). As Reason and Bradbury (2001) argued, there is no one right way for doing action research. The key dimension is to ensure awareness and transparency in making choices and the

promotion of dialogue creating a robust relationship between ideas and practice.

The duality of the Managerial / Staff and researcher role potentially brings about a conflict of loyalty, behaviours and identification. This exists within any insider action research and holds significant implications in setting the design and delivery of the research study within an open and learning culture which safeguards researchers and participants alike. This fosters powerful questioning at the design and fieldwork stages leading to balanced risk taking and engagement in diverse thinking. The early engagement of the Community Development Team in the study, in a genuine collaborative approach, created ownership and required an explicit power sharing approach which positively reinforced individual and collective contributions and this contributed to management of the risk of bias. Overall, this approach engaged the team as fellow travellers, promoted real ownership and partnership whilst modelling new roles and facilitating transformational leadership (Kouzes and Posner 2003). These issues will be discussed in more detail in the section on personal learning in Chapter 5.

### **Engaging the Community Development Team**

Engagement of the Community Development Team in designing and conducting the research was a critical objective in undertaking the study. The aim was to involve the team in robustly evaluating the impact of their work and projects from the viewpoint of the lives and perspectives of service users. A number of organisational and staff development approaches had emerged through the 1990s onwards. Various terms were used: Schon (1987) and Tremmel (1993) talked of reflective practice: Pedlar (1991) and Mc Namara (1996) emphasised 'action learning': Jarvis (2000) focused on team learning: Action research is used by Gore and Zeichner (1995): internal evaluation by (Sonnichsen 2000) and organisational development by Patton (2002 p199). These use qualitative inquiry and case study approaches to assist organisations and generally professional workforce to improve services or develop new understanding of current services (Patton 2002 p170).

Too often in community development dedicated practitioners, with limited resources for evaluation, believe that their project work “made a difference”. However, sentiment is no match for documented evidence of achievement (Kreuter M W et al 1998).

Advantages and disadvantages of practitioner research have been rehearsed above. In summary, advantages can be identified as the presence of existing knowledge and expertise which adds value to the design, conduct and analysis for the study. On the other hand, possible disadvantages of such an approach include lack of time: confidence: expertise and other “insider” problems (Robson 2002).

Additionally, it was important to support the Community Development Team to differentiate between research and the procedures of professional practice. In other words, the research project outcome must demonstrably offer something over and above pre-existing levels of professional insight and understanding Winter (1989).

The above insight underpins the requirement to consider a corporate approach and response to training and organisational development to deliver action research projects such as this. Smithies (1998) argued that this would require:-

- A staff development programme to build committed and a collective workforce;
- Training as part of a change management strategy to promote skills, knowledge and attitudes; and
- Organisational development to enable adaptation and change.

As a consequence, a process of initial training needs analysis was undertaken by the Research Project Steering Group supported by a dedicated Organisational Development Manager. The Research Project Group was made up of the Director of Public Health for Eastern Wakefield PCT, the Head of Community Development, a Service User and myself, operating in the role as Research Director.

Previous experience in developing research and development projects aimed at service improvement had identified that the key to success lies in:-

- Establishing a sound and robust methodology;
- Having a focus on service user feedback; and
- Applying the human equation as proposed by Pfeffer (1998) alongside an understanding of the basic principles of creation of trust, encouragement of change and systems development.

Using these insights, key inputs and outcomes were developed for a facilitated workshop designed to engage the Community Development Team. The outcomes were formally recorded (Appendix 3). Prior to the workshop, tensions emerged between the Research Steering Group and the OD Manager who challenged the fundamental style of engagement proposed for the workshop. Steering values of openness, engagement and partnership centre stage was important in establishing from the outset the style and value base for the research study.

The overall aim was to explain the rationale for the research project: to free up thinking time: promote shared exploration of the complexities: promote thinking outside the box and engagement in genuine enquiry (French and Bell 1999). Additionally, the workshop sought to create a network to support grassroots community development activities and mutual support. In that sense, active involvement to achieve consensus was promoted: the team were to be listened to, informed and engaged. These all form necessary pre-requisite for real participation (Kreuter et al 1998). The approach we took mirrored the values of the Community Development Strategy and were

hallmarked by creation of opportunities for influence: the acknowledgement of diversity: critical listening: provision of resources and the facilitation of networks and alliances for participation (Green 1999).

All members of the PCT Community Development Team were invited to participate in the workshop along with key stakeholders from partner agencies. The participants, who did attend, did so voluntarily. An anonymous list of participants and roles is set out in Appendix 2.

In summary, the programme consisted of an overview presentation of my Doctorate Programme (Appendix 11) and a further presentation by the Head of Health and Community Development demonstrating a potential framework for evaluating community development based on the ABCD Model (Scottish Community Development Centre 2000). ABCD stands for '**Achieving Better Community Development**'. It is a flexible model which sets out what is and what is not community development (Smithies 2000 p19). The ABCD model of community develop also provides a basic framework for considering community development work within a broad health context. The basic premise is that community development is about change.

The workshop considered quantitative and qualitative approaches to evaluation including a framework for interviews with project participant and consideration of possible interviewees (Appendix 3). This was subject to piloting and peer review at the workshop which tested the design and informed the final framework for the study interviews was then agreed. The aim was to maximise participation and influence and promote systematic analysis of practice to inform future practice consistent with approaches promoted by Sim and Wright (2000).

As argued earlier, participation can, of course, mean many different things from influencing people to empowerment of participants. The important message from the literature is that the issue of power needed to be explicitly addressed and incorporated into the evaluation processes. This include being clear about roles and scale of influence in designing and steering the study.

The position the project adopted incorporated such a collaborative and shared communication approach, with the aim of securing partnership as the project progressed in a form of social learning. This increased involvement, empowerment and control by professional community development staff and participants. This approach reflected partnership working and the promotion of relationships marked mutual respect as set out by Kanter (1989).

A collective decision was taken during this design workshop with the Community Development Team that multiple sources of data should be used including relevant documentation, quantitative analysis and description of activity with projects as reported by Community Development Workers and insights generated by the stories of “interesting” service participants. These would be people with a rich story to tell and who would be identified by community development workers and invited to volunteer to be interviewed (Yin 2009). This is a form of sampling in which people are chosen for study not randomly but because they are the most fruitful sources of data for the development of theory. In this context, sampling is not about representativeness but about uniqueness (Keats 2000). Such interviews

*“dig the nuggets of data or meanings out of a subject’s pure experiences, unpolluted by any leading questions” (Kvale 1996 p3).*

This snowballing sampling method can be used to identify within an already known network people who could potentially contribute significantly to the study (Statpac 2009).

This participatory interview approach promoted an in depth study of individual and collective perspectives and most importantly empowers participants by giving them a voice. This commitment to involve people in the setting being studied is a common theme of a participatory approach regardless of terminology (Reason and Bradbury 2001).

## **Developing a Multi-dimensional Approach**

At the core of the research methodology was the proposal for a qualitative interview with service user participants. Within the workshop, a number of quantitative data sources were identified as relevant. This included the numbers of project groups and the number of service users attending analysed by gender and age (Appendix 4). Alongside this, the key strategic and policy documentation was catalogued including the model of community development adopted namely 'Community Development; A Strategic Way forward for Wakefield' (Perry 2002). Finally, the research interviews were designed and this is considered in detail below. Overall, this created a multi-dimensional approach beyond qualitative research which is an approach promoted by a number of authors including Yin (1989): Lee (1999): Pope (2000) and Keen et al (2000). The use of several kinds of methods and data including both quantitative and qualitative can strengthen research studies. This is not to claim too much in relation to this specific study. A pragmatic approach was adopted using data already generated by the Community Development Team and by the consideration of existing policy and strategy documentation. Such an approach is both reasonable and practical, given the resources and time available to the project. The value of adopting this approach allowed different perspectives to be generated which illuminated the core research question.

## **Design of the Framework for Study Interviews**

The workshop involving the Community Development Team was set up to create a real dialogue in the design of the central data collection for the study. This was an attempt to share decision-making, negotiate content and design based on dialogue which is often absent in more traditional approaches to training (Friere 1973). In his work, Friere was concerned with learning through informal dialogue which promoted both understanding and which leads to value driven consciousness and action which is transformational. His political analysis may be considered as simplistic and the practice less radical than the

rhetoric (Smith 2002). However, it does provide a helpful model focused on dialogue, engagement and value driven learning.

The joint learning dialogue was made more powerful by subjecting individual perspectives to peer review to robustly challenge and define the learning outcome. As set out earlier, this allowed piloting of the approach to the study and refinement of the interview design. This use of mutual affirmation created a self-reflection dimension to the task and enabled the whole project team to learn together about the research study, its design and delivery (Mc Niff 2008).

### **Promoting Evidence and Competence**

Opportunities were created for the Community Development Team to express anxieties and to identify barriers to successful completion of the evaluation project. A question and answer session was undertaken to allow these anxieties to surface and for reassurances to be given by myself as the Research Director about issues of time commitment, support and the like. These were then recorded as a record of the workshop (Appendix 3). I sought to empower the Community Development Team by providing written commitment to training, support and the necessary resources to undertake the task (Appendix 3). Reason and Bradbury (2002) highlighted the critical importance of addressing such issues if effective research is to be undertaken and the desired outcomes achieved.

Case Study has occupied an ambiguous place in social science research despite being used frequently in both health and social work research (Reinharz 1992). Robson (2002) argues that in one sense, all enquiries are case studies whilst other commentators emphasise the limitations of case study and its low generalisability (Merriam 1988; Ragin and Becker 1994 and Creswell 1994). Such authors also focused on ambiguity and the scientific quality of the results of such studies because of the interactive role of the researcher. This lack of consensus raises serious questions, some of which have been addressed in the section on insider research. Patton (2002) opens

his commentary on qualitative research by citing numbers of well known and influential writings which are based on case study. These would include “When Battered Women Kill” (Brown 1987): ‘In Search of Excellence’ (Peters and Waterman 1992): and “Respect” (Laurence-Lightfoot 2000). The importance of case study has always been around and is deeply embedded in qualitative research. What is important in establishing the credibility of a case study is the attention to design data collection, analysis, interpretation and reporting in order to be able to present a rigorous and contestable approach.

Case study can be challenging but with good design and conduct can yield valid outcomes (Yin 2009). It involves an empirical investigation of a particular contemporary phenomenon within its real life context, using multiple sources of evidence (Yin 1989). As such, it concentrates on one or a small number of individual cases studied in their own right. My core research question lends itself to this approach, with the intention of facilitating participants in telling their own story in their own way. It focuses on the subjective real life and real time experience of the interviewed participants of community development projects. The approach is rigorous and grounded. What was critical was the clarity of the process of the enquiry governed by critical norms and standards of rationality (Carr and Kemmis 1986). In other words, the design should demonstrate relevance and compatibility to the research question, method, strategy and purpose. The study sought to provide an in depth account of the lives of the User Research Participants who formed an ‘evidence rich’ sample focused on exploring themes rather than on establishing strength or prevalence (Sim and Wright 2000).

### **Choosing the Interviewing Method**

I was aware of a wide range of approaches to interviewing available, each with their own particular advantages and constraints (Rubin and Rubin 1995). Interviews can be time consuming but have the potential to yield data quickly and efficiently. Done badly interviews can undermine the credibility of

research and there can be variations in the outcomes of interviews dependent on the skills and expertise of the interviewer.

Working with the workshop participants, it was decided to adopt an interview guide for the study interviews. This offered an opportunity to prepare in advance an agreed interview schedule. It could be argued that such preparation and its use serves to privilege the position of the interviewer researcher and may constrain the user participant in relation to what can be said or discussed. This was a concern given the purpose of the interview was to explore the perspective of the service user. The approach adopted represents an integrated approach using an interview guide, whilst allowing opportunities for participants to explore other topics at their discretion. Whilst the interviewer is in charge of the direction, the task was to explore the world view of the user participant. As such, the questions were open-ended to avoid bias but structured to facilitate analysis and codification. The questions were formulated to explore the research question of participation and its impact on health and wellbeing to underpin validity (Appendix 5).

Some of the research team had little experience of undertaking research interviews. Consequently, in the training, there was an emphasis on the importance of self-determination of participants in telling their story. This was supported in guidance prepared by me and issued to all interviewers which incorporated best practice (Keats 2000). A full schedule of the guidance is appended (Appendix 6). This promoted a degree of consistency and supported reliability.

### **Constructing the Interview Schedule**

The content and themes of the questionnaire were informed by the research aims, the outcome of my literature review and the experience of the Community Development Team. The May 2005 workshop was designed to create a real dialogue in designing the central data collection study. This was an attempt to share decision-making, negotiate content and approach based

on a dialogue which can be absent from more traditional approaches to training and team development.

The Scottish Community Development Model of evaluation (SCDC 2000) was prominent in informing the approach and content. Smithies and Hampson (1999) 'Review of Good Practice in Community Participation and Health Projects' was also helpful.

The approach taken was made more rigorous and powerful by subjecting individual perspective gathered in the workshop to peer review as part of the programme. This robustly challenged and refined the schedule and learning outcomes. The use of mutual affirmation created a self-reflection dimension to the design task, using a framework of joint problem-solving and learning (Schor 1987). As set out earlier, this also provided an opportunity for piloting the design of the interview schedule at the workshop and revising that in the light of the critique provided by peers.

A further consideration in constructing the interview schedule was the relationship between the researchers and the service participant, some of whom could be regarded as vulnerable. The schedule sought to ease participation in the interviews (Mason 1996). The questions were worded to use terminology with which the participants would be familiar and phrased to be specific yet open-ended, commencing with a number of 'how' questions to ease participants into their role and subsequently shifting to an exploration of the meaning of involvement in the project for each individual participant. This perspective 'giving voice to the user' underpinned the choice of qualitative research method and interview schedule and content. The interview framework is at Appendix 5.

### **Selecting Participants**

Following agreement on the interview schedule and structure, the next issue was to determine which individual participants would best serve to inform the aims of the research project. As my understanding of research methodology

developed and intelligence was gathered through the literature review, research objectives were refined and the case study methodology developed.

As a consequence, more detailed consideration was given to the most appropriate sampling strategy. Understanding the context within which such decisions need to be made was an important piece of learning in undertaking the study. The logic of the sampling method needed to be driven by a consideration of the purpose of the study, the focus of the findings and the resources available. The conclusion was reached that a purposeful sampling framework would provide a richness of data. The focus then would be on a small number of interviews providing an in depth analysis. Community Development Workers were requested to identify “information rich” cases across a range of projects (Patton 2002). The aim was to maximise learning by studying a limited but rich source of data. This purposeful sampling strengthened the study and held the potential to illuminate my research question and provide in depth understanding in the study (Patton 2002).

The limitations of this approach are acknowledged, particularly, if a view is taken which promotes random sampling as the only high quality research method. However, a more balanced view was that the case study approach, based on information rich sampling, was particularly relevant to the specific research question we were proposing. Our research question sought to evaluate from the perspective of individual participants the impact of involvement in community development projects on their health and wellbeing. The selection of interesting, but not unusual cases seemed to open up the opportunity to illuminate the impact of participation in such projects on health and wellbeing of the interviewees. This approach also utilised the experience and expertise of the Community Development Workers in making sensitive judgements on a sample most likely to achieve the research objective. What was proposed was a form of sampling in which people are chosen not for randomness but because they may be the most fruitful. The sampling was not seeking representativeness but uniqueness, each having a particular story to tell, which would then be evaluated to identify themes.

A total of 13 participants volunteered and their details are set out in Appendix 10. Each was involved in one of the 48 projects which formed the operational structure of the Local Community Development Strategy. All Community Development workers were invited to undertake interviews. Six Community Development Workers accepted the invitation.

These are set out below:

| <b>Table iii: Community Development Workers and location</b> |                              |                     |                               |
|--|------------------------------|---------------------|-------------------------------|
| <b>Initial</b>   | <b>Job Title</b>             |                     | <b>Location</b>               |
| LM   | Team Leader                  | Female<br>Caucasian | Castleford                    |
| GT   | Community Development Worker | Female<br>Caucasian | South Kirkby                  |
| MM   | Community Development Worker | Male<br>Caucasian   | Hemsworth                     |
| KU   | Community Development Worker | Female<br>Caucasian | Pontefract/<br>Knottingley    |
| OD   | Community Development Worker | Male<br>Caucasian   | Ferry Fryston                 |
| DW   | Community Development Worker | Female<br>Caucasian | Glasshoughton /<br>Castleford |

The interviewers were mainly female and were from locations across the PCT representing all the main localities in the catchment area. Each interviewer interviewed 2/3 service user participants.

## **Ethical Considerations: Delays and Dilemmas**

During the planning and preparation stages, a number of ethical issues were identified which had to be negotiated. The issues raised related to the potential participants in the study, the Community Development Workers as employees of the PCT and my involvement in directing the research as Chief Executive.

Ethics refers to the roles of conduct and typical conformity to a set of common principles (Reynolds 1979). As with many professions, the NHS has adopted standards for research governance (Department of Health 2001) (2). The research proposal was submitted to the Sub-regional Research and Development Unit and granted research governance approval in October 2004. A submission was also made to the local Wakefield NHS Ethics Committee. Initially this Committee felt unable to approve the application and sought assurances and information regarding a number of ethical issues. The following section addresses these alongside a wider consideration of the ethics. The proposal was also approved by the Middlesex University Programme Approvals Panel (Appendix 1).

The issues raised by the local Ethics Committee related to the potential for a conflict of interest. This concerned two elements of the proposed research study namely insider research and the potential for bias given the position of the Chief Executive as Research Director.

There is no doubt that given the more explicit accountability in public sector services and the need to demonstrate value for money, it is increasingly common for research to be undertaken which audits and evaluates services provided to the public. There are indeed significant advantages in doing so. It gives assurance to service users and commissioners alike about service quality and also demonstrates that good practice can be evidenced. On the other hand, difficulties can be encountered especially in hierarchical organisations and proper safeguards were needed to ensure objectivity was maintained. General principles to establish a robust framework to address

such issues are proposed by Grady and Wallston (1988). These include foresight of potential difficulties; good contingency planning: logging of responses and rationale: and establishing external collaboration. Such issues have been addressed in the study by the work undertaken in the facilitated workshop with the Community Development Team. Potential problems were highlighted and addressed (Appendix 3).

Additionally, a Project Steering Group was established with oversight of the project. This included an independent Member of the Public, the Director of Public Health, the Head of Community Development at the PCT and myself. This provided an open forum where issues could be discussed and decisions taken in a transparent way. Issues of hierarchic position have been addressed in this way and provided safeguards.

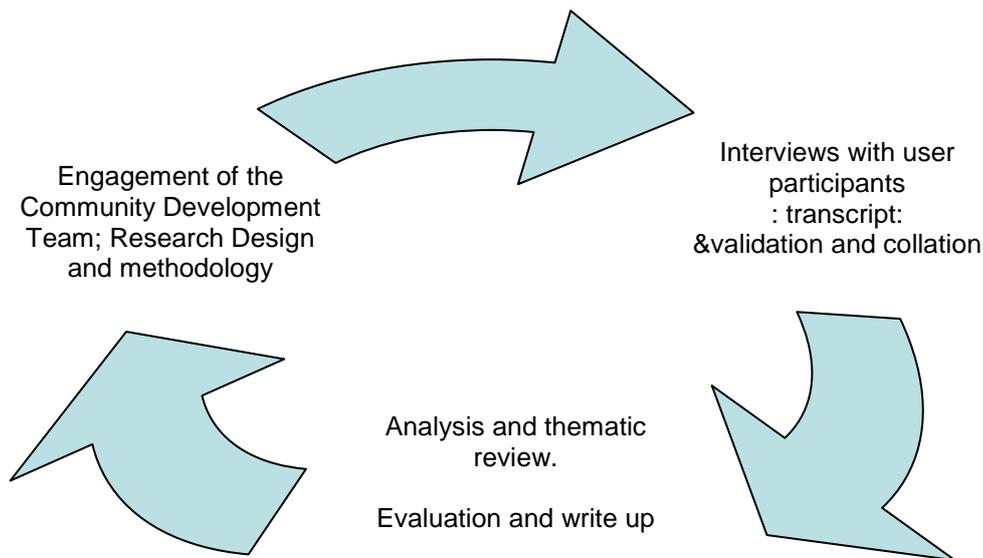
### **Safeguarding Potentially Vulnerable User Research Participants**

A further issue was the safeguarding of participants. In any real time study, especially in studying personal or potentially politically sensitive issues, consideration must be given to safeguarding the welfare of those involved. This is especially the case where some of those participants are potentially vulnerable. Care was taken to ensure a detailed information leaflet and letter was prepared. ( Appendix 7) This outlined the objectives for the research, the right of withdrawal without sanction and details of participation (Bell 1999). The issue was also addressed in the training of the Community Development Worker interviewers and they were trained to explain verbally to participants the agreed framework to complement the written information. Support mechanisms were established to provide both participant and interviewers with access to the Research Director. Two meetings were arranged to consider any outstanding problems. All these safeguards and support systems were designed to ensure that user participants understood the nature and purpose of the research. Participants were asked to sign to confirm they had given informed consent and had not been coerced (McClellan 2006). A copy of the informed consent letter is attached at Appendix 7.

Issues of confidentiality were addressed at the research design stage and set out fully in the applications to the Wakefield District NHS Ethics Committee and the NHS Research and Development Unit which provides research governance approval for all primary care research within Bradford, Leeds and Wakefield. A copy of the application is appended as evidence (Appendix 1).

Informed consent was sought from all participants in a format consistent with NHS protocols (DOH 2001) (2). In addition to the training set out above, each interviewer was provided with a guide to interviewing which highlighted the importance of clarifying the purpose of the project, obtaining fully informed consent and explaining fully the framework of confidentiality identifying risks (Appendix 6). In a written statement to all participants explicit reference was made to confidentiality and the potential use of excerpts from audio tapes being used in the final research paper (Appendix 7). Anonymity was offered, unless any participant wished otherwise. This remains a dominant assumption in research method. However, such norms have been questioned in some participatory research projects where participants wanted to 'own their own stories' (Patton 2002). Participants were invited to verify the transcript of their audio taped interview and made aware that attempts were to be made to anonymise identities. Participants did not request their real names be released and did accept that their roles in projects would be identified. The study was written up consistent with the agreed framework.

The process of the research study is set out below:



**Figure viii: Research Process**

### **Data Evaluation**

The interviews with the community participants were taped by the Community Development Workers with the consent of the interviewees. These were then transcribed and a copy of the transcript was delivered to the individual workers who had undertaken the interviews. Each interviewee was given the opportunity to amend the transcripts which were then returned to me as the Research Director. This validation strengthened the study. Transcribing the tapes was undertaken internally in the PCT and the tapes were stored in a secure cabinet.

Transcribing the interviews ensured that there was an accurate account of the study interviews. This produced accessible and validated documents for analysis. However, as Silverman (1997) points out, there is a need to consider the interplay of spoken language and the nuances of conversation. I addressed this issue by personally listening to the tapes as part of the additional thematic analysis.

Having reflected on the task and discussed the matter at the Research Project Steering Group, it was decided that the necessary expertise to undertake the data analysis was not available within the Trust. As a consequence, I commissioned a local academic who had wide experience in similar studies to undertake the data analysis. A clear commissioning brief was provided following a meeting between the analyst and the Steering Group and a report prepared (Appendix 8).

Data analysis was undertaken of the interviews generated with 13 female participants who had been involved in a broad spectrum of community development projects. ( Appendix 9) The process utilised when analysing the data linked to the overarching research aims for the study and the commissioning remit.

The overarching aim of this research was to develop a research base to understand community development and the impact of participation on health and wellbeing. In order to meet this aim, the data generated endeavoured to capture the perspectives of participating citizens and synthesises those perspectives with practice models. The research also aspired to give 'voice' to service users recognising the importance of community engagement in the process of evaluating and delivering health improvement initiatives.

The approach taken to the data is underpinned by the need to ensure that what emerges can be traced back and evidenced in the actual words of the participants. The analysis followed the process outlined by Smith (1999). Here, in the first instance, an idiographic approach is taken to the analysis; working with the particulars of one participant's interview and then exploring potential generalisations. The process involved coding each interview transcript individually and assigning initial descriptive codes that enable the essential quality of what the data are inferring to be made visible. This is an interpretive process whereby as the analysis progresses themes, that enable a clustering of initial descriptive codes, begin to emerge. Therefore, from a corpus of raw data, what emerges is a thematic organisation of the data. This thematic organisation then becomes the basic structure for the presentation of

the analysis and the necessary discussion (Holliday 2002). It included identification of similarity, contrast, and juxtaposition and traced the relationships (Sim and Wright 2000).

In order to support the analysis with regard to coding, retrieval and auditing the decision was made to use computer-assisted qualitative data analysis software (CAQDAS) – NVivo in the preliminary analysis. (Appendix 9). This in no way detracts from the inductive approach taken to the data. Rather the use CAQDAS is seen as using the computer to support a more effective way of handling qualitative data (Wolcott 1994). Using NVivo enables each transcript to be comprehensively searched and coded with relative ease and at the same time the analysis is highly visible. The introduction of ‘coding stripes’ and data displays in the form of node listings (Appendix 9) ensures that the analysis is transparent. This is a crucial issue for this research where the analysis is commissioned and undertaken by a third party.

While the structure of the analysis presented is rooted in the emerged thematic analysis of the data, it is also impacted upon by the interview schedule used to elicit information. While the transcripts show a high level of engagement and flexibility there is nevertheless an obvious structure in that each participant was asked questions relating to quite specific issues. This demonstrates the ‘connectedness’ (Clandinin and Connelly 1997) of research whereby the outcomes of research are clearly linked to data generation. Therefore, the structured nature of the interview questions are visible, to some extent, in the structure of the analysis that is presented. Participants were first asked to talk about their initial involvement with community development projects moving on to explore that involvement and what it meant for them personally. They were invited to elaborate on their roles and any responsibilities they might hold, reflecting on how such involvement might link into wider health and family related issues. Finally, participants were asked to consider community development activities; how these might be continued and / or improved, and to anticipate what the future might hold for their groups and communities. The transcripts show that some interviews followed this format quite rigidly – others were much more fluid and interactive. This is to be

expected with such a diverse group of interviewees and interviewers (Horrocks 2006).

As I have set out earlier, training had been offered to all interviewers and written guidance provided to ensure a level of consistency (Appendix 6). However, the interviewers were given discretion to allow the user participants optimal opportunities to have their voices heard. This participatory approach was at the heart of the study objectives.

Having commissioned a confidential qualitative evaluation (Appendix 8), I also undertook a complementary detailed study reviewing each interview transcript. The purpose was to complement the N Vivo analysis and identify common themes, teasing out any nuances of interpretation and extending the analysis against a best practice framework. (Appendix 11).

Research into the involvement of marginalised groups in public participation noted that the community development model of participation can provide a way of thinking about need, based on empowering people to develop the skills knowledge base, confidence and social relationships to take responsibility for contributing and defining rather than discovering need (O’Keefe E and Hogg C 1999).

Additionally, three broad levels can be identified where community development impacts on health promotion (Hashagen S 2000). This includes the personal impact on previously marginalised participants who subsequently adopt a critical and reflective stance towards issues affecting them: collective action leading to social and contact networks and a sense of purpose and achievement and involvement of local communities leading to better targeted services reflecting local need. The ABCD model of community development has been discussed earlier. This model can be represented as cyclical with inputs, processes, outputs and outcomes (Smithies 2000 p21).

| <b>Wider Society</b>  |   |   |   |
|---|---|---|---|
| <b>Inputs</b>   | <b>Processes</b>  | <b>Outputs</b>  | <b>Outcomes</b>   |
| <p>Peoples personal experiences of their own and family/friends /community health.</p> <p>Local data on health and inequalities held by agencies.</p> <p>Funding for community development and health workers.</p> <p>Local concerns.</p> | <p>Establishment of an information drop in with resources on health issues and/or about health decision making structures and wider factors effecting health locally.</p> <p>Bringing People together to share, plan and take collective action.</p> <p>Establishment of a food cooperative and community care.</p> | <p>Citizens who are more aware of ways of preventing ill health, how to access appropriate services and support and more aware of the wider influences on their health.</p> <p>Establishment of a local community health forum lobbying for change in wider factors influencing health.</p> <p>Better access to low cost healthy foods and social focus for the area.</p> | <p>Services and structures that better respond to and meet people's needs.</p> <p>More partnerships between professionals and community members and joint agency /community initiatives to tackle the underlying factors effecting health.</p> <p>A better nourished community with effective social networks able to support individuals and groups.</p> |

**Figure ix: Community Development Processes**  
**Source: Smithies J (2000) P21**

In this context, personal empowerment is seen as a process through which individuals and groups gain the knowledge, skills and confidence they require

to be able to take action on matters that concern them. This becomes the fundamental process of community development.

Taking into account the above, I explored the model of evaluation proposed by Smithies and Hampson (1999). This work was commissioned by the Health Education Department as part of a collation of evidence in the field of health promotion. The methodology employed was robust involving eight regional workshops, six national workshops, an expert panel and questionnaires involving 230 participants and projects. The direct involvement of participants in the design of the framework was relevant given the value base of my study. Additionally, definitions of success were explored at a variety of level in terms of individuals involved in projects, developments across whole communities, changes in local organisations and professional practice, interagency working and the influence of national initiatives, policy and practice. Subsequently, the report summarised learning and practice evidence from these sources and developed good practice criteria. These were grouped into five main headings:

- *A clear and realistic role and remit for projects*
- *Adequate and appropriate resources to meet the project remit*
- *Adequate and appropriate management and evaluation*
- *Recognition of the importance of the wider environment within which projects were operating*
- *Building long-term sustainability*  
(Smithies and Hampson 1999 pp 7-9)

In summary, I decided to use this framework representing good practice, in a thematic exploration of the strategic framework for the local community development strategy. The operational framework for individual projects was also evaluated (Appendix 4) alongside the transcripts of the interviews undertaken with service user participants. This extended the analysis and allowed contextual factors to be considered. (Appendix 11).

## **Chapter 4 - Activity**

### **Strategic Framework for Community Development**

Along with strategic partners in the Wakefield Partnership, the Primary Care Trust adopted a corporate Community Development Strategy for the District alongside the Wakefield Community Strategy (Perry 2002). The strategy outlined the main elements for effective partnership working to deliver effective community development. In summary, the intention was that the strategic approach to community development would:

- Improve the effectiveness of the community sector both independently and as a partner;
- Help in tackling problems of community regeneration on an integrated partnership basis;
- Link (community development) to equal opportunities and access policies;
- Link closely to a range of new policies and funding regimes.

(Perry 2002 p4)

The strategy adopted drew heavily on the strategic framework for community development proposed by the Standing Conference for Community Development (SCCD 2000). It reflected the emphasis in Government policy which made explicit reference to the need to involve local people and excluded communities in developing policy and in new ways of working to address issues of neighbourhood renewal and regeneration. Such policies include the New Deal for Communities Programme (1998): Sure Start (1998) and the National Neighbourhood Renewal Strategy (Cabinet Office 2001).

### **Research Service User Participants**

As set out earlier in Chapter 2, 48 community development projects were established involving 600 people. From this number 13 user participants volunteered to be interviewed by the Community Development Workers as

part of this study. Details are provided in Appendix 10. All those who volunteered were interviewed. No other questionnaire research was undertaken with the larger 600+ service users involved in the 48 projects.

The names of participants have been changed in order to provide anonymity. However, presenting the participants as named individuals in this analysis aimed to give the participants a presence in the emergent findings and enable the reader to 'know' the participants in some way thus trying not to disconnect the analysis from those who participated (Robson 2002).

Clearly, it was important to ensure balance in representing the views of the User participants. Appendix 13 sets out the number of times each participant is quoted. The average is 4 with the minimum 3 and the maximum 7. (Appendix 10)

Appendix 4 gives an indication of the breadth and variety of projects where the User participants were involved and engaged in planning, organising and participating. Some of the participants were central to the running of the groups as activists: others just participated in activities. Volunteer participants in the research interviews were from the larger active community work projects. All the key disadvantaged communities (DOH 2000) (1) were represented in the table across a variety of different project groups.

The ages of the participants may also be significant. Only one was a teenager, the majority were middle aged (30 yrs – 60 yrs) and three were pensioners. All were white Caucasian. As set out in Table i. the ethnic population of Wakefield is low at 2.3% overall and nearer 1% in the wards to the east.

All the volunteers were female. This may simply reflect that higher representation in project participation was by females. It may also be the case that care and caring are highly gendered activities with women numerically primary care givers in community care (Featherstone 1994). This issue is explored in more depth in Chapter 5.

## Unemployment, Poverty and Health Inequalities

Analysis of the employment status of the participants revealed that none were in paid employment when they joined the community development projects. Three were pensioners and the remainder unemployed. (Appendix 11). There is considerable evidence that unemployment and income inequality impact adversely on health (Bethane 1997). So too, the work of Kawachi and Kennedy (2002) highlighted the connection of poverty and deprivation which creates multiple social stresses and poor health outcomes. More recently Wilkinson and Pickett (2009) found that nearly three-quarters of 168 studies established a relationship between income inequality and health. The link between unemployment and higher morbidity is well evidenced including higher rates of long-term limiting illness (Bartley 2004) and mental illness (Wilkinson and Pickett 2009).

As I have set out in Chapter 1, the ex-coal mining towns and villages to the east of Wakefield where the participants lived, suffered significant levels of multiple deprivation including poverty and unemployment (Department of Health 2000) (1).

The health status of the participants was highlighted in my analysis. All the participants identified stress and depression as a factor in their lives.

*Joanne: I suffer with depression. I am on anti-depressant tablets”.*

Other illnesses included Fibromyalgia, Diabetes, and Arthritis and Chronic back pain.

Most described a sense of isolation and lack of support in a stressful environment and in some cases stressful and difficult family relationships including domestic violence.

*Suzanne: “She (Mother) used to get on my back all the time saying get up and get out of bed and do something useful”.*

This lack of social support is a recurring theme in the analysis of the interviews with the user participants. Low social status carries with it strong messages of inferiority and as inequalities in the UK have widened, problems of social difference has weakened community life, reduced trust and increased violence (Wilkinson and Pickett 2009 p45). This leads to a state of multiple disadvantage with groups outside the mainstream who are unable to participate fully and who become 'socially excluded' (WHO Social Exclusion Knowledge Network 2008). This term became prominent in 1999 when Tony Blair described it as:

*"a shorthand label for what can happen when individuals or areas suffer from a combination of problems such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health and family breakdown"*  
(Department of Social Security 1999 p23) .

Such multiple deprivation undermines social support and social capital. People on the lowest incomes and the unemployed are more likely to feel unsafe in their local area and compared to home owners those who are living in public sector housing are less likely to trust their neighbours leading to increased social isolation (Balanda and Wilde 2003). Community development may offer a way to rebuild social capital in neighbourhoods and through involvement and empowerment may address psycho-social issues in health (Cook 2009).

### **People getting involved: Process – Personal and Community Need**

When participants were asked what prompted their involvement with community development projects interestingly, some people gave straightforward responses and others described a fairly elaborate and somewhat convoluted process. For example, Ruth explains fairly succinctly why she became involved relating this to her wanting to know what her son was doing,

*Int: How did you get involved in this project at...?*

*Ruth: It wasn't when I first came here it was like our "A", that came first.*

*Int: Is "A" your son?*

*Ruth: Yes, he came first with "M" and "A" and we used to have a bloke come that did drums and I wanted to come and see what he was doing so that is when I came in and had a look and from that day on then we got involved "M" asked me if I would like to go to a craft club and she got me into a craft club at the Magnet. She was the worker that first came here.*

Unlike Ruth, some participants had been referred by health professionals or invited to get involved by Community Development Workers and again this was a succinct and short response that appeared to represent a linear process,

*Joanne: I got involved by the health visitor. She asked me if I wanted to get involved. I have been going for about 3 years.*

However, others, like Sue, gave very detailed accounts of complex relationships and processes that then precipitated their involvement,

*Int: How did you get into what I would call "doing good causes", what motivated you to start particularly working with young kids.*

*Sue: It is very hard to say really, because, I always wanted to work with kids. T [partner] worked nights regular so I never did anything about it, I thought it would be nice if we could run a youth club or something and do it together. But with T working nights like he did I never did anything about it. We started fostering because both of us had this thing about looking after kids and we talked about it for quite some time before we actually looked into it and actually started. We have been fostering for about a year, maybe a bit more and T got the Treasurers job at the Angling Club and as you know with our story it progressed from there, starting up the kids club and everything. But I didn't actually get involved in it personally, until we took them camping, the whole idea was that the kids would do their own cooking on primus stoves that we borrowed from Youth Services. But, when we arrived there it was during the long heat wave and it was actually too dry, tinder dry, so we daren't let the kids loose with spirit stoves and matches. So T asked me if, after the first disastrous day of the men cooking, he asked me if I would take over the cooking, which I did and quite*

*enjoyed feeding the kids. Every time the kids had food of that I got involved and they enjoyed the first residential that much they were clambering for another one. So I said I will do another one providing I can organise it, because I thought the organisation was terrible on the first one.*

The process of getting involved invariably linked into themes around community and personal need and thus it is these two themes that will be explored further.

### **Community Need**

Many participants, when talking about their local communities and local environments, made reference to specific issues that might be impacted upon by their involvement with community development projects. In doing so, for example, reference was often made to keeping kids off the street.

*Ruth: "At the After Schools Club we do art and craft. We try and get them to do different things like sewing, painting, play, models. We go out into the school fields if the weather is nice. To keep the kids off the street".*

This is reiterated by Julie who expands by commenting on the impact on the young people engaged in the project activity.

*Julie: "We have a play scheme for the kids to keep them off the streets. We also we took a group of teenagers to the woods. From what I have been hearing they all enjoyed it and want to know when the next one is due because they want to do something like that again, so we will look into where we can take them".*

Alternatively, community need related to very specific risk factors, for example drug misuse and vandalism that seemingly alluded to wider issues around deprivation,

*June: "I can speak for where I live in..... and it is a deprived area there are no jobs, people are stressed out, relationships, family relationships, partner relationships and all things like that going wrong. Drug misuse and substance misuse round here and all that has a knock on effect for the community and it affects the community and it is shame because I have lived in this village all my life and it used to be a lovely village. Lovely clean and safe and it is not anymore".*

This suggests that when community members get involved, they are being courageous and can thus experience a sense of pride at having taken action. This would seem to relate to Tones and Tilford's (2001) who point out that a healthy society is not only one whose resources are equally distributed, but one which has an active empowered community, where individuals are enthusiastically involved in creating the right conditions needed for healthy people.

Some of the data clearly shows community members becoming organised and taking political action, either in the form of lobbying local and national politicians, or even becoming involved in local politics themselves. Shirley explains how her community responded.

*Shirley: "It was just getting worse and worse and worse. The group then decided that we ought to be lobbying people that could help us, such as our MP's, Local Councillors, local members and police".*

However, the sense of joining together as a community and the potential this might hold for local people is clearly expressed by Sue's quite amusing story,

*Sue: "We decided we would do the cenotaph and it was full of birdie green moss. So J had this bright idea that she would pour bleach all over it and scrub it and I don't know what happened really. Bleach went everywhere and it went streaky but it looked 100% better".*

*Int: "Was it the kid's idea to do that; was it something to do with the Falklands War or Gulf or something as to why they wanted to do something with the Cenotaph?"*

*Sue: "It was during the Gulf war so we did the Cenotaph and then we wrapped it in yellow ribbons for the duration of the war. An old gentleman went passed and he was disgusted at the state of it, he said that when our boys were out there in the Gulf fighting for the country that the things to represent people that have already died and that's why this country's in such a state so that decided the young people that we would clean it up and that was what we would do for our "mad day" because the year previously we had done the school garden. They all enjoyed doing it I think".*

In this account, it is the community members that decided to take action based upon a need identified by another community member. This is then responded to by local people, both young and old actively improving their own community environment. This identification of community action in the form of political involvement and a more material practical taking of action again seems to theoretically relate the work of Tones and Tilford (2001). They argue that a reciprocal relationship exists between community empowerment and self-empowerment. A community, which is empowered, facilitates the development of self-empowerment in its members. Also reciprocal is the relationship between individuals and the environment. Their model shows this to be a two-way relationship where individuals and communities may directly interact with their environment and / or exert pressure on governments or other authorities of power at local / national level to implement a public health policy.

### **Community development projects: 'organisers' and those who participate**

There seemed to be two kinds of community members emerging from the analysis; those who actually participate in a range of community development projects and those people who fervently commit themselves to comprehensively organising and progressing the aims of one specific community or group of people - who arguably themselves form a community (Emmel and Conn 2004) (2).

Rather than providing several examples from different interview transcripts, the analysis will compare and contrast the involvement of Margaret and Joan.

Joan is a member of the Fibromyalgia Group; having suffered extensively over recent years. Joan explains the impact this illness has had on her life and the importance of her involvement in the Group,

*Joan: "It is a kind of arthritis type illness but it affects all your muscles, every joint and you seem to ache. I didn't understand it that much when I was told what it was, a Doctor can only tell you what it is, they haven't got the time to sit down and point everything out to you, so being in the group the people group*

*have all had the same so you know how to control it better and how you can try to keep it under control with your own mood. If you are in a happy mood you forget about your pain but if you are in a sad mood then your pain seems a lot worse. You start thinking about your pain. But when you talk to other people you don't feel as bad. Having the group gives you an opportunity to share your problems. Some of the members of the group go on the internet and find out from the internet what it is and bring the information back to the group. We all get a leaflet of them and we have something to look back on. We have a laugh at the group and talk about other things".*

From this excerpt, it is clear that Joan participates in the group in that she shares her concerns, is able to gain additional information that is both useful at the time and potentially in the future. Yet it is others that go on the internet to bring back information to the group: others that collect the leaflets. This is not a critical observation of Joan's behaviour, indeed, it most probably reflects the behaviour of the majority of the membership. Joan is there to participate and receive support.

*Joan: 'I can go up to the group and talk to people and it eases my mind a lot. They are all a good set ...'.*

Margaret is Chair of a Communities Activities Team, an over-50s club that offers a wide range of activities for people in the local community. Margaret is a founder member of the BCATS and has managed the group from its humble beginnings when the membership was quite small compared to its position now where there are over 30 members. She appears to take personal responsibility for the smooth and successful running of the group,

*Margaret: "We do lots of things ..., next week we have people coming to talk about managing your medicines and we try to get people to come and talk, which is not always easy. It is trying to find people who are interesting to listen to and keep them informed, because if it is all just talking and having a cup of coffee or a cup of tea they will get bored. So we need to keep up their interest. We have exercise every fortnight, I must stress that they are only gentle exercises but we enjoy them and it is a good laugh".*

From the above quote, it is obvious that Margaret takes the role of manager – finding speakers, taking responsibility for keeping people's interest and

ensuring that the activities that are organised are within the capabilities of her membership. Possibly without her commitment in terms of organisation the group may not exist in its current form yet Margaret explains that the role may not have been of her choosing – rather someone needed to do the job,

*Margaret: “M was the Secretary and nobody else wanted to be the Chairman, so I said I would do it, that was in the first instance. Never being a Chairman of anything else before, but I thought I would have a go, and I think I do it pretty well, in fact I have been re-elected”.*

Therefore while much is made of a rather abstracted notion of ‘community action’ the experiential account of Margaret makes visible the importance of ‘organisers’ – individual people who adopt the mantle of responsibility.

Having already identified the role played by community ‘organisers’, it seems appropriate to explore some other issues that relate to communities taking action. Within the literature there are several terms, often used interchangeably, connected with the types of work associated with a commitment to community involvement and empowerment. As Harris (2001) states, community work is defined as,

*‘To work with communities experiencing disadvantage, enabling them collectively to identify needs and rights, clarify objectives and take action to meet them within a democratic framework, which respects the needs and rights of others’ (Harris, 2001, p1).*

Community work then describes an occupation or the work done by workers. Banks (2003) suggests that community development is a little different, although it may be one aspect of community work. For Banks (2003), and in line with the Standing Conference for Community Development (SCCD 2001).

*‘Community development is about building active and sustainable communities based on social justice and mutual respect. It is about changing power structures to remove the barriers that prevent people from participating in the issues that affect their lives’ (SCCD, 2001, p5).*

Thus community development may involve the identification and elaboration of processes designed to strengthen individuals and groups, in order to empower the community itself to work towards change in addressing health inequalities and other issues affecting people's lives. Evidence emerged from the analysis that evidenced active participation in issues that affect people's lives. In this section, the focus will be on how community projects are managed. Already the analysis showed community members taking the lead both in terms of identifying need and responding to such need.

### **The Role of the Community Development Worker**

Throughout the data set, there is evidence of both direct and indirect reference to the work of the Community Development Worker.

Participants made reference to the Community Development Worker as 'back-up' support,

*Mari: "I know I have got backup and that is a big thing knowing that I have got backup, I have only to pick the phone up and G's there, she'll do all she can, it's just a shame that there isn't more workers of them, because, I know they are stretched to the limit to what they can do".*

The above quote shows Mari as the one taking the lead and the Community Development Worker being available and on-call when needed. As might be expected, the Community Development Worker appears in the data as invaluable with regard to accessing funding – making grant applications, obtaining charity status and most importantly managing the process. So, for example, Joyce gives an enthusiastic account of her group's achievements around funding; this is then specifically identified as being related to, rather than as a direct consequence of, the support of the Community Development Worker,

*Joyce: "I think that everything that we have achieved, every grant that we have applied for, whatever we have got they [the transcript does not indicate who 'they' might be] have always come and seen what we have done, they have been able to see*

*that we have spent the money on what it was applied for. ...  
So without people like you we wouldn't have got it".*

This shows the community taking the lead and the Community Development Worker playing a part but not taking control.

Yet there was also evidence of Community Development Workers being more proactive and taking a somewhat more prominent organisational role,

*Int: "What sort of things did you start doing"?*

*Bev: "Well we didn't do a lot with the first lady [Community Development Worker], but, when PC [another Community Development Worker] came along, we started doing a lot more things; we weren't doing a lot with the first lady. We started having different people coming, ... That's when we started getting a few trips up and things, to Town and that. We started going on a few trips with them. Then we also had trips with the Women's Group, we went to such as, places of interest, stately homes and things like that. We went to Chatsworth. Things that I wouldn't have thought about going, Nostel Priory we had like guide taking us round there, things like that, quite enjoyable".*

In relation to communities taking action, it might be that in some instances, it is necessary for the Community Development Worker to take a more proactive stance. As discussed earlier in this section, some community members are 'organisers' and some participate. This may have been a group of women who all wanted to participate with nobody feeling able to become the organiser. Thus there is maybe a need for a substitute or temporary organiser and the Community Development Worker fills this need on a temporary basis.

There was also evidence of the role of Community Development Worker as 'working with' rather than 'for' the community,

*Shirley: "When the economy was alright, when men and women did have jobs, they stopped neighbouring. They became a bit more individual orientated. I'm alright Jack. People should be as one, they should be able to talk to each other and know each other and help each other out, that is wellbeing and your health starts to improve. I really think it does. Because of the work I do in the Community, through working with you, HM, JW*

*[Community Development Workers] and a few more that I can name, there's JE what a nicer guy to work with that J. SP [Community Development Workers]. SP has been fine; thanks to her I think that the District Partnership did then start climbing the ladder".*

Shirley is clearly aligning herself 'with' the Community Development Workers – they are a team working to develop a more cohesive and altruistic community. Therefore, the data provides evidence that shows some of the different ways in which Community Development Workers may be required to perform their role.

### **Funding: vital and all consuming**

Those participants who could be identified as 'organisers' invariably talked about funding: seeking sources of funding, making applications and spending the funds if successful. The role of the Community Development Worker in this process has already been identified. The process of accessing funds appears to bring with it certain pressures for community members who are generally engaged in such activities as volunteers. For example, June uses the battle metaphor to describe her experience working as an organiser in the Fibromyalgia Group,

*June: "In the beginning we got funding from the Primary Care Trust and we were grateful for that to get started but I just feel that we have sort of been left because we haven't had much since and it is like we have just been left to get on with it. The main thing we are so dependent on funding and can't run without funding and to me that is the biggest battle. We are applying for funding all the time".*

Applying for funding is something that is then ongoing occurring 'all the time'. So Joyce explains her disappointment at not being successful yet she moves on to say that her group is still trying to raise funds,

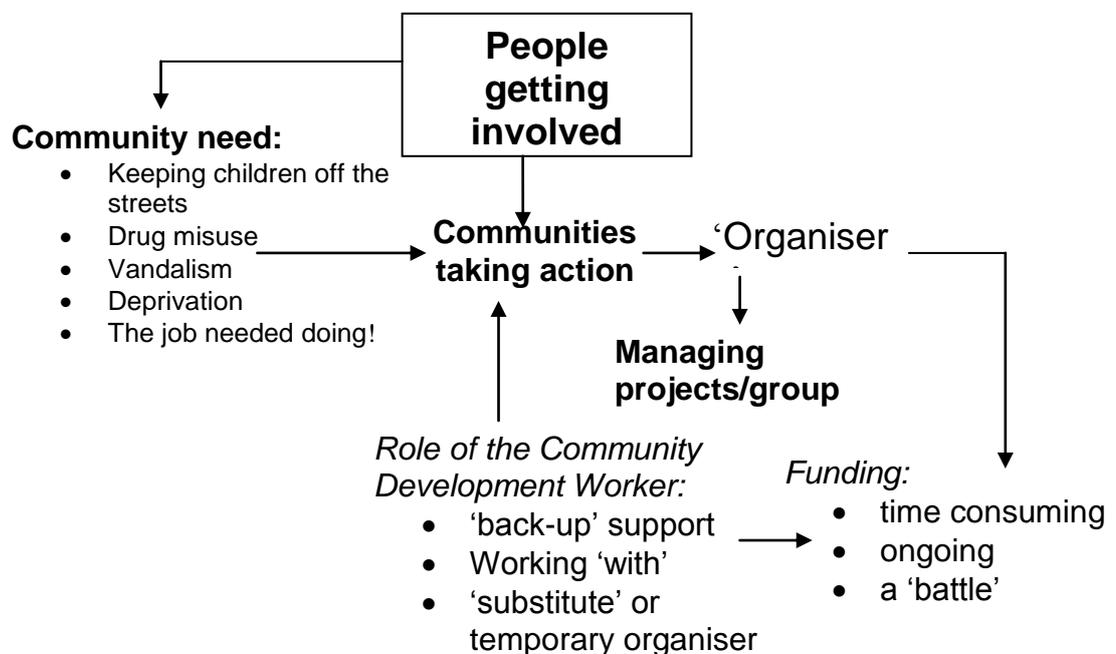
*Joyce: "I was disappointed that we didn't get the lottery grant. ... We are still trying to fund raise for that. I am still trying to get enough money; we must have those toilets done because it is essential they are the worst part in that club. That's what I am aiming for, and aim to do that before I pack in".*

Joyce was determined to secure funding endeavouring to put in place mechanisms that ensure the future sustainability of the community group where she is a motivation force. Once again, this links into the primary function of ‘organisers’; individual community members who are willing and able to devote time and energy to managing their particular groups.

The issue of funding seems to resonate with the whole ideology of community action in that, from this data, it emerges that it is local people who are taking responsibility. Although the task is onerous and ongoing, there seems nevertheless, a commitment to continue with the task. This is seemingly guided and supported by experienced Community Development Workers who seem able to work **with** the community members.

### Overview of the emergent analysis

The diagram (Figure x.) aims to provide a visual overview of the emergent analysis around the identification of community need and communities / people getting involved. The final section will cover the more personal aspects of getting involved as they relate to more psychosocial needs.



**Figure x: Summary of the emergent thematic analysis relating to people getting involved and community need**

## **Personal Need**

In the previous section, it became clear that while the term 'community' is commonly ascribed to groups of people, it is nevertheless often the case, that individual people adopt quite personalised roles with regard to getting involved in community development. In the case of the earlier emergent analysis (Figure x.) – 'organiser' or someone who participates is highlighted. In this section, it is not the actual role that the community member adopts that will be explored, but what participation means for individual people, their families and indeed their wider communities. This relates to the initial analysis where getting involved was shown to be in relation to community need and / or personal need.

## **Individual need**

'Choosing Health' (Department of Health 2004) (1) makes reference to the importance of 'reconnecting with people's lives' underpinned by principles of:

- informed choice – people being able to make their own health decisions based upon credible and trustworthy information;
- personalisation - support tailored to meet the realities of people's lives; and
- working together - building effective partnerships.

What these principles suggest is an acknowledgement of people as autonomous individuals who will have their own motivations and personal desires. The analysis emerging from the data demonstrates this more personal aspect of getting involved – where the motivation is directly related to personal need.

## **'Getting me out of the house'**

Many of the participants referred to their involvement in community development activities as simply: 'getting me out of the house'. However, when considered in more detail this rather obvious outcome is seen to connect

to more health related issues around needing a break from the pressures of everyday life.

*Jane: 'To get out of the house and get away for some peace and quiet.'*

Jane has a child with ADHD and therefore getting out of the house - doing other things and meeting other people is a necessity. For other participants involvement actually sought to avoid depression,

*Joanne: "People have to come to the drop in to get out, to stop depression. I suffer with depression, I am on anti-depressants tablets. It's like if you are not going anywhere, you need to go to these drop ins to get out of it. If it hadn't have been for the drop in I don't know where I would be today. It has been a big help. You meet other people and other people can help you. You can get volunteers to home to your home which I had".*

Interestingly, many participants made reference to wanting to help others, thus demonstrating a level of altruism in their motivation for getting involved. However, often the need to help others had the added effect of making their own lives better as Ruth explains,

*Int: "Why do you keep coming and what makes you still come today"?*

*Ruth:" I have always liked to help children. I have always done voluntary work and have always wanted to look after children to keep them off of the streets. I enjoy coming because everyone is so friendly. I do like to get involved and that's why I like to come. ... I am happier, I am not stuck home any more thinking about problems. It has helped me a lot because I think of other people and helping them instead of worrying about what I am doing. I would rather worry about some one else and help them through their problems".*

One of the participants suggested that her motivation for becoming involved related to feeling 'useful',

*Julie: "Yes. You don't know how far to go, but I get help from "L". Feels good. I feel useful. Now I pick up the phones which I never did".*

Clearly there is far more to 'getting out of the house' than merely changing the physical space. For many participants their involvement in community development activities had a direct relationship with their personal need for either distraction or a more fulfilling life. These data do not in any way contradict the earlier findings around responding to community need. Rather they add to what seems to be a complex and multifaceted picture around 'communities' getting involved with community development; whereby involvement can also be related to a more personal need.

The analysis shows that outcomes can be grouped into three sets of impacts (Figure xi.) impact on the individual with better psychosocial functioning, an impact on health and an impact on the wider family and community. The analysis enables insight into how community development activities might show positive outcomes for individuals, families and communities.

### **Psychosocial impact: functional and supportive**

The analysis thus far has identified some of the stressors and tensions that community members face in their everyday living undermining health and wellbeing. Reasons for accessing community development projects are shown to be connected to community and personal need as well as the desire to be active and involved. However, participants did suggest that for some, involvement serves a therapeutic function. Mari explains the function that her group serves for those who have experienced bereavement,

*Mari; "It is listening to them and letting them get off their chest what they need to get off and then telling them my experiences, telling them how I was in my bereavement. They would say 'Oh yeah, that's just how I've been, I can't believe. Well I'm glad you have told me that because I thought I was going round the bend'. But it isn't it is something that everybody goes through when they are going through the grieving period".*

Being a member of a community group enables people to share their experiences in ways that appear therapeutic in a very broad sense. For example, Joan's account offers insight into how important this can be when asked to reflect on her participation in the Fibromyalgia Group,

*Joan: "I feel a lot more happier in myself, knowing that there is someone there that if I am really in trouble there is "P" or "G" [Community Development Workers] that can help me, there is all the people at the group that understand how I feel, because Fibromyalgia is a depressing complaint altogether, people get down with it so we can all talk and we all understand how we all feel and that lifts our mood a lot".*

Again the role of the Community Development Worker is evident; they are a dependable person who will understand and this is set within a more diffused ability to gain understanding from other members of the Group. Still, one participant clearly suggests that the Community Development Worker is a confidante in times of trouble,

*Margaret: "I can come knowing that it is part of your job and everything can be said in confidence and that it is private whereas when you are outside you don't want people turning round and saying or she is crackers her. I don't get any support at home. So without the group and my doctor I don't know where I would be. So the 2 years that I have been with you I have felt a lot more easy and comfortable and know that I have somewhere to run if I ever get so bad. I am trying to find out ways like coming here that it helps me a lot and then I don't have to go pestering the doctor so it helps here as well".*

The idea that involvement can serve the function of somehow replacing more formal medical interventions was evident for other participants. When Joan was asked what activities she became involved with at the Fibromyalgia Group she says,

*Joan: "It's good to go up to the group to find out that other people is in the same boat as you. You can discuss your pains you are not running to the Doctors every 2 minutes to find out what's the matter with you because with being in the group you talk to them and ask them what pains they get and how does it affect you. It is brilliant".*

For those participants that found involvement served some kind of therapeutic function, there was continual reference to gaining 'support'. Support, in this sense, seemed quite generalised but not at all less important than the previously identified outcomes around therapeutic functionality. For example, Mari spoke of people 'being there' when needed,

*Mari; “Yes, if I have got a problem I don’t take it to all the group, like I get everybody, there is a couple of people who I know I can say, this has happened, that has happened, you know. So, yes, I have got people there as well for me, it works both ways, I have got support if I need it”.*

June suggests that the community development group she belongs to provides her with crucial ‘back-up’,

*June; “... you need that back up. You have got to have that back up. If you were against any problems there has got to be somewhere where you have got to go. I have got that back up with Aspire, because I know that I can just go to G [Community Development Worker] or anybody in Aspire and they will help and do whatever they can even with my college work, I can just ask for help in my theory and stuff like that and its there and I know its there. I have got that back up”.*

This ‘back-up’ is more personal than that referred to in the previous section – it seems to allude to personal reliance, a level of support than can be trusted to be there when needed. Indeed, some participants very forcefully and quite movingly suggested that their active involvement in community development projects had brought about the realisation that their community was their ‘extended family’,

*Suzanne: “Yes I feel a lot happier because even with them I used to bottle everything up and keep them all to myself but now I can get them off my chest which makes life a lot easier. The people are good they are part of the family”*

It appears that involvement in community development projects serves a therapeutic function possibly around personal loss, pressures of life or the actual experience of isolation and depression. However, in addition there is a more generalised impression of developing supportive relationships that have the potential to bring about a sense of security, well-being and trust.

### **Personal growth**

Having become involved with community development activities, without exception, the participants made reference to some kind of outcome that related to personal growth in terms of both skills and knowledge and a quite

specific personal sense. For example, with regard to skills and knowledge many participants were able to list qualifications and training opportunities that they had embarked upon,

*Int: "You say you have become more confident, is there any other ways that you have gained from your involvement"?*

*Ruth: "I have more qualifications as well. I have done first aid, hygiene, child protection, counselling, drug awareness. I have just done the level one for Take 5 for Play. It's to do playschemes. To be a play leader".*

Such training and educational opportunities are in accordance with the overall aim of tackling health inequalities outlined in Choosing Health (Department of Health 2004) (1). Empowerment through education and its impact upon health is the underlying philosophy of Brazilian educator Freire (1973).

Empowerment education involves people in identifying their problems, to critically assess the social and historical roots of these problems, to envisage a healthier society and most importantly to be able to achieve goals by developing strategies to overcome obstacles.

Through the process of community participation, new beliefs are developed by individuals in allowing them to influence their personal and social worlds. The central premise of Freire's philosophy (1972) is that education is not neutral and that it takes place within the context of people's lives. On this context Freire asked who does education serve and for what purpose? Put another way:

*'Does education socialize people to be accepting of their limited roles within a status quo, or does it encourage people to question critical issues of the day and to fully participate in the social and political life of society?'* (Wallerstein 1993 p382).

In terms of participation in social and political life, earlier analysis showed how people had become involved in certain kinds of political action. Possibly this action is related to the educational and training opportunities afforded those who participate in community development activities. However, participation in social life is also demonstrated with regard to other personal growth. Some

participants attributed their success in finding employment to their having taking part in community development training and educational activities,

*Bev; "Because, before that I was only doing an hour a night, just little part-time jobs, you know what I mean, like an hour and a half a day and things like that. This felt like a real proper job. So, I don't know, rather than just end up as doing cleaning or whatever, I thought I am doing to aim high, so I'm going to try for the Receptionist Job, which I wouldn't have had the confidence to do before my courses and things, I don't know, I just thought, you're not good enough for that sort of thing. I just thought, no, I am going to aim for it and I ended up getting it".*

Personal growth also encompasses participants saying that their sense of self-confidence had been impacted upon by their involvement. Ruth explains that she used to be shy and now this has all changed,

*Ruth: "No, I have changed a lot, I used to be quite a shy person and I wouldn't say boo to a goose but joining the centre has made me to become more confident, like I go to meetings now and I will talk at meetings, at one time I would just sit there and not say anything but now if it is a subject I know about I can give a good talk as much as them. I have really come out of my shell, a lot of people say that about 4 years ago you wouldn't have said anything but now they can't shut me up".*

Similarly, Mari talks about how getting involved has impacted upon her sense of "self" after losing her partner. The group have enabled her to not only regain her self-confidence she also believes that she has become more confident than before,

*Mari; "Yes, I am confident, when you lose your partner you lose your confidence, everybody does, your main partners gone and you lose your confidence and it does take a long while to get it back, I have got it back quicker, because I was helping people, and I knew I was helping them. My confidence just grew and yes, I think I have gained a bit more confidence".*

Jane says that she has become more independent as a consequence of getting involved with community development activities:

*Jane: "I am more of a go getter now. I don't sit in the house and do nothing. If I want to do something, I will do it. I am more active. I feel more active".*

Indeed, Joyce goes so far as to suggest that involvement and enhanced confidence develops independence and commitment and as such she is convinced that her membership is committed to the group,

*Joyce: "... I would say that people in that group have more confidence. At one point they would have been sat at home doing nothing and now they are out and are involved. Once you get there, it is amazing to see how far they can go. Nobody will say I can't do it. Everybody has a go. We have had a lot of help from community workers, without that we would have just been plodding on doing ordinary things. Everyone is committed"*

This new confidence and commitment seems to be exemplified in Mari's determination to gain new skills that will help her in her role as 'organiser',

*Mari: "I can find things to put in the magazine, I think it's because I'm not computer literate, I think if I could use a computer, but I can't, and I think it's that, I can find what to put in and how to do it, but I can't use computers. I am going to learn, I am going to try and do it, I am going to give it a go, and I will not let it beat me".*

This quote from Mari seems to typify the psychosocial impact of becoming involved in community development activities – Mari is actively involved, taking responsibility for her own life and learning new skills. Involvement in the community projects seems to have created the necessary conditions for self-improvement.

### **Community Development and its Impact on Health**

The emergent psychosocial impact of getting involved in community development activities would without question imply that the wellbeing of community members is improved. However, the data reveals a number of explicitly health-related outcomes that result from becoming involved with community development projects. With regard to psychosocial outcomes, the data showed that involvement can develop health literacy and offer an alternative to accessing more mainstream health services. However, there was also evidence of involvement enabling a 'signposting' of much needed health services,

*Shirley: "... because from one little project a massive thing can grow. And again from the Impact Office, I worked with LM (Social Worker Student), she was on placement with the PCT, she was absolutely brilliant, she was brilliant to work with, she helped a long way to forming a coffee morning room for over 55's. We are hoping to expand on that. We set the 55's group up in partnership with L who was from the PCT, through that we found that there were quite a few of the people that attended had sugar diabetes and J [Community Development Worker], you were able J to signpost them to various places that could help them".*

Getting involved had enabled Jane to become proactive. One of her children has ADHD and she is able to get 'out there' to gather information that will enable her to be better informed about her child's condition and how to most effectively respond as a parent,

*Jane: "We [gained] a heck of a lot, especially the ADHD Group, even though there is not a lot of people coming, me and the lady I work it with will go out there and get all the information because there is such a lot of information on it to do with mental health, we just keep putting ourselves out there and gathering all the information we can.... With my daughter having ADHD I thought that might be ideal for when she's a bit older".*

Alongside outcomes in terms of accessing mainstream services and relevant health related information, there were many examples of the ways in which becoming involved had brought about lifestyle changes that had the potential to create healthier communities. Joyce tells of her membership participating in an exercise session,

*Joyce: "It was a laugh a minute we never thought would we could do it. To see everyone sat in a circle and doing all these exercises it was absolutely brilliant. ... "D" came back after being very ill and she wept when she saw us because she thought she would never see us again, but even she has signed up to start the back the Fit and Friendly. We have 41 members who have all paid £2 each and it will pay "I" fee. Then the remainder is for the lunch. I have told them that they must pay a week in advance. I think they are so interested now, I said that once they joined they should stay. We follow on after that with bingo. One thing leads to another".*

The account offered by Joyce provides insight into the **cumulative effect** of involvement. Not only are people exercising, they are having fun, meeting

friends, gaining support. Also, the data suggest that people join in other activities that have the potential to enhance their lives. Remaining with exercise, Julie explains how her local GP surgery has become involved in exercise related activities,

*Int: "What do you do with the walking group now? Have you just been on the course and that's it".*

*Julie: "No you go out and do walks and try and get the people in the area you are in to start walking with you. It did drop off but now that we have a surgery involved which are willing to come along but they want to go further a field, they have got transport and are willing to take the back leader and front leader with them. ... So they can get their patients gradually walking if they need the exercise".*

Other participants made reference to lifestyle changes related to healthy eating. Bev had been on a cookery course as a member of her local Women's Group she tells the interviewer how this had brought about changes in her lifestyle with regard to diet,

*Int: "Do you think you eating has improved, do you think you eat healthy food because you have done your cooking course"?*

*Bev: "Yes, I try to, I always try to grill my food anyway, and try to think more about what you're eating. I have made a pact with myself, to try and stay off chocolate, but it has only been in the last couple of months. Because, at the time I was still eating chocolate and things, I'm a chocoholic. But, I thought to myself, no, it's not doing you no good, just try and cut it out, which I have done in the last couple of months, so I have lost a bit of weight in the last couple of months through doing that, you know. I feel a lot healthier with walking and that and whatever".*

These changes often impacted on the whole family,

*Bev: "Me and my children like eating healthy any way but my husband doesn't like been told what he can and what he can't eat. But we don't have fried stuff we always grill; I don't fry anything any more. If we get chips we do then in oil which is healthier than fat and lard".*

While lifestyle changes appear to hold potential for health improvement, there is nevertheless the reality of the physical environment where people live their

lives to take into consideration. When asked to reflect on what she thinks might affect her health, Bev offers the following insight,

*Bev: "I think a lot of it effects where you live. Because where we live we've got like a chemical works, we've got a power station blasting off whatever, and we've got a motorway, so we're stuck right in the middle. So I think a lot of that is to do with that your health, because, a lot of people round here suffer from asthma and other ailments. I think a lot of it is the food which you eat and the exercise that you're getting. All that contributes to your health"*

Getting involved in community development activities appears to have quite a wide range of effects on health related issues. Involvement appears to hold the potential to contribute to better health including mental health, provide additional skills and knowledge and enhance people's sense of self-worth. There are also very tangible health related outcomes that can be identified in terms of lifestyle choices and people becoming better informed about their own health.

### **Community Development and its Impact on Communities**

While this section has primarily focused on presenting data that is suggestive of individual and personal outcomes, this does not in any way detract from an appreciation that people are part of communities. What this section aims to do is relate the rather abstracted ideology of 'community' to actual people's lives in a very obvious and material sense; as this is an emergent theme from the data generated. There appears to be a number of quite concrete community outcomes. Throughout the data there is evidence of people's efforts to provide activities / services for children. Sue's efforts volunteering to work with the children in her own village is just one of many accounts that speaks of the dedication and commitment of community members in terms of meeting the needs of children in their local community,

*Sue: "Since then I have gone on and I have become a volunteer with an Art Workshop' for kids in my own home village on a Saturday morning, I used to have 4 or 5 creative projects that the kids used to do and I really enjoyed doing that. Then I started with the Community Association, I am Secretary for that, we are trying to get a playground for the young people in our*

*village on the top of our common. During the school holidays we do games. We have organised 2 family fun days which have both gone down exceedingly well and that's where we are up to in this moment in time".*

Such efforts have implications for communities. Many of the participants made direct reference to family support: Jane in terms of her child with ADHD, Julie with regard to her children and their involvement in activities and other women spoke of difficult relationships that had been eased with their getting involved in community development projects. There is resounding evidence that for some people getting involved may create far more skilled communities – ones with potential to take action and become economically and politically included. Yet possibly, one of the most evident functional outcomes is the way in which people experience support in their communities – a sense of togetherness, being able to rely on support and understanding where previously this may have been either absent or somewhat unpredictable. This sense of social cohesion appeared as an important outcome of participation.

### **Communities Moving On**

During the interviews, participants were asked to consider what the future might hold for their communities, groups and themselves with regard to their involvement in community development. Responses to this question were quite wide-ranging but nonetheless informative offering insight into the aspirations and expectations of community members. Some of the participants chose to concentrate on quite material aspirations that often had the potential to increase community capacity,

*Julie; “.. there isn't any facilities for disabled children or disabled people to come in. I would like to see a disabled toilet. Stairs are a problem because you can't get anyone upstairs and that's where the computer rooms are. We could have something so that they could get upstairs... There's plenty of people that want to come but some people can't get here because the facilities aren't right. This has been a success but we want a bigger place so we can be more successful and more people can join in so we can have youth clubs. We can't have a pool table in here or snooker, you can't have table tennis because it is not big enough. We could be more successful if we had a bigger place”.*

Margaret has similar thoughts recognising the economic realities of her membership and the running of the group,

*Margaret: "So, as regards to what we will be like in a years time, I think that we will go from strength to strength, but we would definitely like more grants, so that we can go ahead with what we want to do. And then I think we will reach a point, but I don't think we will be dissolving, you see we need the grants because at the moment we don't even have to pay for the room, the church lets us have it free, but if we had to pay for the room then we would have to put the subs up and that might stop people from coming. So, grants please!"*

With regard to making improvements Julie was concerned about the location of projects. She feels able to access out of her own community but she recognises the need where she lives,

*Julie: "The members of the community don't come in like they should do, they are not getting the benefit of the building being here which is a shame. I don't live in this area and if we had this in my village probably the local people would bring more kids down there and more children would probably use it more. But I got told that this property was for both communities and local people won't come from there to here and the property is too far for them to come. ... But in the local village there is that many children down there and walking the streets and 4 and 5 year old children running round with nothing to do which is really a change, it would have been better if the property had been more central so that everybody could have used it"*

This recognition of community need and the importance of her local project seemed evident for Suzanne whose primary aim for the future was:

*Suzanne: "to still be open and bringing people in and hopefully attract more people."*

June's response echoes this but takes it further having very specific hopes and expectations for the future,

*Int: "What would you see as an achievement in 12 months time how would you measure your success then"?*

*June: "That would be a full-time paid co-ordinator, a part-time paid admin worker, counsellors paid for what they deserve because they are all voluntary, they only get travel expenses. I*

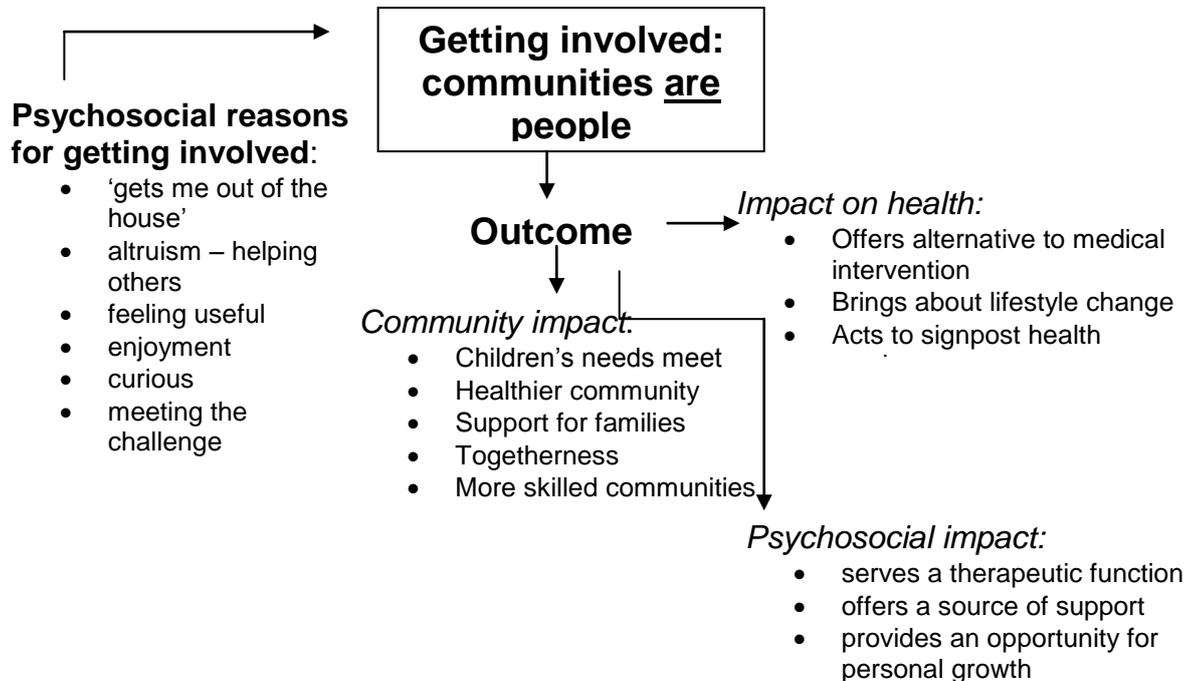
*think it's just being able to be autonomous and self-sufficient. That would double the clients that we would be able to see and save them going on a long waiting list because if they have a long time to wait then that just adds to the problem and it prolongs the problems".*

Autonomy and self-sufficiency seem to be testimony to the success of community development working for participants. June is not expecting any outside agency to provide the actual service; rather she alludes to the community to which she belongs endeavouring to secure a more economically viable position for their group. This positive hope for the futures seems to be part of Shirley's vision for her community,

*Shirley: "My best scenario now is to see brand new buildings on there [her estate where there has been considerable deterioration and houses have been demolished], with, what I call a Community Based Office in there. If every new estate had this, where it was open with a Community Group in there, this is your Community and you have got to look after it, this is what we want to see. Not only have you got a Community Group, but you have an Estate Manager in there that would go round and if anybody weren't putting their dustbins out or leaving them out for ever and a day, he could say 'Would you mind taking that in, we don't need to see it'? .. You could have your PCT's, Opticians, Chiropodists etc, people coming in and offering their services within one building on each estate. I would like to see that, well if it will happen or not, I push for it at every opportunity I get".*

## Overview of the Emergent Analysis

The diagram below (Figure xi.) offers an overview of the data analysis showing how the ideology of 'community' involvement may relate to individual need and outcomes.



**Figure xi: Summary of the emergent thematic analysis relating to personal involvement and more generalised outcomes**

The overviews identified the impact of getting involved at both a personal and community level. The questions that remained related to a consideration of best practice in community development practice and the key levers of success in community projects seeking to ameliorate multiple deprivation in disadvantaged communities and improve health and wellbeing.

Smithies and Hampson (1999) set clear criteria for effective community development including the setting of clear and realistic roles and remit: ensuring resources are adequate for purpose: adequate and appropriate project management and evaluation: recognition of the importance of the wider environment within which the projects were operating and building long-term sustainability. Analysis of the local Community Development Strategy and individual projects was undertaken against each of these criteria for good

practice using the data gained from the interviews with user participants. (Appendix 4).

### **Clear and realistic roles and remit for community development projects**

At a strategic level, the Local Strategic Partnership had, in accordance with Government policy, developed a Community Strategy (Wakefield 2002). Local Community Strategies were a requirement of the New Labour Government and provided an over-arching framework for other services and thematic plans and together with other key strategic plans should influence local activity (DETR 2001). This set the strategic context for the agreement of the local Community Development Strategy (Perry 2002). That strategy set out to integrate health improvement into the mainstream activity of reform and modernisation of services, regeneration of communities and social inclusion of marginalised individuals and groups.

The strategy was explicit about the values which would drive community development and participation. It also clarified the corporate roles and responsibilities of the key partners and sought to promote change within a framework of whole system development and networking (Femie and Pettigrew 1996).

Clearly partnership working to address regeneration and health improvement is complex and requires new ways of working and community leadership as argued by Hamer and Easton (2002). In particular, there were questions concerning the consistency of the agreed approach and the explicit values of social justice, participation, equality, learning and cooperation (Perry 2002 p5).

Heron and Dwyer (1999) argue that the Government's reform agenda is set within a new framework of self-help and individual responsibility and is more concerned with developing a new communitarian moral order. Within this framework, there are responsibilities to self and the community with individual autonomy contingent on meeting those civic responsibilities. Inclusion is limited to the condition that all must contribute as 'stakeholders' and in return can access benefits. This seems a far cry from a more redistributive approach

seeking empowerment and participation (Wallerstein 1993). Such differences in values, often challenge planning and option appraisal and can constrain behaviours conducive to effective partnership (Pfeffer 1998). An agreed strategic approach was helpful in providing clarity of role and remit but at the same time differences in approach undermine strategic intentions and the partnership working between agencies.

At a project level, what was also helpful was the wide ranging remit for individual projects summarised in Appendix 4. Each group was encouraged to develop clear terms of reference. These demonstrated a broad approach to health, taking into account the broad determinants of health which underpin health inequalities. This is not to suggest that these were static but rather represented a continuum which is summarised at Figure xii

| <b>Typologies for Identifying Community Involvement</b> |   |
|---|---|
| Type 1  | Innovator's goal for the community is primarily self-empowerment and improvement in socio-economic status   |
| Type 2  | As above but in the process of developing a community profile and identifying felt need, the community itself acknowledges needs that are consistent with standard preventative medical, health, educational goals e.g. need for better primary care services, accident prevention, dealing with child health problems. |
| Type 3  | Characterised by community health projects. Innovators goal is to enhance health but is prepared to help community work through other more pressing felt needs e.g. to improve cardiovascular health  |
| Type 4  | Innovators goals are primarily those of preventive medicine epitomised by various CHD prevention programmes. More top down than types 1-3 but innovators understand the importance of taking the community with them and utilising existing leadership patterns.  |
| Type 5  | More limited outreach programmes, limited community participation but uses a mix of agencies e.g. media plus schools plus drop in centre and delivery of services to housing estates or workplace.  |

**Figure xii: Typologies for identifying Community Involvement**

**Source: Tones and Tilford (2001)**

This shift along the continuum was evidenced in the participatory interviews:

*“The success side of it, where we have got to now, is how we all work together as a team and everyone helping and supporting each other”. (June).*

The demonstration of the implementation of participatory involvement was then strongly evidenced in the transcripts and showed that these values were embedded and codified within the day to day workings of the projects and professional practice. Alongside this, a wide definition of health was adopted in the terms of reference for projects and was especially important in engagement of vulnerable and powerless individuals in their interaction with health professionals.

*Joan: “It is good to go up to the group to find out that other people is in the same boat as you. You can discuss your pains. You are not running to the Doctor every 2 minutes... and if I am down I can ask for P to come and have a word... It helps me such a lot”.*

### **Adequate Resources to Meet the Remit**

The criteria proposed includes issues of sustainable funding, suitable premises, and the support of experienced Community Development Workers and properly supported participants and volunteer activists.

As indicated earlier, issues of funding were extremely complex with a wide range of funding streams utilised to support the various project groups. The workload in generating and maintaining the funding was demanding on both staff and volunteers. This is a recurring theme in the literature. In over 50% of the projects surveyed by Smithies and Hampson (1999 p24), short-term funding was seen as hindering success. The importance of the issue and the impact is clear in the responses from a number of participants.

*Mari; “I didn’t know how to start with funding. So I asked GB if she could help me get funding and help me run the group to build it into a bigger thing... She got us funding and the group went from strength to strength”.*

Earlier analysis has highlighted how organiser volunteers placed significant emphasis on the issue of sustainable funding and a level of frustration in both, the energy expended in applying for funding and in the absence of longer-term

commitment from statutory partners. In part, this flows from the nature of the funding streams allocated to statutory agencies such as Neighbourhood Renewal Funding which was allocated to Local Authorities on a three year basis. This is exacerbated by a lack of joined up thinking and crosscutting thinking at national policy level. Equally, this may be because integrating health improvement and wellbeing is a relatively new activity for Local Councils and the NHS and the extent to which specific strategies will deliver change in health improvement and inequalities is untested (Hamer and Easton 2002).

As such, there is a reluctance to commit mainstream funding other than joint funding e.g. Drug Action Team, Neighbourhood Renewal Fund etc where joint commissioning and pooled budgeting is a statutory requirement. The PCT did allocate mainstream funding for the Community Development Team (Crowley 2003) but the remaining costs were temporary funds across a range of agencies.

What is clear from the analysis is that funding, whilst a serious resource issue was not an exclusive one, other resource issues were also important. This includes the availability of bases suitable for community development activity.

*Ruth: " The house is a nice place but I think we would have done better if we had looked for a bigger premises so we could do more...there are plenty of people that want to come but some people can't get here because the facilities aren't right...to make it successful we need to move".*

Capital investment in facilities to support ongoing groups is clearly an important issue which all too often is overlooked in planning and initiating community development initiatives. The limitations placed on projects by the lack of proper facilities needs to be acknowledged in the remit for community groups if disillusionment is to be avoided as illustrated.

Finally, there are strong messages in the analysis concerning the need to ensure that there is resourceful and experienced Community Development Team nurturing bedrock of community volunteer organisers.

*Joan; "P and G have been marvellous. I felt secure whereas before I used to have no one to run to".*

This links back to the earlier analysis of the crucial role of the Community Development Team Workers in prompting and supporting embryonic projects. This was particularly important where participants were inexperienced or who chose to take a more participative rather than community activist role. The analysis also emphasised the need to make sensitive assessment of intervention strategies working alongside community groups but not taking control.

### **Adequate and Appropriate Project Management and Evaluation**

There is evidence of these elements both within the strategic framework adopted for the Local Community Development Strategy and in the agreed evaluation framework. Any evaluation needs to address the participatory framework embedded in the strategy which explicitly fosters the involvement of all participants in assessing and understanding the effectiveness and impact of any community develop initiative. The advantage of the approach is that it allows individual projects to be understood as part of a wider strategic and multiple project activity occurring simultaneously within and across communities. This is not to suggest that evaluation of community interventions is not without difficulty. The complexity of the structures can often mean it is difficult to identify what is being evaluated and the links between input and outcomes.

The organisational structure of the PCT included a Head of Community Development who was overseeing the work of the Community Development Team. In turn, she was accountable to the Director of Public Health, a Board level appointment. The day to day management of projects lay with individual workers and an overview of projects individually and collectively was undertaken by the Head of Community Development. This allowed appropriate support to individual projects and the whole community development initiative to be appropriately managed. At several points in the interviews, positive comments are made about the effective management of

projects. The terms of reference for each project are set out at Appendix 4 which set a clear framework to manage activity and direction.

### **Recognition of the importance of the wider environment within which projects were operating**

In this part of the evaluation, issues to be considered included an acknowledgement of past history and experiences; the harnessing of local support and effective agency links and partnership working at a district wide level. From the analysis the following can be identified:

1. Each individual project was framed within a clear strategy which linked to the overall strategic plan (Wakefield Community Strategy 2000) adopted by all the key stakeholders and members of the Wakefield Partnership;
2. The quantitative analysis highlights that over 600 people were involved in a range of projects across the district Appendix 4;
3. The quality of local support also can be identified in the transcripts;

One example is;

*(Ruth) "we got the council to join in we got the Police: we got the Groundworks: we got the school involved: we got about 15 people from the school....it was a great success....there should be more of it".*

This exemplifies feedback from participants who welcome local involvement and a role which fosters the engagement of local support within a framework of partnership working between agencies. This latter element in particular, demonstrates agencies flexing response to felt needs of the community and responding in a bespoke way to resolving those needs in partnership with local people and communities.

### **Building Long term Sustainability**

One of the key policy debates in relation to community development is how to make it long-term and sustainable. Smithies (2000) argues that to do so a

number of elements need to be addressed. Firstly, how does community development ensure strategic fit with the wider policy and policy implementation agenda and secondly if ownership is to be maintained how is it possible to demonstrate 'real gain' for individuals and communities. These issues are also part of the 'social capital' debate which suggests that community development work is long-term and dependent on process (Ledwith 2008).

The analysis of the Local Community Development Strategy demonstrates that it was rooted in the overall District Community Strategy agreed by the key partner agencies. As such, it was embedded in the local strategic intentions and amongst the key priorities for implementation to secure regeneration and renewal of disadvantaged communities.

The analysis of the interview transcripts has significant evidence of both individual, family and community benefit in real terms.

*Int: "Do you think you have changed personally"?*

*Jane: "Oh yes. I mean now the kids are older, I have more time to do that and I go off and do all sorts". (Jane).*

Nor is such change focused solely on individuals. It highlighted the impact on family and wider social networks.

*Jane: "Yes definitely I have learned from them I have definitely learned from them.... I use my counselling skills with my family not shoving it down their throat but I can listen. I listen more... I know my daughter will say...I am really proud of what you are doing, Mum. She says you are really trying and you are achieving something".*

This supports notions of real gain in individuals within fractured and disadvantaged communities, achieving better social functioning and mutual support. This is summed up in my final extract from the data:

*"I don't know what makes other people healthier, I know what makes me healthier and that's being happy and having friends". (Suzanne).*

## Key Findings

The overarching aim of this research project was to evaluate from the perspective of user participants involved in local Community Development projects whether their participation contributed to their health and social wellbeing. A summary of findings is set out:

1. The analysis shows a range of projects were developed as a part of a wide-ranging Community Development Strategy which sought to engage individuals and communities in the most disadvantaged parts of Wakefield District. This Community Development Strategy was part of a wider Community Strategy aimed at improving health and wellbeing of local citizens and communities. Consequently, coherence can be identified between the strategic position of the major statutory and voluntary organisations and the community development projects ensuring clarity of purpose and direction consistent with good practice requirements (Smithies and Hampson 1999) and Cook (2009).
2. The community development projects developed were wide-ranging including self-help groups and community groups some of which were geographically focused and some which focused on communities of interest. This diversity was underpinned by explicit principle of participation set out in the strategic documentation (Perry 2002). This focus on individual and collective empowerment created the conditions within which user participants were able to gain confidence, support and personal control.
3. The participants were predominantly women and children and the volunteer research participants interviewed in the study were all female and predominantly middle-aged. This apparent gender differences in involvement in community development and community action need to be explored further.

4. All the participants were unemployed at the start of their involvement except for three pensioners only one of whom was in receipt of an occupational pension. All participants described living stressful lives with limited support and self-reported ill-health especially depression. They all lived in the communities to the east of Wakefield which had multiple deprivation. They describe the built environment as vandalised and depressing marked by social breakdown exacerbated by poverty, unemployment, and isolation. The study re-inforced the abrasive impact of multiple deprivation on health and wellbeing consistent with findings in relation to the social determinants of health (Wilkinson and Pickett 2009).
5. The findings highlight the complexities of community engagement and community development. Participation was driven in part by personal needs in what participants described as highly stressful lives which lacked support networks. Psycho-social reasons for becoming involved included personal need for respite e.g. getting out of the house, wanting to feel useful, personal enjoyment and satisfaction and wanting to meet new challenges. Other participants became involved because they had identified, either through their family or in the wider community, problems which they wish to be addressed and on which action could be taken. These included creating child care and youth facilities; action on vandalism and improving the environment and addressing drug taking.
6. The importance of the providing and maintaining a robust and sensitive support structure for individuals is underlined. In part this was provided by other participants in the community project and in part by an experienced, paid and trained Community Development Team. The level of support and leadership provided by individual Community Development Workers in specific projects varied dependent of the lifecycle of the project and the skills available from participants and volunteer activists and organisers. Their roles included change agent, service developer, access facilitator and capacity builder (Communities and Local Government 2006). However what was identified was the positive impact of an orientation to work 'with' rather than 'for' communities.

7. A positive impact on health and wellbeing was self-reporting by all the participants. Involvement in the project fostered self-assurance and promoted changes in lifestyle particularly increased fit and improved nutrition. There was also evidence of improvement in health literacy as confidence and skills developed better self-management of health is reported together with more effective and timely engagement with health professionals. Two participants re-entered the labour market in paid employment.
  
8. The voices of the participants were sometimes tinged with frustration and disappointment over the precarious nature of short-term funding, the threat to continuation of the community development projects and possibility of withdrawal of the support of Community Development Team. Sustained action seems to be crucial in addressing what are often complex and intractable social problems (Bauld et al 2005).

## **Chapter 5 – Discussion and Findings**

The aim of my study was to evaluate, from the perspective of user participants living in a deprived northern metropolitan area, the impact of involvement in a range of community projects on their health and wellbeing. The sample group was 13 user participants from a range of community development projects sponsored by the Eastern Wakefield Primary Care Trust (Appendix 10).

A case study approach was adopted involving interviews with User participants who volunteered to tell their stories. The transcripts from the interviews were then thematically analysed initially using NVivo. Subsequently, a manual trawl was undertaken involving listening to the taped interviews and thematic analysis of the transcripts. A framework developed from good practice guidance in Community Development as also used to assess practice. (Smithies and Hampson 1999).

The intention was to disseminate the findings as a case study setting out a community development approach to community engagement and health improvement to inform action by the NHS and Partners on health and health inequalities.

### **Reflections on Methodology, Limitations and Study Design**

Throughout this study, I had been conscious of the issues raised by possible bias not only because this was 'Insider Research' but also because of my status and position as Chief Executive of the Primary Care Trust and the Research Director. This called for considerable exercise of emotional intelligence on my part in both understanding and managing myself and others (Goleman 1999). He argued that emotional intelligence emerges from the synergy in understanding and managing self and understanding and managing others. Better self-management based on accurate self knowledge expands the potential to engage people in a more equitable way and increases rapport with more players. This found synchrony with my personal

and professional values. My leadership style expanded. I was more open and transparent in adopting situational and dispersed leadership in dealing with increasingly complex and strategic issues.

Managing the risk was addressed at the outset of the study with a number of inter-connected actions forming a risk management approach. The early engagement of the Community Development Team in defining the research question and the design of the study allowed opportunities to create dispersed ownership and explicit power sharing, in a collaborative approach which provided safeguards against bias and managed the risk. Joint design and the peer review of the initial proposals as a pilot allowed for refinement. Briefing the team at the workshop and in subsequent review meetings during the interviewing process, secured consistency and clarity of purpose, as well as joint learning and resolution of problems. Further safeguards were built in by establishing a Research Study Steering Group to oversee the work. Interview guidance was also provided to support consistency of approach in the interviews ( Appendix 6)

Clear systems to secure informed consent were established and transcripts were validated by user participants (Appendix 7). Anonymity was established in the write up and all participants are represented in the write up in a balanced approach (Appendix 10). Collectively, the actions taken represent robust and systematic action, within a grounded theory approach, which would have identified any tendency to bias in the study (Strauss and Corbin 1998).

It is pertinent to acknowledge that the sample size in the study was small. Thirteen user participants out of 600 people involved in the projects. I justify my approach by arguing that the nature of my research question was well suited to this kind of study. The important issue was to select an approach which made sense to the study and delivered the desired outcomes (Silverman 2000). The study was seeking to evaluate the impact of involvement and empower the user participants by giving them a 'voice'. The study was grounded in the themes emerging from the interviews with participants. What emerged was 'rich stories' from voices which illuminated

my research question and which, notwithstanding the small sample, produced findings of value in a complex study which was both sensitive and humbling (Robson 2002).

It was significant that the volunteer User participants were all female. I have rehearsed earlier the gender issue in my sample and suggested that this gender representation can be understood from a number of perspectives. These will be considered in the latter discussion.

### **Strategic fit**

As set out in Chapter 3, good practice emphasised the importance of strategic fit and coherence between strategic objects and the role and remit of discrete community development projects which deliver the objectives of the local strategy (Smithies and Hampson 1999). My thematic analysis identified a consistency between the explicit description set out in the Wakefield Community Development Strategy (Perry 2002) and individual projects. This is grounded in the comments of participants and reflected in the literature (Communities and Local Government 2006).

There are clearly a number of slightly different approaches to addressing health and health inequalities, but essentially all focus on setting a strategic framework for change and delivering for communities and individuals. In that sense, improving health might mean concentrating on the big killers of cancer, CHD and respiratory disease, addressing the social determinants of health and promoting individual lifestyle change through social marketing and health promotion (Hughes 2009).

Cook (2009) also proposed interventions should happen at three levels to address health improvement. The 'macro' level indicated national policy drivers aimed at income redistribution etc; at a 'meso' level interventions are taken at a local level by a local Council or Health Trust. This could be a community-wide based intervention. Finally, at a local level individual projects would be delivering. She stressed the importance of alignment and coherence

at macro, meso and micro levels if the cumulative effect was to be secured and objectives achieved.

The common ground appears to be ensuring linkage at all levels of the system and achieving a cumulative impact in an integrated strategy which empowers individuals and communities to secure social cohesion and better health (Cantle 2005). This link has been evidenced in my research study and reinforces this aspect of best practice.

### **Participation, Empowerment and Health Improvement**

As set out in my findings, values of participation and empowerment of individuals and communities were explicitly adopted and delivered strategically and operationally. My findings align with and reinforce the conclusions of existing literature about the effects of participation in community based activities in ameliorating the impact of health inequalities through the development of social capital and social support (Waddell and Burton 2006). Definitions of social capital vary, but the main aspects include citizenship, neighbourliness, social networks and civic participation (Office for National Statistics 2003). My findings highlight the importance of social networks in extending support and contributing to better self-report overall health. Other findings from similar qualitative studies suggest that participation leads to increased socialisation and consequent social support (Bynner and Parsons 2006). Individuals need community and communities need engaged participants to thrive. (Friedli 2009)

My findings highlight how participants identified that their involvement in the projects had facilitated a range of learning opportunities and skill development. This led to improved self-esteem, life skills and wellbeing. There is corroborative evidence in the literature to suggest that where this happens and adults were engaged in improving overall life skills, this promotes greater civic engagement and enhances social capital (Bynner and Parsons 2006).

## Gender

All the volunteers were female predominantly middle aged but with one teenager and three pensioners. This may simply reflect that higher representation in project participation by females. It is possible that their age and location in their life course provided them with the opportunity to give time to devote to community development projects. It may reflect a level of confidence and maturity borne out of family care responsibilities underpinning an ability to 'organise' notwithstanding their lack of formal training and expertise.

It may also be that care and caring are highly gendered activities with women numerically primary care givers in community care (Featherstone 1994). A number of studies have highlighted the role of women as community organisers (Mayo M 1977) and the prevalence of unpaid and underpaid work being done by women at the grassroots (Boswell K and Hunter G 1991). This major contribution made to family, vulnerable groups and communities is especially apparent where there is a lack of social cohesion and accessible and responsive community support services.

This representation of woman participants may also need to be placed within a specific local historical and cultural context. I have set out briefly, in the introduction, the demise of the mining industry and the bitter industrial dispute of the 1984 miners' strike. In the course of that industrial dispute, marked by violence, death, flying pickets and strife, women organised groups to support the industrial action. Women's Action Groups set up soup kitchens, delivered food parcels, joined the picket lines, organised national conferences and delivered a petition to 10 Downing Street to the then Prime Minister, Margaret Thatcher (Archives Hub 2004). It may be that this has local relevance for involvement of middle-aged women as leaders of community projects.

There are also issues relating to the nature of the community projects, their organisational and cultural structures and value base. The projects were marked by a lack of hierarchy and values of equity and participation. This

calls for skills of influence, facilitation and partnership within a model of distributed leadership (Tichy 1997). It has been argued that women's socialisation makes them better equipped to perform the tasks and skills necessary to support a loose and non-hierarchical organisation. Rosener (1990) identified women as being more nurturing and aligning themselves closer to distributed and transformational leadership styles. This would be consistent with men being encouraged towards more thinking activities, use of formal power, and being more guarded with information and women towards more feeling activities and preference to share power and information (Alimo – Metcalfe B 1995). This focus on shared influence, networking, equity and partnership may be particularly relevant for women's leadership style (Grint 1997).

The absence of male volunteers may also link to men's reluctance to get involved in community health programmes (Men's Health Forum 2009). It has been argued that men operate on a need to know basis in relation to health issue namely they don't want to know unless it is critical (Department of Health and Human Science 2004). This may relate to patterns of male socialisation and the emphasis placed on control leading to less flexibility and an inability to integrate across aspects of their lives. Even when men do volunteer they do not tend to take advantage of social opportunities in the same way in which women do (Grizans M 2009).

Finally, the demise of traditional male dominated industries such as coal mining may also impact adversely, causing high levels of exclusion for previous high status males and fostering detachment from local communities, subsequently leading to hostility to community action which is viewed as being carried out mainly by women (Campbell 1993).

### **Impact of Multiple Deprivation**

My thematic analysis of the 13 individual stories uncovered the insidious impact of multiple deprivation on individuals and communities. Taking a wider social determinant model, it is clear that in developed societies, it is the poor that have shorter lives and who suffer more of almost every social problem

(Wilkinson and Pickett 2009). The impact of multiple deprivation is apparent from my data.

My study highlighted the way in which all the volunteer user participants self-reported stress depression and isolation. This is consistent with the literature which identified a significant rise in depression in the UK (Collishaw et al 2004). The most powerful sources of stress are identified as low social status, lack of a social network and stress in early life (Wilkinson and Pickett 2009).

There is also a strong association between deprivation and common mental health disorders with a higher rate identified in manual socio-economic groups. (ONS 2003). Suicide rates for deprived communities also significantly higher than in the least deprived areas (Dunnell 2008).

All the participants were unemployed, although two participants did re-enter the labour market after some time in their community development project. The impact of unemployment is significant. There is a correlation between unemployment and long-term illness (Bartley and Plewiss 2002) and (Bartley 2004). This is supported in my findings and reflected in the self-reported long-term illness figures for Wakefield District (DOH 2000) (1). This serves to emphasis the validity of the model for the social determinants of health with un-employment seen as the greatest determinant of poverty, exclusion and ill-health (Glennerster et al 2009).

### **Lifestyle Improvements**

My study also found participation was linked to greater engagement in exercise, such as increased walking, which in turn promoted personal fitness and enhanced wellbeing. Alongside this, improvement in cooking skills led to better nutrition and diet. This finding aligns with existing literature whereby participation in learning was related to increasing levels of exercise although the gain was less for people in the lowest socio-economic groups (Feinstein et al 2003). Further evidence in the literature reinforced that better diet and nutrition are associated with participation in adult learning (Higgins et al 2008). In turn these changes in lifestyle becomes associated with better mental

health and reinforces the interlinkage between health and wellbeing as well as the marked relationship between socioeconomic factors and health behaviours. (Pressman and Cohen 2005).

Participation in skills development and learning may also have an effect on confidence and self-esteem, leading to higher levels of social participation and social contact. It appears that what is important is the increased social contact and support network which leads to greater social status and a reduction in isolation and depression (Bynner and Hammond 2004). The link with more positive mental health is reported by a number of studies including Aldridge and Lavender (2000) and a pilot scheme where GPs prescribed further education as part of treatment. This reported a range of benefits to mental health and wellbeing (James 2001).

The study also suggests that it is not only the participant that benefits in this situation but their families. The confidence gained in obtaining new skills in adulthood can be a springboard for increased confidence in dealing with children and providing assistance with homework and other learning activities (Cabinet Office 2008).

What appears to be shown is that social support provided by the project participants themselves, the activist participants and the Community Development Team members increased self esteem with a spin off for better mental health and physical health. The increase in social capital as a consequence, in terms of community activity, then becomes associated with better health (Feinstein et al 2003).

### **Participants and Activists**

From the analysis, the research participants appear to adopt roles either as project participant or as organiser / activist. For the former involvement is about securing personal support and informal therapy, respite from stress and depression and a wider social circle of support from the project. For the latter,

more activist role, there was again respite from stress and securing wider social support but within a different context. Some community activists took a political role in creating action, both by the community and external agencies, in developing new and innovative responses to self-identified community need and improvement of the built environment locally.

All respondents, whether in the participatory or activist group, identify the importance of increased social support, social networks and social cohesion. This and involvement in the projects, represented a chance to gain knowledge and develop new skills which positively impacted on confidence, self-esteem and personal growth. In turn, this appears to improve overall health and wellbeing (Hume et al 2005) and contribute to a strengthened and healthier community (Barr and Hashagen 2000).

My findings also recorded self-reported higher levels of confidence and self-esteem as a consequence of participation. This finds resonance in the work of Schuller et al (2004). This qualitative work found that many people at times of difficult and crisis, engaged in leisure courses and that this participation had a positive impact on their mental health and wellbeing. Another important element in the findings was the spill over from increased confidence into health literacy. Evidence suggests participants were able to understand and manage their health better and to engage with health professionals more effectively when access to such services became necessary. This finding is supported by the work of Ley (1988) who found better rates of self-managing conditions, more effective doctor/ patient relationship and more effective management of treatment where adult learning was undertaken whether formally or informally.

However, as I have set out earlier, the communities of eastern Wakefield had suffered from multiple deprivation over many years (DOH 2000) (1). In circumstances where the underlying causes of inequality and poor health are structural, some of the literature question the use of ameliorative services (Dyson et al 2009). This perspective suggests that health improvement and health inequality can only be addressed by tackling income and social

inequality which underpins a social gradient from the lowest socio-economic group to the highest and where health outcomes improve incrementally (WHO 2008). In this model, the determinants of health are socially defined in developed economies through inequality. It is posed that it is inequality which is key to understanding poor health status, declining levels of trust, differential life expectancy, high levels of stress and mental illness and obesity (Wilkinson 1996): (Kawachi et al 1997): (Wilkinson and Marmot 2005): (Marmot 2005): (Curtis 2008) and (Wilkinson and Pickett 2009).

An alternative view in the literature is that a more diversified approach is required to address the complexities of multiple deprivation and health improvement. IDEA suggest a three layered approach involving action on the prevention of the 'big killers' Cancer, Coronary Heart Disease and Respiratory disease through better health care : mobilisation of people to stay healthy primarily through social marketing and finally action on the social determinants of health through promoting health enhancing public policies (Hughes 2009).

In summary, what is happening at a social level has profound implications for individuals and communities. As I have argued, unemployment and income inequality is the principle driver behind social exclusion and ultimately health inequality. Whether health inequality can be improved in a sustainable way without action on economic inequality is questionable. However, for individuals and communities suffering multiple deprivation, facilitating participation and involvement through giving people greater control with better social networks and support improves self-reported health. A social integrationist approach holds validity but will alone not deliver the scale of change required unless accompanied by redistributionist policies.

### **Community Development Team Support**

Throughout the analysis, the participants identified the increase in social support as critically important in generating feelings of better health and wellbeing. The support included professional support from Community Development Team members as well as a wider network of friends. My

findings emphasised the importance of this professional support. Roles undertaken varied and demonstrated a contingent approach focused on working with, rather than, for local communities. The emphasis was on self-help, mutual support, development of neighbourhood capacity and problem-solving and promoting community preferences (Thomas 1993). In this sense, my findings reinforce the roles of Community Development Workers as change agent, access facilitator, service developer and capacity builder consistent with the framework proposed by Communities and Local Government (2006).

The critical role of community development is often overlooked at a strategic and policy level, although community development principles of collective working, equity and participation comes to the fore in local community action. (Communities and local Government 2006). My findings suggest that getting the intervention right optimises participation and contributes to community capacity in developing disadvantaged communities (Harris 1992). Clearly participants come to community development projects for different reasons and with differing levels of skills and personal resources. Sensitive responses impacted on self-esteem and increased personal support which contributed to participation and subsequent empowerment of individual participants (Barr and Hashagans 2000). This in turn, delivered community development as participants identified community need and built capacity to take action and enhance health and social wellbeing (Robinson and Elliott 2000).

### **Funding and sustainability**

Sustained action seems to be crucial in addressing what are often complex and intractable social problems (Bauld et al 2005). The lessons of recent policy in addressing multiple deprivation and social exclusion is that most things worked and made a contribution. Alongside this is a realisation that the impact is never as quick as policy makers hope and that longer-term sustainable funding is a pre-requisite (Hills et al 2009).

There is also an issue of trust which requires a response. The User participants were clear that continuity and funding is a critical issue, not always addressed by statutory partners. As set out in the literature review, levels of trust within disadvantaged areas with multiple deprivation can be low and this can be further undermined by the temporary nature of the funding such as Neighbourhood Renewal Funds and New Deal. This does little to address the low self-esteem and long-term nature of the problems and can promote cynical attitudes to initiatives to address the social determinants of health inequality.

Overall, there appeared to be an unclear relationship between policy aspirations for community development and funding. Where funding does exist, it did not appear to be systematically available and generally is time limited. Community development funding needs to be on a stable basis in order to achieve major step change especially in disadvantaged areas (Home Office 2004).

### **Personal Learning**

The experience of creating, designing and leading this study has been profoundly humbling, challenging and exciting. My interest in Health Inequality, Empowerment and Community Development has a long history. I reflected on my personal leadership journey and explored influences on my personal and professional values – equity, equality, personal and collective empowerment and traced these through to my working class upbringing in the 1950s on Merseyside. I also explored my political radicalisation in my path through higher education and my path through leadership of major Public Sector organisations in Bradford and Wakefield.

Undertaking this study awakened memories of those early experiences of exclusion and racism. I came to the study with a sense of commitment in ensuring the user participants, in the disadvantaged communities of eastern Wakefield, could have their voices heard and could challenge an often prevailing explanation of inequality and exclusion grounded in individual pathology. In a sense, I felt sensitised from the outset to the social injustice

linked to the multiple deprivation of these communities and a driving sense to ensure the story was told with high levels of participation, integrity and ethical standards.

I had learned in recent experience, how to sustain my personal values and set them out in practice even in a hostile environment. Additionally, I had learned to engage, lead and empower staff in an innovative NHS Trust. Both these came to the fore, in the way in which the Community Development Team and participants were engaged both in design and process of the study. In this respect, I have had further reaffirmation of the importance of self-awareness and empathy in creating trust and rapport in “give and take” relationships (Moulding et al 1999) and (Gardner et al 2005). I sought to be inclusive and meet the needs of staff. Bennis (1999) described the supporting conditions for followership which involved encouragement of participation, acknowledgement of input and mutual sharing of influence and power. In turn, as Kouzes and Posner (2003) argued, this delivered teamwork as a necessary pre-requisite for transformational leadership in improving services. I was relaxed in integrating followership and leadership in my day to day management (Thach et al 2006). Alongside this my leadership and project management skills were enhanced in delivering a complex research study.

Where I was on much less familiar and safe ground was on issues of research design and methodology. The learning curve was steep. The establishment of a Study Advisory Group created opportunities to learn from more experienced researchers and wide reading has improved my theoretical understanding. I developed broader perspectives including, an understanding of the boundaries of my own knowledge and a good sense of timing of when to enlist others views and perspectives.

I have undertaken literature researches, commissioned data analysis and enhanced my own skills at designing evaluation criteria and systematically analysing data. This has given me confidence in my current post as Senior Research Fellow with the Marmot Commission at University College London developing a new Health Inequalities Strategy for England post 2010.

I have read more widely than I anticipated, taking in evidence from beyond the boundaries I initially envisaged. This has challenged my understanding and interpretation but has helped me to synthesis complex issues more effectively.

Taking this more holistic view of my study, I have been surprised by the twists and turns - the ethical dilemmas and opportunities of the insider researcher and the difficulties of promoting my participation in a methodological approach focused on work based research and learning, challenged the arguably more traditional health research community.

I was humbled by the stories set out by the user participants and the commitment of the Community Development Team to capture them accurately and sensitively.

Finally, the write up has demanded persistence, application and a range of enhanced skills in analysis, synthesis and presentation. I have never regarded myself as an academic but the insights and skills gained take me further along the path of researcher / practitioner. This will be invaluable in my current work.

The purpose of the study was to consider the impact on the health and wellbeing of user participants of their involvement in Community Development Projects. I wanted to extend the evidence base and disseminated this widely in public services and other institutions. This has already commenced with dissemination of the results within the national public health network and will continue over the coming year.

Additionally, the outcome will inform part of the analysis, development and implementation stages of the Marmot Commission. The study provides a template for implementation of local health inequalities and neighbourhood renewal strategies with a clear understanding of the need to ensure action at a macro, meso and micro level in a co-ordinated and cumulative implementation plan if progress is to be made.

## Chapter 6 - Conclusions and Recommendations

At the start of this research study, my aim was to evaluate from the perspective of user participants involved in local community development projects whether such participation contributed to their health and wellbeing.

Subsidiary aims were:

- To engage the Community Development Team in Eastern Wakefield PCT to be involved in improving practice by developing an evaluation process which captures the perspectives of the participating citizens and synthesises those perspectives with best practice models;
- To create an action research programme which actively engaged service users / citizens involved in the community development projects delivered in the Eastern Wakefield PCT area to give them a voice in evaluating the impact of such initiatives on their health;
- Dissemination of the work widely across key stakeholders as a case example in evaluating community developments contribution to community engagement and health improvement.

I now reflect on this study, the evidence which has been identified and the contribution to my own knowledge and understanding and that of the professions involved in community development and health improvement.

As set out earlier in Chapter 3, there is a paucity of literature specifically evaluating the impact of participation in community development on health and wellbeing especially from a service user viewpoint. In answering the research question above, the study does make a significant contribution to professional knowledge and helps to fill the gap synthesising existing knowledge and creating new knowledge and applications. The study and the recommendations provide both a model for future evaluation of services and

also new insights into providing services which ameliorate the effects of multiple deprivation in disadvantaged communities and begin to create the conditions within which socially excluded people and communities are facilitated to take some control over their own lives.

The study emphasises the critical importance of alignment at various levels of intervention and securing a coherence of approach between strategy and delivery within consistent principles and values. This appears to offer the best possibility of achieving synergy in addressing long-standing disadvantage and deprivation (Cook 2009). This is stressed in good practice guidance on community participation in health (Smithies and Hampson 1999).

The literature and approaches to participation are extensive and varied. It is clear from the evidence of this study that there is potential within mainstream Public Services to adopt a personalised and collective approach to empowerment of citizens. This requires explicit commitment to empowerment and processes which ensure that the voices of service users are heard and outcomes influenced. This means negotiating on issues of power and control and being explicit about roles and accountability within a framework of working 'with' rather than 'for' disadvantaged communities.

The findings also contribute to the debate about the causes of health inequalities which has developed along a number of strands. These attempt to explain how differences in social position impact on health and wellbeing. Singh-Manoux and Marmot (2005) argued that social class differences in health are created and maintained as a result of the socialising influence of socio-economic factors effecting attitudes, beliefs and behaviours. They propose that resilience and the ability to build social networks have to be learned. This study provided significant supporting evidence for this position. This seems to be particularly marked in relation to mental wellbeing as positive relationships between the service users allied to the support of the Community Development Team offered a protective effect away from previous social isolation and negative relationships (Stansfield 1999).

All the respondents were women. Some perspectives for this have been set out although these were not comprehensive. It may be beneficial to undertake a further study into the apparent gender differences in active personal engagement and community action. This might in particular, focus on the social relationship developed by men especially those made redundant from high status employment.

The respondents in the study describe vividly the impact of multiple deprivation on their lives. The stress of such deprivation is highlighted in much of the literature on social epidemiology. Graham (2004) and Wilkinson and Pickett (2009) are two examples. They point the way for upstream interventions which address the whole of the social gradient whilst not forgetting that those at the bottom suffer the most from social inequality. Qualitative evidence suggesting that regeneration and renewal have important roles to play is emerging (Blackman 2001). Such evidence needs to be systematically collated and disseminated to make the case for a shift to a more upstream action to address the gap between the richest and the poorest whilst not forgetting action to ameliorate the impact on those at the bottom. The inequality gap serves to undermine the solidarity that glues together society and citizens. As Sandel (2009) argued:

*'a politics of the common good would make the case for building the infrastructure of civic life ...drawing people out of gated communities and into the common spaces of a shared democratic citizenship' (p11).*

My findings support the need to actively engage with individuals and communities to strengthen social networks and social cohesion and reduce the equity gap. The impact of participation in community development projects is evidenced across the accounts of the User participants. Increases in confidence and self-assurance brought fostered changes in lifestyle as self-esteem and skills increased. Social networks and cohesion developed alongside political action for some activists. This has strengthened the evidence base for community interventions focused on the lowest socio-

economic groups systematically targeting the wider determinants of health (Cook 2009).

My findings also highlight the key role played by the Community Development Team in extending support to the participants by working with individuals and communities on their terms. The basis of community development lies in values of equality, social justice, participation and political awareness (Communities and Local Government 2006). Community development focused on increasing participation can often be overlooked in national policy, as a consequence perhaps, of the local nature of the intervention and the low profile which comes with providing background support rather than upfront, high profile leadership.

Finally, my study highlighted the vexed issue of funding. My findings highlight the frustration and disappointment about the short-term nature of funding for community development projects and the many different funding streams involved. This serves to dissipate effort and undermines attempts to achieve synergy and a sustained and cumulative impact on complex and deeply embedded social and health inequality.

## **Recommendations**

1. That national policy addresses the issue of Health Inequality at all levels, identifying the necessary alignment between meso and micro initiatives at a regional and local level with macro policy at a national level to create synergy and cumulative impact in addressing the social determinants of health inequalities, building civic life, and promoting democratic citizenship.
2. National policy ensures action is taken at the right level in a co-ordinated response to tackle and deliver health equity across the social gradient.
3. Local Authority and NHS Partnerships target specific health inequalities and develop joint interventions focused on the social determinants of

health, increasing social capital and social networks within communities to promote health and wellbeing.

4. Local Strategic Partnerships support community development interventions based on participation and empowerment especially with disadvantaged individuals and communities focused on the wider social determinants of health.
5. A National Community Development Knowledge Network is sponsored by the Department of Health to promote Community Development and develop the evidence base for best practice in addressing the wider determinants of health.
6. That further studies address the gender issues of involvement in community development and regeneration and explore the different ways in which women and men may experience multiple deprivation and respond to community initiatives to address social cohesion.
7. My study sought to place service users and the heart of service evaluation and to give them a voice. This has been challenging for me as a leader in Health care and to the PCT as a statutory health agency. It raises significant issues for future models of evaluation and practitioner research and challenges public sector services to rethink the place of service users in qualitative research into the effectiveness of services.

## References

- Acheson D. (1998) Independent Inquiry into Inequalities in Britain. HMSO. London.
- Alcock P. (1997) Understanding Poverty. Macmillan Press London cited in Carlile S. (2001) Inequalities in Health: contested explanations, shifting discourse and ambiguous policies. In Critical Public Health Vol.11 No.3 2001.
- Aldridge F. and Lavender P. (2000). The Impact of Learning on Health. NIACE.
- Alimo-Metcalfe B. (1995) An Investigation of Female and Male Constructs of Leadership and Empowerment. Women in Management review.Vol.10 pp.3-8 1995
- Archive Hub (2004) @ [www.archivehub.ac.uk/miner2004](http://www.archivehub.ac.uk/miner2004). 04.02.08.
- Arnstein S. (1969) A Ladder of Citizen Participation. AIP Journal July 1969 p216-224 cited in Freeman R, Gillan S, Shearin C, and Pratt J (1997) Community Development and Involvement in Primary Care. Kings Fund Publishing. London
- Association of Metropolitan Authorities. (1993) Local Authorities and Community Development: A Strategic opportunity for the 1990s. AMA Press. London.
- Balanda K. and Wilde J.(2003) Inequalities in perceived health. Institute of Public Health. Dublin, Ireland cited in Cook B. (2009) op cit.
- Baldwin S, Foy S, Hamm T. et al. (1998) Beyond the Baselines. Policy Research institute Leeds.
- Banks S (2003) The Concept of community practice. In Banks S, Butcher H, Henderson P. and Robertson J. (2003) Managing Community Practice: Principles, Policies and Programmes. Policy Press. Bristol.
- Barnes C. and Mercer G. (1997). Doing Disability Research. The Disability Press. Leeds. UK. Cited in Gomm (2004). Op cit.
- Barr A. and Hashagans S. (2000) ABCD Handbook - A Framework for Evaluating Community Development. Community Development Foundation. London
- Bartley M. and Plewis I. (2002) Accumulated Labour Market Disadvantage and Long term limiting Illness. Journal of Epidemiology 31.
- Bartley M. (2004) Health Inequality: An introduction to the theories, concepts and methods. Polity. Cambridge. U.K.

Bauld L, Judge K, Barnes M, Benzeval M, Mackensie M and Sullivan H (2005) Promoting Social Change: The experience of Health Action Zones in England. *Journal of Social Policy*. 34(3),p427-445

Bawden R. and Packham R. (1993) Systematic Praxis in the education of Agricultural Systems Practitioners. *Journal of Systematic Practice and Action Research*. Vol 6.No. 1 Feb 1993. pp 7-19...

Bell J. (1999) *Doing your Research Project*. Open University Press. Maidenhead.

Bennis W. (1999) The Leadership Advantage. *Leader to Leader*.12 (Spring 1999) pp 18-23.

Berkman L. (1992) Emotional support and survival after myocardial infarction. *Psychosomatic Medicine*. 58 pp 459-471.

Berkman L. and Glass T. (2000) Social integration, Social networks, Social support and Health. *Social Epidemiology*. OUP

Berwick D. (1996) A Primer on leading the improvement of Systems. *British Medical Journal*. 9 March 1996 31.12 pp 619-622

Bethane A. (1997) Unemployment and Mortality cited in Drever F. and Whitehead M. (Eds) *Health Inequalities*. TSO. London

Biggs S. and Smith G. (1998) Beyond Methodologies: Coalition-building for participatory Technology Development. *World Development* Vol. 26 No.2 pp 239-48

Blackman T. (2001) Housing Renewal and Mental Health: a case study. *Journal of Mental Health*. Vol. 10 No. 5. October 2001.

Boswell K. and Hunter G. (1991) *Community Development Initiatives at the Grassroots: Community Responses to unemployment @ [www.maf.govt.nz/mafnet/ruraln-z/people-and-their-issues/social-research-and-welfare](http://www.maf.govt.nz/mafnet/ruraln-z/people-and-their-issues/social-research-and-welfare)*.

Bourdieu P. (1984) *Distinction: A Social Critique of the Judgement of Taste*. Routledge and Kegan Paul. London cited in Carlisle S. (2001) op. cit.

Brown A. (1987) *When battered Women Kill*. Free Press. New York cited in Patton (op cit).

Brandt A. and Rozin P. (Eds) (1997) *Mortality and Health*. Routledge. London and New York.

Burke P. and Kirton A (2006) Insider perspective; Teachers as Researcher. In *Reflecting Education* Vol. 2 p1 |July 2006

Bynner J. and Hammond C. (2004) *The Benefits of Adult Learning; quantitative insights* in Schuller T, Preston J, Hammond C, Brassett-Grundy A and Bynner A (Eds). *The Benefits of Learning: the Impact of Learning on Health, Family Life and Social Capital*. Routledge.London

Bynner J. and Parsons S. (2006) *New Light on Literacy and Numeracy*. National Research and development Centre for Adult Literacy and Numeracy. U.K.

Cabinet Office (2001) *A new commitment to Neighbourhood Renewal; Report by the Social Exclusion Unit*. Social Exclusion Unit. London

Cabinet Office (2008) *Getting on, getting ahead: a discussion paper analysing the trends and drivers of Social Mobility*. Cabinet Office Strategy Unit.

Calman K (1998) *The potential for health: How to improve the Nation's Health*.Oxford University Press. Oxford cited In Hunter D. (2003) *Public Health policy*. Polity Press. Cambridge. UK.

Cantle T. (2005) *Social Cohesion: A new framework for Race and Diversity*. Palgrave Macmillan. Basingstoke.

Campbell C. (1993) *Goliath; Britain's Dangerous Places*. Methuen. London

Carlisle S. (2001) *Inequalities in health: contested explanations, shifting discourse and ambiguous policies*. *Critical Public Health*. Vol. 11 No.3 2001

Carr W. and Kemmis S. (1986) *Becoming critical*. Falmer Press. Lewes. UK.

Census (2001) *Census 2001 Key Statistics Wakefield Metropolitan District* Crown Copyright 2000.

Cernea M. (1991) *Putting People First: Sociological variables in rural development*. Oxford University Press. New York

Clark A and Oswald A (2002) *A simple statistical method for measuring how life events affect happiness*. University of Warwick. Warwick.

Clarke M. and Stewart J. (1996) *Public Service reconfiguration and the Citizen*. *Local Government Policy Making* Vol. 14. No.1 pp 34-40

Clandinin D J and Connelly F M (1997) *Narrative Inquiry; Experience and Story in narrative Research*. Jossey-Bass. San Francisco. USA.

Collishaw S, Maughan B, and Goodman R. (2004) *Time trends in Adolescent Mental Health*. *British Journal of Psychiatry*. 45. pp1350- 1362 2004

Coglan A (2001) *Insider action research projects: implications for practicing Managers*. *Management Learning* 2001 31. (10) p49-50 National College for School Leadership.

Communities and Local Government (2006) The Community Development Challenge. Community and Local Government Pub. Weatherby. UK.

Cook B. (2009) Health Inequalities. Southern Health Board. Northern Ireland.

Cooke B. and Kothari U. (Eds) (2001) Participation: The new tyranny? Zed Books London and New York.

Craig C. (1989) Community Work and the State. Community Development Journal. 24(1) pp 3-18.

Creswell J. (1994) Research Design Qualitative and Quantitative Approaches. Sage. London.

Crotty M. (1998) The Foundations of Social Research. Sage. London

Crowley P. (2003) Community Development and Primary Care in Northern Ireland and England. Combat Poverty Agency. Dublin, Ireland. @ [www.combatpoverty.ie](http://www.combatpoverty.ie). 08.06.09.

Curtis S. (2008) How can we address Health Inequality through Healthy Public Policy in Europe? European Urban and Regional studies. 15(4) p 293-305.

Denscombe M. (2003) The Good Research Guide. Open University Press. UK.

Department for the Environment, Food and Rural Affairs. (2007) Natural Environment Public Service Agreement. TSO. London.

Department of Health (1998) Our Healthier Nation: A Contract for Health. CM3854 HMSO London.

Department of Health (1999) Saving Lives: Our Healthier Nation. HMSO London.

Department of Health (1) (2000) Indices of Deprivation. HMSO London

Department of Health (2) (2000) The NHS Plan. HMSO London

Department of Health (2001) (1) Shifting the balance of Power within the NHS. Department of Health London

Department of Health (2001) (2) Research Governance. HMSO. London

Department of Health (2001) (3) Making it happen: a guide to delivering mental health promotion. The Stationary Office. London.

Department of Health (2002) A Plan for Delivery. HMSO London.

Department of Health (2003) Reducing Health Inequalities Action Report. HMSO London.

Department of Health. (2004)(1) Choosing Health; Making Healthy Choices Easier. HMSO London

Department of Health (2004) (2) Health Inequalities: Revised List of Spearhead PCTs. DOH London.

Department of Health (2006) Choosing Health: Making healthier choices easier: Health Profile for Wakefield 2006. @ [www.Dh.gov.uk](http://www.Dh.gov.uk). Crown copyright 2006.

Department of Health (2009) Tackling Health Inequalities:10 Years On. HMSO. London

Department of Health and Human Science. (2009) Wrestling the Tiger. DHSS. Tasmania @ [www.dhhs.tasgov.au/health](http://www.dhhs.tasgov.au/health) 12.01.09.

Department of the Environment, Transport and the Regions. (2000) Preparing Community Strategies: Government Guidance to Local Authorities. DETR HMSO London.

Department of the Environment, Transport and the Regions. (DETR) (2001) Local Strategic Partnerships .DETR. HMSO London. @ [www.regeneration.detr.gov.uk/conindex.htm](http://www.regeneration.detr.gov.uk/conindex.htm). 02.06.08.

Department of Social Security (1999) Social Exclusion. HMSO London

Draper A. and Hawdon D. (Eds) (1998) Improving Health through Community Participation. NHS Health Development Agency. London.

Dunnell K. (2008) Diversity and different experiences in the UK. National Statistician's Article on Society. Office of National Statistics.London.

Dyson A, Hertzman C, Roberts H, Tunstill J and Vagri Z. (2009) Childhood Development, Education and Health Inequalities. Draft Report submitted to the Marmot Commission. London

Elliott J. (1982) Action Research: A Framework for self evaluation in Schools. Working Paper No.1 Teacher Pupil Interaction and the Quality of Learning Schools Council. London cited in Winter J. (1989)

Emmel N. and Conn C. (2004) (1) Towards Community Involvement: Strategies for Health and Social Care Providers: The complexity of Communities and lessons for community involvement. Nuffield Institute for Health. Leeds U.K.

Emmel N and Conn C (2004) (2) Identifying the goals and objectives of Community Development. Department of Health National co-ordinating Centre for Research Capacity Development R&D portfolio Programme No.21

Etzioni A (1993) *The Spirit of Community*. Crown Publishes Inc. New York.

Etzioni A. (2000) *Communitarianism: A Third Way to a Good Society*. Demos. London

Featherstone B. (2004) *Family Life and Family Support: a Feminist Analysis*. Palgrave MacMillan. Hampshire UK.

Feinstein L, Hammond C, Woods L, Preston J, and Bynner J. (2003) *The Contribution of Adult Learning to Health and Social Capital*. DCSF Research Report. Department of Children, Schools and Families. London.

Femie M and Pettigrew A (1996) *Managing through Networks: Some Implications for the NHS*. *British Journal of Management*. 7<sup>th</sup> March 1996.pp81-91.

Feuer L (1969) *Writings on the Politics and Philosophy of Marx and Engels*. Collins. Glasgow.

Foucault M. (1984) *Truth and Power*. In *The Foucault Reader*. Rinhov P. (Ed) pp51-75 Pantheon. New York.

Foucault |M. (2004) *Society must be defended*.Penguin Books. London

French W. and Bell C. (1999) *Organisational Development*. Prentice Hall. London.

Friedli L. (2009) *Mental health, resilience and inequalities*. World Health Organisation Regional Office for Europe. Denmark.

Friere P. (1972) *Pedagogy of the Oppressed*. Penguin Books. Middlesex.UK.

Friere P. (1973) *Education for critical consciousness*. Continuum. New York.

Gardner W, Avolio B, Luthans F, May D, and Walumba F. (2005) *Can you see the real me? Leadership Quarterly* Vol.16 p 343-372.

Gillies P. (1998) (1) *Addressing the contradictions: Health promotion and Community Health Action in the UK*. *Health Promotion International* 13(2) pp. 99-120.

Gillies P (1998) (2) *Effectiveness of the alliances and partnerships for health promotion*. *Health promotion International*. 13(2), pp 16-24.

Glaser B. and Strauss A. (1967) *The Discovery of Grounded Theory; Strategies for Qualitative Research* Aldine Transaction. London and New York.

Glennerster H, Hills J, Piachaud D and Webb J (2004) *One Hundred Years of Poverty and Policy*. Joseph Rowntree Foundation. York.

Goleman D. (1999) *Emotional Intelligence*. Bloomsbury. London.

Gomm R. (2004) *Social Research Methodology ; A critical introduction*. Palgrave Macmillan. Basingstoke. UK.

Gore J M. and Zeichner K. M. (1995) *Connecting Action research to genuine Teacher development*. in Smyth J. Ed. (1995) *Critical Discourse on Teacher development*. Cassell. London.

Grady K E and Wallston B. (1988) *Research in Health Care Settings*. Sage. One Thousand Oaks. C.A. USA.

Graham H. (2004). *Social Determinants and Their Unequal Distribution: Clarifying Policy Understandings*. *The Millbank Quarterly*. Vol. 82, No.1 2004 pp. 101-124 cited in Cook B. (2009) op.cit

Green L. (1986) *Theory of Participation*. Cited in Ward W.B. Ed (1986) *Advances in Health education and Promotion*. J AI Press. Greenwich, C.T.

Grint K. (1997) *Leadership: Classic, Contemporary and Critical Approaches*. Oxford University Press. New York

Grizans M. (2009) *Men's attitude to health*. Elderwise Library CA. @ [WWW.elderwise.ca](http://WWW.elderwise.ca) 12/3/09.

Guba E. and Lincoln Y. (1981) *Effective Evaluation*. Jossey-Bass. London and San Francisco USA.

Hahn R. A. (2002) *In search of the public in Public Health*. *Anthropology and the Health Populations: Global trends and local contexts*. Brunel University UK. Cited in Emmel N. and Conn C. (2004) op cit.

Hamer L. and Easton N. (2002) *Community Planning and Health Improvement; A Review of Policy and Practice*. Health Development Agency. London.

Harris E. (1992) *Assessing Community Development Research Methodologies*. *Canadian Journal of Public Health*. 83. pp 562-566.

Harris V. (2001) (Ed) *Community Work Skill Manual*. Newcastle Association of Community Workers and Community Work Training Co. Newcastle. UK.

Hashagen S. (2000) Developing Healthy Communities; Achieving Consensus. Unpublished Paper Scottish Community Development Centre cited as Smithies (2000) op cit.

Heron E. and Dwyer P. (1999) Doing the Right Thing: Labour's Attempt to Forge a New Welfare Deal between the Individual and the State. *Social Policy and Administration*. Vol 33 No.1 March 1999 pp 91-104.

Hewitt-Taylor J. (2002) Inside Knowledge; Issues in Insider Research. *Nursing Standard* 2002. Vol.16 p33-35.

Higgins C, Lavin T, and Metcalfe O (2008) Health Impacts of Education: A Review. Institute of Public Health. Ireland. cited in Hillage J, Savage J, and Lucy D. *Learning to be Healthier*. Institute of Employment Studies. Brighton UK.

Hills D. (2004) Evaluation of Community level interventions for Health Improvement: A Review of experience in the UK. NHS Health Development Agency. London.

Hills J, Sefton T, and Stewart K. (2009). *Towards a more equal Society*. Policy Press. Bristol.

Hillery G. (1955) Definitions of Community; Area of agreement. *Rural Sociology* 20:111 cited in Jewkes R. and Murcott A. (1996) Meanings of Community. *Social Science and Medicine* 20(4) p 555-63.

HM Treasury and Department of Health (2002) *Tackling Health Inequalities; Summary of the 2002 Cross-cutting Review*. HMSO. London.

Holliday A. (2002) *Doing and Writing Qualitative Research*. Sage. London.

Home Office (2004) *Firm Foundations: The Government's framework for Community Capacity Building*. Civil Renewal Unit. HMSO London.

Horrocks C. (2006) Unpublished confidential Qualitative Analysis Report to Eastern Wakefield Primary Care Trust.

Hoy D.C. (1986) Power, repression, progress; Foucault, Lukes and the Frankfurt School. in *Foucault: A Critical Reader* Hoy D.C. (Ed) (1986) pp 123-148. Blackwell Publishing Oxford.

Hughes L. (2009) *Health Inequalities*. Healthy Communities Supplement. I&DEA Improvement and Development Agency. London.

Hume C, Salmon J, Ball K. (2005) Children's perceptions of their home and neighbourhood environment and their associations with objectively measured physical activity. A qualitative and quantitative Study. *Health Education Research*. 20(1) p 1-13.

Illich I. (1973) Tools for Conviviality. Harper Row. New York.

Jackson C. (2008) The complete A-Z Colliery Names @ [www@BBC.co.uk/news](http://www@BBC.co.uk/news) 10.07.08.

James K. (2001) Prescribing Learning: A Guide to Good Practice in Learning and Health. NIACE.

Jarvis S. (2000) An exploration of Individual and Team Learning in a Public Human Service Agency. Unpublished doctoral dissertation Graduate College, The Union Institute, Cincinnati. USA. cited in Patten (2002) op cit.

Jewkes R. and Murcott A. (1996) Meanings of community in Social Science and Medicine. 43(4) pp 555-63.

Johnson A. (2008) Speech of Secretary of State for Health to International Conference on the Social Determinants of Health. Department of Health. London.

Jones N. (2004) In Depth News: Miners' Strike 1984. @ [www.BBC.newschannel/home](http://www.BBC.newschannel/home) 09.02.09

Kanter R. (1989) When Giants learned to Dance. Simon Shuster. London.

Kawachi I. and Kennedy B. (2002) The Health of Nations: Why inequality is harmful to your health. New York Press. New York.

Kawachi I, Kennedy B, Lochner K and Prothrow-Smith D. (1997) Social Capital, Income Inequality and Mortality. American Journal of Public Health. Vol 87. no.9 pp.1491-8

Keats D. (2000) Interviewing: A practical guide for Students and Professionals. Open University Press. Buckingham. UK.

Keen J, Deeming C, Moore J, and Weatherley H. (2007). New Labour, equity and public service: a Rawlsian perspective. Policy and Politics Vol. 35 No. 2 pp 197-214 (2007).

Keen J, Moore J, and West R. (2006) Pathways, networks and choice in health care. International Journal of Health Care Quality Assurance (226) Vol. 19 Iss4 : p136.

Keen J. and Parkwood T. (2000) Using Case Studies in Health Service and Policy Research cited in Pope C. and Lays N. (Eds) (2000) op cit.

Kelly M, Stewart E, Morgan A, Killoran A, Fischer A, Threlfall A and Bonnefoy J. (2009) A conceptual framework for Public Health: NICE's emerging approach.

- Kelman S. (1975) The social nature of the definition problem in health. *International Journal of Health Services*. 5. pp 609-38 cited in Hunter D.J. (2000) *Public Health Policy*. Blackwell Publishing, Cambridge UK.
- Kemmis S.(1982) *The Action Research Planner*. 2<sup>nd</sup> Ed. Deakin University Press. Victoria cited in Winter R (1989).
- Kitchener M. and Whipp R. (1997) Tracks of change in Hospitals: A study of quasi-market transformation. *International Journal of Public Sector Management*. Vol 10. Issue 1 /2.pp 47-61.
- Kouzes J.M. and Posner B.Z. (2003) *Leadership Practices Inventory: LPI Participants Workbook: 10 Steps to understanding and using your LPI feedback*. Pfeiffer. San Francisco. USA.
- Kreuter M W, Lelin N A, Kreuter M and Green L W. (1998) *Health Promotion Ideas that work*. Jones and Bartlett Pub. London.
- Kumar C. (2007) Foucault, Disciplinary power, and the decentring of political Thought: A Marxian View. @ <http://people.su.se/guarr/ideologi/Ideologi.htm>
- Kvale S. (1996) *Interviews: An introduction to Qualitative Research Interviewing*. Sage. London.
- Lawrence-Lightfoot S. (2000) *Respect: An Exploration*. Perseus. Cambridge M A.
- Layard R. (2005) *Happiness; Lessons from a New Science*. Penguin Books. London.
- Ledwith M. (2008) *Community Work* @ [www.infed.org/community](http://www.infed.org/community).02.06.09.
- Lee T. (1999) *Using Qualitative Methods in Organisational Research*. Sage New Delhi, cited in cited in Cooke and Kothari (2001) op. cit.
- Lewin K. (1997) Action Research and minority problems. In Lewin G. *Resolving Social Conflicts; Selected papers on Group Dynamic and Field Theory*. American Psychological Association. 99 143-152. Washington D.C.
- Ley P (1988) *Communicating with Patients*. Chapman and Hall. London.
- Malby B. And Fischer M. (2006). *Tools for Change: An Invitation to Dance*. Ashford Colour Press. Gosport. UK.
- Marmot M. (2005) Social Determinants of Health Inequalities. *Lancet* 2005. 365. pp1099-1104.
- Mason J. (1996) *Qualitative Researching*. Sage London cited in Robson (2002) op cit.

- May N. (1997) Challenging Assumptions: Gender Issues in Urban Regeneration. Joseph Rowntree Foundation. York. UK.
- Mayo M Ed. (1977) Women in the Community. Routledge and Kegan Paul. London.
- McClellan S. (2006) First do no harm: Law, Ethics, and Health Care. Ashgate. Aldershot.Burlington. YT.
- McMurray J. (1995) Persons in Relation. Faber. London.
- McNamara C. (1996) Evaluation of Group managed multi-technique Management Development Programme that includes Action Learning. Unpublished Doctoral dissertation. Graduate College The Union Institute Cincinnati cited in Patton (2002) op cit.
- McNiff J. (2008) Learning with and from People in the Townships and Universities : How do I exercise my transformational educational Influence for generative systematic transformation. Paper to American Educational Research Association 24<sup>th</sup> March 2008. @ [www.jeanmcniff.com/aera078/JM](http://www.jeanmcniff.com/aera078/JM) 22.06.09
- Mens Health Forum (2009) @ [www.menshealthforum.org.uk](http://www.menshealthforum.org.uk) 26.01.09
- Merriam S B (1988) Case Study Research in Education. Jossey-Bass San Francisco. USA.
- Mosse D. (1994) Authority, Gender and Knowledge: Theoretical Reflections on the practice of Participatory Rural appraisal. Development and Change Vol. 25 pp 497-526
- Moulding N, Silagy C, and Weller P. (1999). A framework for effective management of change. in Quality and Safety in Health care .8.p117-183 cited in NHS Modernisation Agency Summary Report. 2002. DOH. London.
- Muller F. (1983) Contrasts in community participation; case studies from Peru. in Morley D. et al (1983) Practising Health for All. Oxford University Press. Oxford. UK.
- NOMIS (1997). Unemployment in Eastern Wakefield by Electoral Ward. Cited in Baldwin (1998) op.cit.
- Oakley A. (1981) Interviewing Women: A Contradiction in Terms. In Roberts H, (1981) (Ed) Doing Feminist Research. Routledge and Keegan-Paul. London.
- Oakley P. (1989) Community Involvement in Health Development. WHO Geneva. cited in Rifkin et al (2002) op cit.

Oakley P et al (1991) Projects with People: Practice of Participation in Rural development. International Labour Office Geneva.

Office of the Deputy Prime Minister. (1) (2000) Indices of Deprivation 2000. HMSO London.

Office of the Deputy Prime Minister. (ODPM) (2) (2000) Neighbourhood Renewal Strategy. HMSO London.

Office of the Deputy Prime Minister. (2004) Indices of Deprivation 2004. @ [www.odpm.gsi.gov.uk](http://www.odpm.gsi.gov.uk). 13.10.08

Office for National Statistics (1997) Official Labour Market Statistics: Wakefield Metropolitan District Council 1997 cited in Baldwin et al (1998) op cit.

Office for National Statistics. (1999) General Household Survey. ONS London.

Office for National Statistics (2003) Social Capital; Measuring Networks and shared values. @ [www.statistics.gov.uk](http://www.statistics.gov.uk) 10/04/09.

Office for National Statistics (2003) The Mental Health of Older people. ONS. London.

O'Keefe E. and Hogg C. (1999) Public Participation and Marginalised Groups The Community Development Model. Health Expectations. December 1999.2(4) pp.245-254 cited in Smithies (2000) op cit.

Oliver A. (2008) Reflections on the Development of Health inequalities Policy in the United Kingdom. LSE Health. London.

Patton M Q. (2002) Qualitative Research and Evaluation Methods. Sage Publications. London UK.

Pedlar M. (Ed) (1991) Action Learning in Practice. Aldershot Hants, Gower.UK.

Perry S. (2002) Community Development; A strategic way forward for Wakefield. Policy Paper for Wakefield District Partnership 2002.

Peters T. and Waterman R. (1982) In Search of Excellence: Lessons from America's Best-Run Companies. Harper Row. New York.

Pfeffer J. (1998) The Human Equation. Harvard Business School. Boston.

Policy Research Institute (1998) The Household Survey for Yorkshire. Leeds.

Pollock C. (2002) Annual report of the Director of Public Health. Wakefield Health Authority. Wakefield.

Popay J, Williams G, Thomas C. and Gatrell T. (1998) Theorising inequalities in Health: the place of lay knowledge. *Sociology of Health and illness* 20 (5), pp 619-644.

Pope C. and May H. (Eds). (2000) *Qualitative Research in Health Care*. B.M.J Books London

Pressman S and Cohen S. (2005) Does positive affect influence health. *Psychological Bulletin*. 131:6. pp 925-971 cited in Friedli (2009) op cit.

Putnam R.D. (1995) Tuning in, tuning out: the strange disappearance of Social Capital in America. *Political Science and Politics*. December 1995 p 664-83 cited in Wilkinson R G (1996) op cit.

Putman R (2001) Social capital: Measurement and consequences. *Canadian Journal of Policy research*. Spring 2001. pp 41-51.

Ragin C and Becker H. (1994) *What is a case? Exploring the Foundations of Social Enquiry*. Cambridge University Press. Cambridge.

Rapoport J. (1987) Terms of Empowerment: Exemplars of Prevention. *Towards a Theory of Community Psychology*. *American Journal of Community Psychology*. 15 No.2 pp.121-148 cited in Emmel and Conn 2004 (1) op cit.

Reason P. and Bradbury H. (2006) *Handbook of Action Research*. Sage Publications, London.

Rawson R. and Tilley N. (1997) *Realistic Evaluation*. Sage London.

Reed J. and Procter S. (1995) *Practitioner Research in Health Care; the Inside Story*. Chapman and Hall. London.

Reinharz S. (1992) *Feminists Methods in Social Research*. Oxford University Press. Oxford cited in Robson (2002) op cit.

Reynolds P.D. (1979) *Ethical Dilemmas and Social Science Research*. Jossey-Bass. San Francisco cited in Robson C. (2002) op cit.

Rifkin S.B, Lewando-Hundt G. and Draper A.K. (2000) *Participatory Approaches in Health Promotion and Health Planning*. Health Development Agency. London.

Robson C (2002) *Real World Research*. Blackwell Pub. Oxford.

Robinson K. and Elliott S. (2000) The Practice of Community Development in Heart Health Promotion. *Health Education Research* Vol 15. No.2 pp 219-231. Oxford University Press.

Rosener J B (1990) Ways Women Lead. Harvard Business Review. Nov-Dec 1990 pp 119-125.

Rowntree J. (2003) Tackling Health Inequalities since the Acheson Inquiry. Joseph Rowntree Foundation Briefing Paper.

Rubin H. and Rubin I. (1995) Qualitative interviewing: The Art of Hearing Data. Thousand Oak. CA. USA.

Sandell M. (2009) a New Politics of the Common Good. Lecture 4: Reith Lectures 2009. p11 @ <http://downloads.bbc.co.uk/cmhttp/radio/4/transcript/2009/200906/reith/aneupolitics.rft>. 09.07.09

Sanders I. (1970) The Concept of Community Development in Carey L. Community Development as a process. University of Missouri Press. Columbia Mo. USA.

Schon D. A. (1987) Educating the Reflective Practitioner: Towards a new design for Teaching and Learning in the Professions. Jossey-Bass San Francisco. USA.

Schor I. (1987) Critical Teaching and everyday Life. University of Chicago Press. Chicago. USA.

Scottish Community Development Centre. (2000) Strategic Framework for Community Development cited in Smithies (2000) op cit.

Schuller T, Preston J, Hammond C, Brassett-Grundy A. and Bynner A. (Eds) (2004) The Benefits of Learning: The Impact of Learning on Health, Family Life and Social Capital. Routledge.London.

Shaw I. (1999) Introducing Qualitative methods: Qualitative Evaluation. Sage. London.

Silverman D. (Eds) (1997) Qualitative Research. Theory, Method and Practice. Sage. London.

Silverman D. (2000) Doing Qualitative Research: A Practical Handbook. Sage. London.

Sim J. and Wright C. (2000) Research in Health Care. Stanley Thornes (Publishers) Cheltenham, Glos. UK.

Singh-Manoux A. and Marmot M. (2005) Role of socialisation in explaining social inequalities in health. Social Science and Medicine Vol.60 pp 2129-2133.

Smith J. A. (1999) Semi-structured Interviewing and Qualitative Analysis in Smith J. A, Harre R. and Van Langenhove L. Rethinking Methods in Psychology. Sage. London.

Smith M.K. (2002) Paulo Friere and informal education. @ [www.infed.org/thinkers/et-frier.htm](http://www.infed.org/thinkers/et-frier.htm) 18.06.09.

Smithies J. (2000) A Practice Guide for Community Development and Health produced for Scottish Development Centre. Labyrinth Consultancy and Training. Howarth. UK.

Smithies J and Hampson S (1999) Review of Good Practice in Community Participation Health Projects and Initiatives. Labyrinth Consultancy and Training. Haworth UK.

Sonnichsen R. (2000) High Impact Internal Evaluation. Sage. CA. USA.

Standing Conference for Community Development. (2001) Strategic Framework for community Development. SCCD Pub. Sheffield.

Stansfield S, Head J, Fuhrer R, Wardle J. and Cattel V. (2003) Social Inequalities in depressive symptoms and physical functioning in The Whitehall Study 2: Exploring a common cause explanation. Journal of Epidemiology and Community Health. 57. 99 pp 361-367.

Statpac Inc. (2009) Survey sampling methods. @ [www.statpac.com/surveys/sampling.htm](http://www.statpac.com/surveys/sampling.htm) 26.02.09

Strauss A and Corbin J. (1998) Basics of Qualitative Research: Techniques and Procedures for developing Grounded Theory. Sage. Thousand Oaks. CA. USA.

Stirrat R. (1997) The New Orthodoxy and Old Truths; Participation, Empowerment and other Buzzwords. in Bastain S. and Bastain N. (Eds) cited in Cooke B and Kothari U (1997) op cit.

Thach E, Thompson K, and Morris A. (2006) A fresh look at Followership. Somana State University Press. Somona. USA.

Thomas D. (1993) Approaches to Community Work. cited in Ledwith M. (2008) @ [www.infed.org/community](http://www.infed.org/community). 09.11.09.

Tichy N (1997) The Leadership Engine: How Companies build Leaders at every level. Harper Business. New York.

Tones K. and Tilford S Health Promotion; effectiveness, efficiency and equity. Nelson Thornes Pub. Cheltenham. UK.

Townsend P. (1998) Inequalities in Health: The need to construct more comprehensive health policies. HEA Occasional paper 11 March 1998. HEA London.

Tremmel R. (1993) Zen and the Art of Reflective Practice in Teacher Education. Harvard Educational Review. 63(4); p 345-58 cited in Patton (2002) op cit.

Tritter J Q. and McCallum A. (2006) The Snakes and Ladders of User Involvement; Moving beyond Arnstein. Health Policy 76(2006) pp 156-68.

Vershuren S. (2001) Case Studies as a Research Strategy: Some Ambiguities and Opportunities. Social Research Methodology Vol.6 No.2 pp 121-139

Waddell G. and Burton A. (2006) Is work good for your health and wellbeing? The Stationary Office. London.

Wakefield District Partnership (2005) Wakefield Partnership Report. Wakefield Metropolitan District Council. Wakefield.

Wakefield Metropolitan Distract Council (2000) Wakefield Community Strategy. Wakefield Metropolitan District Council. Wakefield.

Wakefield Primary Care Group Survey. (1999) Unpublished Survey cited in Pollock (2002) op cit.

Wanless D. (2004) Securing Good Health for the Whole Population. DOH. HMSO London.

Wallerstein N. (1993) Empowerment and Health: the theory and practice of community change. Community Development Journal. 28(3) pp 218-27.

Wenger E. (1998) Communities of Practice; Learning, Meaning and Identity. Cambridge University Press. Cambridge UK.

Wilkinson R. G. (1996) Unhealthy Societies. Routledge London and New York.

Wilkinson R.G. and Marmot M. (2005) The Solid Facts. WHO Copenhagen.

Wilkinson R. and Pickett K. (2009) The Spirit Level. Penguin. London.

Winter R. (1989) Learning from Experience: Principles and Practice in Action Research.

Wolcott H. (1994) Transforming Qualitative Data: Description, Analysis and Interpretation. Sage. London.

World Health Organisation (1946) Preamble to the constitution of WHO as adopted by the International Health Conference, New York 19- 22 June 1946 and signed on 22 July 1946 by the representatives of 61 States. Official records of WHO No.2 p100 and entered into force on 7<sup>th</sup> April 1948.

World Health Organisation (1986) The Ottawa Charter for Health Promotion. World Health Organisation. Geneva.

World Health Organisation (2008) Social Exclusion knowledge Network Background Paper 1. WHO Geneva.

World Health Organisation (2008) .Closing the Gap in a Generation: Health Equity through Action on the social Determinants of Health. WHO Geneva.

Yin R.K. (1989) Case Study Research Design Methods. Sage. California USA

Yin R.K. (2009). Case Study research. Design and Methods: Fourth edition. Applied Social Studies research Method Series Vol. 5. Sage. London.

