

Making sense of community wellbeing: processes of analysis in participatory wellbeing assessments in South London

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· Introduction

Conventional health needs assessment, in the UK as elsewhere, generally involves the collection and analysis of quantitative data by 'expert' researchers. Shifting the frame from analysis by health researchers to a process of co-learning with community members involves a number of challenges, which this article seeks to address. It draws on experience with Participatory Wellbeing Assessments in the London Boroughs of Sutton and Merton over the last few years.

Putting locally perceived needs on the agenda

Health needs assessments are routinely carried out by health authorities in the UK. Usually they focus exclusively on quantifiable measures of health status, deriving data from epidemiological surveys, admission records and other sources of secondary data. Causal analysis is based on indicators of health and wellbeing defined by those in the health authorities. Rarely do those who experience the health problems identified in such needs assessments have a chance to offer their analyses of what their needs might be, let alone how these analyses might best be communicated and acted on.

In recognition of the limited nature of conventional health needs assessment, Merton, Sutton and Wandsworth Specialist Health Promotion Service (MSW SPHS) embarked on an initial participatory wellbeing needs assessment on a low-income social housing

estate¹ of around 6,000 people in the London Borough of Sutton in September 1996. It had a number of objectives.

First, it sought to engage residents in documenting and analysing their needs, as they themselves saw them. Secondly, by broadening the focus from 'needs' to 'wellbeing', it aimed to stimulate greater involvement and collaboration between a range of professionals dealing with a broad range of wellbeing-related needs. Thirdly, by involving residents at every stage, it aimed to catalyse a process that would build longer-term partnerships for action.

I played more of an active role in this than in previous PRA work, as a participatory researcher as well as a PRA facilitator. As a first step in a longer-term process of changing practice, I needed to create space in the authorities to respond to this kind of work. My direct involvement helped create confidence in the methodology: my 'expertise' helped legitimise a completely new approach. Having laid the groundwork, I was able to build capacity and shift control to community members and local workers in subsequent work with MSW SPHS, limiting my input to training and advice on the process.

¹ Housing estates are clusters of dwellings built by local government, and increasingly managed and owned by private housing associations, which are made available at a reasonable rent to low-income families.

• From participant observation to participatory planning

The participatory wellbeing assessment took six months from initial interactions to a final report. Two and a half years later, processes that were started then still continue². The assessment itself involved a number of distinct stages. Each presented different opportunities and challenges for analysis.

Listening to local concerns

The first phase consisted of a 'listening survey'. I moved into a flat on the estate and spent a month getting to know people. My motives at the outset were partly practical: groundwork needed to be done with residents and local workers to get them involved in the PRA process. But living on the estate also provided a valuable opportunity for learning. I chatted to residents in everyday situations to find out what mattered to them. I got a sense of the different institutional perspectives of community representatives and local health, housing, social and education workers. I built up a network of contacts and the rapport that would prove crucial to both research and analysis.

Building a shared understanding

In the second stage, I trained a team of 30 residents and professionals from different sectors in PRA. We formed six research groups: five worked with particular age groups (children, young people, young adults, older adults and senior citizens) and one focused on asthma, a shared concern amongst residents and health professionals. Each group spent a month working with the community, fitting sessions into their everyday work time. They visited organised groups such as the Senior Citizens' Club, held opportunistic sessions with residents in public spaces and worked with residents' social networks in more private settings.

The PRA work aimed to facilitate a process of identification and analysis of issues, seeking to arrive at workable solutions to be taken up in

² See MSW SHPS (1997) for a more detailed account of this process.

action plans. Aware of how much of the process stays in people's heads after PRA sessions are over, I encouraged each group to note down key points and quotes during the sessions on coloured cards: orange for 'challenges', yellow for 'issues' and green for 'solutions'. The cards were useful in many ways, providing a much more accessible and direct source of information than notes. In subsequent work, we used only two kinds of cards - to indicate 'challenges' and 'solutions'. This also served to make note-taking transparent.

Groups convened informally once a week, and near the end of the fieldwork the entire team came together to share their findings. At this meeting, each research group displayed and reviewed the diagrams and cards that had been produced. Some concerns were common to all. Others were age-specific. Clustering cards and laying them out on the floor served to confirm widely felt concerns in a strikingly visual way.

Following this, the team prepared a public exhibition in the community centre. Over the course of most of a day, around a hundred people came along. Residents were invited to add to and comment on the diagrams and clusters of cards that were displayed. Team members encouraged residents to analyse what they saw and to add their own recommendations. We typed the 'solution' cards and circulated them to residents and the appropriate authorities, to spark engagement with the issues residents had raised.

Planning for action

In the third stage, residents and professionals took part in an action planning day workshop. Posters, leaflets and word of mouth were used to attract as many residents as possible. The team debated who in the authorities would have most interest and/or influence and targeted people from health, housing, education, social services, the police, the churches and the voluntary sector. Residents were invited for the whole day, professionals for the afternoon session. The workshop began by reviewing visual outputs. By creating opportunities to explore what had been learnt before considering what to do, we aimed to encourage shared understanding - not consensus, but an appreciation of others'

concerns - amongst people with quite different perspectives and agendas.

To analyse the possibilities for action, participants sorted 'solution' cards into three categories: 'by us' (community-led), 'with us' (in partnership) and 'for us' (by the authorities)³. This stimulated analysis of responsibilities: important in a context where people look to the authorities to provide. Another dimension was then added, thus creating a matrix-like structure. Residents sorted the cards into 'low/no cost', 'medium cost' and 'high cost' to create a starting point for negotiation with the authorities - whose first question was expected to be about resource implications. This created a chance to reflect on what could be done at low or no cost, by the community themselves - as well as a list of things the authorities should be doing better. Votes were then cast on priorities for action and to highlight suggestions which were unfeasible or plain undesirable. These steps ensured that participants had reviewed all suggestions, through the two sorting activities, before they opted for priorities.

In the afternoon, a range of professionals joined the workshop. Rather than simply telling them which priorities mattered to the community, they were invited to view and analyse the display. Then they too voted on priorities for action. Before they arrived, the residents' stickers had been moved to the back of the cards, out of sight. Once the professionals had voted, the cards were turned over. A ripple of satisfaction ran through the room as surprisingly little disagreement emerged. Consensus was negotiated on a list of ten priority areas.

Working together, residents and professionals went on to create action plans. The room buzzed with energy. A memorable scene was the Director of Public Health sitting on the floor while a resident explained to her what she thought needed to be done.

• **Documenting the process**

Action plans, diagrams, quotes, process notes, interviews and recommendations ended up in a

³ The 'by us', 'with us' and 'for us' framework derives from Tony Gibson's (1994) work.

draft report, for which I took the responsibility of writing. The report was circulated widely on the estate and in the authorities for comment. Residents were surprised and delighted to see their words in print, correcting only a couple of factual errors. Team members spoke of how impressed they were with what they had produced. A health worker told me that she had never thought she could do 'research': reading the report made her realise that she could.

The report became a crucial way of sustaining the process. I heard a resident tell a very senior official about 'our book' with words to the effect that now residents' concerns have been put in print, they could not be ignored again. Another senior official who had opposed the whole assessment process, urged me to include one of the residents' recommendations that had been inadvertently missed out of the summary. Frontline health workers, whose voices had been silenced before, felt vindicated by what was written and emerged with newly found confidence. And the authorities began to take the outcomes much more seriously.

• **Different perceptions, different analyses**

Each phase involved different actors, with different perceptions, in processes of analysis; this gave me different opportunities for catalysing learning and action.

Enabling through 'extraction'?

In the first phase, with the listening survey, most of the analysis was **mine** and most of the learning was one-way. People appreciated having someone listening to them and take their concerns seriously, but it was not until later, that their potential role in bringing about the changes they talked about became evident to them. My 'outsider/insider' position as a temporary resident and consultant to the health authority lent insights - and opportunities for behind-the-scenes negotiations - that fed directly into the process. I moved between community members, local workers, health authority and local government officials. This gave me scope to mediate - sometimes directly, as an advocate - between their different perspectives and concerns. My

'outsider/insider' knowledge influenced how I guided the process, from my awareness of what people were not saying and who was not participating, to who needed to be involved to bring about change. Rather than simply being 'extractive', this phase was enabling: the knowledge I acquired helped me to better facilitate what was to follow.

Broadening ownership

The second phase created opportunities for broadening ownership over the process of learning and analysis. Learning together, residents and professionals created new relationships of understanding and respect. Residents talked of how they saw the estate with new eyes and how much they had learnt from these interactions. Professionals spoke of how they felt the process grounded them and what a difference listening to residents had made. For some, this was an empowering experience; for others, it was deeply humbling. It helped residents and professionals alike to see one another as *people* rather than 'officials', 'patients' or 'clients'. Most importantly, it helped create a shared concern and to open channels of communication. This was especially significant for decision-making. The direct involvement of residents, health service personnel and local authority workers planted seeds for action as part of the process.

Despite opportunities for learning from and about each other, residents had few opportunities to analyse the situation as a whole until the exhibition. Specific issues arose and were analysed in individual sessions. But only the team members had a broader picture of what was emerging. And they brought to the process their own, partial, perspectives. Their 'insider' knowledge, whether of the estate or their own organisations, was crucial in how they chose to facilitate their sessions and document what they learnt. Much of this analysis remained theirs: it was not shared with residents. Although the exhibition offered residents an overview, the team members shaped how it might be read by choosing categories of issues and displaying what they had learnt.

Building partnerships for change

The third stage sought to motivate residents and professionals to form partnerships for change. From a broad consultative stage in which hundreds of residents were involved, the process focused on those willing to get involved in making change happen. The twenty or so residents who came had their own agendas. Their priorities served as a proxy for 'the community', yet they all had their own perspectives either as representatives of particular interest groups, or as particular individuals. Equally, the professionals present influenced the analysis with perspectives shaped as much by personal experience as by institutional constraints on their capacity to act.

The action planning process generated shared commitment to tangible action. By broadening ownership over the synthesis of information and analysis of recommendations, the process also worked to create shared understanding. Allowing all participants to arrive at their own analyses of the evidence presented was important. Inviting the professionals to name what they saw as important gave them a chance to share ownership of the solutions. But the residents had set the agenda. Effectively, the professionals were responding to residents' expressed 'needs': analysing their concerns, voting on their priorities. This required more than facilitation. It relied on behind-the-scenes work by the team to engage key players and a process that would bridge different agendas. Analysis of a different kind was involved at this stage: it was more a case of working out what would work, and who should be involved.

Framing the 'results'

Bringing the bits of paper, cards and ideas together into a report gave me the responsibility for making it make sense. By the time it was finished, the information in it had been sifted and filtered by the many different people involved. At every stage, decisions based on analysis of what was appropriate shaped the process: from initiating a particular exercise, to probing people's views, to deciding what to note, to sorting cards into categories, to prioritising issues. And the

analysis did not stop there: those who read the report made sense of it in their own terms.

No matter how hard a report writer tries to do justice to the wealth of material generated in PRA, the writer's interpretation shapes how it is presented: description is already analysis. Inevitably my interpretation of outputs and of how the report might be read determined how and whether particular issues and themes were represented. I could, and should, have discussed this with the team. But in the rush to finish, I went ahead and did what I thought best. I tried to convey the 'voices' of residents in quotes, diagrams and stories, but chose where to insert them. Despite this, there was a high degree of ownership from those who participated in the process: and residents were delighted because it looked authoritative.

In subsequent work, I encouraged group reports. But this provoked other dilemmas. One group presented lists of bullet-points with no idea where or how they had come by them. A draft report sent to a friendly commissioner returned with doubts about its credibility. I was hauled in to fix it. Building capacity for reporting, as for analysis, takes time; it also requires different kinds of tools, for thinking with rather than just for doing.

• **Strengthening analysis in PRA: challenges and possibilities**

The different layers and stages of analysis in a PRA process do not just happen. Most of the time, they are anticipated and actively facilitated. But a lot of implicit knowledge is involved in making judgements about what to do, how far to push certain issues, how and whether to record what is said and done, and how to catalyse action. Some of that knowledge forms part of people's everyday ways of doing things that they may not be able to explain to others. This implicit, everyday knowledge shapes how people interact with others and how they choose to represent their learning. What emerges is neither a neutral set of 'facts', nor a neutral process.

Making sense of those 'facts' and that process requires more of facilitation. Analysis is a complex, multi-faceted process that shapes every stage of PRA work. If much of the analysis that is taking place is influenced by

thoughts and experiences that people do not, and sometimes cannot, share with others, how can we strengthen the process of analysis? How do we train people to reflect on the underlying assumptions they bring into analysis and that shape their work with communities?

The emphasis in PRA on attitudes and behaviour is an important starting point. By being aware of how our analysis of the 'realities' of others is shaped by our own attitudes, we can reflect better about the extent to which our behaviour affects how people represent their 'realities' in PRA. But we need to go beyond this to find ways to strengthen capacity to catalyse analysis with others, and to effectively document these processes. There is a wealth of relevant, but often obscurely written, work that could be used to build more reflective practice: from anthropological work on writing ethnography to philosophical reflections on knowledge and power. This work offers tools for thinking about what we are doing and for stimulating new insights into learning and action. One way forward is to make this work more accessible so that these conceptual tools can be more widely shared, to sharpen, deepen and broaden processes of analysis in PRA.

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