The impact of participatory budgeting on health and well-being: a qualitative case study of a deprived community in London

I.E. DAN-OGOSI

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The impact of participatory budgeting on health and well-being: a qualitative case study of a deprived community in London

IFEOMA ELIZABETH DAN-OGOSI

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Abstract

Background

Participatory budgeting (PB) is a democratic innovation that enables residents to participate directly and collectively decide how to spend public money in their community. Research demonstrates PB improves social well-being through governance, citizens' participation, empowerment, and improved democracy. Since 2000, PB has increasingly been used in the UK in community development approaches for improving health and well-being outcomes for people living in deprived communities. Yet little is known about how and why PB may impact health and well-being in deprived communities of the UK. This PhD study sought to explore and explain how the application of PB in the Well London programme impacted the health and well-being of people living in a deprived community in London.

Methods

The study employed a qualitative case study design adopting the constructivist grounded theory (CGT) methodology of Charmaz (2006) to explore critical themes from interviews with stakeholders of the Well London programme in Haringey Borough. Forty-one stakeholders engaged in planning, co-designing, co-commissioning, and co-delivering, or benefitted from three interventions commissioned through PB participated in this study between March 2017 and April 2018.

Results

A cross-case analysis revealed six pathways through which PB improved health, particularly for the underserved. PB maximised participation and meaningful engagement; enhanced direct demand and response to the community's needs; individual and collective ownership; action on the social determinants of health; and creative partnership working. These pathways were moderated by the democratic and flexible approach of the PB ethos, particularly the inclusion of residents' voices in the planning and delivery of the interventions. Residents were motivated to act as agents to change their lives by building positive relationships based on social inclusion and integration. As a result, residents' self-esteem, sense of belonging, self-confidence, self-worth, and individual sense of belonging and community spirit increased. Residents gained a

new zeal and agency to tackle the social determinants of health as they understood them in their lives.

Conclusion

When done correctly, PB can promote health and well-being and build more robust and resilient communities through community-centred democratic decision-making. Interventions should aim to increase critical consciousness, health literacy, and the capacity in deprived communities to tackle life-course issues that prevent residents from enjoying good health and reduce structural barriers to accessing services or interventions to improve health and reduce inequalities. The outcomes of this study have policy and practice implications for strengthening the design, commissioning, and delivery of health interventions in deprived communities of high-income countries.

Key words: Participatory budgeting, co-production co-commissioning, community empowerment, health and well-being, inequalities

Author's Declaration

I hereby declare that I, Ifeoma Elizabeth Dan-Ogosi has done this research project and no portion of the work contained in the thesis has been submitted in support of any application, other degree(s) or qualification in this or any other university or institution of learning.

Disseminations of research findings and theoretical reflections

A. Attended seminar series related to this thesis (Oral presentation)

Dan-Ogosi I. E. (2021). Community Empowerment, Concept Definitions, Theories, approaches: Case Studies of Participatory Budgeting. Lecture at the Mental Wealth Mental wealth: knowledge, skills and experience (Level 6) module seminar series, University of East London, Docklands, UK.

Dan-Ogosi I. E. (2017) What's all the buzz about Participatory Budgeting? Balancing Paradigm and methodology Oral presentation at the Institute for Health and Human Development (IHHD) seminar series University of East London, University Square Stratford, UK.

B. Attended conferences related to this thesis (Oral & poster presentation)

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Dan-Ogosi I. E. (2018) How might participatory budgeting influence the health of communities. Oral presentation at the Postgraduate Research Conference (PGR) series. Health Sports and Biosciences. University of East London, Stratford London, UK.

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Dan-Ogosi I.E. Rance S., Findlay G., Harden A. (2017) What's all the Buzz About Participatory Budgeting Approaches to Improving Health and Well-being: Poster presentation at the Women in Leadership: celebrating the impact of visible role models conference, University of East London, Stratford London, UK.

Dan-Ogosi I.E. Rance S., Findlay G., Harden A. (2017). Participatory Budgeting Approaches for Improving Health and Wellbeing: A Mixed Methods Evaluation oral presentation at the Women in Leadership: celebrating the impact of visible role models conference, University of East London, Stratford London, UK.

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Dedication

I dedicate this thesis to my father Joshua Onwusa Chukwuemeka and mother, Veronica Ada Chukwuemeka, nee Illoh, who always let me ask them the how and why questions in a country where children should remain silent in front of elders. To both of you for instilling in me the importance of seeking knowledge at its highest and best and allowing me, at an early age, to critically examine all things before making a conclusion. Without your exemplary lives, I may not have valued the need for higher learning.

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Chapter 1- Introduction

1.0 Introduction to the thesis

Poverty and ill-health are correlated worldwide. Even in high income countries it is well-established that their most disadvantaged communities suffer the most adverse health outcomes compared to the rest of the population (Marmot *et al.*, 2010; Ellis and Fry, 2010; Buck and Frosini, 2012; PHE, 2017a). As Marmot's longitudinal analysis in England has shown, measures of both life expectancy and disability-free life expectancy showed the worst health outcomes for people living in the most deprived areas (Marmot *et al.*, 2010; Marmot and Bell, 2012). For instance, life expectancy is around nine years shorter for males and seven years shorter for females when compared to those in the least deprived areas. The causes of poor health are deep-rooted in social, political, economic, cultural and environmental injustices known as the social determinants of health inequalities (Marmot, 2005; PHE, 2017b; Wilkinson and Marmot, 2003). These unfair and unjust inequities are avoidable and preventable (Marmot *et al.*, 2010; Marmot, 2020). Over time, many United Kingdom's (UK) government public health policy efforts have been geared towards improving health outcomes for deprived communities. Yet inequalities in health between the rich and poor communities of the UK persist.

One such public health policy effort is community engagement (CE) which is about local people improving their health through helping to govern, identify, plan, design, develop, deliver and evaluate local services and interventions (Harden *et al.*, 2016; NICE, 2016). CE seeks to develop relationships between stakeholders, enabling them to work in partnerships to address health-related issues and promote well-being for positive health impact and outcomes for local people (WHO, 2020). CE interventions have been shown to be effective in improving health behaviours, health outcomes, self-efficacy and perceived social support among disadvantaged groups (O'Mara-Eves *et al.*, 2013; Cyril *et al.*, 2015).

Participatory budgeting (PB) has gained traction in the UK since 2000 as a tool for delivering community (engagement) interventions aiming to improve health and well-being and reducing inequalities for citizens. PB is a democratic innovation, which enables citizens and budget holders to make collective decisions on the allocation of public resources to defined local priorities (Avritzer, 2010; Boulding and Wampler, 2010; World Bank, 2003). These

include improved access to essential provisions like clean water, sanitation, health care, housing and education, particularly outside the UK. Citizens are loosely defined in this thesis as people who live in virtual and physical communities where PB takes place (Escobar, 2020). These may include documented and undocumented residents like migrants, homeless people, refugees, lonely and isolated people. The citizens who participated in this project included people interchangeably referred to as residents, local people or community members who live in physical communities.

PB uses CE approaches such as co-production to transform lives in communities (Escobar, 2020). As argued by Wampler (2012a) the four core principles underpinning successful PB are voice, vote, oversight and social justice. It starts with citizens coming together to identify and prioritise community needs, develop proposals, deliberate, vote and decide on the allocation of a proportion of public monies for the purchase of local goods and services. The incorporation of local citizens into PB forums allows citizens to learn about government functions, develop skills, make informed choices and monitor the implementation of community priorities (Wampler, 2007b; Shah, 2007; Wampler, 2012b). However, it is unknown how and why PB may improve health when applied in community-based interventions.

This thesis adopts a qualitative case study approach to explore the impact of PB for improving health and well-being and reducing inequalities in a deprived community of London. It explored the perceptions and experiences of different stakeholders who participated in a community development (CD) programme aimed at improving health and well-being, building community resilience and reducing inequalities in the most disadvantaged communities of London. In this chapter, I first introduce the focus of the thesis by highlighting the emergence of PB in health. Secondly, I present the context of this thesis. Thirdly, I give an overview of the content of the thesis. Fourthly, I define the key concepts of the thesis and discuss studies which highlight its connection to health outcomes. Finally, I describe the research aims and questions addressed by the thesis.

1.1 Emergence of PB in health

In the past 30 years, empirical findings in politics, sociology and economics consistently demonstrate the impact of PB on improved governance, quality of democracy, accountability, transparency, citizen empowerment, participation, social justice and other

democratic outcomes (De Sousa Santos, 1998; World Bank, 2003; Shah, 2007; Baiocchi, 2005; Fung and Wright, 2001; Goldfrank, 2007a; UN Habitat, 2004). PB has been recognised as a model of best practice for local governance internationally by the UK's Department for International Development (DFID), the World Bank, the UN, OECD and UNESCO (Shah, 2007; Heimans, 2002; Cabannes, 2004b; Hernandez-Mendina, 2010). Studies on democratic governance, accountability, transparency and citizen empowerment demonstrate a positive association with better health. Yet, little is known of the impact of PB on health and well-being.

PB began in Porto Alegre, Brazil, in the late 1980s and by 2016, an estimated 2000 - 2700 PB experiments existed globally (Baiocchi and Ganuza, 2016; Sintomer *et al.*, 2013). This evidence base has encouraged several governments and non-governmental bodies to spend millions of dollars, pounds and euros on both centralised and devolved budgets for PB programmes worldwide (Cabannes, 2015; Wong, 2017). Currently, an estimated 11690 cases of PB exist worldwide with about 66% in South America and Europe (Dias, 2018). In the UK, PB was launched in 2006 in the north of England, through the local government's "Strong and Prosperous Communities" White paper (DCLG, 2006). By this time, Bradford, Newcastle, Sunderland and Salford were already experimenting with PB for several types of community-based interventions in the UK. Since then, it has become widespread for commissioning neighbourhood interventions tailored to improving the health and well-being of individuals and communities.

Although, PB has spread across the world, it continues to be delivered through very different approaches (Sintomer *et al.*, 2008). In many countries, such as Brazil, Paris, Canada Portugal and USA, PB is used for deciding the improvements and provision of capital or basic services like health care, sanitation, street paving, transportation and education (Cabannes, 2017; Goldfrank and Landes, 2018; Allegretti and Copello, 2018). But in the UK, except for the devolved nation of Scotland and some cases in London, most PB programmes are sponsored through small grants from non-governmental organisations like the Big Lottery and local councils (SQW Consulting, 2011). Examples include Scotland which combined small grants with mainstream funding £750 to £200,000 (Harkins *et al.*, 2016), and in Dundee, Scotland in 2018 where residents decided over £1.2 million of the cities' capital budget (Escobar *et al.*, 2018), the city of Edinburgh spent £200,000 on highways and housing budgets (PB Partners, 2016) and the London Borough of Tower Hamlets (£2.4 million on mainstream

spending through local area partnerships in 2009 (SQW Consulting, 2011) and £5m over two years (See PB Partners (2016), for examples of hundreds of PB community grant-making approaches in the UK

Significantly, PB has now spread to over 3000 cities worldwide (PBP, 2020). This substantial increase in the adoption and diffusion of PB raises questions as to why governments and Non-Governmental Organisation (NGOs) increasingly use PB for CD programmes. Campbell *et al.* (2018) found 37 evaluations of PB focusing on health and well-being as well as public services yet argued that the processes through which PB influences health and well-being or inequalities were not explicitly identified. It is imperative that PB research focuses on rigorous evaluations that explore the processes through which health is influenced, enabling these pathways to be adequately theorised and explained. A theorised pathway for PB and health, with robust evidence, will help to guide and justify the adoption of PB in policy and intervention implementation. Hence, this thesis aims to explore the underlying theoretical model through which PB may influence health and well-being.

There is an assumption in the literature that PB should promote health and well-being and reduce inequalities because it enables citizen participation, empowerment and a redistribution of wealth to the poor (Boulding and Wampler, 2010; Gret and Sintomer, 2005; World Bank, 2003; Abers, 2000a). Cabannes' (2015) review revealed PB contributed to providing and managing basic services in over 1700 local governments and more than 40 countries globally. The author examined PB practices in 20 cities from different regions where spending US$2 billion on over 20000 projects through PB went into delivery and management of basic services such as water, sanitation, drainage, solid waste collection, public transport, roads and footpaths, health and education and park facilities. Such basic services are wider determinants of health and are essential for improving and maintaining health and well-being and reducing inequalities. Furthermore, PB created new social services, mobilised community resources, increased tax revenue, optimised funding, and attracted government and international agency funding. Cabannes concluded that PB improved social service provisions and management with cheaper and better-maintained projects because of community control and oversight (Cabannes, 2015).

PB facilitates traditionally excluded individuals and communities to contribute to policies that are responsive to their needs. Including such residents target the often-neglected health needs of such communities. Improving health and well-being and reducing inequalities has

been a major public health priority for decades (Townsend and Davidson, 1982; Acheson, 1998; Black, 1982; Jones *et al.*, 2012; Marmot and Bell, 2012; Marmot, 2020). If government is serious about reducing inequalities, traditionally excluded residents should participate in shaping policies about health and well-being. The inclusion of local people in deciding how to improve health in their communities is increasing and active participation in local interventions is claimed to improve health and well-being and therefore, inequalities. For example, volunteering can improve confidence, self-esteem and general well-being, which in some cases, may lead to those people seeking further education or employment (SQW Consulting, 2011).

Scholars of PB (Touchton and Wampler, 2014; Gonçalves, 2014; Boulding and Wampler, 2010), health care practitioners (McKenzie, 2014), developmental bodies (World-Bank, 2015; UN Habitat, 2004) and international and local policies (Overmann and Graubard, 2014; Marmot *et al.*, 2010; Scottish Government, 2015) have consistently promoted the use of PB for improving health and well-being and reducing inequalities. Still, empirical evidence of the impacts of PB on health and well-being of individuals and communities who take part is limited. In addition, little is known of the pathways or processes that lead to the positive health outcomes attributed to PB within deprived community settings in high income countries.

Although research has reported the positive impacts of PB on health and well-being, none of these studies focused directly on the lived experiences of those who participate in PB programmes. Most empirical studies of PB have been quantitative research which measured the impact of PB through increased spending on capital projects like healthcare, sanitation, education and road-paving to produce reductions in infant mortality and extreme poverty (Boulding and Wampler, 2010; Touchton and Wampler, 2014; Gonçalves, 2014; Wampler and Touchton, 2019).

All these studies also focus on similar data from Brazil, an upper middle-income country. Secondly, Brazilian programmes differ from UK PB practices where small grant-making processes are employed to reduce health inequalities in community-based interventions. Therefore, the findings of Brazilian studies may not be representative of the broader UK context or other developed countries. Furthermore, the aforementioned review of evaluations on the impact of PB on health and well-being by Campbell *et al.* (2018), concluded that empirical research employing robust methods for analysing the health and well-being

impacts of PB, particularly outside of Brazil, are scant. The authors call for rigorous qualitative and quantitative evaluations to identify the influence of PB on health and well-being, noting that the pathways through which health and well-being impacts are realised from PB are still unknown. Therefore, my research aimed to employ robust methods to understand how (the processes) and why (reasons) PB may influence the health and well-being (impacts) of individuals and communities or reduce health inequalities in deprived communities in developed countries. Furthermore, my thesis argues that if shared decision-making about funding local priorities between the state and the community genuinely improves the lives of citizens, then research that reveals the processes through which PB interventions may improve health is essential for public health policy and practice.

1.2 Policies that favour PB adoption

The health gains achieved through conventional health promotion methods are partly through the active participation of individuals in community projects (Zakus and Lysack, 1998). Existing literature claims that PB interventions go a step further to improve an individual's social character and civil competencies (Barber, 2003; Wampler, 2007a). Furthermore, the extension of human capabilities to make informed decisions that affect citizens' lives and enhance their enjoyment of it is essential for health and well-being (Sen, 1999). Rather than focus on PB merely as a strategy for improving policies for political governance, accountability, transparency and economic development, PB practice may serve as a complementary method for improving health and well-being and reducing health inequalities.

Global, national, and local policy guidelines support the empowerment of local citizens in deciding community projects and services for improving health and well-being. For example, the World Health Organisation's health promotion guide for attaining universal health coverage, an outcome of the sustainable development strand, suggests that CE is the key to achieving its goal (WHO, 2020). The guideline posits that a platform for CE can be constructed through the five health promotion actions described in the Ottawa Charter (1986) in any setting (WHO, 1986). These are "developing personal skills, strengthening community action, creating supportive environments, building healthy public policy and reorienting health systems". Similarly, NICE (2016) guidance urges directors of public health and other strategic leads engaged in planning, commissioning, or providing health and well-being initiatives to involve local communities to co-produce solutions for improving

health. In the 2010 review, Marmot et al. explained that if local communities participated in deciding local investment priorities, there would be a remarkable improvement in the effectiveness of local public service. In which case, implementation would be targeted directly to local needs, permitting equal access and improved health outcomes (Marmot *et al.*, 2010). Ten years on, Marmot's health equity in England review maintains that there is a need to give local communities more power and decision-making responsibilities (Marmot, 2020). In seeking an exact route towards improved health and well-being, it is assumed that ideally, people need empowerment by government officials and professionals to do so. This statement contradicts and undermines the values of self-mastery and psychological empowerment, which suggests that people are experts of their own health and can make their own choices, given the right opportunities (Rose, 1999; Woodall *et al.*, 2010; Woodall *et al.*, 2013). Therefore, it is imperative to allow residents agency to make decisions about what they need to improve their health or stay healthy.

More recently, the Scottish government recognised the significance of an asset-based approach to health improvement which aims to support and empower communities through the participation of individuals in making decisions that matter to them (Harkins and Egan, 2012). This understanding led to a community empowerment bill passed by the Scottish Parliament in June 2015 and upgraded to an act by July 2015 (Scottish Government, 2015). This bill is designed to facilitate a shift in the power relationship between professionals and citizens allowing the strengthening of community voices in decisions about local investments, ensuring an efficient focus on local needs and outcomes for all. The shift in power relationship from public bodies to communities is often challenging to achieve. For eleven years the Scottish government made increasing effort to empower its citizens by giving them control to make decisions about improving their local areas through PB (Harkins, 2018). Yet, a review of 60 PB processes in 2016 showed a lack of data describing the impacts on health from PB processes. Harkin's report recommends future evaluations of PB to capture narratives of the community context, CE and representation within PB, the democratic process employed, the types of interventions funded and the impacts from PB. My thesis contributes to the PB and health literature by exploring the process of PB implementation, and the interventions commissioned through a qualitative case study which co-constructs narratives with stakeholders about experiences of health and well-being outcomes of participating in PB programme. Harkins (2018) proposes a logic model for PB to enable community practitioners and residents to understand the implementation process

of PB. My research takes the logic model further, by articulating an account of the processes that may lead to health impacts from a PB process in deprived communities such as Tottenham, Haringey. [Is of London more appropriate here? It feels so.]

In 2014, Dr Kwame McKenzie, a mental health practitioner, advocated PB should be used for commissioning community-based interventions to improve mental health. Based on findings from the Department of Communities and Local Government report of 2011 he recommended Health and Well-being boards should use "a form of PB to make decisions on public health priorities, and to choose interventions" (McKenzie 2014:73). McKenzie argues that PB has potential for improving mental capital, which in turn improves the physical health of those who participate. Investigations of quantitative and qualitative studies demonstrating the effects of PB on health and well-being exist in the UK, however, they stand on weak empirical grounds. Some of these studies are merely descriptive and only highlight residents' engagement with the PB process and the transactional nature of relationships between providers and citizens and transference of power and resources rather than transformation of lives (Hall, 2010; O'Hagan *et al.*, 2019; Escobar, 2020; SQW Consulting, 2011). The PB Network website catalogues numerous projects delivered to date.

Additionally, many of the findings from interventions using PB to improve health in the UK are embedded in grey literature in the form of evaluation reports, conference papers, editorials and magazine articles (Wong, 2017; PB Network UK, 2020; Scottish Government, 2019). Many of these studies either fail to evaluate the direct impact of PB on the health of those who participate, particularly the social determinants of health, or fail to report rigorous methods. My study is different because it uses conceptual and methodological depths to make an original contribution to the extant literature. It will do this by exploring the health and well-being impacts of PB through constructing stories about the perceptions and experiences of people from a deprived community engaged in a PB programme.

1.3 Context of the thesis

My thesis presents data from case studies commissioned and delivered in Tottenham, Haringey as part of the Well London Phase 2 programme (WLP2) between 2015 and 2018. As a CD approach, the Well London (WL) framework (Figure 1.1) was designed to enable local communities and organisations to work together to improve health and well-being, build community resilience and reduce inequalities in disadvantaged communities. At its

core, WL aims to work at a local, neighbourhood level to engage and support residents to develop their individual and community knowledge, skills and capacity to act on the issues that affect their health and well-being. At the basic level, WL works to empower residents of the most disadvantaged communities in London to embed physical activity, healthy eating and mental well-being in their daily lives. Additionally, WL uses an asset-based approach by recognising, integrating, strengthening, and adding value to local provisions. In doing so, WL informs the development of services that better responds to residents' needs.

WL began in 2007 and operated in two phases across over 30 of the most disadvantaged neighbourhoods of London: Phase 1, from 2007 to 2011 in 20 lower super output areas across 20 London Boroughs (also called Local Authorities or Councils), while Phase 2 commenced in 2012 and was planned to complete 2015 in 11 neighbourhoods across nine Boroughs. This study is concerned with the WLP2 programme delivered in Riverdale Park ward, an area of Tottenham located in Haringey Borough, which joined later in 2015 extended to 2018. Riverdale Park ward (RDPW) was adopted as a pseudonym for the study site to anonymise the area and prevent/protect the identification of study participants. As this study is focused on the WLP2 programme, all process description will be about Phase 2. A comprehensive description of Well London Phase 1 can be found elsewhere including the Well London site and Phillips *et al.* (2014).

In 2015, the WL team from the Institute for Health and Human Development (IHHD), University of East London (UEL), were approached by Haringey Council to implement the WL programme as part of the Haringey health and well-being strategy. This strategy had three main priorities:1) reducing obesity, 2) increasing healthy life expectancy, and 3) improving mental health and well-being for children, young people, and adults living in the borough. This strategy seemed to align well with the WL programme, which was also supported with matched funding from the Big Lottery and the regeneration department at the council. At the time of planning and delivery of PB, funding was pooled from the regeneration transformation funds, Haringey public health and Big Lottery funding amounting to £78000 for the programme including funds allocated to projects on the voting day.

WL began its operation by recruiting and training residents known as the Well London Delivery Team (WLDT). As key assets, the WLDT members participate in co-design and delivery of the programme. A core function of the WLDT is to support residents to take part

in projects commissioned in WL programmes, to encourage access to services and improve health behaviours of residents. Fundamental capacity building efforts included running outreaches about health and well-being, interpersonal skills, and the production of health promotion flyers. For instance, the training by Royal Society of Public Health (RSPH) enabled residents to understand the health problems of their community and how to tackle these through creating and delivering health interventions that matched the needs of the community. In this study, some WLDT members as well as other residents and organisations were empowered to develop their projects and pitched on the PB voting day.

The WL framework (Figure 1.1) includes an extensive community, assessment and co-design (CEAD) process. The framework is a co-production tool that acts to engage whole communities in identifying needs and designing interventions tailored to improve health and well-being in target communities. The CEAD process is initiated at the beginning of each phase of the WL programme through the involvement of residents in identifying the community's needs. The aim is to ensure the programme is responsive to the needs of the target community. The CEAD process is designed to assure transparency and inclusiveness and involves six basic steps: community profiling and asset mapping; door to door conversations and informal survey; community cafés based on the World Café methodology; Community action workshops; priorities and resources meeting; and feedback where the results of the CEAD process are fed back to the residents and wider stakeholders.

The comprehensive engagement of residents during the CEAD process enables the prioritisation of a range of community interventions based on the needs of the local area. Projects implemented during the WLP2 programme were either commissioned directly through provider services or a voting process during a PB event. See the WL website for a comprehensive description of the CEAD process. The WL programme incorporates a thorough evaluation process, which, in Phase 1, integrated a randomised control trial and other observational studies to evaluate the impact on individuals and communities (Phillip et al., 2014); and a longitudinal cohort study in Phase 2. However, these evaluations did not include the examination of PB's potential influence on the health and well-being of residents.

The WL programme, now called the Well Communities programme, seeks to move its operation to communities beyond London. However, for uniformity, "Well London programme" will be the operational term for discussing the programme in this thesis. Also, for clarity of purpose and operationalisation of terms, the PB process described in this study

includes all the approaches employed in engaging residents in planning, co-designing, co-producing and co-commissioning of projects up to the PB voting event in Tottenham, Haringey on the 4th of March 2017.

On the 4th of March 2017, local residents commissioned nine health and well-being interventions at a community event in a local school. This thesis explores the health and well-being impacts of the PB process up to the event day and three interventions voted for by residents. All other direct commissioning of projects to established providers known to the council were excluded from the data collection process in this thesis. WLP2 comprised of 11 disadvantaged neighbourhoods across nine London Boroughs including RDPW in Tottenham, Haringey. The WL approach has been recognised both nationally and internationally as a best practice approach for CE and empowering individuals and communities by RSPH (Royal Society for Public Health), JA-CHRODIS (Joint Action for Chronic Disease) and What Works Centre for Well-being.

Figure 1.1 The Well London Framework

Source: Well London Website

1.3.1 PB in Well London

PB was introduced into WL during Phase 2 at the beginning of 2013 to enable an increased involvement of local communities in the commissioning process after priority themes have been identified through the CEAD process. In 2013, PB was new for most of the delivery teams. Therefore, the WL team produced a briefing guide to PB's principles, processes, and good practices for WL coordinators, steering groups, and council commissioners to make sure PB fits in WL. In this guide, the team proposed PB as a primary commissioning process for each year of WL within the target community (see WL website for PB guide). Once the PB process has been initiated and projects had begun, the coordinator and the members of

WLDT and steering group reviewed the Project Initiation Document (PID) to employ any budget under-spend to commission interventions to bridge gaps directly.

PB was initiated into the Haringey WL programme two years after the CEAD process and community outreach had been completed, due to administrative challenges. To mitigate the issues arising from a one-year delay in the process, an experienced independent PB expert (Genevieve- *pseudonym*) was hired to facilitate the development and delivery of the PB process, culminating in a PB event day that occurred on the 4th of March 2017. Genevieve provided training and support to WLDT, volunteers, partnership board members and potential applicants to empower them to understand PB and to help co-produce a PB event. Preparations for the PB day started four months before the day, and the promotion, planning and facilitation of the day was co-produced and delivered by the combined effort of a team including the council public health leads, Tottenham regeneration team members, WLDT, the RDPB (Riverdale Partnership Board: a group of residents brought together/trained to give oversight to the process and projects commissioned), UEL team members and a community charity (Kelsey Trust- *pseudonym*: commissioned to manage and support the project leads who won some funding).

Several meetings were held with a steering group including council executives, UEL staff and the PB facilitator to plan the PB event day. The PB facilitator then trained 10 community members comprising of the WLDT and (RDPB). These residents sat on a panel to select the projects that would go forward to pitch on the community voting day. Their role was to carry out due diligence assessments and co-produce the day. Compliance to due diligence entailed being a not-for-profit organisation, having two signatures on the bank account and having a safeguarding policy if they aimed to work with vulnerable groups, and targeting one of the health needs prioritised during the WL CEAD process. The publicity of PB to the community highlighted the funding available, the funding priorities, and for simplicity, adopted the tag line 'Community Dragons' Den' to bring about a collective understanding of the purpose of the event, based on a well-known TV programme.

An attendance list indicates a total of 127 residents who attended and voted on the event, and a total of 28 projects applied to the PB (Community Voting Day) funding. Of the 28 applications, 16 came under the Priority 2 of the WL criteria (improving health and well-being for the community). Applicants included individuals and local organisations who were either resident or worked in the area. Of the sixteen WL Projects, 10 went through to present

their plan to be voted for by the community on the PB day. Of those 10, nine were successful on the day. Before the panel selection, Genevieve trained applicants on how to complete the forms and present their projects on the PB day. This process involved a critical reflection of what would best meet the health and well-being needs of the community and reduce inequalities.

Following the community event day, the Kelsey Trust was charged with providing and managing the administration and support of the project leads, including setting level agreements with projects, grant dispensing and risk management and providing progress reports. On the other hand, the Haringey Council further commissioned Genevieve to provide training and support projects, including project management, monitoring and evaluation and regular contact with the WLDT members to keep them engaged and motivated. Further details of the PB process and findings of impact are discussed in Chapter 4.

1.3.2 Access to the Well London PB site

I received access to the WL programme in November 2016 to conduct this study. My role as a researcher involved field observations in planning meetings and projects, data collection for documentary analysis and recruitment, and interviewing of participants for the process and intervention case studies. Working alongside key actors provided me with first-hand insights of the operational pathways of PB and the role people played in the delivery. This experience informed my thinking for developing the topic guide, selecting participants and carrying out interviews as an insider. The fieldwork started in 2016 and finished in 2018. This deep and prolonged engagement with different stakeholders afforded me a chance to build relationships with many participants and get a better understanding of their lived experiences within the context of operation.

1.4 Research objectives and question

My study investigates the impact of PB on health and well-being for reducing inequalities amongst residents of RDPW who participated in the WLP2 programme between 2015 and 2018. In doing so, it explored the perceptions and experiences of participants of the PB implementation process (residents and stakeholders) and sought to co-construct how they perceived PB had influenced their sense of health and wellbeing.

Overarching research question

To achieve the above aims and objectives this thesis answered the following research question about the PB process and interventions commissioned through PB; -

How does PB promote health and well-being among people living in a deprived community within a community development programme?

1.5 Theoretical perspective

A constructivist paradigm informed this study. The basis of constructivism is the belief that individuals construct the meaning of their own experiences and events (Charmaz, 2006; 2014). This study, therefore, aimed to explore and understand the various meanings of health and well-being attributed to PB as constructed by the research participants. Including multiple perspectives in the cases allowed the discovery of the nuances and pathways through which PB may result in positive well-being. As I planned to explore multiple perspectives, I followed Stake's case study design, which required identifying issues that support the revelation of the intricacy of the cases (Stake, 2005). For instance, early in the fieldwork, I identified potential issues operating within WL (see Chapter 3: methods), practices of PB in the programme and the tensions occurring within the deprived setting. Exploring these issues enabled me to deepen the analysis.

1.6 The significance of the study

This study proposes a theoretical framework that can be used to understand the pathways through which PB may influence health in a community-based intervention within a deprived community. It also proposes a logic model for practitioners to adapt to evaluate PB programmes aimed at improving health and well-being. The logic model shows the various processes and potential outcomes that might be realised through a PB intervention.

Global evaluations of programmes that adopt PB do not focus on the public health impacts of PB on individuals and communities. Vlahov and Caiaffa (2013), argue data available from evaluations of PB programmes are generally not health-specific but demonstrate only indirect impacts on health. They state that:

> *"Determining what improvements in public health can be attributed to PB is perhaps more an art than science. Still the circumstantial evidence for its benefits is striking"* (Vlahov and Caiaffa, 2013, p. 69).

Although, it is challenging to attribute any health outcomes to PB, because of the complexity of programmes in which they are applied, Vlahov and Caiaffa (2013) suggest that some field evidence infers PB can improve health for its participants. Their review reveals a strong connection between PB and many indicators of improved health and well-being. The national PB evaluations commissioned by Department of Local Governments in England evaluation study also reveal positive impacts from PB programmes at local level in the UK (SQW Consulting, 2011), but with no direct links to health and well-being.

Empirical evidence from Brazil highlights the positive links between PB and several outcomes for health (Boulding and Wampler, 2010; Touchton and Wampler, 2014; Wampler and Touchton, 2019; Touchton *et al.*, 2017; Gonçalves, 2014). However, all these studies focus on the mortality measure of health, infant mortality. The studies also focus on the capital spending on health care, education and sanitation by Brazilian municipalities that adopt PB. My study moves beyond capital spending to focus on small grant making in PB to co-construct with participants lived experiences of health and well-being resulting from their participation. My study also moves away from Brazil to understand how the adoption of PB for implementing health interventions within deprived communities in the UK may impact on health and well-being differently and how this may translate to reductions in inequalities.

The Brazilian studies relied on secondary quantitative data to make predictions of the relationship between PB and infant mortality. This focus on quantitative research of PB's impact on health means that there is a has led to a dearth of empirical studies that take a broader look at the psychological and social impact of PB on health and well-being. From current trends in the wide adoption of PB in policy and for implementation of health interventions/bids to reduce inequalities in communities, especially in the UK, it is imperative to interrogate the possible impacts of PB on the wider determinants of health, and how this impact is attained in deprived communities through the lived experiences of participants. This is crucial to ensure that inclusion of PB as a driving force for health is evidence-based.

Most of the Brazilian studies focus on the impact of resources available for spending on capital projects, my study focuses on small grant funding of PB to purchase services and intervention that residents value and enjoy. Therefore, my study contributes to the literature on the social value of money rather than economic value of PB on health. My study in this way has implication for the design and implementation of community-based interventions for maximising health outcomes of PB from minimal funding.

To my knowledge this study is the first study to contribute to the conceptual and empirical gaps in the field of PB by using a constructivist grounded theory and case study approach to explore the public health impacts of PB through the experiences of residents in a deprived community of an urban city. As a result, the findings of my study will have broad ranging implications for the granular details of the role of PB for improving health outcomes for people in deprived communities in high income countries. Also, the study has an implication for policy and practice initiatives that seek to use PB for improving and evaluating health and well-being for the deprived communities in UK and other developed countries.

1.7 Positionality

My philosophical stance as a researcher is vital in the construction of knowledge. Therefore, I discuss my motivation for initiating this study and the conscious reflections I engaged in reaching a level of ethical commitment to ensure the trustworthiness of this research. I discuss issues of reliability in further depth in the section on trustworthiness in the methods chapter of this thesis.

My interest in PB and health emerged when I worked as a research assistant on the Well London programme between 2013 and 2015. My curiosity evolved from a personal experience of observing residents take part in making decisions about budgets for interventions delivered in their communities. The PB process appeared to transform the residents into a world quite different from the realities of traditional programmes I was used to. I often wondered about the changes I saw in residents' confidence to contest for what they wanted to see in their communities and the increased interest to participate and contribute their valuable time in these PB processes.

This made me wonder whether this phenomenon held any potential to contribute to health and well-being or reduce inequalities. To date, research on PB and health depends on

quantitative panel data from Brazil and fail to investigate the lived experiences of the participants of the PB process concerning impacts on health. So, as I queried the PB literature and I realised there was a gap in including the perspectives of those who experienced PB was unexplored, I was naturally drawn to the qualitative paradigm on which this thesis is based. The knowledge of this scarcity in the literature and my experience as a research assistant in PB programmes influence my philosophical stance on multiple realities embedded in the qualitative paradigm. As an avid scholar, I have also delved deep to understand my philosophical position as a researcher and taken several courses to clear my confusion about the most reliable philosophy and method to explore the phenomenon of PB and health. With the tools acquired from participation in research evaluating such interventions and my profound reflections, I took a leap to conceptualise, contextualise and explore this relationship on the platform of interdisciplinary research.

My musings on multiple realities have not emerged from a vacuum. Being born in Nigeria to two academic parents and teachers, I grew up very curious because I was permitted to be in my household. However, this was not always welcome in my society, as children were supposed to be silent when elders spoke, especially girls. Therefore, I was never content with yes and no answers to problems and always wanted to explore more. I later discovered during my MSc programme that this was known as multiple realities.

Growing up in Nigeria in an upper-middle-class background, I sit in a position of privilege and power. Additionally, studying at a PhD level increases this sense of privilege and power towards my participants. Yet, despite these personal circumstances, I have always advocated social justice. I remember fighting for the oppressed and being punished alongside them as far back as my secondary school days, where I would often challenge seniors for inappropriately exerting power over the less privileged students. However, researching this topic within a deprived community initially seemed problematic as participants could view me as 'the other' or an oppressor, coming in as a researcher. I experienced this first-hand as a research assistant working with 20 deprived communities across London in the Well London between 2010 and 2015, where community people distrust researchers. Therefore, I needed to reflect on this issue when entering this deprived community. Furthermore, I had to deeply consider how I entered this space with the added privilege of studying for a PhD. To break down this power relation barrier, I committed to working with participants as equal partners using a co-production to co-construct knowledge.

To achieve this, I entered the site as a participant observer. This qualitative methodology allows a researcher to immerse themselves in the participants' activities to record the events and behaviour in as many scenarios as possible. As a result, I often dressed down to belong to the group. I also cultivated friends with some of the participants to become accepted as one of them. I visited the projects weekly and helped to set up and set down, taking part in some of the activities to experience what the participants were going through. When the project leads introduced me, it often led to a mixed response, some people were proud to have me in the group, and some were sceptical of my involvement. However, with prolonged engagement in the projects, I gained the trust of many of the participants, and it became easy to work with them.

During data collection, I used a conversational method in interviews in a friendly and comfortable style. During interviews, I asked probing questions, listened and thought, and asked more probing questions to enable me to obtain a deeper conversation about the respondent's experience. The interviewee often said they forgot they were being recorded. One interviewee who was worried about being interviewed for the first time sighed at the end of our conversation and said, "oh, that wasn't too bad.

This conversational style allowed time for respondents to reflect on their involvement and make meaning of what changes had occurred in their lives. Another participant said, "you make it easy for me to reflect on how my involvement has changed me; I never realised how much the projected has affected me. Before I used to keep to myself but now, I can't wait to meet the people in my project".

I acknowledge the fact that there are risks of data bias and reliability associated with being a participant observer. This includes participants wanting to please the researcher by offering information to help the research or becoming sympathetic to the study group's perspectives and attitudes on the researcher's part. To avoid this, I constantly reminded myself of the purpose of the study and the ethical commitment and passionate decision I made to ensure a reliable and robust research process.

Another dilemma before me as a proponent of social justice was how do I express the voice of this deprived community and silence my preconception of residents' interaction and experience in previous PB interventions. I thought about how my varied experience as a researcher can be an advantage in shaping the research methods and reporting the events I

observe in this thesis. Therefore, I undertook the challenge to ensure my processes were credible and that my representation of the research reflects the realities of the context and participants under study. To enable me to do this, I followed the constructivist grounded theory methodology of Charmaz (2006) and Gioia *et al.* (2013) to stay close to the data presented to me by the participants and co-construct the information I collected with participants.

Although I cannot claim absolute objectivity here, the account of the study will demonstrate that I engaged in a rigorous and systematic process to ensure that trustworthiness has been maintained throughout the thesis.

1.8 Defining concepts

1.8.1 Health and well-being and mental health

WHO (1948) defines health as the 'state of complete physical, mental and social well-being and not merely the absence of infirmity'. This definition reinforces statements which suggests that the meaning of health encompasses aspects of physical, mental and social well-being as an integrated whole. Although a much-criticised definition in health science, it has been the most accepted since 1948. Much of the criticism of the definition has centred around the absoluteness of the word "complete" with reference to well-being (Huber *et al.*, 2011). The issue with this is that without meaning to, the definition contributes to the medicalisation of society. According to Smith (2008) the completeness in the WHO's 1948 definition of health "would leave most of us unhealthy most of the time". Smith suggests a definition by Sigmund Freud which includes "the capacity to love and work" suggesting that health should be defined based on what makes an individual happy rather than on the disease state.

Another issue with the WHO definition is that it neglects the changes in demography and nature of disease that has happened over time. With the increases in public health knowledge (hygiene, sanitation and nutrition) and advancement in technology and medicine in the 21st century, people are now living longer with chronic illnesses and disability (Huber *et al.*, 1997). Furthermore, living and ageing with chronic disease in this century is now a norm, making this definition counterproductive as it suggests that people living with disabilities and chronic disease are certainly sick. The definition, therefore, fails to consider the human ability to cope with life stressors which bring varying physical, emotional and social

challenges. It also ignores the possibility that humans can attain the feeling of well-being, function in fulfilment and enjoy life despite chronic diseases and disability.

Well-being is the state of being well defined as "a subjective evaluation of how we feel about and experience our lives". It can simply be described as feeling good and functioning well. This includes having a fair share of material resources, influence and control, a sense of meaning, belonging and connection with people and place and the capability to manage problems and change. Well-being is also a contested phenomenon and has been conceptualised through a medicalised lens of ill health for decades (Fisher, 2008). WHO defines mental health as 'a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community (WHO, 2004). There is more to mental health than the absence of illness. It is influenced by socioeconomic and environmental factors and is linked to people's behaviour. Mental well-being is linked to physical health and is clearly specified in the white paper 'No health without mental health' (DoH, 2011). In other words, good health is impossible without a good mental health.

The terms 'well-being', 'positive mental health' and 'mental well-being' are often used in place of each other, although 'well-being' is also used in a broader sense to include physical health (DoH, 2011). Research suggests that significant cost benefits through improvements in physical health, productivity and quality of life are achieved by the slightest improvements in mental well-being (NIMHE, 2005). My interest in well-being in community development approaches is grounded upon public health tenets of illness prevention, health improvement and social organising and community functioning, each contributing to how I define and evaluate the phenomena in this thesis.

1.8.2 Community development (CD)

CD is a process in which community members gain support from agencies to identify and take collective action on issues important to them (AIFS, 2019). A fundamental principle of CD practise is its commitment to giving power to disadvantaged communities (Kenny, 2016). When implemented correctly, CD approaches transfer power to community members and creates stronger and more connected communities. CD is a holistic approach that foregrounds the principles of empowerment, human rights, inclusion, social justice, self-determination and collective action (Kenny, 2010). It considers community members experts

in their lives and communities, values community knowledge and wisdom, and involves community members at every stage (AIFS, 2019). CD programmes are meant to be led by community members, from deciding on priorities to choosing and executing actions and evaluations. CD explicitly focuses on the redistribution of power to tackle the inherent origins of inequality and disadvantage. In addition, CD approaches strongly contribute to achieving better health and well-being outcomes for people in communities.

In this study, WL is conceptualised as a CD process that integrates PB to strengthen the inclusion and participation of residents. It empowers residents through co-production and co-commissioning of interventions that are important to them. It gives residents equal opportunities to participate early in critical reflection about issues in the area, prioritising, ideating, and designing interventions that would best transform their lives and their community. These co-design and co-production processes are publicly executed in several iterations and on the PB voting day. PB is an invitation of residents to allocate a set budget from public funds to projects of their choice that they felt would respond to individual and community needs. In this stage, local people learn about government systems and functions, and they are enabled to exercise political rights and schooled on how to make shared decisions and vote for their preferred projects. The WL model involves a shift in power relationship to individuals who create project ideas, present proposals in a community space to be voted on by residents and deliver the projects to residents in the community.

1.8.3 Impacts

According to Montanye (2017): “In qualitative research, the word ‘impact’ is generally not intended to demonstrate causality, but instead refers to data generated from participants, who freely expressed testimony in their own words, how they perceived they have been affected by a particular phenomenon” (p.14). For example, attending a PB event or social interaction at PB interventions can initiate positive health outcomes in a person's life. The term ‘impact’ references participants’ own truths about their experiences of participating and in the process of exploration participants’ talk about multiple or complex influences about a phenomenon of interest (Montanye, 2017).

1.9 Content of this thesis

This thesis in composed of eight chapters. Chapter 1 presents the focus of this thesis, the importance of the subject and why the study was initiated, key definitions of concepts, the aims and research questions. Chapter 2 provides a critical review of the existing literature on impacts of PB on health, well-being and inequalities and related concepts. This will include historical accounts of PB, its diffusion internationally and in the UK. Chapter 3 outlines the design and methods of the research strategy which includes a qualitative case study drawing from a constructivist grounded theory analysis approach and using a documentary analysis, field observations and interviews with multiple stakeholders of the WLP2, PB programme. Chapter 4 presents the findings from the process case study, while Chapter 5 presents the findings from the project case study. The findings chapters integrate data from field notes, documentary analysis and interviews. Chapter 6 presents the findings from the cross-case analysis of three intervention cases commissioned through the PB process and a conceptual model that shows the processes through which PB may impact on individual and community well-being and reduce inequalities. Chapter 7 discusses the findings considering the existing research, confirming, refuting, or adding to models of PB in literature and research. I also outline the recommendations, strengths and limitations of the study as well as the original contribution of the findings to the existing literature and their implications for policy and practice. Finally, Chapter 8 summarises this thesis and presents three domains of contribution to the literature, theory and methodology of evaluating PB.

1.10 Chapter summary

In this chapter, I have presented the focus of the thesis on the exploration of the role of PB for improving health and well-being and reducing inequalities in deprived communities. I have briefly discussed the challenges of scant research in this field and how my research contributes to the existing literature. I have also defined key concepts and outlined the aim, objective and research questions that guide this inquiry. Finally, I discussed my motivation for carrying out this study and described the content of this thesis. Chapter 2 continues by discussing existing literature on PB approaches to improving health and well-being and demonstrates how this thesis addresses the gaps within the current body of work.

Chapter 2 - Literature Review

2.0 Introduction

Participatory Budgeting (PB) is "a decision-making process through which citizens deliberate and negotiate over the distribution of public resources" (Wampler, 2007:68). Citizens who participate directly in PB programmes are framed as residents, patients, service users and community members depending on the setting and purpose of the programme. PB prioritises citizens in the co-production of the interventions/projects in contrast to traditional forms of participation that prioritise organised civil society or community organisations (Escobar, 2020). PB therefore employs direct forms of participation rather than using intermediaries like civil society organisation to incorporate citizens to improve their lives and communities (Ganuza and Baiocchi, 2019; Escobar, 2020). A more comprehensive definition co-designed by DCLG and the PB Unit states that PB:

> *"Directly involves local people in making decisions on the spending priorities for a defined public budget. This means engaging residents and community groups representative of all parts of the community to discuss spending priorities, making spending proposals and vote on them, as well as giving local people a role in the scrutiny and monitoring of the process (DCLG, 2008, p. 11; PB Partners, 2015, p. 3)"*

These definitions presume that PB gives local citizens the freedom to decide the allocation of a part of public budgets to the types of interventions that are needed in each community to better people's lives. On the contrary, PB can foster clientelist practices in favour of certain parties within a programme (Shah, 2007). For example, Shah, (2007) reports that a government official in Recife, instead of opening an annual carnival budget to a fair transparent allocation of funds, used PB to share public funds to the advantage of participants regarded as "friendly participants", while so called "unfriendly delegates" were excluded from receiving such monies. Shah emphasised that PB can create opportunities for clientelist groups to foster selfish interests leading to a concealment of an undemocratic, limited or top-down nature of public decision making. Clientelism is a secluded transaction occurring between two people of unequal position (Wampler, 2000a). Shah explains that the activities of these clientelist groups can give an appearance of wider participation and inclusive

governance while using public funds to progress the interests of influential elites. In other words, clientelist practices in PB can widen inequalities between social groups of participants contrary to the beliefs of proponents.

Wampler (2000) adds that these processes can mask and strengthen existing injustices. PB programmes were originally designed to challenge clientelist practices, social exclusion, and corruption by conducting budgetary processes that are "transparent, open, and public" (Wampler, 2000:2). However, certain groups could use them to achieve their selfish interests. This means that PB may not always deliver what its principles set out to achieve by supporting an illegitimate and unfair use of power. On the contrary, Avritzer (2010) argues that an important result of the adoption of PB in Brazil was the dynamic transition from clientelist practices to a more public method through which the poor could obtain public goods. Abers (2000b) further confirms that clientelist neighbourhood associations lost access to public goods in the first year that PB was instituted, persuading them to adopt better social practices.

A UK based community programme designed to pilot PB showed PB was used to increase participation at public meetings, giving the participants the impression that their contribution would make a real difference to outcomes (Blakey, 2008). However, PB aims were thwarted by the constraints of pre-set national targets that conflicted with the genuine commitment of local citizens to participate and encouraged control of the process by officials who organised the programme. Therefore, rather than using the wide turnout of local citizens for deciding priorities, government officials used the PB process to find out the best ways of fulfilling national targets. This programme demonstrates another example where PB failed to give local citizens autonomy to decide the allocation of the budgets.

Another criticism of PB is that decisions made about funding in a PB cycle might only reflect the views of a select group of people who are already proactive in the society. For instance, A German study of PB found that stakeholders were characteristically middle-aged, employed men with high qualifications (Masser, 2013). This PB process that failed to widen participation by excluding underserved communities was more likely to widen the health inequality gap between the rich and poor by reducing the government's responsiveness to the needs of the most disadvantaged individuals.

Despite these drawbacks, Shah (2007) argues that when PB is well implemented, it allows governments to tailor services to the needs and preferences of citizens and their communities. This direct response to citizens' needs is said to allow for an efficient use of public resources and make governments more accountable to communities that they serve, enabling improvements in citizens' lives (Cabannes, 2015; Gonçalves, 2014).

2.1 Historical construction of PB: origin and early structure

PB began in Porto Alegre, in the southern states of Rio Grande do Sul, Brazil in the late 1980s. Most of the PB literature attributes its origin to the Workers' Party (In Portuguese - *Partido dos Trabalhadores*- PT) advent to power in Porto Alegre in 1989 (Goldfrank, 2007a; Wampler, 2000; Gollagher and Hartz-Karp, 2013). PB started as a means of decentralising the government to allow for more inclusive governance (Wampler, 2007b; Gollagher and Hartz-Karp, 2013; Goldfrank, 2012; Souza, 2001; De Sousa Santos, 1998; Abers, 1996). Wampler (2000) states that PB programmes were designed to include citizens in policymaking processes, encourage administrative reform, and distribute public resources to low-income neighbourhoods.

According to Wagle and Shah (2003), the PB process started with the *Partido dos Trabalhadores* (hereafter PT) organising two rounds of assemblies, to pool together demands of individual citizens and mobilise the community to select regional delegates. These representatives, along with the mayor's technical officers, then discussed the needs of their communities, debated and decided on what investments to spend part of the public money on to improve goods and services in the municipality. These priority investments were then embedded in the mayor's budget and presented to the National Chamber (Aragonès and Sánchez-Pagés, 2004). The PB process included information sharing of the annual budget provision, discussing, prioritising, voting on budgets, implementation and monitoring. Goldfrank (2007a) gives an account of literature that demonstrates established cases of PB in the late 70s and 80s where individual municipalities controlled by the Party of the Brazilian Democratic Movement submitted their budgets for public deliberations.

The PT made PB popular by experimenting with it in many municipalities. In Porto Alegre, the design of PB was advanced by the combined effort of neighbourhood associations and the municipal administration of the PT (Baierle, 1998; Baiocchi, 2003) but it was not until

1990 that the process was referred to as "participatory budgeting" (Goldfrank, 2007a). The PB label and other modified forms began to be adopted in other cities under the PT in the early 1990s. Since 1989, tens of thousands of residents began to meet in regional capitals to discuss budgets in annual assemblies (Abers, 2000a). The Porto Alegre version of PB is characterised by some or most of the following principles: It is:

- a discussion of the financial dimension or budgetary commitment to the process (the process involves dealing with problems of limited resources).
- a deliberative process that allows the people's voice to influence budgetary decisions directly; citizens decide on the rules that govern the process.
- designed with a redistributive logic that allows deprived communities to receive a fair amount of the budget.
- designed to enable citizens to monitor public spending.
- a process repeated periodically (Sintomer *et al.*, 2005; De Sousa Santos, 1998; Herzberg *et al.*, 2005; Peixoto, 2012).

But in the UK, the Participatory Budgeting Unit has developed a set of values, principles and standards for PB for practitioners to clarify and embed PB in local initiatives and for good practice (see PB Unit, 2009). The history of PB in the UK extends to 2000, but its official launch was in 2006 through the Local Government Strong and Prosperous Communities' White paper (DCLG, 2006). It has since become widespread for commissioning community-based interventions tailored to improve the health and well-being of individuals and communities. International and local policies (Overmann and Graubard, 2014; Marmot *et al.*, 2010; Scottish Government, 2015), community development and health practitioners (McKenzie, 2014; Hall, 2010), developmental bodies, World Bank and UNI-Habitat (Goldfrank, 2012) and researchers (Touchton and Wampler, 2014; Vlahov and Caiaffa, 2013) promote the use of PB as a mechanism for improving the health and well-being of populations. In the UK, several local governments and non-governmental organisations adopt PB for improving health and well-being. Yet how the process of PB and its commissioned interventions influence health and well-being are under-theorised and under-researched. This raises the question: on what evidence do policymakers justify the adoption of PB for improving health and well-being?

2.2 Existing theoretical underpinnings of PB

The major theoretical influences in the development of PB have been the capability approach of Amartya Sen, the empowerment theory of Paolo Freire and democratic theory. The central themes of these theories are critical to health improvement through the development of human capabilities and competencies relating to human development. Although these theories are presented in the PB literature as critical to developing health-promoting human capabilities and competencies, they were mentioned independently of each other (Boulding and Wampler, 2010; Touchton and Wampler, 2014). Furthermore, the exploration of the connections between these theories and health and well-being impacts or human development lacks depth. In this thesis, I argue that the three theories can combine as a lens to help us understand what impacts PB could have on the health and well-being of residents when used in similar interventions like the WL programme and how these relate to health equity.

The main idea behind the triangulation of these three theoretical models was to draw on their strengths and to provide a comprehensive framework for understanding how PB may influence people living in a deprived community to act for their well-being. It draws together the suppositions of the theories for social well-being impacts made in the PB literature (Touchton and Wampler, 2014; Boulding and Wampler, 2010). The three theories are discussed in detail in the following subsections and followed by a fusion model in a proceeding section.

2.2.1 Sen's Capability approach

Sen's capability approach is a theoretical framework with two normative claims: 1) that the freedom to achieve well-being is of primary moral importance and 2) that well-being should be understood in relation to people's capabilities and functionings. The capability approach helps explore how the intrinsic properties of PB are likely to mitigate problems of deprivation, mitigate the social determinants of health and improve lives.

Capabilities, also known as *substantive freedom,* are the doings and beings that people can achieve if they choose to, including being safe, being well-nourished, participating in social life, being healthy, being educated and getting married, travelling; while functionings are realised capabilities*;* that is "the various things a person may value doing or being" (Sen,

1999, p. 75). Things people value include public goods and income but are described in terms of what a person can be or do with these goods and income (Deneulin and Shahani, 2009). Someone's ability to convert a set of means - public goods and resources – into functioning, depends on personal, socio-political and environmental conditions known as *conversion factors* (Burchardt (2006, p. 2). These conditions are the social determinants of health. Improving health and well-being by tackling the social determinants of health is at the heart of CD approaches like the WL programme that work in deprived communities.

Capability is, thus, "a set of vectors of functionings, reflecting the person's freedom to lead one type of life or another… to choose from possible livings" (Sen, 1992, p. 40). The capabilities approach, in contrast to the theory of social justice of Rawls (1972), is more able to accommodate the diversity of human beings and the complex nature of their circumstances. This is because it focuses on an individual and their ability to do or to be whatever he or she values.

Another essential component of the capabilities approach is agency - defined as "what a person is free to do and achieve or values he or she regards as important" (Sen, 1985, p. 203). In other words, it is characterised by a person's ability to pursue the goals that they value and that are essential for the life they wish to lead. Agency involves being an active participant in planning and conducting one's life. Agency has a relationship with methods that emphasise self-determination, empowerment, voice autonomy, authentic self-direction, self-reliance, and the like (Deneulin and Shahani, 2009). A central goal of human development is empowering individuals to become agents in their own lives and their communities (Deneulin and Shahani, 2009). Agency should, therefore, thrive in developmental processes (e.g. PB) that foster participation, public deliberation and democratic practice. Sen argues that in development processes, 'the people have to be seen … as being actively involved – given the opportunity – in shaping their own destiny, and not just as passive recipients of the fruits of cunning development programs" (Sen, 1999, p. 53).

Sen (1999) argues that agency is fundamental intrinsically for individual freedom. Moreover, it is also instrumental for collective action and democratic participation. Although these are two distinct doings, they are both linked aspects of human life. Consequently, agency is a significant dimension of human well-being. Sen suggests that when people's capabilities are extended, they become empowered to make decisions about the things that will improve

their lives and that they enjoy (Sen, 1999). Sen posits two components of human freedom: 1) political freedom which allows individuals the opportunity to discuss and debate and to participate in the selection of values in the choice of priorities and 2) a socioeconomic one which enables them to choose, for example, facilities for health care and education which ultimately determine good mental health and community well-being. Additionally, Sen states, 'individual freedom' is a social product with a dual effect, whereby, social organising expands individual liberty, the right obtained by participants supports not only the improvement of their respective lives but procures more appropriate and efficient public goods. This agrees with Derges *et al.* (2014) whose qualitative study exploring the benefits of participation in the WL programme in three deprived neighbourhoods, revealed a positive relationship between personal agency and well-being. Derges *et al.* (2014), demonstrated that WL activities facilitated transformation for those who participated, enabling them to experience personal and collective agency and social cohesion, leading to further well-being. This means from a capabilities approach perspective, the goal of the WL programme was to expand residents' agency (or empowerment) to enable them to drive action to improve their own lives.

Touchton and Wampler (2014) argue that the adoption of democratic innovations like PB is explicitly designed to tackle the middle and upper-class bias of representative democracies. The authors agree that these democratic processes help to "increase human capabilities and mitigate representative democracy's pro-wealth bias". In other words, the failings of popular democracies to improve health can be mitigated by PB practices. Furthermore, the enhancement of human capabilities increases the potential to generate a virtuous cycle that enables citizens to pressurise statutory governments to allocate public resources more efficiently and fairly (Touchton and Wampler, 2014). Similarly, Boulding and Wampler 2010, suggest PB increases citizens capabilities, through participatory democracy, to exercise civic rights and form bonds of solidarity which enables them to press government to respond to the most demanding needs of the community.

At the broadest level, this inclusion of residents bypasses the political structure of a central government (e.g., in the UK - which does not adopt PB at a national level). It allows citizens to directly and actively participate in deciding what interventions are essential for health improvement at a local level. This function of PB is consistent with Ross' findings (2006),

suggesting that such political structures are barriers to improving material well-being for impoverished communities. Ross' statement justifies the adoption of alternative approaches like PB, which enhances people's capabilities and agencies to engage in individual and collective action for transforming lives. PB allows the co-production of interventions, spanning co-design, co-commissioning, co-delivery and co-assessment of programmes described by Bovaird and Loeffler (2013, p. 5). See Escobar (2020, p. 286) for a detailed description of how PB models and approaches that employ these different co-production elements can become life-transforming for citizens.

Despite its wide adoption and application to various settings and disciplines, the capabilities approach has been criticised for emphasising a liberal-individualist approach (Burchardt, 2006). This means that the capability approach prioritises liberating the individual and "*not social solidarity"*, which is vital for community well-being and reducing inequalities. This implies the freedom to choose only and not the need to belong (Dean, 2009). The need to belong refers to an individual's fundamental desire to cultivate interpersonal relationships. The need to belong hypothesis has been demonstrated to have multiple and robust impacts on emotion, cognition and behaviours, which can affect health and well-being (Carvallo and Gabriel, 2006; Baumeister and Leary, 1995). The common notion that no man is an island comes from the idea that social relationships are essential for well-being. So, how can individuals develop social relationships without the empowerment to do so?

2.2.2 Paolo Freire's Empowerment theory and other perspectives

Community empowerment (CEP) is the process of enabling communities to increase control over their lives (WHO, 2021 para. 1). The word "enabling" implies that others cannot empower individuals, but they can empower themselves by acquiring different forms of power (Labonté and Laverack, 2008) to enable them to act to improve their lives. The CEP process enables community members to cooperate to gain more significant influence and control over the determinants of health to improve the quality of life in their community (WHO, 1998). Empowerment is achieved when people and communities express and present their needs, contribute to decision-making, and change their communities and systems to address identified needs (Fawcett *et al.*, 2010). DCLG action plan 2007, show that an empowered community is confident, inclusive, organised, cooperative and influential over the things that affect their lives (DCLG, 2007). The notion of empowerment assumes that people are their assets, and the role

of the external agent is to catalyse, facilitate or "accompany" the community in acquiring power.

CEP is also defined as a process by which disadvantaged people work together to increase control over events that influence their lives (Werner, 1988). In doing so, disadvantaged people gain power over factors and decisions that shape their lives. CEP is conceptualised as both an ongoing process and a product that leads to social and political change. These definitions make power the central tenet of empowerment, meaning that the transfer of power to communities needs to happen to enable true empowerment. The empowerment process allows communities to increase their assets, attributes and build capacities to gain access, voice, partners and networks to gain control.

One of the ways of enabling individual and community empowerment is through education. The *Pedagogy of the oppressed* written by Paolo Freire provides a framework for educating the oppressed to challenge injustices and gain liberty. Freire presents an analysis of an educational and political philosophy set in the context of the revolutionary struggle in Brazil against poverty and oppression towards the liberation of the poor (Freire, 1970). His work aimed to enable the empowerment of the poor and oppressed and liberate them from systemic inequity that was maintained and perpetuated by the process, practices and outcomes of interdependent systems and institutions in Brazil. Jemal (2017) reveal that if people are unaware of inequity and fail to resist oppressive norms and ways of being continually, then the result is perpetually residual inequity. The author likens inequity to a disease or poison and prescribes critical consciousness (CC) as an antidote to cure the cycle of residual and perpetual inequity in society, recommending CC as a construct with significant scholarly, practice and policy implications.

Freire's critical pedagogy is based of *conscientization* often used interchangeably with CC (Windsor *et al.*, 2014; Shin *et al.*, 2016; Diemer *et al.*, 2016). But Jamal argues that CC is a product of *conscientization* rather than a process. *Conscientization* refers to "learning to perceive social, political, and economic contradictions, and to take action against the oppressive elements of reality" (Freire, 2000, p. 35). It is the *process of becoming critically aware of the structural forces of power that shape one's life leading to action for change. Conscientization involves focusing on the stories of people, and problematising personal/local issues, while exposing socially constructed identities that have been silenced* (Ledwith, 2014).

The predominant social, economic, and cultural reality of the 1960s in Latin America marked Freire's life and his later work characterised by extreme poverty and oppression. Through his personal suffering and direct experience emerged the critical pedagogy which involves questioning, naming, reflecting, analysing and a collective action which brings transformation to the world of the oppressed. Conscientization is a system of education that emancipates instead of controls (Ledwith, 2014). Freire's empowerment theory combines the philosophy of hope and the pedagogy of liberation to explain how disadvantaged people can become emancipated. In other words, at its heart lies the philosophy for empowerment and transformation, relevant to tackling social injustice in its varying forms including gender, race, ethnicity, class and caste (Magee and Pherali, 2019).

Freire believed that human beings are subjects who can think and reflect for themselves and therefore can transcend and recreate their existence. This rejects the worldview that people are objects and unable to think or question their circumstances but are bound to the systems and controls in their world (Ledwith, 2014). Therefore, Freire's critical pedagogy aligns with the health promotion tenets that empowerment is central to tackling the social determinants of health (Marmot *et al.*, 2008; WHO, 2008; WHO, 2009). The notion of empowering communities is far beyond the involvement, participation, or engagement of communities. But it is about including disadvantaged communities in problematising and solving issues that affect them. It includes taking responsibility and ownership and acting on these issues collectively with the goal to cause social and political change locally and globally (Labonté and Laverack, 2008). In other words, CEP must address the social, cultural, political and economic determinants that underpin health, and should seek to build partnerships with various sectors to find solutions.

Although Freire's thesis describes the situation of rural peasants in Brazil, it also depicts the experiences of people living in disadvantaged communities in high income countries. Hence, this methodology is well-suited as a lens for studying disadvantaged communities and is acclaimed to be a tool for empowering impoverished and illiterate individuals worldwide. As with the capability approach, Freire's empowerment theory agrees that when people are allowed to learn and understand complex systems that are foreign to them and have a fair playing field with their superiors (in this case, professionals and statutory bodies), they become liberated and lead better lives (Freire, 1970).

Practical applications of Freire's critical pedagogy in CD approaches include Ledwith's community development work (2001-2020) and the legendary work of Augusto Boal, the Theatre of the Oppressed (Boal, 2008). For example, Ledwith (2014) advocates a radical CD framework for enabling and empowering deprived communities to act on the social determinants of health. Ledwith adopts critical pedagogy in her CD work, using problematisation and dialogue to lift the culture of silence in the communities. A two-way dialogue is essential for the needed reconstruction of cultural identities that lead to narratives of possibilities for social transformation. In other words, communication and people's stories are integral to ensuring CEP. Participatory approaches that encourage dialogue, discussion, and debate lead to increased knowledge and awareness and a higher level of critical reflection for the people involved. Critical reflection enables communities to understand the interplay of forces operating in their lives and helps them make their own decisions. But this is impossible without the re-negotiating of power with those in authority over the seemingly oppressed.

Augusto Boal (1931-2009) was a political and cultural activist and theatre director who used storytelling and drama to portray social and political injustices in Brazil. Boal enabled spectators with suggestions to participate as actors in his plays. His audience would suggest changes and demonstrate their ideas on the stage during a play. Through this participation, audience members became empowered to imagine and practice the change they wanted to see while reflecting collectively on the suggestions, and thereby becoming empowered to generate social action. Theatre of the oppressed then became a practical catalyst for power shift and grassroots activism. This narrative is pertinent to one of the projects commissioned by residents of RDPW through PB and was selected as a case study for this research. A detailed discussion of the case is presented in Chapter 4 and 5.

CEP must involve a process of re-negotiating power for communities to acquire more control. It is inevitable therefore, that if communities should be empowered, then others must share their existing power and give some of it up (Baum, 2008). Power is core in CEP, and health promotion perpetually operates within the arena of a power struggle. However, critical pedagogy of this kind, when introduced to deprived communities can empower lay individuals to identify alternative possibilities founded on more just and equitable

participatory democracy “that promotes sustainable, people-centred development, equal opportunities and social justice” (Craig and Mayo, 1995, p. 1).

Another critical lens through for viewing peoples' empowerment is the Black Feminist Thought in the Matrix of Domination by Patricia Hill Collins (1990). Freire's educational and political philosophy pertains to individual freedom within the context of collective reclamation of power from oppressive systems. In contrast, Collins provides a broader framework of empowerment, which includes the change in individual consciousness and the essential ingredients of social transformation of economic and political institutions needed for social change. Although Collins' work focuses on applying the intersectional paradigm of race, gender, social class, sexuality and nation to understanding the connections between knowledge and empowerment pertaining to African American women, it can serve as a lens for explaining the intersecting oppressions that shape the experiences of other groups such as disadvantaged communities elsewhere.

Like Freire, Collins agrees that there is a significant connection between knowledge, consciousness and the politics of empowerment. However, she argues that there is a need for a paradigmatic shift in how we conceptualise oppression. She suggests that by accepting the idea that gender, class and race are interlocking systems of oppression, Black feminist thought rethinks the social relations of domination and resistance. The term interlocking systems of oppression in black feminist thought is used to describe how people's different characteristics, such as race, ethnicity, sexuality, class and age, can become oppressive instruments towards women and change the experience of living as a woman in society. Furthermore, she argues that offering the oppressed new knowledge of their own experiences can be empowering but can reveal to the oppressed new ways of knowing that allows them to define their realities has far-reaching implications for empowerment. Collins theorises a matrix of domination reveals that the notion of empowerment is more complex than the simple models of oppressor and oppressed suggests. This is because it is structured along the axes of race, gender, class, sexuality and nation and operates through interconnected domains of structural, disciplinary, hegemonic and interpersonal power.

Collins describes the "matrix of domination" as "this overall social organisation within which intersecting oppressions originate, develop, and are contained" (Collins, 1990, p. 10). For instance, Collins references that historically domination has happened in the US through schools, housing, employment, government, and other social institutions that control the patterns of intersecting oppressions that Black women experience. But intersecting oppressions evolve in response to human action just as the shape of domination changes. Moreover, domination varies depending on the context or nation in which it is embedded. This means we cannot resolve community issues with a blanket solution without unpacking the matrix of domination, intersecting oppressions and power politics within these communities.

Therefore, the traditional public health norms of promoting through leaflets and other non-engaging community empowerment methods need rethinking. This system assumes that individuals will be empowered by the information they receive, making the term empowerment take the position of the neoliberal Trojan horse. In this notion, individuals are expected to "pull themselves up by the bootstraps and solve deeply entrenched problems themselves". However, empowerment cannot be about fixing yourself but tackling the structural, economic and political injustices to enable the oppressed to gain freedom to thrive.

2.2.3 Democratic theory

The democratic theory, made up of representative and participatory democracy, is employed as a lens for understanding the participatory and deliberative traditions of the democratic innovations (Elstub and Escobar, 2019; Escobar, 2017). While representative democracy emphasises the involvement of advocates, representatives and experts, participatory democracy compels citizens to interact with other citizens without mediators. As such, politics is viewed as the art of individuals participating in the planning, coordinating, and carrying out of collective action (Barber, 2003: 152-153). PB involves either or both participatory and representative democracy to function depending on the setting.

The deliberative nature of participatory democracy, and its connections with the philosophy of action and reflection, makes it possible for individuals who participate to experience political and social transformations (Barber, 2003). Mündel and Schugurensky (2004) claim

that participating in public policy planning and public service delivery provides an enabling environment for learning democratic values and skills. In the same spirit, Cooke (2000) argues that participation goes beyond improving the participants' moral, practical or intellectual qualities to make them better citizens or individuals who can contribute to decision making and produce new policies.

Aside from contributing to decisions and producing new policies, Pateman (1970) emphasises the power of participation for generating educative effects that contribute to the "development of the social and political capacities of each individual" (p. 43). According to Escobar (2017) these impacts of participation highlight two vital domains of participatory democracy. These include: the sense of efficacy citizens can develop by utilising opportunities for authentic participation in decision-making that affect their lives and the perspective that citizens are far from "pre-packed bundles of fixed preferences and fixed propensities", but they embody potentials that can be "nurtured and shaped, to benefit them and their societies" (Saward, 2003). This significantly contrasts Lippman's (1927) argument that suggests most citizens are likely to be ill-informed, gullible, disinterested, partisan and lacking knowledge, creativity and problem-solving capacity, leaving politics to leaders and experts (Lippmann, 1927).

According to Campbell (2006) and Schugurensky (2004), deliberation stimulates intuitive ideas and helps citizens to look beyond their self-interest to the greater public interest, to develop a mutual understanding among those who participate. In addition, social interactions increase the opportunity for people to confront others with different experiences, worldviews, and viewpoints other than their own. Such connections provide opportunities for people to share their experiences and learn from those of others. Similarly, Scott (2000) argues that individual interests are pooled into shared and common interests through participation. Ryfe (2002) believes that the most significant outcome of these interactions is the creation and maintenance of a shared sense of belonging.

Merrifield (2002) confirms that accommodating deliberative processes and participatory action plans in the practice of public service delivery not only enhances the effectiveness of service provision but also improves the informal learning and competencies of citizens. PB directly encourages civic participation and enhances social learning that enables citizens who are more able, to hold public officers accountable (Touchton and Wampler, 2014; Touchton

et al., 2017; Baiocchi, 2005). Similarly, Escobar (2020) states that the PB process can enable the development of "civic and official capacity to grapple with complexities (e.g. wicked issues), overcome silo thinking, address urgent problems and enable long-term thinking" for collective action to transform lives, community and systems. Whereas Ross argues that democracies produce very few "if any improvement" in material well-being for the poor and that middle-class groups thrive better under democratic rule (Ross, 2006 p.872), Touchton and Wampler (2014) suggest that PB integrates the poor into political venues to make decisions about the issues which affect them. As a democratic innovation, PB creates a public sphere that promotes solidarity over self-interest, public deliberation instead of public opinion, civic education, and agency against public apathy (Escobar, 2020). According to Escobar (2020), this combines with other functions of PB, including mobilising the values and perspectives of professionals and local people to enable well-informed decisions for collective actions about needs, aspirations, trade-offs and priorities that can transform lives, communities and systems.

2.2.4 Fusion model reflection

Figure 2.1 shows a fusion model of the three theories discussed above with all three feeding into each other to form a robust theoretical model for action within the PB programme. The empowerment theory gives the opportunity for people, through the eyes of Sen and Freire, to participate in processes where their capabilities are ignited, and their oppressions are lifted. But this is not possible in the absence of a forum for dialogue where people collectively identify, problematise, reflect and act on the social factors that prevent them from better health and well-being. Therefore, I argue that these theories work together to produce outcomes for well-being in a CD approach to well-being which includes PB.

The framework for this PhD research relies on the assertion that PB programmes involve different stakeholders (citizens or residents, health professionals, community organisations and government officials) through an empowerment process, within a shared space, to allocate a part of public budget for local priority projects or interventions. Touchton and Wampler's (2014) debate ties in with Sen's argument of broadening human capabilities which can, in turn, extend opportunities for enhancing human development and causing transformation of lives. Although Sen's capability approach helps us understand valuable work on human development in terms of people's freedoms and well-being (Gasper, 2002),

it is insufficient to explain the transformations that may occur in people who participate in PB programmes. The capability approach embodies empowerment, but it needs the tools offered by the democracy theory (e.g., deliberative freedom) and the transfer of power through the empowerment theory to be robust.

The PB process can potentially provide individual empowerment through the improvement of deliberative efficacy, e.g., improved knowledge, skills and attitude towards self and community good (Boulding and Wampler, 2010). Further, the extension of the capabilities of individuals who participate in PB programmes may lead to greater freedom to make informed choices, and this may have implications for individual and community capacity building and well-being (Sen, 1999). Another point of reflection is that when priority projects are correctly implemented, it may produce trust for government bodies and improve intermediate health outcomes like sense of control, sense of belonging, the self-worth and sense of community (Wise and Sainsbury, 2007; Shah, 2007; Wampler, 2012a). These lead to empowered individuals with common interests bonding together to create an empowered community (social cohesion) leading to the development of greater social capital. This entire process harnesses and improves personal and collective assets leading to a virtuous cycle of behaviour change, mental health and community well-being improvement.

Public health promotion includes the active participation and empowerment of local citizens, putting them at the heart of health promotion action and decision-making processes. Moreover, it is established that involving communities in initiatives aimed at modifying health-related lifestyle factors is a critical driver for sustained success in CD (Aragones and Sanchez-Pages, 2009). Therefore, any programme that seeks to empower residents must involve them in the deciding of what is needed to improve individual and community health.

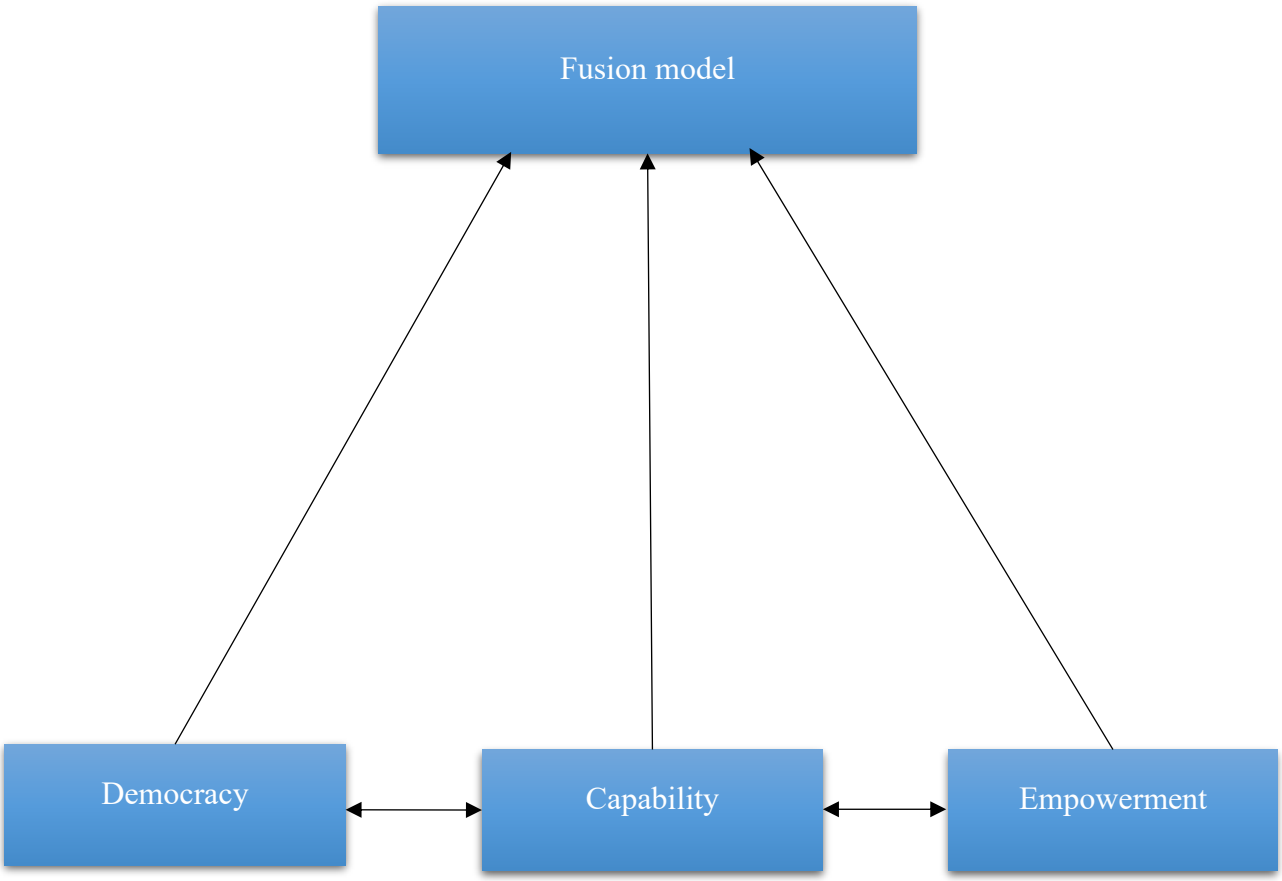

Figure 2.1 Fusion model: the relationship between three theoretical concepts of PB

2.3 Global diffusion of PB since 1989

The adoption of PB for allowing citizens to allocate a part of public budgets spread very quickly globally to places like Latin and North America (the US, Canada) Asia, Africa and Europe irrespective of being low, middle or high income. By 2006, more than 2000 PB experiments existed globally (Sintomer *et al.*, 2013; Baiocchi and Ganuza, 2014), with several governments and non-governmental bodies adopting PB to run programmes. After over 30 years of initiation, the PB Project – an American Charity responsible for coordinating a global PB hub - estimate over 7000 cities worldwide are using PB for local governance and allocation of public budgets (Participatory Budgeting Project, 2020). Of 11690 - 11825 cases of PB, the PB World Atlas 2019, suggests Europe represents about 39% of all cases identified in the world with 4577 - 4676 cases noted (Dias et al., 2019). Concern was, however, raised about the lessening of its potential to empower citizens as it travels the globe (Baiocchi and Ganuza, 2014).

The reason for the rapid spread of PB is attributed to the appeal of its ideas and principles for a broad range of "citizens, civil society activists, government officials and international agencies" Wampler *et al.* (2018, p. 5). Furthermore, beyond its ideas and principles, PB processes create opportunities for changes in attitudes and behaviours at the individual level among a broad spectrum of stakeholders that lead to social impacts (Wampler *et al.*, 2018). Four broad benefits for citizens and government officials are described in the Table 2.1 below.

Table 2.1 Four benefits of PB for citizens and governments

Impact of PB	**Description**	**Evidence**
Stronger civil society	creation of a more robust civil society by increasing the number of groups formed, the range of activities developed and increased partnership working with governments	(Baiocchi, 2005; Baiocchi *et al.*, 2011; McNulty, 2011; Montambeault, 2016; Sintomer *et al.*, 2008; Touchton and Wampler, 2014; Santos, 2005)
Improved Transparency	improved transparency by increasing informal learning of citizens and CSO which allows greater oversight and monitoring	(Wampler, 2007b; Goldfrank, 2011; Shah, 2007)
Greater accountability	Because PB allows citizens to be more likely to be aware of their rights as they become aware of government activities which enable governments to be more responsive to the demands of citizens and support the provision of a shared interest	(Wampler, 2007b; Shah, 2007; Goldfrank, 2011; Alves and Allegretti, 2012)
Improved Social Outcomes	Occurs through better governance, a more empowered and informed citizenry and the provision of social goods tailored to the needs of disadvantaged communities.	(Gonçalves, 2014; Touchton and Wampler, 2014)

Source: Adapted from Wampler *et al.* (2018)

The Porto Alegre version of PB is often cited as the ideal model (see section 2.0 above). However, the diffusion of PB from Brazil to other parts of the world has seen the emergence of multiple variations. Research by Sintomer *et al.* (2005) describes six groupings of PB using classification by the type of funding available. PB processes evolve rapidly, and it may be impossible to distinguish them by the type of funding provided. Therefore, it may be better to classify them by the adoption of its original values and the mechanism used at the point of delivery. Research by DCLG (2011), suggests that despite limited funding, PB produces tangible results with a combination of active community mobilisation and high-quality decision-making processes, leading to the implementation of meaningful community projects. They conclude that the implementation of the prioritised projects on schedule preserves stakeholders' trust for the procedure.

The practice of PB in the past 30 years globally has had varying levels of success and failure in several cities worldwide (Wampler, 2000; Goldfrank, 2007a; Wagle and Shah, 2003). Cities with acclaimed success include Porto Alegre and Belo Horizonte. As Cabannes (2014:8) states "in 2014 at least 1,700 local governments of all sizes from over 40 countries from all continents are experimenting with some form of PB. PB has since been adopted for delivering CD in many countries including cities in Latin America, Asia, Africa, and Europe" (Goldfrank, 2007a; Wampler, 2008; Sintomer *et al.*, 2008; De Sousa Santos, 1998). It has also spread to the US and Canada, including cities like New York, Chicago, Montreal, Guelph, Vallejo (California), and Toronto (Baiocchi, 2015). Although the experiences of PB in different parts of the world vary in design and delivery, they all involve similar principles based on the Porto Alegre experiment (Sintomer *et al.*, 2008; Sintomer *et al.*, 2005). Aragonès and Sánchez-Pagés (2004) suggest that PB in Brazil is characterised by a mixture of components of representative democracy (in the form of elected municipal bodies), and elements of direct democracy (in the form of assemblies) and an elevated level of accountability due to the direct involvement of citizens in the process.

Baiocchi (2005) describes his observation of budgeting forums in Porto Alegre as one in which citizens made decisions that mattered to the well-being of their communities, were willing to learn about issues and the process; and fought for their projects but were committed to the collective good of the community. Even though PB started as a means of improving governance, transparency and the quality of democracy, it is now a method used for allocating a proportion of public resources to a broad range of community-based interventions targeted at improving health and well-being, especially within the UK. However, these interventions do not embed rigorous evaluations that assess the public health impacts of PB (Campbell *et al.*, 2018; Vlahov and Caiaffa, 2013).

2.4 Democracy and health and well-being

At a basic level, democracy is an institutional process through which individuals acquire power for reaching political decisions through a competition for the people's vote (Schumpeter, 1942). The links between democracy and health continue to be the subject of debate for academics, researchers and politicians (Krueger *et al.*, 2015; Ross, 2006; Ciccone *et al.*, 2014).

A large body of evidence demonstrates that democracy contributes to human development by improving the lives of citizens (Touchton *et al.*, 2017; Gerring *et al.*, 2015; McGuire, 2010; Brown and Hunter, 2004; Wampler and Touchton, 2019). Some of these works focus on the impact of electoral democracy on human development, particularly relating to mortality-based outcomes (e.g., infant mortality, child and life expectancy). However, these studies neglect to consider the impact of democracies on individual and subjective well-being. A systematic review by Altman *et al.* (2017) reveals robust evidence that citizens report living more satisfying lives in countries with a parliamentary system of government rather than presidential. Their finds suggest that democratic institutions have substantial impacts on human well-being, matching or exceeding other common predictors of health. My research goes beyond general electoral and mortality-based outcomes to explore the lived experiences of residents to co-construct the meanings they attributed to the health experiences from a PB programme.

Increasingly, empirical research suggests a positive association between countries with more democratic governments and better self-rated health, reduced mortality rates and healthier behaviours of citizens. This happens when elections are transparent and free, corruption is low, civil liberties are protected, and there is increased freedom of the press (Bobak *et al.*, 2007; Klomp and De Haan, 2009; Ciccone *et al.*, 2014). But a systematic review by Ciccone *et al.* (2014) reports varying results between governance mechanisms and health outcomes in low- and middle-income countries. Most of the research in their review found a positive association between democratic governance and improved health; some reported mixed findings and others found no association between governance and health. Their findings highlight four main mechanisms by which health outcomes are influenced in these settings. These include health system decentralisation that enables responsiveness to local needs and values, health policymaking that aligns and empowers diverse stakeholders, enhanced CE and strengthened social capital (p.86). My research aligns with Ciccone *et al*.'s study as it focuses on the empowerment of residents through CE to respond to local needs which the people value and enjoy.

A contrary perspective to associations between democracies and better health suggests that socioeconomic inequalities in health may widen in more democratic societies (Krueger *et al.*, 2015). This is because these democratic countries promote meritocracy (instead of nepotism or corruption), allowing people with higher socioeconomic status to benefit more from health provisions. Ross (2006) and Moffitt (2006) argue that some democracies increasingly spend more on health and education than countries that are not democratic, however, these investments are of greater benefit for middle and upper-class individuals who vote at higher rates than lower-class groups (Ross, 2006; Moffitt, 2015). These findings are crucial for my study because, as a democratic innovation, PB tailors public provisioning to target poorer communities, allowing governments and NGOs to be more responsive to their needs. My research moves away from these national democratic studies to look at how democracy at the grassroots may influence the health of the urban poor.

Exploring the processes through which the PB process influences individual and community health is of major concern for my study. PB is said to involve an extensive CE process; in the case of Brazil, a year-long process, and empowerment of local citizens to respond to citizens' needs and values. Many evaluations of the relationship between democracy and health exist, but empirical evidence on the direct impact of democracy on the health of individuals' lived experiences from direct participation at a local level is scant (Krueger *et al.*, 2015). Good governance, democracy, accountability, transparency, citizen empowerment, and participation have implications for improved health and well-being and can reduce inequalities. For example, Wise and Sainsbury (2007) summarised the links between democracy and health. They concluded that the involvement of local people in democratic societies leads to individual and collective freedoms that encourage decision-making, which has implications for several dimensions of improved health and well-being, particularly, mental health. These include:

> *an increased sense of individual and social respect [,] decreased feelings of alienation, an increased sense of personal and collective control and self-efficacy, a greater purpose in life and hence greater happiness and healthier behaviours. Increased collective action also builds stronger social networks with their attendant health benefits (Wise and Sainsbury 2007:181).*

Wise and Sainsbury argue that community involvement in decision-making better monitor and control these processes, enabling the arrangements to reflect the preferences of most people, which leads to greater satisfaction with government and happier individuals.

Additionally, the literature suggests that PB is designed with a redistributive logic for deprived communities to receive a fair amount of the budget (Goldfrank, 2007b): citizens from poorer communities are allowed to decide on the allocation of some public funds to purchase goods that can improve the quality of their lives (Sintomer *et al.*, 2005; Herzberg *et al.*, 2005; Peixoto, 2012). Furthermore, the right environment to do so allows individuals to make important decisions that will positively influence their well-being. For example, investments in facilities for interventions in local communities that can determine good mental health and community well-being. This aligns with fundamentals of Sen's capability theory earlier stated. Sen calls for evaluations that investigate such principles while focusing on the indicators that prove these associations in an explicit manner (Sen, 1999). My research follows Sen's assertion to explore the impact of decision-making on health and well-being during PB processes in the WL programme. Like Sen, Wise and Sainsbury call for more rigorous research to tackle the huge deficit in conceptual and methodological frameworks for understanding and explaining the relationship between democracy and health.

Souza (2001) reviews the evidence from the 1970s and 1980s on the effectiveness of PB as a significant innovation for increasing citizen participation, more pro-poor expenditure and local government accountability. The review focuses on the experiences of PB in the cities of Porto Alegre and Belo Horizonte using an array of variables. It describes participation in different districts and sectorial citizen assemblies, the available resources and the priorities established. Souza goes further to highlight how the PB process allows historically excluded citizens to decide on priorities for investment in their communities and to monitor government responses to their preferences. While noting the limitations of PB, that is, the exclusion of some of the poorest groups and the lack of success in other cities, Souza notes that PB helped to reduce clientelist practices and helped to build democratic institutions for an unequal society such as Brazil. Souza's finding contradicts Ross' (2006) argument about political benefits reaching only the middle and upper-class.

The findings of a case study funded by the World Bank in 2003 reports that "the Porto Alegre experiment presents a strong example of democratic accountability, equity, and re-distributive justice, with the participation part guaranteeing legitimacy to decisions, and objective budgeting ensuring fairness in an otherwise arbitrary process of translating political decisions into distributed resource" (Wagle and Shah, 2003:3). This report suggests that PB enables poorer neighbourhoods to have a say and be better funded leading to improved access of social amenities. This included increased access to water from 80% to 98%, the proportion of the population connected to sewage system from 46% to 85%, more children from poorer neighbourhoods gaining admission to schools and better roads for disadvantaged communities. This study suggests that providing an opportunity for disadvantaged citizens to express *voice* in a policy-making venue will yield improvements in their quality of life by redirecting budget towards reducing poverty, education, and health care. This buttresses Shah's (2007) argument that when PB is implemented correctly, it allows governments to tailor services directly to the needs and preferences of citizens and their communities. This responsiveness to citizens' needs is said to allow for more efficient use of public resources and to make governments more accountable to communities that they serve.

Research by Wampler and Touchton (2019) moved beyond elections to demonstrate how different elements of democracy act together to contribute to improved social well-being. Using citizens' debate, the authors argue that democratic practices give citizens access to a broad range of rights, creating a foundation for social well-being improvement. This is consistent with Touchton *et al.* (2017) research, which implies that PB mechanisms such as broadening of participation, deliberations, the embeddedness of PB in policymaking venues influence health and well-being. These findings are relevant for my research which sought to explore the PB implementation process and the mechanisms within the PB commissioned interventions to co-construct meanings people make of their impacts on their health.

2.5 Neoliberalism and the determinants of health

Neoliberalism is a political-economic ideology that promotes the idea that human well-being can best be improved through maximising entrepreneurial freedoms within institutional frameworks categorised by individual liberty, private property justices, agile markets, and free trade (Harvey, 2006). Neoliberalism is premised on market-based values, such as individual choice, consumerism, competitiveness, economic liberalisation, efficiency, privatisation, and profit maximisation (Eagleton-Pierce, 2016; Harvey, 2007). Since the late 1970s, neoliberal policies have shaped society, particularly with the broader pillars of deregulation, privatisation and liberalisation, while at the same time culturally individualising health promotion and health education issues (Peck and Tickell, 2003). The first wave of reductions in state funding for industry, housing and welfare began under the Conservative government. This was followed in the mid-1990s, with these policies partially overtaken by the New Labour government designed to control and contain some of the social and economic impacts of growing poverty and inequality. Moreover, since 2010, there has been a return to reducing spending under the UK's intense austerity policies, first under a Conservative-Liberal coalition and then a Conservative government.

Neoliberal methods of governance, often described as an 'Anglo-Saxon' welfare regime in public health research, have been known for their detrimental effect on population health (Coburn, 2004; Borrell *et al.*, 2009; Lena and London, 1993; Siddiqi *et al.*, 2013; Richter *et al.*, 2012) and health inequalities (Olafsdottir, 2007; Bambra and Eikemo, 2009; Eikemo *et al.*, 2008; Levecque *et al.*, 2011; Kim and Jennings Jr, 2009) primarily because of the reduction in the welfare states (Siddiqi *et al.*, 2013; Borrell *et al.*, 2009; Muntaner *et al.*,

2002; Dahl and van der Wel, 2013). In other words, neoliberal reforms contribute negatively to profound changes in health and health equity because of their emphasis on the free market instead of the right to health. Viens (2019) discusses two core concepts of neoliberalism. These are commodification, and individual responsibility, which wields direct and negative impacts on health and health equity. He suggests that health is viewed as an economic good governed by market principles in a neoliberal world. Furthermore, in commodifying health, it is claimed that health services become structured in a way that maximises their instrumental value by producing more efficient and innovative care as opposed to when operated in a welfare system. In this scenario, healthcare becomes overstated as a health determinant with its added medicalisation problem. Viens (2019), states that where health has been seen as a commodity and best structured under market conditions in which people can choose the amount and type of health treatment desired, the responsibility for health is transferred to the individual under neo-liberalism. This means that neo-liberal states like the UK take a step back and allow individuals or struggling local governments to make provisions for people less able to help themselves.

Neoliberal economies are contingent on sustained economic growth; therefore, when there are economic challenges, austerity measures, primarily cuts to spending, are the natural response to help revive the economy (Viens, 2019). However, in countries like the UK, these austerity measures are more profound among disadvantaged communities and socially vulnerable, increasing the already existing health inequity. With scarce resources to fund social interventions, PB provides disadvantaged communities with an alternative opportunity to choose interventions that would better their health. Viens (2019) concludes that there is an urgent need to develop further the body of work that supports us in understanding and illustrating the vital role of political activity and public policy as a determinant of health.

Neoliberal policies that support cuts to health and social care services exacerbate the social determinants of health. The World Health Organisation Commission on Social Determinants of Health produced the final report, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health,* in 2008 to organise evidence on how to promote health equity for all and encourage global action. The main goal of the Commission was to achieve and strengthen health equity within and countries to focus on the causes of

the causes (social determinants of health) rather than the causes of the disease. That is the central structure of the social hierarchy and the socially determined conditions these structures create in which people are born, grow, live, work and age.

It has been fourteen years since the WHO Commission's report on the social determinants of health was published, yet equity gaps persist within and between countries. Without a doubt, the social determinants of health's framework has positively shaped public health policy and practice; however, scholarly reviews of the Commission's work suggest a re-think of its adequacy in addressing the root causes of the gaps in equity and limitations in tackling the inequity gaps in the current global environment, particularly the exacerbated gaps observed between groups during the Covid 19 pandemic (Frank *et al.*, 2020). Katz (2010) reveals that although the report presents a comprehensive explanation of the damaging effects of neoliberal policies on health and offers an invaluable advocacy opportunity, it fails to identify capitalist development as a significant source of the manifold difficulties confronting humanity. Furthermore, although it condemns capitalist excesses, the report does not call out the current issues intrinsic to capitalist systems. For example, neoliberal policies exert pressure on aspects of human life, especially those essential to population health. These include food, water, shelter, sanitation, education, employment, social security, environmental safety, and physical security. Similarly, Yates-Doerr (2020), emphasises the importance of "locating the cause of poor health in social structures to enable an effective tackling of the problem through social (and not individual) action, thereby encouraging social (and not individual) transformation. O'Laughlin (2015) also revealed that HIV/Aids prevention in South Africa was inevitable without a comprehensive understanding of the links between the social milieu and the structural constraints of the population at risk.

These independent critiques of the social determinants of health give us a framework to rethink how we explain the causes of ill health through the frame of social determinants of health. In addition, the authors provide various examples of how structural conditions within communities can prevent a holistic approach to effective health prevention, promotion, and protection practices. In other words, social determinants of health do not exist without the structural conditions causing these inequities. For example, the MBRRACE report reveals that death in black women was five times more likely during childbirth in the UK than in white women (Knight *et al.*, 2018; Knight *et al.*, 2019). Similarly, in the US, studies showed

that the likelihood of death from complications of pregnancy among black women was two to six times more likely than among white women (CDC, 1999). This racial inequality in maternal death rates observed in these studies was attributed to poor treatment of black women due to systemic racism, socio-economic positioning and where they lived. This type of inequity can further marginalise black and minority people in these settings, leading to poorer health and well-being outcomes. This cross-disciplinary and cross-country recognition of the negative impacts of contextually engineered political, social, and economic factors on health has enormous implications for applying the social determinant framework.

2.6 PB and health

A growing body of literature suggests that PB can improve health and well-being of citizens through participation, empowerment and redistribution of resources to poorer communities (Gret and Sintomer, 2005; Shah, 2007; Boulding and Wampler, 2010; World Bank, 2003; Mundial, 2008; Touchton and Wampler, 2014; Gonçalves, 2014). Yet, limited empirical research reports the impact of PB on health and well-being 30 years after its first implementation in Porto Alegre, Brazil. The most comprehensive studies that suggest PB has potential to improve health and social well-being come from Brazil (Hagelskamp *et al.*, 2018; Campbell *et al.*, 2018). Most of these studies have been the analysis of secondary retrospective and routine data. This has led to the lack of depth in the investigations of the different dimensions of health; merely focusing on mortality health outcomes measurements.

One reason that can be attributed for a limitation in the type of data available for research is that proponents of PB do not always articulate the project vision in terms of the public health effects of such innovative and developmental work (Vlahov and Caiaffa, 2013). There may also be challenges with theoretical and methodological development of evaluations that target the public health outcomes of PB interventions or even the lack of incorporation of evaluations during the planning stages of such complex interventions. Another reason why PB and health research is scant worldwide may be the over-reliance of positivist longitudinal data to make inferences between PB and health. As such, alternative methods for exploring what short term or medium-term impacts of PB may result from programmes are needed. This thesis explores the impact of the PB process and project delivery on residents' experiences of health and well-being from participating in the WLP2 PB programme.

Since early 2000 researchers began to suggest that PB can impact positively on public health outcomes for populations. However, the processes through which these health outcomes are achieved, particularly at individual and community level, are underdeveloped and not fully theorised. Notably, only a handful of empirical research studies have examined the impact of PB on health and well-being. For example, Marquetti (2003) analysis of 10 years of PB data and 1991 census data showed that investment spending made through PB in Porto Alegre focused on the more impoverished regions when compared to the more affluent areas. This increased the per capita income priorities in the poorer regions (Marquetti, 2003). The author claimed that this action led to a redistributive effect of wealth as most public investment resources were previously spent in the middle-class neighbourhoods during the 1970s and 1980s. Boulding and Wampler (2010) concur that PB can promote social justice by increasing the resources spent in lower-income neighbourhoods. However, they argue that it is unclear whether this finding resulted in any verifiable improvements in residents' well-being (Boulding and Wampler, 2010).

A second study commissioned by the World Bank showed a significant statistical association between PB and a variety of social indicators of well-being. The report suggests that PB strongly and positively correlated with improvements in rates of poverty and the percentage of homes that had access to indoor plumbing and pipe-borne water (World-Bank, 2008). Again, Boulding and Wampler (2010) agree that these findings contribute the first unmistakable evidence that PB may be improving the lives of Brazil's vast disadvantaged population. The authors praised the World Bank study for its effort to make connections between citizens' participation in PB and well-being but raised questions about the design of the study. Boulding and Wampler (2010) queried the study design based on the use of a limited set of outcomes including only poverty rates, access to water and sewage treatment. The authors, therefore, decided to extend this study by assessing the impact of resources and a broader range of social outcomes.

Boulding and Wampler (2010) examined the relationship between PB and well-being comparing Brazilian municipalities that adopted PB and those that did not. The authors sought to answer two questions, 1) "does the adoption of PB change municipal spending priorities in ways that favour the poor? 2) are the PB programmes associated with improvements in social and physical well-being?".

Boulding and Wampler (2010) drew from an extensive data set spanning ten years (1989-2000) from 220 largest cities in Brazil with more than 100,000 residents to test this association. With PB as the key independent variable and Human Development Index HDI, inequality and poverty as dependent variables, the authors performed statistical tests for changes in health, education, and longevity. They also used the GINI index to measure changes in inequality while controlling for factors relating to levels and changes in poverty, inequality, education and life expectancy. Boulding and Wampler (2010) found no significant improvements in well-being between municipalities that adopted PB compared to those that did not. However, they found small decreases in extreme poverty in municipalities with PB programmes. This finding is crucial because it highlights the possibility that PB may have a positive impact on health by reducing poverty. But it does not tell us how the adoption of PB reduces poverty.

Despite finding connections between PB and improved health, Boulding and Wampler call for caution in overselling PB as a "magic bullet" for improving health. However, they suggest that further research with an increased number of PB years could demonstrate a stronger association with PB. Boulding and Wampler's 2010 study revealed that the average per capita budget could far better predict the changes in HDI than the presence of PB. This finding points to the importance of resources for delivering capital projects and the negative impacts it might cause for trust and health.

An MSc dissertation by McGovern (2012) sought to understand if PB improved population health in Belo Horizonte, Brazil. McGovern found that the adoption of PB increased the propensity for improved city planning and equitable distribution of resources to meet the needs of the poor in an urban city, thereby improving population health. Her research concluded that city government could positively impact health through the effective distribution of resources and policy design that prioritises the needs of the poor or through collective action resulting from including residents' voices in city planning.

Two other similar studies argue that PB significantly improves the lives of citizens when PB remains in place over a long time enabling sustained investment in social policies (Touchton and Wampler, 2014). Touchton and Wampler (2014), using data collected over 20 years across 253 Brazilian cities show a strong association between PB programmes and increases in health care and sanitation spending, resulting in decreases in infant mortality and increases

in civil society. This study confirms Boulding and Wampler's 2010 research, which found that having PB without sufficient resources to deliver public goods is futile. Even so, these debates are not representative of the small-grant funding provided for delivering PB programmes worldwide, especially for health interventions in the UK which are of interest to my study. Touchton and Wampler's (2014) study also does not account for broader indicators of well-being that can be experienced as a result of political freedom, participation in one's community and other social determinants of health (Sen, 1999). It also omits health indicators that may lead to increased confidence, self-efficacy, sense of control, sense of belonging, social connections and networks which have established links to psychosocial well-being (Hagerty *et al.*, 1996).

Similarly, Gonçalves experimented to understand the differences in the spending patterns and health outcomes between Brazil municipalities that adopted PB and those that did not (Gonçalves, 2014). She found that during 1990-2004, there was a marked reduction in the infant mortality rate of municipals that undertook PB compared to non-adopters. Furthermore, Gonçalves' study showed that the interaction between citizens and government officials regarding the allocation of public budgets enabled local resources to be targeted at the most critical needs of the community. This joint working led to a more substantial proportion of public budgets being spent on sanitation and health services, leading to improved living conditions and, in turn, a reduction in infant mortality rates.

Finally, building on previous studies, Wampler and Touchton (2019), adopting a large N study design, combined data from 114 municipalities of Brazil from 2009 to 2016 to examine the relationship between PB and well-being. The authors researched explicitly whether the mechanism or rules within PB programmes could explain the variations found in well-being. They found that broadened participation, increased deliberation and embeddedness of PB in local institutions result in a reduction in infant mortality. This study strengthens the need to study the PB processes or mechanisms which may influence health.

The studies examined above on health impacts of PB used similar data sets from Brazil with slight variation in the period studied to make conclusions about the influences of PB on health and social well-being. Although they all applied robust and careful statistical measures of well-being, they are primarily quantitative studies and therefore, do not account for the lived experiences of stakeholders who took part in the process of PB or participated

in the projects implemented. They also focus on capital spending on health care, education and sanitation and long-term effects on well-being. In the UK, health care (NHS), education and sanitation are somewhat free on receipt and are at a reasonable level and resourced through government funding without PB. Therefore, the findings of these studies may not be representative of the UK experience, which is of interest to my research. These studies are unable to shed light on the individuals' lived experiences of health or well-being through contact with PB in a deprived setting in a high-income economy. However, the studies examined highlight the possibility that the adoption of PB as an instrument for residents to have a voice, can be a precursor to improving health and well-being for individuals and communities.

2.7 Community development for health and well-being

CD has become a significant phenomenon in health promotion and improvement practice. Empowering individuals through CD activities not only provides personal benefits for the most engaged participants but offers opportunities for better well-being for residents by living in a setting which is politically empowering (Christens, 2012). Similarly, Syme and Ritterman (2009) suggest that few subjects are more fundamental to health compared to CD. Although this argument pales in comparison to other significant contributors to health like high-quality medical care, good genetic stock and healthy habits, there is substantial evidence that environmental and community forces have considerable impacts as determinants of health outcomes. The authors base their arguments on the extensive and compelling body of evidence demonstrating numerous factors beyond medical care influence health outcomes (WHO, 2008; Durkheim, 1951; Haan *et al.*, 1987; Acheson, 1998; Berkman, 1984; Evans *et al.*, 1994). Further research documents the impact of social and economic factors on health (Marmot and Bell, 2012; Adler and Stewart, 2010; Braveman and Gottlieb, 2014; Artiga and Hinton, 2019). Although medical health care is essential for improving health, it is recognised that it is not adequate to improve health overall or reduce health inequalities (Braveman *et al.*, 2011). Social economic and other social factors such as income levels, education, the physical environment, levels of poverty concentration and social isolation as well as sense of belonging and sense of community have been noted to combine to impact on individual and community well-being (Jemal, 2017; Stringhini *et al.*, 2010; Braveman *et al.*, 2011; Marmot and Bell, 2012; Braveman and Gottlieb, 2014). The social determinants of health comprise the conditions in which people are born, grow, live,

work and age, and the essential drivers of these conditions, include the distribution of power, money and resources (Marmot and Bell, 2012). PB, when done correctly, helps to distribute power, money and resources.

The literature points to the effort of CD approaches for improving a person's sense of belonging and sense of community. A significant feature of quality of life is the sense of belonging residents feel within their local community (Costanza *et al.*, 2007). It is well established in the literature that sense of belonging is vital to a person's health and social well-being (Kitchen *et al.*, 2012; Shields, 2008; Choenarom *et al.*, 2005; Ross, 2002). For example, Kitchen *et al.* (2015) found that a positive sense of belonging was strongly associated with positive mental health for Canadian-born and immigrant participants. In Kitchen *et. al.'s* study, a positive sense of belonging was also noted to influence homeownership and to be in fulltime work. Immigrants also placed more importance in knowing their neighbours by first names and gaining trust as a determinant of a positive sense of belonging. Furthermore, the immigrants in this study maintained a strong feeling of belonging to their ethnic origin.

There is considerable evidence that community participation is vital for tackling the social determinants of health to improve health in society (McKenzie, 2014; Syme and Ritterman, 2009; Chavis and Wandersman, 2002). Likewise, Syme (2004) social class gradient research strongly suggests that the ability for people to control their destinies and participate in the social factors that impact their lives is essential for health. According to Syme and Ritterman (2009), considering control and participation when implementing CD programmes ensures success. Therefore, it is imperative to explore how PB, a community development approach, may enable people in deprived communities to improve their health.

The term 'community' is a contested concept and can be applied to geographical context or interests (Delanty, 2009). Social science scholars identify several types of communities, including communities as place, community as relationships and community as collective political power (Suttles, 1972; Gusfield, 1975; Heller, 1989; Ledwith, 2014). Diverse communities' processes are well established for improving the quality of community life. These processes include CE, community organisation, community building, and community development. A common theme of these processes is individual participation which yields personal and collective goods (Chavis and Wandersman, 2002). For example, Heller (1989)

asserts that group attachments are central to developing self-identity and self-efficacy and community and group processes impact personal and social development. Similarly, Syme and Ritterman (2009) suggest that people need to contribute to creating and maintaining their physical and structural environment to support the improvement of their health. Furthermore, a variety of literature suggests that citizen participation in community development is a significant method for improving social conditions, improving the quality of the physical environment, preventing crime and enhancing services.

Similar to the above discourses, Ledwith (2008) posits that CD starts with the daily living of local people and is based on the process of empowerment and participation, which leads to sustainable social change. Empowerment uses a form of education which inspires individuals to critically query the reality of their existence, leading to collective action. According to Ledwith (2008), CD follows a process of action and reflection known as praxis, initiated by Freire (1970), to develop a diversity of projects which respond to the issues facing the people in the community. CD approaches which empower people are known to be remarkably effective in improving individual and community well-being. Blunsdon and Davern (2007) found that CD interventions resulted in better personal and neighbourhood well-being than in communities without CD. Ledwith (2008) suggests that the process of empowerment of people in CD is based on the principle of participatory democracy.

PB empowers citizens through participatory democracy to make decisions on public money to purchase commodities and services which improve their lives. Therefore, in this thesis, PB is operationalised as a CD approach. In England, involving communities, especially the urban poor, is fundamental to local and national strategies for promoting health and well-being and reducing health inequalities (Marmot *et al.*, 2010; DoH, 2010). Ten years on many local authorities and communities in England have established effective approaches for tackling inequalities and provided noteworthy evidence on how to reduce inequalities, yet health of the people is still deteriorating and inequalities in health is widening (Marmot, 2020). To date the UK government has not prioritised health inequality despite the downward trend reported by Marmot in 2010 and there is no national health inequalities strategy to tackle the problem (Marmot, 2020). Considering the adoption of PB in many countries has been an acclaimed success in increasing health spending and improving health in Brazil, perhaps the UK government can adopt PB as part of their national strategy. But PB evaluations have not been

focused on its potential for improving health and reducing inequalities. Hence this study moves to explore the processes of PB for improving the health and well-being in a deprived London community.

From a CD perspective, citizen participation is described as 'the inclusion of a diverse range of stakeholder contributions in an on-going CD process, from the identification of problem areas to the development, implementation and management of strategic planning' (Schafft and Greenwood, 2003, p. 19). This mirrors the work done during the Well London Phase 2 programme in Haringey, which combined a community needs assessment process where local authorities and residents engaged in identifying and setting priorities for local needs. The approach involved a level of deliberation, through community action workshop planning to agree on local issues and preferences which are then put to the vote at a PB event.

CD can impact mental health because of its potential to mobilise citizens to problematise issues as well as contribute to improving their lives and communities through community action. This function aligns with the WHO's definition of mental health, which states "mental health is a state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community" (WHO, 2004). Essentially, CD empowers individuals through self-realisation to fully exploit their potential; gain a sense of mastery over their environment; and increase their sense of autonomy (i.e., ability to identify, confront, and solve problems). This aligns with Jahoda's (1958) three domains of mental health (self-realisation, sense of mastery and sense of autonomy). Working productively and fruitfully can often be impossible for individuals for contextual reasons (e.g., for migrants, impoverished or discriminated people), and can prevent people from contributing to their community. Hence, CD can be useful for the social transformation in the context of the urban poor.

2.8 Health Policies, PB and Mental health

The 'Healthy Lives, Healthy People: Our strategy for public health in England' gives equal weighting to tackling mental health and physical health (DoH, 2010). This is because of the Department of Health (DoH) recognises the importance of mental health for individual well-being, human development, quality of life, economic growth, poverty reduction and other

socioeconomic outcomes. In 2011, the DoH mental health strategy, 'No Health Without Mental Health' was launched to improve mental health outcomes for all ages (DoH, 2011) . This strategy set out six key objectives for improving mental health and well-being which include more people: will have good mental health, with mental health problems will recover, with mental health problems will have good physical health, will have a positive experience of care and support, fewer people: will suffer avoidable harm, and will experience stigma and discrimination. This strategy fails to lay out how these objectives will be delivered, or how the outcomes will be measured and therefore presents this study grounds for providing assessable evidence for mental health and community well-being impacts from PB programmes.

Traditionally, public health interventions designed to improve mental health and quality of life are few but effective (CSDH, 2008). However, their implementation is hindered by the stigma associated with mental illness and the rising costs of health services (Layard, 2005; Royal College of Psychiatrists, 2010; Herrman *et al.*, 2005). In contrast, McKenzie (2014) recommends the PB approach, if done correctly, can be effective for improving mental health. McKenzie argues that PB is a catalyst for improving mental capital at a local level (McKenzie, 2014). McKenzie urges health and well-being boards in England to use how they work as a means for improving population health. He states:

> *"I have no doubt that there will be locally chosen and appropriate initiatives that promote mental capital. But participatory budgeting, if done correctly, has the potential to leverage those for even greater benefit, as well as developing resilient and socially cohesive populations"* (McKenzie, 2014, p.79).

McKenzie, (2014) argues PB, when adopted correctly alongside traditional health promotion approaches, can maximise the impact of those programmes on participants' mental capital and improve a resilient and cohesive community. Additionally, McKenzie suggests that PB can improve mental capital through its ability to increase CE and social efficacy which are fundamental for improving mental health and decreasing inequalities in mental health. Furthermore, PB allows a person-centred approach that enables the target populations to

achieve and sustain shared decisions on public health priorities and choose interventions that support health improvement (McKenzie, 2014).

Mackenzie's argument is consistent with England's 2010 'Strategic Review of Health Inequalities', allowing more power and decision-making (devolution) transferred to communities (Marmot *et al.*, 2010). This review argues that increased community participation would significantly improve the effectiveness of local public service, tailoring delivery within the local context, promoting equal access and improving outcomes. Furthermore, the asset-based approach to health improvement dialogue in Scotland supports the CE and participation theme and calls on professionals to change their attitudes from community's deficits modes and, most significantly, needs to recognising and building on community assets and the strengths of community members (McLean *et al*., 2017; Scottish Government, 2018). Asset-based approaches have several functions: they identify protective factors that support health and well-being (Foot and Hopkins, 2010; Foot, 2012; Rippon & Hopkins, 2015). In addition, asset-based approaches make visible and value the skills, knowledge, connections and potential in a community and help to promote capacity, connectedness and social capital. Essentially, they focus on the resources that promote the self-esteem and coping abilities of individuals and communities to enhance the quality and longevity of life. But asset-based approaches are challenging to adopt because they are complex, time-consuming and resource-intensive and frequently countercultural to how many local councils operate (McLean, 2021). Nevertheless, asset-based approaches are firmly embedded in the Scottish Government's policies and legislative ambitions. They adopt PB as a tool to deliver outcomes for these policies, including the outcomes in Scotland's National Performance Framework, which aims to support the citizens of Scotland to live in communities that are inclusive, empowered, resilient and safe and to tackle poverty by sharing opportunities for wealth and power more equally". PB can be considered an asset-based approach that has found a practical application through direct democracy for community members to interact, learn together, deliberate, and influence the division of public resources. In addition, PB enables a partnership approach that allows collective decision making for improved health and well-being for all and is fast gaining widespread acceptance as a tool for enhanced governance, accountability and improved health and well-being (Wampler, 2012; Ganuza and Baiocchi, 2012).

2.9 PB and social capital

A critical research finding of Touchton and Wampler (2014) is that certain features of PB support the strengthening of civil society. The authors suggest that 'PB has generative effects within civil society'- this finding is important for policymakers and researchers interested in social capital (Touchton and Wampler, 2014 p. 1456). Touchton and Wampler (2014) argue that PB rules promote the formation of groups and cooperation with more established groups to put proposals forwards. In the PB literature, there is a broad interest in social capital because of its interconnections to social organising and well-being (Baiocchi, 2005; Baiocchi *et al.*, 2011; McNulty, 2011; Donaghy, 2011; Avritzer, 2009). Avritzer (2009), in a study of PB councils, found that a well organised civil society was important for creating the intended forum for negotiation. On the contrary, Donaghy (2011) observed that elites could influence even a well-mobilised community of organisations if they fail to articulate their demands properly. Nevertheless, social organising encourages collective action from negotiating, deciding and voting for public goods that will benefit poorer communities to holding governments accountable and responsive in delivering residents' preferences (Wampler, 2007b; Shah, 2007). Therefore, communities working together within a PB programme is a means for improving social capital.

Using social factors to explain the health of a community is not new (McKinlay, 1995; Wolf and Bruhn, 1993). Since Durkheim's classic work on suicide, the importance of social integration and social capital for population well-being has become recognised (Durkheim, 2005). Also, following the work of Coleman (1994) and Putnam (2000), empirical studies in public health have been conducted to explain the relationship between individual (known as micro) and area (known as macro/meso) level social capital and population health (Lindstrom, 2006; Subramanian *et al.*, 2003; Subramanian *et al.*, 2002). It is, therefore, worthwhile to explore the emergence or re-emergence of social capital within communities in PB programme and how this may influence individual and community well-being.

Unlike social networks and social support, which are properties of the individual, social capital is a property of a group (McKenzie *et al.*, 2002). Social capital describes the connections among individuals that enhances access to power and resources, and by which decision making and policy formulation are enabled (Putnam *et al.*, 1994). It refers to the informal structures, norms of reciprocity, trustworthiness and social organising that facilitate

individual and collective action. Social capital is derived through the active participation of citizens in their community. For example, Putnam states 'When people associate in neighbourhood groups, PTAs, political parties or even national advocacy groups, their individual and otherwise quiet voices multiply and amplify' (Putnam, 2000, p. 338). But DeFilippis argues that Putnam's idea of social capital is flawed because it fails to acknowledge the issues of power in the production of communities and does not account for social networks that allow individuals to realise and control economic capital for expected gains brought by social capital (DeFilippis, 2001). The author rather hails Bourdieu's idea of social capital which insists that the production and reproduction of capital is about power and social networks are powerless without capital (Bourdieu, 1985).

Lomas (1998) argues that the social organising in a society involves encouraging trust and increased social interaction engendering care for one another as an essential determinant of health. He criticised the imbalance between public health and epidemiology efforts where millions of dollars are spent to alleviate ill health based on individual intervention. Kawachi and Kennedy (1997) agree that the missing link between social relationships and health in epidemiological studies is the social context in which people live. The authors stress the importance of focusing on social connections of entire communities for tackling the health of individuals rather than on the outcomes for socially isolated individuals. According to Putnam, participating in social network and voluntary organisations is essential for life satisfaction (Putnam, 2000) and this is more inclined to occur in the context of democracy. Consequently, a high stock of social capital should lead to more effective societies because it enables collective action. It is, therefore, pertinent to explore the perceptions of social networks and capital formed in the context of PB programmes and their connection to improved well-being for residents.

Grootaert (1998) argues 'Social capital is the glue that holds societies together and without which there can be no economic growth or human well-being' (Grootaert, 1998, p. iii). A similar view is expressed by Wampler (2007b) stressing that involving local citizens in the PB process fosters community cohesion and increases social capital. An example is seen where the Tower Hamlets Council spent £4.8 million over two years to run PB annually, and two primary outcomes were increased social cohesion and social capital within the borough (SQW Consulting, 2011). Despite the differences in the strength of results and challenges in

conceptualisation and measuring social capital, there is a consensus in the literature that social capital is an important determinant of health and well-being. Social capital has been associated with both positive and negative effects on health. Several studies demonstrate that people with a broad range of connections in the community have access to greater resources, hence improved personal well-being (Halpern, 2005; Helliwell and Putnam, 2004; Helliwell, 2007) and are therefore healthier. Civic participation also prevents social isolation, thereby improving people's diverse connections (Putnam, 2000). As people participate in their communities, their civic skills increases, and they become more competent as they become involved in decision-making (Lerner and Schugurensky, 2007; Talpin, 2007). Participation also improves the feelings of being a public citizen and a part of one's community (Michels and De Graaf, 2010). Consequently, people feel more responsible for public decisions. All these accumulate to improve people's sense of well-being.

2.10 PB and inequality

Improving the health and well-being of individuals and communities is vital for public health internationally. Inequalities in health are the avoidable, unjust and unfair differences in health and well-being and life expectancy that exists between groups; in particular between the rich and the poor (Whitehead, 1991; Whitehead *et al.*, 1992). These differences result from the conditions in which people are born, grow, live, work and age called the determinants of health (Wilkinson and Marmot, 2003).

Dahlgren and Whitehead (1991) give the most comprehensive illustration of these wider determinants of health and demonstrate a causal relationship between how they interact with each other to either promote both active and protective influences on lives or undermine health and well-being, both for individuals and communities. Reducing the burden of disease and tackling health inequality through action on the social determinants of health is a priority for public health (WHO, 2011; CSDH, 2008; Lim, 2006; Marmot *et al.*, 2010; Annan, 2000; WHO, 1986; Marmot, 2005). However, little is known about alternative methods through which citizens' health and well-being can be improved. Hagelskamp and colleagues propose an argument for three mechanisms through which PB can reduce health inequalities in US municipalities (Hagelskamp *et al.*, 2018). These pathways include improving psychological

empowerment, building a robust civil sector association and resource distribution to more impoverished neighbourhoods.

2.10.1 Psychological empowerment and inequality

Psychological empowerment is the focus of many CD approaches. It is defined as the psychological feature of the process which enables people and communities to take greater control of their lives (Christens, 2012). Psychological empowerment is linked to improvements in mental well-being in adolescent research (Zimmerman *et al.*, 1999). In addition, research reveals that certain types of CE and political participation can improve health and well-being outcomes. For instance, Radcliff and Shufeldt (2016), in their study of the effect of direct democracy on the quality of life, conclude that involvement in democratic initiatives improves individual well-being, especially for individuals with low-income levels. Similarly, Frey and Stutzer (2002) argue that direct democratic institutions could result in higher subjective well-being rates because of increased participation opportunities. They further assert that democratic processes may serve as methods for citizens to directly control policy, leading to a greater sense of control in their lives. This results in individuals feeling that their voices are more potent in government and can contribute to making a difference in their community. The immediate improvement of health and well-being in more deprived communities can bring about a reduction in inequalities.

Although Frey and Stutzer's (2002) findings show the implicit positive relationship between direct democratic initiatives and subjective well-being, they did not explore the personal experience of improved well-being from participating in a democratic initiative like PB at a local level. Hagelskamp *et al.* (2018) conclude that for PB to reduce health inequalities through increased psychological empowerment, it needs to involve people from deprived communities who experience poorer health and well-being. This is in line with other PB research in health (Gonçalves, 2014; Touchton and Wampler, 2014) , which include the urban poor in decision-making to improve their lives. To explore psychological empowerment in PB programmes, Hagelskamp *et al*. (2018) suggest that "future research should explore the perception of fairness and inclusiveness in the PB implementation process". The authors also suggest that future research should examine whether participation in the ideation phase of the PB process had a different impact on the individuals compared

to the voting phase alone. This is because the contribution to the idea phase requires a substantial time commitment and investment in residents and provides sustained engagement opportunities which should be more impactful on psychological empowerment. As far as I know, my research is the first to explore the health impacts derived from the CD stages of the PB programme, from ideation to the voting day, as well as those derived from participation in the projects commissioned through PB.

2.10.2 PB, grassroot organisations and inequality

According to Hagelskamp *et al.* (2018), PB strengthens communities beyond the individual level by allowing community-based organisations and other grassroots groups to meet and engage in partnership working which can be beneficial beyond the PB process. In examining the impact of participatory processes in Brazil, Coelho and Waisbich (2016) found that the engagement of grassroot based organisations in political processes led to increased mobilisation of community-based organisations and empowered civic sector groups which could push for better policies leading to reduced inequalities. Touchton and Wampler (2014) found that PB programmes were strongly associated with increases in civil society organisations. This means that PB may have potentials to influence community-level changes through an empowered civil society sector structure and collective action to demand policy changes for health.

Hagelskamp *et al*. (2018) reveal that PB advocates in the US emphasise the critical role community-based organisations play in supporting PB to attain its potential for reducing inequalities. Elected officials in the US report new civil society alliances forming in their PB processes (Hagelskamp *et al.*, 2016). Furthermore, community-based organisations (CBOs) in the US play a significant role in engaging disadvantaged communities and hard to reach individuals. PB also strengthens opportunities for collaborative working, building new relationships, stronger ties and improves relations with the government that enable CBOs to work together to advocate for policy changes that can reduce inequalities. The authors stress the need for future research to focus how PB impact on community-based organisation.

2.10.3 PB, resource distribution and inequality

The discussion surrounding PB's ability to reduce inequity relates to its relationship to social justice (Fung and Wright, 2003). PB, beginning at Porto Alegre, Brazil was designed as a pro-poor process which aimed to redirect capital funds from wealthier neighbourhoods to residential areas with the greatest needs, especially targeting people living in most impoverished communities (De Sousa Santos, 1998). The outcome of this redistribution in Porto Alegre was massive.

The types of projects that gain PB funding are one mechanism for reducing inequalities. This is because PB allows citizens to choose interventions that are more likely to respond to their needs. According to Hagelskamp *et al.* (2018), the process of PB raises awareness of community needs that are unknown under normal electoral processes. The authors suggest that if project ideas beneficial to people with the most needs get prioritised and win, it may lead to a more equitable distribution of public funds through PB. Furthermore, if the projects with the greatest needs do not win funding, it may raise awareness to elected officials where spending needs to be prioritised (Hagelskamp *et al.*, 2016). If the funding distributed by PB is more likely to benefit the well-being of the most impoverished residents, PB may contribute to a reduction in inequalities with time.

Proponents of PB argue that it allows 'historically excluded individuals' (most often poorer people) to become gradually included in decision making for improved health and community well-being (Wampler, 2012a; De Sousa Santos, 1998). The inclusion of these excluded groups steadily leads to wealth distribution to poorer areas that better their lot. This finding is important because they force us to think about what happens with inequality when poorer people are empowered through a shift in the environmental and structural determinants of their health. Previous research on the impact of PB on inequality in the UK only focused on equality of access to the implementation process and community events (O'Hagan *et al.*, 2019). Still, it did not tell us anything about the impact of PB on the inclusion of the historically excluded people to decision making and services commissioned through PB. RDPW is known as the most deprived community in Haringey. Investigating how PB affects the health of residents in RDPW is, therefore, an opportunity to add to the debate of

how the adoption of PB may contribute to reducing inequalities through access to decision making and health information.

A systematic review by O'Dwyer *et al.* (2007) states that there is limited evidence demonstrating the impacts of community-based health interventions that reduce health inequalities. The authors suggest that further evaluations need to focus on project outcomes to draw firmer conclusions. Therefore, this thesis explores the potential for PB to contribute to decisions for improving local provisions for health and well-being, leading to reduced inequality. Consequently, my research explores how people who encounter the phenomenon of PB make meaning of their experience of health and well-being as well as inequalities.

2.11 The PB process

There is no consensus on the typology for PB due to its global diffusion and the varying evolving models. This is because PB is context-specific and therefore, not a one size fits all phenomenon (Krenjova and Raudla, 2013). According to Wampler, PB programmes in Brazil are designed to respond to the social, political and economic situation of each city or state (Wampler, 2000). This is true for many cities and countries of the world. In the UK, the Department of Communities and Local Government's national evaluation reviewed varying types of PB processes describing the processes and principles that guide the delivery (DCLG, 2011). Sintomer *et al.* (2008) proposed six typologies of PB to enable a unified/measurable definition across the globe.

2.11.1 PB process in Brazil

The PB process in Porto Alegre, Brazil, is often cited as the ideal type. In his guide to PB, Wampler (2000) synthesised evidence of the most representative forms of PB in Brazil. Here meetings are held throughout the year to enable citizens the opportunity to prioritise public policies, allocate money and monitor public spending. The programmes are designed to ensure poorer citizens are well represented, and public resources are redistributed to poorer neighbourhoods. Wampler (2000) suggests the PB process is initiated by government and citizens to (a) encourage public learning and active citizenship, (b) realise social justice through better policies and allocation of resources, and (c) reform the administrative processes. This arrangement challenges the social and political exclusion of people with low income, allowing traditionally excluded citizens to take an active role in making policy decisions. Wampler

(2000) states that PB rules are complex but sets out the responsibilities of governments and residents who actively participate. These rules govern the meeting procedures and decisions for allocating scarce resources. Local actors, including local government officials, citizens, voluntary organisations, NGOs, and the business community are included in the process. The PB process in Brazil uses local area meetings to prioritise and determine how budgets should be spent based on the population and levels of poverty. This could be through direct representation in the local area or through representatives who attends regional meetings where a broader range of priorities are decided. The government then implements the policies while citizens monitor the delivery of prioritised programmes. This priority setting and allocation of funds in PB have mostly been advantageous in improving the quality of life of citizens through popular spending on health care, education, sanitation, water supply and road paving.

2.11.2 PB process in the UK

For over 14 years, PB has been adopted in the UK to commission a diverse range of programmes. Its application has occurred in many settings, including local, ward and borough levels. An example is the 2014 Manchester PB police programme to reduce the impact of criminal activity and the fear of crime in deprived communities. A sum of £150,000 was spent reconnecting affected communities with functioning and legitimate decision-making while improving community trust with service providers and giving voice and ownership to community leaders to make their neighbourhood safer for all (PB Network, 2014).

Although there have been pockets of PB programmes commissioned through mainstream budgets, most have been small scale grant-making processes (See Escobar, 2018, and 2021 for a description and examples of a grant-making processes). By 2014, £28 million was allocated through PB processes to programmes and several UK local authorities and NGOs increasingly use PB for commissioning programmes, including those tailored to reduce health burdens and inequalities (McKenzie, 2014). For instance, by 2008, Tower Hamlets had spent a budget of £4.8 million across four local partnerships to improve local services voiced by the community over two years.

The PB process in the UK is also wide-ranging depending on the context and reason for adoption. But the method of recording these in still underdeveloped. The main source of

information about these programmes is the PB Network, a voluntary organisation that advocates and supports the implementation of PB in the UK. PB processes in the UK involve a total number of participants ranging from a hundred to thousands in large processes. The scale of PB processes has been from a single neighbourhood level to local authority. Currently in Scotland the PB process is expanding to 1% of the mainstream budget, based on an agreement between the Scottish Government and the convention of Scottish Local Authorities (Escobar, 2018). Other PB processes in the UK remain faithful to the community funds at the local and city level type described by Sintomer *et al.* (2008). The national evaluation of PB by SQW for the Department of Communities and Local Government in 2011 reports that during the set-up stages, PB participants ranged from six to thirty-one people at neighbourhood-level activity to between twenty and over sixty individuals in local authority-wide level. In most cases, these participants were not only involved in deciding various elements of the process but were involved in managing the process.

In other parts of the UK, there have been similar PB processes using small pots of money from NGOs and matched funding from local councils. The PB Network website catalogues PB case studies around the UK covering themes around health, environment, housing, neighbourhoods, policing and young people. Some of these processes are one-offs, and others have run for multiple years. Although PB in the UK varies, they follow Wampler (2012a) four core principles which he claims determines any successful PB. These four principles include voice, vote, social justice and oversight. Other ideas suggested by UK scholars expand these core principles to clarify aspects of PB design and delivery (Harkins and Escobar, 2015; Participatory Budgeting Unit, 2009). The different forms of PB in the UK generally start with a defined budget for a fixed purpose. Residents are then invited to identify and prioritise needs. Individuals or grassroots organisations are then invited to develop proposals. The proposals are then presented to the residents on a community event day, and the projects with the most votes are funded. Although evidence of impacts of the PB process on health is scant, five in-depth case studies of PB in Manton, Newcastle, Stockport, Southampton and Tower Hamlets indicate that PB processes can increase community involvement, self-esteem, self-confidence, community cohesion and community pride (SQW Consulting, 2011). Gains were also recorded in terms of reduced costs, the efficiency of projects and services. The surveys conducted in these five sites also revealed that PB made residents feel empowered to exert influence over local decisions which boosted self-confidence in being able to make a difference in their

community. Contributing to one's community is an element of the definition of mental well-being. Several other recent case studies can be found on the PB Network website.

2.12 Evaluating PB in community health interventions

Campbell *et al*. (2018) suggest processes through which PB may impact on health, social and economic outcomes of participants involved based on UN-Habitat and World Bank reports (Cabannes, 2004a; Shah, 2007) and research by (Boulding and Wampler, 2010). The authors affirm PB can impact health through participation, collaboration, prioritisation and allocation of resources to identify needs resulting in greater use of public funds and budgeting accountability (see Chapter 8 for more details). To enable rigorous evaluations of PB programmes, it is essential to identify and understand the building blocks (inputs, key activities, processes or pathways) of the intervention under scrutiny and the likely outcomes or impacts that may result. A logic framework helps to identify aspects of a programme that needs evaluation and the methods (quantitative or qualitative) to apply.

Chapter 7 of this thesis presents a logic model derived from my reflection of the literature, fieldwork experience, interview analysis, and interpretation of case study data of interventions selected for this PhD thesis from the PB WLP2 programme. The logic model specifies the key enablers, the nature of the CD approach (PB and WL combined) that can happen, the key activities that may improve health and well-being, and the short-term, intermediate, and long-term outcomes that may result when PB is well implemented. This model aims to support the evaluation of health interventions globally.

2.13 Chapter summary

The review of empirical studies highlights the role of PB in enhancing the spending patterns of governments on health and well-being infrastructure leading to improved primary health indicators of poverty, infant mortality and social well-being for years. However, most existing studies focus on mortality-based health indicators, while some highlight that PB can improve health and social well-being. Furthermore, most of the studies focus on secondary quantitative data from population studies in Brazil and fail to account for the variability in health dimensions within the context of local settings of deprived communities in high-income countries such as the UK and the US. Finally, the studies infer a positive relationship between PB and social relationships, social networks, and social capital, and these phenomena directly

impact individual and community well-being. But to date, there is limited evidence of how these outcomes are realised in PB experiments with people living in deprived communities.

While the efforts of the preceding authors of PB, democracy and health are commendable in pointing us to the possible connections between the adoption of PB and health improvements realised, it is significant to note that this has revolved around the same authors. This revelation calls for inquiry into the authors' bias, e.g., how the argument for PB and health has been presented. Moreover, from the reviewed literature, it is evident that there is a pending gap in documenting the citizens' health experiences from their perspective, suggesting a need to refresh the PB research on people who participate in PB programmes. Therefore, it has become imperative to conduct research within PB programmes to understand how participants experience PB or make sense of how PB contributes to transforming their lives and that of their communities, particularly what processes engineer change for different dimensions of health and well-being.

Chapter 3 - Methodology

3.0 Introduction

In this study, I used a single embedded case study design (Yin, 2003; 2009) informed by the constructivist grounded theory (CGT) analysis method (Charmaz, 2006) to develop a framework proposing theoretical generalisations. The theoretical generalisation sought to demonstrate how PB could improve health and well-being in a deprived community. I describe the theoretical frameworks, my researcher stance, study protocol, case recruitment, and data production methods following the design description. Lastly, I present my approach to data analysis to enhance the study's trustworthiness.

Research aims and research question

My study sought to develop in-depth interpretive case descriptions of health impacts of the process of PB (Case 1), and three exemplar health interventions commissioned by PB (Case 2, 3, and 4), through a CD programme. This was to develop an understanding based on a cross-case analysis, of the processes through which PB may promote health in a deprived community. This study answered the question:

How does PB promote health and well-being among people living in a deprived community through (use within instead) a community development programme aimed at health and well-being?

The following sub-questions helped guide the research process:

1. What is the impact of the PB process implementation on health and well-being for reducing inequality? Or how did the PB process improve health and well-being or reduce inequality during the implementation of WL?

2. How and why did the PB commissioned projects improve health and well-being or reduce inequalities?

3. What are the commonalities and differences between the intervention cases in terms of design, delivery and health and well-being outcomes realised?

4. What are the challenges and benefits of participating in a PB programme?

3.1 Research design

Case study design

Case study design is appropriate for investigating a case: "a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident" (Yin, 2009, p. 18) or the researcher has little control over the phenomenon and context (Robson, 2011; Yin, 2002, p. 13). The WL approach as a complex and multifaceted CD programme, incorporating the added layer of the PB element, certainly involves a blurred distinction between phenomenon and context since contexts are different across and within communities. However, Hayes (2022) argues that the case study design being a methodology and method is well-positioned to support researchers with the means of systematically analysing and framing research investigations into context-specific evaluatory research or navigating the intervention design's overall complexity.

Case studies are identified as empirical inquiry useful in addressing "how" and "why" questions about the phenomenon of interest in circumstances that present with a range of factors (Merriam, 1998; Yin, 2009), as those experienced in communities. Case studies can create a hypothesis as well as test a priori theory (Flyvbjerg, 2006; Yin, 2009). Case studies provide a systematic way of exploring events, collecting data, analysing data, and reporting the results (Bass *et al.*, 2018). Consequently, case study researchers are best positioned to understand better why an event occurred the way it did and what might be significant to investigate in future research (Verner *et al.*, 2009). Since PB is a new phenomenon in health, my research aimed to explore contextual events in PB WL programme to create a framework to explain how and why health and well-being is realised through PB processes.

A case is "a specific … complex, functioning thing" (Stake, 2003, p. 2), such as an individual, a programme or an event, like the PB commissioned projects and consequent processes discussed here. My understanding of the case boundaries evolved, as is known with qualitative case studies. I responded to the participants' understanding of my inquiry which at times involved varying CD events occurring in the borough, unrelated to RDPW or projects commissioned through the PB process. This responsiveness illustrates my conscious effort as a researcher to be open to unexpected perspectives arising during case assignments and data collection.

Merriam (1998) defines qualitative case study research as "an intensive, holistic description and analysis of a bounded phenomenon such as a program, an institution, a person, a process, or a social unit" (p. xiii). Stake (1995) defines it as a "study of the particularity and complexity of a single case, coming to understand its activity within important circumstances" (p. xi). Merriam and Stake's definitions provide the opportunity for researchers to put a fence around the phenomenon of study within a well-defined context (Yazan, 2015). Furthermore, Merriam's definition is broader than the ones provided by Yin and Stake and presents the flexibility within qualitative case research strategy to study more varied types of cases (Yazan, 2015).

A single case study involves the in-depth analysis of a single case and can be holistic or embedded (Yin, 2003, 2009). This case study is an embedded case and involves analysing of sub-units within the case (e.g., the WL PB health programme). I gathered data at the programme level (e.g., programme implementation of the PB process - Case 1) and from three PB funded projects (Case 2 - Community Kitchen (CK), Case 3 - Women Together Network (WTN) and Case 4 - Tottenham Folklore (TF)). The research focus remained on the core participants (actors) who took part in the process and those who experienced the projects with the most intimate connection to the phenomenon under examination. Participants who helped the examination of the sub-units of analysis (embedded unit) included the PB facilitator, community members, council public health executives, other council officials and colleagues working with WL.

Two eminent case study scholars, Robert Yin, and Robert Stake suggest different rationales for examining a single case. Yin (2009; 2013) explains that a single case study may provide opportunity to test an existing theory, an extreme case or unusual circumstance or a common case where the case serves as a revelatory or longitudinal purpose. This study explores PB in health interventions, as a common case, using a longitudinal examination to reveal the potential social processes which offer health and well-being benefits to people in a single, low-income urban neighbourhood (see Yin, 2009; 2013). Specifically, the Well London PB programme allowed me to observe and analyse the PB in health phenomenon (common case) which was previously under researched or ignored- combining three rationales for employing a single case study (see Yin, 2013, pp. 49-53). In contrast, Stake seeks to study a case to understand its particularities (intrinsic case study) or answer a research question, a puzzlement, a need to get

a general understanding or insight into a question while studying a case (instrumental case). Both Yin and Stake also discuss justifications for studying multiple cases. Yin (2003) explains that analysis across cases within multiple case studies, may demonstrate comparable results (literal replication) or contrasting results for predictable reasons (theoretical replication), and suggests the identifying of variables across cases to illustrate predictable differences. On the other hand, Stake seeks variety across cases to ensure richness and depth to understand the shared phenomenon of interest (Stake, 2000). Stake's rationale notes the possibility of oversimplifying the complex interactions across cases that may not necessarily be predictable. Yet, Yin and Stake agree that the multiple case study allows the opportunity for the development and elaboration of findings among many cases (Yin, 2009; Stake, 2005). Although not addressed by Yin or Stake and not seen with previous single case studies, I progressed to employ a cross-case analysis that allowed me to examine common or different relationships across case elements.

Strength and limitations of a single case study

The selection of multiple cases risks reducing complex cases to a few comparable variables, resulting in the loss of the intrinsic characteristics of individual cases (Stoecker, 1991). To mitigate this risk, Creswell (2013) suggests that researchers select no more than four cases to examine, allowing enough exploration of individual cases. By these statements, Creswell and Stoecker refer to multiple case studies (holistic or embedded). In this thesis, I applied this principle to selecting only four embedded cases within a single case study. Bass *et al.* (2018), suggest that single embedded case studies are suitable for exploratory research (hypothesis development) and longitudinal case studies (as in this study) offer better confirmability. This longitudinal case study examined the WL PB implementation process and three projects commissioned by PB offering a range of health and well-being initiatives amidst different contexts and community groups and providing the opportunity to identify common and distinct processes. These selected cases within the WL RDPW initiative help to ensure the relevance of findings to health intervention implementation models within deprived communities of London.

In comparing the single case with the multiple case study, Leonard-Barton (1990) asserts that a single case, longitudinal study is low in efficiency with the danger of data overload and the production of much unusable data compared to a multiple case study. Furthermore, objectivity

is endangered by researchers becoming too deeply involved and developing unconscious biases. In examining a highly context-specific process, pattern recognition can tend to be microscopic. In terms of establishing internal validity, however, the single case study has a better opportunity to demonstrate cause and effect in a longitudinal study. The single longitudinal case study also has the advantage of showing a sensitivity of constructs (context and changes) over time compared to multiple case studies done at one point in time. To maximise the strength of this single embedded case study, I researched onsite over 16 months while engaging optimal reflexivity and constant critical reflection of the research process with my supervisors.

This study is characteristic of an instrumental case study (Stake, 1995; 2000) that explores more significant phenomena. An instrumental case study helps to illuminate an issue, a theme, construct generalisation or build a theory (Stake, 2005; Stake, 1995). The broad phenomenon examined in this study is the adoption of PB within a CD approach for improving health, which required a single embedded case study design, analytic in nature to develop a framework highlighting critical aspects of the phenomenon within a real-life setting. An analytical case study includes descriptive data "used to develop conceptual categories or illustrate, support or challenge theoretical assumptions held before data gathering" (Merriam, 1998, p. 38) instead of simply describing each case's events. As little is known of the role of PB for improving health and well-being and reducing inequality within a local context, an instrumental case study was deemed suitable for this exploration.

Research paradigm

This research, positioned within the constructivist paradigm, was conducted using qualitative methods, beneficial when exploring a topic, such as the impact of PB on health and well-being, which is not easily well-defined and does not have a robust theoretical base (Creswell, 2013; Patton, 2002). Constructivism assumes that individuals construct the meaning of experiences and events, and therefore people construct the realities in which they participate (Charmaz, 2006). From this standpoint, the research aimed to elicit and understand how research participants create their individual and shared meanings around the phenomenon of interest. Also characteristic of constructivism is a similar construction of meaning by researchers that "their interpretation of the studied phenomenon is itself a construction" (Charmaz, 2006, p. 187). This shared pattern permits the co-construction of meaning by participant and researcher.

In determining and prioritising patterns within and across the PB projects, the resulting interpretation of my findings is noted as 'interpretive theory' (Charmaz, 2006, p. 126-127).

The acknowledgement of co-construction of experiences and meanings about the phenomenon of interest by the researcher in constructivist research constrained me to conduct research in a reflective and transparent process (Mills *et al.*, 2006). Reflection demanded me to recognise that I was the primary instrument of data collection and analysis (Creswell, 2014) and acknowledge my background, professional identity, familiarity with the context, and biases I bring to the research process (Mason, 2017). It involved "thinking about the conditions for what one is doing [and] investigating the way in which the theoretical, cultural and political context of individual and intellectual involvement affects interaction with whatever is being researched" (Alvesson and Sköldberg, 2017, p. 245). In conducting this study, developing reflexivity raised my awareness of the personal and professional biases I may have brought into the research.

My knowledge and experience of PB and health interventions as a research assistant on previous WL programmes may have caused bias in my worldview of health promotion. Therefore, I needed to begin the study by practising reflexivity about PB in practice and residents' experiences of health; I needed to reflect on how my thinking, feelings and beliefs may influence the data I collect, analyse, and interpret. Reflexivity is "an approach in writing qualitative research in which the writer is conscious of the bias, values and experiences that he or she brings to a qualitative study" (Creswell, 2013, p. 300). Reporting my assumptions and experiences through writing reflective and analytical memos assisted me in achieving transparency (Mills *et al.*, 2006) and ensuring that the findings were based on the data and not on my own beliefs and perceptions.

Furthermore, I realised that my research assistant role in previous WL sites gave me an insider perspective during the research process. My insider perspective strengthened my views, and my contribution to the research setting was worthwhile and positive (Creswell, 2014). In this way, my insider status allowed for prolonged exposure and insider knowledge of the context. Such prolonged exposure to similar research participants and communities enabled better understanding and representation of multiple influences. My knowledge of the research setting enriched my attentiveness, knowledge, and sensitivity to various challenges and issues faced

by residents in a deprived community setting. Throughout the research process, I developed good relationships with the participants while retaining my credibility as a researcher.

Theoretical framework of the cases

In addition to leaning towards a macro-level constructivist paradigm in which this research is positioned, Yin (2003) and Stake (1995; 2000) advocate the importance of establishing a specific theoretical or conceptual framework that structures a case study. Yin supports the development of theoretical propositions from the onset of research but notes that exploratory designs may not offer such propositions (Yin, 2003). However, because this case study is exploratory in nature, I turned to Stake's suggestion of stating the main "issues" to sharpen the focus on the complexity and contextuality of PB and the health phenomenon under investigation (see Table 3.1). Stake suggests: "issues are not simple and clean, but intricately wired to political, social, historical, and especially personal contexts. Issues draw us toward observing, even teasing out, the problems of the case, the conflictual outpourings, the complex backgrounds of human concern" (Stake, 1995, p. 17).

Table 2.1 The initial issues shaping the research

Issue 1:	What contextual factors and mechanisms are in operation within the Well London PB programme in this low-income urban UK setting?
Issue 2:	How does the Well London programme adopt the different ideas and strategies of the PB initiative? For instance, how involved are the residents in decision-making and how democratic is the PB process?
Issue 3	To what extent and in what ways does PB influence the different dimensions of health, well-being and inequalities through the implementation process or projects selected?
Issue 4	What problematic or beneficial dimensions of their experience with PB do stakeholders or residents refer to?

According to Stake, as a researcher better understands the cases, the issues identified at the start of the study evolve because they become influenced by the emic issues the study participants raise (Stake, 1995). In this study, I explored the particularities of each embedded case and used the cross-case analysis to explore shared and different issues.

3.2 Data collection processes

Case recruitment and selection

Before recruitment, ethical approval was obtained from University of East London Ethics Committee (UREC) in April 2017 (See Appendix A). Maximum variation and purposive sampling technique (Patton, 2002) was employed to identify cases among nine commissioned projects that showed varying practices and different contexts while offering different provisions. Purposive sampling enhanced the richness and depth of data collected in this study. See Table 3.2 below for criteria for types of case selected, participants' recruitment details stakeholder categories.

The study inclusion criteria were:

- Community members/residents who co-produced (co-design, and co-delivery) the CEAD process of WL including the prioritisation process community action workshop in the implementation. These residents included the WLDT and resident association board members.
- The PB facilitator, WL programme managers, public health officials and regeneration officers from the council involved in co-designing, co-commissioning, and co-delivering the WL and PB process
- Residents who co-designed and co-delivered the PB process. These were the WLDT and resident association members.
- Residents and non-residents who pitched or delivered at least one PB project
- Community organisations who attended the PB day or supported the PB projects
- Participants of the projects/interventions including volunteers (residents and non-residents)

The following four cases examined in this study were purposively selected as best suited to answer the research questions:

1. Case 1, the WL Phase 2 (WLP2) PB process implementation which was co-produced with residents and facilitated by an experienced PB practitioner

2. Case 2, Community Kitchen (CK) project in which the project lead was a resident of RDPW, a North London ward who bid and won £3000 to run a healthy cooking and eating project
3. Case 3, Women Together (WTN) project in which the project lead was a resident of the Tottenham ward, who bid and won £3000 to provide a project for women who had experienced or were still experiencing domestic violence
4. Case 4, Tottenham Folklore (TF) project in which the project lead was a Haringey resident (but not a resident of the research site) who bid and won £5000 to provide a theatre project to community members

Table 3.2 Recruitment criteria, case type and participant category

Participant category	*Case*	*Criteria*
Programme leaders; facilitators; coordinators; community members, bidders, or Providers	Process (Case 1)	Stakeholders involved in co-designing/ co-producing, planning, delivering, and monitoring of the PB process including residents and community organisations who attended the PB event.
Community members	Intervention (Case 2, 3 or 4)	Residents attending any of the intervention projects
Project providers	Intervention (Case 2, 3 or 4)	Residents or local organisations who applied to deliver an intervention through the PB process

A more detailed description of the cases is presented in Chapters 5 and 6. I employed pseudonyms to represent the names of the three interventions above to assure anonymity. Below, Figure 3.1 illustrates the single case study with its embedded units of analysis where the phenomenon of interest is PB and health and well-being in a deprived community. RDPW is the single case study, and the PB process, WTN, TF and CK are the embedded cases.

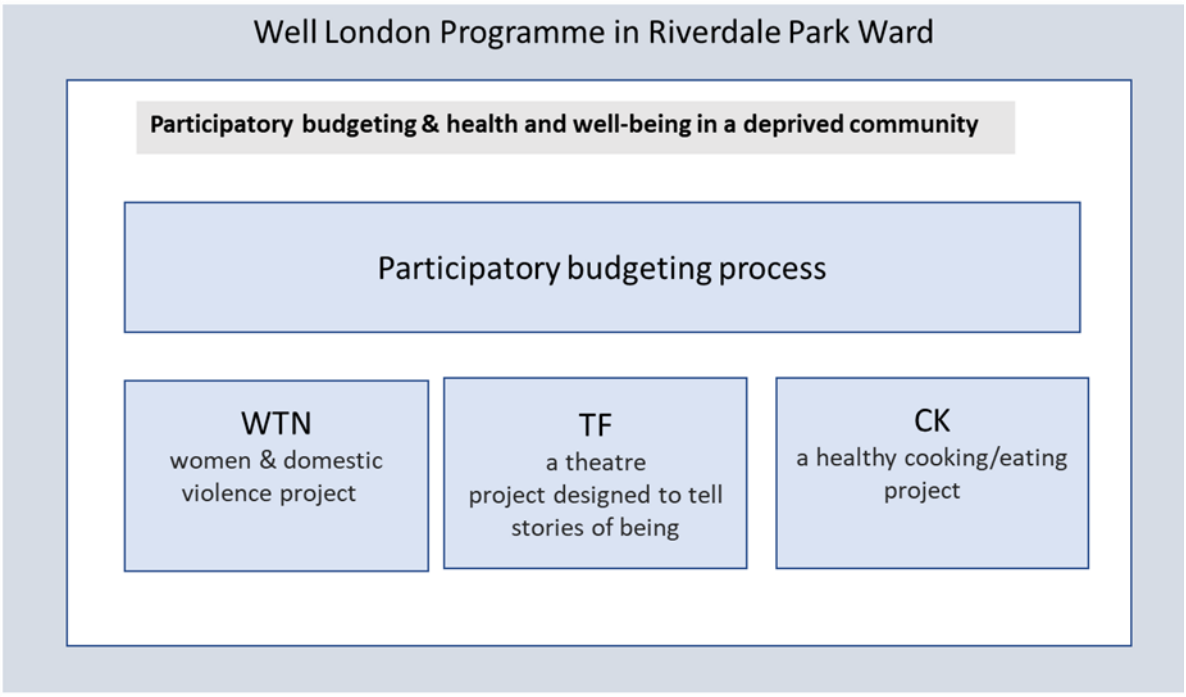

Figure 3.1 Defining the case and its embedded multiple units of analysis

Adapted from Yin (2009, p.46)

Site entry

Approval to use the site for study was obtained from executives of Haringey Council's department of public health. The email correspondence was then presented to UREC for approval to enter the site. After UREC's approval, I joined a series of the steering group committee meetings as well as separate meetings with community members for planning and delivering the PB process. I also attended the PB event day and subsequently the three projects for 11 months on a weekly basis. Attending these meetings enabled me to liaise with programme managers, PB facilitator, council staff and project leads who oriented me to the site (Creswell, 1998). After this stage, participant recruitment began, and a letter of information and consent was sent to each participant through email or in person before the commencement of interviews (See Appendix B)

Participant recruitment

Participant recruitment occurred in two phases: the process case study and intervention case study phases. The process case study recruitment began on 4th March 2017, at the PB event day. I approached over 30 participants for their contact details based on their participation in the event including the project leads who won the bids as well as non-winners. I then emailed or telephoned participants to gain consent for interviews. This effort yielded a few participants for the process case study. However, as I started to visit the sites and engage with the projects, I recruited more participants. Overall, 41 participants were recruited for both process implementation and project case study. Of the 41, 18 interviews were conducted with people who took part during the co-production of the CEAD, PB implementation process or attended the PB event day, while 23 (n10: case 2, n7: case 3 and n6: case 4) participants were interviewed for the project case studies.

In each case, the project leads, and I identified potential participants with varying knowledge of the WL and PB programme. Participants in each project included: the project lead, volunteers, project participants and representatives of community organisations/agencies supporting the projects. At every opportunity, the project leads introduced me to potential participants to enable me to gain rapport with them. The project leads sometimes approached potential research participants on my behalf to request an interview and letters of information and consent forms were provided to each interviewee. Other times they asked me to approach participants myself as I became more familiar with the groups. I negotiated with each participant a convenient time and place for data collection. I did not conduct any formal observations with people who attended the meetings but my role as a researcher learning about the impact of PB on health was generally explained. This allowed me to take fieldnotes as I deemed fit for each case.

Data generation

Information gathered for each case was guided by a data collection protocol consisting of the nature of the information to be collected and likely sources (Yin, 2003). Although I developed a protocol at the beginning of the study to guide data collection, the protocol was applied flexibly. I sought to collect a similar variety of information about each case to answer the topical questions of the protocol; nevertheless, I followed potential lines of inquiry as they emerged, which were unique to each case. The case study protocol for approaching individual

cases in this study is presented in Appendix C. The study protocol reveals a detailed summary of the information gathered at each case, including participants' characteristics and documents reviewed and the critical information collected. I aimed to combine Yin's case study protocol and Stake's issues in this study. In so doing, I distinguished between the initial questions of the protocol, which were informational like Stake's topical questions, and the issues identified at the start of the research, which were more problematic which helped me to understand the individual cases better. Emergent case-specific issues, which advanced over time (Stake, 2005), served as analytic tools instead of research questions to focus my attention on potentially informative events or dynamics and consequently deepened my understanding of each case.

As is consistent with Stake's (2005) constructivist approach and Yin's (2003) case study design, data collection methods in this study consisted of participant observation, document analysis, and in-depth semi-structured interviews. Information (e.g., field notes and documents) was gathered from the inception of the WL programme to the end of the fieldwork to enable me to capture process changes. I attended earlier planning meetings to initiate and deliver the PB process between December 2016 and March 2017, enabling me to observe the process and identify key players in the process for data collection purposes. Interview data collection occurred between May 2017 and June 2018, where 10 to 18 days of programme site data collection happened, with approximately three days a month per case to compile documents and preliminary analysis. Table 3.3 below details each case's type of data collection, amount and time spent transcribing and processing data.

Table 3.3 A summary of data collected from the four cases

	Case 1- Process implementation	Case 2- Women with domestic violence issues	Case 3- Healthy Cooking project	Case 4- Theatre project
Days on site	10 days	18 days	16.5 days	12 days
No of participants	18 people and 1 pilot =19	10 people	7 people	6 people
No of interviews	22 (total interviews – 4 of the project leads were interviewed twice)	11 (total interviews)	7 (total interviews)	6 (total interviews)
Hours of transcription and data processing	111 hours	32 hours	23 hours	16 hours
Field notes	15 hours of documented observations	28 hours of documented observations	23 hours of documented observations	12 hours of documented observations
Documents reviewed	25	16	13	11

Development of interview guides

Information gathered from the study protocol guided the development of the interview guides. I developed three sets of interview guides for the categories of participants I deemed crucial to the study based on the study protocol. The interview guides (see Appendix D) were quality checked and refined in collaboration with my supervisory team. Following this, the interview guides were tested by means of a pilot interview with a key participant with experience of planning and delivering the WL programme with the implementation of the PB element. The pilot interview data was not used to inform the content of the thesis, but the process was useful in testing the appropriateness and soundness of the topic guides. It was also invaluable in sensitising me of the complexity of the boundaries between WL, the PB process and the context, resulting in sequencing the questions and topics, organising of data, and providing initial thoughts for analysis.

When conducting interviews from a constructivist standpoint, I was mindful of Mills, et al.'s (2006) guide to interviewing to be flexible and reflexive to co-construct knowledge and interpretations with the interviewees. Interviews are the best resource for understanding the thoughts of research participants so that their knowledge, values, preferences, attitudes, and beliefs could be reflected (Cohen *et al.*, 2007). Charmaz (2006) explains that "the in-depth nature of intensive interviews fosters eliciting each participant's interpretation of his or her experience" (p. 25). Participant interviews were conversational, at convenient times for participants, in cafés, in project venues between session activities, and in parks. Furthermore, I minimised the power relationships between the interviewees and me by positioning myself as a graduate student seeking to better understand a phenomenon that had puzzled me from my own experience on previous PB programmes. To foster a sense of reciprocity with project leads and participants, I was involved in project set up and set down. I also shared information on key issues arising and some general highlights of research findings from earlier interviews when requested.

I developed a field note observation guide and focused observation guide (see Appendix E; E1) to help record observation during visits to events and projects. Interviews and observations were the principal sources of information, with documents gathered to provide background data and fill in gaps or details of events missed.

Data management

All interviews were digitally recorded, transcribed verbatim, and reviewed for accuracy. NVivo software (QSR International Pty Ltd, 2006) and Quirkos software (Quirkos, 2021) was used to manage the corpus of study data. The Case 1 interviews were entered into NVivo 12, while the data from Cases 2, 3 and 4 were entered in Quirkos. The field notes from observations, reflective memos and electronic copies of programme documents were manually analysed. I found Quirkos more efficient for data management, memoing and visualisation and I used it throughout the remainder of my analysis with reference made to NVivo for the Case 1 data. The confidentiality and anonymity of participants were upheld throughout data collection, analysis, and reporting. Pseudonyms were assigned to all participants and used in quotes.

3.3 Document analysis

Data obtained from various sources and perspectives can strengthen the robustness of the research findings. Documents are valuable tools for providing a rich source of information to complement the data collected through interviews and field observations. According to Yin (2011), documents can "yield invaluable data about things not directly observable" (p. 147) in case study design. Similarly, Merriam (1998) also explained that information from documents analysis could boost the credibility of the research findings and interpretations. In studying the impacts of PB on health and well-being, programme implementation documents, attendance registers, the Borough's health strategy, knowledge about the RDPW and email correspondences about the PB programme were collected and manually analysed to inform the research. I aimed to triangulate my findings of the analysed documents with those obtained from the interviews and the observations. Documents are "a good place to search for answers as they provide a useful check on information gathered in an interview" (Weiss, 1998, p. 260). During my fieldwork, I collected over 65 documents across the four cases from Haringey Council, University of East London researchers, and project providers. I familiarised myself with the documents manually and used the document analysis protocol (see Appendix F) to tease out information that helped me gain insight into the earlier programme delivery before joining, the need for PB in the process, and the level of involvement of community members. All this information aided my understanding of the nuances in the interview data and the interpretation of my findings.

3.4 Data analysis

Merriam (1998) suggests that case study methodology can apply varying methods of data analysis, including the constant comparative method of grounded theory. Grounded theory is a systematic and structured approach to data analysis appropriate when little is known about a phenomenon to produce or construct an explanatory theory that reveals a process intrinsic to the substantive area of inquiry (Glaser and Strauss, 1967; Bryant and Charmaz, 2007; Birks and Mills, 2015). A defining feature of grounded theory is its aim to generate theory that is grounded in the data. For data analysis, I employed constructivist grounded theory approaches (Charmaz, 2000; 2006; 2014) because of their power to develop theoretical constructs from the data rather than impose ideas from existing theories. A theory grounded in the data offers a better explanation than a theory borrowed "off the shelf," because it fits the circumstance, tends to work in practice, is sensitive to individuals in the setting and can represent all the complexities found in the process (Charmaz, 2006, p. 423).

The constructivist grounded theory approach of Charmaz (2000; 2006; 2014) is founded on the social construction of reality by Berger and Luckmann (1967). The social construction of reality recognises participants' agency as co-constructors of meanings and experiences with the researcher. In constructivist grounded theory the researcher seeks implicit meaning about values and beliefs exposed through immersion in the data (Charmaz and Bryant, 2011). The relationship between the researcher and the data, how it is generated and collected, determines the value it contributes to developing the final grounded theory (Birks and Mills, 2015).

The constructivist paradigm views knowledge as a "human construction", which recognises "multiple realities and regards the research process as one through which the researcher and the participants co-construct understandings" (Hatch, 2002, p. 13). Constructivist research aims to understand phenomena through the meaning participants assign to them. The researcher also takes part in constructing meaning as "their interpretation of the studied phenomenon is itself a construction" (Charmaz, 2006, p. 187). This collaboration between the researcher and the respondent helps to generate candid accounts of events about the phenomena (Creswell and Miller, 2000). In this PB health research, this collaborative approach permits the co-construction of meaning by the inquirer and the study participants to inform a comprehensive model that encapsulates the processes through which PB impacts health and well-being and reduces inequalities.

The constructivist grounded theory can strengthen the analysis method while maintaining the participant's voice. As case study methodology can employ a range of analysis methods, Charmaz (2000; 2006) confirms researchers can use grounded theory techniques with varying types of data collection and within different qualitative traditions. Following this tradition, I used a case study design to guide data collection, and constructivist grounded theory analysis methods (Charmaz, 2006) to enable the insightful and systematic questioning of data to allow the development of a substantive theory.

Data analysis was conducted in two phases: Phase 1 was the independent, in-depth description and analysis of each case; and Phase 2, the cross-case analysis of Cases 2, 3, and 4. Preliminary data analysis occurred simultaneously during data collection, in which preliminary case summaries and reflections on the research questions were developed and discussed with my supervisory team. In line with qualitative case study methodology (Stake, 1995; 2005), topics were identified that informed the individual case examination. During data collection, preliminary data analysis built upon such issues, which then informed further data collection.

Stage 1: Individual case descriptions and analysis

In this single embedded case study, I focused on the case description of the process implementation (Case 1) and the interventions (Cases 2, 3, and 4). Each case was analysed and written up separately, providing a contextual description and interpretation. The stages of constructivist grounded theory analysis Charmaz (2006) informed the analysis of data gathered from each case before I turned to a cross case analysis. The following section details the processes in coding and analysing each case and the cross-case analysis. During the individual case studies analysis, I noticed core patterns emerging that highlighted why PB may influence health and well-being through the commissioned projects. This led me to conduct cross case analysis, although I am yet to access a cross case analysis of sub-units in single embedded case study design.

1. Line-by-line open coding

Line-by-line coding, also known as open coding, was used to code initial stakeholder interviews from each case. For example, the interviews included interviews from the PB facilitator, one project lead, one public health lead from the council and one community member who took part in the process. The open coding of different stakeholders exposed me

to multiple perspectives early in the coding process. At this stage, Charmaz (2006) suggests searching for implicit assumptions, illuminating actions and meanings, comparing data with data, and identifying gaps in the data. Although most of the coding was done using NVivo and Quirkos, initial coding was first done manually using MS Word.

As part of the initial coding, I generated in-vivo codes. These are "codes of participants' special terms" and help the researcher stay close to the participants' views and actions in the coding itself (Charmaz, 2006, p. 55; Gioia *et al.*, 2013). These codes are also known as first order codes (Gioia *et al.*, 2013). Two transcripts of interviews from Case 1 were checked by two of my thesis supervisors at this stage. After that, potential emerging concepts and processes that informed the subsequent analysis stage were discussed at our supervisory team meeting. In line with a constructivist approach, this informal analyst triangulation fostered further reflexivity and deeper questioning of the data as these 'new sets of eyes' requested additional clarification and shared impressions of the data. Line-by-line coding was repeated across all cases comparing data with data as analysis progressed.

The process of open coding in my research produced over 800 codes. This signified the point where I "felt lost" in the data, with no solid idea of how to make sense of the data. Although it was very overwhelming, at this point, I had become immersed and remarkably familiar with the data. Gioia (2004) suggests that it is essential to get lost at this stage and fondly says ''You gotta get lost before you can get found.'' This vast number of initial codes made me recognise the complexity of coding and interpreting data. Some of these codes contained just a single segment of data and did not see how they connect with the rest of the data. In contrast, others included multiple segments - the greater the number of references within a single code, the greater the density of that code. Nevertheless, the density of a code does not necessarily indicate its relevance to the research objective; dense codes may inform ideas, actions, or processes frequently occurring in the data. Examples of initial codes and the segments of data which each represent can be seen in Table 3.4 in Appendix G.

2. Focused coding

Focused coding is used to classify the most significant and frequent codes from earlier selected codes under broader conceptual frames to facilitate theoretical development. Some focused codes were contextual in nature and helped to organise the happenings at events and the

projects while others were conceptual, such as demonstrating the potential processes emerging. Some examples of contextual codes included groupings such as “money was an incentive”, “money trickling down”, “difficulty to engage”, “types of projects”, and “self-perception of unhealthy.” These codes were further divided into major topics or sub-codes that captured activity and movement, using the gerund form for labelling. Gerund forms are recommended to use when coding because coding with gerunds “helps to define what is happening in a fragment of data” and to “see implicit processes, to make connections between codes and to keep their analyses active and emergent” (Charmaz, 2006, p. 164). For example, ‘money trickling down’ was broken down to *‘beliefs about money’* and *‘money was an incentive’* showing how PB money was a catalyst for getting people involved. Conceptual codes included *‘community* deliberation and decision-making’ *‘feeling good*, *‘helping out’ ‘feeling entrusted’, ‘coming out’*, *‘feeling safe’* and *‘giving back’.*

3. Theoretical coding

The following coding stage was deciding how the conceptual categories emerging from focused codes related to each other and can be done through theoretical coding (Glaser, 1978). Theoretical coding moves the analysis towards a more abstract, theoretical level and helps you tell a coherent analytical story about the phenomenon (Charmaz, 2006). Its aim is to explore relationships between the conceptual categories that emerged during focused coding and synthesise them into more abstract, core categories. This process was challenging because it aims to create broad, solid concepts that can be synthesised in a theoretical model representing how PB can influence the health and well-being of the individuals in the community. In so doing, I sought similarities and differences among the many different categories. This process helped me reduce the relevant categories to a more manageable number of core categories (e.g., 30 or 35). Core categories are central to illuminating the nature of the phenomenon under investigation from the researcher’s perspective. During coding, the researcher is sometimes struck by emergent theories, theoretical constructions and ideas about data (Alzaanin, 2020).

These categories I developed helped to elucidate the nature of PB and health within the context of WL and with this deprived community. I was occasionally struck by emergent theories, theoretical formulations, and ideas about the data. For instance, the frequency of the mention of PB money was striking and suddenly it struck me that apart from the financial value of money, money was important to the participants for its social value. So, I named a core category

'the social value of money' which came from 'money as incentive', 'money trickling down', 'feeling entrusted' or 'invested in'. I gave these categories labels or phrasal descriptors, e.g., *'connecting with other people'*, '*creative partnership working', 'strong volunteering ethos,* and *'building positive relationships.'* While doing this, I tried to retain respondents' terminologies and consider the array before me. At this point, I turned to precepts by Gioia *et al.* (2013) to ask questions of the data such as "Is there some deeper structure in this array?" treating myself as the knowledgeable co-constructor who can or must think at multiple levels at the same time. That is both at the level of the informant terms and an abstract (second order codes) theoretical level of categories, dimensions and broader narrative and codes, - answering pertinent questions like "What's going on here?" theoretically (Gioia *et al.*, 2013). By so doing, tentative answers were developed to this question following "gestalt analysis" (the whole of anything is greater than its parts) (Gioia and Chittipeddi, 1991), leading to the construction of other questions that helped subsequent interviews to pursue topics that were more focused on concepts and tentative associations emerging from existing interviews. This process is known as theoretical sampling developed by Glaser and Strauss (1967).

4. Memo-writing

A critical aspect of grounded theory to data analysis is memo writing, enabling a researcher to "capture ideas in process and in progress" (Charmaz, 2006). Memos are informal analytical notes I produced during the research process (Charmaz, 2006, p.72). Furthermore, memo writing was crucial for prompting me to analyse my data and codes early in the process (Charmaz, 2006, p.72). I wrote memos throughout data collection, transcribing and data analysis stages. After interviews, the memos I wrote helped me summarise pertinent ideas and potential questions for follow-up and emerging issues requiring further exploration. For example, I explored further the idea that people in the area were difficult to engage and the frequency of the mention of the PB money, what it meant for money to trickle down to the community, what money meant in general, and why such tiny amounts meant anything at all. Considering Charmaz's early and advanced memo questions, (Charmaz, 2006, p.80-81) each emerging category prompted, the reconstruction of data in new ways. During this analysis stage, all data and memos associated with a category were gathered and examined through questioning (Browne, 2003); for example, how is this category the same as, or different from, other categories? What connection can I make between this category and other categories? Comparing concepts within and between key categories enabled me to explore potential

relationships between context, actions and consequences within cases helping me make connections between categories and sub-categories. The memo writing was mainly concerned with comparing codes and categories by employing the constant comparison technique (Charmaz, 2006; Glaser and Strauss, 1967; Gioia *et al.*, 2013).

5. Diagramming and memo sorting

In this study, diagramming and memo sorting was essential for enhancing the distilling of core categories of the emerging grounded models which demonstrates the process through which PB influences participants' health and well-being. In addition, memo sorting and summary diagrams of an individual case was examined and compared to other cases. This process allowed for further clustering of similar themes or categories linking the experiences of PB to participants' health outcome.

6. Development of core categories

In anticipation of cross-case analysis, the main processes pertained very loosely to common elements across cases, including how PB influenced the design and delivery of the projects and how the project leads worked in partnership with residents and community organisations. It was also essential to explore processes enabling project participants to act on the social determinants of their health to improve health and well-being as individuals and collectively as a community. Although I analysed each case separately, issues from previous cases unavoidably influenced subsequent data analysis by raising additional questions. Data analysis and interpretation continued during the writing process revisions of the three case accounts. Throughout the writing process, I critically examined and clarified concepts responding to my supervisors ongoing analytic questioning as well as my own and other colleagues.

Stage 2: Cross-case analysis

In stage 2, I compared the main categories of each case to explore how different contexts and processes varied across the cases. Next, I cross-examined key issues identified for each case to extract common issues. As I progressed to the cross-case analysis stage, I examined case-specific issues to identify those that affected all cases. In total, six cross-case themes were developed by comparing and merging salient case-specific issues. Next, I established eight cross-case issues relevant to all cases; these helped structure individual case accounts that

facilitated cross-case comparison. A list of these emerging issues is found in Appendix H. Charmaz's stages of final analysis (diagramming and memo-sorting and identifying core categories) were re-visited to explore and question data combined from the three cases. Finally, memos from key categories and individual cases (Cases 2, 3, and 4) were examined across cases to determine loosely common and contrasting processes relating to how PB might have influenced the programme, interventions, project leads, or project participants to improve health and well-being. Comparing the main categories across cases helped explore how PB engineered different processes to enhance health and well-being. The refining of concepts and relationships continued during the writing process and the conceptual diagram development.

Although cross-case analysis is mainly done with multiple case studies, I found it helpful in exploring the role of PB in influencing the health and well-being of residents through the design and delivery of Cases 2, 3, and 4.

3.5 Trustworthiness

The trustworthiness of the findings weighs the validity and reliability of qualitative research. Trustworthiness is a set of criteria used to judge the quality of a qualitative study (Bryman, 2016). Lincoln and Guba proposed four criteria for assessing the quality of qualitative research namely: credibility (referring to internal validity); transferability (external validity/generalisability); dependability (reliability); confirmability (objectivity) (Lincoln and Guba, 1986). I will now discuss how I have addressed each of these criteria in my thesis.

Credibility

Credibility assesses whether the research findings are a credible representation of the conceptual interpretation of the data based on the participants' original data (Lincoln and Guba, 1986, p. 286). Credibility deals with the question, "How congruent are the findings with reality?" (Merriam, 1998). Prolonged engagement in the field, analyst triangulation, peer debriefing, and data and method triangulation can enhance the credibility of a qualitative single embedded case study design findings. I was onsite for six weeks to collect data for the PB process (Case 1) and one day a week for eight months in each of the intervention case study (Cases 2, 3, and 4) so that I could collect extensive data from multiple sources. Another way of ensuring credibility was through analyst triangulation. Excerpts of two transcripts from two interviews were reviewed and coded by myself and my Director of

Studies to deepen the first order or initial codes. This process helped me to discuss emerging issues with an experienced qualitative researcher who encouraged sophisticated abstraction by raising additional questions for consideration. Peer debriefing occurs when the analysis of findings is presented to a peer to explore meanings, interpretations, bias, and inconsistencies (Lincoln and Guba, 1986). The process of peer debriefing happened through presenting various parts of my data analysis to my supervisors for extensive discussions. To ensure data and method triangulation, I collected field notes of observations, semi-structured interviews, and documents. Combining these three processes strengthened the credibility of my findings.

Transferability

Transferability is the extent to which the research findings can be applied or transferred beyond the boundaries of the setting (Merriam, 1998, Lincoln and Guba, 1986). A strategy that enhances the transferability of qualitative studies is collecting detailed, thick descriptions through open-ended questions to prompt detailed, lengthy, and contextualised responses. This process allows the reader to determine how closely their situations match and whether they can transfer the findings of this study to their local context. In this thesis, I assured transferability through the thick description of data cluster and the context within which PB was adopted within the WL programme with the intent of providing readers adequate information to reflect on their situations to compare the research contexts (Lincoln and Guba, 1986; Firestone, 1993).

Dependability

Dependability addresses the issue of reliability similar to quantitative research (Shenton, 2004). It is the extent to which the study can be replicated over time to produce similar results. A close tie exists between dependability and credibility, and in realising the one you may achieve the other (Lincoln and Guba, 1986). I achieved dependability by following the same procedure of data collection and analysis across all four cases. This was attained by using observation protocols, interview prompts, and documents analysis to cover the same core issues. The methods of data collection and data analysis employed in this research have also been described, to enable researchers who may wish to repeat it in similar context with similar participants to do so. The reflexivity I employed throughout this study also reinforces the dependability of my research. I kept a field journal during data collection and wrote memos of my reactions, decisions made and emerging interpretations throughout data

analysis. To further strengthen the dependability of my research, I documented the various stages of my data collection and analysis process through field notes and memos to construct an audit trail of the research process available for review by my supervisors, as necessary.

Confirmability

Confirmability refers to the level to which the research results can be verified, confirmed, and validated by others. (Shenton, 2004). It requires that the conclusions of a study are grounded in the participants' experiences and the data provided by them, rather than the researcher's intuition or own biases, preposition, and agenda. Member checking was applied to assure that findings reflect the participants' experiences and ideas rather than my own opinions (Shenton, 2004). Confirmability was enhanced in this study by maintaining a reflexive field journal through field notes and memo recordings of my feelings and insights emerging throughout the research process, to ensure that the findings were grounded in the data and not my beliefs or preconceptions. I also provided a clear audit trail describing how data was collected and derived and noted how I made decisions throughout my inquiry. On an ongoing basis, my interpretations of data were queried by my supervisory team to ensure the findings were based on participants' data. The data stored, coded, and analysed using NVivo 12 and Quirkos will allow data to be traced to the original sources through codes and categories.

3.6 Chapter summary

This chapter described the study's design as a qualitative, single embedded case study design situated within a constructivist paradigm. I presented the case study protocol that detailed the questions and sources for data collection and demonstrated how it provided a general structure for the topical data to be generated. The emerging controversial issues that arose during interviews with respondents deepened my analysis by directing subsequent questioning or lines of further inquiry. All processes surrounding case recruitment and data gathering methods were explained, including a summary of the amount collected from numerous resources. I conducted semi-structured interviews, observations, and documentary analysis of the cases, resulting in a total of 41 interviews, along with about 78 hours observing (over eight months), steering group/community planning meetings, events and project activities and the review of 65 documents across the four cases. Furthermore, I described how constructivist grounded theory

informed my data analysis process using the constant comparison method, employing memo writing, diagramming and memo sorting to deepen the analysis process, while ensuring participants' voice and the data's contextual situation. Finally, I explained the methods I employed to enhance trustworthiness in this study.

Chapter 4 - Findings from the PB process implementation case study

4.0 Overview of chapter

This chapter presents the analysis of the data from 18 interviews undertaken with five groups of participants. They include programme managers from the University of East London (UEL), the PB facilitator, commissioners from the public health and regeneration team from Haringey Council, project providers and residents of a Tottenham ward. These respondents were people involved in various stages of planning, design and implementation of the PB process. The chapter begins with a brief description of the respondents within the sample and goes on to consider the experience of PB within the WLP2 programme which took place between 2015 and 2018 at a ward in Tottenham, Haringey. It will focus on six main themes throughout the data, which provide a temporal account of how residents expressed their beliefs and experiences of health and well-being and about inequality during the process of PB.

The six main themes have been categorised as "*beliefs about health and well-being", beliefs about inequality, "impact on health", "impact on well-being", "impact on community health and well-being", and "impact on inequality".* These themes describe sequentially, events connected to respondents' beliefs and experiences: leading up to the PB event day; the periods immediately before and during the event day; and lastly, participants' effort to ensure the community benefits from the PB programme. This effort refers to *wanting what is best for the community*. Not surprisingly, some residents experienced difficulties during the PB implementation process. I represent this by a *sub-theme of well-being impacts* titled "expressing negative experiences and feelings of the PB process".

4.1 Respondents' characteristics

A total of 18 interviews were undertaken with participants of the CD process up to the PB event day (i.e., WL CEAD and PB implementation processes). The strategies included planning, prioritising, co-designing, co-producing and delivering the PB event day, which happened at a community school in Tottenham, Haringey, on the 4th of March 2017. On the PB event day, residents commissioned nine health and well-being projects through public votes to allocate funding.

A summary of respondents their role and duration on the programme is shown in Table 4.1 below. The findings in this chapter represent the views and experiences of twelve female and seven male participants whose names I have pseudonymised. Participants were between 28 and 80 years and either lived or worked in the research site in Tottenham except for the PB facilitator and the UEL programme managers who were hired to deliver the programme. Findings from documentary evidence (see Appendix I) were also used to complement the results from the interviews, including transcripts of PB event day video, recording the views of participants.

An exciting inclusion of respondents is two residents (Lily and Naomi) of the Riverdale ward who joined the programme in 2015 as WL delivery team (WLDT) members (WL volunteers). Entering from the programme's onset allowed them to participate in the comprehensive community engagement assessment and design (CEAD) process to identify, design and prioritise the needs of the study area. They undertook health improvement and capacity building training organised through the Royal Society of Public Health (RSPH) and Haringey Council, respectively. This process empowered them and about 20 other residents to support health awareness campaigns in the community and develop ideas for the planned interventions. They also participated in the planning and delivery of the PB event day, which took place on the 4th of March 2017, as well as pitching and winning some funding to deliver their own project co-produced during the CEAD process. Including them shed light on events occurring from the earlier stages of the programme to the delivery of the interventions conceived at the beginning from the perspectives of community members.

Table 4.1 Respondents' characteristics: Process case study

Participant Name (pseudonym)	Stakeholder group/role	Gender	Length of stay in project before interview
Gabrielle	WL programme manager; UEL	Female	2 years
Genevieve	PB facilitator	Female	1 year
Amelia	WL Programme manager, UEL	Female	2 years
Moriah	Funder: public health manager Haringey Council	Female	2 years
Fernando	Funder: Regeneration officer, Haringey Council	Male	2 years
Melissa	Funder: public health manager Haringey Council	Female	1 year
Lily	Resident/provider	Female	2 years
Naomi	Resident/provider	Female	2 years
Alice	Resident/provider	Female	1 year
Lauren	Non-resident provider	Female	6 months

Elliot	Non-resident provider	Male	8 months
Miguel	Resident provider	Male	6 months
Elia	Provider/dance director at TF	Female	6 months
Zahra	Resident	Female	1.5 years
James	Resident	Male	6 months
Kathleen	Resident	Female	2 years
Mathew	Resident	Male	2 years
Raymond	Resident	Male	2 years

Research question

How does the process of PB impact on health and well-being or reduce health inequality in a deprived community?

Lines of inquiry

1. *How do stakeholders believe or perceive the PB process is impacting on health and well-being of residents?*
2. *How do stakeholders believe or perceive PB is impacting on health inequalities in a deprived community?*

4.2 Beliefs about health and well-being

Across the dataset, themes about beliefs and experiences of health and well-being were identified among all respondents. At the beginning of the discussions, the respondents talked about their general beliefs about health and well-being as it relates to *personal perceptions of health* and *community health.* These responses preceded questions like "how did you get involved in the programme (residents or providers)" or "why did you decide to use this approach to deliver the programme (commissioners and programme managers)? There were also many references to money being important to improve health and well-being, but this was mostly concerning money reaching down to the community - *money trickling/filtering down*. Although beliefs about health was not an initial concern of this study, these emerging findings revealed important insights about different stakeholders' beliefs of health, well-being and inequalities both of individuals and RDPW community.

These revelations showed the interest and commitment of multiple stakeholders to become and stay involved in the WL programme and PB process. It also reflects on the later opinions and experiences of health and well-being and inequality in relation to PB. These included expressions of psychological or mental well-being, social well-being and physical well-being.

Table 4.2 Thematic framework representing themes, categories and codes discussed below.

Themes	***Second order concepts or categories***	***First order concepts or codes***
Beliefs about health and well-being	*Perceptions of self-health*	*- not healthy at the time* *- not used to going/coming out; self-isolated* *- housebound narratives* *- displaying self-belief*
	Perceptions of community health	*- knowing the best for the community* *- communities are far better at outreaching* *- millions and millions of pounds does not necessarily impact on community health* *- millions of pounds have not made a difference*
	Perceptions about money and health	*- PB money stretches further* *- PB money forces providers to think about how projects will meet needs* *- PB money makes communities think about health* *- housebound narratives*
Beliefs about inequality	*The value of money*	*- money trickling/filtering down* *- engaging community*

		- communities taking control *- making a difference* *- upskilling and training community*
Impact on health	*Impact on healthy eating*	*- informal learning of healthy eating* *- up taking healthy cooking* *- critical consciousness about general health* *- causing a ripple effect*
	Impact on physical health	*- knowledge of community safety* *- being less isolated* *- coming out* *- impact on physical inactivity* *- difficult to engage* *- sense of purpose*
Impact on well-being	*Psychological, emotional and mental*	*- positive emotions; joy, love, happiness* *- feelings; feeling good, feeling valued, feeling confident, feelings of belonging, feeling entrusted* *- gaining confidence* *- becoming resilient* *- gaining and exercising agency* *- personal growth* *- self- worth, self-esteem*
	social well-being	*- connecting with people*

		- having a sense of belonging *- having a sense of ownership* *- building positive relationships* *- having a sense of purpose,* *- having a sense of pride* *- making positive difference and contributing in the community*
	Negative feelings about and experience of PB process	*- feeling angry, frustrated, dissatisfied, disappointed* *- feeling stressed* *- feeling anxious* *- relieving stress*
Impact of community health and well-being	*Perceived impacts on community well-being*	*- building community spirit, sense of community* *- partnership working* *- collective voice in decision-making and action* *- community awareness and health literacy* *- increasing community responsibility* *- realising assets* *- connecting communities* *- building social networks* *- community cohesion* *- social integration*

		- building trust
Impact on inequality	*Impact on social determinants of health*	*- increasing sense of ownership* *- increasing community responsibility* *- transitioning to employment* *- transitioning to education*

4.2.1 Perceptions of self-health

Some of the respondents acknowledged they were unhealthy before the programme. This self-perception contributed to a willingness to volunteer in the WLP2 programme and support of outreach to the community. For example, Lily reflects on how her interest in WL came from knowing: *"I [she] was not healthy at the time".* She said, *"I used to eat a lot of junk, a lot of takeaways".* The comment illustrates a key belief that residents viewed themselves as unhealthy.

This self-perception of unhealthy behaviour was essential for joining WL and beginning their journey to PB. When asked why she joined the programme, Lily expressly said: *"What made me become a part of Well London, was when they were talking about health and well-being".* Lily believed joining WL would help her improve her health. She displayed a health-seeking behaviour and the willingness to engage with a programme that can help her make this change. From this behaviour, I could sense that lay people in this community possess the critical consciousness and aspiration to attain and maintain positive health and well-being and needed some support to achieve their goals.

Lily's concept of negative self-health underpinned her journey into PB and resilience to see the programme to the point of ideating and pitching for her project developed through active involvement in training and workshop activities. These workshops and activities were designed to upskill residents to create and bid for projects responsive to the community's needs. Lily was also concerned about the safety of her children in the community. She had just moved into the

area and perceived the health dangers for her children. This knowledge encouraged her to connect with community activities to find ways to help. Lily said the WL PB programme offered this opportunity.

Similarly, Zahra, a resident, said she had become isolated and disconnected from the community since she married and had children.

> *I've been working in different schools, but since my marriage and my children, I stopped working, it's about 9 years now. Now I'm doing volunteering with Naomi in the women's group (Zahra).*

Zahra was drawn into the programme by Naomi, who lived on the same street with her. Zahra believed being at home prevented her from connecting with other people and getting to know what happened in the community. When asked to explain further; she said: *"If you're isolated, for example, you will be lonely… if you come here your mind will become… fresher."*

When I was in the room with the women, I could feel what Zahra meant by the mind becoming fresh because you appear to forget about the stress in your world and enjoy this new sense of being and freedom created by this community of women. By this quote, Zahra acknowledged she was missing out and showed her belief that connecting with other people was essential for her mental well-being. This belief made Zahra volunteer for the Women Together (WTN) project that won the bid. I coded this issue "*being isolated*", "*housebound narrative*", and *"connecting with other people"*. Women like Zahra were viewed as housebound professionals in Haringey. When talking about women that have joined the programme, Fernando, a regeneration officer from the council, said, *"The women that have left their houses… if you look at some of these women*, *we assume as professionals, they are housebound to a certain extent yeah"*.

Being housebound is recognised as a significant problem in RDPW. A high proportion of residents in this area are employed in low-level jobs or unemployed and receiving benefits. Unemployed people or people in non-rewarding jobs can experience low self-esteem and isolation, contributing to physical inactivity and mental illness. Factors such as education, employment, housing, crime and community are known as the wider determinants of health which can influence the health and general well-being of a population as well as health

inequalities (Marmot *et al.*, 2010). These wider determinants of health also influence people's lifestyle, including diet, smoking, alcohol and drug use, as well as participation in physical activity. A key recommendation in the Marmot 2010 review on the social determinants of health suggests a condition for tackling health inequalities is to create opportunities for people to take control of their own lives. Addressing poor health and reducing inequality in this area of Tottenham was a core interest of commissioners in the Haringey Council as specified in the Joint Strategy Needs Assessment (JSNA) and health and well-being strategies 2015. To achieve this, the council adopted the WL programme with the PB element to enable active participation leading to the community taking control.

Contrary to the negative perceptions of self-health, some participants believed they were healthy and joined the PB programme to propagate healthy living through their existing community projects. For instance, Elliot had been overweight in his teenage years and lost his confidence. As a result, he took up a martial arts programme, lost weight, regained confidence, and started a martial arts programme to help people lose weight and keep a healthy mind.

> *…I started martial art and the weight started coming off, the confidence started coming and it helped me for those teenage years. It helped me find out who I wanted to be in life, you know, and most importantly I wanted to help people (Elliot).*

Here, Elliot expresses his belief in martial arts for losing weight and building self-confidence. This finding was interesting because it meant more residents like Elliot could be an asset to this ward through PB funding to pass on their learned healthy behaviours to others struggling with their health.

Elliot expressed his belief in other ways martial arts could be beneficial to health and mental well-being.

> *I lost my brother in 2001 which was obviously a difficult time… and it had a dramatic effect on my life… It turned upside down. It took me three years to kind of re-find who I was. A lot of pain and heartache, lots of soul searching, but I managed to get through those tough times and thankfully, I'm on the other side now. My belief and martial arts helped me through because it was about your mind, how to control your thoughts in terms of controlling depression, anger and all those feelings from the experience I had.*

Like Zahra, Elliot emphasised the belief in preserving the mind for protecting mental health. Although Elliot did not live in the area, but ran a martial arts project within the community, his belief in the effectiveness of martial arts for improving physical and mental health gave him the confidence to bid for some money to offer his project. When asked why he thinks the community believed in and voted for him during his pitch? Elliot said:

> *…I don't know, I mean you have to ask them directly what made them, you know, vote, but I can only say it is my honesty, I didn't come with any prepared presentation…Yeah, I mean, I've got a lot of self-belief. I mean I'm confident and I believe in what I am doing. That's come from my personal experience (Elliot).*

Elliot's belief martial arts could promote health and well-being led to his self-belief and confidence to pitch it to the community. However, from the community's perspective, it gave them confidence and belief that the community needed this martial arts project and voted for it. Therefore, I regarded "*self-belief"* as an important factor for providers to join the programme and "*displaying self-belief"* for residents to be convinced the projects were health-promoting. This is also an exciting finding because it meant the residents knew and wanted the best projects needed for improving health and mental well-being in their community (coded *"knowing the best for the community").* There is a common belief that individuals living in a community know best what is required to improve and maintain health. Respondents widely expressed this belief in the interviews and welcomed a chance for residents to decide the interventions on the PB event day. For instance, Genevieve explained her observation of the expertise and power of the community to discern what projects were beneficial to them on the PB day.

> *... I think they liked the sense of real power of deciding what went on in their communities... There were two projects that came under the Well Communities that pitched and presented. And from a professional standpoint, I sat and watched those projects, and these were projects for young people. But with my head on they weren't very well fleshed out and they made lot of generalisations about what and how they could deliver. They seemed a little bit unclear... But my concern on the day was the community would go oh young people let's give them a chance. But what I found was the community had the same reservations and they didn't get voted and endorsed by the local community. And not that I was happy it happened, but it reaffirmed the local*

communities are very good at sourcing out what will work in their areas and they are not afraid to put their vote down accordingly (Genevieve).

Elliot also emphasised the idea of community knowing best and the need for government to give decision-making power to the community to ensure interventions are responsive to community needs. As Elliot notes

I like the fact that it gave the power over to the ward to determine how the money is going to be spent. I'm a big believer in the community supporting itself because we are in the best position to know what our needs are, it's as simple as that… The government has to come down to this level you know… I mean come down and see what's going on (Elliot)

The emphasis on power in these quotes demonstrates the call for the government to adopt a community-level approach by empowering residents as experts at choosing responsive interventions. This belief that the community knows best was contested by WL managers, who believed that PB did not necessarily produce the best projects. Therefore, it was necessary to directly commission projects to respond to gaps arising from PB commissioning. However, direct commissioning should depend on the priorities set during the CEAD process suggesting what interventions would respond to the health needs and in line with the health policy of the statutory government. For instance, Amelia offers:

I think it's [PB] really beneficial in the sense of training volunteers. Volunteers get involved in organising it. There is a local ownership of the commissioning process. Uhm… it involves local residents commissioning which I think is really important. So, it's totally in keeping with the Well London's approach and ethos but I suppose I have worries… I don't really think that it necessarily results to the best projects (Amelia).

Amelia, as many professionals do, believed local people were not equipped to make the right decisions about best projects useful for improving health. She emphasised: *You have to be really careful to have strict parameters. So, you get the project you need.* Amelia had the experience of implementing PB in other areas across London and her worry was based on gaps she had observed when engaging PB commissioning. She believed local governments should

keep some money back to fill in gaps where PB fails to commission projects required to fulfil policy demands or prioritised needs.

> *...I don't think it replaces direct commissioning. So, what we've learnt in Well London is, it has its place, but you shouldn't use all the funds to commission through PB. And you need direct commissioning done by the local authorities normally, who is to see where the gaps might be (Amelia).*

Although Amelia's worries make logical sense, it negates broader belief and evidence about the impact of community involvement in decision-making and taking control of positive health and mental well-being (Pennington *et al.*, 2018). My observation of residents contesting for the projects they wanted, how they wanted people to be invited to the voting day and how the projects needed to be delivered to meet their needs during the planning stages led me to believe that residents knew what they needed to improve their own health.

4.2.2 Perceptions of community health

It was common knowledge that this study site in Tottenham was the most deprived in Haringey borough and corresponded with the poor health experienced by residents in the area. This knowledge was based on the health statistics of the borough and lived experiences of residents. For example, Melissa, a public health commissioner expressed:

> *It's our most deprived ward. It's the reason why it's been chosen as the target location… and we know deprivation has certain links with people's health outcomes. So, the more deprived you are, the poorer the health outcomes (Melissa).*

In this quote, Melissa emphasises the belief that deprivation was the cause of the negative health outcomes of people living this city of Tottenham and hence the council's buy in to the WL initiative for health improvement. Interview respondents commonly discussed how the CEAD process enabled the active engagement of residents and key stakeholders in co-defining the problems and co-designing solutions for this city. For instance, during the community cafés of the CEAD process, residents were asked questions like "what type of healthy city would you like to see?" These questions raised awareness of the health issues and caused discussions around what improvements residents wanted to see. Melissa believed adopting positive

language encouraged residents to assume the responsibility of changing the health narrative of the city.

> *And I think that's why people have really latched on to this and we've been positive in our language. [E.g.] "Do you want to have the opportunity to impact positively?" "Do you want to be able to do this and do that?" So, we've been careful with the language we use. People hate the way it's [city] described in our reports and things like that (Melissa).*

Melissa suggests that the people of this city loved their community and detest the negative connotations used to describe their community. According to Melissa, this love for their community activated resident's willingness to take an active role in the programme. This means that using positive language was important for evocating a positive response from the community.

Melissa also acknowledged that there were a series of health problems in the community:

> *So, we know that there is high drug use in the area, we know that there are crime and anti-social behaviour in the area. And there is high mental illness. There are lots of kind of different things (Melissa).*

This recognition of health problems in the research site by public health commissioners in the council informed the decision to prioritise the area for the WL programme. The council executives were willing to try a new way of working that would change this negative health narrative of the place. This was coded as "*buying into PB".*

From my documentary analysis and during fieldwork, I observed that the WL CEAD process helped created a critical consciousness about health among WLDT members (15-20 resident volunteers). These volunteers participated in several facilitated workshops and engaged in deliberations and pieces of training that created a *critical awareness* of the negative health statistics in Haringey. This process inspired residents to think of innovative ideas which could help tackle prevalent health issues in the city. Examples of such ideas included reducing isolation for disabled people, empowering women in violent relationships, uptake of healthy cooking and eating, a theatre programme for connecting people and learning new languages. These ideas led to the formation of core projects such as the wheelchair-based exercise group,

Women Together, Community Kitchen, Tottenham Folklore and Language fun club projects respectively. Three of this form the case studies for this thesis and will be further expounded in Chapter 6.

Other pieces of training received included interpersonal skills and community outreach which enabled community campaign to members of the community, particularly to those who do not traditionally engage. These were done through door-knocking, canvassing in public places and talking to friends and families to get involved. The RSPH delivered the health training, including the 'Understanding Health and Health Improvement Level 1 and 2'.

Cited as an important factor for mobilising residents to join the WL programme, was the perception this community experienced the poorest health in the borough. As Naomi, explained:

> *So, because of the statistics around mental health, and obesity and all those factors that contribute to residents not being well and being able to effectively carry on with their lives - as Well London volunteers, we came on board to see what we can do to connect with our own residents - Being residents ourselves and then signpost them you know, to make positive informed choices for their lives (Naomi).*

The understanding of the community's negative health statistics was also a reason for some of the WLDT members (e.g.: Lily) to staying on the programme. This general knowledge and belief of the deprivation and poor health in the community was a meaningful discussion at the interviews by many other stakeholders. For example, Lily and Lauren spoke passionately of their reason for being involved in the programme.

> *... Because this ward was one of the... still is I think - one of the most affected areas when it comes to health and mental health (Lily)*
>
> *Well, it is the poorest area of Haringey. I mean on every index, every criterion. So, it's got the highest unemployment; it's got the biggest crime rate; it's got the threat of the developments which is huge because it will devastate this area. You've got the highest number I think of beginner English speakers, and you got very little around in terms of ESOL classes and so on (Lauren)*

Apart from this general belief that the community had poorer health, there was a belief, communities are far better at solving their own problems. Genevieve's vast experience of delivering PB across boroughs of London strengthened her belief residents here could do same. When I asked her why she was keen on delivering PB in Tottenham, she said because:

> *…those communities I have had an engagement in PB end up better able to self-diagnose and self-cure empower themselves to bid for further money and out of very small projects come charities and not for profit organisations, and they go from strength to strength in delivering results in their communities (Genevieve).*

Genevieve notes:

> *I've had intimate knowledge and experience of where, when you give local communities the power and the opportunity to be their own problem-solvers, they not only do so, and do so very well. They are far better at outreaching and attracting the residents and communities they work in. They do far more with very small resources than large organisations do with thousand or if not millions of pounds (Genevieve).*

Many respondents agreed with Genevieve that communities were far better at solving their own problems and reaching out to other community members. These statements were coded as "*communities know better"*, "*communities are far better at outreach"*, and "*PB money reaches further*".

Fernando's comments about tangible successes of some of the projects, reflected in the following quotes, reiterates Genevieve's statement about PB money.

> *But there are real examples of success we can already touch. And not just success in the sense of seeing money really stretched in terms of the level of the activities that take place. So, in terms of like averages, projects have 35 people every week. You cannot feed 35 people on Tuesday afternoons for £3000 for one year. It is impossible to do that. They are extending their remit. But the good thing is PB enables people to do that. If I learn from you that I can add a food element to it with no extra cost, I will probably do that. Yeah, with £3000, If I was to fund a voluntary organisation, to come and deliver…they will deliver less… but these projects… they engage with around 25-35 people every week (Fernando).*

The belief that community members were far better at outreaching their communities was evident in the commitment of some residents who despite the one-year lag and problems

experienced in the programme stayed on to see their efforts brought benefits for the community. For example, Lily had some challenges during the process, but when asked why she did not leave the programme, she said loudly, "*because this ward needs help"!*

To further buttress Genevieve's point about communities being able to self-diagnose and use money prudently to solve the problems, Lauren's comment below was striking:

> *...But you have to think; you had to focus down, that was what was good about it, you had to focus down on why your project was going to help people in this area (Lauren).*

Lauren explains here that as a provider, you must show how your project can help the community if you would be voted to deliver. As noted by Lauren, there was a consciousness about the health needs attached to the money offered through PB. This consciousness meant individuals involved in the development of ideas and project for the bidding process needed to think deeply about how their projects would be responsive to these health needs.

This meant PB money links to residents expressed needs during the CEAD process and had to be fulfilled accordingly. Providers, therefore, realised they would not be getting any money if their projects did not align with the priorities set during the CEAD process. This belief expressed by Lauren relates closely to Elliot's self-belief in his project, where providers should be able to convince the community about the value of their projects for meeting community needs.

4.2.3 Perceptions about money and health

I observed that stakeholders viewed the PB money as an incentive for getting residents involved in discussing the health issues. The knowledge that residents could apply for the money sparked a curiosity about personal and community health. According to respondents, the programme raised individuals and grassroot organisations' interest in what health issues they could tackle if they won some money. When asked *how PB could help deliver the purpose of the Well London programme or the plan,* Genevieve noted explained PB increases individual reflections and collective interest about health in the community. It also generates thoughts and deliberations about how they could resolve these health issues.

> *Okay so, the PB process itself certainly is a tool for raising awareness… it's about health initiatives going on in the borough. So, when you put up these little pots of*

money, and you say it's about health, people start to think of what health is… and what it means to their community and what it means to them (Genevieve).

Smiling, she continued to say:

This means PB enables conversations about the meaning of health to begin in the community. They also think about how they can help improve and be part of that. The money itself incentivises people to get involved. It's not great riches but is a tool or resource that people can use. The mechanism for raising awareness just means that it goes out to people who are perhaps not traditionally engaged in improving their own health and well-being unless they hit a point of crisis. Unless they get diagnosed with err… diabetes, or they have issues of high blood pressure. A great majority of people don't go to medical practitioners unless they absolutely have to and therefore, they may have undiagnosed health-related issues (Genevieve).

Acknowledging that PB money is minimal for making huge impacts, Genevieve asserts PB money is a tool for raising awareness about health and attracts hard to reach people usually missed through traditional health promotion efforts to actively get involve. When asked to provide examples about the impact of PB in engaging members of the community, Fernando corroborates Genevieve's statement with his example about engaging middle-aged men.

Another example in the women's group. If you ask me there's lots more than normal going on. I mean just going back to the CK, in terms of the people being engaged at the CK… As an engagement officer, the hardest people to engage is middle-aged men (Fernando).

Fernando's problematic effort to engage certain members of this community is echoed in this quote. Engaging middle-aged men and married women in interventions was difficult from the council's perspective and by some respondents in this study. As Fernando notes:

There's a lot of narratives that get banded about, which is, the men go to work, and the women stay home to look after the children (Fernando).

This quote infers the *housebound narratives* earlier mentioned about women who do not traditionally engage. Genevieve believes PB money can attract a broader range of community

members because of the flexibility it allows for individuals to create fun activities that are attractive to community members.

> *But when you say there is a pot of money for health-related stuff and the community design and create really engaging, interesting, fun activities for people to do, it becomes less about health and more about the engagement of something that is fun that has health benefits to it… So, the PB process is a mechanism that enables that to happen (Genevieve).*

This quote suggests PB indirectly enables community members to act on their health through mechanisms devoid of rules and regulations of traditional methods of health promotion.

The belief about own health, perceptions about community and the belief about PB money were instrumental for various stakeholders to join and commit to the PB programme. The belief the PB process could support the delivery of positive health and well-being outcomes led to their involvement despite the difficulty this new way of working posed for them. This demonstrates when more individuals from deprived communities are attracted to health and well-being interventions through participatory mechanisms, there is a possibility that it may reduce inequalities.

4.3 Beliefs about inequality

Many of the participants expressed their opinions about reducing inequalities in communities from different perspectives. Beliefs about inequality were expressed by mainly professionals when asked why they decided to adopt PB or why they thought this approach would work. Their talks were focused on 'the value of money', 'engaging communities', and 'taking control'.

4.3.1 Money trickling down

This theme emphasised the value of money for reducing inequality. Money was important for reducing inequalities but not in the traditional sense of investing in healthcare delivery or using statutory providers. Across the different respondents, there was an agreement that large sums of money have been invested in deprived communities for years without making a difference in reducing health inequalities. For instance, Gabrielle and Genevieve commented that health

inequalities have persisted in London for centuries despite huge funding investments made by governments. Gabrielle was assertive about the lack of change in inequalities from the considerable investments in funds over the years. When asked the reason for using the PB approach, she states:

> *Well, it was on the basis that… we know inequalities [has persisted for years] … well take London as an example, so if you look at the maps of inequalities in London, they haven't changed, for not years, not decades but centuries. And all the public health and health promotion initiatives and the billions of pounds that have been invested in improvements in health care, increasing access to healthcare, what have we got? …have we got a reduction in health inequalities? No! Something is missing' (Gabrielle).*

Similarly, Genevieve comments:

> *I have seen millions and millions of pounds and been part of programmes, that have seen and spent millions of pounds in particular deprived communities and the responses have been varied and the recipients, the residents... engagement have been quite varied, and those communities have not necessarily been left more empowered for the injection of funding (Genevieve).*

These quotes infer the value of the money for improving inequalities lies in its approach of engaging communities and not in the volume. Naomi and Moriah were more specific, saying that the amounts of money that have been invested in this ward have made no difference for improving outcomes for people living here. From Naomi's perspective, money has not been spent in a way that made a difference (coded as *making a difference or filtering down*) in the community and clearly states:

> *My biggest experience of being engaged is that… a lot of things doesn't get filtered down to the community. So much funding and bids often come in the back of these heads, but it hasn't made a difference. Money is not filtered down properly and in regard to the level of deprivation. So, it would be good to make sure funding is filtered down properly and done so that the grassroots organisations benefit properly. There is*

> *still a lot of work needed to ensure that money reaches the ground and grassroot organisations (Naomi).*

Similarly, Moriah, who has worked in the community for about ten years, agreed despite all the money spent, poor health persists, and not much difference in health outcomes have been achieved. "*This community [RDPW] has had a lot of money thrown there previously and it hasn't made any difference, in terms of outcomes"*. This quote reiterates that spending large sums of money in a community does not necessarily translate to the desired change planned. When I asked Moriah why the council decided to adopt PB, she told me, *'…look I think it's a fantastic concept'*. For Moriah, it was about trying a different approach after many years of pushing the traditional delivery method. She admits the money was limited but acknowledged involving the community was necessary for bringing change.

> *So, although it wasn't a lot of money, I felt it might be rightly or wrongly helpful for getting people involved. It was something about local people saying this is what we're going to do. We're going to run the project - this is what we think is the priority, so it is giving power more. It's a shame it wasn't more money, but there you are, that's why... rather than council coming in and saying we think you need this… (Moriah)*

4.3.2 Engaging communities

Many stakeholders believed that directly involving individuals in co-producing and delivering the change they want to see is powerful in reducing inequalities in communities. For instance, Amelia asserts:

> *Well, PB is only quite a small element of the overall approach. But Well London is a co-production [approach] and CD programme. It's very much a bottom-up approach. It makes local residents as equal partners. It provides them with the skills to sustain the activities and to support each other to make healthier choices. And live healthier lives, and it builds stronger local communities. So PB fitted very well with that (Amelia)*

This quote illustrates co-production, a core element of PB, enables active individual engagement and made them feel like equal partners. This process of becoming equal partners, as Amelia notes, impacts on people's abilities to gain skills which help them better their lives, build healthier communities and, in turn, reduce inequalities.

Both Genevieve and Gabrielle also believed that the genuine direct involvement of individuals in the community could reduce inequalities. Gabrielle explains how this works in theory:

> *My theory is that the missing link in efforts to reduce health inequalities is communities determining and taking control. So, you concentrate your effort in a sort of proportionate universalism approach where you focus your investment in the most disadvantaged places on a sensible size to get the development of communities. And then what you see is… you bring those communities up nearer to the more affluent. So, the gradient is like that [gesturing with her hand], and you bring them… Sorry, you draw it up (Gabrielle).*

What Gabrielle explains here is like the "inversion of spending priorities" adopted by the PT to distribute PB money in the Brazilian cities of Porto Alegre and Belo Horizonte (Wampler and Touchton, 2017). Inversion of priorities was initiated through PB to reverse several decades of public resource spending favouring middle- and upper-class neighbourhoods to help poorer citizens and communities receive larger shares of public expenditure. It is a process of weighting votes to favour more impoverished and disadvantaged communities to reduce inequalities between rich and poor areas. Although the PB application was different in Tottenham, it follows the same principle of wealth distribution, allowing disadvantaged communities to benefit.

4.3.3 Communities taking control

More than engaging communities was the need for communities to take control of and transform the social determinants of health. For example, Gabrielle comments, "*the missing link in efforts to reduce health inequalities is in communities and communities determining and taking control"* of their lives. According to Gabrielle, it is about empowering the communities to develop skills and assets within the community that enable individuals themselves to take action to improve their own health. When asked what theoretical considerations were adopted to empower residents to take an active role in changing outcomes for inequalities, she states:

> *…it's empowerment, its building social support networks, connecting communities, a sense of place, skills, asset building, realising the assets that are there including - mainly the people themselves - skills development, hence our training communities programme (Gabrielle).*

During the CEAD process and the PB phase, activities and workshops were designed to upskill resident and grassroots organisations to create ideas for projects and bid for funding to deliver health and well-being interventions and inequalities. Many respondents argue PB was useful for empowering communities to take control. However, the themed projects that make it to the PB day are those identified and prioritised by the community in the CEAD process.

> *Which is why we always say, do PB because it is a process - it is empowering, and people feel more control. The fact that if it's done well and is based on community - identified themes or needs. The whole approach is about skilling up. In the process leading up to PB, there are workshops etc. for people who's got aspirations and ideas and helping them to translate those into a proposal and then into action. All of these is empowering for people involved in the bidding (Gabrielle).*

Extending the value of money was an essential notion for buying in to PB. Both professionals and residents emphasised that the value of money is extended when communities actively engage and take control to distribute money to projects that will improve health and well-being, ultimately reducing inequalities.

4.4 The perceived health and well-being impacts of PB

The terms "health" or "well-being" were used loosely by respondents in the process data to mean eating healthy, feeling well, feeling good, feeling valued, having a sense of purpose, connecting with other people, and having a sense of belonging (personal) or sense of community (social) and opening of the mind (cognitive ability - increased knowledge and skills) to a bigger picture transitioning to education or employment. These concepts of well-being suggest three aspects, which underpinned the development of health and well-being for those involved (professionals, providers and residents). Health and well-being were discussed in their broadest sense to incorporate social, emotional and physical aspects of life. These included expressions of psychological or mental well-being, social well-being and physical well-being dimensions.

Many stakeholders viewed the PB and the WL CEAD implementation processes as mechanisms for improving health. Participants highlighted many aspects of PB responsible for evocating positive feelings and actions as health-promoting. Commonly, when involved in activities that promoted their physical, emotional and social well-being, residents and non-

resident providers were more inclined to positively contribute to their own lives and the communities they lived and worked in. A core function of the PB element of WL was to train individuals to assess bids, complete a bid application and learn to present their ideas to residents for voting at a voting event. Therefore, the WL managers considered it a small part of the whole process and not capable of health benefits on its own. When asked what health and well-being benefits can be attributed to PB, Amelia replied:

> *Uhm well in isolation it will be quite limited. Uhm but as part of the programme it's very much a key thing about empowerment, giving people responsibilities and making them a part of the decision-making process. Which we know are health-promoting. So, that's where its benefit lies. And it's very similar in a way to the community engagement process, which does the same thing… So, it's giving people control… yeah it is empowering people… By listening to what they want... And by taking notice of that. So that's where the health benefits are probably around mental health… it gives people control (Amelia)*

Although, this quote suggests that the function of PB in WL is small, it highlights key pathways PB may influence health. It indicates that PB gives decision making powers and control to people which are important for improving mental health. Amelia also suggests listening to the community and taking notice of their needs empowers them and can be health-promoting. The quote aligns with findings from evidence reviews of Popay *et al.* (2007) and O'Mara-Eves *et al.* (2013) which suggest that engaging communities and giving control to citizens in deprived communities to act on social determinants of health are effective in enhancing well-being and human flourishing. Additionally, active participation in the WL process was demonstrated to have health benefits for people living in deprived communities (Derges *et al.*, 2014).

Many respondents suggest the PB implementation process enabled active participation, including upskilling and empowering residents to compete to act on the changes they wanted to see. In addition, parts of the PB process were seen to promote physical, mental and social well-being. The following quotes demonstrate health-promoting pathways that could extend beyond the PB implementation process.

Because they were going to take a prominent place in the delivery of PB, so, there was like a whole training scheme that was done around them. … I think for the community it would have made them feel empowered because they are making decisions about how this money is going to be spent and what they are going to benefit from it (Fernando).

So, it's quite empowering and skilling and what happens is that people generally might ask very good questions. And make good choices. So, it allows you to see democracy in action (Amelia)

…my experience of working on a number of projects over the time is people do gain knowledge, skills and experience and if I talk about Haringey in particular, I can think of two particular projects that went for funding. …they don't just go for the funding, I provide a support package behind them, which is how to apply for the funding? And how to write their bids and so on. I can think of two specific examples that have gained a great deal in terms of the direction they are going (…) even though they are just immediately recipients of the funding. So, they only just got their funding approved. They already got an eye into the future. They already want to learn how to write more bids and to apply for more funding in the future not necessarily just from this programme but wider (Genevieve).

The following sections reveal findings from analysis interviews identifying perceived increases in health and well-being benefits described by participants of the PB process.

4.4.1 Health impacts

The perceived health benefits for individuals and communities described by respondents include greater knowledge and awareness of healthy lifestyles, improved attitudes towards food, and willingness to exchange new foods with healthier options. For instance, Lily says:

The training was very good. The training made me swap from junk food to healthy eating. I used to cook a lot with meat and fish, but now I can eat vegetarian. It has impacted my kids… and I am teaching other parents how to cook and eat healthy meals… You know I am from an African background. (Lily).

This quote illustrates how participation in CEAD training and PB workshops led residents to learn to eat healthier and a readiness to share this new healthy habit with family and community members. The WL capacity-building training extended beyond individual improvement to community champions, who initiated projects through PB to influence whole communities. The emphasis on being African resonates with me and echoes everyday discourse about how African foods are unhealthy and incompatible with slim figures due to their high carbohydrate and fat content.

Commissioners and project deliverers observed changes in residents' attitudes and behaviour towards healthy living. As a result, some, like Fernando, became optimistic about the potential for the programme to generate significant shifts in healthy lifestyles in the long term.

> *...but also seeing the levels of sustainability. We see the people taking on not only the advice provided but what they've been learning on the ground or through this programme as part of their lifestyle (Fernando).*

Although such aspirations that PB programmes can cause long term changes in lifestyles may be idealistic, the short-term changes observed were significant. They contributed to individual and community investment, enthusiasm and motivation to support the projects to thrive and extend beyond the funding provided through PB. The relevance of this aspect of PB will be explored further in Chapters 6 and 7.

When asked to explain further what changes to lifestyle was being evidenced in residents' attitudes and behaviour, Fernando replies:

> *...especially in terms of like diet. I mean I get people like preaching to me about what I need to be eating [Laughing] and what I don't. And these were the same people you'd see them with boxes of chicken and chips all the time. So, the shift is already happening yeah. Which just need further support (Fernando).*

This quote illustrates the perceptions of other respondents (Naomi, Elliot, and Genevieve) of how *informal learning* of healthy practices could encourage successful personal and community shifts in healthy lifestyles. It also suggests observable shifts in eating habits which was initiated to enable PB project providers to become champions of change for lifestyle behaviours.

An example of such a shift initiated through *informal learning* during the PB day, was an encounter between Miguel and James. James believed he already ate healthily but Miguel who pitched and won a bid to supply fresh foods and vegetables to people in the community taught him a new thing about healthy eating.

> *…That guy [Miguel] who was talking about healthy eating. I went to him, and he told me that when you are eating a banana, the brown part is healthier that than the white bit because normally I cut the brown part out (laughing loudly). Which I don't do now (James).*

These sorts of conversations about lifestyle changes were common among residents as the PB money attracted residents to events, and information about healthy living habits became the topic of discussions among individuals and groups.

Another example is Lily, who speaks about being healthier from the knowledge gained from the healthy eating workshops. When asked how being involved impacts her daily living and made her feel she said:

> *It makes me feel good. I keep saying it makes me feel good. I keep saying much healthier. It makes me feel much healthier, I'm gonna say… much healthier because I eat healthy (Lily).*

Throughout the interview discussions, there was no mention of physical activity gains by the respondents. There was, however, mentions of outreaches and canvassing done by the WL delivery team members to mobilise community members and inspire people to take part in the WL programme. These activities meant these community champions were leaving their homes and walking from place to place to deliver flyers and talk to people. I saw these activities as unintended gains to physical activity during the PB process. For instance, on one occasion when WLDT and the RDPB were meeting with the PB facilitator to decide the venue for the event day, we walked around for about 40 minutes inspecting the halls until the residents agreed on the community school. This was a common practice with the planning process and meeting attendance.

According to Naomi, she felt good about the PB event day because it created an awareness for her project that inspired more women to join her project enabling them to leave their homes, reducing isolation. When asked about the impact of the PB event day on her daily life she said:

> *...It's good because you're changing your life... and you are inspiring others and women are inspiring others and people are less isolated. People are coming out and they are getting the help they need (Naomi)*

The phrase "coming out" in this quote indicates a physical move of people from their houses to get involved in the programme. This was a common observation among many respondents who said PB was fundamental for engaging residents in WL activities. As James notes

> *...I have been a counsellor in this ward 14 years and I do appreciate it's difficult to get people involved and even with a lot of regeneration going on where the council is trying to get people involved and is spending a bit of money and staff hourage. It's still difficult… Well, when there is money available, (...) people tend to appear. So, I was just interested generally yeah… I think it was good because it [PB process] did get people involved. So, I was impressed and to be quite honest, it makes a change to have some local residents having some input on where the money is spent rather than the council officers who probably none of them live in the area and they got their contacts they tend to use all the time… (James)*

This quote illustrates the expression of many respondents who noted the residents of this ward were very difficult to engage. However, getting involved in the PB programme meant people were getting out of their houses and taking an active role in deciding and delivering projects that might bring the change they want to see.

PB also provided a *sense of purpose* or a structure to daily living for some residents (Lily, Naomi, Alice) and non-resident service providers (Lauren & Elliot) who found it challenging or have never competed for funding through traditional methods of commissioning. For example, Lauren when asked how receipt of the funding has affected her daily life, said:

> *Oh, it's big, I have turned it on like a fulltime job [Both Laughs]. I realise I've bitten off - slightly more than I can chew. I will do it but it's taking 3 days a week. 3 workshops a week and then the rest of the term (Lauren).*

For this 80-year-old woman, getting her project commissioned through PB made her *feel entrusted* and increased the zeal in her to commit to working three days a week to ensure the project was successful. Thus, increasing her physical activity levels and for those who attended her project weekly. PB votes gave her the opportunity to deliver a project intended to improve people's sense of belonging and a sense of purpose which in turn made her feel entrusted by people's votes and gave her a sense of purpose. Feeling entrusted and having a sense of purpose was a common feature among providers who won money from residents' votes on the PB event day. Having a sense of purpose may have some association with being physically active because it made Lauren develop a plan to organise three workshops a week within different projects and enabled her to physically leave her house to recruit and engage community members who were known to be "*difficult to engage*".

PB was also mentioned as a mechanism which enabled the community to vote for projects which included physical activity themes to their projects. PB enabled Elliot to deliver a free martial arts project to people who could not afford to attend the gym. It was also common among projects who bid for the money to introduce an element of physical activity within their projects. This was possible because the PB money enabled them the flexibility to offer extra services for free.

4.4.2 Well-being impacts

The key aspects of well-being impacts identified during discussions with respondents about the PB process include psychological, emotional and social well-being. These dimensions of well-being relate to aspects of personal and community health and mental well-being. Comments such as *feeling good, feeling valued, connecting with other people*, *having a sense of purpose*, *having a sense of belonging, feeling or gaining confidence and sense of ownership* were consistent themes across the different types of stakeholders.

4.4.1 Psychological and emotional well-being

Gaining confidence

Most stakeholders described how residents gained confidence through participating in the PB process. Creating ideas to solve health problems in the community and bidding through a presentation to residents gave providers the opportunity to demonstrate ownership and

responsibility which were perceived to have contributed to feelings of value, accomplishment and a sense of pride. Besides, winning the votes of the community validated the worth and need for the projects in the community. This was cited by providers as a boost to their confidence. The community was said to have gained confidence as well from being empowered to choose a solution from an array of projects to help tackle health issues in their community.

> *I think it is a confidence booster, I think it is very empowering when you stand up in front of a group of people and it is an idea you've had in your head that no one's listened to before and then there's people that get behind you and support you and agree with this. It's definitely - I think for people's emotional well-being and confidence, it's definitely a booster and I think it is amazing… it is very empowering when you put the power back into the hands of the local community and say this a time for you guys to decide what happens in your local area. I think that's the main thing (Melissa).*

Melissa explained the PB process empowered residents to learning new skills which helped them to flourish and accomplish things they were unable to do before. She suggests an empowerment pathway to confidence for individuals and the community through PB decision-making below.

> *I think upskilling a lot of the people who have been involved. Whilst they have these ideas, some of them have never been to school before, have never had to like write these sort of applications, have never had to present their idea to a group of people and I think over time when you are upskilling the community and empowering them, people grow in confidence, they gain new skills and then they are able to flourish and present (Melissa).*

Melissa describes a trajectory she observed through the programme and reveals conversations she had with residents who have been actively involved in the training, planning, design and delivery of the programme.

> *Well, it is definitely a boost for mental health and emotional well-being. And I think that there's been some good examples of how people have gone from volunteering to putting forward an idea, becoming a project lead and now gaining employment. And*

when you follow that trajectory, you see it does have a massive impact and people have come up to me and say to me, "I don't even have any qualifications", you know, "I didn't go to school, I didn't do this and I didn't do that but through coming through this programme and standing in front of people and then accessing the personal support packages and accessing the training is giving me new skills" (Melissa).

This quote represents key discussions with a resident who explained how the programme was transforming lives by providing a pathway to pursue further education and employment for her and other community members. This finding indicates that the programme has raised aspiration in the community that led to tackling some social determinants of health. These quotes suggest certain benefits of mastery and empowerment for individual community members who before now did not have the competency to apply nor the qualifications to excel in areas of life such as gaining further education or getting a job. PB offered these individuals a unique advantage to shine in this way and to experience success in the things they love doing and enjoy.

Positive emotions

Positive emotions such as joy, happiness, love, satisfaction and a sense of pride at being a part of the PB process were identified as necessary for residents and providers to continue in the programme and create a virtuous circle of improvement. In addition, these positive emotions can initiate a psychological disposition for people to feel good and sustain those feelings in the future (Fredrickson, 2001). For instance, Melissa notes that the whole programme, including the PB aspect, has enhanced mental health and emotional well-being, leading to the transition into work. As Melissa described in the quote above.

Feeling good was a positive experience expressed by residents and providers to demonstrate their enjoyment of the different stages of the PB process. For instance, Alice, described feeling good at being able to pitch her project to a broader audience to showcase her project.

Uhm… in a kind of feeling way, it feels good, because it's always hard when you are doing something out there on your own, and nobody knows how you are doing it, why you are doing it on your own, you just feel a bit weird, you are the only one that is doing it. When you feel that there are other people that are on the same page as you. Then you feel good (Alice).

Before presenting her project on the PB day, Alice claimed it was difficult to get community people to join her project. However, the PB event day helped *create awareness* of her project to a wider audience. Many providers commonly cited the process of pitching as crucial for feeling good, feeling valued and gaining confidence. Providers felt validated as their projects were voted for by residents who did not know them before the event day. Providers suggest by voting them to deliver the projects, the community was entrusting them to deliver interventions of value. This feeling of entrustment made project providers feel valued and confident that they contributed positively to their community. This concept is consistent with the WHO's definition of mental well-being which incorporates a person's ability to "work productively and fruitfully and is able to make a contribution to her or his community" (WHO, 2001).

Providers who won the community vote expressed feeling good, suggesting the community's validation enhanced the feeling. Talking about her experience of bidding, Lily said:

> *Yeah! Yeah! My project won the vote… I feel good… I feel good… and if I just went out and applied for funding in the papers, and they brought the money down, I would feel okay, I will feel good as well but why this one is very good is because the community decided (Lily).*

This quote highlights a key finding reflecting the feelings of most residents who attended the PB event day. A review of the video, which documented participants views about their experience of the PB day, revealed expressions of joy and happiness by residents, providers and observers that the community could decide who gets the money to deliver relevant projects. Video respondents included Naomi, Ella, Kenneth, Lily and Lauren and others not quoted in this chapter. For example, when asked why she said the community voting day was good, Naomi explained:

> *No, that is good, because community is taking control… It's decision-making by the community. That's another bottom-up approach that I'm talking about. Community is empowered to say that you know what, instead of you telling us that this person is gonna do this to us and so on, we are able to hear for ourselves and we decide they're going to deliver. So that was fantastic, that aspect of it was good (Naomi).*

Feeling good was also expressed as *feeling well* by some respondents who felt WL allowed

them to contribute to their community. Raymond in the following quote describes how being a part of the process made him feel a sense of belonging and reciprocity. These feelings were expressed about the CEAD process and the PB element.

> *...it felt quite well to be doing something like that. And just the feeling of being a part of that. That spirit of helping each other (Raymond)*

Feeling good was also mentioned in association with the "*give back*" process by many participants who attended the PB event. Give back is an intentional system of reciprocity incorporated into the PB event by the PB facilitator. According to Genevieve:

> *So, I do a mechanism called to give back, and that was the opportunity for the successful projects to give back a little bit of their funding because it helps one of the partially funded projects to get some money. ...There is no obligation for them to give any funding. But often they're very generous, and they do. And so, they can give anything from like 50 quid to couple of hundred pounds, and that's really empowering for them because they feel a sense of camaraderie, of community of support. It's really nice for the project that's not quite got all its funding to see that they are valued and appreciated by the community. The residents love to see it in action because they can see that their vote has been well-invested because they see that the projects that they voted for are not just interested in the money. They are interested in the community and is evidence for them by seeing this project give back money to support other projects (Genevieve).*

Genevieve's comment represents the feelings of many participants who witnessed the "give back" process. Give back was note as increasing community spirit, community cohesion and trust. Providers who gave some money back also expressed happiness about giving some money to less successful projects. This meant that the give back process was also important for the individual as well as community happiness and satisfaction. Comments from different stakeholders about "*give back*" include:

> *Oh my God, that was the best part of it. I felt good, happy, and I was part of helping someone else's project move forward (Lily).*

I love the attention, and I love the generosity of how the other projects which were successful gave to the other projects who weren't that successful. The generosity, the togetherness, I just feel that we need more of these events (Kenneth).

My God, no, no... that was awesome…?... I am so glad that we were able to pull the other projects up and help them as well to be part of the project and to get some money (Naomi).

And then the actual voting day - I just thought was brilliant, and everybody did. And I gave some of my money away… I liked it at the end when you could give back some of your money to somebody that hasn't got it (Lauren).

The concept of giving is internationally recognised as part of the five ways to well-being which empower individuals to develop resilience, improve well-being and lower the risk of mental health problems (Aked *et al.*, 2008). This is consistent with research which demonstrates that regular giving (time, money or presence), can increase happiness, life satisfaction, social connectedness, and a general sense of well-being as well as reduce mortality (Post and Neimark, 2008; Dunn and Norton, 2014; Dunn *et al.*, 2008; Casiday *et al.*, 2008). Research shows that those who give are likely to receive directly from those they gave to or indirectly from someone else (Simpson and Willer, 2008). Generosity can foster a sense of trust and cooperation that strengthen ties between people (Lyubomirsky, 2010). Embedding acts of giving into the PB process is therefore valuable for initiating the sense of individual and community well-being among residents. It can also begin and heighten social support networks and social capital.

4.4.2 Connecting with other people: Self-esteem and feelings of belonging

Alice suggests that the process promoted positive mental health for residents who participated, including boosting self-esteem, a sense of belonging through connecting with others. Social connectedness has a positive effect on both physical and mental well-being (Cornwell *et al.*, 2008).

She notes:

> *…But in terms of the process… I think in terms of the people, mental health… self-esteem, feelings of belonging. And connections with other people. As I said, it's about feeling a part of something… you not on your own … a sense of community, yes, I think that's good for my mental health, because as much as I like to think independently, I do rely on other people ultimately. Like you know, I do believe most of us do (Alice)*

Alice suggests people need each other and the PB process made people feel a part of something other than themselves, leading to a sense of community which is important for positive mental health. Alice joined the programme when PB was kicking off with workshops about the bidding process. Therefore, her comments exclude the CEAD process and mainly describes her experiences of the PB process up to the event day.

Sense of belonging was also perceived by Moriah as part of the change occurring in the area because of PB. When asked how PB was going to mitigate the impact of the regeneration activity going on in the area, she explained, it was empowering the community and giving a sense of belonging to residents who took part.

> *…Well, I suppose for those people out there it gives a sense of belonging, doesn't it? Okay, something is happening, like I say, right there now rather than in 20 years' time, even if it is small. The council, they saw it was doing something different (Moriah).*

This quote illustrates how council members saw PB as an opportunity to enable the community to have a say now rather than further down in years. It also implies that although the PB money was a small pot, it allowed the community to feel included in decisions about health and well-being improvements in their community. This means PB was enabling a notion of '*mutually beneficial gain*' for both council and community members. The council was benefitting from using PB to attract engagement from a difficult-to-engage community and the community were feeling a sense of belonging despite the uncertainty and distrust about the ongoing regeneration.

Talks of *feeling valued, happy and confident, increased self-esteem and self-worth* at being a part of the PB process were also common among residents and providers of projects, especially around CEAD and PB's decision-making processes. For instance, Lily described how the process impacted on her self-value and the community.

The big thing about this is that years ago, I didn't know who I was, I used to not value myself… I used to be the kind of person who just be around other people for help. I used to say; I can't do this… Being involved in the community makes me value myself, my kids and my community (Lily).

Interestingly, Lily described how her "sense of helplessness" transformed into a person who could function in the community and value herself by becoming involved in the WL programme. Lily was one of the WLDT members involved from the beginning so, her description of gain in this quote referred to the whole process. Lily associated her origin of "feeling well" to her involvement in deliberations and decision- making with other residents, leading them to effect changes in the community. According to Lily, this directly impacted on her mental health and well-being. Looking at me intently, Lily asked:

Do you know that being a part of people who make decisions about what happens in the community can… or being a part of the people who have their own project to make a difference, I think that's all great and can impact on your mental health and well-being? (Lily).

Lily also expressed that the democratic decision-making process of PB helped develop individual and collective sense of belonging, ownership and control and increasing happiness and self-esteem.

There were many other people involved, and each time we used to meet and discuss and plan stuff, that made me happy because that made me so proud… I was proud to be part of the people who live in my community who were part of taking decisions (Lily).

There was a consensus between public health commissioners and residents that involving residents in prioritising and commissioning interventions enhanced responsiveness to their needs. For instance, Melissa explained that engaging non-traditional decision-makers to govern their community contributed significantly to the resulting impact.

I think the decision-making being in their hands. I think that that's had the biggest impact on what's happened from there (Melissa).

She emphasised that inequalities gaps widen when communities are not involved in solving their problems. Melissa echoed earlier conversations about widening inequalities.

> *...talking to people and really understanding why some of these issues exist and I think that you won't get that unless you engage properly with the community. And this is the reason why we've been able to see the impact that we have done. Because oftentimes we widen health inequalities with our approaches because you will deliver an intervention but the people that you want to benefit don't engage at all in the process (Melissa).*

4.4.5 Informal learning and mental health

Increasing mental health awareness was also a meaningful conversation among respondents. For instance, Lily said the training during the CEAD process helped her gain a critical awareness of mental health. She learned new ways of maintaining healthy behaviours to control daily life stressors.

> *Doing this course made me understand health is not just physical. Do you understand? It can be about alcohol and smoking and eating habits, and mental health... I did mental health first aid as well. And the mental health first aid helped me a lot, a lot a lot… ". How can I put it? I learnt how to calm down more. Yes, calm down more, and I learnt how to balance when I am stressed... now I know if I don't calm down, it can turn into something else (Lily).*

This kind of personal benefits was evidenced throughout the interviews as respondents outlined how the learning within the programme opened their minds to issues of health and mental health, which was unknown to them. This impact on learning about mental health was emphasised by Naomi, who claims that the pieces of training helped to shape her way of being. She now promotes mental well-being in the community by bringing women together.

> *For me that [training] helped to shape me. Everything I'm doing has to do with the whole health and well-being concept even when I'm dealing with people, even today I'm always talking about to be well, and well-being (Naomi).*

The training opened participants' minds to life-long learning and inspired them to promote health to the community. Naomi and others now promote health in the community

> *...Always learning means that you're always trying to get more information to add a different dimension to the whole health and well-being concept. There is other training out there, life coaching, other things that I'm looking at now, that can help me. I always try and pick up other training (Naomi).*

When asked how the training helped Naomi personally, she said:

> *I mean it really opens your eyes. It empowered you, and you learn a lot... different things that you didn't know in terms of health and the area that you are in and the high level of obesity... where the borough is ranked. So you… it opens up your eyes so you can able to say that you know… by learning about those things you are able to start formulating ideas you want to do... and that's what helped us to tighten the women's group and some other things like the Zumba come up, cos it's exercising, the next I did healthy eating - multi-culturally. So, most of those training influenced the activities that I was able to implement within the women's group. And then I've gone on as well to open... a soup kitchen which is called, food kitchen which is once again tackling... healthy eating concept again for people less privileged (Naomi).*

This quote suggests the power of informal learning for enhancing health literacy for individuals and the community. This quote also emphasises the notion that PB cannot exist without a comprehensive CE. Without the WL CEAD process involving training communities, there would be no empowering process for residents to develop ideas and create health-promoting projects for themselves or their community. A challenge in the Haringey WL CEAD process was lack of lead time in PB process which could have improved residents' skills-sets like the Porto Alegre and New York PBs, which are cyclic and one year long.

4.4.3 Social well-being impacts

The social well-being impacts of PB were mainly about how it made residents feel a part of the community, building positive relationships, having a sense of purpose making a positive difference and contribution in the community.

4.3.3.1 Building positive relationships

Community members enjoyed interacting with each other, with providers and professionals; some of whom they would not have encountered in their daily lives. The WL CEAD process, the PB bidding process workshops, PB event planning and voting day increased opportunities for residents to interact with each other and build positive relationships and support networks. The entire concept of getting people involved through training communities, CEAD process and PB made the WL programme attractive to individuals in the community, increasing engagement.

> *I think the Well London and PB programme has provided a platform for them to come together to have those discussions, to support one another to reassure and to acknowledge the issues each other is facing... an example today [training workshop with residents] would be… people had some anxieties about how they were going to get funded, which they held close to their chest. But because we'd run a workshop in a way that was about there are no rights and wrongs or mistakes, just ask questions, and we'll see what the answers are. They relaxed and asked the pertinent questions, which opened up a dialogue and it meant the other projects came forward and spoke their concerns (Genevieve).*

This quote demonstrates the PB workshops were flexible and allowed social interactions allowing supportive relationships to form across different groups. Before the PB programme, many of the existing providers worked in silos, not knowing what other projects worked in the area. PB provided a forum for these projects to begin to collaborate to strengthen each other's work. Evidence from two professionals describe how PB impacts on awareness raising, skills development and social relationships.

> *…So, the first step in the PB process is to raise awareness in local community to let people know that this is happening and to define the criteria of who could and couldn't apply. Then offer workshops and opportunities, initiatives for those people who are interested to find out more, to talk to one another, to network, to develop their bids perhaps to do some partnership working. To do some of the necessarily scoping of their project. So, when it came to the point of writing their bid, they'd kind of covered all the bases and felt confident going forward (Genevieve).*

One of the comments that came out of the PB from organisations is that they often didn't know each other existed and so one of the outcomes they were hoping for is that there would be a list circulation of the different organisations so they could do their own networking to strengthen themselves (Melissa).

These quotes illustrate the pathways through which PB encouraged partnership working and collaboration between individuals and organisations. The PB process was also helpful in creating awareness of the projects that existed in the local community. Many participants commented they did not know about the projects beforehand. Providers showed excitement their projects were getting known. For example, Lauren, when asked if the community voting day had created an awareness for her project she responded excitedly: "*Absolutely, Yes. We are getting known. Tottenham Folklore is getting known".*

Other examples of PB's influence on sharing skills, networking and building social relationships were described by Alice and Lauren:

...so that networking aspect getting to know other community groups ...what other people are doing, that's PB… About sharing of skills, uhm kind of identifying people who are part of this ward and who want to promote this wonderful community and support it, to me I think that's very important. I think to me it has given some people the start in starting up something they want… they have been passionate about (Alice).

Everyone that got the money had either been along to some of these preparation things or they talked to somebody. I remember meeting somebody who was doing the wheelchair bound dance project by chance at the SLB handing her form in and we went off and talked about the whole thing about trustees and everything. So, there was a lot of skill swapping, and it was really good. What I want to say is I've stayed in touch with WTN, P'sW and CK and I tried to work with the person working with very challenging young adults. But I do think that interchange between all the groups is the thing that should come out of it. So, in itself it should be about community cohesion as a process because I didn't know these projects before. So, the link itself is important and the real thing (Lauren).

Many of these providers had never worked on or bid for a project before. But the PB process allowed them to interact, swap skills and build supportive, positive relationships, which empowered them to progress their projects. Lily stressed how being involved with positive people in the community allowed her to grow and increase her sense of self-value. This finding has implications for positive mental well-being.

> *I used to say… oh I can't do this, or that, do you understand? But being involved with my community makes me value myself more because I always have positive people around me (Lily).*

4.3.3.2 Having a sense of purpose, making a positive difference and contribution in the community

PB allowed community members feel happy and proud because they were contributing to decision-making in the community. This enhanced a sense of purpose which made them feel a sense of belonging to the community. Lily describes her feeling about being involved in the earlier stages of the WL programme when she and other community members sat to deliberate on the things they wanted to see in the community.

> *There was a lot of other people involved, and each time we used to meet and discuss and plan stuff that made me happy. I was so proud to be part of the people who live in my community who were part of taking decisions (Lily)*

Here, Lily expresses joy and happiness and a sense of pride for contributing positively to her community. The decision-making process and the contribution to the community made Lily feel valued, and these promoted a sense of purpose and self-worth. For instance, Lily explains:

> *People come to me and say how amazing I am. And that what I am doing in the community is so amazing, so good. I didn't have that for many years. So that made me value myself more. That made me think to myself; oh, hold on, I can do this for myself. That makes me say hold on I am important for this community, I'm important for myself and my family, yeah (Lily).*

Genevieve also described how a group of under-represented women in the community thrived through PB.

> *There is a project called WTN, and they've been awarded funding. These are women*

> *who have the unfortunate record of being connected by being victims of domestic violence... now they were socially isolated. Domestic violence does isolate people and often the partners specifically act to isolate the individual from their family, their friends, and their community to maintain control. It's [WTN] been a forum in which those women come together, do physical activities, get involved in community clean-ups, get involved in health talks and discussions, and a whole range of things. And the testament to this was that on the day, most of the women involved in the project got up and presented it... and these were women who possibly didn't have a voice prior to that, and so that's quite a powerful example of those women feeling much more socially included and engaged and empowered (Genevieve).*

The WTN project was conceived during the CEAD process by Naomi for women in violent relationships. According to Fernando, professionals in Haringey described these women as housebound and were hard to engage. Competing for the PB money empowered them to engage and feel socially included. It gave them a voice and increased their sense of purpose, as they could contribute to their community and make a difference. I interviewed Zahra who led the presentation, and she excitedly told me how it made her feel.

> *I felt quite proud of myself because you know I'm doing something for my community, and the group that we're running. Cos, to get this money if I had to do that speech, I will do anything that will help. Cos, we need it here, so many women are coming now, we're getting more women every week… without the funding it will be really hard (Zahra).*

4.4.4 Expressions of negative experiences of the PB process

Despite positive feelings expressed by respondents about PB, many participants experienced instances of frustration, anger, dissatisfaction and disappointment at some aspects of the process. These aspects included poor coordination, communication issues and lack of understanding of some part of the PB process (Voting and form filling).

For example, there was confusion and lack of clarity at one stage of the programme, leading to a one-year lag. Many residents who were part of WLDT became frustrated about waiting for something to happen and left the programme in anger. Naomi explained the difficulty residents experienced to support the ongoing work.

… We were a bit let down because we were doing the training. We were coming out; we are putting ourselves forward, we were carrying the Well London programme because we want it to work coming to our area, we really wanted for the area to make sure that it went well. So, that at least anything more coming; like other people coming behind us would follow. We were promised that we can choose individual courses and then it would be paid for. However, that didn't come through. They promised to teach us how to write bids, how to put all the little mini groups we've started formulating and filling forms… [but for some time] nobody got contacted us... When things got dragged down, a lot of people got frustrated and people started and tended to drift away because you're volunteering, you are doing things, you are going to the event and then nothing was coming back and it's like once again the community feeling... let down (Naomi).

Commissioners and programme managers also discussed the feelings of frustration about the lag.

And I think some of the community members were frustrated because it was like finally, we have this opportunity to do something, and it feels like it's not happening anymore (Melissa).

The delay in the process was caused by several factors such as changes in council staffing, poor coordination, and poor communication to residents about the programme. However, it was mitigated by two significant decisions by the council. First, a town hall meeting was initiated with residents to find a way to continue the programme. Then the council hired an experienced PB facilitator and a community charity organisation, Kelsey Trust, to coordinate the programme and support providers to plan the PB event and deliver projects. As a result, PB was viewed as a catalyst that reignited the programme.

The PB process also posed challenges for residents. For example, some respondents voiced residents' anger and frustration about completing the PB funding application. Naomi explained they were promised support and guidance to articulate their ideas and fill in the forms for consideration, but this did not materialise until an external PB facilitator was hired.

I mean I felt a bit disappointed... but then again Genevieve has given us some examples and different sheets of what to do and where we can get things and

research …But initially we were let down and people became really quite angry and didn't want to put any more work in really. Now, when Genevieve came on board, we started picking up ourselves again (Naomi).

An experienced PB facilitator was essential for improving lay people's understanding of the PB funding application and to prepare providers for presenting their bids. The PB facilitator started workshops that brought providers together and made the process clearer and accessible. These workshops also offered skill swapping opportunities for residents and networking, strengthening project articulation and delivery. Nevertheless, some residents were excluded from applying for funding due to the complexity of the paperwork, as Lauren notes:

…the process was rigorous, and a lot of people aren't used to form filling. One very nice man that I met came along to all the meetings trying to do some free food bank and he didn't put in because it was just too hard. What I'm saying is you need a certain level to be able to do it… I don't know how you avoid that really, but I do think they did give a lot of support, but it was quite a paper heavy way of getting money like compared with Heritage Lottery. Heritage Lottery was easy in comparison and Arts Council which you think should be more, Arts Council is a doddle. You just write something to send it off. So, it's harder process which is fine. I'm not complaining because I got the money, but it's like - but you can't just do it in a community you have to put the infrastructure of support into it. That's what I was saying. So, I don't think you could just walk into a community like this and think that people will be able to do those forms (Lauren).

Lauren's explanation represents the views of many respondents who complained that the PB process was paper-heavy and too complicated for the members of the community, and this led to many people with project ideas to become excluded.

Another cause of disaffection and distrust was the inconsistency of promises to the WLDT members. Initially the coordinator informed them some monies were ring-fenced for them to start up projects they had designed during the CEAD process, but this was not the case. Also, some allowances were given to some volunteers and not others. As Lily notes

> *So sometimes it's so hard when you come with your kids, and you have to keep them in the classroom with you. In the beginning, we were promised to be paid some money, each time we had workshop or something, to provide our kids nursery fees. It becomes... Sometimes you can't get that. And also, they promised that there was a pot of money for some of us who come up with an idea connected with health in our ward and we are gonna get support and be able to apply for that funding. Also, was promised to pay our bus fare each time we come and lunch each time we come…: you see, it's weird… with some people it happened but some people it didn't* (Lily).

Lily was disappointment but was not discouraged from continuing "*... that didn't make me feel like stopping".* While residents like Lily did not stop attending the programme, some left out of frustration as Naomi stated earlier. Lily confirmed this by saying: "*But I was just observing each time, each time, and each time. Because of that a lot of people stopped coming".*

Lily was committed to seeing WL work in her community. Despite these challenging and stressful circumstances, she and some other residents stayed in the programme. For example, when asked why she remained in the programme, Lily said: "*because I knew what I was getting. I knew at the beginning how Well London helped me a lot to build up myself" [and] "because the community needs help."* Lily said that her positive experience during the earlier stages of the programme increased her resolve to stay and enjoy more benefits. When asked to reflect on her overall experience of the programme, Lily said:

> *"My experience has been good because every experience cannot be all roses. You will always have the good part, and the bad part, and a balance of both for wellness. That teaches for next time. That experience helped me a lot a lot a lot a lot a lot (Lily).*

Lily explains how the experiences helped her be more resilient and the possibility of resolving future problems with it. Individual and community resilience is vital for well-being and human flourishing. This finding is consistent with the popular understanding in the PB literature that individuals will contest for what they want to see in their community and WHO's definition of mental well-being. Lily notes:

That bad part made me stronger. Sometimes, when bad stuff happens around you, you have to be there to change it round. Because if I said I didn't want to be part of it no more and walk off. It will happen again. Do you understand? (Lily)

These quotes represent a key finding of how contending for what residents wanted to see in their community increased individual *resilience and community responsibility* for programme success.

The pitching on the event day was also a source of anxiety for many residents who had never presented or were not used to talking in front of an audience. For example, Lily expressed her anxiety and fear at having to present her project. She expressed her feelings of apprehension and stress:

I was so scared… and nervous... it was so so so scary… So, you're like wow, you can just fail. Do you understand? You can just go and stand there, and they will say to you there's nothing for you, you know (Lily).

Although pitching was scary for many residents because it was new, they did it because they wanted the money to make a difference in the community. Despite this fear, Lily said: "but it was good". When asked, what was good about it? She explained:

"I used to be unable to stand in front of people…, you will tell me to go and stand like that to do a speech, I will tell you no way! *Oh my God, I was shaking like a chicken. It made me feel happy and nervous at the same time. Does that make sense? I have not done something like this before; I used to not be able to talk in front of people. I used to be very shy." (Lily)*

These quotes represent the experience of many lay residents who pitched on the day. They lacked the confidence to stand before the community to pitch. They were also apprehensive to fail to win the money. According to Lily: *"You can just go and stand there, and they will say to you there's nothing for you".* Lily's confidence grew as she watched others present.

Oh, my God the important thing I remember about the community event day. It's when we started, the people who came [to pitch] … and I stood there [Laughs], and I watched them… And they finished, and I said, okay that means I can do that [laughs] when it's

my turn, and I said that's easy that means I can do that, but I was still shaking [Laughs]. Because I have never been in a project or a part of set up like that. It was new to me, too new to me, and that will make me, next time I'm not gonna be shaking like this time (Lily).

This example of personal growth experienced by Lily resulted from the challenges of the process where negative situations turned into constructive learning experiences. Additionally, the pitching on the PB event day was initially seen by some respondents as detrimental to community relationships. Many participants felt that it was unhealthy for people in the community doing good work to compete for the money. Lily expressed her initial feeling of unhappiness at the concept of competing for the money:

The only thing yeah, although not negative… was in the beginning, I wondered why they have to put people who work together in the community against each other trying to sit down and pitch to win something… But today, when I sit down and rewind back and think about it, it was worth it. It worked well (Lily).

Participants felt all presented projects were needed in the community, and providers should not have to compete for the money to deliver them. However, on further reflection, respondents said that it was good because it made providers feel accountable, valued and entrusted by the community to deliver an intervention that would respond to residents' needs. Another thought was that since the money was limited, PB was fair and the best way to divide the money because the community could choose what they wanted.

I thought it was very, very interesting. I was excited. I got goose bumps hearing about the projects, and I thought, this is an amazing thing to do because there are lots of projects going on and the money is limited. So, nothing is fairer to have people from the community vote for what they want to see. But I really liked the choice of projects, and I think all of them are helpful and useful in the community (Ella)

I've been looking for something like this. This type of approach where the community has the power to make decisions about what they want and that's fair from my point of view (Elliot)

When asked how he felt about getting the people's vote, Elliot explained:

I was pleased because it was direct indication that there was a need for the programme. So, if the community votes for your project … that's direct feedback, you know. So, from my point of view I was extremely pleased. I felt wanted. I felt needed by the community. So, you know again it just feeds into my passion and keenness to deliver a programme, rather than deliver a programme that you're not sure it's gonna be successful with the people who really want this (Elliot).

Participants commended the PB event for creating awareness of local projects and a start to community partnerships between project providers. The event was praised for its impact in promoting health, improving social relationships and learning of community assets. These findings have implications for the development of social capital within and between groups.

When you finish your pitch… what was good about it is that you hear everybody pitching about their projects and that makes you also learn or see what else happened out there (Lily).

Lauren agreed with Lily suggesting:

…absolutely, yes! We are getting known. Tottenham Folklore is getting known. The actual day was wonderful because that's when I met Naomi and Lily from WTN, that's when I met people from P'sW, yeah. So, I've been told I've got my group; I will develop from there (Lauren).

These experiences of frustration, anger and disappointments are not surprising or uncommon in community interventions like WL, which are multi-component and complex with many stakeholders involved in driving the programme. However, the decision taken by the council to kickstart the programme with the PB element using an experienced facilitator increased residents' engagement and consequently, the success of the programme.

4.5 Perceived impact on community health and well-being

Community well-being was experienced in the sense that there was a mobilisation of critical factors that initiated and could sustain community health and well-being. This included *building community spirit or sense of community*, *having a collective voice in decision-making*

and action, building trust, community awareness, increasing community responsibility and realising or recognising assets.

4.5.1 Collective voice and action

Before the Well-London programme, people worked in silos in this ward, however, with money decisions to be made about what health interventions to bring to the area; there was a need to pull the community together. This began with the Well-London WLDT members committing to making a difference through training and deliberations that they received through the training community's aspect of the programme. The training and deliberations led to a collective understanding and voice, and what action was needed to bring change to the community.

> *This initiative shows the community is coming together with a little bit of money from the government or Well London or wherever it comes from, you're making decisions that affect the community directly this is empowering (Elliot)*

4.5.2 Community awareness and health literacy

Making a difference to the community health and well-being was important to both community members and professionals. To achieve a difference in community health, residents needed to understand the health baseline for the ward and to spread health messages throughout the area. The health awareness training and workshops raised this awareness among the WLDT. After undertaking the health workshops and training, the WLDT members began to feel responsible for the community's health and well-being. They worked together to make collective decisions that would enable a change in the adverse health statistics they had become aware of in the workshops.

During interviews with members of WLDT, they explained how they developed an individual and collective responsibility to make a difference in their community. The WLDT members were aware that the programme was about health, and they made concerted efforts to know more to enable them to contribute to making the change for them, their families and the community. For example, when asked what she was expecting to gain from the WL programme before she joined, Lily said:

To be honest from the beginning I was not expecting nothing more than - when I first heard about health and well-being. Oh, that was what made me join. I was expecting to improve my health (Lily).

Lily had been worried about personal health and joined because she wanted to make a difference for herself and her family. She wanted to know her community more and to be involved in helping the community. Her active participation as a WLDT member enhanced her engagement with the community and opened her eyes to take notice. Her involvement in the earlier outreaches and later PB aspect of the programme consolidated her outlook of the community.

Because being part of all those projects, today, I know what is out there, I know how dangerous it is out there when it comes to kids, knife crime, gun crime and stuff like that. That make me protect more my kids, my family and me (Lily).

In this quote Lily expresses her increased awareness of danger in the community and ways to enhance physical safety for her children and herself. This means that active engagement was crucial for enhancing physical safety. Apart from safety, Lily also mentioned her increasing uptake of healthier eating. Earlier Lily talked about up taking healthier eating habits and how the training had empowered her to bid and run a community PB project for children, including healthy eating and mental well-being. These newly acquired health improvement messages allowed a rapid and virtuous circle of information sharing and action between individuals and the community.

Naomi, when asked what changes she had noticed in the community, also talked about the increased knowledge and awareness of health issues and what to do to get well.

I mean with all the Well London projects that have been out there, like you've got information about health out there now. People are more aware now, but the thing is yeah, ...people still have other things to battle with in terms of finance and so on. But they are more aware now as a result. And the most important thing they've been told, and they know, and they've been made aware that's the best you can do (Naomi).

Respondents commonly expressed that the PB event day helped to raise awareness of the health projects in the community, and many participants viewed this as empowering for the community.

> *It is empowering for the community as a whole to see that their identified themes are gonna be translated into action and there's money that's gonna be invested. And the fact that the same community come back in and had a vote. That is raising awareness of what is gonna happen and also giving them more sense of control. So, it is all about control and empowerment (Gabrielle).*

> *…they [unsuccessful projects] had had their awareness raised because they had been a common chatter that there wasn't much going on in this ward, and this was a real opportunity for them to see what small projects and initiatives were going on. They'd had the opportunity to network with people. There was an enhanced sense of community. Because they felt pleased and that a lot of people were doing good in their community, but they weren't aware of this. They loved hearing about the projects, and the potential to engage in these projects and there was just a really optimistic feel about it (Genevieve).*

> *It was an interesting event because there were so many things. It's not just women's group, there were other organisations, and it was really nice to know your local area, and what is going on in it. So, if I didn't go to that event, I would have only known about my one, but when I went, I saw drama things going on and then there was another one with the food (Zahra).*

4.5.3 Increasing community responsibility and realising assets

The PB process was instrumental for providers to ensure that their projects were the right fit to improve community health and well-being. This deeper reflection on how projects could support residents' health meant that providers worked on the design of their projects to ensure the responsiveness to the community's need. In discussion with Lauren, she said that the process of PB was fair because:

> *… it made you focus your mind on how your project would impact health… for example, I do think doing drama helps people's mental health, and it stops people being lonely.*

Being in a play, you come together, but you have to think; you had to focus down on why your project was going to help people in this area that was what was good about it (Lauren).

Lauren's project was a theatre production aimed to bring people together to create a play about migration to the area. The PB process forced Lauren to critically explore how her project could promote health before presenting her proposal to residents. Lauren had to redesign her project to include drama therapy workshops for more profound experience to promote health. Lauren could see how competing projects could impact health and knew she had to convince residents about the health impacts of her theatre production.

Because I mean, I met so many other people there like the wheelchair dance class. Well, it was obvious how it was going to help residents, but something like Tottenham Theatre, it was a bit harder to argue, and I was really pleased that the community voted for me. Because really what they were voting for wasn't me or Tottenham Folklore it was that they wanted this in their lives. And you are looking at mental health and health and what I've uncovered is I've done so many workshops. (Lauren)

Lauren was pleased with the PB process because it allowed the residents to see how her project could impact their health and mental well-being. Lauren's positive emotion here reveals empowering residents to choose what they wanted for their health was beneficial to residents and gain for Lauren, who learnt to improve her project to fit residents' needs.

I found that an aspect of the PB process made community members responsible for the community's well-being. Interestingly, PB enabled residents to own projects and improve their sense of purpose and mental well-being. For example, James noted that owning projects would help resident providers feel less depressed. When asked for his view on how PB may be affecting people's lives in the community, the following conversation ensued:

***James**: Well, if those projects that were successful are monitored properly, I think they would*

***Me**: So, it's about the types of projects that would improve lives*

***James**: It's not only that, it is also, for the project providers, it is improving their lives as well*

***Me**: Can you tell me more about how this process might affect their lives*

***James**: Well to put it quite bland, I think that they would be less depressed*

[Both laugh loudly]. Perhaps I had better say less sad (more laughter) with the way things are these days

James illustrates a crucial finding showing that empowering community members to contribute meaningfully to their community can improve mental health. Councils should recognise residents as assets and include them as active agents to significantly impact health outcomes at a local level. This finding, therefore, highlights a notion of mutual benefit for providers, the wider community, and the council.

The notion of being less depressed or less sad indicated by James helps to explain the code *having a purpose.* The providers, through winning a bid to deliver their projects to the community, now have a meaning to their lives, and this is impactful for better mental well-being (*less depressed*). Not surprisingly, this personal growth for providers relates to building community assets that are sustainable for community health improvement. Melissa explains further:

And I think that's definitely impacted people's confidence; it's helped them in terms of their presentation skills and in the way they put forward their arguments. And now we are developing them to bid for further funding. They've gone through the whole process, so they are becoming familiar. Some people have started having training in building company structures and setting up a community organisation and things like that. So, we are thinking about longer-term sustainability. Yeah, we don't want it to end there (Melissa).

Naomi also talked about her WL training experience and how she was transferring this learning to the community.

Well… I have been to places to go and talk about the programme. I have been on training to the Wheel of well-being. I have delivered training and activities from what I have learnt from the Well London in the community. For example, I've done laughing yoga, the Wheel of well-being, signposting... I've learnt about all the different health and well-being projects and things that I can pass on... Most of the stuff I learnt I've

delivered it in the women group. So, they have done the Wheel of Well-being, whether it's the spiritual... take notice. So, we've been delivering all of that to them and teaching them a lot of about health, well-being... even the laughing yoga has become quite popular in our ice breakers. And the meditation we've done quite a bit of that and some other things we've been practising within the community (Naomi).

This quote illustrates the increasing health literacy in the community through the PB commissioned projects. Health messages learnt during the CEAD process were passed on to others in the community. Providers had become champions of health and took responsibility to transfer learning to recipients of their projects about what it meant to be well and to uptake holistic health. This finding has implications for a virtuous circle of improvement for community members as health literacy gets passed on to family members and friends.

4.5.4 Connecting communities - building social networks and cohesion

Bringing the community together was a big focus of the WL programme. Connecting with other people was recognised by many respondents as necessary for improving social integration and inclusion, community cohesion, social capital and a sense of community. These concepts are well-established in the literature as correlates of improved health and mental well-being. Many respondents hailed PB as vital for bringing community members together.

The PB process was crucial for providers to tailor their projects to respond to this aspect of community health. For example, Lauren explains in the following quote how her project would be meaningless if one of the outcomes were not about connecting people in the community.

You had to do your bid; you had to concentrate on the outcome. It's okay for me to go on about theatre, but the outcome had to be community cohesion, it had to be about bringing the community together. Otherwise, I might as well not do it, really. Do you see what I mean? (Lauren).

Lauren felt that the PB process was good because it forced projects to fulfil the health objectives of the programme, or they would not get the vote from residents. In addition, respondents noted several aspects of the PB process helped people *take notice, connect to others* and *increase their social networks*. These included the PB day planning meetings, workshops with the facilitator and the PB event day. For instance, Amelia explained.

So that networking aspect... getting to know other community groups. See what other people are doing, that's PB (Amelia).

Melissa also explained that the PB day was essential for bringing people from different backgrounds together. Throughout the transcripts, respondents noted that cultural groups are homogenous in the area and worked in isolation from others.

And I would also say just on the community voting day; I think it's seeing people from different backgrounds all come together. I think that's what we've been able to demonstrate. Sometimes, a lot of the communities that exist within this area of Tottenham existed in silos or stayed within their own groups (Melissa).

This quote highlights the notion that the PB day provided opportunities for social integration, inclusion and networking. For instance, the "give back" process (see 4.3.2.1 above) was also crucial for fostering a sense of community. At interviews and during the event day, different stakeholders gave their opinions about the "give back" system. Many of them talked about how happy it made them feel and how this single act pulled the community together during the voting day.

4.6 Chapter Summary

In this chapter, I have discussed the findings from observations, document analysis and interviews with 18 participants of the PB process, which took place from 2015 to 2017 following a CEAD process and culminating in a community voting day. This chapter demonstrates that PB is health-promoting but can also evocate negative experiences for actively involved residents, sometimes leading to frustration, disappointments, dissatisfaction and exclusion from a programme aimed at improving health.

The finding demonstrates that local people and professionals had viable and holistic perceptions of health and well-being, which they constructed through their being involved in the PB process. Some of these included positive and negative beliefs, feelings and experiences which were responsible for developing future states of well-being and could reduce inequality within groups.

Six major themes were constructed through participants' talk of joining or being involved or staying in the programme. I found beliefs about self-health and community health to be instrumental for joining WL and led to resilience by local people to remain and establish projects that were responsible for promoting and improving health in the community. The commissioning power of PB led to money trickling or filtering down to the community and having a mutually beneficial effect for both professionals and residents who had seen substantial investment in this ward for several years without any difference to health outcomes. The findings of this chapter have implications for practitioners and policymakers when considering the implementation of the intervention, including PB. The next chapter presents the case descriptions and interview findings of health and well-being impacts realised from three PB projects (WTN, TT and CK).

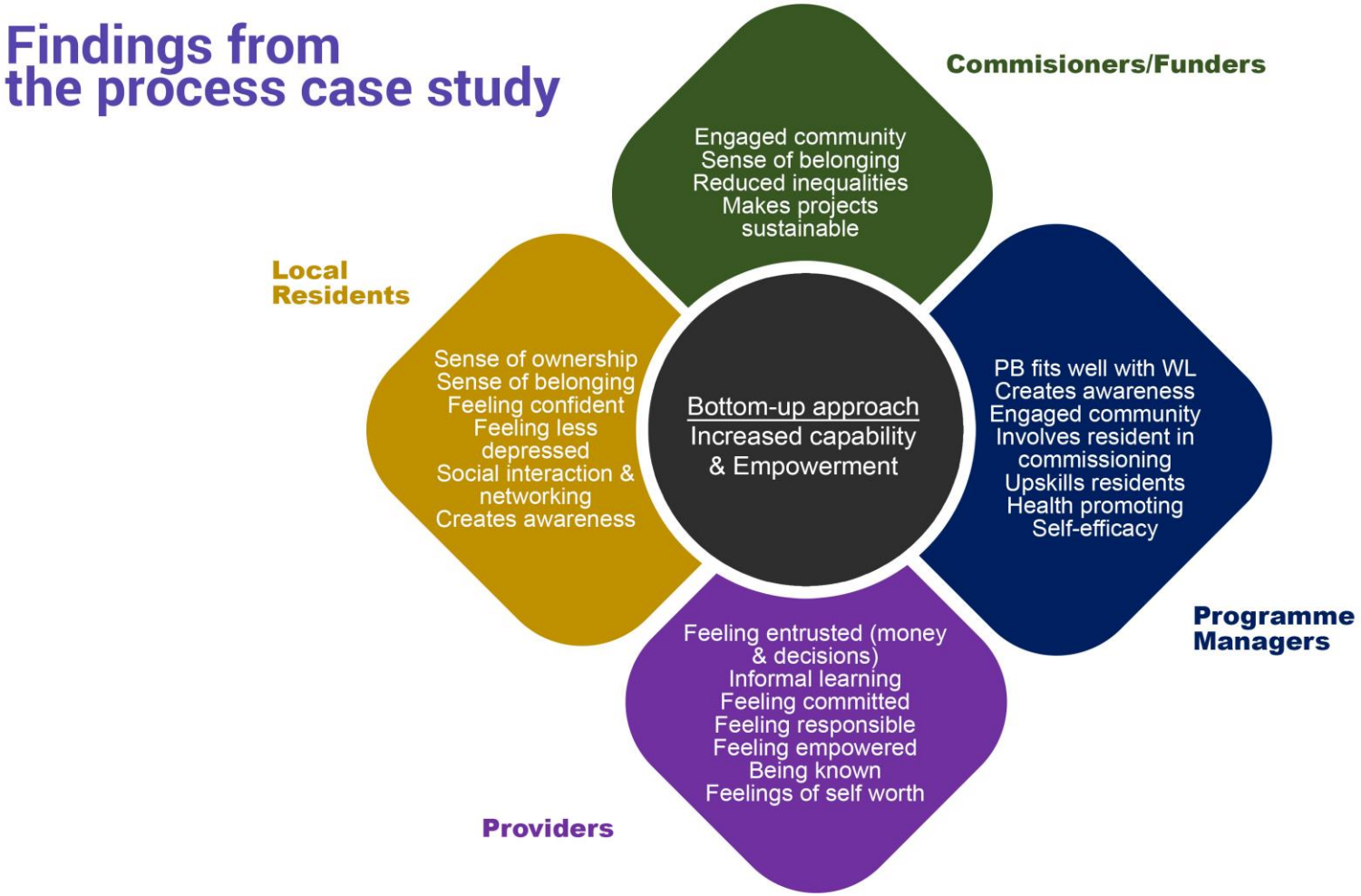

Figure 4.1 Impacts of the PB process described by multiple stakeholders who participated

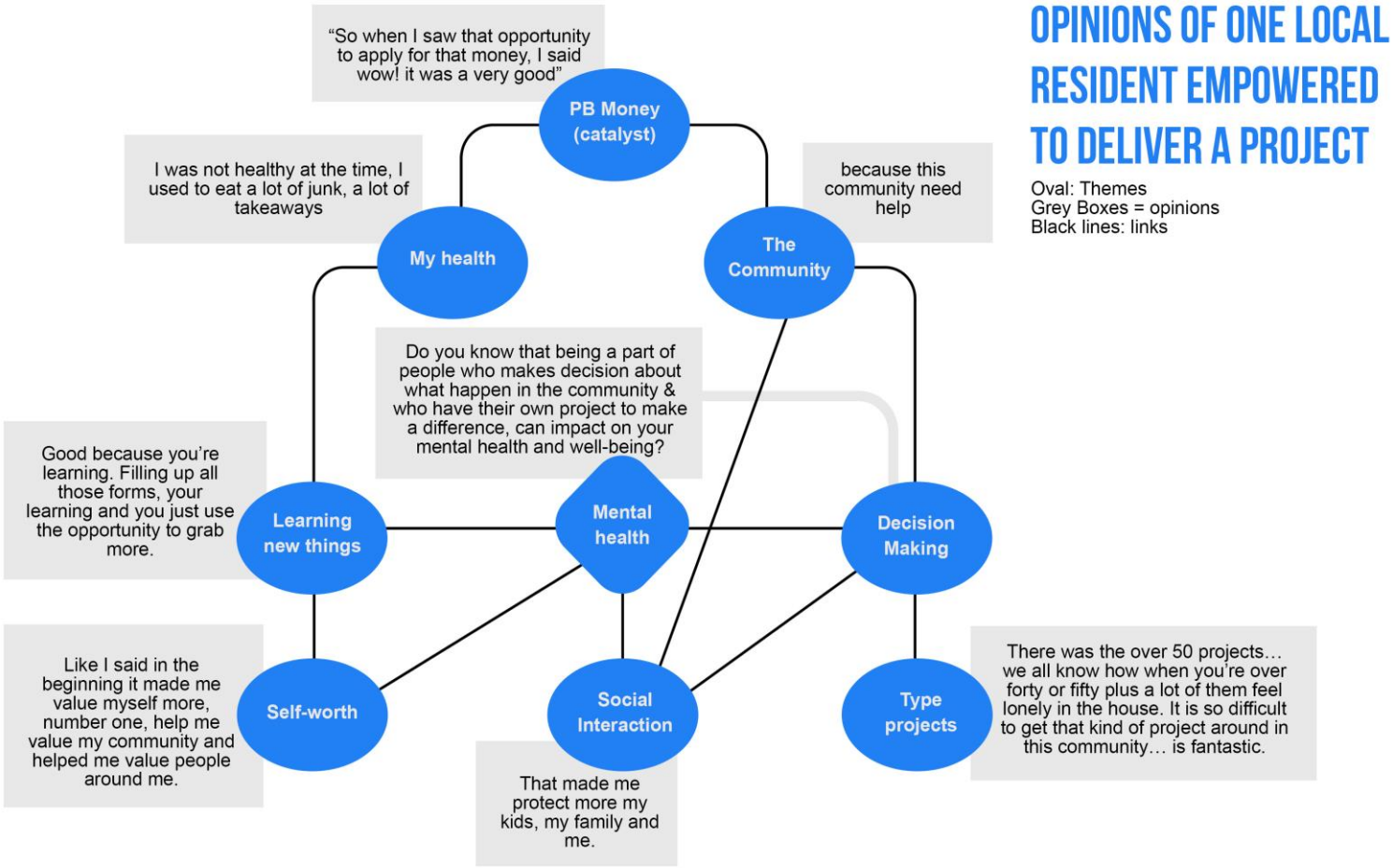

Figure 4.2 Comments from a project lead about the impacts of the programme on individual and community well-being.

Chapter 5 - Findings from the intervention Cases 2, 3, & 4

5.0 Introduction

This chapter presents an analysis of observations and interviews from project providers and participants of three interventions commissioned through participatory budgeting (PB). The case studies include Community Kitchen (Case 2 - CK), Women Together (Case 3 - WTN), and Tottenham Folklore (Case 4 - TF). This chapter lays out the experiences of residents within each case study to understand the contribution of PB in forming and shaping how health and well-being was experienced by residents who attended these interventions.

The chapter begins with a detailed within-case description and analysis of the three projects before attention is turned to a cross-case comparison. This results in a synthesis detailing the commonalities and differences between each case study that make them unique as PB interventions chosen by the community. The within-case analysis presents five significant factors or conditions which enabled improved well-being within projects from participants' perspectives. As with the data from the previous chapter, no one project was an 'ideal' representation of any project from PB outside of WL, although as will become apparent, each of the projects may have ethos closely reported in previous evaluations of PB programmes.

The following research questions apply to all three case studies.

Research Questions

1. How and why participatory budgeting projects improve residents' health and well-being or reduce inequality? (**C*onditions for improving health*)**
    a. What health and well-being experiences do participants construct or report? (***Benefit to physical health; benefit to well-being***)
    b. How are these experiences related to participatory budgeting? (in other words the, impact or influence of PB on the way the projects were conceived and delivered or ***association to PB*)?**

Main finding 1: Perspectives of health and well-being

A common category across the three case studies was the perceptions of health and well-being expressed by respondents. The key aspects of health and well-being identified from respondents'

interviews were social and emotional, including 'feeling good', 'feeling happy', and 'relationships with others' and were consistent across all projects.

Respondents used the terms health and well-being interchangeably without considering the meaning, interpretation, or contemporary application. I categorised all impacts on physical health as "health" and impacts on psychological, emotional, mental, and social well-being as "well-being". Health and well-being were standard discussions by participants during interviews. All respondents perceived improving health and well-being as an integral part of participation in the projects. This was not surprising as the project planned to enhance healthy behaviours among residents who attended the WL programme.

I described health at the level of physical health as safety, coming out (i.e., physically coming out of their homes and being involved), having good food or healthy eating, physical appearance (weight, looking better) and modelling behaviour (people modelling good behaviour to change their lives). On the other hand, I described well-being at the level of psychological, emotional, mental, and social well-being. These conversations were like the meanings respondents of the process interviews ascribed to health and well-being in Chapter 4. Respondents were consistent in describing dimensions of well-being relating to confidence-boosting, being happy, being valued, sense of belonging and community belonging or spirit.

Section 5.1 Case 2: Community Kitchen

5.1.0 Background to Case 2

Community Kitchen (CK) is a healthy eating club designed to improve the uptake of healthy eating habits by transient, homeless, and permanent RDPW, Haringey residents. The club's focus is *Priority 2* of the Well Communities programme, aimed at empowering adults to lead healthy, fulfilling lives. CK project started as a project for families with an intergenerational focus. However, a few months into the project, many women with children dropped out, leaving mostly male and female members without children.

CK ran weekly sessions from 1-5pm at a community hub in RDPW every Tuesday for a year and then moved to a church venue on the same street on Thursdays. The project attracts people of different ethnicity: Afro-Caribbean, Black African, White British, Somalian, Polish, Indian

and Bangladeshi. Quarterly 50 to 60 people attended CK session, with an average of 20 to 40 weekly attendees. Its attendees include people with different socioeconomic, demographic and health background.

Alice (pseudonym), a resident and project coordinator, entered the WL programme at the start of the PB phase and learnt to bid for the money to run a CK project for residents for a year. She ran food stalls around Tottenham without much success before she heard about the opportunity to get some PB funding and free space provided by the council. Alice encouraged a participatory approach to running the sessions attracting eleven volunteers engaged in cooking, collecting free groceries from nearby supermarkets, setting up and clearing up, providing musical entertainment, weekly registration, and evaluation.

Professional cooks from amongst the residents were also paid to provide healthy meals sometimes. CK won £3000 from the PB funding event in March 2017 and a further £5000 from Residents' Partnership Board (RPB) to provide legal aid to its members for housing and immigration issues. The sessions' recruitment was mainly by word of mouth, through professionals attending the group and popularity because of the PB event. In addition to the hot, healthy meals provided each session, peer support and networking between attendees was encouraged to help integration between attendees. The project collaborated with partner organisations such as Haringey Law Centre to train a volunteer, and a volunteer cook was referred to the Food Safety course. The project records healthy lifestyle changes: uptake of healthy eating habits, identifying with people from their neighbourhood, reducing alcohol intake, improved personal hygiene, and a sense of self and belonging.

5.1.1 Respondents' characteristics

Participants of CK I interviewed include four males (M) and two females (F). Six were residents, and one lived elsewhere in Tottenham but volunteered as a legal advisor in the project. Alice was the project lead, a resident of Tottenham whose idea was to bring people together through healthy eating and cooking to enhance intergenerational bonding. As Alice states:

> *Many people are very destitute, but I like the fact that we, and this is intentional, that we have a mix of people. So not everybody is homeless or destitute not by any means.*

And the idea is to bring people together to see what we've got in common. And how we can help each other (Alice).

Respondents were aged between 30 and 70 years with many unemployed consisting of homeless people, and transient residents. I also used extracts from interviews from participants of the process case study interviews relevant to the CK project. For example, quotes from Genevieve (F), and Fernando (M) (See Table 6.0 for participant descriptors).

Table 5.1 Respondents' characteristics (CK).

	Participant Name (pseudonym)	Mins	Type of participant	Age range	Ethnicity	M/F	Educational attainment
1	Habib	150	CM	30-40	Asian	M	MA
2	Hendrix	30	CM	65-70	White British	M	AL
3	Billy	50	CM/volunteer	40-45	Black African	F	NVQ L 4
4	Holly	30	CM/	35-40	Black African	F	NA
5	Alice	60	Project lead	30-35	White British	F	Degree
6	Herbert	90	CM/Legal adviser	35-40	Afro-Caribbean	M	NVQ L 2
7	Fernando	60	Regeneration CE officer	35-40	British Caribbean	M	Degree
8	Genevieve	60	PB facilitator	50-55	Black British	F	Degree

5.1.2 Main findings: Factors or conditions for achieving increased feelings of health and well-being

This section reveals findings from thematic analysis of interviews, identifying six factors contributing to participants' increasing sense of well-being.

Category 1: Becoming active and health behaviours

Coming out

The most common discussion around physical health was about '*coming out'*. Participants used '*coming out'* to represent leaving home and doing activity in the community. These activities include attending regular weekly sessions of PB projects across RDPW to improve aspects of physical health or well-being. RDPW residents were known for their lack of engagement in community activities, and the council was keen on changing this narrative through the WL PB projects.

Participants described "*coming out*" as enjoyable and a way to meet people. Holly, born in Tottenham, but had lived in RDPW for 17 years, expressed she had become more active because of coming out to the projects. I observed Holly for a while, but I did not feel comfortable to approach her for an interview because of her quiet demeanour until Alice, the CK project lead, introduced us. So, I was quite surprised when without prompting, Holly cheerfully told me: *"And I really like living in Tottenham".* When I asked why she liked living in Tottenham, Holly said: "*Just peoples… all the different people…* and she emphasised: *"Yes, I'm happy living here".*

Holly was happy living in Tottenham because of the diversity of people. She expressed how the CK project helped her "*come out"*.

> *…to bring yourself out just get to talk to people, see what else is going on… …it's good to socialise and bring yourself out a bit more (Holly, resident)*

Holly's initial attraction was lunch and a chance to meet friendly people. Holly admitted the CK project led her to join Tottenham Folklore (TF), where she took up a significant role in the "Tottenham Highway" community play. It also helped her "*become aware"* of another place where good food was served, and she met more people, which she needed. This meant "coming out" overlapped with engagement aspects that helped improve Holly's health and well-being:

… it can lead to other things… it's led to meeting someone [Lauren] who is doing acting and I have ended up doing this acting which I never thought I'd be able to do because I'm a quite shy person. Doing that has really boosted my confidence. It has really helped me, I feel good (Holly).

Coming out to CK helped Holly meet Lauren and made her act in a play. This doing and being emphasises Sen's, (1999) increased human functioning which increases the feeling of wellness. Getting involved in the community play meant Holly was getting about more, which has implications for becoming more physically active including acting on stage and increasing confidence. Also, the drama exercises before the play's performance included some physical activities.

Holly's experience of involvement in the project echoes those of many other residents. For instance, the provision of "*good food"* was important for many of the participants to come out. Billy, a transient resident, who had fallen into bad luck with his business leading to very low income and deterioration of his health stated:

Lying in bed, and your stomach's rumbling, you know you've got to do something. So, you've got to get out of the house, right. So, this kind of like opens you up (Billy).

Lying in bed here signifies sedentary behaviour common among unemployed residents of Tottenham. A sedentary lifestyle increases health risks issues like heart disease, some cancers and diabetes. Getting out of the house involves being active, and CK was responsible for Billy getting out of the house for food. Billy's narrative represents those of many residents who attended CK, as participants were either mostly transient residents (including the homeless), mentally ill, drug and alcohol dependent, on benefits or low income. According to Billy:

Well look, when you're in a state of mental [ill health] you know, depression and as I said to you what I found is you need interaction. Basically, you don't want to talk to anyone, but hunger drives you out (Billy).

One function of the project was to provide food. Alice suggests:

The idea is to bring people together and we do this through, cooking and eating together because that's a sort of universal thing done in all cultures and throughout history people cook and eat together. It's part of human interaction and human like

social life… some people might come because they're lonely, or bored or feeling low in mood and they know they need to get out, so they'll come to us every week (Alice).

Alice's quote buttresses Billy's idea that CK contributed to reducing his sedentary lifestyle. It also emphasises residents know what they need to improve physical and mental health and the part CK played to respond to this need. This finding supports the understanding that residents know better what they need to improve their lives, and resident providers are better at responding to these needs (See Chapter 4).

Good food and healthy eating

Another aspect of good health commonly discussed in the interviews was providing healthy cooked meals in the project. Many participants came out of their houses every Tuesday primarily for the food provided at the CK project. As Alice notes:

"People tell each other, so often someone will come in and say 'I've come here because someone said I could get help with such and such here.' Or 'I've come here because someone said the food's good' (Alice).

Alice also identified poverty and issues with benefits were reasons the CK attracted residents. She also suggests that food was a primary reason for many participants to come out of their houses every Tuesday to CK.

And other people come because they know they're going to get a free meal and they're living in poverty. Some of them have no income at all because they've slipped through the benefits net and some of them are homeless, even living in tents, on Tottenham marshes because the austerity means the cutbacks in services plus the housing crises means they're destitute (Alice).

Food was fundamental to participants of the CK project. As noted in my field note, on the 4th of October 2017, CK had access problems to their venue and was forced to have their Tuesday session on the lawn next to the venue. Alice was eager to carry on with the session, and so were all the participants (n25 people). It was an exciting afternoon as I watched everyone adamant to carry on despite this challenge. Volunteers set up the cooking utensils quickly using electricity from one of the participant's homes. Others brought out chairs and mats from their homes and people settled down to enjoy their afternoon. Music played softly in the background

contributing to the already exciting atmosphere. The food was served, and everyone was happy to be a part of the success and accomplishment of the day including me.

The expressed need and demand for CK demonstrated through PB votes show its importance in this community (Bradshaw, 1994). The show of ownership displayed in the face of this challenge showed they benefited from CK. Participants' adamance to continue the session was also instigated by the bond of solidarity that I observed forming within the group and the community action to satisfy a need.

Similarly, Herbert comments that even when CK participants came for advice on housing, benefit or immigration, food was always the primary objective: *"what I'm saying is, some of them just come for the food"*. During the 4th of October 2017 session, I observed residents commenting about the quality of the food and its importance for good health. These comments resonated with me as I ate the food and reflected on how meaningful this food provision would be for the people from this neighbourhood. I could hear them say the food was nutritional, and they would replicate these at home to improve their health. Later while interviewing Herbert, he explained how a similar community project he worked on enabled participants to gain healthy weight a few months after, according to doctors who worked with them.

> *... we can see, with some of the food that they were getting, it was very reasonably nutritious they [doctors] could see over a free form of period people had a healthy weight gain and how it had helped them (Herbert).*

The food's presentation was also crucial for making residents feel valued as Alice and Fernando noted:

> *....you know the food always looks delicious, it's colourful, it's well cooked, and it's nicely presented, It's not a load of slop on a plate at all. I think that's important because even though slop on the plate can be perfectly nutritious but just presenting food in a beautiful way makes people know they're being cared for, that's quite important (Fernando).*

> *...colourful food tends to be fresh food, fresh fruit, vegetables, not overcooked, but looking beautiful, and people respond to that. And you can see their eyes light up as they're looking at the food., 'Mm, that looks nice, oooh.' So, that's a good thing. '...oh healthy eating', so, people comment. ...They notice it's healthy and fresh food. People*

do say, 'we do talk about cooking at home, and how easy it is to cook this and how cheap it is to cook this'. We haven't got any evidence or proof, but people do respond, and they seem to think, 'Yeah I could do that, I'll try this.' Or 'How do you make that?' 'What's in that?' (Alice).

Fernando spoke of lifestyle changes of community members he had noticed:

There are real lifestyle changes especially in terms of like diet. I get people like preaching to me about what I need to be eating and what I don't. And these were the same people you'd see with boxes of chicken and chips all the time. So, the shift is already happening (Fernando).

The quotes above demonstrate good food can make people feel valued and can cause changes in behaviour. *Modelling behaviour* represents how people were copying good behaviour and this is evident in the effort of participants to adopt healthy cooking and eating habits.

Although Herbert agreed the food was beneficial for well-being, he argued the other services provided were more valuable. He emphasises more tangible results would be seen with free food four days a week.

The good thing with this is the nutrition, what people are eating. ...the other services we offer helped them to a greater extent, but hey, if having something decent to eat for one Tuesday helps with their mental health and their well-being in that sense, then that takes some of the pressure off. It's quite negligible… remember it's only one afternoon a week. However, if one day, they can get something to eat and they can take something home with them and that helps them, yes? Some residents have talked about making better choices with regard to what they're eating, but I'm sure when the pressure's down and there's only £2 in their pocket, I think it's got to be the chicken and chips £1.99 deal that is going to help them through the night. To get a decent meal even somewhere like here you've got to look for about £5 and upwards. (Herbert).

This quote suggests it takes more than providing a healthy meal once a week to enable people from deprived communities to uptake, shift to and maintain a healthy diet. However, having hot meals once a week empowers them to act to make a difference. Herbert suggests this is important for resident's mental health and well-being. Significantly, Herbert's quote also

indicates residents were making healthier choices of foods despite the one day a week provision.

Modelling behaviour and changing physical appearance

Modelling behaviour was closely linked to change in physical appearance and other lifestyle changes such as improved hygiene, taking up jobs and making healthier choices like decision to tackle alcohol and drug addiction:

> *…there's a Polish gentleman who lives with Hendrix, [a volunteer at CK], …. He's seen how Hendrix disciplines and carries himself. And we've had to give him discipline regarding substantially cutting down on his drinking …smartened himself up; we send him off for jobs ...just made him more focused on what he can do. He is now looking healthier… He comes there every week; there's a caseworker who has been working with him, that's helped. He had terrible thrombosis, serious, like an acute situation with his leg, and it looks a lot healthier, and he's making better choices and healthy lifestyle choices (Herbert).*

This quote mirrors the observation Fernando made about the lifestyle changes he had noticed, particularly with two residents he was acquainted with. He tells me the story of Simeon, a resident who had become homeless and was living in a van. Simeon could cut vegetables and become a part of the group without formalities of traditional interventions.

> *Within the project itself, they've [residents] been allowed to participate… without many rules and regulations. If you connect that to the traditional way of funding projects, you usually have 150 rules of all the things you can't do. With PB, we are trusting the community to run itself (Fernando).*

Fernando suggests this inclusive practice allowed residents to experience a sense of belonging and exercise confidence to voice their needs to services. This led to a transformation in circumstance, which caused a change in behaviour and physical good health within a few months.

> *…Certain services started to come in. One of the services that came in was the legal advice around housing. Then he started engaging with them directly. So, there was no need for him to be intimidated by going somewhere into a corporate environment. And*

like you imagine, someone who has been homeless for several years, he had a particular aspect to him in how he looked and, in the way he smelt. And he didn't have to be intimidated. So, he engaged and in a matter of about three to four months, he got housed. So, when he got housed, you could see his demeanour completely changed. And even his narrative continued to change, he started to think I'm housed, and he began to dress up. And he was like going; now it is time for me to look after myself. I need to stop drinking - I need to drink a lot less. He still hangs around with people in the community group. Every time I see him, whether it is a Friday night, Monday morning, he always has this positive outlook to his narrative to his life. And that didn't even take that long (Fernando).

When I queried the "*three months*" turnaround time of Simeon's circumstance; Fernando responded:

Probably, I'd say in six months; he went from being a homeless person, you would classify as on the verge of suicide into becoming a really, really positive person that you see him now walking up and down the street, stop to smile, he would laugh with you, and even looking to get of better health and stop drinking (Fernando).

This demonstrates that the direct response to resident's needs can empower them to develop a positive outlook and enhance their capacity to enjoy life and build social relationships. Interestingly, Fernando insists PB provides an enabling environment for projects to respond to residents' needs by removing formal requirements of participation. This finding strengthens the evidence that PB interventions are responsive to residents needs and has implications for residents' engagement in community-based projects to improve health.

Alice expressed modelling behaviour as one of the evolving benefits of the CK project. She highlights her reason for setting up CK was to bring people from diverse generations to model good behaviour.

For example, participants can copy "*helping out"* which can encourage engagement.

...It's kind of by example and role modelling. If you ask someone to help, and then someone else sees someone else is helping, ...they'll jump up and say, 'Well, what can

I do?' ...it's just by showing and allowing and permitting people to take ownership (Alice).

Alice suggests involving people in running the project enhanced participation and ownership. This, in turn, enhanced a sense of purpose and commitment by residents. Alice gave residents agency and freedom to take control and contribute without being micromanaged.

If someone's cutting up the salad, you know, let them make the salad how they want to make the salad. Don't be standing over them telling them, don't do it like this, do it like that, do it like this. But you can have a conversation, and obviously, there must be food safety and hygiene and stuff. I always say to people do it how you usually do it, ..., or try to encourage ownership for people to understand it's not a service being done for them, it's something they can shape and be part of.

Similarly, Hendrix, a resident turned volunteer, states:

I more than enjoy, I gain more helping other people. Because this is not just where you come and eat. This is where you come and learn by example. You come here, and you learn how to help other people when you help yourself.

Despite the evident *behaviour modelling* in the CK project, which increased social support, Alice suggests some existing environmental factors prevent positive behaviour change.

...and a lot of the people that come to us, the first thing they do when they come in the room is come and tell me how they're doing with their giving up their drinking or whatever they're working on, which is interesting. People really want to make changes but find it very, very, hard and they're not living in the sort of environment or situation that makes it easy (Alice).

Alice notes changing behaviour is challenging in RDPW because of evident structural barriers.

RDPW has been malignant terribly over the years, and it's been neglected. And many people with problems have been moved there and just left to get on with it. And because of the austerity, people aren't receiving the same services they're used to. If you want to go to rehab, it's not as easy as, 'Oh, I want to go to rehab, can you take me to rehab?' ...you must prove yourself by going to meeting after meeting in the community to prove

your motivation. And obviously, with people around you all drinking and using drugs and the other stresses and strains of life, it's very hard to make that shift (Alice).

This quote highlights the neoliberalist political, social and economic injustices that tend to hold people back from thriving in society. Despite these challenges, this PB project enabled a growing sense of community and ownership forming and people could express their needs.

Mm, mm, I see people do talk to each other and talk to me and they seem to feel quite comfortable and at home, they'll shout out their opinion about this that and the other and there will be a discussion or, and then the fact people help so there is a sort of ownership. But in terms of taking control and I don't think people feel and I don't think, they can. I mean they can't, they can't, let's be realistic. So, people …they are trying to take control of their lives. So, people may come for weeks, and weeks just come and eat, suddenly they might come up and say I've been dealing with this, it's been worrying me, and I need a bit of help. So that is a form of people taking control of their own personal lives, trying to decide and seek help to make some changes. And we see a lot of that (Alice)

This quote suggests the CK projects give people agency to begin the journey to recovery from life stressors. Still, they need a supportive environment to enable this recovery process to be maintained.

Alice expressed her CK project was *"more about participation and community empowerment and people finding a voice by coming together".* Alice emphasises CK intentionally brought all types of people together to enable a collective effort to support each other to make the change they wanted to see. This was evident in respondents' examples of legal and lay support and tangible lifestyle changes. For example, some people got housed and began seeking to improve their immigration status or gain employment.

Category 2: Enhancing positive relationships with others

Participants that found connecting with other people and talking to them regularly was fundamental to enhancing well-being. The CK group always had a buzz around it when I visited. People were always speaking to each other, sometimes loudly with a lot of laughter, enjoying each other's company. For instance, on the 28th of November 2018, when I visited,

45 men and women were sitting around the room. I felt welcomed around the room as I talked to people from diverse backgrounds and ethnicities.

Connecting with other people

Connecting with other people helped Billy reduce stress and feel normal again. Billy was depressed and thought he needed to seek help for rehabilitation. *I'm so low I thought I'd go through rehabilitation again get myself back into the groove again.* But he met Alice who told him about the CK project.

> *The opportunity to talk to people, discover your pain is not yours only - other people have got their own pain. Right and meet the people that bring you back to normality in terms of the conversation, the way they talk to you. It makes you feel like you're kind of normal again (Billy).*

Despite living in debilitating conditions, Billy suggested interacting with others in similar situations and sharing stories helped him develop a positive outlook and enhanced his capacity to feel normal again. Billy started to enjoy life and contribute to the CK project and volunteer in other community projects. Up taking volunteering by Billy here overlaps with *"modelling behaviour".* Sharing stories was a source of love and affection, and this brought happiness to many. Hendrix himself was very lonely and had no one to talk to until he joined the CK project:

> *Because a man who is hungry, a man who don't receive help, and affection and somebody to listen to, that man is being thrown outside, is being thrown from hearing his story and England is one of the greatest and richest countries in the world but it's not the money, it's the love, it's the thing you have, happiness is in your mind …I mean I have somewhere to talk, I have somebody to see, I'm a pensioner and I live… I am by myself. Before the CK is started, I got lost because I have no one to talk to, I trust no one. But when the Cook Up come, that was the light up to my heart (Hendrix).*

Hendrix no longer felt a part of the problem but a part of the solution. "*Well, I am not lost anymore; I am part of the solution, and I am very happy to be able to give a hand".* Billy expressed a similar sentiment. *"So, I come here, if Alice needs anything done, she says, 'Billy will you do this?' I'm just happy to do it, that's all there is to it really".*

Connecting and talking with other people were significant factors cited by participants for coming into the CK project. The importance of supportive, positive relationships was evident. Many of the participants were isolated and had no friends or people to talk to but coming to the CK enabled them to make new friends and feel connected. Holly came to the CK because she was told she would meet people:

> *I tried it out, and since then I have been coming here most times, 'cos it's enjoyable, nice food, good people. And I have made a couple of friends. See Danna there, she done the acting with me (Holly)*

Holly asserts the CK helped her come out and talk to people: "*it's good to socialise and bring yourself out ...get to talk to people, see what else is going on."* Hendrix's earlier comment about having someone to talk to echoes Holly's comment above. Socialising reduced loneliness and increased residents' sense of well-being.

Talking and building networks

The CK project appeared to provide a space for people to share stories of good and bad times. Despite the buzzy nature of the project when you walk around the tables you could hear serious conversations about people's personal issues. People felt safe and comfortable to talk and it felt like informal counselling was taking place. People were learning new things and new ways of coping. Herbert explains why people come into CK. "*I think primarily where they feel relaxed, at ease, its informal. They can get something to eat" (Herbert).*

He affirms CK is a comfortable space for people. Herbert's emphasis of the informality of the space and how uncommon gathering of people from mixed backgrounds strengthens the evidence that PB projects increases engagement:

> *I reckon it's one of the few places you can get that number gathering, about maybe 40+ people where it's got to be congenial, quite amicable, quite relaxed, quite informal. Voices get raised but you're not going to see fights and shouting and screaming and all the rest of it. It's going to be jocular; I know the guys are there, and there's a bit of testosterone (Herbert).*

Fernando shared middle-aged men in RDPW are hard to engage in community activities. He highlights unless you go to the pub or are talking about issues like banning prostitutes or closing

the bars, you do not get their attention. However, the CK has managed to attract this group of traditionally hard to reach community.

> *There's lots going on. There's lots more than normal. I mean in terms of the people that are being engaged at the CK… As an engagement officer, the hardest people to engage is middle aged men. That's exactly the group there …it's still difficult, it continues to be difficult. Unless I go to the pub then I go and have conversations with middle aged men, they are quite hard to engage unless you're talking about specific issues, [like banning prostitutes], I guess from a man's psyche is important- you're just like crossing the line (Fernando).*

Fernando's comment suggests the CK enables difficult-to-engage groups to participate. Increased participation of underserved people here is consistent to the impact of PB (Cabannes, 2004a). Becoming relaxed and familiar enabled people to share stories and helped others to learn new ways of coping with their problems. Many lonely residents found solace in coming to the project and building positive relationships enabling a positive outlook to life and a sense of purpose. *Talking to people* regularly at the CK enabled residents to build positive and long-term relationships, enhancing a sense of purpose and increasing connection. Billy expressed the connection he felt:

> *Well, personally it makes me feel connected. So much so I'm even questioning whether I'm going back to south London (Billy).*

The CK meeting gradually became a therapeutic space where residents could share their problems or needs and feel lighter. Sometimes residents offered help or signposted other residents to where they can get help. These conditions enhanced the building of positive relationships and trust among residents. In speaking about the regularity of the Tuesday club, Alice comments:

> *People come feeling relaxed, they know what to expect, it's always more or less the same people, the same staff, same volunteers. So, it's quite a relaxed atmosphere, and I've noticed people do talk to each other. Even though they may come from different parts of RDPW or have a completely different walk of life, they still talk to each other, and they become familiar and get used to each other (Alice).*

Talking continued outside the CK project, strengthening connections, and increasing the social support network and social capital.

> *Consequently, after meeting someone here, next thing, you bump into them down the street, so, it's got a way of connections, because other than that you wouldn't meet them. But you're actually on the same level when you're sitting at the table and meet each other, and when you see each other on the street, you have a different connection than if you just saw them in the street (Billy).*

This kind of benefit was evidenced throughout the interviews as participants described processes where their feelings of lack of safety, distrust, isolation, and loneliness were mitigated by the developing positive connections in CK.

Billy, a transient resident, believed his membership in CK strengthened his social network and social capital. He refers to permanent residents as "*rocks in the stream".* He notes Raymond, who tirelessly supported other residents:

> *There are many good people here, like Raymond, who is a soldier in terms of his work. He's tireless, and he's dedicated to helping local people. ...they challenge residents like me and everyone else ...I mean, after I'm gone, they'll still be here. I'm going to move on ...I mean, everyone's a stream, and they're like the rocks in the stream. So, consequently, they're linked to a whole variety of people and services because they're here all the time. I mean, all I can tell you about is what I've encountered in the short time I've been here. And all I can say is they've made me feel very welcome (Billy).*

Here, Billy expressed the value of residents like Raymond with a wider social network and resources brought to the group and the feelings of belonging it brings. This finding is interesting because it demonstrates implications for bonding social capital extending to bridging social capital. (Brisson and Usher, 2005). The conversations evident in CK shows a development of bonds of solidarity and trust building among participants:

> *So, you do get those exchanges more, where people believe the other person will care about what you're saying or what's important to you and give you time. I'm not romanticising this wonderful picture of village harmony ...but there is a bond of solidarity and loyalty people have knowing they're from a similar situation, and we all need help sometimes. It does take time to grow. You can't just make that happen (Alice).*

The sense of being listened to, heard or understood enhances connections important for positive physical and mental well-being. Developing trustworthy connections among participants was associated with the feelings of self-respect, self-efficacy and self-worth and belief in the ability to take action over your life (agency).

> *This is where you come and learn by example. You come here, and you learn how to help other people when you help yourself … It's not only food I get here. I get respect, for myself and I can help other people at the same time. (Hendrix).*

Hendrix expressed residents achieved a positive sense of self and engaged in learning to transform lives through connecting. Connections in social groups reduces the risk of future depression or relapse (Cruwys *et al*, 2014; Cruwys *et al*. 2013). Developing a positive sense of self described by Hendrix was important for contributing to a strong volunteering ethos discussed below.

Category 3: Having a strong volunteering ethos

My analysis showed that giving back to the project was empowering for participants who were committed to the project. Giving back, coded as *"helping out",* was a starting point for recovery and growth for many participants who also improved their lives through getting help.

> *This is not just Cook Up this is the golden door to peace, love, and to help yourself and other people (Hendrix,).*

> *...what we've noticed is people like to give back in different ways. Some people might want to wash up; some people might give back by bringing someone else who needs help. Some people help prepare the food, just we've noticed there is a vast willingness to lend a hand. And I think people get something unique from being able to do that, rather than just being on the receiving end and being served by the people, which is nice. I do think people get more from being able to participate and be part of something (Alice).*

The idea of giving time and support freely to existing service correlates with reciprocity (Putnam, 2000) emphasising participants' willingness to contribute to project development. Hendrix and Alice attribute volunteering to feeling valued, belongingness and well-being. This finding highlights the impact of CK on personal and broader community well-being.

Billy confirmed his volunteering increased both personal and community well-being:

> *Volunteering makes you interact with people, you know, what they're going through, or you have some idea because of your own circumstances, so generally you come out feeling better, always come out feeling better because of your talk - look, people you meet, you discover they're also volunteers and then you get involved,…as a consequence of volunteering here, I'm now volunteering at the allotment… because of my movements around here (Billy).*

Billy came to the CK to receive help but later started volunteering for the project. As result of the confidence gained here and knowledge of other community events, he moved to volunteer at a community gardening project, which has implications for well-being beyond the project.

Category 4: Action on social determinants of health

The additional £5000 grant allocated to CK was used to provide a legal advice service for people with housing, immigration, benefit, and employment issues. This became a valuable resource for residents identified with such difficulties.

Habib, a homeless resident said coming to the CK is different because in traditional settings you get basic information about your situation, but at the CK you get:

> *…lots of help, advice, how to move, how to work. There's lots of things particularly like, in this situation I'm homeless, or it's like really hard (Habib).*

Habib gets food and interaction, which helps tackle the loneliness. *Well, first in terms of food, at the same time …the getting together.* Pointing to a group of homeless Polish men and women sitting on another table; he said:

> *It's like, look at those people around you, it's like, there's loneliness in each of them, it's a solitude and the problem, is, they try to overcome that with alcohol, this just makes it worse for them. It's like how you call it …hmm, alcoholism, in a way, why cos when they're on the streets at night, it gets really, really, cold, and like them, they need a drink to survive that (Habib).*

In the above quote, Habib explains how his Polish friends survived these difficult conditions on the streets by getting drunk. He went on to explain how he copes with the cold and loneliness on the street:

> *...like for me I prefer rather than for me to take a beer, I prefer to smoke a joint. Why? Because see what it does to your brain… it only moves neurones regarding to pleasure, relaxation, joy, and it reduces stress and anxiety. And when it's doing that what it does… it burns fat; it burns sugar and produces warmth inside you. You know when you are feeling good, when you are happy, you won't be feeling cold (Habib).*

Telling Habib's story helps to get his voice heard about the sufferings of homeless people not only in Tottenham but around London and gives context to the development of those who came to the project and got housed. Getting housed was coded five times and was used to describe progress made to being housed or people being housed through the legal advice they received at the CK. Habib's story also echoes Fernando's story about Simeon, a homeless man, who got housed. Simeon's story was like the other homeless visitors to the project but different because he got involved in the process of "helping out" at the CK. According to Fernando:

> *When Simeon got housed, you could see his demeanour completely changed. He continued to come and participate in the programme. And even his narrative continued to change, he started to think "I'm housed", and he started to dress up and all that. And he was like going, "now it is time for me to actually look after myself'. I need to stop drinking - I need to drink a lot less" (Fernando).*

Similarly, Alice talked about Bryan, another homeless man who increased in well-being within a few days of having a place to sleep and personal care.

> *Someone I referred to a winter night shelter got a place in the winter night shelter, which isn't always easy cos usually there's a waiting list. He'd been living homeless, and what a lot of people do is sit on the bus all night because it's the only dry place you can get. Also, because this man had no recourse to public funds, it's not easy to be accepted into any projects. But the winter night projects do take people in that situation. So, he went there, and three days later he came back, and he looked like a completely different man, he'd shaved and cut his hair, and he was standing upright. And I realised*

cos someone else had told me before that after you've spent nights, weeks, and months on buses, you can't lie down straight because your body becomes bent (Alice).

'Getting housed' or a place to stay was associated with changes in physical health observed in Bryan. This meant that as soon as the structural barrier of housing was lifted, Bryan's personal care improved, leading to increased well-being. I witnessed this narrative of enhanced well-being common among residents who engaged with Herbert, the volunteer legal adviser, at the CK. Alice and Herbert, keenly supported project participants homeless residents like Bryan with immigration issues:

...and Bryan looked great, and he's still going, he's still at the night shelter. They're going to refer him to an organisation. I've learned about Praxis, where they provide accommodation and legal support for people trying to resolve their immigration status. ... (Alice).

From supporting residents, Alice enhanced her access to community resources, extending the group's social capital. This is an important finding as it demonstrates CK participants could enjoy benefits of bonding and bridging social capital. This finding also has substantial implications for alternative delivery of social services where traditionally excluded residents are reached to improve well-being and reducing inequalities.

Category 5: Creative partnership working

Partnership working was evident among PB projects in CK and with local organisations. The CK project liaised with organisations such as Haringey Law Centre to provide training for volunteers to provide case work and counselling for people with benefit, housing, and immigration issues.

So, we've been invited for training by the Haringey Law Centre and that's really benefitted our guests because we've been able to give more effective advice and support and signposting to them. Herbert has liaised with them over specific cases, and he's got advice from them about how to manage particular cases and what sort of options there are so that's been really good (Alice).

Other PB project deliverers supported each other. Lily, project lead of London Family Club (LFC- pseudonym), helped to cook in CK. The importance of this collaboration meant that money was stretched as Alice did not have to pay for a cook when Lily was able to help.

> *I know for a fact there's a lady called Lily who runs a class up here. She sometimes works in the kitchen in Alice's project (Billy).*

Partnership working was seen as action for change, where participants gained access to information and advice from local agencies to support decisions about changing their circumstances.

> *I look at the CK and see people walking in. They know "I'm going to get a warm meal ...hey, there's that guy who's constantly pestering people over there if they want some help or advice and there's other information I can pick up"; there'll also be BUBIC, who are drug and alcohol service, drop-in as well concerning drug and alcohol service information they give out. They gave a client some information with some immigration issue to the Migrant Resource Centre (Herbert).*

This quote demonstrates how community organising can give people control over their circumstances to address inequalities. Partnership was also evidenced in residents giving money towards the food to keep the project going.

> *We've had other people put money in as well. ...even some of the guests, there was one guest who just before Christmas gave me £20. And I know he doesn't have regular work because he talks to me. I've known him from the neighbourhood for years (Alice).*

Partnership meant participants actively volunteered in CK to save cost and ensure sustainability of the project. Fernando attributes project participants' willingness to volunteer to PB because they assume ownership. He asserts CK has survived on £3000 a year because of the strong partnership with volunteers.

> *They've been surviving because there is an element of co-production there and co-delivery within the actual delivery of the programme. That's what PB does (Fernando).*

Explaining co-production and co-delivery, Fernando said participants become invested in making the project sustainable.

To me, it means the client becomes the deliverers of the programmes as well. …they start volunteering no. 1, no. 2 they start looking out for ways to improve the programme because they start to put value into what they are doing. So, they start to look at sustainability not in the way we discuss sustainability but how they understand sustainability which is, "I come here every week, on a Tuesday, I value the company. It's making my life better, so I contribute by cutting vegetables, and I'm not just improving my well-being in terms of the food that I am eating, but I am improving my mental well-being. My brain is releasing the right chemicals because I now feel valued. And I feel part of something bigger than myself" (Fernando).

Contributing to the project increased residents' physical and mental well-being, including eating healthy, feeling valued and sense of belonging to something bigger than themselves. Additionally, involving residents in running the project and working with a range of public sector agencies and local organisations facilitated participation in decision making and problem-solving processes which helped residents develop skills to act for change individually and collectively.

Category 6: Creating a sense of community

Whenever I visited the CCUP project, I noted the CK project attracted people from multicultural backgrounds and countries. I observed that many were not English speakers or had English as their second or even third language. Nevertheless, participants felt a sense of commitment and ownership to the project. This was evident when respondents expressed a strong affiliation to the people who attended the project and their love of being welcomed to participate and *"help out"*. Alice, explained:

There must be people with at least between 10 and 15 languages and cultures. We've got Sudan, Somalia, Turkey, Albania, Poland, Lithuania, Bangladesh, Africans, Caribbeans, Jamaicans, Italian, Portuguese, Mauritius Brazilian, Columbian, British. A few people that come see themselves as Londoners. They've been here for generations. For most people that come, what we've got in common is we've all come from other places, and we are looking to find a home, a belonging, a sense of belonging in where we now live (Alice).

Hendrix, expressed value and a strong connection to the CK and its participants:

> *It's a golden door for knowledge and lead by example because everybody who is here have a heart and a great mind, morals, and principles, that no politician can have. Or if he has, sold it for a penny. I am more than part of them. I am one of them, and I will be with them until the day I am in heaven. And even in heaven, I give them a free ticket to come (Hendrix).*

Alice expressed how the CK project was improving her daily life.

> *I do feel I'm more part of my community. When I'm out and about I see people, like today, I was going to do something with Raymond but ended up just being here and enjoying being here and helping a bit and having a meal and touching base with people. I told people about other stuff that's happening in our community. Some people don't watch the news, but they still want to know what's going on. So, I discuss it because I'm interested in what's happening. Before, I worked outside London, and will always be in my car, so I never got a chance to meet anyone or bump into anyone. But since starting up the CK project, I've been walking around more in my area and going to the Cook Up every week and having to ask people to help me and I help them, like when I arrive with the car, people come to help me unload the car (Alice).*

These quotes evidence many aspects of lifestyle changes occurring among the CK participants, but essentially involvement in a PB project increased a sense of belongingness which reduced sedentary behaviour, increased social interaction, giving back, and taking notice. Also, participants increased their sense of community belonging and well-being through contributing to the CK. Being able to contribute to your community is a core factor for improving mental well-being and human flourishing. These findings are consistent with five actions for well-being identified by the New Economics Foundation (Aked *et al.*, 2008).

Being voted for through PB increased the feelings of achievement and a sense of community. Alice explained that participants felt a strong sense of respect and pride for being selected by the community. This increased confidence and hopefulness, belongingness and strengthened participants' sense of ownership.

> *...because I told the people we won the funding and it had been voted for by the community. I think that gave people a sense of optimism and self-respect that they were part of something other people knew about and had voted for and that they were part of that. So, I think that gave us all a feeling of self-pride (Alice).*

The legitimacy of the CK permitted through a public vote by residents increased the freedom of association of diverse people from the area, leading to social integration and a circle of lifestyle improvements associated with different dimensions of well-being.

> *When people vote for you and say we like what you're a part of... is a good thing. Then you know the shame people may have potentially felt about going to get free food evaporates because it's been legitimised. Everybody thinks it's important, and the doors are open, and everyone can come in. We do have people from all walks of the community who have lived there for ages, older people who come in, and some people just come in to support us now and again. Some people from the participatory budget do come in to see how we're getting on (Alice).*

Alice suggests PB inspired support from non-recipients of the CK who attended the voting day. This support came in the form of words of affirmation or gifts of money to the service.

The positive relationships developed in CK enhanced residents' sense of purpose and connection to other health promoting activities happening in the community. For example, Holly *became aware of other* community activities like the TF project, increasing her connections and sense of belonging and well-being. Allowing anyone to attend the CK encouraged participation from residents who would traditionally not engage in community activities. Hendrix referred to the CK project as a *"golden door"* for access to community provision for improving human capability, which enhanced belonging to the community. He claimed immigrant residents unable to speak the English language get help with access to ESOL Centres to learn to communicate better in English. Hendrix emphasises this helps such residents to increase their sense of community belonging.

> *What I have seen here is people come and they don't even speak the language and they go into a school to learn English, no matter how old they are, 60, 40 whatever age and they end up being part of the real community. This is the golden door to knowledge and knowledge is power (Hendrix).*

Language barrier is a hindrance to community belonging for immigrants (Salami *et al.*, 2019). 65.3% of the population in Haringey consists of non-white-British ethnic groups. This includes families with no recourse to public funds, people seeking asylum, EU migrants, and under-documented or undocumented migrants (see Welcome Strategy Haringey: A Welcoming Borough for All & Haringey Census Statistics). The freedom to participate in the CK removed the structural barriers in traditional provisioning to enable traditionally excluded people to gain access to provision capable of improving their well-being.

5.1.3 Section Summary

Participatory budgeting is popular for increasing engagement and responding to residents' needs. Respondents reveal PB influenced the CK's design and delivery, maximising participation and engagement of traditionally excluded residents. The informal and flexible methods employed to recruit and retain participants increased the involvement of residents. They enabled various residents to seek help and engage in beings and doings essential for enjoying life, including the five ways of well-being recommended by the New Economics Foundation in 2009.

Regular participation increased connections between residents, leading to social bonding based on acquired self-value, confidence, belongingness, a sense of purpose, and increased capability to improve health and well-being individually and collectively. Many characteristics of the CK influential in adopting healthy behaviours have implications for improving social service provisioning. For example, involving residents in the day to day running of the project with fewer rules and regulations and positioning external agencies to provide help, aside from the free hot meals, contributed to the lifestyle transformations discussed by respondents of this study.

Section 5.2 Case 3: Women Together Network

5.2.0 Background to Case 3

Women Together Network (WTN) is a social interaction and engagement club targeting women who have been in violent relationships. The WTN project was set up to respond to Priority 2 of the WL programme designed to improve the uptake of physical activities, increase healthy eating and improve mental health for individuals and the community. Priority 2 aimed to empower all adults to lead healthy, fulfilling lives. The project welcomes women from all levels of society from age 18 and above, from all race and ethnic groups living in the Tottenham ward in Haringey. WTN ran weekly Wednesday sessions from 9am to 5pm at a community hub in RDPW. Participants are a diverse group from Afro Caribbean, African, Turkish, White British and Somalian dissent. WTN attracted 50 to 80 participants quarterly with 20-25 recording weekly attendance. It also accommodated children and young people attending with their mothers. The group was set up by Naomi (pseudonym), a local resident and WLDT member, who suffered domestic violence herself.

The group won £3000 in March 2017 at the PB event organised through the WLP2 programme (see Chapter 4). Naomi, (the project lead) claims the project gained popularity with the local people after the PB event. Further recruitment has been through word of mouth, flyers, council website, and outreaches through events like the Black History month organised by the group. The group offers a series of activities including, Women Creative House (sewing, knitting, and jewellery-making), Women's Energiser (Ice breakers & Zumba), peer support, Multicultural Cuisine (Cook, Taste and Share), Women & Family Breakfast, walking group, art therapy for mindfulness and many more. All these activities were free and created to increase community connections and build social relationships.

The project also invites speakers to improve women's knowledge of increasing financial literacy/ independence, getting back to work, or becoming self-employed. On several occasions when I visited, I was able to observe guest speakers talk about self-employment, financial literacy, feeling good and beauty advice for self-image building.

The group had 10 volunteers who helped run the sessions developing skills and confidence to run their own projects in future. The volunteers have also accessed a few training courses including the Food and Hygiene and the Wheel of Well-being courses. Some of the women

have moved into employment and self-employment through participating in this project and others have returned to college.

Table 5.2 Respondents' characteristics (WTN).

	Participant Name (pseudonym)	Mins	Type of participant	Age range	Ethnicity	Educational attainment
1	Zahra	40	Volunteer	30-35	Bangladesh	NVQ L 2
2	Siobhan	35	Community outreach worker	40-45	Afro-Caribbean	TBC
3	Zainab	10	Volunteer	30-35	Asian	NVQ L 2
4	Cynthia	10	CM/Volunteer	35-40	Black African	NA
5	Leticia	24	Business connector/ volunteer	30-35	Black African	Degree
6	Franca	20	CM	35-40	Black African	NVQ L 2
7	Zena	35	Volunteer	30-35	British Asian	Degree
8	Katrina	10	Financial counsellor/Job centre representative	40-45	Afro-Caribbean	Degree
9	Mayo	60	CM	50-55	Black African	O Level

10	Naomi	60	Project deliverer	30-35	Afro-Caribbean	O'Level
11	Vivian	20	Volunteer	35-40	African	NVQ L4
12	Fernando		Regeneration CE worker	35-40	Brazilian	Degree
13	Genevieve		PB facilitator	40-45	Black British	Degree
14	Melissa		Public health commissioner	30-35	Black African	Degree

5.2.1 Respondents' characteristics

The Riverdale Park women I interviewed were similar in many aspects. They were mainly house-wives or single mothers with low educational attainment, described as stay-at-home mums and known to be isolated from a wider social network. Another commonality was that almost all the women were unemployed or self-employed with low income. For example, Zahra, a volunteer, explained:

> *I have three children, three boys. I live in RP, and, before I was a nursery nurse. I was working in different schools, but since like my marriage and my children, I stopped working, it's about 9 years now (Zahra).*

Zahra helped to run the WTN project and ensured women felt welcome and engaged in the day's activities. Another group of women I interviewed were different from the above RDPW women, were in work and attended as representatives of community organisations. Katrina, Siobhan, and Leticia partnered with Naomi to offer access to community resources. These resources included funding or training workshops.

5.2.2 Main findings: Factors or conditions for achieving increased feelings of health and well-being

This section discusses the thematic analysis of interviews which identified five conditions which contributed to increasing participants feelings of well-being. These factors include building positive relationships, developing a strong volunteering ethos, actions on the social determinants of health, creative partnership, and developing a strong sense of community.

Category 1: Improving physical health

Respondents described perceived nutritional benefits for women and their children involved in WTN, including greater knowledge/ awareness and improved attitudes towards healthy eating, and willingness to partake in cultural foods new to them.

Food/healthy diet

Providing healthy meals for women and children for breakfast and lunch was a priority of WTN project. It was an incentive for the women with low income challenged with providing nutritious meals for their household. Zahra explains:

> *And we have free breakfast and lunch here. There's always a different cultural food every week. Parents who don't have time to make breakfast for their children come here and make their children breakfast and take them to school. Even with lunch, they don't want to cook at home, and there's always someone who's doing cooking every Wednesday. So, they come and eat here (Zahra).*

Zahra's quote above highlights the finding which demonstrates the food aspect of WTN enables the uptake of healthy eating and allows some respite for women who participate. Low-income neighbourhoods offer greater access to food sources which promote unhealthy meals. By providing healthy meals, WTN project promoted healthy eating and nutrition education to women. Fernando attributed this to the flexibility of PB projects to respond directly to the needs of the community to improve well-being

> *Projects are extending their remit. But the good thing is that participatory budgeting enables people to do that, if I learn from you that I can add a food element to it with no extra cost, I will do that (Fernando).*

Health and well-being were viewed as a by-product of the delivery of PB projects.

> *I've seen benefits that link with health education and nutrition education. I've seen elements that link with improving people's mental health. I've seen people's general well-being being improve, because if I'm gonna think… the basic needs of people are usually to do with shelter, food, safety, or the sense of safety and knowing that people care. And through participatory budgeting obviously it's not- in a sense it's not participatory budgeting but it's like the programmes that get delivered through participatory budgeting promotes all those four things. So, therefore, normal health and well-being is by-product of participatory budgeting (Fernando).*

Similarly, Mayo expressed the importance of the free food initiative in meeting the needs of the community:

> *It's wonderful because sometimes some families may not even have money. So, I think it's good because sometimes they want toast, you're able to give them toast. Sometimes things are very difficult with some of them, maybe their benefit has been called off and they don't have these things, so if a child can come in there and have a juice or a drink to go to the classroom, it's really nice (Mayo).*

Naomi learnt the importance of a healthy diet through the WLDT training and embedded it in her project design to encourage the women to adopt it at home. This was a significant step in supporting women who came into the project to implement better diet options.

Another aspect of food and healthy diet is the encouragement of multicultural women to cook healthy meal options from their ethnic backgrounds to share with others.

> *Even the food that we're eating is different. It's not like at home… I will cook my traditional food, but when you come here every week there's a different food, there's different people cooking it. …There are all different cultural food …it's all minority group women, like black, Asian, white, everything, it's all mixed group here. It's such a nice group here; I like it (Zahra).*

Zahra liked being in the group because she experienced cultural diversity and richness not known to her before. Bringing your cultural meal meant that women critically considered what they were offering. On one occasion, when Naomi asked me if I could prepare food for the women, I (as a participant-observer) had to think deeply about making my Jollof rice, a staple

Nigerian dish, healthy for the women to consume. I reduced the fat content and grilled the chicken rather than deep fry. Naomi explained the impact of this practice:

> *They're learning, they're eating better. Cos even with the food, we do a lot of healthy eating and having this knowledge makes you eat well. A lot of women have changed their diet. We're teaching them a lot of things that they can change in their lives, it doesn't have to be expensive. But simple little things like having more brown bread and or whole wheat for breakfast. So, they've learned a lot and a lot of them have changed their lives and that's why we always have breakfast in the morning (Naomi).*

Naomi also saw changes in eating patterns:

> "*...a lot of their eating patterns have changed. Even I find that my eating pattern has changed. I eat well, I look after myself. I buy my bulletin and do my smoothie. I try to do more cooking and less take away."*

Another aspect of food sharing was discussed as a bonding mechanism for the women:

> *Last time I was here, there was a long table pushed together and they had cooked this meal of chicken curry with lovely aromas around the room and there was like 25 women eating, talking, laughing, playing with their children all around the table, growing together with food that they had prepared themselves and that was a lovely moment (Siobhan).*

Siobhan's observation above reveals an important finding which replicates research about the significant physical health and well-being benefits for families who eat together on the same table (Walton *et al.*, 2018; Harrison *et al.*, 2015; Berge *et al.*, 2015). Although these studies' findings relate to health benefits in families, their effects translate to experiences described here. The WTN group viewed themselves as a family unit and eating together was a forum for promoting healthy eating, healthy weight, better communication, increased self-esteem, sense of belonging and other psychosocial benefits. The combination of cooking, eating, talking, and playing provided an opportunity for the women to learn about each other's cultures. It also provided a forum for developing English language skills where women relaxed and engaged in "everyday conversations".

Finally, the practical way of involving the women in up taking healthy eating habits emulates a powerful sales technique called tell-show-tell used for decades to get buy-in to products. This method is hailed by Genevieve, the PB facilitator as an effective mechanism for changing the lives of many generations to come.

> *Revolutions happen in the hearts and minds of people before they happen on the street. So, once you change someone's mind about stuff, whether it's about their health, their well-being, their belief system, or their environment, that's an irreparable change. Because once they flip that switch it's very hard to flip it back again and therefore, they may take more responsibility. They not only take more responsibility for their own health, but it influences the health of the people around them. So, when you get a mum and you teach them how to cook nutritiously and she sees the health benefit for her children in terms of the concentration, their general health and well-being, you not only have affected how that mum cooks and her attitude to food, but you've influenced the palate of the children who then influence the parent's palate and the food that their children eat. So, you've made an almost irreversible change by that intervention (Genevieve).*

In this quote, Genevieve expressed optimism of the potential for PB projects like WTN to transform lives by driving a circle of health improvement from individuals to communities and generations to come.

Becoming active

RDPW women were branded as housebound by professionals and challenging to engage. Therefore, keeping active was a new phenomenon to them. For instance, Fernando, a Community Engagement officer explains:

> *If you look at some of these women who have left their house, we assume as professionals that they are housebound to a certain extent. Suppose you see them at the GP surgery; the automatic professional assumption you'd make is "that type of woman stays at home." There's a lot of narratives that get banded about. For instance, men go to work, and women stay home to look after the children and look after the home. (Fernando).*

This was the experience before WL and PB were initiated at RDPW. Many women confirmed this during interviews.

> *Because I didn't used to go out. Like I said, I was a housewife, I use to love cleaning and cooking but since I came here, I'm not doing cleaning and cooking (Zahra)*

Although housework is considered a form of keeping active, many respondents were happier to come to WTN to participate in the activities including Zumba, group walking, and sewing, which provided various benefits. For example, several respondents expressed their experiences and enjoyment of keeping physically active:

> *We had Zumba. Exercising physically - we need it to exercise our body and our mind (Cynthia).*

> *We used to do the Zumba in the morning after breakfast before doing sewing and it was very nice …for the Zumba you must do it every time to see the changes. It's not like you do one day and its finished. (Vivian).*

> *…I think it's a good place, it's encouraging women in the area and because there's such a diverse group of women, culturally it gets them into doing things, keeping them active and keeping their confidence well (Leticia).*

> *A lot of people turn up for exercise. There is a lady that comes for exercise; she says, 'Oh, I need to look after myself.' At least, she's not paying; it's free. She can come to work on that aspect of what she thinks she needs in looking after her health (Mayo).*

These quotes highlight the benefit of *keeping active* to physical and mental health. Vivian recognises that consistent physical activity is good for maintaining health improvement. The free provision was an incentive to keep participants engaged. Money from PB was essential to enable a grassroots project to make this provision available. For example, some of these women were exercising for the first time as money was a barrier before.

> *Some of them are exercising for the first time, some of them have been signposted to healthy living activities. They are not staying at home like they use to and are less isolated. Sometimes we do 'walking'. If people turn up and want to go with the walking group to the marshes. I do the Zumba. I do more walking now. I was always taking the*

bus. We're looking to branching off into doing women only gym, women only swimming and we're going to start going back to women cycling (Naomi).

This is a fundamental lifestyle shift for women who were deemed *"housebound"* and *"difficult to engage."* The women responded to doing exercise classes together as they found this more enjoyable than doing housework at home all day. They also felt less isolated when they attended and engaged with other women at WTN. It shows that motivation is beyond physical activity and the emotional aspect is a key driver enabling women to come out and meet one another and engage in exercise. The quote also shows an aspiration to engage in continuous active lifestyle essential for the extension of healthy living to old age.

Category 2: Enhancing positive relationships

The importance of creating a positive, supportive relationship was evident in the WTN project. Coming out to the group was necessary for connecting with other women in the community. This led to building positive relationships essential for sharing information about local resources, integrating into the community, and well-being. Building trustworthy connections among the women overlapped with feelings of *self-worth* and *self-efficacy*, *being human/self-discovery*, *building trust*, *reducing social isolation*, *increasing social networks* and *belief in the capacity to take action* over their lives.

Coming out and connecting with other people

'Coming out' and '*connecting with other people'* were perceived to promote positive relationships which were important for personal growth and community well-being. Coming out had both personal, emotional, and social well-being impacts for participants. Leticia a community outreach worker partnering with Naomi, expressed positive feelings about connecting with other women.

I think it's a good thing. Even me, I like coming here. There's nowhere you can go unless you are blessed to have a family network. ...This is somewhere people can go and make new friends outside of the friends you have. Even better, they're in your community so you can develop a relationship (Leticia).

WTN space was also '*welcoming',* leading to *inclusion* and active participation:

I 100% feel welcome; that is another thing. I think it's the welcome feeling; there's like a homely spirit. Where you feel you can come in, sit talk to anyone. In the outside world, sometimes, people have armour up, so you don't get to see, but here everyone's guard is down (Leticia).

Whereas here [WTN) I've seen women arrive at week one ...they are already smiling, they are already part of the group. They are already 'included', they are already picking stuff up to do, they are 'helping out' (Fernando).

Although most women spoke about having a family, it was a welcome change to have women with common interests with whom to talk.

And then when I started coming for the women's group it was also very good for me because I met new people, very new people. Ladies from different backgrounds and I started meeting them, they are friendly, they talk (Vivian).

Talking to other women was very important to Vivian as this enabled her to expand her network. Coming out to the group for many of the women was a significant change from their everyday experience. This was expressed as a welcome escape from the routine of daily life. The freedom to leave home once a week to *'do something different'* with other women was a cherished outcome for many respondents. It provided some respite and space to do something more meaningful for personal development, relaxation, and enjoyment. For instance, Zahra explained:

Now I'm doing volunteering with Naomi in the women's group. I started about six months ago and it's good. Since I started, I've met new people. We help women with a domestic violence problem. And even those without this problem come and have free time from home, think freely, and do activities of interest, instead of staying at home and be isolated (Zahra).

A key finding was the impact on social isolation. Staying at home, ironing, cleaning, and cooking were necessary for family support. However, it isolated many women from a wider community and prevented access to local resources, impacting positive well-being. Genevieve, the PB facilitator, explained PB offered women agency to demand for a service that helped reduce social isolation, promote functioning they value and enjoy.

> *There is a project called WTN and they've been awarded funding. And these women have the unfortunate record of being connected by being victims of domestic violence. They were socially isolated. Domestic violence does isolate people and often the partners specifically act to isolate the individual from their family, their friends, and their community to maintain control. WTN has been a forum in which those women come together, do physical activities, get involved in community clean ups, and in health talks and discussions and a whole range of things and the testament was that on the day, most of them women involved in a project got up and presented it. These were women who possibly didn't have a voice prior to that and so that's quite a powerful example of those women feeling much more socially included and engaged and empowered (Genevieve).*

According to Genevieve, PB gave these Tottenham women the agency and freedom to demand for a service they enjoy and value. This evidence aligns with Sen's capability approach of agency and freedom of beings and doings which improves functioning for well-being.

Naomi further illustrated the impact of coming out of social isolation.

> *It's a fantastic thing to come to the group because it's part of reducing isolation. Usually, the women are at home. But coming out makes many people go to the women's group, and it's part of eradicating the social isolation. Some of them don't get up, but by the time they start coming to the women's group, you can't even find them for the rest of the week. They start going out, you're like kind of, 'Are you coming to women's group?' 'Oh no, I'm out there doing this.' And I'm thinking, but this person never used to come out at all. You find that you've opened them to look. There are things in the library they can do with their children (Naomi).*

The above quote indicates *coming out* to the group increased knowledge of the community and active access to local resources. This increased exposure to information about local activities/resources, in turn, enhanced confidence, self-worth, and self-efficacy in accessing local resources, which positively impacted women and their family's well-being.

Many respondents explained sharing stories and building trust with other women contributed to building positive relationships.

> *In the women's group, you spend one day with somebody, the talk you have and the friendship you start having and the trust is different from the person you see for three hours in a play group with the children, or you see on the way (Vivian).*

In this quote, Vivian emphasised the time spent in the women's group created opportunities for bonding and trust-building, lacking in other community activities with less time involvement. This finding is essential when planning time interaction for community activities, especially where 'building positive relationships' is vital for improving well-being.

Women also expressed positive emotions about connecting with other women including opportunities for *finding work and solving housing problems.* For instance, Franca received help to free certified training.

> *I love it because you see different culture, and then you come together you see new faces, new helpers. Sometimes we have helpers from job centre …if you have housing problem, you're looking for job and some courses. If you go outside there, you need to pay £50 but here you get it for free, with certificate. I mean it's so friendly (Franca).*

The emphasis of getting free support and certified training was a common experience for women who felt empowered to act on the social and economic barriers to their well-being.

Another aspect of *'coming out'* was the exposure to other service providers who aimed to reach out to women in this ward. As Siobhan and Fernando noted, the WTN project provided a forum to meet women who would not traditionally come out.

> *When I was initially looking for women to come to 'Create Your Future', it was quite difficult. The thing is to go to women's groups, and that's where you can get real grassroots information and meet women. So, that's what I would say to any outreach worker now (Siobhan).*

Siobhan said before her visit to WTN, it was challenging to access women and provide support to meet her organisation's goal for funding received. However, having women in one room enhanced her ability to offer personal and collective support.

Coming out to the women's group was a source of increased happiness for many of the women. For instance, Cynthia, a resident explained the change to her life: *"I think it has changed my*

life, I feel much happier when I'm here, is like one family". Also, describing the changes to her life, Franca, another resident expressed enthusiastically:

> *No! I'm happy, now it's like er, I work for myself. I'm happy, and the fear I used to have has gone. And then at the same time they tell you how to register your business. So, I registered my business and now I'm working for myself, I get time for my children and I get time to come here, because I don't want to miss this day (Franca).*

Before attending the group, Franca had no means of livelihood. However, being a part of the group encouraged her to start her own business. Franca told me that having her own business has given her renewed confidence in herself, the freedom to achieve and a greater sense of agency to act on the social determinants which deter her health. When asked if she would recommend the WTN project to other women in the community, she said:

> *Oooh! I'm so glad for Naomi to open this kind of project. It keeps you going because to be honest with you, if I didn't come here, I don't know what else I would start from. It gives me confidence and I'm happy to be here (Franca).*

Franca's experience was evident in the lives of many of the women who attended the project. Many expressed becoming confident which overlapped with being happy. Zahra explained: "*It makes me more confident and happier in the women's group."* Her feeling about participating in the group was:

> *...very good, I am happy to be a part of the group. Since I started there's not a day I'm upset or anything. I feel the day makes me happy, because the drama group, I enjoy that as well. And the sewing I like sewing (Zahra).*

This quote illustrates the perception of the community workers who expressed the women developed confidence from the support they received from other women with similar issues, the project lead, and her volunteers.

> *I think all that develops your confidence if you're meeting other women who have similar situations who can share and support each other. Naomi is very good at speaking to them and listening to their problems. She has two or three administrative tight support women who are very, very good (Siobhan).*

A source of happiness for women was partaking in activities like sewing, drama therapy, laughing therapy and cooking. The project was also very accessible and free. This was illustrated by Siobhan a community outreach worker who partnered with Naomi to deliver the Create your Future programme at WTN.

> *The women seem very happy, and they seem to be coming for quite a long time as well, which again it quite unusual. It helps that the groups are in the middle of the [RDPW] estate. So, it's close to the estate, close to shops, it is also close to the children centre. So, if they come to Naomi's group, they can have the children here or they can drop them at the children centre nearby so even though they are financially held up, they have service reaches that make sense (Siobhan).*

As I visited the group weekly, I observed what Siobhan explained in the quote above. The women were dedicated to attending the project and it was interesting to see the women so happy and engaged. Most of them told me they lived close to the hub and their children's schools were close by and this was very convenient for them. This finding has implication for planning and delivering of community-based projects for women with minimal income. I was also surprised at how women freely discussed with each other and shouted out if needed to get attention. There was also a lot of laughter in the room that made anyone feel welcome as part of the group. It was easy to see that laughter was a big part of the group activities as Zahra and Vivian noted in the quotes below:

> *So, I always think it's a day where you can come and have a laugh and talk and have a good day and enjoy yourself and you've got other friends you can talk to, other women by your side, so I think it's good (Zahra).*

> *You don't know, you say hello to each, you make coffee and tea and then we were doing laughing therapy and laughing therapy, you must make the other people in front of you to laugh. You must create the laughter (Vivian).*

These quotes demonstrate a relaxed atmosphere where laughter was prioritised as a healing mechanism for women to be well. Several studies reveal the positive effects of laughter and humour on psychological, physiological well-being, mental well-being, and quality of life. (Akimbekov and Razzaque, 2021; Zhao *et al.*, 2019; Bennett *et al.*, 2014)

Therapeutic space

Respondents often referenced the WTN group as a therapeutic space where women could come and be themselves, feel human and feel better. It was a welcoming space that enabled women to relax and discover themselves away from children and spouses. The storytelling about their past and current experiences was a healing balm and women felt okay to show their vulnerabilities to other women, which was important for some women to think that they were not alone in their struggles. Leticia explains:

> *I think it's a real community …everybody is familiar with each other, there's a comfortableness …you're allowed to be a bit vulnerable. So, if today, I have an issue, there's someone there that will help you, maybe, not by giving you something, but giving you words. Knowing that someone's in the same position but then can encourage each other to overcome this sort of thing to make each other feel good about each other (Leticia).*

These interactions described by Leticia above were significant for strengthening the women's abilities to cope and enhance their self-belief and resilience to improve their lives. Women were encouraged by the words of other women who had similar experiences. Similarly, Vivian explained listening to others telling stories made her feel comforted and learn ways to deal with them.

> *...But when you find other people telling their own story, you find that you are not alone and those people talking with you, they are showing you that they step out of the trouble. …it means that it's not finished. You can't get your life stuck because you are in this situation. Then you see that it's still open and there are opportunities. There are many things you can do to solve your problems (Vivian).*

Naomi was quite emphatic about the therapeutic nature of the group's activities. These included sewing, sharing stories, and colouring. Naomi also believed that information sharing by the women, improved informal learning, increased knowledge, and better access to community resources.

> *It's quite therapeutic! All those things are part of health and well-being. It's like mindfulness, you stop, and you do things. When the women are out and about they're doing, they rush and they're home and the family, they can't get to do things for*

themselves, but by being there sewing you have someone beside you talking, doing things together, you're talking, you're sharing, you're connecting with people, you're learning (Naomi).

Naomi refers to taking notice and learning. These are essential aspects of the five ways to well-being important for positive mental well-being. Similarly, Fernando expressed the therapeutic nature of the WTN space as the freedom to exist and heal as a woman without the label of domestic violence. He believes the WTN atmosphere allows all women to be themselves and engage in fun activities which impact on positive health and well-being.

So rather than being processed into something better, women are better from the moment they walk through that door, and they are accepted despite their issue and despite the reason for being there …they come together doing what women do, chatting, talking and it's therapeutic. It is positive, it is making their life better (Fernando).

The group's connection is viewed by respondents as enabling women to feel relaxed, a place to engage in laughter and enjoy oneself. Some respondents felt WTN was a place for women to feel comfortable and be human again.

So, I always think it's a day you can come and have a laugh, talk, have a good day and enjoy yourself, and you've got other friends you can talk to, other women by your side. So, I think it's good (Zahra).

It's very safe, people are comfortable being themselves, and it's a place where they can feel confident about what they're doing. And at least you've got that time …people are cooking for each other to me it's a real community that's what it feels like …the world is not that safe, so if you can find somewhere where you can feel safe. I think it takes you back to the basic …being human, being like a human being again (Leticia).

Being human, being oneself and enjoying oneself in these quotes signified attainment of normalisation needed for the women to feel well. The relaxed and safe atmosphere was an escape from an everyday routine to temporarily forget life stressors and be normal. It also increased a sense of identity and self-discovery. Being a victim of domestic violence impacts women's identity but coming into WTN where other women discuss their circumstances and find help felt safe for Leticia and women like her.

Leticia further emphasises:

> *...I felt like it was a very safe place, as a woman to be in. Not in terms of body protection, but women can feel comfortable to relax, to eat. It's a bit of an escape from their day-to-day. It's like the place I can come to remember myself and do good things for myself. I feel like I'm coming back into being myself without the kids. I think if you are in a safe place, it would impact your mental health (Leticia).*

Leticia contrasting WTN experience with traditional methods of managing women in domestic violence explained being in the sessions removed the label of 'domestic violence' and helped women feel safe and be themselves to find solutions to their issues. "*I feel like when it comes to women's things you have domestic violence shelters …it doesn't feel like that here and I think it's good they don't put it out there as that".* Similarly, Zahra's buttressed the benefit of coming to WTN.

> *Sometimes as a woman, you have problems at home, and you don't have anyone to share it with. But in here they can share with each other their feelings. It's been nice, the women's centre, it's not only for sewing and doing other activities, it's somewhere where someone can help you. Especially when you're going through domestic violence. Who do you go to? You need another woman who can support you. All the women here, we're all as one. We're sharing and, anyone who has problem they speak to Naomi, me or anyone in the group and they have a good time, all their worries will go (Zahra).*

Zahra's quote above demonstrates well-being benefits resembling talking therapy in psychology. Peer support was emphasised as a resource for solving women's problems.

Connecting with other women helped some women forget their pains and focus on other meaningful aspects of life. There was evidence of health promoting storytelling and drama therapy which helped women relive past experiences. Siobhan explains drama therapy combining personal stories promoted psychological and emotional well-being among the women:

> *They also had a drama session where women were sharing stories from their childhood and from their culture and talking about themselves. It was a general form of chat led by an English woman which was encouraging and listening and taking a real interest*

in some of the stories the women had. So, it's all good. It helped them to remember themselves (Siobhan).

The benefits expressed in this section were a result of WTN responding to the communities need, a strong attribute of PB projects.

Strong volunteering

A strong volunteering ethos was established in the women's group from the onset. Women were invited to help from the minute they entered the space, and this became a norm for most women who joined. Zahra was invited to volunteer in the group and after a while began to run the group with nine other women when Naomi picked up a job in the council as a safety officer.

Naomi lives on my road, and one day she asked me if I could volunteer in WTN and I didn't have a job and she helped me. (Zahra).

Zahra and other women gained knowledge, skills, and confidence to manage the group, increasing their human capital from *'helping out'*. Apart from gaining personal skills, Zahra and her team supported other women uptake training and jobs, which helped raise economic and cultural capital for women in the group.

We even help people to go on jobs, job training, so we have a special person who comes and does that. Does the form and helps people who don't have a job to give them jobs and things (Zahra).

Volunteers' contribution to running the group helped increase the opportunity for women to engage in fun activities that reduced isolation and improved mental well-being. This contribution was also cost-effective for the project, mostly funded for only £3000 for a year.

Since I started, I've met new people and we help the women, the Woman with A Voice, we help women with like domestic violence problems or help, even if they don't have domestic violence problem it's here to come to. They come and have free time from home, come and there's activities going on which they can be interested in instead of staying at home and be isolated (Zahra, volunteer).

Volunteering was also crucial for *getting help*. The women in this group supported each other by picking up each other's children from school or running a crèche to enable women to focus on their activities.

> *... When there's lots of children, we set up the activity in this room for the children to do, and there's a person, one of the volunteers will come and look after the children here (Zahra).*

> *After we got to know each other or sharing the responsibility of picking and dropping each other's children from school, sometimes babysitting other parent's children, so like helping each other (Cynthia).*

Picking up each other's children became a practice beyond sessions. When women had childcare issues outside the Wednesday sessions, they could count on other women for help with free babysitting.

> *Yes, for free we help each other, she keeps mine, I will keep hers and it rotates, anytime anyone is in a fix they have somebody to call because they know each other (Cynthia).*

This finding has implications for trust and bonding social capital development in this community.

Numerous research studies demonstrate the strong association between volunteering and improved mental health and well-being. The UK's Civil Society Almanac 2020 reveals volunteering has a substantial impact on four aspects of human life, beneficial to well-being, social cohesion, and employability.

Category 3: Action on the social determinants of health

PB as a CD approach empowers communities to act on the social determinants of health. The change model developed by Naomi was based on her involvement in WL and PB (see Chapter 4). Naomi included women in learning new things that helped them realise agency and freedom to take control and ownership of their well-being. By design, WTN activities significantly enhanced aspiration to further education and employment. For instance, sewing bags and accessories for women in prison promoted self-employment skills.

One volunteer told me about the sew bags for women in prison project. This is an excellent opportunity for unemployed women in the community looking after their children to address self-employment skills (Leticia).

Zahra explained giving back made the women feel good and proud because of their achievement in alleviating other women's challenges in the community:

The contribution was good because if you do something for helpless people, you feel good about yourself. Making bags for the women in prison made us pleased with ourselves and proud. Before coming to the women's group, I didn't know how to sew. I started from zero; now I know most of the stuff about sewing. So, I am glad I came and learnt so many things ...cushion covers, bags, scarves. So, I am proud of myself for learning (Zahra).

Zahra expressed positive feelings about learning new things and giving back. Learning new skills gave the women a sense of purpose and giving back was fulfilling (Aked *et al.*, 2008). Sharing experiences among participants empowered them to learn survival skills, to act to take control of their lives, as Katrina noted, and Vivian buttressed:

The struggles you have with bills, with the children, with relationships, everybody has it. And if you put yourself where you can talk to others, you can feed from their experience, you can learn, you can motivate, and you can grow (Katrina).

By meeting other people talking about how you are looking for a job and this person talking about how she went about to get a job, you learn something from that. Even Lauren offered to do a one-one interview with me, and it helped me. So, when I had an opportunity to interview for the job, I got the job (Vivian).

Franca became self-employed and began to earn money for herself and family through her engagement with sewing and this made her feel in control of her life.

...they helped me because I was a bit afraid to start my own business with my children ...they come here especially for self-employment. I got confident and discussed my plan, they tell you how to register your business. So, I registered my business and now I'm working for myself. ... I'm happy, and the fear I used to have has gone. Now I get time for my children I feel good because I control my money, I control my children, there's

no pressure for you to tell your employer "Oh I can't work today because my child is not well etc" (Franca).

Feeling in control made Franca feel good and removed the stressor of balancing her work and looking after her family. The WTN project also raised women's aspiration to go back to further education.

There's Juliet … she is currently not attending because she is doing courses. But when I first met her was when she first started coming to the women's group. She was in bad shape, domestic violence, she's got two kids. She was feeling isolated, and she used to say "I always look forward to coming here because you are the only people, I talk to during the week apart from the kids. I thought I was going mad". All that boosted her confidence, and she started to find courses, thinking of finding a job and moving home (Fernando).

Similarly, Katrina, a financial coach evidenced how she encouraged women to return to work.

And I've taught the value of working means your children look up to you. If mum and dad work, children will go to work. If mum and dad don't work, you can guarantee those children won't see the value in working, and then I teach them how to become financially independent and free from debt (Katrina).

Naomi also invited motivational speakers to inspire participants to gain employment. Sharing stories using positive language was empowering and boosted women's confidence to act to improve their lives.

Naomi also empowered volunteers to run the project. This increased their sense of ownership and skills and the sustainability of the project.

I've empowered women to run the group by themselves … we've created another level of women, taking ownership. I'm now able to step aside and they're able to do what they have learnt; cos we teach them skills and they're now running it themselves (Naomi).

I can assure you if you went to the women's group and you picked up six women, and you put them here in this building and say do the same you did on the day. They will do same (Fernando).

Category 4: Creative partnership working

The PB event day exposed WTN to a creative partnership with local organisations which helped extend women's network beyond the group's bonding to a bridging social capital. Naomi explained how women were inspired by each other and charity organisations to improve their human, cultural, and economic capital.

It's good because you're changing lives, and you are inspiring others, and women are inspiring others, and people are less isolated. People are coming out and getting the help they need, and we're linking in with other providers to work with the women. We have somebody dealing with the employment; we have somebody dealing with advice and guidance; we have others dealing with healthy lifestyle activities (Naomi).

Siobhan from Cassey's (pseudonym), an art company with funding from the Prince of Wales Social Fund and National Big Lottery introduced the "Create Your Future" programme to Naomi. WTN benefited from training to develop transferable skills for employment like team working, interpersonal skills, and hands-on craftwork.

I've got the go-ahead from my manager to talk about what we can do for Naomi's project. The eligibility is women must be 12 months unemployed or economically inactive and from ethnic minorities. Since much of these women are from ethnic minorities, there is a rich scene of potential to get funding (Siobhan).

Siobhan partnered with Naomi to provide more support: *"We can provide sewing machines, a sewing tutor, jewellery classes and Information, Advice and Guidance (IAG).* The IAG offered empowered participants to recognise the transferable skills they had to find work.

They've got lots of skills acquired at home; they can transfer into work. It could be housekeeping, good time management, managing crises, and peoples' egos, all transferable to customer services. Some people have had work before they have done administrative roles, and they can pick up from there and develop skills in their

confidence building; they can prepare a CV, practice their interview technique and take it from there (Siobhan).

Contact between women and organisations like Siobhan's increased women's agency and freedom to act for change individually and collectively. For example, Cynthia and Franca, received help to find work.

Some people came from the jobcentre to teach us to do our CVs. Now we have CVs and can search for jobs. You fill in an application according to your interest, and then you get to know what job to search for that marches you (Cynthia).

Because I met someone here who talked to us about self-employment - how to stand on your own two feet, because sometimes it's hard, you say, 'Can I do it? Or I can't do it?' but with someone behind you to push you, it's helpful. I was afraid to start my own business with my children, but I got confident from the talk and started my business (Felicia).

The engagement with WTN increased the resources women like Cynthia and Felicia accessed to enhance their confidence to tackle unemployment, a significant determinant of health. PB proponents argue PB directly responds to individual and community needs. These findings demonstrate that WTN aligned PB evidence and was creative and resourceful in responding directly to communities' needs.

Category 5: Creating a sense of community/community spirit

Fostering community spirit was a building block of the WTN learned from WL and the PB process. This was evident when respondents talked about feelings of togetherness, strengthening each other, having shared ownership in improving their community.

When you talk about society, we talk about community, and what we realise and learn is, community is what we make of it. Community is everybody coming together, stakeholders, residents, immigrants, all multi-cultures and religion, colour, creed coming together, and strengthening each other, empowering each other (Naomi).

Naomi's belief in her community was strengthened through learning from the PB process and votes from residents to take ownership of their lives and improve their community. This was evidenced in my conversation with Melissa and Fernando:

> *And I think these community hub projects have brought people together… if you look at WTN when you walk into their group … you see people from all different backgrounds participating in the projects and cooperating with one another. It's created fluidity between communities (Melissa).*

Melissa was confident PB had created projects that increased participation and community cohesion. Fernando elaborates how WTN community has become self-sufficient and functional despite cultural barriers.

> *There are language barriers there. Despite different cultural backgrounds, you've got European women mixing with eastern Europeans, mixing with Caribbean, mixing with Africans from different parts of Africa, mixing with Middle Eastern women. And it's such a melting pot. It's unbelievable. You walk in and you've got this amazing rotation, you see the African woman on the sewing machine teaching an eastern European woman how to sew. You've got the Middle Eastern woman cooking with three or four other girls trying to see what she is doing and learning from it. Then you've got someone in the corner being taught how to speak English. Someone in another corner completing a form, it's such a crazy environment... But when I say 20 women, it could be like fifteen different nations (Fernando).*

This action created a robust social network that led to bonding and community spirit non-existent in RDPW previously. The melting pot metaphor emphasises the integration of multicultural women thriving and living healthier through information sharing and peer support. This finding has implications for policy and practice when planning interventions to increase heterogeneous bonding and social cohesion in difficult to engage communities.

The group bonding and solidarity became attractive to partner organisations:

> *I like Naomi's group. The moment I walked in, I want to work with this group because they are the only ones where all the nationalities are honestly working together and enjoying each other's company …I was struck by the way all women from all culture*

were mixing together. This is quite unusual because in Haringey you have Africa specific group, age specific groups. But in Naomi's group they were all working together it seems to be the feminist impulse is working properly and efficiently and I want to make sure her group at least got some funding some support from our organisation (Siobhan).

Learning about each other's cultures helped the women understand different perspectives within their community and helped to dispel negative stereotypes and personal biases about different groups. Celebrating diversity increased Trust and respect as people from diverse cultures contributed to language skills, new ways of being and exciting experiences. These contributed to increasing community spirit and individual well-being. Being a part of the group reduced fear among the women. Vivian explained how this can happen:

People are scared when I drop catalogues even at the door of their house. But if people from the community come to groups like this and they meet each other, I don't think one neighbour would be so scared because she would know the next-door neighbour is their person (Vivian).

This quote suggests PB projects increased social connections essential for improved community safety and health. Similarly, Zena, a volunteer cook, explained she was more relaxed on the streets.

I cook here so everyone can know our traditional food and I know something about the other communities and …now when I walk in the street, I know most of them, so I can I feel relaxed (Zena).

This quote demonstrates a sense of freedom and connectedness that increased Zena's feelings of safety, confidence, and sense of belonging to a community that supports her well-being.

As with Vivian and Zena, Naomi agreed WTN created an enhanced sense of *community spirit* which was motivated by understanding differences and accepting other people's way of living.

With community cohesion, if people are committed, you learn other people's culture and their way of life and can tolerate them. Because we are mixing, it helps to understand the Turkish community, the Muslim community and we understand how they all behave and that's about us coming together. We started talking which we never use

to do. ...And these projects have brought us all together ... normally when you have women's group you don't tend to have this type of women's group. But here we have everybody in the group (Naomi).

5.2.3: Section Summary

Significant findings in this section demonstrate PB's ability to increase community bonding through increased flexibility in responding to community needs. The exposure of WTN during the event day increased partnership working. It also increased agency and freedom to become a part of a project which promoted social inclusion, social network, social capital and integration. Evidence from interviews and field notes showed how this PB project promoted connectedness and reduced loneliness among previously isolated women, increasing a sense of purpose and belonging, which enhanced peer support and community spirit. By engaging in the group, women became aware of other's community activities, improving health literacy and access to other beneficial community resources for acting on the social determinants of health. Many women changed their diet to healthier options, which meant the whole family diet became impacted. Increasing confidence and self-esteem enhanced women's aspiration to further their education or find work. These increased the control women had over their lives, including work-life balance.

This project's findings have implications for bonding and bridging social capital for health practitioners and policymakers interested in implementing community health interventions

Section 5.3 Case 4: Tottenham Folklore

5.3.0 Background to Case 4

Tottenham Folklore (TF) is a small-scale, drama-based project, for people living in the RDPW funded through PB. The evaluation aimed to explore the conditions that enabled TF participants' experience, increasing health and well-being. TF was developed and led by Lauren (pseudonym). Lauren, a 69-year-old artistic director of drama, had 35 years of experience teaching and working with neighbouring schools, pupil referral units, and young people classified as Not in Education Employment or Training (NEET).

TF won £5000 through the Residents' Partnership Board, collaborating with WL to improve people's health and well-being. It was co-facilitated by Abel (an acclaimed published poet and actor), Marvin (with considerable experience in writing and performing) and Elia (artistic director of dance & co-director with Lauren). The target group for Tottenham Folklore were the adult refugees and migrants to Tottenham.

Aims of the project:

1. To run theatre workshops about people's journey to Tottenham with people and groups from RDPW.
2. To create a theatre piece based on community members' stories
3. To strengthen the RDPW community by helping people to find their voice through drama and sharing storytelling
4. To develop theatre drama and communication skills in people who have not done, or done very little, drama in the past
5. To raise confidence by participating in a challenging drama presentation

These initial aims of the project were further crafted during the PB workshops to match the Priority 2 ambitions of the WL programme, aiming to improve health and well-being among residents of RDPW. These aims were pitched to the community during the PB event day on 4th February 2017.

Overview of the project

Three phases of the project and activities

Tottenham Folklore, delivered in three phases, included workshops, rehearsals, and theatre performances. The workshops took place in three venues with participants from CK (Section 5.1), WTN (Section 5.2), People's Universe (PU), which also won PB money, and Coombs Croft Library. Lauren collaborated with these PB projects and the library to recruit participants.

Seventy-two drama workshops were held between March and August 2017. The workshops lasted from between 1 hour 30 minutes to 2 hours and had a regular weekly attendance of 12 people. Workshop activities included training for a play performance, drama games and exercises to boost confidence and enjoyment. The primary facilitator was Lauren, while Marvin, a writer and performance expert, led the drama games. The drama workshops were influenced by ideas from Augusto Boal, the Brazilian philosopher, theatre-maker, political activist, and founder of the Theatre of the Oppressed, who used drama to empower people and communities in Brazil between 1956 and 1971 (Boal, 2008).

Each workshop was fully active, based on improvisation and storytelling and designed to give each participant a voice. The group dynamic became creative, focused, and welcoming. Lauren used a non-cognitive approach icebreaker involving touch and non-verbal theatre such as sculpting to motivate trust and engagement of participants at the start of workshops and later included stories about participant journeys. As the play progressed, the theatre production focused on developing each participant's account. The methods of promoting communication between participants were predominantly through drama devices. The group had social events like coffee/drink after sessions, helping participants feel included, valued, and wanted.

The rehearsals took place between September and November 2017 every Saturday from 2-5.30pm. The play's rehearsals were co-directed by Lauren, Abel, and Elia and took place at the Bruce Grove Youth Centre, 639 High Road and People's World. The project directors met twice a week before every rehearsal to plan and organise.

The third phase was the theatre performances at the Bernie Grant Centre in Tottenham, the Haringey 6th Form Centre, White Hart Lane, the Antwerp Arms in Tottenham and Ye Olde Rose & Crown Theatre Pub in Walthamstow. The play was titled 'Up on Hill' (pseudonym)

and advertised using flyers, a Facebook page, Twitter, articles in Tottenham community press and word of mouth.

A team of volunteers supported as musicians, singers, media organisers, organising props, tickets, raffle draws and stage management.

Participants' characteristics

Project participants were mainly adults between 18-80 years from diverse ethnic backgrounds, including people from Bangladesh, Sri Lanka, Cameroon, Jamaica, Barbados, Cardiff, India, and other African backgrounds. Five young children under sixteen, children of the cast members, also participated in the play. All participants at the workshops were from RDPW, but Lauren recruited extras for the performance. Most participants were migrants who had settled in RDPW, refugees, and a few were British people who moved to RDPW and had never participated in theatre. Some participants were people living with various physical and mental disabilities, and most were unemployed and on benefit.

Table 5.3 Respondents' characteristics (TF)

SN	Participant Name (pseudonym)	Mins	Type of participant	Age range	Ethnicity	M/F	Educational attainment
1	Lauren	150	Artistic director	65-70	White British	F	MA
2	Raymond	30	Resident	65-70	White British	M	AL
3	Hannah	50	Resident	40-45	Black African	F	NVQ L 4
4	Vivian	30	Resident	35-40	Black African	F	NA
5	Abel	90	Co-director/Cast	35-40	Afro-Caribbean	M	NVQ L 2

6	Holly	20	Resident	30-35	White British	F	NA
7	Daniel	60	Resident	50-55	Afro-Caribbean	M	O Level

5.3.1 Respondents' characteristics

The participants of TF I interviewed were similar in many respects. They had all lived in Tottenham between 10 and 60 years. They were primarily migrants from around the world and had many difficult emotional stories to tell about settling in Tottenham. Participants were ethno-culturally diverse, mainly retired, unemployed or self-employed adults with a limited social network. The interview participants included Lauren (F), and Abel (M) (play directors) and three female and two male residents between 30 and 70 years.

The stories told by TF participants were significant as Haringey ranked the fifth most diverse boroughs in London (ONS, 2001). It helped other groups gain insight into various ethno-cultural experiences and journeys of settling in Tottenham. For example, stories about the Windrush generation, Biafra, White British people who first settled in Tottenham, Syria and India were noted. Lauren shared that many TF participants experienced physical, emotional, or mental health problems and theatre could help them heal and achieve positive mental health and social well-being.

> *...lots of them had emotional problems, mental health issues. Many others had had ...Maybe mini collapse at the end of their working lives and for them it was just fantastic (Lauren).*

Lauren expressed gratitude for the PB votes and was committed to use theatre to meet the mental well-being needs of the community because of the trust invested in TF.

> *I felt accountable to those people who voted for me. They didn't vote for me to put money into keeping theatre going. They voted for a play and a series of workshops and every time in the play, we went a bit low, we would talk about that process [PB] and I described the process [PB] to the people who had not been there. ...we felt we owed that community something (Lauren).*

Although Lauren believed the arts was important for people's well-being, PB helped TF remain focused during challenging times. PB process provided an opportunity for residents to vote for aspirational, artistic, and culturally enriching projects like TF.

> *I thought it was fantastic because in the middle of Tottenham, you got people voting for a theatre. ...there are so many other needs you could have done, there's food, there's*

social clubs, there's children, there's boys out on the street with knives. But they voted for the theatre because I suppose the arts are essential to people's well-being but it [PB] was what inspired it [delivery] in many ways (Lauren).

By voting for TF, residents demanded for a project which will benefit them individually and collectively. This demonstrates the evidence that PB gives control to residents to choose what will benefit their community (See Chapter 4).

The nature and competitiveness of the PB process influenced the way Lauren conceived and delivered TF. By becoming more thoughtful about how TF would impact on RDPW residents, Lauren ensured it was democratic and inclusive. This finding supports the evidence that PB enables projects to respond to the residents' expressed needs.

The process of TF wasn't scripted play. It was a devised play which meant that you are more democratic. You involve the people who are involved in the theatre production (Lauren).

Lauren allowed participants' decision-making powers throughout the production. For example, Abel gave freedom to cast members to determine how their parts evolved:

...I found myself more efficient within the crew. I can say to Hannah, "you are strong woman, you can stand a little bit like a soldier". And she would hear it quietly because I am saying it like another actor. And she also has power, she could say, maybe you can do this with your coat". I would say "Okay". So, there is this reciprocal energy going on (Abel).

Hannah agreed that she had the freedom to decide how her part will be formed:

...yeah, you are allowed, but they correct you if there is any mistake, put things in order, and help you stretch your imagination. ...you are not being given maybe this is what you will do or sharing it or all that, no (Hannah).

This inclusive practice was evident through the project's design; the workshops rehearsals, and performance of 'Tottenham Highway'. This enhanced participants' *deep engagement* and *time commitment* because it made them feel empowered.

5.3.2 Main Findings: Factors or conditions for achieving increased feelings of health and well-being

Findings from interviews reveal TF theatre as a PB project provided conditions that *increased residents' sense of well-being.* These conditions are discussed using critical themes in obtained from my analysis.

Category 1: Building positive self and community well-being

Story telling

Evidence from respondents revealed storytelling had positive impacts on participants' well-being. Several respondents described the perceived benefits from storytelling, including: '*making their voices heard/having a say, self-belief/self-efficacy), therapeutic/healing process, growth/enhancement, agency/freedom), taking notice valuing others, celebrating diversity, becoming/being creative, feeling of release), and not being alone'*. Being a devised play about their experiences and personal stories the arts became a tool for transforming lives through release and shared learning.

Making their voices heard/ having a say

Some respondents felt storytelling was essential for making people's voices heard about their life in RDPW. Some stories were used to express participants' feelings on political issues about the Windrush, refugees' experiences and immigration and the regeneration issue in RDPW, i.e., the Haringey Development Vehicle (HDV). For instance, Raymond perceived the performance helped the community voice their feelings about controversial issues affecting residents.

> *... as the play developed, it became even more worth doing. I felt we really had something important to say there and there was stuff to say about the housing situation... Controversial stuffs, that were important too. People's compelling stories (Raymond).*

The HDV issue seemed pertinent to people and TF helped residents air their dissatisfaction about the housing issues at the time.

...I have three people who were actively involved in the anti HDV campaign, but even if we hadn't, I would have dealt with that issue because, if you're trying to be honest and you're asked to do a community play, the only community issue in the area is HDV. So, some of them thought it was politically important to make their voices heard (Lauren).

TF provided a platform for people to tell their traumatic stories. Lauren explained:

So, people told their sad stories, their vulnerable stories, difficult stories. For example, Veronica's [participant in the play] story about Windrush. She came over as a little girl in 1950s. Even though the Windrush story is such a common one, people know the history from Jamaica... landing at Tilbury in 1952, but a lot of people don't know it. So, a lot of feeling that this is my chance to say my story (Lauren).

The story Tottenham Folklore tells is sort of my journey here as well. Sometimes depression, losing your job, ending up feeling isolated and not having an outlet or not being aware you can change the trajectory of your journey (Daniel).

Daniel told many difficult stories about his life including being homeless, nearly being put on an antidepressant, and feeling isolated. Telling his story helped Daniel accept the reality of his life.

I now realise that I have to accept my life. I expected a lot of other things ...the expectations are still there but, I have to accept the reality now and deal with it. It (TF) helped me to come to terms with what I expect and what I accept (Daniel).

Acceptance is a psychological resource that empowers an individual to see life stressors as facts that cannot be changed and decide to adapt and adjust (his/her thoughts and feelings) to the stressful situation. Telling his story made Daniel come to terms with his past stressors and decided to do meaningful things projecting his life towards a positive outcome:

What it does is it takes me back on the journey to the beginning, and it sort of compares to where I am now (Daniel).

On the impact to his well-being, he exclaimed:

> *Oh yes! I am doing a lot now with writing. Writing poetry and script has always been something I like. So, TF has given me the opportunity to write my part and my story. So, whenever [laughing] I am performing, I use that knowledge, write my lines or express myself. It's (TF) brought me full circle back to my creativity …to using a platform to listen to myself and to assess my progress in life or my journey (Daniel).*

This quote demonstrates making his voice heard enabled Daniel remember himself and reactivate his identity as a writer and sense of purpose. Some other residents like Holly and Raymond activated new identities as actors in a play.

Some participants were encouraged to overcome their self-doubt and lack of self-worth by making their voices heard.

> *So, there were times when people would leave the play because they were nervous or something and I would go and find them, sit with them, listen to them and I would say at the end of the two hours…Your story is rich, your life is rich. Your way of sharing your story and your life is now this opportunity. Otherwise, we stay here, and nobody knows your story (Abel).*

The strong facilitation by directors made residents gain agency to overcome their lack of self-worth and doubt and tell their stories. Telling their hidden stories was important for participants to take control and make positive changes which transform their lives.

Realising self-belief/ gaining self-efficacy

There was evidence storytelling had an impact on participants' self-belief and self-efficacy. Increasing self-belief overlapped with the directors' (Lauren and Abel) *strong facilitation*. For example, when asked "how performing in the play had changed your daily life?", Hannah described how her belief in her ability to act in the play was fortified by Lauren.

> *I'd say I have been encouraged…not being cautious of how I speak, because I said to Lauren, "my language differs, since English is my second language... She said, "but I can hear you, I hear what you speak" … it makes me to be encouraged and be bold not to look at my level of speaking… It makes me to feel confident and comfortable with*

myself, and it has impacted in me in a way, I don't need to look at any person before I can speak or to know if I can do anything with the person, I no longer feel shy to speak (Hannah).

Lauren used positive language to affirm Hannah, giving her an increased sense of self-efficacy and self-belief to interact with others. The ability to tell your story enables individuals to believe in their capabilities to achieve positive outcomes for their life as noted by Abel:

When they can tell that story [good or bad], they are able to believe that they can now embody other successful stories. I'm sure a lot of them now say "I never thought I could do that. So, next year, I am going to go to college and do this", whatever it is. Because of the newness of it. So, you are your story (Abel).

This statement is consistent with Sen's capability approach, which indicates people's freedom to achieve well-being is of primary moral consequence and well-being correlates with people's capabilities and functioning (Sen, 1999). Other respondents confirmed this during interviews. For example, Holly told me acting in the play boosted her confidence, and now she feels she is capable of functioning better in other areas of her life.

What does that mean to you… boosted your confidence? (Me)

…it meant a lot to me because I never thought in my life I'd ever get on the stage and do something. And I did it …I did …And I feel if I can do that, there is a lot more I can do (Holly).

Similarly, Abel explained the process of storytelling in theatre can increase the connections and friendships between people.

… Saying your story enables you to believe you can make another story. But hearing other stories so close with their breath on you and the change of clothes and there is always this "hi how are you doing? Are you alright?" It emboldens you (Abel).

In this quote, Abel describes the organic process through which participants formed friendships and how empowering it was. The stories embodied a more phenomenological experience of their story beyond words which was itself empowering. The quote also reveals the ability to tell your own story increases your self-belief to achieve better outcomes for your life.

Therapeutic/healing process/ feeling of release

Evidence from the interview with respondents suggests the play production process was gratifying and empowering for the participants. This included the workshops, rehearsals, and performances. Many participants who told their stories or listened to others were perceived to have experienced a feeling of release (catharsis), which is known to cause emotional freedom from stresses from present and past adverse events. This testimony strengthens the concept that the process of theatre production and public performance in a play can have dramatic therapeutic benefits for individuals suffering from emotional problems and mental health difficulties (Snow *et al.*, 2003; Leckey, 2011).

Respondents revealed many participants broke out in tears while telling their stories or listening to other accounts. What they could not express in words they expressed in tears, embodied release of pain, anguish and frustration. For example, Abel explained, "*there was a lot of tears"*. When I asked what the tears signified, Vivian explained the tears meant the migrant women in her group were able to remember what they left behind and deal with their feelings about it:

> *And the drama therapy was good for the ladies because a lot of them they have very hard situation, they went through war and everything and when they came in …living in this country no one never opened their mouth. The pain was inside, but by talking about how you left your country because the main point of the therapy was "how do you feel when you were packing bag and living your country?" "How do you see yourself?" "… "How do you remember where you left?" And it was a healing process for a lot of us. A lot of people crying remembering. And it was a very good healing for a lot of ladies (Vivian).*

Other respondents interpreted the tears from participants as an emotional response from the negative events that had happened in their life. For instance, Abel explained that sometimes the tears were expressions of frustrations and regret about not achieving in life but also tears of joy for being able to succeed in doing the theatre.

> *I think there were frustration, regret… people getting on about lots of things they didn't do, couldn't do. And we beat ourselves up. And the tears are frustration and a belief they perhaps can't… And tears of joy for success- "oh my God I did it! and "I can't*

believe it". I think it's [tears] a manifestation of what's going on inside. And, it's looking after someone is also looking after yourself, the best way of seeing yourself being looked after is looking after somebody else. That's a big leap, because you are saying why, nobody does it for me but the moment, in the play, I saw Nabina the Indian woman hugging the homeless man [Daniel]- she is from India, and he is black, black, black. And usually, those two are not known to mix ever. She recognises him and his loneliness. "Yeah, I will give it [hug] to you. And he's got her warm skin stuck against his warm black skin. Her brown all pressed up. ...she can see it's a spiritual connection. Barriers go down. So, yeah, these are the tears (Abel).

The emotions people shared increased bonding across cultures. The quote highlights some semblance of common human experiences that transcends words and division, connecting people from different backgrounds and helping them to heal together. I probed Abel more about the phrase *"a manifestation of what's going on inside"* and he replied:

...I think it is a part of a healing process. I think it's too much to say that now everything is gonna be alright. But it's a balm, and in the future, they know now what the balm smells like, what it feels like and they can go out. Maybe Vivian will now go to Cameroon dances where she wouldn't previously. Before, she would stay with the kids. But now she would say, "what now, I am going to treat myself. I will get a babysitter, cos the balm is where the people are". So, they've identified that (Abel).

Abel confirmed the evidence theatre can be soothing and begin healing for participants. Abel acknowledged the process may not eliminate the emotional and mental health problems, but participants now recognised some healing pathways. In other words, participants had increased their knowledge of tackling future stresses through storytelling and connecting with others. Daniel's experience of drama therapy and performance reiterates Abel's view of the theatre process and the impact of social interaction for healing. Daniel embraced theatre as a mechanism for dealing with his negative emotions.

You don't need to keep those negative chemicals in… that negative chemical imbalance doesn't need to remain in you. You've found the mechanics of it…. You've learnt to recover or how to repair it (Daniel).

When I asked Daniel if he thought it was a healing process, he said emphatically:

> *If you wanna call it healing, by all means, because that's what it is. You've healed yourself or you try to heal yourself and it works. In 2007, I was a very angry person, very upset, losing jobs, this, and that... And it's still a learning curve. I am not there yet. I am not anything else more than what I am here now, and I am still learning and learn every day. But it is good, not bad. …the play with Lauren …with TF, it's almost as if you are writing your own part …it's like a therapy (Daniel).*

Daniel called his experience therapeutic because he found his experience curative. He likened this impact to going to psychiatrists for psychological treatment, which he suggested was a waste of his money.

> *Because I don't have enough money… or not say I don't have enough money, but I wouldn't waste my money going to a psychiatrist anyway [Laughing] (Daniel).*

This quote suggests a problem with access to mental health services. Besides the stigma, money was an issue. But PB had enabled Daniel to attend a therapeutic service without a label to heal his problems for free. Therefore, this is valuable when considering alternative interventions for mental health.

Self-discovery/self-awareness/taking notice,

For some participants, telling their stories enabled them to become self-aware of the despair that lay deep in their hearts from past events.

> *…what I realise is that I had chemical imbalance grievances. And once you are able to articulate that you can deal with it". … If you are unaware of it then obviously [Both Laughing], you won't be able to deal with it (Daniel).*

Daniel explained that "chemical imbalance" accumulates from stressors of life.

> *You can get imbalance from the negative side… From the tragedies of life and from the miseries and the pain because I'm sure you are aware [Both Laughing] that this is what life is all about especially for a certain class or a certain race of people. TF made me realise the imbalance and what I needed to do to get the balance back (Daniel).*

TF gave Daniel the agency to identify his problems and take action to improve his well-being. For other participants like Holly, TF made her discover her creative self. Like many participants, she had never been in a play.

> *... in my whole life I never thought that I would ever get on stage and do that [act] ...if I can do that, I can do other things that I might not do (Holly).*

Holly's self-awareness and self-efficacy increased through the theatre process. This finding identifies theatre as a psychological empowerment tool for health practitioners. Apart from individual self-discovery, the community was also impacted.

> *...individual people and their own journeys were given respect and so it was individual voices. So, it's this mixture between community and individuals realising themselves (Lauren).*

Abel asserts that the play gave participants agency to do something different, be creative and imagine a quality of life outside of their reality.

> *I think for many of them it was a chance to exist outside of their… own personal mindset. They could embody a being outside of their own mindset. They can embody a past, present and future. They could have a resonance of life more than before on a phone or more than in a letter or more than in the laundrette or in the pub. Now this is their chance to have a resonance for the world (Abel).*

This quote suggests that participating in the play made participants extend their capabilities. This being and doing is what Sen (1999) describes as the agency and freedom to enable people to feel that they can embody other positive stories and functioning. In other words, they can move beyond the structural limitations in their lives and achieve more than they thought possible. Abel echoing what many of the participants told me, said:

> *I'm sure a lot of them now say, "I never thought I could do that". So, now next year, I am going to go to college and do this, whatever it is because of the newness of it. So, you are your story (Abel).*

Hearing other people's stories was as insightful for the cast members as it was for the audience. It helped people come to terms with what other people from the community were facing

and *value each other* or *take notice*. For example, Raymond told me he now understands the perspective of different communities:

> *And the other one, of course, is the experiences of people in the Caribbean community who came here in the 1950s. And the prejudices that they encountered, which, we all know about ...but to hear it from someone who has experienced it... particularly refugees' experiences; very moving. And you read about things in the paper to get to hear of someone's account of what it's like to be a refugee. It really hits it home (Raymond).*

This finding overlaps with *celebrating diversity*. Hearing other people's story opened people to the experiences of others who were different in age and from other cultures. This increased understanding and tolerance and enabled participants to work well together.

Not being alone.

Story telling was responsible for people to feel a sense of *not being alone.* It was a recognition in oneself and others - a shared sentiment, challenges and fears and trauma they experienced in the area and how these can be overcome. For example, Lauren explained:

> *I think the impact of the play was that it presses some emotional buttons. You see somebody else saying their story and you think, well, I have that. Oh, that was similar to me and you think you were alone. So, it was a bit contagious that people were telling their emotional stories and other people were listening and hugging (Lauren).*

Some of the stories told were painful but encouraging and lessons for others to act on their lives. For instance, Abel explained:

> *A vulnerable person seeing another vulnerable person, feels safer than some guy or some woman strutting around saying hey you should be like me. Why don't you get up, just get up, I do. I don't know why you are staying at home all the time. But when you say, I find it hard to get up too. If I help you to get up, will you help me to get up? (Abel).*

The stories made participants feel a sense of belonging and connection to one another. These included recognising that if someone who has experienced trauma can smile, then you can

cope/overcome too. For example, Abel and Hannah reveal their perceptions of how telling stories can affect other people's behaviour.

> *So, now Bob can see Hannah's journey and say, I'm gonna have her laughter. The journey was horrible but look at how she can still laugh. Look how she can still smile (Abel).*

> *I am now telling the story, somebody might learn from it and say oh, if this person can pass through this, so mine is not a new thing, so I can overcome it (Hannah).*

These quotes reveal that storytelling gave people agency to thrive again.

Category 2: Learning and doing theatre

Learning and doing theatre presented an opportunity for residents to learn new skills and grow in confidence, self-esteem and increase their sense of self-worth. Many felt it was life-changing and brought a sense of achievement and pride. The play was improvised, and participants were empowered to tell the stories they preferred. This increased decision-making powers, increasing *equality of voice* and *reciprocal energy.*

Confidence/self-esteem/sense of self-worth/ sense of achievement and pride

The positive effects on resident's confidence, self-esteem, and sense of self-worth was evidenced in respondents' comments. For example, Raymond explained that his confidence, particularly in his ability to express himself and relate to other people had grown:

> *Yeah, that was a good challenge to overcome in my personal development. My being able to speak into an audience which I haven't done to that extent at all. I have only ever asked questions in a meeting. I've never given a lengthy speech (Raymond).*

Similarly, Holly, believed she gained in her confidence and sense of self-worth during the production.

> *I have ended up doing this acting which I never thought I'd be able to do because I'm a quite shy person. Doing that [play] has really boosted my confidence. …Yes, it meant a lot to me because I never thought in my life that I'd ever get on the stage and do*

something. And yeah, it has really helped me, I feel good…it made me [feel] confident and I am really proud of myself (Holly).

Acting in the play made Holly feel good and increased her sense of self-worth and pride. Lauren also elaborates on confidence gained by Raymond and many other participants.

…in the actual participants, the confidence was phenomenal. It was great. I can mention 10 of them. One was Raymond, when he joined, he had a throat constriction. He was very concerned that people would not hear him. But we worked on it. He knew he had to work on it, and he did, and one of the real successes was his development and his confidence to be able to tell his story So, the growth *in self-confidence and self-esteem with the participants was enormous. Even the co-director Abel affirmed that he had increased in confidence and self-esteem (Lauren).*

When I asked Abel how the project had changed his daily life, he replied:

My day is now bigger, fuller. I believe now, I can do more. Their stories are my stories. I have more confidence; I am less inclined to stay in whatever comfort zone I had. So, I'm stepping further. Same as them (Abel).

Respondents also expressed participants felt a sense of pride and achievement from affirmation from the audience and each other. Hannah and Lauren explained their feelings of achievement:

I feel great because the first time we did it in Bernie Grant, I was surprised to see my functional skill teacher coming down to say, "Hey Hannah is that you? I didn't know you can act." Yeah, that was fantastic (Hannah).

It was lovely. So, I think in the community there is a sense of pride in being able to say we put this show on and wasn't it good (Lauren).

Acting in costumes at a professional theatre and in front of an audience of 200 also helped raise participants' self-belief and confidence. Abel expressed how the cast felt about being in Bernie Grant:

Yes, it makes you look professional. You've got your dressing room and the mirror and the lights, you go Uhhhh, I've made it. Is this me? (Abel).

Community cohesion/spirit

A sense of community cohesion and community spirit was experienced during the workshops. This was also evidenced when residents showed support for the cast and directors of 'Tottenham Highway'. For example, the group bonding during the workshop made participants volunteer to act in the play:

> *Yeah, it [workshop games) was funny, it was good; it was good to encourage the group spirit to be built up there. There was comradery between the groups of people. That most of us went on to take part in the play at the end (Raymond).*

The community showed strong support for the cast at Bernie Grant. This was perceived as encouraging and strengthened ties.

> *...community cohesion for example. I think not only was it there with the cast and the workshop but also when we did it at the Bernie Grant. We had the community solidly behind us in the audience. We hadn't had an audience and didn't know how it would go down. And within the first five minutes we realised that the audience was laughing, it was crying, it was shouting, it was singing, it was clapping. And once we felt the warmth of the audience, the performance rose (Lauren).*

Category 3: Enhancing positive relationship

Nine months spent together in the workshops, rehearsing together, and performing the play led participants to form strong bonds. The participants grew together as a group, established friendships grew stronger, and many new friendships were fostered. During this time, participants had been involved in drama exercises of touch to engender trust, role plays, development of their stories and debriefing meetings while sharing drinks at cafés after rehearsals. These activities created an organic sense of community where participants came to care deeply for one another and served as solid support for each other's progress in healing and developing their parts. Unknowingly, they had created a therapeutic community where each person felt a sense of belonging and learned to heal through another's help.

Lauren explained that TF provided a space for people to feel safe to work together and engage in therapy and healing.

You get very close; differences are respected whether you're eighteen, eight, or eighty. Importantly everyone was from different ethnic groups, and that was important. It was a space in Tottenham to come together on something that everybody wanted to do. It was very healing and, as would be, of therapy (Lauren).

Coming out and connecting with other people

To enable a close bond to form, participants had to come out of their houses first. Coming out to engage in activities in Tottenham was challenging for professionals to achieve with residents. But PB had raised awareness and created ownership where recruitment into TF was possible through collaborating with other PB projects. Also, an opportunity to vote an aspirational, artistic, and culturally enriching project like TF put them in control to make changes in their lives.

Refusing Loneliness/ rejecting isolation

A common theme among respondents was endemic loneliness and social isolation in RDPW. Before the PB programme many people were lonely and isolated. However, voting for TF opened a space for meeting new people and bonding with friends in the local area to whom these lonely people could unburden.

P*eople are very lonely here [RDPW] and it is good to go out and…- even if everybody is not friendly, you will find one person who can tell you nice things and then it is good (Vivian).*

Hannah expressed her experience of isolation and its impact on integration to the community:

…Since I've been here, I am always indoors because I don't know anybody, and I don't have friends. So, it's just now I start mixing up. I don't know so many activities going on in the community because I am always indoors, No socialisation (Hannah).

Abel explained speaking about loneliness in society was taboo. But Tottenham theatre, through storytelling, singing and poetry, made it feel normal to talk about feelings of loneliness.

…every single story was about isolation. Loneliness… is like the forbidden word… Loneliness is debilitating, crippling. …Nobody wants to admit to being lonely and this community theatre helped one to not only escape that but find devices … to be free of

it to some degree. Because you now know how to say hello to the woman in the shop. You now know your neighbour is someone you don't know. Just like the cast members, you have now acquired this capacity. I think there is very few things as wonderful a gift as people sharing with you their moments, their stories, their incapacity… "I don't know how to do this, but I am going to try and do this". I think that's a gift. I think it's beautiful. And I think people would draw from not having to stay at home (Abel).

Abel suggests TF was important for bringing people out of their homes. He emphasises TF helped people to increase their capabilities to extend their connections and reduce loneliness.

Participants became physically and emotionally engaged with each other. For instance, Hannah was an indoor mum and wife who had immigrated to London in 2006 without the right to stay in the UK. As a result, Hannah said, "*I just keep blank to everybody, no phone calls, nothing, nothing!"*. Hannah's immigration status had prevented her from coming out: "*I feared to go out until 2010 when we started to apply for the stay".* She had no friends or belonging to the community.

Hannah also felt the need to come out due to feeling unsafe at home because of a neighbour who caused her stress and anxiety. Hannah explained her reaction to this situation was to go out. *"So, all those now led me to come out."* Hannah walked into the drama workshop by chance and felt welcomed. Hannah developed a friendship with Vivian at TF who also encouraged her to join WTN. Vivian explaining changes experienced by people she knew in the programme suggested that Hannah now enjoys meeting people:

I can see changes in people, like Hannah. We were meeting at TF and then I told her of WTN …I encouraged her to attend regularly, and she will meet new people, get involved and do things when you drop the children in school, do some sewing and, you will see that you will learn something. Now she starts appreciating meeting other people and it is nice (Vivian).

Coming to TF opened new connections for Hannah in WTN. This has implications for increased social capital like impacts of PB programmes reported in the literature. Grassroots projects find funding difficult to obtain but PB opened spaces for TF to bring people together and increase sense of belonging and social capital among people in a deprived community who have suffered adverse emotional events and became isolated.

TF provided a safe space for people to connect emotionally and express themselves to other people. For example, Abel explained the value of the emotional bonds among participants:

> *Our group became richer; emotionally rich. I think there is a great underestimation of the currency of emotional content; the value of it. Also, being able or allowed to feel... Sometimes they are at home on their computer... Now, they are here with real lives and people were crying at times …real laughter in telling their stories (Abel).*

Coming out to TF helped reduce sedentary living and increased connections with real people. Increasing connections enhanced friendships and allowed people to feel safe to release trapped emotions that may be detrimental to health and mental well-being. This finding provides information about the value of informal spaces as health-promoting avenues for everyday people to deconstruct negative emotions and improve their well-being.

Belonging/feeling known

Participants gained a sense of belonging from becoming known in the community. For example, Lauren and Hannah recount their experience of being recognised by people in the community because of their role in TF.

> *So, sometimes you go on the street, you see somebody, even the other day when I came to WTN, somebody told me I will come, to watch the play. I heard your story that day (Hannah).*

> *…we were so entrenched in the community by this time, partly because of this [PB] money. I remember sitting at the doctors and a guy said, "Oh, I'm sorry. I can't come to the workshops" and I didn't even know him …So, it is incredible. Word also spread about the play, people knew about it and they loved it. We felt fantastic. We felt validated (Lauren).*

Lauren and Hannah felt a sense of belonging and affirmation from being known as part of TF. People also developed friendships they could trust from engaging with TF activities, important to sense of belonging. For example, Hannah had become friendly with people in the group and could rely on them to help when in need.

The one from Afghanistan [Abdul], each time he sees me he says, "Oh my sister". And occasionally, I have seen Holly pass the market and I have called her. It's not only because we did the play…, because there will be a time you might need somebody. And if I need somebody urgently, I can check on my phone or email and say I need so and so person (Hannah).

Asking one or two people for help is an important element of psychological well-being. It demonstrates an individual's ability to take control of their problems and life. It also indicates that the individual feels confident that they can get help from members of their social network and social capital.

Building positive relationships with other people was also crucial for feeling relaxed and reducing stress. For example, Hannah became more comfortable and stress-free when she joined the group. She was no longer worried about the stress from her neighbour at home.

yeah, after then [joining the group] I relaxed, and am in the midst of people, I don't think more about inside [home] when I come out. I put away all those stresses, everything, so I concentrate more on what we are doing [theatre] (Hannah).

Expressing the community's needs through the play was perceived to create a sense of control and belonging. For example, Lauren explained, "*the play united community members to defend their community and strengthened demand for what they wanted".* The stories of the theatre were about gaining a sense of belonging to a community, particularly Tottenham, and TF gave residents freedom to recount their experiences demonstrating the importance of belonging.

Workshops were deeper in a way because they went into people's massive feelings about where they've come from and what they left and how they settled here. Often the stories were really distressing. What they thought, what they experienced when they arrived. So, it's how do you survive in a lost and lonely city? How do you do it? Of what Vivian said is… it's about belonging, and you could go to one place and not belong. You could go to Tottenham, we were saying, and belong. So, it's about belonging and if in London that is where you can live. So, it was a big pro-migrant, diverse, pro-diversity story …how could it be anything else, if you're in Tottenham? It was about the politics, the community. …it wasn't just the HDV (Lauren).

These findings about theatre are essential for alternative health promotion practices for improving a sense of belonging.

Category 4: Drama therapy

Lauren affirms TF was also inspired by Augusto Boal's philosophy: "*I'm influenced a lot by somebody called Augusto Boal".* Boal's work was influenced by the educator and theorist Paulo Freire. Boal created the "Theatre of the Oppressed" in the 1960s as an interactive theatre that intentionally transforms disadvantaged people's lives by acting out social problems while spectators become performers. Analysis of the transcripts identified *which* represents the experiences and changes participants felt by acting out their social problems.

Loving/ touching/ trusting/ feeling safe

The drama therapy made participants relax and increased trust to relate with and enjoy working with others. For example, Vivian explained her experience:

> *She [Lauren] was calling it drama therapy because it was for everybody to make things that was inside to come out. And she had relaxing exercise she did to help us feel confident around others …like you can leave your body and other people carry you around then you learn how to feel confident or to trust other people (Vivian).*

Drama therapy increased positive feelings about others. For example, Lauren explained:

> *It was very loving. Everybody loved each other and love changes a lot. …Once you've done all that all that touchy thing. You love each other, and everyone did love and cared about each other. That is the atmosphere (Lauren).*

Here, Lauren refers to the exercise in touch and trust that participants encountered during the workshop. Abel touched my hand and explained why touch is important.

> *Yes, spiritual touch, physical touch, cerebral touch, being listened to, like "say that again, it's such a lovely thing to hear, for me to say to you, say that again, I wanna hear you say that again … you are saying what I have is important" (Abel).*

Abel suggests physical, mental, or spiritual touch was powerful in showing recognition of another and an important aspect of taking notice which can be reciprocal.

> *But it is very important to get touch… Sometimes, a touch is a tool. Sometimes touch is acknowledging someone. Some people you can't touch at all. But the sensuality is that I see you. It's an appraisal. It's very underestimated …And you can go home dancing from that. "I know this because somebody has looked at me like that, somebody has touched me like that… I am passing on what has been done to me" (Abel).*

Lauren, supports Abel's theory of the impact of physical touch by suggesting:

> *…a South American, Augusto Boal, he used this theatre in communities, and it's also been used both politically and therapeutically. So, I used a lot of that in the workshops. …you don't talk, it's all touch and feel and body and that means it's easy for anyone to access and the talking comes later and to me that's important because some of those people in the play, what I think they liked was being held, been touched, being rocked, … it had a therapeutic element to it (Lauren).*

Touch was healing but also accessible to those for whom words were difficult. Participants also loved learning new skills TF offered and aspired to them. "*They loved doing it. They love getting the skills, skills. They never thought they could do it. But it was full of love" (Lauren).*

Daniel also expressed positive feelings about being involved in TF as being in love for the first time.

> *If you can remember when you were young and you fell in love, nothing seemed impossible. Everything seemed possible, everything was attainable, and everything was there for you to reach. So, you had that chemical. Yeah, the positive chemicals, that adrenaline that feeling of health, love, vitality, it's transcends you. You could go without sleep; you could forget that you were hungry (Daniel).*

This intense experience of love reflects having a positive outlook to life and a feeling of well-being from being in the theatre process.

Feeling good/ feeling better

Expressing their social problems through storytelling made some participants feel good or better. For example, Hannah suggests her story was important for others to understand her identity and validate her.

Yeah, I feel good, and now looking back to how my life started …because is not a sweet journey for me …it makes me happy, I now feel that by telling my own story, people can get a clue of who I am and …somebody might learn from it and say oh, if this person can pass through this, so mine is not a new thing, so I can overcome it (Hannah).

Telling her story made Hannah reflect on her journey. This made her feel good and happy about the progress she had made in her life. Hannah believed her story can strengthen self-belief in others in similar circumstances to succeed.

Similarly, Lauren emphasises drama was essential for enhancing well-being.

It is to do with the drama and the emotional wellbeing of everybody in it. …it wasn't about mental health. I think that's quite important. People have all got their troubles and they were able to feel better about themselves. It's enhanced people's feeling of well-being (Lauren).

Lauren also expressed positive feelings about the impact of the workshops and performances on the participants and audience. "*And the workshops, I worked very hard, and I love them. That was just pure well-being.*" When I asked her to tell me what she meant by "it was pure well-being". She replied,

Oh, I felt great; I mean, just as they felt great, I felt great. I feel fantastic... I can't believe it, it was marvellous. I'm thrilled. It was everything I hoped it would be. It was fantastic. It was so rewarding. And I loved it and I feel great. No, I feel great (Lauren).

Lauren's excitement was shared by cast members and the audiences at various location of the play. This was evidenced by the exciting, loud chats and laughter after the play noted in my field notes from the performances at the Sixth Form Centre and Antwerp Arms. I noted a sense of pride and achievement on the faces of cast members and the audience. Lauren's good feeling was because of the play's success and recognition she got from community members.

I think I've grown, enormously. That I've been able to do it and the audiences were so strong in the affirmation of me. It's humbling to be honest, to get that response. I feel fantastic. I feel embarrassed because, I suppose you're not used to getting this accolade. …It's so strong. (Lauren).

Positive emotions of contentment, joy, happiness and love expressed by participants can generate a psychological disposition for people to feel good and to sustain those feelings in future (Fredrickson, 2001). Despite the participants' challenging circumstances, these pieces of evidence suggest that sharing their stories enabled them to adopt a positive outlook and increased their capacity to enjoy their life by recognising their achievements and contribution to community happiness.

Normalising self /self-identity

Analysing the data revealed that TF made some participants feel normal. For instance, Daniel expressed his fears of not being normal due to societal perceptions of him.

> *You see at one point the society was telling me that I didn't quite fit. I couldn't work with people, or I couldn't be normal. I couldn't understand what was going on. So, it's worried me a little bit to think that I was abnormal (Daniel).*

Daniel revealed TF made him feel normal because of people's story:

> *But what I am realising now is that, sometimes society is very abnormal, and you might be normal, but the way is working now, you have become abnormal (Daniel).*

When I asked him, what being normal meant for him, he said:

> *Normal is sort of trying to have a good day, be able to share and understand people and communicate with people in a way where it is normal. You don't have to be afraid or fearful of them, even speaking to you now makes me feel very normal… Health is your wealth. The chemical grievances that we harbour, if we can deal with them, we are better off (Daniel).*

The social interaction he experienced in TF assured Daniel he could work with people. He opened himself to people in a safe environment which led him to deal with his negative feelings from past traumas.

Theatre of the Oppressed is widely known for its potency for empowering and stimulating positive changes in disadvantaged individuals and minority groups in modern society. Through workshops, rehearsals, and performance, participants explored past experiences and be

loosened out of the rigid social roles or frameworks that held them back. The theatre process, including drama exercises, enabled participants to self-express and critically appraised their lives and gain a positive outlook for the future.

5.3.3: Section summary

When delivering interventions in deprived communities, through traditional commissioning, health practitioners tend to focus on the basic needs like food, shelter and education as highlighted in Maslow's hierarchy of needs. The PB process provided a platform for residents to vote more aspirational, artistic, and culturally enriching projects like TF with therapeutic properties. Through storytelling and self-expression during drama therapy workshops and performance, participants gained agency, self-belief, confidence, and resilience to take action on their health and well-being and transform their lives.

PB process and Augusto Boal's philosophy of participatory theatre inspired TF to enable participants to engage in psychotherapeutic experiences reported to cause symptom relief, emotional and physical integration, and personal growth. This in turn became a basis for participants to reflect on their lives, accept realities and commit to a positive outlook to life. Prolonged engagement in storytelling and play production allowed participants to gain strong bonds of solidarity and a sense of belonging, increasing their sense of safety, control, and capabilities to be and do more in life.

Chapter 6 - Cross case analysis interpretation

6.0 Introduction

In this cross-case analysis, I identify and explore broader concepts that help create an understanding of the association between participatory budgeting (PB) and its impact on health and well-being from the respondents' perspectives and abstracts from particulars of the interventions cases to generate a framework that demonstrates how PB influences health and well-being of individuals and communities.

This chapter examines the contextual and enabling factors that facilitated the community's positive health and well-being outcomes through the PB commissioned interventions. The factors considered within the context of each case study inherently reflect key values, principles and modes of influence PB wields on the health and well-being of participants. These include involving residents to deliberate and decide the budget for health and well-being interventions in their community, building capacity among residents by providing and promoting training, to enable them to support the CD initiative, enabling all residents to participate, particularly the traditionally excluded and impoverished citizens. Collectively, these factors represent lenses through which one may view differences or similarities between the cases. Highlights of the impacts of PB are mentioned to provide context for the conception, design, and delivery of projects but the pathways through which health and well-being are realised through its PB process have been extensively discussed in Chapter 5. Therefore, this chapter only considers comparisons of the commissioned interventions; Community Kitchen, Women Together and Tottenham Folklore projects (CK, WTN and TF).

6.1 Contextual underpinning and the development of the cases

PB aided the conception and delivery of effective health interventions for the individuals and the community through the WL programme. When used in CD to improve health and well-being, as exemplified in the four cases (the process, CK, WTN, TF), PB serves to align community assets and strategically include residents' voices to enable more equitable sharing of power between agencies and the community. These include government agencies (in this case Haringey Council and funders), providers, grassroots organisations and community members who are traditionally disengaged from meaningful engagement from health services and society because of the circumstances of their birth, where they live or work. Thereby increasing opportunities for meaningful engagement for these disengaged groups to participate

with and within their community. In addition, PB enhances the mobilisation and empowering of communities to govern themselves through power-sharing processes that encourage individuals to take decision-making responsibilities for themselves and the community (see Chapter 5).

Throughout the programme from WL CEAD process to the PB event day and projects, there was evidence of a shift in power relationship where residents were empowered to have a voice or participate on their own terms rather than in a statutory institutionalised sense. Residents took the driving seat to ensure projects were prioritised according to the needs of the community. In other words, PB changed the relationship between government officials, and residents (most of whom got funded to provide a projects). This engendered trust between government and the people as well as the community as they pulled together to improve outcomes for the community. This result would have been impossible without the political will Haringey Council official including the public health executives and their regeneration colleagues. In other words, executives of the council were committed to and determined to make a difference in the individual and community health and well-being of disadvantaged people living in RDPW. Having used other conventional means of public health promotion and interventions without much success, they were willing to try new ways of working. Therefore, they were willing to surrender power (in cash and kind) to see their desired outcome, including involving community members as agents of change.

Through WL, the training of community members to champion the improvements in health and well-being combined well with PB in this programme to design and deliver interventions that residents can accept, value, engage with, and invest in. Likewise, this system paid off as trained providers transferred learning to volunteers and participants, enabling the project to thrive and people to make fundamental changes to their health and well-being. The providers also learnt to share power with community organisations and residents, enhancing a healthy partnership between the projects, services, and project participants. All these led to projects' sustainability beyond the funding period.

The common denominator between all three intervention case studies in this thesis was PB commissioning through public votes. As seen in Chapter 5, PB gave residents the impetus to determine what types of projects were delivered, giving ownership and control to the community. Fundamentally, when individuals can control aspects of their lives, it positively impacts their mental health and well-being, transforming various aspects of their existence. On

the other hand, when an individual has no control, there is a likelihood that their mental health and well-being will be negatively affected. In other words, giving control to residents through the PB process to commission projects of their sense of well-being. The PB process through WL gave residents power, authority, and some sense of value that their opinion counts and that they count. This narrative reveals how PB clearly contributes to improving people's mental health and well-being.

A strong theme that resonates throughout the PB process is one of connectedness that started from the process of PB and through to the projects. Before the application of PB, many people in RDPW were unconnected to each other. Also, many people did not know what projects were going on in the area. As is common in many deprived communities, there was distrust and fear of people and government agencies in the community, particularly with the ongoing regeneration. However, this cross-case analysis reveals PB threw residents together enabling them to develop a sense of solidarity as described by Durkheim (1893, 1964). The PB day provided residents and agencies with both shared and structured opportunities to connect and interact socially in the area, and act collectively to decide changes needed to improve lives in the area. However, the commissioned projects provided residents organic connections based on their one or more common experiences or interests, giving them a better sense of where they live and who they are living beside. Furthermore, the projects offered both shared and structured opportunities to interact socially, discover additional connections, and solidify social bonds. Working together on projects allowed residents to see an entire range of people working to better their area, offering an experience of community life that inspired feelings of belonging and community unity.

In very deprived areas like RDPW, a high proportion of people live on subsistence levels. This means that many people from impoverished communities focus on attaining fundamental needs like food, shelter, and clothing. But people from impoverished communities do desire more concrete ways of living that lead to a better quality of life or that impact the wider determinants of health like access to health care, education, work and recreational activities. However, they do not have access to the resources or opportunities that would enable them to achieve these functions they love and enjoy. The data presented in Chapter 5 provides evidence for this statement, particularly when respondents stated that the circumstances of participants' lives constrained them from achieving better life outcomes (Alice, Naomi and Lily). PB however, encouraged the community to express their needs and aspirations including demanding for

more tangible, cultural, artistic forms of expression or opportunities. For instance, voting for the aspirational theatre project reflected the demand and attainment of this function. In addition, PB provided a platform where residents got exposure to new and various kinds of projects that exposed them to informal learning about enriching their lifestyles to promote their health and well-being. The pitching on PB day highlighted these interventions and made them aware of improving their well-being, allowing them to advocate for them actively through their voting.

Reflecting upon the influences of PB as a catalyst for inspiring communities to engage in individual and collective action to transform lives, I have conceptualised six main pathways through which PB contributed to the shift of power to communities to change their lives and society. These six pathways were:

1. The design and the delivery of projects
2. Maximisation of participation and meaningful engagement
3. Demand and direct response to community need
4. Action on the social determinants of health
5. Individual and collective action and ownership
6. Creative partnership working

The following sections discuss these pathways across the cases and the common and contrasting factors that made PB projects influence positive health and well-being outcomes for the individual and community.

6.2 The design and the delivery of projects: the influencing power of PB

Findings from across the case studies suggest that PB had a predominant influence on how the projects were designed and delivered. The competitiveness for the funding made project leads more proactive in designing projects to meet the objectives of the WL programme and the prioritised needs by the community. The project leads, commissioners, programme managers, and residents categorically stated that PB inspired how the projects evolved and were delivered.

First, the PB process started with engaging residents and providers in thinking about health and well-being in relation to the PB money trickling down to the community. For example, Genevieve, the PB facilitator, stated that bringing the community together to discuss how to spend the money on the community was a catalyst for people to think about what health is to them and the community and how they can be a part of the improvement process. This point highlights the social value of money, which I will discuss in detail in Chapter 7. In Chapter 5,

we also see Lily stating that the PB programme helped her reflect on her unhealthy diet and how the PB money helped her conceive a project to help the community. Similarly, Lauren (TF's lead) explained that competing for funding through PB forced her to think deeply how her theatre project could bring about health and well-being impacts for participants, leading her to design workshops that deepened participants' experiences.

This process of critical consciousness was an important aspect of change management mirrored across the three case studies. The three project leads designed WTN, TF and CK to enable residents to become conscious of their lived experiences, accept the realities of life, and work to make meaningful changes to their individual and collective health and well-being. A solid example of this was Daniel of TF. He recognised and accepted his condition as reality and decided through the project activities to make a difference in his life by letting go of the negative influences that held him back. Similarly, many women in WTWTN became motivated from their storytelling, motivational speakers, and activities with other women to reappraise their lives and aspire to gain employment or return to education.

The participatory nature or inclusion of the participants' voices and engagement in the development and delivery of projects significantly point to the application of PB. An example was how Alice in CK gave participants more say in the project's development and involved people cutting vegetables and cooking. Similarly, in WTN, women set up and set down and cooked to support the project. The involvement of residents in cooking healthy meals enabled residents to learn ways they could cook differently to improve their health. Similarly, helping to source the ingredients also showed many residents that healthy foods offered less expensive options and were readily available in nearby stores. Lauren from TF increased the democratic involvement of participants by enabling decision-making powers in the play production process. Her reflection on why participants voted for her helped her redesign her drama workshops and pay attention to the changes the participants suggested throughout the theatre process, making participants feel heard and their wishes acted upon. These pieces of evidence were corroborated by Fernando's comment about how PB projects were intentionally designed to promote health and well-being, particularly mental well-being. The participatory nature adopted by the projects leads in their design and delivery, reflected the democratic nature of PB and therefore enabled the WL programme to achieve the health and well-being outcome's objective.

These statements strengthen the existing evidence that PB allows residents to actively participate in deliberations over the choice of projects to allocate public resources that respond directly to the needs of the community (Wampler, 2012a). This also links to the evidence from WHO (2021a), which states that improving health literacy among communities is the foundation on which residents are empowered to play an active role in 1) improving their health, 2) engaging successfully with community action for health, and 3) demanding governments to meet their responsibilities in addressing health and health equity.

6.3 Demand and directly responding to the community's needs

PB was conceptualised as a catalyst that precipitated changes in the community in the way a tiny spark lights a fire. Although the application of PB was a small part of the WL programme, many stakeholders valued its use for the commissioning of health interventions. More than half of the interviewees referred to PB as an enabler of decision-making from the ground up (bottom-up approach), upskilling individuals, creating a buzz in the community, creating awareness of community projects, and getting people engaged. Enabling people to have a say in commissioning projects allowed residents to demand interventions that would meet their needs, thereby responding directly to individual and community needs.

In traditional commissioning, interventions are funded based on prescribed needs inferred by health professional expertise or knowledge of the community. In contrast, PB gives power to the people to demand and directly commission their expressed and felt needs that directly responds to the needs of the individual and the community. This change in power relationship enabled residents' voice needs uncommon in traditional commissioning. For instance, PB allowed residents to aspire to more culturally satisfying needs by choosing interventions like the theatre project, which became beneficial for skills building, relationship building and emotional well-being. PB presentation enabled community members to vote for more culturally inspiring projects like TF and WTN, which, somewhat unknown to them, would raise aspiration and increase efficacy in reflecting on past lives and gaining insight to deal with barriers to health.

The WLP2 programme lagged for a year due to difficulties arising from the coordination. PB played a crucial role in kick-starting the programme again when a knowledgeable and experienced facilitator was employed by the council. PB was excellent at generating interest and excitement in the community and relaunching the WL programme aims and objectives. It

was also a tool for raising awareness of the health problems in the ward and increasing individual and collective commitment to make changes to the adverse health effect on individuals and the community. Participants suggest that PB was a mechanism for promoting the WL programme wider to people who are not traditionally engaged in their health. All three case studies show that when you involve communities in co-producing (co-commissioning) exciting activities to meet perceived needs in their lives, it becomes less about health messages but more about collective action that is fun and underpins health and well-being benefits for all. Evidence from the case studies revealed that the lay residents' providers and participants of the projects knew what they wanted for their health and were willing to engage as long as they were involved through informal and flexible ways to make the decisions for change.

The traditional public health method for delivering health messages is through leaflets and posters for health prevention, promotion and protection. In doing so, it is assumed that residents do not know what is good for their health and need to be told. For example, Haringey borough has resource centres that provide leaflets and posters about varying health issues but Herbert who provided advice at the CK suggests that leaflets are not enough. In his experience, people in the area may not have enough "literacy or skill" to read messages on leaflets or the *confidence to say [Herbert] I don't really understand this …my English isn't that well, and I can't really read that well or my understanding isn't good"*. And he said, *"sometimes if we're hammering people with the same message [repeatedly,] it's a turn off". You've got to have something to draw on, to have someone to do stuff and help in your own way"*. Herbert states that practical advice and conversations as well as showing people through actions within the projects were more beneficial and significantly made the difference in the choices people make when they leave the projects. This type of community action, visible in all the PB projects, enabled people to make lifestyle changes within a short term in the projects. According to the Fernando, *"there are real lifestyle changes especially in terms of like diet… so the shift is already happening".*

The PB commissioned projects were unusual compared to traditionally designated types by funders. This is because the PB aspect of the WL programme provided a platform for community members to prioritise and demand projects they felt were necessary for improving outcomes for them individually and collectively. This statement confirms the familiar saying that community members know best what is essential for improving outcomes for their health and well-being.

The projects mimicked the PB democratic processes. As a result, they were flexible and participatory, to the point of being democratic in how they evolved and were delivered. This flexibility gave residents a say in how the projects were designed and run. Consequently, on the one hand, providers felt accountable to deliver their promises during the pitch on the event day. On the other hand, they were willing for residents to decide changes in the daily running of projects. Having a voice in the projects' delivery and being heard made community members feel valued and committed to the projects, giving them a sense of control and feeling of empowerment.

6.4 The maximisation of participation and meaningful engagement

The inflow of participants to, and engagement with, the projects was motivated through unique mechanisms. For example, the pitching on PB day, trickling down of money to the community, the nature of and provision of the projects (flexibility, food, and theatre), and connectedness offered. The PB day helped to create awareness of the existing and new projects and served as a catalyst for maximising participation and engagement through three domains: increasing the visibility of local projects, increasing access to community assets and connectedness, and engaging the traditionally disengaged.

6.3.1 Increasing the visibility of local projects

The pitching of the projects on the PB event day increased the community awareness of the existing projects in the borough and ward. The PB event day therefore increased the visibility of projects that were put forward to tackle health and well-being issues in RDPW. The pitching increased the knowledge of new projects and popularised existing ones giving access to them. It enabled voters to identify and access local projects that would respond to their needs. It also allowed networking between projects that later partnered to optimise their offer to the community.

Interviews revealed that participants who voted for the projects naturally participated in projects of their interest, increasing participation and engagement overall. Therefore, the PB day was influential for maximising participation and engagement. Before the PB event day, most projects that were pitched were unknown and recorded low attendance. However, some project leads claim that participation increased as people joined because of the PB event day. Participants like Raymond, who voted for the TF project, therefore joined TF based on his vote.

This finding is significant and unique to PB and contrasts with the traditional commissioning of intervention behind closed doors. So, from the outset, participants are automatically recruited before the project takes off.

The findings from the case studies suggest that the nature of bidding and pitching through PB was influential in ensuring that projects were tailored to deliver the community's identified health and well-being needs. In particular, the pitching of projects to a community audience made the commissioning process transparent, and the project leads accountable to individuals and the community. For example, Lauren in TF stated PB made her accountable to the needs people had voted for and increased her willingness for participants to have a say in what the project was offering. This type of commitment informed greater participation and engagement from participants as they noted that the projects, they had prioritised, and voted for were responding to their expressed need.

The pitching and parallel delivery of the PB project was essential for maximising participation within and across projects. Participation in one encouraged involvement in other projects going on in the community. In some cases, participants were those who voted on the event day and targeted projects to join. As projects developed, participation was noted to increase within and across projects.

In contrast, the CK project failed to sustain the engagement of an intergenerational community as intended because women with children felt uncomfortable participating alongside people with drug and alcohol addiction. This led to the exclusion of women and children from CK, indicating that not all community projects can cater for all people at the same time. Similarly, WTN only catered for women, excluding men in violent relationships. In contrast, TF attracted a multi-generational group as it developed, although this was not an intended outcome.

6.3.2 Access to community assets and connectedness

Another common thread across all projects was the theme *"coming out and connecting with others."* This signified increased interest in the PB projects and engagement of residents with each other and with services. The PB event day provided a forum for local services to have stalls and network with the commissioned projects. This act allowed creative partnerships to form between local agencies and projects opening access to community connectedness. For example, many agencies became engaged and offered services and advice to the women in

WTN and direct casework for residents in the CK. Connecting to others within projects was also responsible for participants to become aware of local activities that were going on in the area. This awareness increased access to local services and activities. The WTN was particularly evidenced for women to get connected to community activities for their children. Naomi mentioned that after women became involved with the WTN project, their *'eyes became open'* to community activities, increasing social connectedness.

One impact of *coming out* was the influence on reducing sedentary behaviours. People came out to the projects because they wanted to alleviate hunger or loneliness and become more active attending one project or the other. For instance, all three projects attracted lonely residents who increased their sense of belonging and access to other community projects, which further strengthened their social networks and social capital. An example was Billy, a transient resident who became a core volunteer in CK. In WTN, many women engaged in Zumba and walking groups for fitness and exercise. *Coming out* to CK and WTN gave residents access to free hot meals. In contrast, TF only invited participants sometimes to cafés for a drink after sessions. The food element in CK and WTN was a powerful incentive for many residents on benefits, the homeless, the poor or for women who needed respite from routine housework. In addition, the food aspect had beneficial outcomes for adopting health and well-being eating behaviours.

Food is a commonly included incentive in health intervention with disadvantaged communities. However, food was demanded through PB and designed to give maximum health benefits through modelling behaviour in this case. Particularly, in how accessible healthy cooking and eating can be with minimal income. Participants were invited to join in sourcing, preparing, and cooking the food. In addition, participants were drawn into dialogues about the colour, texture, freshness of the food, and the cost of preparation to encourage the adoption of healthy eating behaviours. These conversations were instrumental for many participants to respond to the invitation to change their cooking and eating habits or try healthier food options. These processes were evident in WTN and CK.

The presentation of the food enabled people to feel valued and loved. In CK, participants experienced love and feelings of value by the quality of nutritious food (texture and food colour) offered to them. Interviews with Alice and Fernando reveal how residents' respond to the beautifully colour and nutritious food presented to them at CK. Alice says, *"and you can see their eyes light up as they look at the food*". Fernando comments, "*just presenting food in*

a beautiful way makes people know they're being cared for, that's quite important". Participants at CK commented to Alice about feeling able to cook the same kinds of food at home as they perceive from the project that they were not expensive or difficult, initiating a change in diets and behaviour towards healthier foods. In contrast, in WTN, love and value were evidenced when participants cooked together and sat at a table to eat with children, as experienced in family settings. For example, Siobhan reflects on how, "*there was a long table pushed together and they had cooked this meal of chicken curry with lovely aromas around the room and there was like 25 women eating, talking, laughing, playing with their children all around the table, growing together with food that they had prepared themselves and that was a lovely moment".* WTN became a forum for promoting healthy eating, healthy weight, better communication, increased self-esteem, a sense of belonging and other psychosocial benefits. The benefits of learning to cook healthy meals and eating, as well as eating together increased better communication among residents, increased self-esteem, sense of belonging and other psychosocial benefit while promoting healthy eating.

Food was a common ground for people from multi-cultural backgrounds to connect and interact in effortless ways that encouraged social connectedness, reducing social isolation and increased belongingness. However, community groups in Haringey are known for their homogenous nature. Organised groups included the Kurdish, Turkish, Jewish, Irish, and Polish communities. These homogenous groups are known to have activities that cater to children and adults' needs. Belonging to this social network helped people in these groups have a sense of belonging and community spirit that enabled them to access assets in Haringey through their existing social capital and thrive. In contrast, many not so organised other ethnic or tribal groups lacked the resources to support members of their communities. But the PB projects gave the impetus to mobilise heterogeneous group bonding, resulting in community connectedness and cohesion previously not experienced in Haringey, as reported in participants' interviews (e.g., see Siobhan's comments in Chapter 5- Creating a sense of community/community spirit).

In addition, the PB projects created a sense of community by integrating people from various races and cultures, thereby increasing social cohesion through cooking and eating together, telling stories and connecting through informal networks. In the case of WTN, the incorporation of a multi-cultural cuisine made other women learn to appreciate and respect norms and values from different cultures. In contrast, Lauren (TF) having attempted and failed to recruit Turkish, Kurdish, and Jewish residents because they already had satisfying provisions

for themselves and their families, recruited participants from WTN and CK. This helped to enable further heterogeneous group bonding for people across projects and enabled cultures to mix, increasing community bonding and social cohesion.

Although it is common in traditionally commissioned community interventions in deprived communities to adopt food to introduce healthy eating behaviours, the food interventions in the PB projects were different. This is because WTN and CK project leads, being residents themselves, understood the need to respond to poverty and the nutritional needs of the community. Therefore, they strategically promoted food as a tool for the active participation of residents in the sourcing, preparing, and cooking of the food - this increased participants' interest in adopting good healthy behaviours and promoting it to others and their children. Furthermore, WTN and CK employed food as a resource for increasing participation, modelling healthy eating, and growing connectedness and social integration among participants. This act encouraged regular attendance and deepened the experience for participants, increasing confidence in adopting social relationships and well-being.

In contrast, TF did not engage a food element. Instead, they met at cafés for debriefing. This could be excluding for participants who could not afford the cost of buying food in the cafés. However, this may not be an issue because some participants benefitted from the free food at CK or WTN, and I did discuss the element of food with TF participants.

6.3.3 Engaging the traditionally disengaged

An important and common theme noted across all projects was the ability of projects to attract traditionally disengaged individuals. Respondents highlighted that before the application of PB, the public health department in the Haringey Council had invested huge amounts of funding to improve health outcomes for this community in the past but made little progress [see Moriah's and Naomi's comments in Chapter 4, Section 4.3.1]. Melissa and Moriah (senior public health executives in the council), Fernando (regeneration engagement officer) and James (councillor), commented extensively on how the PB projects have engaged and sustained participation of non-traditional participants (see Chapter 5). For instance, the CK attracted homeless people, migrant communities, people on benefits, people with challenging health conditions and substance misuse problems. The WTN group consisted of women in violent relationships or recovering from them and were enabled to meet in an informal setting to heal

and thrive. These groups were known to be traditionally disconnected from services and community assets in Haringey.

The WL programme with the PB element is seen as a good fit for co-producing outcomes for engaging everyone from the bottom-up. This approach enabled everyone to feel included in the decision making and giving people a sense of belonging to a part of something bigger than themselves. All projects attracted people from several backgrounds, races, and cultures. In particular, the TF brought together people from the arts, both young and old, enabling an intergenerational community to develop organically, while the CK brought people with complex needs and those doing well in the community to mix. Similarly, women from the area known as housebound and jobless mixed with professional women from different agencies who helped them to see multiple possibilities to re-enter the world of work and education.

All three projects became a currency for social relationships to develop beyond the norm in Haringey. PB paved a way for people to come together organically without many statutory regulations imposed on their entry. There were no checks at the doors whether they were fit to enter. This was evidenced by Fernando and other participants in Chapter 5 as a reason people easily joined the projects. Also, joining in the delivery of the projects enabled residents to be themselves, feel a sense of belonging and ownership. While working together in a flexible and informal environment, community members were able to communicate with one another, facilitating positive friendships and social connections beyond boundaries. The projects became meeting points for people with shared interests and experiences to share stories and find solutions to their problems. This increased the bonds of solidarity and feelings of community spirit. Participation and engagement increased as people felt welcomed and gained freedom and agency to participate in different activities.

Additionally, participants with challenging issues gained agency and freedom to interact with others who could help link them up to services. For instance, CK allowed the homeless and transient community, including people without immigration status, to begin a journey of resolving multi complex issues that represented structural barriers to health through the legal advice provided by a volunteer. Similarly, sharing stories of how they overcame problems in the community, women in WTN helped other women access services that were unknown to them. In addition, the PB projects created informal spaces for people to connect organically; as a result, individuals began to mentor others and helped them transform their lives. Although traditionally commissioned projects allow these kinds of approaches, the freedom of access as

well as flexible methods and informal environments enabled by PB provision made it easier for traditionally excluded people to freely engage and have a say through their stories.

Consequently, people made strong bonds that increased their sense of belonging, social connectedness, social network, and capital. My findings suggest that social isolation and loneliness reduced as new friendships were formed and old ones strengthened across cultures and walks of life. These informal spaces also reduced fear and increased the sense of safety known to significantly hinder social integration in Haringey.

6.5 Actions on the social determinants of health

The thematic outcomes assigned for all PB projects were improving health and well-being and reducing inequalities. My findings suggest that CK, WTN, and TF, targeted the common influences on the social determinants of health linked to Maslow's hierarchy of needs, including basic needs (food, warmth, and safety), psychological needs (belongingness, esteem, and love needs), and self-fulfilment (involvement in creative activities that brought out innate potentials) needs. These were noted in the food aspect offered by CK and WTN; specifically, providing hot meals for people in poor communities was influential for increasing participation and improving outcomes for healthier cooking and eating habits and building social relationships. Influencing individuals to cook and eat healthily meant that friends and family members were impacted positively; likewise, sharing meals enabled people to connect with others and build positive lasting friendships. In contrast, TF used storytelling and drama therapy to create an atmosphere of friendship and helping one another to build social networks and capital between members of the group and outside. Delving deeper into people's lives, TF, CK and WTN also involved various forms of storytelling to increase connectedness and positive friendships.

Through the activities of the interventions, individuals gained skills by contributing time and physical help. For example, people helped set up and set down, cook, creative storytelling, or assisting another person in CK, WTN and TF, leading to people feeling a sense of achievement, actualisation, and self-esteem. For example, Lauren felt pride and fulfilment for accomplishing the theatre production about people's stories to Tottenham, which could not get funding before PB. Similarly, Naomi had always wanted a project to empower women suffering from or who have suffered domestic violence. Alice wished for a healthy eating project to help people connect and solve issues impacting community spirit and the social determinants of health. All

three providers expressed their thrill during interviews at getting the PB funding through the decision-making process by the community. Without the offer of money through PB, these sorts of projects would not be considered by health professionals. Furthermore, these lay providers' flexible and participatory approach would be elusive in traditionally commissioned interventions due to statutory bureaucracies.

Some actions taken on the social determinants of health experienced in these cases mapped well with the notion of five ways to well-being initiated by the New Economic Foundation (NEF) in 2011 as part of the Foresight Project of Mental Capital and Well-being. The projects empowered people to connect, become active, take notice of their innate abilities, learn new things/ways of living, and give back in the form of volunteering and helping others. For example, the skills people gained through learning new things and connecting to others increased their aspiration to return to study, find work or start self-employment, enhancing their opportunities to improve income and social protection. Connecting with services like the Haringey Law Centre enabled CK to provide advice on immigration, housing, and benefits to protect income and bring social security. Connecting with people in the community gave access to various health services or community access from learning from people's stories- coming together of different people into the projects impacted social inclusion and non-discrimination of challenged people (e.g., homeless, disabled, people with alcohol, drug abuse, and mental health issues, and loneliness).

6.6 Individual and collective action and ownership

PB was the focal point for uniting the experiences common to all project's development and growth. Having voted on the PB day, participants wanted to see the project do well and therefore assume individual commitment, responsibility, and ownership for ensuring the continued success of the projects.

A common theme running across all case studies was ownership observed among residents because of their involvement in deciding the projects. The decision to choose and fund projects laid a foundation for people to become invested in seeing commissioned projects succeed. This is a significant point that reflects the positive influence PB has on the success and sustainability of the commissioned projects. Residents became invested in seeing positive outcomes from commissioned projects enabling them to thrive and become sustainable.

The devoted and sustained attendance to sessions evidenced this sense of ownership. Furthermore, participants encouraged their friends and other community members by word of mouth and regular calls to attend sessions. For instance, findings from the TF project show that some participants would have given up telling their stories but encouraging words from others made them stay in the project. Similarly, Vivian from WTN introduced Hope to TF, and Alice encouraged Kay to join TF. This finding intricately links to maximum participation where people participated across different projects. This community mobilisation of individuals increased a sense of belonging and ownership among residents.

PB mobilised additional resources for some of the projects, including cash and volunteering. This was an aspect of individual and collective investment where residents (including non-participants) gave their time and money to ensure the project was sustained beyond the funding provided through PB. For example, in CK, residents gave cash and participants volunteered to collect free food offered by local supermarkets for food preparation at the CK. So, although £3000 was a small pot of money to run the CK project for a year, the matched funding and the volunteering in the projects increased the resources for the projects thereby making them more sustainable through the year. CK, WTN and TF also got matched funding from direct commissioning by the council and charity organisations to recognise their work's impact. These mobilised funding as a result of PB extended the work of the projects and increased the impact seen. For example, the CK employed a trained staff to give legal advice and case work provision to residents with immigration, housing and employment issues leading to people tackling the social determinants of health that had been going on for years (see Chapter 5).

Participants experienced ownership in several domains during the WL programme and in projects. First the ideas for improving the health in this community was discussed and prioritised with residents through the community cafes and community action workshops. Then the WLDT members and other residents joined in co-producing and designing the projects that went forward for the PB bidding process. Also, a trained resident board helped to select the project to go to the PB through a due diligence procedure. All these processes were empowering for the residents involved. These co-production processes with the community and the impetus to vote gave residents a sense of ownership of the commissioned projects. This sense of ownership during the process was transferred to the running of the projects. Participants contributed to the decision-making processes during the delivery of projects. This increased

their sense of purpose, collective responsibility, ownership, and control, which were necessary for increased happiness, self-esteem, and self-worth.

6.7 Creative partnership working, strong volunteering and capacity building.

The PB projects involved participants in working with a range of public sector agencies and partner organisations. This nurturing of community partnership was evident in all cases, and it allowed sharing of power and valuing the contributions each partner brought. The creative partnerships enabled participation in decision-making processes that helped people act for change individually and collectively, including the project's growth and personal well-being. The freedom of participants to make decisions for change was informed by the exposure of providers to the participatory processes of PB. For instance, in the CK, participants liaised with Haringey legal advice service to improve the outcome for immigration, housing and benefits issues that had been ongoing for years. As a result, participants receiving this free service gained the confidence to make the right decisions to better their conditions. Similarly, the contribution of local agencies such as Jobcentre Plus and financial advisers enabled women in WTN to aspire to work and go into self-employment.

Likewise, TF employed local partners such as artistic/dance directors, musicians, poets, and drama therapists to maximise the outcomes for participants. Respondents from the TF project interview claimed that they could decide how they told or acted their stories, increasing their sense of control and ownership of the drama process. TF also received additional funding from a charity to support their theatre production. This joined up working between community members and local agencies or partners facilitated new possibilities for social action, as was seen with the WTN group collaborating with a prison agency to sew bags for women with children in prison. Such CD activities that foster networks with local agencies can improve individual and community capacity and functioning.

The sharing of power was also evident in the decision-making process involved in organising the projects. In all three cases, providers consulted participants in the projects' daily running, allowing them to contribute positively and sustainably to the projects because of the sense of ownership they felt. For instance, in CK, participants and non-benefitting residents sometimes contributed money to enable the project to continue to provide free food and drama workshops respectively. This willingness to contribute financial investment for the continuation of the

projects made the £3000-5000 sustainable beyond the PB funding demonstrating the demand and need for the projects.

The involvement of residents in the day to day running of the project was significant for participants to build capacity individually and collectively. In WTN and CK, participants could set up and set down and contribute to the cooking voluntarily. This led to increased informal learning of project management and delivery described by Fernando in Chapter 6 as "beyond classical volunteering" as individuals developed skills that could enable them to deliver a similar project in future. A strong link to this was that participants could draw on the support of the project leads to deliver similar projects elsewhere.

In WTN, the project lead, Naomi, had no formal qualification but got a job in the council from the skills she had gained from running WTN. This transformation was a significant success for Naomi, the council, and the project. In addition, volunteers stepped up to run the project increasing individual and community capacity. Overall, this circle of improvement in capacity building was beneficial for the individual and community functioning. Also, in CK, participants acted as mentors to others, helping people tackle alcohol problems, personal hygiene issues and housing problems.

In contrast, TF's contribution to capacity building was unique and different to WTN and CK. For example, TF developed innate personal skills for acting, which led to community capacity to perform and see a community theatre, a rarity for the Haringey poor.

Unintended, all three projects enabled residents to recognise innate and latent skills which they had forgotten about or did not envisage possible. For instance, individuals like Kay and Raymond realised their ability to be creative in the theatre production process. At the same time, Daniel rediscovered his potential to write and its ability to cause healing for him. The commitment for participants to enjoy and function in the PB projects increased their motivation to learn and actively try things for the first time and create a new life.

Significant examples of collaboration were seen between the WTN project, the Jobcentre, with the independent financial adviser and other community organisations, who pooled external funding to support work on employability and other capabilities among the women, including financial independence. Similarly, the CK project worked with the Haringey Law Centre to provide legal advice to participants who had lost their benefits, were homeless and had serious

immigration problems that were barriers to their quality of life. TF project lead, Lauren, expressed anxiety during our interview about her fear of recruiting participants for her play. But working with WTN and CK, and other existing PB projects, enabled her to recruit participants for her programme.

Figure 6.1 below presents a graphical representation of the six cross-case analysis findings of how PB influence transformation of lives described above. The diagram shows the six processes or pathways influenced by PB on the left and the ways in which the pathways motivated and mobilised individual and collective action on health and well-being.

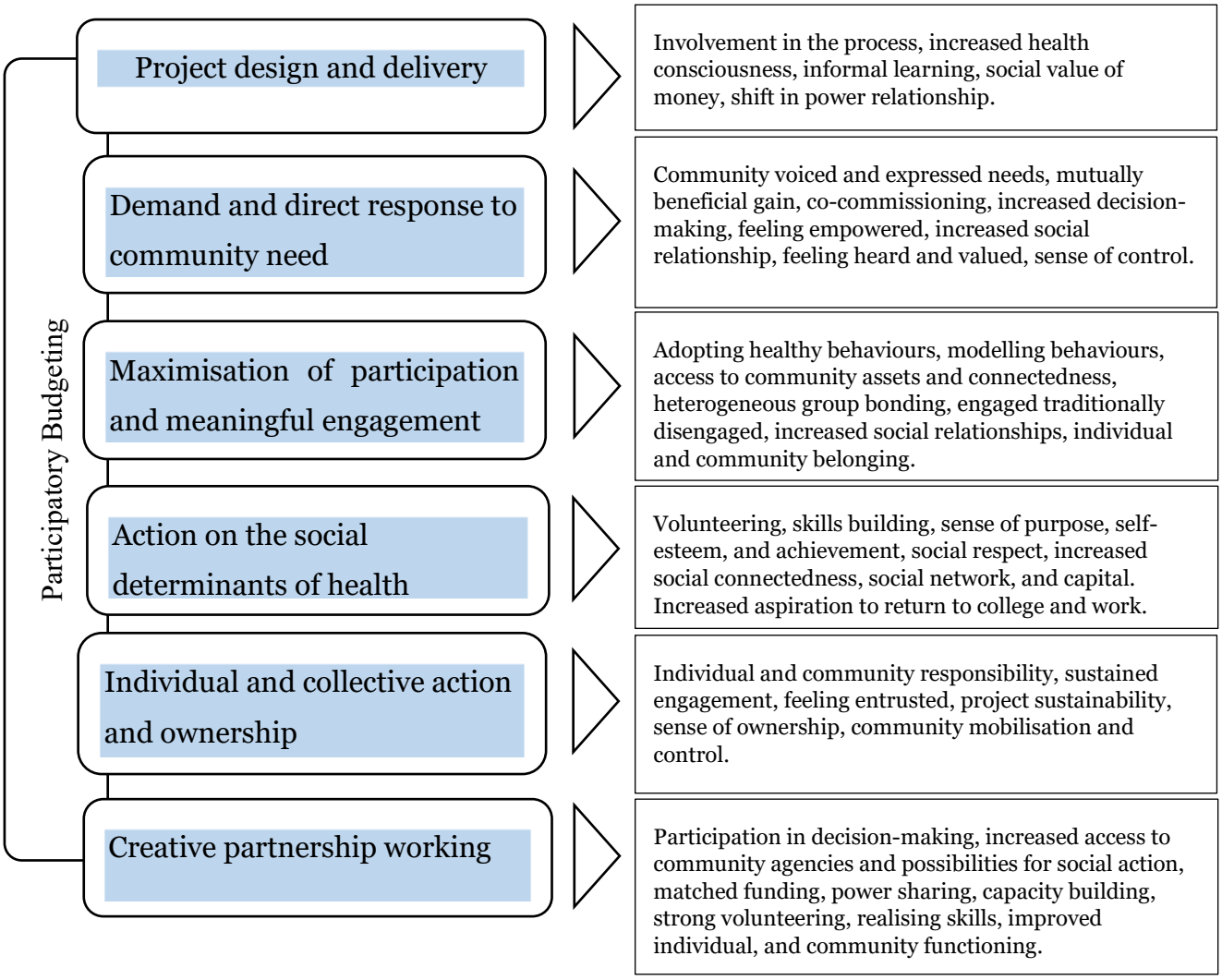

Figure 6.1 Cross-case analysis model- six influences of PB contributing to health and well-being

Integrating the concepts described above, I present a pictorial representation of PB's impact on health and well-being in Figure 6.2 below. The conceptual model was adapted from and inspired by Schölmerich *et al.* (2016) to depict how combining PB with WL gave birth to individual and community health and well-being. The two circles at the top of the triangle represent PB and WL coming together to engage multiple stakeholders (rectangle in the middle), which led to a critical reflection of assets and needs in the community. This gave rise to empowered residents and project providers creating ideas for change through a transformation in power relationships and people gaining freedom and agency, control and ownership to co-design, co-commission and co-deliver projects that directly responded to the individual and community needs. While the WL CEAD process influenced an initial mobilisation, capacity building and a desire/willingness from residents to participate, PB was a catalyst for creating awareness in the borough of projects going on in the community. This increased the visibility of the projects enabling maximisation and meaningful engagement, forced the design and delivery of the projects to respond directly to the community's needs, increased creative partnerships and allowed individual and collective action on the social determinants of health. Positive impacts on the social determinants of health lead to reduced health inequalities (Marmot *et al.*, 2010; PHE, 2017a; PHE, 2017b).

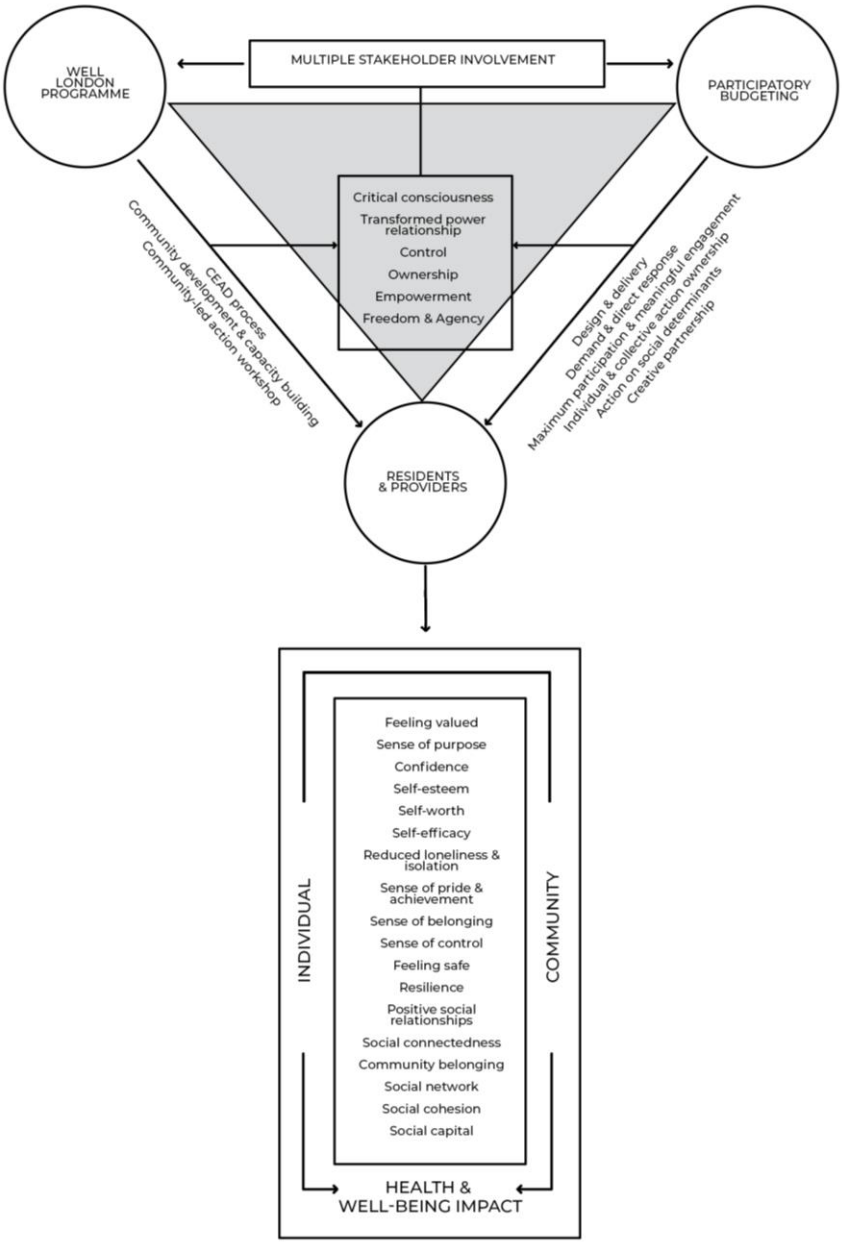

Figure 5.2 Conceptual model illustrating how PB processes enhanced health and well-being

6.8 Chapter summary

This cross-case analysis enabled me to identify and explore the broader concepts that elaborate an understanding of how PB inspired three community interventions to contribute to individual and community well-being. Thus, helping me to build a framework to reflect how PB initiates positive health and well-being impacts through projects designed and delivered to respond to individual and community needs. PB gave commissioning power to decide certain types of projects often excluded from traditional commissioning, enabling health interventions to match the basic needs as well as culturally aspirational projects seen as impactful on health and well-being. Interestingly, even though the three case studies were quite different in their values, structure, and offerings, the cross-cutting themes from the analysis were more common than contrasting.

Analysis reveals the design and delivery of the three case studies were influenced by PB through the competitiveness brought on by bidding for funding in the community space. Although their offerings were unique, the engagement processes were flexible and relaxed, allowing individual and collective voices in running the projects. In addition, involving residents in the day-to-day decision-making processes of the projects increased residents' sense of ownership and control, enhancing residents' mental well-being.

Residents were enabled to freely participate without the strict regulations by which traditionally commissioned interventions must adhere, such as having the correct immigration status to remain in the country This hassle-free environment of the projects increased the willingness of traditionally excluded residents (restricted by immigration laws, homelessness and ill health) to participate in ways that enabled friendships to form in dimensions that reduced social isolation and loneliness. Additionally, the development of social relationships enhanced social networks and social capital. Participants reported feeling included and loved, increasing their sense of belonging and community spirit.

The significance of engaging community members in commissioning and change management was vivid in how participants became invested in the projects beyond the classical volunteering enabling the sustainability of the projects beyond the funding. Volunteering by participants and creative partnerships with local agencies and services strengthened the health gains experienced by participants involved in the three interventions. Findings from the cross-case analysis support the application of PB alongside CD approaches to enhance capabilities among

local people to shape the design and delivery of interventions that support individual and collective well-being. Therefore, it is instructive that combining PB in CD approaches like Well London can heighten and sustain the dimension of health and well-being outcomes experienced by participants.

Chapter 7 - Discussion of findings

7.0 Introduction

In this study, I investigated the impact of participatory budgeting (PB) on the health and well-being of residents of a deprived community in London. To my knowledge, this is the first study that explored the impact of PB for improving the health and well-being of individuals and communities at a micro level involving resident providers in the UK. The study used a constructivist grounded theory approach to make sense of how PB improves health and well-being. Qualitative studies are limited in PB research; therefore, this study contributes to the research on the lived experiences of participants of PB, demonstrating how they construct the impact of PB on their health and well-being and the potential to reduce inequalities.

My study identified six processes through which PB can impact health and well-being, transform lives, and potentially reduce health inequalities. Some are consistent with previous research, and others highlight how new ways of working with PB can maximise outcomes for health and well-being. These included the effective prioritisation, co-design and the delivery of projects, maximising participation and engagement of residents, direct demand and response to the community's need, individual and collective ownership, and the action on the social determinants of health. These pathways were moderated by the democratic and flexible approach of applying PB ethos, particularly the inclusion of residents' voices in the planning and delivery of three interventions for health and well-being. The following sections presents discussions of the main findings, including PB's impact on different dimensions of health and well-being that can reduce health inequalities.

The richness of the data obtained from respondents of four case studies evidenced a deep appreciation and acceptance of the application of PB for implementing health intervention in a deprived community. The health and mental well-being of residents were improved through the ownership of the process and deep engagement in the interventions leading to enhanced social relationships, social inclusion, social integration, greater sense of belonging, increased social network and capital. PB was a catalyst for increased participation and co-production of interventions tailored to the community's needs. Many residents became empowered and gained agency and freedom to act on the social determinants of their health through informal learning in the programme and better access to local agencies and services, increased participation in enjoyable community activities without statutory regulations of traditional commissioning and increased social interaction. Through the stories by other participants'

activities during the programme, many residents were empowered to evaluate their realities and find ways to intentionally change their circumstances for the better. The use of health literacy approaches by resident providers and professionals in a relaxed environment, resulted in increased understanding and adoption of healthy eating, physical activity, and mental well-being behaviours, and provided education on how to maintain a healthy lifestyle for individuals and the community.

7.1 Community empowerment: co-commissioning and co-delivery

It is widely understood that CD approaches engage a radical agenda of empowerment to institute social change in communities (Ledwith, 2014). My study found that combining PB with WL, a CD programme using a CEAD process to train lay residents to create and develop interventions, was significant for residents to take control of their own health. The WL CEAD process trained residents to drive the programme and like the Porto Alegre styled PB, enabled residents to co-design and produce interventions which directly responded to the needs of the community. Unlike the Porto Alegre PB model however, the WL PB empowered lay residents and grassroots organisations to bid and deliver interventions. On one hand, residents received the impetus to deliver projects through a public vote and on the other hand, PB offered residents the choice and freedom to demand services that helped reduce social isolation and promote functioning they value and enjoy (Sen, 1999). What my study confirms is that by training communities and involving them in delivering and commissioning what types of intervention suit their needs, they choose projects that target the social determinants of health to transform their lives. This is consistent with Escobar (2020) whose review of PB processes shows that co-commissioning of projects with residents had transformative potential to tackle health, social, economic and political inequalities. This evidence also aligns with Collins' (1990) position suggesting that enabling oppressed people with new knowledge to take control of their lives can be empowering. In addition, showing oppressed people new ways of knowing and being that allows them to define their own realities has far-reaching implications for empowerment. In this project, residents were able to improve their sense of health and well-being through the types of interventions they commissioned through PB. For example, the theatre project enabled residents to reflect on their lives and began to write new stories of their lives. The PB projects focused on tackling the nutritional, educational, employability and communal aspects of social determinants of health. Furthermore, my study showed that

residents are better at outreaching other residents, increasing participation and investment in the projects due to solidarity and social bonding.

7.2 Deliberation and citizen's mobilisation

The WL and PB space created a platform for people to deliberate and consider the health issues in the community. This space enabled residents to become critically conscious about their personal and community health, enabling a collective responsibility to create solutions in the form of projects commissioned through PB. The process of critically positioning oneself to deepen awareness of their state of being is referred to as "Conscientização" (see Chapter 2). This Portuguese word stands for critical consciousness or critical awareness, which refers to "learning to perceive social, political and economic contradictions and to take action against the oppressive elements of reality" (Freire, 2000, p. 35). The process of conscientisation moves an individual from a position of learned helplessness to a critical mode where they explore their existence, which involves a reflection on reality, a critical stock taking of one's life. The outcome is identifying the causes of one's current state of reality and considering its implications and the development of meaningful actions to alter this reality. It is an invitation for individuals and communities to take strong critical stances about history, society, and even politics as the first step to meaningful change. My study corroborates this theory which, as I found, is a core element in operation within the WL PB programme.

My data showed that the WLDT learned about the health problems of the community, deliberated on it, and decided to act individually and collectively to tackle the problems. The team was trained to conduct outreaches and work with the community to reflect and act on the social determinants of health. This led to lay people developing projects that went forward to the PB voting day. This mobilisation of citizens created a circle of reflection and action which continued in the projects that were commissioned as the project providers engaged their new skills to train participants who joined their projects. Residents took a risk by coming out to the projects telling stories of their realities and learning from each other ways in which these realities could be transformed into positive experiences and enjoyment of life (Weffort, 1967). Residents were enlightened by the health education received and were no longer afraid to act against the realities which impacted their health and well-being. The fear of freedom discussed in Chapter 1 of *"Freire's Pedagogy of the Oppressed"* was eliminated by the liberating health literacy engaged within the programme (Freire, 2000).

This notion of health literacy closely aligns with WHO's evidence, suggesting enhanced health literacy empowers residents to play an active role to improve their health, participating successfully with community action for health and demanding governments address health and health equity (WHO, 2021a; WHO, 2021b). Furthermore, improving the health literacy of the most disadvantaged and marginalised communities accelerates equity and beyond. Residents in this study attained the requisite knowledge, personal skills, and confidence, enhancing their capability to improve individual and community health by changing personal lifestyles and living conditions (Sen, 1999; WHO, 2021b). Residents also realised innate skills and re-enacted previously dormant skills to do and be what they liked and enjoyed. The new competencies gained empowered residents to transform their lives. PB therefore, creates opportunities for residents to become competent citizens who take control for their own lives. Furthermore, the continued involvement of residents in change management maximised participation, increased ownership, and positive health outcomes for many in the community.

7.3 PB extends the impact of traditionally commissioned projects

Co-produced community-based interventions designed to improve residents' health and mental well-being often accomplish success on some intended outcomes. For instance, a previous evaluation of the WL programme by Phillips *et al.* (2014), shows some evidence of impact on secondary outcomes reducing unhealthy eating-score (MD: −0.14, 95% CI −0.02 to 0.27) and increased perception that people in the neighbourhood pulled together (RR: 1.92, 95% CI 1.12 to 3.29). However, the research demonstrates no impact on the primary outcomes (healthy eating - relative risk [RR] 1.04, 95% CI 0.93 to 1.17) and physical activity (RR: 1.01, 95% CI 0.88 to 1.16). The study concludes that the findings of the trial did not provide supporting evidence to demonstrate that the non-experimental components of the interventions improved healthy behaviours, well-being, and social outcomes. The authors felt that low participation and the churn of the populations compromised the impact of the intervention. While this may be true of the results, quantitative evidence does not fully account for the lived experience of participants in a study. On another level, it may be challenging to collect accurate information through surveys from people in a deprived community with low educational attainment and multiple disadvantages. Therefore, my study adds to the literature some granular details of the lived experiences of PB participants and various health benefits that accrue from their engagement.

Although community-based interventions can show success, the adoption of PB in this study extends the level of impacts experienced by residents. This is because PB allowed residents to drive the process by taking ownership through identifying, co-designing, and co-delivering the programme and interventions. Furthermore, it gave residents the responsibility to commission the projects that aimed to meet their needs. These led to two significant dimensions of needs satisfaction in public health; one, the demand for services that residents would engage in and enjoy and two, a mutually beneficial outcome for residents and the funders (public health practitioners). In terms of demand for services, PB empowered residents to openly voice their needs for certain projects, making them meaningfully tailored to residents' needs, increasing participation and engagement. This finding corroborates the earlier quantitative evidence in the PB literature that suggests an impact of PB is that it appears to bring government functioning closer to citizens' preferences which resulted in improvements in living standards (Gonçalves, 2014; Touchton and Wampler, 2014; Boulding and Wampler, 2010).

Satisfying the demands and needs of residents led the notion I termed 'mutually beneficial gain', which I observed in my data. This idea describes happiness at the outcomes achieved by PB for selecting and delivering the interventions which directly responded to the community's needs. It demonstrates the acceptance and buy-in to PB from all involved in the programme including residents, programme managers and Haringey Council executives who contributed to the funding of the programme. This notion of mutually beneficial gain was evident in the satisfaction expressed by residents and funders at the positive outcomes from the PB aspects of the programme experienced in RDPW. The ability of PB to increase resident's participation, enhance a sense of community and integrated partnership working across projects and with other community agencies, was truly satisfying. The increased acceptance and buy-in was the result of residents' voice being valued to make demands of the projects through their votes. My study adds to this notion the recognition that when residents are democratically included in assessing and prioritising needs in their community as well as co-producing the interventions, it increases the success of community-based interventions. By actively engaging communities through PB in processes like Joint Strategic Needs Assessments (JSNAs), public health leaders, clinicians (e.g., GPs) and policy makers will save time, increase value for money and maximise outcomes for the communities they serve.

7.4 Democratic participation and impacts

The democratic choice of an individual is known to impact health, particularly mental health. Wise and Sainsbury (2007) explored the importance of democracy as a forgotten determinant of health and its impact on mental health. They reflect on the potential for democracy to enhance collective decision-making, to increase different dimensions of health and well-being, increase social networks, community cohesion, and social capital. The authors affirm democracy increases the individual's sense of self and social respect, decreases feelings of alienation, increases personal and collective control and self-efficacy, a greater purpose in life, and hence greater happiness and healthier behaviours. My study substantiates the work of Wise and Sainsbury (2007), having found similar patterns across all four cases studied. Similarly, (Ciccone *et al.*, 2014) found an association between governance mechanisms and health. As in this study, their study illustrates that good governance can have a positive direct and indirect effect on health. My study extends their analysis by showing the relationship between governance and health and highlighting how governance provided through PB impacted the design and delivery of evidence-based interventions to produce life-transforming effects for RDPW residents.

PB provided a deliberative space for disadvantaged people to express their individual and collective needs and commission it. Moreover, these deliberative decision-making spaces are considered a pathway for promoting new relationships among citizens, community organisations and government officials, establishing the basis for investing in public resources that poor citizens need (Touchton *et al.*, 2017). In other words, these new relationships strengthen the recognition of what to fund. My study shows that the WL PB programme brought multiple stakeholders in Haringey to deliberate, prioritise, and fund the projects that directly met the needs of poor residents. My data also supports the evidence that PB enhances the individual and collective decision-making of residents during the PB process and within the commissioned projects. The social connections established throughout the programme increased social networks, community cohesion and social capital. The ability to give back to the projects and each other increased the individuals' sense of self and social respect, decreasing the feelings of alienation, while increasing the sense of personal and collective control and self-efficacy. These gave residents a greater purpose in life and happiness and the motivation to live healthier lives.

PB is widely recognised for engaging traditionally excluded citizens and expanding their voices and votes in deliberative venues (De Sousa Santos, 1998; Baiocchi, 2005; Abers, 2000a; Wampler, 2007b). For the last 50 years, neoliberal policies have shaped society, culturally individualising health promotion and health education issues (Peck and Tickell, 2003). Neoliberal methods of governance have detrimental effect on population health (Coburn, 2004; Borrell *et al.*, 2009; Lena and London, 1993; Siddiqi *et al.*, 2013; Richter *et al.*, 2012) and health inequalities (Olafsdottir, 2007; Bambra and Eikemo, 2009; Eikemo *et al.*, 2008; Levecque *et al.*, 2011; Kim and Jennings Jr, 2009). Unlike neoliberal practices, which alienate the poor and other underrepresented groups, PB acts to restore the agency of these groups in an otherwise disenfranchising environment. In this way, excluded populations bring new ideas and issues to the programme to cause social change that responds to this population through the wealth distributive ethos of PB (Wampler, 2012a). My data corresponds with these pieces of evidence as many people previously excluded from society meaningfully engaged in the RDPW PB process and projects, bringing new ideas and issues that were developed to transform lives. Social exclusion is a fundamental cause of health inequalities (Marmot, 2018). Furthermore, the "lack of hope and limited opportunities to transform one's circumstances are consequences of this exclusion." (Marmot, 2018, p. 10). Marmot advocates that to address health inequality from the perspective of social exclusion is "to bring socially excluded populations in from the cold—literally and metaphorically—and to provide them with the opportunity to be part of a diverse and flourishing society" (Marmot, 2018, p. 187). A systematic review by Luchenski *et al.* (2018) provides evidence that advocates that inclusion health approaches can make a significant positive difference to the lives of four groups of socially excluded populations. Their review showed that interventions involving homeless individuals, prisoners, people with substance use disorder, and sex workers to improve their own health made a difference in their lives.

PB provided hope and opportunity to traditionally excluded people to transform the circumstances that impact their lives, improving health and thus health inequalities. I argue that social inclusion was achieved in the RDPW WL programme through PB by enhancing opportunities for and access to resources, voice, votes and respect for rights to the socially disengaged. These included the homeless, people with migration issues, women in violent relationships, people with alcohol and drug use disorder, mental health problems and transient residents. PB's deliberative and democratic nature gave these excluded populations the impetus to contribute ideas and control issues that affect their health. The PB process enabled these

groups to participate flexibly in society, enhancing their opportunity to access within-group and external resources, have a voice and exercise their rights to contribute meaningfully to their community. Being able to contribute meaningfully to society is fundamental for improving mental health and thus inequality.

7.5 PB's influence on increasing social relationships

Previous researchers have theorised about the significance of social relationships when considering their impact on health and well-being. Umberson and Karas Montez (2010) explored three broad pathways that inform how social ties influence health: behavioural, psychosocial, and physiological. For example, psychosocial mechanisms may include social support, personal control, symbolic meaning, norms, and mental health. At the same time, behavioural pathways may influence health, mortality, and morbidity by influencing health behaviours, and physiological processes explain how supportive interactions with others benefit immune, endocrine, and cardiovascular functions and reduce allostatic load that may result from life stressors. For example, psychosocial mechanisms may include social support, personal control, symbolic meaning, norms, and mental health. Government policies and programmes often include social ties as mechanisms directly or indirectly for enhancing population health and well-being.

The ONS report, "*Measuring national well-being: an analysis of social capital in the UK"* presents four critical aspects of social capital: personal relationships, social network support, civic engagement and trust and cooperative norms that can impact health (Siegler, 2015). It suggests that social capital represents the social connections and the benefits they generate for individuals in society. The immense value of social connection was apparent in my data for all residents involved leading to group bond formations between people from various backgrounds. I related this to the influence of the positive experiences during the PB process and continuation in the projects for people with similar issues and heterogeneous groups. By pulling together to vote for the projects they believed in, people valued connecting with others and community assets. My study adds to this notion the recognition that such interactions need to be meaningfully engineered by a process like PB, which enhances motivation and agency for people with multiple disadvantages.

7.6 PB's impact on mental well-being

PB provided an enabling environment for social inclusion into society through enhancing mental capital and mental well-being. The 2008 Foresight review explicitly defines mental well-being as a dynamic state where individuals can develop their potential, work productively and creatively, build a positive relationship with others, and contribute meaningfully to society. Aspects of mental capital consist of a person's cognitive and emotional resources, which I found that participants invested in the intervention cases as they entered the spaces. These made residents feel relaxed, gaining power and agency to be flexible and efficient with their learning, acquiring new levels of emotional intelligence and social skills and resilience in the face of stress. In other words, empowering residents enabled them to become agents to improve their own lives. This new way of being, increased states of mental well-being and mental capital and caused participants to aspire to more than they were. The United Nation's report on leaving no one behind, advocates the inclusion of all peoples (United Nations, 2016). This was evident from my observation and participant interviews as all kinds of residents were invited to take part in the programme. My study adds to this notion the recognition of the need for all people to participate in society without the usual bureaucratic restrictions imposed on community interventions, which further sharpens the structural barriers for participation. There is a distinction between democratically inspired and transparent participation and a top-down approach, which tells residents what to do instead of doing it themselves. This distinction is what my study demonstrates because it reveals that it is possible to leave no one behind.

There is compelling evidence that social integration leads to reduced mortality risks and a better mental well-being state (Seeman, 1996). My data demonstrates that PB promoted social integration in RDPW by enabling an environment where people from various backgrounds could interact and participate equitably. During the WL CEAD process, PB event day, and within the commissioned projects, social integration was strongly evident. The PB programme gave access to decision-making, participation in a safe, stable, non-discriminatory environment and respect for diversity, where minority, disadvantaged, and vulnerable people could access services previously inaccessible. Before the PB intervention, my data reveal the lack of trust and fear of people from other backgrounds in the community. But my data shows that during the intervention, people from diverse cultures, races and ethnic backgrounds formed strong connections allowing for enhanced social ties. These new bonds between participants increased the feelings of safety, sense of belonging, and greater connectedness to the community,

enabling people to feel secure and improve mental health and well-being. The main aim of the public health Haringey and regeneration commissioners was to involve all communities, particularly, the most deprived to engage with community services hence the adoption of WL with the PB element. This is consistent with the Foresight review which concludes that "Encouraging and enabling everyone to realise their potential throughout their lives will be crucial for our future prosperity and wellbeing" (Cooper *et al.*, 2008).

7.7 The social value of money

Money was an extraordinarily fundamental concept in this study, not for its economic power but its social value. The value of money rarely extends beyond its economic purchasing power for healthcare in the extant literature. For example, Goncalves (2014), concludes that PB was associated with increased government spending on basic sanitation and health services (such as water and sewage connections, waste removal). The authors suggest that this spending pattern led to a significant reduction in the infant mortality rate among municipalities that adopted PB, showing that money can translate to positive health outcomes for healthcare. Similarly, Touchton and Wampler's (2014) research suggests that the relationship between PB spending on healthcare and health outcomes was greater in magnitude and stronger in statistical significance for municipalities that have applied PB for a more extended time than those who used it for less than four years. The authors conclude that the results in healthcare (reduction in infant mortality) observed from PB were not associated with short-term shifts in funding priorities but with long-term institutional and political change, which support recurrent spending on health and sanitation. My study includes but moves beyond this economic value of money to the *"social value of persons"* as worthy of investment, which can have a significant relationship to how the individual's self-esteem improves in the PB programme. The PB money invested in RDPW programme was not vast amounts to buy health and well-being goods or interventions or reduce the distress about lack of money. In addition, it could not buy enough health goods to the extent that makes a marked difference in the health state of the community as one-off spending. However, it purchased community buy-in because it influenced the feeling of being invested in as a person or a community - a type of validation where people's worth is considered valued.

The consistent mention of the PB money by respondents during interviews led me to explore the meanings participants placed on the money spent on securing health for them, which I conceptualised as the "*social value of money*." The social value of money was a significant

thread throughout my data. In exploring this thread, I found that money meant more for the project, the people and community than the commercial value in this study. In general, money was important for feeling valued and loved, impacting on people's self-esteem and self-worth. Zhang (2009) explored this relationship between money and self-esteem in decision making. His study provides the understanding that the meaning people place on money can influence the extent to which money can substitute for self-esteem boost.

In the same manner, I take a leap beyond the tangible economic investment to explain the intangible aspects of *'investment'* as a form of honouring or valuing people which I observed in the PB process. For example, respondents referred to the large amounts of money that had been spent by the Haringey Council for several years with little or no impact on health and well-being for this community [see Chapter 4, Section 4.3.1 for more details]. However, with the PB money, residents' felt valued that the money was trickling down to them; spent by them and directly on them. They also felt valued because they were entrusted to be the problem solvers for their own community issues. Consequently, the value placed on the PB money was observed from the people expressing their innate value through bidding and voting for projects they feel mean something to them. In other words, people invested their time voluntarily to make the changes they value and love. As Graeber (2001) puts it, "value emerges in action; it is the process by which a person's invisible potency – their capacity to act – is transformed into concrete, perceptible form" (p.45). Essentially, Graeber argues that people invest their energies in the things they consider most important, or most meaningful. For example, the homeless deemed it important to vote for the food project because they felt it was important for them. PB enabled them to vote without the statutory regulations that would prevent them from gaining employment or voting in a politics in society. This I relate to esteem building which moves from the fully tangible health outcome to the intangible well-being I observed in this study. This act of commissioning projects was a source of self-esteem boost for residents and a sense of pride for the community. This notion is consistent with the capability approach, which suggests that choosing what you think can enable you to function and enjoy is essential for improving well-being (Sen, 1999).

Furthermore, money was important for attracting residents to participate and engage in thinking deeper about what health is for them and for the community, especially for the traditionally excluded and transient residents. The social value of PB money meant that the programme had a wider reach for the excluded communities. Communities who would not typically engage

joined the project and meaningfully contributed because they felt their voices were heard. Their contribution brought them closer to community services that mitigated the structural barriers to their health. For example, being homeless can exclude an individual from work and financial empowerment (Brown *et al.*, 2012). The PB projects allowed these previously excluded residents to aspire to employment and education due to creative partnerships and connections with community services that mobilised advice they value in a conducive environment. In the projects, transient communities and homeless people contributed to the day-to-day decision making of running the projects, enabling them to feel included and increasing their sense of value, self-worth, and sense of purpose. In other words, PB enabled social services to come to the people rather than the people seek it. Social welfare policy has been theorised to create feelings of inclusion that leads to a sense of belonging essential for full citizenship (Pierson, 1993; Skocpol, 1995; Mettler, 2007).

Involving residents in commissioning projects relevant to theirs and their communities' needs gave them a sense of control and self-worth and a sense of belonging, leading to a sense of place, ownership, pride, and community spirit. This ability to take an active role in deciding money had strong implications for feelings of value and mental health. While residents felt entrusted to co-create and co-produce solutions tailored to their community's health needs, the PB project providers felt entrusted with money to deliver the demands or relevant projects for health in the community. This democratic community involvement in change management was significant for the ownership, commitment, and sustainability of the project. The PB money offered opportunities for individuals to access free services deemed too expensive for people from deprived communities, increasing the demand and use of the service. It also, allowed many residents to engage with new activities to improve healthy eating and cooking, physical activity, and mental well-being for the first-time, increasing resilience in people to maintain these newly formed behaviours.

7.8 Implications of the findings

These findings have significant implications for how PB programmes, seeking to improve health and well-being, are designed and delivered to respond directly to the needs of individuals and the community. Governments and non-governmental organisations, and health practitioners have been seeking to improve health and well-being and reduce inequalities for centuries. Still, the gaps toward equality and equity among peoples remain. Disadvantaged groups are worse off for all health indicators and outcomes compared to the rest of the country

(Marmot, 2020; Corris *et al.*, 2020; PHE, 2017a). It is therefore imperative that community-based interventions are designed and delivered to respond directly to the needs of deprived communities by giving voice to the residents who know best what the community needs to improve lives.

The active participation and engagement of disadvantaged groups are incredibly beneficial for creating aspirations and building resilient and more robust communities, thereby reducing ill-health burden and health inequalities. My study shows that PB can promote health by facilitating meaningful participation and engagement of disadvantaged groups through the shift of power to co-design, co-produce and commission interventions that enable health-promoting indicators of health. These include building strong social relationships, social inclusion, and social integration and by minimising structural and statutory barriers preventing people from accessing community assets for improving their lives. However, by not offering spatial and culturally safe spaces for these under-represented groups to thrive and function, policymakers, governments, and health promoters may fail to address the needs of these groups who could benefit from community services that help tackle the social determinants of health.

In this study, public health practitioners and residents in Haringey evidenced that large sums of money have been spent in RDPW for many years without making much difference in health outcomes for the community. However, this study showed that the small amounts placed in the hands of community members through PB votes effectively transformed the lives of individuals and the community in this Haringey neighbourhood. Public health directors, health promotion practitioners, government agencies, mental well-being practitioners and NGOs must note the impact of micro-interventions for addressing deep-rooted inequalities at the grassroots. Micro-intervention like the one in this study can potentially include residents more meaningfully than other macro interventions may neglect. When residents are allowed to lead in improving their lives, they deliver outcomes that respond directly to their community's immediate needs, and projects become sustainable for longer than the funding. For example, many of the projects commissioned by residents through PB in RDPW are still ongoing because of the community's personal responsibility and ownership.

Through the WLP2 PB programme interventions, residents targeted the common social determinants of health, as discussed in Chapter 6. However, there is a common thread in my data that informs the significant prevailing structural factors in the Haringey community that caused persistent inequities, and the action on the social determinants of health is insufficient

in sustaining the improved health and well-being achieved by these interventions. An example is the neoliberal model of health, where systems of care are cut or removed, preventing people from getting the health or social care they need. In other words, social determinants of health do not exist in a vacuum but are categorically created by the disservice of certain groups (Katz, 2010; O'Laughlin, 2015; Yates-Doerr, 2020). It occurs when society neglects the poorest creating the context for inequalities and poorer outcomes for the poorest. Public health and health promotion practitioners should therefore seek to adopt and develop interventions which not only tackle the social drivers of poor health but mitigate the structural constraints confronting individuals and communities. As Katz (2010) puts it

> *Unless these political and economic realities are confronted, poverty, powerlessness, and huge inequalities will continue to accelerate through the first decades of the 21st century. And the resulting deprivation and misery— the first and direct cause of disease and death in poor communities—will increase, as will insecurity, chaos, and violence.*

7.9 Limitations of the study

In terms of study limitations, consideration of a larger number of case study sites might have allowed for broader applicability of findings to a wider range of settings. However, I chose depth of research to breath. Selecting four diverse cases within a particular case study enabled me to conduct a more in-depth exploration of the phenomenon of PB and health within each case. Additionally, collecting data from many sources was advantageous and beneficial in adding context to the participants' experiences. The use of constructivist grounded theory by Charmaz (2006) strengthened my analysis of the data, prioritising the voices of previously unheard citizens and enabling me to develop a theoretical framework for understanding the processes through which PB influences health in a deprived community located in an urban centre. Prolonged engagement with the cases also enabled me to build trust with the participants and experience the breadth of variation among cases and individuals. This, in turn, helped me select cases and interpret the findings and overcome misrepresentations of participants' meanings.

As a qualitative study, the influences of the local setting should be considered when gauging the transferability of this study. For example, accessibility to local services, ongoing regeneration issues at the time of the study, relational trust issues between the council and the local people, council provision for people in this deprived community. Also, of note is my entry

into the case study site one year into the initiation of the WL programme. However, this was mitigated by the documentary analysis which gave me some insight as to why PB was adopted in this case. My previous work with WL also helped me understand the basic components delivered and why. All these helped inform my case selection, participant recruitment and data collection and interpretation of findings.

Another limitation relates to the difficulty with gathering information from people who dropped out of the project, particularly the period between the WL CEAD process and the initiation of the PB process. This information would have strengthened our understanding of the best ways to prevent a lag in the process delivery and increase momentum for the PB initiation in future intervention. However, this was mitigated by discussions with programme managers and WLDT members who succeeded in securing the community's vote to deliver projects.

An additional limitation of this study is that due to the Covid-19 pandemic, I could not return to the case study site to share my findings with the participants as intended, preventing them from commenting on my initial analysis of their study data. Nevertheless, copies of the transcript and analysis were sent to some participants for comments, strengthening the check on trustworthiness.

7.10 Recommendations for future research

Research on the impacts of PB on the health and well-being of individuals and communities, particularly exploring the pathways through which it improves the lives of people who participate, is sorely lacking. It has been argued by other scholars that there is a dearth of research on the pathways through which PB contributes to improving well-being, and the evidence to establish these pathways is severely lacking (Touchton and Wampler, 2014; Campbell *et al.*, 2018). Additionally, Vlahov and Caiaffa (2013), argue that although it is challenging to determine what improvements in public health can be attributed to PB, the circumstantial evidence for its benefits is visible. Furthermore, a recent systematic review concluded that with the increasing interest in PB, there is a need for rigorous qualitative and quantitative research to identify the impacts and processes of PB to substantiate the claims regarding its potential to empower communities and improve people's lives. With deprived communities being worse off around issues relating to health and well-being, particularly

mental well-being (PHE, 2017a) future health and well-being programmes applying PB must be accompanied by robust evaluations of PB and health and well-being.

For decades, the extensive spread of PB worldwide, particularly in Latin America, Europe and Africa, and anecdotal evidence of its benefit in the United Kingdom, has given strong currency that residents can actively participate in developing and maintaining their communities. Yet, a lack of health-specific quantitative and qualitative data limits the ability to measure the impact of PB on health and well-being, particularly mental well-being globally. This deficit in health evaluations of PB has resulted from practitioners of governance innovations and development interventions preferring to focus on the social justice and human rights benefits of those projects. But health outcomes are solid indicators of a better quality of life. My findings powerfully demonstrate that PB can be health-promoting and supports developing more robust and more resilient communities and reducing inequalities. Therefore, future research should be accompanied by evaluations of the effectiveness of such programmes and the pathways that enable health outcomes to be realised.

7.11 Chapter Summary

This chapter highlights and discusses the impact of PB on various dimensions of health and well-being when people from deprived communities are empowered to participate directly and meaningfully in a community-centred approach to improving health. Although structural barriers to health exist within the Riverdale ward, the different projects, despite differences, delivered health and well-being impacts through the influence of PB. PB improved the projects' visibility and gave residents ownership, which enabled them to become invested in the sustainability of the projects. This pathway allowed the funds to go further through a strong volunteering ethos that evolved, community partnerships and attracting matched funding.

The social value of money was particularly evident in the way residents felt entrusted with money to deliver health outcomes for their community. In addition, the value individuals felt seeing that Haringey Council empowered them to choose what their community needed and valued, and money being spent directly on them were instrumental to increased participation and meaningful engagement.

Finally, this study showed health dimensions impacted related to the social determinants of health which have relevance for reducing health inequalities experienced by different groups

that participated and compared with the Haringey population. Impact on health inequalities was evident in people taking active steps to gain employment, going into education and taking active steps to change health behaviours through health literacy which was central to the programme.

Chapter 8 - Conclusion

8.0 Introduction

This study demonstrated how PB, when combined with a CD approach that uses a comprehensive engagement, assessment and design process to co-design and co-produce health interventions with residents in a deprived community, can lead to a plethora of favourable health outcomes for residents.

Although the case studies selected differed in their nature and structure, their design and delivery style were influenced by PB to directly match the residents' needs. The PB process forced the project providers to remain accountable and transparent, working flexibly to maximise the inclusion of residents' voices in day-to-day decision making of the interventions. This behaviour increased participation, social inclusion, social integration, and the opportunity for residents to be directly involved in improving their health and mental well-being. Despite the political and social context of regeneration, distrust and fear of others experienced in the Riverdale ward, PB mobilised residents to individually and collectively take action to tackle the social determinants that impacted their health.

Within the study, PB was conceptualised to ignite excitement about health and enabled residents to critically reflect on their conditions and move to act against the structural barriers to their health and well-being. Through a process of cross-case analysis, I conceptualised six pathways through which PB contributed to individual and community health and well-being: 1) the design and the delivery of projects, 2) maximisation of participation and meaningful engagement 3) demand and direct response to community need 4) action on the social determinants of health, 5) individual and collective action and ownership and 6) creative partnership working.

This research contributes to understanding how PB can mobilise estranged communities to participate and engage meaningfully with community agencies and other health care providers to get and adopt health literacy at a hyperlocal level. It joins previous research to emphasise the centrality of empowerment of residents, participation, and advocacy for health promotion programmes. Embracing the values of PB meant that project providers recognised the historical power tensions between the community and the powers-that-be, leading to the adoption of equity and justice and new ways of working to produce health outcomes for residents. Through

this work, power was shifted to the community who became valuable resources within the projects; thus, benefiting their own and others' health and well-being. Through individual, meaningful engagement, CD provision was stretched, leading to the sustainability of the projects beyond the funding. PB in this study enabled a multi-component CD programme to go further in delivering unintended and the intended outcomes.

Finally, PB can be health-promoting as well as helping build stronger and more resilient communities and reduce inequalities through community-centred democratic decision-making in the process, increased participation of traditionally excluded residents, the types of projects commissioned and willingness and commitment by community members to make a difference to community health and well-being.

8.1 My contribution to the field of PB, health and well-being

The original contributions of my thesis to the current state of PB and health and well-being research and practice include three main domains. These are the contribution to the knowledge gap of PB on health and well-being; theorising and conceptualising the role of PB in health; and methodological approaches for PB in health research. The following sections describe and analyse my contributions in these three domains.

8.1.1 Knowledge gap

Previous research on PB mainly focused on the outcomes for democracy, accountability and transparency of the process (De Sousa Santos, 1998; Fung and Wright, 2001; World Bank, 2003; UN Habitat, 2004; Baiocchi, 2005; Shah, 2007; Goldfrank, 2007b; Avritzer and Ramos, 2016); and social and economic developments (Heimans, 2002; Cabannes, 2004b; Hernandez-Mendina, 2010; Cabannes, 2015; Godwin, 2018; Brun-Martos and Lapsley, 2017) making research on PB and health impacts scant. Nevertheless, available scholarship of the impact of PB on health and well-being and inequalities demonstrate that PB can reduce poverty and improve health and well-being and reduce inequalities (Touchton and Wampler, 2014; Boulding and Wampler, 2010; Gonçalves, 2014). But these are primarily Brazilian studies that use similar panel and routine data collected based on area and participation data (Campbell *et al.*, 2018), and do not employ an in-depth case study qualitative methodology as my study does. Furthermore, the Brazilian studies do not reflect the perceptions and lived experiences of people living in deprived communities in London, England (a high-income country) and how

PB influences their well-being, despite the varied contexts of inequality, in which they live. In the context of England and the devolved regions of the UK, there is even fewer PB research in England (see Campbell, *et al*, 2018 and PB Network website), particularly in terms of health and well-being. Therefore, my research also contributes to the application of PB in health context in a high-income country among deprived communities. It elucidates how PB can be used in a deprived community in urban centres and how the voices of these people living in deprived communities can be emboldened to improve their own health and well-being and work toward reducing inequalities.

On the scholarship of PB and health, there are no known English studies that demonstrate the impact of PB on health in deprived communities, in particular those that evaluate the perspectives and lived experiences of multiple stakeholders of a PB programme. Circumstantial evidence of health impacts from PB programmes exists, but they are held in grey literature found in reports, newspapers, and PB websites (PB-Network, 2015; Hall, 2010; Vlahov and Caiaffa, 2013). Through observation, documentary evidence, and co-construction of interviews with multiple stakeholders, my study revealed that PB impacted individual and community health, by giving control to individuals, reducing loneliness, social isolation, and improving self-esteem, self-worth, social connectedness, community belonging and social cohesion, and social loneliness. All these social factors are contributors to health and health inequalities (Link and Phelan, 1995)

Although previous research shows that PB increases the active participation of previously excluded citizens (Souza, 2001; Wampler, 2012a; Cabannes, 2015), they describe this in terms of how participation permits citizens to deliberate among themselves and with government over allocating public resources. In contrast, my research demonstrates how participation was maximised and how meaningful engagement was achieved by lifting statutory regulations, which enabled homeless people, housebound women, people with challenging immigration issues and others to participate in the PB process and interventions in a conducive environment. Residents also showed a willingness to participate through shared ownership to tackle the social determinants of health. Therefore, my research provides specific context and nuances of how meaningful participation was achieved and experienced and by whom. In addition, instead of infant mortality as a health indicator, my research showed how residents perceived PB to affect their health and well-being through psychological and sociological determinants. These included reducing loneliness, feeling included, feeling valued, gaining social respect, building

positive relationships, and increasing heterogeneous bonding with people from other nations, races and ethnicities, leading to social integration. All these culminating into people revaluating their lives and taking up new roles in society, including going back to school and gaining employment.

In alignment with previous research, my study demonstrates that the inclusion of residents in deciding which project to be delivered, enabled the projects to respond to the community's needs (Boulding and Wampler, 2010; Cabannes, 2015). However, my research illuminates further how projects met the community's needs because it reveals the nuances of the lived experiences and the interactions within the projects that led to short term and intermediate outcomes of improved well-being for residents. For instance, participants expressed gaining a sense of well-being due to participating in prioritising the health issues, designing the WL programme, commissioning the interventions and contributing to and influencing how the projects ran and were delivered. In addition, the active participation in the programme and interventions led to people realising their innate skills and potentials and developing new ones, allowing them to pursue further education, work or enhance their social sphere of influence, ultimately tackling the social determinants of their health.

Touchton and Wampler's (2014) research hinted at a link between involvement in PB and the development of social capital. My research showed that PB enabled ordinary people from all cultures, races, and backgrounds to interact in a flexible and enabling environment, mobilising a heterogeneous community to increase their sense of belonging, community spirit, pride, and social cohesion. Furthermore, building supportive, positive relationships seen through the PB process and in the projects, led to increased social network and social capital. Many participants from the three interventions expressed their confidence in asking for help from people previously outside their social sphere since joining the programme. Many also found support or advice to tackle structural barriers to their well-being. For example, in CK and WTN, residents met with local agencies who could motivate them to self-employment, find work or advice on immigration or housing issues for which they previously had no solutions. In addition, hearing other participants' stories of how they overcame similar difficulties encouraged some participants to launch out and find answers to the structural determinants of their health.

My research also extends the understanding that democracy is good for health, particularly mental health. The links between democracy and enabling citizens to gain sense of control

which ultimately impacts on health is well-established (Wise and Sainsbury, 2007; McKenzie, 2014; Escobar, 2020). PB enabled decision-making through co-production during the CEAD process and on the choice of delivered interventions in RDPW. This brought emotional and tangible transformations to life, as described in participants' interviews. Escobar (2020) explains how co-production in PB can generate public value through enabling collaboration and co-commissioning between professionals and citizens across communities of place, practice, identity and interest to tackle health, social, economic and political inequalities. Furthermore, the direct involvement in the democratic process in the WL PB process was cited as necessary for improving residents' mental well-being, including feeling valued, feeling respected, having senses of achievement and pride in contributing to society. Including residents as co-producers in prioritising and designing the process and running the projects was important for individual and collective investments and willingness to participate and change lifestyles. Individual and collective investments manifested as local agencies and participants volunteered their time, energy and dedication to ensure the success of the projects, enabling more people to benefit and ensuring the sustainability of projects.

Previous research on PB and health focused on capital investment and spending patterns on health care and sanitation to suggest an impact on poverty and infant mortality (Boulding and Wampler, 2010; Goncalves, 2014; Touchton and Wampler, 2014). In contrast, my research contributes to the literature on how small pots of money can bring value to human life to make people feel well. The social value of money was an unintended outcome that corroborates previous research, which states that if PB is done correctly, it can positively impact basic services and improve community outcomes (Cabannes, 2014; Shah, 2007). This means that PB money can produce short term and intermediate outcomes for health if well planned and targets the greater needs of residents. Furthermore, this notion extends Cabannes' result, indicating that PB "projects are cheaper and better maintained because of community control and oversight"(Cabannes, 2015). The PB money stretched as matched funding was received from residents, community charities and the local council, as project benefits were seen.

Another contribution to knowledge is the answer to the question, "to what extent can 'small scale' PB make a difference in a context of profound structural inequalities and injustices?". Through the data collected by observation and interviews, the thesis reveals the power of micro-interventions for addressing structural (macro) inequalities. The participants in this study were multiply deprived and suffered oppression, including poverty, homelessness, and

various illnesses caused by the neoliberal political-economic policies. Yet, with the small grant funding, residents were willing to take control and transform their well-being, ignoring the structural barriers caused by neo-liberalistic practices. My theory of change and the lessons learned from this study is simple. When residents are allowed to lead in programmes intended to improve their lives, they will do more than is expected and transform well-being to magnitudes not seen in traditional public health interventions. My study demonstrates that micro-interventions can impact needs at the grassroots. Many PB practitioners focus on macro or big grant projects, but these do not necessarily make the changes seen in this study. As evidenced by multiple stakeholders, millions of pounds had been spent by Haringey public health team in the past without any noticeable changes in the health status of the people. However, when residents entered the driving seat, they delivered interventions that best responded to the community's needs; some of those projects have thrived beyond the funding provided.

Finally, my research contributes to the literature on PB by raising PB within health literature by highlighting PB's influence on individual and community health. In particular, the links between democracy and health, reflection on the interplay between theories (democracy, empowerment and capability approach) as a lens to view how PB may contribute to the dimensions of health possible through the application of small grant PB in CD approaches.

8.1.2 Conceptual and theoretical contributions

A main goal of my study was to develop a framework to explain how PB influenced the health of people in RDPW who participated in the PB programme. This is because one main concern at the beginning of this study was that there were no clear frameworks to guide the evaluation of the role of PB in showing how impacts on health and well-being are produced in deprived communities at a local level. This thesis presents a model in Chapter 7, which shows six main processes through which PB impacts health. From the perspectives of multiple stakeholders, PB empowered residents to co-produce outcomes for health through the design and delivery of the PB process/projects and enhanced their demand and direct response to their needs. In addition, PB maximised participation and meaningful engagement while increasing individual and collective engagement as well as creative partnerships to act on the social determinants of health in the community. As a result, residents reported reduced loneliness, reduced social isolation, increased self-confidence and esteem, a sense of belonging, feeling valued and community spirit, leading to a better sense of self and purpose, with outcomes such as returning

to education or work. This model can be a starting point for practitioners and researchers to reflect on how they design and implement PB programmes to improve participant perception of health and well-being and toward reducing inequalities.

Another original contribution from my thesis is the development of a logic model which articulates the context through health and well-being that may be realised through the application of PB within a CD approach like WL. The CEAD CD process carried out in WL can be likened to other PB processes in Brazil, other Latin American countries and the US, where residents are allowed into a public forum to present and deliberate on issues that adversely affect individuals and the community. As the design process in the US the CEAD process enabled residents to learn, critically reflect on and deliberate about the health issues in their area, prioritise the greatest need through a community action workshop and with professionals. Residents were also allowed to develop proposals into tangible projects targeted to tackle health issues in the area. Residents then voted for the projects that most served the needs of the community. In contrast to the US or Brazil, PB residents and community organisations in RDPW were entrusted with the funding by the council and through residents' votes to deliver the prioritised projects.

Rigorous evaluations of PB programmes require identifying and understanding of the building blocks (enablers, inputs, key activities, and the process or pathways through which health and well-being are realised) of the intervention under scrutiny and the likely outcomes or impacts that may result. A logic framework helps identify aspects of a programme that needs evaluation and the methods (quantitative or qualitative) to apply. For example, in Table 8.1 below, Campbell and colleagues describe how PB can affect health. The authors listed participation (involving communities), collaboration (exercise of political rights, gaining civic skills and increased social cohesion), prioritisation and allocation of resources to identified needs leading to greater use of public funds and accountability of budgeting as stages that can lead to health. But there was no reference to how these aspects of PB may directly impact health and well-being or inequality. Indeed, the authors specify a gap in the literature showing the processes through which PB affects health and well-being.

Table 8.1 The effects of PB on the health, social, democratic and economic outcomes of individuals

The intervention, PB, is expected to impact on the health, social and economic outcomes of individuals involved through the following stages, derived from UN-Habitat and World Bank reports (Cabannes 2004, Shah 2007) and (Boulding and Wampler 2010, page 126):	
• ***Participation:***	*communities can decide how designated public money is spent.*
• ***Collaboration:***	*being involved in the PB decision process enables citizens to exercise political rights, develop civic skills and build social cohesion.*
• ***Prioritisation***	*improvements in priority public services may improve the wellbeing of individuals in that community, either directly through impacts on their health (*e.g., *reduction in disease, better access to medical services) or* via *social determinants of health (*e.g., *housing, education).*
• ***Allocation:***	*distribution of resources according to identified needs results in greater efficiency in the allocation of public funds, and greater accountability of budgetary procedures.*

Source: (Campbell *et al.*, 2018)

To support PB practitioners intending to evaluate health outcomes and impacts, I developed the following model seen in Figure 8.1. The model specifies the key enablers, WL a CD approach occurred, the key activities that combined to improve health and well-being showing the short-, intermediate- and long-term outcomes and health impacts resulted when PB was implemented in Haringey Borough. This model was developed from a review of the literature and my fieldwork experience, including the document review, observation and interview analysis, and interpretation of data collected from the case studies (process and intervention) on the WLP2 programme.

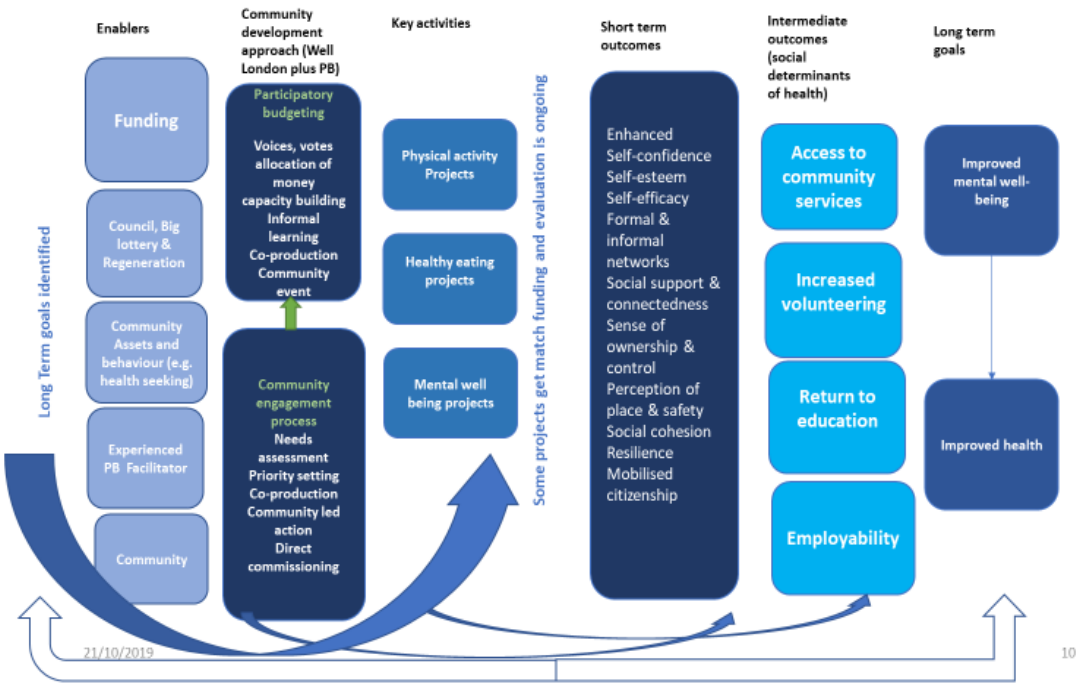

Figure 8.1 Logic model showing the process and outcomes of PB in WLP2

8.1.3 Methodological contributions

Previous PB health studies have focused on quantitative measures, whereas my research employed qualitative constructivist grounded theory (CGT). This inductive approach enabled me to generate new theory from the data gathered through participant interviews described in Chapter 7. CGT helped me co-construct from the participants own words and experiences the meanings they attribute to their health through participation in the PB programme. As PB gives voice to individuals and their community, the CGT presented a robust process to empower the voice of previously unheard people through interviews and increased the richness of the findings from the cases. The CGT also enabled me to understand and explore the social processes occurring in the programme, in the absence of an adequate theory about PB and health improvement, to strengthen the interpretation of the findings, as mentioned earlier. This is a significant contribution to PB health research, in providing a baseline for evaluating future PB health programmes for researchers who aim to hypothesise or test a theory (Yin, 2009).

Another original methodological contribution to PB health research in my thesis was the use of a single embedded case study. The method enabled me to examine within-case data and develop a cross-case analysis of events or processes that demonstrated how participants perceived their realisation of health and well-being through the application of PB. Being able

to frame my research investigation within this multicomponent programme that incorporates PB another multifaceted phenomenon is ground-breaking for PB research in health phenomenon. Furthermore, the ability to develop a systematically robust method analysis that highlighted and illuminated the contextual issues which enable PB to improve health is pioneering. The case study approach provided the opportunity to both frame the research investigation and systematically analyse the cases within the WL programme and this is fundamental to the credibility of my findings (Hayes, 2022)

The cross-case analysis gave a higher-order level of depth to understanding the pathways participants perceived led to positive health and well-being, illustrated in the theoretical framework in Chapter 7. For example, the lower-order level understanding included the reason people entered the projects or helped out. In contrast, higher-order level of analysis meant that through the cross-case analysis, I was able to understand and construct the pathways through which PB influenced the design and delivery of the projects, why participants were willing to participate and invest their time and to act on the social determinants of health while collaborating with each other and local partners. Therefore, the cross-case analysis reinforces my findings as these as cross-cutting themes from the three intervention cases are more likely to be pathways to positive health and well-being experienced by participants. A review of previous research shows an absence of single embedded case studies that have analysed data across the embedded cases within this case study type. Therefore, my study extends and demonstrates how the single embedded case study can be optimised for comparing events and outcomes from cases within a single case.

Finally, after exploring a wide range of qualitative research methodologies, I resolved that understanding the complexity of PB's influence on health within a multi-component CD approach is most appropriately conducted within the constructivist paradigm. This is because the constructivist approach best captures the richness and diversity of the multiple realities of different key players in a programme. The CGT helped me regard knowledge as a human construction and recognise the multiple realities of each participant to co-construct the meanings they assigned to how PB was influencing their health through the implementation process and within projects (Hatch, 2002). Collaborating with the participants enabled me to generate candid accounts to inform a comprehensive model that encapsulates the interplay between PB, health and well-being and the influencing contextual factors within WL and RDPW (Creswell and Miller, 2000) .

To promote the constructivist perspective, I drew from a case study design (Merriam, 1998; Stake, 1995; Stake, 2005) and employed the CGT approach to my data analysis (Charmaz, 2006). I also employed a case study design to gain an in-depth understanding of the phenomenon (PB and health) and the meaning for those involved (Merriam 1998). This effort enabled me to create thick descriptions from multiple sources of data to represent the multiple perspectives and experiences of participants in the programme. In combining case study with CGT, I aimed to develop theoretical models grounded on the data (Glaser, 1978). Combining CGT with the case study methodology gave additional power of precision and credibility in capturing and reporting the accounts of multiple stakeholders within the programme and corroborating data within and across cases that reflects PB's impact on health and well-being. This is a valuable contribution to the discussion of research methods which can be used to examine PB and health, particularly within a multicomponent CD approach to delivering improved health and well-being.

8.2 Chapter Summary

This chapter brings together the concluding thoughts of my thesis, particularly what I explored and my contribution to the field of PB and public health research and practice. I argue that the contemporary public health interventions geared towards improving health and well-being for communities or reducing health inequalities are insufficient and may even widen the gaps. This may be because of failures to respond to community needs and distrust for statutory organisations providing such interventions. Therefore, as a solution, I recommend PB as a complementary and innovative way of increasing participation and meaningful engagement of residents to control the issues that impact individual and community health. Interventions could aim to increase critical consciousness, health literacy and capacity of people in the deprived community to enable autonomy or agency in dealing with life course issues that prevent them from enjoying good health. Furthermore, interventions could include efforts to reduce the structural barriers that prevent access to interventions and services to improve health and well-being and reduce health inequalities.

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Appendix A: Ethics Approval letters & Research intergrity certificate

University of East London

Dear Ifeoma

Application ID: ETH2021-0228

Original application ID: UREC 1617 18

Project title: The impact of participatory budgeting (PB) on health and well-being- a case study of a deprived community in London

Lead researcher: Mrs Ifeoma Dan-Ogosi

Your application to Ethics and Integrity Sub-Committee was considered on the 26th of August 2021.

The decision is: **Approved**

The Committee's response is based on the protocol described in the application form and supporting documentation.

Your project has received ethical approval for 2 years from the approval date.

If you have any questions regarding this application please contact your supervisor or the secretary for the Ethics and Integrity Sub-Committee.

Approval has been given for the submitted application only and the research must be conducted accordingly.

Should you wish to make any changes in connection with this research project you must complete 'An application for approval of an amendment to an existing application'.

Approval is given on the understanding that the UEL Code of Practice for Research and the Code of Practice for Research Ethics is adhered to.□□

Any adverse events or reactions that occur in connection with this research project should be reported using the University's form for Reporting an Adverse/Serious Adverse Event/Reaction.

The University will periodically audit a random sample of approved applications for ethical approval, to ensure that the research projects are conducted in compliance with the consent given by the Research Ethics Committee and to the highest standards of rigour and integrity.

Please note, it is your responsibility to retain this letter for your records.

With the Committee's best wishes for the success of the project

Yours sincerely

Fernanda Silva

Administrative Officer for Research Governance

University of East London

Dear Ifeoma

Application ID: ETH2122-0013

Original application ID: UREC 1617 18

Project title: The impact of participatory budgeting on health and well-being: a qualitative case study of a deprived community in London

Lead researcher: Mrs Ifeoma Dan-Ogosi

Your application to Ethics and Integrity Sub-Committee was considered on the 7th of September 2021.

The decision is: **Approved**

The Committee's response is based on the protocol described in the application form and supporting documentation.

Your project has received ethical approval for 4 years from the approval date.

If you have any questions regarding this application please contact your supervisor or the secretary for the Ethics and Integrity Sub-Committee.

Approval has been given for the submitted application only and the research must be conducted accordingly.

Should you wish to make any changes in connection with this research project you must complete 'An application for approval of an amendment to an existing application'.

Approval is given on the understanding that the UEL Code of Practice for Research and the Code of Practice for Research Ethics is adhered to.□□

Any adverse events or reactions that occur in connection with this research project should be reported using the University's form for Reporting an Adverse/Serious Adverse Event/Reaction.

The University will periodically audit a random sample of approved applications for ethical approval, to ensure that the research projects are conducted in compliance with the consent given by the Research Ethics Committee and to the highest standards of rigour and integrity.

Please note, it is your responsibility to retain this letter for your records.

With the Committee's best wishes for the success of the project

Yours sincerely

Fernanda Silva

Administrative Officer for Research Governance

8th February 2017

Dear Ifeoma,

Project Title:	**Stakeholders' views and experiences of participatory budgeting health programmes**
Principal Investigator:	**Dr Susanna Rance**
Researcher:	**Ifeoma Elizabeth Dan-Ogosi**
Reference Number:	**UREC 1617 18**

I am writing to confirm the outcome of your application to the University Research Ethics Committee (UREC), which was considered by UREC on **Wednesday 18 January 2017.**

The decision made by members of the Committee is **Approved**. The Committee's response is based on the protocol described in the application form and supporting documentation. Your study has received ethical approval from the date of this letter.

Should you wish to make any changes in connection with your research project, this must be reported immediately to UREC. A Notification of Amendment form should be submitted for approval, accompanied by any additional or amended documents: http://www.uel.ac.uk/wwwmedia/schools/graduate/documents/Notification-of-Amendment-to-Approved-Ethics-App-150115.doc

Any adverse events that occur in connection with this research project must be reported immediately to UREC.

Approved Research Site

I am pleased to confirm that the approval of the proposed research applies to the following research site.

Research Site	Principal Investigator / Local Collaborator
1 - Over-50s Connect Hackney Aging Better project 2 - Well London Phase II Haringey project 3 - North of England Commissioning Support Unit's Mental Health Pound project 4 - Participant's home 5 - Local cafes and libraries	Dr Susanna Rance

Approved Documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
UREC application form	3.0	4 February 2017
Appendix 1- Confirmation of consent to use the data	1.0	10 October 2016
Appendix 2 – Interview topic guide for community members	2.0	23 January 2017
Interview topic guide for Programme Leaders, Project Deliverers and Commissioners	2.0	23 January 2017
Participant Information Sheet	3.0	4 February 2017
Participant Consent Form	3.0	7 February 2017
Appendix 3 - Email from Director of City and Hackney Together, Hackney Community Voluntary service	2.0	23 January 2017
Email from North of England Support Unit Senior communications and engagement locality manager	1.0	10 October 2016
Email form Marion Morris, Head of Health Improvement	1.0	7 February 2017
Risk Assessment form	1.0	10 October 2017

Approval is given on the understanding that the UEL Code of Practice in Research is adhered to.

The University will periodically audit a random sample of applications for ethical approval, to ensure that the research study is conducted in compliance with the consent given by the ethics Committee and to the highest standards of rigour and integrity.

Please note, it is your responsibility to retain this letter for your records.

With the Committee's best wishes for the success of this project.

Yours sincerely,

Fernanda Silva
Administrative Officer for Research Governance
University Research Ethics Committee (UREC)
Email: researchethics@uel.ac.uk

CERTIFICATE of COMPLETION

This is to certify that

IFEOMA DAN-OGOSI

has completed the course

Research Integrity Modules

10 May 2015

End of course quiz - Biomedical Sciences Grade: 90.00 %

University of East London

Appendix B: Participant information letter and Consent form

Information Sheet for Programme Leaders, Project Deliverers Commissioners and Community Members

The University of East London Research Ethics Committee (UREC) has reviewed and approved this study.

Director of Studies
Dr Susanna Rance
Institute for Health and Human Development
University of East London
Tel: 020 8223 4058
E-mail: s.rance@uel.ac.uk
Student researcher
Ifeoma Elizabeth Dan-Ogosi
Institute for Health and Human Development
University of East London
Telephone: 02082234099
Mobile:
E-mail: ifeoma@uel.ac.uk

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this study.

Title of study: ***Stakeholders' views and experiences of participatory budgeting health programmes***

Invitation to take part in a research study.

I would like to invite you to take part in this research study by giving an interview that will last between thirty minutes to one hour. The information in this sheet will tell you why the research is being done and what this means for you. Please take time to read it or ask for it to be read to you so that you can decide if you want to participate or not. If you are unsure of anything, or you would like more information, feel free to call me (Ifeoma Elizabeth Dan-Ogosi) on the numbers at the top of this sheet. You can take time to decide whether to take part or not. If you choose not to take part, this will not disadvantage you in any way. You will be given a copy of this sheet to take home with you.

Who is carrying out this study?

This study is part of a self-funded postgraduate degree, which is being carried by myself, Ifeoma Elizabeth Dan-Ogosi, in partial fulfilment of a PhD degree at the Institute for Health and Human Development, University of East London. My Director of Studies, Dr Susanna Rance, second supervisor, Professor Gail Findlay and third supervisor, Professor Angela Harden will support this research throughout its duration.

Why is this study being done?

Participatory budgeting is becoming popular for allocating money to health and wellbeing projects or services in communities. Many researchers have said it is important for improving health and wellbeing and reducing the differences people experience in their health. This study is part of my PhD research, which plans to look at how participatory budgeting programmes work in the community in three UK sites, two in London and one in Newcastle. I want to get a better understanding of how participatory budgeting in used to fund projects or services in the community setting and what effects these programmes have on the people who take part.
I also want to know how members of the community, project deliverers, commissioners and providers who take part in these programmes understand and experience participatory budgeting in their areas.

Who is being asked to take part?

People who live or work in three UK communities selected for this project and have experienced a participatory budgeting process or have taken part in the projects or services funded by this process. Only adults (18 years or older) will be able to participate in this study. If you consider yourself to be a vulnerable adult and want to participate in this study, you are also welcome to take part. I have a clear, enhanced Disclosure and Barring Service (DBS) certificate which qualifies me to interview you. However, I will be working with your care support worker (if applicable) to ensure that we have your consent.

Do you have to take part?

No, you are free to decide if you want to take part in the study or not. If you decide to take part, you will be asked to sign a consent form. You are free to change your mind and stop at any time, even during the interview, without giving a reason. You can choose not to answer any question that you do not wish to answer. If you decide to stop, there will be no disadvantage to you in any way

What do you have to do if you take part?

If you agree to take part, I will ask you to sign a consent form. You will put your name on this form, but as the interview is anonymous, the consent form will be kept separate from your interview recording and the paper version of what you say. Then invite you to have an interview in a place and time that is convenient for you. It may be at a community centre, a library near where you live or at the programme centre because I do not have permission to interview you

at home. The interview will last between 30 minutes to one hour. During the interview, I will ask you some general questions including your age, marital status, education, ethnicity, occupation and range of income. This information will not be used to identify you but will be used to get a clearer idea about the kinds of people who took part in participatory budgeting programmes who gave me interviews. I will then ask questions about your experience of involvement with the participatory budgeting programme, how this has affected you, or your community. I will also ask about what worked for you and what did not and how things can be made better next time. The interview will only take place once, but I might request a further meeting if I need further clarification on some questions.

What are the possible advantages of taking part?

You may find there is a benefit in having a say in how health interventions are funded in your community by talking about your experiences. By sharing your story, you will help participatory budgeting professionals, and policy makers understand better ways of planning and delivering projects and services in future. By so doing, you will be contributing to improving health care provision in your community.

Are there any risks involved in participating?

You would need to give up some of your time to attend the interview, and you may need to travel, as the interviews will not be in your home.
I will not be raising any particularly sensitive issues in the interview questions. However, if the discussion raises painful memories and feelings for you, you are free to change the subject if you wish, or move on to the next question, or end the interview. I will respect your wishes at all times. I will be able to give you information on how to get support if you feel the need for it.

What will happen to the information?

I will use the audio-recorded tape to type up the content from the interview and will remove all names and identifying information in the typed interview document. The tape will be destroyed three years after the end of the study (it is kept for this time in case there are any doubts about understanding what was said, and how). In the notes, and what is written about the interviews, it will not be possible to identify which person made any particular comment. The written information will be securely stored, by the university's Data Protection Policy, and will be destroyed after five years. The results of the study will be presented in a PhD thesis and distributed in other ways (e.g., academic papers) that highlight the new knowledge gained to support government and community efforts to meet people's needs better when using participatory budgeting to deliver projects in the community. The results of the study may be shared with your community in the form of a presentation.

How will I maintain your privacy and confidentiality?

Your interview will be anonymous, and your name will not appear on the audio-recording file or the paper version of what is said in the interview. The information that you provide during and after the interview will be anonymised and linked only to a numbered code. Any information you give that you want to be kept off the record will remain confidential. It will not go into the study report. Please note that confidentiality will be maintained as far possible unless a disclosure is made that indicates that the participant or someone else is at serious risk of harm. Such disclosures may be reported to the relevant authority. The study follows the Data Protection Act 1998 and preserve the rights you have under this Act. The audio recordings will be destroyed at the end of three to five years, and all paperwork will be kept confidential. Only the consent form that you are asked to sign will have your name on it, and this will be kept separately from your interview recording and transcript. Final results presented in reports, papers and presentations will be anonymised, and your name will not be on them.

Whom to contact for further information?

University Research Ethics Committee

If you have any concerns regarding the conduct of the research in which you are being asked to participate, please contact:
Catherine Fieulleteau, Research Integrity and Ethics Manager, Graduate School, EB 1.43. University of East London, Docklands Campus, London E16 2RD (Telephone: 020 8223 6683, Email: researchethics@uel.ac.uk)
For general enquiries about the research, please contact the Principal Investigator on the contact details at the top of this sheet.

INSTITUTE FOR HEALTH AND HUMAN DEVELOPMENT

Consent Form for Programme Leaders, Project Deliverers Commissioners and Community Participants

Stakeholder's views and experiences of participatory budgeting health programmes

Please tick as appropriate:	YES	NO
I confirm that I have read, or heard and understood the information relating to the above research in which I have been asked to take part. The nature and purposes of the research have been explained to me and I have had a chance to discuss the details and ask questions about the information provided. I am satisfied with the information I have received.		
I confirm that I understand what is being proposed and the procedures in which I will be involved have been explained to me. Therefore, I know what my part will be in the study and how it may affect me. I also confirm that I may be contacted for a follow-up interview regarding this project and my contribution at this interview may be used for future research.		
I understand that the interview will be audio-recorded with possible word for word quotation of my words to assist with preparing research reports. I understand that what I say during the interview will not linked to my name. a) I give consent that the audio recordings will be kept for between three to five years in accordance with Protection Act 1998. b) I prefer my interview not to be audio-recorded. I give consent for the researcher to take notes of what is said during the interview.		
I understand that my involvement in this study, and particular data from this research, will remain strictly confidential as far as possible. Only researchers involved in the study will have access to the data. However, where disclosure is made, which indicates that the participant or someone else is at serious risk of harm. Such disclosures may be reported to the relevant authority.		
I understand that I have the right to stop taking part in the study at any time and I do not have to give any reason. I know that if I do withdraw, it will not disadvantage me in any way. I understand that my data can be withdrawn up to the point of data analysis and that after this point it may not be possible.		
I understand that anonymised quotes will be used in publications from this research		

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I understand that the findings from this research may be published in peer-reviewed journals, presented in academic conferences or in seminars organised by the programme coordinator.		
It has been explained to me what will happen once the project has been completed.		
I know who to speak to if I have concerns about my participation and know how to reach them.		
I hereby freely and fully consent to participate in the study, which has been fully explained to me and for the information obtained to be used in relevant research publications.		

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Interviewer's Name (BLOCK CAPITALS)

.....

Interviewer's Signature

.....

Date: .....

Appendix C: Case Study Protocol- Well London PB process and three intervention cases

Questions for the case and information gathered	**Main sources of information**	**Data collection method**
Context and History What contextual factors, theories and mechanisms are in operation within Riverdale Park ward PB Well London programme in connection to health and well-being? What were the different steps involved in co-production of the PB Well London initiative? How were residents selected and included in the CEAD process of Well London? How and why was PB chosen as a method of commissioning interventions? What was the overarching role of PB in the Well London programme? How was the different ideas, principle and strategies of PB initiative adopted within Well London programme in this setting? How were residents invited to participate in the PB element of Well London programme? To what extent were they involved and what	**Document:** WL programme implementation documents, (WL project brief, flyers and posters), Haringey website, advert on social media, news magazine, Haringey Health and Wellbeing Strategy 2015-18, Haringey's Clinical Commissioning Group Five- year plan (2015-18), Well London framework, Haringey's community's strategy document 2018, Eventbrite adverts, email correspondences and meeting minutes **People:** Haringey public health and regeneration staff, UEL WL programme managers, Haringey Council public health staff members, PB facilitator, WLDT members, Project leads/providers, PB planning meetings (Steering group, and Riverdale partnership Board members: the neighbourhood partnership board)	Documentary review, semi-structured interviews

were the outcomes and impacts of these? What factors or mechanisms enable or inhibit the implementation of PB for health and well-being Riverdale ward?		
PB process implementation case 1 What is the impact of the PB process implementation on health and well-being? Who were the key players in the PB process implementation and what were their roles? How were residents included in the PB process? In what terms did certain groups of stakeholders talk about PB? How did PB impact on residents' participation and engagement and why? How did participants of the process implementation construct their beliefs and experiences of health and well-being? How did participants perceive that PB is impacting on inequalities in the community? What were the challenges and benefits of participating in a PB process implementation?	**Documents:** WL PB guide, WL CEAD process report, PB implementation report, PB event programme, **People:** Haringey regeneration staff, Haringey Council public health staff members, UEL WL programme team members, PB facilitator, WLDT members, project leads/providers, community members	Semi-structured interview, document review, direct observation, participant observation
What types of projects did residents commission through PB? How and why did the PB commissioned projects improve health and well-being or reduce inequalities? What processes did PB influence to contribute to health and well-being?	**Documents:** Riverdale PB event day video, Projects quarterly reports, community members, project leads/providers, **People:** Visits to the projects, extracts from	Semi-structured interview, document review, direct observation, participant observation

How did residents experience PB in connection to the different dimensions of health, wellbeing and inequalities in three UK settings? How did residents describe their experiences and the influence of being involved in the PB projects on their lives – in what dimensions? And to what extent? Within these descriptions, what place do they give to health, well-being and inequalities and what life changes were evident from their participating? What problematic or beneficial dimensions of their experience with participatory budgeting do they refer? What are the commonalities and differences between the intervention cases in terms of design, delivery and health and well-being outcomes realised?	council regeneration staff and PB facilitator interviews, project's Facebook pages, attendance registers and project delivery records.	

Appendix D- Interview Guides

Participatory budgeting (PB) approaches to improving health and wellbeing in communities (e.g., Well Communities' Programme in Haringey, Hackney over 50s project).

Interview questions for community members

Introduction

- *These questions may be asked of community members who participated in programmes where participatory budgeting was used to allocate resources or funds to implement health interventions. Participants may be male, or females aged 18 or over who live or work in the area and are/were involved in the process/event or intervention.*
- *The potential interviewee will have looked at the project information sheet before the interview and agreed to participate, signing the consent form. The interview will be recorded if the person agrees to this; if not, I will take notes on what is said.*
- *I will encourage the interviewee to share their experience of being involved in the programme and their feelings about it. The first few questions will help to put the interviewee at ease before getting into questions about their knowledge or experience of the programme. There will be several questions, which may be used as prompts if the interviewee needs clarification about the meaning of some questions or has difficulty remembering.*
- *I may or may not use all the questions in this guide and may add others as needed; depending on the answers, the interviewee gives or if there is a new line of enquiry that needs to be explored. It is quite possible that only a few of questions will be used, for instance, if the interviewee is willing and talks freely about their experience and feelings, mentioning things in the order they want.*
- *I understand that it is vital to listen carefully to the interviewee's answers and remember to follow on from them to explore more deeply, rather than trying to fit too many questions into the interview. It is fine to have some pauses in the interview while the person is thinking of what to say. However, it is also important to show the interviewee that I am listening to their answers.*
- *The interview can last about thirty minutes to one and a half hours.*

Process and outcome evaluation

Part 1: Background of the interviewee; getting to know them

1. Can you tell me about yourself?

Prompts:

- What is your role in this community if any?
- What is your job/occupation?
- What are your interests?

Part 2: Knowledge, adoption and acceptability of participatory budgeting for delivering health interventions

1. Can you tell me what you knew about this programme [insert name of programme] before getting involved?

Prompts:

- What do you know now about the programme?
- Have you ever been involved in this kind of project before? If yes, could you tell me more?
- Can you tell me what made you get involved in the programme?
- What do you know about how this programme was planned or organised? E.g., what approach was used and why.

2. Can you tell me how you became involved in this programme?

Prompts:

- How were you invited to join?
- What is your role in this programme [voters, observers, WLDT]?
- How long have you been involved?
- Are you still involved?
- Can you tell me if other community members were involved in this programme? If so, what was the means of communicating or advertising this programme to them?
- How do you feel about your involvement?

Part 3: Experience of participation in the PB event on (insert date if needed) (optional, only participants who attended the PB event e.g., voters, observers, WLDT if appropriate)

1. Can you tell me more about your involvement in the [insert name of programme] e.g. Well Communities event, which took place on (insert date)?

Prompts:

- How did you get to know about this event and what was your involvement in it?
- How did you feel about the event?
- What is your view of the way the community event was delivered?
- How did the community receive or react to this way of selecting interventions for implementation in the community?
- What types of interventions were selected?
- What do you feel about the types of interventions selected?
- What was interesting about them? What was difficult?
- What worked well and what didn't and why?
- What could be done differently?
- Are there any other issues/challenges you might want to discuss about the event?

Part 4: Participant's experience and talk of the influence of being involved in participatory budgeting in relation to health and well-being or inequalities

1. Overall, can you tell me about your experience of being involved in the programme?

Prompts:

- How do you feel about how it was planned and organised?
- What was your expectation upon joining the programme?
- How do you feel about it now?
- Can you tell me about how this programme may have affected your daily life or that of a member of the community you know?
- Can you give examples of any impacts this programme may have had on the community? E.g.
    a. Health & wellbeing

b. Inclusion
c. Social isolation
d. Social cohesion
e. inequalities
f. Capacity building (Training & Employment, volunteering)

Part 5: Experience of participating in the interventions? (Optional for participants who are taking or took part in an intervention/s)

1. Can you tell me about your experience of the project you are participating/have participated in?

Prompts:

- What is the name of the project you are participating in?
- How did hear/know about this project
- Can you tell me when you joined this project?
- What made you join the project?
- What were you expecting the intervention to be like?
- How does the project run?
- Tell me about your experience of the project.
- How do you feel about participating? For instance, what do you gain from coming here?

Part 6: Impacts of participating in Well Communities/PB project on the community

1. Thinking about the involvement of community people in the programme/project, can you tell me of any difference this project has made for the people in the community?

Prompts:

- How have people responded to the project?
- What difference have you noticed in individuals
- What has this project contributed to the community?
- Can you tell me if this is different from what you have noticed in previous projects you have been a part of and why?
- How have these changes, if any, influenced the community?

Part 7: Impacts of participating in Well Communities/PB programme on individual

1. Thinking about yourself, in what ways has participating in this programme affected you daily life.

Prompts:

- Since participating, have you noticed any changes within your daily life; can you give me examples of these changes?
- If yes. What do you think has influenced any of these changes?
- Would you be interested in participating in similar projects in the future?
- Would you recommend participating to others?

Part 8: Rounding off

Prompts:

- Is there any other thing you would like to tell me about your experiences?

Thank you for participating in my study.

At the end of the interview, I will ask participants to complete a data form with the following background information.

a) Age
b) Ethnicity
c) Gender
d) Educational attainment:
e) Job role
f) Location

Participatory budgeting (PB) approaches to improving health and wellbeing in communities (e.g., Well Communities' Programme in Haringey, Hackney over 50s project).

Interview questions for programme coordinators, commissioners, funders and PB facilitators

Introduction

- *These questions may be asked of programme coordinators, commissioners/ funders or programme facilitators who were involved in planning and delivering programmes where community members participated in allocating resources/funds to implement health interventions. Participants may be male or females aged 18 or over.*
- *The potential interviewee will have looked at the project information sheet before the interview and agreed to participate, signing the consent form. The interview will be recorded if the person agrees to this; if not, I will take notes on what is said.*
- *I will encourage the interviewee to share their experience of being involved in the programme and their feelings about it. The first few questions will help to put the interviewee at ease before getting into questions about their knowledge or experience of the programme. There will be several questions, which may be used as prompts if the interviewee needs clarification about the meaning of some questions or has difficulty remembering.*
- *I may or may not use all the questions in this guide and may add others as needed; depending on the answers, the interviewee gives or if there is a new line of enquiry that needs to be explored. It is quite possible that only a few of questions will be used, for instance, if the interviewee is willing and talks freely about their experience and feelings, mentioning things in the order they want.*
- *I understand that it is vital to listen carefully to the interviewee's answers and remember to follow on from them to explore more deeply, rather than trying to fit too many questions into the interview. It is fine to have some pauses in the interview while the person is thinking of what to say. However, it is also important to show the interviewee that I am listening to their answers.*
- *The interview may last about thirty minutes to one and a half hours depending on the availability of the participant.*

Process and outcome evaluation

Part 1: Conversation about the interviewee.

1. Can you tell me about yourself?

Prompts:

- What is your job?
- How long have you done this job?
- What was your role in this programme?

Part 2: Contextual considerations

1. Can you describe the approach used for delivering this programme?

Prompts:

- What did you know about the approach before you got involved in the programme?
- Did you have to adapt this approach differently?
- If so, why? What wasn't working that made you adapt it differently?
- How did you decide what adjustments to make?
- What factors did you consider when planning and designing this programme?
- What steps were involved in the implementation process?
- How were individuals in the community involved in the programme?
- How useful did you find the method used to implement this programme?

Part 2: Theoretical considerations

1. How have you defined the method used to deliver this programme?

Prompts:

- Did any theory inform your programme?
- If so, how did you integrate it into your intervention?
- What are the mechanisms of change that you think were important?
- How are these mechanisms reflected in your intervention design?

Part 3: participant's experience of participation

1. Thinking about your involvement, can you tell me about your experience of the programme?

Prompts

- What are some of the challenges and constraints you experienced?
- In what ways do you think your programme was successful and why?
- In what ways could do you think your programme was unsuccessful?
- What reasons can you attribute to the lack of success?
- How was the project funded?
- If you had unlimited funding, what would you have done differently?

Part 4: Acceptability of the programme/impact on individuals and community

Prompts

- How did individuals or community receive the programme?
- Can you tell me of any impact the programme has had on the community?
- Can you give examples of any of these impacts? E.g.
    a. Health & wellbeing
    b. Inclusion
    c. Social isolation
    d. Social cohesion
    e. inequalities
    f. Capacity building (Training & Employment, volunteering)
- What do you think has influenced these changes?
- Would you implement this type of programme in the future?
- Would you recommend this approach to other commissioners or funders?

Part 5: Rounding off:

Prompts

- Is there anything else you would like to tell me about your experiences?
- Would you mind completing a short demographic questionnaire?

Thank you for participating in my study.

a) Age
b) Ethnicity
c) Gender
d) Educational attainment
e) Job role
f) Location/ length of time worked or lived in the area
g) Length of time involved in the programme.

Participatory budgeting (PB) approaches to improving health and wellbeing in communities (e.g., Well Communities' Programme in Haringey, Hackney over 50s project).

Interview questions for project deliverers

Introduction

- *These questions may be asked of community members or representatives of community organisations who were funded through a participatory budgeting process to implement interventions in their communities. Participants may be male or female or aged 18 or over and live in the area.*
- *The potential interviewee will have looked at the project information sheet before the interview and agreed to participate, signing the consent form. The interview will be recorded if the person agrees to this; if not, I will take notes on what is said.*
- *I will encourage the interviewee to share their experience of being involved in the programme and their feelings about it. The first few questions will help to put the interviewee at ease before getting into questions about their knowledge or experience of the programme. There will be several questions, which may be used as prompts if the interviewee needs clarification about the meaning of some questions or has difficulty remembering.*
- *I may or may not use all the questions in this guide and may add others as needed; depending on the answers, the interviewee gives or if there is a new line of enquiry that needs to be explored. It is quite possible that only a few of questions will be used, for instance, if the interviewee is willing and talks freely about their experience and feelings, mentioning things in the order they want.*
- *I understand that it is vital to listen carefully to the interviewee's answers and remember to follow on from them to explore more deeply, rather than trying to fit too many questions into the interview. It is fine to have some pauses in the interview while the person is thinking of what to say. However, it is also important to show the interviewee that I am listening to their answers.*
- *The interview can last about thirty minutes to one and a half hours depending on depending on the availability of the participant.*

Part 1: Conversation about the interviewee.

1. Can you tell me about yourself?

Prompts:

- What is your job?
- What is your experience of delivering projects in the community?

Part 2: Knowledge, adoption and acceptability

1. Can you tell me what you knew about this programme before getting involved?

Prompts:

- What do you know now about the programme?
- Is this different from any programme you have been involved? If yes, why?
- How was this programme implemented?
- What steps were involved?
- How do you feel about the implementation of the programme?

2. Can you tell me how you became involved in this programme?

Prompts:

- How did you hear of the programme?
- How long have you been involved?
- How do you feel about your involvement?

Part 3: Experience of participating in the community day event

Application process

1. Can you tell me more about your experience of participating in the PB event?

Prompts:

- Did you put in an application?
- If yes, what made you decide to apply?

- How did you find the application process?
- What support did you get during the process?
- How did you feel about presenting your project to the community?
- Did you receive any funding?
- If yes, how did you feel about the funding you received?
- If no, how did you feel about that?

Selecting projects at the PB event

- How do you feel about the types of interventions selected?
- What important things can you remember about the selection process?
- What worked well and what didn't and why?
- What could have been done differently?
- Are there any other issues/challenges you might want to discuss about the event?
- How did you feel about how the event was implemented?

Part 4: Participant's experience relating to health and well-being or inequalities because of being involved in the PB programme

1. Overall, can you tell me about your experience of being involved in the programme?

Prompts:

- What were you expecting when you joined the programme?
- How do you feel about that now?
- Can you tell me if this programme has affected your daily life or that of a member of the community you know?
- Can you give examples of any impacts this programme may have had on you, your neighbours, family members or anyone in the community you know? E.g.
    g. Health & wellbeing
    h. Inclusion or exclusion (acceptance or rejection of being involved)
    i. Social isolation
    j. Social cohesion
    k. inequalities
    l. Capacity building (Training & Employment, volunteering)

Part 5: Experience of participating/delivering an intervention?

1. Can you tell me about your experience of delivering this intervention?

Prompts:

- What is the name of your project?
- What are the key aims of your project?
- Do you think that you have achieved so far?
- How do you feel about delivering this project?
- Can you give examples of any difference you have noticed since delivering this project?

2. Can you describe how the community has responded to your project?

- How do/did you recruit community members to join your project?
- What were you expecting their response to be like?
- How do you feel about that now?

Part 6: Impacts of participating in Well Communities/PB programme on the community

1. How do your project participants describe their experience?

Prompts:

- What do they think about being involved?
- Since delivering this project, have you noticed any changes in the group who have joined?
- Can you think of anything that has influenced these changes?
- Can you give examples of any impacts your project or this programme may have had on the community? E.g.
    a. Health & wellbeing
    b. Inclusion
    c. Social isolation
    d. Social cohesion
    e. Inequalities
    f. Capacity building (Training & Employment, volunteering)

Part 7: Impacts of participating in Well Communities/PB programme on individual

1. Thinking about yourself, in what ways has participating in this programme affected your daily life.

Prompts:

- Since participating, have you noticed any changes within your daily life?
- Can you give me examples of these changes?
- If yes, what do you think has influenced any of these changes?
- Would you be interested in participating/delivering similar projects in the future?
- Would you recommend participating to others?

Part 8: Rounding off

Prompts:

- Is there any other thing you would like to tell me about your experiences?
- Would you mind completing a short questionnaire about yourself?

Thank you for participating in my study.

a) Age
b) Ethnicity
c) Gender
d) Educational attainment:
e) Job role
f) Location/ length of time lived in this community.
g) How long have you been implementing community interventions?

Appendix E: General Field Note Observation Guide

Aim: to guide initial observation to get an overview of what activities or events, actors/stakeholders, and projects related to PB within the Well London programme. Also, how can what I observe help shape the interview questions, who to interview and what projects would most help answer the *i*nitial issues observed and how these contribute to the research study question or deviate from it.

To Describe	**To be observed: Questions to ask during and after my observation**
***What** are the main events/activities related to the WL PB initiative related to my concerns*	What are the possible defining features of the different activities/events? When do these occur (during the day, and in relation to other activities)? Who is involved?
***What** are all the activities concerning PB that needs observing.*	What processes might these events be a part of? Which of these processes can provide opportunity to see/understand PB processes better (i.e., involve interactions, allow for change over time)? Who might be able to provide some background and context to these fundamental activities?
***What** fundamental interactions happen between the providers, PB facilitator, programme managers and participants. And how these relate to the co-production and development of WL PB processes.*	What are the various interactions going on? Who can tell me what these mean and how these interactions contribute to the process of planning, co-design, co-commissioning and delivery of PB?
***Who** are all the people (stakeholders) involved in the PB events/activities of the Haringey WL programme?*	What are different people involved in the different events? What different roles/functions they seem to take on and how do these changes? How do these people influence PB processes? And how does the PB processes influence them. Which of these people would provide diverse perspectives on the WL and PB events or projects or processes?
***What** are the impacts of PB on the projects commissioned? How are these possible and why?*	What are the reasons participants give for these impacts and reasons these impacts are important for individuals and community?

Appendix E1 Focused observation Guide

Aim: to guide specific observations of meetings, interactions and events identified by myself or an informant as important in understanding the PB initiative with the intention of describing key activities, events, and actors in the PB process/interventions and how these unfold/change overtime.

To be Described	Focused and Interpretive Questions to Ask Myself during and after observation
*Stated **purpose/ nature** of the interaction*	Why did I (or an informant) think this would be helpful for me to observe? What stage/phase of the WL PB process might this be?
***Physical** setting and who are those present?*	Where are they and how does what is going on contribute to the development of the PB process or interventions commissioned? How are people organised/positioned? What are they doing or saying? Who isn't here? How might the context or setting or set up suggest structural or systemic influences? Who is guiding or leading? What power relationships are on display? Does this change over time? How and why?
***What** the PB facilitator/project leader/providers doing and saying*	Where is they in relation to others? Who is are they directing their words/actions to? How do people accept or respond to these actions? What does actions from PB/facilitator/project leads accomplish/achieve? What were you expecting to observe compared with your expectations? What wasn't said/done? What could be done differently?
***What** are project participants or residents saying and doing?*	What roles/duties do they take on? How is this decided? Who helps whom? What changes throughout the observation? How does do project leads respond? How do project providers interact with others (programme leaders and residents? What is the nature of these interactions?

Appendix F: Documentary analysis protocol

Theme	**Rationale for PB adoption**	**Pre-implementation**	**Engagement process**	**PB event delivery Event Day plan/ sifting process**	**Actual PB day**	**Delivery of selected projects/intervention**	**Evaluation of the programme**
Question set 1	**Why** was PB chosen as opposed to the traditional method of delivery? **What** PB model was adopted? *Or **how** was it differentiated?* Definition, etc.	**How** was the PB process developed, how was the funding application process decided? criteria for sifting projects?	**What** processes were involved? Who were involved? **How** was the engagement process organised? How were funding applicants invited to participate? What was the application process?	**How** were the projects selected? Who was involved in this selection? How was the PB money allocated?	**How** was this organised? How many participants signed up or turned up? What was the nature of the event? How was the voting organised?	**What** type of projects *were commissioned*? **Who** are the deliverers and approach to monitoring and delivery? **How** much was allocated to which projects? **How** much was the assigned for the total programme? How was this spent?	**What** is the plan for programme evaluation?
Question set 2	**How** was the decision made decided? Consultation or co-design? what catchment area is included for the intervention? How was this decided?	**Who** was involved in the design? **How** much was allocated to the PB interventions? **How** much was allocated to the implementation?	**How** was the wider community invited to participate, how was this communicated? Were there any outreaches?	**Who** organised the PB event day? Who was invited to participate and how were they invited? What was the turn out rate? How were people invited to participate?	**How** did participants respond? What was the atmosphere like? **Who** conducted the event?	**Who** are the target participants? How were participants invited to participate?	**Who** to evaluate the programme?

Types of documents collected	Background papers, project implementation documents, maps and charts, attendance records, financial records etc.	Background papers, Meeting notes or minutes, agendas, diaries, invitation to join, email correspondences, attendance records etc.	e.g. training, presentation and support documents for applicants and delivery organisations/volunteers, advertisement documents such as flyers, posters, Eventbrite form, brochures, application documents/forms newspapers, all other communication documents etc.	Event programmes, pictures from the event day, voting documents if any, financial records, attendance records etc.	Attendance register (Eventbrite record) PB event video	Attendance registers, registration docs. Advertisement docs, project plans/delivery documents, financial reports etc.	Evaluation framework, evaluation reports or case studies etc.

Appendix G: Quirkos data analysis screenshot- Examples

***Table 3.4**: Samples from initial coding and Quirkos data analysis*

Initial Grounded Theory Coding

Examples of Codes	Initial Narrative Data Coded
Sample from Case 1 PB Process implementation process	
Employing a flexible approach Using bottom-up approach	Well, it was much more flexible, because it could incorporate priorities, Erm and it was a devolved model. and it allowed sort of key service providers to see, to play a role and see what was happening on the ground and the mainstream the approach
Giving power to local residents Making healthier choices Building stronger local communities Receiving Peer support Using Bottom-up approach fitted quite well with PB	Well participatory budgeting (PB) is only a quite small element of the overall approach. But its erm – but Well London is erm is a co-production. And it fitted. it was the first time I'd ever heard of PB, but I could see it fitted really well with the approach we were taking which was giving power to local residents. It provides them with the skills to kind of sustain the activities. And to support each other to make healthier choices. and live healthier lives, and it builds stronger local communities. So participatory budgeting fitted very well with that
Giving commissioning power to residents	It (PB) allowed local residents to get involved in local commissioning
Bringing the community together	You had to do your bid; you had to concentrate on the outcome. It's okay for me to go on about theatre, but the outcome had to be community cohesion, it had to be about bringing the community together. Otherwise, I might as well not do it, really. Do you see what I mean?

Feeling valued, feeling good, feeling important, feeling self-confident	People come to me and say how amazing I am. And that what I am doing in the community is so amazing, so good. I didn't have that for many years. So that made me value myself more. That made me think to myself; oh, hold on, I can do this for myself. That makes me say hold on I am important for this community, I'm important for myself and my family, yeah.
Being a part of decision-making Owing a community project Impacting on mental health and well-being	Do you know that being a part of people who make decisions about what happens in the community can… or being a part of the people who have their own project to make a difference, I think that's all great and can impact on your mental health and well-being?
Sample from intervention cases 2, 3, 4	
Coming out Keeping women active Building confidence	…I think it's a good place, it's encouraging women in the area and because there's such a diverse group of women, culturally it gets them into doing things, keeping them active and, keeping their confidence well (Leticia).
Coning out Connecting with other people	Lying in bed, and your stomach's rumbling, you know you've got to do something. So, you've got to get out of the house, right. So, this kind of like opens you up…Well look, when you're in a state of mental [ill health] you know, depression and as I said to you what I found is you need interaction. Basically, you don't want to talk to anyone, but hunger drives you out.
Feeling valued/cared for Eating nutritious food	….you know the food always looks delicious, it's colourful, it's well cooked, and it's nicely presented, It's not a load of slop on a plate at all. I think that's important because even though slop on the plate can be perfectly nutritious but just presenting food in a beautiful way makes people know they're being cared for, that's quite important.

Modelling behaviour Looking healthier	…there's a Polish gentleman who lives with Hendrix, [a volunteer at CK], …. He's seen how Hendrix disciplines and carries himself. And we've had to give him discipline regarding substantially cutting down on his drinking' …smartened himself up; we send him off for jobs ...just made him more focused on what he can do. He is now looking healthier…

Appendix H: A list of emerging cross-case analysis issues

During the cross-case analysis the following issues emerged as important across the cases and were recorded to aid a structured analysis.

1. How does PB (Participatory Budgeting) influence the design and delivery of the Well London interventions?

2. How were decision making prioritised within the cases; who were included and who were left out?

3. What mechanisms influenced increased participation and meaningful engagement of participants across the cases and what limited participation if any?

4. How does PB influence the interactions among project participants and between project leads and what are the commonalities and differences across the cases

5. What things/ mechanisms are most important to participants of the projects and how are these reflected across the cases?

6. How does PB influence the development of community partnership within and across the cases?

7. How does PB influence the strategies and processes within the cases?

8. To what extent do participants ascribe the different dimensions of health and well-being to the application of PB?

Appendix I: Excerpts of summaries from documentary analysis

Documentary analysis was carried out to provide historical and current information about the cases. These included information about activities/processes (e.g., world cafes, community action workshop, door knocking, co-production, commissioning etc.), events (PB process planning and design, PB event day), resources (source of funding, volunteering, etc.) within the WL PB programme. Information from documents aided the development of the interview guide, maximum variation sampling of participants (i.e., participant recruitment) and interpretation of data to build theoretical and logic models. An inductive technique ensuring information gathered was grounded in the data was adopted.

Table 1: Sample reference documents

PBD 1	Northumberland Park Well London Participatory Budgeting criteria.
PBD 2	http://wellcommunities.org.uk/news/2017/04/a-successful-participatory-budgeting-process-for-haringey/
PBD3	**About *Well London* and the *Well Communties* Framework approach.** **November 2015.***Gail Findlay FFPH, Director of Health Improvement, Institute for Health and Human Development, University of East London.*
PBD4	Haringey Well London Interim Assessment Patrick Tobi, Jin Tong, Ruby Farr, Gail Findlay, November 2015
PBD 5	Communities in the driving seat: a study of Participatory Budgeting in England Final report. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/6152/19932231.pdf
PBD 6	Haringey Well London Participatory Budgeting project plan proposal
PBD 7	Interview transcripts from the PB event day video. Can also be viewed on the PB Network website.

	on 8 March 2019 in Case Studies, England, Neighbourhoods, News, Videos https://pbnetwork.org.uk/i-got-goosebumps-community-voting-day-in-haringey/
PBD 8	Well Communities Community Voting Day report
PBD9	Northumberland Park Partnership Board and Well Communities Community Voting Day 4th March 2017
PBD 10	Haringey's Health and Wellbeing Strategy 2015-18 https://www.haringey.gov.uk/social-care-and-health/health/health-and-wellbeing-strategy
PBD11	Successful Well London Funded Applications (Priority 2)
PBD12	Tottenham Regeneration Programme, Well London Programme: Love Lane Estate and Northumberland Park Estate, Tottenham, Project Initiation Document, November 2014
PBD13	Well London Delivery Group Meeting 23rd September 2014

Table2: Documentary analysis- extracts from WL PB programme

Aim:

Theme	Questions Set 1	Question Set 2
Rationale for PB adoption **Documents reviewed: Pbd2, pbd3, pbd4**	*Why was PB chosen as opposed to the traditional method of delivery? What PB model was adopted? Definition etc.*	*How was the decision made? Consultation or co-design? what catchment area is included for the intervention? How was this decided?*
	Participatory budgeting directly involves local people in making decisions on the spending priorities for a defined public budget. This means engaging residents and community groups representative of all parts of the community to discuss spending priorities, making spending proposals and vote on them, as well as giving local people a role in the scrutiny and monitoring of the process (**PBD.no.5)** While one or two of the coordinators and commissioning organisations had previously been involved in PB locally for other programmes, it was a new approach for WL and for most of the coordinators. The well London framework was agreed by council member as a good fit for the Haringey Council Pathfinder project. PB was used as the primary commissioning process for each year of WL within each target community, as a response to the identified needs of the community. Once the PB process was completed, and projects under way, the coordinator (with the support of the WLDT and steering group) would review the Project Initiation Document (PID) and, with any budget under-spend or through leveraging resources/programmes from partners, will then seek to directly commission programmes to meet any gaps (Well London PB Guide)	PB was introduced in Well London Phase 2 (WLP2) in early 2013 as an effective means of involving local communities as much as possible in the commissioning process for locally-led projects and programmes designed to meet the priorities identified through the WL community engagement process. PB stemmed from the Haringey Health and Wellbeing strategy which was developed was developed following a review of the 2012-15 Health and Wellbeing Strategy and significant pre-consultation work with partners, service users and residents. A draft Strategy was put out for consultation in February and March 2015, and changes were made to the Strategy based on participants' feedback. See the Health and Wellbeing Strategy Consultation 2015-18 page for a summary of the consultation responses. The Health and Wellbeing Strategy 2015-18 was approved by the Haringey Health and Wellbeing Board in 23 June One of Haringey's Clinical Commissioning Group Five- year plan (2015-2018) core objectives: • Explore and commission alternative models of care • More partnership working and integration as well as a greater range of providers

	The model adopted was the Well London/***Well Communities Framework approach*.** It delivers high levels of participation and empowered communities with increased knowledge, skills and confidence and greater capacity for working together to make a positive contribution to their community's health and wellbeing **(PBD.no3).** It was proposed that the Well London model is used in the Riverdale Park Ward in Tottenham, specifically to be used on the Love Lane and Riverdale Park estates, to deliver community-based health improvements using the Well London model across a one plus one-year period. The focus of the Riverdale Park Pathfinder is completely in line with the Well London ethos of fully resident led approaches and we (Tottenham Regeneration in Haringey Council) expect this to be realised from the earliest possible stages. Objectives • Use the Well London approach to deliver a range of resident led health and wellbeing initiatives in the Love Lane and Riverdale Park Estates. • Increase community capacity through the work of up to 8 Well London volunteers, supported through the role of the coordinator, Increase the skills, capacity and resources of residents to improve levels of healthy eating, physical activity and improve overall wellbeing forward residents. (**PBD.no12)**	• Engaging communities in new and more innovative ways to build capacity for populations to enhance their own health and wellbeing • Redefine the model of primary care providing proactive and holistic services for communities, "supporting healthier Haringey as a whole**" (PBD.no 10).** Participatory Budgeting was delivered at the level of the Community Committee across the area **(PBD.no5)**

	PB gives the community more control over how money is spent locally, allowing them the chance to run projects themselves and to decide what projects get funded in their area. **Model adopted** was the Well London/ Communities Framework Approach	
Pre-implementation	*How was the PB process developed, how was the funding application process decided? criteria for sifting projects?*	*Who was involved in the design?* *How much was allocated to the successful PB interventions?* *How much was allocated to the implementation?*
	• Communities were brought together to identify their health and wellbeing priorities, • residents identified a number of priorities which are important to them. these priorities are used as criteria for choosing projects to be funded. The following priorities were identified: • Activities that bring the community together • Engaging and supporting young people • Opportunities for skill sharing and volunteering • Creating/increasing pathways to training and employment • Improving the environment and community safety. • increasing access to affordable healthy diets and healthy physical activity, and improve mental wellbeing **(PBD.no4)** • The criteria will help people applying for funding for their project to understand what will be supported, and what might not be supported, through the scheme. • Residents submit project ideas and present them to the community	The focused drive towards the community voting day began 4 months earlier through the commission of Gayle Wallace and associates to project manage the event and provide training and support to volunteers, board members and potential applicants. The promotion, planning and facilitation of the day was brought about by drawing together a team which included the local authority's public health lead, Tottenham regeneration team, Well Communities volunteers, the Riverdale Park Partnership Board, Selby Trust and representatives form University of East London. Volunteers and board members were trained and supported by the project lead to carry out due diligence assessments and co-produce the day. £26,995.00 was allocated to the implementation of all projects. **(PBD.no.11)** Up to £5000 was allocated to each project.

	• residents applying for funding had a chance to share their ideas and see if residents support the ideas	
Engagement process	*What processes were involved? Who were involved? How was the engagement process organised?* *How were funding applicants invited to participate? What was the application process?*	*How was the wider community invited to participate, how was this communicated? Were there any outreaches?*
	Street/Doorstep interviews. Community 'world' cafes. Profiling, Asset Mapping, Service audit; Appreciative inquiry. Community and stakeholder co-production and action workshops, Local volunteers, Well London Delivery Team; (WLDT) Training & skills, development; residents Participatory budgeting Participatory design and delivery, Co-production **(PBD.no3).** The promotion, planning and facilitation of the day was brought about by drawing together a team which included the local authority's public health lead, Tottenham regeneration team, Well Communities volunteers, the Riverdale Park Partnership Board, Kelsey Trust and representatives from University of East London. The key remit of the team was to publicise and promote the event in the ward, support the planning and development of the voting day including any associated resources as well help facilitate on the day **(PBD.no7).** PB event promotion took place both through physical flyers and electronic and other mediums (**PBD.no6).** **Application Process** Volunteers (Riverdale Partnership Board and Well London Delivery Team members) appraised application submissions,	It began with a door knocking survey to begin conversations, gathering information and running two cafes (dressed like a cafe including tablecloths, flowers etc.,) – one in the morning and one in the evening. The cafes will only be for community members and no other stakeholders as it will be run on a world cafe model. We will need table raptors to capture. The event will be written up along with the desk-based data and mapping to produce a report. A community action workshop which will bring in other stakeholders will then take place. The purpose of the workshop is to feedback what the community told us at the two cafes and what the data says. This will set out key principles which underpins everything done in the Well London programme and what's unique to that community (**PBD.no13).**

	Successful applicants written to, to invite to PB event including guidance on event (**PBD.no6).**	
PB event delivery Event day plan/ sifting process	*How were the projects selected? Who was involved in this selection? How was the PB money allocated?*	*Who organised the PB event day? Who was invited to participate and how were they invited? What was the turn out rate? How were people invited to participate?*
	The projects were initially pre-assessed for compliance with due diligence requirements such as being a not-for-profit organisation, having two signatures on the bank account and having a safeguarding policy if they aimed to work with vulnerable groups (**PBD.no8).**	Gienevive (PB facilitator), a team which included the local authority's public health lead, Tottenham regeneration team members, Well Communities volunteers, the Riverdale Park Partnership Board, Selby Trust and representatives form University of East London. Riverdale Park ward residents were invited to participate in the PB process (**PBD.no1).** A total of 112 people booked to attend the event prior to the day and approximately 15 people arrived on the day to participate who hadn't registered but whose details were added to the list (**PBD.no8).**
Actual PB day	*How was this organised? How many participants signed up or turned up? What was the nature of the event? How was the voting organised?*	*How did participants respond? What was the atmosphere like?* *Who conducted the event?*
	More than 40 applications for projects were submitted in Tottenham, and the projects ranged from physical activity to creative drama groups and food growing. There was a total of 28 projects which applied to the Community Voting day pot for funding. Of the twenty-eight, sixteen came under the priority 2 'Well Communities' criteria.	• The event was very, very well attended. • The approach and concept were extremely well received by the local community, the projects and the local ward councillor. • There may have been greater numbers attending if the publicity promoting the event had gone out

	They were initially pre-assessed for compliance with due diligence requirements such as being a not-for-profit organisation, having two signatures on the bank account and having a safeguarding policy if they aimed to work with vulnerable groups. From the sixteen Well Communities Projects, ten went through to be considered by the community. Of those ten, nine were successful on the day (**PBD.no9).** A total of 112 local people registered to attend the event and 15 more showed Up on the day (**PBD.no8).** While people collected teas and coffees, they were welcomed by a wonderful ballet performance led by a local group of young dancers who took to the stage showing a great amount of talent and passion. The presentations included group performances, demonstrations, fun facts and group speeches, with the presenters ranging from young people under 16 groups of elderly residents. **(PBD.no2)** The event was split into 4 rounds of voting, and while the votes were counted, there was locally sourced fresh food to enjoy. The voting day ended with a 'give back' round, during which all funded projects were given the opportunity to hand money back to projects which hadn't been successful. This meant that all projects who presented were allocated money. People were very generous, and each 'give back' was met by loud cheers from the audience (**PBD.no2).**	earlier. The late delivery increased the intensity and focus needed at the latter stages to encourage people to attend. Some feedback has been received by at least one board member that some people who would have liked to attend remained unaware of it taking place (**PBD.no8).** • Interview with different members of the community produced the following answers about their experiences: ***James:*** *"It's really impressive. There are a lot of people here. In Riverdale Park its often difficult to get people involved. I think we have cracked that problem here. And some of these groups doing projects, I really didn't know that they existed, or what they were doing, and they are obviously all doing good stuff, so hopefully we can improve the area, and they'll get motivated and perhaps we can do it again sometime."* *That feeling of mutual support, of being on a learning curve, and a sense you were helping other projects was especially evident in comments made by Rosa, who was also willing to give back some of the funding her group had been awarded in a pay it back process, to enable another group progress: (**PBD.no7).*** ***Lily:*** *"Oh my god, that was the best part of it, I felt good, happy, and a part of someone else's project moving forward."* **(PBD.no7).** ***Ella:*** *I thought it was very, very interesting, I was excited. I got goose bumps hearing about the projects, and I thought, this is an amazing thing to do because there is a*

		lots of projects going on and the money is limited, so Nothing is more fair to have people from the community vote for what they want to see. But I really liked the choice of projects and I think all of them are helpful and useful in the community (Ella, participant at the event day) **Natalie:** *Okay, I was sceptical originally because I thought there was a lot of people here who have never had this much money offered to them. I've never been in an event like this before and I didn't know how constructive it was going to be offering people money and basically asking them to compete for it. It is a nice community event. It is a shame that it had to be in competition for money. It is a nice community event with all these different projects and as far as I am concerned all these different projects should run par and par. They all need to be running all of them. So, it's really good for people just to find out what is going on in the area and really come together and communicate and decide to help each other and different people can offer their expertise. So that's what I think was good about it* So said one of the participants in the "Community Voting day", held in Riverdale Park, Tottenham Haringey in 2017 **(PBD.no7)** Genevieve (PB facilitators), a team which included the local authority's public health lead, Tottenham regeneration team,

		Well Communities volunteers, the Riverdale Park Partnership Board, Kelsey Trust and representatives from University of East London.
Delivery of selected projects/intervention	*What type of projects? Who are the deliverers and approach to monitoring and delivery? How much was allocated to which projects?* *How much was assigned for the Well London programme? What proportion of this money was spent on PB?* The selected projects for this PhD study were: 1. Process Case Study (PCS) – Process Implementation stages involving the CEAD process and the PB process up to 4th of March 2017 event day where local residents voted for or commissioned health and wellbeing projects to improve individual and community wellbeing. 2. Tottenham Folklore (TF) 3. **Sponsoring Organisation**: Bernie Grant Arts Centre **Description:** Find your voice. Tell your story. Why, when and how did you come to Riverdale Park? Let's hear your voice in this DYNAMIC COMMUNITY PLAY. Tottenham Folklore interweaves your stories from RD and all over the world, creating one BRILLIANT play. We kick it off with exciting Drama Workshops in venues in Riverdale Park. Your talents and skills needed. Beginner's welcome. Tottenham Tapestry will enrich this community. 4. Women Together project (WT)- Reach Trust **Sponsoring Organisation** - Mencap	*Who are the target participants? How were participants invited to participate?* **Case 1**: Process Case Study (PCS): All residents of Riverdale Park Ward **Case 2**: Community Kitchen- (Adults in Riverdale Park Ward **Case 3**: Women Together (WT) project: Women who are victims of domestic violence **Case 4**: Tottenham Folklore (TF) project: Adults in Riverdale Park

	Description: Women Together works with girls, women and their family who have been or currently affected by domestic violence, prostitution, incest, female genital mutilation, human trafficking and other forms of abuse. Our aim is to empower women to lead fulfilling lives and change their future. We provide advice & guidance, peer-support groups, health and well-being activities, training and volunteering opportunities for women 5. Case 1: Community Kitchen (CK) **Description** Cook and Eat for Health: For more than a year CK has hosted a free, weekly, open door, support, and social event on Park Lane, run entirely by volunteers. CK is known for bringing residents of all cultures, generations and walks of life together, to cook and eat healthy food. We promote a sense of belonging, social inclusion, and well-being with a free nutritious meal, a warm welcome, a listening ear, lively conversation, and an invitation to get involved. **(PBD.no 9**)	
	The projects ranged from physical activity to creative drama groups and food growing (**PBD.no2).** £60,000 was allocated to the Well London programme **PBD.no7).**	
Evaluation of the programme	*What is the plan for programme evaluation?*	*Who to evaluate the programme?*
	All projects, as recipients of public money were expected to provide evidence that they have used the money for the purposes for which it was given, and to deliver the agreed outcomes. As well as any formal monitoring arrangements, it is expected that the coordinator and WLDT members regularly	The overall evaluation was assigned to the University of East London (UEL) researchers based at the Institute for Health and Human Development. The researchers were tasked with effectively measuring outcomes and evaluating the Well London programme

	will liaise with project leads to offer support, spot any problems at an early stage and deal with questions.	Each project lead was tasked to local monitoring and evaluation of their individual project including: 1. Collection of attendance register 2. Quantitative surveys using tools prepared by UEL researchers to conduct a pre and post evaluation of outcomes and impact. 3. Produce impact case studies based on individual participants. 4. Produce quarterly reports about their projects.