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‘Lady, is this civilisation?’

A case study of community participation in a health development programme in Aotearoa New Zealand

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Abstract

Community participation is a key feature of major global health declarations and a fundamental principle of health strategies in Aotearoa New Zealand. However, the frequency with which it is espoused belies the complexities associated with its practical application. Engaging communities in primary health care programmes designed to improve their health has been identified as a major challenge.

This study's objective was to explore community members' perspectives of participation within a health development programme. The programme chosen aimed to increase the fruit and vegetable intake of targeted population groups, including Māori, Pacific peoples, and low income earners. A qualitative instrumental case study approach was adopted to examine the programme and investigate what influenced, constrained, and sustained community participation. Data collection included fieldwork over an eighteen-month period. Two programme projects were selected as the study foci: a community-led project involving distributions of thousands of free heritage variety plants; and, instigated by health services, a project establishing community gardens. These projects provided markedly different pictures of participation occurring within the same programme. The plant distributions had widespread appeal, while the community garden faltered.

Community participation fitted within a description of 'focused social action'. Participation was motivated by needs, values, and interests. While some were personal and family based, the programme also became an imagined vehicle for addressing wider health, social justice, and environmental sustainability goals. Ongoing challenges related to defining targeted communities and groups, varying degrees and types of participation, and different perspectives of participation, especially as health sector staff worked from an equity mandate and community members spoke of equality.

Programme groups established as mechanisms to foster community participation had contradictory effects, engaging some as advisors, while failing to reach communities targeted for the programme. The complexities of health sector bureaucracy both enabled and constrained the programme and community participation.

This thesis provides an in-depth examination of the complexities of community participation in action, the contradictory effects of contexts enveloping programmes, and the resolve of community members. It increases our understandings of how community members perceive health programmes and community participation, which are critical factors in improving population health.

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Table of Contents

CHAPTER ONE: BACKGROUND AND CONTEXTS	1
Introduction	1
Doing development studies research at home	2
Positioning this study in relation to the context of my interests	3
Aotearoa New Zealand as part of a globalising world	5
Whanganui – the home of the programme	10
Summary	13
Chapter outline	14
 CHAPTER TWO: HEALTH, THE HEALTH SECTOR AND DEVELOPMENT - OVERLAPPING CONTEXTS FOR THE CASE	 16
Introduction	16
Linking development and health	16
The context of the effects of health transitions	19
The context of primary health care centred on health development	20
The context of health promotion	25
The context of the publicly funded health sector in Aotearoa New Zealand	31
Summary	38
 CHAPTER THREE: UNDERSTANDINGS OF COMMUNITY PARTICIPATION	 39
Introduction	39
Participation as the focus of many disciplines	40
Creating a space for a focus on participation	41
Participation	43
Community as the actor	48
Understandings of community	49
Participation as a social practice	61
Community participation in health development	67
Conceptual and practical challenges	78

Areas for further exploration	81
Summary and conclusions	82
CHAPTER FOUR: RESEARCH DESIGN AND METHOD - A FRAMEWORK TO LOCATE THE GLOBAL IN THE LOCAL AND THE LOCAL IN THE GLOBAL	84
Introduction	84
Developing a research framework	84
Case study	85
Data collection methods: Accessing the local	93
Data analysis	101
Multiple realities	108
Focusing case study on ethical research with communities	118
Fieldwork: Negotiating access and involvement	122
Conclusion	133
CHAPTER FIVE: APPLE TREES, TOMATO SEEDLINGS, COMMUNITY GARDENS AND ‘HIGH NEEDS’ POPULATIONS – THE GRAB A BITE THAT’S RIGHT PROGRAMME	135
Introduction	135
Phase one: From envisioning to the commencement of programme funding (July 2005 – June 2006)	136
Phase two: Bedding in the programme – growing projects out of the proposal (July 2006 – November 2007)	157
Phase three: Revisiting community participation in the community garden (December 2007 – June 2008)	168
Summary	173
CHAPTER SIX: COMMUNITY PARTICIPATION IN A COMMUNITY GARDEN - RELATIONSHIPS BETWEEN PLACE, SPACE AND COMMUNITY	175
Introduction	175
Seasons in a community garden	176
Community participation as inherently bound to this place, this space	184
Back to the beginning – community in a community garden	210
Summary	214

CHAPTER SEVEN: COMMUNITY PARTICIPATION AS FOCUSED SOCIAL ACTION	217
Introduction	217
Focused social action as participation	217
Connecting and building on peoples' and groups' current interests	218
Focused social action – examples from the Community Gardens group	231
The plant giveaways as linking growing plants and food with health benefits	257
Summary	262
 CHAPTER EIGHT: COMMUNITY PARTICIPATION IN STEERING A PROGRAMME - A CONTRADICTIONARY SPACE OF PARTIALLY MET EXPECTATIONS	 264
Introduction	264
An uncertain space for stakeholders and community	265
Tracing the contradictory space through the Terms of Reference	282
Budgets – an unresolved Steering Group issue	295
A programme under many watchful eyes – ongoing negotiations	297
The Steering Group as a community space	303
Summary	304
 CHAPTER NINE: A PROGRAMME BOTH OF AND AHEAD OF ITS TIME	 306
Introduction	306
Global and local increases in food and energy prices	306
An intensified national and local focus on HEHA and food security	308
An intensified national and local focus on gangs	310
Increased international and national popularity of gardening, community gardens	310
Postscript: Tentative successes in community participation in the community garden	311
Summary	313
 CHAPTER TEN: SUMMARY, THEMES, AND CONCLUSIONS	 315
Introduction	315
Focusing on community members' perspectives	315
Summary of the themes emerging from the case study	318

Community participation as focused social action	318
Understanding community conceptions of local and community	322
The influences of contexts and choreography on community participation	322
Overarching theme: Community participation – an ongoing challenge in health development	331
Implications for practice	333
Limitations of this study	335
Recommendations for further research	336
Concluding statement	337
APPENDICES	339
Appendix One: WDHB Health Needs Assessment (Executive Summary)	340
Appendix Two: Visual representation of the ‘spidergram’ model	342
Appendix Three: Paper presented at the IIQM conference.	343
Appendix Four: Information sheets	347
Appendix Five: Consent forms	351
Appendix Six: Ethics’ committee approval	353
Appendix Seven: Community gardens literature	354
Appendix Eight: Glossary of Māori words	358
REFERENCES	359

List of Figures

Figure 1 Map of Aotearoa New Zealand	10
Figure 2 The health sector in Aotearoa New Zealand as related to GABTR	37
Figure 3 Inherent complexities in community participation	80
Figure 4 People gardening - individuals, families and groups	101
Figure 5 Autumn leaves hiding a new community garden	103
Figure 6 The rationale for the development of polyvocal layering	110
Figure 7 Community garden car park	166
Figure 8 Four seasons in a raised garden	177
Figure 9 Four seasons in a garden row	178
Figure 10 Scarecrows watch over the community garden	180
Figure 11 Garden ready for people and planting	181
Figure 12 Active participation in a new community garden	181
Figure 13 The first planting day	182
Figure 14 The green belt, including Te Mana Park, dividing Aramoho	185
Figure 15 Different perspectives of the garden in this space	199
Figure 16 Variations of vandalism - butchered broccoli	204
Figure 17 Variations of vandalism - demolished shed	204
Figure 18 A Community Gardens group meeting	235
Figure 19 Street signage - direction but no information	245
Figure 20 Action during a working bee	253
Figure 21 Produce harvested for delivery to the Food Bank	254
Figure 22 Steering Group attendance	284
Figure 23 Members' perspectives of the role of the Steering Group	290
Figure 24 Newly erected 'welcome' garden sign (and graffiti)	312
Figure 25 Children playing in the garden at dusk	313
Figure 26 Final themes	318

List of Tables

Table 1 Treaty of Waitangi provisions	8
Table 2 Modes of participation	44
Table 3 Descriptors of participatory actors	46
Table 4 Selected definitions of community participation / involvement in health development	69
Table 5 Models / toolkits using the pentagram model	76
Table 6 Data collection activities	94
Table 7 Application of a community-up ethical framework	119
Table 8 GABTR programme milestones in phase one	139
Table 9 GABTR programme milestones in phase two	157
Table 10 GABTR programme milestones in phase three	169
Table 11 My visits to the garden	194
Table 12 Attendance at working bees	253
Table 13 Steering Group membership	267
Table 14 Evaluating the governance model	288
Table 15 Two different projects in one programme	317
Table 16 Implications for practice	334
Table 17 Literature review related to community and communal gardens	354

List of Abbreviations

CEO	Chief Executive Officer
DHB	District Health Board
GABTR	The Grab A Bite That's Right programme
HEHA	Healthy Eating Healthy Action (strategy / programmes)
MDGs	Millennium Development Goals
MOH	Ministry of Health
NZDep	New Zealand Index of Deprivation
NZTCA	New Zealand Tree Crops Association (Central Districts Branch)
NGO	Non-governmental organisation
PHO	Primary Health Organisation
WDHB	Whanganui District Health Board
WRPHO	Whanganui Regional Primary Health Organisation
WDR	World Development Report
WHO	World Health Organisation

Chapter one: Background and contexts

Introduction

This thesis presents an exploration of community participation, a concept that is entrenched, mandated, and also contested within the fields of development studies and health. Grounded and focused by a broad research question related to investigating community members' perspectives, a qualitative instrumental case study approach was used to examine the phenomenon of community participation. A health promotion programme, Grab a Bite That's Right (GABTR) was selected as the case. GABTR is a small, local, innovative health promotion programme developed within a New Zealand Ministry of Health (MOH) strategy of 'Healthy Eating Healthy Action' and set within primary health care. The programme's broad aim was to increase the fruit and vegetable intake of specific population groups of Māori, Pacific peoples and low income earners¹.

The title of this thesis – 'Lady, is this civilisation?' - was drawn from a question I was asked by a young child. He was interrogating me about people's collective actions (his and mine included) within that health programme. My interest was in the experiences of people, such as this young lad, who became the actors in what was "... actually being done in the name of participation" (Cornwall & Brock, 2005, p. 1044) to improve health.

The specific research question was 'What is community participation in the GABTR programme from the perspectives of the community.' The research aims, in relation to the GABTR programme, were to:

- explore how community members participate and describe their participation;
- investigate how community members' perspectives of their involvement may change during their participation;
- examine the contextual factors which influence community members' participation; and
- describe the diversity of types of participation.

¹ The programme development and implementation are detailed in Chapter Five.

In this chapter, I background this research in relation to my interests, and Aotearoa New Zealand² as contexts to the exploration. Following this is an overview of the thesis, including a description of the approach taken to present the case study.

Doing development studies research at home

Except for advice on gardening (and the reason for people seeking that advice will become clearer in the case study chapters) the most frequently asked question about this study was ‘why development studies in Aotearoa New Zealand?’ Although assured this ‘type’ of study was possible I was repeatedly confronted by two discourses which, in my experience, continue to frame development studies. Firstly, development studies was still what you did in ‘other’ places (overseas), and secondly those other places were inhabited, in the main, by ‘other’ people.

This is also obviously not only my experience. For example, in the fieldwork text *Doing Development Research* (Desai & Potter, 2006, p. x), which includes a chapter on researching at home, the editors preface the work with the comment that the book will be useful for those “... embarking on research and fieldwork overseas.” In another text (Potter, Binns, Elliot, & Smith, 2004, p. 43), a statement is made that the “... issue of our responsibility to distant others basically asks how likely we are to be beneficent to people who are worse off than ourselves, but who live far away.” While partially agreeing with some of the purported practical benefits of researching at home (Unwin, 2006), such as the possibilities of deeper contextual understandings and the potential of a longer period of engagement, I disagreed with other generalisations, especially the idea of inherently being an ‘insider’. Other authors (Scheyvens & Storey, 2003) problematise the binary positions inherent in spatial differences and instead focus on clarifying the field associated with development fieldwork.

² In agreement with the approach of others (Dyck & Kearns, 1995, p. 145), I use both the “... Māori and official (colonial) names in recognition of the bicultural reality” of this society. I also recognise that the history of the use of the label Aotearoa is also contested (M. King, 2003).

Jones (2000), who also problematises the spatial divide and its effects in some areas of development studies, uses the term ‘convergence’ related to policy and theoretical overlaps. My key motivation for situating this research in Aotearoa New Zealand was because of my interest in convergences of human experiences between and within countries. These convergences are not just negative, as in the embodiment of global health inequalities (Nguyen & Peschard, 2003). They extend to the positive links associated with indigeneity where “... the common threads that bind indigenous communities are linked to their similar socio-economic positions, their rejection of assimilation, [and] their comparable aspirations for greater autonomy ...” (Durie, 2005, p. 3). I was specifically interested in participants’ experiences of being an ‘actor’ in programmes, often developed by others for health improvement, in tandem with the normative proliferation of community participation as a means and end in health policy and practice.

Positioning this study in relation to the context of my interests

This research came about because of my personal and professional interests in the areas of health, development, and community participation, and their intersection within the philosophies, ideologies and practices of primary health care. I have worked as a public health nurse in urban and geographically remote communities in Aotearoa New Zealand, and latterly my focus has been in the areas of curriculum development and teaching about community and population health. Together these experiences heightened my desire to focus practice, teaching, and research on health and wellbeing, and in particular, the salutogenic factors (Antonovsky, 1996) that create health rather than illness. Working with individuals and communities also enriched my understandings of the benefits of utilising community development approaches in professional practice and, in particular, the strengths and resiliency enmeshed in communities. It also demonstrated how people’s capabilities to achieve what Sen (1985, p. 203) describes as “wellbeing freedom” are so often constrained by factors outside of their control.

Community participation has been a long standing personal interest, mainly developed from my divergent experiences of activities that could be categorised within this concept. As a health professional and as a community member I participated in community involvement³ activities, especially ‘consultation’ exercises, related to health sector reforms. Universally these experiences, over many years, seemed unsatisfactory for both me and many others present. In contrast, my involvement in community-driven health development projects has been challenging, but much more fulfilling.

My interest in development, as a framework and context for professional practice and an area of academic study, was expanded and challenged when in the late 1980s and early 1990s I worked as a volunteer⁴ nurse in Botswana. At that stage Botswana was seen as “... a major development ‘success story’” (Simon, 2003, p. 14), to the extent that the organisation I worked with stopped sending volunteers there soon after. In 1990, Botswana ranked 58th out of 130 countries on the Human Development Index and New Zealand was 118th (United Nations Development Programme, 1990)⁵. While appreciating the progressive development then occurring in Botswana, and its ‘advanced’ standing in comparison with neighbouring countries in terms of measures such as the Human Development Index, I witnessed a different reality in my day to day work, one that is hidden within aggregate measures. Specifically, this was the beginning of the HIV/AIDS pandemic which now frames many discussions of Botswana and development. As a country it is seen positively in relation to the high level of accessibility to antiretroviral drugs (UNAIDS/WHO Working Group on Global HIV/AIDS and STI, 2008), and yet the dramatic decrease in life expectancy related to the pandemic is devastating for the population.

³ Within this thesis I use the terms participation and involvement interchangeably for stylistic variation and because community members used these terms synonymously.

⁴ This was a two year assignment with Te Tūao Tāwāhi Volunteer Service Abroad, a non-governmental development organisation, principally funded by the New Zealand Government.

⁵ The scale has now been reversed. In 1990, 130 was the top rank. Now 1st holds that position.

Although my role at that time was to improve the care provided to sick and premature infants within hospitals, I was unable to ignore the wider contextual features which resulted in or contributed to these babies' and families' needs for special care. Poverty, poor housing, lack of access to preventative health services, lack of education, communicable diseases, the social isolation of some groups, and teen mothers all combined, somewhat malignantly, to penalise the futures of the young, vulnerable and marginalised.

Although not to the same extreme or degree, the factors determining health were broadly the same as those I had experienced working within Aotearoa New Zealand. The differences in human experiences between the countries were relative, about context and degree, but the causative and associated determinants of ill health converged across countries. There were also convergences in the resilience people demonstrated in adverse circumstances, and many possibilities for learning and sharing.

Aotearoa New Zealand as part of a globalising world

While fitting firmly within a classification of a 'high human development' nation with a Human Development Index rating of 19th of 177 countries (United Nations Development Programme, 2007/2008), Aotearoa New Zealand occupies a contradictory, but common position. The composite nature of the Human Development Index disguises divergent human experiences within the nation, specifically related to health disparities. Addressing these health disparities was a high level objective of the health sector and the programme explored in the case study within this research.

A Ministry of Social Development report (2007, p. 120) suggests that generally "... New Zealanders have a good level of social wellbeing and our wellbeing continues to improve across a number of domains." While some indicators, such as rates of suicide and unemployment have improved markedly over a decade [to 2007], levels of obesity increased and income inequality deteriorated. While most people in that study reported that others could be

trusted, "... nearly one-fifth reported they sometimes felt lonely or isolated" (Ministry of Social Development, 2007, p. 120). In addition, in a report for the Children's Commissioner and Barnados (Fletcher & Dwyer, 2008, p. 4) the authors suggested that 230,000 children (22% of all children) were "... living in households with incomes below the 60-percent-of-median income poverty line, after taking account of housing costs". Also noted was how the distribution of child poverty was uneven across population groups, with higher rates among Māori, Pacifica, and sole-parent families.

In the foreword to a recently published document which tracked the trends of ethnic and socioeconomic mortality between 1981 and 2004, the Director-General of Health commented:

In New Zealand, as elsewhere, inequalities in health exist between ethnic groups and social classes. These inequalities are not random: in all countries, socially disadvantaged and marginalised groups have poorer health, greater exposure to health hazards, and less access to high-quality health services than their more privileged counterparts. In addition, indigenous peoples and ethnic minorities tend to have poorer health. In New Zealand the extent of these inequalities is unacceptable. (McKernan in Blakely, Tobias, Atkinson, Yeh, & Huang, 2007, p. iii)

Māori and non-Māori ethnic groups demonstrate socioeconomic gradients in health status, but research "... implies that Maori are disproportionately affected by the health consequences of lower socioeconomic status" (MOH & University of Otago, 2006, p. xii). Explanations for health disparities in Aotearoa New Zealand include differential access to the social, cultural and economic determinants of health and to health services (National Health Committee, 1998). Specifically highlighted are the effects of macroeconomic and structural changes in society, especially in the 1980s and 1990s (Blakely, Fawcett, Atkinson, Tobias, & Cheung, 2005), and the complex links between culture and ethnicity, as played out in the ongoing impacts of colonisation which are labeled as historical factors (MOH, 2002c; Public Health Advisory Committee, 2004). While income inequality (and its relationship to social

capital) is theorised as a key explanation in other countries, some authors argue that this appears to be of lesser importance in the context of Aotearoa New Zealand (Judge & Paterson, 2001; Public Health Advisory Committee, 2004).

Macroeconomic policies are one of a suite of development policies which have unintended consequences on population health (Cooper Weil, Alicbusan, Wilson, Reich, & Bradley, 1990; Phillips & Verhasselt, 1994b). They form both driving forces of economic globalisation and intermediary factors between world markets, national economies and population health (Woodward, Drager, Beaglehole, & Lipson, 2001). The effects of their implementation are widespread. For example, in Aotearoa New Zealand economic reform between 1986 and 1992 included "... deregulation of the labour market, imposition of tight inflation targets, and budgetary constraints in social sectors, notably education and health" (Bloom, 2000, p. 30). The policies underpinning the changes that occurred in the 1980s and 1990s, while similar to those occurring in many other countries, have been labeled as "... an extreme example of the neoliberal and new-right agenda" (Blakely et al., 2005, p. 120). Others (Phillips & Verhasselt, 1994a, p. 305) posited that Aotearoa New Zealand provided a "... salutary example" of the negative effects of these policies. It is argued (Blakely et al., 2005, p. 121) that it "... seems highly likely, based on what we know internationally and nationally about the determinants of health, that the increase in social inequalities during these two decades translated into widening health inequalities." Since that time there have been changes in the pattern of health inequalities, but during 2000-2002, there was still a gap of 8.2 years for males and 8.8 years for females between Māori and non-Māori life expectancy at birth. At the same time males living in the least deprived deciles could expect to live 8.9 years longer than those living in the most deprived deciles and the difference for females was 6.6 years (Ministry of Social Development, 2007).

Another globalising force which provides an important explanation for health disparities in the context of Aotearoa New Zealand is that of colonisation. During the nineteenth century European colonisation had immediate and long

term negative effects on the health of Māori, resulting from infectious diseases, land alienation, and weakening of political power bases (Durie, 1998). While identifying that Māori health comprises many different realities and that there have been marked improvements over time, Durie (p. 6) reminds us that “... Māori health cannot be separated from the historical and contemporary experiences of Māori in Aotearoa/New Zealand.”

Concerns in the late 1830s about the health status of Māori were identified as important motivations for the development of the Treaty of Waitangi (Durie, 1998), the founding document of Aotearoa New Zealand which was signed in 1840. Still, in 2002, the MOH (2002c, p. 20) identified how action to reduce health inequalities related to structural determinants of health could include “... systematic implementation of the provisions of the Treaty of Waitangi in policy, planning and service delivery.” In Table 1, the provisions of the Treaty, as described by Durie are presented. He distinguishes between the two versions (Māori and English) of the Treaty, and also outlines the modern-day implications of these provisions.

Table 1 Treaty of Waitangi provisions

	<i>Article One</i>	<i>Article Two</i>	<i>Article Three</i>
<i>English Text</i>	Crown sovereignty	Tribal property rights	Royal protection and citizenship rights
<i>Māori Text</i>	Crown authority to govern	Tribal authority over cultural, social, and economic resources	Royal protection and citizenship rights
<i>Twentieth century implications</i>	Parliament’s right and authority to govern	Tribal right to exercise tino rangatiratanga ⁶	Māori individuals’ right to expect a fair share of society’s benefits

Source: Durie (1998, p. 84)

The Royal Commission on Social Policy (1988) identified participation (together with protection and partnership) as a concept which reflected a

⁶ Tino rangatiratanga is translated as absolute sovereignty (Ryan, 1997) and autonomy, “... Māori control and determination” (Durie, 1998, p. 56).

fundamental principle of the Treaty of Waitangi. Its conceptual definition and application remains contested, but participation by Māori within the health sector is both legislated by the government and necessitated by Māori.

Structural determinants of health are much broader than those encapsulated within the health sector and Māori have been key players in developing their own solutions, based on positive models of health and frameworks of Māori health development (Durie, 1998, 2005). Improving Māori health status remains a challenge, one intertwined with different and evolving understandings of the application of the Treaty of Waitangi, biculturalism, the interaction of determinants of health, and the responsibilities of the health sector for reducing health disparities.

While Aotearoa New Zealand experiences a unique set of circumstances that frame the structure of its society and therefore the health of its population, as a country it is an active participant in international processes that also influence its society. It has been an early signatory to, or participant in, international agreements and movements in diverse areas including the original work on primary health care with the World Health Organisation (WHO), the *Framework Convention on Tobacco Control*, and the *Kyoto Protocol*. There are clear lines of convergence between international agreements and the Government strategies adopted and implemented within Aotearoa New Zealand, often with local adaptation. For example, the *Ottawa Charter for Health Promotion* (WHO, 1986) is widely utilised as a framework within the health sector, in conjunction with the inclusion of the three articles from the Treaty of Waitangi (Health Promotion Forum of New Zealand, 2002).

These factors – the health disparities experienced within Aotearoa New Zealand, the explanations offered for their existence, and the adoption (and involvement in development) of international policy approaches related to health – all converged within the health programme that is explored in the case study. In the next section, the region in which the programme is enacted is described.

Whanganui – the home of the programme

The GABTR programme was unique to the Whanganui⁷ city and region (see Figure 1). The Whanganui District Health Board⁸ (WDHB) region (which provides the boundaries for the programme) “... covers a total land area of 9,742 square kilometres, most of which is sparsely-populated, mountainous terrain with a few densely populated centres...” (WDHB, 2006, p. 7). The Whanganui District population (slightly bigger than the city but smaller than the WDHB region) at the same census was 42,639, with a decrease of 630 since the 2001 census (Wanganui District Council, n.d.). The city was the major of those ‘densely populated centres’ described, but in this instance the concept of population density is relative only to the sparsely populated rural areas. The WDHB population at the last census (2006) was 62,208 (Statistics New Zealand, n.d.).



Figure 1 Map of Aotearoa New Zealand

⁷ There is a public debate as to whether the city name should be spelt as Wanganui (current spelling) (Laws, 2008) or Whanganui (the Māori spelling) (Taonui, 2008). I chose to adopt the original Māori spelling in recognition that “... names are part of both a symbolic and a material order that provides normality and legitimacy to those who dominate the politics of (place) representation” (Berg & Kearns, 1996, p. 99). I have also followed the convention of the local health sector organisations which cover the region known as the WDHB region. However, I have attempted to maintain the spelling conventions chosen by other organisations.

⁸ WDHB is one of 21 District Health Boards (DHBs) in the country. DHBs are responsible for assessing their region’s health, planning and purchasing health and disability services for that population, and delivering publicly funded services such as hospital and public health services (Cumming & Mays, 2002).

The key demographic features of the Whanganui District population are its higher percentage of over 65 year olds (17.3% compared to 12.3% nationally) and those identifying as Māori (19.7% compared to 14.6% nationally). There are lower percentages of Pacific Peoples (2.1% compared with 6.5% nationally) and those of Asian descent (2.1% compared with 9.2% nationally). It has a higher unemployment rate, lower median income, and lower rates of home access to telephones, cell phones and the internet than the national average. Marginally more homes were owned than nationally, and the rent for those not owned was considerably less than the national average. At the same time, the average spending on food for households was \$6,179, significantly below the national average of \$7,004 (Wanganui District Council, n.d.).

The geographic features of the region are significant. These include its location beside the Taupo volcanic zone, the seismic activity in the area, and its propensity to flooding, with the Whanganui river catchment the largest in the region (WDHB, 2006). The rural area is utilised in the main for agriculture and horticulture.

History of the city

Māori inhabited the region well before European settlement⁹. As explained by Downes (1976, p. 1), “(l)ong before Maori came to these shores from his distant home in Hawaiki (so says the legend), the gods alone held possession of the land”. The city history combines two key factors of significance in this study, land (including the river) and food. Historian (M. King, 2003, p. 172) describes the purpose of the founding of the city “... to provide additional land for the overflow of Wellington settlers and to supply the mother settlement with pigs, pork and potatoes.” Land ownership remains an area of contestation today, developing from the actions at that time when “(a)lmost all the mistakes that could have been made *were* made by the New Zealand company land

⁹ It has been described that the “... Whanga-nui [sic] tribes relate [that] their ancestors first came to New Zealand in the Aotea canoe, which probably arrived about the year 1350” (Downes, 1976, p. 2). Different descriptions of the process and time of those arrivals exist.

purchasing agents in ... Wanganui”¹⁰ (M. King, 2003, p. 181). This situation was also described in a collection of historical writings:

Wanganui’s early years were wrought with unrest. The New Zealand Company established the town to try to relieve the pressure on its Wellington settlement, but as soon as settlers began to arrive in 1840, they discovered that the New Zealand Company’s ‘purchase’ of the land from local Maori was extremely questionable. It soon became clear that the company had not acted honourably and Maori, who had their land taken and were prevented from accessing traditional food-gathering grounds on the river, made their displeasure clear to the settlers.

The settlers persevered despite being urged to abandon the town. Colonial soldiers were soon called upon to protect the settlement and as many as 800 soldiers were based there during the 1840s – they often outnumbered the settlers by as many as three to one. It wasn’t until 1848 that an uneasy truce was reached between Whanganui Maori and Wanganui residents. (Alexander Turnbull Library, 2006, p. 84)

Nowadays the city is well known nationally for its art and culture, historic buildings, its local political figures, Māori activists and sites of contested land ownership. Residents of the city, when interviewed in 1999 (Wanganui District Council, 2005), considered that the city was most well known throughout the country for its sports facilities, its river, and Moutoa Gardens (also known as Pakaitore). The latter two features hold high cultural significance for Māori as sites of historical land alienation. A survey of community members undertaken for the District Council in 2008 found that 76% of the respondents intended to continue residing in the city. Compared to three years before, 42% reported that the general quality of life had improved, 43% believed it was about the same, and 10% felt that it had deteriorated (Wanganui District Council, 2008).

¹⁰ Throughout this thesis I have used italics in quotes as in the original, unless otherwise stated.

Health in the region

The region's health, as described in the Health Needs Assessment (see Appendix One for a summary) published in 2006 (WDHB, 2006) paints a negative picture, with only small increments of improvement since the last assessment in 2001¹¹. A report summary noted that:

The high level of deprivation is the biggest factor for the health of the residents. The impact on the district's overall health is significant having higher mortality and hospitalisation rates compared to the rest of New Zealand. Māori in the district have higher mortality (1.6 times) and hospitalisation rates (1.3 times) than non-Māori. ... The major health problems in the district are cardiovascular disease, lung disease, cancer, diabetes, [and the] health of Māori in the district. (WDHB, 2006, p. 3)

While significant health needs are clearly identified, the WDHB has itself experienced ongoing problems, in particular with its provision of specialist hospital services and governance. In response, in April 2008, the Minister of Health intervened and added Crown Monitors and new members to the governance Board (Cunliffe, 2008). While this study was underway, the District mayor was the second highest polling elected member of the WDHB (MOH, 2007a), demonstrating how health services and the health status of the population remain very much in the political spotlight.

Summary

The contexts described in this chapter set the scene for an exploration of health and development in the following chapter. Aotearoa New Zealand and Whanganui provide contexts for the case study which, while unique, also contain features present in many other communities and societies. As a health development programme, GABTR was focused on improving food intake

¹¹ There is an immediate disjuncture between a philosophical position of positive health promotion and the description of population health in narrow terms related to morbidity and mortality. This inherent contradiction is so widespread (nationally and internationally) as to be nearly universal but this does not change its problematic nature.

(specifically fruit and vegetables) and nutrition, especially for those experiencing poor health and disadvantage. A high level objective of the health sector, in which the programme was based, also relates to reducing health disparities. It was within this complex and contested arena that the GABTR programme was situated and community participation enacted.

Chapter outline

In Chapter Two the complex interrelationships between health and development are examined. Concepts such as health development, primary health care and health promotion are explored, with, where possible, a focus on food and nutrition. A food and nutrition programme is the basis of the case study presented later. This chapter is completed with a brief overview of the health system of Aotearoa New Zealand, which forms part of the case context.

Chapter Three presents an examination of the literature, research, policy and critique of the conceptual development and practice of community participation. Community and participation are addressed as singular and combined concepts, as are associated concepts such as public, citizen, and involvement. This analysis problematises the development of silos of knowledge that artificially separate these concepts into unique and independent spheres.

In Chapter Four the research framework is described and explained, as is its application during the fieldwork. The framework is built around a research approach of an instrumental, longitudinal case study, informed by qualitative and postmodern perspectives, and reinforced by an ethical standpoint on working with communities.

Chapters Five, Six, Seven, Eight and Nine constitute the case study and analysis of community participation in the GABTR programme. In Chapter Five, an overview of the context, development and implementation of the programme is presented using three overlapping phases as a structure. These

phases, 'from envisioning to the commencement of programme funding', 'bedding in the programme – growing projects out of the proposal', and 'revisiting community participation in the community garden' are built around key programme milestones. Community participation was both a predetermined focus and an emergent issue within the case. In Chapters Six, Seven and Eight the findings around this issue are presented with a focus on participation as related to place, space and community, participation as focused social action, and the contradictory space of community participation in programme governance. Chapter Nine concludes the case study by again refocusing on broader contextual factors of the case.

Chapter Ten completes the thesis. An overarching theme is described, which identifies how community participation remains problematic and challenging in practice although it has become normative and orthodoxy in policy. The limitations of the study and recommendations for future research and practice are presented.

Chapter two: Health, the health sector and development - overlapping contexts for the case

Introduction

In the previous chapter I described a number of the overlapping contexts which envelop this study, including a broad overview of the health status of populations within the programme region and Aotearoa New Zealand. In this chapter the focus turns to the relationships between health and development, and in particular primary health care and health promotion as vehicles for improving the health of communities and reducing health disparities. These provide additional, overlapping contexts for the case.

In common with the Government's "action on health" as spelt out in *The New Zealand Health Strategy* (A. King, 2000b, p. vii), the health development programme which forms the focus of the case study (Chapters Five – Nine) was developed to improve the health of the population, and specifically that of Māori, Pacific Peoples, and those with low incomes. The structure of the health sector where the programme was manufactured as an 'innovation', and in which community involvement was enacted, is also described. This exploration leads to an analysis of community participation as concept and praxis in the following chapter.

Linking development and health

Although there is consistent agreement that development and health are interrelated, and the consensus is repeatedly restated in different forums, the features of that association are debated. The end of the 20th century brought a re-examination of population health improvements over time and a frequent finding was summarised in the statement that "(w)e have failed to realize the importance of placing health at the centre of development and [acted] on it"

(Herrell & Mulholland, 1998, p. 88). Slightly different perspectives on health emerge from each piece of work.

How does health relate to development? The first point to note is that the enhancement of health is a constitutive part of development. Those who ask the question whether better health is a good ‘instrument’ for development may be overlooking the most basic diagnostic point that good health is an *integral part* of good development (Sen, 1999b, p. 623)

At the same time that Sen was writing about good health (status) being an integral part of development, it was argued in a World Development Report that development “... must move beyond economic growth to encompass important social goals – reduced poverty, improved quality of life, enhanced opportunities for better education and health, and more” (World Bank, 2000, p. iii). Here health, improved quality of life, and reductions in poverty are presented as separate but linked concepts. Concurrently, in a major report developed for the WHO which explored the relationships between health and development, a key finding was that health “... is a priority goal in its own right as well as a central input into economic development and poverty reduction. The importance of investing in health has been greatly underestimated ...” (Commission on Macroeconomics and Health, 2001, p. 16). Consensus about a relationship therefore has not necessarily led to prioritised and consistent investment over time. It has been argued that politics and its regional structure have combined to reduce the effectiveness of the WHO, even though it “... has done more than any other UN body to make health the cornerstone of development policy” (Horton, 2003, p. 181).

The macroeconomics and health report followed the international commitment to the Millennium Development Goals (MDGs) which built on agreements made during United Nations conferences in the 1990s (Haines & Cassels, 2004). Three of the eight MDGs are specifically health related. Combined with a fourth goal, to eradicate extreme poverty and hunger, is the argument that “... health is at the heart of the MDGs, with the recognition that better health is

central to the global agenda of reducing poverty as well as an important measure of human well-being in its own right” (Dodd & Cassels, 2006, p. 380). Major concerns have been raised regarding the progress towards achieving the targets associated with the health-related MDGs, but the commentaries on this issue provide an important dialogue on the relationships between health and development. To meet the goals, the need for international collaboration has been highlighted, and a current threat is the “... absence of more extensive redistribution of wealth across national borders” (Labonte & Schrecker, 2004, p. 1672).

While arguing that the health related MDGs need to be adapted to the particularity of the circumstances of each country, Foster (2006) also makes the salient point that it is ‘health’ strategies that are required rather than ‘health service’ strategies, mirroring the call made by others (Evans & Stoddart, 1990) many years before. Congruent with the arguments that health disparities can only be reduced with multi-sector approaches, where health is but one sector, Deville (2006, p. 27) argues in relation to the MDGs that there is a need to take “... a holistic view to development and poverty rather than focusing on health only.” All of these arguments mirror those challenges that led to, and were subsequently prioritised in the international health agreements and global strategies, back to that of the *Declaration of Alma-Ata* in 1978 (WHO & the United Nations Children's Fund, 1978). These arguments - the need to address the broader determinants of health and the specific role of health systems in health improvement - continue to challenge and frame the responses of health sectors within different countries and globally. Health systems are also confronted by changing population health issues associated with development. These changes are described generally as population health transitions, which provide another important context for the case.

The context of the effects of health transitions

The complex links between health and development are encapsulated in descriptions of the transitions used to theorise about changes in countries' population health profiles, especially increases in life expectancy. These changes are linked to a wide variety of factors. Urbanisation, the agricultural and industrial revolutions, economic growth (WHO, 1999), social development, increasing literacy, population movement, poverty reduction, the provision of basic needs such as safe food and water, and health care services (especially related to family planning and population approaches such as immunisations) are all implicated (Martens, 2002). The 'health transition' encompasses both demographic and epidemiological transitions (Martens). It includes shifts towards aging populations, declining fertility rates, increasing longevity, and improved infant, child and maternal mortality rates. Also associated is an overall change from a high incidence of infectious diseases and under-nutrition to conditions related to non-communicable diseases, and 'lifestyle', such as Type 2 diabetes. There are many criticisms of the theoretical descriptions of the transitions and their actual applications to the health profiles of countries. These critiques include that the ongoing impact of communicable diseases has been seriously underestimated (Mathers & Loncar, 2006). However the overall pattern of change is identifiable within the health status of the population of Aotearoa New Zealand.

Now the concept of 'double-burden' overlays the health transition, where countries continue to experience high rates of diseases related to poverty, such as infectious diseases, while also burdened with increasing rates of chronic health conditions, usually (but inaccurately) linked to affluence. This double burden exists at multiple levels. For example, while the WHO continues to do work on childhood malnutrition, it also must respond to the dramatic increase in obesity rates and the associated non-communicable conditions (Prentice, 2006). Malnutrition and obesity coexist as issues down through the national level and community level to that of the family. As an example of the global

nature of these health issues, the ‘obesity pandemic’ which originated in the United States of America, moved rapidly to become a feature in many poor nations (Prentice). In that shift it has become simultaneously a disease of affluence and poverty. The correlations between socio-economic status and obesity are now identified as different depending on the environment (Fezeu et al., 2005; Song, 2006).

The changing health profile related to non-communicable diseases is of most relevance to this case study. Now identified as a “global pandemic” affecting developed and developing countries, the impacts of non-communicable conditions are significant and the costs for treatment of chronic diseases, many of which are preventable, are already described as “staggeringly high” (Spinaci, Currat, Shetty, Crowell, & Kehler, 2006, p. 33). Reducing rates of non-communicable conditions such as cancer, cardiovascular disease, diabetes, and obesity, and improving nutrition were all priority population health objectives identified by the MOH in Aotearoa New Zealand (A. King, 2000b). Reduction in the rates of these conditions was also a broad aim of the implementation of Healthy Eating Healthy Action programmes such as GABTR.

The population health profiles and changes which have been encapsulated in the health transition are important in terms of the development over time of health sector structures and responses both nationally and internationally. Two of these, primary health care (the broad philosophical and structural setting of GABTR), and health promotion (the programme approach), provide important contexts for the case.

The context of primary health care centred on health development

There are a number of definitions of health development including that it is “... the process of continuous, progressive improvement of the *health status* of individuals and groups in a population” (WHO, 1998b, p. 8). With a focus on the complexity of the many past and present factors that influence Māori health

and on the means of that improvement, Durie (1998, p. 1) defines Māori health development as “... essentially about Māori defining their own priorities for health and then weaving a course to realize their collective aspirations.” The concept of health development also encapsulates the aim of the health sector’s ongoing response to the global, social, and political features that broadly frame development.

The historical interactions of these features, which led up to the watershed of the *Declaration of Alma-Ata* and which built on the 1948 *Universal Declaration of Human Rights* (Labonte & Schrecker, 2004), are described:

The 1978 Alma-Ata declaration crystallised many post-war experiences in health care, particularly in the developing countries. From the political chaos of post-war Europe emerged a period of global retrenchment in which conflicts of ideologies and conflicts over political control sharpened. The establishment of Communist China and the struggle for independence of the colonial world not only marked a new political reality but brought into focus universal values of liberation and concern for the oppressed. The calls for social justice and equity permeated all spheres of political and social life in both developing and developed countries. (Walt & Rifkin, 1990, p. 13)

Over time, health sectors reflected the changing global ideologies and realities, such as the need to develop health systems in newly independent countries in the 1950s, the influence of the new economic order on a change to basic needs and community development approaches in the 1960s, and the idealism that enabled questioning of old ways in the 1970s (Walt & Rifkin, 1990). Although the differences in health status of populations, both within and between countries, had been of ongoing concern, it was the recognition that the health sector responses were ineffective and in some cases damaging, that created the space for international work on primary health care in the 1970s. The events and agreements of that time continue to be reflected in the work of health sectors (nationally and globally) today.

Although some precursor models of health care existed, such as Community-Oriented Primary Care in South Africa (Mullan & Epstein, 2002; Tollman, 1991), in the 1970s it was recognised that many countries were struggling with health care systems that were “... all too often being devised outside the mainstream of social and economic development” (WHO & the United Nations Children's Fund, 1978, p. 38). These systems were often based on medical professional dominance, were expensive, reliant on advanced technologies, based in urban areas, and, of key importance, were not addressing the causes of ill health or actual health needs of populations. It was argued that probably four-fifths of the world's population had no access to health care on a regular basis (WHO & the United Nations Children's Fund).

This convergence of issues, in terms of population health status, health systems, and development, provided the backdrop to a number of agreements. In 1977, unanimous agreement by the World Health Assembly led to *Health for All by the Year 2000*. This developed into a global strategy of that name (WHO, 1981), with its target on equity in health status linked to peoples' participation in economically and socially productive lives (Starfield, 1998). The following year the International Conference on Primary Health Care in the Union of Soviet Socialist Republics led to the development of the *Declaration of Alma-Ata*. That Declaration provides the most commonly used definition of primary health care. As a “... development philosophy” (Lyttleton, 1996, p. 29) primary health care was defined as:

... essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of both the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close

as possible to where people live and work, and constitutes the first element of a continuing health care process. (WHO & the United Nations Children's Fund, 1978, pp. 3-4)

Key components included in the *Health For All* strategy to be achieved through primary health care included the need for global cooperation, adaptation to meet the specific needs of communities and countries, the emphasis on disease prevention and health promotion approaches, the involvement and cooperation of all sectors, and the goal of equity of health status (Baum, 1999). From its inception, primary health care was also centred on community participation. Participation was described in a number of ways including as a process, linked with rights and duties, built on self-determination, and individual, family and community capacity building. In combination with education, active participation with health services in the planning and implementation of health care, was identified as important (WHO, 1981; WHO & the United Nations Children's Fund, 1978).

Importantly, but less well known, twenty two recommendations for health system changes were also developed as part of the Alma-Ata conference. The first and fourth recommendations linked health and development and addressed the need for governments to include primary health care in national development plans, and to coordinate action for health within the health sector and also in other sectors. The second recommendation related to community participation in primary health care. Governments were given the responsibility to both encourage and ensure that community participation occurred (Tarimo & Webster, 1994).

In describing primary health care as a “philosophy” of a health care system, a “set of activities”, a “level of care”, and an organising strategy for health services Vuori (1985, p. 221) identified a range of different interpretations of the concept that still have currency. Importantly, although this typology is frequently used, the purpose of the paper in which it was presented was to argue that the common approach to care in many countries – primary *medical*

care – needed to be changed into primary *health* care. Vuori (1985) argued that this change was reliant on a number of philosophical, practical, and disciplinary shifts. These shifts included a change in ‘focus’ from illness and cure to health, prevention, and care; a change from treatment and episodic care to comprehensive care and health promotion; changes from medical specialists to general practitioners and teams; and responsibility moving from the health sector and professionals to intersectoral collaboration, community participation and self responsibility. These shifts in focus still remain incomplete, problematic and contested within health sectors.

Initial debates as to the appropriate scope of primary health care as either selective¹² or comprehensive (Berman, 1982; Unger & Killingsworth, 1986; Walsh, 1988) are being revisited in a new way with the advent of the MDGs and the recognition of the double burden of communicable and non-communicable diseases. Also, the latest strategy of *Health for All in the 21st Century* (WHO, 1998a), which again takes a social justice approach, combines health outcome targets with the need for comprehensive essential primary health care (van Herten & van de Water, 1999). Other ongoing challenges related to primary health care include multiple definitions in use (Sheaff, 1998), lack of understanding of the concept by community members (Pedersen & Wilkin, 1998), an uncertain space for the integration of traditional health practices (Van Der Geest, Speckmann, & Streefland, 1990), and contested links between public health, primary health care, and primary (medical) care. Concerns remain as to whether primary health care is assisting in the reduction of health disparities. The need for a return to a more radical agenda for primary health care (and health promotion), as initially envisaged to meet their original goals (Baum & Sanders, 1995), has also been argued.

¹² Selective primary health care was suggested as an alternative to the broader, more comprehensive primary health care defined in the *Declaration of Alma-Ata*. It was described as health care that would focus on the prevention and treatment of a small number of diseases, which were identified as the major causes of morbidity and mortality in developing countries and where evidence-based interventions existed (Unger & Killingsworth, 1986; Walsh & Warren, 1979).

In Aotearoa New Zealand, while the primary health sector structure has, until lately, reflected a focus on primary care, fundamentally built around medical general practitioners (Barnett, Barnett, & Kearns, 1998; Marriot & Mable, 2000), there was a significant history of practices, such as indigenous public health work which would now be identified as primary health care (Durie, 1998). There has also been a high level of consideration of primary health care and its principles throughout sections of the health sector with statements on primary health care developed many times (for example, Allocation and Organisation Committee, 1987; Crengle, 1999; A. King, 2000a; National Health Committee, 2000; New Zealand Board of Health, 1988; Tukuitoronga, 1999). The way these manifest in the health sector is explored later in this chapter.

The context of health promotion

Interrelated with the international primary health care movement was that of health promotion, which was cemented as a health sector approach and priority with the First International Conference on Health Promotion held in Ottawa, Canada in 1986, and co-sponsored by the WHO, the Canadian Public Health Association, and Health and Welfare Canada. Canada provided an important context for the conference. A key Canadian report known as *The Lalonde Report* (Lalonde, 1974) from the Minister of Health and Welfare in 1974 had raised concerns about the rising health care costs and a lack of associated improvements in health status of the Canadian population. As a result many lifestyle, health education and social marketing programmes were developed and health promotion approaches were refined. Similar reports were then published in other countries (Bhuyan, 2004), creating a space for international discussion on health promotion. From this conference the *Ottawa Charter for Health Promotion* (WHO, 1986, p. 1) was developed, as a response “... to growing expectations for a new public health movement around the world.”

There were two driving forces behind the Ottawa Charter. It was clear that the Health for All by the Year 2000 strategy was not being adopted by industrialised countries, and the limitations of the lifestyle and behavioural approaches were increasingly being seen as requiring a new conceptualisation for health promotion. Also the time was opportune for a major health promotion statement. Health budgets continued to expand in the 1980s and the prospect of cutting these by improving the health of populations became increasingly attractive. (Baum, 1999, p. 35)

The Ottawa Charter was built on previous work including that of primary health care, *Health for All*, and intersectoral action for health. Baum and Sanders (1995, p. 150) argue that the principles of the Ottawa Charter "... were similar to the Alma Ata Declaration, but couched in terms more likely to appeal to western governments." In the Charter, prerequisites for health - peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity – were purposefully documented. In what was to become a seminal definition, health promotion was defined as:

... the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being. (WHO, 1986, p. 1)

Three basic strategies were an important part of this Charter, 'advocacy' for health, 'mediation' between competing interests for health, and 'enabling' people to achieve their health potential. These were combined with priority action areas. The priorities were to develop 'healthy public policy', 'supportive

environments' for health, and to 'strengthen community action', while addressing the need for 'personal skills' to be developed, and health services reoriented towards a health care system which "... contributes to the pursuit of health" (WHO, 1986, p. 3). While the integration of all of these strategies was seen as important within health promotion action, the awareness and understanding of the socio-environmental context in which the action occurs was identified as a crucial component (Jackson et al., 2007).

There have been a number of conferences since that time, each refocusing and reprioritising areas, but building on the original Ottawa Charter framework. For example, the importance of comprehensive approaches and the use of specific settings formed major parts of the *Jakarta Declaration on Leading Health Promotion into the 21st Century* (WHO, 1997). The Jakarta conference was significant for a number of reasons. It was the first international health promotion conference to actively engage with participants from developing countries, shifting the focus that had driven the Ottawa Charter development over ten years before. Secondly, the complex issues related to public-private partnerships and the effects of globalisation on health promotion were discussed for the first time and these issues were to drive agreements at later conferences (WHO, 2005).

Whereas the past Declarations and Charters have provided a framework of action points, priorities and strategies for health promotion practitioners, the most recent charter, the *Bangkok Charter for Health Promotion in a Globalized World* (WHO, 2006) is aimed at "... a different audience: governments and politicians at all levels, the private sector, international organisations as well as civil society and the public health community" (Laverack, 2007, p. 4). Contemporary driving forces which influenced the development of the Bangkok Charter included recognition of the effects of environmental change, world trade, urbanisation, disasters and new understandings of the effects of the broader determinants of health which positioned health as a "... global public good" (de Leeuw, Tang, & Beaglehole, 2006, p. 1). Globalisation forces were seen to offer both challenges to health which needed to be mitigated and

opportunities that could be maximised (Tang, Beaglehole, & O'Byrne, 2005). In the Bangkok Charter (WHO, 2006, p. 10) the definition of health promotion again reinforces the fundamental right of all people to enjoy the "... highest attainable standard of health" without discrimination. Health is again defined in its broadest sense, including mental and spiritual wellbeing. Its association with public health in tackling threats to health, including those from non-communicable diseases, is detailed. The basic principles of justice, equity and access remain important and have been restated through all of the declarations and charters to date, due to their continuing relevance (St Leger, 2007).

Communities are identified as having a critical space for participation in this latest charter, where it is identified that together with civil society, they have an important role in leading health promotion action, while also being able to hold both the private sector and governments accountable for the health effects of their policies and actions (WHO, 2006). While the health sector's role was described as building health promotion policies and partnerships, four other commitments were made related to the promotion of health: health was to be "... central to the global development agenda"; it was to be a "... core responsibility for all of government"; it should become "... a key focus of communities and civil society"; and lastly, "... a requirement for good corporate practice" (WHO, 2006, p. 12).

As with the international agreements for primary health care, the local adaptation and implementation of the strategies and frameworks in practice is where the complexity emerges. While health promotion is linked with processes and aims such as capacity building (Hawe, King, Noort, Gifford, & Lloyd, 1998), community capacity building (Laverack, 2006; Raeburn, Akerman, Chuengsatiansup, Mejia, & Oladepo, 2006), partnerships (Crisp, Swerissen, & Duckett, 2000), individual empowerment (Tones, 2001), and community empowerment (Laverack, 1999; Laverack, 2001; Laverack & Wallerstein, 2001), debates continue about its use and ability to achieve those aims. These include theoretical and political debates and pragmatic difficulties. The definition and scope of health promotion remains contested (Tones, 2001).

Tension remains between focusing health promotion activities at individuals, structures or society (Baum, 1999; Grace, 1989, 1991), and the conflation of health education approaches to health promotion is common. Intersectoral action, a cornerstone of health promotion, is complex in theory (Delaney, 1994) and practice (MOH, 2008b). Tensions emerge for countries such as Aotearoa New Zealand, as signatories to international health promotion agreements, when advocacy and lobbying occurs by organisations and coalitions whose services are contracted and paid for by the Government (Health Promotion Forum of New Zealand, n.d.).

Overlaying these issues are ones of health promotion workforce capacity, both within the health sector and in other sectors. Private, voluntary, and nongovernmental organisations are now identified as “... critical for positive [health] solutions in many countries” (WHO, 2003, p. 2). Simultaneously those same groups are being identified as potential partners for health promotion action (WHO, 2006). However for many community groups and voluntary organisations health outcomes are secondary or latent goals (Easterling, Gallagher, & Lodwick, 2003b; Trojan, Hildebrandt, Deneke, & Faltis, 1991). The tensions of negotiating the balance between resourcing disease treatment and health promotion can be seen at all levels, right up to the World Health Organisation (Reid & Pearse, 2003).

Concerns are frequently raised about the evidence for the use of health promotion approaches, and specific methods of programme implementation (Berentson-Shaw & Price, 2007). Evidence does not exist, it is not sought in the design of programmes, or programmes have not been evaluated in ways that enable that evidence to be developed. For example, with the current global focus and spending on obesity prevention it is alarming to read that “... knowing what works and what does not work for obesity prevention is difficult because the evidence base is so limited and the settings in which interventions have been tested are so few (mainly primary schools)” (Swinburn et al., 2007, p. 305).

Health promotion has become a well accepted discipline and tool in Aotearoa New Zealand (Wise & Signal, 2000). Intersectoral action has become a commonly adopted strategy, for example within 'Health Promoting Schools' initiatives. Legislation and policy guidelines are commonplace, congruent with a framework of 'healthy public policies'. However they have been introduced with much public debate, specifically related to individuals' rights. The recently implemented Ministry of Education national administration guidelines provide an example with the requirement for schools to "... promote healthy food and nutrition for all students; and where food and beverages are sold on school premises, [to] make only healthy options available" (Butler, 2008, para. 2). The debate about this rule continues with support from schools which had already successfully implemented such a strategy (often in association with Health Promoting Schools programmes), and disapproval from other schools and the businesses providing school food outlets.

Nongovernmental organisations and coalitions drive health promotion in a number of areas, for example the Cancer Society, the Public Health Association, and the Agencies for Nutrition Action, the Health Sponsorship Council, and the Health Promotion Forum. Indigenous models of health and health promotion have been developed based on Māori health paradigms (Durie, 1985, 2008). Te Pae Mahutonga (Durie, 1999), a model for Māori health promotion, is based on the stars of the Southern Cross¹³. Knowledge has been developed of settings specific to Aotearoa New Zealand for health promotion and health action, such as marae, and partnerships created with their associated committees (Ratima et al., 1999).

Primary health care and health promotion provide important overlapping contexts for the case. In both, community participation (as examined in the next chapter) is simultaneously presented as a core philosophical, theoretical

¹³ This model, which Durie (1999) argues could resonate with other New Zealanders as well as Māori, includes four tasks and goals of health promotion (mauriora – access to a secure cultural identity; waioara – environmental protection; toiora – healthy lifestyles; te oranga – participation in society) and two prerequisites (nga manukura – leadership; te mana whakahaere – autonomy).

and practical component and a major challenge and area of contestation. In the following section, the context of the health sector in Aotearoa New Zealand is examined.

The context of the publicly funded health sector in Aotearoa New Zealand

The configuration of any health care system reflects many factors including the historical background, social organisation, political system, cultural framework, and demographic features of the country (Blank, 1994). Since the early 1980s the health sector in Aotearoa New Zealand has undergone repeated restructuring, labeled as health reforms, as also happened in many other countries (Brown, 1996; Gauld, 2002). The changes have been expansive and sector wide. They include an increase in total health expenditure, as a proportion of the Gross Domestic Product, from 7.3% in 1996 to 9.4% in 2006, spending which ranked 16th out of 30 Organisation for Economic Cooperation and Development countries in 2002 (MOH, 2008a).

The changes have included alterations in funding arrangements, service delivery mechanisms, the role of locally elected community members in governance, and the division of the country into health service regions (Cumming & Mays, 2002). Over time, purchaser provider splits and then reintegration, and devolution of accountabilities and responsibilities occurred (Bloom, 2000; Marriot & Mable, 2000). Ideological approaches such as economic rationalism (Brown, 1996), including “... macroeconomic restraint and microeconomic restructuring” (Ashton, 1993, p. 59), were adopted. Overlaying these has been a trend of shifting focus from hospitals towards community, although this has been prioritised in different ways at different times. For example, in the 1980s considerable health sector work was directed at community projects based on health promotion and community development principles (de Lacey, 1984, 1989a, 1989b, 1989c). To reflect that focus for a

short time the district offices of the Department of Health¹⁴ were relabeled as 'health development units' (de Lacey, 1989a).

Costs and benefits resulted from all of these changes. For example Durie (1998, p. 164) noted how there "... have been many Iwi [tribe] initiatives which have taken advantage of the health reforms. They have in common a commitment to integrated development – cultural, social, economic – based on Māori tribal structures." The environment was also conducive to the development of other 'third sector' (non-government, non-profit) primary care organisations, such as union health centres, which focused their care on vulnerable populations and used community development approaches (Crampton, 1999; Crampton, Dowell, & Woodward, 2001). A renewed acknowledgement of the broader socioeconomic influences on health has also occurred (Public Health Advisory Committee, 2006), leading to a re-examination of the place of the health sector in improving the population's health. This has resulted in a stronger focus on intersectoral work, collaboration and partnerships. While there is debate as to whether the structural reforms or incremental changes which have followed have had the most impact, the alterations resulted in major changes to both the health sector and the people employed within it (Ashton, Mays, & Devlin, 2005).

In relation to the health programme that provides the focus of the case study there are some key issues related to the health sector and the history of restructuring which provide an important backdrop. These relate to the newness of the organisations, their developing relationships and the organising structures within which they work, interrelated with the mandated strengthening of community participation within the whole sector.

¹⁴ The Department of Health was a predecessor to the Ministry of Health

New organisations, new relationships and a space for community voices

In 1999 with a desire to, amongst other things, prioritise health promotion and disease prevention, and integrate what they called the ‘community voice’ into decision making, the New Zealand Labour Party heralded a new round of health sector reforms (Ashton et al., 2005). These reforms had effects within all of the layers of the sector, from the MOH down. While the MOH (see Figure 2) provides national policy advice, and acts as a “... regulating, funding, and monitoring agency” (A. King, 2001b, p. 4), it also contracts for some national population health services and has roles in facilitating collaboration and coordination within the sector. The Ministry, which has recently undergoing significant internal restructuring, has been responsible for the development of a number of national health strategies, including *The New Zealand Health Strategy* (A. King, 2000b), *He Korowai Oranga: Māori Health Strategy* (A. King & Turia, 2002), and *The New Zealand Disability Strategy* (Minister for Disability Issues, 2001). These strategies provide the principles and priority population health objectives which organise the work of the health sector. Toolkits, such as one to improve nutrition (MOH, 2001), and epidemiologically driven objectives and targets have also been developed, as has implementation monitoring. Considerable levels of strategic direction are therefore provided to those working within the health sector, with the health and disability strategies both included within public health legislation (“New Zealand Public Health and Disability Act 2000,”).

The next layer, DHBs, were established in 2001 under legislation (“New Zealand Public Health and Disability Act 2000,”). These Boards are defined as organisations which “... protect, promote and improve the health and independence of a geographically defined population” (A. King, 2000b, p. 49), with the focus on a community defined by geographic boundaries a requirement under the Act. Each Board is responsible for providing or accessing primary and secondary health and disability services for its region. Therefore, DHBs comprise a number of components – hospital and related services, public health centres or units that provide health protection and health promotion services, and funding and planning units which assess population

health and manage service contracting. Under the Act, DHBs are required to have a governance board that includes Māori representation and members elected by the community. Specific legal requirements within the Act mandate when boards must consult with the communities they serve, such as about major changes to strategic plans (MOH, 2002a).

DHBs were therefore new entities, although usually the people and in many cases the clinical services provided were the same as pre-reform. What changed were responsibilities regarding population health assessment, the level of community representation on boards, especially with regard to Māori representation, the degree of localisation of service provision possible, and, eventually, the relationships with the Primary Health Organisations (PHOs) in their area.

The reforms extended into the primary health care sector. *The Primary Health Care Strategy* (A. King, 2001b), based on the definition of primary health care agreed upon at the Alma-Ata conference (WHO & the United Nations Children's Fund, 1978), identified the importance of population health approaches¹⁵ and primary health care to the achievement of the goals of *The New Zealand Health Strategy*, specifically the reduction in health disparities. Interestingly, this approach was described as “... striking, in that the mainstream primary health care system has been redesigned with an explicit focus on [reducing] health inequalities as a guiding principle” (Hefford, Crampton, & Foley, 2005, p. 10).

PHOs were the new entities, with the lead PHO associated with GABTR established in mid-2003 (see Figure 2, p. 37). Some developed from Independent Practice Associations (which had functioned as management organisations, owned by general practitioners), or from Māori or Pacific health service providers or development organisations. PHOs are “... funded by

¹⁵ Population health approaches are those actions undertaken by the health sector to improve the health of a population or group of people (Public Health Advisory Committee, 2006). These approaches have been features of the health system in Aotearoa New Zealand for some time (Malcolm, 1994), but have recently received increased attention.

DHBs for the provision of a set of essential primary health care services” for the people enrolled with the organisation (A. King, 2001b, p. 5). In these organisations their ‘community’ relates to the people ‘enrolled’¹⁶ rather than a geographic community, allowing for the development of different models of PHOs across communities and the country.

Mandated minimum requirements included that PHOs were not-for-profit, and provided (or contracted) first line treatment services as well as those related to prevention and health promotion. They must demonstrate responsiveness to local needs. As well as collaboration with other health service providers to ensure service coordination, PHOs were required to “... work with those groups in their populations (for example, Maori, Pacific and lower income groups) that have poor health or are missing out on services to address their needs” (A. King, 2001a, p. 3). While there was a requirement for service users, providers, community and Māori representation (as stakeholders) on the governance board of each PHO (MOH, 2007c), it was also suggested that wider community involvement should be nurtured. The MOH even provided general guidance on what could be included in a community participation policy for each PHO (MOH, 2002b). In this guide the focus was on the ‘voices’ of Māori, Pacific, rural and service user communities, and how decisions would be communicated with those populations. It was later recognised that:

¹⁶ Individuals ‘enrol’ with a PHO through their chosen primary care (general practitioner/health care provider) service. Although theoretically the enrolment is with a PHO, public confusion remains as to the role of those organisations (MOH, 2006b). Health care providers are not required to contract with a PHO but need to do so to obtain increased payment subsidies which reduce co-payments made by service users. With PHOs now providing direct care services (e.g. nursing services) this area of enrolment is confusing for the public. With health promotion programmes aimed at population groups that may be enrolled with different PHOs (or not at all) then ‘enrolment’ is of lesser priority, but the need for collaboration between organisations is of importance to reduce service gaps or duplication.

The *Minimum Requirements for Primary Health Organisations* did not specify how the community voice should be heard at the governing level, but did state that there must be processes in place for genuine community participation and that this should include communities, iwi and consumers. (MOH, 2007c, p. 15)

PHOs, of which there are currently 81, continue to be created. They differ dramatically in the size of the populations served and the breadth of services provided. Different funding formulae operate based on capitation and the demographic features of the enrolled populations. Increased government co-payments for primary medical care have been rolled out over time. These funding changes have dramatically reduced service users' costs for routine primary medical care over time, a strategy designed to reduce the effect of the "... medical poverty trap" (Whitehead & Bird, 2006, p. 390) in which high costs of health care become a cause of poverty.

Figure 2 (adapted from the Ministry of Health's *Structure of the New Zealand Health and Disability System*) demonstrates the complex layers of the current health sector with service agreement, funding, and reporting lines detailed as related to the GABTR health promotion programme. As demonstrated in Figure 2, DHBs and PHOs *both* provide health promotion programmes and services, *both* are required to be responsive to local needs, and *both* must have community and Māori representation on their governance boards. The structures developed in the latest health reforms are still evolving and changing, as are relationships between those organisations and with others. In response to the reforms and the health sector challenges encountered, recommendations have been made again about the need for more intersectoral collaboration and the adoption of 'whole of government' approaches to improve the health and wellbeing of the population and to reduce health disparities (Public Health Advisory Committee, 2006). Concerns about the governance arrangements of PHOs continue to be raised (MOH, 2005c).

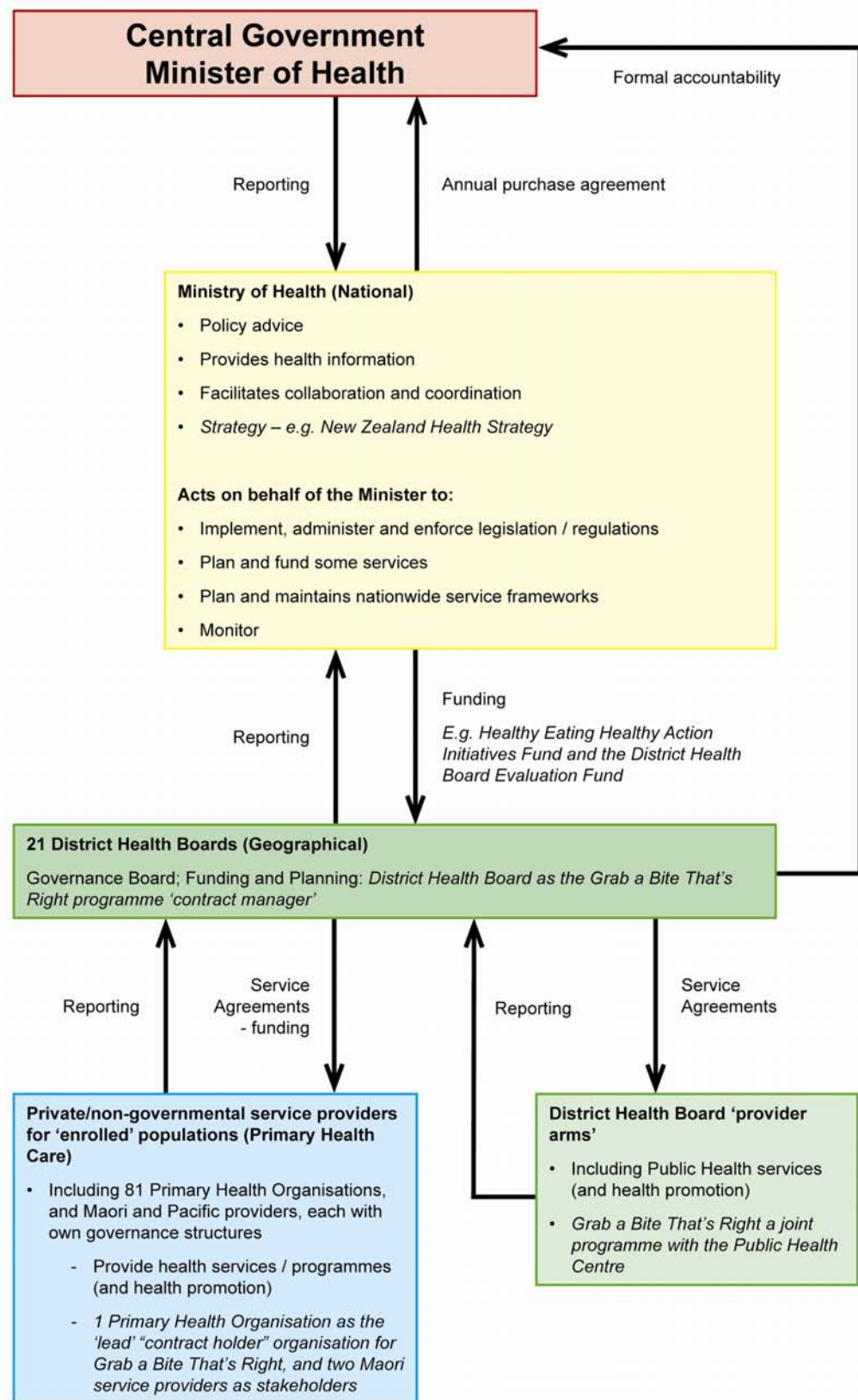


Figure 2 The health sector in Aotearoa New Zealand as related to GABTR

In 2005 the MOH provided a report as advice to the new Minister of Health. The document, *Health and participation: An active agenda* (MOH, 2005a, p. 2) provided strategic advice and clearly identified the health sector aim for all New Zealanders of "... active people, actively participating in communities", and one for DHBs of "... encouraging community participation." Interestingly, in relation to this case study, the areas of food and nutrition programmes, the Healthy Eating Health Action Strategic Framework, and community development with local government, were highlighted. The health sector involvement, with other sectors, in addressing broader socioeconomic concerns in programmes was described as a way to "... increase social capital ..., increase people's (individual and community) competence and control over their life circumstances, including their health and health-related behaviours" (MOH, 2005a, p. 30). In drawing together MOH perspectives on the goals of health development, the need to address the broader determinants of health, and the prioritising of community participation, this document provided a useful backdrop to the implementation of the GABTR programme.

Summary

In this chapter a number of overlapping contexts to the case have been examined. These contexts included the international focus on health within development, the impacts of health transitions, and health development as a framework for primary health care and health promotion. In describing some of the key international and national developments related to primary health care and health promotion, areas of contestation were explored such as the evidence for interventions and multiple definitions. The description of the health sector in Aotearoa New Zealand also provided another context, one in which the case - GABTR - was developed and implemented. The shifting terrain of the health sector structure was described as were challenges and opportunities that this restructuring offered to different groups. In the following chapter, the focus turns to the expansive literatures related to community and participation and the concept of community participation.

Chapter three: Understandings of community participation

Introduction

In the previous two chapters overlapping contexts relevant to the case were presented. These contexts included the health status of the people of the Whanganui region, and perspectives of health development. In this chapter the gaze turns to contemporary understandings of community participation and community participation in health development. Together, these interwoven contexts are important for two reasons. Firstly, community participation (the research focus) and case study (the chosen research approach) are both recognised as context-bound and therefore those contexts need to be described. Secondly and specifically related to this chapter, community participation is a topic about which much is already known and written. The contested knowledge and practices related to community participation therefore provide an important backdrop (a ‘potential’ context) to the case in which community participation within a health development programme is examined.

Community participation within the health field nestles within a landscape of multiple overlapping disciplinary discourses of participation, including those of development studies. Within these discourses participation has been brought to the fore and superimposed over traditional and cultural patterns and practices of social involvement within societies. Positioned as something neoteric and evolving, participation is simultaneously contested and orthodoxy. It is imbued with the potential to empower, while unintentionally disempowering others. Meanwhile it is also presented as method, strategy and ideology to guide practice. This chapter concludes with an identification of key areas where the knowledge of community participation is partial and which therefore justifies the choice of the research focus.

Participation as the focus of many disciplines

Participation, in many guises, is the focus of theorising within a number of disciplines. In practice, participation as social spatial¹⁷ action, occurs at many levels and can be many things. It can be people's everyday activities of living and participation in society and community, their participation in organised programmes to improve their and their family's health, volunteering, participation in programme or organisational governance, and civil participation in democratic processes. Separately and collectively these varied 'involvements' are important.

From the perspective of communities, the range of types of participation provides many possibilities for involvement. From the perspective of a programme the range of types of participation offers many possibilities for community engagement. For disciplines and researchers, the range provides areas of overlapping interest and contestation. This has resulted in the development of silos of knowledge related to what are identified as different types of participation.

Participation has been a topic of separate study in a number of ways, for example as public participation, community participation, and stakeholder participation (as will be explored further in the chapter). While specific terminology is useful at times, it also may limit shared understandings. For example, the common practical difficulties of accessing representative voices is experienced in the arena labeled as public participation, and concurrently but separately under the guise of community participation. Therefore I have chosen to draw on a broad range of literature across those silos within this chapter (and the thesis as a whole). This is congruent with key arguments within this thesis. Firstly, the separation (and isolation) of types of participation appears in the main to be a theoretical device. For community members this differentiation is

¹⁷ Space is a commonly used metaphor, descriptor, framework, structure and device used for positioning and analysis of participation. In this thesis I have drawn on the work a number of authors (Cornwall, 2002b, 2004; E. Jones & SPEECH, 2001). Their work utilises that of Lefebvre (1991) from *The Production of Space*, where the intertwining as one of social, mental and physical spaces is examined as are the linkages between energy, space and time.

of less importance. Secondly, sectors (such as the health or education sectors) are also artificial devices and participation framed within any one sector may improve health. Therefore, social participation resulting in an increasing sense of community may be as 'healthful' as attendance at a health service in some instances. Thirdly, to improve health, especially within a health promotion programme, the broad determinants of health must be a core focus. Therefore participation is related to action on those determinants, most of which lie outside the health sector. Fourthly, intersectoral action is well accepted as a mechanism of action within health promotion, and therefore many disciplinary perspectives of community participation may coexist within a single programme.

Creating a space for a focus on participation

The societal and global features that converged to create the space for the current focus on participation, and which maintained that for a period of nearly thirty years, overlap within the disciplines of health and development. Some authors argued that for development studies the 1980s was the decade of participation (Botes & van Rensburg, 2000), and Oakley (1991, p. vii) suggested in 1991 that "... we are currently in the age of 'participation'". Meanwhile the primary health care and health promotion movements of the 1970s and 1980s (as described in the previous chapter) were also producing a similar prioritisation of participation. This resulted in a focus on the concept of community participation in health development, sometimes labeled community participation in health (Oakley & Kahssay, 1999; WHO, 1985). Community participation is identified as "... axiomatic in health development" (Woelk, 1992, p. 419), and "... well entrenched in mainstream health discourse" (Morgan, 2001, p. 221). However, in tune with other disciplinary perspectives, it "... rarely met the expectations of health planners/professionals" (Rifkin, 1996, p. 79). Participation and community participation became neoteric, although there was also recognition that participation was not something totally new.

Involvement in society was accepted as a normative and structural feature of communities, although Midgley (1986c, p. 8) argued that advocates of community participation "... believe that conventional participatory networks are inadequate." Those conventional networks now often appear to be identified as the 'contexts' in which 'new' forms of participation are situated. Contexts include people's social histories, cultures and traditions of participation, and economic and political policies and structures. Many authors (Harrison, 2002; E. Jones & SPEECH, 2001) argue that contexts create a particularity of participation while others recognise that traditional patterns of participation continue to operate concurrently with new types (Tandon, 2002).

Historical antecedents to community participation

Midgley (1986b) identified three general historical antecedents of community participation: political theories and Western ideologies, especially those of democratic theory; a community development movement of the 1950s and 1960s; and western notions of social work and community radicalism. The community development movement had ties to colonial administrations in Africa and Asia (Hadjor, 1992) after the Second World War, but Dudley (1993) identified that community participation was utilised even earlier by the colonial administration in the 1920s and 1930s. Others (Midgley, Hall, Hardiman, & Narine, 1986, p. vii) identify how community participation "... replaced earlier versions of formalized community development" which were colonial and post-colonial (Hickey & Mohan, 2005) in structure and different in focus from more recent approaches to community development.

What is now identified as the orthodoxy of participatory development was created by reaction to and reflection on the impacts of a variety of international, national, and local events and trends. These trends included increasing recognition of poverty, social exclusion and the negative impact of neoliberal economic policies (Mayo & Craig, 1995). A focus on people rather than professionals in United Nations development policies (Rifkin, 1996; Zakus & Lysack, 1998) was also a key influence. In addition, arguments

associated with equity (Paul, 1987), people's rights of access to basic needs and to human rights (Gaventa, 2002), and to involvement in things that affected them (Midgley, 1986b) came to the fore. Concerns with sustainability of developmental change, with the failure of conventional top-down approaches to improve people's lives (Chambers, 1995), and with the need for local people to provide resources for projects (Oakley, 1991) were also identified. There were also debates as to whether community participation was needed to achieve project sustainability (Gonzalez, 1998).

Now, participation, and specifically community participation, is both mandated within policy and contested at many levels – regarding its 'modern' antecedents at international, national and local levels, its place as an ideology, its definitions, its use as a method for research and practice - and for its purported benefits and outcomes. While an individual analysis may focus on specific points, overall, the critiques offered are similar across disciplines, for example (as will be explored further in this chapter) the complexity of community and the place of power relationships.

Participation

After a number of decades of study in a number of disciplines social participation is still identified as a messy, inherently disorderly, and contradictory concept (P. Jones, 2003). Although it is argued that there are universal features of participation, especially at the levels of ideology and strategy, which operate across settings (P. Jones), participation at the level of practice is usually considered as bound to context (Botes & van Rensburg, 2000).

There are extensive writings in which authors seek to clarify the concept of participation and its application. One set concentrates on the 'actors' as participants in participation. Cornwall (2003) draws on the work of a number of authors and presents a typology (Table 2) which relates modes of participation with how participants are viewed.

Table 2 Modes of participation

<i>Mode of participation</i>	<i>Associated with ...</i>	<i>Participants viewed as ...</i>
Functional	Beneficiary participation	Objects
Instrumental	Community participation	Instruments
Consultative	Stakeholder participation	Actors
Transformative	Citizen participation	Agents

Source: Adapted from Cornwall (2003, p. 1327)

While in Table 2 participants associated with community participation are viewed as ‘instruments’ for a programme, in this study I have chosen to use the descriptor of ‘actors’ as a neutral term for participants - individuals and groups – acting or undertaking different roles. This is to reflect that there is no universal acceptance of how roles such as community participant or stakeholder are defined and also because there is much overlap of these roles in practice.

The actors in participation

Participation is a social action, enacted within a particular social space and time. Even with the number of qualifiers, such as citizen and community used in combination with participation, the actors are generally situated within two frames. Firstly, actors are potentially anyone who is *not* of government / state or organisation and can be described broadly as ‘local’. This is reflected in the argument by Midgley (1986c, p. 4) who suggests that central to the rationale of community participation “... is a reaction against the centralization, bureaucratization, rigidity and remoteness of the state.” Within the writings about community participation in health development another point of differentiation exists in that the actors are also assumed to be *non*-health professionals, and therefore theoretically not directly aligned to the health sector, except as actual or potential service users.

Secondly, actors are ‘representatives of’, as agents for something else. They may be identified as users *of* specific services, or beneficiaries *of* projects, or *of* community. The only related term which clearly challenges these frames is the use of the term ‘stakeholder’. The MOH (2003a) in Aotearoa New Zealand uses the term stakeholder to describe a range of groups including health service and education providers, and organisations and networks associated with Māori and Pacific groups. Therefore, in that usage the term encompasses a mix of health professional and non-health professional groups. Universally, the literature referring to stakeholders is based around consultative rather than broadly participatory approaches and Chess (2000, p. 25) argues that “(t)he concept of the stakeholder may need to be broadened beyond the usual meaning of interest groups to include people from diverse geographic areas, various ethnic groups, and organizations such as local governments and businesses.” This would move the definition of stakeholder back closer to that of community members. When qualifiers are used with the term participation, and this is not universal, the actors are variously described as is outlined in Table 3.

In addition, authors also use terminology such as ‘local’ (Uphoff, 1986) and ‘popular’ (Bugnicourt, 1982; Connell, 1997) to describe general types of participatory actors. Popular participation, which historically had much favour in the United Nations and its agencies in the 1950s (Fonaroff, n.d.), is the only term which no longer seems to be used widely. It has been replaced, it seems, by the notion of citizen participation.

All of the descriptors used (in Table 3) have both specific and general definitions and this creates complexities in drawing conclusions from the literature as to the individuals or groups under examination. Citizen participation may relate to the individual actions of citizens or to “... collective civil society actors” (Houtzager, Lavalley, & Acharya, 2003, p. 1) who act on behalf of others. It may also be a specific form of participation, counter to the “... consultation industry”, in the shape of citizens’ juries (Kashefi & Mort, 2004, p. 290).

Table 3 Descriptors of participatory actors

Participants described as ...	<i>Examples of authors</i>
People	Hollnsteiner (1977) Jones (2003)
Public	Chess (2000) Florin (2004) Loewenson (1999)
Citizens	Arnstein (1969) Clark (2001) Cornwall (2002a) Gideon (2005) Jones (2002)
Beneficiaries	Paul (1987)
Users	Mosquera, Zapata, Lee, Arango and Varela (2001)
Consumers	Christison (2001) Consumer Focus Collaboration (2000)
Customers	La Voy and Charles (1998)
Stakeholders	Brody (2003)

Trends in the description of actors

There are broad ideologically driven trends in the use of descriptors for the actors, including general shifts away from ‘beneficiaries’, the ‘public’ and ‘users’ and more emphasis on ‘citizens’ and ‘stakeholders’, with the ongoing use of ‘community’ over time. These shifts in terminology are never complete and some terms cycle back into vogue, begging the question as to what will be next and why. Many descriptors are used concurrently in time, and often synonymously within individual pieces of literature. For example in an article on *public* participation Thurston, Vollman, Meadows, and Rutherford (2005, p. 400) noted that “(t)he movement to increase *community* involvement has focused on the belief that increased *consumer* participation will provide the information ...” (emphasis added). They thereby included ‘public’, ‘community’ and ‘consumer’ as qualifiers and descriptors of participants.

Shifts in terminology usage can be drivers of future change, or can reflect historical changes in perspectives. Mawdsley and Rigg (2003) tracked key themes in the World Bank *World Development Reports* (WDRs) from 1978 to 2000/2001 and identified trends in language and development approaches. They stated:

A change easily observed over the last 20 or so years has been the progressively stronger interest of the WDRs in people, as individuals and through various social groups as ‘civil society’. Earlier on in this process this is more presentational than substantive. ... As an integral part of the emergence of a more participatory development orthodoxy, and the growing focus of concern on the essential involvement of civil society, the Reports have had to move away from a more traditional neoliberal construct of ‘economic man’ and engage with the complex and gendered nature of individuals and society. (Mawdsley & Rigg, 2003, p. 280)

A number of authors specifically identify the differences between the descriptors of actors. Midgley (1986b, p. 23) distinguishes between popular participation and community participation, with the former related to “... broad issues of social development and the creation of opportunities for the involvement of people in the political, economic and social life of a nation.” Community participation is then described at the level of the “... direct involvement of ordinary people in local affairs” (Midgley, p. 23). It can be assumed that the actors in these descriptions are the same, but that the ‘purpose’ or the social role of participation is the differentiating factor. Jones and Gaventa (2002) argue that there are differences between users and citizens and community, and that although community participation is less associated with concerns about rights, useful lessons can be learnt about it that have relevance for the study and practice of citizen participation. Liamputtong, Gardner and McGartland (2003) differentiate between consumer and community participation in health services, and Opie (1998) further differentiates consumers and users, arguing consumers can choose whereas

health service users may have no choice. Others position community participation and participation in citizenry as complementary (Francis & James, 2003).

The terminology used to describe the actors signifies features of the space for participation. The participant, as actor, does not change by the act of labeling but what he or she may enact – the social role as spatial practice – does change. That space segregates analyses and practices, such as who may participate (for example as a user or stakeholder), and what activities he or she may participate in. These actor descriptors act as theoretical devices – in an abstract rather than real space (Lefebvre, 1991). In a ‘real’ social space, the actors may be simultaneously participating as community or community members, as citizens, the public, or as service users. This then raises the question as to who decides as to the specific actor needed for a specific action in a specific space-time.

Community as the actor

Any descriptor, such as community, must be meaningful (Asthana & Oostvogels, 1996) for both the actor and others. The concept of community, by itself, is a subject of considerable analysis but the overlap between understandings of community and community participation has not always been well considered.

On the face of it, the ideas of ‘community participation’ and ‘community’ have a strong affinity. It could be expected that the arenas in which either is discussed would overlap and explicitly inform one another, particularly given that their meanings are not agreed. Yet it is remarkable to find that the body of literature devoted to community participation in health appears to have developed quite separately from the discussion of community in the literatures of analytic social commentary. (Jewkes & Murcott, 1996, p. 555)

Theoretical attempts at defining the concept of community have caused much angst, especially within the social sciences (Jewkes & Murcott, 1996) and the concept of community is identified as “... inherently complex and difficult” (Bent, 1999, p. 29), “... deceptively simple” (Jewkes & Murcott, p. 555), and one that has proved “... highly resistant to satisfactory definition” (A. Cohen, 1985, p. 11). In spite of these complexities, community is identified as the actor in key national and international documents and health policies, often without clear critique or recognition of the inherent complexities.

Understandings of community

The definition of community included in the Alma-Ata Declaration, which launched the current primary health care movement, with its focus on community participation was that “(a) community consists of people living together in some form of social organization and cohesion. Its members share in varying degrees political, economic, social and cultural characteristics, as well as interests and aspirations, including health” (WHO & the United Nations Children's Fund, 1978, p. 49). Wayland and Crowder (2002, p. 232) identified the three key dimensions integrated in this definition of community as “... spatial, social and political.” The spatial and social dimensions reflected the areas of agreement identified by Hillery (1955) in a seminal sociological analysis of definitions of community. Hillery identified sixteen different concepts of community in use in literature at that time. Three components in combination were important: community encompassed a specific geographic area or space (a locality); a degree of social interaction (networks); and common links or ties (identities and interests). The addition of the political dimension in the Alma-Ata Declaration provides the conceptual link between community and participation through social organisation. Rifkin, Muller and Bichmann (1988) argue that this political component is what enables the enactment of participation in primary health care. The social and political dimensions specifically become relevant when community participation is understood in its broadest sense, encompassing processes of community development and community empowerment.

A more recent definition is community as:

A specific group of people, often living in a defined geographical area, who share a common culture, values and norms, are arranged in a social structure according to relationships which the community has developed over a period of time. Members ... gain their personal and social identity by sharing common beliefs, values and norms which have been developed by the community in the past and may be modified in the future. They exhibit some awareness of their identity as a group, and share common needs and a commitment to meeting them. (WHO, 1998b, p. 5)

This definition, provided in an international glossary of health promotion terms, has a stronger focus on identities, while still situating the people within a geographical area. This focus on geography remains strong for pragmatic reasons.

Locality, geography and community

In practice, differentiation of communities using locality and borders is a common but potentially problematic strategy. Community is defined in *The New Zealand Health Strategy* (A. King, 2000b, p. 48) as "... a collective of people identified by their common values and mutual concern for the development and wellbeing of their group or geographical area." This definition includes both the possibilities of spatial and common interest components, a more appropriate response than relying on geographical boundaries alone (Oakley, 1989). While in Aotearoa New Zealand DHBs are mandated to improve the health of people within set geographical locations (as discussed in the previous chapter), PHOs may be based on communities of interest, creating many opportunities for overlap, but also for disjuncture.

Geographic health sector boundaries, in practice, may not represent the borders of established communities, such as iwi (tribes), or the geographic boundaries

of other sectors, such as education. Geographic health sector boundaries also change during health reforms. For example, during the formation of Area Health Boards in Aotearoa New Zealand in the 1980s, long-standing health sector boundaries, which also reflected well developed community alliances, shifted.

Community and place

Communities are not organisations. Communities do not restructure, adopt a new set of principles, or review their track records as communities. The individuals and organisations which make up a community come and go. People are born, move in and out, grow older, die. Community organisations grow, flourish, and become irrelevant. People may live in one community, and work in another, be born in one community and move to another, keeping roots and values from the past. (Sargeant & Steele, 1999, p.18)

Although geographic boundaries may delineate a community it is the people who are the actors. As identified by Sargeant and Steele (1999), communities change and identities and common interests are flexible, evolving and also create multiple groupings within any and every community. For example, the rapidly changing demography of Pacific Peoples in Aotearoa New Zealand alters the society as a whole, and in particular communities in specific geographic areas (Cook, Didham, & Khawaja, 2001; Macpherson, Spoonley, & Anae, 2001). There are also ongoing changes within the community of Pacific Peoples which may relate more to shared interests and identity than geography. Massey (1994, p. 115) argues that "... the characteristics of any place are formed in part through the location and role of that place within a wider structuring of society ..." and "... the identity of a place is formed out of social interrelations, and a proportion of those interrelations – larger or smaller, depending on the time and on the place – will stretch beyond that place itself." Therefore, as community is created through participation, the place of that community develops its own identity.

In Aotearoa New Zealand, Durie (2001) has explored the relationship between whānau (extended family), community and Māori health. Durie provides a useful description of the overlap between the concepts of whānau and how whānau interlink with broader groupings of iwi and hapū (tribe and sub-tribe) in terms of membership, the main goals, the principal activities and how those result in positive health outcomes. Some definitions of whānau, such as “... *an assembly of people of like mind and interests gathered for a common purpose*” (Metge, 1995, p. 55) dovetail with accepted understandings of the concept of community and represent the overlay of ethnicity, culture, identity and collectivity. The traditional link between whenua (land) and whānau provides the link to location. Lunt, Spoonley and Mataira (2002, p. 358) suggest that for Māori, “(c)ommunity is that sense of place where there is connection to the land, to one’s kindred spirits and to the ‘knowledge’ told through *their* narrative.”

Collectivity, identity, and community

In everyday usage the term community infers a collective grouping of individuals with some common link, “... some threshold of emotional commitment” (Hall, 2005, p. 124). Both the collectivity and links are crucial in perspectives of community participation. Simultaneously, the collectivity is contested and what those links may be, how they are formed and maintained or broken, has been the basis of considerable analyses.

Collectivity implies a degree of homogenisation into a common grouping. That process conceals individual identities and the inherent diversity within any group is lost (Bethke Elshtain & Beem, 2002; Chambers, 2001; Dyke & Dyke, 2002; Murray Li, 1996; Wayland & Crowder, 2002). Therefore, when used without critical differentiation, community can sometimes be read as shorthand for able-bodied, middle-aged, literate, white, middle-class, male, and in many cases, urban. This can influence the action of community participation, especially regarding which groups do or do not participate, who represents

groups, and who makes those choices. A focus on community as collectivity may also represent notions of uniformity, restricting the recognition of strengths inherent in the diversity of views and experiences within any community (Hickman, 2004).

Simultaneous identities, shifting identities, and membership of multiple communities are often disregarded. Macpherson clearly identifies some of these issues in relation to Pacific Peoples in New Zealand.

... their identities – that is, what it means to them to be a person of Pacific descent – have begun to diverge from those of their parents and from one another. General agreement on the nature of identity is now more difficult to obtain: in place of *a* Samoan or *a* Tongan identity, one finds *various* Samoan and Tongan identities. These in turn are nested within an emerging Pacific identity which embodies certain common experiences of growing up as a person of Pacific descent in Aotearoa and which reflects the dynamic reality of being a Pacific person in a complex society. (Macpherson, 2001, p. 67)

Therefore, identity is evolving and complex, as are its links to ethnicity and culture. Identifying the ethnic composition of communities is also complex and an area of much analysis (Bedford & Didham, 2001), but a critical part of understanding community as a social dimension is the place of the interrelationships between culture and identity and common interests.

Some sections of communities do not participate, cannot participate or are blocked from participating. The groups commonly affected most by either inadvertent or deliberate obscuration include women (Cornwall, 2003; Murray Li, 1996), children and the elderly, those with disabilities, the poor, and those identified by others primarily by their ethnicity or sexual orientation. Even when groups such as women (Cornwall) and Māori (Durie, 1998) are specifically identified as members of a community, or as the community, the heterogeneity and diversity of those groups may be missed or ignored.

Community can also be used to discriminate members and non-members of social groups. Sibley (2003) suggests that community engenders the sense of border experienced between self and other. Cohen (1985, p. 12) argues that as well as containing a relational component community also reflects a 'boundary', a sense of distinction and "...simultaneously both similarity and difference." The boundary can also reflect local identity (Cuthill, 2002), but again, these social and relational borders and boundaries are flexible, contested, and importantly individual.

The analysis of the concept of community contains key issues for community as actor in community participation. Alperson (2002) identified how community, especially when representing spatial or common interest groupings, can be identified as a normative descriptor. The definitions by Hillery (1955), King (2000b) and the WHO and the United Nations Children's Fund (1978) are all normative. They include what Mayo (2000) perceives as ideal-type, romantic components. Other authors (Lauderdale, 2001; Skidmore, 1994), have described abstract perspectives of community including cohesiveness, collectivity, and homogeneity and stability, which Sartwell (2002) argues really means stasis. Importantly, Campbell and Jovchelovitch (2000, p. 264) argue that "... it is *through participation* that the key constituents of community are enacted." Community, including shared identities, social representations and power are therefore created and transformed by participation. This reinforces the argument that community is evolving and the space of participation is changeable and changing.

Community as the physical space for participation

Community is not only the actor; it is often the physical-social space for participation. This has special relevance for analyses of community participation in health development as community, as a site for health interventions, has its own particular meanings. These meanings reflect perspectives on where community participation in health is assumed to take place or is deliberately positioned.

In the health sector, community may be identified as the 'other', the place outside of specific institutions, generally hospitals (Lewis, 1999). This generally only refers to particular types of organisations as some health institutions are identified as situated within the community space. These include primary health care clinics and community pharmacies. Community may also be identified as the situation for behaviour change (Hawe, 1994), a setting and venue for health promotion, and the type of organisation implementing the programme (Easterling et al., 2003b).

Etic and emic perspectives of communities

Much of the literature on community participation provides an etic perspective of communities, one constructed by others. This outsider position can create problems, the most common being different understandings between members of communities, (the target for interventions), and those charged with organising or providing the programme. Understandings of communities held by professionals can be restricted and restrictive (Mayo, 2000). Ideas about how communities function may be imposed (Wayland & Crowder, 2002), and outsiders "... often neglect to take into account the diversity and conflicting interests conveniently camouflaged under the banner of 'local people'" (Eversole, 2003, p. 783).

Another problem is that communities can be 'constructed' by others. In a study of community participation in the United Kingdom Jewkes (1994) identified how non-community members working mainly on *Health for All* projects 'constructed' communities using what were symbolic boundaries. These boundaries enabled the non-community members to separate different community groups from each other, but were ideological rather than practical. Jewkes (1994, p. 4) argued that the construct of 'community representative' was "... an illustration of the belief that 'communities' so constructed are 'real'" and yet the community representatives only represented a privileged section of the voluntary sector. When the conceptions of a community are

based on etic perspectives of perceived commonalities of experiences and interests, and these perspectives are used as the basis of health programmes, then participation in the programme may not occur, may be restrained, and the viability of programmes threatened.

Complete agreement about a definition of community would be impossible to reach and would probably be of little use in practice, but the multifarious definitions and uses of the term community do mean that identifying community as the actor in participation is complex, and there are many possible implications of each of the ways that it may be defined. Not all authors have sidestepped the problematic of community in practice. Many of the documents providing analysis of the challenges of implementing the recommendations of Alma-Ata include identification of issues and some offer potential solutions (for example, Ahmed, 1978; Fonaroff, n.d.; Oakley, 1989; Tarimo & Webster, 1994; WHO, 1985). The solutions generally include consideration of ways of accessing community voices and partnership with or development of community organisations.

Approaches to accessing community voices

In discussing the range of candidates seeking election to DHBs, and identifying this diversity as illustration of "... strong support for community involvement in health" the then New Zealand Minister of Health stated "(t)he whole purpose of having a *community voice* in health is to ensure boards *truly reflect* the communities they serve. But this can only happen if *groups* put forward strong candidates and support them" (emphasis added, A. King, 2004, p. 1). This quote portrays some of the complexities about community members providing voices of the community, also needing to reflect the community, and a focus on groups. It is also difficult to clearly differentiate community actors because there is so much overlap in the use of descriptors such as community, citizens, the public and people. The only group which is occasionally addressed separately is that of health service users and patients, generally because this group is identified as having a particular self interest (Mooney & Blackwell,

2004), or personal experience (Sergeant & Steele, 1999) with the health service.

There are three broad and overlapping ways in which accessing community voices (including citizens, public and people) is enacted in practice: the census approach, the identification of common groupings, and the application of notions of representation.

Census approach

At one level the census approach, where each member of a community could potentially be involved, fits closely with early ideas of community participation grounded in distinct localities. Here most community members could be involved in an activity, because of numbers, proximity, or access to resources. For example, a case study of the use of a ‘census-based, impact-oriented’ approach to primary health care in Bolivia (Perry et al., 1999) was based on identifying each resident and ascertaining their views on health priorities. Contrasting in scale, a modified census approach included the distribution of twelve million survey forms in the United Kingdom, seeking feedback on National Health Service priorities. Anderson and Florin (2000, p. 1554) described this latter activity as an “... overly simplistic approach” to consulting the public.

Common groupings and organisations

Approaches which identify common groupings within communities meld with locality and common interest definitions of community. One categorisation, identified by health services, is of communities of interest or target groups, including ethnic groups, minority groups, older people, service users, localities such as neighbourhoods, and the general public (Labyrinth in Smithies & Webster, 1998). Another similar grouping is of organised groups and special population groups, who may be considered as marginalised or at risk of exclusion (Fonaroff, n.d.).

Much attention is given to processes of identifying and gaining the participation of recognised groups rather than addressing the issues related to involving the general public, who were often not thought to be particularly interested in involvement for a range of reasons (O'Neill, 1992). These groups, which may be nongovernmental organisations or voluntary associations, were originally labeled as health development structures (Baum & Kahssay, 1999; Loewenson, 1999; WHO, 1994) and more recently, with the further focus on citizenship, as local civil society organisations (Laris, Baum, Schaay, Sanders, & Kahssay, 2001) and civil society (WHO, 2001, 2002).

Some organisations or roles are specifically developed as vehicles for community participation and it is common that these groups include a mix of community members. Community health groups, such as village health committees, may provide a process and organisational structure for community participation in some countries (Khuwaja, 2000), and that group may be involved in the management of health facilities and any volunteer health workers (Uzockukwu, Akpala, & Onwujekwe, 2004). In countries such as Aotearoa New Zealand, specific roles may include membership on health service governance boards or on community development boards.

With an increasing focus on partnerships and collaboration with community groups some issues have been identified. Community groups, not developed specifically as a vehicle for community participation, may not have formal organisational structures (WHO, 2004b). Group representatives may have limited mechanisms for consultation or feedback to the membership of those groups. As Williams (2004) identified in a description of community participation in South Africa, there was no particular framework or regulations regarding what constituted a community organisation, no formal feedback mechanisms were in place, and the organisations did not necessarily have membership lists or constitutions or regular meetings. Authors (Crowley, Green, Freake, & Drinkwater, 2002, p. 320) identified how "... a criticism commonly leveled at community involvement exercises is that they attract the

same group of ‘professional meeting-attendees’ or establish a self-sustaining clique, which is unrepresentative of the wider community.”

Leadership within organisations is always critical to their success and Woelk (1992) suggests that in the initial stages of a health programme, full community representation may be less of a priority than competent group leadership. That leadership may also include identifying other potential community members who have demonstrated an interest in health concerns within the community. This can be a pragmatic response to a complex issue of representation (Lockett-Kay, 2005). Community leaders are often identified as natural representatives of communities, although Rifkin (1986) argues that it is a fallacy that community leaders will always act for the best interests of all people. There are also different interpretations of who community leaders may be, for example civic leaders or those of local organisations (Silver, Weitzman, & Brecher, 2002).

Community representation

A representational approach within community participation is complex mainly because of the inherent challenges of representing something as undifferentiated as community. Representation can be descriptive, whereby the representatives are prescribed according to their own demographic characteristics. It may be substantive, when more attention is paid to whose interests are served by the representative, or by “*acting for others*” (Pitkin, 1967, p. 12). It can be constitutional, in representing others or “... speaking for common values and politics” (Clark, 2001, p. 8). Organisation of representation can also attempt to reflect the main areas of dispute or disagreement, or to remedy perceived or actual non-participation of some groups (Coelho, 2004). It is becoming more common to see representation, mediation and advocacy interlinked (Mohan, 2001) so that representatives focus their skills on assisting excluded groups to set up their own organisations, rather than speaking for them (Clark).

The main critiques of representational approaches are that they can result in selective participation (Botes & van Rensburg, 2000; Jewkes & Murcott, 1998), representation can become a pseudo-professional activity (WHO - Regional Office for Europe, 1991), and that representation, as a voice, does not necessarily mean influence (Cornwall, 2003). When community organisations are the vehicle for participation, there may be conflicts as to whether the organisation represents the wider community or the specific concerns of the organisation (Sullivan et al., 2003).

Rationale for 'community' as the participant

In relationship to participation, community can be used as a catchall phrase for local people, who already have some social organisation in place (Ahmed, 1978; WHO, 1985), whose understanding or involvement in common problems may increase their motivation to act (Agudelo, 1983), and whose human rights open a space for them to be involved in matters which affect them (WHO & the United Nations Children's Fund, 1978). Those local people also have human, financial and knowledge resources, identified as "... a lay health resource" (Nakajima, 1992, p. 3) which can be used for the common good in improving population health, with services brought closer to those people, and practices developed which are congruent with local knowledge and culture. Community is also the space where people live their lives, and where the determinants of health operate through individuals, families and whānau, to create health. This includes providing the majority of 'health care', which is non-professional in nature (Levin, 1992). Oakley (1989, p. 3) states:

... the scientific knowledge needed to radically improve the health of the majority of the world's population already exists and that what is mainly required is knowledge of how to achieve the massive, widespread involvement of people themselves, not just in supporting the health services and enabling them to function, but what is more important, in determining health priorities and how to allocate scarce health resources.

Understandings of community create a particularity of the space for participation, specifically community participation. That is a complex space. In summary, there are inherent complexities of community as the actor / participant:

- There are multiple, varied and overlapping ways of defining and understanding community. These include: community as related to locality, geography and place; target groups; collectivity and identity; as a physical space for participation.
- Etic and emic perspectives of community are in play.
- Differing rationale for community (as the participant) exist.
- There are multiple ways of accessing community voices.
- There are complex disciplinary critiques of community and its application in practice settings.

This complexity is then intertwined with the challenges of participation.

Participation as a social practice

Social participation is generally identified as inherently good and empowering for individuals and societies. At the same time it may reinforce the exclusion of some groups and may reproduce inequalities (P. Jones, 2003). The ‘goodness’ of participation can be seen in some of the positive, value laden descriptors used in relation to participation. ‘Good’ participation may be genuine (Dudley, 1993; Hildyard, Hegde, Wolvekamp, & Reddy, 2001), true (Botes & van Rensburg, 2000; Dudley, 1993; Hollnsteiner, 1977), active (Mora Ramirez & Lopez Orozco, 1976), responsible (Tandon, 2002), authentic (Midgley, 1986a), meaningful (Gaventa, 2002) and effective (Clark, 2001; Greene, 2003). In contrast there is little written about adverse participation, except as a critique of imposed participatory processes. There is also some emerging research which demonstrates how some types of social participation may be distressing to participants (Berry, Rodgers, & Dear, 2007).

Participation as drawing together many actions

Descriptors arise because of the range of activities and processes which are drawn under the umbrella of the singular term of participation. Authors use devices such as scales (Mosse, 2001), ladder analogues (Arnstein, 1969), modes (Hollnsteiner, 1977), degrees (Brager & Specht, 1973), typologies (Pretty, 1995), and types (S. White, 1996) to present continuums or hierarchies of participation. These continuums / hierarchies extend from degrees of non-participation, minimal input or tokenism, which is often orchestrated by a top down approach, to idealised complete community or citizen control and empowerment, with a range of levels or steps in between. The range of actions, drawn together under the term participation, is expansive and includes informing, education, consultation, and partnerships within programmes.

Most of these devices position power relationships as central to the differences although various ‘types’ of participation may be more appropriate in specific situations or at different times, especially within a project cycle. Consistently running through analyses of participation and across disciplines, are concerns about the relationships between participation and power, and specifically how power is constructed, changed, concealed, and reproduced in forms and structures of participatory practice (Barnes, Sullivan, Knops, & Newman, 2004; Chambers, 1995; Milewa, Dowswell, & Harrison, 2002; Nelson & Wright, 1995; G. Williams, Veron, Corbridge, & Srivastava, 2003).

There is some recognition regarding the balance needed between the quality of participation and quantity. More participation is not necessarily better participation (Berry et al., 2007; Contandriopoulos, 2004). Other authors take a ‘developmental’ approach to participation and argue that “... it is by going through the process of participation that participation is learned and actualized in the public sphere” (Guareschi & Jovchelovitch, 2004, p. 314).

Benefits of participation

The arguments for participation are many and are directly related to the types of actors (enacting their social roles), for example users versus community versus citizens, and also the types of participation. Broad social arguments for, and purported benefits of, participation include the development of a sense of community and individual and collective responsibility, social development, and increased social integration (Midgley, 1986b), social inclusion (Harrison, 2002; P. Jones, 2003), community empowerment (Chambers, 1995; Paul, 1987), political, social, and cultural transformation (Mayo & Craig, 1995) and conscientization (A. White, 1982). These expansive benefits are difficult to assess or measure, especially in a short project timeframe, and are also likely to reflect the effects of multiple variables rather than solely participation per se.

Actors have many personal and collective motivations for participation. For example, in a case study of a community health committee in Melbourne, Australia (Boston, 1999, p. 75), participants attended the committee meetings for a wide variety of reasons including to stay in contact, to meet new people, to check the use of health resources and to "... make Australia a true multicultural country". These rationale could be linked to many theoretical analyses, for example the development of a sense of community or of social capital (Baum & Ziersch, 2003), or of social networks (P. Jones, 2003; Putnam, 2000; Rissel, Khavarpour, & Butler, 2001).

Other benefits of participation are more constrained and often related directly to specific projects, actions or services. These include cost sharing, increased project efficiency and effectiveness (Paul, 1987), increased community sense of responsibility, and self reliance from direct involvement in projects (Hollnsteiner, 1977), better use of human and local resources (Bugnicourt, 1982), use of local knowledge, and counterbalancing expert (outsider) perspectives (Hollnsteiner; A. White, 1982).

Categorising perspectives of participation

Oakley (1991) categorised these perspectives of participation in a number of ways, including the arguments for participation as a means or ends and as three main interlinked groupings. Those groups are of participation as contributions, participation as organisations, such as nongovernmental organisations, and participation as empowering. Although there are some changes in the description of the concept of community participation over time, these categorisations are still clear in the literature. They also signify points for analysis.

A more common categorisation of community participation relates to the intended uses and outcomes, and a typology of means and ends imperatives is widely used. In the first, community participation is identified as the means to enable health projects and services to operate. This may be by a combination of preset and top down objectives such as the community providing financial and resource support, increased efficiency related to the community having buy-in and ownership, and importantly, by drawing on community interrelationships to increase service efficacy and maintain programme relevance (Asthana & Oostvogels, 1996). This approach may also be a “... *utilitarian* effort” (Morgan, 2001, p. 221), when community resources, such as land and labour are used by governments and donors to offset service costs. It is also described as “... technological or target oriented” (Mosquera et al., 2001, p. 52) and it fits with development literature whereby ‘functional’ and ‘instrumental’ modes of participation have been identified. Cornwall (2003, p. 1327) argues that the functional mode of beneficiary participation operates to “... enlist people in projects or processes, so as to secure compliance, minimize dissent, (or) lend legitimacy”. The instrumental mode, which she associates with community participation makes “... projects or interventions run more efficiently, by enlisting contributions, [and] delegating responsibilities” (Cornwall, p. 1327).

Community participation can also be perceived as an end in its own right and this is associated with critical and empowerment approaches and community and people-centered development (Morgan, 2001; Mosquera et al., 2001;

Nelson & Wright, 1995). This approach is also similar to what Cornwall (2003) identifies as a transformative mode of participation. Mosquera et al., (p. 52) argue that the means and ends approaches are diametrically opposed and that “(n)either of these perspectives explicitly recognizes that the degree and form of people’s participation depends significantly on the political and economic system in which it takes place”. The cultural heritage and history and the social organisation all mould community participation in practice.

Participation has also been linked to other conditions and concepts and again these connections relate to the actors of participation. In analysing the relationships between the MDGs and poverty reduction strategies, Maxwell (2003) links ownership, participation and empowerment as themes which are important in recognition of the political nature of poverty reduction. The World Bank (2000) relates participation to quality of life and the WHO (2004b) discusses the relationship between community participation and advocacy. Citizenship and citizen participation bring into play concepts such as governance, accountability, partnerships and the state (Gaventa, 2002; Nyamu-Musembi & Cornwall, 2004). Participation features in discussions about both participatory and representational democracy (Cuthill, 2003). Discussions about social capital also revolve around social participation (Baum & Palmer, 2002; Campbell & McLean, 2003; Cuthill, 2003; Kumar, 2002a; Lane, 2003; Liu & Besser, 2003; Putnam, 2000). As a result of the diversity of uses and perspectives around participation, attempts at singular definitions and descriptions would be fruitless.

Participation as contested

There are many analyses of the complexities inherent in a focus on participation, ranging from the ideological basis underpinning participation to its enaction in practice. At the ideological level, Stone (1989, p. 206) argues that community participation “... as promoted by international donor agencies is based on Western notions of self-reliance, equality and individualism.” In her study of a development project in Nepal she questioned the cross-cultural

viability of the concept when it is underpinned by values which may be counter to those displayed within the local social organisation.

The values and beliefs which underpin community participation, such as democracy, are rarely made overt (S. White, 1996). As multiple modes of community participation are operating within society at any one time then different values will also be present in different actions or plans for action. The desire for participation is also based on underlying assumptions, including that communities and organisations want to have the public involved and, in relation to policy development, the belief that conflicts of opinions can be accommodated (Ong, 2000). Participation has also been criticised in terms of its use on "... normative grounds" (J. Cohen & Uphoff, 1980, p. 213) rather than when participation is most appropriate. It is also often used in such a way that the complexities inherent in participation are ignored (Harrison, 2002): for example, who decides on the model of representation adopted or which actor is most appropriate.

The negative impacts of the enaction of power in participation are also critiqued. White (1996) suggests that participation may both challenge and maintain established orders of dominance. She argues that "(i)t is important to see participation as a dynamic process, and to understand that its own form and function can become a focus for struggle" (S. White, p. 6).

Who participates is also an area of debate, with participation "(h)olding out the promise of inclusion" (Cornwall, 2003, p. 1325). Three key conditions for participation include a degree of autonomy which enables freedom to participate, the ability to be involved, including skills and resources, and a willingness to be involved (Cary, 1970). All of these conditions are contested. Freedom is by itself complex. Sen, in his authoritative work *Development as Freedom*, argues that:

... freedom is not only the basis of the evaluation of success and failure [of development], but it is also a principal determinant of individual initiative and social effectiveness. Greater freedom enhances the ability of people to help themselves and also to influence the world.... (Sen, 1999a, p. 18)

Constrained freedoms restrict participation as do social exclusion, social disadvantage, poor health and poverty (Baum et al., 2000; Sen, 1999a). Non-participation (Cary, 1970) or selective participation may result. Also, an important freedom and right is that of choosing not to participate (Streeten, 2002).

The debates of the concept of participation overlay all of the documented rationale for community participation. These debates are useful in informing an analysis of community participation in health development as the concept and practice exist within the space of the general knowledge of participation and specifically community participation. In summary, social participation is complex because:

- Many actions are included within the singular term of participation.
- Those actions are then categorised in many ways.
- The purported benefits of participation are expansive, from individual to social and community.
- The challenges with participatory action are widely critiqued.

Community participation in health development

There is a long history of institutional support for various forms of community participation within the field of health. In the 2004 World Health Report, the WHO (2004b, p. 44) cited the 1948 WHO Constitution which stated that "... informed opinion and active co-operation on the part of the public are of the utmost importance in improving health." Although Oakley (1989) suggested that there has been acceptance within the WHO that community involvement

can be distinguished from community participation, and that involvement signifies a more personal, deeper relationship, this differentiation is no longer clear in the literature.

Community participation has been included as a core component of the major primary health care, public health and health promotion strategies and international agreements, including the *Declaration of Alma-Ata* (WHO, 1978) and the *Jakarta Declaration on Leading Health Promotion into the 21st Century* (WHO, 1997). Oakley (1989, p. v), in a major review of the issues associated with the implementation of community involvement in health, suggested that it "... emerged as an imaginative new approach which seeks to bring together the formal, professional health structure and local people with their knowledge and resources." Although this may have been identified as 'new' and 'imaginative' for the health sector at that time, there had been a considerable history and acceptance of community participation in other fields (Oakley, 1989; Ugalde, 1985).

Describing community participation in health development

Identifying that a single definition of community participation would be problematic (Rifkin, 1986), and not universally applicable, many authors have provided definitions or descriptions of community involvement or participation in health development as highlighted in Table 4.

Table 4 Selected definitions of community participation / involvement in health development

<i>Year</i>	<i>Author</i>	<i>Definition / Description (emphasis added)</i>
1978	(WHO & the United Nations Children's Fund, 1978, p. 50)	"... the <i>process</i> by which individuals and families <i>assume responsibility</i> for their own health and welfare and for those of the community, and develop the capacity to contribute to their and the community's development. They come to know their own situation better and are motivated to solve their common problems. This enables them to become agents of their own development They therefore need to realize that they are not obliged to accept conventional solutions that are unsuitable but can improvise and innovate to find solutions They have to acquire the capacity to appraise a situation, weigh the various possibilities and estimate what their own contribution can be. While the community must be willing to learn, the health system is responsible for explaining and advising, and for providing clear information about the favourable and adverse consequences of the interventions being proposed, as well as their relative costs."
1981	(World Health Assembly cited in Fonaroff, n.d., p. 21)	"... a <i>process</i> by which partnership is established between government and local communities in <i>planning, implementation and utilization of health activities</i> in order to benefit from increased <i>local self-reliance</i> and social control over the infrastructure and technology of primary health care."
Circa 1983	(Fonaroff, n.d., p.22)	"... collective, purposeful community action which covers all members of the community and which can be either voluntary or officially sanctioned."
1985	(WHO, 1985, p. 12)	"... an inherent quality of life, ... a common activity of people for centuries. Community involvement is also central to all aspects of human development of which health is but one. Although the nature of community involvement will vary from society to society, it is essentially the process by which <i>people strive to better themselves</i> and seek legitimacy for their actions. People have the right to community involvement and this right is not a suddenly discovered feature of human society but a renewed recognition of community involvement as a central value of all human activity."
1988	(Rifkin et al., 1988, p. 933)	"... social process whereby specific groups with shared needs living in a defined geographic area actively pursue <i>identification of their needs, take decisions and establish mechanisms</i> to meet these needs."
1988	(WHO, 1988, pp. 10-11)	"Community involvement addresses itself to the task of mobilization, putting in motion a widespread <i>process</i> of collective organization and involvement which leads to increased human and material resources at the local level being channeled into development efforts. It seeks to create support mechanisms in order to establish the preconditions for full participation and to clear the way for the required changes."
1990	(Rifkin & Cassels, 1990, p. 39)	"The term 'community participation' is open to a variety of interpretations. In some health systems participation can more accurately be described as compliance (getting people to accept interventions or act on the advice of professionals); in others the major concern is contribution (getting the community to provide material or financial support to supplement the efforts of professionals); ideally, but rarely in practice, it is concerned with <i>collaboration in planning and managing initiatives</i> ; and in others it describes activities and resources that are controlled by community members independent from the formal health system."
1993	(Morgan, 1993, p. 5)	"There are multiple definitions of participation, which range along a continuum. At one end, participation can be initiated at the grassroots level without professional sponsorship; at the other it is imposed from above, with the organizational components defined by professionals and state authorities. ... Participation is first and foremost a political symbol, by nature amorphous, flexible and adaptable."
2007	(Neuwelt, 2007, p. 83)	"The <i>process</i> of involving communities (iwi, Māori communities, other ethnic or identity-based communities, present consumers, potential consumers and community organisations) in the <i>planning, delivery and evaluation</i> of an organisation, such as a PHO. Participation can occur at many levels of the PHO, and in many different ways"

These definitions and descriptions reflect perspectives of community participation over a thirty year period. They demonstrate changing, but also remarkably consistent perspectives of community, perceptions of the desired role for communities within the health sector, the rights of communities, and the responsibilities of health organisations. Participation is frequently identified as a process, and planning and delivering programmes are identified as appropriate spaces for involvement, amongst others. Also encapsulated are the understandings of community participation superimposed over societal and social participation, and also the political nature of community participation within the health field. The challenges associated with community participation are also identified, including how it can be imposed on communities and how relationships between professionals and the community are important in shaping the participation that occurs.

Categorising approaches to community participation in health

There are a number of approaches to categorising community participation. In an analysis of case studies of health programmes from planners' perspectives, Rifkin (1986) identified three broad but critical approaches to community participation, related to the philosophical positions of the planners themselves. These positions reflected how health was defined and how the actions of communities fitted with that definition. The 'medical', health services' and 'community development' approaches (Rifkin, p. 241) continue to be reflected in the literature.

Within the *medical approach* a narrow health definition related to the absence of disease circumscribed community participation to become the "... activities undertaken by groups of people following the directions of medical professionals in order to reduce individual illness and improve the general environment" (Rifkin, 1986, p. 241). An example is the use of a network of local health agents in Ecuador, trained to undertake community surveillance of infectious diseases. As a result of this programme yaws was believed to have been eradicated (Anselmi, Moreira, Caicedo, Guderian, & Tognoni, 2003). In

Niger, community members were provided with basic education so that they could notify health professionals of the outbreaks of specific diseases (Ndiaye, Quick, Sanda, & Niandou, 2003). In this latter example, although the authors identified the community members' work as building a type of social capital, reflecting a more community development focused perspective on community participation, it appears that the community members were primarily needed to make up for health service resource deficits.

The *health services* approach is based on a more expansive definition of health, including mental, physical and social wellbeing. Rifkin (1986) identified that this approach focuses community participation on the active involvement of community members in the delivery of health services. In an early example, before primary health care and community participation were endorsed in the *Declaration of Alma-Ata*, Shah (1976) presented a case study of the use of 'link workers' in the Kasa project, India. These link workers provided a range of care related to nutrition, maternal and child health, and encouraged individual and family self-help. Although the work related to the provision of specified health services, elements of community development underpinned the whole project.

In the *community development* approach Rifkin uses the work of Sterky and suggests that health is framed as resulting from the combination of political, economic and social development (Rifkin, 1986). Rifkin argues that community participation therefore reflects active community involvement in decision making for that development. In a primary health care experiment in Karachi, Pakistan (Agboatwalla & Akram, 1995, p. 384) a community development approach is evident. The project, which was initiated by a nongovernmental organisation, utilised community members as community workers to address sanitation, literacy, income generation and health issues to "... provide a comprehensive package of socio-economic uplift."

Choreographing the community participation of others

Cornwall (2004) identifies different spaces for participation which have flexible boundaries. For example she uses the term ‘invited’ spaces to describe those spaces that provide potential for participation, whereas ‘popular’ spaces reflect opportunities for participation developed by people themselves. While spontaneous community participation in popular spaces can and does occur within health sector led programmes, the ‘invited’ spaces created for the participation are important in the shape of that social action. There are many guides to ‘engaging communities’ as ways of seeking out community members and groups. For example in a toolkit for use in the context of health organisations in Aotearoa New Zealand, “... simple rules for meaningful community engagement” are provided (Neuwelt, 2007, p. 30). These include suggestions to use community venues for meetings, to provide kai [food / drink], have childcare and interpreters available, offer koha [donation / gift] for community member’s work for the organisation, share information, and specifically to “(a)llow TIME for meetings, so that meaningful discussions can take place” (Neuwelt, p. 30). Also outlined in the toolkit were culturally appropriate ways to engage with Māori.

At a broader level an Australian Report (NSW Health Department, 2001) identified the need for action at multiple levels to facilitate community participation. At the local level it was recognised that there needed to be a commitment to participation and structures in place that included policies and guidelines for community participation. Support for community representatives was needed as was staff support for participation. Finally, evaluation of the structures for participation should occur in collaboration with community members. This report also documented responses needed at state level. All of these factors have been identified consistently over time by authors including Oakley, Bichmann, and Rifkin (1999), Rifkin (1986), and the WHO (1991).

Evaluating and measuring community participation

As Brownlea (1987, p. 605) states, “(p)articipation is supposed to make a difference” and therefore there should be some effect. Measuring or evaluating community participation has been the topic of some, but probably insufficient, attention considering the potential imbued in community participation in the international declarations of health (WHO, 1978). Those international declarations led to a rapid identification that measures of community participation would be needed (Ahmed, 1978). Initial approaches included the use of quantitative measures, translated into levels of participation, such as ‘low’, ‘medium’ and ‘high’. These measures were mainly applied to assessment of community participation in the management of health programmes (Agudelo, 1983).

Preliminary indicators of community involvement were developed at an interregional WHO meeting held in Brioni, Yugoslavia in 1985. The purpose of this meeting was to review progress regarding community involvement for health development since the *International Conference on Primary Health Care* at Alma Ata in 1978 (Oakley, 1989; WHO, 1985). The suggested criteria and indicators related to community input into policy, processes (such as training people for community involvement), outputs, effects, and finally, the impact of community involvement in terms of access to health services. Fonaroff (n.d.) argued that additional indicators related to self-reliance, and social control of primary health care infrastructure and technology, would also be required.

Evaluation at the macro level

Evaluation of the *Health for All* strategy, in which community involvement was a core principle, demonstrated the complexity in creating measures. ‘Global indicators’ were developed and Global Indicator 2 referred to the “... number of countries in which mechanisms for involving people in the implementation of strategies have been formed or strengthened, and are actually functioning” (WHO, 1987, p. 49). Although positive trends were

identified in 1987, difficulties were noted in ‘developing’ community participation. These related to the recent economic constraints, and the obstacles associated with socioeconomic and cultural factors such as poverty, illiteracy, and values. Concurrently, the author identified how any measurement of community participation and the community’s satisfaction with that process must be linked to the “... social, cultural and political conditions in each country” (WHO, 1987, p. 111).

Evaluation at the programme / service level

The WHO measured community participation at a macro level, enabling cross-country comparisons. Other authors focused their attention at an organisation or programme level. Work revolved around describing or measuring the effects as outcomes and outputs of programmes into which participation had been instilled as an input. The argument followed that if community participation, however defined or implemented, was an identified part of a health programme, then positive outputs from that programme would also reflect a positive effect of community participation. Examples included a measurable reduction in diseases such as yaws (Anselmi et al., 2003), an increase in mothers’ understanding of how to correctly prepare oral rehydration salts after an education session from a village health worker, or washing hands before feeding in an intervention group (Agboatwalla & Akram, 1995). These effects were then directly related to the specific programmatic definition of community participation (if there was one). In these cases, the medical and health services approaches to community participation (Rifkin, 1986) were to the fore.

Others focused their work on identifying specific measures of community participation. Early attempts included quantification of the number of people involved in an activity (Agudelo, 1983). Broad indicators, such as how many people attended a community meeting, or from a gendered perspective, the proportion of women interviewed (MacCormack, 1992), have been included in many programme evaluation reports. These provide a relatively crude measure

but a point for comparison. Of course attendance at a meeting does not necessarily reflect active participation (Rifkin, 1986), quality participation, (Rissel et al., 2001), or the sharing of power.

Others provided combined evaluations of both health outcomes and measures of active community participation. There are many qualitative, descriptive case studies which describe the processes and effects of community participation. A comprehensive evaluation of efforts to improve perinatal health in Turkey, based on active community participation (Turan, Say, Gungor, Demarco, & Yazgan, 2003) used five indicators: community group knowledge and skill gains; community group participation in decision making; group continuity; community group continuation of the health program; and advocacy initiation. Positive outcomes of both increased community capacity and population health improvement were identified.

Specific measuring tools

Specific tools for measuring community participation as it is integrated into either organisational practice or health programmes have been produced. Rifkin et al., (1988) developed a pentagram model. This measure, developed deductively from factors related to community participation identified in case studies, provides a descriptive model underpinned by a neutral perspective of the value of participation. Uses of the model include enabling longitudinal comparisons of community participation in a programme, identifying potential areas for improvement, and locating contrasting perspectives from different participants within the same programme. Although the authors identify a close relationship between equity and participation in primary health care, especially related to the participation of those identified as the poor, the pentagram model does not provide a continuum of this factor and this is an area needing further research (Bjaras, Haglund, & Rifkin, 1991; Rifkin et al.).

The pentagram type of model (also called spider graphs) has been widely used and adapted as described in Table 5. The factors measured have been broadly

aligned in this table, although not all authors provided conceptual definitions of their process indicators for comparison.

Table 5 Models / toolkits using the pentagram model

<i>Models / toolkits</i>				
<i>Authors</i>	<i>Rifkin</i> (Rifkin et al., 1988)	<i>Chilaka</i> (Chilaka, 2005)	<i>Fairfax et al.</i> , (Fairfax, Green, Hawran, South, & Cairns, n.d.; South, Fairfax, & Green, 2005)	<i>Neuwelt</i> (Neuwelt, 2007; Neuwelt et al., 2005)
<i>Focus of tool</i>	Programme assessment	Cross-country comparison	Organisational self assessment tool, United Kingdom	Organisational self assessment toolkit, Aotearoa New Zealand
<i>Examples of use</i>	Sweden (Bjaras et al., 1991); Aotearoa New Zealand (Eyre & Gauld, 2003); Nepal (Bichmann & Chaulagai, 1999); Tanzania (Schmidt & Rifkin, 1996)			Aotearoa New Zealand (WRPHO, 2008)
<i>Components / process indicators</i>	Needs assessment	Needs assessment	Opportunities	Consultation and decision making
	Leadership	Political commitment	Diversity	Links to wider community Māori responsiveness
	Organisation	Community organisation	Procedures Communication Staff support	Organisational structure
	Resource mobilisation	Resource mobilisation	Resources	Use of resources
	Management	Programme management		Consultation and decision making

In the original work (Rifkin et al., 1988) each factor (process indicator) is scored against a continuum related to a judgment of whether participation is narrow (for example, dominated by professional decision making) or wide (for example, active community participation, including planning, implementation and evaluation by the community with health professionals acting as a resource), or at a point in between. Specific descriptors are presented for each point on the scale. When the continuums are aligned in a spoke configuration at the point of zero, connections can be drawn between the spokes, providing a

visual descriptor of the breadth of participation in the particular programme (See Appendix Two). Some authors (Rifkin et al., p. 934) argue that the lowest score possible is one rather than zero because "... there already exists some participation which people undertake to meet their health needs." Importantly, no correlation is made between community participation and improved health status. The issue of whether community participation can and does positively influence health outcomes is widely debated (Crampton et al., 2001), but "(t)his lack of evidence is not the same as absence of effect" (Russell & Smith, 2003, p. 763).

In the Tanzanian study a number of benefits and limitations of the model were identified. Benefits included clarification of community involvement problems, development of a common language as the research team understood community perspectives of community participation, and health managers' better understanding the experiences of the community (Schmidt & Rifkin, 1996). Differences in comprehension of the ranking scale resulted in the limitations. Problems included a culturally specific understanding of leadership, confusion with indicators related to management and organisation, concern that some dimensions of participation were missing, and problems of 'bias' related to involvement of research team members who also had responsibility for parts of the health project (Schmidt & Rifkin). Researchers in Aotearoa New Zealand suggested possible additional dimensions of "... 'sustainability of participation', 'equity in participation' and 'the dynamic socio-political context'" (Eyre & Gauld, 2003, p. 189), although it is unclear how these could be easily integrated. A recent study (Chilaka, 2005, p. 990) uses the same pentagram configuration to draw cross-country comparisons of a 'community participation value' (Cp value), which is the sum of five process indicators. Chilaka's work presents a new measure which needs further research to test its validity, reliability, and comparative value.

When community participation is conceptualised in relation to broader perspectives such as increasing community capacity, social capital, empowerment and community development, then different evaluation

approaches are required. Community perspectives are deliberately sought out and different research approaches are being utilised (Ndekha, Hansen, Molgaard, Woelk, & Furu, 2003; Ramella & Bravo De La Cruz, 2000; Sanderson & Kindon, 2004). Boyce (1993, p. 92) argues that measurement approaches such as the pentagram model (Rifkin et al., 1988) reflect an “efficiency” paradigm based on utilitarian-liberalist perspectives and that a different paradigm is required to capture broader outcomes. There also needs to be recognition that “... both the collection and interpretation of evaluation data are systematically biased in favor of those with influence” (Boyce, 1993, p. 92). He suggests that an empowerment paradigm would be based on an understanding of the negative influences of power inequalities on participation.

Rather than concentrating on one perspective over the other, Rifkin (1996, p. 88) suggests that both the “... target-oriented and empowerment frames” have relevance but, by themselves, are too limiting. She argues that:

It is no longer useful to formulate questions in terms of whether community participation has the objective of adding resources or empowering people; is a means for health improvement or an end in itself; whether participation must be active or merely passive; whether it means that professionals or community people should control the programme; whether community participation is a process or a product in a health programme, whether community participation should be evaluated in quantitative measures or qualitative assessments. Rather, it now can be argue [sic] that these apparent differences should both be examined and both make contributions to our understanding. (Rifkin, 1996, p. 88)

Conceptual and practical challenges

There is general agreement across disciplines that evaluation should be planned (Laris et al., 2001), programme values and terms need to be clear (Hawe, 1994), and participatory claims realistic (Hickey & Mohan, 2005). Disentangling the effects of other factors, such as social and political factors, is

difficult (Oakley, 1991; Zakus & Lysack, 1998), and long term monitoring may be necessary to identify some outcomes (Frankish, Kwan, Ratner, Warf Higgins, & Larsen, 2002), such as empowerment (Tassniyom, 1997). Other areas of agreement include that no single instrument will capture all facets of participation (Crowley et al., 2002), data collection can be costly (Crowley et al.), and that no one universally acceptable model could be developed (WHO, 1991). Seargeant and Steele (1999, p. 47) also suggest that evaluation of participation should include both process and impact and their relationships, and include "... the extent to which involvement has achieved both its general and specific purposes".

In practice it can be difficult to differentiate process and outcome measures and evaluations (Thurston, Vollman et al., 2005). Participatory monitoring and evaluation techniques may be useful (Oakley, 1989) and the methods congruent with the values and beliefs underpinning community participation, but their use is not synonymous with evaluation of community involvement in health (WHO, 1991).

A case study of public participation for women's health in Canada (Thurston, Vollman et al., 2005) identified a range of pragmatic issues relevant to evaluating participation within organisations. They identified that managers and front line staff held different understandings of the purposes and processes of public participation. Organisational staff changed frequently; therefore common understandings of public participation within a single organisation were unstable over time. Importantly, they also identified that successful strategies which supported participation often related to individual personal contacts and social networks, which are not usually included in measures or evaluations of participation.

While there is a long history of community participation in health development, as has been shown in this review of literature, as a concept, it remains disorderly and complex. Figure 3 draws together the key issues identified in this chapter that underpin that complexity.

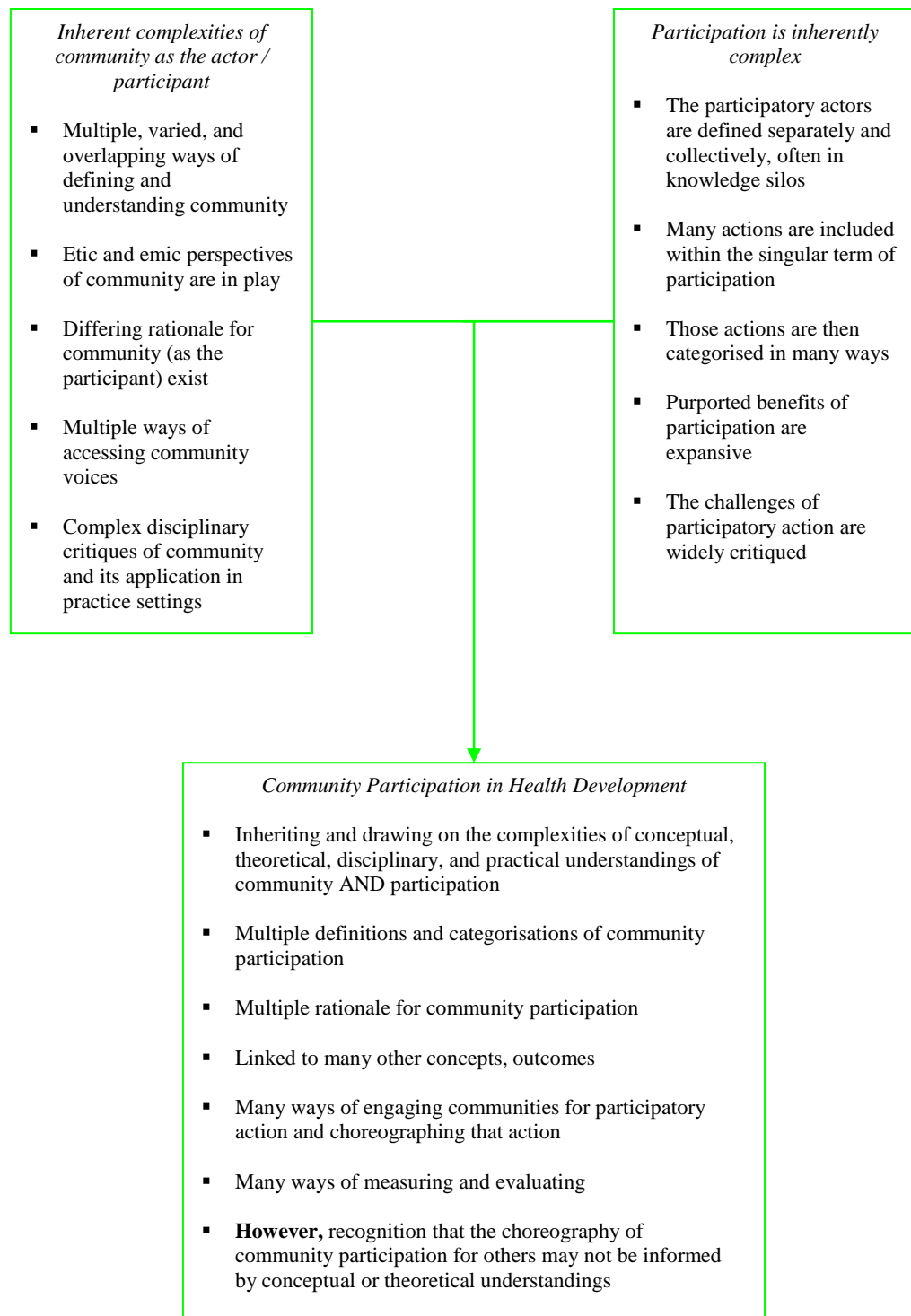


Figure 3 Inherent complexities in community participation

Areas for further exploration

There are a number of areas which are not well covered in the literature reviewed about community participation in health. Firstly, in the context of Aotearoa New Zealand, contemporary research exploring community participation in primary health care (Eyre & Gauld, 2003; Lockett-Kay, 2005; Neuwelt et al., 2005) focuses upon community involvement in organisational structures or service users' perspectives (Christison, 2001). Evaluations of community action projects (Greenaway & Witten, 2005; MOH, 2005d) provide evidence of projects into which community participation was an input, rather than being the conceptual focus of the study. There is therefore a gap regarding how community participation as a concept and policy is instigated within health programmes within the primary health care setting. The case of GABTR provided an opportunity to see how community participation and engagement, which were identified by the MOH as "... important considerations / features" (MOH, 2005e, p. 18) in programme design, were developed.

Secondly, Harrison (2002, p. 588) identifies that less attention is directed to how "... participatory agendas are generated or what they can tell us about development partnerships" and also how there is a gap between policies regarding participation and actual practice, which may reflect "... non-ideal participation" (G. Williams et al., 2003, p. 189). Partnerships are a core component of programmes in primary health care and therefore an understanding of how these are developed and maintained, as well as the space between policies and practice, is crucial.

Thirdly, in a study of citizen participation in the health sector in Bangladesh (Mahmud, 2004) a range of perspectives of incentives for community participation were identified. In the local context, there appears little exploration of the motivating factors for community participation in primary health care programmes. By researching community members' perspectives of their participation, then motivations for that participation may emerge.

Fourthly, it is argued that “(t)here is a prevailing image within the participatory development literature of communities ‘waiting to be mobilized’ through the actions of outside agents” and there is little analysis of spontaneous participation within a community space of social networks (G. Williams et al., 2003, p. 171). This informal participation (C. Williams, 2003; G. Williams et al., 2003) is identified as an area requiring more research. In this study, the research framework, based on case study and fieldwork in naturalistic community settings, offers the opportunity of capturing informal and spontaneous participation.

Finally, more research at the micro-level of participation could help to identify who participates, their experiences of participation, their identities as participants, and who they speak for (Cornwall, 2002b). Collectively, the gaps identified were used to develop the research framework and specifically the research questions as discussed in the following chapter. The broad, initial research question for this study was ‘What is community participation in the GABTR programme from the perspectives of the community?’

Summary and conclusions

This chapter has provided an exploration of the many and varied understandings and conceptualisations of community participation generally and community participation in health. The theoretical issues and practical challenges related to community participation transect disciplinary foci as health and development intertwine. Both of the concepts of community and participation are, by themselves, complex and contested and this carries over to the more specific notion of community participation in health development. The considerable body of literature, including theoretical explorations, research and especially case studies, provides multiple definitions, approaches to, and evaluations of community participation in health. It remains obvious that community participation - while now orthodoxy - provides an ongoing challenge, while what is unclear is how widely the conceptual understandings of community participation are used to inform practice.

There are some gaps in the literature, specifically related to how community members perceive their roles and actions and how these fit with other social spaces for community participation, and this is the focus of the case study. In the next chapter the research framework, including design and method, is presented.

Chapter four: Research design and method - a framework to locate the global in the local and the local in the global

Introduction

In this chapter the research framework for this study is described. Case study, as the research approach, is examined in terms of its usefulness in addressing this study's research questions and in relation to the debates that surround its utility as a research approach and output. The design of this study, as informed by theoretical positions of postmodernism and qualitative inquiry, is also presented. These positions were adopted to maintain congruence between understandings of the phenomenon of interest, the research design, my conduct, the management of ethical issues, and the re-presentation of the case. The fieldwork processes of gaining approval for the study, accessing the organisation (and programme), and the evolution of my role as a participant observer are described, as are the data collection and analysis techniques used. This exploration enables the reader to position the case study in relation to the conduct of the fieldwork. Hamel, Dufour and Fortin (1993, p. 38) describe case study in terms of singularity which is "... characterized as a concentration of the global in the local." The research framework built around case study offered a unique potential for examining a phenomenon such as community participation in the local and the global contexts.

Developing a research framework

In the previous chapters a number of overlapping contexts to the case were presented. Inherent in these contexts were many perspectives that needed to be drawn together and accommodated within this study. Those perspectives included the diversity of community, the complexity of social action as participation, and the dynamics of interactions within the health sector, and between the health sector and communities. My overarching standpoint was an exploration of health in its broadest sense. When applied to communities this

perspective can accommodate community actions as powerful, and can capture the diversity and resilience inherent in communities. Because the case study is of community I hoped to create descriptions and analyses with the community rather than about them, as suggested by Kearns (1998). Hence, my framework was informed by positions of positive health, community research, post modernism and naturalistic qualitative inquiry. These could all be integrated within a case study approach, and case study as a research approach and output will now be examined, and its fit with this study explored.

Case study

Hammersley and Gomm (2000, p. 2) argue that “(i)n one sense all research is case study: there is always some unit, or set of units, in relation to which data are collected and/or analysed.” There is a long history of case study use and development within disciplines, including development studies. This history is made complex by case studies not always being clearly identified as such (Stake, 1994), and research being retrospectively labeled by others as case study. Platt (1992, p. 17) argues that the use of case study “... has often been imprecise, carrying ideological connotations rather than analytical denotation.” The history of case study as outlined by Hamel et al., (1993) positions the method at the forefront of the development of anthropology and sociology. This history provides links to its relationship with the Chicago School and social constructionism and interactionism, and its focus on the development and use of particular methods. Fieldwork, participant observation, multiple data sources of observation, individual interviews, combined with emic perspectives from community research are augmented by case study’s links with social survey and monographs (Hamel et al.).

Scholz and Tietje (2002) also provide a detailed description of the use of case studies in different disciplines. The disciplinary focus and framework of knowledge generation and application moulds the use of case study so that, for example, the case study of educational programme evaluation is qualitatively different from the concentration on sustainability and the testing of models in

case studies in natural sciences. The use of the teaching case in medicine, where novelistic case studies are used for description of concepts, explanation and examination of diagnoses as well as therapy, differs from the development of case description used in law education. In summarising "... teaching and researching by means of case studies should be conceived of as open learning approaches that encourage community involvement – an active, democratic approach" (Scholz & Tietje, 2002, p. 23).

The diversity of application of case study and the depth of disciplinary focus in its development account for the different perspectives taken by authors who now write about case study. It is therefore the researcher's responsibility to outline specifically their individual selection from the range of possibilities of approaches to case study and to explain how that selection is operationalised within the research.

Defining case study – many approaches to the study of a case

Case study was chosen as the research approach for this study because of the centrality of the case and contexts in its focus. As was examined in the previous chapter, community participation as social action is contextually specific and so interaction between the case and its environment was crucial. However, there are many forms of case study. Gerring (2004, p. 342) identifies case study as a "... definitional morass" and outlines confusing uses of case study to mean a qualitative study, ethnographic and fieldwork investigation, a study with a small sample size, and process tracing. As Gerring argues, none of these adequately define case study and case study can be positivist, or descriptive, interpretive and theory building. An additional layer of confusion arises from case study being both the process of studying cases and the product of the research (Merriam, 1998; Stake, 1994).

Definitions of case study as a research approach vary, arguably because authors give priority to different attributes and components of case study research, and the histories of disciplinary use of case study differ, as do pressures for certain

types of knowledge development within some groups. When describing case study as a research strategy Yin (2003b), a key author in case study method literature whose approach straddles both quantitative and qualitative inquiry but is more consistent with a positivistic approach, provides a technical definition which encompasses both scope and design. He posits that case study is “... an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident (Yin, p. 13).

As is encapsulated by this definition, Yin’s (2003b) foci relates to careful delineation of the case as a contemporary phenomenon, and the bounded system. He prioritises data triangulation, framing the design with a priori theoretical constructs, and generalisability. This definition is also process oriented (Merriam, 1998). Similarly, writing in the area of political science, Gerring (2004, p. 342) proposes a case study definition as “... *an intensive study of a single unit for the purpose of understanding a larger class of (similar) units*” and therefore focuses on the intensity or depth of the study and specifically generalisability. Stake (1978; 1994; 1995; 1997), who uses case study in educational programme evaluation concentrates on the case as the unit of study and although he states “(t)he real business of case study is particularization, not generalization” (Stake, 1995, p. 8) he offers an alternative construction of “naturalistic generalizations” specific to case study (Stake, 1995, p. 71).

Dimensions of case study are emphasised by Hammersley and Gomm (2000, p. 2) who identify the most important dimension as the “... *number of cases investigated*” and the interrelationship with the “... *amount of detailed information* that the researcher collects about each case studied.” The relationship between these two dimensions is crucial: the smaller the number of cases studied, the more in-depth that study should be. Although there are advantages and disadvantages to both single and multiple case designs (Yin, 2003b), single cases, by definition, are likely to be more in-depth investigations.

Hammersley and Gomm (2000, p. 3) also identify an additional dimension, arguing that "... case study researchers construct cases out of naturally occurring social situations." The context of researching social situations impacts on the data collection, types of data (which may be qualitative, quantitative or a combination), the analyses chosen, and the position of the researcher. The construction of cases also means that each case, to varying degrees, evolves throughout the research, with a narrowing focus (Stake, 1995). Alteration or redefinition of one component of the case will affect all other components (Gerring, 2004).

A wide variety of perspectives on the research design of case study exist and variations can be plotted along a continuum. One endpoint reflects high levels of forward planning, use of theoretical frameworks and propositions, specific strategies for data analysis, within and cross case analysis, and the prior formulation of the final format. Quantitative methods may be used. This approach is epitomised by the writings of Yin (2003b), whose background is in experimental psychology. At the other end of the continuum research design and definitions evolve throughout the research, the researcher, case and contexts are intertwined, and less attention is placed on structured analyses. Qualitative methods are used. The work of many of the case study researchers in education (Stake, 1995) and sociology (Hamel et al., 1993) are more congruent with this latter approach.

As a method of choosing and constructing cases, case study research is a research approach rather than a research methodology and there is much variation within and across disciplines in the research designs, processes, and outputs. Degrees of variation are most pronounced within the perspectives of what constitutes a case and how it is bounded, how contexts are defined, the relationship of contexts to the case, the place of phenomena and issues, comparability and generalisability, and quality judgments of case study. In this study, the variation of case study chosen is informed by with the work of Stake (1995) and Merriam (1998), enabling a stronger focus on particularisation

rather than generalisation, and on the evolution of issues within the research even though the social phenomenon (community participation) had been pre-selected.

What is a case? Identifying the local

Identifying the case is crucial: "... the single most defining characteristic of case study research lies in delimiting the object of study, the case" (Merriam, 1998, p. 27). The case is described in a number of ways. For example, Orum, Feagin and Sjoberg (1991, p. 2) provide a sociological research process definition of case study as "... an in-depth, multifaceted investigation, using qualitative research methods, of a single social phenomenon." In this instance the single social phenomenon becomes the case. Stake (2000) concentrates on a number of identifying features of cases, while recognising that there is no widespread agreement as to those features or their interrelationships. He argues that a case is specific, bounded and integrated as a system, and importantly, identifies that the definition of the case may alter during the study. The case may be an individual, an organisation such as a school, a programme or policy, a group such as a community (Merriam, 1998), a nation or group of nations (Gerring, 2004). In this research the case is that of the GABTR programme.

Selecting the case

There are many criteria associated with the selection of the case(s). Stake (1995) presents a typology of intrinsic, instrumental and collective case studies. In intrinsic case studies the researcher wants to develop a specific understanding of a particular case. Within instrumental case studies the case is of secondary interest to a focus upon social phenomena which occur within the case, rather than this particular case itself. In practice intrinsic and instrumental case studies are not clearly delineated from each other, instead "... a zone of combined purpose separates them" (Stake, 1994, p. 237). My research mainly fits Stake's (1994) criteria for an instrumental case study. The case – the GABTR programme – theoretically was of secondary interest while the social phenomenon/issue of community participation was the focus. In reality both

were intertwined. A single case study design was chosen because of the anticipated complexity of examining a programme described as new and innovative and the desire to explore the phenomenon of interest in depth. My focus was on the case, contexts and issues rather than comparison or generalisation. The study can also be described as longitudinal, from an alternative typology of case studies described by Jensen and Rodgers (2001) in which case studies can be described as snapshot, longitudinal, pre-post, patchwork or comparative.

Bounding the case

While Yin (2003b) identifies that the boundary between case and context may not be clear, case boundaries are recognised as important for delimiting and focusing the case (Cutler, 2004) and pragmatically for indicating specifically what will be studied (Merriam, 1998). Boundaries may be physical or geographic to reflect place, but may also be times, events and processes (Harling, n.d.). Stake (1994, p. 244) uses the concept of bounding as in “... conceptualizing the object of study.” An initial case study research decision involves choosing to either let the boundaries emerge (as in this study, although the programme contract provided a time limit) and is supported by Harper (2000), bounding the case, or instead constructing study propositions. This decision will frame research process and output in quite different ways.

Relationships between contexts and the case

Contexts which form the natural case setting and the case itself cannot always be clearly delineated, and the boundaries between case and contexts are fluid. Although in-depth description of contexts of the case is generally accepted as important, the rationale for this action differs. Some authors argue that full description of contexts is crucial to enable subsequent generalisation, although there is disagreement about what that generalisation entails. Stake (2000) relates the understanding and description of contexts to the holistic particularity of the singular case, with an appreciation of the number of complex contexts within which any case occurs. Contexts encompass historical, ethical, legal,

physical, political, social and personal domains. Together they form the particular situationality of a specific case. Stake (1995, p. 85) argues that the description of contexts creates part of the “... vicarious experience” of the reader who is then able to make naturalistic generalisations. In this study the accepted contextual nature of community participation provided a natural fit with the importance placed on context in case study.

Research questions and issues

Rather than choosing to develop theoretical propositions, as suggested by some authors (Eisenhardt, 1989; Yin, 2003b), I chose to adopt Stake’s position (1995) regarding research questions and issues. Stake (1995, p. 16), aligns case study within qualitative inquiry and uses “... *issues* as conceptual structure.” Issues, which may be problems, are also used to form initial research questions and are inextricably bound to personal, social, and political contexts.

In this research my curiosity and interest in the phenomenon of community participation in health promotion programmes and primary health care was the motivation for the choice of the case. As was explored in Chapter Three, theoretical explanations of this phenomenon are developing in the literature, but in the main reflect health service perspectives rather than those of the participating communities. Therefore a key motivation in choosing to use an inductive, qualitative approach, without formal theoretical constructs, was to examine community perspectives through the use of a broad, initial research question of:

‘What is community participation in the Grab a Bite That’s Right programme from the perspectives of the community?’

As a mainly instrumental case study, I chose to include community participation as the phenomenon of interest and a foreshadowed problem (which then evolved into the main issue) in the research question. The research aims, in relation to the GABTR programme were to:

- Explore how community members participate and describe their participation;
- Investigate how community members' perspectives of their involvement may change during their participation;
- Examine the contextual factors which influence community members' participation; and
- Describe the diversity of types of participation.

Within-case sampling

Formal sampling strategies are not usually part of case study research as the purpose is to study a case (Stake, 1995). Merriam (1998) identifies how two intertwined levels of sampling are usually required in qualitative studies. The selection of the case is followed by within-case sampling unless the case is so small that the total case is studied. Within-case sampling includes purposive sampling for data collection and theoretical sampling (Merriam), where the sampling is driven in response to data analysis to meet theoretical development needs rather than statistical needs. Purposeful sampling is described as when:

Cases for study (e.g., people, organizations, communities, cultures, events, critical incidences) are selected because they are 'information rich' and illuminative, that is, they offer useful manifestations of the phenomenon of interest; sampling, then, is aimed at insight about the phenomenon, not empirical generalization from a sample to a population. (Patton, 2002, p. 40)

Purposive and theoretical sampling should result in an 'adequate' sample size that enables "... by virtue of not being too large – the deep, case-oriented analysis that is a hallmark of all qualitative inquiry, and that results in – by virtue of not being too small – a new and richly textured understanding of experience" (Sandelowski, 1995, p. 183). Sandelowski's use of 'adequate' reflects factors such as the research design and questions, the choices of purposive sampling approaches, and the researcher's experience in data collection and analysis. Some authors argue that purposive and theoretical

sampling continue until theoretical saturation develops, whereby no new data are collected and the categories into which the data have been integrated are complete (Glaser & Strauss, 1967) and closure can be reached (Huberman & Miles, 2002). However, although I purposively sought out people and social activities and utilised techniques of theoretical sampling to build my analysis, data saturation was not considered a possibility. As a community study undertaken in a prescribed timeframe the case study must remain tentative and open rather than artificially complete.

In this study the plan for sampling within the case evolved. I started by developing a tentative, theoretical structure of ‘individuals as community’, ‘groups as community’ and ‘organisations as community’, and health development structures. This typology is explained in more depth in a conference paper included in Appendix Three. It was developed before my involvement began with the GABTR programme. As I learnt more about the GABTR programme my understanding of what and who could become participants in my study increased, although the typology remained relevant as a theoretical device. Different parts of the case (as programme projects) came into play in stages, and so new people became involved over time.

Data collection methods: Accessing the local

Rather than prescribing set data collection methods, case study researchers utilise a broad range of types of data and data collection methods. Yin (2003b, p. 86), whose structured approach to case study includes the development of a case study protocol, identifies six “... sources of evidence” including documents, archival records, interviews (focused, structured and unstructured), direct observations and participant observation, and physical artifacts. Although framing case study research in quite a different way, Stake (1995) suggests that the researcher use a similar array of data collection methods. Emphasis is placed on observation and description of contexts, interviews and document review, all aimed at understanding the case. The activity is framed

by the research questions and issues, and collected by the researcher choosing the best time, place and person.

Table 6 Data collection activities

<i>Data Source</i>	<i>Examples of my involvement, the quantities and the type of data obtained</i>
<i>Participant observer</i> - over 80 days based at WRPHO	<ul style="list-style-type: none"> • 15 Steering Group meetings • 7 Steering Group sub-committee meetings • 6 Community Gardens group meetings • 11 programme evaluation meetings • Visit by the Minister of Health • 2 nutrition and physical activity day workshops • Setting up / dismantling the shopping mall scarecrow display • 2 targeted plant distributions to rural areas • Many other meetings, presentations about the programme and projects
<i>Participant observer</i> - events outside of working days at WRPHO	<ul style="list-style-type: none"> • 10 events at the garden site • 2 large public plant distributions • Over 30 visits to the community garden • Attendance at a community group meeting
<i>Formal interviews</i>	<ul style="list-style-type: none"> • 23 interviews with 21 people • 1 meeting with two Ministry of Health staff
<i>Photos</i>	<ul style="list-style-type: none"> • Over 200 photos taken of people, places, events
<i>Documents and other media</i>	<ul style="list-style-type: none"> • Newspaper / magazine articles about the programme and the people involved • Programme publicity – such as GABTR newsletters • Programme proposal documents • Programme service plans, reports • Agendas, minutes and programme coordinator's reports • Organisation (WRPHO) documents such as newsletters, Annual Plan. • Other organisation's documents e.g. WDHB Board minutes, District Council minutes • Radio interview recordings

In this study multiple data collection strategies were chosen (see Table 6), including participant observation and interviews, to increase understanding of the case, contexts, and phenomenon. Congruent with the arguments of Hutchinson (1990), I anticipated that some flexibility in the selection and application of methods would be needed over time. As a result methods were adapted (for example shifting from semi-structured to more conversational

interviews) and new sources (photos) added in response to the realities uncovered in the field. Over time I maintained a summary file in which I grouped collected data and data collection activities into categories for that month and the fieldwork period. Categories included interviews completed, meetings attended, involvement in programme activities, and documents accessed.

Interviews and conversations

The interview as a data collection tool takes many guises, from unstructured, or semi-structured to structured, face to face to electronic, one to one to group, brief and a single event, or in-depth, and occurring many times (Fontana & Frey, 2003). In case study research the interview is one of a set of commonly used data collection techniques (Stake, 1995; Yin, 2003b). Interviews routinely form part of qualitative inquiry (Kvale, 1996), with various types of interviews needed at different times within any research. Minichiello, Aroni, Timewell and Alexander (1995) argue that in-depth interviewing is an appropriate approach to use to access individual's words and the interpretations inherent in those words. They state:

... if we believe (as most researchers using qualitative methods do) that social reality exists as meaningful interaction between individuals then it can only be known through understanding others' points of view, interpretations and meanings. If meaningful human interaction depends on language, then the words people use and the interpretations they make are of central interest to the researcher. (Minichiello et al., 1995, p. 73)

When events and activities cannot be directly observed by a researcher, in-depth interviewing provides access to the people involved, their verbal descriptions of their social realities, and their understandings of those events as social realities (Minichiello et al., 1995). Those verbal descriptions often contain the language and terms used in the local setting, and accessing that language assists in clarifying phenomena (Patton, 2002). It can assist in

respecting local constructions without imposing others' perspectives (Chavez, Duran, Baker, Avila, & Wallerstein, 2003). Some things and situations cannot be observed and interviewing may be the only way to access that information. Examples include past events, situations where observation is not possible, and the intentions, feelings and thoughts of individuals (Patton).

Kvale (1996, pp. 15-16) suggests that the two interlinked aspects of an interview are "... the personal interrelation and the inter-view knowledge that it leads to..." The interrelation includes both interaction and relationship as interpersonal elements, and shifts interview from being a neutral data collection tool (Fontana & Frey, 2003) to a "... moral enterprise" (Kvale, p. 109). The focus on these aspects is congruent with postmodern approaches whereby interviews and the understandings generated are reflective of the social context of the interview and "... the historical and social constructions of both interviewer and interviewee..." (Grbich, 2004, p. 120). Interviews can capture multiple perspectives of a phenomenon which are expressed during an interview or which may become clearer during data analysis across interviews (Kvale).

In this research interviews were a useful data source for a number of reasons. As the programme was already underway when I became involved, interviews enabled me to gain historical perspectives. The process of arranging interviews created a more formal space for me to talk with people I had met during my fieldwork. Each person interviewed was given a written information sheet (Appendix Four) and signed a consent form (Appendix Five). I initially developed separate forms for programme staff and community members, but the community member version was used in all but one situation. Interviews also provided me with an opportunity to explain my involvement in the GABTR programme. It gave participants an opportunity to tell me what they really wanted me to hear, and what they thought I needed to know. Initially the interviews were semi-structured, exploring perspectives about the programme and people's participation, for example, in the Steering Group. Later they became much more conversational and more congruent with the perspective of

interviews as ‘inter-views’ (Kvale, 1996). During these latter conversations my experiences with the programme also became part of the mutual exploration, as was my tentative data analysis.

I interviewed 23 people, with two people being interviewed twice. Interviews ranged in length from a brief and focused 10 minutes to over 90 minutes, with an average of 48 minutes. This time excluded cups of tea, sharing meals, and tours of personal gardens and orchards that formed an important part of the process. Interviews occurred where it suited the participant. Some were undertaken at their work and others in participant’s homes or public spaces, such as cafes. All interviews were undertaken in English, and conversations included Māori words/phrases which are in common usage. Therefore no language barriers were encountered. The overlapping roles of interviewees included community members, gardeners, members of the garden organising group, Steering Group members, and health service employees.

People’s roles did not neatly fit into categories such as ‘Steering Group member’ or ‘community representative’. I initially thought that I would mainly be interviewing community members as (artificially) separate from health sector employees. I soon found that this binary position could not be maintained. Some health sector employees were the ‘representatives’ for community groups, some members of community groups, and some community members’ interests were more specialist than general. Therefore, when quoting from transcripts I have only used an interviewee number. I have not used pseudonyms, identifiers or attempted to specify roles except in a general way. Although aware that this reduces the depth of the data presented, it was important in a small case study to provide as much anonymity as possible. Participants would have been easily identifiable if roles had been specified.

At times, for clarity, and in relation to both interviews and documented observations, I have identified the role the person or their gender, or alluded to their age in general bands only. I specifically did not collect data related to

ethnicity and age. With so much of the data collection in the study occurring via participant observation, there were no appropriate spaces for independent verification, or especially relevant for ethnicity, no chance for self-identification.

Although fascinated by what other people and groups, uninvolved - but on the margins of the programme - thought about it, especially when there were issues associated with those groups' non-participation, I chose not to intervene between the programme and those groups by seeking interviews. To do so may have created another barrier for the programme. Also, because I interviewed other community members, they often had relationships with those groups and freely reported their perspectives. I often heard from multiple sources the same reason for a group or individual not or no longer being involved.

I deliberately did not seek to interview each person at the same phase of the programme and often waited some time before requesting an interview. We could then discuss that person's actual participation rather than what they thought they might do. While mainly successful, this strategy meant that I lost contact with some who later withdrew from the programme or were no longer involved. Towards the end of 2007, a few people did not reply to interview requests. Aware that there was much dissatisfaction with parts of the programme, I had deliberately chosen to use email as the mode of contact for these people. Unlike others interviewed, who I had met on a number of occasions by "... being there" (Sixsmith, Boneham, & Goldring, 2003, p. 578) in the social action of the programme, I had either never met these people (who were listed as programme group members), or had not seen them at programme activities for months. I stated in my email that I would not contact them again if no reply was received. I had no way of knowing if the person's email address had changed, if the person did not want to be part of my study, or if the concerns about the progress of the programme were the issue.

Interviews were digitally recorded, uploaded and transcribed in full by myself soon after the interview. Personal identifying features were removed. I

recognised that transcribing interviews is a process of “... translating from an oral language, with its own set of rules, to a written language with another set of rules” and that this results in “... decontextualized conversations” rather than copies of some reality (Kvale, 1996, p. 165). I followed the option of full word by word transcription and attempted to capture broader contexts and my experience of the interview as postscripts to the transcript. I also added other contextual details, for example using ‘**bold**’ to highlight emphasis and indicating other behaviours such as laughing. (Many of the interviews were punctuated by lots of laughing, especially about gardening antics and recipes.) Whereas some authors such as Stake (1995) suggest that notes of interviews are all that is required, in a longitudinal case study where I wanted to analyse data thematically, then full transcription was required.

Participants were given the option to edit their transcripts, and three chose to do this. Minor changes were requested: clarification of points made, providing additional information, and removing details about that individual’s relationships with others.

Participant observation

Whereas interviews enable access to verbal descriptions of socially constructed phenomenon, participant observation involves both “... participation in and observation of, behaviour or action in the context in which it occurs” (Minichiello et al., 1995, pp. 69-70). This data collection strategy was crucial in an exploration of perspectives of participation and participation as social action. On a continuum from passive, detached observation to active participant observation, observation is a fundamental tool in social research (Angrosino & Mays de Perez, 2003), although acceptance of this conceptualisation based on the researcher’s role is not universal. Others frame the degrees of participation and observation in relation to researcher membership roles in groups and communities (Adler & Adler, 1994). In this study, as will be explored further in the section on fieldwork, participant observation was a key data collection activity. It enabled understandings of the

contextualisation of action to surface. Also congruities and incongruities between interviews and within the activities of participation were uncovered. For example, those that reported the most participation were rarely the ones I observed to be most involved in the programme.

Photos

Photos became important data, and a key data source. I took photographs at programme events and found these augmented observations and other data sources. I cross-referenced and included photos within my field notes. They supported and sometimes challenged my data analysis. For example, at a community garden event (see Figure 4) I observed people working in small groups, up and down the long garden beds. When examining my photos, and getting to know the people, I realised that many of these groups overlapped more than I had recalled, with members of a family in the middle of individuals from a community service group. This pattern was repeated in other photos and so I again looked at my interpretation.

Even though all of the photos were taken at public events, I was aware of the need to be careful in using them. They were open to interpretation, and could be used to show participation in a number of ways. Where possible I sought permission to take them. I obtained extra copies of my photos and, when able, shared them with the people pictured. The photos became valuable ‘discussion starters’, often followed by detailed recollections of the events. Over time, the photos also captured some of the history of the programme. For example, I gave copies of the photos of community garden events (from months before) to young people who had at that time been actively involved. They enthusiastically showed them to the newly appointed garden coordinator who was then able to connect with these young people about their prior involvement. The photos had provided a valuable link for sharing.



Figure 4 People gardening - individuals, families and groups

(Te Mana Park community garden 24/4/07)

Data analysis

Case study data analysis methods include a combination of specific approaches for case studies, such as cross case synthesis (Yin, 2003b), and general approaches of content, thematic, statistical analysis, and constant comparative analysis similar to that undertaken within grounded theory studies. While integrating common processes of qualitative inquiry, such as overlapping phases of data collection and analysis, and positioning the researcher as analyst, Stake (1995, p. 77) reminds the researcher that “(t)his is case study, not general qualitative research.” His descriptions of analysis emphasise the researcher as analyst, using the skills of observation and cognitive processes rather than structured schema for coding and categorising.

In this research, general qualitative approaches were utilised, chosen because of their potential to further understanding of the case, and to be congruent within a broad framework of postmodernism. This ideological position, which is both “... transitional and non-finite ...” in nature (Grbich, 2004, p. 18) includes consideration of aspects which relate to the researcher, the researched,

the ontology and epistemological position, and the research design and method, with perspectives that:

- The capacity to dialogue with other contextual and temporal influences is usual.
- The search for reality 'out there' is qualified by a recognition that the tools, language and processes of discovery (as well as the interpretations and actions of individual researchers) are socially and culturally constructed and require further examination.
- Not only are research processes seen as being subject to social construction, but other social processes, such as morals and laws, are also constructed discourses which have served to maintain the power bases of particular groups.
- Any borders (disciplinary, research approaches, country and culture) are also constructions that can be crossed, incorporated or reconstructed. (Grbich, 2004, p. 18)

These perspectives are all congruent with contemporary understandings of the concepts of community and participation, their social construction, embodiment in social processes, and the importance of contexts in case study.

I adopted the approach of constant comparative analysis (Glaser & Strauss, 1967), whereby all data were constantly compared with all other data and everything was data. I used an appointment diary to record brief meeting notes and plans and maintained a personal journal, a self reflection on my researcher and fieldwork experiences. This became a valuable tool for the development of beginning theoretical ideas which were later integrated into field notes.

I wrote and typed up extensive field notes daily, usually documenting three to five pages about my participation in activities and meetings, my observations, conversations held, future plans and 'mini case studies'/vignettes. I developed vignettes after recognising participants were describing or demonstrating various 'types' and components of community participation. I wrote many

‘data questions’, some theoretical and some practical, where the data posed more questions than it answered. An example was after I observed a young male inadvertently ride over part of the new garden on a motor bike. The garden, a few weeks after planting, was then, as can be seen Figure 5, covered in autumn leaves.



Figure 5 Autumn leaves hiding a new community garden

(Te Mana Park community garden 5/5/07)

I wrote in my field notes:

How does my current obsession with garden signage (or the lack of it) relate to community participation?

Signage as identity, claiming space, permanence, ownership, transformation from one space to another:

How would the young boy on the motorbike know that the garden was now there, the space use had changed (from ‘empty’ grassed park to vegetable gardens), the ‘ownership’ had changed (now leased) even though this was and apparently remains public space – but now it is no longer free space - it is occupied?

Signage as providing direction, making overt (the garden is not visible from the street)

Pointing the way, showing direction - one of the [community group] members emailed. She spent ½ an hour trying to ‘find’ the garden for the publicised event but hadn’t succeeded – thwarted participation!

Signage as providing information, inviting involvement:

There is nothing to tell visiting people what is happening, planned (e.g. for the different gardens), needs doing (hoeing, planting), how can they participate (can anyone plant anything anywhere, are there rules, how would they know this was an organic garden?), who to

contact? It therefore feels very 'random.' Lots of people report 'checking out' the garden individually. At least three people took water and watered plants when there was no rain. (Did they water the same or different plants?)

Data questions:

1. At how many meetings, over what time period, has signage been discussed?
2. How long does it take for signage to be erected after the lease was signed?
3. What information is provided on the signs?
4. What information is added to the signs over time?¹⁸

I therefore started a computer file in which I summarised the discussions, decisions and actions around 'garden signage'. Eventually, when the garden sign was installed, I had a 22 page long document of discussions and cross references about signage and related issues.

My field notes were highly personal, and both reflective and critical of my own involvement, while providing what Coffey (1999, p. 121) calls "... matter-of-factness" in detail. Field notes often remain private and the "... self remains hidden and distinct from the texts that are consumed and read by others" (Coffey, p. 121). I chose to include some excerpts of field notes in the case study, mainly so that my active involvement was not obscured. However, I controlled the selection of excerpts, and was aware the process of selecting excerpts was never a neutral activity.

Writing combined field notes, vignettes, and data questions raised some of my preconceptions and assumptions. For example, after attending the garden site blessing I wondered why so few Steering Group members (the programme 'governance' group) had attended what I thought was a 'milestone event.' On reflection I realised that I had assumed they would attend. Therefore I had to reconsider my interpretation of that data. Later I learnt of other explanations for absence, including how personal and family sickness thwarted attendance for a few. I also reflected on my own attendance - not only to support the

¹⁸ Field notes, 5/5/07, pp. 3-4.

programme and the programme coordinator - but also to collect data. Others also had multiple roles. It was only by getting to know people over time that participatory actions and motivations were clarified.

For transcript analysis I used cut and paste techniques, and while leaving the transcript as a cohesive whole, developed a matrix for each interview. This included descriptive topics, emergent themes, quotes, links to other data, and further questions. I maintained a list of combined themes from all data, including from analysis of field notes, documents, photos and vignettes. I then carried out a process of line by line analysis using a number of questions such as:

- What is going on here in the case?
- What types of community participation does this reflect?
- What are the factors framing community participation in this way?

Thematic analysis was used to analyse textual (documents, interview transcripts, and records of observations) and gain an in-depth and holistic understanding. The resultant themes are used to structure the case. There are a number of forms of thematic analysis. In this research, the data analysis approach was informed by components of the thematic analysis work of Boyatzis (1998), and qualitative data analysis of Ritchie and Spencer (2002) and Patton (2002).

In identifying the technique of thematic analysis as “... a way of seeing” Boyatzis (1998, p. 1) defines a theme as:

... a pattern found in the information that at a minimum describes and organizes the possible observations and at maximum interprets aspects of the phenomenon. A theme may be identified at the manifest level (directly observable in the information) or at the latent level (underlying the phenomenon). (Boyatzis, p. 4)

Boyatzis (1998) extends his approach past the development of themes into the production of a code which could be used to describe the decision making

process of analysis and for framing future research. In this way his use of the term 'code' as an output of analysis is somewhat atypical within qualitative method literature where 'coding' is usually identified as the process of placing data within categories. In this study, themes were developed but codes were not.

Data were analysed for both latent and manifest themes (Boyatzis, 1998), within common groupings such as the Steering Group and the Community Gardens group and also across those groupings. For example, each Steering Group meeting provided one 'piece of data', all meetings together provided a 'data set', and that compared with other data provided a combined set.

Some data were more appropriate for quantitative analysis. I therefore developed a variety of tables and Excel spreadsheets related to data including individual and organisational attendance at meetings, at programme events, and meeting length. These data were analysed using descriptive level statistics.

Triangulation and confirmability

For many authors data triangulation is inherent in case study and a strength of the approach (Hutchinson, 1990; Stake, 1995; Yin, 2003b). However, the expected outcome of triangulation varies and it is described in different ways. Hutchinson (p. 192) argues that:

... one source (e.g., documents) can confirm or refute evidence found with another source (interviews or participant observation). Thus findings that are suggested by a preponderance of evidence from multiple data sources are more likely to be accurate than those that rely on one source.

Stake (1995) and Yin (2003a) both discuss the common conceptualisations of triangulation as data triangulation, investigator triangulation, theory triangulation and methodological triangulation. Demonstrating a positivistic approach, Yin (p. 100) also differentiates between data triangulation which

results in “... convergence of evidence” towards a single fact and the non-convergence which occurs when individual data collection methods result in separate rather than combined findings and conclusions. Other authors (McDonnell, Lloyd Jones, & Read, 2000, p. 387) suggest multiple data collection methods are used to enhance rigour by “... contributing to the search for ‘completeness’ of data”, strengthening data analysis and providing analysis confirmation rather than factual verification.

Pragmatically, data were collected for triangulation in this research, but I aimed for data confirmability rather than expecting to locate facts (as is discussed further in the section on judging the quality of case studies). Some data lent itself to triangulation, such as milestone dates and meeting attendance. Other data, such as perceptions and experiences of events, were collected with an expectation of many perspectives existing.

My analysis was confirmed in a number of ways. Firstly, as my involvement with the programme spanned 18 months, issues emerged and remerged over time. For example, I noted the Steering Group role confusion in my field notes in January 2007. Throughout that year interviewees talked to me of their uncertainty about the Group role, and the role confusion played out in the decisions and discussions within the Group. Finally, an external programme evaluation identified the same issue.

Using a process of peer/member checking I asked three participants to read my case study and to comment whether I had captured the programme and their experiences of it, whether there were important points missing, or with which they disagreed. I also asked if I could have written the case another way. The feedback given was confirmatory, with comments that it was ‘true’, ‘thorough’, ‘fair’ and that it would be difficult to write it in another way.

Multiple realities – different descriptions and explanations operating independently and simultaneously

There is some discussion of how a constructionist position, which allows multiple realities, may be accommodated in case study (Lincoln & Guba, 2002; Stake, 1995) although not all authors attend to this complexity as evidenced by the discussions of triangulation towards single facts. In examining complexity in social science research, Law (2004, p. 162) identifies multiplicity as "... the simultaneous enactment of objects in different practices, when those objects ... are said to be the same. ... This arises because practices are endlessly variable and differ from one another." Different realities also interfere with each other because practices occur within the same space and overlap. I anticipated that individuals, groups and organisations would describe their perspectives of community participation differently even if those experiences all occurred within the case, an event or time. Convergence of description of facts - events, times, dates and places - could occur, but was unlikely for the meanings attached to the practices.

Multiple realities are aptly described in the application of what has become called the Rashomon principle or parable (Kusa, 2003), whereby various actors experience and report a single event differently. This brings to the fore key components of the research design and conduct. A reflexive researcher position may reduce occurrences of data sources being selected on presumptions of the potential truth value of some sources over others. Tentative conclusions (Lincoln & Guba, 2002) can hold the case open to possibilities. Findings and discussion can be identified separately or carefully interwoven, and Gilgun (1994, p. 376) suggests:

Research reports must account for the findings' multidimensionality, ... by presenting the multiple patterns of phenomena and by describing the context and conditions under which these patterns appear. These presentations are characteristic of studies using multiple sources of evidence and represent dimensions of thick description.

In this research different perspectives are presented within the case to illustrate the contexts, case and its issues. Some counter or contradict other data. Figures have been incorporated into the case that present the “... polyvocality of social life” (Coffey, 1999, p. 118) and layering of different experiences and perspectives embedded in thick description. These figures have been developed to portray the multiple voices and perspectives of an event (the planting day at the community garden – see Chapter Six, p. 182), issues within the social action in the case (the challenges inherent in one of the programme groups – see Chapter Seven, p. 235), and multiple perspectives on one issue (different ideas about the purpose of the Steering Group – see Chapter Eight, p. 290). The polyvocal figures demonstrate ways in which the case and contexts intertwine, how social action is simultaneously past, present and future focused, and multiple perspectives co-exist, consistent with a postmodern inquiry. It also enabled me to own my part in the construction of the case. In developing this technique, I have drawn on the approaches of ‘simple’, ‘complex layering’, and ‘data display’ described by Grbich (2004). Figure 6 portrays how components of the research design and method overlapping with the chosen research focus are drawn together in the figures.

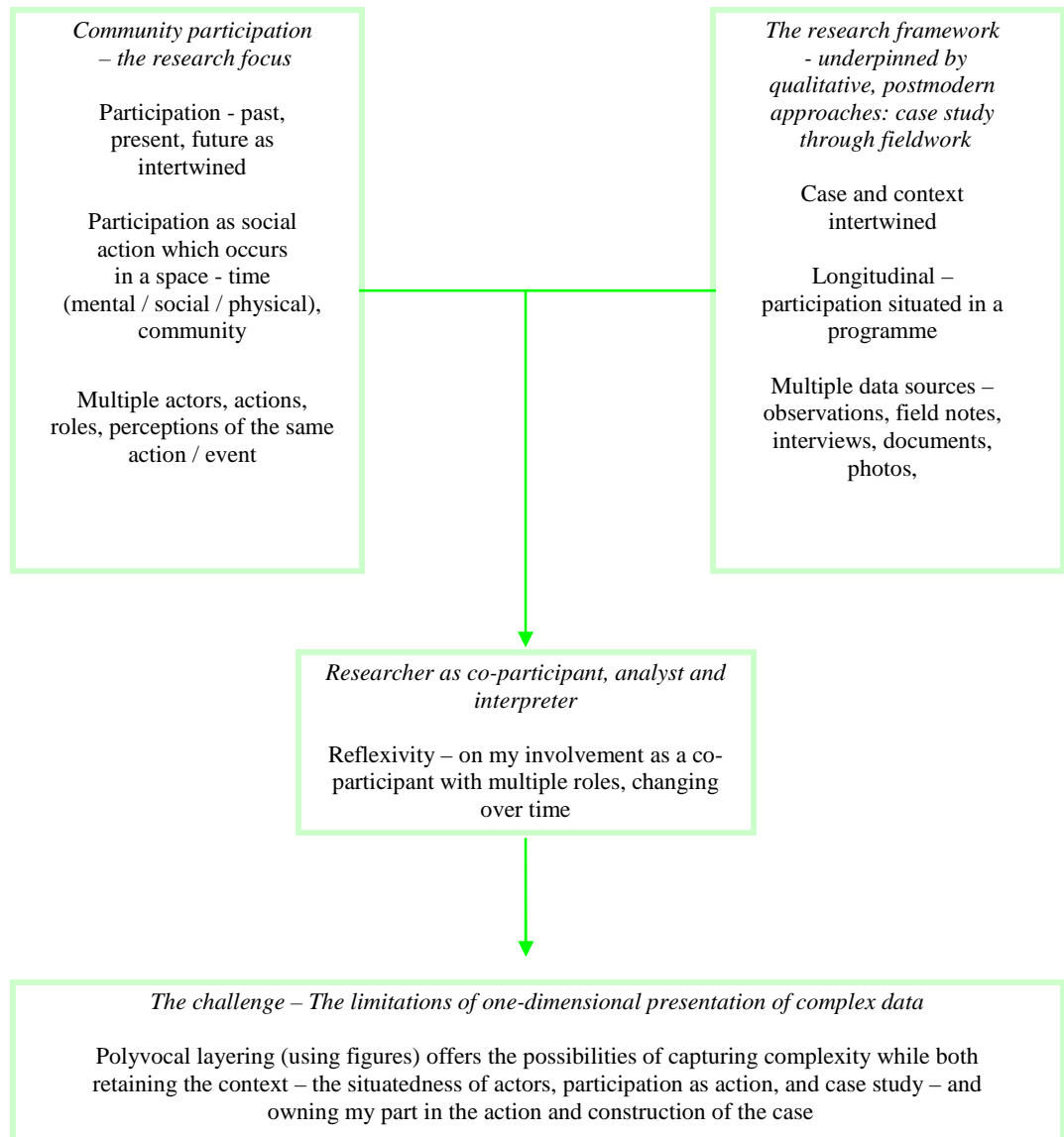


Figure 6 The rationale for the development of polyvocal layering

Agreement exists that case studies undertaken using qualitative inquiry will contain a depth of description, often identified as ‘thick description’, as a core approach to representing the case and analysis (Hamel et al., 1993; Merriam, 1998; Stake, 1995). Thick description is variously defined as “... the complete, literal description of the incident or entity” (Merriam, pp. 29-30), and the presentation of research in such a way as to try to “... establish an empathetic understanding for the reader through description ... conveying to the reader

what experience itself would convey” (Stake, 1995, p. 39). Geertz (1973), who uses the notion of thick description and attributes it, and its correlative of thin description, to the work of Gilbert Ryle, presents a more complex perspective and calls for the use of layers of interpretation. In this research layering of interpretation has been developed by representing analysis of issues and events in a number of ways and within a number of themes. Photos, field notes, sections of documents, my interpretation of observations, as well as interview excerpts, have been included within the case. Participant’s speech within quotes has been minimally edited (as were my own field notes) for clarity. But in doing this, and in choosing the quotes for inclusion, I tried to heed the concerns of Maynard (1997) who argues that the participant’s voice can be denied in the process. Merriam (1998, p. 194) argues that:

While the final write-up or case report may have a greater proportion of description than other forms of qualitative research in order to convey a holistic understanding of the case, the level of interpretation may also extend to the presentation of categories, themes, models or theory.

In this research the case is presented using descriptive phases and themes. Those authors who position case study within qualitative inquiry put varying degrees of focus upon presenting a descriptive narrative of the case with separate analysis, or alternatively presenting a combination of vignettes, description and discussion (Merriam, 1998). Although vignettes were developed during data analysis, they have not been included in the case as it would have been impossible to maintain the participant’s anonymity. Consistent with the variety of approaches to theoretical propositions and a priori knowledge and its place in case study, there are a range of perspectives associated with the use and integration of literature into case study. I have chosen to integrate literature, as suggested by Eisenhardt (1989), into the case study, as is common within qualitative inquiry, to provide comparisons of the findings with literature which may contain similar or conflicting perspectives.

Inferences and generalisability: Case study as local and global?

As has been described, there is debate about the nature and purpose of case study (Hammersley & Gomm, 2000) and as a result there is also contention as to how findings relate to other research, cases and contexts. As research should be able to pass a "... utility critique" (Sandelowski, 1997, p. 125) and demonstrate its usefulness beyond this piece of research, the relationship of this research to other knowledge is crucial. In addition, research utilisation also brings many users into play, all who have their own agendas (Sandelowski, 2004).

There are a number of specific positions on the generalisability of case studies. These include the place of replication logic and analytic generalisation (Bergen & While, 2000; Gilgun, 1994; Yin, 2003b). These approaches do not fit comfortably within qualitative inquiries where replication is not a goal (Schofield, 2002). Instead of statistical inferences, others argue for the development of logical or causal inferences (Mitchell, 2000). Bassey (2001) proffers the use of 'fuzzy generalisation' that reflects possibilities rather than certainty, and appears to attempt to integrate the complexities of social contexts and social science research within this configuration. In critiquing Bassey's concept, Hammersley (2001, p. 220) argues that it would seem "... that fuzzy generalisations are simply scientific generalisations that are not yet (and perhaps never will be) fully developed, in that their scope conditions are not specifiable."

More compatible with qualitative inquiry, other authors identify with the particularity of case study. As case study, with a focus on that case, then no presumption of sample representativeness is offered and no claims to the generalisability of findings are made. Rather than suggesting that the findings have no wider application, the position taken is that "... the first emphasis is on understanding the case" (Stake, 1995, p. 8). While arguing the particularity of case study, Stake proffers that case study lends itself to an alternative form of generalisation – naturalistic generalisation. In contrast to statistical generalisation, it is an internal cognitive process of the reader. This response to

reading the case study is reliant on the researcher providing thick description of the case and context (Stake). The reader then decides on the relevance of the case to other cases. Naturalistic generalisation has been critiqued by others (Donmoyer, 2000; Lincoln & Guba, 2000) who debate how much of an alternative position it is and what it offers to case study.

Within the qualitative inquiry literature authors also debate the relevance and appropriateness of generalisation from any inquiry and specifically case study research. Schofield (2002, p. 172) identifies that within qualitative inquiry literature there is "... a widely shared view that it [generalisation] is unimportant, unachievable, or both." In a chapter entitled *The only generalization is: There is no generalization*, Lincoln and Guba (2000) provide an analysis of the frameworks purported to enable generalisation in case study research, including Stake's (1995) work on naturalistic generalisations. They argue that the classic definition of generalisation does not fit with qualitative inquiry. This incongruence arises from what Lincoln and Guba describe as deficiencies in the concept of generalisation: the inherent reduction required, reliance on the assumption of determinism and inductive logic, and importantly, an assumption of freedom from both context and time. Those authors suggest the application of the concept of transferability, based on fittingness, supported by thick description. They use Cronbach's concept of the 'working hypothesis' and argue that:

Local conditions ... make it impossible to generalize. ... the 'working hypotheses' are tentative both for the situation in which they are first uncovered and for other situations; there are always differences in context from situation to situation, and even the single situation differs over time. (Lincoln & Guba, 2000, p. 39)

The variety of conceptualisations of inferences, generalisation, representation and replication within case study, some based on classic definitions and others on alternative concepts to replace the classic definitions, arise from a range of issues. These include different disciplinary foci, especially related to knowledge generation, differing paradigms underpinning the inquiry, debates

within the qualitative research literature, and different understandings of the purpose of case study. The stance taken in this research is that case study research within a qualitative inquiry results primarily in an in-depth case study and contextualised and particularistic knowledge of the case and phenomena. As a secondary outcome the case study may add further to the broader understandings of that phenomenon in other contexts, may provide the grounds for theory building and theory testing, and may provide practitioners and other researchers with knowledge and insights that those individuals may then choose to test and apply in practice.

Judging the quality of the research process and case study

There is debate within the case study method literature as to how and what quality judgments should be made about both the research process and the final case study. Much of the discussion follows from a negative critique and identification of the specific limitations of case study research as is explored later. The arguments centre around the clarity of purpose of case study and what could be the logical expectations of such a research endeavour.

Although identifying that quality can be judged using concepts including data dependability, confirmability, credibility and trustworthiness, Yin (2003b) chooses to apply the tests of construct validity, internal validity, external validity and reliability within his work. He argues that because "... case studies are one form of such research [empirical social research], the four tests also are relevant to case studies" (Yin, pp. 33-34). If case study research is based on the philosophical underpinnings of qualitative inquiry, specifically holism, acceptance of multiple realities, and the reflexive position of the researcher then Yin's formulation is difficult to apply.

Stake (1995, pp. 108-109) writes of validation and places an ethical responsibility on the researcher in stating "(i)t is true that we deal with many complex phenomena and issues for which no consensus can be found as to what really exists – yet we have ethical obligations to minimize

misrepresentation and misunderstanding.” A key process suggested by many authors to reduce the likelihood of misinterpretation of data and misrepresentation of cases is triangulation – “... a process of using multiple perceptions to clarify meaning, verifying the repeatability of an observation or interpretation” (Stake, 1994, p. 241). Observation, as interpretation, is not recognised in this conceptualisation of triangulation.

Lincoln and Guba (2002) proffer an extensive range of criteria for specifically judging the product of case study completed within a naturalistic and interpretive inquiry. Resonance, rhetorical, empowerment and applicability criteria form a framework with sub-criteria within each.

Resonance criteria relate to how the case study demonstrates ‘fit’ within the paradigm which underpinned the study. Lincoln and Guba (2002) argue that the minimum requirements are the case study report must demonstrate the influence of values related to choices made in the research and reflect the multiple realities, subjectivity and their social construction within the inquiry. A priori theories are identified as problematic especially when they are causal, generalisation must be rejected, and the reflexive position of the researcher should be identified. In this study a priori theories were not used to frame the study and the subjectivity and reflexive positionality of the researcher is explored (later in this chapter and throughout the case study).

Rhetorical criteria relate to the assessment of the form, structure and presentational characteristics of the case study. Lincoln and Guba (2002) use the work of Zeller; unity or strength of the overall organisation of the case study with coherence and corroboration, simplicity or clarity and craftsmanship in the writing. Lincoln and Guba (p. 210) extend the criteria of craftsmanship to argue that careful writing of the case should demonstrate power and elegance, creativity, openness and tentativeness, demonstrating independent thought and “... the writer’s emotional and intellectual commitment to craftsmanship”, display courage and lastly, should demonstrate egalitarianism. The final point clearly identifies the place for the ethical and moral stance of

the researcher within the epistemological inquiry, in terms of both researcher conduct and the writing of the case.

Similar to Stake's (1995) conceptualisation of naturalistic generalisation by vicarious experience, Lincoln and Guba (2002, p. 214) suggest empowerment criteria that, by focusing on the emotional and intellectual responses of the reader, the case study "... will *empower, activate, and stimulate* the reader to a level of responsiveness and use that does not characterize research reports typically."

The final product criteria relate to the applicability of the case study to other contexts or situations resulting from inferences made by the reader and transferability made accessible by thick description. Again, these criteria relate to the reader's experience. Lincoln and Guba (2002) argue that studies that meet the applicability criteria facilitate application by providing experiences for the reader and these experiences may stimulate reexamination and reconstruction of the reader's existing construction. By meeting the process criteria the product criteria will also be strengthened and process issues can in turn detract from meeting product criteria.

Both Lincoln and Guba (2002) and Stake (1995) place considerable emphasis on the experience of the reader in relation to case studies and although the criteria offered go some way to providing a framework for assessment, the complexity of focusing on readers' responses is arguably unmanageable. The criteria put forward by Lincoln and Guba are useful in that they provide congruence between the research design and method, quality judgments and the paradigm underpinning qualitative inquiry, but the empowerment criteria offered which outline proposed cognitive responses of the reader remain problematic.

Limitations of case study research

As with any research approach, case study has specific and general limitations. Yin (2003b, p. 10) identifies “... traditional prejudices” against case study as criticisms of the lack of rigour, the lack of a basis for scientific generalisation and that case study research takes too long and results in “... massive, unreadable documents” (Yin, p. 11). Except for the latter point which is stylistic in nature, the other two points are in common with arguments against the use of naturalistic inquiry. The issues of the perceived lack of rigour and scientific generalisation have already been covered in some depth.

Gerring (2004, p. 341) takes a position of tradeoffs instead of describing limitations, identifying the “... characteristic strengths and weaknesses” of case study in comparison to cross-unit analysis. Case studies have an affinity with intrinsic case comparability rather than external representativeness, description rather than causal design, a focus on depth rather than breadth, unit homogeneity leading to internal case comparability, the possibilities of developing causal insights, and exploratory theory generation rather than theory testing.

Case study was chosen as a component of the framework of this research because of its focus on particularity of the case and the importance placed on context and phenomenon which were critical in an examination of a concept such as community participation as social action. Other research methods or approaches could have been adopted, for example community based participatory research (Minkler & Wallerstein, 2003), action research or participatory research. While holding promise, these methods would have been difficult to apply within the particular context of the case (the GABTR programme), especially as the programme was already underway when I became involved. Also, I was interested in describing and exploring the way that community participation was choreographed and developed within a programme rather than in changing the programme. It was also important to integrate other framework components specifically chosen for their congruence with ethical research within communities.

Focusing case study on ethical research with communities

To counter the potential “... colonizing nature” of research (Minkler & Wallerstein, 2003, p. 6) which impinges on principles related to individual and collective rights to distributive justice, respect for persons, minimisation of harm and social and cultural sensitivity, consideration of my ongoing relationship with the community and programme was critical. My conduct was therefore simultaneously an issue of congruence between the mode of inquiry and research design through reflexivity, and consideration of the broader historical and social contexts.

The way that writers position the researcher within case study research are divergent, spanning the position of unbiased investigator (Yin, 2003b) to the researcher-as-instrument approach of reflexivity as common within naturalistic inquiry (Delamont, 2002; Janesick, 2000). Delamont (p. 8) suggests that:

Reflexivity is a social science variety of self-consciousness. It means that the researcher recognizes and glories in the endless cycle of interactions and perceptions which characterize relationships with other human beings. Research is a series of interactions, and good research is highly tuned to the interrelationship of the investigator with the respondents.

I have chosen to position myself within the case study as a way of explaining my “... social, philosophical, and physical location in the study” (Janesick, 2000, p. 389), as well as revealing how the study was culturally, historically and personally situated (Gergen & Gergen, 2000). In negotiating a reflexive position, I used tools such as maintaining field notes, a research journal, questioning and re-questioning inferences and interpretations, and reconsidering how my role was renegotiated throughout the course of the study. The reflexive researcher position is no longer one of ‘other’ to the study as the research is co-produced to varying degrees by the social interactions.

Smith and Cram (in Smith, 2005 p. 98) identified a “(c)ommunity-up approach to defining researcher conduct.” Built on cultural values implicit in kaupapa Māori research (research based on Māori philosophy), these authors provide practical guidelines which ground the ethical conduct. This framework, while reflecting a specific Māori research approach, is likely to meet the needs of other cultural groups as well (Cram, 2001). Unique to Aotearoa New Zealand, this framework resonated with me and I attempted to use it in working with individuals, groups and organisations as described in Table 7. However, as with understandings of culturally safe practice (Ramsden, 1993), only the participants could appraise the outcomes of my efforts.

Table 7 Application of a community-up ethical framework

<i>Components of the community-up approach (Smith & Cram in Smith, 2005, p. 98)</i>	<i>Core ethical principles - Code of Ethical Conduct (Massey University, 2004)</i>	<i>Examples of application in this study (explored more in the fieldwork section)</i>
“ <i>Aroha ki te tangata</i> : A respect for people – allow people to define their own space and meet on their own terms.”	Respect for persons	I was mindful of how my study may require extra work for people and may interfere with the programme implementation. I attempted to allow people to define their involvement in my study in their own ways.
“ <i>He kanohi kitea</i> : ... meet people face to face, especially when introducing the idea of the research, ‘fronting up’ to the community before sending out long, complicated letters and materials.”	Social and cultural sensitivity, respect, informed and voluntary consent	I had face to face meetings with programme staff before commencing the fieldwork. When possible, I invited people to participate in interviews after I had met them.
“ <i>Titiro, whakarongo ... kōrero</i> : Looking and listening (and then maybe speaking). This value emphasizes the importance of looking/observing and listening in order to develop understandings and find a place from which to speak.”	Respect for persons, social and cultural sensitivity, justice, respecting privacy and confidentiality	I tried to focus my participant observation on respecting the actions of others and looking, observing and listening rather than speaking out. This was not only so that I could gain data for my study but so that I could respect the programme and the people involved – it was their programme in which they were investing time and energy and passion. This position was not what was expected by everyone – some wanted me to speak out much more.

<i>Components of the community-up approach</i>	<i>Core ethical principles</i>	<i>Examples of application in this study</i>
<p><i>“Manaaki ki te tangata:</i> Sharing, hosting, being generous. ... a value that underpins a collaborative approach to research, one that enables knowledge to flow both ways and that acknowledges the researcher as a learner and not just a data gather or observer. It also facilitates the process of ‘giving back’, of sharing results and of bringing closure if that is required for a project but not a relationship.”</p>	<p>Respect for persons, justice, social and cultural sensitivity</p>	<p>I shared my time, energy and the resources to which I had access, such as networks, books, videos, and people. For example after visiting other community gardens and talking with the people involved in those I provided CD copies of my photos and other information to both programme staff and community members.</p>
<p><i>“Kia tupato:</i> Be cautious. This suggests that researchers need to be politically astute, culturally safe, and reflective about their insider/outsider status. It is also a caution to insiders and outsiders that in community research, things can come undone without the researcher being aware or being told directly.”</p>	<p>Minimising harm to individuals, groups, organisations, the researcher, avoidance of conflicts of interest</p>	<p>The reminder to be cautious was important, especially as over time I felt more comfortable in some contexts and with some people. Reflecting on my changing identities as sometimes an outsider, insider, professional, and community member was a constant challenge.</p>
<p><i>“Kaua e takahia te mana o te tangata:</i> Do not trample on the ‘mana’ or dignity of a person. This is about informing people and guarding against being paternalistic or impatient because people do not know what the researcher may know.”</p>	<p>Respect, social and cultural sensitivity,</p>	<p>As will be explored in the case study, when things did not go well in a programme then this value needed to be to the fore in my awareness and actions. Case study, with its focus on case and context, provided a balance for me in that the problems encountered were rarely in the domain of the actions of one person or group.</p>
<p><i>“Kaua e mahaki:</i> Do not flaunt your knowledge. This is about finding ways to share knowledge, to be generous with knowledge without being a ‘show-off’ or being arrogant. Sharing knowledge is about empowering a process, but the community has to empower itself.”</p>	<p>Respect and social and cultural sensitivity</p>	<p>I attempted to share the knowledge that I have, and had access to but also to be purposeful in explaining how there were many areas where we could learn together.</p>

While this framework was developed and applied it was also recognised that:

In the spaces between research methodologies, ethical principles, institutional regulations, and human subjects as individuals and as socially organized actors and communities is tricky ground. The ground is tricky because it is complicated and changeable, and it is tricky also because it can play tricks on research and researchers. (Smith, 2005, p. 85)

Negotiating the tricky ground was an ongoing process from proposal to post completion with my decisions underpinned by multiple considerations; the protection of participants from harm, the academic requirements of research, the method driven process, and the ethical consent and assent requirements.

Applying the ethical framework of rights and responsibilities was challenging. For example, three options are available for presenting a case study; as an open and identifiable case; as a case which is anonymous; and the middle ground, where the case may be identifiable but the individual participants are presented as anonymous. It is improbable that a community could be successfully anonymised in a country the size of Aotearoa New Zealand (Tolich, 2001). A case study of the particularity of a specific programme implemented within a community, which includes contextual features such as demographics and history, is immediately identifiable. While removal of identifying details could offer superficial individual anonymity, other participants are likely to be able to identify each other. With ethical conduct and human rights in the foreground as well as appreciating the practicalities of community based research, an open case, with anonymous participants was pragmatically the most possible in this research and was what was negotiated with the lead organisation involved and with individual participants.

A number of participants commented that they were not concerned about being identified, while one community member specifically stated that I could use that person's name. Complete case anonymity would considerably reduce the

case and contextual description and the provision of information which would enable the reader to position the local contexts of the case in the global context of other cases. In the next section the application of the research framework is explained as it unfolded within the fieldwork.

Fieldwork: Negotiating access and involvement

Fieldwork seemed a logical approach to data collection in this research. I felt excited by the premise of qualitative research espoused by Charmaz (2004, p. 980) that a "... deep understanding of studied life means entering it." Having spent some time exploring the theoretical perspectives of primary health care and health promotion and deciding on my topic of interest – community participation - in mid-October 2006 I learnt of the newly initiated health promotion programme (GABTR). This programme was being led by Whanganui Regional Primary Health Organisation (WRPHO), one of two (at that time) PHOs in that region. One of my research supervisors, Maureen Holdaway, was a member of the WRPHO Board of Directors. She contacted the Chief Executive Officer (CEO), introduced me and my area of interest. I subsequently spoke with the CEO who arranged for me to speak with the GABTR programme coordinator.

The programme coordinator, support worker and I met on a number of occasions and I shared my, at that stage, broad application for ethical approval. We discussed the programme and talked about how my study might fit with their work. We also spent some time talking about our respective backgrounds that brought us together. At this stage I became aware of the identities that differentiated us as people. I was older, pākehā (non-Māori of European descent), and employed (on a very part time basis for the duration of my research) as a university lecturer teaching in the areas of community health and primary health care. I had previously worked in the health sector for over 15 years. The programme staff were both Māori, younger than me, and in new jobs. Both were also new to working in the health sector, in community work, and in health promotion. Two of us were new to the Whanganui region. We

were all female and none of us were what we would call experienced in gardening! These similarities and differences were only manifest in our meeting and sharing: I felt and was older in relation to them, I felt and was pākehā in relation to them. My role as a university lecturer, sidelined to become a full time student, seemed to come to the fore as one of my identities even though, in my mind, I had put it into the background. Coffey's (1999) arguments that field work is identity were certainly congruent with my experiences.

Whereas I had anticipated that my newest identity as a researcher would be the one that took the most work on my behalf, I soon realised that my other selves were as likely to have an impact on how I developed relationships in the field and also what others expected of me. I chose to openly discuss (on a number of occasions, with programme staff, and others involved) how this was 'their programme' and my role was to support them, rather than to take over. While believing I had some experiences and skills and access to resources that may aid the programme, I could only offer help.

The initial discussions were tentative, with me aware of the emergent nature of qualitative research (Charmaz, 2004), but knowing that others may have different understandings. We did not know how my involvement and study may unfold. I was specific regarding what my research would not be – an evaluation of the 'success' of the programme. After these discussions I applied for ethical approval for the study from the Central Regional Ethics Committee, with notification to the Massey University Human Ethics Committee. The programme coordinator also discussed and gained endorsement for my potential involvement from the Steering Group of the GABTR programme.

As a pākehā researcher, I sought guidance from individuals with iwi networks within the programme area as to the appropriate mechanisms to consult with Māori about my research. I could not anticipate whether Māori individuals and groups would eventually be potential participants in my study. I was aware of the complexity in seeking both individual and collective informed consent

(Health Research Council of New Zealand, 1998), especially for a study about participation in the public arena. I did not want to fall into the trap of “... pākehā paralysis” (Tolich, 2002, p. 164), whereby pākehā researchers exclude Māori participants. Consultation was undertaken, on my behalf, by one of my supervisors (Maureen Holdaway), with a regional pan-iwi group. She agreed to oversee and ‘take responsibility’ for my conduct. During the conduct of the research, if I was visiting Māori groups, for example iwi health services, the health sector staff whom I accompanied sought permission for my presence in advance.

Over the next few months I supplied more specific programme information to the Central Regional Ethics Committee. I had face to face and email discussions with GABTR programme staff. WRPHO staff sought clarification as to what the outcome of my study would be and the feedback from my study that would be provided to them. I offered to provide feedback in any forms that would meet the organisation’s needs (for example, a written report, oral presentations, and a copy of the completed thesis). I reinforced that although I could provide feedback during the progress of my study (which I did), that the main reporting would happen once my research was completed.

I discussed the proposed length of time of my involvement with WRPHO staff and suggested that a year (from January to December 2007) would be a suitable length of time for the purposes of my study. I suggested that I would like to ‘stay in touch’ with the programme, especially the work of the Steering Group, until the end of the first contract period in June 2008. Programme staff and the Steering Group agreed. These time periods were chosen for pragmatic reasons: the time I could commit to full time data collection, the constrained timeframe of the programme, and the hope that this length of time would be sufficient for the study of the case.

I was surprised at how smooth this process of negotiating access to the organisation was but I also became aware of how ‘new’ the WRPHO was as an organisation and that they had no specific policies in place at that time that

covered my involvement as a ‘volunteer’ and researcher. It made me aware of how I needed to ‘safeguard’ the organisation, especially as this was an open case study and the organisation would be identifiable. Over time I did this in a number of ways, including by discussing the types of research policies which could be developed for use with future researchers. Once ethical approval was granted (Appendix Six), my work with the programme and simultaneous data collection began in mid-January 2007.

Becoming a participant observer research student

As GABTR was a community programme I had anticipated that most of my time would be spent working with community members. I quickly realised that this was unlikely to happen, in the short term at least, as on commencing fieldwork, the programme only existed within the health sector. The first community garden was months from commencement and other activities were all driven by programme staff. There was no ‘community’ site as such, no community related to the programme with which I could begin to engage. It forced me to reconsider how I was mentally imagining the programme community and also to agree with the perspective that community is created by social action (Campbell & Jovchelovitch, 2000), rather than being ‘out there’ waiting to be accessed. I chose to start by gaining understandings of the GABTR programme as the case.

My trips to Whanganui (one hour’s drive from my home) developed a routine of their own. My constant companion of my research bag contained a digital recorder, camera, information sheets, consent forms and diary. Once work started on the community garden I took a change of clothes for (occasional) gardening, and water for hand washing.

Between October 2006 and June 2008 I made over 100 trips to Whanganui. Most trips involved the whole day, usually leaving home at 7am and returning around 6pm. Sometimes, I traveled for single meetings or interviews. Depending on programme activities, which I tried to join in, I traveled at

different times. For example, the land blessing started at 6am and other events occurred on Saturdays. I often visited the community garden at the end of my day before traveling home, spending time wandering around, checking the growth, gardening, and talking to anyone there. My involvement changed over time, driven by a number of different factors. Overlapping phases of my involvement included: transitioning from visitor to honorary staff; helping out – being a volunteer worker on the programme; entering new fields, when things are not going so well; and shifting focus.

Transitioning from visitor to honorary staff

My transition from visitor to honorary WRPFO member was rapid and occurred over the period of a few weeks. During this time:

- I was provided with a desk, chair and access to a telephone in the Health Promotion office with the programme staff. This was ‘my space’ when I was physically present, and was used by others when I was not.
- I was advised that I needed a WRPFO photo identification card. After a discussion about my role, ‘research student’ became my label.
- My name was added to the staff location board - I no longer signed in as a visitor.
- I was ‘reminded’, as were programme staff, of the need to complete details on the location board when leaving the office.
- Although my involvement was with the GABTR programme, other staff talked with me about their own research, their studies, and their work.
- A staff member described me as ‘their researcher’ when I was asked to talk to a visiting nursing student about community assessments.
- WRPFO included a brief description of my study and photo in their regular newsletter which is sent to all General Practices in the region.

I was asked to provide another brief study outline for the GABTR newsletter which was sent to all programme contacts (approximately 600 people/groups, most of who were plant recipients). Over time, I was aware that different

versions of my study and explanations of my involvement in the programme were circulating even though I had tried to provide consistent explanations. For example my involvement and study was described in a District Health Board meeting as an example of innovative and cost free alliance in a discussion about evaluation of the programme (WDHB, 2007). I had little control over these versions of my involvement or how organisations and people could choose to describe it. My involvement was complex – sometimes participant learner in the gardens, sometimes experienced community nurse, and always a data collector.

I was given free access to GABTR programme documents including meeting agendas, minutes, and service plans, and on occasion I was supplied with documents which were identified as confidential (such as the programme budget) and I agreed to not to divulge that material to others or use it in my study. This material was important for my understanding of the case.

Helping out – being a volunteer worker on the programme

Throughout my year as a volunteer programme staff and I developed a way of working. It evolved rather than being formally planned. During my ‘WRPHO days’, which were usually two to three per week, I was updated on programme progress, and we discussed the day’s and week’s plans and priorities. Throughout the week I was copied programme emails, and when arranging meetings, the programme coordinator requested permission for me to attend. Only one group said ‘no’ and that meeting was not directly related to the components of the programme which were my main focus. I purposefully left it up to the programme coordinator to decide on the meetings that she was comfortable for me to attend. I thought that it was important for her to be able to undertake her role, especially as it was new for her, without my interference and constant presence.

When not physically present in Whanganui I often worked on programme activities including providing feedback on letters, and documents, accessing

literature relevant to the programme, finding teaching resources, and providing input to the development of the evaluation plan. Sometimes this material became the basis for our work on my next day at the WRPHO office.

Initially, as I developed an understanding of all of the components of the programme I attended meetings with programme staff. I soon learnt that I needed to be more particular about data collection and I found that restating my research interest helped me decide on my data collection priorities. I eventually identified that two components of the programme – the community gardens and the public plant distributions – were central to my study. These were the only parts where the GABTR programme was the organising body (in conjunction with other organisations) and was responsible for orchestrating community participation.

My involvement varied depending on programme phases and activities. Initially, I felt uncomfortable working out what my involvement would entail and was aware that it was also awkward for programme staff. I didn't want to 'interfere' or 'take over'. I tried to monitor myself and to be purposeful (with myself) about my rationale for acting, or speaking, or not speaking. For example, in the first weeks of my fieldwork, programme staff (coordinator and a support worker) decided to undertake 'door knocking' as 'community consultation' around the first community garden site. As a nurse with community experience and as a teacher of community nursing to nursing students, my professional focus on safety meant I was concerned. I was aware that programme staff were not experienced community workers, so decided to have an up-front 'safety' conversation, based on my experiences. I asked questions such as if the WRPHO had policies and procedures for staff safety, if they had name tags (I hadn't seen any staff wearing them and the newly ordered ones hadn't arrived), and how visits would be recorded (to stop work being repeated unintentionally and to enable some evaluation). I also asked questions such as: 'what will you do if nobody is at home?', 'what will you do if there are dogs on the property?' As a result, name tags and a small flyer were developed, a cell phone was taken with us, and a list was maintained of

addresses, information requested or given, and further contact requested. The exercise was not particularly successful, with few people home, but I noted that the procedures developed were used again later in the year.

Creating a balance between participating and observing was quite difficult. My natural tendency was to participate more than less. For example, during a community garden event, the sight of a few hundred unplanted vegetable seedlings near the end of the day sent me into a flurry of planting. However, as with other events, when the whole day's activities were taken together I had seen over 50 people, talked to at least 30, and had worked physically hard. I had learnt much about gardening. When I talked, sometimes weeks, or months later, with others who had been present, my perspectives of the event were expanded.

During the time that I was involved as a volunteer programme staff and I discussed the programme extensively and worked collaboratively – often side by side at the computer developing programme plans, reports, and a conference abstract and poster. We often 'brainstormed' about how the programme goals could be met. I left the acceptance, rejection, or further development of those ideas to her. However, sometimes I suggested that discussions with one of the programme groups, such as the Steering Group, or her manager, could be valuable. I found the programme goals a useful framework and we often explored suggestions in terms of meeting those goals and how this could be demonstrated in the programme evaluation. This way of working continued throughout the year and also when an interim programme coordinator took over.

Entering new fields

The GABTR programme linked with a number of organisations, groups and individuals and I therefore found that I frequently entered new fields and needed to introduce myself and my study. Soon people would introduce

themselves and tell me that they had been told about my study by others or my work by someone else.

Wearing a large WRPFO name tag was impractical and inappropriate when involved in activities such as gardening. I therefore attempted to introduce myself to new people, usually stating my name and that I was 'helping out as a volunteer, while researching about community participation in the programme'. My choice to be so open about my research was based on a number of factors:

- I thought that ethically people had a right to know that they were talking to a researcher.
- Some people assumed that I was in charge of the programme when they met me and programme staff together (probably related to my age rather than anything I had done). It was important to me that this was corrected.

I planned to interview, if they consented, all committee members before attending my first Steering Group meeting. Unable to contact some people, this became impossible. I did discuss my attendance (and note taking) with the people I interviewed. At my first Steering Group meeting I requested a small amount of time to introduce myself (for those that I had not met) and to explain my involvement. I also outlined the Group's 'rights', in being able to ask me to leave meetings, or to delete notes (which never happened). I offered to leave the room for the Group to discuss this but it was not required. I repeated this information when new people joined the Group. Initially, when asked for input in the first meeting I asked the chairperson whether I should answer but the meetings were quite informal and I was assured on more than one occasion that my involvement was welcomed. I took notes during the meetings, covering meeting content, topics discussed which were not on the agenda, and about problem solving in the Group. I was sometimes asked for advice and sometimes gave my comments freely (especially later on) without being specifically asked – I joined into the conversations. My input was usually about the work that the programme coordinator and I had been doing.

Everyone was asked to introduce themselves at the first Community Gardens group meeting that I attended. Again, I outlined the rights of the group with regard to my involvement. Unlike the Steering Group, which had a reasonably stable membership, the Community Gardens group membership fluctuated. At subsequent meetings I tried to introduce myself to new members before each meeting. People asked me about my study during the year and some asked me to meet with them and provided me with their contact details. Sometimes these additional meetings were research related, other times were about that person's own interests. Over the time of my involvement in the programme I came to know some of these people well.

When some things are not going so well

As will be explored in depth later, parts of the programme progressed well, others faltered. This was 'tricky ground'. The issues for me, in the areas of the programme that were struggling, related to the difficulties of negotiating the tensions of being an insider and outsider (Clingerman, 2007; Minkler, 2004). What did I do, what did I have a right to do, who did I have responsibilities to, and what was I expected to do, were all questions that concerned me. Although I had started with a neutral perspective of 'here I am - use me in any way that helps the programme', over time this changed. I invested considerable amounts of time and energy into the programme while working as a volunteer. I was no longer impartial about the programme as an object – it was now about people that I knew - their hopes, dreams, passions and relationships. I desperately wanted it to succeed, and to 'write up' something positive. In particular I was wary of how programme failure could be reflected on the community.

At times I felt under considerable pressure as my data collection brought me into contact with people who were unhappy about the programme's progress, who told me so, and who voiced their desires for a positive solution. I also became aware that as a researcher I was probably the only person that was involved in most parts of the programme (except for programme staff) and had

the time to think about it extensively. That time to think, in a programme with significantly constrained timeframes, seemed to be something of a luxury.

Over the year my involvement gradually changed. Instead of helping programme staff with tasks that they wanted assistance with (such as developing the conference poster), I began talking about the implementation of the programme a lot more – what I was seeing and experiencing. An example was my anticipated ‘nightmare’ of the 2000 head of broccoli, ready at once, with no agreed harvesting and distribution plan! In talking with community members who expressed frustration, I explored with them what possible solutions they could attempt, such as asking for further information or speaking directly with the programme coordinator or later on, the garden coordinator. In taking on an advocacy role I felt better able to negotiate the tricky ground and “... the politics of field work” (Coffey, 1999, p. 71). At different times and with different individuals and groups I felt that I advocated for the programme, the programme staff, the organisations involved, and for community members. While this worked well in some instances, it was not always so. One person challenged me that I should have been more open about the problems I was seeing. In response, others said this was not my role. In hindsight, it was impossible to get the balance right as the programme and its challenges and importantly, the relationships evolved over time.

Shifting focus

A number of factors converged to create the time to focus more on community members’ perspectives of their participation. These factors included:

- Getting to know community members as programme activities became more grounded and specifically the community garden was established.
- The end of the agreed twelve month period with the WRPFO.
- The programme coordinator left work at the WRPFO. For some time there was no permanent replacement. Components of the programme were delegated to a number of different people.

For me this reverse transition meant going back to where I had thought I would start (in the community). It had been planned with WRPHO staff and Steering Group members throughout the year. When visiting the WRPHO in February 2008, after a gap over Christmas, I found that in a reversal of my transition to honorary staff a year before that my name was absent from the staff board - I signed in as a visitor - and the office space was now occupied by others not associated with the GABTR programme.

These physical changes were helpful for me as I had been concerned about how I could 'exit' that part of the field. For the next six months (until June 2008) I visited WRPHO regularly associated with the monthly Steering Group meetings. (The Group had given me permission to continue attending their meetings.) Separately, I also met with community members and worked at the community garden. In conjunction with WRPHO staff I met with the newly appointed garden coordinator and shared information about the groups that had offered to support the garden. Community members continued to email me and kept me informed about the programme. I visited the community garden for the last time within the artificial boundaries of my data collection and of the initial contract for the programme on the 26th June 2008. Since that time, community members asked me to join a support group for the garden, although this has yet to eventuate. I therefore feel I have transitioned to become a (honorary) community member and my relationships and interests can continue at that level.

Conclusion

In this chapter I explained the development of a research framework including my choice of case study to explore the case of a health promotion programme – GABTR - and the phenomenon of community participation. Case study, as an approach rather than a methodology, enables the researcher to develop a flexible and responsive research design. This is highly appropriate for exploration of individual and group social action within a community setting. Data collection, analysis and display methods were described as were the ways

that ethical issues were anticipated and addressed. My involvement as a field worker / programme participant / programme volunteer was described to illuminate the complexities and challenges experienced and also how these roles are reflected in the description of the case.

The next five chapters form the case study, starting with a description of the GABTR programme interwoven with the key contextual factors that influenced its development or coexisted at the same time. The next chapters provide an exploration of the case study phenomenon and issue of community participation. Events, developments, and individual and group responses to the programme implementation are revisited under different guises to examine the complexity of participatory action and the layering of my interpretation. The case study is completed with a reexamination of the contextual factors which evolved, developed, and sometimes influenced the life of the programme.

The following conventions have been used in the presentation of the case study.

...	Material edited out – part of a sentence
[...]	Material edited out – more than a sentence
[]	Editorial comments for clarity
Field notes	Field notes, date of entry, and page if quoted
Bold	Emphasis e.g. loud speech
(LB)	My initials – my questions / comments
<i>Italics</i>	Participant's speech
(Int. A/B. p. x)	(Interviewee number; 1 st or 2 nd interview of that person (A or B); transcript page number)
Book Antiqua type face	Quotes from my field notes

Chapter five: Apple trees, tomato seedlings, community gardens and ‘high needs’ populations – the Grab a Bite That’s Right programme

Introduction

The previous chapters provided a range of contexts for the case and the research framework used to examine the case. In this chapter I describe the GABTR programme – the case - from its genesis in July 2005, to the original contract end in June 2008. One person’s vision of distributing disease preventing apple trees throughout the region evolved into an umbrella programme covering a range of projects. These projects, all built around an aim of increasing people’s fruit and vegetable intake, included apple tree and tomato plant giveaways, capacity building workshops, and the development of a community garden. I examine this programme - its aims, milestones, and challenges - through three relatively distinct phases: phase one, from envisioning to the commencement of programme funding; phase two, bedding in the programme – growing projects out of the proposal; and phase three, revisiting community participation in the community garden. I also examine broader contextual factors, linked to those presented in the previous chapters, which both opened and controlled the space in which the programme was developed and implemented.

GABTR is a complex programme¹⁹, simultaneously typical and atypical of health development projects worldwide. While mostly a top-down, health service driven programme, it contained bottom-up, community-led project components. Although well resourced financially, its success was totally dependent on the passion, interest and participation of individuals and community groups. This chapter sets the programme scene, providing the context for the examination of community perspectives of community participation in the following chapters.

¹⁹ I use ‘programme’ as the descriptor for work undertaken under the umbrella of GABTR. ‘Projects’ is the descriptor for discrete parts of work within GABTR, such as the plant distributions and community garden development. Participants used the terms interchangeably.

Phase one: From envisioning to the commencement of programme funding (July 2005 – June 2006)

This phase encapsulated the planning and funding application stages of what was to become the GABTR programme. The final funding application, submitted to the MOH in mid-October 2005, was the culmination of three months work. It reflected the combination of a unique set of people, organisations, and visions, and its development created much enthusiasm.

“We were so excited about this when we put the thing [application] in. We knew we would get funding for it. We knew the Ministry would be interested in it and they really are. And that’s the other thing, that nationally it has a profile, even though we haven’t actually promoted it. But you know the newness of it and the whole thing around the trees and it being such a community thing”
(Int. 11A, pp. 6-7)

The proposed programme aim was to “... increase the consumption of fruit and vegetables by improving affordability, availability and accessibility, with a specific focus on Maori, Pacific and high needs communities” (WRPHO & WDHB, 2005, p. 3). Overtly about increasing fruit and vegetable consumption, it was underpinned to varying degrees by beliefs about family and whānau (extended family), growing communities, relationships, sharing knowledge, the broader determinants of health, and sustainability. The specific programme objectives, related to the Whanganui region, were listed as:

- | | |
|------------------------|--|
| <i>Objective one</i> | Supporting rural/urban communities to “... develop nutrition and physical activity programmes in key settings of significance to Māori, Pacific and high needs communities.” |
| <i>Objective two</i> | “Support kōhanga [Māori early childhood centres / language nests], early childhood centres, and schools to develop nutrition and physical activity programmes with a focus on gardening” |
| <i>Objective three</i> | “Increase awareness of the benefits of gardening and healthy food choices” |
| <i>Objective four</i> | “Evaluate and monitor the effectiveness of all GABTR projects.” |

Objective five “Explore the health benefits of other fruit through ongoing research” (WRPHO & WDHB, 2005, p. 4)

The proposal evolved from and was situated within the contexts discussed in the previous chapters, such as health sector reforms and a renewed focus on primary health care and health promotion. It was also influenced by a global and national interest in food, nutrition and non-communicable diseases.

An intensified national and international focus on cancer prevention, food, nutrition, and activity

The *New Zealand Health Strategy* (A. King, 2000b) provided a new framework for action within the health sector, with an identification of population priorities including improved nutrition, reducing obesity rates, an increased level of physical activity, and a reduction in the incidence of cancer, cardiovascular disease and diabetes. As well as targeted objectives across the population, there was also recognition that health inequalities experienced by Māori, Pacific peoples and those from “... lower socioeconomic groups” (A. King, 2000b, p. viii) needed to be reduced. This Strategy then became one of the drivers for the development of the *New Zealand Cancer Control Strategy*, the result of a “... collaborative venture with cancer NGOs” (WHO, n.d., p. 2). Other drivers included cancer group stakeholder pressure, direction from the WHO in supporting cancer control programmes, and recognition of the increased incidence of cancer. Importantly, the *Cancer Control Strategy* (MOH, 2003e) focused on primary prevention as well as screening, treatment services and palliative care. From this a *Cancer Control Action Plan 2005-2010* was developed (Cancer Control Taskforce, 2005).

Concurrently, work on the 1995 *National Plan for Nutrition* (Public Health Commission, 1995) was revisited and recommendations included in two new Healthy Eating Healthy Action (HEHA) documents. One provided background information (MOH, 2003c), and the other a strategic framework (MOH, 2003d)

for HEHA action. These documents were released before the World Health Assembly endorsed the World Health Organisation *Global Strategy on Diet, Physical Activity and Health* (World Health Assembly, 2004).

Together these strategy documents reflected growing concerns about the worldwide health transition in the major causes of morbidity and mortality, with a rapidly increasing burden of non-communicable diseases. Except for tobacco use, all other major risk factors for non-communicable diseases “... high blood pressure, high concentrations of cholesterol in the blood, inadequate intake of fruit and vegetables, overweight or obesity, [and] physical inactivity” (WHO, 2004a, p. 2) were linked to physical activity levels, food and nutrition.

In Aotearoa New Zealand, the combination of the *HEHA Implementation Plan 2004-2010* (MOH, 2004) and the *Cancer Control Strategy Action Plan* resulted in new funding to meet the HEHA vision, “... to create an environment and society where individuals, families and whanau and communities are supported to eat well, live physically active lives, and attain and maintain a healthy body weight” (MOH, 2005e, p. 1). Prevention of diet and nutrition related cancers and those associated with a lack of physical activity were part of the plan. The MOH issued a Request for Proposals in August 2005 for specific, contestable funding, the HEHA Initiatives Fund. Table 8 overviews key milestones in phase one of the programme between July 2005 and the end of June 2006, and demonstrates the interplay between key organisations over that time.

Table 8 GABTR programme milestones in phase one

<i>Jul – Sept 2005</i>	<i>Oct – Dec 2005</i>	<i>Jan – Mar 2006</i>	<i>Apr – June 2006</i>
Newspaper article published - stimulates Tree Crops' proposal	Short programme proposal to WRPHO Board	MOH proposed programme start date - delayed	WDHB secured funding to draft the first GABTR service plan
Tree Crops' proposal to WDHB, meeting followed	GABTR proposal signed off by WRPHO & WDHB		
MOH Request for Proposals	Proposal sent to MOH		
WDHB supports Tree Crops' apple trees funding application			
Whanganui Wellbeing Group members agree to draft proposal but not oversee the programme			

The local context – changing health service approaches and a passion for apples

In that same month (August 2005) the Central Districts Branch of the New Zealand Tree Crops Association (NZTCA Central Districts Branch) submitted a proposal to the WDHB (NZTC Central Districts Branch, 2005). Tree Crops, a voluntary association, brings together people involved in growing 'productive' trees. The Central Districts Branch has a special interest in the links between "... diet, particularly fruits and nuts, and health" (NZTC Central Districts Branch, 2005, p. 3). The Branch was involved in activities including collection of heritage fruit tree samples from around Aotearoa New Zealand as part of a 'heritage apple recovery programme' and obtaining chemical analyses of the fruit from national and international research institutions. Ongoing research, procured by the Branch, included examination of the anti-proliferative activity of apple compounds against specific liver and colon cancer cells.

The Tree Crops' proposal was in response to a local front page newspaper article (Stowell, 2005) entitled 'Big changes ahead for health services'. The article included statements by the then WDHB CEO, Memo Musa, outlining the need for local health services to adopt a population based approach to meet

community health needs and to stay within budget. It signaled a shift “... towards keeping people healthy rather than simply continuing to provide the same services” (Stowell, 2005, p. 1). This article informed the Whanganui community of the upcoming five-year district strategic plan and their opportunities for input through a submission process. The plan reflected a:

“... complete switch as far as annual plans go and very much looking at a population health focus for the first time probably, rather than being disease based.” (Int. 11A, p. 1)

Instead of seeking funding, the proposal aim was collaboration between the Tree Crops Association Branch and the WDHB to enable propagation and distribution of 5000 free ‘high health’ apple trees to Whanganui residents. Based on population census figures, one-third of the community’s households could then have access to a tree. Two intended benefits were the survival of endangered heritage apple trees and, over time, an improvement in the population’s health. This was described as a sustainable and simple intervention:

“That apple tree will survive for 100 years, produce apples throughout that time, so that is an intergenerational answer – and not only for the people within one household, but for their neighbours, their family. It’s just so simple.” (Int. 4A, p. 11)

The proposed apple trees for distribution were specific heritage varieties, ‘Monty’s Surprise’ and ‘Hetlina’ which, through chemical analyses, were identified as “... having the most potential as high health ‘medicinal’ apples” (NZTC Central Districts Branch, 2005, p. 6). Monty’s Surprise is a heritage variety, discovered in Aotearoa New Zealand in 2001 and Hetlina is an older European variety. The special features of the Monty’s Surprise tree and apples were described:

“It’s a very clean apple, it’s clearly got high levels of disease resistance and ... if the variety can prevent disease in itself, that’s another indicator it can do that in humans. ... It’s a unique variety, it has unique physical characteristics - large leaf size, round leaf shape as it matures - and no other apple tree has that.” (Int. 4A, p. 2)

Research findings on the beneficial compounds in the apples were included as part of the proposal.

“... we didn’t ask the hospital board [DHB] for any money, we simply asked for their support ..., we said ‘let’s make a joint application to a local charity to fund the project’ and they said ‘no’. And then the District Health Board came back and said ‘we support you but we can’t make a joint application with you.’ But that was alright, we found a local philanthropist who came forward and said ‘I like the concept. I will pay for the first 850 trees’ and he gave us a cheque.” (Int. 4A, p. 4)

Even though the WDHB was unable to be a party to a joint funding application it supported the overall proposal of the fruit trees distribution and Tree Crops applying for other funding. Therefore the Tree Crops’ proposal, with a focus on fruit trees, anti-cancer compounds, good nutrition and improving community health provided a unique, community initiated programme base for GABTR.

There was, however, a clear understanding that the ‘tree giveaway’ was not reliant on the participation of health services. Instead the proposed fruit tree distribution became a starting point. A Steering Group member recalled that:

“...[health sector staff] went back to [Tree Crops] and said ‘..., can we build something around this tree giveaway?’ Because the tree giveaway was always going to happen ... - even if the DHB didn’t support him he was going to get public funds, funding from somewhere, and it was going to happen anyway.” (Int. 11A, p. 3)

Another Steering Group Member described the conversation as:

“... [she suggested] to him ... ‘well, if you are going to give trees out let’s use the HEHA framework to give trees out so that they are going to where we can get the best health dollar’, I guess, ‘or result.’” (Int. 8A, p. 1)

The ‘best health dollar’ signaled an important underlying difference in perspectives, one that will be explored subsequently. During the next few months the original proposal was melded with health service approaches, firstly into a WRPHO Board proposal (Pene-Jones, 2005), then into an initiative fund proposal (WRPHO & WDHB, 2005), submitted to the MOH in October 2005, and finally, after some delays, into a service plan for the period

of March - July 2006. GABTR programme funding commenced in July 2006, a year after the article that prompted the first proposal was published.

Intermixing a community initiated vision with health service approaches

The period of drafting and redrafting proposals into an action plan, in this case a programme service plan, is an important one for any programme as the decisions made at this stage have long lasting consequences. These decisions become statements about philosophical positions - whether overt or hidden - aims and objectives, models, service plans, budgets, and evaluation measures. With a team of people involved, different points are prioritised, and as a result the focus of a programme may change quite dramatically during this period.

The GABTR proposal stage created a space for bringing together a particular group of individuals and organisations, some of whom were new to working together. This was described by a District Councillor in a news release:

We've seen two different initiatives come together, offering great possibilities for our community. Mark Christiansen's Monty's Surprise apples, with their wonderful health-giving properties, are being made available to Wanganui people, thanks to Mark and his team.

At the same time, the Wanganui Regional Primary Health Organisation and the Whanganui District Health Board – Good Health Wanganui Public Health are progressing the 'Grab a bite that's right' project, aiming at strategies to improve the health and wellbeing of our community. (Wanganui District Council, 2006a, para. 2-4)

This new space enabled synergies to develop and also tensions, some novel and some more longstanding, to emerge. A key factor in this proposal stage was the complex juggling of the needs of all organisations, groups and individuals that became 'stakeholders' in the application. While some needs could be accommodated, others were non-negotiable. All health services in Aotearoa New Zealand are mandated to work towards reducing health inequalities. The

funding proposal therefore needed to explain how the programme approaches would be consistent with this mandate. Whereas the Tree Crops' proposal was based on sharing apple trees throughout the community, the health service organisations needed to demonstrate an approach targeted to specific population groups. During negotiation about the funding proposal, discussions were held to clarify this point.

"... [the Tree Crops' person] just wanted to know distribution-wise what we thought. You know 'how could this happen?' And so we started talking population groups, or where the DHB would be coming from if we were looking at distribution. [...]. And ... he was always really clear about how one in three houses would have a tree ... but always open to suggestions as well. (Int. 11A, p. 2)

Later, when the WRPFO became the proposed contract holder, a similar discussion was held.

"... [Tree Crops] didn't actually care how the apple trees were going to be distributed. ... it wouldn't have worried him if he had just rolled up with a trailer and had just poked them in Springvale Park. He really didn't care – that wasn't what was driving him so he wasn't too pedantic. [WRPFO staff member] was quite strong about who the groups should, the priorities should be, that fitted in with our mandate around addressing inequalities. (Int. 14A, p. 4)

While those issues were seemingly resolved in the proposal stage, they were revisited during programme implementation (as will be discussed in later chapters). An underlying issue was of different perceptions of community participation and community action. Community members generally perceived community action and community participation as focused on equality – equal opportunities for everyone. This was juxtaposed against the framework mandated for and adopted by health sector staff which reflected an equity (fairness) approach aimed towards reducing health disparities. Both approaches, underpinned by different values, were discussed as 'facts.' A similar tension was identified in a community action project related to alcohol, also implemented in Aotearoa New Zealand:

During the course of this project it became apparent that the concept of a professional 'community of interest' did not fit easily with some of the perspectives amongst the internal project group. Strongly held views were expressed by some that 'real' community action meant

localised community development and grassroots activities working from a local community not a professional funder or provider agenda. Whereas the professional agenda was driven primarily by strategies derived from evidence-based research, coupled with local knowledge and experience, it was considered by some that the emphasis needed to be reversed with local issues driven by local communities at the forefront of any community action. (Conway, Greenaway, Casswell, Liggins, & Broughton, 2007, p. 1871)

Differing ideas must be expected within health programmes, and contrasting perspectives are held by people within sectors and organisations as well as across them (Laverack, 2005). A community group member associated with GABTR commented on subsequent but similar tensions over the programme aim:

*“... we have a slightly different agenda to Grab a Bite That’s Right. That was an issue that had to be thrashed out at the last meeting. [...]. It came up at the subcommittee on the community gardens when we were presented with the proposal and it said the purpose of the community gardens was to ‘ensure the availability of affordable, accessible fruit and vegetables to **high needs communities**.’ While we accepted that the funding to run the gardens was, that was one of its main agendas, we thought that that was unnecessarily narrow. ... we saw the community garden as being able to help, mainly as a catalyst, to be able to get people to garden on their own bits of land. We thought that that was an environmental sustainability objective that the whole community would be interested in, not just a high needs community. So we had a bit of a battle over that. And some of the issue was semantic I suppose, but I was a bit concerned that a couple of people in the group more or less said that the money is coming from Grab a Bite That’s Right and therefore we get to decide the agenda and I thought that that kind of proprietorship was not necessary and it was alienating.” (Int. 3A, pp. 3-4)*

Here again the tension is obvious, related to an underlying difference in philosophies, with some individuals and groups considering community gardens, in particular, as being for the ‘whole’ community rather than just for targeted groups. The tensions also related to bureaucratic decision making – the

programme and its projects had to relate to centrally decided MOH priorities for it to be funded and for that funding to be maintained. This was described as:

“... quite a bureaucratic process. We are tied to the people that provided us with the money and we’re tied to doing what we said we would do. And so we have to be really careful of that. We have to jump those hoops even if they are difficult.” (Int. 8A, p. 4)

A health sector staff member on the Steering Group commented:

“Working with communities is hard and particularly working with communities that don’t have an understanding of health and the ‘health speak’. And we are tasked with reducing inequalities in our community and they really just want everyone to do it.” (Int. 8A, p. 3)

While the ‘health speak’ of health inequalities, high needs, target groups and deprivation makes sense at a strategic and policy level within a health sector focused on health disparities, the complexity arises when those terms are applied to people and communities. It is how those terms (that become labels) are communicated within a programme and to community members that is important. Moncrieffe (2007, p. 85) argues that there may be differences between what “... labels formally signify in high policy-making circles, and what they mean for the persons charged with managing policy on the ground; communities and the sub-groups among them; and for the labelled groups themselves.”

Other sectors also had bureaucratic processes to be negotiated. For example, early on confusion arose over whether community gardens or orchards were being planned. A policy analyst for one organisation wrote a paper which added to the confusion:

“[The proposal writers] had to present at the community development committee so one of their policy analysts has to write up a paper But instead of coming to [the proposal writers], they wrote it up. [...]. But he [the policy analyst] had in his head that it was around community orchards, not community gardens, so the paper was written up ... about community orchards. And it was like ‘no, it was never orchards.’” (Int. 11A, p. 19)

Multiple layers of bureaucracy and programme structures

This confusion around gardens or orchards recurred throughout the programme. While there were challenges, working together with motivated community members and groups, such as Tree Crops, was seen as a bonus for the health services:

“... here are some likeminded people who all think the same I think. Their principles are the same, how they do it is different. [...] working together, alongside of the community and alongside of interesting people like [two community members]. [...]. But these are good guys that are out there that have a great sense of pioneering spirit that we kind of almost shop dress I guess, or window dressing. [...]. And they believe it and they are passionate and they are interested and they are proud of what they do and it is a privilege for us to have been able to wrap something around and for them to be willing for us to be part of it.” (Int. 14A, p. 4)

The process of health service organisations wrapping a programme around a community initiative brings with it layers of bureaucracy. A key decision in the development of the funding application (WRPHO & WDHB, 2005) related to which organisation would ‘lead’ the programme and ‘hold the contract.’ An intersectoral group with an interest in nutrition and physical activity - Whanganui Wellbeing – was already in existence. Members included representatives of organisations including the WDHB, WRPHO, a nongovernmental cancer organisation, a regional sports trust, District Council, and a local tertiary education provider. A Tree Crops Association member was asked to join. Whanganui Wellbeing eventually chose not to become the contract holder for the GABTR application but agreed to support the application. A programme structure model, developed for another programme led by Whanganui Wellbeing, was chosen for GABTR. This model included a governance/steering group²⁰ and the employment of a coordinator. This meant that the contract would:

²⁰ There was ongoing discussion throughout the programme as to whether this was a Governance, Steering or Advisory Group. This will be discussed further in Chapter Eight.

“... sit with either the District Health Board or the Primary Health Organisation. Because there was no stipulation in the original thing [request for proposal protocol] around where the contract would sit and that decision was made ... [at the WDHB]. [...]. But because it was a community development type project it made sense to sit in the PHO. [...]. ... with the idea that [an experienced health promoter] would be there and we would be there to support the project and we would have the Steering Group in place, which was basically Whanganui Wellbeing with extras, that would guide the programme so that it had that public health focus, public health, health promotion focus and that it kept that.” (Int. 11A, p. 5)

A WRPHO staff member described WRPHO’s perspective on the decision making process:

“...right from day one there was some talk, there was a bit of argy bargo [lively discussion] I think as to whether this should be a PHO or should this be the DHB... . [...]. ...but [WRPHO staff member] was quite a strong person and she had quite a strong sense of ‘this is core PHO work’, ‘this is where we go with our vision’, ‘this is us being closer to the community than they [WDHB] are.’ [...]. But yeah, I guess it was the first very big project that the DHB, from a public health point of view, didn’t have control over.” (Int. 14A, p. 2)

Here the newness of the organisations, their developing relationships (as described in Chapter Two), and the contested space for health promotion were being played out in this ‘joint’ programme. A benefit for the programme in the contract being held by the WRPHO, a Charitable Trust, was that it could apply for additional funding support from community groups.

“...so there was some gain about what as [an organisation with] ... charitable trust status ... can we offer as an extra. And so that has proven to be useful because that’s how we have gone to the Community Foundation for that funding, which the DHB could not do. (Int. 14A, p. 7)

The small programme size (eventually with one part time staff member), and its isolation as ‘the’ health promotion programme in the organisation²¹

²¹ Other projects which could be identified as having a health promotion component were underway, but HEHA and GABTR were consistently identified in the organisation’s documents and on its website as its health promotion programme. It was also the only health promotion programme run from the ‘Health Promotion Office’ at WRPHO during that time.

contributed to some of the later difficulties. However the small size of the WRPFO also created opportunities:

“... because we are not so huge and our accounting and our whole financial systems aren’t so bureaucratic as what we have at the hospital [DHB], it’s really easy to isolate off project money and to have that flexibility, ‘we need petty cash, we need this’ – like the actual movement and ability to flow a project such as this is changing all the time. (Int. 14A, p. 7)

MOH staff also saw advantages related to the size of the region for its health services and GABTR. They identified that health service staff and organisations were already known to each other, and that they were already working together on other projects (MOH staff, personal communication, 27 November 2007).

Ministry of Health directives

The protocol for the HEHA initiatives fund application (MOH, 2005e) provided significant directives that shaped the evolving GABTR proposal. These directives included that the funding was ‘one off’, with the programmes to be sustainable after this time, that initiatives must reflect joint proposals “... designed and delivered in collaboration between DHBs and PHOs” (MOH, p. 1), that they be consistent with public health and community action strategies, and that they meet the vision of the HEHA Implementation Plan, as quoted earlier. There was a requirement that DHBs and PHOs worked with other health service providers and local communities to meet identified local needs. A targeted approach to focus on those groups with ‘high needs’, specifically Māori, Pacific peoples, and those from low socioeconomic groups, was also required. There were additional requirements that the proposing organisations match²² the funding from the Initiatives Fund, and that activities identified as core health service work or which were already funded would not be eligible. Importantly the fund provided a “... financial incentive for PHOs to reorient their activities to include a health promotion approach ...” (MOH, 2005e, p. 1).

²² There did not appear to be a requirement to ‘equal’ the funding, rather to commit to some financial or resource input.

These requirements signaled both national priorities related to nutritional goals and the population groups targeted, and also secondary aims about the structure and functioning of the health sector as described in Chapter Two. The secondary aims related to health sector tensions identified by the MOH. These tensions included the need for more communication and collaboration, and an awareness of differences in the health sector capacity, experience, and skills in health promotion and community development.

Piecing together an innovative and exciting programme

Those involved in the development of this funding proposal talked of their collective enthusiasm and passion as well as their relatively unfettered brainstorming:

“... [three health sector staff] just sat down and brainstormed. You know ... huge things ... that the town will have fruit trees growing on all the berms²³. We went big on our vision ... because we thought it was so important. ... So our original proposal was very, very big but I guess that’s how I got involved. It’s exciting to be able to do something which is innovative and ground breaking. [...]. It was quite expensive, it was a little outrageous I guess in our thinking. If you don’t ask you don’t know. (Int. 8A, pp. 1-2)

Others were also involved in brainstorming and the title of the programme arose from one of those sessions at the Whanganui Wellbeing forum. Interestingly, Grab a Bite That’s Right was once the title of a National Heart Foundation of New Zealand poster designed for use with school children.

“Originally we called it ‘The Big Bite.’ [...]. Because New York is called the Big Apple and so we couldn’t have that, so it was going to be The Big Bite” (Int. 11A, p. 8)

Final components of the programme included in the funding application were expansive and encompassed a number of overlapping areas of action:

- Public distribution of fruit trees, planting fruit trees in parks and open spaces, fruit giveaways, and provision of fruit to the local Food Bank;

²³ Road verges

- development of settings based²⁴ community gardens;
- improving access to healthy food, the development of teaching resources, and integration of gardening concepts in te kōhanga reo (Māori early childhood centres), early childhood centres, kura (Māori medium schools) and schools;
- assisting in the development of nutrition policies in te kōhanga reo, early childhood centres, kura and schools, marae (Māori meeting area of extended family / tribe), churches and workplaces;
- supporting the sustainability of the Fruit in Schools programme;
- ‘train the trainer’ programmes for community health workers, and education programmes and gardening competitions aimed at increasing knowledge and skills of community members on gardening and healthy nutrition;
- ongoing research with a focus on other fruit varieties and effects on chronic diseases such as diabetes; and
- evaluation and monitoring of the programme.

These projects were chosen because:

“... this had to be different [than current programmes] but even though it had to be different it still had to link to other things. So that’s where we sort of tried to think outside of [what services were already provided], so like the Food Bank stuff. [...]. ... trying to fit everything together and plug gaps.” (Int. 11A, p.7)

Developing linkages between other programmes and supporting their sustainability were seen as priorities. For example, primary schools in high needs areas involved in a MOH project entitled ‘Fruit in Schools’ were required to become self sustaining in obtaining their fruit supplies for distribution to the pupils within a period of three years. It was proposed that the GABTR programme offer fruit trees to these schools, thereby meeting its own

²⁴ A ‘settings approach’, as separate from issue or population approaches, is identified as fundamental within health promotion theory and practice. The choice of a setting defines the specific location, the target individuals and groups for the intervention “... and the frames of the setting itself as a target of intervention. Most health promotion activity is bounded in space and time within settings that provide the social structure and context for planning, implementation, and evaluating interventions” (Green, Poland, & Rootman, 2000, p. 1).

objectives and those of the schools simultaneously. Project linkages were also important because there were already a number of contracts for projects – related to the national priority of HEHA - within the areas of food and nutrition. In addition, a number of local health service providers focused on communities with high needs. While recognised that it is the combined effects of interventions and health promotion activities that add up to an “... ecologically sound health promotion program” (Green et al., 2000, p. 9), duplication of services and programmes needed to be guarded against. This duplication was within as well as across organisations:

“... it was also trying to ... keep clear of where this [programme] sat with Grab a Bite and where this sat with Public Health.” (Int. 11A, p. 8)

The effects of externally controlled timeframes

The MOH had a short timeline for consideration of the funding proposals. After submission in mid-October 2005, decisions were to be announced by early November 2005, and successful initiatives were to commence, after contracts had been signed, on 1 January 2006. The funding period was to span three financial years with an implementation period of 2½ years - 30 months from 1 January 2006 until 30 June 2008. In reality the MOH received more applications than anticipated (33 proposals from 13 DHBs, with 20 funded) and there were a number of delays in negotiating the contract for GABTR. Therefore the funding did not start until 1st July 2006, six months after the commencement of the programme timelines.

The Ministry required modifications to the original application, and specifically a reduction in the programme budget. This changed the configuration of communication and decision making, with, for example, the Ministry communicating directly with the Planning and Funding Division of the WDHB, rather than with the proposal writers from the WRPHO and Public Health Centre (WDHB). The Planning and Funding Division has overall responsibility for planning, purchasing and funding regional health services (WDHB, n.d.) and specifically managing the contract of the successful

application. This additional layer of bureaucracy caused significant tensions around maintaining the essential health promotion focus of the programme, as described by a person involved at that time:

“... and he [Planning and Funding staff member] said ‘no, you need this and this and this changed.’ And it was like ‘hell no.’ ... we would have to go through this whole explanation process of why that was how it was, and if you change it to such and such it wasn’t health promotion. And that held things up quite significantly from what I remember. That was ugly actually.” (Int. 11A, p. 12)

The impact of the delays was described by a WRPFO staff member.

Oh, it was a significant delay with the Ministry. [...]. ... the timeframe is always ambitious and they can never meet it. [...]. ... then there was some delay between the Ministry and the DHB getting the contract, and then the contract coming to us. Actually the timelines didn’t stack up and so [staff member] was having to report that ‘we haven’t achieved any of these outcomes because we haven’t received a contract yet’. So it didn’t get off to a great start from that perspective. (Int. 14A, p. 7)

The funding delay was made up by ‘double payments’ for the first six months (July – December 2006), although there was no clear recognition that ‘making up’ six months in a community development type project was unlikely, especially with other complexities, such as the employment of new programme staff. Also, ‘three financial years’ was confusing to many involved in the programme, as, taking into account the six months of double payments and an implementation phase of 2½ years, it reflected two calendar years instead²⁵.

A number of factors came together in the proposal stage which would later impact on the programme as a whole. Firstly, there were time pressures to develop collaborative proposals. Between August and mid-October many discussions were held with individuals and organisations, a contract holder negotiated, and a proposal with a full budget was developed. The proposal was signed off by the WRPFO Board and WDHB, and finally it was submitted to the MOH. The work on this funding proposal was undertaken by staff in addition to their usual work, without recourse to extra funding or resources. A

²⁵ The length of the funded contract was still being debated at an Evaluation Advisory Group meeting at the end of June 2008.

small amount of additional funding was secured by WDHB in late March 2006 for the development of the successful proposal into a service plan. This plan needed to accommodate the required funding reduction and the delay in programme commencement.

Secondly, the Request For Proposal template (MOH, 2005e) did not require a detailed proposal to have been written – it was descriptive in terms of required aims, programme components, collaboration and linkages with other programmes, and local needs. The level of ‘evidence’ required regarding proposed interventions was minimal. This reflects both a degree of laxity regarding the level of evidence required for the implementation of social policies, which is identified as a problem internationally (Muir, 2008), and a lack of carefully evaluated interventions specific to the areas of food and nutrition (MOH, 2001; Obesity Action Coalition and Te Hotu Manawa Maori, n.d.). Although there were few locally evaluated food and nutrition intervention evaluations on which to draw, nationally and internationally there are many. (See Appendix Seven, Table 17 for examples of evaluations and other literature related to community gardens.)

It should also be noted that the Ministry was still developing its own guidelines for evaluation of all HEHA programmes, based on programme logic. A MOH (2006a) document on developing programmes using programme logic became available after the programme commenced and to meet an identified nationwide workforce skills gap, free courses in programme evaluation were offered around the country in 2007. There was a requirement that ‘evaluation’ was mentioned in the proposal, but a detailed plan was not required.

On examination, the links between all of the programme components and the aims were somewhat tenuous, with a mix of process and short to long term outcomes. Some of those outcomes would have extended well past the end of the proposed programme contract, a problem identified in other health promotion programmes funded for short periods (Fleming et al., 2007). A programme logic model was only developed when a request for additional

evaluation funding was made in 2007, over a year after the project commenced²⁶. However, some people had seen evaluation as a priority from the beginning:

“... I said ‘I’m really concerned about evaluation.’ And he [a person previously involved] said ‘we don’t need to worry about that because that will come when they start doing something.’ I said ‘actually no, this is such a ground breaking project it needs to happen from day one’, and ‘we need to be evaluating the processes, it’s probably more important than the activity in this.’”
(Int. 8A, p. 4)

There was also no requirement that a local needs assessment, for example related to regional food security²⁷, had been completed, or the ‘local’ community consulted as to their perspectives of their issues and potential solutions. There are many planning guidelines available, specifically related to food systems. For example, the *Urban and Peri-Urban Food and Nutrition Plan* (WHO - Regional Office for Europe, 2001, p. 18) provides a generic planning process to identify “... what problems are created by the existing food systems and to find the potential for change.” Key stages in the plan relate to building partnerships, undertaking a situational analysis and developing a common community vision.

The funding proposal did not require a literature search of both national and international literature to justify how the programme components or separate projects, such as community gardens, could meet the aim and to identify what lessons could be learnt from other’s experiences. While an unpublished literature search (from another organisation) was cited in the application, the only literature used was anecdotal. The minutes of the Wanganui District Council’s Community Development Committee (Wanganui District Council,

²⁶ This contested Fund had multiple objectives including developing an evidence base of programmes which were (or were not) working well and developing the evaluation capacity of DHBs. The applicants had to be DHBs, even though programmes, such as GABTR, may not be led by that organisation. The DHB had to “... lead or manage the evaluation” (MOH, 2007d, p. 13).

²⁷ Food security is defined as “... the ready availability of nutritionally adequate and safe foods, and the assured ability to acquire personally acceptable foods in a socially acceptable way” (Obesity Action Coalition and Te Hotu Manawa Maori, n.d., p. 60).

2006b, p. 2795), when support for the GABTR programme was requested, included a salient comment about local experiences:

The concept of a Community Garden has been explored by the Council in recent times but it has never been well supported by the community. One example of a Community Garden is at Polson Park where the local community wanted and agreed to maintain apple trees for the community. The scheme faltered after a few years through the lack of ongoing maintenance after the loss of the project organiser.

Although this did not mean that the programme should not be established it did forewarn of possible problems, although how this information was acted upon is unclear.

Thirdly, the secondary objectives of the fund related to requiring organisations and groups to work together, to put in joint applications, and to share knowledge and expertise. Although critical to health promotion and community development programme success, working across sectors and organisations and with community members and groups is always more complex and time consuming than working within a single sector or organisation. As argued by others (O'Neill, Lemieux, Groleau, Fortin, & Lamarche, 1997), while there is agreement in the literature as to the need for intersectoral action, and the key components of a definition are accepted, there is no consensus as to how to make it work in practice. Also effective working relationships between organisations and their members require at least organisational support, clarity in understanding each other's roles, programmes, responsibilities and accountabilities, and agreement over reporting requirements.

A busy but exciting phase

In summary, the foci of the first phase included 'wrapping' a health sector programme around a local community initiated proposal, envisioning and developing links with current HEHA related projects, working across sectors, and meeting local and national funding criteria. That funding criteria reflected

national and international health priorities for service provision related to current and forecast health needs. The funding criteria also contained secondary aims, driven by the MOH, related to the development of relationships between DHBs and PHOs generally and the building of health sector capacity in health promotion and community development. All of these factors needed to be interwoven with the local context. I asked a Steering Group member how this programme was particularly relevant to the Whanganui setting and the reply given was:

“Why Whanganui? I think we’ve had one [community garden] that I know of, that was probably five years ago when a woman tried to get a community orchard on Durie Hill, and I don’t know what happened to that. There has been some work in the Pacific Island churches here around community gardens. Whanganui has quite an interesting ‘green’ population and quite a lot of people who are interested in things like organics, permaculture, those areas. And I think on a wider scale there’s been all that interest in organic gardening but also that 5+ a day²⁸ thing, so I think it fits into the wider context. ...Why it happened now I don’t know – what I do find interesting is that I was at a meeting ... with people who were teaching environment issues in schools and they were talking about the establishment of community gardens within schools as part of [that programme]. So that is interesting that this idea has come up in two different places. And of course we have had the iwi²⁹ ploughing up some land bank land and planting vegetables as well. (Int. 1A, p. 5)

Together these local and national factors contributed to the context of the programme and influenced how it was rolled out and implemented in phase two. They also impacted both positively and negatively on the community participation in the programme (as will be explored in the following chapters).

²⁸ ‘5+ a day’ is a national social marketing campaign which aims to increase fruit and vegetable consumption.

²⁹ A local Māori activist ploughed and planted a small section of land at a disused hospital site, quite close to where the community garden in the GABTR programme was eventually sited. This action received national attention. During this research many people spoke of that ‘garden’.

Phase two: Bedding in the programme – growing projects out of the proposal (July 2006 – November 2007)

Theoretically, this phase commenced with the beginning of the funding on the 1st of July 2006, although in reality the first few months were preparatory, and it was some time later that major work on the programme started. The service plan, used to drive the programme work and set reporting requirements, was submitted to the MOH in mid July 2006. Table 9 sets out the major milestones within phase two, the implementation stage of the GABTR programme.

Table 9 GABTR programme milestones in phase two

<i>Jul – Sept 2006</i>	<i>Oct – Dec 2006</i>	<i>Jan – Mar 2007</i>	<i>Apr – June 2007</i>	<i>Jul – Sept 2007</i>	<i>Oct – Nov 2007</i>
GABTR funding starts	Steering Group formed	Support worker position finishes	Garden site blessed, hoed	2 nd apple tree distribution starts	Garden water supply installed
1 st apple tree distribution	Community Gardens group formed	Capacity building workshops x 2	Evaluation fund application submitted	Garden working bees start ³⁰	Garden coordinator position advertised
Programme staff x 2 employed	WRPHO health promotion advisor leaves	1 st site chosen for garden abandoned	Community garden planting day	Garden concrete pad, shed installed then damaged	Programme coordinator on leave, part time replacement
Presentation about the programme to the District Council		Garden lease signed for 2 nd site	Last Community Gardens group meeting	Community garden street signs installed	Tomato seedling distribution
Tour of potential garden sites			Scarecrow day - cancelled		

Giving away apple trees – a key milestone

The first Monty’s Surprise apple tree distribution of approximately 800 trees, driven by the need to give away the grafted stock in the dormant winter period, went ahead in August 2006 under the umbrella of the GABTR programme. At the embryonic stage of the programme, it was really a collaborative endeavor between the Whanganui Wellbeing Forum and Tree Crops. This ‘tree

³⁰ ‘Working bee’ is used to describe a group of volunteers undertaking a specific task together, usually for charity.

giveaway’ became an important programme milestone even though it would have happened without the programme being in existence.

Occurring before specific GABTR programme staff were employed, it was influential. It was the first of a number of ‘giveaways’, it represented the origin and nub of GABTR – apple tree distributions - and processes adopted at this early stage, including donating plants both to targeted groups and the public, were repeated later in the programme. Also, a pamphlet given with the trees to the public, which specifically mentioned the ‘anti-cancer properties’ of the apples, was to become an ongoing point of tension throughout the programme. Although primary prevention of cancer, especially nutrition related cancers, was one of the drivers for the MOH Initiatives Fund, making ‘claims’ about anti-cancer properties in fruit within the programme brought a range of perspectives to the fore. On one hand ‘cancer prevention’ effectively raised community interest (as will be explored more in Chapters Seven and Eight) and many people who came to collect the apple trees (and later the heritage tomato plants) freely commented that they wanted the plants because of their anti-cancer properties. A person involved in the first apple tree distribution suggested:

“People were standing waiting and one lady was complaining about the wait and another lady said ‘I would wait here all day if it is going to stop me getting cancer.’” (Int. 16A, p. 2-3)

Primary cancer prevention also provided links between the work of organisations, such as a nongovernmental cancer organisation and GABTR. One person described how this link sparked their initial interest in the programme:

“And so when they started talking about it [the proposal] I thought that was something I would really like to be involved in, especially with the cancer link.” (Int. 16A, p. 1)

On the other hand, health organisations, including the MOH, were all concerned that the public needed to be both safeguarded against these claims and that the organisations needed to be protected. A Steering Group member commented:

“... it became difficult [to be involved] when they were making the claims about the prevention of cancer. National Office were saying ‘we need to step back from this.’” (Int. 16A, p. 1)

Negotiating the way that cancer prevention was portrayed to the public took much energy throughout the rest of this phase and contrasting perspectives held by different individuals and groups continued to emerge. This one tension made overt the level of control exerted within what was identified as a community-led initiative and the complexities for community organisations working with the health sector. These factors will be explored more in Chapter Eight.

New programme, new staff, new roles

GABTR was developed as a joint programme³¹ between the WRPHO, WDHB (and community) for the whole WDHB region, including the Whanganui city area and a large sparsely populated rural area. As the ‘contract holder’ the WRPHO was responsible for employment and housing of the programme staff. This was a time of major staff change within the WRPHO. An experienced health promoter and co-writer of the proposal and first service plan left in December 2006. The programme initially linked with the work of that person. Her leaving was described as:

“... a huge loss ... she was such a strong visionary leader.” (Int. 14A, p. 8)

There was also a perception of a loss of programme history:

“Because we didn’t have anyone sitting in the PHO that truly knew what or how things had come about ... how that contract got to be where it is and how, you know the parties involved in it, and where the passion and stuff comes from, and how important that is” (Int. 11A, p. 6)

Concurrently, individuals new to the health sector and health promotion were employed in the GABTR programme. In early September 2006 a HEHA support worker commenced work followed later that month by the employment

³¹ What was meant by a joint programme was an ongoing area of tension, with various perspectives expressed by different organisational members over time.

of a HEHA coordinator (later to be renamed as the GABTR programme coordinator). These were two new positions, and the support worker position was short term (until March 2007):

“... because [support worker] was the ‘catch up’ person ..., because we had the money and because there was a delay and quite a lot of work that hadn’t been done, [support worker] was employed to support [programme coordinator] to get some really big wins on the board for the six month period.” (Int. 14A, p. 8)

The WRPHO internal management structure also changed, altering the reporting lines for GABTR programme staff. Once key staff were employed, the foci of this phase became the development of the programme structures, and translating the outcomes of the programme into project plans to meet the service plan milestones. This was daunting for a staff member who had not been involved in the development of the programme, who was new to the region and the health sector, and who did not have established networks in a programme that was built around collaboration.

Established personal and professional networks are important in the collaborative implementation of any health promotion programme and take time to develop (Fleming et al., 2007). Many of the social networks used by health promoters are developed from their own personal, social activities which they then draw on in their work. Also, the history of the programme and its development was important, but not always easily conveyed, or its importance understood, by people new to the programme. These issues were compounded by health sector conventions, such as the use of service plans and performance measures which, while useful, are inherently reductionist in nature, especially within a health promotion programme³².

³² My argument is not that service plans in themselves are problematic - they provide a useful guide to programme implementation and for evaluation and reporting of progress. However, they can have the effect of reducing community participation to ‘tick boxes’, rather than being a strategy which underpins the whole programme. The performance measures, for example, around meeting with groups who may benefit from the programme may have no outcome of the actual engagement of those groups in the programme.

Development of programme support structures

A description of the governance structure of the programme was required in the proposal. This was outlined as a "... collaborative relationship between key stakeholders and the community. A steering group to guide the development, implementation and evaluation of the initiative will be formed" (WRPHO & WDHB, 2005, p. 2). The programme structure should also set the relationship between the contract holder and the programme staff and the vision for this structure was described.

"... you have the contract holder, the coordinator, and ... the advisory group – governance group, steering group – whatever you want to call it. And the relationship between the coordinator and the contract holder is just that. So the contract holder administers the contract but other than that the steering group drive and make the decisions basically. But it hasn't ... turned out that way. [...]. ... that three way relationship is quite tricky. Because with the contract holder holding the money and not really liking to relinquish it ... or let another group of people sort of run something, ... it does get kind of tricky." (Int. 11A, pp. 5-6)

The first monthly Steering Group meeting was held in mid-October 2006. The work of this group will be explored more in Chapter Eight, with a specific focus on community participation in the 'governance' of the programme. A group with an operational rather than strategic focus, the Community Gardens group, was also established by programme staff in mid-November 2006 and it met until July 2007. Its membership fluctuated considerably over that time, and there was some membership overlap between the two groups. The workings of the Community Gardens group will also be explored further in Chapter Seven.

Translating words into a living programme of action

When I first met with programme staff towards the end of 2006 while negotiating my future research involvement I developed a rudimentary appreciation of the complexity of the GABTR programme. Coming partway through the programme's implementation, and while mutually negotiating my role, I struggled with making sense of the overall programme and its components. In my field notes I wrote:

“As it has been described to me I have an overwhelming sense of the programme going with a really good idea without a strong theoretical framework of health or health promotion or anything to fit it in to. I suppose I have an urgent desire to see that framework developed – do others see that need too? Will have to wait and see.”³³

Later, on reviewing the programme documents, I realised how the programme framework appeared to have been hidden in translation into the service plan, which happened before the programme staff were employed. On reading the full HEHA service plan - I had initially only been given the section of the document related to the ‘service description’ and ‘performance measures’, as had the Steering Group - and in talking to others involved in the development of the Request For Proposal document, the potential programme framework became clearer. Many possible models and frameworks were included in the initial proposals, and first service plan including the Ottawa Charter priorities, Te Whare Tapa Wha (a Māori model of health), and government strategies including the *Primary Health Care Strategy* (A. King, 2001b) and *He Korowai Oranga, The Maori Health Strategy* (A. King & Turia, 2002). I believed that extricating and applying these theoretical perspectives would be difficult for programme staff with no background in health promotion and community development.

At that time the staff were very involved in establishing and working with the Steering Group and Community Gardens group, with a strong focus on the development of up to four community gardens. The apple tree giveaway had been followed by a small tomato seedling giveaway (approximately 200 plants had been donated by a community member. These were potted up and distributed by staff). A programme launch had been planned, with active marketing of the whole GABTR programme. This included many newspaper articles, advertisements, a competition, and programme staff giving away fruit at the city Christmas Parade. The staff were also networking with other HEHA type programmes linked to GABTR and had attended a festive day for the Whakataetae Whakatipu Maara o nga Kōhanga Reo programme (Te Kōhanga

³³ Field notes, 11/12/06, p. 2.

Reo Edible Gardening Competition). I was impressed by the amount of activity happening within the programme even if I did not clearly understand how it all fitted together.

Trying to make up for lost time

The degree of urgency to ‘catch up’ with programme milestones and to maintain the momentum from the proposal phase was palpable in the programme documents. Community gardens had already become a major part of the programme work during this phase even though they were only one of fourteen listed foci in the original Request For Proposal document. The GABTR programme coordinator later suggested that during this phase, when one community garden was established, she had spent approximately 75% of her time in work on the community garden project. In the Request For Proposal document the ‘development of community gardens’ was clearly linked to settings, which were identified as “... Marae, Kura, Kōhanga Reo, church groups, rural communities, schools etc” (WRPHO & WDHB, 2005, p. 3).

Before the GABTR programme coordinator started work events occurred related to the planned community gardens. When combined, these developments shifted the focus away from specific settings, to ‘community’ as the setting, which is identified by some authors³⁴ as “... a more problematic setting” (Boutilier, Cleverly, & Labonte, 2000, p. 250). Meetings were held with the District mayor, and five people presented the programme to the Wanganui District Council Community Development Committee. At that latter meeting support from the council was requested. This included “... gifting of available unused and appropriate land to be used for the development of community plots and orchards”, operational advice from Environmental Services, and “(a)n elected members’ representative [for participation] on the programme’s Governance Forum” so that the council could have “... direct feedback and input” into the programme (Wanganui District Council, 2006b, p. 2797).

³⁴ Other authors, such as Raeburn (2000), see more potential in community as a setting.

In addition nine community members and individuals involved in GABTR as staff or stakeholders visited eleven potential community garden / orchard sites on District Council land. Sites were considered against specific criteria including location (low socio-economic areas, public accessibility, close to education providers, fencing, and proximity to housing), size of the plot and its potential use, soil fertility and preparation needed, and access to water, power, shelter. Four sites were chosen as priorities for development over the next three years, with others identified as having long term potential.

As recognised by the GABTR programme coordinator, much of the work in this phase was based around the community garden project. Initial work was undertaken on gaining a lease for one site (Alma Road, Gonville) – a priority site following the ‘land review tour’ – because “... very little work [was] needed to get it up and running, fully fenced, road frontage, shelter established, fertile soil, possible sharing of onsite building for education” (WDHB & Good Health Wanganui, n.d., p. 4). Gaining access to this first landlocked site was fraught with difficulties, and there were unresolved issues in terms of historical relationships with the land between a church school, community group and the District Council. These escalating tensions spilled over to affect community members who resided near the site. The Steering Group voiced concerns that those difficulties were external to GABTR and attempts to gain access to develop a garden could have a negative impact on the whole programme³⁵.

A new site for a new community garden

In February 2007, the Steering Group chose to shift the focus to another site (part of Te Mana Park). In a programme with a constrained timeframe this delay was significant as individuals had spent:

“... quite a bit of time preparing to develop a garden in Gonville and it didn’t happen due to lack of land and access there. So that was when we turned our sights on Te Mana Park community garden. And probably if we had been able to do that from the

³⁵ Field notes, 12/2/07, pp. 3-4.

beginning that would have given us more time to develop or engage our community more, but that is how things roll.” (Int. 19A, pp. 14-15).

Te Mana Park is within the suburb known as Aramoho³⁶ (or Aramo by some), which encapsulates two Census Area Units, Lower Aramoho, with an average NZDep³⁷ score of 10 and Upper Aramoho with an average NZDep score of 8 (using the small area index of deprivation adopted by the health sector in New Zealand – NZDep2006) (MOH, n.d.). The ethnicity³⁸ of residents in Upper and Lower Aramoho equates to 66% European, 26.7% Māori, 2.87% Pacific Peoples and 1.66% Asian, with a total resident population of 3963 (Statistics New Zealand, 2006a). Aramoho met the priority population requirements for the GABTR programme with these demographic features.

The new community garden site was formally leased (at no cost) by the WRPFO from the District Council on the 30th of March for a term of 16 months. The leased piece of land formed a raised section of Te Mana Park. For over 100 years the area had been farm land, then a poultry farm, and more recently, a soccer field. It was now a large, empty, neatly mown field which was identified in District Council documents (Wanganui District Council, 2006d, p. 25) as fitting their criteria as “Sports grounds – other”, differentiating it from areas identified as premier parks, neighbourhood reserves, and conservation areas. The ideal minimum asset requirements for this category included “... good quality, free draining, flat land, ... seating, car parking,

³⁶ I only found one description of how Aramoho was so named. It is recorded that “Ara-muhu, usually called Ara-moho, [was] so called because about six generations ago a man named Hau-e-rangi, of the Patu-tokotoko tribe, was lost in the bush and died of starvation. When his body was found it was noticed that he had been wandering round and round in a circle, forcing a way through the heavy undergrowth. Hence the name, meaning a circular track” (Downes, 1976, p. 34).

³⁷ “The NZDep2006 index of deprivation ordinal scale ranges from 1-10, where 1 represents the areas with the least deprived scores and 10 the areas with the most deprived scores” (Salmond, Crampton, & Atkinson, 2007, p. 8). Although similar information is used to create the scale the ranges are opposite to that used by the Ministry of Education. Therefore the Aramoho School adjacent to Te Mana Park is recorded as a ‘decile 2 school’ (Ministry of Education, 2008).

³⁸ Statistics New Zealand uses the following definition of ethnicity: “Ethnicity is the ethnic group or groups that people identify with or feel they belong to. Ethnicity is a measure of cultural affiliation, as opposed to race, ancestry, nationality or citizenship. Ethnicity is self-perceived and people can belong to more than one ethnic group” (2006b, p. 1).

lights, toilets / changing rooms, shade, trees, fences, rubbish bins and signage” (Wanganui District Council, 2006d, p. 26). Surrounded by boundaries of a primary school, a stream, residential houses with high fences, and separated from a lower, larger open space (mowed lawn) by large established Plane trees, the main entrance to the site was through a car park identified by a small sign labeling this as ‘Te Mana Park’ (see Figure 7). There were three other potential entrances through the other boundaries. The adjacent lower park had previously been mined for pumice, and then later used as a sports field. A block of changing rooms / toilets had been removed and all that remained was a concrete pad. Lighting towers were present but not in use. There were no rubbish bins or accessible water supply.



Figure 7 Community garden car park

(Outside Te Mana Park 4/4/07 – community garden site is to the right of the large trees)

The land was blessed and hoed on the 2nd April 2007 and the first community planting day was held on the 21st April. (These events will be discussed more in Chapters Six and Seven). Throughout the rest of this phase attempts were made to develop this garden, with a few events held at the garden, including the winter apple tree distribution. Monthly working bees commenced in August and finished in December, with a one-off working bee held in February 2008. Infrastructure at the garden was established very slowly with two standard ‘community garden’ street signs installed in August, a garden shed erected in September (and later removed in January 2008 following repeated demolition

through vandalism), and water piped on site in October. A position of garden coordinator / manager was advertised in October, seven months after the work on the garden site commenced. At the end of this phase in November 2007, the garden was struggling and overgrown, with few signs of community participation. There had been some activity – vegetables planted in April had been harvested - but those involved in the programme were unaware where much of the produce had gone, and little further development or replanting had occurred.

Other projects progressing well

There had been much work undertaken on the programme as a whole while the focus was on the community garden. This included a further two plant ‘giveaways’ involving the distribution of approximately 3,000 Monty’s Surprise apple trees between July and October, and the distribution of approximately 4,000 heritage tomato seedlings in November and December. These giveaways included public events on set days where people came to a number of city and rural venues and collected their plants, and also targeted distributions to individuals, organisations and groups identified as the GABTR target groups. In the light of much community interest in the free plants and especially in their special properties, the organisation and implementation of the distributions took some time and the commitment of a number of people.

Other work for programme staff included involvement in two day-long ‘capacity building workshops’ for community health workers, community members and practice nurses on nutrition, diabetes and physical activity; development of separate funding applications for additional programme evaluation funding and for infrastructure for the community garden; involvement in teaching about childhood nutrition in a child care course; and networking with other HEHA type projects and health service providers locally and regionally. Newsletters were published regularly and distributed to those with an interest in the programme or who had collected free plants. Newspaper articles were written and presentations were given to groups such as Rotary

clubs, high schools, and the schools involved in the Fruit in Schools programme, with a focus on the community garden. A poster was developed and presented at a national conference, outlining the intersectoral nature of the programme. The programme coordinator was also sent on short introductory health promotion, evaluation, and community development courses.

This phase was one of much activity, with what appeared to me to be a focus on achieving the specifics of the service plan in terms of the identified 'performance measures.' Projects within the programme, such as the plant distributions and the community garden, took a considerable amount of time and energy, with quite dramatic differences in outcomes. The apple tree and heritage tomato plant distributions, driven by community members as part of a small organising group and also involving a larger group as willing distributors, took place on time and involved a considerable number of members of the public as recipients, even if the majority did not appear to come from the 'target populations' for the programme. (These events will be discussed more in Chapter Seven.) In contrast, after an initial enthusiastic burst of planting, at the end of this phase the community garden showed little positive development and minimal involvement of community members. It was recognition of this 'problem' of a lack of community participation which became the focus in the third phase of the programme.

Phase three: Revisiting community participation in the community garden (December 2007 – June 2008)

The programme work during this phase was influenced by a number of factors and events including more programme staff changes, and the looming end of the contract period and associated formal programme evaluation. Concurrently, negative news about the community garden and especially the ongoing vandalism of the garden shed, reported in the city newspapers, raised the issue of the lack of progress in developing what was labeled as 'community buy-in' for the garden. At a time in the programme cycle where the focus should be on building on progress and evaluation, new work - specifically related to

community engagement in the community garden - was being undertaken to meet specific performance measures and to address identified problems. The programme milestones of this phase are outlined in Table 10

Table 10 GABTR programme milestones in phase three

<i>Dec 2007 – Feb 2008</i>	<i>Mar- May 2008</i>	<i>June 2008</i>
Part time Garden Coordinator appointed	Programme coordinator leaves New health promoter working part time	Steering Group advised of funding for one more year
Damaged garden shed removed	Shed replaced by container	GABTR programme evaluation report due
Programme coordinator returns from leave, working part time	Grow your own day event and garden courses start	Graffiti art event postponed
Garden working bees stopped	Garden ‘Welcome’ sign installed	End of 1 st contract period

Rethinking approaches

I asked a WRPHO staff member in late November 2007 about the lessons learnt regarding the progress of the community gardens. The reply was:

*“I think we have to start with the community first and ... while it was problematic and it was an opportunity and the council gave us land and stuff I think if we really want to get a sense of wellbeing up and driving it [the community garden] you have got to have the community up and mobilised enough and interested in wanting to be going there. And I think **we imposed that garden on the community** ... and so is it any wonder that it is not really flying. And so it’s going to be uphill for a while. That’s not to say that it can’t be turned around But we need to pay for it. We’ve gone about it the wrong way in my opinion and so now we have to pay to get it up to where it needs to be.” (Int. 14A, p. 17)*

Around the time of this discussion the WRPHO decided to advertise for a paid garden coordinator (initially for 15 hours per week) to focus on organising the garden and working to increase community participation. This person was also given a separate contract to provide home gardening workshops for people and groups who met specific target group referral criteria. Also, discussions were held regarding employing an ‘events coordinator’ as necessary to run events at the garden site. Over time, the only event was a successful ‘Grow your own day’ held at the end of March 2008. This event drew in local community

families who participated in a range of activities including seed planting and eating a free healthy lunch. A 'Graffiti Art' event, for local children to paint the garden container (the replacement for the garden shed which had been destroyed), had to be postponed due to inclement winter weather in June 2008.

Some new members were invited to join or attend the Steering Group meetings³⁹, and a community development plan, based on the community garden, was developed by WRPHO staff, submitted to the Steering Group for comment, and then parts were actioned. A WRPHO staff member who had previously been a member of the Steering Group came back onto the Group and coordinated the work focused on the community garden in collaboration with the newly appointed garden coordinator.

Programme staff changes again

At the same time there were more staff changes with the programme coordinator on maternity leave for four months, then working part time, and then leaving the WRPHO in mid March 2008. An externally contracted staff member worked one day a week during her leave, and another staff member was contracted to do additional administration work on the programme during that time. As previously agreed, I also reduced the time I spent working with the programme staff from December 2007. A new part time health promoter, with responsibilities for the GABTR programme as well as other work commenced employment at the WRPHO in early April 2008. The effect of staff changes within other health promotion programmes has been identified (Fleming et al., 2007). While it cannot necessarily be avoided it does have a disrupting effect with a loss of momentum (Conway et al., 2007), especially when programme timeframes are already constrained.

³⁹ These individuals included a person who had been involved in the Community Gardens group and a gang member whose title was 'Gang Liaison'. There was some confusion over time as to the processes involved and whether these people were officially Steering Group members.

As had been identified there was recognition that past approaches had been largely unsuccessful in gaining community buy-in and the response was that additional resources were needed to support the development of community participation of individuals and groups in the community garden in particular. It is interesting to revisit the original short proposal provided to the WRPFO Board for sign-off in October 2005 in which it is stated in relation to the proposed GABTR programme that “(i)t is advantageous for the members of WRPFO to be part of this region-wide initiative where minimal output is required” (Pene-Jones, 2005, p. 1). Instead of the minimal input envisioned, much new work was needed.

The reasserted focus on community participation at the community garden was driven by the WRPFO, with some involvement of WDHB staff, although there had been ongoing concerns raised about the lack of participation since the garden had been established. All of the new direction was clearly encapsulated in the programme proposals, service plans and performance measures, and Steering Group and Community Gardens group discussions. Some points which were now acted upon, for example the position of coordinator for the community garden, had been discussed in many forums and prioritised, but not progressed, throughout the whole programme.

Overlapping timeframes and the impact of bureaucracy

During this phase the complexities of working within a health sector bureaucracy became clearer. As identified previously, the programme contract period was confusing to many of the people involved in the programme. It was also a very short time period for a programme based on a community development approach, where medium to long term outcomes are more relevant, often with interventions over time periods of five or more years (Raeburn, 2000). One participant clearly identified the resulting pressures:

“... I understand that we have a contract and we have to meet certain outcomes under that contract but ... some of these things seem to be at the expense or the detriment of the programme moving forward. Because it is not fully engaging the community. And although we would like to think that we are doing good, we are not necessarily doing that in the best way. And there is pressure, time pressure – people are saying ‘we have only got three months, we have got to do as much as we can’ – but in reality we are more likely to turn people off, I believe – in really pushing out random events ...” (Int. 19A, p. 26)

Added to this were intra-sector agreements about ‘rolling over’ funding – that the MOH would notify the WDHB of the status of the funding prior to the end of the contract period and they would then notify the programme. It was therefore anticipated that the Steering Group would be aware of this decision in December 2007 and could plan accordingly. The Steering Group was notified in its mid-June 2008 meeting that funding was now available for a further year, but in the meantime there had been much uncertainty and this had been communicated to community members by different people. A discussion with a community member in February 2008 was recalled:

“He [community member] wanted to plough the entire thing [garden site] and mulch it, compost it, create that fertility of the soil. And I said to him ‘we have only got to the end of June for the lease of the land and for the programme to run.’ And he said ‘what’s the point, what is the point?’ You know, ‘if it is going to be taken away at the end of June, realistically, what can people do?’ And even with the PD [periodic detention – community work] guys doing the work there, preparing the soil. If you plant something now it might not be harvestable by June. And if there is no one to take that on board it is going to be a waste of time and energy and enthusiasm.” (Int. 19A, p. 27)

Concurrently, the evaluation of parts of the programme was not due to be submitted till after the end of the programme contract period and was therefore not available for any decisions about further funding. Six monthly reports had been submitted to the WDHB and MOH about progress in the programme, specifically about the meeting of performance measures, but these were short descriptive reports only. It was generally understood by those in both the

WDHB and WRPHO that the funding for GABTR from the Initiatives Fund was one-off and not to be repeated.

Overlapping deadlines

Although the programme has been presented as a linear timeline with relatively limited overlap, in practice there were multiple timeframes operating concurrently, all of which created complexity within the programme. These timeframes included those of:

- The MOH with the delays and difference between the funded and implementation periods, and the separately funded evaluation.
- The programme – as first designed, then altered and finally extended.
- The District Council – with a land lease of 16 months.
- The six month contract of the support worker.
- The seven month contract of the garden coordinator.

These and other factors - such as perception of urgency created by ‘boxes to be ticked off’ in the service plans – were overlaid by the accepted time that it takes to establish any garden and a community garden in particular. Also influential on the programme development was the time it takes to develop relationships with individuals, groups and organisations, especially for staff new to the area, to the health sector and to health promotion and community development practice. Additional to this was the need to develop and maintain relationships within and between health sector organisations and with community groups and members.

Summary

In this chapter, the GABTR programme has been described, with a focus on the key contextual factors which influenced the programme development and implementation, and its key milestones. This exploration has raised some core tensions existing within the health sector, including new structures and new foci and importantly, the effects of MOH secondary aims and processes which overlaid the programme and had to be accommodated.

Another tension related to different understandings and perspectives of how to approach community health development. While community members generally described an equality approach – health (and therefore a health programme) for everyone, health sector staff described an equity approach, with ‘health speak’ of target groups and high needs populations. Both perspectives were based on philosophical beliefs and values and remained unchanged during the programme. Both were also presented as fact. Both influenced visions of community participation in the projects.

Another tension related to programme implementation in a constrained timeframe by changing staff, some of whom were new to the programme, to health promotion and to the health sector. Unclear understandings of what a joint programme meant in practice, how the programme structure was designed, combined with health sector tools such as reductionist service plans which appear to strip away models and theories to focus on performance measures and outputs, created a complicated programme.

However, while the community garden project struggled, the plant giveaways were much more successful. Taken together, the projects within GABTR were synergistic so that external programme evaluation report authors suggested it “... must be noted that despite the challenges this programme has generated, the majority of stakeholders still have an unwavering belief in the programme and the benefits it can supply” (Whakauae Research Services, 2008, p. 49). This inherent contradiction between projects within a single programme was played out again with the ways that individuals and communities became engaged in the programme over time.

In the next three chapters, the issue of community participation in this programme will be explored through various spaces and lenses. This examination will revisit milestone projects, events and structures such as the groups set up as mechanisms to involve community members in the programme.

Chapter six: Community participation in a community garden - relationships between place, space and community

Introduction

In the previous chapter I presented an overview of the GABTR programme, from its inception until the end of the formal funding period in June 2008. During this time some events stood out as milestones for the programme – their significance linked to completion of service plan performance measures and also in achieving the vision of some of the programme instigators. The apple tree and tomato plant distributions and ‘giveaways’ fitted within this milestone description. These were short term, engaging activities, where the ongoing participation of community members related to growing their own tree or tomato directly for their or their family’s benefit.

Concurrently, a community garden was being established and this was reliant on ongoing community participation for its sustainability and success. Stake (1995) suggests the use of ‘issue questions’ to structure case study. In this instrumental case study, one issue remained constant. Community members’ perspectives of community participation was my initial research interest, and as was outlined in the previous chapter, community participation remained a programme aim, problem, and issue. It was also seen as a solution throughout the programme, especially for the community garden. In this chapter I explore community participation in the community garden. This examination focuses on that participation as linked to this place⁴⁰ and space⁴¹, and as a result what is seen as local and community becomes contested. This leads to an exploration of community participation as focused social action in the following chapter.

⁴⁰ In this chapter I use ‘place’ to refer to both the geographical site (of Te Mana Park), and the associated ‘sense of place’ as in how that place is experienced by people.

⁴¹ As described in Chapter Three, I use ‘space’ as a term to describe a variety of spaces (social, mental, spatial and temporal) which are socially constructed. I accept, as do others (Kearns & Joseph, 1993), that both the terms place and space are ambiguous.

Seasons in a community garden

As described in the previous chapter, the community garden at Te Mana Park evolved out of a programme aim related to the development of settings based gardens. The availability and willingness of the District Council to lease land at no cost in high decile (low socioeconomic) suburbs was one factor which propelled the focus away from naturally bounded settings, such as schools and marae, to public spaces. Although at least four gardens⁴² were initially envisaged, the community garden at Te Mana Park⁴³ was the only one established during the period under study. Slowly, as the issues associated with developing a large community garden were recognised, talk of additional gardens ceased. During a Community Gardens group meeting the programme coordinator suggested that ‘Te Mana Park would be the only garden’⁴⁴, although this was not recorded in the meeting Minutes. Instead of developing more community gardens, other gardening projects started in April 2008 and involved supporting groups of individuals to develop small home-based gardens. WRPFO staff again raised the possibility of another community garden associated with a new health centre at the Steering Group meeting in May 2008, but Group members (and I) reiterated the need to learn the lessons from Te Mana Park.

From a programme perspective:

“... the community garden was just one aspect of the Grab a Bite That’s Right programme and ... the region [the programme covers] is so large – ... all the way up the river to Raetihi and Ohakune, Waiouru, Taihape, Marton and Bulls. It’s a huge area to cover and to maintain regular contact with networks.” (Int. 19A, p. 16)

⁴² There was already a number of ‘community gardens’ in rural areas – including those associated with marae and with a youth centre.

⁴³ Although there were many discussions (formal and informal) about the local community naming the garden as a way of increasing local ownership, these discussions never progressed and so the garden was either referred to as the community garden at Te Mana Park or eventually as the Te Mana Park community garden.

⁴⁴ Field notes, 6/3/07, p. 4

There were also other projects underway within the programme. But for community members who had become involved in the Community Gardens group or who lived nearby, the garden was seen as ‘the’ GABTR programme.

“... I read about Grab a Bite and I thought ‘that’s what we need’, you know. I got quite excited about that and it asked for people with an interest in gardening to indicate support so I rang up ... and said ‘I really like the idea, the sound of this, the idea of having a community garden.’” (Int. 12A, p. 2)

The community garden at Te Mana Park went through phases of intense input, to benign neglect with vegetables growing with minimal intervention and care, to constrained attempts to redevelop, and finally, to reinstatement of a small part of the garden, mainly driven by the newly appointed garden coordinator. On one level these phases were related to seasons: the wintering over of crops planted hurriedly in autumn; harvesting in spring; the effects of drought over summer; with partial re-establishment of the garden in late summer, and again in autumn (see Figures 8 and 9).



Figure 8 Four seasons in a raised garden

(Te Mana Park community garden. Top left 11/6/07, top right 8/9/07, bottom left 5/2/08, bottom right 26/6/08)



Figure 9 Four seasons in a garden row

(Te Mana Park community garden. Top left 21/4/07, top right 29/7/07, bottom left 27/10/07, bottom right, 11/2/08)

The phases also related to significantly constrained programme timeframes, and reflected community responses to this project's implementation. Although there were ongoing challenges, there were also many small increments of community participation which could also be identified as positive achievements.

Possibilities for participation

A football field-sized park turned into a garden site creates many spaces for community participation. As was outlined in Chapter Three, much of the literature and research on the topic of community participation relates to community involvement in programme governance (Bjaras et al., 1991; Neuwelt, 2007; Rifkin et al., 1988; South et al., 2005). While this was naturally of interest in this research, I was also fascinated by what community members thought about community participation and what they did as community members participating in a specific project. This enabled me to explore “... participation normatively (who should participate) and positively (who does participate)” (Eyles & Litva, 1998, p. 252).

The public events held at the community garden between the lease signing at the end of March 2007 and the end of 2007 (when my main period of data collection finished) included a blessing of the land, a planting day, and six ‘working bees’⁴⁵. An apple tree distribution from the site was also combined with a display of scarecrows throughout the garden. Of the five scarecrows, one was the only entrant in a competition for early childhood centres that was initially planned as an event to be held at the garden (see Figure 10).

Due to inclement weather the scarecrows were placed in a local city shopping centre instead, with static displays providing information about the garden. They were then shifted to the garden in time for display at the apple tree giveaway. The other four scarecrows were made by individuals and groups to show support for the project.

⁴⁵ One of the working bees was organised by a community group soon after the planting day and was not widely publicised. The monthly working bees held between August and December 2007, with another in February 2008, were organised by programme staff.



Figure 10 Scarecrows watch over the community garden

(Te Mana Park community garden 6/7/07)

These events allowed me chances to ascertain something about the people who attended – how many came, who came, what they did, how they did it, and sometimes, why they had come. Over time, I could also follow patterns as I got to know people and they got to know me and we met and discussed the garden. What was often more obvious at the events was who was not there, and later how few people attended. But, initially, and on many levels, the community garden started on a positive note with the blessing⁴⁶ of the land and the first planting day. Figures 11, 12 and 13 provide a photos and a description of the first planting day, the activities undertaken, my impressions of the day and how community members described their activities.

As a milestone for the community garden project and the GABTR programme this day was both a measured success and a demonstration of the current and future issues and challenges. People liked the ‘idea’ of a community garden. Thirty three people, including children entered their details into the ‘Visitors’

⁴⁶ The ‘blessing’, as it was labeled in the event advertisements, was performed at Te Mana Park by a local kaumātua (elder) using tikanga Māori (Māori protocol). Modifications from a traditional dawn ceremony were explained, the service was undertaken partially in te reo Māori (Māori language) with English translations supplied, karakia (prayers) were said, water was sprinkled around the site, a hāngi (food cooking) stone was buried in the centre of the plot, and waiata (songs) were sung.

Book’⁴⁷ that was available on the day. Additional notes, all positive, written in the ‘comments’ included:

“Glad I came.”

“Brilliant.”

“Pleased to help.”

“Very worthwhile idea. We had fun.”



Figure 11 Garden ready for people and planting

(Te Mana Park community garden 4/4/07)



Figure 12 Active participation in a new community garden

(Te Mana Park community garden 21/4/07)

⁴⁷ The idea of a book to record contact details was useful but the label of ‘Visitors’ Book’ sent contradictory messages as to the ownership of the garden, as did my saying ‘Thanks’ as described in Figure 13.

Community participation in 'The 1st Big Planting Day' at the Community Garden at Te Mana Park, Saturday 21 April 2007, 1-3pm (Field notes)

<p>A participant observer's perspective – my story</p> <p>I arrived early (10am), full of anticipation. People were already there. After the 'blessing', two weeks earlier, this seems like 'it' – a key milestone in the programme and at the same time for my study – community participation in action?</p> <p>Getting ready for today had taken much work. A community member had organised the seedlings, the garden plan, for the land to be rotary hoed twice since the blessing. The tractor was there now, transforming a playing field.</p> <p>I talked to many people while we gardened, feeling awkward explaining my involvement as a 'research student'. But people talked really freely – there seemed to be something non-threatening about gardening talk.</p> <p>I was asked lots of questions but didn't know the answers (and felt I should). I had asked the same questions previously - they remained unanswered. Some were about gardening – I am a novice at that.</p> <p>I planted and planted – didn't stop for lunch. The shadows grew longer, people left, and the trays of unplanted seedlings didn't reduce much. I was concerned – what was going to happen here next? Who will arrange it? What would happen to the 1,000 unplanted seedlings?</p> <p>As I packed up to leave late in the afternoon I said 'thanks' to an older man as he also left. He said "why did you say thanks? – it's a community garden". And then "are you part of this, because normally you would dig up the land now and leave it over winter and then plant it in spring." My relief that people had come was tinged with concerns of what are 'we' doing here?</p>	<p>Before today - the blessing and rotary hoeing, 2 April 2007, 6 am</p> <p>Four days after the lease was signed between the WRPHO and the District Council the land was blessed and immediately rotary hoed. There was real urgency to get this, the 'first' garden, underway. Pressures combined, of wanting to see this project progress, and knowing the end of the winter crop planting season was fast approaching. As a public event attended by 14 people, the blessing was itself a milestone. Actions on that day, such as the extensive rotary hoeing, became very significant for the project.</p>
	<p>Preparing to turn a playing field into a potential community garden</p> <p>3,000 seedlings purchased; 2000+ invitations / fliers distributed in the local suburb; radio and newspaper adverts placed; nearby groups visited; residents in the closest streets visited; sunscreen dispensers, a gazebo-tent, balloons, and displays set up; a 'visitors' book' to record attendance developed.</p>
<p>Over 50 people came – comments included:</p> <p><i>"I'm too old to garden but I wanted to come and show my support"</i></p> <p><i>"I live around the road, walk my dog here every day – I wondered what was going on here"</i></p> <p><i>"To be able to show the young ones how to garden here, the way that I was taught to garden."</i></p> <p><i>"This is about supporting community – that's what people do"</i></p>	<p>Participation as action</p> <p>People - watched, asked questions, had conversations, told stories, shared ideas on planting, tools, their gardening experience / inexperience, knowledge of organics, permaculture, likes / dislikes of vegetables, views on what should be planted, where, when and how; hoed, spread fertilizer, planted plants, shifted turf.</p> <p>Came with plants, tools, a worm farm.</p> <p>Brought themselves, children, their extended family, neighbours.</p> <p>Came as individuals, family / whanau, locals, members of groups and organisations.</p> <p>People worked alone, in small groups, with friends / whanau, with strangers, and kids joined in or played separately.</p> <p>Stayed for minutes to over six hours.</p> <p>Questions, questions and few answers</p> <p><u>The adults asked me:</u></p> <p><i>"Why hadn't the site been 'round-upped'?"</i> [Sprayed with herbicide.]</p> <p><i>"How will you stop vandals?"</i></p> <p><i>"What about rabbits?"</i></p> <p><i>"Has the soil been tested – what did they find?"</i></p> <p><i>"Why are you using blood and bone / lime?"</i></p> <p><i>"Who is in charge here?"</i></p> <p><i>"What do you want me to do?"</i></p> <p><i>"What is the plan?"</i></p> <p><i>"Is this the right way to do it?"</i></p> <p><i>"Where is the water supply?"</i></p> <p><u>The kids asked me:</u></p> <p><i>"Lady, is this civilisation?"</i> A young preteen novice but enthusiastic gardener asked me while we gardened together. He had appeared with two mates – on the way to their fort which I assumed was somewhere in the long grass and trees beside this 'park'.</p> <p><i>"What do you know about civilisation?"</i> I asked. He replied – "looking after people", "working together", "sharing things" – at school they had been learning about civilisation.</p> <p><u>Questions followed:</u></p> <p><i>"Were the plants [supposed to be] 20 – 30 [cms] apart?"</i> (They had been given specific instructions by another adult.)</p> <p><i>"Who would stop the vandals?"</i></p> <p><i>"What about [name of older boy] who breaks off the trees here?"</i></p> <p><i>"Who will look after the plants?"</i></p> <p><i>"Who will eat the vegetables?"</i> (I made a comment about 'veggies' and was asked if I meant vegetables.)</p> <p><i>"Can we eat them – are we allowed to?"</i></p> <p><i>"Are you camping here?"</i> [Having seen the tent.]</p>
<p>Planted</p> <p>Mainly in rows - cabbages, leeks, cauliflowers, broccoli, silver beet, lettuces, and endive. Someone artfully planted pansies and calendula in little groups.</p>	

Figure 13 The first planting day

When talking to people later in the year about the planting day, many fondly remembered the event and their descriptions included:

“...a really nice day, quite a number came and I thought ‘this is fantastic....’” (Int. 10B, p. 11)

“Yes I went to the April planting, which was a great day really. It was really good, and it was good to see some youngsters there and people come along. [...]. I remember coming home with a very sore back with all the bending over” (Int. 12A, p. 5)

As well as the positive perspectives, some people were more guarded. As is identified in Figure 13 (p. 182) many people were asking key questions for which there were few answers. The questions related to what had been done to date – specifically ploughing such a large area - and how the garden would be developed, worked and progressed over time. Different perspectives on horticultural techniques were being aired openly, and the desire for some direction, structure and leadership was also articulated. There were also concerns raised about who would do the work. A community member reflected on the planting day and also some of the consequences of the approaches taken:

“Well, I’d like to have seen fewer things planted then, more concentration in a tighter area, more care taken with what was planted. It should have been mulched, what was planted should have been mulched better. [...]. I would probably use it [the community garden] to point out what you shouldn’t do” (Int. 18A, pp. 6, 7)

The questions asked by the children (Figure 13, p. 182), including who would look after the plants and stop the vandalism that they knew occurred already, were insightful, pragmatic and reflective of local knowledge. The exploration of whether this activity fitted with learning about ‘civilisation’ as civil action portrayed how thoughtful the children were about the day – this place and space – and that the action occurring was meaningful for them as local community members. It also demonstrated clearly the overlaying of concepts in practice, such as ‘community’ and ‘citizen’ which are often separated within

theoretical analyses (for example, Arnstein, 1969; Cornwall, 2003; Kahssay & Oakley, 1999).

Community participation as inherently bound to this place, this space

To meet the GABTR programme aim, the positioning of this garden was important. Not only did the land need to be suitable for gardening and for a public garden (as has been previously described), the ‘community’ also needed to meet criteria as residing within a high decile area, with populations from the ‘target groups’ of Māori and Pacific peoples and those with a low income. The Aramoho demography and the site of Te Mana Park met these criteria, but, as identified by a community member, individuals within the target groups may not be in ‘need’ of the project:

“And this is another thing – talk about the target group being Māori, Pacific Island and low socioeconomic – why don’t they say ‘poor whites?’ Are all Māori in need? Are all Pacific [people] in need? You know there is a terrible presumption about that.” (Int. 10B, p. 5)

As is typical of any community, it was as diverse as it was homogenous. A community member describes the community:

“It’s kind of like there is a whole divide, that school [the primary school beside the garden site] is a whole divide.”
(LB) *“Right through the community.”*
“So ... even Mitchell Street and Aramoho going up that way are probably white, predominantly white middle class and then you have got the pocket of Paterson Street, Kotare Street which is low socioeconomic and then you have got the gang⁴⁸ further down. It’s interesting, Māori and low socioeconomic, so there is like pockets” (Int. 20A, p. 18)

Later in this interview we discussed how it was probably not so much the school that created the physical divide through the community but possibly the stream which ran beside both the school and Te Mana Park. This area, the stream, school and Te Mana Park also represents the official census boundary

⁴⁸ The gang refers to the Mongrel Mob gang, a chapter of a New Zealand gang and one of a number of gangs in the Whanganui community. The suburb of Aramoho is known as the neighbourhood of this gang. When referring to ‘the gang’, community members often included anyone associated with the gang - whānau - partners and children.

between Upper Aramoho (to the right in Figure 14) and Lower Aramoho (to the left).

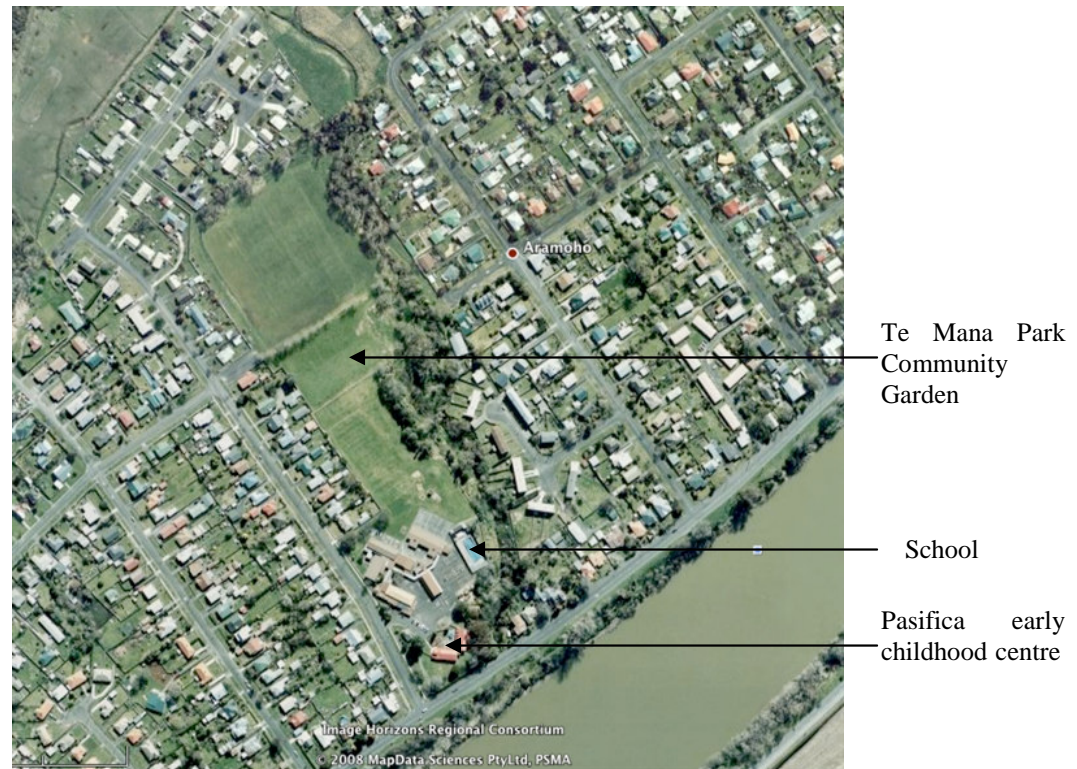


Figure 14 The green belt, including Te Mana Park, dividing Aramoho

The perceived lack of a strong sense of community was also identified by another:

“The lack of a cohesive community is [an issue], a wide range of people live in Aramoho, a very wide range and to engage them all in one particular project like the gardens in a positive way is not easy.” (Int. 19A, p. 13)

“... there’s not as big a sense of community as there used to be in years gone by,” (Int. 9A, p. 6)

Raeburn (2000, p. 284) argues that “... most New Zealand suburban and other communities have a powerful underlying desire for community, ... even if this is not immediately apparent from what people are currently doing or saying.” Certainly the community garden was predicated on a perception that a positive

sense of community for that community would be an outcome of the intervention. 'Local' therefore held special, but disputed, significance.

A garden for local people

To meet the programme aim people from the local community were perceived as the ones who would be involved in the garden, as is outlined in information about the project that was released before the garden site was leased:

“Council’s looking at Council-owned sites which could be lent to the project for developing the gardens and orchards. For this to work and to be sustainable long-term, we need members of the community to become involved in community gardens that will be established near them. (Wanganui District Council, 2006a, para. 4)

Another person involved in the early stages of the programme describes a vision for community gardens which is very much related to the garden being for local people:

“... in the ideal world I would like to think that people will come along here that don’t have gardens. They will be supported by those experts we have, the kaumātua down the road, those people that have volunteered their expert time to come along, and they will show them how to nurture the garden, how to grow their things. Those people will then go home and do that at home but will also feed back in so that they are a second layer. So that when new people come they can see, ‘hey look, this is what I did, check my garden out at home. I did, I worked here [at the community garden] for six months until I really felt comfortable, got all the skills that I needed.’ And ‘go and see old Joe over there if you want to know about potatoes’ and ‘so and so is the expert on this and Bob down the road is an expert [on that].’” (Int. 8A, pp. 11-12)

Encapsulated in this quote are the ideas of the garden being integrated into the community spatially as well as the garden and home linking synergistically. Other key concepts included drawing on local expert cultural knowledge from kaumātua, experts in gardening, and the sharing of information between generations. The dual foci of community building around relationships combined with growing food are obvious and reflect findings of research into other community garden projects, for example in the United Kingdom

(Holland, 2004), Toronto (Wakefield, Yeudall, Taron, Reynolds, & Skinner, 2007), and New York City (Schmelzkopf, 1995). Different people involved in the project put varying degrees of priority on those two components but both were crucial for the success of a community garden, as a community member identifies:

“You can’t have the garden without the reasons for coming there as a community and enjoying each other’s company and supporting each other.... [...] So therefore community is quite as important as the food, and that is the two strands.” (Int. 10B, p. 1)

The specificity of ‘as a community’ brought out different perspectives of who was the local community.

Contested local identity - who is local?

Although the answer to the question of who is local seems self evident, especially within a project which is targeted at a particular community – as in both the locality and people - this was not so. Many discussions occurred with people involved in the programme, both health sector staff and community members, and specifically in the community garden project about ‘which were the locals that attended such and such an event?’ ‘Were they from the ‘target groups’? Many comments were made about how people who attended events came from outside the local suburb:

“Because the day they did the planting, the main planting, there was a couple came down from [a more affluent suburb] and those two, I actually spoke to them, ... they had come along ... and it was really neat to see them. And at the last working party there was a lady turned up on her bicycle and I think she had come from a fair distance away....” (Int. 9A, p. 7)

In a small city the size of Whanganui the concept of local remained complex. An additional factor compounding the complexity was that without additional clarification⁴⁹ regarding the type of community garden this would be, many

⁴⁹ I was unable to find any documentation or to identify where any agreement was reached as to the ‘type’ of community garden envisaged. Emphasis on communal gardening or individual allotments or a mix of types changed depending who I spoke with or what documents I looked

community members who were interested in the concept of community gardens saw these as gardens for the community as a whole, community in this case being the city, and wider, rather than the suburb. Health sector staff had a stronger focus on local community members as proxy for the target groups for the programme. This raises a core issue in relation to understandings of community participation and health promotion and how those concepts are somewhat incongruous with health sector constructions of target groups and at risk groups (Bunton, 1998).

For some, close proximity to the garden was seen as important for their personal ongoing participation. A few people who had previously attended Community Gardens group meetings chose not to continue or to reduce their participation once a garden site, away from their own suburb, was selected for the garden.

“... I kind of knew that I probably wouldn’t be getting that involved because it’s [Te Mana Park] just too far, it isn’t my neighbourhood. But I have been down a few times just to show support.” (Int. 18A, p. 5)

This person went on to comment that:

“[Te Mana Park] – you see that is even further away... and further away from my friends and so their involvement dwindled....” (Int. 18A, p. 3)

This person’s interest was also in establishing a community garden within his own suburb. For the individuals who held a philosophical view of community gardens being associated with the work of other groups with interests in social causes, specifically related to environmental sustainability and social justice, this was a common desire. Proximity was also seen as a pragmatic gardening issue, and a community member with much experience in community gardens commented:

“The other factor is having to go somewhere means that you only go there once a week and you are never there to turn the water on, turn it off, do other things.” (Int. 17A, p. 8)

at. The issue was not that a type of community garden was most appropriate; rather that individuals and groups were working towards different visions.

This pragmatism highlighted a key tension. For the garden to be sustainable it needed regular and ongoing work and therefore people's participation on a regular and ongoing basis. The programme focus was on events, such as the planting day, as a way of drawing people to the garden. For most of the time there were no ongoing structures in place. There were no information signs signaling what could be done, what needed to be done, whose garden it was, what the plan was for the garden, and who people could contact for information. With no-one regularly at the garden who knew about it and how it linked with the GABTR programme, the garden was in limbo. As a result there was a hiatus in capturing those who showed any interest outside of the event days, or even in directing those who joined in as to what they could do next. For example, the garden was chosen as one of the city sites for a apple tree giveaway specifically so that people would be drawn to visit the garden while collecting their free tree. At this time (July, 2007) the garden was in its winter 'benignly growing phase' with the crops that had been planted in April well established and the five scarecrows on display. Over 200 people came to the garden to collect their tree. In my field notes I noted that:

- Probably $\frac{1}{2}$ or maybe $\frac{1}{3}$ of the people went and looked around the garden.
- People came to this site because it was close to home (e.g. some of the young kids), or they had missed out (getting a tree) from the garden centre sites last year, or they had read or heard about the garden / scarecrows and wanted to visit and used this as an opportunity to do so.
- Probably $\frac{1}{2}$ of the people I spoke to didn't know that the garden was there (no signage), probably $\frac{1}{4}$ knew that the garden was there and had visited it (but many commented that they didn't know what they could do in the garden, how the garden worked - no signage again). Others had heard about the garden but hadn't visited⁵⁰.

Events, such as this, operating without infrastructure, meant that people who found the garden or who heard about it and visited had few avenues for participation unless they were confident in gardening, able to supply all their own equipment, and very motivated and prepared to 'go it alone.' Although there had been much information distributed locally and throughout the city

⁵⁰ Field notes, 7/7/07, pp. 1-2

about the garden, including flyers, newspaper articles and advertisements, this written information had limited effect in drawing people to the garden to work.

When should / would local people get involved?

There was general agreement from the Steering Group and the Community Gardens group that community members should be part of the project development from the beginning and this was noted at the first Community Gardens group meeting and documented in the minutes as “(c)ommunity gardens haven’t been established in Wanganui before⁵¹, so the key to success is running the project the right way. The first step is to have the community on board”⁵².

Those involved in the programme directly, either as programme staff or as members of the Steering or Community Gardens group, also expressed quite different perspectives on when ‘the locals’ should or were likely to be involved in the garden. One pressure which impacted on the amount of preliminary work that programme staff could do to foster more participation from local community groups and individuals related to the short time between obtaining the site lease and the perceived need⁵³ to get the gardens planted before winter.

“... and yes I know that we need to plant the gardens at a certain time. But actually we have to get all that structure around it sorted. [...]. Saying we will get the gardens started, planted and we will pull them [community members] in later, I don’t think will work, and that worries me.” (Int. 8A, p. 7)

In reflecting back on the rush to get the community garden underway a Steering Group member commented:

⁵¹ Community members told me of a number of different community gardens and orchards which had previously been developed, some in quite close proximity to Te Mana Park, and some operating quite recently.

⁵² Community Gardens group minutes, 22/11/06, p. 2.

⁵³ As was identified by a community member at the planting day (Figure 13), another approach would have been to hoe the land at that time and then concentrate on preparing it for spring planting (while also working with the community to engender support for the garden). The short project timeframes and need to see results appeared to militate against this approach. The community garden project had to fit within the bigger predetermined programme timeframes, with seasons for planting, and with divergent opinions of how and when the establishment should occur. This therefore raised the problem of project leadership.

“Certain members of the community, such as the Community Gardens group wanting to see action; certain members of the Steering Group wanting to see action in terms of ‘where is this’? ‘When is this community garden going to be up and running’? So there were some issues like that around key milestones, ... - some of them weren’t ready for their time.” (Int. 19A, p. 11)

This then had a compounding effect:

*“... as far as I am aware they [two people named] were the only **real locals** we had who were involved in that day [the blessing]. And that was very important – that would be a milestone – it was very important in terms of the development of that community garden to have community buy-in right from when we had the blessing. The ground work that would have been involved in really getting the community on board would have taken a lot longer than that April deadline that we had, of getting things done” (Int. 19A, p. 13)*

Sometimes different perspectives of the timing of local people’s participation were related to personal preferences, cultural patterns, and comfort with involvement at different stages, such as participation in planning and meetings versus active gardening. An ongoing tension in the project related to the lack of balance between those who gave advice versus those who were, as one community member identified in a Community Gardens meeting, ‘practical people’ who would be actually involved in doing gardening work⁵⁴.

Just before work on the garden site was commenced I spoke to a Steering Group member about involving one of the programme target groups in the garden:

“...I haven’t done anything about [getting people involved in the] community gardens as such because we’re not at that stage yet ...”

(LB) *“... I’m really interested in that because a number of people have said about different groups getting involved in the gardens at different stages and I wondered what the right stage would be for your community?”*

“To get them involved with the hands on, the original preparing of the garden.”

(LB) *“Okay, so not so much about the planning about the gardens?”*

⁵⁴ Field notes, 10/4/07, p. 1.

“No, the people I’m thinking of, not at this point in time. ... These people that I’m thinking of are more doers.” (Int. 7A, pp. 2-3).

Another Steering Group member outlined a similar point in terms of working with these communities:

“... [a member of a community group] said, ‘you just let me know when they start digging. That’s what we are interested in. As soon as the first spade goes into the ground I want to know, because that’s when we’ll come.’ Because they consider all that other planning kind of stuff, ‘that’s where you fellas sort that out, we’ll come along when it’s [underway].’” (Int. 6A, pp. 5-6)

From my observations at events held at the garden and in discussion with others it was unclear as to the breadth of participation in the garden by people from the targeted ethnic communities. There was consensus that any involvement was likely to have been minimal with a small change once the garden coordinator was employed⁵⁵.

Others, while identifying that local people needed to be involved in the garden from the beginning, also recognised that the process of the community taking ‘ownership’ of this imposed garden may take time:

“... I imagine quite a lot of our members [of a community group] will be there to do the first turning of the sod to get the gardens going, even though we will then bow out and let the local community take over, which is probably what will happen.” (Int. 3A, p. 2)

“Because ideally, in three years time we won’t need to be involved, the community will be doing this themselves.” (Int. 8A, p. 22)

Identifying what skills different groups of people could bring to the garden was also identified as important:

“You have got to have middle class people, because they are the ones that know how to work things, ... we can get money from the PHO for this and we can apply for this or we can ask for support from there.” (Int. 10B, p. 12)

⁵⁵ Field notes, 10/4/08, p. 1.

A mental picture therefore develops of a simple idea and aim of a vegetable garden being developed in a public space, enmeshed with competing perspectives of who should or would be involved in that garden and when that participation would occur. An imagined, ideal-type community (Mayo, 2000), which is often un-located in space and time (Murray Li, 1996) that would organically be drawn to participate, did not eventuate in reality.

Contrasting visions with reality: When there is little participation

Although the theoretical discussions and dreams about who would participate in the garden were important for those planning the garden project, it soon became obvious that except for attendance at a few events, the garden was largely empty and untended. A community member, interviewed five months after the garden was first planted, stated:

“Because honestly, between the working bees [which had started the previous month] you can’t see any obvious signs of anybody actually going in and doing anything” (Int. 9A, p. 6)

This person also noted:

“... I have found that if you are up there, there is usually only yourself there. [...]. ‘Cause even the ones that were at the [Community Gardens group] meeting, I haven’t seen hide nor hair of. A lot of them, I haven’t seen there [at the garden].” (Int. 9A, p. 2)

Another community member commented on how a community garden without the community involved and present was just a garden:

“... so really the whole [project], it depends on developing a community garden doesn’t it, the ‘community’ part of the garden.” (Int. 10B, p. 10)

Personally, the lack of community participation became clear to me as I repeatedly visited the gardens and no-one else was there. In the nine months between the land blessing and the end of December 2007 I visited the garden (outside of the small number of events held there) on 26 occasions (as described in Table 11), on different days of the week, at different times of the day – but always during daylight.

Table 11 My visits to the garden

<i>Others present at the garden during 26 visits (outside of GABTR planned events)</i>	<i>Number of times observed (n=26). Multiple categories possible</i>
No-one else	15
People gardening / harvesting	2 (2 individuals once, and once a family)
People walking dogs	4
Children playing in the garden	3
Adults in the garden or next door park – came and spoke to me or I spoke to them	4

The most common question people visiting asked of me was ‘whose garden is it?’ In response I asked people whose they thought the garden was. A few said that it was ‘the community’s’. Other replies included that it was associated with the local polytechnic, the District Council, and the nearby school⁵⁶. Except that it was on land leased from the Council and that organisation supported the garden, these latter replies were all incorrect.

I usually spent about 30 minutes at the garden, often using this time to draft field notes, and so sometimes would see a number of people over that time. But the overwhelming sense was of emptiness. A Steering Group Member who visited the garden regularly described it to other members of the Steering Group as ‘desolate’⁵⁷. The emptiness of the garden also became even more obvious when I printed my photos, which I took on most visits, and slowly the realisation dawned that I had an enormous number of photos of growing vegetables and later weeds, with very few people.

⁵⁶ Field notes, 17/6/07, p. 1

⁵⁷ Field notes, 10/9/07, p. 2.

Participation in the garden as a part of becoming local

In talking to people about why they got involved in events at the community garden I found that of the small group that had the most involvement in the community garden through GABTR programme⁵⁸ activities, being ‘new’ to the city was a common theme:

“... I have been living in Whanganui for about 18 months now ...”
(Int. 18A, p. 1)

“... we moved to Whanganui about two years ago ...” (Int. 12A, pp. 1-2)

“... we are relatively new to the area so it’s a good way of getting to meet people too.” (Int. 9A, p. 1)

“... we have only been here five years” (Int. 10A, p. 5)

What was also common for those people was a strong sense of participation in the garden as offering the opportunity to ‘ground’ oneself – spiritually, and physically. This aligns with reported benefits of community gardens in quite different contexts such as New York City (Schmelzkopf, 1995) and Toronto, Canada (Wakefield et al., 2007). The following description of a community member’s participation in the blessing of the garden site clearly portrays this. The event incorporated two intertwined events – a blessing and turning of the soil ceremony held at dawn, followed immediately by large scale rotary hoeing of the plot.

“... I made a big effort to go to the blessing ceremony ...”
(LB) “So you made a special effort to go to that, can you tell me why?”
“Yeah, well having recently arrived in Whanganui, I felt it was important for my own sort of grounding process, if you like. And I felt I could participate in that ceremony ... because I am interested in Māori affairs. There were other reasons, but due [primarily] to grounding myself.”

⁵⁸ There was of course participation in the garden which was not linked to the programme and was not known of by programme staff or myself – this will be explored later in this chapter.

(LB) “So tell me your recollections of that event.”

“I cycled from here and was a little bit late and so was cycling like mad and then,... because I thought I knew a short cut ... - go through the school grounds right to the fence, park my bike and then hop over, which I did. So I thought where are they? Very, very misty, still quite dark. And just through the mist, I could see a group of people. And you were all just standing there and because I was late I imagined you were just about to start making your way across to where I was. So out of courtesy your group didn’t move but just watched me make my way towards you. So it was a bit surreal really. ... But my recollections were of, is it [name of kaumātua], I was terribly interested in that ..., and I was very pleased to have taken part in that. Because from a spiritual point of view it was important for me to be there from the beginning of something – and of course at that point we did have high hopes for the place. And then after [kaumātua] spoke for quite a long time and we did the planting of the thing [a hāngi stone] and ... [I] got something from my bag, an apple I think, and put that as an offering, ... I was pleased to have done that.” (Int. 18A, pp. 3-4)

For this person, the blessing therefore encapsulated a combination of the cultural and spiritual, as well as being involved in a project ‘from the beginning’ and holding ‘high hopes’ for the future. I personally found this ceremony deeply significant, both for myself and for the programme as a whole. In my field notes I recorded some of my own experiences during the ceremony:

“We started with the karakia in the car park – in Māori and then with a discussion about the meaning in English (rather than a literal translation). This included comments about the land and ancestors There was fog all over the field and the sun was beginning to rise. The peace was palpable, it made me think about all my academic ramblings about what this space was. There were bird calls and birds flying overhead – very nosily breaking the peace – and loud drips of water off the trees lining the park. The grass was really wet with dew and as the sun rose and the sky lightened, the park was so obviously green – a change from a few weeks ago when it was browned off with the heat and lack of rain. It did seem important that the place was green for hoeing and planting⁵⁹.”

With extensive advertising and over 500 invitations sent, 14 people attended this event. That included the kaumātua and his wife, a programme staff

⁵⁹ Field notes, 2/4/07, p. 1

member and two family members, five community members (three had been involved with the Community Gardens group), three members of the Steering Group, and myself. Following the blessing, the site was rotary hoed and of those attending, five men were actively involved in this process to varying degrees. Others not involved drifted off from the group and left the park.

Compared to the peacefulness associated with the blessing, the ploughing was an active and enthusiastic process with the men measuring and plotting out the garden beds with string lines, the tractor hoeing, and the soil being examined and the amount and size of the pumice commented upon. Pieces of concrete (apparently from old soccer goal posts) were removed and garden plans were discussed, including places for tomatoes and fruit trees espaliered along the fence.

There had been many discussions about staging the development of the garden. This was specifically so that those involved could manage the work⁶⁰. Two clear phases of development were identified, but after the blessing enthusiasm seemed to take over. Within a period of about an hour, ten long beds 1.5 metres wide, approximately 40 metres long,⁶¹ and a large ten by ten metre square, for later conversion into a raised round garden, were rotary hoed. Another square garden was rotary hoed before the planting day two weeks later. This made for a very large garden, the size of which was soon to become a key problem. The design differed from the agreed staged implementation, and this was in a community where, to date, there had been little direct interest in the garden.

I was intrigued by how few people from the local suburb attended the blessing and hoeing (three from the area directly surrounding the Park), how few members of the Steering Group attended (three from the membership of twelve at that time), and how no other WRPFO staff, except for one programme staff member, attended. What surprised me most was that although the activity

⁶⁰ Community Gardens group minutes, 6/3/07.

⁶¹ The long beds were designed so gardeners could easily reach over them and the District Council contractors responsible for mowing the grass as part of the lease could do so easily.

occurred at daybreak in a public park surrounded by houses this appeared not have raised the attention of community members or even the police. As I drove out of the car park at 8.30am, children were sitting on the Park fence and walking to school as if nothing had happened. I felt as if I had been trespassing.

Relationships with this space

Rather than transforming the space into something new, the garden overlaid a pre-existing space, it was appropriated as described by Richardson and Jensen (2003). Developed on public land, there was no *local* community participation in that site choice. Official District Council public consultation would have been required for other proposed garden sites (Wanganui District Council, 2006c) if a change in the land use description was planned, but not for this site. This created confusion in the discussions by different groups as to what ‘community consultation’ was required legally rather than ethically or morally to place a garden there. Contrary to some views expressed that the Park was an empty space - waiting to be filled - people already had relationships with it in a number of ways as described in Figure 15 (p. 199).

These people’s experiences with the space which now contained the beginnings of a garden demonstrated prior ‘ownership’ of the space by the children and their re-appropriation of the garden (by using the vegetables as toys) which had appropriated their space. These experiences resonate with the argument that community “(g)ardens may also be both a source and a focus of tensions” (Schmelzkopf, 1995, p. 376). Also shown was the degree of watching and noting by the adults, and community relationships being played out over the garden between adults and children, reflecting community participation as part of social life (Campbell & Jovchelovitch, 2000).

Different perspectives of the garden in this space

<p>Adult female (interviewed 10/07)</p> <p>"Yes, I know Te Mana Park already, ... I go past there every day – twice a day sometimes."</p> <p>"I didn't join in that day [planting day]. I joined in the next time and the next time [working bees]."</p> <p>(LB) "So when you are there and it's not working bee time, do you see other people picking the veggies?"</p> <p>"Yeah, I see other people picking the veggies, and I see kids pulling them out and chucking them."</p> <p>"I have planted some silver beet plants and lettuces there." (Int. 13A, pp. 2, 4)</p>	<p>Adult female (interviewed 09/07)</p> <p>(LB) "So how often are you going to the garden now? "Well now that the weather is coming into being a bit nicer, a little bit more, maybe once or twice a week. ... If I'm up there twice ... one of those will be actually to do something [gardening] and the other time will be to see if anybody has done any damage."</p> <p>"I've been keeping an eye on that young tree that you planted, just to make sure it's still there."</p> <p>"Well, I enjoy gardening ... it's the love of gardening and I do a lot of stuff voluntarily My involvement with the gardens stems back to grandparents that were keen gardeners."</p> <p>"... I went along to the meetings [Community Gardens group] and I was ... probably slightly curious to see whether it would take off and fly or not. Because we have been here 2½ years and it was sort of 'okay', you got to know the area to a certain degree and knew the groups in the area, and I was just wondering if we would get to fly or not. I'm surprised it has sort of survived this long to a certain degree."</p> <p>(LB) "When you say survived to a certain degree? "Well ... the damage has only been minimal but the participation from the wider community hasn't been particularly big."</p> <p>"... I dug up our rhubarb patch here [at home] ... and I have planted three back here and taken four or five up [and planted them in the garden]." (Int. 9A, pp. 2, 3, 6, 11, 16)</p>
<p>Female (interviewed 03/08)</p> <p>"I regularly walk through there on my morning walks ..."</p> <p>"I have got a large section myself, as have most people on my block. I'm not inclined to garden; I gardened when I was younger maybe – that was when I was home with young kids. I work full time now and I can buy cheap fruit and veggies from PakNSave or Aramoho Fruit and Veg. But I did think it was a good project, I did think it was rather interesting but when I got over there I thought 'oh my gosh' ... 'this is huge, ... – absolutely huge.'"</p> <p>"I think the idea, the philosophy behind it is okay but the garden is just too huge. I have a friend who lives, whose house backs right on to that garden and she said 'oh I heard all the noise...' But even she has got a high fence, she has tomatoes growing ..., she has got her own little garden."</p> <p>"As far as I was concerned there weren't any Maori [as a target group] that came to those working bees. I tried to talk my brother into it because he is a gardener, he lives probably two streets along ... he said 'why would I want to do that, I've got my own garden.'"</p> <p>"You know I am actually quite removed from the garden. I don't think anybody in our street even cares about the garden." (Int. 20A, pp. 15, 16, 19, 20)</p>	<div data-bbox="758 1052 981 1946"> <p>Female (interviewed 03/08)</p> <p>"... probably the most support we have had in that community is from the kids. ... they have been there from the beginning and it is nice to see them because we know their names and they know who we are now.... And they get stuck in, ... and they have a bit of advice – 'you can do this and have a go at that....' He said [local adult community member] ... 'they don't have a park for the children in Aramoho. ... and he said 'well, all these other suburbs they have got ... playgrounds for the kids and we get a garden.' ... He was saying 'this is the kids' playground.' That is their playground and there is nothing for them to play with except a cabbage as a soccer ball. (Int. 19A, pp. 19, 20, 27, 28)</p> </div> <div data-bbox="981 1052 1340 1601"> <p>Male, talked together at the gardens (Field notes 1/5/07)</p> <p>Walks around the Park each day – exercising his dog. I have seen him here a number of times, including the 1st planting day – always happy to have a chat. He knows the Park's history.</p> <p>Says local kids asked him if he is the 'guardian of the garden' – he is 'keeping an eye on the place', and 'tells kids off' if he sees them doing any damage.</p> <p>He has a few vegetable plants at home but finds gardening too hard now. He was pleased that someone had come to check on the garden progress. He told me what needs be planted now. I left thinking – 'but who is going to do the planting?' 'Whose job is it?' 'Whose garden is it?'</p> </div> <div data-bbox="981 1601 1340 1946"> <p>Local kids at the gardens (Field notes 6/7/07)</p> <p>At every event at the garden I notice the same small group of kids appear – the ones who told me about their fort at the 1st planting day. Today five young ones appeared soon after we arrived and eagerly helped us to 'plant' the scarecrows. We picked cabbages and lettuces together for them to take home. One young boy told me how he likes to eat lettuce with mussels.</p> </div>

Figure 15 Different perspectives of the garden in this space

Before there was a garden there was ...

One of the first questions I asked residents who lived in close proximity to the gardens was ‘what is/was Te Mana Park used for, what happens there?’ A reply included:

“We had touch [rugby] practice there. [...]. ...at the school and on the top part exactly where the garden is. But there never used to be a fence there. [...]. It had previously been used as a rugby league practice ground but in winter it is just really, really boggy. So it was just one big green belt that people would walk through when they walked their dogs” (Int. 20A, pp. 16-17).

Before the garden was established I joined with two programme staff who had planned a ‘door knocking - community consultation’ activity in the streets neighbouring the Park. The site had been chosen by others many months before. I had suggested that it would be useful to learn more about the Park (as a community space) and so the purpose of this activity was to find out about the current Park use and also to ascertain potential interest in the garden.

Of the 17 houses I personally visited no-one was at home in 11 and one family were in the process of leaving the area and so were not interested in talking to me. Of those where someone was home, one person knew of the proposed garden, knew the Park had been previously (but not currently) used for sport practice, and immediately told me of the problems of vandalism at the Park, including graffiti. She also noted that the District Council did little to the Park except to plant some trees which had been damaged, and to mow the grass. This reflected a view expressed in a community survey undertaken in 2000 for the Wanganui District Council (National Research Bureau Ltd., 2000, p. 29) where a respondent was quoted as saying - “... Te Mana Park – it’s been completely neglected. All that ever happens here is it gets mowed.” The resident I spoke with also noted that the Council provided no amenities there.

Three other adults that I spoke with, all with young children at home and living within a few minutes walk, did not go to the Park at all. When I asked ‘why’

the reply was that ‘there was nothing there’⁶². Programme staff were also told that there was a history of vehicles (cars and motorbikes) regularly being driven over the Park, and that the Council-provided barrier bar between the car park and the Park was repeatedly damaged and removed to allow vehicles to enter the Park. This concern about damage as both a threat and an actual event was voiced by community members on an ongoing basis.

At a Community Gardens group meeting soon after the door knocking exercise and before the garden was established, the programme staff gave feedback about their ‘consultation’ with the community. In the Minutes it was noted:

Concerns were raised about having a community garden in Te Mana Park.

- There is a fair bit of vandalism and vehicle damage. Something needs to be done about the access ways where vehicles can easily get in.
- The landsite is too big to do all at once.
- Suggest erecting a farm style fence around the garden to keep vehicles and stray animals out.⁶³

These concerns set the Park and therefore the garden site as something of what Schmelzkopf (1995, p. 364) described as a “contested space”, where competing demands collide. Also raised was the issue of the complex relationships between places and health, labeled as “place effects” (Macintyre, Ellaway, & Cummins, 2002, p. 125). Authors (Witten, Exeter, & Field, 2003, p. 162) argue that “(i)mplicit in the provision of public amenities such as parks, recreational facilities and social and cultural services, is a belief that they are beneficial to residents’ well-being.” Te Mana Park, while being a large open space, was apparently contributing little to residents’ wellbeing before the garden was installed. To turn it into a place and space for health and wellbeing (Fleuret & Atkinson, 2007; Frumkin, 2003) would require the negative factors already in play to be managed.

⁶² Field notes, 26/2/07, p. 2.

⁶³ Community Gardens group meeting minutes, 6/3/07, p. 2

Vandalism as participation and as influencing participation

As discussed in Chapter Three, one of the criticisms of discussions around the concept of community participation is that it is generally seen as something that is inherently positive, and words used to describe participation include ‘authentic’ (Midgley, 1986a) and ‘meaningful’ (Gaventa, 2002). So when the most obvious sign of regular activity in a space, in this case the garden site, was visible damage (labeled as vandalism), this raised questions for me including:

- How does this action fit within an exploration of community participation?
- Does all activity at this site (public space), even vandalism, constitute participation in the project?
- How does this ‘type’ of participation (as evidenced by the damage) influence the participation of others?

Before the garden was even established much of the discussion with community members related to their concerns that the garden would be vandalised, especially as access to the site was completely open⁶⁴ but the space itself was secluded. Interestingly, internationally and in quite different environments, fencing of community garden sites to either keep people or animals out raises issues in terms of closing down the purported public space (Schmelzkopf, 1995) and pragmatically, being costly (Ward, Ballif-Spanvill, Fuhrman, Solomon, & Widdison-Jones, 2004). There was a history of property damage in the area generally and specifically at the Park, with graffiti and tree damage at the Park, and vandalism and burglaries reported at the adjacent school. Having already experienced vandalism, and with an expectation that

⁶⁴ Some of the initial planning documentation for the garden development identified that they would be fenced, locked outside of specific hours, and that local people would hold access keys. There were also discussions about the need for the spaces to remain public and therefore open to be both philosophically congruent with some people’s perspectives of community gardens and also to meet District Council requirements that the space remains open. This requirement was not documented in the site lease. It is unclear how the decision was made that Te Mana Park would be an open garden and the issue of fencing and security for the site was raised repeatedly by community members.

the garden would become a site of future damage, community members suggested that this was one of the reasons why a local school had not become involved in the garden⁶⁵. A community member commented in relation to the vandalism at the garden:

“But ... the damage in the garden now is just a continuity of the damage I have seen done up there to young trees We have heard stories [before the garden was established] of people tying their motor bikes to the young trees and towing them out, ... it’s just a mind set.” (Int. 9A, p. 3)

After listening to these concerns and also hearing the questions asked directly of me at the planting day about safety of the garden I returned to the site three days after that planting day to see what had happened in the interim. In my field notes I wrote:

*“Went to the garden (4.30pm). It is very dry – no rain so far. Some plants are looking great, some were looking miserable. [...]. There were about ten plants just lying on the soil – I think pulled out by the flock of blackbirds that were there when I arrived. The garden desperately needs ongoing care – it does look a bit of a mess, but without water soon, it will be a disaster. Emailed [staff member] today regarding the lack of water and birds – hopefully it will either rain or something will be done to get water on the site (and people will be around to do the watering). It would be terrible if the lack of water was the failure point. No sign yet of the two legged (human, not bird) vandalism that people warned about.”*⁶⁶

There was a gradual escalation in the deliberate damage at the site, which people told me related to school holidays. It was directly linked to site developments, such as the garden shed, which provided more opportunities for destructive activity. Types of damage varied from small seedlings pulled out and dumped on the grass or in the nearby creek, established strawberry plants and two year old fruit trees carefully removed from the gardens, to the new garden shed completely wrecked within two weeks of installation (see Figures 16 and 17). Following continued damage, and negative media, the remains of the shed were removed five months later. There were ongoing levels of petty

⁶⁵ Field notes, 7/5/07, p. 3.

⁶⁶ Field notes, 24/4/07, p. 2

vandalism, such as footprints in the new garden shed concrete pad, and attempts at graffiti in the shed using lipstick.



Figure 16 Variations of vandalism - butchered broccoli

(Te Mana Park community garden 29/8/07)



Figure 17 Variations of vandalism - demolished shed

(Te Mana Park community garden 2/1/08)

Once I found a very smelly, dead and decomposing hedgehog in a plastic container neatly planted in one of the raised beds amongst the broccoli. The

five scarecrows lasted approximately two weeks before they were removed because of extensive wear and tear and deliberate damage⁶⁷.

People had different ideas about who was responsible but overall the perception was that it was youth causing the damage – from local preteens, to older youths, to those associated with the gang, to youths visiting the area. This mirrors the perceptions of “... young people as an inherently problematic presence in the public realm” (Collins & Kearns, 2001, p. 401). Some adults reported that they had seen people doing the damage and had either ‘told them off’, reported the damage to the programme coordinator, or had phoned the police, depending on the severity⁶⁸. A local community member reported to the programme coordinator that while harvesting vegetables to deliver to the Food Bank she was verbally harassed and the picked vegetables destroyed by a group of young people. This person felt intimidated and was concerned about retribution from those responsible if the police became involved⁶⁹, and I never saw her at the garden again. In this case the person knew the culprits, but in many instances, either the damage occurred when no-one was around or the people responsible were unknown.

The damage was certainly noticed and commented upon. After reports from community members, newspapers ran articles with photographs entitled ‘Vandals attack shed at community garden’ (Maslin, 2007) and ‘Vandals strike at the community garden’ (Stowell, 2008, January 9, p. 15). In this latter article a local person was quoted as saying:

⁶⁷ The damage to the scarecrows was partially wear and tear, demonstrating inexperience in making scarecrows, and little consideration by the makers that they would remain outside during winter. I had commented to a few people, including some friends who helped me to make our own scarecrow, that the scarecrows should not be too well dressed (having seen some of the clothes that had been donated for the purpose). Poignantly, some of the children who helped us to install the scarecrows in the community garden asked if they could take the knitted jerseys that adorned them, to keep themselves warm. These jerseys were out of fashion but in good condition. It clearly demonstrated the gulf between the circumstances of those involved in the garden in different ways.

⁶⁸ Field notes, 24/9/07, p.1.

⁶⁹ Field notes, 26/9/07, pp. 2-3.

A shed was built to keep tools safe on site. But John, a local man who walks his dog there almost daily, says the small building has been so steadily vandalised that it has never been used. Elsewhere in the garden stakes have been pulled out, small fires lit, the shed siding scattered and the fences marked with graffiti. The vandalism happens at night, and John says it has been disheartening. (Stowell, 2008, January 9, p. 15)

Being disheartened was a common reaction. Another person phoned the programme coordinator to detail concerns. Living locally, being aware of the history of damage in the area, walking through the area regularly, watching the damage escalate, and already suffering from depression, this person suggested the programme should be disbanded⁷⁰.

But this was not the only reaction. On talking to people about the plants that had been removed from the garden (including strawberry plants that I had purchased and planted myself, and two of the three apple trees planted), more than one person commented that the plants had probably been removed so that they could be cared for properly. Others suggested that they were being used to establish gardens elsewhere. A community member recounted a discussion with another:

“She saw someone wandering down the street with a whole lot of seedlings that they had taken out of the garden and she said to them ‘they are for the garden’ and the child responded that ‘mum said we are going to have a garden at home so we are taking them to plant there.’” (Int. 21A, p. 6)

One community member, interviewed in September 2007, who continued visiting and working in the garden, stated:

“... I have talked about this initiative to some of my cronies and I think it is a characteristic of people who are growing older and have seen it all before, and are cynical and are often quite negative. They expect it to fail dismally – [they say] ‘oh yes it will fail, the vandals will get it, I told you so, the vandals will be in, nobody will want to do any work.’ And I think a lot of these things

⁷⁰ Field notes, 24/9/07, p. 1.

they are saying are probably very true but I think that you have got to be very positive about it and even if you touch one heart out of several it is worth doing. And there will be setbacks, like this vandalism that we have had and there will be more than that. Somebody is going to come in one day and raze the crops to the ground I am sure, but we will just plant it again. (Int. 12A, p. 16)

One part of the organisational reaction to the ongoing damage was to distribute a feedback form to the local community surrounding the garden, requesting that community members comment about the garden development. Questions included whether the resident had visited the garden, their ideas on how the garden damage could be avoided or reduced, what was needed to enable the local community to have pride in the garden and what would encourage them personally to be involved in the garden. There was limited community response to the 1,400 forms distributed, with eight written replies received and two telephone calls to the programme coordinator⁷¹. Of the written replies, five people had visited the garden. Suggestions for reducing the damage included:

- Recognition that there will always be some damage;
- storing equipment with local residents or at the school;
- people casually visiting and working in the gardens;
- deliberately engaging local children and adults; and,
- security surveillance by private companies or by the WRPFO, and installing lighting, security cameras, and high security fences.

Actions suggested - all revolved around getting people, especially young children more interested - and included:

- Involving schools;
- more information to local residents via newsletters, publicity, (while one person commented that the garden had been well publicised);
- participation rewards, such as ice cream for children, gardening competitions; and,
- electing a group of local caretakers.

⁷¹ Field notes, 8/10/07.

Some people provided their contact details (although this was not requested) so that they could now join in (having noted that this was the first time they had heard about the garden). Final comments provided included:

“Proceed despite vandals. Don’t let the vandals get the idea they win.”

“It’s a great idea and congratulations on doing so well. Sorry I can’t help. Good luck!”

“Get children to get involved in community things during holidays without a cost.”

“Congratulations! It’s a wonderful thing you and your team of gardeners are doing.”

“The garden is a wonderful idea and we do hope you will be able to make it flourish and become a meeting place for families who share a love for home grown veggies and flowers (and fruit).”

“Any community project should try and include people who live next door to be the watch dogs.”

I was unsure as to whether the last comment reflected a hint from those specific people mentioned that they should have been contacted directly or that it was a general statement. The other comments reflected those often heard when the project was discussed in nearly every forum. These included positive acclamation for the idea of a community garden, many ideas of what could and should be done, but few tangible offers from people interested in becoming actively involved. At the same time things were happening at the garden outside of project events that were loosely linked to the programme as a whole.

Participation outside of project events – where have all the cabbages gone?

There was limited organised work happening at the garden but, in spite of the lack of maintenance, the seedlings planted in April grew. The question then arose as to where the produce went - what happened to the produce from over 2,000 cabbages, cauliflowers, and leeks? With no ongoing coordination of the garden at this time, only some of the produce could be accounted for:

- I gave lettuces to young children playing in the garden when we erected the scarecrows. These children were some of the ones that had helped

plant the seedlings. One of the boys told me that he came and picked the lettuces regularly⁷².

- Produce was harvested and distributed amongst the people that attended a working bee and some was then delivered to the Food Bank the following week⁷³.
- I spoke to a community member who told me of harvesting a few vegetables from the garden. As a person on a low income she identified how her involvement at the garden included: “*Collecting vegetables, which is good. You don’t have to pay for them*” (Int. 13A, p. 3).
- A community member talked of distributing produce to elderly people.
- On visiting the garden I found local people harvesting vegetables a few times – once an elderly gentleman picking broccoli⁷⁴, and once a young family harvesting and eating raw potatoes⁷⁵.
- A lot of the produce went to seed, and the same brassicas remained in the ground a year later.

In considering the use of the garden produce a number of different perspectives came to the fore. On one hand, as an open community garden, did it matter who took the produce and was programme surveillance appropriate? On another hand, for the garden to be sustainable over time there needed to be a balance between the work going into the garden and the produce coming out. This imbalance was an ongoing problem, with little new planting and maintenance being done. In addition, the project was to be evaluated against its main aim of increasing fruit and vegetable intake within specific population groups and without evidence as to who obtained the produce, progress against this aim was difficult to assess.

⁷² Field notes, 6/07/07, p. 2.

⁷³ Field notes, 8/09/07, p. 1.

⁷⁴ Field notes, 11/09/07, p. 3.

⁷⁵ Field notes, 8/12/07, p. 1.

Back to the beginning – community in a community garden

With the lack of community participation in the garden and the recognition within the WRPFO that the project was not progressing as planned, community participation, specifically of groups, was reprioritised late in 2007. This brought to the fore some challenges which had been simmering throughout the life of the project.

Negotiating tricky ground: Involving groups in the garden

During the time of the establishment of the garden there were upheavals in the local community, especially related to gang activity in the city. A child of a member of a rival gang of the Mongrel Mob died after shots were fired into a house. As a result twelve men faced charges ranging from murder to manslaughter, to “... taking part in an organised criminal group of Mongrel Mob members, prospects and associates ...” (‘Another Jhia accused admits gang charge’, 2008, p. A5). This resulted in increased local, regional and national interest in gangs generally and specifically in the Aramoho community. This was evidenced by questions asked in parliament from the National Party (the party in opposition at that time) member – Gerry Brownlee – to the Minister of Police. The question asked of the Minister of Police (Hansard Source, 2007, para. 1) was:

Question: Has she been advised of reports in the *Dominion Post* that Mongrel Mob members in Aramoho, Wanganui, were earlier this week “guarding their fort” and that “a Ford Falcon circled the area with a rifle prominently displayed in the back seat”; if so; what actions did police take?

The garden was sited one street away from the gang headquarters and early in the phase of establishing the garden this gang was clearly identified as one of the groups that should be contacted about the garden⁷⁶. This was a community that had co-existed with the gang for a long period of time and before the garden was established I attended a meeting between the programme staff and

⁷⁶ Steering Group minutes, 16/4/07, p. 3.

a local community organisation in which gang participation in the garden was discussed. A community member clearly identified how gang participation could be positive for the project, and outlined how the gang helped with the maintenance of their organisation's property⁷⁷. Others, throughout the project, suggested additional reasons for the gang to be involved, including that gang members and their whānau would probably meet the programme target group criteria, were local to the garden, and that gang participation in the garden would also stop the vandalism occurring. Formal discussions with gang members did not occur until the third phase of the project, in late 2007, when community participation was reprioritised. This was seen as a positive development, but with a note of caution:

"...I think one of our key developments is having more involvement with our gang liaison [named] ... he is really good. He knows what is happening down there [in the community], he knows the people, and he can get his point across at any level. The only thing is that I am aware that the community itself is bigger than [the gang member] and his community. It is bigger than that and there are many others out there that are still not being engaged who might live two doors down from the gardens." (Int. 19A, p. 14).

A community member also commented:

"... I totally agree that it is important to have the gang involved, it's the scaring people away thing that we have got to worry about." (Int. 10B, p. 11)

Another reiterated this point:

"And can you imagine gang members [at the garden] - you need a bit of a balance. Yes, it is good to get them involved and to get their buy-in but you have got to be careful of the mixture of the garden – you could scare the living daylights out of some of the gardeners down there." (Int. 20A, p. 21)

For individuals to go to the garden they needed to feel safe there. On a number of occasions events at the garden brought this point to the fore. For example, soon after the shooting associated with the gang I visited the garden and met an elderly gentleman harvesting vegetables with a large machete-like knife. This seemed both comical and surreal at the time considering the other events

⁷⁷ Field notes, 15/2/07, p. 2.

happening in the community. Although I felt safe at the garden, taking into account that I was usually totally alone and I only visited during daylight hours, I noted on a number of occasions that others did not necessarily feel the same. This garden was conceived as a space for the development of a sense of community and for that to happen, safety was important, as was contact with other community members. Interesting, community surveys of a small group of Aramoho residents identified that 76% in 2007 and 81% in 2008 felt safe away from home ‘most of the time.’ Feeling safe at home during the day increased from 94% answering ‘most of the time’ in 2007 (Wanganui District Council, 2007) to 100% in 2008 (Wanganui District Council, 2008). The perceptions by some of feeling unsafe at the garden were therefore at odds with feelings of safety within the community generally.

Two groups who heard about the community garden from different sources showed interest in becoming involved. Both groups, one being a school for young people with special needs (already with a horticulture programme), and the other being a mental health unit, wanted opportunities for their members to interact with other community members and be involved in everyday, productive activities. For the school this was explained as:

“... ‘here we have special needs people that have ... some special needs. They need to be out in the community, they need to have some gardening skills, they need to have some interaction with ... somebody they don’t interact with normally’ ... and the HEHA [community garden] project slides into that nicely because they need people at the community gardens ...” (Int. 5A, p. 2)

The school’s participation never developed past the stage of showing interest. The group associated with the mental health unit did undertake work at the garden on a fairly regular basis over a number of months but slowly they also stopped attending. While they were working at the garden the lack of infrastructure was an ongoing problem – they needed to collect tools and then return them to the WRPHO office - which is some distance from the garden and in the centre of the city. There was no water on site for most of the time they were involved, even though they offered to water the garden regularly. With no garden coordinator, the plan for the work to be done at the garden was

unclear. Therefore a group that had initially been enthusiastic in wanting to learn organic gardening techniques, and whose members were excited to hear that they could harvest the vegetables for their own use in May 2007⁷⁸, were no longer in contact with the programme by the end of December.

Another group that was asked to do work at the garden was those doing compulsory and supervised community work (usually referred to as periodic detention). Different teams of these workers put up the marquee at the garden for the apple tree distribution, laid the shed concrete pad, installed the shed, and then once the community garden coordinator was employed, began to work more regularly at the garden, mainly doing weeding. I talked with those workers and their supervisors on a number of occasions and believed that most would have been members of the programme's target populations and many also lived locally. One supervisor explained that they would not bring workers who had association with gangs other than the Mongrel Mob to this garden⁷⁹.

In each of the work gangs (usually about six males) there were always one or two who were interested in gardening and who asked lots of gardening questions and also gave advice. As an example, on one occasion two young male workers toured the garden with me and helped me re-stake one of the apple trees. Neither had known of the garden before their community work here. They shared their despondency when I showed them where the other fruit trees had been removed and then gave me lots of advice as to what should be done at the garden including:

- Setting up at least six sprinklers. (There was a watering ban at that time in the city.)
- Using Crystal Rain (water retention crystals).
- Putting down weed mat to reduce the maintenance.
- Adding wooden edging to the raised beds to retain the soil⁸⁰.

⁷⁸ Field notes 1/05/07, p. 1.

⁷⁹ Field notes, 27/2/08.

⁸⁰ Field notes, 27/02/08, p. 2.

Even though they were doing the work at the garden, these two men had little understanding of what a community garden was about and how they could be involved in it outside of their supervised work.

Involving groups in the garden created a link between the project and community groups. It had the potential of meeting the needs of both the group and the project, and especially with a garden the size of Te Mana Park, it was a practical way of getting some of the work done. But it also needed to be managed and coordinated. Early into the project a Steering Group member commented that it was unlikely that the special needs school, which had shown initial interest in the garden, would wish to bring their pupils when those doing community work were present. It was also intimated that those doing community work did not necessarily want to do their work at the gardens when others were around either. Therefore, there was much complexity around community participation in the garden, and much more need for coordination and management than had been initially imagined.

Summary

In this chapter the various perspectives on 'local' and 'community' and the way that these were interpreted by different actors within the project have been explored. Different understandings influenced people's participation, both positively and negatively and created tensions. Those tensions specifically arose when attempts were made to overlay a programme aim, which targets specific groups, over the concept of a community garden, which is usually understood as being open, inclusive and including.

Relationships with the space in which the garden was established were also influential, but not enough to draw people into the project in the longer term, especially when the garden infrastructure was so slow to develop. Events at the garden supported one type of short term participation but this in no way guaranteed ongoing participation and engagement. If a prior relationship with the space was to be the draw card for groups and individuals, and their

participation was to move from watching to action, then positive change needed to happen in the garden space over time. This raised ongoing tensions of who would be responsible for enacting that change – actually doing the garden work - who was in charge of the garden, and where was the infrastructure to support that work.

Community ownership and community buy-in were constantly discussed by those involved in the programme as being required and a priority. This was seen as the way to get work done, as the solution to problems such as vandalism, and as the imagined outcome of a successful community garden. Community buy-in could be demonstrated in multiple ways. I asked a community member:

(LB) “So tell me what community buy-in would look like to you.”
“People would know that the garden was there, they would know why it was there, they would drop in, maybe on a daily basis, go and do a bit of weeding, they might have a bit that they could call their own, there would be discussion, they might end up owning it, they would end up owning it, and they would see it carry on because they owned it, in spite of, even with no funding, because they would save their own seeds, and work with those seeds, and people would bring donations. There would be all ages, all ethnicities, all working together.” (Int. 20A, p. 22)

This vision of overt, inclusive community participation contrasted with signs of continued vandalism at the garden. The vandalism portrayed a clear marker by another, mostly covert group, of ownership, control and power over the space. The vandalism, which for a period of time was the most obvious sign of activity at the garden, significantly disheartened some people and provided a barrier to their participation. For others, it was perceived as an expected and predictable challenge and one that could be overcome by persistence.

All community gardens take time to develop, both as gardens and as community spaces. Those which result from top-down planning and which are imposed on communities face additional, but not insurmountable, challenges. In this case the imposition was further complicated when the community in which the garden was sited already experienced disadvantage. But, as will be explored in the next chapter, there are many features and types of participation, many individual and group motivations and drivers for participation, and different projects capture and engage communities in different ways.

Chapter seven: Community participation as focused social action

Introduction

In the previous chapter community participation and its contested relationship within place and space was explored, with a focus on the community garden at Te Mana Park as the context for participation. A core challenge identified in that chapter arose from the different perspectives held by people associated with that project on the conceptualisation and operationalisation of ‘community’ and ‘local’ in a programme aimed at target groups.

In this chapter, the exploration turns to personal and group motivations that led to people’s participation in what I have labeled as ‘focused social action’. Although some participation was spontaneous in nature, for example the young children joining in the planting day, most was more considered. The motivations, as driving forces, ranged from meeting individual needs to broader concerns about society, politics, the economy and global ecological threats. Motivations and interests both created and restrained spaces for different types of active participation. Types of participation also differed between individuals and groups, and over time. Two projects within GABTR provided different contexts and spaces for the examination of the focused participation of community members. The operational management of the community garden and the working bees held there provided one example and the plant distributions another. This sets the scene for the exploration of the space for community within the programme governance in the next chapter.

Focused social action as participation

Success for the GABTR programme was reliant on active, specific, ongoing and committed community engagement with individuals, groups and organisations. The specific directions towards increasing fruit and vegetable intake and gardening were set by the programme aims, as were the target

populations. What was not pre-specified within the programme, but which was alluded to, was what that participation as action would look like.

There were ongoing challenges in connecting with and maintaining some degree of engagement, specifically for the community garden development. This was clearly represented by the periods of non-participation – the largely empty field, the lack of progress in the community garden, and also the active but negative participation – seen in the intentional damage which occurred there. There were also spaces which opened to engage focused participation for limited periods of time. An exploration of the participation that occurred within those spaces makes visible the importance of connecting and building on people's and group's current interests, their self identified needs, their desires for particular types of participation, and the recognition that participation is a active, ongoing, and dynamic process. It is these facets of participation that will be examined in more detail.

Connecting and building on peoples' and groups' current interests

As well as community participation being inherently bound to the place and space, there were other key personal and group motivations for involvement in the community garden and in the other projects within the GABTR programme. These drivers were always multiple and overlapping. As well as being pull factors – to gain initial engagement and maintain participation over time for some people - they could also operate as push factors. Push factors, when interests were not maintained and needs not met, resulted in people and groups not engaging with, or 'walking away' from the programme.

Tapping into established personal interests

Participation in all parts of the programme primarily followed a personal interest, in this case, for gardening and food production. This was a nearly universal factor which brought to the fore a constant quandary within the programme. This dilemma related to whether the programme was both reaching its target audiences *and* meeting its aims. To do so it was anticipated

that the gardens and the plant distributions would need to engage individuals and groups who were assumed to be *new* to gardening⁸¹, while also reliant on those *with* gardening skills. Many of those with the gardening skills that chose to become involved were neither local to the garden nor from the programme target groups.

Involved community members described an interest in gardens and gardening that was often multigenerational. It was common during conversations and in interviews to hear stories about parents and grandparents and their gardens:

“ ... I had a long dead uncle that managed allotments.” (Int. 10B, p. 1)

“My involvement with the gardens stems back to grandparents that were keen gardeners. They came out from England after the war and green veg. were just about unheard of. And to come to New Zealand and have a piece of ground that they could do what they liked with, and plant veggies out and grow whatever they wanted, was a real bonus to them” (Int. 9A, p. 16)

“... my father had a vegetable garden of sorts . [...]. War time – we had a thing called ‘dig for victory’ – with war time there were lots of building sites that had been started on a piece of land ... - and they turned them all into allotments. (Int. 17A, p. 2)

These participants all described what have been identified as historical motivations for community gardens worldwide – wars, food shortages, and migration (Twiss et al., 2003). These were also seen as the basis for what some authors label as the “... community gardens movement” (Saldivar-Tanaka & Krasny, 2004, p. 399).

Initially the family history of participation in gardening seemed significant in relation to people’s involvement in the programme. I soon found virtually all the people that I talked to - who were either involved in the programme or not - could identify that some of their family had been home vegetable gardeners to

⁸¹ Because no pre-programme assessment had been undertaken this was assumed.

some degree or another. Home vegetable gardens seemed to be a feature of the social history for many people in Aotearoa New Zealand as is described in the following quote:

“I grew up watching my mother; she was passionate about growing food. [...]. My mum was the gardener and she shoveled and hoed and hoisted, and father was permitted to do pruning and boring things like spraying fruit trees and pruning. He was a great pruner. I’ve got all this [family history], no wonder I see it as natural.”
(Int. 12A, p. 2)

What was more significant was that this family participation translated into personal interest for those most actively involved in the community garden, especially via events organised within the GABTR programme. As a result, interviews completed at community member’s homes often included tours of their gardens, sharing garden stories, and sometimes, sampling of produce. For others, the family history, especially of large garden plots, hard work, and childhood memories of unpalatable home grown vegetables (broad beans and brussel sprouts were frequently mentioned) acted as a deterrent both to home gardening and also towards participation in the community garden. A community member, who joined in one of the working bees when the community garden was at its most untended stage, commented that it reinforced all her preconceptions about gardening. She suggested that ‘this was just too hard’ – like her father’s gardening when she was a child⁸².

Gardening interests linked to perceived benefits

For those that did become involved their personal interest in gardening was often associated with beliefs about the positive benefits of gardening, home grown and local produce, and social participation. One community member described how gardening was:

“Essential for my mental health and for my physical health, ... I think the physical exercise is the first one. I am a pre-diabetic. I am surrounded by my family that stick insulin needles into themselves every day and I don’t really want to go down that path. And so I enjoy going out and digging and all the labour and all the things

⁸² Field notes, 10/11/07, p. 3.

that people say they don't like, I really like that. And I can go out into my garden feeling utterly tired and 'I'm too tired to garden today – oh I feel wretched, I feel rotten, I've got this worry or that problem'- and I'm a different person when I come in. It just dissipates any stress. I would die if I could not get my hands dirty." (Int. 12A, p. 3)

Another community member also described another positive effect:

"I come from a gardening family and nothing gives me more of a thrill than to pick something from the garden...." (Int. 15A, p. 1)

These sentiments reflect the positive physical and psychological effects of gardening as described in the literature (Bhatti, 2006; Groenewegen, van den Berg, de Vries, & Verheij, 2006). They are something of a double edged sword, as while people conceived of the community garden as offering these promises for positive effects, its slow development created disillusionment and disappointment. This acted as a push factor for some individuals and, as identified by others (Ziersch & Baum, 2004), participation in civil activities could also be a health risk for some people. I asked one person, who had initially attended some events, why they felt unsure of their continued participation. Part of the reply was about psychological risk:

"... I don't want to be involved in another disappointment." (Int. 17A, p. 12)

As well as focusing on the potential for individual benefits from the activity, others also identified food quality as a major advantage and motivating factor for their interest in the programme. Comparisons were drawn between the differences in quality between heritage⁸³ plants organically grown at home (and potentially grown in an organic community garden) to commercially grown produce. A community member identified how different perspectives about this point were held by those involved in the GABTR programme itself:

"[The aim of the programme is that] people need to be consuming more fruit and vegetables, [but] it is not the answer because they are talking supermarket fruit and vegetables, modern commercially bred varieties...." (Int. 4A, p. 3)

⁸³ Community members used the terms heirloom and heritage interchangeably.

Another commented:

“And for me there is a, there’s an enthusiasm within the [Steering] Group for heritage vegetables and you know it is going to be very interesting to see how that interfaces with the cultural issues. Because I mean there is part of me that says these are really interesting issues. But at the end of the day I actually think that if you are looking at ‘health needs’ type outcomes for vegetables then kids are better to eat coleslaw than they are to eat chips with their fish and chips. And you know it doesn’t matter if it is a heritage cabbage or a whatever cabbage – it’s the health benefits. (Int. 1A, p. 9)

These divergent perspectives on a topic were just one example of how individuals and groups came together in the programme with different aims, interests and worldviews. Interestingly, few people mentioned to me that home gardening was a cheaper alternative than purchasing fruit and vegetables and many people identified that maintaining a home garden was expensive in comparison. ‘Cheap’ fruit and vegetables were available from a number of outlets in the city, including a well known shop in the suburb of Aramoho where the garden was sited, and at a city Saturday market. There was also a well established ‘whānau garden’⁸⁴ less than a kilometre from the community garden. The area certainly did not fit within the definition of a ‘food desert’⁸⁵.

People also identified the personal energy costs in maintaining a home garden. For those that did this already, choosing to become involved in the community garden was about balancing and prioritising one garden over the other, as described by a community member:

“I didn’t want to get involved and get more and more past what I could reasonably do – my own garden was suffering enough – I was struggling to keep up with that. (Int. 17A, p. 12)

⁸⁴ A ‘family’ garden organised by a well known local person, where vegetables were made available or sold to extended family and local people. One of the initial concerns raised by local community members was how the community garden at Te Mana Park would impact on the whānau garden (and the local vegetable retailer). The limited amount of produce harvested from the community garden meant that any effect would have been small.

⁸⁵ Food deserts have been described as areas where “... poorer neighbourhoods have worse access to retailers offering fresh fruits and vegetables ...” because of a lack of consumer demand for them (Flowerdew, Manley, & Sabel, 2008, p. 1242).

This was an important consideration that differentiated this garden from many others described in the literature. Whereas virtually all of the residents in Aramoho had access to land (either rented or owned) which they could garden, many community gardens developed in other places exist to provide that land and space, for example, in inner city environments and in high rise housing areas (Urbis Keys Young, 2004). Even when the focus was on providing land, many authors identified that the coming together of community and community development was as, if not more important, than food production (Glover, Parry, & Shinew, 2005; Saldivar-Tanaka & Krasny, 2004). There are many community gardens established in areas where people have good access to land but those gardens need to draw on different motivations for participation.

Additional pull factors for participation in a community garden

As well as being a space for gardening, community members who became involved in the community garden imbued it with additional personal and community benefits. A participant described how meeting others at the garden reduced social isolation:

“Yes, I have been coming to the working bees – love it.”

(LB) *“So what do you like about the working bees?”*

“You can talk to people, because I live alone” (Int. 13A, p. 3)

Not everyone desired social contact at the garden. One community member informed me that he only worked at the garden when no one else was there and another told me how she liked being at the garden when others were there but wanted to work alone.

Other community members saw more expansive possibilities in the future of the community garden. Interestingly, these were all linked to broader determinants of health and the principles underpinning health promotion. The potential for building communities, and linking societal interests such as social justice, political activism, sustainable ecological development, self sufficiency, and responses to global threats including global warming, were all identified. For these community members, their motivations for participation were

congruent with those found in other studies (Barnes et al., 2004, p. 61), where “... commitment to a cause” and a personal history of activism were found to be important. The community garden was potentially seen by community members as a natural adjunct to individuals’ and groups’ other work and interests in these areas:

“... [the community garden project has] got lots of elements which relate to sustainability – education, and growing food environmentally, benignly - and it’s the sort of project that brings people together. It’s got a sense of community, empowerment, yeah, a whole range of things that go hand in hand with sustainability.” (Int. 3A, p. 10)

“ ... and [I have] been involved in social justice, the movement for a number of years ... but interested in food for quite a long time, the politics of food” (Int. 18A. p. 1)

For service clubs it provided another possible avenue for helping out and volunteering, and a space for meeting their mandate of service to the community. Some service club members did become involved in the first planting day. However, in spite of many suggestions over time by a number of people that they would be ideal groups to be more involved at the garden site, specific requests for their participation – for example in building raised garden beds – never eventuated. Presentations by programme staff were delivered to a number of service clubs but they were focused on the broader GABTR programme and links with schools rather than direct requests for group action.

For the individuals and groups that had some participation a community garden was seen as timely. I had a number of discussions with people at the garden, at the scarecrow display in a shopping mall, and at community meetings about how community gardens were needed *now* to pre-empt future local, national and global problems. For example, one older woman told me how she wanted the community garden to be successful because she didn’t want to garden at home alone. She wanted to be with other people and this was the ‘way of the future’⁸⁶.

⁸⁶ Field notes, 29/3/08.

These issues were a real motivator for some and also a factor that meant they remained involved even when project progress was slow and difficult. This perspective was described with some passion:

“It’s a pilot project and I am looking climate change and peak oils squarely in the eye and I think that is going to have some radical impacts on our community. And I think we needed to have these sorts of things in place ten years ago. And it’s a pilot project and it’s really important to me that it succeeds so that it can be rolled out around the country. So that is why I am still [involved] ... I could see that it was going to fall over, the wheels were about to fall off and I couldn’t sit by and let that happen and so that is why I am still there.” (Int. 21A, p. 15)

This dual perspective, of believing in the concept while concerned about the widespread ramifications of the community garden project failing and therefore staying involved, was also identified by another community member when interviewed in September 2007:

“... I think something has to be done or it [the community garden] will collapse. [...]. A. There will never be another community garden, not in Whanganui for the next 20 years. Because everyone will point back here and say ‘it didn’t work.’ They won’t know why it didn’t work but they will say ‘it didn’t work’, ‘the community didn’t want it’. [Talk about the upcoming local government elections] – if he [local political figure] is under threat he will certainly lash out at things such as the community gardens and then it will get national [attention, and people will say] ‘another failure of the health service in Whanganui.’ (Int. 10A, pp. 19-20)

While these concerns drove a few people’s individual ongoing participation, the participation of other groups was not maintained. For example, a group which was initially enthusiastic about the prospect of the community garden, as described in a newspaper article that stated that the group had “... taken [action] with a community garden at Mitchell St in Aramoho ...” (‘Surf’s up say SW Trust members’, 2007, p. 3), had limited involvement. It was another example of the nature of participation as tentative, “dynamic” and changing over time (S. White, 1996, p. 11). Some individuals and groups were watching and waiting for development to secure their participation and a few were determined to make it happen.

The community garden was also identified as a necessary solution to another perceived societal problem. Many of the people involved in the programme described their concerns that younger generations had lost understandings of where and how food was produced in contrast to how it was commercially packaged and sold. The community garden was seen as having the potential to change this perception:

“... I really like the ... the idea of having a community garden. Because it does worry me that young ones, especially, have got no idea where their food comes from, and no idea how to grow it. [...]. Then you see children growing up and all they know is frozen peas from the supermarket. I think it's a great shame. We have got this wonderful piece of the planet here. Well I don't know, you could wax lyrical and get all spiritual and godly but I think, you know, we have the earth here and that what it's for. It's here for, we should use it to produce our food” (Int. 12A, p. 2)

“...I am afraid that there are a lot of people that think their cabbages and cauliflowers come from the local supermarket – not anywhere else” (Int. 17A, p. 14)

“... when I was doing a shift as a supervisor at a local supermarket I was amazed at the number of older children that we employed who didn't know what the vegetables were, and certainly didn't have a clue what to do with them. [...]. So obviously they don't eat them if they don't know what they are. That quite surprised me in this day and age.” (Int. 15A, pp. 1, 2).

In response to these concerns, a number of participants envisaged further development of the garden project, and the GABTR programme as a whole, into:

“... more food preparation stuff, basic cooking things because I think that is really central. People don't know how to make bread, ... there is no reason for children to be hungry in this country. It is just a lack of cooking skills I think.” (Int. 21A, p. 14)

“But teaching them also how to cook You can grow it and give someone a cabbage and they will go [sigh], so I believe this project is going to take another step into teaching people how to cook.” (Int. 5A, p. 4)

Mainly these were positive conceptions of what the community garden (and the GABTR programme) could become and do for individuals and others. They did act as supporting pull factors to at least initially engage some people. Cooking food was included as part of the garden day event organised in March 2008 and this activity was seen as a positive contributor to the day's success. Another pull factor, the free produce available, resulted in some contradictory, but nevertheless focused types of participation.

Access to free vegetables – contradictory messages about reciprocity

The community garden was an open public space and so anybody could harvest the produce at any time. A draw card to the garden for some was the free produce. A community member who also participated in the working bees commented:

“... *I am very interested in the gardens, the way it is progressing.*”

(LB) “So tell me why you are very interested.”

“*Because you can get veggies free.*” (Int. 13A, p. 1)

There was a commonly held perception that community gardens generally operate by a degree of reciprocity between work done at the garden and produce taken. For example, two older women, on separate occasions, told me that they would never harvest vegetables from the garden because they hadn't done the mahi (work)⁸⁷. Both having their own home vegetable gardens, they found the work associated with those enough for them to manage. Nevertheless, the garden was established with limited local consultation, for a long time few people were at the garden, and there were no signs to inform anyone of the intended use of the garden. As a result people used the garden to meet their own needs, again as focused social action. I heard of a number of different perspectives of how the garden could be used:

- A community member was informed by youth that as a garden for the community they would take whatever they liked.
- People told me that as the produce was free they would take it.

⁸⁷ Field notes, 6/7/07, p. 2; 29/3/08, p.1.

- A young girl told me, that ‘sometimes her horse ate the cabbages’⁸⁸.

Although the produce may have been used by individuals who would have fitted within the profile of the programme target groups, the lack of balance between the work involved in growing the produce and the taking of produce significantly impacted on the sustainability of the garden.

It was not just that maintenance work was not undertaken in the garden, but also that it was obvious that produce was being harvested before it was ready – for example immature corn picked when the plants were approximately half a metre tall, and late-planted potatoes harvested in November rather than February or March. This behavior was clearly linked to the still unanswered questions asked early in the programme (Figure 13, p. 182) such as who would look after the plants and whose garden was it, and who could eat the produce. The lack of rules about the garden, or even paternalistic oversight, resulted in what I believed to be unintended consequences. The community garden became, for some, a space for taking, with no responsibility for other involvement. These actions were certainly not those described by the people who were involved in the programme or those who were interested in the concept of a community garden. It was also not that described or envisaged by the group of people who had initially come together to plan and develop community gardens within the GABTR programme. However, it was deliberate action and it meant that people met their own needs.

Importantly, once the garden coordinator was employed and a few people were more regularly at the garden then small, positive changes started to happen, which benefited both the people involved and the garden. A community member described being at the garden over a year after it was established:

“...I stayed later till it got dark and four or five or six people would come down on their bikes or on foot at dinner time when they were cooking their dinner, to cut a few leaves [of silver beet] and take them home. And every single person stuck around and talked to me and helped me pull out a few weeds....” (Int. 21A, p. 13).

⁸⁸ Field notes, 24/4/08

This shows how community members' participation was dynamic and, for some, directly related to meeting their own needs. It also demonstrated the positive effect of social relationships, when someone was at the garden to relate to rather than the garden being an 'empty' field (as described in Chapter Six) for people to take from.

Nationally and internationally there is a growing and renewed interest in community gardens and an extensive body of literature which examines the issues and challenges from many perspectives (See examples in Appendix Seven, Table 17). While some literature describes the potential of community gardens (T. Hancock, 2001), the research and practice based material provides valuable insights into the challenges in community garden development, specifically related to community participation, and in community gardens as a community level intervention. In an example from Montreal, (Bouvier-Daclon & Senecal, 2001) where community gardens were developed as part of a programme to stimulate social interaction, individuals surveyed identified the possibility of meeting people as a key motivation. In fact, the collectivity present was weak and that social interaction was superficial only.

Many different types of gardens come under the nomenclature of community gardens. In one example, authors (Ferris, Norman, & Sempik, 2001, pp. 561-562) identified eight possible classifications of community gardens in the San Francisco Bay area: leisure gardens; child and school gardens; entrepreneurial gardens; crime diversion gardens/work and training gardens; healing and therapy gardens/quiet gardens; neighbourhood pocket parks; ecological restoration gardens/parks; and demonstration gardens. Their description of entrepreneurial gardens, the purpose of which was "... diverse, but is clearly driven by the need to alleviate poverty and social exclusion ..." (Ferris et al., 2001, p. 563) partially aligned with the rationale for the community gardens planned in the GABTR programme. It also overlapped with other categories, and over time people expressed the perspectives that Te Mana Park could also

be a work and training garden, as well as demonstration garden site, a leisure garden, and a school garden.

The programme aim positioned the community garden at Te Mana Park in relation to increasing fruit and vegetable intake, rather than as a combined space for community building and community gardening. Although frequently identified as an appropriate community level food and nutritional intervention (Moron, 2006), there has been little research undertaken that actually measures changes in food intake for those involved in community gardens. In those studies where this has been evaluated the community gardens have usually been settings based gardens such as those in schools (Twiss et al., 2003) and there the change identified was small. In a descriptive evaluation of the over twenty years of community garden development in Sydney (Grayson & Campbell, 2000, p. 6), the authors argued that food productivity from those community gardens was “... far below their potential” because of underdeveloped gardening skills and a lack of time. Other challenges identified for those gardens included insecure land tenure, maintaining relationships with neighbours and land owners, attracting new gardeners and finding funding and insurance sources. In contrast, the gardens were seen as effective social venues, were generally environmentally sustainable, and were relevant to the needs of the people who chose to become involved.

A number of Australian state-instigated gardening projects have been evaluated. In its second phase, The Department of Health funded ‘Community gardening in SA project’ (Hunter, 2006) was focusing on sustainability of the community and school gardens which had been established, with the major work being undertaken to strengthen the volunteer base for the gardens. This included identifying training opportunities for volunteers and potential volunteer groups (such as pre-service teachers), and developing partnerships with groups and other similar programmes to support intergenerational gardening. Interestingly, nutrition was a lesser focus than broader community development objectives. In an extensive evaluation of a Community Greening programme which was a joint project between the Botanic Gardens Trust and

New South Wales Department of Housing (Urbis Keys Young, 2004) and which included case studies of a number of community gardens linked to high rise housing, improvement in health and community resilience was one of five key objectives. The findings of this study included that:

The benefits of the program in terms of improved health and community resilience are apparent, especially in terms of combating social isolation, increasing interaction between different cultures and between social housing and other residents, giving people a sense of place and of purpose, pride in their achievements and increasing ownership and use of shared spaces. Benefits to the physical health of participants through exercise and better nutrition are also reported to have occurred. (Urbis Keys Young, 2004, p. 40)

Importantly, the projects being evaluated all had been operating for some years, an important point of difference with the community garden at Te Mana Park, which by comparison was very new. Therefore, examination of participation in the group that was developed to inform the garden's progression displays dimensions of community participation as focused social action in a novel and rapidly evolving space.

Focused social action – examples from the Community Gardens group

The complexities inherent in community participation are manifested in the workings of this group. The structure for the collective known as the Community Gardens group⁸⁹ was set up by the WRPFO. I asked the question:

(LB) "... so who decided who would then be invited to that group?"

"Basically we just, it was through word of mouth. We sent out information through all our networks, through the Steering Group as well. As far as I recall we went out through the Steering Group, through Public Health, and we may have even advertised publicly for people to become involved – whoever was interested in

⁸⁹ Although I refer to this as a 'group' because this was the collective noun programme staff and I used, I became aware that participants did not necessarily see themselves as members, rather as people that attended one or more meetings. I was not aware of any group terms of reference.

community gardens, the development of those - to get in touch. ... and so those people from the community that were interested then got in contact ... and we invited them along to a meeting.” (Int. 19A, p. 4)

The focus on inviting people interested in community gardens had the effect of drawing in, temporarily for most, and engaging those who already had an interest in gardening and community gardens. As described in minutes of the Steering Group meeting⁹⁰, “(t)he purpose of these meetings [of the Community Gardens group] is predominantly operational, how the gardens will be operated, structured and managed. It enables community participation in the project.” This description provided a focus on this group contributing input into the functional management of the gardens, and also operating as the avenue and space for community participation in that management. It also highlights important contradictions.

To meet the programme aim, capable gardeners were not the group whose participation was most desired, and yet these were the people who responded to the invitation, and who were needed to make the garden work, at least in the short term. It is a known challenge that community gardens often attract those who already garden (Urbis Keys Young, 2004). This situation raised inherent dilemmas related to community participation in a programme with intervention ‘target groups’. Firstly, the capable gardeners (who generally did not appear to fit the demographics of the target groups) were needed for ‘instrumental’ purposes for others (S. White, 1996). This potentially contradicts broader principles of health promotion and community participation including social justice, equity, self determination and community diversity (Bunton, 1998). It certainly challenged some community members’ perspectives that a community garden was for everyone. Secondly, the process of targeting “... may produce collateral damage” (Nguyen & Peschard, 2003, p. 458), especially by reinforcing stereotypes and separating groups – those targeted - from those not, but needed. Thirdly, as can occur in a top-down process

⁹⁰ Steering Group minutes of the meeting of 11/12/06, p. 2

(Boutilier et al., 2000), the community was constructed by the health sector in ways that were different from community members' perceptions of that community.

By separating the gardening from the place where the garden could be developed⁹¹, then those with relationships to the place and space, but not with gardening, were unlikely to see this as a personal motivator or invitation for their own participation. Although pragmatic, the approach of inviting people interested in community gardens also positioned the management of any garden as potentially separate from the work that needed to be done in the garden.

Nevertheless, it was crucial that people with an interest and expertise in gardening and community gardens were also brought into the project. There was never an expectation that the programme coordinator would be an expert in community gardening, instead that person's role was to manage the programme. The GABTR programme was organised and run by health services, and the GABTR programme coordinator was engaged in facilitating a number of projects within the programme, of which the community gardens project was only one. From the theoretical perspectives of health promotion and community development, this project facilitation approach and working with communities rather than doing the work for them, was appropriate. However, in practice, most community members expected that someone would be 'in charge' of the garden that knew about gardening. In the absence of anyone else, (and before the garden coordinator was employed months later) the programme coordinator was seen as that person.

The specific operational focus for the garden also theoretically separated this group from the Steering Group, which was involved in the governance of the whole GABTR programme. This division was seen as important:

⁹¹ This group was set up before the decision was made by the Steering Group that the garden would be established in Aramoho.

“And I think there may have been something either in the service plan or it came from the Steering Group⁹² that we needed a working group to focus on the gardens, as opposed to the Grab a Bite Steering Group concentrating on the gardens. Because it [the Steering Group] can become operational, ... and that wasn’t the intention of the Steering Group.” (Int. 19A, p. 4)

These factors, the operational and ‘working group’ focus, the separation from the Steering Group, and space for involving community members, were all important, but were also complex.

The Community Gardens group in action

Formed in November 2006, this group met eight times between then and July 2007. As one of the links between the programme and community members and groups, it could be seen as critical in the community garden project. To illustrate the challenges in this forum, one of the meetings (3 May 2007) that I attended⁹³ is used as an example for discussion (Figure 18, p. 235). This meeting was chosen for specific examination because it occurred a few weeks after the planting day, a long awaited milestone for the community garden project. As well as re-presenting the meeting, I have also integrated dates when the issues were first raised (prior to this meeting) and also the eventual outcomes. This information demonstrates the repeated discussions over numerous meetings, and the slow progress over time. In many ways this meeting was representative of all of the meetings I attended. Community members had much knowledge and experience to share (including in establishing community gardens or similar projects, such as teaching home garden development).

⁹² I was unable to find the basis for the development of this group either in meeting minutes or in discussions with Steering Group members.

⁹³ I attended all six of the meetings held after I started data collection on the programme. Minutes of the previous two meetings were made available to me.

The Community Gardens group - A space for ideas, advice, expertise, and community members

Meets 12.10 – 1.45pm, some arrive a little late, others leave early.

Attended by ten people: Six community members, two Steering Group members, the programme coordinator, myself.

The meeting of Thursday 3 May 2007

At the WRPHO office, 1½ weeks after the planting day. Advertised from 12-1pm. Chaired (and minutes written) by the programme coordinator. Email invite to group (22 on list, including four WRPHO staff, six community members (also Steering Group members), 11 other community members, and myself), sent five days before, with an RSVP request and agenda.

Agenda items: water/irrigation, design, maintenance, vandalism, barriers.

A report provided on the last meeting's action points including storage shed options, new shed costs, street signs and on-site signage, funding application details for garden equipment.

As a participant observer my overwhelming impression was of: A 'slow' meeting, attendees had much expertise and enthusiasm for the project. It felt like a brain storming session. Topics previously discussed were raised again. Many offers to help. A palpable urgency as the garden has now been started.



Figure 18 A Community Gardens group meeting

The challenges encapsulated in this description of the meeting, all of which are complex and overlapping, include who were the Group members, the ambiguous ownership of the meeting as an operational forum, the convoluted pathways between ideas, decisions, actions and outcomes, and, over time, the relationship between this group and work in the garden at Te Mana Park.

Group membership

As was described in Figure 18 (p. 235), the meeting was attended by ten people, with apologies⁹⁴ given by another five people. Designed as a community forum, the balance between those with a mainly professional health sector focus rather than those more interested in gardens and gardening was important. Meeting participants, excluding myself, were:

- One programme staff member.
- Two Steering Group members, one representing a health service and one representing a community group.
- One person representing a health service that wanted to use the garden as a therapeutic space.
- Five community members.

Although not so obvious in this meeting, clear tensions arose at different times because there was often a perceived imbalance of health sector ‘staff’ in relation to the numbers of community members. Staff could be those directly employed on the GABTR programme, or those employed by the WRPFO, or those also employed in some capacity linked with the programme. These

⁹⁴ Although I documented apologies for this meeting, these have not been counted for other analyses (either of the Community Gardens group or the Steering Group) as I became aware that it was the usual practice of the programme coordinator to ‘ring around’ on the morning of meetings to both remind people and to gather the apologies. In my mind, this made the giving of meeting apologies a more passive than active process. I noted that some people only ever gave apologies and never attended meetings. This passive participation created an illusion of programme support which was without depth or substance.

people were differentiated from those who were not employed⁹⁵ within the health sector. It was not the employment that was identified as the issue or to suggest that either group had the most valid involvement, but that their interests in the project could be and were often different. For example a staff member that attended some of the meetings made the comment in an interview that:

“... my only agenda is to improve health outcomes.” (Int. 6A, p. 12)

This was quite a different perspective than that expressed by the community member who during a meeting questioned the number of ‘practical people’ on the meeting email list - those who would actually work at the garden⁹⁶. At times the imbalance of health sector staff meant that a misleading impression of community support could be developed if the total number of people attending a meeting was then equated with people interested in either managing or working in the garden. However, in reality, there was no universal distinction between the groups, with some community members on the group uninvolved in the garden and attending meetings only, and a few staff members more actively involved. This contradiction was inherent in the comment made by a person involved in the programme in a number of ways who said:

“So my involvement in the [Community Gardens] group was a three way thing, my interest in this role [current employment], my interest as a Steering Group member, and my interest as someone who enjoys gardening anyway.” (Int. 11A, p. 24)

This last quote encapsulates how people involved in the programme had different roles and many interests. Over the life of the Community Gardens group, meeting attendance ranged from an impressive 13 people (two programme staff, four Steering Group members – one health sector employee and three community members - and seven other community members) at the

⁹⁵ Steering Group and Community Gardens group members were not paid for their meeting attendance or for any other expenses of participation. Of course some were in paid employment specific to health services or linked programmes.

⁹⁶ Field notes, 10/4/07, p. 1.

second meeting in December 2006, to three people (one programme staff member, one community member, and myself) in April 2007.

When interviewed in January 2007, a person then involved in both the Steering Group and the Community Gardens group described what was to be a key characteristic of that group:

“... but the sub-committee [Community Gardens group] isn’t really stable [in its membership]. It’s not stable yet, there are different people coming and going” (Int. 3A, p. 7)

Over the eight meetings, 25 people (excluding two programme staff and myself) attended one or more meetings. Of these, 10 were individuals employed by health services or organisations with links to GABTR, or were members of the Steering Group. Only one participant lived within easy walking distance of the community garden at Te Mana Park. A comment was made that in retrospect:

“... with the Te Mana Park community gardens, it would have been more beneficial to have quite a few members on a group like that Gardens group – from the Aramoho community. And as such if we had that community support behind the gardens right from the beginning it would have made developments a lot easier.” (Int. 19A, p. 5)

Again, the identification of the lack of people ‘local’ to the garden is clear and this was discussed many times. Community members also identified how the Community Gardens group had become complicit in the garden being a ‘top-down’ development, one imposed on the community⁹⁷.

The fluidity of the membership of this group can be seen when later in the project two of the community members became linked to the programme in different ways, one as the paid garden coordinator and another as a member of the Steering Group. One person commented about their own preference for participation:

⁹⁷ Field notes, 10/4/07, p. 1.

“I’ll stay on the Steering Committee as long as I think I’ve got something to add to it but if it came to a choice between that or the Community Gardens subcommittee, I would probably do the Community Gardens subcommittee.” (Int. 3A, p. 5)

This deliberation about where individuals could best have input, use their skills, and have something to offer was a frequent factor related to ongoing individual participation. Excluding the programme staff and myself, 52% (13 people) attended one meeting only, and the maximum number of meetings attended was six of the eight (by one person). With less than half of the people returning for a subsequent meeting then the meetings were obviously not addressing their needs and interests. One person identified how the meetings failed to capture the initial enthusiasm of attendees:

“Because they [the meeting participants] were all older age group people [in contrast to the younger programme staff members], hugely passionate about what they do, hugely enthusiastic about being there. And all they had to do at that time - even if we had done the brainstorming thing – it never happened. [...]. ... there was no ‘we want you to be here.’ There was no bringing them into the fold. [...]. And even if at the first meeting or the first couple of meetings they [community members] had had an opportunity to say ‘this is what I am good at’, ‘this is the time I can give.’” (Int. 11A, pp. 25, 27)

At least one new participant attended all but two of the meetings. New people came as they were invited by programme staff or by other community or organisation members. The changing ‘membership’ and the variety of interests and experience of meeting attendees made this a somewhat complex group. A community member commented:

“I was impressed by [programme staff member], a sort of gentle person. But a major impression of that particular meeting was [it was] dominated by several men that were present and I felt that she ... didn’t have enough weight to manage it, chair the meeting, to provide balance between the participants. I didn’t really participate much ...”

(LB) “Was there a reason for that?”

“Yeah, because there were one or two males dominating and I didn’t want to pitch in and kind of compete with them.” (Int. 18A, p. 2)

Demonstrated in the quote is the sensitivity to the dynamics of the meeting, and the inexperience of programme staff, with what was perceived as domination by others who were focused on their own group's interests for the garden. I asked the same person what they had wanted to personally achieve from the meetings:

“Well I was there to offer support and to ... volunteer ... that I could get involved. I was also aware than Gonville [where the first garden site was planned] is not my suburb and what I was interested in was introducing myself and I am also interested in creating a garden for [suburb] and I did make that point briefly.” (Int. 18A, p. 2)

I also asked what the factors were that meant that this person had stopped attending meetings:

“Well time really – often [the meetings] were in the middle of the day, in lunch time during the week and obviously I have to earn a living so couldn't be there.” (Int. 18A, p. 3)

Another group member described the same difficulty with attending meetings:

“Yes, she [programme staff] contacted me about the working committee / party. But unfortunately I have a job, a little job which occupies me ... around the lunch break. [...]. But it [the meeting] was 12 o'clock so I was not able to go. So I really didn't have a huge input at that point. ... I got to one meeting, but I was very keen to see the idea come to fruition.” (Int. 12A, pp. 4-5)

Difficulties for people attending meetings in the middle of work days, and not meeting people's needs were key factors in the declining attendance. These are recognised barriers to participation (Easterling, Gallagher, & Lodwick, 2003a). Another factor related to the ambiguous ownership of the meeting space.

The ambiguous ownership of the meeting as a community forum

Before participating in a meeting I had imagined that this would be a working group, meeting at the garden (once it was established) or nearby, and that it would be largely informal. I was therefore surprised to find that this was a formal group, meeting at in the WRPFO offices, with the programme coordinator as the chairperson, an agenda, apologies recorded, and minutes

distributed (see Figure 18, p. 235). Instead of creating a community space in a community place, this felt (to me) very much like a space controlled by the health sector – an invited space (Cornwall, 2002a), with all the inherent challenges. I wondered how this affected people's ongoing engagement with the group. I asked a community member about the meetings and she replied:

“... a typical meeting, a lot of waffle. But it was interesting ... to see the knowledge [about gardening] that was involved [...]. It was typical meetings, a lot of talk and the usual palaver - talk, talk, talk. People hadn't been up there [to the garden] and they needed to go and see things. That was obvious on a few occasions. Those are typical committee meetings, so lots of yabba and getting off on diverse sidetracks. But yeah, it was really good and [programme coordinator] steered them pretty good.” (Int. 9A, pp. 7-8)

This quote encapsulates some of the key issues around the meetings. They were set up as places to talk, rather than to work, there were lots of ideas, expertise shared, and advice given. Also, they existed in a separate physical space from the garden. Some people had never, or certainly once it was established, not recently visited the garden. They were unaware of the context for the discussion, specifically the challenges related to the garden size and layout.

Another community member commented:

“... [I started attending] when they started to discuss the paperwork behind it [the project], and while it seemed unsatisfactory, I was interested enough to stick in because I just think the idea of a community garden has much to offer. [...].

(LB) *“You were saying about the paperwork; there was a lot to do?”*

“...I think once you know what you are doing the paperwork should be able to be done alongside the actual physical doing [of gardening]. And the first meeting or two I went to, it was worrying about the aims and the paperwork part of it ..., and certainly at that stage there was a feeling that the paperwork had to be done before the actual garden got started. And there was a certain frustration among some of the people. Quite clearly, one group was into getting the paperwork right first and the other group was saying ‘the planting season is coming up; we need to get on and get planted.’ And so you know you did have that dichotomy right there and then. (Int. 10A, pp. 2, 3)

That dichotomy, between planning (and dealing with the bureaucracy involved in a health sector-led programme) and working, was only one of the unresolved challenges within the group. The lack of resolution was a problem over time as a framework for the development of the gardens was never actually formed by this group⁹⁸. Instead of this group managing the gardens, much advice was sought and given.

The convoluted pathways between ideas, decisions, actions and outcomes

As can be seen in Figure 18 (p. 235) participants had much experience and expertise to share and gave advice freely, for example in relation to signage, the garden coordinator position and the garden water supply. There were three main themes which encapsulated nearly all of the discussion over all of the meetings: giving advice; infrastructure and resources; and the need to involve people in the garden. This was excluding the discussion, led by programme staff, about the programme aims, objectives, and target groups.

Firstly, much *advice* was provided on how the garden ‘should’ be developed, with discussions and some disagreements around using a variety of techniques and approaches. These included using organic principles⁹⁹, heritage plant varieties, permaculture and no-dig techniques, mulching and compost making. A community member described a high level of frustration that the advice given was ignored or not acted upon:

⁹⁸ A draft three-page framework (Community Gardens Plan Proposal) was developed by the GABTR programme coordinator late in 2006. It included common principles for any of the proposed gardens – such as timelines for garden establishment, the need for a budget, for garden managers, the hours of operation, and ecological sustainability. Another document, the Community Gardens Management Plan Outline (18/12/06) which included details of the proposed gardening methods, mowing and maintenance, weed and pest control etc. was also developed by the programme coordinator and circulated to the Steering and Community Gardens groups in 2006. The reported response was that these documents went into too much detail and provided rules that were not needed. Unfortunately, many of the points identified in the documents (which most people I spoke with were unaware of), such as the need for a garden manager, a storage facility and signs, were what these Groups then spent their time discussing for many months.

⁹⁹ The use of organic principles appeared to be the decision which was consistently agreed upon. It was also an important draw card for some people and groups who wished to learn about organics.

“... there has been a lot of frustration. Just being sought out for advice, and then considering it very carefully and thinking about it and getting back with the advice, and then it’s not been listened to. That has been very frustrating.” (Int. 21A, pp. 1-2)

It was not just a problem experienced by this person. A discussion with another person was recounted:

“... [a community member said] ‘... what a waste of time, ask for my advice and not follow it’ – he was really miffed.” (Int. 21A, p. 7)

One somewhat contentious agreement reached by meeting attendees related to the proposed physical layout for the community garden. A community member had been asked to develop the overall design and shape of the gardens, and a plan with a staged implementation was presented to the group. Group feedback included debates about using the no-dig concept instead of ploughing, the large size of the site, the need to get the garden underway, and the ways that other cultural patterns of gardening could be incorporated¹⁰⁰. Although there was general consensus about the overall design, the people initially involved in ploughing the site ignored the group agreement to stage the project and instead cultivated the whole site. This enthusiastic attempt to get the project moving was to be counterproductive and reflected overall lack of control of the project. The effects were described:

“... I was pretty shocked to see what they had done when I went down there. Because it was widely ambitious, as we have seen, it wasn’t able to be sustained.” (Int. 21A, p. 1)

It also showed that community members had quite different opinions on how the garden should be developed, a challenge that has been identified in other community gardens (Schmelzkopf, 1995). Community members also had different ideas about how the design process should have been undertaken, and considered that community members local to the garden should have been involved. Two other community members had agreed to help the community

¹⁰⁰ Community Gardens Meeting minutes, 6/3/07.

member who had presented the design of the garden but they saw their role in a different way:

“... ‘we want to guide the community through a design process’.
Because it is really important that they have ownership of that.”
(Int. 21A, p. 2)

There were frequent discussions both inside and outside of the meetings around the garden being too big. A community member identified the problem and suggested:

“I think it would have been better to start smaller and work up.
[...]. That is why, what we really need to do is bring it back to a
smaller project” (Int. 17A, pp. 13, 14)

Being consulted and giving advice are qualitatively different actions from operationally managing the garden and its development. As the Community Gardens group became a giver of advice, its role was significantly constrained. Arnstein’s (1969) seminal work on the ladder of citizen participation positions ‘consultation’ within the band of ‘degrees of tokenism’ and argues that:

... citizens may indeed hear and be heard. But under these conditions they lack the power to insure that their views will be *heeded* by the powerful. When participation is restricted to these levels there is no follow-through, no ‘muscle’, hence no assurance of changing the status quo. (Arnstein, p. 217)

The lack of power to assert change was also inherent in the second theme evolving from the work of the Community Gardens group. There was ongoing discussion about the *infrastructure and resources* needed for the garden to be successful. This included many debates about having a ‘face of the garden’ (as separate from the programme coordinator) as is outlined in Figure 18 (p. 235). Suggestions extended from either inviting a local person to become the community garden contact person / guardian, to setting up, or asking another community trust to find funding for a paid garden manager. This discussion reflected other debates throughout the programme and this project in particular. Debates included whether the face of the garden should be a *local person* (stuck between the potential for developing social capital on one hand and the

divergent ideas of who was local on the other), a *volunteer* (with the different perspective that ‘volunteering’ may bring), or a *paid employee* of either a charitable trust or of WRPHO. Employee status raises challenges, including different responsibilities and accountabilities to organisations and the community. As is described in Figure 18 (p. 235), this issue was discussed without resolution for many months and finally resolved, temporarily, nine months after the garden was started.

Another ongoing discussion (Figure 18) about infrastructure related to the need for street signage to direct people to the garden. Two street signs were installed (see Figure 19 below) at the end of July 2007, but they provided no information, just direction.



Figure 19 Street signage - direction but no information

(Sign installed outside the community garden 29/8/07 – four months after the lease signed)

A common comment was that individuals, not living in close proximity, did not know of, or could not find the garden. The need for notice boards at the garden to provide information such as who to contact about the garden, the garden

plan (and what was permitted under the council lease¹⁰¹), was also recognised. Also, the notice boards could inform garden visitors of the garden coordinator's regular hours, and of any planned events. These were all practical and pragmatic points. A community member, interviewed in September 2007, who knew the local environment, identified the need for garden infrastructure:

"It will be interesting to see what happens come November of this year because that is when we had all the trouble with rain last year here. [...]. We have little bits of light rain, very light rain, not a hell of a lot. And if this keeps going water up there [at the garden] is going to be absolutely critical. Or else we are just going to lose everything up there. [...]. Signs regarding, even just with weeding. Because someone had been in last week and had done some weeding but they had just thrown it out onto the grass strips in between. [...]. So signs on how to harvest the stuff, what to do with green waste, if you are going to weed – put the rubbish over there. Again its one of those things – everything is being run on a shoestring" (Int. 9A, pp. 23-24).

Inherent in that discussion was also the need for agreement on the processes to be used at the garden as without those, the few people who did use the garden, were again 'going it alone.' Over a year after the garden was established, I visited it. Alone, aware of my limited gardening knowledge, and also with no information to refer to I found it difficult to decide what I should be doing.

- Should I remove grass from the sides of the raised gardens (or was it meant to be left to hold the bed shape or retain moisture)?
- Could I compost all weeds? (I knew that the compost heap was probably not operating in such a way as to 'kill off' some plants.)
- Some plants I classed as weeds (dandelions) and would remove from my own garden were identified as herbs by others.

After half an hour of gardening and angst I stopped. Having done this repeatedly over the last year I expected that this was also the experience of others¹⁰².

¹⁰¹ The District Council lease included specific statements about the types of plants (fruit, vegetables, and herbs) which could be grown, what could be composted (no animal waste) and what changes could be made, with council permission, on the site. The processes of surveillance of the site by the council were also documented.

¹⁰² Field notes, 24/4/08.

Another community member, interviewed in September 2007, voiced the urgency for the infrastructure:

“Yes, and we actually desperately need people, and if there are people, then more people will come. And I see signs and the coordinator, I suppose it doesn’t matter which comes first, but I see both of those as the really top priorities. [...]. I wish that we had had a person the moment the planting was there, if not before, I wish that we had had a coordinator named and in place. Because to plant and to ignore is such a waste.” (Int. 10A, pp. 17, 18)

Discussions about garden infrastructure and resources were made more complex by the issue of access to financial information. Meeting attendees were made aware that money had been obtained from a community trust for resources for the garden, but, except for generalised discussions about the costing options for a garden shed, were not the decision makers about how that funding would be used. This was therefore an ongoing point of discussion, both formally within meetings and informally. One community member commented about the expense related to the use of pea straw as mulch during a working bee – it was too expensive to use in this person’s own home garden¹⁰³.

Another community member recognised how that cost needed to be balanced with the community resource available to do the work, and mulching was an effective and efficient technique for managing the large size of the garden. I asked a community member what lessons could be learnt from the project. Part of the reply given was:

“...resourcing it – if there hadn’t been that stinginess right at the beginning, if it had been much better resourced it would have been much more successful a lot earlier, simple things like a couple of hundred dollars worth of mulch. Now that I know how much money [is in the budget], then it’s ridiculous that we didn’t have mulch – that is absolutely ridiculous. (Int. 21A, p. 21)

As well as being informed that no money had been budgeted for the community garden, community members were asked to give advice (or make decisions) without access to a budget. With no further accountability, this was an ongoing tension in both the Community Gardens group and the Steering

¹⁰³ Field notes, 11/8/07, p. 1.

Group (as will be explored in the next chapter). It was not just that people wanted to know what the budget was, but that they wanted to make responsible decisions, which included balancing spending on resources and prioritising, working out what could be paid for and what could be sourced from the community.

There was also the misperception by some community members that some resources were donated rather than having been purchased, and this differentiation was important to people. One community member was concerned about returning plant trays. Having seen seedlings left over after the first planting day, the plants were shared with a school horticulture programme. Believing that the seedlings had been donated, the person stated:

I've got one empty tray sitting out there and I know they belong to [company] so I want to get them back ... and sort of apologise. 'Cause I mean they have been really great about donating all this stuff so you don't want to put them off ever helping again." (Int. 9A, p. 19)

A community member with experience in a number of community gardens recounted his experience with funding dilemmas – the two sides of access to resources:

"... one of the things that happened at the other community garden ... we got some money I think we got \$300 or something. My thoughts being, and it happened at Te Mana, was that we should use the money for the set up of the place. We needed a shed to keep things, and perhaps if we had some money over we could buy a few tools and keep them there and so on. We ended up paying out some of the money for some hay – the person would have been quite happy to give it to us." (Int. 17A, p. 11)

The ongoing and unresolved issues related to infrastructure and resources graphically portrayed why resource mobilisation and access to resources are identified as components in the models used to measure community participation (as displayed in Table 5, p. 76). Although the measures of resources may cover different things, such as community contributions (Rifkin et al., 1988), or community representatives being able to influence the allocation of resources (Neuwelt, 2007), a consistent need identified was that

of the transparency of decisions and their communication to the public (Fairfax et al., n.d.).

The third ongoing theme of the discussions over all the meetings related to different ideas about how to *involve people in the garden* and specifically involving individuals and groups that were local to the garden. There were many discussions about how local children could make the garden signs, have a garden naming competition, make posters to display at the garden, to involve local schools and early childhood centres, the gang, and to develop graffiti art on all of the high corrugated iron fences. Fun days and events at the garden, cooking demonstrations, fund raising events, and tours of the garden for different groups were all discussed. A few of these ideas were eventually implemented but for most it was over a year since they had been proposed. By that time, the people first making the suggestions were no longer involved. With no clear transfer of information, new people were then covering the same ground and making identical suggestions again.

These three themes, the giving of advice, the issue of resources for the garden and the concerns about involving the local community, were consistent throughout all of the meetings I attended. All of the themes overlap, but the overarching issue was that the pathway between floating the ideas, decisions being made, and those decisions being implemented, was poorly defined and convoluted. It reflected the way that Community Gardens group participants had been given no clear direction that they could manage the garden, and this was what was expected of them. Instead their role was established as advice giving, and it was then up to individuals if they also became involved in the work at the garden. There was little clarity as to who would do the work. At times I felt that there was an expectation from some community members that the programme staff would do the work because of their paid employee status.

At the same time project progress was very slow and this was to become the major push factor – people walked away - or literally disappeared from the

project. Few people signaled their impending disappearance from the project, but some did:

“And I think at the last meeting [community member] certainly said that really there was no point in her coming to those meetings. She wasn’t saying it in a huff. She was really saying there was no practical reason to be there. And I probably agreed with her but I am not willing to not come because I think it needs to be done.”
(Int. 10A, p. 4)

In other studies it was found that rather than being involved in overt conflict about the progress of health promotion programmes, community members just withdrew (Boutilier et al., 2000). Nevertheless, while some people walked away from the project, a few individuals remained involved, or became involved sporadically. Activities undertaken by those individuals included:

- Visiting and speaking at schools about the garden.
- Talking to others and encouraging their participation.
- Providing information for school newsletters and voluntary groups.
- Making scarecrows (having sought donations of materials first).
- Visiting local businesses and asking for project support, including requesting donations of equipment and resources.
- Circulating information about the garden through their networks, including work and volunteer organisation newsletters, email lists and web pages.
- Becoming a liaison person between the programme and other groups or organisations.
- Delivering produce to the Food Bank, to elderly people, or others who could benefit.
- Storing resources locally (before the shed was in place).
- Regularly visiting and working at the garden.
- Supporting the garden coordinator.

Some of these activities were undertaken independently, others with the support of the programme coordinator, who provided information packs, pamphlets, and flyers for distribution. Others freely offered help at the Community Gardens meetings. A consistent factor was that those participants

were already involved in other volunteer-type groups and organisations including schools, churches, environmental groups, service clubs, and political parties, as well as a variety of workplaces. The way in which some individuals have multiple social networks and involvements has been found in other studies (Barnes et al., 2004) and within the GABTR programme, those networks were an important community and programme resource.

Although some people placed the blame for lack of progress either with the programme coordinator or the WRPHO, others identified different issues. The Community Gardens group had no clear purpose or role in decision making. One community member described it as:

“... the ‘no-name’ group, because really we are just people who would like it to work and we haven’t got a function as such.” (Int. 10A, p. 4)

Interviewed in January 2007, six months into the programme, a person involved in both the Steering Group and Community Gardens group noted personal frustrations and challenges within the programme as a whole. The lack of progress with the garden project was clearly expressed.

“To be 100% honest it feels as though I have been involved for too long considering the lack of progress. That’s not very diplomatically put. I’m frustrated by how long it’s taking to get stuff off the ground. [...]. But I would just love to see the gardens being worked over and not still planned and discussed. But I understand [the programme staff] are being as diplomatic as they can in that they have a very sharp focus given to them by the funders and ... the Garden group definitely want to open it up and make it much broader than the funder wants and so [the programme staff] are probably treading a bit of a tightrope trying to bring all the strings together....” (Int. 2A, p. 2)

Instead of being the operational group as planned, its members provided advice, which may or may not be acted upon by themselves or others. The overlap with the Steering Group work, and confusion as to how priorities could be decided without access to budgetary information, added further dissatisfaction. Also, community members and group representatives attended meetings motivated by their own needs and interests. This space for

participation, partially controlled by issues related to programme target groups, appeared unable to accommodate those sometimes divergent needs.

The meetings were ineffective in progressing the garden project. After repeatedly hearing community member's concerns about the lack of garden development and the futility of the meetings, I suggested that consideration be given to changing the meetings to regular working parties at the garden with a short, informal meeting held at that time. The regular working bees commenced in August 2007, and were advertised until January 2008¹⁰⁴. No meetings were held during the working bees.

The relationship between this group and work in the garden at Te Mana Park

I had assumed, and so had others, as described in some of the quotes, that the Community Gardens group was a 'working' group interested in gardening in contrast to an advisory group that provided information. (There was the parallel discussion occurring as to whether the Steering Group was a governance forum or an advisory group for the whole programme.)

Therefore it was interesting to analyse participation by this group and others in the activities organised at the garden. There was limited crossover between Community Gardens group meeting participants and those involved in the five organised working bees held later in the year. Of those who had attended one or more Community Gardens group meetings (excluding programme staff and myself), 72% (18 of 25 people) never attended a working bee. Four people attended one, one person attended two working bees, and two people attended three of the five. Obviously the change in focus to *working* rather than *talking* either came too late, or those people were not interested in working at the garden. Also, by this stage the garden was in a state of disrepair and gardening was very hard work and mainly non-productive. It also demonstrated how community participation is a process that "... occurs before, during and after

¹⁰⁴ This was the time that the garden coordinator started work. Another working bee was organised in February 2008 but it was poorly advertised.

the particular point in time ...” (Thurston, MacKean et al., 2005, p. 241). What had gone before clearly influenced current participation.

The working bees as a different group, a different space

As well as the small group of people who were involved in the Community Gardens group and who also attended the working bees, 15 new people (who had not attended meetings) joined the working bees (see Table 12). At least four had attended the April planting day. Predominantly, these people lived quite close to the garden.

Table 12 Attendance at working bees

	<i>Working Bee</i>				
	11/8/07	8/9/07	13/10/07	10/11/07	8/12/07
People who had attended one or more Community Gardens meetings, excluding programme staff /myself	2	4	1	2	3
1 st working bee attended by individuals who had not attended a Community Gardens group meeting	5	3	3	3	1
Total number of people working during the working bee	9	15	9	9	6



Figure 20 Action during a working bee
(Te Mana Park Community Garden 8/9/07)



Figure 21 Produce harvested for delivery to the Food Bank

(Te Mana Park Community Garden 8/9/07)

I had anticipated that it would be quite easy to count how many people attended – as a rough estimation of community support (see Figure 20). It was a little more complex than I initially imagined, especially as I actively participated in the gardening and the site was large. This also meant that different numbers of attendees (as a sign of community engagement) were reported as having attended (for example, to the Steering Group). During the working bees participation looked like many different things.

- People attended for different periods of time, sometimes as short as ten minutes, and sometimes for the whole advertised time of two hours (or longer).
- Local children joined in for different periods of time¹⁰⁵.
- Some people brought children with them, aged from toddlers to teenagers. Sometimes these children became actively involved¹⁰⁶.
- On one occasion two workers at the garden during a working bee doing community work (part of the group installing the shed) came and actively involved themselves in the gardening¹⁰⁷.

¹⁰⁵ Field notes, 8/9/07.

¹⁰⁶ Field notes, 10/11/07.

¹⁰⁷ Field notes, 8/9/07.

- People continued to use the space as before, walking through (often with dogs), during the working bee. They may or may not talk to anyone or participate in the gardening activity¹⁰⁸.
- On one occasion an elderly woman arrived with a large rhubarb plant. This family plant, with a long history of being shifted around the country, was offered to the garden so that if something happened to the original plant she would know where another plant was. This woman gave it to those of us working at the garden during the working bee. It was left up to us to plant it¹⁰⁹.

Individuals who attended the working bees and who had not been involved in the Community Gardens group came for a range of reasons. Two people were relatives of programme staff and were very active in supporting the programme, having also attended the land blessing and the first planting day. Others said that they came to see what was happening. One school teacher wanted to investigate options for class participation.

The monthly date for the working bees was well advertised with public notices in free newspapers, on the radio, and distributed via email lists. The dates were chosen arbitrarily, but with care not to overlap with the regular meeting of a local environmental group. As soon as the dates were publicised, another gardening event timetabled with the first date, came to notice. As publicity had already gone out, and this was planned as a regular occurrence, the date remained unchanged. A community member also identified another clash:

“The working bees are on the second Saturday of the month. On the second Saturday of the month in the morning we have the [community group] market which goes on till 12 o’clock. By the time I come away from that market these days I’m not feeling like going anywhere else.” (Int. 17A, p. 12)

With a change in programme staff and the new emphasis on the work of the garden coordinator, advertising for the working bees stopped. Unfortunately,

¹⁰⁸ Field notes, 13/10/07.

¹⁰⁹ Field notes, 13/10/07.

the cancellation of the working bees was not communicated to all those who had been involved and on meeting a community member near the garden that person told me of repeatedly going to the garden on the second Saturday of the month, as had been advertised, but finding no-one else there¹¹⁰. This person now rarely visited and was unaware of the ‘new’ hours or of the appointment of the garden coordinator as there were still no information signs at the garden.

A difficult space for community participation

The difficulties that have been described, and which were simultaneously threats to the success of the programme and its solutions, also illustrate how community participation in this project reflected types of focused social action. These included that it was dynamic, specific, interests and needs focused, and intentional. In an examination of the role of citizens in community development three conditions were associated with participation (Cary, 1970). Individuals had to be able to choose, autonomously, to be involved, and they needed the ability and willingness to participate. The meeting attendees met all three conditions, but these conditions being met did not guarantee their engagement. As a group, they were particular as to their participation, and as is congruent with the arguments that contexts create particular types of participation (Harrison, 2002; E. Jones & SPEECH, 2001), they identified when the space created for their participation was not meeting their needs – they walked away. The dynamic nature of their participation only became obvious over time. Community participation as a dynamic process is congruent with the arguments put forward by many authors (Eyre & Gauld, 2003; S. White, 1996; Zimmerman, 1995).

Community members’ varying levels of experience and expertise and their different interests brought much diversity to the group and challenged the normative label which Alperson (2002) argues is often applied to community as a grouping. Nevertheless, community members showed a heightened

¹¹⁰ Field notes, 13/4/08.

awareness of the need to involve others who were local to the garden, thereby simultaneously being community members and different from other community members. In this way they described embodiment of the sense of boundaries inherent in descriptions of community (Sibley, 2003).

While a few community members were determined that the project would work, their resolve was driven by wider societal and global issues – this specific garden was a small potential part of the solution and an appropriate space for local action. Some community members were sympathetic to the lack of experience of programme staff, but they were intolerant of what was perceived as ignored advice, the lack of progress, and health sector responsibility for imposing the garden on a community without taking the appropriate steps to engage with that community first. The problems encountered dramatically affected community participation in the programme. They are also the same problems which are commonly described in the literature related to community participation (Campbell & McLean, 2003; Oakley, Bichmann, & Rifkin, 1999; Parry & Wright, 2003) and health promotion (Easterling et al., 2003a). A more positive view of participation as focused social action can be seen in an examination of the plant distributions.

The plant giveaways as linking growing plants and food with health benefits

Whereas the community garden caught the attention of a relatively small number of people already interested in gardening, and specifically those curious about the concept of a community garden, the plant distributions had mass appeal. In total, a combination of approximately 7,800 heritage tomato seedlings and Monty's Surprise apple trees were given away over an 18 month period. Some were distributed within regional rural areas using a targeted approach to community groups, iwi committees, marae - for marae gardens or whānau - and to health services for distribution to their clients. The targeted approach was most successful when established social, cultural and professional networks were utilised.

While the targeted distributions tapped into established networks and built on positive relationships, the majority of the plants were given away at single-day public distributions held in the city at a number of sites. For the 2007 apple tree distribution these sites included a farmers' market, garden centres, the community garden and a school. The first apple tree distribution in 2006, which was mirrored by the same enthusiasm in 2007, was described:

"... it was an amazing success.

"(LB) So how many trees did you give out then?"

"560 I think, on that day, and we ran out. We had to turn hundreds of people away – it was heart wrenching.... It was just such an amazing time. We were right inside the garden centre and the queue started forming. It was supposed to be 11 o'clock but they started coming at nine o'clock. And we started handing trees out and the queue went right out past the counter - out of the garden centre and down their driveway and down the road. And people kept on coming in and telling us where the queue was, how long it was. And there were people directing traffic. Yes, they had a policeman directing traffic at the end of the road because there were just so many cars trying to get into the street." (Int. 4A, p. 5)

The intense widespread interest resulted from variety of factors. Firstly the plants were free. Secondly, the plants, as heritage varieties, were believed to hold special qualities, be easy to grow, disease resistant, and their produce was linked with health benefits. Thirdly, some of the community members associated with the trees and tomato plants had high personal profiles in the community in relation to heritage plants and research into their qualities. In addition, the distributions were identified as something unique to the Whanganui region. Combined, these factors captivated the community.

The resulting active engagement could be seen in the way that over 40 people volunteered to help at the apple tree distribution in April 2007. These people included senior staff from the WDHB, staff from the Public Health Centre, staff from the WRPFO, District Councillors, Steering Group members, Community Gardens group members, and a number of members of community groups associated with GABTR. Other groups freely offered resources and support. For example relationships between members of the Tree Crops

Association and other groups resulted in the glossy plant care pamphlets and inserts about the community garden being heavily subsidised by a printing company. At the plant distributions other community organisations provided a free marquee, free bottles of water for helpers, and the District Council loaned traffic control cones.

The plant distributions were widely advertised under the umbrella of the GABTR programme. There was also a significant amount of independent advertising organised by the people whose idea the plant distributions were, sometimes with links to GABTR and sometimes without. This independent advertising, in the form of newspaper columns – especially related to gardening and the emerging research about the chemical analyses of the plant produce – was what most people that I talked to identified as the source of their information about the plant distributions. Therefore the plant distributions were to most obvious manifestation of GABTR being a joint and collaborative programme, with the plant distribution project led by community action.

Motivations of those who came to collect a tree included missing out on a tree the year before; wanting another tree (one person brought a photograph of his planted tree to show us); collecting trees for relatives and friends and those who lived outside of the Whanganui region; and specifically wanting a tree for people with, or who had previously had, cancer. A number of people wanted to thank someone for their tree, with more than one person wanting to pay for it. People commented about how ‘special’ and ‘precious’ the trees were and many asked for more than one tree; most were comfortable with the one-tree-per-household approach. Many people asked how to plant and care for the tree – everyone was given a pamphlet that provided this information. In contrast some people appeared flabbergasted that others would not know something as simple as this. Families came – with children and parents together – to collect a family tree¹¹¹.

¹¹¹ Field notes, 7/7/07, pp. 1-3.

In subsequent interviews I asked people their motivations for getting their free tree:

(LB) “Can you tell me why you went and got the apple trees (one last year and two more this year – one for a friend)?”

Because they were heirloom, they were the old fashioned ones. And not only that, I was most interested in the claims – these compounds, these antioxidants, whatever it is - good for diabetics and anti-cancer properties.” (Int. 12A, p. 14)

More obvious at the tomato plant distribution were a small number of people who told me of how they wanted to start a garden and how collecting the tomato plant was the first step. Growing a tomato plant was seen as manageable, achievable, and there was likely to be a positive recompense for the energy expended. This was in direct contrast to some of my discussions held with community members in the community garden, which was seen as too big, unmanageable and with little opportunity to see real progress. A number of couples came together to the plant distributions and were planning competitions as to whose tomato plant would produce the most fruit. A helper at one of the sites of the tomato plant distribution commented:

“In some ways it was really good because ... I met really nice people. There were some really nice people that had brought their kids along because they were going to attempt to grow the tomato because it was free. There were other people who were just quite rude and just wanted their freebee and probably didn’t even want to give us information [contact details for a database]. And we went to another site; they were there as well so they had got more than one tomato – greedy as far as I was concerned. It was probably a really good collaborative day because we had Public Health members there and they were really helpful and got into the spirit of things. [Community member] was there on hand to describe the tomatoes and he was really good.” (Int. 20A, pp. 6-7)

I asked another helper at the tree distribution as to why people had come to collect trees:

“Because they were free. ... No, that’s a bit cynical. If they had been charged, I don’t think there would have been a fifth of the people there. But that’s not the main reason. People did it because it was free but probably an equal reason was that they were going to get a really good product. So both of those reasons were roughly the same.” (Int. 18A, p. 8)

There was much overlap between the people who collected both a free tomato plant and an apple tree. I had a conversation with a community member who had requested a number of tomato plants:

(LB) “Now I know that you got a tomato plant.”

“A tomato plant [laughing].”

(LB) “So did you get an apple tree as well?”

Yes, an apple tree. And my apple tree is successful. I put it in a pot, a big tub, and read the instructions carefully” (Int. 15A, p. 9)

As previously described, the plant distributions and giveaways were seen as key milestones for the programme. Whilst not detracting from the potential positive effects, some people had thought that consideration of other approaches to meet the same aim could be worthwhile.

“With the distribution of the trees, I really like it going to schools and kōhanga because that makes sense, and again it’s the [health promotion] settings thing But all the rest is going to people like me that could afford \$8.00 for a tree. ... And if you look at the people that came [to get a tree] ... they weren’t the ‘poor and downtrodden.’” (Int. 10B, p. 2)

“... if you take it back to the cultural thing – meeting your target groups – certainly Māori and Pacific Island groups, you have got that koha [donation/gift] approach. You never get anything for nothing, nobody gets anything for nothing.” (Int. 10B, pp. 6-7)

The plant distributions were effective in creating a different space for people’s participation. That participation, as focused social action, took many forms with community participating as helpers, donors, and recipients. Curiosity was turned to action by virtue of the plants being free, and the links being made between a heightened community awareness of cancer, the antioxidant (read as ‘anti-cancer’) health benefits of some foods, and a re-emergence of interests in growing fruit and vegetables. A Steering Group member identified how the plant giveaways captured:

“...the public’s perception of what’s important ... to them personally.... [...]. ...it’s the whole public thing, and cancer is important to people. And sometimes I feel that we don’t do things, promotion wise, well enough to pick up on that kind of thing, to get people involved. ... and yeah, the community giveaway is huge because you don’t often expect things free, and it has a health angle on it....” (Int. 11A, pp. 30-31)

Framing health promotion messages around community anxieties, in this case concerns about cancer, is now being identified as a productive approach (Downing, 2008), although within GABTR it was still contentious. The participation was also short-term, public, and for some, altruistic. This enabled alternative perspectives of participation as social action to come to light in a different space than that offered by the community garden project. Also illustrated were the positive effects of tapping into people's interests and perceived needs, even if there is some gap between how those interests are viewed and the values underpinning them. Programme staff recognised that there was a large gap between collecting a bare rooted stick of an apple tree and meeting part of the programme aim of increasing fruit intake¹¹² (although a much shorter period for the tomato seedlings). Internationally, other similar projects, such as the Million Tree initiative in Los Angeles, have also been controversial in terms of long term effects and sustainability. Nevertheless, there has also been recognition that this sort of project can have many benefits as broad as civic engagement and environmental improvement (Zahniser, 2007).

Summary

In this chapter community participation has been explored through a lens of focused social action. Two projects within GABTR, the community garden and the plant distributions, provided different contexts, spaces, and "... opportunity structures" (Barnes et al., 2004, p. 61) for that action. Some key characteristics of the action were explored. These included the capturing and building on established interests, the dynamic but tentative nature of participation, and community members' specificity regarding the types of participation they desired.

¹¹² It was anticipated that the trees would take about four years to fruit although community members reported small numbers of fruit after periods as short as one year.

What was also shown to be important was the context of that participation and the different spaces created for it in a largely top-down programme. Various types of participation came to light, as did the ambiguity in the role differentiations between health sector staff and community members in relation to the work done. While community members held positive beliefs about the need for and the benefits of a community garden, the Community Gardens group struggled to either meet its member's needs or its purpose within the programme. In contrast, the garden working bees, while also struggling and largely unsatisfying, did more effectively draw in community members local to the garden. The two projects demonstrated an array of community participation but also the many constraining forces that restrict that participation.

In the following chapter the examination of the issue of community participation in the GABTR programme shifts to focus on the governance space, another space created for community participation.

Chapter eight: Community participation in steering a programme - a contradictory space of partially met expectations

Introduction

In the last three chapters, an overview of the three phases of the GABTR programme has been provided and community participation was examined in relation to two overarching themes. Firstly, participants' relationships with the community garden as a place and space were shown to be important. This was not just as context to the programme but as inherently linked with the community response to the programme. Secondly, the way the programme built on and captured community interests - as focused social action - was explored. The marked differences between the levels of community engagement within different programme projects were examined, with an exploration of one of the mechanisms instigated specifically for community participation – the Community Gardens group.

In this chapter, the gaze turns to another avenue for community participation in the programme - the Steering Group. This Group¹¹³ inhabits what I have termed 'a contradictory space of partially met expectations.' It is where the challenges and tensions which arose in the first and second phases of the programme are revisited time and time again. In spite of this, at times, uncomfortable space, resilience and determination by some Group members made things happen. In the following chapter, the case study is completed by an exploration of the broader contextual factors which have shaped the space for the GABTR programme during its short existence.

¹¹³ Within this chapter 'Group' refers to the Steering Group.

An uncertain space for stakeholders and community

Throughout the last three chapters the Steering Group for the GABTR programme has been mentioned or alluded to on multiple occasions. This is the Group that evolved out of the statement required in the initial Request for Proposal template provided by the MOH where the ‘governance and/or management structure for the initiative’ was to be described. The answer provided, as has been explained previously, was that “(t)he *governance* for this project will be a *collaborative relationship* between *key stakeholders* and the *community*. A *steering group* to guide the development, implementation and evaluation of the initiative will be formed” (emphasis added, WRPHO & WDHB, 2005, p. 2). Inherent in this quote are the complex and contested concepts of governance, steering, collaborative relationships, stakeholders and community. It was into this space that community members and groups were invited to join with those from a range of health sector organisations and with programme staff to ‘lead’ the GABTR programme.

There were high expectations as to what this Group could accomplish within the boundaries of the programme scope and contract period. Over time it became obvious that those expectations were partially met, but that the Group faced some core and ongoing challenges. If the programme was being steered mainly by the Group then this would be evident in a number of ways. Firstly, a clear pathway between the ideas put forward, decisions and direction given by the Group, and programme outcomes should be identifiable. Even taking into account the newness and innovative status of the programme, progress on a number of fronts was painfully slow, with the plant distributions the exception. There was widespread comment within and outside of Group meetings that advice given did not translate into actions, specifically in the community garden project. Examples, of which there were many, all related to engaging the community: the need to have discussions with the local gang before work on the garden commenced; the need for a variety of signs and information boards at the garden; the need to get local groups involved; and the need for a garden coordinator. These were all partially achieved after long delays. As was

explored in the previous chapters, those delays had ramifications for community participation in the project.

Secondly, if the Steering Group was the main driver, the Group would be functioning as a collective - or beginning to do so - with a clear sense of purpose and understanding of its role in the programme. As will be explored further, this was not so. In the second phase of the programme it was difficult to ascertain who 'controlled' and led the programme and the work done. Performance measures from the service plan were met, as were all reporting requirements, but the overall intent of the programme, and especially the community garden showed little progress. In the third phase many decisions were made seemingly independently by the WRPHO outside of the Steering Group¹¹⁴ and the responsibility for re-enlivening of the community garden had mainly fallen to the newly appointed garden coordinator. Those decisions were then shared with the Steering Group. I never heard a discussion in the meetings that said 'how did that happen?' or 'why did it happen now?' The way the Steering Group functioned was partially a response to the uneasy space created for it, which resonates with the argument that "... public participation takes place in a specific organisational and social context from which it cannot be extracted" (Contandriopoulos, 2004, p. 322).

Setting the focus on stakeholders

In the initiatives fund application (WRPHO & WDHB, 2005) members of the Steering Group were to be separate entities of 'key stakeholders' from organisations and groups *and* 'the community'. A list of nine proposed organisations as Steering Group members were listed in the application, and over time, another three groups were included (as shown in Table 13).

¹¹⁴ For most of these decisions, such as the employment of a paid garden coordinator, these had all been discussed multiple times in the Steering Group and in the Community Gardens group so that in essence the WRPHO was implementing decisions made previously.

Table 13 Steering Group membership

<i>Organisation / position</i> (community groups / members coloured; health sector organisations un-coloured)	RFP ¹¹⁶	<i>Terms of Reference</i> ¹¹⁵						
		1	2	3	4	5	6	7
WRPHO GABTR Programme Coordinator ¹¹⁷	✓	✓	✓	✓	✓	✓	✓	✓
WRPHO Pasifika Nurse ¹¹⁸	✓	✓	✓	✓	✓	✓	✓	✓
WRPHO Community Advisory Group ¹¹⁹	✓	✓	✓	✓	✓	✓	✓	✓
WDHB ¹²⁰	✓	✓	✓	✓	✓	✓	✓	✓
WDHB Public Health Centre ¹²¹	✓	✓	✓	✓	✓	✓	✓	✓
Māori Health Organisation A ¹²²	✓	✓	✓	✓	✓	X	X	X
Māori Health Organisation B ¹²³	✓	✓	✓	✓	✓	✓	✓	✓
Health NGO ¹²⁴	✓	✓	✓	✓	✓	X	X	✓
Community Group A	✓	✓	✓	✓	✓	✓	✓	✓
Community Group B ¹²⁵	X	✓	✓	✓	✓	✓	✓	✓
Community Organisation A	X	✓	✓	✓	✓	✓	✓	✓
Community Organisation B ¹²⁶	X	✓	✓	✓	✓	✓	✓	X

¹¹⁵ The seven versions of the Terms of Reference provided to the Steering Group are listed 1-7. These were distributed in October 2006, February, March (2), May, June and September 2007. Another three versions in circulation were not distributed to the Group.

¹¹⁶ Request for Proposal – application to the HEHA Initiatives Fund

¹¹⁷ Initially both the programme coordinator and programme support worker attended meetings. Once the programme support worker position was disbanded, WRPHO administration staff attended some meetings to take minutes. The programme coordinator was replaced by an interim part time coordinator for a period, and both the coordinator and interim coordinator attended some meetings. The interim coordinator then attended some meetings as the external evaluator and then was replaced by the Health Promotion Advisor in April 2008.

¹¹⁸ Two staff members covered this position over time, one becoming the Group chairperson from February 2008.

¹¹⁹ Although the organisation is part of the health sector, this position was for a community representative on the Community Advisory Group of the organisation.

¹²⁰ This position was that of the contract manager within the WDHB. Due to staff changes this position was covered by two people over time.

¹²¹ Due to staff changes, this position was covered by two people over time, with a third attending three meetings.

¹²² Never attended a meeting.

¹²³ Last meeting attended November 2007

¹²⁴ Never attended a meeting.

¹²⁵ This organisation was represented by one person who stopped attending meetings in September 2007. In December 2007 another person with links to that organisation was invited to join the Group.

¹²⁶ The person representing this organisation withdrew from the Group in February 2007.

Table 13 shows the groups listed as organisational members and how those groups changed only slightly over time. However, staff changes altered individual membership, with for example, four people fulfilling the role of programme coordinator or health promotion advisor with responsibility for the programme. The positioning of members as organisational representatives is what differentiated this Group from the Community Gardens group, although there was some overlap in the people involved. What is of interest is the number of positions identified for community groups in contrast to the health sector stakeholders. (Actual attendance figures, as discussed later in this chapter, showed on average two health sector attendees for each community member present.) There was an expectation of dual roles for some members and this will be explored further in this chapter. The description of the Steering Group in terms of governance and stakeholders was described again in the service plan for the period of the 1st July 2006 – 30 June 2007. Here, under the title of ‘quality’ the Group was described, again with community groups as a separate entity from stakeholders:

The Governance Forum will primarily be made up of stakeholders who work in public health/health promotion and community members/groups. The combination of the two will ensure that the project co-ordinator and the project itself are guided to achieve the set outcomes, while allowing for modification when appropriate for the best effect in the community.¹²⁷

This Group was established within two weeks of the employment of the new programme coordinator, during the rush to make up for deadlines delayed by funding and contract negotiations, and late staffing appointments. It was a common theme that most people on the Steering Group, including programme staff, did not know how other members, as stakeholders or community members had been selected:

¹²⁷ GABTR service plan, 1 July 2006 to 30 June 2007, p. 8

“... essentially when I came on board all of the members for that, who were going to sit or who were going to be invited to sit on that group had been chosen. I am still not sure how that process happened. I am not sure who decided which organisations should be involved, which community members,” (Int. 19A, p. 3)

It was also not clear from the minutes of the first meetings that there were any focused discussions on who the members were and why they were present in this forum. Swyngedouw (2005, p. 1995), in a discussion of the contradictions in the new focus on governance groups, argues that the “... participants in such forms of governance partake (or are allowed to partake) in these relational networked forms of decision-making on the basis of the ‘stakes’ they hold with respect to the issues these forms of governance attempt to address.” As well as attributing importance to the ‘stake’ members hold, “... assigning ‘holder’ status to an individual or social group is not neutral in terms of exercising power. In most cases entitlements are conferred upon participants by those who already hold a certain power or status” (Swyngedouw, 2005, p. 2000). One Steering Group member identified some of the ‘stakes’ and ‘holders’ within the GABTR Group as:

“Their Steering Group, if you notice, is composed, ... they all have a reason for being there. You know there is some guy that knows about trees ..., and there’s interest groups like the Māori interest group – they all have a raison d’être,” (Int. 5A, pp. 1-2)

That *raison d’être* related to organisations and groups, initially identified as those needed for programme success, and communities of interest for the programme and its projects. It also reflected personal interests in the programme, and high hopes for its success. A Steering Group member commented:

“I’m on [the Group] because I think it’s really, really important.” (Int. 2A, p.1)

Personal motivations for participation were identical to those identified by others involved in the programme in different ways as was outlined in Chapter Seven. Some of the members had previously worked together within the Whanganui Wellbeing Forum, which was a mainly ‘professional’ space for

organisations interested in nutrition and physical activity. The mode of stakeholder participation identified in the Terms of Reference for the Steering Group was that members would be representatives.

Stakeholders as representatives

The process of becoming a stakeholder differed between Group members. Some representatives had been formally nominated by their organisations or groups for that role:

“... they [WRPHO] asked for a [organisational] representative and so I was nominated and now I am on” [the Steering Group]. (Int. 2A, p. 1)

For others their membership was a component of their employment role. Although unsure why, one member had received a personalised invitation to join the group, rather than an organisational invitation having been offered. For this person, utility to the group and programme was most important:

“Initially I was unsure about what I even had to contribute. But I said ‘I will come along for a little while and just see how it goes’ and, you know, whether I’m actually able to contribute anything.” (Int. 1A, p. 2)

For another member, it was clearly the organisation that was the member:

“... yes, put my name down as an organisation that would like to be part of this.” (Int. 16A, p. 1)

Another Steering Group member discussed how their representative role developed after they had joined the committee:

“I think I was initially put up for the committee because I bring a few skills or experiences. [...]. So the [community group] was just a subsequent development but it seemed like a convenient group to represent and they are keenly interested” (Int. 3A, p. 5)

Another Steering Group member found that the group that they were put on to the committee to represent already received programme information from another source. Therefore, this person shifted their focus:

“So I have sort of changed my direction slightly from the original intention and I still report back to the [organisation]. [...]. So I have said, ‘how can I help the success of the project through my linkages, my networks and things I do here’” [within current employment role]. (Int. 5A, pp. 1-2)

Again, utility for the Group was seen as important and this was a common theme with members constantly reassessing what they could personally offer the Group. None of those people quoted were still actively involved in the Group in June 2008. As well as differing ways of joining the group, the work required in the representative role also differed between members.

The work of being a representative

For some Steering Group members they had an organisational mandate and their membership was contingent upon their continued participation in their own organisation. This role of being an organisational representative was complex. Firstly, it meant, in a small programme, with a number of linked local programmes, in a small region, that many people ‘wore more than one hat’ at meetings:

“... most members represent an organisation although they ... don’t necessarily sit there with one hat on. They also sit there with their community member hat on and some other hats they might have as well. [...]. I believe the majority of the members of the Steering Group would believe that they are there with their organisational hat on as opposed to being a community member. There may be the odd one that is there from a totally different angle, not from a business organisational view and not from a purely community member view, but from a different angle all together.”(Int. 19A, p. 6)

These multiple roles sometimes reflected the “... matrix of relationships, both the vertical relationships within projects (of funder, fund holder, evaluator and community project team) and the horizontal relationships across projects (between funders, fund holders, evaluators, and community project members) that influence community action projects” (Greenaway & Witten, 2005, p. 145). The combined role of organisational stakeholder and community was

displayed at times, especially when there were repeated discussions on how to involve people and groups at the community garden. At different times throughout the programme it was clear that the ‘multiple hats’, which could be organisation and community, or organisation and programme, were both a cause of consternation and at times an asset to the programme. In an interview, a non-member of the Steering Group relayed a conversation that person had had with some members about the function of the committee and what was perceived as conflicting roles:

“... [I said] ‘this is an advisory steering group. You have not understood governance, this is not what it was set up to do, and it is not appropriate for you to be delving into this. And what you guys need to do is to take your other hats and park them up while you are performing this function.’ But in fact there were a number of them that couldn’t do that.” (Int. 14A, p. 12)

In reality it is difficult, if not impossible, to step between roles – especially those between contract management and programme governance – when there were concerns about the progress of the programme. Also, dual roles held potential for the programme – with relationships in the MOH and networks with the DHB. Members used their multiple roles to the advantage of the programme and outside of the Steering Group meetings I heard members describe how in one role they could access information that may not be available within another role¹²⁸. People’s descriptions of which organisation they did or could represent on the Steering Group changed over time, but these were not necessarily communicated to, or heard, by all members.

Representation usually includes a transfer of information between the organisation or group represented and the Steering Group, with the representative as the vehicle. Individual members had very different responsibilities regarding ‘reporting back’ to their organisations and groups about the programme.

“ ... I report back to them [a community group] what’s going on. ... It’s just been really informal ... - just saying ‘well, we had a meeting and this is what we discussed’” (Int. 3A, p. 5)

¹²⁸ Field notes, 28/3/07.

Some were not required to report back, others only reported to employers that they were members of the Steering Group, and others were required to provide detailed written reports about the programme. Sometimes those reports were written by programme staff for the Steering Group member and sometimes the Steering Group member wrote these independently. What Swyngedouw (2005, p. 2000) described as the "... widely diverging mechanisms of deciding on representation and organising feedback to their constituencies" was further complicated when Steering Group members also held additional functions. For example, one Steering Group member was the contract manager for the programme in the DHB.

The process of reporting to the Steering Group only occurred occasionally and at Group member's instigation until the title of 'reports' was added to Steering Group revised agenda handed to members during the meeting of May 2008. I was interested that my name was included as a Steering Group member. As members had not been given any warning of this new addition, the only 'reports' given were those of agenda items which had already been signaled and added to the agenda before the meeting¹²⁹.

Representation as being an advocate for...

Steering Group members expressed a number of different perspectives regarding the purpose of representation. These ranged from serving the interests of tax payers to representing ethnic groups which were the target populations for the programme. These encapsulated both the representational strategies of "speaking of" and "speaking for" (Mohan, 2001, p. 157). I asked a Steering Group member who represented specific ethnic communities how that representation worked:

"Well I guess I'm always thinking, whatever is discussed, I'm always thinking 'how is that going to affect the people I represent' and 'in what way?' And 'in what way can [ethnic group] be

¹²⁹ Field notes, 19/5/08.

represented in this group and what can they bring to this and how are they going to capture [their interest]?’ Because the other thing is that the [ethnic] group, of course they have their own cultural identity which is different from other groups, but the need, the basic needs are the same as many other groups that I have represented before as well.” (Int. 6A, pp. 4-5)

Interestingly, this Group member was not personally a member of the ethnic group being represented, but was in the position due to their employment role. Congruent with the arguments presented by Clark (2001) this member was working with the group represented to develop their own structures for advocacy within another committee. I asked the question of this person:

(LB) “So you are in a unique role on the Steering Group in that you are advocating for a group rather than just representing them, would you agree?”

“Yeah, I would say I advocate for that group and represent that group with their goodwill. I represent them because they have asked me, because they are happy for me to do it, not because I belong to that group.” (Int. 6A, p. 8)

Representation of other communities of identity which were also identified as communities of interest in the programme was also complex.

Māori representation – communities of identity

The space for Māori representation on the Steering Group related to two interlinked but somewhat contradictory positions. These plural positions were identified in the answers provided in a number of the sections of the initial Request for Proposal template. These positioned Māori participation in the GABTR programme firstly in relation to poor Māori health status and health disparities as a justification for the programme and its approaches. This alludes to Māori as a vulnerable group. Secondly, in the proposal, connections were drawn between the proposed programme and the frameworks of Māori health development laid out in *He Korowai Oranga, the Māori Health Strategy* (A. King & Turia, 2002). Also included in the proposal application (WRPHO & WDHB, 2005), was acknowledgement of the three principles associated with the Treaty of Waitangi, of partnership, participation and protection. These are, in contrast, positions of strength, self determination, and resilience. While

congruent with an “... indigenous health responsiveness framework” which focuses on specific goals, principles and pathways for Māori (Durie, 2008, p. 372), in practice the two positions provided a somewhat contradictory and complex space for any Māori representation in the governance of the programme. It is one which is repeated time and time again in health programmes throughout the country.

In a toolkit developed to assist PHOs to involve communities in their governance it is argued that:

Māori may see their role in representation differently to non-Māori. In the words of a Māori participant in this research, a representative on the governing body of a kaupapa Māori health organisation [an organisation working within a Māori philosophy], ‘Māori don’t only represent their hapū/iwi [sub-tribe/tribe], but also their whakapapa [family tree].’ In other words Māori often speak first on behalf of their whānau. (Neuwelt, 2007, p. 33)

That mode of representation was different to the space created for Māori representation on the Steering Group, which had originally been linked to two Māori health service organisations. Over time it fell to one member of one organisation, and informally to programme staff, who also identified as Māori. In the *Whakatataka, Māori Health Action Plan 2002-2005* (MOH, 2002d) the focus is on partnership instead of representation:

Māori partnership in decision-making, and participation in planning and delivering health and disability services will ensure a system that works for whānau, hapū, iwi and Māori communities. Māori participate as skilled and valued decision-makers, health clinicians and professionals, researchers and managers, and as whānau, community health, public health and disability workers. (MOH, 2002d, p. 17)

Whether an organisation or “... communities of identity” (Campbell & Jovchelovitch, 2000, p. 264) were being represented, or a specific partnership sought, is unknown and this dilemma has been identified in other studies

(Lockett-Kay, 2005). The pragmatic difficulties for Māori organisations providing representatives for all of the programmes they could be involved in were articulated by one participant:

“And they [Maori health services] have a very limited resource ... and we [mainstream organisations] say ‘you have to have the iwi provider on there, you have to have.’ But often it is tokenism and it’s really hard for them unless it fits [with their own work], and they are just stretched often. And then you get people ... sitting on there [on the Steering Group] who have very little to offer. And it’s not because they don’t want to, but it’s not their role, and they have been told to sit there, ..., and it is really tricky.” (Int. 11A, p. 23)

Moving beyond tokenism to developing and maintaining representation and partnership with Māori communities is a recognised complexity in governance groups. In a recent evaluation of intersectoral health projects this was an issue for three out of four of the initiatives (MOH, 2008b). The nature of representation in itself is complex, when all ethnic groups are inherently heterogeneous and each grouping has its own interests, processes and priorities. Also, as has been identified in many sectors and programmes in Aotearoa New Zealand (Office for the Community and Voluntary Sector, 2007), representatives from the same groups, including Māori and Pacific peoples, are constantly in demand by virtue of the groups being identified as the target groups for programmes.

In a recently published report of research into Māori perspectives on volunteering and the sense of duty to meet cultural obligations (Office for the Community and Voluntary Sector, 2007), Māori participants identified a number of motives for their participation in mahi aroha¹³⁰ (the term identified by key informants as more appropriate than volunteering). The grouping of motivations labeled as ‘political’ encapsulated components including cultural survival, Māori social and economic development, and input into mainstream social and economic development. The work of providing advice for mainstream organisations was identified as time consuming and often without

¹³⁰ Mahi aroha was defined as “... work performed out of love, sympathy or caring, rather than for financial or personal reward” (Office for the Community and Voluntary Sector, 2007, p. 13).

recognition of the degree of additional work needing to be undertaken to consult with Māori communities. It was also identified as “... essential to ensure that Māori had input into policy decision-making” (Office for the Community and Voluntary Sector, 2007, p. 26). Without what could be identified as robust Māori community (rather than health organisation) representation on the Steering Group it was interesting to explore with committee members as how they perceived the representativeness of the Group.

Steering Group representativeness

I asked some Steering Group members about the composition of the Steering Group and one member commented:

“I think the community representation possibly could be a bit wider, but that might make it more unwieldy. There’s a lot of people who represent the health department in various ways [on the Steering Group] and, not that we have had, that it has come down to voting, so it’s not really an issue about how many community representatives there are. I don’t feel that the community is disempowered or anything. I think that the balance is probably about right.” (Int. 3A, p. 7)

Separating community members (as representatives and ‘non-employees’¹³¹) from those employed in the health sector, and the balance between these two ‘factions’, was seen as important. Other members provided different descriptors for collectives within the Steering Group:

“... I believe that there are some ‘action groups’ represented in the Steering committee and ... there are some ‘helping groups’ – they all want it to succeed, but for different reasons.” (Int. 5A, p. 3)

Another member commented:

“I’m not sure who drew up the list [of members] but it seems pretty representative to me, it’s good.” (Int. 2A, p. 4)

I then asked what the Steering Group was representative of and the reply given was:

¹³¹ Field notes, 16/4/07, p. 4.

“Of the community, and also of the groups that might do a lot of the work.” [Then listing two community groups and a Māori health service provider as examples.] (Int. 2A, p. 4)

These comments about the representativeness of the Steering Group focus on ‘who’ was in the Group rather than the ‘level’ and type of participation (S. White, 1996). Within the literature on community participation in health promotion programmes the community referred to is often expansive. For example, “(c)ommunity involvement in health therefore means that all those sections of the community having a particular interest on health-related issues can pursue them either directly or through representatives” (WHO - Regional Office for Europe, 1991, p. 4). Communities may also be more limited to the groups likely to be impacted upon by the programme. A short document produced as a guide for primary health services developing health promotion programmes (MOH, 2003b, p. 3) identifies how health promotion is theoretically “... an inclusive and participatory process involving the community of interest in determining action.” A “normative argument” therefore positions that these groups, the communities of interest, have a ‘right’ to be involved and included in what is being planned for them and which may alter their lives (Julia & Kondrat, 2005, p. 537). In the Steering Group model for GABTR what was missing was the space for participation of those communities listed in the programme aim and this was recognised by some members.

A community representative raised the question of ‘were there enough community members on the group?’ at a Steering Group meeting. This person then gave an example of how, in personal experience with other similar committees, there were always more spaces for non-employees (community representatives) than employees. The response given by a WRPHO staff member was that there were ‘six’ non-employed people within the Group and that this was ‘a good number’¹³². It was unclear as to who was included in the six positions as at that time there were only five community group positions.

¹³² Field notes of Steering Group meeting, 16/4/07, p. 4.

One local community member was brought to a meeting once but without any clear introduction to the work of the Group, to the GABTR programme as a whole, and without a purpose to be there, this person reportedly asked after the meeting as to ‘why was I there?’ Also the Group had not been given prior notification of this person’s attendance and so some members, while appreciating the person’s useful input at the meeting, also asked what the person was there for.

Both Māori and Pacific Island ‘representation’ was ‘covered’ by health sector employees. There was no provision for local communities of place (Campbell & Jovchelovitch, 2000) and lower socioeconomic groups of other ethnicities to be involved, except through the Community Gardens group, while that group was meeting. No space was deliberately developed on the Steering Group for rural groups, and for those with other special interests such as children, people with disabilities, or new migrants. Target groups for health promotion programmes have been recognised as having limited participation and control in other projects. In a study of five community health promotion projects in Canada “... relatively low numbers and a restricted range of participants, difficulties in recruiting and maintaining participants, declining rates of active participation over time and limited target group influence and power” were all identified as issues (Boyce, 2001, p. 1551).

Although the Steering Group did not appear, for a range of reasons, to be the right avenue for strategic participation in the programme by some groups, there were also few other appropriate or effective spaces. This is certainly not a unique challenge within this programme alone and the problem is summarised simply as “... the need to ensure that those on the receiving end are involved in the thinking, planning and assessment of benevolent acts, is something that is promoted endlessly but rarely done in a truthful way” (Klouda, 2007, p. 110). There was nothing that blocked a variety of groups from being invited to join, but as an “invited space” rather than a “popular space” (Cornwall, 2004, p. 2) then the inviting needed to be an active process.

Representing the programme and programme work

Some Steering Group members created opportunities for the GABTR programme and specifically eased the way and supported programme staff in developing links with other projects or in obtaining resources. Outside of the Steering Group meetings, some Group members represented the programme and its projects in a number of forums. The representation occurred in diverse ways, from presenting lessons learnt from the programme at conferences, to introducing the programme when networking with other groups and organisations. Community members were as active as health sector employees in this area. These community members were also the Group members, who when interviewed, said they did little work for the programme. For example one participant who had presented a number of proposals to the Group and had arranged networking meetings for programme staff said when interviewed:

“My participation is limited to attending [the meetings], reading the material.” (Int. 5A, p. 5)

The space that had been created and which had also evolved due to the initial proposal requirements, timeframes, member’s interests, networks, and the focus, somewhat informally on stakeholder representation, resulted in a particular type of social action within the programme. In an analysis of issues with the increased mandate for public participation, Connelly (2006) argued that:

... actors are constrained and enabled by the formal and informal structures within which they operate. The impact of, for example, resource constraints, deadlines and taken-for-granted routines is important, since these may well induce a minimalist approach to public involvement that does not reflect conscious decision making over programme design.” (Connelly, p. 17)

In summary, the focus on stakeholders as organisations, groups and representatives appeared to create a void in the membership of the Steering Group. This gap related specifically to the communities that were targeted by the interventions. As a result, there were repeated discussions within the meetings ‘about’ those communities and how to get ‘them’ involved. This was

a distinctive process of what appeared to be unintentional ‘othering’ and ‘speaking for’ communities. However, this occurred, in the main, without any clear mandate from those groups to do so¹³³, which is a basic indicator of community participation (WHO - Regional Office for Europe, 1991). It also demonstrated the issue of others defining the community for that community, a practice in which “... disparate views of community” (Wayland & Crowder, 2002, p. 230) may develop between those of and outside of the community. The process of othering clearly signified non-participation of these communities of interest – both as communities of place and communities of identity - in the Steering Group. This was the same issue identified as the ‘problem’ in the community garden project. Therefore, the ‘problem’ of community participation was reproduced in all layers of the GABTR programme, from the community garden project to the governance group. White (1996, p. 6), in an analysis of the political nature of participation, argues that “... while participation has the potential to challenge patterns of dominance, it may also be the means through which existing power relations are entrenched and reproduced.” There is therefore a need, in a programme largely controlled by the health sector, to develop appropriate ways of enabling participation and also to explore what the right ways for participation are for those groups, as defined by those groups (Chess, 2000; S. White).

The ways the Steering Group functioned reflected a contradictory mixture of things brought into the space: of individual enthusiasm and passion; of extensive individual networks; willingness to work; and determination for programme success. Simultaneously, individuals were concerned and disappointed with the lack of programme progress, reassessing their and their organisation’s continued participation, and some members had withdrawn from the programme – either signaling this to programme staff or just no longer attending meetings and/or responding to contacts. The Terms of Reference for the Steering Group were identified as one of the issues for this Group.

¹³³ Field notes, 12/4/07, p. 1.

Tracing the contradictory space through the Terms of Reference

One of the first questions I asked programme staff on beginning my field work in January 2007 was ‘what is this group – is it advisory or steering or governance?’ I asked this question as in reviewing some of the documents I had been given, there seemed to be more than one version of the purpose and function of this group. The answer given was that the ‘Governance Forum’ was in practice the Steering Group¹³⁴. At the last Steering Group meeting I attended in May 2008, the same question was again asked by a Steering Group member as confusion over the Group role was unresolved¹³⁵.

None of the proposal developers attended the first Steering Group meeting and so their visions of how this Group may function were not shared at that time. Of the programme designers, one person’s position had been incorporated into the role taken by the new programme coordinator and the other two people were unable to attend. This created a space for a reinterpretation of the governance plan, bringing to the fore different perspectives from those envisaged. This is a problem identified in other programmes (Cornwall & Brock, 2005). Decisions about the Terms of Reference for the Steering Group composed a major part of the discussion at that first meeting¹³⁶. These Terms of Reference outlined the purpose, objectives and membership of the Group as well as how the agenda, minutes, meeting facilitation and timetable would be managed. Also documented was the annual review of the Terms of Reference.

The Steering Group in action

The Steering Group met in the WRPHO offices on a monthly basis¹³⁷. Meetings starting at 12 noon and were advertised for one hour, but over 19 meetings¹³⁸ (excluding the evaluation meeting of April 2008), they ranged in

¹³⁴ Field notes, 23/1/07, p. 2.

¹³⁵ Field notes, 19/5/08

¹³⁶ Steering Group minutes of the meeting 16/10/2006, p. 1.

¹³⁷ Except for January 2008

¹³⁸ The meeting of April 2008 was described as an ‘evaluation meeting’ for the Group to have formal input into the external programme evaluation. The meeting for this month had been

length from one to two and a half hours, with an average meeting time of 113 minutes, consistently well over the agreed time period. It was commonplace for people to arrive late or leave early, citing other commitments. Including meetings only, this represented over 36 hours of programme discussion¹³⁹. The length and frequency of the meetings were repeatedly alluded to as problems, both within and outside of meetings. Both were included as ‘weaknesses’ in the programme SWOT analysis¹⁴⁰. What was also discussed was that for some of the Group members who were not employed within the health sector, attendance at these meetings was ‘in their own time’; it was precious ‘unpaid’ time. Productivity in the meeting – good use of the time – was as important as chronological time, and both the time spent in meetings and the lack of forward progress in the programme were both identified as issues. For others, their availability was limited by their employment which was not related to the programme. Therefore attendance at meetings in their lunch hour was just that, a space of an hour, with commitments each side. These sentiments were clearly articulated by one Steering Group member:

“... you know we have a diverse group. We have people who are there because they are employed and this is part of their role – so they are paid to be there. And you have other people, you know, who are not employed to be there – so we go voluntarily in our own time to work on that. And so we need to keep that focus very much there. We are not there to fulfill an administrative function and report to anyone really because that’s not what it’s about.” (Int. 4A, p. 9)

As well as differentiating the paid from the unpaid, this Group member also ascribed different roles for members related to those characteristics. Excluding myself and ‘visitors’¹⁴¹, Steering Group meeting attendance ranged from five to 11 members (from a list of what was to become 12 organisational positions listed in the Terms of Reference). Over 19 meetings the average attendance

cancelled because new programme staff had recently been employed. This evaluation meeting was then labeled as a Steering Group meeting by programme staff at the time of the meeting.

¹³⁹ Some Steering Group members also attended Community Gardens group meetings and sub-committee meetings for the plant distributions as well.

¹⁴⁰ The SWOT analysis – of Strengths, Weaknesses, Opportunities and Threats – was completed as part of a Steering Group meeting to inform the development of the programme service plan for the next year. Field notes of Steering Group meeting, 11/6/07, p. 4.

¹⁴¹ Visitors (labeled as such by me) included a student nurse, new Public Health Centre staff and the gang liaison person.

was seven members. Attendance by members not employed within the health sector ranged from one to five people, with an average of 2.6 community members per meeting.

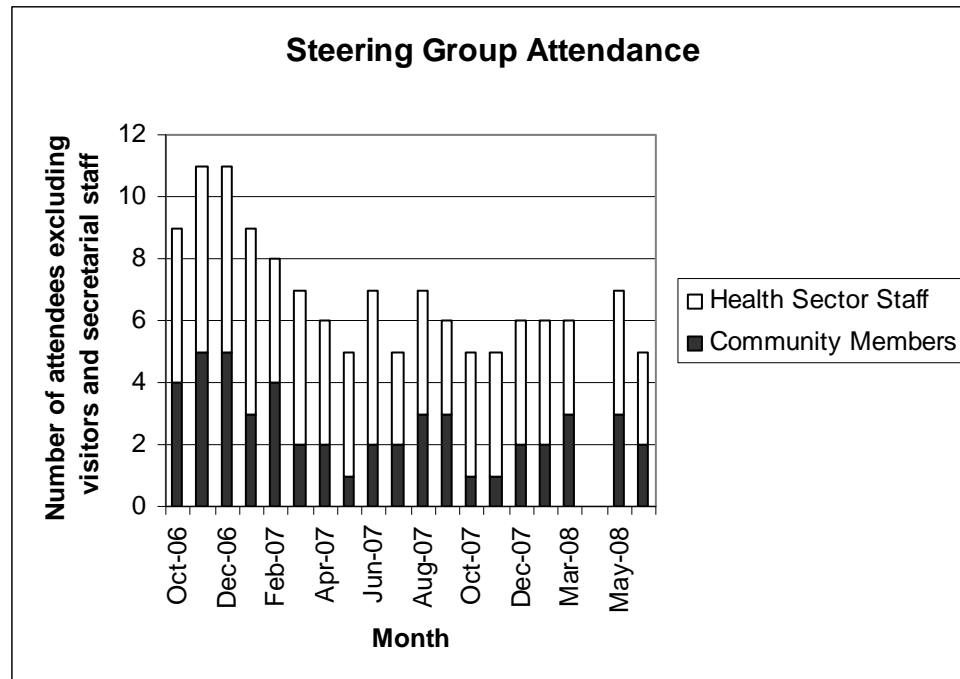


Figure 22 Steering Group attendance

Figure 22 shows a pattern of declining attendance during 2007. A participant summarised the issues as described by others:

“... there would have been one, two, three, maybe five that were going to the meeting regularly. But there had been a bigger group previously. People had told me that they had stopped going because they had deemed it a waste of time because they just talked about so many operational things.” (Int. 20A, p. 10)

The declining attendance, including one organisation withdrawing after raising concerns about individual agendas being introduced¹⁴², and a number who stopped attending or who attended occasionally, was only reversed when new people were invited to meetings in December 2007. Of the new people, one person had been a member of the Community Gardens group that was no longer meeting and this person’s membership was then attached (informally) to

¹⁴² Steering Group meeting minutes, 12/3/07.

a community group. The member who had previously represented that group had stopped attending meetings some months before. Another person was brought to a meeting by one of the new members and introduced as the ‘gang liaison’. The Terms of Reference did include a statement that “Membership may change according to requirements and with approval of the steering group, coordinator and WRPHO CEO”¹⁴³ but it was unclear if this directive was followed and ‘approval’ sought. The new people were introduced to the Steering Group but their membership status was unclear and confusing:

“Who are the members of the governance group? It says on the Terms of Reference that people can be brought on but I am not sure what the process is to bring them on. Does everybody on the group have to agree, because we had an instance when [community member] was asked to come and sit on the Steering Group – does that make her a Steering Group member? (Int. 20A, p. 12)

There was also no statement in the Terms of Reference regarding the status of the meetings as open, or closed, or clarification of whether the public or visitors could attend. The meetings were essentially closed as they were not advertised outside of the Group membership, and agendas and minutes were only circulated to that group. Individual meeting attendance for members (excluding programme staff) ranged from 0% (one person who was unable to commit to attending meetings and their organisation was included on all but two versions of the Terms of Reference) to one community member, a Group member from the beginning, who attended 95% of the meetings over time. The average for organisational/group meeting attendance was 65%. At many meetings, individual members voiced formally, or informally, their concerns that either they, or another member was planning to or had stopped attending meetings. ‘Burning people off’¹⁴⁴ was one description given to the effect on membership of the number of meetings where there was little progress.

¹⁴³ GABTR Steering Group Terms of Reference, 10/9/07, p. 1

¹⁴⁴ Field notes of the Steering Group meeting, 11/6/07, p. 3

Revising the Terms of Reference

The Group Terms of Reference were regularly revisited (documented in the minutes for 11 of the 18 meetings between October 2006 and April 2008) and can be seen as proxy for the way in which the Steering Group space was contradictory. Seven versions of the Terms of Reference document were circulated in attempts to clarify the Group's role, with changes being presented by those from the health sector – either the WDHB or WRPHO. A major change implemented was in the Group facilitation.

After four meetings the facilitation of the Group was shifted from the responsibility of the programme coordinator to the Group. A number of members told me how difficult, uncomfortable and unsafe it was for the programme coordinator to be responsible for chairing the meetings (and sometimes taking minutes as well). Interestingly, in an article exploring difficulties experienced in a health promotion programme in Australia, the authors identified that the project manager (equivalent to the GABTR programme coordinator) had been provided with professional development opportunities which included attendance at the project's advisory group (Fleming et al., 2007). This reflected a quite different approach than that taken in the GABTR programme, where the programme coordinator was originally also the Steering Group chairperson.

The position of meeting chairperson became un-fixed, with a decision about the next facilitator made at the end of each meeting. It was evident that some members were uncomfortable taking the role of meeting facilitator and during the time that the position was unfixed, WRPHO or WDHB staff chaired the meetings 82% of the time. I was asked to chair a meeting but declined¹⁴⁵. Eventually, in February 2008, a WRPHO staff member became the ongoing facilitator after concerns were raised about the effects of a lack of continuity¹⁴⁶. A change that had been made for positive reasons to support the programme coordinator and the work of the Steering Group had had unintended

¹⁴⁵ Field notes, 16/4/07, p. 6.

¹⁴⁶ Field notes of the Steering Group meeting, 10/12/07, p. 2.

consequences. Instead of a chairperson, with responsibilities related to the work of the group, the development of agendas, and importantly, with follow-through of ideas over time, the role of facilitator appeared to be only running the meeting during the meeting time.

Changes were made in sections of the Terms of Reference related to the Group ‘purpose’ and ‘objectives’. The initial Group purposes were described as to:

1. Provide leadership, direction and advocacy for the programme at a strategic level.
2. Provide a forum for consideration, discussion and direction of programme initiatives – planning, issues, concerns etc.
3. Support the development of yearly service plans.
4. Ensure reporting requirements and project coordination are adhered to appropriately.
5. Provide information/guidance to the coordinator and support worker.
6. Promote and encourage intersectoral collaboration and co-operation within and outside the health sector¹⁴⁷.

Later a statement related to including “... sign off on all media/promotional material, programme expenditure and MOH reporting” was added¹⁴⁸. Finally in an un-numbered version given to the Group in September 2007, the purposes were condensed to those listed above as 1, 2 and 6. The ‘sign off’ statement was removed.

A similar dance around the issues of role occurred with the ‘objectives’ of the Steering Group. In one version there was a focus on monitoring the service plan implementation, providing advice and guidance to the coordinator, and advising the WRPHEO CEO of issues or problems in the programme or with the programme staff. The Steering Group was also to “... act as community representation for collaboration on projects”¹⁴⁹. In a later version these

¹⁴⁷ GABTR Terms of Reference, Version 1.118/02/2007, p. 1

¹⁴⁸ GABTR Terms of Reference, Version 1.120/03/2007, p. 1.

¹⁴⁹ GABTR Terms of Reference, Version 1.131/03/2007, p. 1.

objectives were again condensed and slightly modified so that the Group was to:

- Assist the development and monitoring of annual service plans.
- Provide information/guidance on programme initiatives.
- Advise of any issues/barriers that arise toward the programme.
- Participate and provide community representation on programme initiatives – information on relevant community initiatives would be brought back to the group¹⁵⁰.

Although some members of the group appeared more interested and active in the discussions about the Terms of Reference, other members seemed less interested and were more focused on particular projects. This different focus on the function of this Group as a committee was obvious when a discussion was held with the Group as part of the programme evaluation. The Steering Group was asked to rate its participation (see Table 14) in the programme on a five-point likert scale using a question developed by the Evaluation Advisory Group, which included some Steering Group members. The component related to the programme ‘Governance Model’ (using the term from the original Initiatives Fund application) asked the group to make a consensus decision and to rate its performance.

Table 14 Evaluating the governance model

1	3	5
As a result of uncertainty about its role, the Steering Group has had minimal impact on the GABTR programme meeting its goals and aims	Between the ranges	Based on a clear understanding of its role the Steering Group has provided excellent leadership and programme support to enable GABTR to meet its goals and aims

Those present in the meeting rated the Steering Group as representing a 2¾, (ranking this factor between 2½ and three in discussion). The average of those who replied via email was 1½. What was interesting was the discussion undertaken to reach the meeting consensus – specifically about whether this

¹⁵⁰ GABTR Terms of Reference, September 2007, p. 1.

was a governance or advisory group. I asked if the Steering Group had ever done any 'process' work to explore how this committee would operate. The answer given was 'no', but that it would have been useful at the beginning¹⁵¹. It is unsurprising that the Group was still in a formative stage when it is well recognised that:

The development nature of community development means that evaluation cannot happen realistically in less than five years. A sustained effort is required to develop a group of people, for them to define their objectives, take action, learn from their mistakes and successes and establish sufficient confidence in their ability to effect change. (Baum, 1999, p. 353)

This time and work to develop the Steering Group was a crucial constraint within GABTR. I hoped the ranking exercise, carried out in April 2008, would support the Group to undertake the group process work needed, but the programme had only two months till the end of the initial contract. The layers of confusion and differing opinions over the purpose of this Group were obvious when I interviewed Group members at different times during the programme.

The voices included in Figure 23 (p. 290) described their different understandings of the purpose and role of the Steering Group, including, as has been discussed previously, the Steering Group as a link between the community and the programme. Additional perspectives expressed include the uncertainty with the role, the knowledge and skills of group members, and the relationship between the Steering Group and programme staff.

¹⁵¹ Field notes, 14/4/08, p. 2.

Members' perspectives of the role of the Steering Group

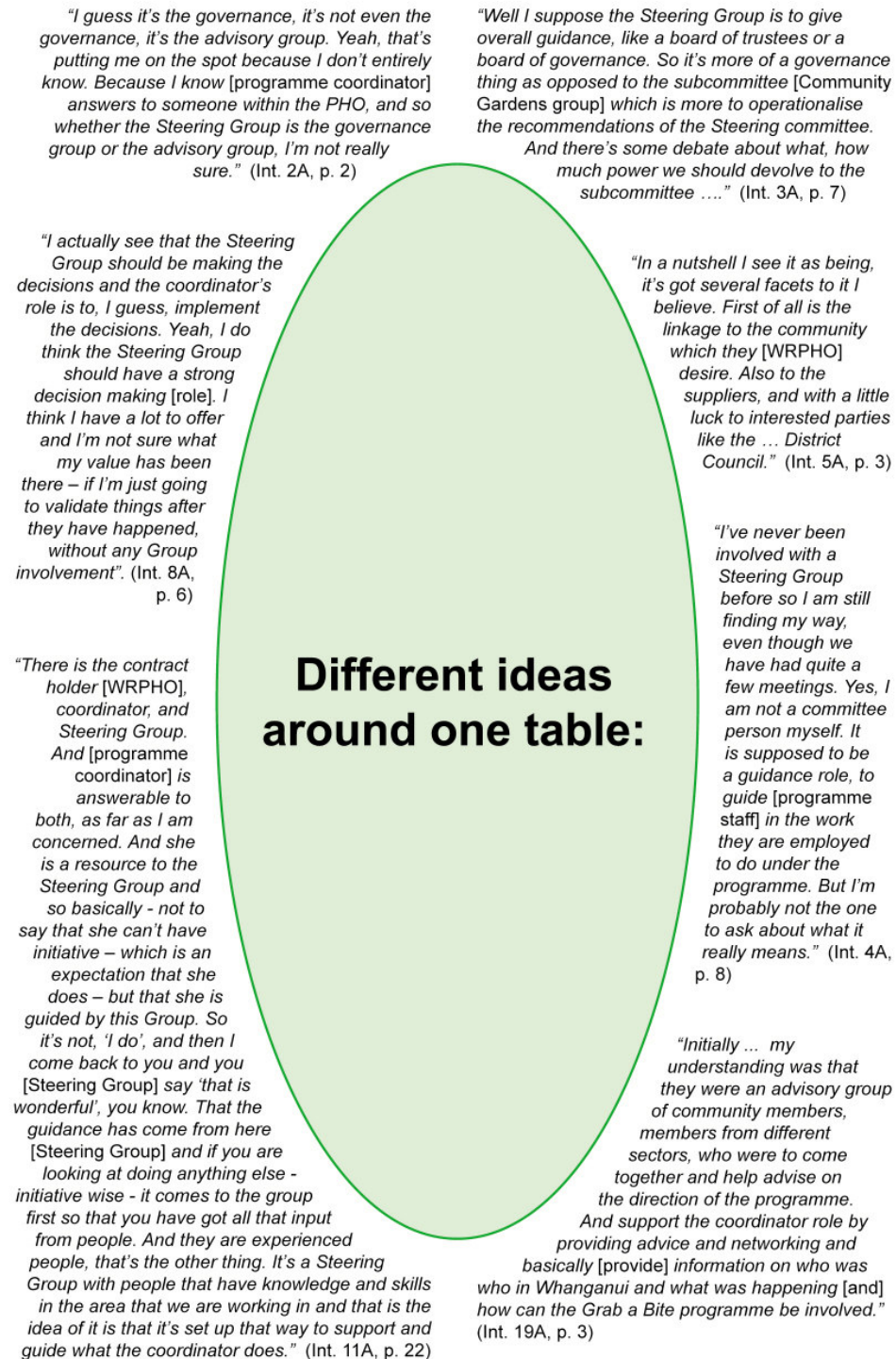


Figure 23 Members' perspectives of the role of the Steering Group

Uncertainty with the purpose of the group

As has been described, Group members expressed different perspectives of the committee's function as to whether it was purely in an advisory capacity, or held overall programme governance, or something in between. WRPHO staff not on the Steering Group expressed to me on a number of occasions that the Group's role was advisory¹⁵². Together, these "... ambiguous or vague roles ..." when linked with other factors such as weak representation and limited authority are known to undermine meaningful participation (Loewenson, 1999, p. 5).

While one person (in Figure 23, p. 290) clearly identifies their lack of Steering Group experience – *"I've never been involved with a Steering Group"* – to describe their lack of clarity, another participant uses the analogue of *"board of trustees or a board of governance"* to describe the Group's role. In Aotearoa New Zealand, these are important points of comparison. Legislation, (for example, the "New Zealand Public Health and Disability Act 2000,") mandates that DHBs have community representation on their governance boards. In addition, all state schools must have a Board of Trustees, including members from its parent community, as set out in the Education Act 1989 (Ministry of Education, 2007). For many people, their main experience with 'governance' is with the Boards of Trustees associated with their children's schools. Still, governance is a much contested space especially with regards to the balance between accountabilities, financial responsibility, representation, and community representativeness. In addition clear differentiation between operational matters and programme governance (often defined as strategic) matters is complex. Interestingly, after recognising a skill and knowledge gap around governance at the level of PHO governance boards, the MOH produced a small 'governance guide' on this topic in 2007 (MOH, 2007c). Sub-committees of a PHO governance board are described in this document, but no other governance or advisory committees within the organisations, such as the GABTR Steering Group, are mentioned.

¹⁵² Field notes, 13/8/07, p. 1; Field notes 21/11/07

On a number of occasions I listened to conversations about the programme governance model (of the Steering Group and its relationship with programme staff). The perspective that was repeatedly expressed was that this was ‘the’ model required in the health sector, rather than this was ‘a’ model¹⁵³. In an evaluation of four intersectoral community health projects throughout Aotearoa New Zealand, each initiative had a different governance structure, two of which were informal groups and two of which were “... formally constituted governance groups” (MOH, 2008b, p. xiii), showing a range of possible models. Brownlea (1987) also argued that community members may not understand the participation structures put into place, or how those structures, such as the Steering Group, fit with other participatory mechanisms. It is therefore beholden on the health sector organisations to articulate these structures in a meaningful way for non-sector participants.

Over time the Steering Group became, by what appeared to be default, a multifaceted space. Not only was Group work undertaken, where ideas were put forward, proposals tabled, and tasks allocated, but also it was where the theoretically ‘joint’ and ‘collaborative’ nature of GABTR was played out, especially the relationship between the WDHB and WRPHO. Although the collaboration extended outside of Steering Group meetings for the plant distributions, it was less robust for the community garden project. Even at the garden site blessing, there were limited signs of collaboration, except at that stage, from members of supporting community groups. A participant stated:

“It was disappointing not to see anyone from the PHO there [at the land blessing] apart from [named person], and only a few Steering Group members. At times, even though it was a collaborative project, it did seem like ... a one-person team.” (Int. 19A, p. 14)

Concurrently, the Steering Group meetings were also the key space where programme staff received feedback about the work that they had done on the programme, for example the design of flyers, pamphlets and signs, all of which

¹⁵³ Field notes, 14/4/08, p. 2.

was very operational in nature. This seemed somewhat contradictory to the arguments that this should be a strategic rather than operational group, but appeared to be a pragmatic response, driven by some member's concerns about some of the work being undertaken, and a desire to be supportive of programme staff who were inexperienced in these types of projects. This desire was described by a Group member:

“... [programme staff] *needed, you know, the health promotion and public health experience in that [Steering] Group, but also the community experience in that group to guide what she was doing.*”
(Int. 11A, p. 22)

With the lack of clarity from many quarters about what this Group existed for, and its multiple sub-roles, this was an especially contradictory space into which to invite community members.

Community knowledge and expertise

As explained by another participant in Figure 23, there was an expectation and belief that the Steering Group was also the space where expertise could be shared to guide the programme and the point is made that the Steering Group is composed of people that have ‘*knowledge and skills*’. Inherent in this quote is the overlap between operational and governance matters whereby some people were invited onto the Group for their specific skills and attributes, as people that ‘do’ rather than people that ‘govern’. As another participant said, “*I am not a committee person myself.*” Although linked through a common interest, the skill sets between governance and undertaking a project are different, as are those of community representation.

Interestingly, it was the breadth of community member's skills and attributes and their ways of bringing these to the meetings that was impressive. For example, at one Steering Group meeting it was the community members present that talked of the need to include traditional cultural foods within a project encouraging people to grow gardens. It was also the community members who cited research and research authors associated with identifying the association between foods traditionally eaten by ethnic groups and

protection against metabolic disorders¹⁵⁴. Therefore, ‘expert’ community knowledge was an important adjunct for the programme, something which is not often captured when the focus is instead turned to group or stakeholder representation. It also raised the issue of the combination of knowledge needed for the programme including health professional knowledge and expert (also professional in some cases) knowledge of the particular project work. Jenkins (2008, p. 139), in a re-conceptualisation of women’s participation in a health promotion project in Peru identifies a process of “... grassroots professionalisation.” She also challenges the traditional dichotomy of local versus expert to identify local experts. Some community members of the Steering Group in GABTR fitted much better within a description of local experts rather than of community representatives. This again highlighted the community gap in the Steering Group.

Relationships between programme staff and the Steering Group in a joint programme

The other theme, portrayed in Figure 23 (p. 290), is the different perspectives held about the relationships between the “*contract holder, and programme coordinator and Steering Group.*” Inherent in this discussion is also the place for other key stakeholders. As was outlined in Chapter Five, when the programme was proposed, a model of those relationships was developed but in the operationalisation of the model, different tensions came into play. As a collaborative programme, there seemed to be a lack of clarity as to which organisation or individual had responsibility for what, and how this joint responsibility would be played out. A number of participants also identified this as an issue:

“And this collaborative way of working is still quite new and there are going to be times where things don’t work.” (Int. 11A, p. 34)

¹⁵⁴ Field notes, 19/5/08.

“...but even in terms of working collaboratively with other organisations, in partnership with the DHB, even working in that type of model in this programme is new. It is so new. And this whole programme has been a huge learning curve in terms of how those models will work.” (Int. 19A, p. 28)

The ‘new’ ways of working, the lack of clarity of Group purpose and different agendas as to what that purpose should be combined with other factors to make this a contradictory space for everyone, including community members. Additional factors included the changing Terms of Reference, and the overlap of people and work between the Community Gardens group and the Steering Group. Discussions around the programme and project budgets provided a concrete example of an unresolved issue within the Steering Group.

Budgets – an unresolved Steering Group issue

As was explored in the previous chapter, there were repeated discussions within the Community Gardens group about money for the garden resources and concerns were raised as to how that group could make decisions. Identical discussions occurred in the Steering Group meetings. The concerns were summarised in a statement included in the minutes of the February 2008 meeting, under General Business.

“Concern was again raised about the project budget not being available to the Steering Group. In the absence of a budget, project planning cannot take place as the group have no idea how much money is available for activities. It was suggested that as discussions between the GABTR Coordinator and PHO management have not resulted in progress that the Steering Group draft a letter outlining their concerns.”¹⁵⁵

Different perspectives were expressed over time about access to the programme budgetary information. These varied from:

¹⁵⁵ GABTR Steering Group meeting minutes of 11/2/08, p. 2.

- A programme budget under broad headings was provided (excluding staff costs) at the Steering Group meeting of the 12/2/07. Members raised concerns about the expense associated with the programme evaluation and the lack of funding for the garden project. As a result, one member decided that lunches would no longer be supplied for the meetings¹⁵⁶.
- Staff reported at different times that the WRPHO management either did or did not think this Group needed access to the information, as it was operational information¹⁵⁷.
- Specific details of what a small budget line (research) covered changed over time, and that part of the programme was eventually funded from a different source.

These differing perspectives demonstrate how organisations are not homogenous entities (Cornwall & Brock, 2005), with different people holding different knowledge and understandings. This creates a confusing situation for community members, as is portrayed in a participant's comments:

"... they [Steering Group] were still asking about budgets. But it seems to have gone around again because the chairperson who is ... from the WRPHO is saying 'we should see the budget.' But it is actually the PHO that is saying 'no, you can't see the budget.' So their rep. who is the chair, I don't know, there seems to be a bit of communication breakdown." (Int. 20A, p. 11)

At the last meeting I attended in May 2008, a WRPHO staff member informed the Group that there was a specified amount of money available in the budget¹⁵⁸ and this Group could provide suggestions for projects which would meet the programme aims. This was the first time that I had been aware of the Group being asked to do this type of work. There was no discussion about projects or how decisions would be made in the meeting. It was another example of the contradictory space of the Steering Group and the programme

¹⁵⁶ Lunches were provided for a few special meetings but one community member declined to partake, not wanting to waste the programme funding.

¹⁵⁷ Field notes, 16/4/07, p. 3.

¹⁵⁸ Different information was provided as to whether this money was inclusive or exclusive of staff costs and other projects already agreed to and whether it was to be spent before the end of the first funded period (June 2008) or the end of 2008.

as a whole. I had recently been working at the gardens when members of the public had been debating whether it was appropriate to ask for \$15.00 to buy an extra key for the water tap¹⁵⁹. I had advised them to ask, but they were under the impression that the project had little money (because of previous responses given to requests). The unresolved discussions around budgets clearly resulted from different perspectives, held from within and outside the Group as to its function and role in the GABTR programme. The Group itself was unable to resolve the issue as it had no authority to do so. In contrast, a contentious issue which underwent ongoing negotiations within the Group related to the sharing of information about the health benefits of the plants distributed to the public.

A programme under many watchful eyes – ongoing negotiations

As a ‘pilot’ programme - an initiative within the health sector - there was a perception of a heightened degree of ‘surveillance’ of its progress. This surveillance looked like different things - the formal evaluation, the conditions for continuing the lease of the council land for the community garden, and as the MOH concerns over the anti-cancer claims made about the apple trees. My study, although not directly related to the pilot study description, was also seen as surveillance by some. The programme surveillance came to the fore clearly during the work of a number of subcommittees of the Steering Group associated with organising the plant distributions and specifically the pamphlets given to members of the public. Issues that arose mainly concerned the negotiations necessary to balance the agendas of all stakeholders and community groups as partners in the component of the programme which was community-led.

The space for community leadership

As has been described, the projects related to the plant distributions were led by a community member of the Steering Group, and had originally been the driver for the whole programme. Being ‘led by the community’ had important

¹⁵⁹ Field notes, 29/3/08.

implications for the programme, one of which was the success of the initial funding. At nearly every Steering Group meeting this member would enthusiastically discuss plant distributions. For example, at the meeting of 19th May 2008, potential plants for distribution in the year included thousands of peach and apple trees, Māori seed potatoes, tomato and cape gooseberry plants.

The Tree Crops Association had ongoing scientific research being undertaken to identify those plant varieties with the most potential health benefits, and this research was in the main funded from outside of the GABTR programme. The main findings were shared with the Steering Group. Each time a plant distribution was proposed the Steering Group was asked if it would support these distributions under the umbrella of the programme and to make some funding available (although they could only endorse the request). A main part of the Steering Group participation (and that of the subcommittees) revolved around designing the distribution process to meet the programme aims and to reach the programme target groups. It was during these discussions when members most overtly advocated for the population groups targeted by the programme, demonstrated their community knowledge about what would work locally and for specific groups, and acted as representatives of their organisations. As discussed by Clark (2001) the discussions were often based on common understandings, values and beliefs about communities, rather than what was particular to a specific community.

The discussions were always lively, productive and respectful of different perspectives. They were also sometimes challenging. For example, one Group member suggested that the plants should be distributed from a particular site because people who already gardened would collect them from there. The effects would ‘trickle down’ into the community and this would lead to a positive outcome for evaluation¹⁶⁰. This position was countered by other members and eventually plants were distributed from a range of sites in different areas of the city. Targeted distributions, of a smaller number of plants,

¹⁶⁰ Field notes, 11/10/07, p. 1.

also occurred to other groups and settings. Steering Group members also assisted with the public distribution days, and some were also involved in distributing plants as part of their own work.

As an intersectoral forum, the Steering Group was able to effectively draw on its members' links, and those of their organisations, with a wide range of individuals, groups and communities in both urban and rural areas. These included community organisations, health service providers, cultural groups, schools, early childhood centres, councils, and businesses. As was described in the previous chapter, community engagement with the plant giveaways was high for a range of reasons including the public profile of some of the individuals involved, the free status of the plants and the reported anti-cancer / antioxidant properties of the plants. It was this last point that created a tension linked to the programme being intersectoral, community-led, but within health sector surveillance.

Making health claims - a potentially dangerous game

The programme roots in sharing the health benefits of apple varieties and the *Cancer Control Strategy* initiative funding came together in the programme, but this engagement was under surveillance and had implications for the programme as a whole. On talking with MOH staff about the programme, one of the first comments made to me was that there were concerns about the 'anti-cancer' claims being made and that there were expectations that these would be dealt with by the WDHB (Personal communication, MOH staff, 27/11/07). There were many discussions between the WDHB and the MOH and the WDHB and the Steering Group. Over time the concerns were framed as related to two key points. Firstly, the main concern was that anti-cancer claims could lead to health services being seen as responsible if, in the future, a person who had eaten the fruit developed cancer. Secondly, concerns were raised by the Ministry of Health that health services could not be seen to 'endorse' *one*

product, such as one brand of apple¹⁶¹. Instead, HEHA programmes must advocate the consumption of a *variety* of fruit and vegetables, as was outlined in the *New Zealand Food and Nutrition Guideline Statements for Healthy Adults* (MOH, 2007e). The first was valid, but the second appeared more as a red herring, especially considering the weighty significance of the first, and also that the original funding proposal had been specific about particular apple varieties.

The major place of contestation arose in relation to the information included in the pamphlets (which were separately funded by a business in support of the projects). It was not that there were doubts about the research that was being undertaken by reputable researchers in Aotearoa New Zealand and overseas, but the way that the research findings were being extrapolated and then communicated to the public. A core issue identified with health claims is not just what is said but what community members understand by them (P. J. H. Jones, Asp, & Silva, 2008). Concerns were also raised that, for example, eating apples or tomatoes was only one of the facets in disease prevention. The problematic claims were clear in the 2006 version¹⁶² of the pamphlet which had a main heading of *The Fight Against Cancer* with a subheading of the programme title - 'Grab a Bite That's Right'. As well as information on the apple tree variety and ways to plant and care for it, other statements included:

We wish to give you the world's best anti-cancer apple variety. The compounds within these apples, including their pips and their flowers, can prevent the growth of cancer cells within your body and your family's, before they can become a problem. ... Currently one in three New Zealanders will experience cancer in their lifetime. This is an appalling statistic. It is time to take responsibility and control of our lives again, to ensure that we do not become one of these statistics. The latest research by the New Zealand Tree Crops Association has found apple varieties with very high levels of quercetin flavonoids and

¹⁶¹ Field notes, 11/6/07, p. 1.

¹⁶² As was described this first apple tree distribution occurred within a month of the implementation of the GABTR programme.

procyanidins (much higher – 300 to 400% more, than any commercially available varieties) that can inhibit the growth of cancer cells. Cancer cells can take 12 years to get a hold in the body, to the point that a cancerous growth can be detected, and before modern medicine can be used to treat it. It is our hope that by eating these apples during this 12 year period, you may well inhibit the growth of any cancer cells, and prevent the onset or effectively treat the cancer before it becomes a problem.”¹⁶³

As well, ‘proven medicinal qualities’ and ‘anti-cancer benefits’ were also mentioned.

Over time, attempts were made to manage the claims:

- In 2006, the WDHB logo was deliberately not included on the apple tree pamphlet. The WRPFO and Whanganui Wellbeing Association logos were included as supporters.
- In 2007, the apple tree pamphlet was rewritten and the discussion about the potential health benefits of the apples was reworded to read: “The Monty’s Surprise variety has been chosen by NZ Tree Crops Association for you as the superior apple variety for human health.” In spite of agreement that all anti-cancer statements would be removed from the pamphlet, the final version included a heading of ‘Anti-cancer Benefits’ and anti-cancer compounds in apples were discussed. The final version had been sent to programme staff prior to printing, but this inclusion, which was later identified as ‘accidental’ by the author, was not identified. To make it clearer that the pamphlet ‘belonged’ to Tree Crops, no health organisation logos were included on this version. A separate GABTR programme insert was provided, with the WDHB and WRPFO logos included on that. Comments were later made that the distinction between the two pamphlets was too subtle for the public to identify.

As a Steering Group member identified:

¹⁶³ Apple Tree Pamphlet, 2006, pp. 1-2.

“... [The apple tree] research is really important but we cannot make statements about these cancer reducing properties. We have to be careful about that. We have a responsibility with the DHB on board to be really careful about the things we are saying....” (Int. 8A, p. 18)

As well as being a negotiation over the reading level of the material presented, the words used, and potential health claims, this was pragmatically about continued and future programme funding and organisational participation. As was alluded to in a number of Steering Group meetings, programme funding was contingent upon the overall programme and individual projects being compliant with MOH strategies and guidelines¹⁶⁴. This was even though this project was community-led, mainly community funded, and supported widely by the community. It also reflected different values coming to the fore in the discussions about the pamphlet.

I was also aware that, while driving for the same aims of population health improvement and disease prevention, there were different perspectives in play. Importantly, although the health sector had a degree of control, in the end the pamphlets for this distribution¹⁶⁵ still mentioned anti-cancer benefits as did the various advertisements and newspaper articles about the plants and the plant distributions which were organised by community groups outside of the GABTR programme. The energy and passion which so effectively drove projects meant that one message ‘got out’ in spite of attempts at health sector control. In the plant distribution projects there were many times when one group’s continued public health claims about anti-cancer properties were described as ‘a dangerous game’¹⁶⁶, one that could have meant that the whole programme, which was already under surveillance, came more into the spotlight. It also resulted in some Steering Group members and the

¹⁶⁴ The health sector compliance with New Zealand health strategies is a statutory responsibility under the New Zealand Public Health and Disability Act 2000.

¹⁶⁵ There were further discussions and negotiations for the pamphlets for each variety of plant distribution. An additional issue identified in a subsequent draft pamphlet was that much of the material included breached copyright laws. This problem highlighted the range of skills needed to develop health promotion material with community groups - including addressing cultural patterns, literacy, legislation, and copyright.

¹⁶⁶ Field notes, 9/7/07, p. 1.

organisations they represented needing to balance their continued participation as stakeholders on an ongoing basis. I asked one Steering Group member what success for the GABTR programme would look like. Their reply was:

“Sorting out the anti-cancer claim, I would like to see it sorted out. I actually haven’t stepped back because of that, that wasn’t the reason. But in saying that it’s probably, I guess, made me a bit more aware of my involvement in it. It wasn’t initially the reason but now I am very aware of my level of involvement because of the claims. Because you know, your credibility, you get one shot at that really.” (Int. 16A, p. 8)

Both the potential impact on organisations and individuals of these claims are portrayed in this quote. The negotiations that went on to attempt to manage the claims could be analysed from a number of perspectives, including professional power-holding, the role of governance, and the state. They can also be seen as illustrations of the “... necessary contradictions of community-led health promotion” where balancing power relationships within the groups involved requires difficult work (Cornish & Ghosh, 2007, p. 496). With the increasing emphasis on community participation within partnerships through multi-sector approaches, health services are encountering more assertive community groups (Milewa et al., 2002). This provides challenges and opportunities for all involved.

The Steering Group as a community space

The Steering Group model adopted in this programme as an avenue for community participation came up against multiple hurdles, some which were overcome and others which were not. As the Group was unable to develop a strong sense of a collective identity to solve some of its challenges in leading the programme then meaningful community participation remained elusive in the programme as a whole. This is a common experience, one which is well documented in the literature. It is not necessarily about a failure to engage but as Connelly (2006, p. 21) argues “... because of the managed nature of their engagement” which follows prescribed rules of what community participation should look like.

The common theme in the solutions offered is that community participation in governance and decision making needs responsive and flexible structures. Those structures need to be adapted for local and changing conditions (Chess, 2000). It requires deliberation as to the value of community participation within specific circumstances (Jewkes & Murcott, 1998). Challenging power relations are expected and planned for (Cornish & Ghosh, 2007). Also, the complexities of representing community and specific communities, needs to be recognised (Jewkes & Murcott). Health promotion principles also provide guidance in identifying priorities for the work of the Steering Group. Those principles are identified as:

... multidisciplinary; community participation – throughout and in identifying stakeholders; opportunities for sharing and developing awareness (of roles, values and visions); a balance in emphasis between structure, task and process; appreciation and trust; awareness of broader context; and exchange of ideas on ways of influencing that context. (Delaney, 1994, p. 223)

Deliberate work to address and incorporate these principles into the work of the Steering Group offers the potential to create a space that meets the expectations of all of those involved – organisations, groups, individuals and communities. It may also address the contradictory nature of the space within the constraints imposed on it.

Summary

The Steering Group was developed and existed as an “invited space” (Cornwall, 2004, p. 2) and these types of spaces provide the potential for either redesigning or reinforcing existing power relationships and rules. That potential was enhanced by the groups and individuals which came together to steer this project – health sector organisations and community groups. The negotiations that went on within the Group regarding the plant distributions and the pamphlets meant that some of the aims of the programme and the aims of a community group could be met simultaneously. But this was a largely

contradictory space, where the Group had limited accountability, no responsibility for finances, and its potential to lead the programme was largely untapped. As the Steering Group was positioned within an invited space, then some responsibility has to go to the inviters to open the dialogue, set the scene, be watchful and, if and when necessary, review the progress. Many of the challenges for the Steering Group can be traced right back to the initial stages of the programme when short application deadlines, contract delays, restricted implementation timeframes, inexperienced staff, and multiple staff changes, all came together in a programme that was new and innovative for all involved. These challenges were also duplicated throughout the programme.

The search for meaningful community participation remained a core challenge in all phases and stages of the GABTR programme. The issue was reflected within and across the programme layers – from the grassroots level of the community garden, to the spaces specifically created for community participation – the Community Gardens group and the programme Steering Group. Some community members on the Steering Group clearly challenged the dichotomy of local/expert and in the main, instead of bringing general, community knowledge, were experts in the specifics of projects. This therefore created an unfilled gap for community representatives from the identified communities of interest for the programme. It also brought to the fore the complexities in seeking organisational representation for communities of identity. These challenges then impacted and framed the work of the Group members who were representing organisations in the health sector.

In the following chapter the case study is completed by a re-examination of the contextual factors which have forcefully shaped the space created for the GABTR programme.

Chapter nine: A programme both of and ahead of its time

Introduction

In the last four chapters the GABTR programme has been described and community participation in its projects analysed. Many resulting issues have been explored including difficulties in the way that communities of interest were engaged in parts of the programme, challenges within health sector organisation relationships, and the complexities placed on community when ‘stakeholder’ is the mandated mode of community representation.

As Chapter Five commenced the case study with an exploration of the factors - local, national and international - that converged to create the space for the GABTR programme, this chapter completes the case study by again examining contextual factors. In the relatively short time period between the GABTR programme proposal development as a combined community and health sector innovation in late 2005, and first contract completion in June 2008, major events enveloped and in some ways superseded parts of the programme. Together these events combined to reinforce its space. These local, national and international developments positioned the programme as both ahead of its time and timely. These factors also reinforced the need to allow programmes, and the community participation within them, time to develop.

Global and local increases in food and energy prices

The identification of a global crisis in food production and energy price increases worked to make the GABTR programme timely. Increased food costs were related to energy prices, such as transport costs. In addition, “... global food market” forces (Caraher & Coveney, 2004, p. 591), were significantly increasing the costs of locally produced food, such as dairy products. The retail cost of tomatoes rose 79.7%, and fruit and vegetables increased 3.1% overall (NZPA, 2008), during the time that the free plants distributed to the public were fruiting. In July 2008 Statistics New Zealand announced that nationally the cost of food had increased 8.2%, with fruit and vegetable costs rising 5.2%

in the last year. This was the highest annual increase in 18 years (Statistics New Zealand, 2008).

Internationally, a report *Food and Fuel Prices – Recent Developments, Macroeconomic Impact, and Policy Responses* (International Monetary Fund, 2008) was released. This report linked the effects of food and fuel price increases in a range of countries across a number of areas, including levels of poverty and balance of payments. In outlining the report in a radio interview, a International Monetary Fund official suggested that in comparison with many countries “... commodity exporting countries such as New Zealand and Australia are benefiting from higher prices” (*High prices put economies under strain, says IMF*, 2008, July 2 July 2, p. 1). In another report on the world food situation it was warned that higher “... food prices will cause the poor to shift to even less-balanced diets, with adverse impacts on health in the short and long run” (von Braun, 2007, p. 13).

At the individual and community level, the increasing prices were having dramatic effects, with reported increases in the use of Food Banks again. Throughout Aotearoa New Zealand, newspaper headlines warned of the widespread problem (“Families on the brink,” 2008; “Food banks desperate as shelves empty,” 2008), including ‘Food bank running on empty’ (Katterns, 2008). In Whanganui, the work of the City Mission’s Food Bank and the plight of its clients were profiled in a full page newspaper article (Ferguson, 2007). Again, the desired links between the local Food Bank and the GABTR programme¹⁶⁷ were timely. Specifically the community garden held potential and the targeted distribution of tomato seedlings to the Food Bank gardeners and clients, which occurred late in 2007, assisted both programmes to meet their needs.

In a proactive response to increasing energy costs, over forty groups around Aotearoa New Zealand, including one in Whanganui, were investigating the

¹⁶⁷ This was one of the fourteen GABTR programme foci.

Transition Towns concept. Initiatives related to Transition Towns are based on assumptions related to the need to plan for lower energy consumption, and to develop community resilience and collective action (Transition Towns New Zealand Aotearoa, n.d.). Community gardens and community food production were identified as compatible initiatives. Although the organisational links were weak, having significantly suffered during the development of the project, the group involved in the Transition Towns in Whanganui was broadly supporting the establishment of the community garden at Te Mana Park, and relationships were gradually and tentatively being rebuilt¹⁶⁸.

An intensified national and local focus on HEHA and food security

The national implementation of the HEHA strategy was progressing rapidly and this included the development of programmes which overlapped with GABTR programme objectives and projects. Examples included the national development of nutrition guidelines for use in schools and early childhood centres¹⁶⁹ (MOH, 2007d), the employment of HEHA Project Managers at DHB level, and new roles developed for district coordinators for HEHA programmes who administered a specific Nutrition Fund. The Nutrition Fund (MOH, 2007d), designed to support the development of school-based healthy eating projects, resulted locally in a number of schools using this funding to develop edible gardens. Other national programmes included ‘Mission-On’¹⁷⁰, and ‘Feeding our Futures’¹⁷¹ were also building in intensity.

There had also been a Health Committee *Inquiry into Obesity and Type 2 Diabetes in New Zealand* (Health Committee, 2007). This report focused strongly on the need to modify the “... environmental determinants of eating

¹⁶⁸ Minutes of Steering Group meeting, 16/6/08

¹⁶⁹ Support for the local development of these guidelines was one of the initial fourteen aims of the GABTR programme.

¹⁷⁰ The Mission On campaign was launched in September 2006, aimed at young people to the age of 24 years and targeting increased physical activity and improved nutrition. It is led by Sport and Recreation New Zealand and involves a number of Ministry groups including Education, Health and Youth Development (MOH, 2007d).

¹⁷¹ Feeding our Futures is a Ministry of Health social marketing campaign aimed at encouraging parents to increase their children’s intake of fruit and vegetables (MOH, 2007b).

and activity patterns ...” to create a healthy social, physical and cultural environment, and included a specific need to increase “... the availability, accessibility, and affordability of healthier foods ...” (Health Committee, 2007, p. 13). This mirrored the aim of the GABTR programme. The authors of the report also identified that the HEHA strategy was inadequate to meet the health challenges faced by the country, and that there were problems with its implementation and evaluation. A significant part of the Government’s response (New Zealand Government, n.d.), which was overall in agreement with the Inquiry report, included identifying the need for a revised and enhanced focus on coordinated, sector wide, HEHA programme activity.

Highly relevant to GABTR was the recognition by the Government of the importance of securing community buy-in for interventions, especially from the priority population groups. The need to use community development approaches was also identified. In addition, as part of its response to the Inquiry, the Government agreed to extend the Fruit in Schools programme to more schools. The apple tree distributions to targeted schools had been a major intersectoral link within the GABTR programme. Collectively, these responses highlighted the relevance of the GABTR programme and also some of the issues related to community participation which had developed during its implementation.

A food security toolkit for Māori was developed and released in October 2007 (Obesity Action Coalition and Te Hotu Manawa Maori, n.d.). This document included 27 initiatives relevant to Māori food security operating around the country, of which the GABTR programme was listed as one. Of these programmes, eight others included the development of gardens, mainly within early childhood or school settings. Most were new programmes, one to two years old, and few had been comprehensively evaluated. Therefore there were many possibilities for sharing lessons learnt by other, mainly health sector groups, using community or settings based gardens as an intervention.

An intensified national and local focus on gangs

While the Wanganui District mayor and elected DHB member Michael Laws, was speaking out publicly and in national forums against gangs, a Bill designed to increase prison penalties for those involved in gangs (The Organised Crime Bill) passed its first reading in Parliament. Another Bill (The Gang Insignia Bill), designed to outlaw the wearing of gang patches in public, also passed its first reading in Parliament (Burns, 2008). This Bill was a direct response to the gang violence described in Chapter Six. Concurrently, but more discretely, the renewed focus on community participation in the community garden resulted in the garden coordinator and health sector staff beginning to engage with the local gang. Tentative new relationships saw a local gang member left 'in charge' of the garden for short periods during the garden coordinator's absence¹⁷².

Increased international and national popularity of gardening, community gardens

Something of a home gardening renaissance, portrayed in newspaper subheadings such as "(p)lants, seeds flying off garden centre shelves" (Palmer, 2008, p. 2), was also underway during the GABTR programme implementation. Home gardening, as cheap, time efficient and health promoting, was being sold as a 'new' trend during two current affairs television programmes on different channels during one week in September 2008. In the same week a newly revitalised community garden developed within a council-owned flat estate in Wellington was profiled ('Garden gives flats life a lift', 2008). That area had previously experienced both illegal drug and gang problems. Also recently reported was a new community garden development in a largely state-housing suburb in New Plymouth. Motivating factors for the participation of people and development of this garden included sharing knowledge and experiences and "... the rising cost of food and people's desire to know where their food came from. The garden would help educate people and teach them gardening skills which might have been lost in

¹⁷² Field notes, 26/6/08, p. 1.

the last few generations” (Palmer, 2008, p. 2). These were the same sentiments expressed by participants within this study. The District Council in that area also reported that community gardens and orchards had been mentioned in about half of the submissions for a recent neighbourhood reserve management plan.

Also, the roll-out of the successful Australian schools-based programme of *Kitchen Garden Cooking With Kids* (Alexander, 2006) was profiled widely in Aotearoa New Zealand. This programme involved substantial investment in school gardens and school kitchens (considerably more than that offered for similar type projects in Aotearoa New Zealand). It included the integration of both gardening and cooking into school curricula, and was also heavily reliant on community members for resources and as volunteers in both the gardens and kitchens. Importantly, the processes and challenges experienced in the development of the programme, as well as the resources used, were carefully documented and widely available.

Postscript: Tentative successes in community participation in the community garden

On one of my last visits to the community garden in May 2008, just before the end of the first contract period, I saw changes that meant I labeled this as my ‘hopeful day’¹⁷³. Physical improvements in a small section of the garden were visible with bark on paths around the raised garden, and signs of organised planting. I had been told by community members that some new tensions had developed about the garden. These included disagreements regarding the garden coordinator being a paid position (while others were ‘expected’ to garden for free), and health sector staff disagreeing about how local groups should be contacted and by whom. Older challenges continued, such as teepees built at the ‘Grow Your Own Day’ being repeatedly broken down (and then reinstated by gardeners until finally the gardeners gave up). Tools and equipment had been taken from the storage container when the keys had been

¹⁷³ Field notes, 28/5/08.

misplaced. But this damage was all minor ‘wear and tear’ and the social issues raised showed more active engagement with the garden, rather than the past position where it was just an empty space.

More significant for me was that on this visit I was not alone – the garden showed embryonic signs of becoming a community space. The garden coordinator and I worked together for a number of hours. Others also came. A local woman visited with her dog. She was surprised to find the garden, having just seen the newly erected sign (see Figure 24). She wanted to know about the garden and although she couldn’t commit to regularly working there she offered to grow seedlings at home. Another local woman, who sometimes gardens here also stopped for a brief chat, again walking her dog.



Figure 24 Newly erected 'welcome' garden sign (and graffiti)

(In the car park beside Te Mana Park Community Garden 19/5/08)

A group of children appeared with a programme coordinator for a local sports trust, some with relatives in tow. The children were participants in an after-school HEHA programme for children from high needs communities. Sometimes visiting the garden as part of their programme, this group spent a number of hours learning about and planting peas and beans, mulching, and

tasting fresh produce, such as raw rhubarb. As I left the garden at dusk (see Figure 25), some of the children waiting for their parents were happily running around the garden beds, chasing each other energetically.



Figure 25 Children playing in the garden at dusk

(Te Mana Park Community Garden, 19/5/08)

Many issues remain with the local community and with local groups who were alienated from the project over time during its difficult and faltering development. The long term sustainability of the garden remains uncertain. But for this small space in time it felt as if finally a community garden as part of the GABTR programme may begin to meet its potential and the visions of those that proposed it.

Summary

In this chapter the case study has been completed by an overview of local, national and international trends that have made the GABTR programme both timely, and in some ways, ahead of its time. Global food and energy markets and forces, an intensified national health sector focus on food and nutrition, and local interests in environmental sustainability and groups such as gangs, all converged in this programme.

Tentative signs of changes in the community participation in one of the projects, the community garden, demonstrated how within a relatively short and constrained programme timeframe, lessons beginning to be learnt about working with communities (and attention to health sector responsibilities in a sector-led programme) may begin to produce initial results. The changes were small and hesitant and unlikely to overcome all of the problems that had arisen, however, they showed potential.

In the following chapter the case study is summarised and the key themes are revisited to conclude the study.

Chapter ten: Summary, themes, and conclusions

Introduction

Evolving from a personal fascination with community participation in health development, I explored the phenomenon conceptually and in practice within this study of the case and interwoven contexts of the GABTR programme. Community participation was pre-selected as a case focus, and as the programme evolved, it emerged as a challenging issue within all levels, from communities of interest to programme governance. In this chapter, the case study is summarised and the overarching theme discussed. Key findings are identified that could be used to inform other health sector-led health promotion programmes.

Focusing on community members' perspectives

The objective of this research was to examine community members' perspectives of community participation in a health development programme. The research questions in relation to the GABTR programme were to:

- Explore and describe community members' participation;
- Investigate how community members' perspectives changed over time;
- Examine the contextual factors which influenced participation; and
- Describe the diversity of types of participation.

The case

The case – GABTR - provided a health promotion programme that was both similar to other health development programmes worldwide and also unique. The similarities and uniqueness created important contexts for community participation. Points of comparison with other programmes included that it was, overall, a health sector-led programme, it had a constrained implementation phase, and the programme funding was, on the whole, from an organisation external to the community. Therefore the programme had to be

compatible with the priorities and timeframes, and compliant with the processes of that organisation, the MOH. The programme aim was targeted, so that population groups, identified as experiencing poor health status and disadvantage, became key communities of interest. Those groups (and others) could choose to become actors in a programme designed and, in the main, managed for them by others.

The programme, while small, was unique. The use of community and settings based gardens as a health intervention is well documented. However, the model of mass plant distributions is less common. It was this latter project, and its combination with other projects, that created key points of difference. The plant distributions formed the nub of the programme proposal, were collaborative ventures, and were clearly community-driven. However, health sector surveillance was also a feature to be negotiated and managed in this project. The programme was new. While some people involved had experience with similar projects, the intersectoral nature of the programme brought organisations, some new in the health sector and others new to collaborating with the sector, together in novel ways.

An important feature was that community members' participation in the projects was completely voluntary. Personal benefits were clear in the plant giveaways as people received free plants that they could grow, share and harvest from. In the community garden project the personal and community benefits were, in the main, projected; what 'could' happen in the future 'if' the project progressed, what the garden 'could' look like, and what it 'may' become. In this project there was a disjuncture between the reality and visions, and the pathways between.

Community members' participation in the programme and their perspectives of that participation were described within the case study. Two separate but fundamentally different projects within the programme, as detailed in Table 15, provided illuminating comparisons of community participation occurring

within the same broad contexts, but with different results regarding community engagement.

Table 15 Two different projects in one programme

	<i>Specific projects within the GABTR programme</i>	
	<i>Plant distributions</i>	<i>Community garden</i>
<i>Led and driven</i>	Primarily by community	Primarily by the health sector
<i>Project breadth</i>	Specifically focused on distributing plants with identified health benefits although the overall aim was expansive regarding improved population health	Broadly focused on establishing community gardens. Shifted from bounded settings (e.g. schools) to the more undifferentiated setting of community
<i>Length of engagement desired</i>	For most, short term engagement in collecting plants with longer term plant growing and fruit harvesting	Overall, long term engagement was needed to maintain the garden
<i>Captured involvement by</i>	A combination of: <ul style="list-style-type: none"> • Being unique to the region • Community personalities involved • Free to recipients • Tapping into personal and community interests with heritage plants and concerns about cancer • Many possibilities for people to participate as donors, recipients, helpers • Targeted distributions effectively built on personal and professional networks 	A combination of: <ul style="list-style-type: none"> • People's interests in the <i>idea</i> of community gardens • People's wider interests, e.g. environmental sustainability, food production • One-off events • Many possibilities for participation • For a few people, being local to the garden
<i>Challenges</i>	Difficulties with the 'anti-cancer' message in a health sector funded programme Balancing community groups' aims of equality with the targeted equity health sector approaches	Difficulties with building the infrastructure to support the garden Managing people's and groups' diverse and sometimes conflicting interests Constricted programme timeframes Modest participation by the targeted groups

Summary of the themes emerging from the case study

Three levels of themes emerged in this case study, as shown in Figure 26.

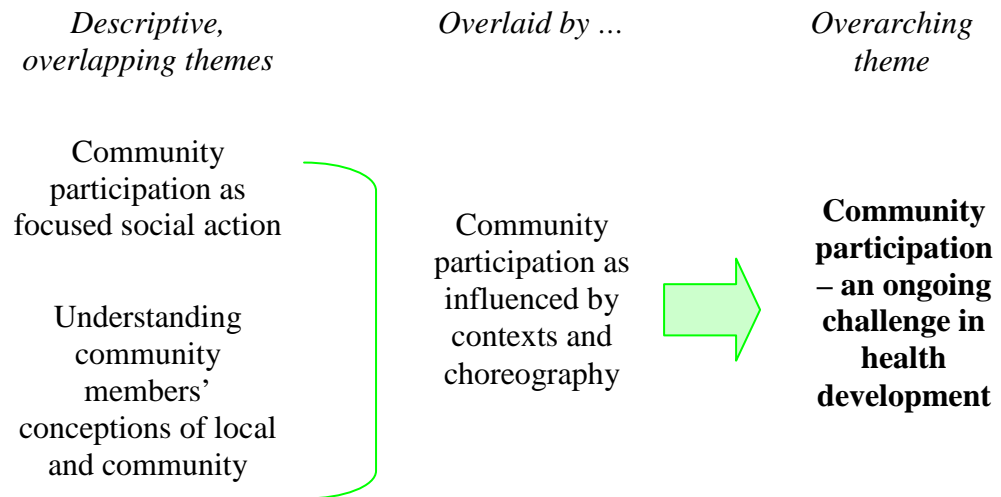


Figure 26 Final themes

Community participation as focused social action

Within the case study, community participation emerged as fitting within a description of 'focused social action'. That participation was dynamic, built on personal interests, focused and intentional. Some interests were narrower, with participation built around meeting immediate personal, family and whānau needs. For others, personal interests were much broader, linked to ideals and values, including the desire to build and sustain communities, improve population health, demonstrate social justice, and be environmentally sustainable. This programme became their imagined 'vehicle' for achieving community action related to broader societal goals. While differing in breadth, these interests could, in the main, be accommodated within the programme aim.

Where a project was reliant on ongoing community engagement, community member participation changed markedly over time. A few individuals and

groups stayed involved, but many people and groups walked away. This was either a passive process, for example, by no longer attending meetings, or an active one, through formal resignation. Community members (and health sector staff) described much frustration at the slow programme progress and levels of bureaucracy. Once people disengaged because of dissatisfaction, they did not generally re-engage at a later time. This was even though their purpose and interests for becoming involved remained.

The intentionality of focused social action meant that some types of participation, such as vandalism at the community garden, were incongruent with ideal-type models and typologies of community participation present in literature (for example, Arnstein, 1969; Brager & Specht, 1973; Pretty, 1995; S. White, 1996). This was not ‘nonparticipation’: Arnstein positions nonparticipation as manipulation and therapy, the two lowest rungs on the ladder of citizen participation. Instead it was active but damaging action. As mainly covert action, it affected others’ participation; galvanising a few people’s resolve for a time, while significantly disheartening others. However, how it reflected people’s and groups’ interests remained unknown. As argued by White (p. 14) “... participation and non-participation, while they always reflect interests, do not do so in an open arena.” These negative actions reaffirmed community participation as focused ‘social’ action, action occurring within the social world, not bound by the programme, but intertwined with it. Again, the community garden, as a manifestation of the programme, was shown to be a vehicle used by others for their own interests. Methodologically, this social action also reinforced how in case study “... the boundaries between phenomenon and context are not clearly evident” (Yin, 2003b, p. 13).

Community participation as multilayered and multidimensional

The small size of the programme meant it was possible to examine community participation across programme layers, such as the involvement of community members who participated at a strategic level, and those involved at an operational level. This created a point of difference between this study and

others that address only one level of participation. Individuals' and groups' participation overlapped different programme layers, and for some, across projects. For a few, overlapping involvements demonstrated a considerable commitment of time and personal resources to the programme. Individuals described deliberately considering where to position themselves within the programme - they wanted to feel useful - and, for a few, were very motivated and determined for it to succeed.

Other studies have found low levels of social, civic and health activity participation from disadvantaged groups (for example, Baum et al., 2000; Boyce, 2001). In this research, the few community members most involved were not members of the communities of interest, already had broad social networks, and actively participated in their communities. They then utilised those networks to support GABTR projects. This action provided important grounding of the programme within the community, especially when programme staff were still developing their own networks. Importantly, it meant that community members were constantly prioritising their participation in a number of projects and groups, with GABTR only one of many.

Different knowledge, different approaches

The binary positions of health sector staff/professional/specialist versus community/lay/generalist, inherent in descriptions of community participation (for example, Fonaroff, n.d.), were challenged in this study. The division of roles related to these positions were blurred and fluid. Personal participation in the community, broad social networks, general interests, and for some, inexperience in the health sector, all combined in different ways so that health sector staff, their participation in the programme, and their perspectives of participation by themselves and others were often quite similar to those identified as community members.

In comparison, some community members had specific, quite specialist knowledge and interests that they brought to the programme, for example in

relation to community networks, horticultural techniques, and plants. An issue related to these 'non-discrete' roles included how the range of knowledge could be considered and utilised within the programme. Importantly, it also created another issue: when the people identified as community members on the Steering Group were not representing or stakeholders for 'the community', how community members of the groups targeted by the programme could participate in what was being planned and implemented for them.

The programme focus on particular groups for participation brought forth an unresolved tension within the case of different approaches to health development. Community members generally described a desire for equality - the projects, as interventions, were inclusive - for everyone. This perspective underpinned their personal participation, and whom else they saw the projects as for. While some programme targeting was accepted (related to the health sector's participation), perceptions of exclusion were not. In contrast, health service staff described and acted on the sector equity mandate to work to reduce health disparities. This equity mandate was a form of positive discrimination; "... the unequal, but equitable, treatment of unequals ..." (Wiseman & Jan, 2000, p. 217).

While both equity and equality approaches can be combined, and in the latter plant distributions this was partially addressed using 'targeted distributions', these different perspectives clashed at times, mainly over the programme aim. In a number of forums, the community garden was described as a garden 'for' Māori, Pacific peoples and those from lower socioeconomic groups as populations experiencing poorer health and disadvantage. While this created a vehicle and space for some group's altruistic approaches (community participation 'for others'), it unintentionally but negatively labeled the garden space. More significantly, it lessened the necessary gap between the 'health speak' of policy population concepts, disadvantage, deprivation, health inequalities, high needs, and target groups, and actual people. Simultaneously it also raised the issues inherent in the application of any aggregated population data to individuals within population groups. Those individuals may or may not

personally perceive that they were disadvantaged, may or may not experience disadvantage or poor health, and may or may not conceive the health intervention as an appropriate response to any disadvantage experienced. However, they, again unintentionally, became labeled as targets for a programme into which they had had no input.

Understanding community conceptions of local and community

Closely associated with participation as focused social action, were the relationships people held with the site chosen for the community garden as a place and space. What the place was perceived as, its historical usage, and what some groups wanted in their community instead of a garden combined in various ways and with different levels of importance. These relationships with the place within the community – some negative, some neutral and some positive - were powerful influences on the types of participation that occurred for people ‘local’ to the garden. Those relationships were more general and appeared to be of less importance for those from outside of the local area. A key finding in this study, congruent with that of others (Jewkes, 1994; Jewkes & Murcott, 1996), therefore related to the complexity of ‘community’, specifically for the community garden. While ‘local’ to the garden was prioritised as proxy for the target groups, it was also challenging as different perspectives of local existed.

The influences of contexts and choreography on community participation

In this research, the case contexts created, constrained and choreographed the space for community participation. Supportive contexts, operating in different ways, included an increased global, national and local focus on healthy food, food production and nutrition. These were also individual passions and community interests. Other overlapping supportive contexts included the renewed prioritisation of primary health care, health promotion and population health approaches within the national and global contexts.

Constraining contexts related in the main to the health sector. While MOH funding enabled the programme to be established (while independent funding supported some projects), the programme application processes, contract delays, short programme timeframes, and workforce capacity, significantly constricted the work needed to fully develop the programme. Good intentions for community participation and positive health outcomes became somewhat lost during the translation of brief programme proposals, developed without local needs assessments and evaluation plans, into performance measures. These types of pressures around projects in England have been labeled as “... endemic projectitis” (Berkeley & Springett, 2006a, p. 2879), while in Canada (Boyce, 2002, p.67) the same issues precluded “... public participation in needs identification, skill development and ongoing participatory activities.” The secondary aims encapsulated in the application processes, such as the requirement that the programme be a joint venture between health sector organisations, combined with health sector workforce capacity issues to create a complex programme. These factors all became part of the case and its overlapping contexts, and they were important in framing community participation in the programme.

Nested, overlapping environments and their effects on community participation

Similar contextual issues were identified within explorations of the constraints (Berkeley & Springett, 2006a) and barriers (Berkeley & Springett, 2006b) experienced by *Health For All* initiatives in England. These authors present a model of “... nested environments” which constrained those initiatives (Berkeley & Springett, 2006a, p. 2884). Multiple environments, congruent with my use of contexts, from the environments surrounding the initiative, through organisational, inter-organisational, governmental policy, and the general national environment, nested together within the social world. Importantly, constraints:

... are imposed by each superordinate environment to the environment which is nested immediately within it. This environment, in its turn, interprets these constraints, adds its own constraints to them, and imposes them *all together* on the environment which is immediately nested within it. Thus, constraints get propagated 'down' the entire system. (Berkeley & Springett, 2006a, pp. 2883-2884)

While these authors (Berkeley & Springett, 2006a) concentrated mainly on the effects of the constraints on the initiatives themselves, within this research, those same constraints flowed through to influence the community participation in the programme. Some constraints and barriers held different importance. Conflicting conceptions of health and illness between health organisations and the community, which was a key barrier in the English study (Berkeley & Springett, 2006b), was of lesser importance here. In contrast to that study, the individual projects developed under the GABTR programme had the potential to offer a more holistic approach to social and health issues, rather than being biomedically and single-issue focused. However, a community member involved in GABTR saw the programme as the vehicle to change the health paradigm in which the health sector operated.

"[My] secondary role [in the programme] is probably to bring in a shift in paradigm in health. And that is a little bit grandiose, but it's just to bring in alternative concepts, not so much concepts, maybe more the practical side. To make headway it's got to be grassroots. [...]. It's a challenge because you are dealing with a diverse group of people ... and many of them have been educated through the [health] system so they know contemporary health understandings, which is why we have the problem to begin with.

(LB) So you are talking about a medical model of treatment and cure rather than about prevention?

Yes. (Int. 4A, p. 6)

Another difference was that English *Health For All* projects overlaid established health sector structures, whereas GABTR developed with an extra layer of complexity. Some organisations were relatively new, evolving out of restructuring, and therefore health sector relationships were still in flux.

The nested environments model is also useful as it can be used to portray how conceptions of community participation are affected, influenced and become more complex as they are manipulated through the layers of the health sector. Pathways leading from concept to policy to instigation (Zakus & Lysack, 1998), and then melding with community expectations and processes, reconstruct community participation to be and look like different things. In a convoluted and continuous process, the description of community participation in global strategies, such as the Alma-Ata Declaration and *Health For All*, becomes endorsed by the government and mandated (with subtle changes) within legislation and national strategies such as *The New Zealand Health Strategy* and *The Primary Health Care Strategy*. Those policy concepts then flow through different implementation paths – different levels in DHBs, PHOs, programmes and projects. Each layer adds complexity and reinterpretation. As the act of participation then takes place within the social world, factors within that world, such as understandings of rights encapsulated within the Treaty of Waitangi, lay understandings of factors associated with health disparities, and the differential positioning of groups within society, then come into play. Mosse (2001) argues that:

... it is possible to see that there is an oblique relationship between the rationality of ‘participation’ policy and the world of practice; to see how projects and programmes shape as well as implement policy; how the language of policy is co-opted from below as much as imposed from above; how there is never a singular voice, or harmonious consensus around projects (Mosse, p. 32)

With so many layers of understandings and different perspectives in play at any one time, a key issue is related to communication. In a study of community participation in primary health care in Brazil, which demonstrates the global nature of the problem, a key finding was that the “... first and perhaps most important difficulty is the development of a common language about participation between the various actors and stakeholders in the participatory process” (Guareschi & Jovchelovitch, 2004, p. 318). A common language may not be developed, especially within short project timeframes, but a first step is

recognition that different perspectives and expectations exist. This can only occur if space is allowed for groups and individuals to communicate those expectations. While some people within organisations did understand these issues, that understanding was not universal. Organisations themselves are not “monolithic” and therefore the people within those organisations hold many and varied conceptions of participation (Nelson & Wright, 1995, p. 7).

The contradictory impacts of the clamour for the community voice

A context which had contradictory effects was that of the current health sector (and state) focus on accessing and integrating the community’s voice(s) into service planning, implementation and governance. Midgley (1986b) described a typology of four ideal-typical modes of state approaches and responses to community participation. These were anti-participatory, manipulative, incremental, and participatory modes. The current participatory focus within Aotearoa New Zealand articulates broadly with the participatory mode, but while this created a space for community participation, that space was relatively undefined and contested at the programme level.

While the complexities of community participation in the governance of DHBs and PHOs is receiving some attention (for example, MOH, 2007c), the issues that currently affect those governance boards were replayed at the level of programme governance. The GABTR programme governance structure was ‘downgraded’ to become a programme advisory group by the end of the first contract period. The specific issues affecting that Group reflected the lack of community participation from Māori, and from the communities of interest in the programme, and how community participation in programme governance interfaced with community participation in organisational governance. The overlapping modes of participation *chosen for* community members as representatives and stakeholders were also undefined, a complexity identified within other similar programmes (Jewkes & Murcott, 1998). Community members were not necessarily aware that these roles had been conferred upon them, and there was some confusion as to why community members were

participating in the programme governance group, except to fulfill a normative function that ‘required’ community members present. This was congruent with the argument that “(t)hrough participatory practices conventions develop and acquire the status of ‘common sense’ and become normative simply by being performed repeatedly” (Kothari, 2001, p. 146).

Unequal spaces for communities of interest

Although not measured, it was obvious that there was modest to little participation in the community garden and in the operational management and governance/advisory layers of the programme from the groups who were programme communities of interest, Māori, Pacific Peoples and low socioeconomic groups. In contrast, the settings and targeted approaches were more successful in engaging these groups as recipients of the plant distributions, especially when processes to access these groups built on established personal, cultural and professional networks.

It is well recognised that those targeted for interventions often experience multiple constraints that affect their participation (Baum, Sanderson, & Jolley, 1997; Brownlea, 1987), and that selective participation results (Campbell & McLean, 2003). The unequal nature of participation by those already disadvantaged within society is, unfortunately, a common research finding (Baum et al., 2000; Boyce, 2001, 2002). This inequality can then perpetuate the existing inequalities (Mercer, 2002), which the programme was designed to reduce.

Boyce (2002, p. 67) examined the effects of bureaucracy on community participation in health promotion programmes in Canada and argued that “... the participation of disadvantaged community members is fundamentally different from that of privileged community members with more resources. Financial and social support mechanisms are necessary adjuncts to community participation by disadvantaged persons.” While support mechanisms for participation are useful, clarity is needed as to whether structures developed for

community participation, especially at the programme governance/advisory level, are designed to facilitate community representation.

If community representation is desired, then the complexities of accessing and representing something as amorphous as community need to be acknowledged and managed. An important consideration is that "... allowing the voice of the marginalised to be heard is a more valuable objective than accurately representing all views" (Baum et al., 1997, p. 125). In addition, community representation needs to be positioned alongside a group's rights for self determination. As cited earlier and simply described by Durie (1998, p. 1), "... Māori health development is essentially about Māori defining their own priorities for health and then weaving a course to realize their collective aspirations." Māori and the other groups targeted in this programme needed an appropriate space in which they could define their priorities and set their own goals. While the health sector has an important part to play in supporting these processes, constrained programme timeframes, and workforce issues were realities that affected its ability to undertake this role effectively.

Overlaps in mechanisms and roles for community participation

Project operational and programme advisory/governance layers overlapped considerably in both the work undertaken and the people involved. That duplication created ongoing role confusion in two of the mechanisms developed by health service organisations for community participation - the Steering Group and the Community Gardens group. Problems of leadership and decision making that were experienced in these groups were repeated. At times there was an obvious disproportion between the relatively large numbers advising the programme versus those actually doing the work. In contrast, the plant distributions created an avenue for short term, altruistic participation by many people as helpers and resource donors. Small Steering Group sub-committees, formed to organise the distributions were effective in achieving their goals, were collaborative in nature and, bounded by deadlines for plant distribution, progressed in a timely manner. These issues demonstrated the

importance of considering how participation is choreographed, which constructs people's entitlement to participate, the status of participants, and processes of accountability (Swyngedouw, 2005).

A small programme in a small region resulted in much overlap of people involved and in the roles they undertook. Duplicated roles and 'multiple hats' brought synergies to the programme with much networking occurring informally or simultaneously in other programmes. Individuals often knew each other, and lessons learnt in other programmes could easily be shared. For organisations, the programme created a space to also meet their own secondary goals related to positioning themselves within the restructured health sector.

There were also challenges, especially when some people were uncertain as to the roles that they and others undertook. For example, assumptions were made as to who was 'representing' Māori in the programme governance, and there was confusion as to whether that representation was as a 'voice of' Māori as tangata whenua and a Treaty of Waitangi partner with the Crown, or as an advocate and 'voice for' Māori as a target group of the programme, or as a health service organisation collaborating within the programme.

Power relationships and programme ownership and leadership

The enaction and choreography of community participation is often described in relation to power relationships (for example, Guijt & Kaul Shah, 2001; Llewellyn-Jones, 2001; Nelson & Wright, 1995; Rifkin, 1996). In this study power – embodied and experienced as control – emerged as a feature of participation in different ways. Three interlinked issues were important. Firstly, the 'joint' nature of the programme, between health sector organisations and community, was apparent in the bringing together of stakeholders and representatives involved in the governance and garden management forums, and in the collaboration that enabled the plant giveaways to take place. However, joint decision making was less obvious, and people's participation in programme decision making was an area of contention throughout the

programme. When difficulties occurred, one health sector organisation appeared to take over the decision making.

Secondly, in the community garden project there was much confusion as to whose project this was, with an obvious desire for overt ownership to be declared. Community members related 'ownership' to 'responsibilities' for the project development and management. While the community garden was at times described as belonging to 'the community' and at others a community group signaled that they had established it, its imposition without robust community consultation (and choice) resulted in the ownership being disputed and contested by different people. For most of the project the garden was nameless and ownerless. Also, with no handing over to the community of both the responsibility and resources for infrastructure development, it was perceived by some as a potential drain on the community, and a site for negative participation, rather than an asset. Community members believed that it was set up to fail and this, they believed, had the effect of re-labeling the community as 'the problem', reinforcing the problematic of community that led to the garden being sited in this suburb in the first place. As a direct result, modest positive participation by that community occurred and the participation that did occur was tentative.

Thirdly, and specifically in relation to the community garden project which was health sector-led, leadership was seen as lacking. Health promotion project leadership has been identified as an important factor in relation to power dynamics and community participation (Boyce, 2001). Usually the concerns raised are that the community may be disempowered by the choreography of participation by bureaucracy, but this belies the complexities in the nature of community power itself (Barr, 1995). While the lack of leadership of the garden project created much annoyance, because community participation was voluntary, community members asserted their authority to walk away from the project or alternatively to use it as a vehicle for other purposes. In contrast, the plant distributions were community-driven and the powerful surveillance of the health sector was diminished by the level of passion and the high public profile

of the community members involved in this project. This created a different outcome, but one which was not without its problems.

Overarching theme: Community participation – an ongoing challenge in health development

As identified in the case study securing community engagement through community participation within the programme was complex, challenging, and a core ongoing issue. This situation is in no way unique to this case. Thirty years after the inclusion of community participation as a ‘revolutionary’ principle in the *Declaration of Alma-Ata*, community participation and intersectoral engagement were identified together as “... the weakest strands in primary health care” (Lawn et al., 2008, p. 917). Those authors went on to argue that “(c)ommunity participation for health was a central tenet of the comprehensive primary health care approach, although perhaps more difficult to implement than the technical elements ...” (Lawn et al., 2008, p. 924). This differentiation of community participation from the technical elements of primary health care was shown to be important in this case study and it is that differentiation that creates key areas of learning.

Community participation is not a technical element but it does require expertise

The technical aspects (for example in this case, the development of a garden) did not require the expertise of the health sector; in fact it was recognised that the knowledge of how to undertake this technical skill was held by community members. However, working with communities to engender their engagement in a programme designed for them, requires skills and expertise, quite different from the technical aspects of gardening. As identified in the theoretical analyses of community presented in Chapter Three and in the conceptions of ‘local’ which emerged from this research in Chapter Six, communities and community groups are diverse and have different interests and foci. Bringing those varying perspectives together to work in partnership and managing them with a single programme requires skills, especially in partnership working,

group facilitation, and robust consultation processes. The complexity in this programme was not technical, it was social - about human behaviours, relationships, personalities, agendas – and how those played out in the social world.

There is an extensive body of literature regarding how to engage *with* communities, design programmes *with* them, work in partnership *with* them, negotiate the implementation of top-down programmes, work *with* different ethnicities, and involve community members in particular activities within programmes such as programme governance. This literature spans, as examples, health promotion (Laverack, 1999), community development and community work (Munford & Walsh-Tapiata, 2001, 2006), primary health care (Neuwelt, 2007), community action (Duignan et al., 2003), health services (Consumer Focus Collaboration, 2000; Taylor, Wilkinson, & Cheers, 2008), public and population health (Baum, 1999; Labonte, 2003), health and social policy (Liamputtong et al., 2003), and development studies (Kumar, 2002b). However, in practice individual practitioners and service providers hold different levels of knowledge regarding the theory and praxis of engaging communities.

Four main overlapping factors, as identified within the themes already presented, were influential in the development of relationships between the programme and communities in this case. These factors illustrate why and how community participation remains an ongoing challenge:

1. **Workforce issues:** Issues included inexperienced and part time staff, a small programme, and staff changes. In this situation a *theory-practice gap* existed. The ‘common sense’ and now ‘normative’ perspectives of working with communities held by some more experienced health sector staff belied their personal and professional skills, experiences, and networks that they brought to their own work.
2. **The influence of bureaucracy on the choreography of participation:** Many contextual factors included short proposal writing times, delayed contracts, restricted programme implementation timeframes, and health

sector conventions significantly influenced the programme's implementation. Community participation and engaging communities became (at times) *one of many performance measures*. This is an alternate, problematic conception rather than community participation and community action being the programme as a whole, with the 'technical' aspects being the ones measured. Also health sector restructuring resulted in the *expertise in health promotion being split across organisations*. Those organisations needed to develop ways of working collaboratively; this secondary aim of the initial programme funding was in play during the programme. It created an additional factor to be negotiated by everyone involved – including community members and junior programme staff.

3. **Communities of interest need special attention:** When programmes are targeted at specific groups, that attention relates to recognition (by others generally) of the special 'needs' of those groups. Two factors are therefore important. Firstly, how those communities are 'engaged' in a programme designed for them by others rather than having a programme 'imposed' on them (as a participant described the community garden being imposed on the community). Secondly, how the special needs of the communities of interest can form the basis for partnerships within programmes. While many frameworks and models exist, workforce issues and bureaucracy intervened. In a health sector-led programme, attention was needed in considering *the spaces created for communities of interest* and whose needs those spaces met.
4. **Communities are complex:** Communities and community groups remain diverse, changing and challenging. This factor will always remain in play.

Implications for practice

Table 16 describes a number of specific research findings from the case study. Linked with those findings are implications for practice, drawn from experiences with the GABTR programme. The findings overlap and intertwine

with the themes already presented, but are practice based rather than theoretical.

Table 16 Implications for practice

<i>Key research findings</i>	<i>Implications for practice</i>
<i>Groups and people became aware of and engaged in projects at different times.</i>	<i>Critical times</i> existed for participation and consultation, individualised to groups and communities. Robust processes of ‘consultation’ <i>before</i> project implementation (when participation of those groups was desired) was vital.
<i>Discussions with individuals and groups about the projects needed robust feedback mechanisms.</i>	Ongoing <i>formal</i> communication processes, relationship building, and feedback were important. Culturally appropriate channels for consultation and communication were crucial as were networks with community leaders. Local knowledge was communicated through <i>informal</i> discussions with community members. Local knowledge often contained critical action points for project progress.
<i>Tapping into people’s/groups’ varied needs, interests, and values as a first engaging step.</i>	While <i>needs</i> were personal and family/whānau based, <i>values</i> underpinning the <i>interests</i> were often much broader than the project. Asking what people wanted from a project and their participation was an important first engaging step towards a degree of <i>community buy-in</i> .
<i>Initial engagement was tentative</i>	Initial engagement was <i>exploratory</i> , not committed action for most. In a health sector-led programme it was <i>watchful</i> of progress.
<i>Participation was prioritised alongside other personal /group priorities.</i>	Community members wanted to know <i>what</i> the health sector was offering, what it <i>wanted</i> from them and <i>how</i> they could become involved. <i>Communication processes</i> and the <i>language</i> used were important. ‘Health-speak’ of health sector jargon created a barrier.
<i>The health sector has responsibilities if it leads a programme.</i>	Community members looked for project leadership, direction, infrastructure and organisation that they could fit with. The health sector was seen as responsible for the project organisation but community members were willing and able to provide leadership, direction, infrastructure and organisation with <i>appropriate coordination mechanisms</i> in place. Clarity over resource access was important.
<i>Participation looked like many different things.</i>	Participation included providing advice, gardening, networking, volunteering time and resources. When engaged, community members were <i>generous</i> with their time and active participation <i>but</i> needed to see satisfactory project progress. <i>Negative</i> , but active participation also occurred

<i>Key research findings</i>	<i>Implications for practice</i>
<i>When given the choice community members adopted different roles based on their interests, skills, networks and resources.</i>	<i>Mechanisms</i> designed to facilitate community participation needed: a clear mandate; competent facilitation; and, if appropriate, time for group process work. Multiple, overlapping roles were complex to manage. People also chose <i>not</i> to participate and to <i>disengage</i> when their or their group's needs and interests were not being met.
<i>Communities and community groups, like organisations, were not homogenous entities.</i>	Community members / groups held divergent, often contrasting (sometimes conflicting), views and knowledge which could inform projects. Communication channels and transparent decision making were crucial, as was leadership and facilitation.
<i>Communities of interest targeted in programmes need an appropriate space created for self-determining participation</i>	Established social and cultural networks and relationships were important for accessing communities of interest. Settings approaches bounded the target groups and were more effective than undifferentiated community approaches.
<i>Community participation was social participation via the vehicle of the programme.</i>	While community participation can become a performance measure for health services, for community members' community participation was the whole programme and their social participation within their community.
<i>Contexts of the programme impacted on community participation.</i>	Programme timeframes, health sector workforce capacity issues, practice conventions, and secondary aims embedded in programmes constrained community participation. Global, national and community interests provided engaging contexts.

Limitations of this study

As was examined in Chapter Four, the findings of qualitative case studies cannot be generalised to other places or programmes. However, with consideration of the study's limitations and the contexts of the case, insights gained may inform research into similar programmes and practice.

The limitations of this study relate to the case being small and my involvement as a participant observer in a 'living' programme. While envisaged as an expansive programme in the proposal stage, during implementation it became more constrained in size, with, for example, only one of the four planned community gardens commenced within the contracted timeframe. Once involved, I realised that some programme components were organised by other groups and organisations. I therefore chose to concentrate on the community garden and the plant distributions and not to explore those other components in

depth. Also, except for a one-day workshop, networking, and plant distributions, the programme was largely confined to Whanganui city.

I respected the 'living' status of the programme. While I was generously introduced to individuals, groups and organisations, there were some I could not access. For privacy reasons I could not access the plant distribution databases and so data were limited to that gained during my personal involvement in distributions. I also chose not to investigate the nonparticipation of some groups in the programme; therefore a full exploration of participation in the programme was not obtained. This decision was based on my desire to let the programme evolve as planned.

Recommendations for further research

This case study was focused on community members' perspectives of community participation in one health development programme. Some key unanswered questions emerged from this study, some were raised by participants as issues, and others developed within the case analysis. Issues for further research include: the interface between layers of community participation in programme advice, governance, and organisational governance; how organisational policies for community participation are enacted within programme governance groups; and, what mechanisms for community participation in programmes reduce the "... socio-demographic gradients in participation" (Boyce, 2001, p. 1558) observed in this study and others.

Concluding statement

This research provides insights into community members' participation and their perceptions of that participation within a single health development programme - the case of Grab a Bite That's Right. Developed from a community member's vision, this programme, with linked projects, was developed by health sector organisations. Two projects provided different avenues for participation within the same broad contexts: one project remained community-driven, narrowly focused, and engaging; another was health sector-led, more undifferentiated, and made faltering progress. In that latter project, the complexities of establishing community gardens combined with health sector constraints, such as condensed programme timeframes. Community participation, while pre-selected as an issue for examination, emerged as a programme challenge and solution in its own right.

The question in the title of this thesis – 'Lady, is this civilisation?' - encapsulates an important community perspective of community participation. For community members the theoretical division of actions as civil/public/community held no particular interest. Participation was social action, grounded in the present, reflecting past experiences, future hopes and dreams. It was prioritised against other competing priorities. People involved thought about their participation in different ways. Some looked to meet their own needs, others the perceived needs of others, especially of their community. Some wanted to find congruence with their own interests, passions, and values that were much wider than the programme aim. The programme became an instrument for achieving those broader visions. While focused, participation was also tentative. Some people watched for project progress, others worked hard to try to make it happen. When that progress was deemed to be unsatisfactory, and this could not be successfully remedied, people walked away. Contexts of the case were key determinants of action – some supported, and others constrained community participation over time.

For good reasons, community participation is now a normative feature of health development programmes in Aotearoa New Zealand and in many other countries, as it is in health organisation governance. However, as shown in this research, at the programme level this orthodoxy has not overcome the complexities inherent in translating the concept of community participation into practice. In many ways, it has added an additional layer of complexity to be negotiated by all those participating in health development programmes. I leave the final words about the case to a community member:

“I think community development is a difficult thing that not everyone understands. Buy-in from the community is the most important thing I think. Don’t force a project into a community that doesn’t understand it, ... doesn’t want it. But on the other hand ... nothing is a failure if you learn from it and I think some people have learnt a lot of things” (Int. 20A, pp. 25-26)

Appendices

Appendix One	WDHB health needs assessment 2005
Appendix Two	Visual represent of the 'spidergram' model
Appendix Three:	Paper presented at the IIQM conference
Appendix Four:	Information sheets
Appendix Five:	Consent forms
Appendix Six:	Ethics' committee approval
Appendix Seven:	Community gardens literature
Appendix Eight:	Glossary of Māori words

Appendix One: WDHB Health Needs Assessment (Executive Summary)

This Health Needs Assessment, the second undertaken by the Whanganui District Health Board will provide a basis for the development of the revised District Strategic Plan and will feed into planning and prioritisation processes. It can be used at all levels of decision making, to inform the community and provide a basis for service development and change. In addition, it may be used as a basis for communities and other health agencies to develop their own programmes to encourage health and wellbeing.

Key issues

The District's population

The Whanganui District Health Board area:

- Has a decreasing population and is expected to drop 9.5% to 59,279 by 2021.
- Has an increased proportion of Māori, 22%, that will increase 15% from 14,120 to 17,860 by 2021.
- Has an increased proportion of older people, 14.3%, that will increase 39% from 9,200 to 13,020 by 2021.
- Is a region of high deprivation overall, with an average NZDep2001 decile of eight.
- In the Whanganui territorial authority's population 52% live in the deprivation deciles eight to ten as do 70% of Māori in the region.

The Whanganui District Health Board area: Health Situation

The high level of deprivation is the biggest factor for the health of the residents. The impact on the district's overall health is significant having higher mortality and hospitalisation rates compared to the rest of New Zealand. Māori in the district have higher mortality (1.6 times) and hospitalisation rates (1.3 times) than non- Māori.

The growing number of older people will place an increasing burden on health services as health problems associated with older people will also increase.

The major health problems in the district are

- Cardiovascular disease
- Lung disease
- Cancer
- Diabetes
- Health of Māori in the district

Relative to New Zealand, Whanganui also has higher rates of:

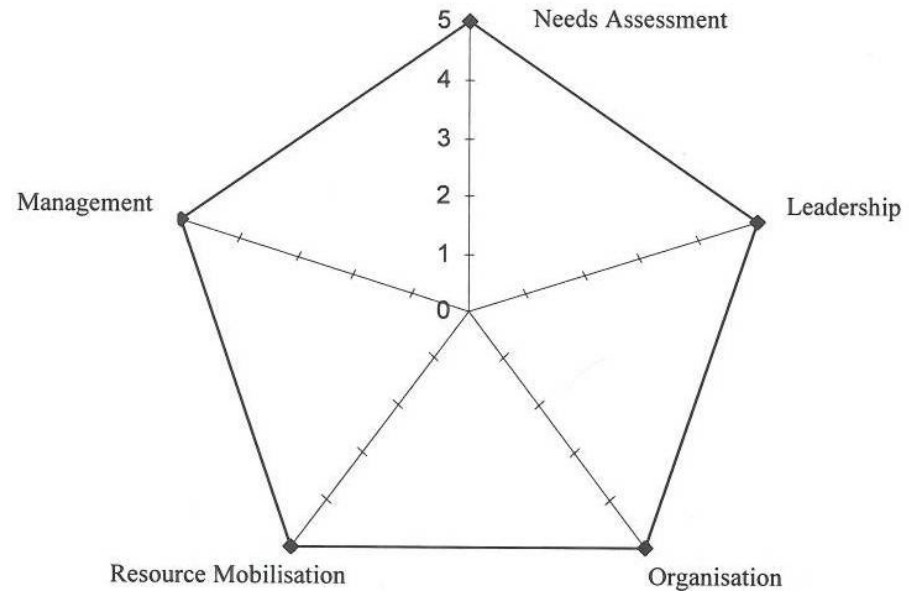
- smoking, especially Māori where 49% smoke,
- smoking in the district's youth, especially females, where 29% of 14 year olds smoke regularly,
- hospitalisations of children from injury (1.3 times the national rate),
- hospitalisations for dental conditions and skin cancer.

Areas of particular concern

Areas identified in this Health Needs Assessment of particular concern and affecting a reasonable number of people are (in no particular order or priority):

- Cardiovascular disease especially for Māori, people from areas of high deprivation, and males
- Prostate cancer.
- Lung cancer in Māori
- Colo-rectal cancer in people of non-Māori, non-Pacific ethnicity
- Access to primary care services especially for Māori, Pacific, people from areas of high deprivation and males.
- Respiratory conditions especially for Māori, people from areas of high deprivation, and children.
- Diabetes especially for Māori and Pacific Peoples
- Access to services for Maori, and people from areas of high deprivation.
- Mental Health. (WDHB, 2006, pp. 3-4)

Appendix Two: Visual representation of the ‘spidergram’ model



(Source: Rifkin et al., 1988)

Appendix Three: Paper presented at the IIQM conference.

Advances in qualitative methods conference, Surfers Paradise, Australia, July 2006

Author and presenter: Lesley Batten

Nailing down a nebula: What is community in a case study of community participation in primary health care?

Introduction:

Community is often synonymous with the future direction for health care. Despite the constant use of the term community, with its everyday connotations, it is often unclear as to what it means or what authors wish to portray by its use. There is a considerable body of literature providing multiple ways of defining community. Generally definitions include either people who reside in a geographical location, the social interaction of groups of people, the common links and identities held by groups, or all three (Hillery, 1955). Nevertheless the concept remains nebulous when those definitions are applied to community as the subject and site of research. As Denzin and Lincoln (2000, p. 3) state “qualitative research is a situated activity that locates the observer in the world.” What, therefore, is the situation of community?

In this paper I will explore the complexities I faced in attempting to ‘nail down’ the concepts of community into strategies for sampling within my current PhD study. This study is a qualitative inquiry of community perspectives of community participation in primary health care. These strategies needed to be broad enough so that they did not preempt community defining itself in multiple ways, but specific enough to accommodate the ethical approval requirements of identifying potential participants. I argue that it is the application and operationalisation of concepts, such as community, into research practice which provide us with many of the opportunities and challenges for qualitative research.

Background

I thought that I had a good understanding of what ‘community’ is until I started actively researching this ‘thing’. I have worked as a community nurse, have taught courses about the health of communities, have completed a number of different types of community health assessments, and have reviewed the extensive literature written about community more than once. Why then, did I feel as if I had fallen into a rather large black hole when I tried to identify potential participants who would enable me to explore community perspectives of community participation? This was especially so when I was interested in communities for their richness and multilayered dimensions rather than just their structural features. I seem to have missed something crucial in my journey to this point. As a fellow researcher so kindly put it as I tried to provide the mandated two sentence description of my research: “Well what is it that you are actually researching? Community is a bit big and nebulous isn’t it?”

Nebulae

Like most researchers using qualitative methods, words and concepts and their meanings fascinate me, as does my very basic interest in astronomy. Thinking about community in terms of nebulae was somehow comforting. Like nebulae, ideas of community have changed over time and both are about something which is identified as ‘ill-defined’, both include multiple entities – groups, communities, dust, stars, both are the repository of history and reflect their broader environments. Neither is easy to nail down but that is what is required for research and ethics proposals.

Letting the community define itself

After a period of angst I have chosen to use a combination of three sampling strategies, the first being to let the community define itself and its members. But as Carol Grbich (2004, p. 61) states, “... complex/chaotic systems (which I argue that communities must be) will need initial

articulation, as will their interactions with other systems.” When we combine two complex systems – community and health systems, then the interactions are doubly complex.

Community involvement or participation has reappeared as a directive in New Zealand government health strategies (A. King, 2000b, 2001b; A. King & Turia, 2002) although it could be argued that some mixed messages are given as to how communities are defined. As new health structures develop, some organisations are visibly struggling with what it may mean for communities to be actively involved. For example in December 2005 the New Zealand Minister of Health (MOH, 2005b) requested a report because of concerns raised about community involvement in Primary Health Organisations, which are the new local not-for-profit primary health care service contractors for a defined community. That report identified that only 9 of 74 constitutions of Primary Health Organisations provided specifically for consumer representation, 45 provided for Maori representation, 45 provided for community representation, whatever that may be, but only 5 provided for meetings that could be held in public. These are only crude measures of narrow perspectives of community participation but they do show a trend away from active community involvement. This was in spite of community involvement being a basic requirement for these organisations. If the organisations are struggling, then what of the communities and how easy is it for them to define themselves when community borders have been set nationally?

There are also two specific problems with the strategy of the community defining itself. Firstly, we know that there is a very real issue of elite capture. When researching in the areas of primary health care and health development, elite capture generally refers to people already associated with the health sector, often health professionals, and especially those who have retired, identifying themselves and then being identified as representatives of the community.

Health professionals are logically also members of communities and they can and do have valuable input. They should, it could be argued, also know both the health sector and the community. But it is important to remember one of the main reasons that primary health care, with a central concept of community participation, came into being. This was, as Knight (in Liamputtong et al., 2003, p. 7) states “a radical reinterpretation of health services that would redress health inequalities through a commitment to greater justice and equity in health resources allocation.” It requires a fundamental move away from hospitals and health professionals being seen as the source of health to those being seen as a resource for communities. As Smithies and Webster (1998, p. 9) identify, when discussing the influence of social movements on community involvement in the health sector - “... health was an important community work issue and should not be left to health professionals.”

Unfortunately it has also been identified (Coney, 2004; Llewellyn-Jones in Liamputtong et al., 2003) that as a group, health professionals are in fact one of the principal barriers to enabling effective community participation in the health sector. Attitudes, concerns about control of resources, and a strong grounding in biomedicine, can all result in blocks to community involvement. Therefore, care needs to be taken if members of this group are then defined as voices or representatives for the community.

A second issue which arises if the community defines itself relates to the groups which already experience disadvantage within that community. Hancock and Morabito (2003, p. 39) identify that “In the health arena, structural disadvantage impacts on the capacity to participate and to be heard, whether for reasons of chronic illness, disability, mental health problems, low income, unemployment, homelessness, refugee status, recent arrival as a migrant, or having a first language other than English.” Duckett (in Liamputtong et al., 2003) also adds ethnic groups and older people to the list. If a groups’ ability to participate in society is already compromised or denied will that group be identified when a community defines itself? Many researchers have recognized that when community involvement is a component of a health project it rarely results in challenges to the structures within communities that deny participation to others. As a researcher, do I want to repeat that hegemony?

Being more specific

So in my search for community perspectives of community participation I have some comfort with letting community define itself and its members in a number of ways, while being sensitive to the issues around elite capture in representation and the need to identify disadvantaged groups who may be denied participation. I still needed to actually identify participants within the community. Community participation occurs as an interaction of individual and collective social behaviour, but community itself cannot be accessed directly. I have taken the position that indirectly, community can be accessed through individual, group, and organisational behaviours and the identification of the personal meanings attached to those actions which occur for the collective of community rather than solely for individual benefit. The last point is important - the focus on the collective of the community - as it enables some operational differentiation between the individual using primary health care services as a consumer as separate from the broader concept of community participation.

Using the guiding concern of “where community perspectives could be accessed from” I developed a simple typology. This typology covers three overlapping clusters, of ‘individuals as community’, ‘groups as community’, and ‘organisations as community’.

Individuals as community

Individuals who act on behalf of the community either formally or informally form one cluster of potential participants. These individuals may be community members, individuals who represent the community and individuals who have leadership roles, which may be at the neighborhood or civic level.

Groups as community

Established interest groups provide another component of community, one in which the focus of the group may result in some homogeneity of ideas. Groups are more likely to engage in formal processes of community participation and groups provide potential access to individual group members and group leaders who act on behalf of the group. At a recent public forum for people interested in community participation in the new local Primary Health Organisation, groups represented included those and their families with mental illness, heart conditions, and after strokes, the Samaritans, the Ethnic Council, those who work with prisoners and Age Concern. As well as support, these groups also often engage in health advocacy for their members’ special interests.

Organisations as community

Organisations, as non-human entities, need to be considered separately as participants and the issues involved in accessing community perspectives and organisation’s voices are paralleled here. Groups and organisations overlap somewhat, but many non-governmental organisations, in particular, are actively involved in community health advocacy and some may offer health services as well. For example the major national provider of well child services for 0-5 year olds in New Zealand, the Plunket Society, is also involved in advocacy for children and families at the regional and local level. It, as an organisation, speaks for sections of community and is part of the community and therefore offers, I argue, a community perspective. There are also a number of health service providers which are community driven, such as iwi (tribal) health services and some are community owned. These could be classed as ‘by community, for community’ services.

The typology of individuals as community, groups as community and organisations as community should enable a broader range of community perspectives to be accessed and to balance the expected elite capture expected with community self identification. Some of the groups previously identified who may traditionally have less of a voice may also be able to participate through groups and organisations, or will be actively sought out. It is hoped that it will also enable the capture of what Cohen (1985, p. 19) identifies as the relational boundaries within and around communities, and also the “symbolic dimension” of community. He states:

It is that the community itself and everything within it, conceptual as well as material, has a symbolic dimension, and further, that this dimension does not exist as some kind of consensus of sentiment. Rather, it exists as something for people ‘to think with’. The symbols of community are mental constructs: they

provide people with the means to make meaning. In doing so, they also provide them with the means to express particular meanings which the community has for them. (A. Cohen, 1985, p. 19)

This symbolic dimension of communities is important as it is a mediating factor of why communities participate, how they participate and what the expected outcomes are of community participation in primary health care. This is especially true if we consider and want to capture the purported ethereal and abstract benefits of community participation such as community empowerment and increased social capital in contrast to more concrete benefits such as improved service responsiveness and increased consumer satisfaction.

Health development structures

A third overlapping strategy has also been adopted to identify community perspectives. This involves identifying what the World Health Organisation (1994) labeled as health development structures.

Health development structures are defined by Baum and Kahssay as “groups and organisations, governmental or non-governmental, formal or informal, that can be used to bring about socioeconomic and health transformation in a given area” (Baum & Kahssay, 1999, 97). Importantly, most have a long history of providing mutual support and cooperation and community action. Health development structures are separate from health service facilities and management and include a number of groups. These groups include:

- Organisations, groups, or recognized bodies at the community level
- Informal or formal structures
- District, sub district and community level structures
- Structures more directly linked to the existing district health services (such as health committees) or less directly linked (community groups, religious groups). (Baum & Kahssay, 1999, p. 97)

In a multi-country study of health development structures in eight less developed countries the World Health Organization (1994 p. 6) identified multiple formal and informal organisations and importantly, the networks of community participation that operated between these organisations.

In conclusion, it is hoped that a combination of the three strategies – letting the community define itself, the typology of individuals as community, groups as community and organisations as community, combined with the identification of health development structures – will not only enable me to access a broad range of community perspectives but also so that there will be congruence with the broad tenets of qualitative enquiry and theoretical understandings of community. Important considerations are that commonalities of ideas within community do not necessarily reflect uniformity, that organisations and institutions are not enough to represent community, especially its symbolic and relational boundaries, and that there is much complexity in attempting to identify emic and etic perspectives associated with community (A. Cohen, 1985).

The aim in identifying these sampling strategies has not been to define community in one particular way or even in multiple ways or to fall in the trap of what Cohen (1985, p. 38) describes as the abyss of theoretical sterility (related to) obsessive attempts to formulate precise analytic definitions”. Instead it is to enable access to community perspectives of community participation in primary health care in a way that captures and embodies that nebulous, ill defined and often contentious concept of community. The next frontier is persuading ethics committees that community is neither a black hole nor nebula for the researcher or the participants.

Appendix Four: Information sheets



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A Case Study of Community Participation In Health Development

INFORMATION SHEET (Community Members)

The study

The need for community involvement in the planning, operation, and governance of community health programmes and primary health care services is accepted nationally and internationally. There are many ways that this community involvement occurs, sometimes organised by health services and sometimes by community groups. In this study I want to explore what that involvement entails for community members involved in the 'Grab a bite that's right' programme organised by the Whanganui Regional Primary Health Organisation. This programme is under the umbrella of the national Ministry of Health *Healthy Eating, Healthy Action Strategy*. There are a number of parts to this programme including the development of community gardens and the planting of a specific type of apple tree, which is reported to contain high levels of beneficial antioxidants. Partners and stakeholders in the programme include marae, community groups, and schools. I am interested in who participates, what they do, and who they may represent.

I will collect information by interviewing community members, stakeholders, community representatives and some community leaders who are interested or involved in this programme. I will also be involved in observing, taking notes and, with permission, audio-taping some meetings about this health programme. I may also ask to spend some time with individuals who are identified as community representatives. This may involve me attending meetings those individuals have with the groups that they represent, if the group agrees. This data collection will occur over a period of about 12 months. The information collected will be developed into a case study of community participation. This will be written into a thesis.

I will ask some individuals if I can interview them about their involvement in the 'Grab a bite that's right' programme. If you are invited to participate in an interview you can choose to discuss this with friends or whānau before making your decision. You will also be able to decide on an interview venue that suits you. The interviews will probably take 30-45 minutes and I may ask to interview you again at a later date. The interview will be audio-recorded with your permission and you will be able to read, edit, and keep a copy of the transcript if you wish. Transcripts of the interview will have personal information that may identify you removed. Instead of using your name I will replace it with a general identifier such as 'community representative'. Research information will be stored in a locked filing cabinet and on pass-word protected computer files. That information will be destroyed after 5 years by a staff member at Massey University.

A Case Study of Community Participation in Health Development,
December 2006

1



The researcher

My name is Lesley Batten and this research is part of my study towards a PhD in Development Studies in the School of People, Environment and Planning at Massey University. I also work part time as a Lecturer in the School of Health Sciences. This research is being supervised by Dr Katharine McKinnon from the Development Studies Programme and by Dr Maureen Holdaway from the Research Centre for Māori Health and Development.

Your rights:

You are under no obligation to be involved in this research. If you decide to participate, you have the right to:

- Request an interpreter
- Decline to answer any particular question
- Ask for the audio-tape to be turned off at any time during an interview / meeting
- Withdraw from the study at any time up until when you have returned a copy of your interview transcript to the researcher
- Ask any questions about the study at any time
- Provide information on the understanding that your name will not be used
- Be given access to a summary of the study findings when the study has finished
- Ask me to leave a meeting

Where can I get more information about this study?

Please feel free to contact the researcher (Lesley Batten) or my supervisors (Katharine McKinnon and Maureen Holdaway) if you have any questions about this study

If you have any queries or concerns regarding your rights as a participant in this study you may wish to contact a Health and Disability Advocate

- Telephone 0800 423 638 (4 ADNET)

Committee approval statement:

This study has received ethical approval from the Central Regional Ethics Committee

Contact Details:

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A Case Study of Community Participation In Health Development

INFORMATION SHEET (WRPHO Staff)

The study

The need for community involvement in the planning, operation, and governance of community health programmes and primary health care services is accepted nationally and internationally. There are many ways that this community involvement occurs, sometimes organised by health services and sometimes by community groups. In this study I want to explore what that involvement entails for community members involved in the 'Grab a bite that's right' programme organised by the Whanganui Regional Primary Health Organisation. This programme is under the umbrella of the national Ministry of Health *Healthy Eating, Healthy Action Strategy*. There are a number of parts to this programme including the development of community gardens and the planting of a specific type of apple tree, which is reported to contain high levels of beneficial antioxidants. Partners and stakeholders in the programme include marae, community groups, and schools. I am interested in who participates, what they do, and who they may represent.

I will collect information by interviewing community members, stakeholders, community representatives and some community leaders who are interested or involved in this programme. I may also ask to spend some time with individuals who are identified as community representatives. This may involve me attending meetings those individuals have with the groups that they represent, if the group agrees. I will also be involved in observing, taking notes and, with permission, audio-taping meetings about this health programme, in which you may be a participant. This data collection will occur over a period of about 12 months. The information collected will be developed into a case study of community participation. This will be written into a thesis.

Any transcripts of community meetings in which you are a participant will have personal information that may identify you removed. Instead of using your name I will replace it with a general identifier such as 'WRPHO Staff'. Research information will be stored in a locked filing cabinet and on pass-word protected computer files. That information will be destroyed after 5 years by a staff member at Massey University.

The researcher

My name is Lesley Batten and this research is part of my study towards a PhD in Development Studies in the School of People, Environment and Planning at Massey University. I also work part time as a Lecturer in the School of Health Sciences. This research is being supervised by Dr Katharine McKinnon from the Development Studies Programme and by Dr Maureen Holdaway from the Research Centre for Māori Health and Development.

Your rights:

You are under no obligation to be involved in this research. If you decide to participate, you have the right to:

- Request an interpreter
- Decline to answer any particular question
- Ask for the audio-tape to be turned off at any time during community meetings
- Ask that your personal responses be removed from a transcript of a community meeting
- Ask any questions about the study at any time
- Provide information on the understanding that your name will not be used
- Be given access to a summary of the study findings when the study has finished
- Ask me to leave a meeting

Where can I get more information about this study?

Please feel free to contact the researcher (Lesley Batten) or my supervisors (Katharine McKinnon and Maureen Holdaway) if you have any questions about this study

If you have any queries or concerns regarding your rights as a participant in this study you may wish to contact a Health and Disability Advocate

- Telephone 0800 423 638 (4 ADNET)

Committee approval statement:

This study has received ethical approval from the Central Regional Ethics Committee

Contact Details:

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Appendix Five: Consent forms



Massey University
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www.massey.ac.nz

A Case Study of Community Participation In Health Development

PARTICIPANT CONSENT FORM (Community Members)

This consent form will be held for a period of five (5) years

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I have had the opportunity to use whānau support or a friend to help me ask questions and to understand the study

I understand that taking part in this study is my choice

I may choose to withdraw from the study at any time up until when I have returned a copy of the interview transcript to the researcher

I understand that the location of this study will be made public but that my involvement in the study will be kept as confidential as possible by the researcher. Pseudonyms or general labels, such as 'community representative' will be used instead of names in any research reports

I agree / do not agree to the interview being audio-taped

I wish / do not wish to receive a summary of the results of the study

I wish to have an interpreter Yes / No

I would like to edit the transcript of my interview Yes / No

I agree to participate in this study under the conditions set out in the Information Sheet

Signature: _____ Date: _____

Full Name – printed: _____

Postal Address (for study results summary / interview transcript):

Researcher's Signature: _____ Date: _____





**A Case Study of Community Participation
In Health Development**

**PARTICIPANT CONSENT FORM
(WRPHO Staff)**

This consent form will be held for a period of five (5) years

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I have had the opportunity to use whānau support or a friend to help me ask questions and to understand the study

I understand that taking part in this study is my choice

I may ask to have my personal responses removed from a transcript of a community meeting

I understand that the location of this study will be made public but that my involvement in the study will be kept as confidential as possible by the researcher. Pseudonyms or general labels, such as 'WRPHO Staff' will be used instead of names in any research reports

I agree / do not agree to community meetings being audio-taped

I wish / do not wish to receive a summary of the results of the study

I wish to have an interpreter Yes / No

I agree to participate in this study under the conditions set out in the Information Sheet

Signature: _____ Date: _____

Full Name – printed: _____

Postal Address (for study results summary):

Researcher's Signature: _____ Date: _____



Appendix Six: Ethics' committee approval



Central Regional Ethics Committee

Ministry of Health
Level 2, 1-3 The Terrace
PO Box 5013
Wellington
Phone (04) 496 2405
Fax (04) 496 2191

14 December 2006

Lesley Batten
School of People, Environment & Planning
Massey University
Private Bag 11 222
Palmerston North

Att: Lesley Batten

Dear Lesley

CEN/06/11/099 - Community perspectives of community participation in primary health care: A case study in New Zealand
Lesley Batten
Whanganui Regional Primary Health Organisation

The above study has been given ethical approval by the **Central Regional Ethics Committee**.

Accreditation

The Committee involved in the approval of this study is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, April 2006.

Progress Reports

The study is approved until **December 2008**. The Committee will review the approved application annually and notify the Principal Investigator if it withdraws approval. It is the Principal Investigator's responsibility to forward a progress report covering all sites prior to ethical review of the project in **December 2007**. The report form is available on <http://www.newhealth.govt.nz/ethicscommittees>. Please note that failure to provide a progress report may result in the withdrawal of ethical approval. A final report is also required at the conclusion of the study.

Amendments

It is also a condition of approval that the Committee is advised of any adverse events, if the study does not commence, or the study is altered in any way, including all documentation eg advertisements, letters to prospective participants.

Please quote the above ethics committee reference number in all correspondence.

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

Yours sincerely

A handwritten signature in blue ink, appearing to read 'Claire Yendoll'.

Claire Yendoll
Central Ethics Committee Administrator

Email: claire_yendoll@moh.govt.nz

Appendix Seven: Community gardens literature

Table 17 Literature review related to community and communal gardens

Theme of literature	Examples – place and Author (s)	Key issues identified
<i>Illustrations of different types of community gardens or communal gardens for different groups</i>		
<i>Allotment gardens</i>	The Netherlands (Groenewegen et al., 2006)	Research underway examining the links between green space (vitamin G) and health, well being and social safety.
<i>School based gardens</i>	Las Vegas, Nevada (O'Callaghan, 2005)	Identified the need to link closely to school curriculum, reliant on teachers/principal support. School gardens developed for many reasons related to education, conservation but not nutrition.
	Australia (Alexander, 2006)	Full description of the establishment of school gardens and associated kitchen activities.
<i>Gardens for ethnic groups</i>	Aotearoa New Zealand (Finnis, 2004; MOH, 2005d)	Pasifika families – this programme is described by a number of authors.
	New York (Saldivar-Tanaka & Krasny, 2004)	Latino migrants.
<i>Low income neighbourhood gardens</i>	New York City (Schmelzkopf, 1995, 2002)	Community gardens part of a community gardening movement. Many different types of gardens described. Ongoing tensions about the right to land/space in urban environments. Also, tensions between gardeners are identified.
<i>Gardens for women</i>	Mali (Ward et al., 2004)	Advantages and disadvantages for women involved in community gardens. A major issue was the opportunity cost - women who gardened could not also be involved in other programmes such as those aimed at literacy.
<i>Gardens specifically linked to health programmes</i>	Aotearoa New Zealand (Finnis, 2004; MOH, 2005d)	Provides example of Pasifika Healthcare's gardening projects. Begun in Pacifica early childhood centres, extended to backyard gardens and then to community gardens.
	Australia (Hunter, 2006)	Department of Health programme in South Australia.

Theme of literature	Examples - Author, reference and place	Key issues identified
	USA (Twiss et al., 2003)	Associated with California Healthy Cities and Communities initiatives. Research findings included increased levels of physical activity and school students beginning gardening at home after participating in school programmes.
<i>Gardening for older adults</i>	(Bhatti, 2006)	Issues of communal garden spaces for older people and in residential settings.
<i>Community gardens development guides</i>		
<i>School based gardens</i>	Australia (Alexander, 2006)	Full description of how to establish a school based garden and kitchen.
<i>Top-down or bottom-up garden development</i>	Australia (Grayson & Campbell, n.d.)	Comprehensive overview of how to start community gardens either using a top-down approach or a community-driven approach.
<i>Council guidelines</i>	Auckland, Aotearoa New Zealand (Auckland City Council, 2002)	City council policy on the establishment of community gardens
<i>Reported / proposed benefits of community gardens</i>		
<i>Community capital</i>	Canada (T. Hancock, 2001)	Argues community gardens able to support the development of social, ecological, human and economic capital, combined as community capital.
<i>Health benefits</i>	Toronto (Wakefield et al., 2007)	Research findings included perceived positive health effects of community gardening including improved nutrition, access to food, mental health and increased physical activity.
	New York (Armstrong, 2000)	Motivations for community gardening included: better tasting food; organic food; exercise; mental health; good family activity; traditional cultural practice; enjoying nature.
<i>Quality of life</i>	USA (Waliczek, Mattson, & Zajicek, 1996)	A nationwide survey. Community gardens of more significance for some ethnic groups and women placed higher importance on garden aesthetics and cost saving.
<i>Community building</i>	Canada (Glover et al., 2005)	Community gardens as sites for resource mobilisation, civil action – less about gardening, more about community building.
	San Francisco Bay (Pudup, 2008, p. 1228)	Analyses how organised garden projects are linked with "... individual, social and spatial transformation."

Theme of literature	Examples - Author, reference and place	Key issues identified
<i>Ethnic group interactions</i>	USA (Shinew, Glover, & Parry, 2004)	Research investigating race and its relationship to community gardening. Identified that different ethnic groups place different priorities on food provision from community gardens.
<i>Community development</i>	New York (Saldivar-Tanaka & Krasny, 2004)	Research examined the role of Latino community gardens in community development. Land tenure was important as was the opportunity to grow ethnic foods.
<i>Sustainable social development</i>	USA (Ferris et al., 2001)	Identifies an overlapping typology of community gardens including those for leisure, child and school, crime diversion/work and training, healing and therapy, neighbourhood pocket parks, ecological restoration and demonstration gardens.
	United Kingdom (Holland, 2004)	Identifies multiple types of community gardens. Food provision ranked 6 th as the purpose of gardens, with education, community development and leisure being ranked in 1 st and 2 nd equal places. Argues that sense of community was a strong feature for all gardens.
	Montreal (Bouvier-Daclon & Senecal, 2001)	Research findings suggest superficial social interaction in the community gardens, even though there were frequent exchanges of advice, plants and seeds amongst gardeners.
<i>Evaluations/ outcomes of community gardens</i>		
<i>Descriptive evaluation</i>	Australia (Grayson & Campbell, 2000)	Uses an evaluation framework of impact, efficiency, effectiveness, progress and sustainability. Key recommendations include starting small and employing garden coordinators.
<i>Comprehensive evaluation</i>	Australia (Hunter, 2006)	A second phase evaluation with a focus on the links between school and community gardens and employment schemes.
	Solomon Islands (Terracircle Association Inc, 2004)	Effects of different ethnic group's traditions of family versus shared gardens.

Theme of literature	Examples - Author, reference and place	Key issues identified
	Australia (Urbis Keys Young, 2004)	An extensive evaluation of a 'Community Greening' programme. Programme objectives included reduction in crime and antisocial behavior, improving health and community resilience, improving educational and employment opportunities and improving agency coordination and information sharing.
<i>Fruit and vegetable intake</i>	Michigan (Alaimo, Packnett, Miles, & Kruger, 2008)	Fruit and vegetable intake increased for urban adults where the household participated in a community garden.
<i>Community gardens identified as an appropriate nutrition intervention</i>		
<i>Local level intervention</i>	Aotearoa New Zealand (MOH & University of Otago, 2003)	Identified as a potential strategy to improve nutrition.
	United Nations (Moron, 2006)	Linked with food security

Appendix Eight: Glossary of Māori words

<i>Aotearoa</i>	New Zealand
<i>Hangi</i>	Earth oven
<i>Hapu</i>	Sub-tribe; clan
<i>Hauora</i>	Health
<i>He korowai oranga</i>	The Māori Health Strategy – can be translated as ‘a cloak of health’
<i>Iwi</i>	Tribe
<i>Kaumātua</i>	Elder; older man
<i>Kaupapa Māori</i>	Māori philosophy
<i>Koha</i>	Donation, gift
<i>Kura</i>	Māori medium school
<i>Māori</i>	Indigenous peoples of the land
<i>Marae</i>	Meeting area of whānau or iwi
<i>Mauriora</i>	Access to a secure cultural identity*
<i>Nga manukura</i>	Leadership*
<i>Pākehā</i>	Non-Māori (usually of European descent)
<i>Tangata whenua</i>	Māori people; people of the land
<i>Te kōhanga reo</i>	Māori medium preschool education centre (literally ‘language nest’)
<i>Te mana whakahaere</i>	Autonomy*
<i>Te oranga</i>	Participation in society*
<i>Te pae mahutonga</i>	A model for Māori health promotion*
<i>Te reo</i>	The language (Māori)
<i>Te whare tapa wha</i>	A Maori model of health described by Durie (1985)
<i>Tikanga</i>	Custom; meaning
<i>Tino rangatiratanga</i>	Absolute sovereignty
<i>Toiora</i>	Healthy lifestyles*
<i>Waiata</i>	Song; psalm
<i>Waiora</i>	Environmental protection*
<i>Whānau</i>	Extended family
<i>Whenua</i>	Ground; country; land

Unless otherwise identified the translations were adapted from *The Reed dictionary of modern Māori* (Ryan, 1997).

* As defined and described by Durie (1999)

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