Building Synergies, Building Bridges: the growth of PHM Scotland

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Context

PHM Scotland was founded as a result of discussions at the first UK People's Health Assembly held in Nottingham in 2012 as part of ongoing mobilising around a UK PHM. Because health governance is partially devolved to the nations that make up the UK, and because of recent political developments in Scotland (the 2014 Independence referendum and an increasing number of devolved powers planned for 2016 and beyond), it was felt that different conversations about how health could be improved in Scotland were likely, and indeed necessary. These political developments served as useful vantage points for mobilising local communities and the third sector around a critique of the existing policy climate and towards a fairer and healthier vision of Scotland.

Scotland is one of the nations within the United Kingdom that is partly administered through powers reserved to the UK parliament and partly through the Scottish parliament (devolved since 1999), to which the UK parliament devolves selected powers. Which powers are devolved is not a settled question, and thus forms part of the political debate within which PHM must find a space.

So the question of which administration to focus on for solutions can be a complex one. Health and social services, and policies that are identifiably "public health" (and environment) are devolved to the Scottish administration, but other relevant powers are not. Among those are occupational health and safety provisions, along with many not generally considered to be "health" such as: living wage, many areas of welfare, employment conditions and industrial democracy, most (non-income) tax powers. This geo-political context demands that our analysis of the politics of health is informed by a robust understanding of health issues and policy climate in Scotland (and similarly England, Wales and N. Ireland). Such understanding was deemed essential for organising locally to develop a programme of action that could feed into UK-level organising and action and inform change at local, national and regional levels.

Description of the experience

The first UK People's Health Assembly in July 2012 was crucial to the development of PHM Scotland and PHM UK. Not only did the Assembly bring together individuals, third sector groups and networks from across the UK to resist regressive policy shifts and organise around an alternative vision to health, but it also helped generate a consensus that such vision must be firmly grounded in a region- and context-specific understanding of key threats and people's lived experiences. Following the assembly, participants from Scotland were inspired to form a Scottish arm of the PHM, led by Anuj Kapilashrami. An approach combining action research with capacity-building and public health advocacy was implemented:

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- Third sector health organisations were invited to brainstorm key health issues and generate consensus on a people's movement for health equity
- A participatory action research undertaken by Dr. Kapilashrami helped gain an experiential understanding of the health effects of austerity, and identify local priorities. It involved: consultations with 14 health and community initiatives; public meetings and drop-in story-telling sessions; focus groups with black and minority ethnic women; and participation in community events.

As the research progressed, communities of inquiry and action evolved to address issues significant for those participating, and eventually culminated in the 2nd UK People's Health Assembly held in May 2014 in Musselburgh, Scotland. It attracted 120 participants from across the UK, representing 32 third sector organisations, including some longstanding groups advocating for improvements in health (health activists, environmentalists, carers, trade union health and safety representatives), 10 academic institutions and various representatives from across the National Health Service. On the basis of their shared analyses of the current situation, notably the health effects of poverty and austerity-led changes taking place in the UK and in Europe which were articulated through powerful personal narratives, participants at the Assembly called for the development of concrete proposals for collective action based on the vision of social justice and health [PHM UK 2014; Medact 2014]. Crucial links were made with international PHM chapters (India, Nicaragua/ Argentina, Australia, South Africa) at the assembly to learn from experiences of campaigns and action strategies utilised in these diverse contexts.

A steering group for PHM Scotland was formed with representation from community-based organisations, academia, and advocacy groups. The group facilitated a participatory process to enable the development of a Scottish people's health manifesto (the idea of which stemmed from the experience of PHM India as well as brainstorming on strategies in the UK Steering group meetings). The process involved:

- Distilling key action points and demands from the Assembly discussions, participatory action research and an open call issued to Assembly participants and wider networks requesting suggestions for further health proposals/demands.
- Grouping demands under broad themes for inclusion in an online survey, circulated to the PHM mailing lists (200+ members) and their networks, which sought to collectively identify and prioritize demands with greatest support.
- Informing the manifesto (and its several iterations) with feedback received via the survey and public consultation events (in Edinburgh & Glasgow) that helped clarify demands and action points, leading to the current version of the manifesto (adopted in March 2016).

A particular strength of this process was its ability to capture perspectives of communities of place and people representing diverse sectors with shared interests. This ensured that each proposal was underpinned by both empirical research and community support, suggesting it is possible to combine public health's traditional, evidence-focused approach to policy with more deliberative and democratic approaches. As described in more detail elsewhere (see Kapilashrami et al. 2015) the participatory process revealed observable differences between the prioritisation generated via the

online survey (completed largely by academics and policy advocates) and the action research that engaged socioeconomically and politically disadvantaged communities. The former focused primarily on economic, political and commercial ('upstream') determinants of health while the latter generated a mix of policy reforms targeting specific groups (e.g. comprehensive rehabilitation and recovery programs for drug users) and demands to improve the accessibility of public services (e.g. combating abuse and stigma attached to people in difficult circumstances or socially excluded groups including ethnic minorities and people without documents; increasing the availability and quality of mental health services; comprehensive equality training to front-line providers to deliver culturally appropriate and sensitive care). These differences, which prompted us to continually revisit the manifesto, emphasise the importance of foregrounding inclusive processes and on-going dialogue with diverse communities in effective movement building efforts that aim to transcend academia-practice-activism divides.

Priorities and analysis generated through the above process has been used to inform other policy dialogues at local and national levels. For example, we submitted our views and demands on the future of devolution and Scotland's health post-referendum to the Smith Commission[2]. More recently, following the Scottish elections in May 2016 we published commentaries on political party manifestos highlighting gaps in their commitment to address health and health inequalities (Robertson et al. 2016; Kapilashrami et al. 2016). We facilitated sessions on health inequalities at the Scottish Green Party conferences for two consecutive years, and led dialogue with representatives of other political parties (SNP, Labour). Building on the learning acquired through organising locally, and drawing on synergies built with other campaign groups, PHM Scotland & PHM UK led an assessment of the UK government's progress in achieving the right to health and submitted two shadow reports to the UN Committee on Eco Socio and Cultural rights jointly with the Politics of Health Group and the Just Fair alliance.

Reflections and challenges in movement building

Whilst there are certainly individuals involved in this process, PHM Scotland appears to be succeeding in part by finding common ground with other established networks and organisations and building bridges between and amongst them. There is a willingness, or even an enthusiasm, for people from varying organisational and socio-economic backgrounds to adapt to one another's needs and agendas to work together and to draw in people from the other networks they belong to. An example of this is how a sister organisation, the Politics of Health Group, has subsumed its activities in Scotland within the PHM process described here.

The objective of forming a broad-base alliance on the right to health underpinned early mobilisation strategies. Since the Edinburgh assembly, a mix of health advocates, activists, academics, health and social service managers and practitioners, and (perhaps to a lesser extent) policy-makers interested in social, political, economic and commercial determinants of health have been engaged in identifying a common cause and collaborating to build a movement and advocate for change. Members of the steering group of PHM Scotland bring particular strengths and expertise (on issues,

2 Smith Commission was set up in September 2014 in the wake of a 'NO' vote in Scottish Independence Referendum to take forward the devolution commitments on further powers for the Scottish parliament.

links with particular networks and political parties and processes) that strengthen mechanisms of outreach and advocacy.

The passion for improved population health amongst PHM participants is, of course, a strong uniting force, and the manifesto process was key, as already discussed, to capitalising on this and building understanding between people with a wide range of perspectives and experiences of public and population health. However, efforts to bridge divides and work across sectors (via public dialogues and health assemblies) revealed the absence of a unifying language across these constituencies. For example, a public event to generate awareness on the extent of health inequalities must be able to translate research and policy issues and generate analysis in non-academic language. This was a useful learning in the initial stages of mobilisation that was addressed, to some extent, via i) effective linkages with community-based groups that are crucial in such alliance, and in facilitating public events; and ii) using participatory methods in such public meetings.

Those who have become active in PHM Scotland have often adapted their pattern of work to some extent, and some have taken on additional roles as a result. The role of academics has perhaps been notable in this context, operating as hybrid 'academic activists'. With central involvement of academics (committed to the global PHM since its inception) in the early growth of PHM Scotland, it is likely that this ability to morph roles has been key to catalysing the movement. Yet, there are threats that limit transformative possibilities.

The academic 'culture' in the UK requires that the researchers strive for objectivity, continually reflecting on their research practice to manage subjective perspectives. Furthermore, the academy is faced with tremendous pressures of greater job insecurity and constant demands for demonstrable results. In this context, public engagement is often viewed as means to an end, i.e. a pathway to achieve impact of the research carried out, not an end itself. Efforts to build a social movement for health equity stands in stark contrast with this approach, thus posing tensions between institutional demands and reform objectives of movements; between public health research and advocacy/ activism. Notwithstanding these challenges, there are growing calls that public health researchers become more involved in politics and advocacy; opportunities and implications of which, we have reflected elsewhere (Kapilashrami et al. 2015).

Roll out of austerity offers a significant threat to movement building. The austerity plans of recent UK governments following the economic recession have not only threatened the health of the nation but also fragmented social cohesion, with the community and voluntary sector facing some of the worst impacts. While this underscores the imperative for solidarity movements, such weakening of the third sector poses challenges for movement building. Community groups involved in PHM Scotland are working in contexts of entrenched deprivation; with the roll out of austerity they are faced with cuts in their programmes and salaries and retrenchment of staff, at a time when the demand is growing.

Relevance for the movement (Learnings from the Scottish context)

While the strength of PHM lies in extending/informing policy discourses with a strong political

economy analysis of health, such analysis needs a firm grounding in people's perspectives and experiences. PHM Scotland thus follows a two-pronged strategy in movement building: i) informing policy and public discourses on health with strong political economy analysis; and ii) making people's voices central in such discourses. To this end, a participatory process is vital, and one that:

- Provides a context and space to build understanding and networks between a very wide variety of people and perspectives on public health;
- Does not shy away from lived realities, indeed incorporates them into a research, evidence and advocacy agenda;
- Builds democratic legitimacy, both to build common cause (where inevitably there will be some disagreement on content), and to be persuasive for government decision-makers.

As part of a small study to consolidate past learning and develop future strategy, we interviewed several people both involved in PHM Scotland and who had come into contact with it. The strongest feedback was undoubtedly around building networks, breaking down barriers and building really constructive links and working relations across these (previous) divides. The increasing quality of links between academics and health/community practitioners was particularly valued by both groups. Those involved in the steering group all reported having had their thinking challenged and stretched by the encounter with people with similar values but with very different perspectives and experience.

Looking more outwards, all felt the manifesto and the process of its development served as a concrete vehicle for improved public engagement in the policy-making process. It is a model that others are considering replicating outside Scotland. Several too noted the value of engaging with political parties to help raise the overarching health narrative – as opposed to "ill-health" narrative common in political discourse. Recent commentaries led by few PHM members have made progress in establishing this alternative health paradigm, and bringing to light the commercial determinants of health.

To continue to work, in our experience, local PHMs need:

- A range of perspectives in any central steering group with a willingness to adapt to one another's perspectives;
- A focus on building links and collaborations with other organisations addressing health, democratic accountability including corporate accountability, corporate power, poverty, discrimination;
- Timely action to make use of advocacy windows: For example, national and local government elections.

It is only by embracing participative, inclusive and deliberative processes and principles of solidarity, that an active and vibrant health movement can be created in Scotland and the UK, with connections to our international friends. We believe a democratic and engaged movement of individuals and organisations passionate about health and social justice can allow a forum for progressive ideas, skills-sharing, cooperation among already effective groups and organisations and

above all for the political momentum to achieve success through the parliamentary process. By bringing together progressive organisations actively tackling the social determinants of health we believe we can strengthen this movement with the expertise, support and credibility for success; offering a strong countervailing force to the current neoliberal agenda.

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