INTRODUCTION

Those involved in partnerships between public sector authorities and the communities they serve find the work stimulating and challenging. This is despite the many barriers to joint working described in research and practice literature, which reportedly result in frustration and often disappointment (Goumans and Springett, 1997; Ranade, 1998; Green, 2000). Many barriers result from power imbalances between the statutory authorities (Balloch and Taylor, 2001) who generally initiate and therefore dominate the partnerships, and communities, who often join the partnership in the interest of, and therefore invitation of, statutory authorities (Ward, 2000). Despite widespread recognition of the barriers, general enthusiasm for establishing partnerships across sectors does not seem to have diminished: indeed more and more are being established, at national and local levels, as logical, multi-sectoral solutions to complex problems. Amongst the earliest health promotion partnerships was the World Health Organization (WHO) Healthy Cities Project, initiated by the European Regional Office of the WHO in 1987 (Kickbusch, 1989). Through this programme, health promoters were actively invited to tackle the determinants of health through an inter-sectoral approach, working closely with politicians and communities towards radical, social change (Tsouros, 1990). From the outset, the challenge to the domination

**SUMMARY**

Partnerships between local governments, health districts and non-governmental and community-based organizations are an increasingly important part of health promotion practice, as well as other policy and programme areas. Two inherent tensions in partnership working have been widely described. First, partnerships are generally set up as ‘top down’ initiatives, which advocate a ‘bottom up’ approach, with the inevitable power imbalances that this implies. Secondly, the gains made by partnerships tend to be limited compared with the claims made for them. Despite these tensions, individuals and organizations continue to devote considerable effort to making partnerships ‘work’. This paper describes a study, which explored the implications of these apparent contradictions of power imbalance and potential disillusionment within partnerships. The study explored partnership working between community and statutory organizations within two very different Healthy Cities initiatives, one in the UK and the other in South Africa. This paper focuses on why the partners contributed continued effort and energy into maintaining the partnerships, despite their awareness of the constraints. Findings suggest that partners dealt with the tensions first by assuming a discrete identity as an ‘entity of boundary people’ that operates at the interface between the statutory sector authorities and the communities in question; and secondly, by reducing their activities to specific ‘boundary’ issues that do not threaten the main agenda of the authorities.

**Key words:** community participation; partnerships; power imbalance

**Boundary workers and the management of frustration: a case study of two Healthy City partnerships**

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of power by the authorities was noted. As Tsouros, the coordinator of the European Project, argued:

... in this new approach ... health advocates have to learn to share power with people rather than wield power over people. [(Tsouros, 1990), p. 19]

However, much research suggests progress has been largely incremental or marginal, rather than the radical changes that had been hoped for (Goumans and Springett, 1997; Pickin et al., 2002). European studies suggest that traditional divisions and power relationships between the sectors have been maintained (Berkeley, 1998; Ziglio et al., 2000), and that most partnerships tend to function at an operational rather than a structural level (Goumans and Springett, 1997; Gillies, 1998), resulting in a failure to achieve desired policy and infrastructure changes (de Leeuw et al., 1998). Evaluations in developing countries have shown a similar pattern, with Harpham et al. (Harpham et al., 2001), for instance, concluding that Healthy Cities Projects were determined by the municipal programmes rather than changing them. Healthy Cities partnerships are not unique in failing to deliver anticipated gains. Balloch and Taylor (Balloch and Taylor, 2001), drawing on a range of UK studies covering health, social care and urban regeneration partnerships, argue that the difficulties have been underplayed, both in practice and in the literature, and that communities, lacking the capacity to respond to the requirements of the partnership, are often 'set up to fail'.

**Healthy Cities as partnerships**

Partnerships in general can be seen as a specific form of social governance that came to the fore in the context of post-neoliberal attempts to embrace inclusivity and pluralism in planning and delivery (Larner and Craig, 2002). It has been suggested that it is impossible, in descriptive or theoretical terms, to distinguish ‘partnerships’ from other forms of inter-organizational work (Geddes and Bennington, 2001), and indeed a number of terms are used in the literature rather loosely, including ‘intersectoral collaboration’, ‘coalitions’, ‘coordination’, and ‘interagency working’ amongst others (Taket and White, 2000; Balloch and Taylor, 2001; Glendinning, 2002). Despite the difficulties in conceptually delineating the features of ‘partnership’, a programme that has a high level of commitment, mutual trust, equal ownership, and the achievement of a common goal (Costongs and Springett, 1997; Taket and White, 2000) is perhaps a workable pragmatic definition, in contrast to ‘networks’, which might, in contrast, involve sharing information or other resources, but not for the explicit purposes of joint working (Taket and White, 2000). If difficult to delineate theoretically, particular features of ‘partnership’ are certainly embedded in participants’ expectations. Healthy Cities, in particular, involve expectations of high levels of commitment and involvement from partners: indeed, there is an emphasis on evaluating process indicators for Healthy Cities initiatives (Werna and Harpham, 1995). Given these expectations, it is perhaps not surprising there have long been uncertainties about how far the WHO Healthy Cities Project can live up to its radical aspirations. Farrant (Farrant, 1991), for example, noted that its ‘atheoretical pragmatism’ could lead to the misappropriation of the radical concepts by those in positions of power and Baum suggested the advantages of the malleability of the approach for those in control (Baum, 1993):

[The] eagerness to sell the concept has led to a tendency to see Healthy Cities as anything the customer wants (radical social movement to a useful inter-department committee for instance) so long as they call it ‘Healthy Cities’. [(Baum 1993), p. 32]

There are, theoretically, tensions inherent in the very idea of partnerships as a form of governance. Community organizations are recruited into the machinery of social governance in collaboration with traditional statutory organizations that continue, as Larner and Craig put it, to be ‘organized in strongly ‘siloed’ ways inherited from welfarism’ (Larner and Craig, 2002). The Healthy Cities approach elides the mismatch between the ‘post-modern’ notion of ‘partnership’ (Kelly et al., 1993; Petersen and Lupton, 1996) and ‘silo’ structure of contributing organizations. Statutory authorities remain structured in bureaucratic patterns, characterized by self-interest, inflexibility and resistance to change, and are typified by hierarchical structures and distinct boundaries (Considine, 1994; Harpham and Boateng, 1997; Pickin et al., 2002). Managing structural tensions at the interface between flexible, collaborative partnerships and the organizational structures of statutory partners entails considerable ‘boundary work’. There is a growing literature on the content...
of this work, focusing in recent years on the kinds of individual skills as well as the structural and other resources required. Williams, for instance, using the term ‘boundary spanner’, draws on the extensive literature and his own empirical research to emphasize the range of expertise needed for individuals in this role, including skills in network managing, personal communication, brokering and policy entrepreneurship (Williams, 2002). Craig, referring to ‘strategic brokers’, notes that the heavy demands of this kind of boundary work are increasingly becoming core to the tasks of many in both community and statutory organizations, although the burden often falls heavily on under-resourced community workers (Craig, 2004).

In summary, then, partnership development is prioritized in the context of contemporary social governance, but empirical studies suggest their rather limited potential for change. In the context of tensions between the orientations of partnership working and the traditional structures of statutory organizations, the work of those at the boundary has come increasingly into focus. This raises a number of interesting questions around the motivations of those involved. At first sight there is little incentive for contributing energy and effort into partnerships that are unlikely to achieve major policy gains. Yet the practice contradicts this assumption. Are those involved, then, suffering from naivety, or an excess of optimism that their partnership is likely to avoid the tensions widely described in the literature? How do those working at the interface cope with possibility of disillusionment, given the limited potential? This paper aims to explore this paradox. Of particular interest are the tensions that arise from a ‘top down’ initiation of what aims to be a ‘bottom up’ approach; and, given this tension, the reasons for the continued commitment to the partnerships, particularly by those who work across the boundary.

METHODS

A case study approach was used to follow two Healthy Cities projects, one in the UK and one in South Africa, for 1 year and 6 months, respectively. The two cities were very different—one being in a developed country and one in a middle income country. (South Africa is technically a middle income country, but a substantial proportion of the population live in developing country conditions.) In both sites one author (R.S.) used ethnographic methods to analyse the development and progress of the initiatives, from their onset up to and including the time of the study. Multiple methods were used for data collection, including formal in-depth interviews with each respondent; informal field interviews with respondents and people from the partner organizations; participant observation of meetings and events; and documentary analysis, which included publications, notes of meetings and policy documents. A total of 51 people, all active in the Healthy Cities programmes, were interviewed in the study: 29 in the UK site and 22 in South Africa. [Respondents were elected councillors, senior managers and mid-level officers from the Health, Social Services, Planning and Community Development Departments of the health and local government sectors; coordinators of related partnerships (Older People’s Network, Local Agenda 21, Community Safety); community workers based in voluntary sector/non-governmental organizations, academics from local universities and research institutes, and representatives from the community. The broad categories were the same in both countries, although the structure of involvement differed according to the local contexts.]

It is important to note that this was not a comparative study. All Healthy Cities projects (and other partnerships) are developed in particular local political and historical contexts, and it would not be appropriate or methodologically feasible to compare the cities: two were included to aid generalization, and to offset the risk of focusing on issues that were purely local concerns.

RESULTS

Activities and constraints

The two study sites were typical of partnerships described in the literature in several respects. First, those involved had a high level of commitment, and expended considerable energy to make the partnerships work. This was borne out by the intensity of activity described, read about and observed. The diary of one unpaid community representative, an older person, is illustrative. During a 4-week period, she attended 18 meetings, planned and participated in a health promotion event, attended two rehearsals for a drama group, and was interviewed on the radio.
All these activities were directly related to the partnership programme. For paid officers, the level of activity was just as challenging, with many reporting a heavy burden of meetings, working groups or committees to attend:

I think I will be on both [groups] … I have the network group every two months, the strategy group every three months, then I get roped into going to other meetings, which means it is very hard to do the work. (Coordinator)

These facilitation and coordination activities resulted in considerable duplication of effort, with increasing demands spread amongst a limited number of people.

Secondly, these partners reported barriers to progress that were typical of the wider literature. Statutory authorities’ representatives, for instance, recognized the bureaucratic divisions within their organizations, described explicitly in South Africa as ‘silos’, and community representatives referred to the ‘bureaucratic’ and slow processes of the authorities:

We were still very much in our silos … everybody is still focusing on their own business plan, meeting key performance indicators, and it is really focused on that … People don’t want to hand over an initiative they are running in their particular directorates, for fear of losing their credibility, or [not] being able to say ‘this is my project’. (Senior manager)

[The council] has all this red tape and processes to follow … eventually when it reaches the man at the very top, I’m sure the message is somehow different and he doesn’t really understand the importance of it. (Community representative)

Community frustrations were intensified by a perceived lack of genuine commitment by the authorities. Councillors and senior managers were described as being supportive of the concept of partnership working, but not the practice. There was certainly empirical evidence from observations to support this perception, with managers observed at partnership forums arriving late and leaving early, often then to be seen outside the meeting ‘networking’ with colleagues on more general authority business.

Thirdly, the level of mistrust between the sectors was also perhaps typical. This was not unexpected, particularly in South Africa, given the historical context of apartheid. Community concerns included ‘tokenistic’ inclusion of communities to comply with policy directives, and the failure of the authorities to respond to their input, resulting in a belief that the authorities had their own agenda, regardless of the wishes of the community. One community worker expressed the frustration described by many:

… you have turned up at the wrong meeting, and you should go to the ‘x’ committee next month. Except no-one knows when or where the ‘x’ meetings are because it is public information that is not public, that is kept in an office somewhere. (Community worker)

More unexpected, though, was the overt criticism by professionals of each others’ sectors and departments, including the way that partnership priorities would be overridden if self-interest came into play. One local government officer, describing a joint planning exercise, admitted the limited commitment to collaboration:

We would forget consultation and we would forget our partners in health or anyone else … because of the costs, the benefits. (Senior manager)

The dominance of the authorities

Two examples illustrate how the dominance of the statutory authorities was manifest in the organization of the partnerships. First was the concept of ‘representation’. From the authorities’ perspectives, community involvement was about providing a ‘representative’ voice of the community, to enhance the authorities’ understanding of the communities’ needs, and to assist in their decision making processes. As a result, representatives were sought that reflected the demographic profile of the community, with a specific focus on representation from the different minority groups. This requirement, however, did not consider accountability back to the community, a far more important criterion of representation for community representatives.

We didn’t want to say we are a microcosm of older people in the city … so right from the start we were keen to be linked to community groups, to older people’s groups in all parts of the city. (Community representative)

Authority representatives, in contrast, were not subjected to the same scrutiny, being automatically considered eligible by virtue of their professional standing, despite some admitting to neither experience nor understanding of the communities that they were working with.

The second manifestation lay in expectations about how community representatives would
function once part of the partnerships. Interestingly, both the authority and community participants assumed that communities would have to adapt, and adopt the norms of the authorities. This included complying with the authorities’ procedures; learning their language (the ‘jargon’) and attending meetings at the convenience of officials.

What is needed is … a better understanding of how we operate … so that [the communities] know when their contribution is going to be vital, they will speak properly, know how the meeting is run, know the appropriate ways of doing things. (Councillor)

In other words, their effectiveness relied on how well they internalized and replicated the culture of the authorities. To facilitate this, the authorities encouraged or arranged support and training for communities, to provide them with information and to develop their self-confidence. This was acknowledged by the communities as being useful, in providing them with additional information and skills in the ‘rules of the game’ that increased their effectiveness in negotiations. However, it had the potential for distancing community representatives from their constituencies, and of compromising their integrity in the process.

Inevitably, there were differences in the motivation for involvement, and hence priorities for action:

I think for the communities it is often about how they experience life there. For the council it is often from the perspectives of statistics and those details. (Coordinator)

Community representatives were, predictably, primarily concerned with issues directly relevant to their communities’ daily lives: their priorities were predominantly about material changes. Authority representatives generally participated as part of their role, either their political function in the case of councillors, or their job in the case of officers. At a personal level, their main concern was future career prospects, and their accountability was, inevitably, to their organization. At a strategic level, as many admitted, priorities were generally determined by macro professional, organizational or political contexts:

You know at the end of the day, what counts is what comes down from the Secretary of State, not what people say. (Senior manager)

These disparities are not surprising. As ‘top-down’ initiatives, it was inevitable that there would be a power imbalance within Healthy Cities, with statutory authority dominance. Indeed, all members of the partnerships in this study reported acute awareness of the contradictions that they were working under. As one coordinator explained:

If the community infrastructure you are building has its expectation that it will now have a definite influence on the institutions, while the institutions basically want to carry on as normal … then you have a real problem, and that is the tension that is always kinda there. (Coordinator)

Yet, in their pragmatic, everyday work, people behaved as if these contradictions did not exist. Indeed, a rhetoric of optimism, about both the potential for specific achievements, and the notion of partnership working in general, was the overall tone of the interviews and meetings in both cities:

I think everybody has got the same objective … at the end of the day I am still very hopeful that we can continue to strengthen our relationship. (Senior manager)

This is potentially a rather precarious working position, and it does raise a question about how those working at this boundary manage its inherent tensions.

Rationales for continuing: ‘a foot in the door’ and ‘gatekeepers at the door’

Given these tensions, well described in the literature and widely acknowledged by participants in this study, what was the ‘added value’ that kept both communities and authorities involved in the partnerships? A striking observation of the partnerships in both cities was the way they appeared to cooperate despite these difficulties. They had developed a good understanding of each other’s roles and requirements, and as part of this awareness, had modified their demands from what was desired to what was feasible. This acceptance did not represent a loss of identity. Rather it created a new one:

I don’t belong to any sector, I belong to all of them.... (Coordinator)

The individuals participating as partners had assumed a distinct role of ‘boundary people’ at the interface between the authorities and the communities, as part of a new partnership.
‘entity’, and as an entity, they were keen to bridge the gaps between the different perspectives and to find common ground:

The more you are involved, the more opportunity you have to see where things should relate together.…

(Community representative)

This meant that they were able to develop and achieve a shared vision, shared goals, shared objectives and a shared approach, at least at the boundary itself, even though these represented (and were recognized as representing) compromises. Furthermore, the partners displayed considerable mutual respect in the process: the references to each other were generally positive and constructive, which was interesting given the general mistrust between partner organizations, referred to earlier. Much of the ‘work’ of the partnerships was the development of this cohesion.

Accommodation to the ‘entity’ norm inevitably differed for the sectors, reflecting their motivation for involvement and the level of control they had within the partnership. For the community representatives, involvement represented a ‘foot in the door’ of the decision-making processes of the authorities. Whilst they did not lose their concern for real change, they recognized the value of improved dialogue as an incremental step:

So at the end of the day, people can say … I’m still waiting on a house, but at least they have started on x, y and z. (Community representative)

This incrementalism was not seen as a weakness, but rather a strategy for longer term achievement, providing an opportunity that they did not have as ‘outsiders’. As one community representative put it:

… Even if we don’t have the outcome we wanted, we have a process. (Community representative)

Through their involvement in the partnerships, those from authorities reported a growing commitment to making the ‘rhetoric’ of community participation a reality. However, this came with continued, and perhaps inevitable, domination. As their primary responsibility was the protection of the interests of their organizations, their contribution to the boundary work was as ‘gatekeepers at the door’, endeavouring to maintain the agendas of the partnership within the limits of the authorities’ policy frameworks. As one manager admitted:

The idea was to put issues on the table and then hopefully [the communities] would be saying those are the issues we must take forward for the project. (Senior manager)

This position, not surprisingly, led to a conflict of interest for the authority representatives, for as well as maintaining the interest of the authorities, they were also endeavouring to satisfy the agenda of the partnerships. One way of resolving this dilemma was by steering the partnerships towards marginal, process oriented, short-term interventions: and whilst these may have been more limited in scope, they had the potential for demonstrable success. Examples from the study included a community-based survey to assess need rather than adopting the authority priority in South Africa, and a revised, community-led process for consultation in the UK.

DISCUSSION

In the context of the gap between aspirations and practical achievements of Healthy Cities projects, we explored how the inevitable tensions of working in partnership were managed by those involved. We suggest that the burden for those ‘boundary people’ working at an inherently unstable interface between organizations meant that considerable activity was dedicated to attempting to resolve tensions and building the partnership entity as an end in itself, reducing the amount of time for constructive programme development. A process of ongoing accommodation occurred, which enabled the partnerships to continue. What made the contribution of boundary people possible, despite the recognized constraints, were capabilities for flexibility, innovativeness, and for negotiating shared agendas that justified the input of the different sectors, even if these were within the boundaries set by the authorities. The partnerships adopted ‘satisficing’ (Simon, 1957) compromises: solutions that were ‘good enough’ if not optimal, and that adopted an explicitly incremental approach that enabled a level of progress, whilst not ‘rocking the boat’ (Lindblom, 1959).

These compromises achieved a ‘centre-ground’, which had some benefits or ‘added
value’ for all partners. For the authorities, the partnerships represented innovative, if small scale, programmes that supplemented their mainstream agendas. Furthermore, they were seen to be working collaboratively, a requirement by governments in both countries. For the communities, their involvement resulted in some material gains, which, whilst more limited than hoped for, were of value. More importantly, the partnerships provided an avenue for a relationship with the authorities, with the anticipation that these would assist in future negotiation. There was also the added by-product of ‘empowerment’ that resulted from the interaction with the authorities (Wallerstein, 1993). The achievement of a local ‘boundary entity’ became a prized end in itself, acting as an incentive for partners to continue efforts at partnership working. Finally as ‘boundary people’, the partners were able to adopt a strategy of diplomacy and persuasion, described by Ranade (Ranade, 1998) as ‘constructive challenging’.

It would be erroneous, however, to assume that the communities were devoid of influence or power. First, many of the changes described by the participants were the result of community influence, as noted earlier. This view is reflected in the literature which shows that the stronger the involvement of communities in partnerships, the greater the impact and the more sustainable the gains (Gillies, 1998). Secondly and importantly, the case studies illustrated a deliberate choice by the communities to remain involved in the partnerships, rather than exerting their power to withdraw and challenge the authorities from the outside through a more radical ‘social action’ approach (Baum and Cooke, 1992).

**CONCLUSION**

The tensions that exist within partnerships between statutory sector authorities and communities are well known, and those participating in partnerships often become disappointed or even disillusioned. Yet neither the literature nor the respondents in the study raised any suggestion that existing or future partnerships should not be developed. Those working in the Healthy City partnerships studied here had a dual obligation to be both sophisticated about the limitations of partnership working, and committed and optimistic about its potential. This potentially exhausting position was maintained through a strategy of establishing an entity of ‘boundary people’ who could develop shared norms of working, despite mutual mistrust between the organizations they represented. For community representatives, the incentives for continued participation were to maintain their ‘foot in the door’, whereas authority partners used the boundary entity to act as ‘gatekeepers at the door’, limiting community impact on the authority’s agenda.

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