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COMMENTARY AND DEBATE

Meeting equitable (health) needs: a call for radical reflexivity in implementing interventions for just health outcomes

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ABSTRACT

Urban interventions for health are widespread, yet doubts exist about their capacity to address residents' needs equitably. It is common for interventions to attempt some form of participation to include marginalised residents. Scholars emphasise the need for this to be meaningful. Nonetheless, despite the theorisation and subsequent recommendations on how participation should be carried out, it often continues to fall short in practice, as tokenistic or passive participation, with limited political impact. We reflect on a widely unexplored factor: how a lack of diversity in the decision-making teams of projects might shape participation. To do so, we reflect on our experiences working in health interventions teams, one in neighbourhood food environments in Amsterdam and the other in urban green spaces in London. Both projects had an explicit mandate to reach marginalised communities to address health inequities, using co-creation to achieve this. We unpack challenges brought by a lack of diversity in teams, identifying structural factors at play. We thus propose that a radical reflexivity in interventions should move beyond theory, to how participation unfolds in practice, and at least requires critically interrogating funding structures, hiring practices and team members' positionalities.

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Introduction

Municipality- or public agency-led health interventions in urban environments, whether focused on physical, aesthetic, social or other changes, are widespread, yet doubts exist about their capacity to address residents' needs equitably. Scholars often question whether interventions are accessible to their intended recipients and inclusive to promote health equity within their given contexts (Cole *et al.* 2021, Kotsila and Anguelovski 2023, O'Neill *et al.* 2023). For example, urban greening interventions can instigate processes of gentrification when the needs of residents, especially those marginalised due to class, race, gender, ability and other intersecting protected characteristics, are not effectively considered (Gould and Lewis 2016, Amorim Maia *et al.* 2020, Anguelovski *et al.* 2022). They can be physically or socioculturally displaced (Anguelovski *et al.* 2021) and excluded from proposed health benefits (Anguelovski et al. 2019, 2020, Pain 2019, Elliott-Cooper *et al.* 2020, Versey 2023), by which interventions often exacerbate existing inequalities and create new types of social, environmental and health injustices (Cole *et al.* 2019, 2021, Cole 2020, Triguero-Mas *et al.* 2021).

It is common for urban health interventions to attempt some form of participation to include 'marginalised' or 'vulnerable' residents throughout, or partially, in different project stages (Arcaya *et al.* 2018). Scholars call for the need to meaningfully involve people, especially those in marginalised groups, and in a way that their contributions hold power. This includes involvement in early research and design stages of interventions, implementation and evaluation, which might otherwise 'problematically privilege' researchers' knowledge over residents' lived experience (Kerkhoff and Pilbeam 2017). Scholars argue that a collaborative approach should aim for equitable partnerships between stakeholders (Israel *et al.* 2010), sharing power amongst community partners and jointly deciding on core values to reflect a collective vision (Israel *et al.* 2005).

Here, 'marginalisation' refers to the structural and historical causes of inequities that might affect residents (Munari *et al.* 2021). Health equity in these projects is generally seen as 'eliminating disparities in health and in the determinants of health that adversely affect excluded or marginalised groups' (Braveman *et al.* 2018, p. 3). Moreover, for the purpose of this paper 'marginalised groups' are acknowledged from an intersectional perspective (Crenshaw 1989, Williams *et al.* 2023), meaning more than an undiverse (e.g. class, socioeconomic status, race, ethnicity, gender, etc.) category of a 'marginalised resident'. Rather, it acknowledges that belonging to

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multiple social categories might shape the experience of structural disadvantages that contribute towards varied, dispersed and unique health needs (Ghasemi *et al.* 2021), warranting urban health intervention design accordingly.

Despite the articulation of theories and practical recommendations for meaningful participation, it continues to fall short in application, thus herein lies an important gap in understanding (Caperon *et al.* 2022). Participation is often carried out tokenistically, as passive participation, at select stages, with minimal political impact (cf. Swyngedouw 2005, Bess *et al.* 2009). This can contribute to feelings of disempowerment, an inability to claim a right to the city and to validate citizenship (O'Neill *et al.* 2023). Several structural factors explain why this might still be the case, such as extractivist research practices (Kaplan 2021), funding constraints (Luger *et al.* 2023) and municipal budget cuts (Gourgues *et al.* 2022). However, this commentary reflects on a widely unexplored factor: how a lack of diversity in decision-making teams contributes to exclusive participation, which can be extrapolated to higher levels of operation such as programs, agencies and senior leadership levels. This lack of (predominantly socioeconomic and racial) diversity, we argue, perpetuates a tendency of urban health interventions to one-dimensionally address health inequities without considering institutional, socio-economic, political, cultural and other factors, contributing to tokenistic participation and people's experienced inequities more broadly.

We address this gap, reflecting on our own experiences working as part of urban health interventions teams, one in neighbourhood food environments in Amsterdam and the other in urban green spaces in London. FoodCLIC (2022–2027) was an EU-funded action research project, working towards healthy, sustainable and just food environments in city-regions. At least half of the project activities were required to include and benefit 'people in deprived and vulnerable groups'; those who live in historically marginalised neighbourhoods and whose food environments are often relatively unhealthy and unsustainable (Pineo 2022). Co-creation sessions in the form of workshops with local stakeholders to design activities were at the core of the project. Comparably, the Parks for Health project (2019–2021) in London teamed up with local stakeholders to facilitate Green Social Prescribing activities in parks, to improve residents' mental and physical health and reduce social isolation. Co-creation sessions are held semi-regularly in the form of workshops, with voluntary and charity-sector organisations, local parks staff and volunteers, generated collaborative guides for good practice, wellbeing, and diversity and inclusion in parks, in terms of exposing barriers to access. In doing so, they aimed to prioritise marginalised groups with relatively low health outcomes and develop accessible and "inclusive green spaces for a local population of roughly 40% Black, Asian or other minority ethnic groups.

Both projects had an explicit mandate to reach marginalised communities to address health inequities, opting for co-creation as the participatory method to achieve this. At the same time, both projects were orchestrated by socioeconomically and racially undiverse teams, which was also repeatedly mentioned by participants we worked with. The majority of team members were from middle-class backgrounds, with municipal or academic salaries putting them well above median income earners in both the UK and the Netherlands, as well as the majority of White and male decision-making team members, all with higher education qualifications, of which most were Master's level or above. Moreover, we would like to state our own positionality as two researchers with certain privileges, which may translate to positions of power in some settings, whilst experiencing discrimination and disadvantage in relation to certain characteristics in others. Identifying as a White, female researcher (in the role of project evaluator) and half White, half Middle Eastern, male researcher (in the role of scoping researcher), both from lower middle-class backgrounds, we recognise how this may have shaped our reflections. In some instances, our privileges set us apart from the lived experiences of the residents that we were speaking to, as they shared experiences that were unrelatable. Nonetheless, employing awareness of the power differentials at play and empathy allowed us to make space for residents' conclusions to lead our analyses and reflections.

Moving beyond an awareness of positionalities and power asymmetries within decision-making teams, this commentary argues that a lack of diversity within decision-making teams can still impact who participates and how participation unfolds in urban health interventions, and we highlight key procedural and structural factors that might be relevant to focus on addressing. This commentary does so by reflecting on interviews and fieldnotes made during our work. We thus propose that scholars and practitioners alike should critically interrogate questions such as who orchestrates participation, how it unfolds in practice, and what are impacts on health inequities. We recommend the need for a *radical reflexivity*, which not only asks decision-making teams to reflect on positionalities and power asymmetries throughout participatory and collaborative stages of urban health interventions but also requires the space to structurally act upon these reflections (Galuppo *et al.* 2023). To this extent, we offer practical recommendations related to including community representatives, changing hiring practices and funding goals.

Impacts of a lack of diversity in decision-making teams

Shaping who participates

In the two projects we worked on, the lack of socio-economic and racial diversity in decision-making

teams as described above had clear implications on the methods chosen to communicate with different groups to initially engage them in a project. Where participation was included in the project scope, it had the potential to widen perspectives on required needs and feed input from stakeholders from more varied socioeconomic and racial backgrounds than the project team itself. For example, in the case of Parks for Health, they contacted as many local voluntary and charity-sector organisations as possible to act as community representatives. Nonetheless, there was still an inherent level of selection bias in doing so, meaning that a comprehensive representation of the population was not achieved.

First, communication methods were not tailored to reach different community groups, for example, considering whether a group responds best to online communication, flyers, handouts or speculative phone calls, as well as a consideration of language requirements. As the first step being made in building lasting and trusting relationships, where it has been widely evidenced that trust is foundational in community engagement with residents (Geller *et al.* 2014), this was a considerable hurdle. Such barriers could work to discourage (often more vulnerable) communities from being involved in projects. Where homogenous project teams might struggle to comprehend other demographics' lived experiences far removed from their own, this can result in the further marginalisation of groups through the systemic deprioritisation of their needs.

Second, certain communities may have context-specific negative socio-historical relationships with public institutions, where previous engagement with the government (Cohen and Wiek 2017) or research bodies (Metzler *et al.* 2003) may have also worked to further marginalise groups. Parks for Health continually struggled with building long-lasting, trusting relationships with community members, to encourage their involvement in local park spaces. This was seen in co-creation sessions where municipal facilitators assumed conceptualisations of power between residents and themselves and were unable to fruitfully convene the sessions accordingly. As such, it was difficult to receive adequate input on decisions from the discussions held.

Distrust in Amsterdam similarly proved to be a major barrier to engage people in FoodCLIC's co-creation sessions. In Amsterdam Noord, in particular, many residents feel distrust towards public institutions, due to historically impoverished neighbourhoods paired with rapid urban redevelopments and concurrent gentrification (Gemeente Amsterdam 2024). The FoodCLIC team, while 'undiverse', overcame this by being backed by a key neighbourhood representative who referred them to a food bank coordinator. It was because of this 'chain of trust' that participants felt comfortable attending events, as they would have otherwise refrained from doing so, generally feeling a clear division between themselves and others. This example illustrates that context-specific power asymmetries due to socio-historical relations, if not addressed, can withhold people from participating.

How participation unfolds

Furthermore, we observed how relatively socioeconomically and racially undiverse project teams impacted how decisions unfolded in team meetings and in co-creation sessions. First, project team members were seen to favour and put forward their own needs in the design of urban health interventions. For example, in decision-making meetings, a Parks for Health team member referenced how they and their friends interacted with urban green spaces, framed these as universal desires, and advocated for what they felt was important to consider in the park's program design. A lack of diversity within decision-making teams can result in residents' needs being understood as those that align with a more White and middle-class demographic, rather than those with lower health statuses in the area, often aligned with communities of colour or lower-income residents (Krieger *et al.* 2011, Rosenfield 2012). This was reflected in the project evaluation, where residents felt discouraged to attend park activities, due to not feeling represented by the activity type, its coordinators or attendees.

Furthermore, project teams can lack consideration of whether certain terminology might alienate people within participation. Project teams can be susceptible to overusing jargon, where unnecessarily complicated or technical/academic language can exclude participants. For example, FoodCLIC team members introduced the project to residents diving into the theoretical underpinnings of 'food system transformation', linking it with policy-making and urban planning. The lack of diversity of the project team was arguably embodied and amplified by the language used, misaligned with the lived reality. Participants criticised the explanation for being too theoretical, turning the project into something that people felt inclined to distrust, commenting explicitly that the project team 'consisted of three, white researchers' (fieldnotes, May 2023).

Mechanisms hindering just outcomes

Educational inequalities

Educational inequalities contribute to some extent to undiverse project teams and the aforementioned

issues. Higher levels of education are often somewhat unattainable for lower-income populations. In the UK, the average Master's degree stood at £17,109 in 2024 (British Council 2024) and reached up to £36,000 at Russell Group (Ivy League) institutions (London School of Economics 2024). Comparably, postgraduate loans cover £12,167 of tuition (UK Government 2024). The education reforms of the 1990s subsequently saw the previous inequality in higher education access at undergraduate level pushed to the next level of qualification to Master's degrees (Mateos-González and Wakeling 2022). In the Netherlands, state scholarships were abolished in 2015, where the percentage of students taking out loans increased from 18% to 57% (Bolhaar *et al.* 2020). With an increasingly competitive job market, increased inflation, housing costs and the cost-of-living at an all-time high post-covid pandemic, student debts became an increasingly less enticing option, particularly for lower-income students who often have to borrow more.

Other factors exacerbating or sustaining educational inequalities include the reduced likelihood of students obtaining a higher level of education than their parents, as well as the culture of higher education institutions not necessarily welcoming lower income or racial and ethnic minority students. Other evidence shows that lower income and minority students are 'less well prepared academically; ill prepared to select colleges, apply for admission, and secure acceptance' (Haveman and Smeeding 2006). This means that students with less educated parents from more working-class backgrounds are often likely to remain in the same socioeconomic bracket. Yet, these are often people with worse health outcomes that could stand to benefit the most from urban health interventions. Consequently, those instigating projects in lower income neighbourhoods are often trying to understand lived experiences worlds apart from their own. Although project participation *should* include voices beyond those of people trained in higher education institutes, comprehending the importance of this and ensuring a diverse reach in engagement is prioritised, are challenges in themselves, often exacerbated by the limited awareness of the disparities that exist between the project decision-makers and lower-income residents.

Funding structures

In another vein, funding structures play a key role in sustaining a lack of diversity in project teams, where resource deficiency can massively inhibit the capacity to overcome it. EU-funded projects are often trapped in the cycle of overpromising to acquire funding and resource deficient in execution. As a result, project workers are often structurally overworked (Mascarenhas *et al.* 2021, Luger *et al.* 2023), in turn stifling the prioritisation of certain tasks such as the capacity to meaningfully fulfil inclusive participation criteria. For example, in the first year of the FoodCLIC project the project officer was scheduled to work 2.5FTE (full time equivalent) for 6+ months during initial project scoping and data collection. The participating authors are also overworked by 0.2FTE per week, juggling another EU-funded project requiring similar commitments. It became commonplace to joke about working nights and weekends, from one deadline to the next. Given the default operation of 'survival mode' for the team of three (mostly) White, male, higher-educated researchers, the paramount necessity of inclusion of, and co-design with, people in marginalised neighbourhoods was difficult, despite featuring in the project proposal. EU-funded projects often fail to enable space for critical reflection on issues of diversity, equity or justice, notably in the participation of citizens, as well as preventing space for reflexivity on positionality and privilege, and how this might translate in action.

Conclusions & recommendations

Where current research calls for participation in urban health interventions to mitigate health inequities, it cannot be assumed that merely re-emphasising the importance of 'inclusive' and 'meaningful' participation suffices. Creating non-hierarchical networks of engagement under neoliberal urban governance cannot counter the inevitable power asymmetries (re) produced through participation (Swyngedouw 2005, Baxter 2022). In not acknowledging this, participation practices are susceptible to the structural challenges in which they wish to solve.

We have identified and reflected on key instances in which a lack of socioeconomic and racial diversity within decision-making teams can have significant impacts in dominating the trajectory of urban health intervention projects and potentially steer it away from more inclusive participation in practice. We have seen this occur in the scoping, research and design stages of the projects we discussed: in terms of *who* participates and *how* their input is incorporated, recognising key impacting structural factors including educational inequalities, hiring practices, and funding structures in the case studies discussed. We acknowledge that other overarching structures often also play a role in other instances nonetheless, these reflections hold crucial implications for future urban health research and interventions, and are widely applicable. When undiverse decision-making teams contribute to sidelining the lived experience of marginalized groups in urban health interventions, we argue that this plays into existing tendencies of urban health intervention projects to neglect institutional, socio-economic, political, cultural and other contexts.

Thus, departing from our own experiences, we propose four key recommendations:

(1) First, we urge project teams to structurally include community representatives in core decision-making processes. For example, they could be hired as consultants and involved early on in funding applications to influence the distribution of resources. Similarly, in consortium projects, community representatives can co-apply for funding as consortium stakeholders. Simultaneously, it is crucial that projects also set aside the resources required to learn how best to work together (cf. Coombe *et al.* 2020; Turin *et al.* 2021), and that funders equally take this into account. Doing so, could address a range of impacts identified from a lack of diversity in project teams, including those associated with language use and communication methods. This is particularly relevant in the context of sociohistorical power imbalances and making communication decisions in reaching out to prospective participants.
(2) In a similar vein, we suggest that hiring practices consider (to some extent) deprioritizing higher education qualifications and instead hire on the basis of candidates' *capacity to reflect* on their lived experience and critically apply this to project decision-making. We also recommend that this be accompanied by increasing resources for outreach to different communities to encourage applications, setting staffing goals and having work policies responsive to different life circumstances such as varied work schedules for care responsibilities, flexible leave policies and job sharing. Such efforts can 'attract and retain a workforce' for urban health intervention projects 'that reflects and understands the ethnic and cultural diversities within the populations that they serve' (Bond *et al.* 2013, p. 82), let alone incorporate other intersectional perspectives.
(3) Next, once more diverse teams have been created, people from minority backgrounds need to have space secured for them to contribute and their voices prioritised in discussions. Crucially, caution should be exercised in not burdening 'minority representatives' with the weight of 'diversifying the conversation'. Representatives from marginalised communities should not have to take on the responsibility of 'educating' others about their experiences. Rather, the burden should be on those with more power to address their own (White) privilege.
(4) Finally, and most importantly, decision-making teams should practise *radical reflexivity*, forging space for reflection of individual and collective *positionality* to challenge assumptions on who should be involved and how, as well as institutional sociohistorical and present constraints. Doing so is a crucial step in embracing rather than negating different experiences in participation in urban health interventions, and the power relations and privileges inherent to participation (Baxter 2022). However, we urge to move away from a modernist ideal of reflecting on one's positionality to claim objectivity (D'Arcangelis 2018) and instead promote the act of radical reflexivity to articulate assumptions, values and normative standpoints, critically interrogating how structures and power asymmetries work through research and praxis, and what can be done about it. This is again to move away from an individual process (e.g. D'Arcangelis, 2018; Mayor 2022) and instead towards a more collective process (Strumińska-Kutra and Scholl 2022; Temper *et al.* 2019) that can support the structural changes necessary for urban health interventions, as suggested in recommendations 1, 2 and 3. It is precisely this kind of praxis that was absent in the projects scrutinized in this commentary, and what we argue urgently needs integration into the implementation of (EU-)funded projects, including as a core criterion for receiving funding for urban health intervention projects. Yet, avoiding tokenism being transferred to these practices is perhaps a consideration for more in-depth future research directions.

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Jonathan Luger is a PhD candidate researching food insecurity and urban food governance at the crossroads of

environmental sciences, public health, and geography. His current work examines people's lived experiences of food insecurity, the role of (in)formal food banks, and caring relationships in Amsterdam. He also investigates the politics and justice dimensions of public administration-led food policy development across European cities. Specializing in transdisciplinary action research, his methodologies include creative, theater-based workshops and reflexive monitoring.

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