Understanding access to healthcare in diverse neighbourhoods: an ethnographic perspective

Aleksandra Kazlowska

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Introduction and context

As cities in Europe become increasingly diverse and dynamic through migration, policy-makers seek to ensure that both new and long-established residents can access health services that meet their needs. In the area of healthcare, the challenge of adapting services to cater for increasingly diverse populations is compounded by the economics of austerity in many European countries. Furthermore, gaps in knowledge about the way institutions work and a lack of information can make the task of accessing health provision difficult for residents.

Consequently, the UPWEB project ("Understanding the practice and developing the concept of welfare bricolage") - funded through the NORFACE Welfare State Futures Research Programme, utilised the concept of 'healthcare bricolage' to explore how residents in superdiverse areas accessed health services. Through drawing on the work of Levi-Strauss (1962), Derrida (1967), Deleuze and Guattari (1987) and Andersen (2008), bricolage was defined as involving the creative mobilisation, utilisation and / or combining of different resources, knowledge, ideas, materials and networks to address a health concern. In particular, the UPWEB project explored how residents (and indeed institutions) combined or re-combined resources as a way of overcoming healthcare challenges and turning them into opportunities, through mobilising, mixing, re-assembling and re-using resources (Phillimore at al. 2018a). In sum, two super-diverse neighbourhoods were selected in four cities (Birmingham, UK; Bremen, Germany; Uppsala, Sweden and Lisbon, Portugal) according to contrasting deprivation-levels, histories of immigration and welfare regimes.

The concept of superdiversity (Vertovec, 2007) attempts to capture the unprecedented intersection of overlapping dimensions of difference relating to people's origin, ethnicity, faith, socio-economic position, legal situation, gender etc. It helps to move beyond groupism and an ethnically focused approach to migrants constructed in opposition to so-called host societies, towards multi- dimensional perspectives which acknowledge the interplay of different factors that influence the lived experience and needs of individuals (Vertovec and Wessendorf 2010). Arguably, the concept of superdiversity informs more in-depth and complex understanding of the needs, barriers and strategies of residents in diverse neighbourhoods as well as challenges faced by service providers (see Phillimore, 2015).

Consequently, the research conducted as part of delivering the UPWEB project involved a mixed methods cross-sectional research design, including qualitative interviews with residents and service providers and a household survey with residents. However, it was deemed to be important to consider how individuals "do bricolage" in different super-diverse neighbourhood contexts. Therefore, in the UK two 'mini ethnographies' were conducted in the city of Birmingham between February and July 2017 to examine the ways in which people seek help to address their health and well-being concerns and their methods of "doing bricolage".

Both of the mini ethnographies took place in densely populated areas of Birmingham where the majority of residents are of ethnic minority background from both settled groups and new arrivals thereby representing archetypal superdiverse neighbourhoods. The areas of research represented places of concentration of migrants living in Birmingham who had come from over 160 different countries and who varied in terms of age, immigration status, religion and educational backgrounds

(Phillimore 2013). The selected neighbourhoods continue to be receiving areas for asylum seekers, many of whom remain there once they gain their refugee status. In addition, the neighbourhoods selected for analysis were some of the most deprived areas in the city. Despite some ethno-nationalistic tensions witnessed in the past, in recent years the neighbourhood superdiversity of the case study areas was perceived largely positively and meant that they had become sufficiently attractive to individuals from diverse ethnic, religious and country of origin backgrounds (Pemberton and Phillimore 2016). In addition, the wider context for the research included the importance of welfare policy in the UK and its local implementation which can be characterised by a 'liberal' regime, austerity cuts, restructuring of the welfare state, the provision of basic free medical care (except for irregular migrants) and increasing levels of welfare chauvinism (Phillimore at al. 2015).

The observed mini ethnographic sites were therefore chosen in a way that represented two different types of institutional settings: i) a small-scale charity institution; and ii) a large-scale state funded institution. Respectively, the first mini-ethnography was carried out in a site run by voluntary organisations providing support to refugees and asylum seekers. The second mini-ethnography was undertaken in a state funded centre providing local residents with well-being and health related services.

The ethnographic research itself was carried out systematically through guided observation accompanied by conversations, note and picture taking as well as gathering relevant documents such as forms, leaflets etc. The names of the sites of the observation and the people interviewed have been omitted or changed to maintain confidentiality. In the case of the small-scale charity, the observation was carried over a period of several weeks on the days when the organisation was open. Due to the intimate nature of the venue, I was introduced to users and approached by volunteers who explained the different features of the building. In turn, I was frequently involved in short casual conversations with users. I also engaged in longer informal conversations with those in more senior roles. I visited the charity and the larger-scale state funded institution on different days of the week, and at various times to capture differences in users and the ways they used each facility, including those attending for regular activities as well as for one-off events. Observations ranged from being present in a lunch club through to more formal (state-funded) activities promoting health and well- being. In respect of the larger-scale state funded institution I also undertook several conversations with members of staff and volunteers working at the centre as well as one semi-structured recorded interview with an individual in a managerial position. In addition, I also drew upon used interview material undertaken previously with both providers by the UPWEB team to inform my conversations and observations. The mini ethnographies were conducted after receiving full ethical approval from the University of Birmingham Ethical Review Committee and the research fully complied with the University's ethical guidelines. In addition, written consent from the mangers of both organisations was received in respect of undertaking the research. Notices were also displayed in the both case study locations informing users about the research.

Mini-ethnographies

CASE STUDY 1: Small-scale charity institution

Background: This initiative was set up at the beginning of the new millennium by a group of religious organisations working together in response to the dispersal of asylum seekers to local neighbourhoods. At the outset, the organisers intended to create a place where people could come and stay if they had nowhere to live, but because they could not offer long-term accommodation, the idea of a drop-in was developed instead.

Subsequently, a diverse range of organisations and individuals has supported the initiative - in practical and financial terms. Hosted by one of the organisations, a drop-in and lunch is held regularly (once a week). Although aimed primarily at asylum seekers and refugees, other visitors seeking support are also offered lunch, and are often signposted to other charities. In addition to the provision of food bags and second-hand clothing, it offers practical assistance in dealing with more formal issues, including health and well-being related issues. The organisation also aims to provide a place of welcome and friendship for asylum seekers (and others) in order to counteract high levels of poverty (sometimes even destitution), isolation and exclusion resulting from legal, economic, social and cultural barriers as well as (in the context of Asylum Seekers) Home Office dispersal policy. The initiative therefore plays a 'gap filling' role (Mayblin and James 2018) in the case of those who are left impoverished, unsupported or destitute. The service helps individuals and families to build resilience and offers users emotional support. It also offers assistance to users suffering from high levels of anxiety due to traumatic experiences such as loss of family members, persecution, violence and human trafficking. Furthermore, it helps asylum seekers to become accustomed to new cultures and institutional systems in a time of uncertainty, and through the period in which their applications are being assessed.

Characteristics of users: According to those offering voluntary support, somewhere between 15 and 30 individuals visit the initiative every week, and with some attending for over a decade, while others have visited more infrequently. Such numbers were confirmed during observations. However, the service does not gather specific data about users as it was felt that this could deter some individuals from attending and undermine its informal, individual-focused ethos.

The organisers estimated that since opening around 1500 asylum seekers and refugees had attended the club in total. During the period of observation, the initiative was attended by individuals from countries such as: Afghanistan, Albania, Ethiopia, Eritrea, Ghana, Iran, India, Kazakhstan, Nigeria, Sudan, Syria, Turkmenistan and Turkey. They usually came individually, even though the majority of attendees lived with their families in the UK. Nevertheless, some mothers with children and whole families were also present. The volunteers were almost all White British women over the age of 60.

The atmosphere during the observed lunch club was busy but relaxed. Attendees interacted between themselves and with volunteers. The users came and left at different times (some even missed the lunch, and just attended for food bags or to meet other participants). In general, the attendees sat at 4-6 different size tables but sometimes they changed places. The largest table that was closest to the kitchen generally had a mixed diversity of individuals - in terms of ethnicity and gender - and with

one or two volunteers also present. Individuals at the table were frequently involved in simultaneous activities. For example, one individual could be breast-feeding her child, a volunteer could be teaching one of the participants basic English or knitting, and two or three others may be talking whilst others could be simply observing, reading a newspaper or looking at their phone. Regardless of the different language competencies that were evident, individuals attempted to communicate in English, helping themselves and others with gestures or attempts at translation.

A second table located behind the largest table was usually occupied by a group of women from Africa who spoke between themselves in English and French quite loudly, sometimes laughing and singing. Migrant families or individual migrants frequently occupied the other (smaller) tables in the room and engaged in private conversations with the volunteers. In general, the volunteers were moving around. Some were busy cooking meals, bringing lunch and preparing food bags, while others sat for a while at one place and spoke to individuals on a one-to-one basis or in a small group and then moved somewhere else. Children stayed with their parents or played together in a small room next to the main lunch venue.

The majority of attendees had heard about the club through word-of-mouth. In addition local charities had often referred people. However, it was argued that the initiative had not promoted itself widely due to challenges of coping with larger number of attendees in the past.

Users varied in terms of their legal position, ranging from acknowledged refugees, individuals applying for refugee status, those who have been given a negative decision on their application to remain and were subsequently appealing, and those who are "under-the-radar". Their life situations also differed. A number of clients had no access to public funds, no other support and nowhere to live (this meant that some slept rough or lived on sofas). However, there were also people who attended who received state support, including Syrian resettlement refugees who were being assisted by the state. Some users - even after receiving documents which had formally approved their legal position in the UK - still attended because their English was felt to be insufficient to get a job; due to their mental health undermining attempts to enter the job market; or because they needed help to navigate the health system, secure accommodation and / or obtain access to other services.

For some participants, past experiences had particularly impacted on their physical and mental health. Attendees described how they had been through the trauma of fleeing their countries and that they had often witnessed violence, had sometimes been tortured, trafficked or raped, and had been trapped in houses, drugged and forced to become prostitutes. Some minors were noted as travelling on their own, and had sometimes risked their lives to make a journey. Other users remained separated from their families and were worried about relatives still in danger. One volunteer pointed to the traumas people had gone through but also stressed the ability of users to rebuild their resilience once in a relatively safe environment such as the UK: *It's like a little ticking time bomb, isn't it, the long-term mental health of people? But, at the same time, we can see people are really resilient, that asylum seekers and refugees are really resilient and have a different value to life. But they have to grieve the life they've lost, the families they've lost* [I2].

According to providers who were interviewed, the users of the club encountered different types of problems once they were in the UK. Some were going through lengthy and complex legal procedures with uncertain outcomes. Their life choices were often severely restricted (e.g. in terms where they live and their ability to work). One volunteer spoke of the uncertainty, stress and anxiety that asylum seekers and refugees were put through and how this had impacted on their mental and physical health: *So, I definitely think the waiting process, the being told you're lying — Most of our people have escaped from situations where their life is at risk; that's why they're claiming asylum. There might be a faith issue, there might be a family issue, it might be a cultural issue and that's why they are here. So, they've got the trauma of that, and then they arrive here and have to go through the asylum process which is just not good for their health…*[I2] The interviewee also gave an example of one elderly asylum seeker who after receiving a letter from Home Office saying she needed to move out of G4S housing and having a disagreement with a GP, came to the club where she had a stress- induced stroke.

The experiences of a young asylum seeker who had been waiting 12 years to obtain his papers was discussed by volunteers. They described how he had experienced random attacks in the streets of Birmingham and had a very limited social network. As a consequence of violence and uncertainty it was argued that he was extremely anxious and had turned to the initiative for support on a regular basis, and had now attended for over eight years:

> *He barely used to come out of his house because of anxiety and just the stress of the long- term impact of waiting for his papers. I think, just having somewhere to come on Fridays — He likes helping at the end if he can. So, just getting him helping; just being here for the things that cause him anxiety, whether it's his housing — He had a problem with his bed, so we looked at how to get a grant or get a charity so we could get him a bed. So, we did that. He's now happily married, but his income isn't big enough to get his family over, but he's currently trying to get a passport for his daughter.(…) I believe he finds it [the club] somewhere where there's no hidden agendas. We are what we are; we're transparent, we're respectful of him (…) I think he's been here, tested us and found this is a safe place. I think we've helped him with the small things and then we've helped him with the big things. We've laughed with him; he's just a good man who we've been supportive of over a long term. We're here, open almost every Friday of the year, he knows that roughly the same volunteers are here, so there are familiar faces; there are familiar visitors. This is like a refuge, a place where you can come, and he can come and help us as well. He can just come, find peace and know that there are people here that can help him so he's not stuck* [I2]*.*

Consequently the initiative can help people to rebuild their lives and navigate a new society (e.g. finding accommodation, a job and / or securing access to services), as well as overcoming barriers such as isolation and racism.

Users and the need for welfare bricolage: The users of the club had complex, multifaceted health and well-being needs which they attempted to address through health and well-being bricolage activities. As such, in addition to seeking help through formal state funded health services, they also used their own knowledge and looked to secure support through informal advice from their own

social networks (and over and above support from state institutions and refugee or migrant specific organisations / other "mainstream" NGOs).

Indeed, attendees discussed their health and well-being concerns with other clients and volunteers. During these conversations individuals exchanged their expertise based on their own experiences, previously received advice and treatment as well as their cultural knowledge of different forms of healing (e.g. herb treatment). Participants discussed their GP and dentist appointments and problems with getting prescriptions. Individuals also turned to the volunteers as experts, mediators and facilitators in order to obtain help in addressing their health and well-being needs in new institutional settings. They asked for medical letters to be explained, support with phone calls for appointments and assistance in filling in forms to get free prescriptions (for example, one of the users needed help to understand his fertility test and when to take his pills). Some asylum seekers were afraid of revealing their home address to state providers or lacked stable accommodation and so they gave the address of the initiative or volunteers (as required). For some users experiencing severe mental health issues who were unable to access appropriate services and obtain sufficient assistance, visiting the club was the only time that they received help and advice.

Provision and welfare bricolage – multiple forms of support and belonging and anchoring: The initiative not only provides users with food and material help, but also offers advice and practical support. It helps people with their bills or debts, and offers support with legal and medical issues. One of the volunteers has a specific role to support individuals with legal issues, including finding solicitors and / or mobilising support from other members of the local community.

The service also seeks to provide asylum seekers and refugees with emotional support through offering a friendly and safe environment: *They* [users] *see us as a safe place, a family, a support place when they come back* [I2]. Trust is built through openness, mutual respect, recognition, sharing and information exchange:

> *I think just a smile, care and compassion; just remembering peoples' names and letting people know they're valued. We treat people well and with respect and I think that does an awful lot for people. They're not judged here; they're not – we don't ask questions, we take them for who they are. We don't question their claims* [I2].

The sharing and exchange of experiences includes having a common meal where volunteers and users eat together, and where they can celebrate important events such as birthdays together (volunteers would often bring a small gift and a special cake, and sing *Happy Birthday*). Volunteers also attempted to help users overcome difficult experiences, such as those who had lost family or friends in bombing in Syria:

> *I took her round all the volunteers and we all hugged her and said our sorrows and then, when more people came (…) we had a minute's silence to just remember them, and everyone was silent. Then, afterwards, I said, <Please do feel free to go and show your care to Sara>, and it was just amazing to see women from different countries just going and hugging her – people who might not have spoken to her that much just showing their love and support. I think that's one thing we do. We laugh when people are laughing, we cry when people are*

crying and just. We want this place to be a safe place where people feel they can come and feel supported [I2].

Physical contact (e.g. handshakes or kisses while greeting or hugs where people were upset and distressed) also helped to express compassion and arguably tempered power inequalities between providers and users. Volunteers emphasised using physical contact as a way of reducing the distance with users, and to build trust: *I purposely hug the women and welcome them* [I2]. This view of physical contact is shared by some practitioners and clinicians who point to healing and well-being benefits of touch for both patients and carers (e.g. Phelan 2009, Leland et al. 2017). In spite of this, the synthesis of literature by Green (2017) demonstrates the predominance of a defensive, avoidant or control-oriented stance towards touch in social work.

Volunteers additionally offered attendees the use of allotments in which some decided to grow vegetables. Funds were provided for items such as wellington boots, tools, seeds and a shed. A volunteer interviewed pointed out that involving users in growing food has not only practical significance (people can produce free food for themselves) but also healing benefits (it includes physical activity in the fresh air and contact with nature):

> *It's their plot of land that they're working on that's nearby (…) The four of them working together, the fresh air, and the nature. For some of them, it's very normal. I think almost all of them would normally have done farming or grown crops in their country. So, I think it's mentally good for them as well, isn't it, the ability of grow something from a little seed and then eat it? We had food given to us. There's one guy, he's given us food that he's grown, so I think they'd like to give back to us what they've grown. (…) It's their thing; we're not running it. It's their baby, so it's given them the power and the dignity to run their own thing.*

The above quotation also highlights that gardening allow individuals to engage in reciprocity with members of host communities. This is important to individual's well-being and integration (Phillimore at al. 2018c). Opportunities for mixing and friendship are important too and existed in various forms (e.g. by volunteers providing child care, taking users' children to the theatre, helping the children of migrant families with their English homework etc.). Hence the significance of mixing with different people was evident:

> *Actually, integration really works if they are integrated and connected with other women…We think, if we get one together it's going to be of a similar – actually, a mix really helps and the fact that she knows people here have all gone through difficulties, that helps as well. Also, a lot of them want to get out of the mindset of 'I am an asylum seeker,' or, 'I am desperate.' They want to hang out with people who have normal lives* [I2]*.*

Moreover, the initiative offered both users and volunteers opportunities for belonging and anchoring (Grzymala-Kazlowska 2015). For example 'Leila' (pseudonym) who had recently secured refugee status after many years of living in the UK, felt insecure, isolated and had struggled to settle down. She explained that she attended the lunch club because it provided her with "*a sense of belonging*". Furthermore, the lunch club provided volunteers with an opportunity to be involved in meaningful

social activities, and helping them to feel needed and less isolated. One volunteer summarised the benefits as follows:

> *A lot of our volunteers, when they started coming to work here, they're at a time in their life where it was changing from maybe being working to retirement or - I know a lot of people here, who are volunteers, who have had mental health problems or depression or, like, low self-esteem. By coming here they themselves - and helping people – even if it's washing up – it means they've got purpose in their lives. So, definitely, I know people who have volunteered here and it's been good for them. That's an unusual slant, but I know that it definitely gives people here a purpose. Rather than being sat at home, by coming here, they make a difference to people. Just being a volunteer that helps* [I2]*.*

The importance of the initiative to volunteers was evident in the case of the oldest volunteer who kept coming to the club despite being too weak to physically help. Instead she engaged in conversation with users, taught them English words and looked after children to allow their mothers to eat lunch.

The lunch club could therefore be characterised as an open, safe and inclusive space where different people can meet not only in terms of ethnicity and legal status but also in terms of age and social position:

> *You could start similar things to this that have no real agenda, no religious agenda, no funding agenda. I know you need the right people, but I just think this sort of place would benefit the man who's at home, like, the young black man who's got mental health problems who doesn't know how to cope, or the pensioner who's on their own, is lonely. We can have people in different countries come and be unity. I think we could have people who are British who could come and just feel safe. I think if something like this was made, because it doesn't cost much and, you know, if you've got the right people and use volunteers, it's - I would start up many of these. Clone them (laughs)* [I2]*. I think the key is having a place where people come and feel like it's a safe place and this building (…) I think the fact that we have people working here who are generally non-judgemental and compassionate* [I2]*.*

Finally, although the club itself is run by a coalition of local churches, food for meals (sometimes ready meals) and food bags were often delivered by other charities, including a faith institution of a different denomination and whose leader brought products and engaged in conversations with volunteers and users of the lunch club. The club also referred and signposted users to other local charities or organisations: *"We try and help the women as much as possible and signpost them to different people as much as possible and equip them so that they have more opportunities"* (I2). Indeed, it was highlighted how an elderly lady had been assisted in finding a home, and who had been denied refugee status and hence could not live with her family and was sleeping on a mattress in a volunteer's kitchen: *We've referred her to the other charity I work for, called X [the name omitted]. So, through that, she was then able to access X [the name left out], because they're a referring agent* (I2).

The list of cooperating organisations included charities providing housing for asylum seekers and supporting them financially, NGOs assisting individuals in dealing with formalities and offering legal help and organisations delivering a counselling service and supporting vulnerable individuals (e.g. abused and/or trafficked women). The initiative also hosted guests teaching about healthy eating, a masseur and a NGO mental health provider offering short-term cognitive therapy and one-to-one counselling.

Challenges: Despite such activities, the existence of the lunch club was not uniformly accepted and supported by all members of the church in which it was located. Although there was a substantial group of volunteers involved in the club, it was also claimed there was some resistance to its activities:

> *We're in a church and the minister is very supportive of what we do. A lot of the church members are very supportive of what we do. But this is a church that's been going for a long time and there are some people who are against us and there are people who are racist in their hearts* [I2].

Moreover, it was suggested that in the past the club was opposed by some church members and that volunteers running other activities had tried to sabotage the operation of the club (e.g. by hiding pans, by complaining about the state of facilities after lunch etc.). The significance of selecting volunteers on the basis of their skills, availability, openness and tolerance had therefore been important, according to those interviewed. Organisers of the initiative had also focused on monitoring and counteracting prejudices and preventing conflicts. They explained that they challenged anyone who acted in a way that could cause distress to others. They argued that they had worked through some conflicts between volunteers and users and challenged problematic behaviours of users towards others in order to maintain a "safe" environment.

During the observation process I also noted tensions between users relating to the distribution of food as well as the distribution of attention and recognition from volunteers. Some users complained that the food in bags was not being equally distributed in terms of amount and content. It was argued that some visitors were treated better (i.e. they got more and better quality food) and were more supported because they had closer relations with the staff. Sometimes users swapped food items between themselves or gave unwanted products to others. Food sharing also led to some tensions between the volunteers over the organisation of the process and rules of sharing. There were also some tensions around the distribution of second hand clothing. Other observed conflict related to the use of allotments. Differences in users legal position and their respective entitlements also caused some tensions:

> *I remember one of the ladies saying "It's alright for the Syrian resettlement people. They've got housing, they've got a worker, they've got this, they've got that. They've got it easy compared to us. It's not fair" but then just reminding them that these guys have had to escape their farm in Northern Syria where the Kurdish people are and they've had to go and live in a camp in another country.* [I2].

Because of limited resources, the lunch club's offer was limited to those who were able to attend, although volunteers were aware of the fact that some asylum seekers had struggled to travel to the lunch club as it was too far for them to walk and they were unable to afford to pay for transport.

Implications for tactics and logics of welfare bricolage: Overall, the initiative operates on a low-cost basis through a creative approach to using existing resources and offering the support of volunteers / using their local knowledge to refer help seekers to other NGOs. Indeed, the club makes use of the cultural capital of volunteers in terms of languages spoken, their teaching skills and their social networks.

The lunch club adopts a personalised approach to users, which varies according to people's situation and needs. For example, while somebody is in crisis or after receiving negative news, it was apparent that volunteers often dedicated more attention to such individuals and offered quasi-counselling. Asylum seekers who were particularly vulnerable due to their age or life situation (e.g. having young children) were prioritised in terms of time and the scope of help offered (for instance, they were given more support and attention and more healthy and nutritious food).

Bricolage could be observed in how users were signposted or referred to different providers (e.g. state sector, other charities). Users and volunteers exchanged information about different ways of dealing with health concerns, for example based on previous GPs advice, the use of herbs and alternative therapies and medical treatments originating from migrants' home countries. In general, the club adopted a wide, holistic and long-term individualised approach to dealing with health and well-being emphasising, on the one hand, the role of different stressors behind many health and well-being problems, and emotional resilience and the importance of social support on the other.

CASE STUDY 2: Large-scale state funded institution

Background: The second observation site was a state funded centre offering a wide range of leisure, fitness and well-being activities. The centre has hosted sports and social activities for over a century. Currently it offers various facilities for individual and group exercise. Those eligible for the city's Leisure Card or the Passport to Leisure Card (PLC) may attend free of charge activities within the 'Be Active Free Scheme' (PLC owners are also given discounts for paid sessions). The centre may be characterised not only by the diversity of its offer but also the variety of its users and staff members in terms of ethnicities, gender, age and faith.

The centre is located next to a green area that can be used for outside activities. However, despite the surrounding area being patrolled and gated, some elderly users noted how they were afraid of walking through it on their own and preferred guided activities in terms of the use of the space. One interviewee attributed her fear to a stigma attached to the wider neighbourhood area rather than being an actual safety issue. Hence the reputation of the wider neighbourhood appeared to make it harder for the centre to reach out to potential customers / other users:

> *My biggest thing for [the name of the area] is to change the mindset of some people, the mindset of some groups, of some organisations because (…) you hear some people say, "Well, it's dangerous at [the name of the area]." (…) "Oh yeah, but groups of boys hang around."*

They're not troubling anybody, you know. They hang out in the park. They're sitting and they're not doing anything. (…) The only way we're going to do that is growing as a community. Not just [the name of the site] but growing as a community (…). If all the groups and all the organisations grow together, we can change the mindset of people that use the area, that come into the area, and that will make it easier for people to come and workout and enjoy the area that they live and work in [I3].

The centre gathers socio-demographic and health related data about its users through an application form which asks users about their hearing/visual/physical impairments, learning difficulties, memory condition, mental health issues, stamina/breathing problems or fatigue, and social/behavioural conditions (e.g. Autism, Asperger's Syndrome, Attention Deficit Disorder). The centre also assesses individuals' health and well-being needs and risks in order to recommend appropriate exercise pathways with the aid of the "Physical Activity Readiness Questionnaire PAR-Q". This inquires about any issues that may impinge on physical activity, such as a potential bone or joint problem, a heart condition, high blood pressure, recent or current pregnancy, diabetes, asthma, severe stress, depression or anxiety diagnosed by a GP, recent surgery or other medical conditions or medications which could affect an exercise programme. In addition, Coronary Heart Disease (CHD) risk factor is assessed on the basis of relatives with CHD, smoking, hypertension, high cholesterol, sedentary lifestyle, obesity and impaired fasting glucose. All of this information helps to identify health conditions of users, to determine the level of risk to users associated with physical activity and to recommend a proper exercise programme for users. Before using the gym, all clients need to have an induction and declare potential health conditions alongside being instructed how to use the suite equipment. Additionally, the Specialist Activity Programme and Referral Form secures patients' consent for the centre to cooperate with their GP to tailor an optimal exercise programme. This is linked to the Be Active Plus Scheme which is a GP exercise referral programme to aid chronic disease management due to cardiovascular risk, hypertension, obesity, diabetes, asthma, coronary heart disease, previous cardiac events, strokes/TIAs, surgeries, neurological conditions (e.g. stable multiple sclerosis or Parkinson's Disease), depression/anxiety, fibromyalgia, osteoarthritis, rheumatoid claudication, intermittent claudication, physical disabilities, osteoporosis), and where customers are individually supported by a trained centre staff member during a given period of time. Furthermore, users can also be also offered three specialist exercise classes: falls prevention (for those having history of falls, Parkinson's disease or other conditions affecting their motor/balance control and movement), better breathing and proactive classes for people who have had cancer.

Characteristics of users: The centre is one of the largest providers of its kind in the city and attempts to cater for different groups of residents in terms of ethnicity, gender, age, faith and sexuality. The facility is predominantly used by sixteen to sixty-nine years old (around 75% according to attendance figures in May 2017). The second largest group are children 6-15 years – about 15% of the total number of users. However, it was reported how the nature of users had changed in recent years with a shift away from being male dominated:

We used to have free weights in the gym, and so we were getting a very young population of males, of young boys who would come in and make noise and (grunting noises) whenever they were lifting the weights, and banging the weights, and that kind of scared away other females or older people. They'd come in and you could see from their body stance that they

were put off, and then we wouldn't see them again. Since we've got rid of the free weights, the clientele has changed (…) So now we've got rid of them — The younger guys aren't coming in so much, and now we're seeing more of the older people. Our female usage has gone from sort of 25% to 49% in the last sort of – I think it's six months. [I3]

Currently women constitute over 40% of all clients, and are of a diverse age and background. They use the general facilities of the centre but are also offered ladies only sessions as well as special events, for example related to women's empowering campaigns.

Because large numbers of users were either unemployed or economically inactive, the majority of programmes and activities on offer at the centre during the day were free. The centre attempts to have the broadest possible offer of free activities to encourage participation. However, after four o'clock in the afternoon it was apparent that numbers were lower because individuals have to pay for the activities on offer regardless of whether they were eligible for subsidised / free leisure activities. Nevertheless, some customers preferred the sessions on offer later in the day at the centre, as they were less crowded. In contrast, during the free '*Be active'* sessions, the centre was so busy that after each session everybody is asked to come out and join a queue and re-swipe their cards. This system allows for recording the attendance at the centre to gather information about users and the financial support that the centre needs to address their needs. The centre also had to re-organise how customers use different facilities, for example, limiting the time individuals can spend on cardio-vascular equipment to maximise usage across as wide a group of people as possible. In addition, for certain classes, especially spin classes (exercise bike), users can only get tickets half an hour before the class to prevent people from coming in the morning and getting tickets for themselves, their families and friends.

In winter, particularly during school breaks, it is quieter in the centre and it is evident that less women were present. This may be due to caring responsibilities. Whilst the centre had previously tried - without success - introducing a crèche, at the time of research it was again reconsidering its provision in light of the popularity of the *Be Active* programme. However new rooms would be needed as well as trained and qualified staff (e.g. having CRB checks).

Users and the need for welfare bricolage: Queues of users awaiting access to the gym or aerobic classes demonstrated the diversity of clientele including girls and boys of different origin, middle aged Muslim women in scarves, elderly women in Sari and elderly African-Caribbean men. Apart from long-term residents and newly arrived migrants, it was apparent that the centre was sometimes used by travellers and the homeless who came to use the shower. One employee who was interviewed noted that paid sessions were mainly used by middle-class individuals of Asian origin:

> (…) *very rare on an evening you'll see white middle-class people here. It's mainly the Asian middle-class that come in the evening, who come to the paid sessions. They'll pay the money to come here, whereas in the daytime, the white middle-class will come in to use the free sessions as well* (I3).

On top of other dimensions of diversity, users have varied health and well-being related conditions, including: asthma, arthritis, heart disease, high blood pressure, diabetes, obesity, cholesterol

problems, joint pain and replacements, cancer etc. Others were also noted as suffering from stress and depression. Staff at the centre highlighted how addressing mental health problems has been particularly challenging: *So that's probably our hardest group is dealing with people with mental health issues because we don't know how they're going to behave until they come in* [I1]. Examples of difficult situations include helping individuals who were suicidal and dealing with disruptive behaviour or threats to staff.

Provision and welfare bricolage – resource creativity and signposting and brokering: The centre offers an increasingly wide range of programmes and activities, such as the gym, swimming, aerobics and other types of class exercises, table tennis, badminton, martial arts, runs, biking activities, walks, outdoor Tai Chi and Zumba. Some of these activities are run directly by the centre's team, whereas others are delivered or co-provided by external state funded and/or charities. The organisation also provides space to outreach organisations such as a Muslim organisation facilitating women's integration and improvement of English skills.

Under the *Be Active Plus* scheme specialised one-to-one sessions are delivered with trained staff to encourage individuals to become more active and / or to go back to work. The focus is on supporting people to manage their own health conditions. The centre also offers special group activities such as swimming lessons and activities in water for visually impaired individuals, hearing-impaired users, children with a wide range of disabilities and adults with chronic health conditions. Offering provision for people with psychological and learning disabilities was again deemed to be particularly important: *So we're trying to get more for the autism because physical disabilities are being catered for but it's not the mental disabilities that we're finding are being catered for. So the autism, the ADHD, things like.* [I1].

Although the centre already has an ethno-nationally diverse clientele, it is trying to encourage more diversity and increase its inclusiveness by focusing on residents, including the under-sixteens and the over sixties. Activities for those under 16 are currently limited due to a shortage of trained staff although the centre works in partnership with other organisations (for example by providing space) to deliver programmes to young people. To attract those over the age of sixty, the gym is being re-modelled to make it more accessible. The management wants to provide more space to different clients - for example, transgender individuals – in order for them to feel more comfortable while using the facilities. To engage with Muslim women the provider offers women-only swimming sessions, with women lifeguards and with users permitted to wear whatever they want as long as it is clean and they have got a swimming costume underneath (e.g. t-shirt and leggings).

Improvements intended to make the centre more open to diversity include a dance/exercise studio with a separate entrance in order to accommodate more people and to be accessible for individuals with physical impairments:

> *We're utilising the space as much as we can so that we can get people in. The more people we can get in, the better. But at the same time, we have to follow health and safety. So we're expanding it so that we can get more people to use the facilities, especially for this dynamic that we have in this area. A lot of people don't work and we're trying to encourage them to come in. So if we don't have the area, then it'd become difficult* [I3] *(…) So this is why we're*

expanding because we've identified that we need the area because, for example, the gym sessions you see on the hour – and there are so many that go up there – we want to give them more space and we want to be able to open for disability. It's not that we're going to put more equipment in but we have to open the space so that we can encourage people who are less able to be able to use it [I3].

The changing approach to accessibility and inclusiveness is exemplified by plans for developing the reception and ground areas alongside a full facelift and refurbishment of the whole building (including the gym, dance studio, steam room, pool, changing lockers and adding new consultation rooms):

So the alternative for us is we provide a room on the ground floor to start an initial meet and greet. So we're going to start that. That's something that's in the planning now. It's actually going to be started probably by next week where we're encouraging them, okay, you can just walk in or wheel in on the ground floor into that sports hall and we'll start from there to have an interaction. We're just going to see how it goes, until the rest of the barriers can be broken down (…) So at the moment we're going to try and use the ground floor as much as possible, utilise what we have as much as possible [I3]*.*

The envisaged developments also reflect the changing concept of the centre from a place focused on physical activity to a place of social gathering addressing a combination of different health, well- being and social needs:

Well again, it's the idea that fitness does help with lots of things, and it does help with mental health issues because you're getting your mind off — We use one of the machines in the gym. I always tell people, you know, if you take your hands off and not hold on when you're doing cross-trainers and things like that, you have to then think of what you're doing because, if you don't, you'll fall off. So it's a kind of mindfulness in a way and it gets people away from their problems […] Again, a lot of mental health issues sometimes is to do with loneliness and, nicely enough, if you do come into our gym, you very rarely come into the gym and have no one to speak to. […] Then after the class, people stay and they all chat and it is quite a social commitment when you're doing the classes (…) [I1]

The management therefore envisages that the centre could play an important social role as a hub of encounter and socialising, for example by offering club-like activities:

Because all the pubs are closing down, the older men in the communities, especially the black men, haven't got anywhere to go, and they love their dominoes. So I wanted to get that set up here. I want to get a thing, like a tea dance, but then I was thinking, I don't know what dances to do (laughs). So again, it's trying to get things like that to get the older people in, to give them something to do because the pubs are closing down. Some people don't like to go to pubs, but they would like to play skittles and dominoes and cards. Sort of like a youth club but for older people, that's kind of [I1].

But providing more accessible facilities needs to be accompanied by improvement in transport to the centre. At the present, respondents felt there was insufficient transport. More services such as 'Ring and Ride' and / or a special taxi service for customers with movement limitations had the potential to help increase the up-take of services.

Various outreach activities are run to connect with diverse residents and increase usage. If the weather permits some classes are held outside and users can bring their children. The centre has also started cooperation with a local faith organisation to encourage elderly people to use its facilities. Information is being shared between the two organisations and trained staff from the centre visit the faith organisation to try to recruit older people. Centre staff participate in a local steering group established to facilitate working with GPs and pharmacies who are encouraged - instead of prescribing medication - to prescribe social activity and exercise and to sign patients up to activities at the centre.

In addition, users are referred and signposted to other health and well-being services including mental health: *Like I said, we have our list of things here which tells us where Birmingham support lifestyle referrals [are]. There's different things downstairs. We have a list of anything to do with mental health. There's our safety services and things like that that we have to phone. Welfare services, we've got all the numbers downstairs* [I1]*.*

As such, the centre has attempted to mobilize and combine internal and external resources. For example, in terms of dealing with communication challenges the language skills of staff and customers (as informal interpreters) has been used to help with translation:

> *I've got the names of all our staff members here that speak different languages, so if we have a problem with language barriers, we'll try to get people to come back on a day when one of our staff members are here that can help. And then Birmingham City Council have got a lady as well who speaks Polish and Russian and German, and we can phone her if we need to and she'll do an over-the-phone conversation/translation for us. (…) I normally ask them [customers] if they have got somebody to bring them with them [laughs] (…) We ask people what language they speak and then we'll see who we've got around and if they can come out and help out. I've used customers as well (laughs). If we have to, we'll call customers over and ask customers, "Can you speak this language? Could you translate for us?" and they tend to. I have to say, we've got some really lovely customers here* [I1]*.*

Similarly, because they have insufficient staff, the centre has asked mothers for help with watching children when they have organised children's activities. Outreach activity and events have are heavily dependent on volunteers. Brokering is therefore crucial: the staff at the centre can be viewed as brokers – linking residents, state funded health and well-being institutions (under the NHS umbrella) and NGOs:

> *Yeah, yeah, you do get people sort of telling you about that [using alternative medicine like acupuncture and massage] because, when you're in the gym or in a class, customers do eventually think that you are a doctor and they will bring everything to you. "Oh, I've got a lump here." "Oh, I've got a pain here." And they will ask you for advice and we kind of say,*

"Well, we're not doctors. Go back to your doctor." Or they'll come in and they'll say, "Oh, I had acupuncture and it's done this," or, "I tried this the other week and it was really nice (…) And sometimes it is a bit of that, you have to keep pushing people or rather the people have to go back and push their GPs (…) Literally, we do feel like doctors and psychiatrists at points because people will come. I've had ladies that have come and told me they've got out of domestic violence (…) [I1]

Centre staff were treated by users as medical and psychological experts with whom they could share their problems and concerns, and to ask for advice around health concerns, life problems and lifestyle issues (e.g. diet, losing weight etc.). As an example, one member of staff noted how they had helped to diagnose a tumour of a user after noticing that a user had an enlarged and solid stomach. They advised her to visit her GP who had previously dismissed such symptoms.

The centre team recounted how they developed expertise through learning about clients' symptoms and experiences over time: *And so you'll ask them, "What is it? Can you explain it to me?" because once you know and you've met somebody that's got something, then it makes it easier when you meet somebody else who could have, or if they're showing the symptoms, you'll be like, "Oh well, have you tried this? Have you spoken to your doctor about this? Have you asked him that?"* [I1]. Such activity also helped to build trust through direct contact with users, as well as through openness and willingness to offer support. Centre staff were trained to different degrees in respect of providing support to users:

So, level two, you are just taking care of the general population in the gym. Level three, you've got a specific — So, on level three, there's high blood pressure, diabetes, arthritis, joint problems. And then level four would be cancer and heart rehab, people with COPDs. Or if they've got a combination of lots of problems, then they go to a level four because it's taking (…) It's twelve weeks, but if she [the specially trained staff member] *feels that you need more time, then she'll give you another twelve weeks and she stays with you. Every time you're here, she's with you. Whereas with us, with the level threes, we may meet up with them a couple of times. Every time they come in the gym, just sort of go, "Oh hello again. How are you doing? How this doing?" you know, and make sure they're okay. If there's any difficulties, then they'll come back to us and we're their reference. Then level two, general population, you come in and you have your induction and that's it. If you see us and you need us, give us a shout, but we won't necessarily come to you and go, "How are you doing? Do you need your programme up, or any problems?" Whereas we would on a level three, even more* [I1].

Challenges: According to those interviewed the biggest barrier for the development of the health and well-being offer was not having enough staff trained to deal with different health issues or to work with young people: *As I said, the worst thing is the staff. We need the staff to do that, and we don't have as many. So again, we are looking and we are seeking and we're recruiting as best as possible, within our limits. The organisation we work for, there are a lot of limits and restrictions in terms of what you can do, and in terms of getting people in* [I3].

A further challenge related to infrastructure development: in order to develop its infrastructure and programmes the centre has to go through a lengthy bureaucratic process to obtain the necessary

planning and building regulation permissions as well as to bid for funding. This has made it difficult to overcome physical barriers and to address the needs of people with visual impairments and in wheelchairs.

A third challenge has related to communication. Thus far 'word of mouth' appears to have been the most effective way of attracting new customers and partners. However, observations and discussions have highlighted how the provider has a relatively poor internet presence and it does not uses social media extensively. The centre's website does not include activity timetables, instead it relies heavily on leaflets and flyers in the centre's reception hall. Hence efforts are being made to improve information dissemination, and promotion and advertising activities through web-based media.

In sum, the centre is continuing to develop its offer and doing whatever it can to make the most of the resources available to it – both financial and non-financial: *I think it's just who works there and whatever we can get in. (…) I assume they would love it in every centre, but it's just being able to hit and have the specialist teachers as well that can work in those areas as well* [I1]. This might be described as a strategy of selective optimisation.

Implications for tactics and logics of welfare bricolage: The centre operates in an unstable neoliberal market reality with shrinking welfare provision and changing rules of provision and entitlement (e.g. due to Brexit), as well as being constrained by its own bureaucratic characteristics (such as a lengthy process of change acceptance and implementation). Nevertheless, it has attempted to develop creative ways of developing and adapting. Changes have been made gradually by mobilising and using different resources:

> *It's kind of a little bit of trial and error. As instructors, as people that are working in the service, we're asked to come up with ideas; how can we get people into sport? So, people come up with ideas and we run it. We'll give it a go and, if it hasn't worked, we'll try something different. We'll see what does work and we keep trying things* [I3] and learning though doing *"Ooh, let's try this. Let's try this and see how it works."* [I3].

and

> *(…) we are the spotlight and there are places in Europe that are coming over and are looking at what we're doing, and the whole of England are looking, even though we don't get very much publicity (…) Yeah, they're coming and looking because the figures are amazing for the resources that we're taking away from the National Health Service in medication. People are either being cut down, their visits to GPs are being cut down, so we're saving the National Health Service an awful lot of money. And if we're doing it here where it's free, it could then work in countries where there is no free healthcare, because everybody seems to be suffering with the same thing. Obesity, high blood pressure, diabetes are the three that's hitting everybody* [I1].

Conclusion

The two mini ethnographic case studies exemplify different types of settings for employing bricolage by their users as well as illustrating different institutional responses to dealing with the complexity of

health concerns in superdiverse communities. In both case studies, there are some similarities in that there is an acknowledgment that diverse and complex health conditions need to be addressed in a multi-dimensional and individualised way through bringing together a different range of services and activities. To this end, it was apparent that the larger centre had expanded its sports and well-being offer and was working on developing closer and more trustful relations with users through wider forms of social activity. Similarly, the lunch club was also providing practical help and emotional and social support alongside basic food provision. Both utilised relationships with other organisations to diversify their offer drawing in expertise from elsewhere when they lacked it themselves.

But there were also important differences between the two case studies. The lunch club may be seen as holistic provision very much focused around the needs of the individual. It has employed a multidimensional approach and has supported many users over a long period of time in an individualised and personalised way. Activities are time and labour intensive. Due to limited resources, the initiative is only able to support a relatively small numbers of clients at any one time. Its operation is heavily facilitated by volunteerism in terms of staff and other resources. In turn, its operational mechanisms allow for the optimisation of resources. Volunteers bring and utilise their resources in a flexible way and also benefit from their involvement. Such settings therefore provide considerable freedom and flexibility, allowing creative mobilisation of resources as the provider bricolages to meet diverse needs.

On the other hand, the larger centre was predominantly focused on large-scale community provision in terms of its health promotion and prevention activities. It provided an institutional setting, space and facilities for some forms of social encounter and for individuals to self-manage their health and well-being activities. Although it has larger infrastructural (the facilities), human (the staff) and financial (funds) resources than the first case study, it was apparent that the centre was sometimes constrained in terms of its funding mechanisms and rules of operation (as a state funded and governed institution). In turn, it was attempting to adapt to users by increasingly involving volunteers in its work, through working in conjunction with other state funded and non-governmental organisations and using limited resources (for example, staff and equipment) in new ways to try and reach and cater for the diversity of local populations. However, from an institutional point of view, voluntarism was more supplementary and arguably less flexible, impinging on levels of creativity and user and provider bricolage practices.

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