THE POSSIBILITIES OF PRACTICE.
Theoretical, methodological and ethical notes from an Anthropology-Public Health collaboration in UK

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LAS POSIBILIDADES DE LA PRÁCTICA. Apuntes teóricos, metodológicos y éticos para una colaboración entre la Antropología y la Salud Pública en el Reino Unido

Resumen: El presente artículo pretende, a través de una visión de la práctica antropológica en el Reino Unido, sugerir ideas para abrir el camino a una antropología peninsular más dinámica y dialogante. A través de la consideración de una evaluación etnográfica de un programa de salud pública en el Reino Unido, se exploran los puntos positivos que pudieran extraerse de la práctica antropológica en ese país. El artículo explora cómo la antropología académica británica conecta con otras disciplinas, agencias e instituciones para ofrecer reflexiones que revierten tanto en la evaluación de acciones sociales como en la producción de nueva teoría antropológica. Esta labor a la vez teórica y práctica es posible gracias al anclaje en una tradición teórica renovada constantemente a través del diálogo interdisciplinario, la utilización de metodologías colaborativas que requieren del compromiso de instituciones e investigadores y la preocupación por las cuestiones éticas que rodean a la labor antropológica.

Abstract: This article aims to suggest ideas for a more dynamic anthropological practice in Spain, through the examination of and comparison with anthropological practice in UK. Using an ethnographic evaluation of a public health programme in UK as a departing point, the author explores the positive aspects which could be extracted and extrapolated form the anthropological practice in that country. This article reviews the ways in which British anthropology connects with other disciplines, agencies and institutions in order to offer reflexive commentaries which have an impact both on public health interventions and on anthropological theory. These theoretical and practical dimensions are possible thanks to British anthropology's grounding on theoretical tradition (a tradition which is constantly renewed through interdisciplinary dialogue), thanks to the use of collaborative methodologies (which demand the implication of institutions and researchers alike) and thanks to the concern with the ethical questions arising from the anthropological enterprise.

Palabras clave: Antropología aplicada. Teoría, Ética, Interdisciplinariedad.
Applied Anthropology. Theory. Ethics. Interdisciplinarity

I. Introduction

In 2011, I was invited to participate in the symposium entitled "El sentido de la antropología hoy: responsabilidades, dilemas y acciones" ("The meaning and purpose of contemporary anthropology: responsabilities, dilemmas and actions") in the XII Congress of the Spanish Federations of Anthropologists (León, September 2011). When thinking about what kind of paper I could write to it in with the organisers remit, that is, to critically comment on the state of contemporary Spanish anthropology, my first thought was that I was far more familiar with British social, medical and applied anthropology than I was with the anthropological activity in Spain during the last 20 years. From this perspective, what could I say that could contribute to a critical review of the state of things, and perhaps to collective suggestions for a way forward for Spanish anthropology? I then reflected on the general differences between British and Spanish anthropological practice (both academic and applied) as I understand them, and it occurred to me that a critical consideration of what I know best could help to throw into relief both the limitations and the opportunities for the development of the discipline in the other case.

Given my somewhat limited practical knowledge of the Iberian situation, it would have been presumptuous to simply list the kind of disciplinary frameworks and practices I feel are "well done" in British academic anthropology, as it is probable that those might have been incorporated and even surpassed in Spanish anthropology a long time ago. However, I had been recently involved in an original collaboration between anthropologists, health and social scientists, and public health and enforcement practitioners, for the implementation and evaluation of a regional tobacco control programme in UK. My work in this project, the challenges it had posed, the manner in which the ethnographic team had endeavored to resolve them, and the reflections it had motivated could serve as a springboard to comment on the forms in which contemporary British anthropology aims to reinvent and sustain itself in the 21st century through applied work and interdisciplinary collaborations. But the challenges and difficulties posed by new forms of anthropological practice, ushered in by new disciplinary interests and by new social, political and economic conditions surrounding academia, are not to be seen only as "problems". Those challenges represent opportunities to critique, refine and improve our theories, methodologies, ethics and epistemologies, and to find new hybrid or interstitial spaces within which to practice new forms of our old trade. Thus the following sections do not intend to be systematic, exhaustive or pedagogical, but merely to provide indicative notes as to possible new directions for anthropology, both in UK and in Spain, and ideas for new forms of working and engaging both with multi-disciplinary partners and with the larger society.

II. The case study

A public health initiative in the North of England

In September 2010, I started participating in the evaluation of a public health programme entitled "North of England Tackling Illicit Tobacco for Better Health" (the NoE programme from now on). This programme was the result of an unusual and original collaboration between various institutions and organisations across the North of England, some of them involved directly in tobacco control (such as the northern regional tobacco control offices and the Department of Health) and others involved in law enforcement (including Her Majesty

Revenue and Customs, HMRC, Trading Standards and the Police Department). The formal launch of the Programme was in July 2009, and was funded by a grant from the Department of Health.

The Programme was based on evidence of high incidence of smoking in all three North of England regions, and of illicit tobacco (smuggled, bootlegged and counterfeit) compounding this problem, as the wide availability of illicit tobacco undermines other tobacco control measures. The main aim of the NoE programme was thus to increase the health of the population in all three regions of the North of England through reducing smoking prevalence by (a) reducing the availability (supply) of illicit tobacco; and (b) reducing the demand for illicit tobacco by supporting existing tobacco control measures. It also aimed to raise awareness of the issue of illicit tobacco among the public, to engage with relevant health and community workers, and to develop infrastructure to aid identification of illicit markets, information sharing and enforcement. The Programme intended to achieve the above broad aims through an effort of concerted action between health and enforcement agencies.

The programme's evaluation

The NoE programme constituted a complex community initiative, which aimed to promote positive changes at several levels (Judge; Bauld, 2001). The complexity of the programme was further compounded by its implementation across the three regions of the North of England (North East, North West and Yorkshire and Humber), which differ not only in size but in regional and local organisational structures. Complex community initiatives are not easy to evaluate, and are usually not suitable for experimental design (Judge; Bauld, 2001).

As the NoE programme was being set up, its Governance Board approached Professor Ann McNeill at the UK Centre for Tobacco Control Studies (UKCTCS) at the University of Nottingham, an expert in health promotion and policy who was commissioned with putting together a team of experts to provide the overall evaluation. Professor McNeill and her team proposed a theory-based evaluation. The NoE programme had been developed on the basis of a Logic Model, which "illustrates the logical relationships that the stakeholders believed existed between the inputs of the programme (the resources) and the activities the programme undertakes and the changes or benefits that result from it"[1]. The NoE programme's Logic Model was in turn underpinned by a Theory of Change. A Theory of Change is a "systematic and cumulative study of the links between activities, outcomes and contexts of the initiative" (Connell and Kubish 1998). That is, public health programmes that take a Theory of Change approach are, in essence, hypotheses about improvement in the health of a population: they chart a course that is shaped by a vision of change and how it will occur – and succeed or fail according to veracity of that vision (Pawson; Tilley 2004). A Theory of Change entails "the articulation of the underlying beliefs and assumptions that guide the development and implementation of a strategy" (Hernandez; Hodges 2006: 166) and involves defining the characteristics and assessing the needs of the specific target population, deciding what needs to be accomplished (outcomes), and designing strategies to attain the desired results.

The task of the evaluation team was therefore to appraise not only the programme implementation and outcomes but also – and importantly – the principles and understandings of

1 *Evaluating the North of England Illicit Tobacco Programme*, UKCTCS, September 2009.

change on which the Programme rested, how consensus about them had been reached, how well they have been explored and defined, and how effectively a logical pathway had been developed between problems, strategies, objectives and outcomes. This, as we will see later, opened up all sort of possibilities for anthropological theorisation.

The main evaluation was conducted by social scientists who specialised in tobacco control and public health research, and who utilised both quantitative and some qualitative methodologies for the evaluation of the programme. For instance, Key Performance Indicators were agreed upon with programme partners from different agencies, and baseline data was obtained from a variety of previously existing research. This baseline data was then contrasted with upcoming data from newly commissioned research (both by the programme and by other research bodies and governmental agencies). However, the evaluation team noted the difficulty of assessing quantitatively certain aspects of the programme, such as the dynamics involved in the development of partnerships, the influence of differing institutional and regional work "cultures" and practices in the setting up and achievement of goals, and the manners in which the programme's aims and objectives were cascaded down to and understood by frontline workers. It was important to pose those question in order to elucidate what organisational and interpersonal elements had had an impact both on the setting up of the programme and its conceptual logic, as well as on its day-to-day running, which might have in turn an effect on its results (either positive or negative). It was assumed that those elements were linked to socio-cultural and interpersonal factors such as professional backgrounds, disciplinary assumptions, gender or levels of trust in relationships, among others. Thus it was decided that this evaluation should include what we can call an "ethnographic strand".

The ethnographic strand of the evaluation was then put under the remit of Drs. Russell, Lewis, Heckler and the author of this article, all of us members of the Medical Research Group at the University of Durham. The team used their experience of embedded and action research (Reason; Bradbury 2000; Huxam 2003; Lewis; Russell 2011) to carry out collaborative ethnographic research with the primary objective of elucidating the gaps in the research undertaken by other members of the evaluation team (as mentioned above) and to give a richer and more narrative description of the day to day running of the programme.

The main ethnographic and qualitative methods used to gather data for the ethnographic evaluation were the following: participant observation; informal and semi-structured interviews; narrative and discourse analysis of previous and parallel pieces of research commissioned by the NoE programme and other similar programmes; narrative and discourse analysis of documents, emails and other forms of written communication prepared for and by NoE programme stakeholders; and narrative and discourse analysis of documents, research, websites and communication by other organisations and researchers on the topic of illicit tobacco or related topics. It is also important to note that ethnographic research methods evolved and adapted to changing circumstances during the course of the evaluation.

Anthropological collaborations in UK

The collaboration between academic anthropology, other academic disciplines in the social or health sciences, and public health institutions is not new to this project. Academic anthropology has been collaborating with outside agencies for some decades, both in the UK and outside, and has included participation in programmes not only in health but also in

education, social welfare, and international development among others. Yet it is only since the eighties that social scientists (and among them anthropologists) began to play "a major role in research on health problems and programmes" (Rosenfield 1992: 1343). This was in part a result of the realisation that a solid health research base could only be achieved by linking research, policy and action, and that thus both social and medical sciences had a significant role to play at all levels, including providing evidence, working on implementation, and evaluating results.

In the particular case of public health problems and programmes, early collaborations between academic social science disciplines (including anthropology) and health institutions tended to be carried out in practice as clusters of separate activities. Each one of the tasks was carried out by a specific disciplinary collective and reflected its paradigmatic approaches and thus so-called collaborations never fully engaged in real trans-disciplinary research and action. For instance, anthropologists might have provided the "socio-cultural" context for a particular public health problem (such as obesity or tobacco consumption) by producing ethnographic writings which represented the views and experiences of the population as well as charting the connection of the particular problem with various social, cultural, historical or economic factors. Yet often the task of anthropologists ended there, and the information they provided was treated as "soft data" and therefore different from the "hard evidence" provided by statistics. The anthropological practice has been in many cases separated from the "real" work of design, implementation and evaluation of public health programmes, tasks which have been left to both health practitioners and quantitative social scientists.

In recent times, however, collaborations between anthropology, other social sciences, and public health bodies have taken a different turn. A movement towards real participation and integration of efforts have resulted in the formation of multidisciplinary teams, which have aimed to transcend disciplinary boundaries to produce real interdisciplinary research and practice. In this context, interdisciplinarity must be understood not just as a random amalgam of separate theories and methods, used at different times and for different purposes, but as a true effort of exploration of the interstices between traditional disciplinary boundaries, and of the possibilities those interstices afford for the emergence of new integrated theory and methodology.

Thus anthropologists have been given the opportunity to become part of multi-disciplinary teams which have focused on specific public health issues, approaching them from a variety of theoretical and methodological angles, and linking multi-paradigmatic research with grounded and integrated practice. An example of this could be previous research carried out by members of the Medical Anthropology Research Group in Durham in connection with tobacco control (Russell; y otros, 2009). At the request of public health practitioners, these Durham anthropologists engaged in ethnographic research about "new organisational forms in public health" (Lewis; Russell 2011: 399) through a study of the first dedicated tobacco-control office in the UK. They were embedded at all levels of the programme from the beginning, as "some kind of team members" (Lewis; Russell 2011: 400) who, whilst retaining some independence, provided informed and meaningful continuous feedback to their collaborators who could and would answer back.

It must be noted that this development towards multi and interdisciplinary research and action is not exclusively the result of a new appreciation, on the part of public health bodies, of the potential benefits of anthropology's epistemological and methodological approaches,

as alternative forms of knowledge for their evidence-based practice. Medical anthropology itself began some time ago to move its gaze from its more traditional objects of study (notions of health and illness in other cultures, medical beliefs and practices, culture-bound illnesses) to focus on emergent contemporary issues, such as the socio-culturally grounded explanations for the health behaviours of particular populations, the reasons and potentiality for public health changes, and the connection of health with economic and political global systems. Furthermore, the very theoretical and methodological foundations of health institutions and organisations, as well as of medical scientists and practitioners, have become also a matter of interest for anthropologists, both within medical anthropology and within social sciences studies of science.

The motivation for this anthropological move towards less traditional and more emergent themes is not due only to intellectual curiosity and to changes in the theoretical paradigms of anthropology. It is also due to fundamental changes in the way academia has come to be conceptualised within society and funded by the relevant (mostly governmental) bodies. In the case of the UK, there has been a move of late towards a more socially accountable, more relevant and impactful form of "doing" anthropology, demanded by both society and governments and instigated by deep changes in the funding models for research. That is, in order to be able to receive grants for research activities, UK academic anthropologists have been forced to leave their ivory towers and enter into collaborations with other disciplines and public bodies, as multi-disciplinary and applied research projects are seen as more appropriate (both intellectually and financially) and therefore more likely to be successful in funding applications. Academic anthropologists are thus now required to negotiate research topics, questions, and methodologies within larger collaborative projects. Finally, they also need to demonstrate the social or economic impact of anthropological research activities, by explaining how these are of benefit for the society as a whole or for a particular population, and by allowing evaluation and audit of the results.

The changes in funding priorities for academia and the introduction of stringent research activity audit and of public impact evaluation are complex and difficult topics which are not per se the object of this article. Suffice to say that whilst those new conditions might bring many benefits to the anthropological community (such as a deeper implication of the discipline with emergent and important societal issues) it might also shape anthropological practice (and thus theory) towards a more science-based or policy-based model. A model which values speed of research, applicability of results, and conciseness in dissemination in detriment of the long-term engagement, importance of the theoretical production, and "thick" narrative account of results of the anthropological enterprise. Yet there are many opportunities afforded by multi-disciplinary collaborations with other social and health disciplines and with public health bodies, opportunities that I will discuss in the following sections, through the particular case of a tobacco control programme evaluation described above.

III. Methodological and Epistemological Possibilities

As it has been mentioned above, several members of the Medical Anthropology research Group of Durham University were in charge of the ethnographic strand of the evaluation of the NoE programme. That a group of medical anthropologists is involved in an evaluation of a public health programme as part of a larger interdisciplinary team is not a unique situation in itself. However, in the NoE programme the collaboration between different

disciplines and partner agencies was somewhat original. As already mentioned, partners included members of both public health and enforcement agencies, which is an extremely unusual pairing; in addition to this, the ethnographic evaluators were working as partners in the programme in their own right, and not simply as external evaluators. This created the necessity for uncommon aims and objectives and resulted in novel methodological solutions and exchanges. This situation also made it possible for the anthropological team to obtain unexpected results in terms of anthropological theory, which in turn brought new ethical dilemmas to our attention. All of these will be explored in turn briefly.

In methodological terms, although all participating anthropologists were members of the Medical Anthropology Research Group, not all of us were actually medical anthropologists, or even experienced evaluators of public health (or simply health) programmes. Yet it was our capacity to bring "a fresh pair of eyes", as socio-cultural anthropologists, to the topic of tobacco control research and implementation which was most appreciated by both the evaluation team and the programme partners. It was precisely this appreciation for the specific qualities of anthropological research which also made the main evaluators (public health social scientists) and the partners (public health and enforcement practitioners) to request an ethnographic element within the evaluation. The idea was that we, as anthropologists, would be able to use our ethnographic skills to engage with participants in the programme, both in conversations and in shared activities beyond meetings and briefings, in order to collect a "thick description" (Geertz, 1993) of certain aspects of the programme which could not be researched by or understood through quantitative data or even by other qualitative methodologies such as questionnaires of structured interviews. Interestingly, the suggestion of ethnographic research as an integral part of the evaluation also introduced specifically anthropological questions and concepts into it. For instance, issues such as "how do partners engage with each other given their differing work cultures and disciplinary ethos?" presupposed the importance of understanding partners' socio-cultural backgrounds in order to comprehend their relationships, and the necessity to situate these in the context of historical hegemonic relations between groups and institutions. Thus there was a two-way relationship between the introduction of ethnographic methods into the programme evaluation and the reshaping of the very aims and questions of the evaluation, which produced an interesting epistemological turn.

Furthermore, ethnographic evaluations are rare in the context of public health, as they usually require levels of time and depth which are not normally available in a world dominated by the need to turn rapid results within permanently threatened budgets. Yet in our case we had this luxury thanks to the level of trust and commitment exhibited by evaluators and partners, underpinned by previous successful collaborations such as the one mentioned before. This trust, which of course had to be constantly renewed and reassured through our professional and ethical behaviour, afforded us the time to fully pursue proper ethnographic research, as our work was now more fully understood by our partners. Most importantly, it also afforded us a significant level of access to the inner workings of the programme (to private conversations, off-the-record comments, gossip, and chance events) and also to the partners themselves, who lent themselves as "objects" of study. It must be reiterated here that the ethnographic evaluation was fundamentally a process evaluation, as what we were out to assess was not the impact of the implementation on the target public, but the dynamics of communication and collaboration between programme partners, the differences in "cultures of practice" between agencies, and the way the programme was understood at

sub-regional level and among frontline workers. This dual position of programme partners as both "collaborators" and "objects" posed methodological (and ethical) questions which called for novel solutions.

Working as members of a team and with and among □reflexive□ practitioners of other disciplines implied that we were □working in collaboration with, rather than socio-cultural apprentices to, our subjects□ (Lewis; Russell 2011: 399). It meant we needed to understand the priorities and modes of thinking and working of our health and enforcement partners as equally valid to ours in a common enterprise, forcing us to be weary of anthropology´s tendency to establish (though various techniques) forms of ethnographic authority (Clifford; Marcus, 1986). We also needed to account for the reflective and informed capacity (and right) of our partners to answer back and to challenge our explanatory models, the validity of our research methods, and the accuracy and resonance of our conclusions. Yet, as collaborators with specific capacities which were distinct from those of our partners, we were also obliged to produce critical evaluations and commentaries, which had to be necessarily inscribed in our own paradigms to produce explanations alternative and even contrary to theirs. Walking those fine methodological lines was not always easy and definitively not always successful, but the interdisciplinary vocation of the project demanded that we stuck to that interstitial space.

Finally the NoE programme, as many other public health programmes, was subject to tight time schedules, happened simultaneously in various places and at various levels, and consisted of disaggregated and partial activities. The ethnographic team had to learn to adapt to this fragmented and fluid context, and develop techniques based on the principles of multi-sited ethnography (Marcus, 1995) and actor-network theory (Latour, 2005) which accommodated to the forms of programme partners and to the contours of the programme itself. For instance, we had to be able to attend a board meeting one day in Manchester, as participants-observers, and an illegal tobacco police raid on the following day in a small community outside Leeds, in which we were only allowed to be peripheral observers, and which required very careful reporting in order not to infringe security rules. We also followed the track and fate of particular documents as they travelled from executive meetings via middle managers to front-line workers, thus traversing different notional and situational worlds which interpreted and used them in very different ways.

IV. Theoretical Possibilities

In our dual position as ethnographic evaluators and partners, we learned invaluable lessons about how to work with specialists in other disciplines, practitioners in public health and enforcement, to understand (and provide) explanations inscribed within different paradigms, to work within stringent time-scales and other practical limitations, and to pursue objectives which were not strictly anthropological or ethnographic, and very much applied. But aside of interdisciplinary methodological lessons, and within our ethnographic evaluation remit for the programme, we were able to engage with anthropological theory and to further certain theoretical dimensions which go beyond medical anthropology or public health studies.

It has been mentioned before that the programme rested upon a supposedly agreed Logic Model, underpinned by a Theory of Change (a hypothesis about what health aspects need improving in a population and how change can be effected and will in fact occur). As part of the ethnographic evaluation, we conducted research into partners' assumptions about how

to stop people from dealing in and demanding illicit tobacco, and about how they thought people's attitudes and behaviours could be changed. The data we collected through our enquiries made us realise we were not just gathering information which would help to further applied theory about the effectiveness of public health interventions. We became conscious that what we were uncovering through our interviews, conversations and observations were conceptual models of the person. That is, partners had implicit ideas about personhood, about how persons were constituted, interacted, functioned, and responded. These ideas about the nature and configurations of persons are necessary to identify who is the target of an 'intervention', and how best to design such an action to effect meaningful changes. And our ethnographic data was backed up by our narrative and discourse analysis of programme documents, and even by a review of the tobacco control literature. In this way, we were able to reflect on and contribute to mainstream anthropological theory beyond the limited confines of public health programme evaluation research.

Thus a whole new (and novel) theoretical angle stemmed out of our ethnographic research, which had only had an applied and specific objective in the first place: to provide anthropological support and evidence for the programme evaluation. We began to develop what we called "Models of the smoking person in tobacco control", and we distinguished three major paradigmatic ways of understanding and conceptualising the person in this public health area.

First was what we termed "the core individual and the smoking epiphenomena", which reflected a vision of the person as a unitary being constituted by a stable core and a movable periphery. According to this vision, frequently expressed by our partners, persons possess, extraneous to their 'core', movable immaterial appendages in the form of values, ways of thinking and, most importantly, behaviour. These epiphenomena are regarded as external and somewhat unessential to the being of a person, things that can and, in some cases should, be changed. They are attributes put there in the first place by others in the form of social norms, peer pressure, or media messages, or else they result from an inner taint or weakness. What follows is a logic of addition /subtraction: if it was added, it can also be taken away. This model of the person provides the underlying rationale for many anti-smoking campaigns including the illegal tobacco programme which is the object of this article. Programme partners took the view that by dramatically exposing the criminal nature of this particular epiphenomenal behaviour to illicit tobacco smokers and their surrounding communities, such smokers would be persuaded to drop their behaviour as a now seriously compromised appendage.

The second paradigmatic view of the person which we identified was that of "the smoker as victim". This common perspective in tobacco control imagines the smoking person as devoid of agency. In one explanation, the addictive substances contained in tobacco imbue the desire to smoke and compel the action of smoking, through an impulse which is ordered from within their own bodies but by an agency other than their own. In a curious twist of paradigmatic frames, tobacco functions as an agent or actant in the purest Latourian sense (Latour 2005). The smoking cessation concern here is with an addictive substance, a fight that takes place within the bodies of the smokers but in which their agency is questionable: the idea is to excise (largely through medicalised interventions) the material actant from within and to keep it firmly on the outside of the non-agentive body. Smoking is, so to speak, extirpated.

There are other traces of the 'Pavlovian automaton' in theories of the person implicit in

tobacco control. These include ideas that smokers have become so due to the brainwashing effects of localised, erroneous social norms, product placement in the movies, 'smoking walls' in supermarkets, and so on. Partners in the North of England programme proposed that illicit tobacco use was particularly high amongst 'vulnerable' classes of persons in deprived communities. Children or young single mothers were seen as simply and unwittingly falling into a trap.

Finally, another common view of smoking persons was that of "the smoker as perpetrator". On the opposite side from non-agentive visions of the smoking person, but somehow co-existing with them, are the interpretations of the smoker as hyper-agentive: the smoker smokes deliberately, knowingly, exercising a vicious will, courting risk and causing public damage and self-damage. Whilst the non-agentive smoker was a victim, the hyper-agentive smoker is a perpetrator: entrenched, hardened, cunning. Several partners in the North of England programme spoke of illicit tobacco smokers as deliberately seeking and indulging in its use, and avoided focussing their tobacco control efforts on the categories they variously identified as "hardened regular", "culturally ingrained", or "cheap champions". It is interesting to note the slippage that occurred between the illicit/illegal/criminal nature of the object (illicit tobacco) and the vague but insidious criminalisation of the subject (the illicit tobacco smoker), despite the fact that, once bought, smoking illicit tobacco is not a criminal or illegal activity. This could be linked to the presence of enforcement partners and paradigms in the programme, but could also be traced to recent development in public health thinking, which sees health as a moral imperative for the individual, and those who do not look after themselves are conceptualised as veritable "deviants" (Metzl; Kirkland, 2010).

Agency transforms the perverted intentionality of the smoker into a conscious decision-making process. Smoking attitudes and behaviours in an agentive person may be based on false premises and warped information. It follows, in common with the persistent trope of other health education domains, that when provided with the correct information, the rational decision-maker will necessarily and inevitably undertake a behaviour change in the face of such compelling evidence. The North of England partners spent a significantly large proportion of their budget in a social marketing campaign which attempted to inform the public of the criminal nature of the illicit tobacco trade. The assumption was that this information would persuade people in deprived communities to reject and denounce both the consumption and the marketing of illicit tobacco in their neighbourhoods.

Different aspects of our theoretical findings have been presented to general anthropological publics in international conferences (Carro-Ripalda; Russell, 2011) and published in interdisciplinary journals (McNaughton; Carro-Ripalda; Russell, forthcoming). Our theoretical theses have been received with enthusiasm by fellow anthropologists inside and outside medical anthropology, particularly among scholars specialising in personhood and biopolitics.

V. Ethical and epistemological considerations

As we have just seen, our dual role as ethnographic evaluators and programme partners allowed us a position from which we were able to fully participate in most programme activities whilst retaining a critical distance with respect to partners' assumptions and paradigmatic views. The trust we developed with other partners was invaluable to give us access to people's innermost ideas and thoughts, and we were privileged witnesses of how those ideas became actions in the programme. However, this dual position also generated a tension

between being insiders yet outsiders, and it was at times difficult to navigate. In amongst other things, it brought new ethical dilemmas to our work: how could we achieve the passage between seeing our partners as equal collaborators to considering them subjects in our study? And what kind of "knowledge" were we producing in our interactions with them?

UK academic practice, particularly when it comes to health issues, undergoes stringent processes of ethical approval. There are usually ethics committees at departmental and faculty levels, and projects which involve external partners are also evaluated by these (for instance, social science research within the National Health Service has to comply with NHS ethical procedures). Thus our project (both the overall evaluation and the ethnographic strand) had been ethically reviewed and approved by our respective departments and by the management board of the NoE programme. Furthermore, we systematically asked for informed consent from our partners, and we followed the ethical guidelines of the Association of Social Anthropologists of the UK and Commonwealth.

But ethical considerations are not just a matter of formal compliance with well established rules and regulations. Ethics is a process, a continuous engagement with both the subject matter of our discipline, and the subjects and objects of our studies. There is a long tradition in UK of questioning the positionality and authority of the ethnographer, and many books and articles are devoted to this subject. This reflexivity is very characteristic of UK anthropological practice, it is taught at degree and post-graduate level, and it compels UK-trained anthropologists to make ethical deliberations an integral part of our work. Ethical considerations are not just a matter of professional and human courtesy, but they are intimately linked to the form and quality of our research results, as they shape and define ethnographic findings' validity and resonance, and the degree to which our research participants will "own" what we write about them.

This British tradition of ethical reflexivity compelled us to think very carefully about the nature of our relationship with partners, and also about the epistemological nature of the knowledge which was produced through our interactions. Thus we had to navigate carefully the boundaries, the continuities and ruptures which lay between the tasks of conducting an applied interdisciplinary and collaborative evaluation, the aim to further applied public health knowledge, and our desire to produce bona fide social-anthropological theory. This was most important as we had to fulfil the ethnographic evaluation remit for which we were being paid, but we were also expected to collaborate in the achievement of conclusions which could be usable by public health practitioners, and thus inscribed in paradigmatic frames that rendered them comprehensible for its professionals. As anthropologists, we did not always agree with such paradigmatic frames, and in some cases they went against out conceptual understandings. What we did on those occasions was to enter into dialogues with our partners which would produce a form of consensual knowledge which met with the approval of all parties, and which was informed by the various forms of evidence that had been obtained through the evaluation research. This process of negotiation highlighted the relativistic and contextual nature of disciplinary knowledge.

Most notably, we had to negotiate the very notion of "knowledge" with the different academic and non-academic partners involved in the NoE programme. The wildly differing understandings of what constitutes "data" or "evidence", and how these are to be obtained and used, also foregrounded the great differences in forms of knowledge production among disciplinary and professional traditions. As those forms of knowledge and knowledge production also sit in a hierarchical order, we found ourselves on many occasions justifying our

ethnographic and anthropological methods, and defending the validity and accuracy of the conclusions to which we had come through them.

Finally, at the most basic ethical level, we had to make sure that we did not alienate or discomfort our partners by what could be considered our inquisitive or even intrusive forms of questioning. In addition to making our theoretical objectives clear to them, we engaged in conversations with them about our theoretical partial results, to test whether our interpretations held any resonance, even if they were thought of as not entirely relevant or to the point. Our theoretical results are now being published not just in mainstream anthropological journals, but mostly are aimed at peer-reviewed public health publications, so that these professionals can critically review our findings, and engage in further dialogues with our discipline.

VI. Conclusions

In this article I have examined an interdisciplinary evaluation of a public health programme in UK. Through a consideration of the terms of the practical task and of the collaboration between different partners, agencies, and institutions, I have presented briefly the methodological, theoretical, ethical and epistemological dilemmas that the anthropologists in charge of the ethnographic strand had to face. Yet an argument has been made that whilst these dilemmas represented challenges that required skilful negotiations which were not always successfully achieved, they also represented significant opportunities for the critical production of anthropological theory, the creation and testing of interdisciplinary methods and ways of working with disciplinary others, and the platform from which to reflect on important ethical and anthropological dilemmas. I have also argued that the grounding of the anthropological evaluation team within the history of interdisciplinary evaluations in UK, and within a long tradition of disciplinary theoretical, ethical and epistemological reflexivity, provided the confidence to explore and improve old and new avenues of anthropological work which facilitates the continuous advancement of our discipline. It is hoped that those small and humble lessons from a UK project will provide the basis of inspiration for Spanish anthropologists and public health practitioners alike, and will prompt them to enter into new forms of practice and collaboration.

Acknowledgements

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