

Learning from Practice: Evaluating a Community Involvement Team Within a Health Action Zone

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Abstract

The range of activities and the focus on partnership working in Health Action Zones create challenges for evaluation. This paper describes the evaluation of a Health Action Zone initiative aimed at increasing community involvement in health across a health district. The design and implementation of the evaluation have been shaped by the policy context, the diversity of activities and the range of stakeholders from different sectors and communities. A collaborative approach to research has enabled findings to be fed into policy and practice. The paper reflects on the evaluation process and discusses some of the methodological and ethical issues that have arose.

Health Action Zones were an early initiative of the new Labour Government, creating areas that were to be 'trailblazers' tackling some of the most intractable problems in health and health care (Department of Health, 1997; Secretary of State for Health, 1997). With their emphasis on partnership working and community involvement, Health Action Zones (HAZs) present challenges for evaluation but also opportunities for learning lessons that can be more widely applied to the evaluation of other broad, multi-agency initiatives. Those involved in the evaluation of such initiatives, whatever the scope and intensity of the planned evaluation, are required to make key decisions on design, measurement and implementation. Yet despite the enormous potential for sharing learning and improving the fit between methodology and evaluation practice, issues and experiences relating to the research process tend to be under-reported. The aim of this paper is to describe the experience of setting up a small scale, collaborative evaluation of a Health Action Zone (HAZ) Community Involvement Team and to reflect on some of the 'real life' issues that have arisen. Many aspects of evaluation practice discussed here have relevance to carrying out practice focused evaluations in other settings in the health and social care sectors. The intention is not to promote a particular approach or method but instead to share experiences and encourage debate in the spirit of Health Action Zones being 'learning organisations' for practice, research and policy.

The paper starts by describing the national evaluation context and identifying some of the research challenges within Health Action Zones. It goes on to briefly describe the initiative which was the subject of the evaluation under discussion. The application of an evaluation framework, the choice of methods, and the rapid appraisal of baseline information are then described. This is followed by a discussion of some of the emergent issues,

including the politics of collaborative evaluation, feeding findings into practice and the difficulty of measuring complex interventions involving different stakeholder perspectives. The paper concludes by drawing out the lessons learnt and the value of collaborative approaches to evaluation.

Evaluation in Health Action Zones

There are 26 Health Action Zones in England which vary in size and, in the main, cover areas of deprivation (Judge et al, 1999). They form part of the government's overall policy drive to tackle health inequalities through strategic objectives of partnership working, modernising services and addressing public health needs in local areas (NHS Executive, 1997; Department of Health, 1999). The nature, purpose and context of Health Action Zones create unique challenges for evaluation whether at national, district or project level. On the one hand, Health Action Zones provide an opportunity for learning as services are reshaped and innovative practice is pioneered across different sectors. On the other hand, there is an imperative for Health Action Zones to create the conditions for a genuine and discernable shift in health and a reduction in health inequalities. Evaluation, therefore, needs to both feed into developmental processes as well as provide a robust assessment of the impact and effectiveness of Health Action Zones and the strands of activity within them (Jacobson and Yen, 1998; Judge et al, 1999).

Health Action Zones, by their nature, encompass multiple projects and activities which typically involve a range of stakeholders. The National Evaluation team identified two major issues for evaluation – the need to focus evaluation efforts and an acceptance that traditional approaches to evaluation are insufficient (Judge et al, 1999). The emphasis on partnership working and community involvement, underpinned by a broad model of

health, has implications for evaluations of individual projects and initiatives within Health Action Zones. Local evaluators need to be able to measure change in multi-faceted interventions, involving inter-sectoral collaboration, which are often linked to other strands of work in a Zone. At the same time they have to take account of ongoing structural changes taking place in the NHS and local government. This rich and messy context requires new approaches to evaluation and the National Evaluation team has adopted an overall framework for Health Action Zone evaluations based on two models – Realistic Evaluation (Pawson and Tilley, 1997) and Theories of Change (Fulbright-Anderson et al, 1998). Realistic evaluation is a model developed for evaluating policy programmes based on linking the context of a programme and the mechanisms through which change will take place to the outcomes. It can be expressed as a configuration: Context [C] + Mechanism [M] = Outcome [O] (Judge et al, 1999). Theories of Change is an evaluation model which was developed in America arising from work done with Comprehensive Community Initiatives. It adopts a participatory approach to evaluation involving stakeholders in articulating ‘purposeful activities’ that are expected to lead to specified outcomes (Connell and Kubisch, 1998). It is believed that by unpacking the assumptions behind the choice of actions, claims for attribution will be strengthened – a problematical area given the complexity and range of activities in Health Action Zones. The National Health Action Zone Evaluation is using these two models because they provide an appropriate framework for evaluating such complex policy initiatives (Judge et al, 1999).

Whatever the choice of evaluative framework, for local evaluators working with specific projects and initiatives, the key questions remain how and what to measure. Decisions on the establishment and implementation of an evaluation will be determined by the need to collect meaningful data and to generate findings that will be of value to practitioners and policy makers in local contexts. This paper goes on to describe the approach taken in one small scale, collaborative evaluation within Bradford Health Action Zone. Key lessons learnt are highlighted in Box 1.

Box 1:

Key lessons for evaluation practice

Using an evaluation framework can help structure data collection and identify priority areas

Key informants can be used to get baseline information quickly

Qualitative methods allow different perspectives to be explored

Draw up an ethical statement and be clear about how findings will be used

Collaborative research strengthens the links between research and practice

Bradford HAZ Community Involvement Team

There was a strong commitment within Bradford to community involvement in health prior to Health Action Zone status being granted. In order to progress the agenda and help translate policy into practice, a dedicated team of workers was established in 1999, funded through the Health Action Zone. The overall aims of the team were to promote community involvement in health planning, decision making and delivery and to work with others to build capacity for participation in organisations and communities. It was decided that the main focus of work would be on developing organisational capacity for involvement within the new Primary Care Groups, later to become Primary Care Trusts. The structural changes in the NHS were seen as a golden opportunity to build community involvement practices in from the beginning as these new organisations developed. The team consisted of one manager and four workers each attached to one of Bradford’s four Primary Care Groups, now Trusts. It was envisaged that team members would be key actors in creating and maintaining links between the Primary Care Trusts, other statutory agencies, and the community and voluntary infrastructure in localities and at district level.

During the period of the team's establishment, a collaborative evaluation was set up with Bradford Health Authority, University of Bradford and the team, to run over the course of the team's initial funding period to March 2002. The innovative and challenging nature of the team's work in new health organisations meant that it was important to know what worked, what difficulties arose and what lessons could be applied to mainstream work. The purpose of the evaluation was therefore threefold: to make an assessment of progress towards objectives; to examine the processes involved in building community involvement in health; and to provide feedback to inform future activities. In addition, the evaluation has been one of a number of case studies of specific projects that are part of the overall Health Action Zone evaluation in Bradford and also the National Evaluation of Health Action Zones, *Building Capacity for Collaboration* (Barnes et al, 2001).

A Framework for the Evaluation

In line with the recommendations of the National Evaluation of Health Action Zones, all local evaluations in Bradford adopted Theories of Change as the basis for an evaluative framework. Theories of Change provides a framework which links the context and rationale for activities to expected outcomes and long term goals (Connell and Kubisch, 1998). The evaluation of the HAZ Community Involvement Team was also set within an overall approach developed in Bradford for practice oriented action evaluations in health and social care. These 'Action Evaluations' use an inclusive approach to support staff to set goals, monitor activities and review progress (Fawcett, 2000).

In the early stages of the evaluation, work was done between the health authority, university and the team manager to look at key questions: Where are we now? Where do we want to be? What works and why? This led to the production of a simplified Theories of Change statement, where long-term goals were linked to short and medium term expected outcomes based on team activities. At this stage wider stakeholder involvement was not sought as the rationale for the focus of activities had been developed following extensive work around community involvement in the district, including a consultation exercise over the local

authority community development strategy and some research taking soundings from local voluntary and statutory organisations. Once the overall evaluation framework was in place, the evaluation team worked with the team manager and health authority lead to agree the main research questions, methods of data collection, along with some provisional indicators of progress. An example of how these were linked to the expected short and medium term expected outcomes is given in Box 2.

Box 2:

Example of linkage between team outcomes, research questions and methods

Long term goal: The involvement of local communities, communities of interest, service users and the wider public in service planning, delivery and decision making

Medium term outcome	Short term outcome	Research questions	Examples of indicators of progress	Research methods
Core principles of community involvement are embedded at PCT and general practice level	Each PCT has adopted a patient and public involvement strategy	Is community involvement being routinely built into the planning and activities of PCTs? What has been the impact of the HAZ Community Involvement Team?	Strategies adopted by PCT boards Changes in the pattern of community involvement activities within the PCT	Analysis of policy documents HAZ Community Involvement Team reports Repeat audit of PCT community involvement activities

The complex and dynamic context of the Health Action Zone, the diversity of the team's activities and the number of partners, all influenced the evaluation design. Team members were working with a wide range of individuals and groups, including managers, health professionals, statutory agencies and community groups. It was decided to use multiple research methods in order to fully capture the diversity of the work and to obtain different stakeholder perspectives on the impact of the team. Pluralistic evaluation incorporating the

perspectives of different stakeholders has much to offer in evaluating broad health programmes or services (Smith and Cantley, 1985; Curtice, 1993; Springett, 1998). There is, however, a risk that using multiple methods will result in an evaluation design that is impractical to implement in terms of its scope or alternatively leads to superficial, as opposed to meaningful and valid, data being collected. Findings can be also undermined by methodological and epistemological inconsistencies associated with triangulation (Blaikie, 1991). Experience in Bradford has shown that an evaluation framework, that carefully links outcomes, activities and research methods, provides a useful structure for the evaluation process. Given the diversity of stakeholder groups and the range of team activities, it has been easy to feel overwhelmed at times by the richness of the context and the number of potential areas for investigation. Having an agreed framework, however, has made it possible for the evaluation to retain a sharp focus on the priorities for data collection. These tensions between capturing the breadth of the work and the need for in-depth information are illustrated by the approach taken to gather baseline data.

Baseline Assessment

Two early tasks for the evaluation were the collection of baseline information and the establishment of monitoring systems. The rapidly changing policy and organisational context, both nationally and within the district, meant that a rapid appraisal of the current situation was required so that any subsequent change could be measured. Deciding what would be taken as a baseline was problematical for a number of reasons. Firstly, the team had not started with a blank sheet as there were many interlinked strands of community involvement activity across different sectors in the district. Secondly, the evaluator came into post after the establishment of the team and work was already well underway at the time of the rapid appraisal. Thirdly, the then Primary Care Groups were emerging organisations still in the process of establishing staff and responsibilities. All these factors meant that it was inappropriate and impractical to make a retrospective assessment limited to the time prior to the team's appointment. Instead a rapid appraisal of different aspects of community involvement work was undertaken to achieve the best possible picture of the context in

which the team had started work. Three main aspects were included: the background and key features of involvement activity in the district; the early responses of the Primary Care Groups to the involvement agenda; initial activities and impact of the HAZ Community Involvement Team. Data was collected from a number of different sources including: local policy documents; diaries completed by the team prior to the evaluator being appointed; interviews with individual team members; and interviews with key informants from the statutory and voluntary sector. In addition a baseline audit of community involvement activities and aspects of organisational capacity within the Primary Care Groups was undertaken during their first year of operation: April 99-March 2000. The rapid nature of the process meant that the baseline assessment was reliant on information provided by key informants and was not an in depth assessment, nonetheless it provided very useful information about the different strands of community involvement activity in the district during the period of the team's establishment.

Monitoring Activities

One of the prime purposes of the evaluation has been to inform the development of the work of the team and related strategy. This has implications for both the structuring of data collection and the feedback of results. There was an agreed need for data collection instruments which would capture the team's experiences while work was rapidly developing, at the same time as facilitating reflection on progress and processes. There is an emphasis on collecting data on activities within a Theories of Change approach (Connell and Kubisch, 1998). It was decided that team members would complete short reports every two months which would describe activities undertaken and identify any barriers or enabling factors. Team members placed activities into one of six categories which were devised to relate to short and medium term outcomes. All meetings and events attended were also recorded. In addition to the reports, it was agreed that the evaluator would meet with individual team members every six months and conduct unstructured interviews to facilitate further reflection on the work. Collecting monitoring information has enabled progress to be plotted as well as identifying new areas for further data collection.

Measuring Shared Work

Although the application of a Theories of Change framework can help structure data collection, there are still decisions to be made about choosing appropriate measures (Gambone, 1998). The team's work is focused on promoting organisational change and building community involvement into health as the normal way of doing business. Some aspects of organisational capacity, such as training courses or budgets for involvement, can be easily measured. However, the essence of the work is about promoting a qualitative change in the culture of primary health care organisations. Measuring that change presents challenges for the evaluation. One of the medium term expected outcomes talked of 'embedding the principles of community involvement at Primary Care Trust and general practice level'. The more ownership of those principles is spread throughout an organisation, the more difficult it is to tease out the impact of the team. Enabling, working behind the scenes and promoting community involvement in mainstream work, means the team's work is less visible and the outcomes often indirectly achieved. The evaluation has had to investigate what resulted from the team's work with other individuals and groups in primary care as well as collecting data on activities under the direct influence of the team. Although Theories of Change can provide a very helpful structural framework, the methodological challenges of evaluating interventions involving health alliances and inter-sectoral collaboration remain pertinent (Curtice, 1993; Gillies, 1998). For this evaluation, it has been important to acknowledge that while the team has made a unique contribution to building community involvement, it has not worked alone.

Evaluating partnership work not only creates problems around attributing impact but also in relation to differing perspectives and meanings. In the first stage of the evaluation, data collection was focused on seeking the perspectives of those in primary care organisations. Work on community involvement is relatively new for many health professionals and individuals can have varying levels of understanding of what is meant by concepts such as participation and involvement. Members of professional groups can hold different perspectives on health and the role of communities

(Brown, 1994; Jewkes and Murcott, 1996). Team members commented in early interviews how their work was based on a broad social model of health while many of those in primary care appeared to have a more clinical focus. Lack of understanding amongst health workers of the link between community involvement and health improvement is likely to have an impact on the work and progress of the team. The presence, therefore, of differing perspectives and meanings has profound implications for the evaluation, both in terms of methodology and identifying barriers to progress. Barnes argues that, when researching public participation, evaluation has to 'reflect the reality of a complex and contested set of perspectives and purposes' (Barnes, 1999). To address this, the evaluation design has encompassed investigation of differing perspectives through interviews with different groups of stakeholders in the organisations involved. Qualitative interviews with open ended questions have been used to allow different understandings to be explored. When collecting more structured information the evaluators have been clear about what is or is not included when using key terms such as community involvement. A 'Ladder of Participation' has been used which categorises participation activity according to the degree of power sharing involved and gives examples of typical approaches and methods at the various levels (Wilcox, 1994). These can range from information giving (Level 1) through to partnership working and supporting local initiatives (Levels 4 and 5). The Ladder has been adopted in the Bradford HAZ Community Involvement Policy. It has been used at various stages in the evaluation as a tool to help bring clarity to different meanings around community involvement, to allow respondents to see what types of activities might be included and to map activities.

Early Gains and Long-Term Change

Despite the inherent difficulties of measuring shared work, data has been collected which has allowed an assessment to be made of the team's progress against medium and short term expected outcomes. As illustrated in Box 2, the evaluation has sought to measure changes in organisational capacity relating to the expected outcomes. This has involved looking for structural changes as well as investigating more qualitative aspects such as

commitment within an organisation. By the end of their first year of operation all the Primary Care Trusts had patient and public involvement strategies with attached budgets in place. The evaluation found that the team has contributed to developing new participatory structures in the health service as well as promoting links between the Primary Care Trusts and other forums (South and Green, 2002). The evaluation has also sought evidence of Primary Care Trusts being involved in an increasing range of activities across all levels of the Ladder of Participation. Data has been collected on community capacity building activities. Findings showed that the team has been involved in supporting a range of health partnerships and groups in their localities. Team members have helped build connections and links for voluntary and community organisations as well as offering more direct support to specific groups as appropriate. Much of this work has been aimed at enabling participation of marginalised groups including those representing black and minority ethnic communities.

Like many Health Action Zone initiatives, the team has been funded for a time-limited period, with the intention that the work lays the foundations for later long-term change. Some positive outcomes from the early work have already been identified. Examples of early gains include networking which has enabled sharing of resources; voluntary and community organisations securing funding; and information on community needs being fed into planning processes. With the focus on organisational development and capacity building, the evaluation has not been designed to assess the quality of participatory activities nor the impact on different communities. It is, however, important that community perspectives are included in addition to the views of those working within the statutory sector. This part of the evaluation is currently being undertaken through focus groups with some specific groups and communities. Inevitably a small scale evaluation does not have the capacity to examine this in any depth, particularly given the range of work and the number of different communities involved. Recognition of the importance of evaluating the impact of community involvement activity has led to a multi-agency group in Bradford working together to develop an evaluation tool that

organisations can use to evaluate their practice. This tool is based on the Active Partners benchmarks for community participation in regeneration (Yorkshire Forward, 2000).

Linking Research and Practice

In an action research cycle the development of a project is shaped by the research findings, alongside the research process being informed by the needs of the project. It was recognised that findings from the evaluation needed to be fed back at an operational and a strategic level. Since the beginning of the evaluation, regular meetings of a steering group of the evaluation team, the team manager and the health authority lead have been held and the evaluator has attended team meetings as required. Presentation of draft findings has promoted valuable discussion on the processes of changing involvement in health and enabled further validation of those findings. Partners have been able to participate in shaping the evaluation process and identifying aspects for investigation. Community interests are not directly represented on the small evaluation steering group. Although this might be seen as a weakness given the topic of the evaluation, the reasons relate to the primary focus on organisational development and the practicalities of getting representation from the many diverse communities involved. Instead reports on the evaluation go to a district-wide multi-agency strategy group, with voluntary and community sector representation. There are many different strands of community involvement activity in the district, either associated with the Health Action Zone or other initiatives, and the evaluation steering group has taken the approach that the evaluation is part of that context not separate from it. An effort is made to disseminate findings as widely as possible to all stakeholder organisations in the district.

Finding what works, and what doesn't work and why, is the essence of the approach adopted in Bradford and it has meant that the evaluation findings can inform the development of practice and policy. It needs to be recognised that such an approach places considerable responsibility on the practitioners and the evaluators. In this evaluation, team members have had a responsibility to record their experiences truthfully – 'warts and all' - in order that learning can occur. They are aware that

findings are fed into different local policy arenas. The evaluation team has had a responsibility, not only to report findings accurately and ensure results are fed back, but also to ensure that individuals and their work are not exposed. Anonymity is not always possible because individuals work in specific contexts and would be recognisable even with disguising names. The need to know has, therefore, to be balanced with protecting individuals and their work. The evaluators have worked to gain a relationship of trust with the team. Early in the evaluation, a clear statement about access to data, confidentiality and feedback of findings was agreed with the team. A similar ethical statement is given to all other participants and this statement has guided the evaluation practice. There has been a genuine commitment from the team, health authority and university to work through ethical issues as they arise and to reflect honestly on the evaluation process.

There have been calls for more collaborative relationships to be developed with researchers, policy makers and practitioners to increase research utilisation (Frenck, 1992; Davis and Howden-Chapman, 1996). Evaluation that fosters a collaborative approach and encourages participation of stakeholders in evaluation design, data collection and analysis has many strengths and it is argued can 'increase the relevance and credibility of evaluation results, as well as the likelihood that the results will be used' (WHO European Working Group on Health Promotion Evaluation, 1998). It is also argued that it can, in certain contexts, impose significant limitations on evaluation (Pollitt, 1999). Tensions can arise in the collaborative relationship and the need to achieve a consensus could be seen from some research approaches as compromising the objectivity of the researcher. Overall, the benefits of developing a close collaborative relationship in this evaluation have enabled greater learning to take place, not only in relation to the team's work, but also with evaluation practice.

Conclusion

Evaluating any initiative or project in the context of a Health Action Zone presents challenges because of the dynamic nature of the context and the emphasis on partnership working and

participation. Yet the potential value of evaluation in assisting the learning processes around what works and doesn't work is enormous. The evaluation of the HAZ Community Involvement Team in Bradford has thrown up a number of issues of design, measurement, attribution, ethics and dissemination. This evaluation has not been about researching a demonstration project but has been about trying to make sense of shift in organisational and professional practice around public involvement. Despite the range and diversity of the team's work, it has been possible to structure the evaluation, to pose key questions, to gather data and to measure outcomes. The collaboration between university, health authority and team has supported an iterative process of refining data collection thereby maximising the collection of meaningful data. Feedback loops have been created so that findings are directly used to inform the development of practice and policy.

Acknowledgements

The research this paper describes was undertaken at Bradford University with funding from Bradford Health Action Zone. We would like to thank Dr. Barbara Fawcett for her helpful comments on early drafts of the paper.

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