



**Combat Poverty
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COMMUNITY PARTICIPATION AND PRIMARY CARE:

LEARNING FROM THE BUILDING HEALTHY
COMMUNITIES PROGRAMME

Dr Philip Crowley
November 2005

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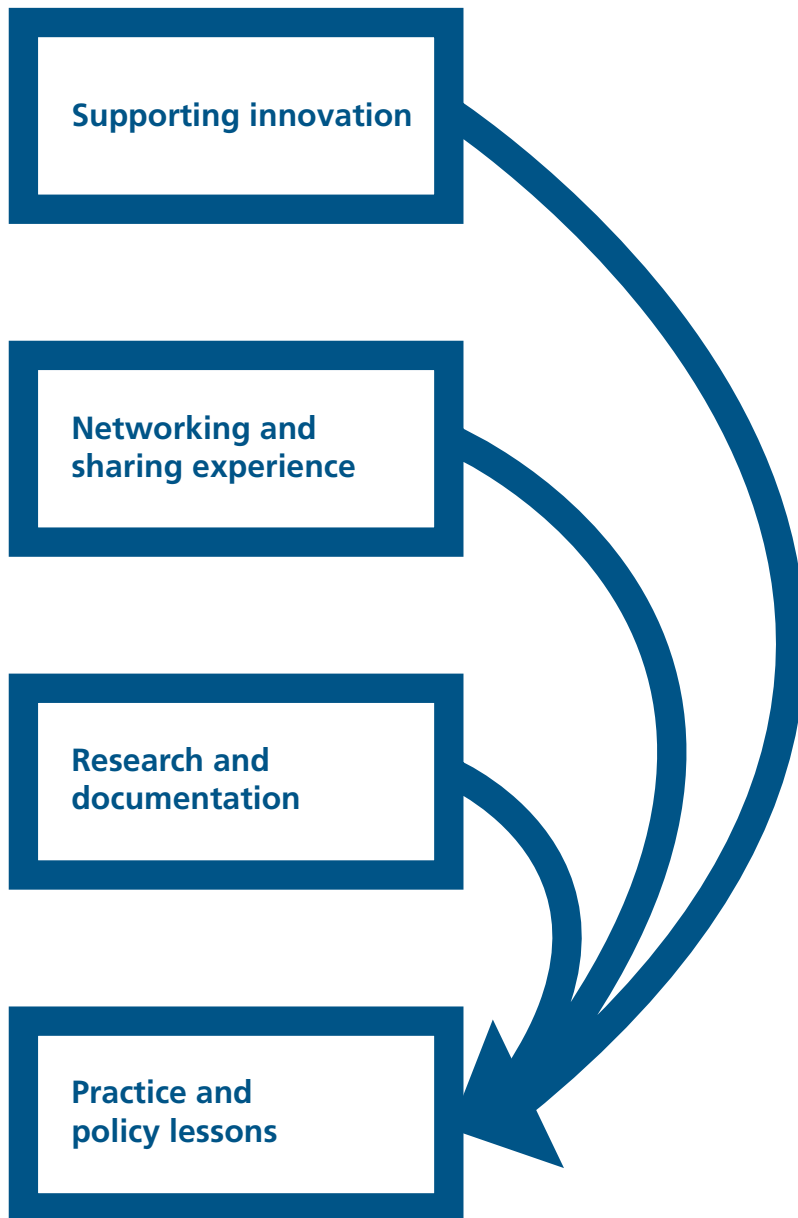
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There are four inter-linked elements to the Building Healthy Communities programme:



The BHC programme is situated within a rich policy context- the health targets in the revised National Anti-Poverty Strategy, the publication of the National Health Strategy and the Strategy for Primary Care. Each of these, in different ways and to varying extents, recognises the need to engage with communities in addressing their health needs.

2. Purpose of the Paper

Public and community participation in health is important in order to ensure that health services are developed in ways that are appropriate to local needs. The process should ensure that the underlying causes of ill-health and health inequalities are addressed. This is particularly valid in the area of primary care as it is here that most people, and especially those experiencing disadvantage, come into contact with health professionals. Combat Poverty is committed to capturing the learning from the BHC programme and translating the lessons from practice into the policy arena, including those relevant to the contribution of community participation to primary care.

This paper was commissioned to explore what can be learned from the projects funded under the Building Healthy Communities programme about links between communities and primary care. By highlighting and drawing on the experience of four projects, it aims to clarify the potential of community development and community participation approaches to health care. It also aims to highlight the positive outcomes of models of community participation in meeting the primary care needs of disadvantaged communities. The paper outlines the processes necessary to facilitate meaningful participation and partnership. In doing so, it promotes an approach that recognises and supports the participation of communities experiencing poverty in shaping and delivering primary health care services and aims to demonstrate the value of this not only to the communities, but also to the health service.

The paper is based on a focused review of literature relating to: health reform and health services in Ireland; community development; community development approaches to health and the BHC programme, as well as a detailed examination of four BHC projects. These projects have the explicit aim of improving community participation in primary care services. Three of them were funded by the Department of Health and Children. The analysis of the work of these projects focused on the lessons they provide regarding the process of community participation in primary care. All literature about the projects was reviewed and interviews were held with key actors in each project.

3. Community Development and Community Participation Approaches to Addressing Health Inequalities

Combat Poverty has defined community development as:

'a process whereby those who are marginalised and excluded are enabled to gain in self-confidence, to join with others and to participate in actions to change their situation and tackle the problems that face their community'.

(Combat Poverty 2000)

Community development is a method that ensures that communities can work together and focuses on inequalities, including health inequalities. In particular, community development builds community structures and promotes participation. It fosters greater openness and leads to the increased engagement of community organisations with other bodies.

Webster (1990) has described community development and health as:

'helping those involved to look at why their health is the way it is' and 'helping groups take action over their own health...and feed into an ever more effective health policy'.

(Webster, 1990)

Thus the interaction of community development and health is not just about community organisation but also about institutional and policy change.

Characteristics of community development which contribute to facilitating community participation and tackling inequalities in health are:

- It actively seeks to involve people and minority groups who live in disadvantaged communities in issues which affect them. This is the case even where communities are experiencing consultation fatigue or apathy, as in the case of the Fatima Mansions project below.
- It creates opportunities for dialogue in order to democratise decision-making. This requires investment in those members of the community who are actively participating. Hence, the BHC project located in Lifford/Clonleigh has ensured community representation on the Primary Care Team Implementation Project, who have now identified a need for training for their continued participation.
- As illustrated in the projects, a community development approach identifies and sets out the community's agenda. It grows and flourishes when communities see changes to which they have contributed.
- It uses existing networks, creates new alliances and uses innovative methods to encourage participation through ensuring accessibility, as seen in all four projects profiled here; and
- It ensures that service provision is more relevant and effective.

Community development is one approach to community participation. Terms such as consultation, partnership and empowerment are often used interchangeably. While these terms do not strictly have the same meaning, it is difficult to discuss community participation without reference to community development. Among disadvantaged communities in particular, community participation will be more difficult where community development principles are not already established or accepted as a prerequisite. Community participation has been usefully defined by the Chief Medical Officer as:

“...a process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change.” (Chief Medical Officer, 2001)

Moreover, this report identifies community participation as:

“...an essential component of a more responsive and appropriate system of care which is truly people-centred.”

Community participation means having an input into structures in which decisions are made and planning takes place. Participation in these structures gives communities a chance to take an active part in decision making and planning. It enables communities to share and exchange information and learning. Participation differs from consultation as the latter gives people an opportunity only to inform decision making and planning.

Participation gives communities an opportunity to influence and participate in the decisions that affect them and to have their views acted on. As a result policies and services intended to tackle poverty and inequality are much more likely to work if the people and communities they are designed for are involved in their planning and implementation.

The benefits of community participation in addressing health inequalities include:

- Improved and more relevant policies to address health inequalities
- The anticipation of problems at a design stage
- Services which are more responsive to the needs of the community
- Equitable and inclusive services which help to address social exclusion and poverty
- Increased resources as services are more cost effective and,
- Services becoming more accountable to the communities they operate in and for

4. Community Participation in Primary Care Policy

One of the key objectives of The National Health Strategy 2001: *Quality and Fairness – A Health System For You* is ensuring that the patient is at the centre of the health services. Making provision for the participation of the community in decisions about the delivery of health and personal social services is one of the key actions identified to support this objective.

This objective and action is reflected in the Primary Care Strategy, which commits to community participation: Recommendation 19 of the Primary Care Strategy states that:

“Mechanisms for active community involvement in primary care teams will be established. Community participation in primary care will be strengthened by encouraging and facilitating the involvement of local community and voluntary groups in the planning and delivery of primary care services. Consumer panels will be convened at regular intervals in each health board. At local level, primary care teams will be encouraged to ensure user participation in service planning and delivery. Consumers will also have an input to needs assessments initiated by individual health boards. A greater input from the community and voluntary sector will enhance the advocacy of primary care teams in ensuring that local and national social environmental health issues, which influence health, are identified and addressed.”

(DoHC 2002)

Ten Primary Care Teams have been established in order to create strong links between general practitioners and primary care staff normally employed by health boards and to provide a method for investment in expanding primary care services with the employment of new members of staff. They are also designed to encourage different health practices to work together in a given geographical area and deliver more integrated and effective services. Primary Care Teams typically comprise GPs, nurses, physiotherapists, occupational therapists, social workers, health care assistants, home helps and administrative staff.

The BHC projects that are promoting participation and partnership are therefore clearly relevant to the work of the Primary Care Teams. By promoting community participation they can contribute to the input from the wider community and voluntary sector. The Primary Care Strategy states that this will enhance the advocacy role of the Primary Care Teams.

5. Building Community Participation in Primary Care: The Work of Four Building Healthy Communities Projects

Although all of the BHC projects are based on community development principles, the following four projects are particularly focused on community participation in primary care development.

Community Representation in a Primary Care Team – Lifford/Clonleigh Resource Centre

This area in east Donegal was one of the ten sites for an initial Primary Care Team funded by the Department of Health and Children. Thus there were new resources for health for the area and there was an onus on the health board and the local general practice and other primary care providers to engage with local communities.

The Lifford/Clonleigh Resource Centre has received funding under the BHC programme in both 2003 and 2004. The aim of this BHC project is to facilitate meaningful participation of the Castlefinn and Lifford communities in the Primary Care Implementation Project in Lifford. This participation was facilitated by a working group comprising membership from the Community Development Project, the Primary Care Team and the health services. It was achieved through focus groups and the establishment of a local Community Health Forum. The Forum operates as an accountability structure for the three community representatives on the Primary Care Team as well as being an active partner in meeting the health needs in the local area.

The approach taken by the Lifford/Clonleigh BHC project is clearly based on community development and community participation principles - seeking to reach as many excluded and minority groups as possible, to build the capacity of the community to identify their own health needs and the measures to address these, and to develop partnerships between the various stakeholders and sectors. The project worked with both the local people to develop their participation and with the primary care professionals to develop their understanding of the role for community groups. Much of this work was carried out through focus groups, which, although time consuming, proved to be empowering and particularly effective at engaging hard-to-reach groups. Having these focus groups facilitated by someone independent of the Primary Care Team and the health board was also a positive element. In addition, meetings were held with the health board and GP representatives and relationships of trust have developed. The project had the advantage that most of the local population attends the general practice involved and was known to the GPs.

The Community Health Forum has identified a number of priorities for the community representatives to feed into the primary care team. They include issues that directly affect the health service alongside non-medical priorities such as the need for support groups, benefits advice, childcare support and environmental issues. Many positive developments have taken place in the area, most of which have been spearheaded by the Community Health Forum. The process of building the participation of the local communities is gradually breaking down the barriers between communities and the health professionals. The relationship with the GPs and public health nurses has been very positive. The project has led to greater participation of minority groups and a greater understanding by the

wider community of minority groups' perspectives. An additional positive outcome has been the coming together of the two separate areas of Lifford and Castlefinn and the exchange of learning and mutual support between the two communities. All of this was helped significantly by the fact that there was an existing community project with well-developed community links.

However, there is still work to be done to ensure that the issues which are directly relevant to the community are built into the Implementation Project. The community representatives have identified their need for training to strengthen their role in pursuing the community's agenda. The community, however, continues to be concerned about ongoing funds for the participation process.

Health Needs in Isolated Communities – Meitheal Forbartha na Gaeltachta/Comhar Dhuibhne

MFG/Comhar Dhuibhne is a community partnership with a focus on social inclusion through a community development process. It implements the Local Development Social Inclusion Programme in the Corca Dhuibhne region in West Kerry. The organisation has established links with the local community and has been asked by the health board to lead on developing links between the Primary Care Team and the local communities. The process was started with a community needs assessment to establish a baseline and to further develop existing links and create new links with other community groups.

Funded in 2004 by the Department of Health and Children, the aim of this project was to increase participation of disadvantaged groups in local primary care planning and to increase access to information and health services. The project has a particular focus on mental health services. Funding will facilitate the setting up of focus groups to identify health needs and engage marginalised people in the Primary Care Project Planning Team. It will support new and existing groups catering for specific needs, such as lone parents, men, women, teen parents and people with mental health needs. It will strengthen links with the Primary Care Project Planning Team to improve local access to health planning. The long-term goal of this BHC project is to create a community network that will nominate representatives to the Primary Care Team and to whom the representatives will be accountable.

This project clearly illustrates some of the challenges facing the development of community participation in primary care. MFG acknowledges some apathy amongst the community regarding the possibility of achieving change. Among the Primary Care Team, a number of issues arose. The Team was wary of raising expectations regarding what could be changed. There was a sense that the Primary Care Team was struggling to get organised and was concerned that it was not sufficiently coherent to engage with the local community. The members of the Primary Care Team were new to each other and in some cases had never spoken to each other. They did not initially understand how the community organised.

Although it has been necessary to convince the Primary Care Team of the importance of developing a good process for community participation and that this requires time and funds, a number of successes have been achieved. Some community representatives have been placed on the Primary Care Team and, in particular, the GPs involved have been keen to hear what the community's needs are. The GPs have already linked with community structures, with one GP sitting on the youth subcommittee of the community partnership.

Linking Social Development, Health and Physical Regeneration – Fatima Groups United

Fatima Groups United is a representative group of residents and community groups who are working to ensure that social regeneration is integral to the overall regeneration of Fatima Mansions in Dublin. The Group received funding in 2003 under the BHC programme. The aim of the BHC project was to use community development approaches to empower the local community in the development of a community health and well-being centre in the area and to do so, if possible, in partnership with at least one of the local general practices. Reflecting the social determinants of health model, the project also sought to ensure that the needs of the community would influence the social regeneration of the estate. They also sought to develop and promote an understanding of the links between poverty, environment and health.

This project faced a not uncommon problem in community development – consultation fatigue among the local population. The area had been the subject of many community consultations in the past, making it more difficult to inspire them to participate. The participation of local people was further hampered by uncertainty amongst them about their futures in the area as it underwent major regeneration. The pre-existing population of Fatima Mansions has been reduced from 1500 to 500 through re-housing and the new development will have a significant element of private housing. However, a field trip to Ballymun energised local people and highlighted the positive nature of cross-community learning and support.

The project illustrates the very real need for the community to identify its own health needs and priorities, as well as the need to negotiate these with the mainstream health services and professionals, and engage with non-health related services. The community wants the proposed centre to focus on alternative therapies, health education, a baby clinic, citizen's advice and other services. This is based on both the needs identified by the local community and the broader aims of the project. For example, the development of citizen's advice is an example of work that could help tackle some of the underlying reasons for people's poor health that result in their attending the GP.

The local GPs have engaged well with the community representatives. The community sees great advantage in linking their proposals with those for a health centre with the general practices, as this will lead to more rounded and holistic services. The GPs have seen advantages in having the non-medical issues which they are unable to deal with tackled for their patients.

The long-term and often complex nature of ambitious community development and community participation approaches is highlighted by this project. The proposal to construct and shape the development of a new building means that the planning process is very long-term and the building may not get built for three or more years. The fact that the Coombe hospital, two local general practices and the health board are all involved has led to complex negotiations involving many different agendas. The overall approach has been to build relationships and build on common ground.

In seeking to build the capacity of the local community to actively participate in accessing primary care, a community development and health training course has been developed. Twenty local people are attending this training. This course is developing the skills, knowledge and capacity of the participants themselves. Through a well placed community support infrastructure it is putting health on the agenda of community groups in the Dublin 8 area. Lastly, it is ensuring that a community development approach to health will be central to the development of any local health strategy.

Primary Health Care Group Mulhuddart – Greater Blanchardstown Development Project

The need for a primary health care facility has been identified as a priority in Mulhuddart. Its population is expected to exceed 10,000 over the next three years. Statutory and community groups have come together to form the Primary Health Care Group. Funding under the BHC programme was secured in 2003 to help the Primary Health Care Group in Mulhuddart to establish a process whereby the community can participate in the development of services. The aim of this project was to engage local residents to influence the development of primary care services, specifically a general practice and pharmacy, in the local area. It sought to increase the community's capacity for lobbying for the provision of services, and to produce a template which would influence the implementation of health initiatives in other deprived areas.

BHC funding was used to produce a research report (Cosgrove 2004) that developed an analysis of the health problems and possible obstacles to addressing them. The report also set out a clear strategy for the community to pursue in trying to influence decision-making at all relevant levels of the health service. This proved useful as a guide for future community action and brought together data that could be used in making the case for health resources in the area.

The community sees their work in this programme as an example of building research into practice. Through local consultation and community participation a stronger community voice developed to make demands for resources. An extensive needs assessment of the local community was conducted and community health activists were identified. A direct political lobbying approach was used and questions were asked of the Minister for Health and Children in the Dáil about what was going to be done about an area with such poor primary health care. Contact was made with the Department of Health and Children and Health Service Executive (HSE) officials. A very high political and public profile for their issues has been achieved and the Minister for Health and Children has been in touch with them to assure them that the area's needs are being considered.

Considerable progress has been made through this project. This is testimony to the power of community participation which has translated into lobbying service providers and politicians at national and local level. A pharmacy has been established in the area, more public health nursing has been brought in to serve the area and a community welfare officer and speech and language therapy service have been established. Three new GPs and a dentist are setting up in the area and a site has been identified for a primary care centre.

6. Community Participation and Primary Care: Key Lessons from the Building Health Communities Projects

The evaluation of the overall Building Healthy Communities programme has highlighted a number of key lessons (Combat Poverty, 2004). The processes that have been developed by the projects have increased understanding across participant groups of each other's issues and especially of minority group issues. Networking of projects selected under the BHC programme has been key to supporting these relationships. The programme has facilitated the development of participation processes and structures for communities. Community training courses have been developed to expand community capacity. Relationships between community groups and service providers have improved in many instances and there is an increased awareness of health issues amongst the communities involved. All of these positive outcomes are illustrated by the projects outlined above. In addition, key lessons from the projects can also be further distilled.

A review of community development initiatives attached to primary care in Northern Ireland and England (Crowley, 2003) facilitated the identification of the features or ingredients of good practice in community development responses to primary care. Many of these features are reflected in the lessons arising from the BHC community participation projects.

Flexibility

In the first instance, it is noteworthy that all four projects outlined are attempting to achieve different objectives, working in different settings and with varying degrees of exposure and access to those working in primary care. The first lesson from the projects, therefore, is that community participation is an approach that is flexible and that can be adapted to the specific circumstances of the community.

Developing allies in the Primary Care Team

The development of key allies in primary care is a feature of good practice and is evident in the BHC projects. Some of the community initiatives have worked to develop a number of allies as an initial way of making contact with the Primary Care Teams.

Including people experiencing poverty and disadvantage

The majority of the community participants in each project are experiencing poverty, social exclusion and, in many instances, poor health. While some of the projects actively sought to engage particularly vulnerable and excluded minority groups, others did not. In those that did not, such minority groups are relatively or entirely absent. This illustrates the importance of developing specific approaches and a commitment to the inclusion of such minority groups. If efforts are not made to include disabled or ethnic minority groups, for example, they will effectively be excluded.

Developing the understanding of the Primary Care Team and other primary care professionals

It is widely recognised that working with the community in isolation will not be as effective as initiatives that also involve developing the understanding and commitment of the primary care professionals. The BHC projects outlined demonstrate the effectiveness of working with the primary care providers to improve community participation and

primary health care plans and services. Where support for community participation was, perhaps, low among the Primary Care Team or other professionals, the projects worked to address their concerns, develop their understanding of the processes and support their involvement in these. This work is key in developing an understanding of the resources required to properly support community participation.

Ensuring access to the participation process

All of the projects located their participation processes within the local community, thereby making geographic access relatively easy. However, other access issues arose and were dealt with to varying degrees by the projects. These included disability access to community buildings and the provision of child and elder care supports. While some of the projects may have the capacity to 'tag' onto other community facilities, financial support to address these access issues is essential.

Engagement of GPs

Most, but not all of the projects are located in areas where the general practice covered a coherent geographical area, where GPs showed themselves to be very positive about engaging with each other and with local communities and where dialogue has been respectful and constructive. Some GPs welcome the opportunity that community participation affords them to explore dealing with the wider issues affecting their patients' health. Lack of time will always hamper general practitioner participation, however, as the demand for patient contact is considerable.

Building on existing community structures

This is one of the fundamental principles of community development and community participation. All of the projects above used their existing relationships with community organisations and developed new links with other organisations to make their participation process as inclusive as possible. Working in this way proved to be an efficient way of engaging local communities. The only caveat to this is that one must still ensure that the community project leading the process is not working with a limited number of local groups and effectively excluding others. Some of the projects failed to engage distinct groups in their process, for example young people. In seeking to engage existing groups it is important to develop a flexible process whereby these may participate in different ways. Not all groups will feel comfortable at health forum meetings or at committee tables.

Recognising previous community experience

While the Primary Care Strategy presents an opportunity for local communities to engage with primary care, two of the projects found that the communities were not all that keen to become involved in what they viewed as another consultation process or were apathetic and sceptical of the real potential to effect change. Care must be taken that the purpose of the participation exercise is clear and that there is something in it for the communities. Otherwise they may refuse to participate or become disillusioned by the process. Any consultation should start with an exercise that summarises what the community has said in previous consultations. In the projects above, previous needs assessments were built into the process. Locally driven research and visits to other communities facing similar difficulties were used to address these issues.

Being realistic and honest about what can be achieved

It should be stated that Primary Care Team development per se does not offer a huge range of options to the community to influence. The real benefit of community participation may be seen in the engagement of the Primary Care Team in the wider community agenda. Contrary to community perceptions and expectations, the Primary Care Team itself is often quite disorganised. It may not have a clear agenda and may struggle with the requirement to teamwork.

The Primary Care Team attempts to marry very different cultures. The independent business culture of general practice, the line-management hierarchy of health board employees and the less structured relationships within communities can be quite at variance with each other. All of these issues place a limit on what can be achieved in the short to medium-term, and many concrete outputs will not be seen for a number of years. However, where this is made clear, communities can adjust their plans and expectations and conflict and frustration can be minimized if not entirely avoided.

Supporting community representatives

Many approaches to community participation favour community representatives on Primary Care Team committees. It is important to be aware of the potential problems with such an approach. Community representatives can become "co-opted" on to these committees and cease to truly represent the community. They may not have prior experience of committees or fully understand their role in representing the wider local community in all its diversity. They may have discriminatory attitudes to some groups. Community representatives need training around these issues. This has been recognised by both project promoters and some community representatives themselves. Efforts by some of the projects to develop community networks and fora that could act as a sounding board and a mechanism for accountability of the representative back to the local community are important.

Developing a broader and holistic understanding of health

The community definition of health and health services may be substantially different from those of primary care professionals. Frequently communities embrace the social determinants of health model that draws in socio-economic and environmental factors and sees action in these areas as being as important as the primary health services themselves. Community primary care needs are also shown by the projects to encompass alternative therapies. This may conflict with the health professionals' understanding of what is important to health.

Resources, resources, resources

Although the need for secure and long-term finance to properly support community participation in an ongoing way is undoubtedly a key resource requirement, it is not the only necessary resource identified by the projects. Time is a key resource and the short timescale for the Building Healthy Communities project funding was felt to be unrealistic.

Many other issues can intervene to put the community participation work on primary health on hold for periods of time. Appropriate staffing is also a key resource that the projects require. The experience of the projects illustrates that it is more appropriate and cost-effective to employ a development worker than to employ a consultant on a daily rate. Some of the projects underline the importance of having someone to facilitate the participation process.

7. Conclusion: Challenges and Opportunities

The Building Healthy Communities projects have demonstrated a very positive experience in developing community participation. They have used funding to facilitate processes where a wide cross-section of community groups have been engaged and where minority groups have been included in many instances. Both challenges and opportunities to build on this work remain.

The current health reform process poses a number of challenges to community participation in primary care. It is based on national strategies that do not necessarily lend themselves to the best interest of local communities. The health reforms are accompanied by the Health Act 2004. This Act provides for a range of mechanisms to enable the Health Services Executive to engage with local communities but does not have specific guidelines on community development and the involvement of local community organisations focusing on health inequalities. The Act commits to establishing four regional public fora that will be made up of local elected politicians.

The Primary Care Strategy places emphasis on consumer panels as a mechanism for involving the community in health service planning that suggests an approach involving 'patients' rather than communities. It lends itself to the purpose of exploring health service quality issues rather than to investigating community proposals to improve their individual and collective health. Primary care populations, natural geographic communities (Neve 1997), communities of interest that may organise city or countywide and health service organisational boundaries rarely correspond. Power is unevenly distributed between general practices (and especially doctors) and local communities must be dealt with (Draper and Hawdon 1998) as this can impede equal participation of communities in health planning. Doctors may have more information, better connections with health management and use their professional prestige to over-ride community priorities. The dominance of the medical model (Taylor et al 1998) and the tension between the practice list and community as locality (Brown 1994) may hinder community participation in primary care. However, since the Primary Care Strategy was launched there has been further policy development and thought in the area of community involvement. In 2004, both a *Framework to Guide Development of Primary Care Team and Networks* was published alongside *Guidelines for Community Involvement in Health*.

Specific issues arise concerning the engagement of general practices and GPs in primary care and community participation. Primary care and general practice in Ireland has not traditionally seen itself as having a role in public health development, concentrating rather on illness treatment. General practices tend to be pressurised with little time for anything other than seeing patients. However, many GPs also understand that people feel they should be doing more about many other issues and needs relating to health. Some are open to playing a role in public health development involving community participation.

Nonetheless, a number of the pilot Primary Care implementation projects cover coherent geographical areas and some represent the amalgamation of a number of existing practices. This offers a clear opportunity to pursue a community development and participation approach to engaging local communities (both geographical and of identity and interest) with primary care in Ireland.

The Primary Care Strategy is an obvious opportunity for communities to engage with primary care professionals to advance their health agendas. Despite a lack of clarity as to the meaning and the methods of community participation to be employed, the proposal to develop Primary Care Teams involving communities is a positive and challenging one. Although there are significant power, cultural and perspective differences between the main players, there is much to be gained by both the primary health services and disadvantaged communities in the development of participatory partnerships.

8. Recommendations

1. Primary Care Teams should seek to engage local communities in all their diversity, including ethnic minorities, people with physical and sensory disabilities and other minority groups. In particular, accessible channels of communication must be developed within primary care.
2. The process of engaging local communities and supporting community participation in Primary Care Teams needs to be appropriately resourced. Resources should ensure that the process is accessible in terms of geographic location, childcare support, interpretation etc. There is a need to think creatively about how the process can be best resourced or how existing resources can be harnessed or re-distributed.
3. Employing a worker or part of their time to facilitate the process and to build community capacity should be considered.
4. In engaging with local communities Primary Care Teams should be prepared to listen to the community's agenda and accept that, although this will probably be broader than one relating only to health services, it should be valued and taken seriously.
5. Services should be not be developed solely on the basis of traditional definitions of health but should encompass more holistic definitions that encompass areas such as poverty, environment, crime, fuel, benefits, jobs, transport etc. (Crowley et al, 1998).
6. Pre-existing community structures, networks and processes should be recognised and built on. This provides immediate opportunities to build upon their history, local knowledge and networks.



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