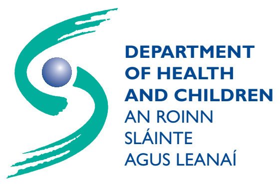
BUILDING HEALTHY COMMUNITIES PROGRAMME

BUILDING HEALTHY COMMUNITIES

A NATIONAL CONFERENCE

PUTTING POVERTY AND SOCIAL INCLUSION AT THE CENTRE OF HEALTH POLICY AND PRACTICE



WEDNESDAY 21ST MAY 2003

ROYAL HOSPITAL KILMAINHAM, DUBLIN

Conference Programme

9.00am	Registration
9.30am	Welcome and Conference Overview
	Ms Helen Johnston, Combat Poverty Agency
10.00am	Key Note Presentation: Poverty, Health and Community Participation - Making the Links
	Dr. Jane Wilde, Institute of Public Health
10.30am	*Building Healthy Communities* - The Challenges
	Performance and Presentations
	Community Drama Group
	Sláinte Pobal
	Community Development Health Network, Northern Ireland
11.15am	TEA/COFFEE
11.30am	The EU Context - Policy Responses to Poverty and Health Inequalities
	Mr Michael Hüebel, Directorate General for Health and Consumer Protection, EU Commission
12.00am	Building and Implementing an Irish policy response
	Mr Charlie Hardy, Department of Health and Children
12.20pm	Plenary Session
12.45pm	LUNCH
2.00pm	Launch of the *Building Healthy Communities* Programme
	Mr Micheál Martin T.D., Minister for Health and Children
2. 15pm	Workshops
	1 Working Together, Respecting Autonomy - The Experience of the Travellers Primary Health Care Project
	2 Community Participation In Primary Care Strategies
	3 Nutrition, Food Issues and Health
	4 Building Community Responses: Roles, Relationships and Supports
	5 Inter- sectoral working
	6 Findings from Literature and Policy Review - Poverty, Health and Community Development
	7 Community-Based Participatory Research

Note: Workshops will feature perspectives and inputs from both Communities and Health Providers

3.30 pm	Summary Report from Workshops
3.45 pm	Open Forum and Closing Comments
4.30pm	Conference Close

The Context

The National Anti-Poverty Strategy (NAPS) identified health as a key priority in addressing poverty. This is also recognised within the NAPincl process. The EU Health Programme stresses the need to address health inequalities through tackling the major determinants of health, including poverty. Reducing health inequalities and the promotion of community participation are features of both the National Health Strategy: *Quality & Fairness: A Health System For You* and the Primary Care Strategy.

The links between poverty and health inequalities are well-documented and increasingly recognised in health policy and practice. In addition, participation by those experiencing poverty and social exclusion, and those who represent them, is required in order to develop appropriate and effective responses.

Community Development is acknowledged as having an important role to play in strategies to address poverty and social exclusion and provides a vital link between the experience of poverty and social exclusion and the development of effective policy and practice responses. This, in turn, can lead to improvements in health and well being and reductions in health inequalities.

The *Building Healthy Communities Programme* will support innovation and networking and increase understanding of and evidence on the links between poverty, community development and health.

Purpose / Aims of Conference

- To promote understanding of the links between poverty and health inequalities
- To explore opportunities for advancing the anti-poverty agenda within health policy and practice
- To consider the role and potential of community development in tackling poverty and health inequalities
- To endorse the contribution of people experiencing poverty and those who represent them to the development and delivery of policy in relation to health
- To provide an opportunity for networking and sharing of experience

This conference will launch the Combat Poverty Agency programme *Building Healthy Communities*. It will also inform the Department of Health and Children in the implementation of health targets in the National Anti-Poverty Strategy.

Who should be there?

- Policy and decision makers in relevant areas
- Community development / anti-poverty groups and organisations
- Health service workers
- Research bodies with poverty, health inequality interests
- Voluntary Sector service providers

BUILDING HEALTHY COMMUNITIES

WELCOME

Helen Johnston
Director, Combat Poverty Agency

WHY A CONFERENCE ON HEALTH?

- Links between poverty and health inequalities
- National Policy Context
  - National Anti-Poverty Strategy
  - National Health Strategy
- European Context
- Combat Poverty programme

BUILDING HEALTHY COMMUNITIES

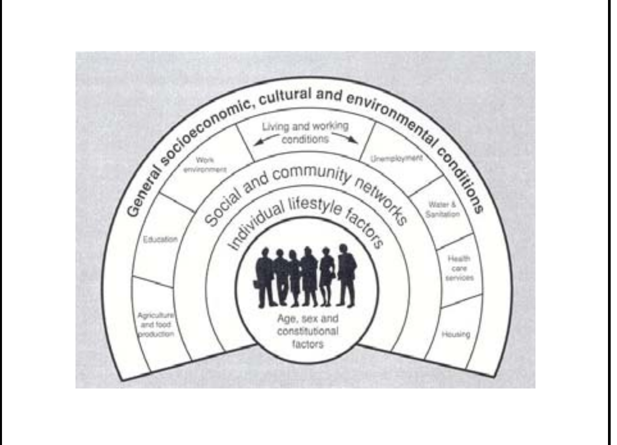
- Importance of participation
- Community development approaches
- Building Healthy Communities Programme
- Partnership with Department of Health and Children

CHALLENGES

- Access to health services based on need
- Developing a social model of health
- Prioritisation of resources
- Integrated responses
- Acknowledging the role of community development
- Building an evidence base
- Responding to diversity
- Focus on improving outcomes

AIMS OF THE CONFERENCE

- Understanding the links
- Putting poverty at heart of health agenda
- Role of community development
- Contribution of people experiencing poverty
- Networking and sharing experience



"The primary determinants of disease are economic and social and therefore its remedies must also be economic and social."

The strategy of preventative medicine
Rose, G. 1992

Challenges

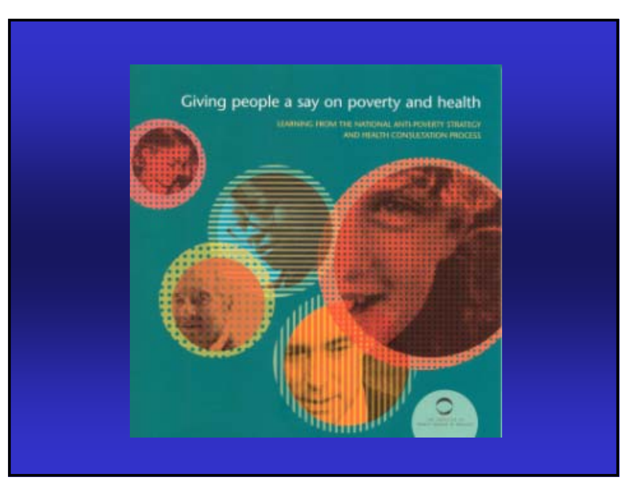
Robust and clear policies

Equity oriented targets

Community development

Multi-sectoral work

Equitable and effective health services



National Targets to Reduce Inequalities

Reduce gaps:

- **premature mortality for heart disease, cancers and injuries**
- **life expectancy for travellers**
- **low birth weight rates**

Declaration of Alma Ata Primary Health Care

- Key to social and economic development
- People have right and duty to participate in planning and implementation of health care
- all Governments should have policies and action plans to sustain primary health care

WHO, 1978

Building Trust

- Opportunities for dialogue (voices heard)
- Contribute to agenda (community needs)
- Build on networks & alliances (innovative approaches)
- Involve excluded people

"It is at the edges that interesting things happen."

Evans, E
The Personality of Ireland, 1973

"We have no way of living in a place, we have no way of belonging to that place, unless we continue to imagine it."

Eavan Boland,
Imagining Ireland

BUILDING HEALTHY COMMUNITIES

COMMUNITY DEVELOPMENT APPROACHES TO HEALTH

PRACTICE ISSUES : OPPORTUNITIES & CHALLENGES.

SLAINTE POBAL

- HEALTHY COMMUNITIES
- HOLISTIC APPROACH
- "TAKING CONTROL OF YOUR LIFE"

COMMUNITY DEVELOPMENT APPROACH

- Social Change
- Collective Action
- Participation and Inclusion
- Empowering
- Process directed
- Creative

Change Formula

- A + B + C = > X

A = Unacceptable situation
B = Vision for better future
C = Practical first steps – plan
X = The cost of change

PRIMARY HEALTH CARE

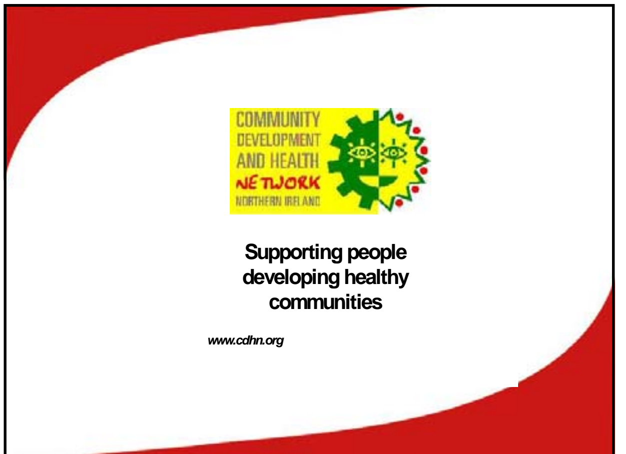
DIAGNOSIS
TREATMENT
PREVENTION
COMPLEMENTARY

OUTCOMES

- LOCAL RESOURCE GROUP
- ACCREDITATION
- ON-GOING DEVELOPMENTS

ISSUES OPPORTUNITIES CHALLENGES

- LOCAL INVOLVEMENT
- PARTNERSHIPS
- CAPACITY BUILDING
- SUPPORT NETWORKS
- QUALITY ASSURANCE
- VALUING COMPLEMENTARITY



CDHN Strategic Aims

- Developing and sustaining the **Network**
- Highlight links between poverty,inequality and Health and how CD works for **change**.
- Tools for **practice**
- **organisation**

Together for Health

Supporting people supporting communities

Working to effect change at policy, organisational and practice level to promote and support community activity on health issues to promote action to redress poverty and inequalities in health.

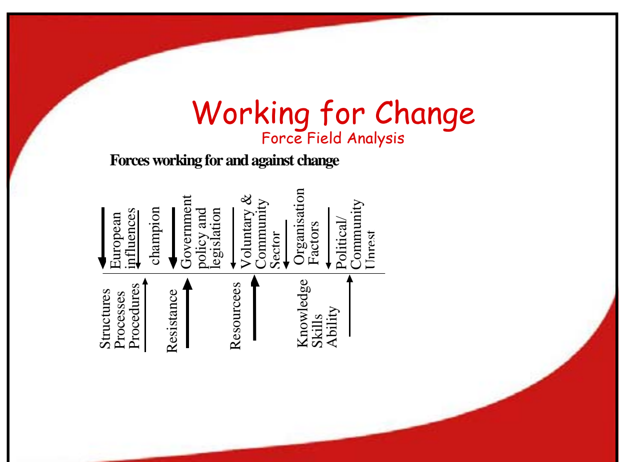
Networking

- "Networking is the process by which relationships and contacts between people or organisations are established, nurtured and utilised for mutual benefit"
- Gilchrist 1995

The case for Networking

- information exchange
- support and solidarity
- common purpose, shared values
- forum for debate and discussion
- negotiating and articulating a collective view

The use of networks and networking is both an expression of the values of community development and a means by which community development is achieved.



Constraints

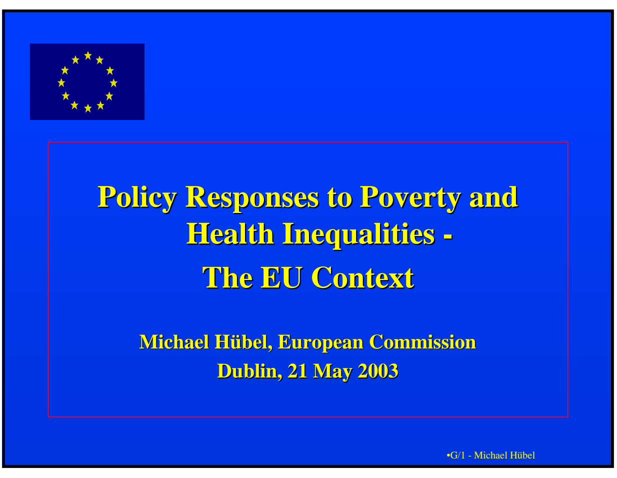
- Bureaucracy
- Pressure on resources
- Conflicting models
- Dominance of medical model
- Deficiencies in education, training and professional development
- "Initiative" overload
- Low morale

CD & Health Core Skills

- Knowledge of practice, principles & policy
- Link to Health
- Identification of local needs
- Networking
- Partnership working (multi-sectoral)
- Multi-disciplinary working
- Group work skills
- Organisational development
- Funding
- Monitoring & evaluation

Overview of current activity in NI

- Community Education/Information
- Arts & Health
- Partnerships
- Influencing policy
- Self Help and Social support
- Targeting inequalities
- Health Rights/Accessing services
- Community Action - Research
- Environment



Poverty and Health (1)

Substantial differences in

- life expectancy (up to 5-10 years)
- 'healthy'/disability-free years of life
- general health status
- smoking, drinking, obesity levels
- environmental risks, housing

between richer and poorer population groups

Poverty and Health (2)

Substantial differences in health services

- access to services
- health insurance coverage
- levels and quality of services and treatments

between richer and poorer population groups

Specific concerns: e.g. mental health

Tackling health inequalities

We need joint approaches across sectors:

- health policy (targeting health services, public health, risk factors, determinants)
- social policy (social inclusion, social care, living conditions)
- employment policy (secure jobs, working conditions)
- co-ordinated approach across communities

Public Health in the European Union

- Only since 1993 a specific Treaty Article (129 - Maastricht) on public health
- 1993: Framework for action in the field of public health - Eight public health action (= funding) programmes
- Many Community policies and actions impact on health and health systems

Public health activities - Examples

- **Health threats**: communicable diseases, Directives on blood, tissues, health security
- **Tobacco**: advertising, ingredients
- **Health promotion** and **disease prevention**: nutrition/obesity, cancer, drugs, settings
- **Health monitoring**
- **Health and Environment**: e.g. EMF

Public health activities - Health inequalities

- **Focus on key health determinants:** Smoking, nutrition, alcohol
- **Health inequalities**: Project on the role of health promotion (advocates integrated approach, impact assessments, community approaches)
- **Health inequalities:** Monitoring

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1999/2000: A new Role for Health in the Community

- New Commission - Health and Consumer Protection portfolio and DG
- Important factors:
  - Health concerns related to Enlargement
  - New health threats
  - New challenges to health systems, ECJ cases
- 2000: Communication on Health Strategy

•G/1 - Michael Hübel

Health Strategy (May 2000)

Two components:

- A new public health framework (which includes the new programme)
- Increase coherence and co-ordination on health issues across Community policies and actions

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Community policies have an impact on health and health systems

- Internal Market - Products (pharmaceuticals, medical devices, food, ...)
- Free movement of health professionals, citizens seeking health care, and health services
- environmental policy – rules on water, air, quality, emissions
- social policy – social protection, health and safety at work
- research – life sciences programme; telematics – information society, eEurope
- preparing for enlargement

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Towards a co-ordinated health strategy

- Health Impact Assessment, Integrated Assessments
- Joint actions (e.g. health and environment, telematics and health, drugs, …)
- Instruments of co-ordination (Interservice Group on Health)

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Health and Social Policy

- Social Protection:
  - Future of health care and care for the elderly (co-operation on quality, access and financial viability)
  - Reimbursement of health care across borders
- Social inclusion: Health services as one priority
- Social funds: Investment in health sector
- Health and safety at work
- Poverty and health: Studies

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New Public Health Programme
➢Adopted September 2002
➢Runs from 1st January 2003 until 31 December 2008
➢Initial Budget €312M (budget to be reviewed)
➢Replaces eight existing programmes
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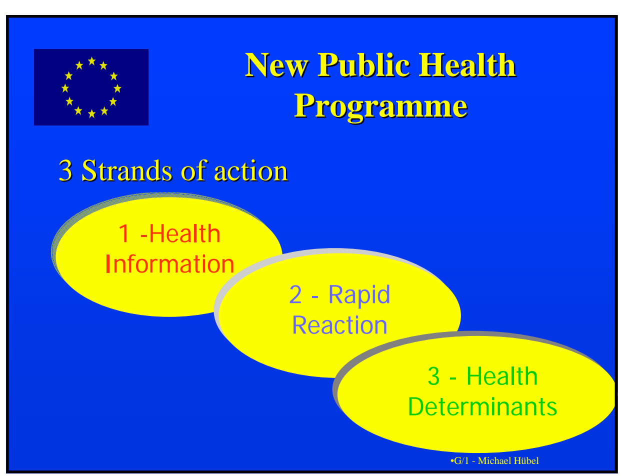
New Public Health Programme
3 Strands of action
1 -Health Information
2 - Rapid Reaction
3 - Health Determinants
•G/1 - Michael Hübel

New Public Health Programme
Key Points:
➢ Integrated approach to public health
➢ 'Enabling mechanism' to support policy development
➢ Actions to be substantial, large-scale, wide coverage and multi-annual
➢ Covers 15 Member States, applicant countries, EEA/EFTA countries
➢ Tackling health inequalities priority in programme decision
•G/1 - Michael Hübel

Programme Calendar
Sept 2002
➢ Programme formally agreed
March 2003
➢Call for Proposals 2003
July 2003
➢ Second Committee Meeting Selection of Projects
Autumn 2003
➢ Funding decisions
Autumn: Call for proposals
Spring: Funding Decisions
Committee Meetings
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Work Plan 2003 - Priority areas Cross-cutting themes
• Health impact assessment
• Health in the applicant countries
• Inequalities in health (reporting, experience and best practice, networking)
• Implications of patient mobility for health services
• Promoting best practice and effectiveness
• Ageing
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Priority area Health information
• Developing and coordinating a health information system
• Operating the information system
• Developing mechanisms for reporting and analysis of health issues, producing public health reports
• Improving access to and transfer of data
• E-health
This will include information on health inequalities
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Priority area
Health determinants

- *'Analysing the situation and developing strategies on social and economic health determinants, in order to identify and combat inequalities in health and to assess the impact of social and economic factors on health'* (programme decision)
- Socio-economic factors to be considered in all actions aimed at lifestyle-related determinants

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Involving Stakeholders: The EU Health Forum

Principles

- Information and consultation mechanism
- Open and transparent
- contributes to health policy development
- provides networking opportunities

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EU Health Forum

Three complementary elements:

- Open Forum: Platform for general exchange of information and discussion (from 2004)
- Health Policy Forum: for European umbrella organisations (since 2002)
- Virtual Forum: Information, discussion and interactive consultation (started in 2002)

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Develop the Community's health strategy

- Ensure coherence and complementarity
- Understand Member States' and stakeholders needs and requirements
- Define the scope of the Community's role

New Communication (Second half 2003):

- Review progress
- Plans for coming years ('Vision 2010')

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Four priorities for further action (D. Byrne, Gastein 2002)

- Effective action against health threats
  A European Centre
- Improve co-operation of health systems
- Addressing health determinants across Community policies
- Information

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Health and social inclusion

- History of programmes on poverty and social ex-/inclusion
- Social inclusion process
  - Open Method of Co-ordination on poverty and social exclusion
  - Inclusion programme

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Social inclusion process

- Common objectives (including access to resources and services, including health)
- Agreed indicators (including health-related data)
- National Action Plans on poverty and social exclusion (first in 2001, next due in July) include health
- Joint report on poverty and social exclusion

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Some conclusions from the NAPs/incl: healthcare

Three broad strategies arise from the NAPs/incl to provide better access to healthcare for all:

1. developing disease prevention and promoting health education;
2. improving adequacy, access and affordability of mainstream provisions;
3. launching initiatives to address specific disadvantages

Strategies are combined differently in NAPs/incl according to national situations and priorities.

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Developing disease prevention and promoting health education

Mother and child care providing for regular health screenings, including vaccination;

Preventive care at school, including regular consultations and health training as part of the regular curriculum (e.g. Finland);

Preventive care at work in accordance to health and safety at work legislation or, for those unemployed, free regular health screenings offered by social or health services (e.g. Austria)

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Improving mainline provisions

Promoting **affordability** (e.g. France - universal health coverage scheme- and Belgium -maximum health cost bill)

Promoting **access** to healthcare : general policy aimed at a more balanced geographical distribution of health services; local or regional initiatives aimed at better co-ordination between social and health services (e.g. Denmark); nation-wide recognition of a Charter of user's rights, including the need to reduce waiting lists (e.g. Sweden)

Promoting **adequacy**, and in particular, making services more responsive to cases of emergency (e.g. Portugal)

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Launching initiatives to address groups with specific disadvantages

Specific groups mentioned in the NAPs/incl: the elderly; immigrants and ethnic minorities; people suffering from physical or mental disability; homeless; alcoholics; drug addicts; HIV positive; ex-offenders; prostitutes

Particular emphasis on a growing number of situations of **dependency** of the elderly

Mental health raised by a majority of NAPs/incl

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Conclusions

- Addressing health determinants requires actions and building coalitions:
  - across traditional policy boundaries
  - across different levels of government
  - involving stakeholders and communities
- Linking the health and social policy agenda is particularly important
- The EU can help, but will not solve the problem

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GREAT –
NEARLY A METRE
OF POLICY ....
•G/1 - Michael Hübel

http://www
Further information on
Public Health Policy:
http://www.europa.eu.int/comm/health/index_en.htm
•G/1 - Michael Hübel

"Building Healthy Communities" – Combat Poverty Agency Conference

Charlie Hardy Dept. Health and Children

21 May 2003

Key NAPS for Health Targets

- Reducing differences between socio-economic groups in
  - premature mortality
  - low birth weight
- Improving Traveller life expectancy

Key Targets (contd.)

- To reduce the gap in premature mortality between the lowest and highest socio-economic groups by at least 10 % for circulatory diseases, for cancers and for injuries and poisoning by 2007.
- To reduce the gap in low birth weight rates between children from the lowest and highest socio-economic groups by 10 % from the current level, by 2007

Key Targets (contd.)

- The gap in life expectancy between the Traveller Community and the whole population will be reduced by at least 10 % by 2007.
- Life expectancy of Travellers & of Refugees & Asylum Seekers should be monitored so that targets can be set for Refugees & Asylum Seekers & revised for Travellers by 2003.

Measures and Actions

- Improved access to services and eligibility for them
- Wider Public Policy
  - health impact assessment and intersectoral work
- Monitoring and Research re. targets and indicators

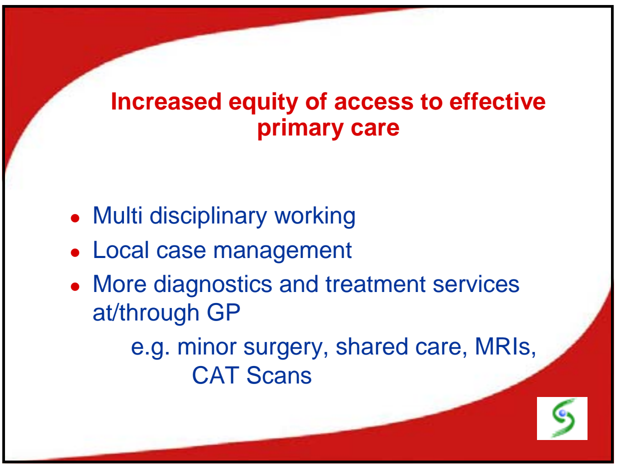
Policy Measures

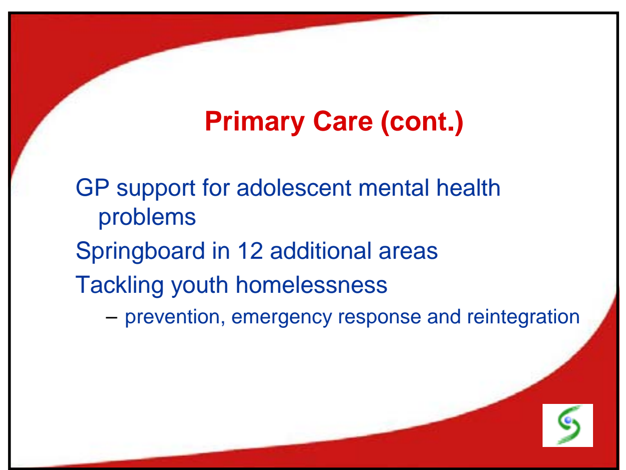
Increased equity of access to:
- Primary Care
- Acute Care
- Interventions for CVD and Cancer
- Community Supports for continuing care

Injury Prevention Strategy

Integrating Equality Dimension into health services.

Medical Card – income threshold & barriers to uptake





Equality Dimension - Reports

TF on Travellers

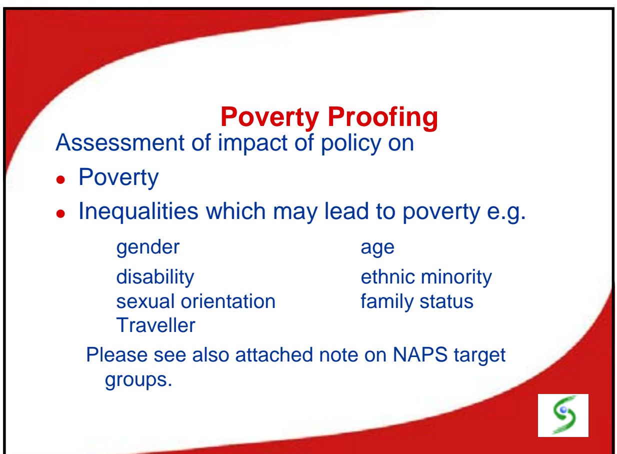
Status of People with Disabilities

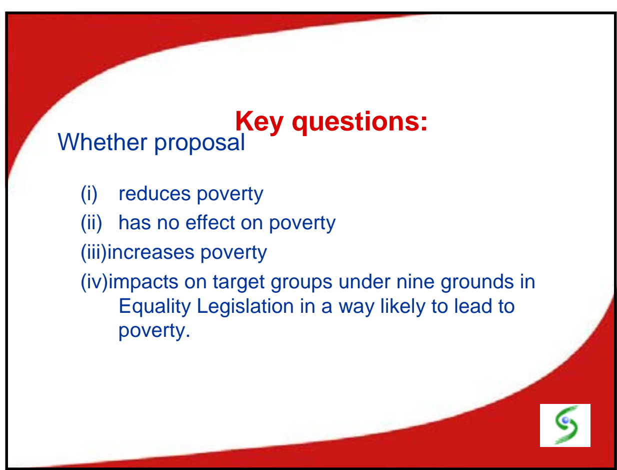
EA reports - Implementing Equality for

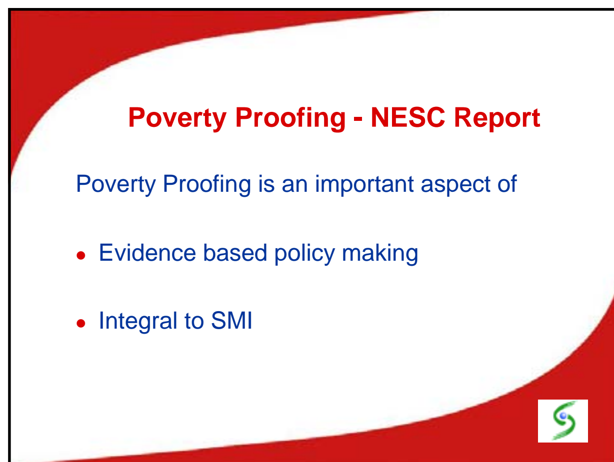
- Older People
- LGBs
- Carers (planned)

Nat. Action Plan Against Racism

Nat. Plan for Women



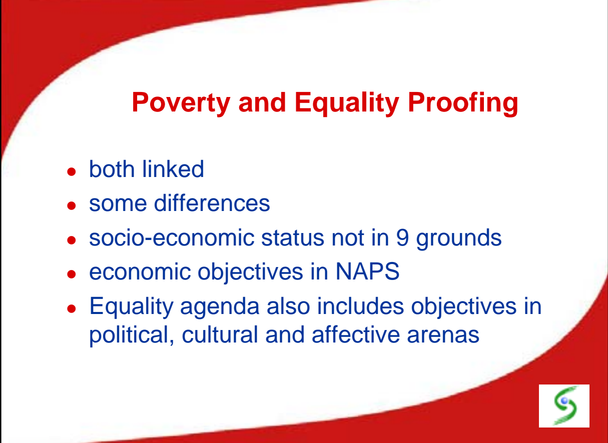

Key questions:
Whether proposal
(i) reduces poverty
(ii) has no effect on poverty
(iii)increases poverty
(iv)impacts on target groups under nine grounds in Equality Legislation in a way likely to lead to poverty.

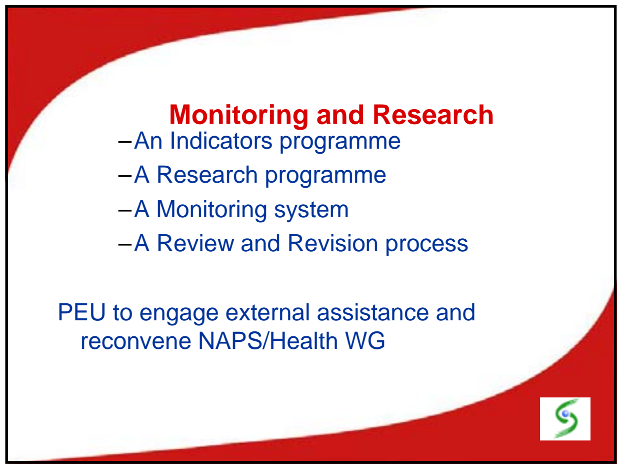

Poverty Proofing - NESC Report
Poverty Proofing is an important aspect of
Evidence based policy making
Integral to SMI

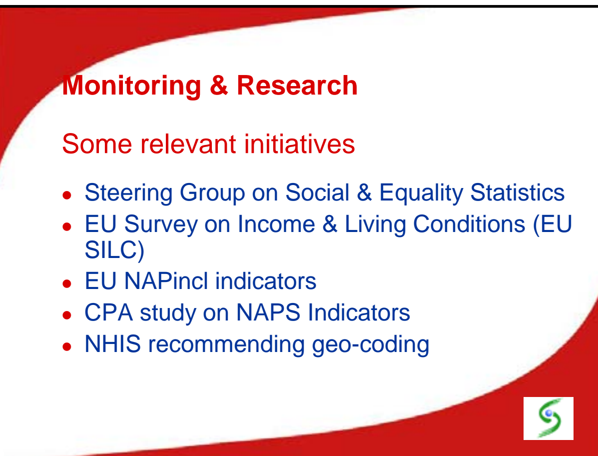
Poverty Proofing - NESC Report
2 objectives of Poverty Proofing
awareness raising among policy makers
more in-depth study of major policies

Need to distinguish
policies which are self evidently anti-poverty
policies not anti-poverty but could have impact on it
Both need
indicators
data sources which allow measurement against time-defined targets

Poverty Proofing – Training
Modules in general service training courses
Modules appropriate to remit of specific Depts. incorporated in their training
so that proofing becomes embedded in all policy & delivery processes.


Poverty and Equality Proofing
both linked
some differences
socio-economic status not in 9 grounds
economic objectives in NAPS
Equality agenda also includes objectives in political, cultural and affective arenas


Monitoring and Research
–An Indicators programme
–A Research programme
–A Monitoring system
–A Review and Revision process
PEU to engage external assistance and reconvene NAPS/Health WG

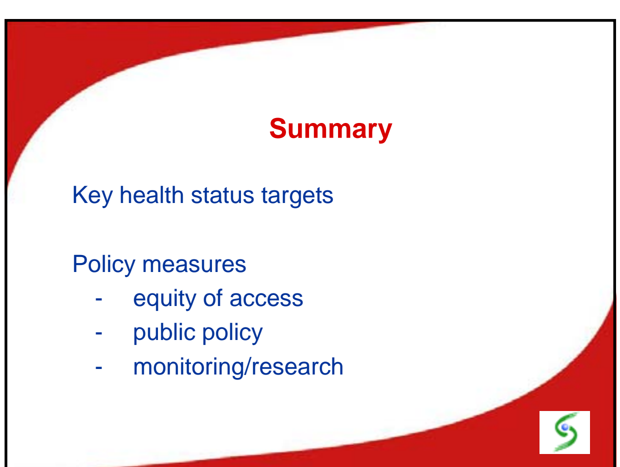

Monitoring & Research
Some relevant initiatives
Steering Group on Social & Equality Statistics
EU Survey on Income & Living Conditions (EU SILC)
EU NAPincl indicators
CPA study on NAPS Indicators
NHIS recommending geo-coding

Wider Public Policy Measures
Health Impact Assessment (HIA)
Multi-sectoral Work for Health

Health Impact Assessment (HIA)
National Health Strategy commitment
CMO's Office developing an approach
IPH work programme

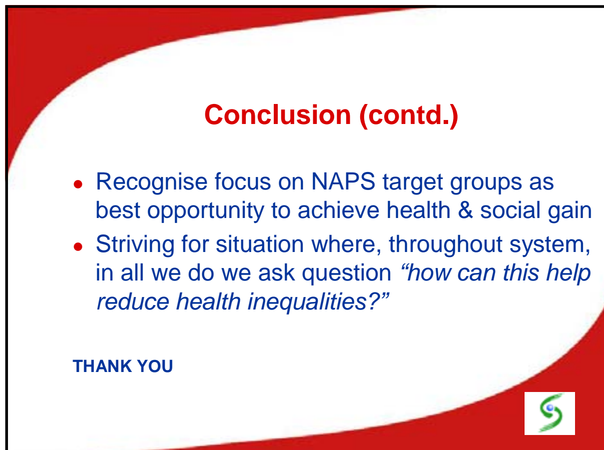
IPH & DOHC in Partnership
Developing
policy seminars for senior management
training courses for HIA practitioners
review of HIA tools

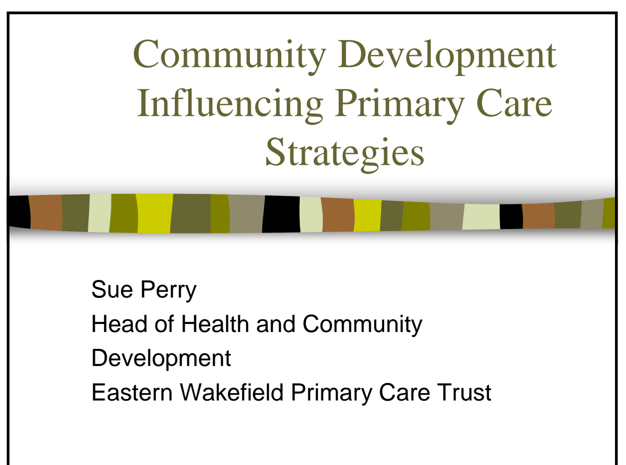
Multi-sectoral Work for Health
Interdepartmental Committee
Actions and indicators in WG Report
Capacity building for staff and community

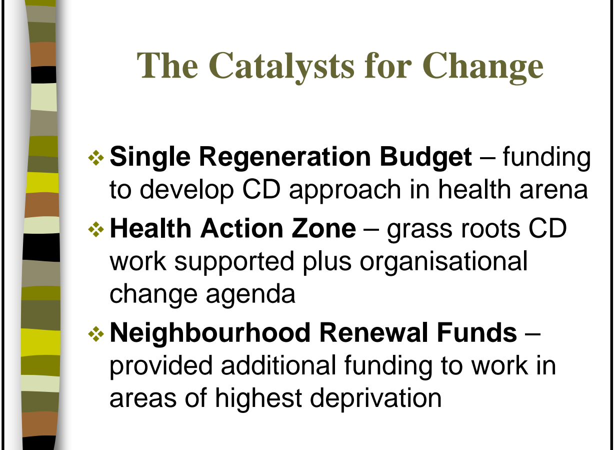


NAPS – Social Inclusion

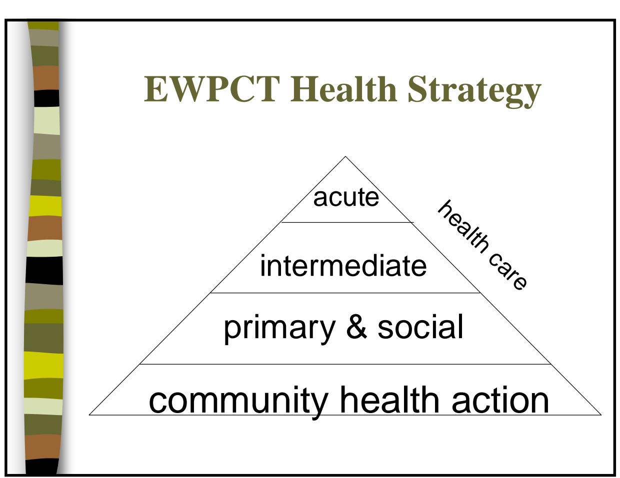
- Make Practical
- Not an isolated item
- Mainstream into all policy implementation
- Social Inclusion Performance Measurements

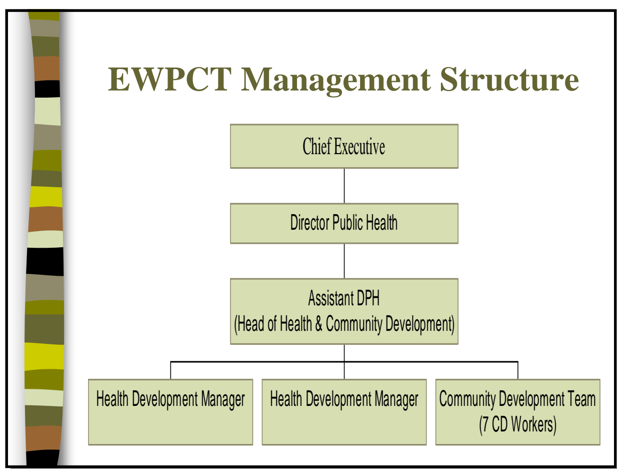



Community Development Influencing Primary Care Strategies
Sue Perry
Head of Health and Community Development
Eastern Wakefield Primary Care Trust


The Catalysts for Change
Single Regeneration Budget – funding to develop CD approach in health arena
Health Action Zone – grass roots CD work supported plus organisational change agenda
Neighbourhood Renewal Funds – provided additional funding to work in areas of highest deprivation

Policy Context
Acheson Report
Community Involvement at the heart of government plans for regeneration
Social Inclusion
Local Strategic Partnerships
Inequalities in Health –Cross Cutting Spending Review


EWPCT Health Strategy
acute
intermediate
primary & social
community health action
health care


EWPCT Management Structure
Chief Executive
Director Public Health
Assistant DPH
(Head of Health & Community Development)
Health Development Manager
Health Development Manager
Community Development Team
(7 CD Workers)

Community Development Initiatives
Tenants and residents groups – lobbying, campaigning etc.
Environmental projects – on derelict pit sites
Support groups – bereavement, stress, benefits advice etc.
Participatory research
'Pathway to Health Action' - training

Issues and Challenges

- Long term nature of process – no quick fixes
- Performance management systems
- Future changes in policy
- Level of appointment of CD staff
- Shortage of experienced CD staff
- The need for effective evaluation
- Culture change in a predominantly clinical environment

Community Development

A Strategic Way Forward for Wakefield

Sue Perry
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(on behalf of)
Community Development Good Practice Group

September 2002

Foreword

As a very new DPH I am painfully aware of my obligations in respect of health improvement and health equality. I am also conscious that ‘new’ DPHs are expected to be ‘known and respected by communities, not distant bureaucratic figures’ I am therefore keen to fulfil that obligation. Happily, in Eastern Wakefield I am supported by a keen and enthusiastic team of public health workers, including 8 Community Development (CD) workers.

Many of the CD team are local people, members of local communities who know the patch and know local people. They have the training, skills and abilities to facilitate the real change that needs to happen to improve health, but that is not enough. In order to ensure that long term commitment is given to supporting what is essentially a long term process of change we need to place community development work in a strategic context. I welcome this document as it presents us with an opportunity to do just that.

Community Development is about building strong foundations and empowering people to take positive choices for health and well-being. It is an essential component of public health work and keeps me in touch with the people that I serve.

Val Barker
Acting DPH
Eastern Wakefield PCT

Community Development

A Strategic Way Forward for Wakefield

Summary

This document aims to consider some of the key areas of legislative and policy change as they are affecting Local Strategic Partnerships (LSPs) and seeks to do so from a perspective which argues the case for the relevance of a strategic community development approach. It aims to provide a basis for working with people, not only on issues of local concern but also when developing wider programmes and policies.

The document outlines the main elements for effective community development and provides a strategic framework which is intended to:

- Improve the effectiveness of the community sector both independently and as a partner
- Help in tackling problems of community regeneration on an integrated, partnership basis
- Link to equal opportunities and access policies
- Link to policies of decentralised services and decisions
- Link closely to a range of new policies and funding regimes.

Reviewing the community development function in organisations should be as important as reviews of other functions.The framework incorporates a strategy checklist which is rooted in the principles of community development and clear guidelines on the responsibilities of organisations to ensure there is a clear understanding of, and commitment to community development.

A community development approach starts with people in communities coming together to address themes. It supports the connections that exist between them and the fact that individuals, groups and organisations need to learn from each other and co-operate if consistent and sustainable change is to be achieved. Information is included on the existing infrastructure networks operating in the Wakefield district at a community and professional level.

Appendix 1 offers an organisational self assessment tool, the tool is designed to help the nominated community development lead person to assess the strengths and weaknesses of a given organisation. This tool draws its format, structure and some of its content from the Bradford Community Involvement Indicators Tool and the SCCD National Strategic Framework for Community Development.

Appendix 2 presents an overview of community development activity across Wakefield district. The information is drawn from interviews with staff from 11 different organisations. It provides a snapshot of where community development is currently focused, and the context within which it seeks to operate.

Appendix 3 provides the terms of reference for the Community Development Good Practice Group who were commissioned to undertake this piece of work on behalf of the Health and Social Well Being Partnership.

Community Development

A Strategic Way Forward for Wakefield

Introduction

Community Development Good Practice Group

The Community Development Good Practice Group is a formal part of the LSP structures. It is a partnership group, drawing membership from a variety of agencies and networks concerned with community development across Wakefield. Its aims and objectives (*see appendix 3)* have been agreed by the Health and Social Well Being Partnership. These are extensive and are cross-agency, cross district, cross issue and cross communities. The remit is concerned with improving the effectiveness of existing community development work, and shifting mainstream policy, priorities, and ways in which agencies and workers currently operate. It is fundamentally concerned with supporting the management of change. The group owes much to the advice and support of Labyrinth Consultancy during its period of development.

The aim of this document is to provide a basis for working with people, not only on issues of local concern but also when developing wider programmes and policies. It is about working with communities first, recognising their interests, expertise and experience and building on this as the basis for development. It is this approach that will result in equitable, relevant and sustainable change.

Community involvement lies at the heart of government plans to make a real difference to people's well being, and to regenerate the economic, environmental, social and health aspects of their lives. However, the starting point for action is often the initiative and not the communities themselves. This can result in disjointed development with people being overwhelmed by the demand to respond to initiatives and take part in increasingly complex organisational arrangements. Community development is a process which joins up environmental, economic, social, demographic, technological, political and other issues by empowering communities to work on their own agendas to improve the quality of life. It has clear values and commitments as its starting point rather than predetermined structures and solutions.

This framework draws heavily from 'A Strategic Framework for Community Development', published by Standing Conference for Community Development (SCCD) in May 2001. The SCCD framework has been endorsed by the Association of Local Authorities in Northern Ireland, the Community Development Foundation, and the Local Government Association, it provides a welcome clarity and strategic vision for effective community development work to flourish and bring about real change.
Following the SCCD model, this document outlines the main elements for effective community development and provides a tool to analyse current contexts and practice. A strategic approach to community development will:

- Improve the effectiveness of the community sector both independently and as a partner
- Help in tackling problems of community regeneration on an integrated, partnership basis
- Link to equal opportunities and access policies
- Link to policies of decentralised services and decisions
- Link closely to a range of new policies and funding regimes

Policy Context

Most current government policies make an explicit reference to the need to involve local people, carers, service users, socially excluded communities and so forth in developing policies and new ways of working e.g. Neighbourhood Renewal, Health, Crime and Disorder and Housing. Government have also supported the development of a National Community Development Strategy in order to strengthen the community development approach as a way of ensuring public accountability and the empowerment of local communities and communities of interest. The Active Community Unit (based within the Home Office) is co-ordinating an inter-departmental working group focusing on a more joined up approach to community development work. The ACU expect the profile of community development, and the resources available to support it, to be significantly increased as part of future government spending review

What is community development?

Community development is about building active and sustainable communities based on social justice and mutual respect. It is about changing power structures to remove the barriers that prevent people from participating in the issues that affect their lives. Community workers support individuals, groups and organisations in this process on the basis of the following values and commitments.

Values

Social justice – enabling people to claim their human rights, meet their needs and have greater control over the decision- making processes which affect their lives.

Participation – facilitating democratic involvement by people in the issues which affect their lives based on full citizenship, autonomy, and shared power, skills, knowledge and experience.

Equality – challenging the attitudes of individuals, and the practices of institutions and society, which discriminate against and marginalise people.

Learning – recognising the skills, knowledge and expertise that people contribute and develop by taking action to tackle social, economic, political and environmental problems.

Co-operation – working together to identify and implement action, based on mutual respect of diverse cultures and contributions.

Commitments

Challenging – discrimination and oppressive practices within organisations, institutions and communities.

Developing – practices and policy that protects the environment.

Encouraging – networking and connections between communities and organisations.

Ensuring – access and choice for all groups and individuals within society.

Influencing – policy and programmes from the perspective of communities.

Prioritising – the issues of concern to people experiencing poverty and social exclusion.

Promoting – social change that is long term and sustainable.

Reversing – inequality and the imbalance of power relationships in society.

Supporting – community-led collective action.

(Strategic Framework for Community Development, SCCD May 2001)

The Role of Community Development

Community Development is undertaken with communities of place, identity and common interest. The community development process works with communities to analyse, initiate and influence social change.

If community development is to fulfil its full potential it is important that its role in achieving equal opportunities, accessibility, participation in democratic processes and sustainable economic, social and environmental change is recognised. These themes are important across government and within the private and voluntary sectors.
Organisations in all sectors can provide crucial support to community development by adopting a strategic framework and ensuring that it applies in all the work of their organisation.

A community development approach starts with people in communities coming together to address these themes. It supports the connections that exist between them and the fact that individuals, groups and organisations need to learn from each other and co-operate if consistent and sustainable change is to be achieved. Community development spans the traditional boundaries of organisations in a way which is flexible and responsive to the priorities and concerns of communities.

A Strategy Checklist

This does not mean that communities can do everything or that the resources of statutory, private and voluntary organisations are no longer required to achieve change. A community development approach ***does*** mean that government and organisations in the private and voluntary sectors will:

- **Act on the basis of the values and commitments of community development**
- **Support action by community groups and organisations, community businesses and neighbourhood councils.**
- **Have clear processes which enable communities to influence their policies, programmes and priorities.**
- **Recognise the right of communities to propose alternative courses of action.**
- **Value different types and levels of participation.**
- **Build local, regional and national strategy through dialogue with people and organisations active within communities.**
- **Recognise the function of community development and allocate resources to it in their strategies.**
- **Recognise the resources, information and support required by community representatives and organisations when working in partnerships.**
- **Change working practices and time scales to enable participation by communities.**

(Strategic Framework for Community Development SCCD 2001)

Resources

Resources are crucial to effective community development. While the involvement of community activists and volunteers is unpaid, the process of community development has to be supported by funding, staffing, information and a range of other resources. It is important that theses resources are accessible and allocated on a basis that is secure, equitable and transparent.

Funding

Community development requires several types of funding. Generic community development should be funded on a long term basis from mainstream sources. Community work posts should be placed on an agency's establishment rather than being funded through short term contracts. Funding of specialist posts should be co-ordinated and relate to overall community development strategies.

For many community groups and organisations long term funding is required. Easy access to smaller sums of money is useful for many smaller scale projects. The Local Strategic Partnership can play a key role in helping groups to access funds from other sources by providing information and, when necessary, match funds.

The introduction of specific funds should be preceded by an analysis of need and consultation with potential beneficiaries. Mechanisms to monitor the overall distribution of funds and include communities in setting priorities are also necessary.

Simple application procedures, quick decisions and funding in advance and not in arrears are all important, it is not helpful when funds for small amounts require a disproportionate

amount of time making applications and producing accounts. Research suggests that take up and use of funds improves where there is a development worker supporting groups in applying for and managing resources.

Staffing

In the past community development has suffered from an insufficient number of posts designed to provide general support to community activity, it has been easier to obtain funding for specialist posts. Yet the evidence is that if general support work is not undertaken, then community participation will be weak. It is the combination of generic community workers with the availability of specialist staff that produces the best results. Experienced staff with knowledge of community development are also required within the management, policy and programming functions of organisations.

Information

Crucial for community groups and community workers is the ability to access information from government and other organisations that is clear, jargon free, and available in relevant places, formats and languages.

Wakefield and District Community Network
The Network currently has 255 members drawn from various groups and organisations**.** It offers**:**

- Quarterly forums which enable members to communicate and share information and knowledge
- A bi-monthly newsletter exchanging information.
- A data base of members.

The Network is supported by statutory training and Health funds. It also relies on ‘in kind’ support. There is a steering group of members to manage and co-ordinate the network.

Evaluation

Community development has measurable outputs and outcomes (*Achieving Better Community Development – Scottish Community Development Council).* Evaluation helps to assess the effectiveness of community development projects, programmes and policies, and why they are or are not successful. It should be a continuous process so that experience effectively informs future planning and development.
Evaluation should have the values and commitments of community development at its heart. It should be a participative process in which measures and indicators are relevant to, and produced with the communities concerned. It should be an empowering experience with all those involved having their say in setting the criteria and analysing the findings.

Learning, training and occupational standards

People are the main resource for community development. The learning that takes place when people come together to share experience, perspectives, knowledge and skills is crucial to the process of change through community development.

In parallel to this strategic framework the Community Work Training Group are developing a strategic framework for community development learning, which will be based upon the guidelines developed by the Federation of Community Work training.

To support these learning opportunities community work has had occupational standards for a number of years. These are used as the basis for the content and endorsement of courses. The standards are relevant for activists, volunteers, professional community workers, staff in other professions who are contributing to the community development process, managers and councillors.

Features of community development learning

Effective community development learning is based on community development values and commitments. A key feature is the value placed on people's experience as the starting point for reflection and analysis. Community development learning aims to create accessible learning opportunities, often within people's communities.

Wakefield Community Work Training Group
This group is a 'feeder' group into the Wakefield Learning Network. Its membership consists of representatives from the community, voluntary and statutory sector who have an interest in developing and supporting community development learning processes. The group are currently involved in devising a framework to support the development of learning and training opportunities needed by people and organisations involved in community regeneration. A core theme of the framework is the absolute improvement in the content and quality of training and learning opportunities for those with an interest and commitment to community involvement based on the values and principles of community development.

Community Activists and Volunteers

For many people who left school with no formal qualifications, involvement in community development and community based learning can offer appropriate first learning opportunities. The increase in self esteem and self confidence, the reduction in social isolation from being part of a group, and the development of new skills empowers many people to go on to more formal education and to make positive life changes.

Community Workers

Generic community work is an occupation that requires knowledge, experience and skills. It is based on ethical principles and values. Its role is to build individual confidence and organisational capacity in communities, to make links between communities and work on public policy and programme development. Generic community development workers require education, training opportunities and qualifications that recognise this role and are comparable with those available to similar professions.

CODE
This group is concerned with providing peer support to grassroots community development workers. It focuses on identifying and developing a professional development programme, keeping in touch with national trends, information sharing and proving a 'feed back' loop into the Community Development Good Practice Group. Its membership is open to all community development workers across the district.

Community Development Managers

Community development requires the support and involvement of knowledgeable and experienced managers because of:

- The inherent tensions faced by workers between the issues and priorities of the communities they are working with and the demands of their employing agencies.
- The need for policy, strategy and organisational development to enable community empowerment and support grassroots community development.

The policy of government and the demand for local authorities and other organisations to increase community involvement – because this is a key component of Community Strategies, Best Value, Social Inclusion, Health Improvement and regeneration policies – underlines the importance of having effective community development managers. Learning and development opportunities are therefore crucial for this group.

Community Development Managers Group

This group meets bi-monthly. Its membership consists of people with responsibility for managing CD staff and/or CD resources. Its main areas of focus include information exchange, identifying issues of wider policy, staff and project management issues.

Other professional and service managers

Many agencies are seeking ways of improving how they relate to, and work with communities. The majority of staff and managers in these sectors have limited experience and understanding of community development, yet the potential of theses staff to contribute both to strengthening communities and to providing services in more appropriate ways is considerable. This requires dissemination of existing good practice and professional training and in-service development courses should be adapted to include community development.

Elected members

It is important that politicians have a better understanding of community development. This can be achieved through the contact and dialogue that community groups and workers have with politicians. An introduction to community development values and processes

and the relevant policies of the Local Authority should be included in training courses for councillors.

Working in partnership

Partnerships where community representatives, elected members, managers and staff work together are increasingly important. For partnership working to be effective it should be backed up with opportunities for partners to build up their knowledge, skills and understanding together.

Quality Assurance

To be effective, community development requires competent organisations where there is an understanding of, and commitment to community development. Reviewing the community development function in organisations should be as important as a financial audit and reviews of other functions.

Responsibilities of organisations

- Have clear policies in place for community development.
- Recognise that community development is a long term process which requires a long term commitment.
- Provide information to the public and staff about the organisation's commitment to community development and what that means.
- Undertake community development, and allocate resources, in ways that promote equity within and between communities.
- Be transparent about the deployment of staff, finance and other resources.
- Recruit staff and volunteers fairly and give attention to their training and long term development.
- Be committed to promoting the health and safety of volunteers and employees, giving consideration to the specific risks inherent in community development.
- Have in place recording systems which ensure accountability.
- Have clear and well publicised processes that enable stakeholders to provide feedback.
- Dedicate time and resources to evaluation and commit themselves to share experience with others.

(Strategic Framework for Community Development, SCCD 2001)

Action Plan

Action	Timescale
This document is endorsed by the LSP	End of October 2002
NRF Bid to support strategic coordination endorsed by LSP	End of October 2002
All partner organisations make this document available for discussion at senior departmental/service level	October 2002
All partner organisations identify steps to develop own action plans – including support needed to develop plans	November 2002
All partner organisations identify lead person to develop action plans	November 2002
Feedback regular progress reports to LSP via CDGP and CIAG groups	Ongoing

Roles of Community Development Good Practice and Community Involvement Advisory Groups

- To ensure links are maintained at a district level and nationally
- To offer support and practical help
- To co-ordinate links between action plans

Appendix 1
Community Development - Organisational Self Assessment Tool

Introduction

This tool accompanies the Wakefield Community Development (CD) Framework. Once the Framework has been adopted by the Local Strategic Partnership, all local partners will be encouraged to develop their own organisational action plans in relation to CD. In the case of larger organisations it will be much more useful, and practical if each department and/or service undertakes their own assessment. These can then be brought together if desired, to give a picture of the whole organisation, and assist you in drawing up a 'whole organisation' CD strategy, as well as individual departmental/service CD action plans. However you will need to identify someone to co-ordinate this work across all your different departments/services to take this forward effectively. In the rest of this paper, when the word 'organisation' is used, please take it to mean or department or service, which ever is most appropriate).

This tool is designed to help the nominated lead CD person for your organisation undertake an assessment of the strengths and weaknesses of your organisation. The nominated lead may bring together other staff to collectively use the tool, or draw together a range of individual views and perspectives, and then co-ordinate those responses. The scoring system will help you look at where your organisation needs to develop its CD work, and can assist you in developing a very practical action plan.

This Tool draws its format, structure and some of its content from the Bradford 'Well Connected', community involvement assessment tool, although this is a much simplified[1]. It also draws heavily from the SCCD national Strategic Framework for Community Development[2], and SCCDs 'CD questions for local strategic partnerships' article[3].

Using the Scoring Guidance

This section is abridged from the Bradford 'Well Connected' Tool

This is a self assessment tool, but it is intended to be challenging. It can be an aid to continuous improvement if you are honest and consistent in your assessment of your organisation's situation and performance. The scoring guidance below is intended to help

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[1] Fairfax P.; South J.; Green E.; Hawran H. and Cairns L. Well Connected. A self assessment tool on community involvement for organisations. Bradford Health Action Zone. 2002. Available on www.haznet.org.uk The framework, using key questions , scoring and evidence, was developed and piloted in Bradford and has been adapted for the Community Development Organisational Self Assessment Tool

[2] Strategic Framework for Community Development: Standing Conference for Community Development (SCCD): 2001

[3] Questions for local strategic partnerships: SCCD Newsletter : …. 2002

you think through the issues raised by the sub questions, under each of the six main question headings.

The first time that your organisation uses this Assessment Tool should be seen as an opportunity to take stock. Community Development (CD) is a complex issue and the development of appropriate mechanisms for implementation will take time. It is unlikely that any organisation will score well in every area. It is more likely that you have some strengths and other areas that need much greater consideration and more work. As you 'take stock' you can usefully identify the actions necessary to move your organisation forward. If your organisation is just beginning to develop its CD work you could use this as an action planning tool in the first instance, to help you put in place to sort of mechanisms and practices which you will need to take forward CD.

Scoring

The scoring is based on looking at the extent to which there is:

- A strategic approach to community development
- Good practice throughout different areas and levels of the organisation
- A range of opportunities/support for community members (and staff)

Scoring criteria	Score
Strategic approach adopted and implemented throughout organisation. Range of opportunities/support available. Good practice seen throughout all areas and levels of organisation.	**10**
Developing a strategic approach, implementation patchy but activity in most areas, some opportunities/support available	**6-9**
No strategic approach, ad hoc activity, limited opportunities/support available	**1-5**
Not doing it, not thought about it	**0**

From:Bradford 'Well Connected' Tool

How to go about the scoring

Decide what your organisation's score is for each sub question using the criteria set out in the box above. The idea is to do a quick assessment based on what you know about your organisation. However it is also important to log the evidence on which you are basing the score you give your organisation in relation to each sub-question. Don't get stuck on trying to find an 'exact' score – the tool is designed to help you get an overall picture – small inconsistencies won't make a difference. If there is uncertainty or disagreement over a score, then average between the scores that different people perceive to be correct.

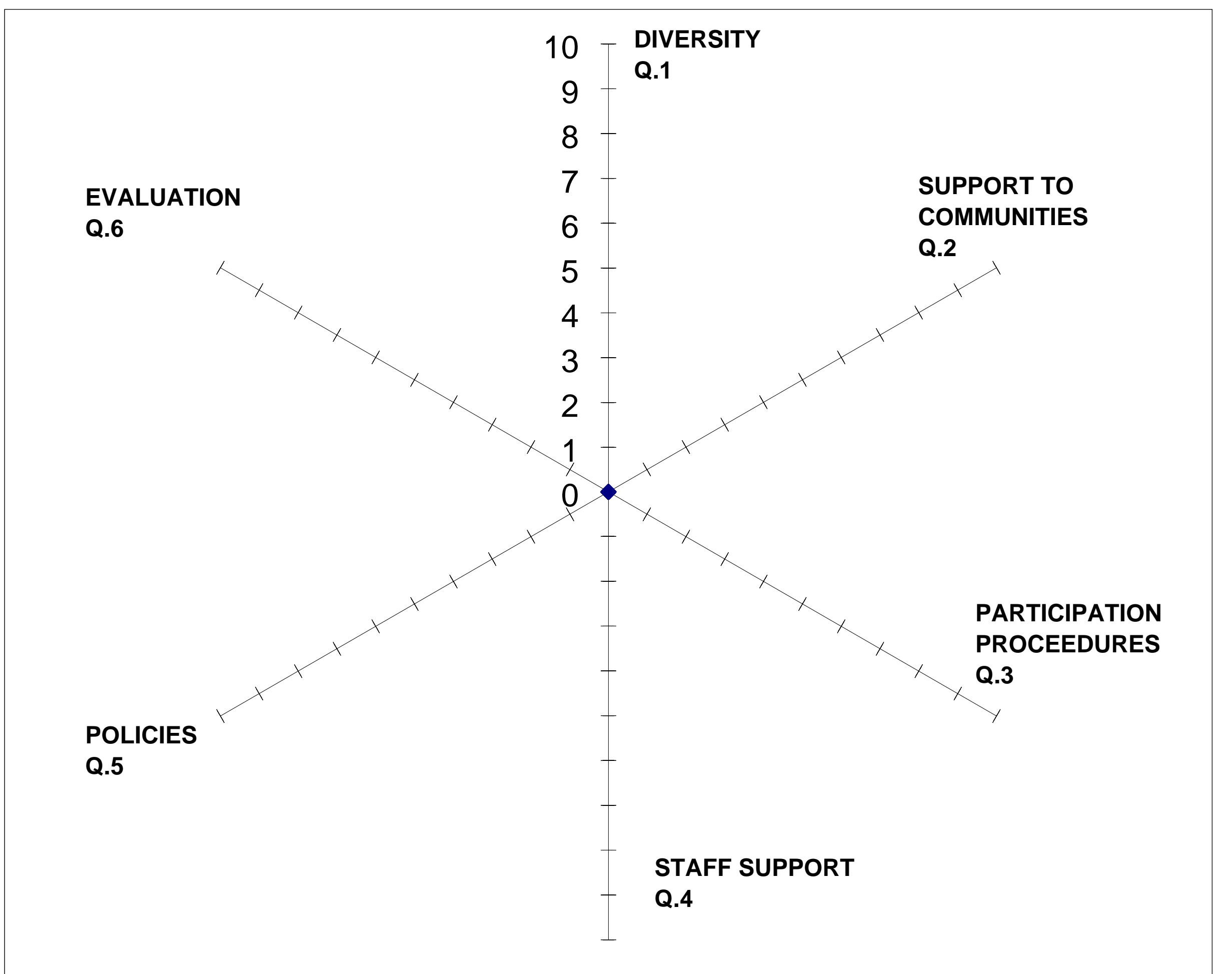
When you have completed the questions and scoring, enter your scores on the table and work out your average score for each aspect of the tool (by adding the sub questions scores under each of the six main questions, then dividing that total by the number of questions. These scores can then be plotted on the web, and entered into the scores box on page 4. This can be returned to at a later stage (see below) and a second assessment made to look at progress.

Next Steps

Plot the scores on the 'spider-graph' on page 4, overleaf. This will help indicate (in a visual form) the organisation's strengths and areas where more work needs to take place. Use this to draw up an action plan for taking forward and implementing the CD framework as it relates to your organisation's main roles and responsibilities.

The Community Development Good Practice Group can help you to both apply this self-assessment tool, and to draw up your action plan. They can also assist you in linking your plan into that of other organisations, and across the different sectors who serve Wakefield's population.

Six months after you begin to implement your action plan, it will be useful to return to the tool, and re-assess your scores and strengths and weaknesses.



	Question	**Total Score 1st assessment**	**Average Score 1st assessment (total divide by number of sub-questions)**	**Total Score 2nd assessment (six months later)**	**Average Score 2nd assessment (total divide by number of sub-questions)**
1	DIVERSITY				
2	SUPPORT TO COMMUNITIES				
3	PARTICIPATION PROCEDURES				
4	STAFF SUPPORT				
5	POLICIES				
6	EVALUATION				

Community Development Organisational Assessment Tool	Where are you now? (perceptions)	How do you know? (evidence)	Score	Actions proposed and timeframe
KEY QUESTION 1 ***Is the diversity of the District's communities reflected in everything your organisation does?*** i) Is an equality strategy in place and implemented? ii) Are resources for community development (e.g. paid worker time; grants; information and advice) allocated in ways which promote equity within and between communities? iii) Does your organisation take into account ways of contacting, supporting and engaging with communities of interest as well as geographical communities? iv) Do you have systems in place to enable local communities, including socially excluded communities, to be involved in the identification, evidencing and interpretation of community needs? v) Is the diversity of local communities reflected in the people employed and/or who are active in your organisation (on your Board; Mgt Committee or Elected Members for example) ? iv) Do marginalized communities and geographical groupings participate in influencing priority setting, and decision making at all levels within your organisation?				

Community Development Organisational Assessment Tool	*Where are you now? (perceptions)*	*How do you know? (evidence)*	*Score*	*Actions proposed and timeframe*
KEY QUESTION 2 ***Does your organisation support action by community groups and organisations?*** i) Do you employ community development workers to offer CD support to local people, groups and organisations? ii) Do you make funding available to local communities and groups to enable them to organise themselves and run their activities? iii) Do you offer information and/or advice to local communities and groups to enable them to organise themselves effectively and to develop robust organisational structures and procedures? iv) Do you offer community development learning and skill based training to local people and community group members to enable them to work effectively within their communities, and in partnership with local organisations and partnerships?				

Community Development Organisational Assessment Tool	Where are you now? (perceptions)	How do you know? (evidence)	Score	Actions proposed and timeframe
KEY QUESTION 3 ***Do the procedures in your organisation make it easy for communities to understand and participate?*** i) Do you have accessible information available which clearly explains your purpose, structure, decision making and priorities? ii) Do you have clear procedures and mechanisms for enabling communities to influence your policies, programmes and priorities? iii) Are public events and meetings and other similar events organised in ways which are appropriate to the purpose and do they facilitate effective participation. – e.g. through outreach; appropriate publicity; consideration of location, timing etc. iv) Do you have mechanisms in place to ensure feedback to communities and local people about what has happened as a result of their input and participation? v) Do you have a system in place for the quick payment of expenses incurred by community representatives when working in partnership with your organisation? Is this well publicised, and easy to access? vi) Are any of your buildings, communication technology, printing or other equipment made available for community use (e.g. for community group meetings; to aid groups with their publicity; funding applications etc.) vii) Are expertise within your organisation, such as finance, employment, marketing, partnership working, made accessible to community groups?				

Community Development Organisational Assessment Tool	*Where are you now? (perceptions)*	*How do you know? (evidence)*	*Score*	*Actions proposed and timeframe*
KEY QUESTION 4 ***Do you ensure that all the people involved in running your organisation have the knowledge, skills and support necessary to engage with the community?*** i) Has your organisation taken measures to develop skills and understanding of working in partnership with the community at an organisational and individual level? ii) Does your organisation enable and support staff to be involved in partnership working with the community? iii) Does your organisation have mechanisms in place that ensure that when there are differences between your organisation and local communities, staff who work with communities are not under pressure to put organisational loyalty before their duties to support the independent voice of local communities? iv) Are staff who work with communities given time to enable them to network with other CD workers through attendance at appropriate groups and meetings? v) Are staff involved with CD work given access to appropriate, skilled support and supervision? vi) Is your organisation a member of one of the national body established to support CD (Standing Conference for Community Development (SCCD)). Do you circulate the information and materials produced by SCCD to all key staff?				

Community Development Organisational Assessment Tool	*Where are you now? (perceptions)*	*How do you know? (evidence)*	*Score*	*Actions proposed and timeframe*
KEY QUESTION 5 ***What policies does your organisation have, or sign up to in a partnership role in, that support community development?*** **i**) Does your organisation have its own business plan/action plan/ strategic framework? Does CD feature in this? ii) Do you have access to, and use, a copy of the Active Community Unit (Home Office) /SCCD National Framework for Community Development? iii) What plans has your organisation developed to take forward your role as a partner in key national and local strategies such as Neighbourhood Renewal and other policies and mechanisms aimed at addressing deprivation, social exclusion, community safety and poverty and inequalities, and in particular the requirements in such policies for developmental support to enable community involvement?				

Community Development Organisational Assessment Tool	*Where are you now? (perceptions)*	*Score*	*How do you know? (evidence)*	*Actions proposed and timeframe*
KEY QUESTION 6 ***Does your organisation have a monitoring and evaluation framework for assessing the effectiveness of CD work?*** i) Does your organisation have systems in place for measuring the effectiveness of CD work your staff are involved with, or that you fund, or support through partnership working? ii) How does your organisation enable local communities to play a role in monitoring and evaluation of community based schemes, and of the quality of services you provide to local communities? ii) How does your organisation share learning with other key local bodies and with local communities?				

Appendix 2
An overview of CD work across and within Wakefield District

This short overview of CD activity across the Wakefield District is drawn from interviews with 14 staff from 11 different organisations. It provides a snapshot of where CD is currently focused, and the context within which it seeks to operate.

Specific CD strategies and frameworks

Several Wakefield District partnership and organisational documents either make direct reference to CD (e.g. Neighbourhood Renewal Strategy; Community Plan) or implicit reference to CD (e.g. Community Safety Strategy).

Only one body, Wakefield Housing Services, has a formal CD strategy. However the document, which is dated 1998/99, is not thought to be in current use, and in any case developments nationally and locally mean it is rather out of date. The Wakefield CD Project (Barnardo's) has a strategic action plan for its work, and as it is a specific CD agency, then this could constitute an organisational CD strategy. Several other bodies also fall into a similar category, though their work is not wholly CD, such as Lupset Community Centre Association (LCCA).

Eastern Wakefield Primary Care Trust (PCT) is planning to produce a Trust 'Public Involvement Strategy' and also specific public involvement strategies for each of the primary care practices and service areas that fall within its remit. A specific CD Strategy is also being produced, which will underpin the involvement and tackling inequalities work. Bodies such as Voluntary Action Wakefield District (VAWD) and Age Concern are currently developing new strategic plans for their organisations, and these are likely to include sections on how these bodies perceive their CD role.

A CD Definition

Most organisations do not have a formal, written down definition of CD, but feel clear that they could define CD, and recognised how it was different to community consultation for example. Most people referred to explicit CD values and principles that informed their approach to working with communities, and which were central to their understanding of CD. St Catherine's mentioned a theological basis and values to all their work with local communities.

Action for Health; Barnardo's; Groundwork and Wakefield MCD Development Department all mentioned that they used the Standing Conference for Community Development (SCCD) definition and/or CODEworks definition (which was adapted from SCCD's definition). The Wakefield Housing Service's CD Strategy used the SCCD definition in its introduction.

As this is the most commonly recognised definition of CD used across the district, and it links Wakefield's CD work into a wider national framework, it has been adopted in this document (see page 3…).

Evaluation

Two organisations, Barnardos and Action for Health, referred to using a specific CD planning and evaluation methodology known as ABCD.[4] Most other organisations are linked into monitoring and evaluation within the overall schemes that they are part of. There is some national evaluation of Groundwork schemes for example, and the PALS schemes have been given some guidance on evaluation. Part of Age Concern and Action for Health's CD work is SRB funded, so links into SRB output and targets monitoring; the same applies to the Sure Start work operating through the Lupset CCA. On the whole these were not felt to be that relevant to CD, as they give a picture of what is happening, but are not tools that can measure the impact of change, or what has changed as a result of CD interventions.

There was interest from many people in developing a joint approach to evaluation that could be adapted to different schemes. ABCD was not known about by all agencies, and may be worth exploring further as a possible tool for wider use, particularly as it is nationally recognised.

District wide CD work

As its name suggests Barnados Wakefield Community Development Project is almost exclusively a CD organisation. The majority of its funding comes directly from national Barnardos, though it also obtains a substantial percentage of its funding for some of its local CD work from Wakefield Council and schemes such as SRB and RECHAR. Barnardos plays a pivotal role in supporting Wakefield wide CD work, and is the key organisation in supporting networking and information sharing on CD across the district. They co-ordinate and/or make a contribution to all the key CD bodies that operate a District level, outlined below.

There are a number of different initiatives and working groups' active in Wakefield at the moment, all of which have different briefs, but which link into Community Development work across the District.

Community Development Good Practice Group – Chair Cllr. Mark Burns-Williamson

This group feeds directly into the Local Strategic Partnership process and structures. Its full terms of reference are included as Appendix 3. Its main aim is to support the development of a strategic approach to community development across all agencies and sectors working with communities across Wakefield. Thus it is the key body in relation to the development and implementation of this document.

[4] *Achieving Better Community Development: Planning and Evaluation Tool*, 2000, Scottish Community Development Centre

Community Involvement Advisory Group (CIAG) – lead contact Keith Henshall Wakefield HAZ

A document, 'Getting people Involved: Working towards a joint approach to community, user, carer and citizen involvement across Wakefield district' was produced and published by Wakefield Health Action Zone and its partners in March 2001. This was brought together by CAIG. CAIG feeds in directly to the LSP. Its main roles are to co-ordinate work on developing and implementing a joint approach to community involvement in the District; to facilitate learning across the LSP; to provide community involvement policy advice and guidance and to facilitate the development of shared mechanisms and plans for community involvement across partnerships and partner organisations in order to inform the development of future plans.

This group is liaising closely with the CD Good Practice Group. CD is seen as work that underpins, and adds a social inclusion dimension to community and public involvement work.

Codeworks – Lead contact Mary McNulty/Helen Monks

This group meets on a bi-monthly basis. It is aimed at people who have CD as their main brief. Its main areas of focus are information sharing; support and professional development.

Wakefield District Community Network – Lead contact Joe Lennon

This network, which has been in existence for over nine years, aims to 'develop a district wide network where people can express their support for community development work by sharing and developing their knowledge and skills'. It meets three times a year, and is has a wide-ranging membership, including community activists. In between meetings, information is shared, and a database of member's details is held and updated to encourage networking and joint initiatives. The Network's newsletter is called 'Outernet'; a website is being developed.

CD Managers Group – lead contact Pete Hulse & Sue Perry

This group meets bi-monthly. Its membership consists of people with responsibility for managing CD staff and/or CD resources. Its main areas of focus include information exchange; identifying issues of wider policy concern; staff and project management issues.

Community and Voluntary Sector Forum Steering Group – Lead Tony Dean

VOX (the Voluntary and Community Sectors Forum for Wakefield District) was launched in July 2002, following a year of development. Its aims are to promote, encourage and contribute to the advancement of the Voluntary Sector, Community Sector and Communities of Interest across the district. It aims to do this by bringing together all of the organisations and groups within this sector so that they can have a voice at, and be represented on, all of the strategic and community planning bodies within the district, as well as regionally and nationally. VOX administers the Neighbourhood Renewal Community Empowerment Fund.

Neighbourhood Renewal (NR) Steering Group – Lead contact Lee Adams/Graham Brown

This brings together the chairs of thematic partnerships and individuals who are operating as an LSP/NR Support Unit The NR Steering Group have been concerned with the development of the NR Strategy; emphasis has now shifted towards implementation. CD features strongly in the NR strategy.

Communities of Interest (C of I) Steering Group – Lead contact Hibou Drusden

This body is co-ordinating both organisational development work in relation to equity and social inclusion issues, and outreach and development work to help strengthen networking and representation amongst and between a wide range of communities of interest.

Community Regeneration Action Group (CRAG) – Lead contact John Erskine

Set up initially as a short life action group, CRAG has evolved into a reference group for Wakefield First on matters relating to community economic development. It also has a sub-group, the Developing Communities Strategy Group, which falls within Wakefield's European Funding Programme. CRAG is an advisory group, rather than a representative group, though there are plans to bring SRB community representatives on board in the future.

Wakefield Community Training Group (WCTG) – Lead contact Chris Hollins

The group is presently involved in producing a CD Learning Strategy. It feeds directly into the LSP structures via the Lifelong Learning Partnership. The WCTG want to link the CD Learning Strategy across all the LSP structures and link into other strategies more effectively. In particular they hope to clarify how CD learning links into the

Neighbourhood Renewal Learning and Skills Group, as they have some overlapping agendas.

At the moment the CD Learning Strategy only focuses on adults, but the introduction of citizenship lessons into school curriculum will open up CD training and learning opportunities, along with other developments such as the proposed 'Youth Parliament'.

Area Panels

A recent paper to the Council's cabinet, from the Chief Executive, set out the Council's plans for Area Panels. 8 are proposed, covering the District. They will be constituted as Council sub-committees, although there will be CD implications, especially as the Panels will have responsibility for developing local plans, have paid staff and budgets to spend and allocate. At the moment these Panels appear to focus on public involvement rather than CD, though their brief may expand when they become more established.

Patients Forums and Commission for Public and Patient Involvement (CPPI) – Lead contacts (Wakefield West PCT) (Eastern Wakefield PCT)

These bodies are currently the subject of legislation as part of the NHS modernisation. When they pass into statute Patient's Forums will be developed for each PCT and NHS Trust. Their outline brief includes community development and community capacity building, supported by the national level CPPI.

Community development directly with local communities

Given the numbers of CD groups and networks across the district (see section above) there appear to be very few people employed with a specific CD remit. There are workers with briefs that link to CD in some way, such as economic development workers employed through SRB initiatives and through St. Catherine's and Lupset Community Centre Association for example. However, most of these workers do not have backgrounds in CD and a CD approach is not used consistently by most of them.

Some organisations employ staff with specific remits which do not mention CD in their job titles (e.g. West Yorkshire Charity Information Bureau's funding advisors) but where the organisational aims and ethos mean that a CD approach is expected from all staff.

Others (such as the Police/Housing Services' 'Estate Rangers') are not necessarily perceived by their employing bodies as CD workers, but may in fact adopt a CD approach, depending on their own personal backgrounds and skills.

As well as playing a key role at District level, Barnardos is involved in local neighbourhood based CD work, in areas such as Normanton. However, they only have a small staff group, and thus can only act as a CD resource in a limited number of areas at any one time.

CD work in relation to specific issues or areas of concern

Health and the environment are two broad issues where Wakefield has developed specific CD workers and initiatives. The Health Action Zone initiated the employment of a number of workers with a specific CD and health brief. With the demise of Wakefield Health Authority and the expanded roles of Wakefield's two Primary Care Trusts (PCTs) most of these workers are now employed through these two organisations. In all there are now 8 (based in Eastern Wakefield PCT. All of these are on short term contracts. In addition one member of Eastern Wakefield PCT staff, on a permanent contract, is responsible for the management of the PCT CD staff and for strategic level CD work across the PCT.

Groundwork have a 'Community Links Team', consisting of a team manager and five staff, who work in a range of geographical communities, but focus specifically on environmental issues.

Some CD is underway with specific communities of interest. However, this is very patchy and, on the whole, has relied on the voluntary sector initiating and resourcing this work, for example Age Concern have a worker, some of whose work encompasses CD with older people in two specific geographical areas. The work planned through the Communities of Interest Steering Group should assist the District in devising a more strategic and even handed approach to supporting CD work with the wide range of communities of interest.

Gaps

With no strategic overview of CD at district level, CD tends to be most active in areas where either communities themselves have initiated action, often in partnership with a voluntary body (such as St Catherine's and Lupset Community Centre Association) or where communities of interest have developed initiatives.

A number of bodies such as the HAZ; Banardos and Groundwork tend to work in parts of the district that have high levels of deprivation, or in areas where they have been invited to work in partnership with another body (such as an SRB). However this has not taken place in a planned way and so some communities receive no or little CD support. Other areas, which may have mixed populations and thus do not necessarily appear to be the most deprived, may miss out on CD support altogether, further compounding the social exclusion and marginalisation of the less affluent, or socially excluded residents in those areas.

Development agencies such as SRBs may undertake CD work, or they may work with other bodies to undertake that work. However, this is dependent on the particular brief of a scheme and not all Wakefield's regeneration initiatives are involved in supporting CD work. Bodies such as local housing offices may undertake or support CD work in their local areas, but this is dependent on the individuals concerned rather than an agreed District approach.

The district wide information sharing and networking that take place looks very comprehensive on paper, but several of the groups and networks outlined above are operating on the good will of individuals or small voluntary agencies, and with little resources. Several are in a fragile state, and their membership bases need

strengthening. There is also a case for rationalising the numbers of groups and networks, but that is unlikely to happen until there is clear CD strategy for the District.

Contributors to the mapping section

- Sue Perry: Action for Health (now Eastern Wakefield PCT)
- Barbara McCullock: Age Concern Wakefield District;
- Margaret Saunders: Eastern Wakefield Primary Care Trust;
- Andy Dalton: Groundwork;
- Mike Holt: Lupset Community Centre Association Ltd.;
- Mike Croft: St Catherine's;
- Peg Alexander: Voluntary Action Wakefield & District;
- Pete Hulse and Eileen Bradshaw: Wakefield CD Project, Barnardo's;
- Hibou Dursden: John Erskine: Maggie Bellwood: Wakefield MDC (Central Policy Unit; Development Department; Housing Services);
- Chris Hollins: West Yorkshire Charities Information Bureau;
- CI Nick Bartrum: West Yorkshire Police

(Mapping compiled by Jan Smithies of Labyrinth Consultancy)

Appendix 3

GOOD PRACTICE IN COMMUNITY DEVELOPMENT GROUP

Terms of Reference

Overall Aims

- To develop a district wide policy in relation to community development
- To develop a strategic approach to community development which is shared across all partnerships and agencies working with communities, within the Wakefield District.

Objectives

- To map current community development practice across the district, in line with the national CD Mapping initiative
- To develop a joint definition of community development, and shared principles and values, based on the National Framework for Community Development (SCCD/ACU May 2001)
- To develop a set of shared guidelines in relation to good practice, which are subscribed to, and acted on, by all local agencies and sectors, based on the National Framework for Community Development
- To co-ordinate the different community development groupings and networks that exist across Wakefield in order to ensure that there is a clear communication channel from the grassroots to the LSP structures and to all local key bodies and agencies, and visa versa
- To explore the development of a 'Community Development' agency to ensure joint approaches to issues which affect all community development workers and initiatives, such as evaluation, information, coordination and channelling of funding, skill sharing and so forth.
- To identify the organisation development implications of community development and identify ways of accessing support for agencies, sectors and initiatives in their work to implement the district wide community development policy.
- To support the development and monitoring of district wide indicators, outputs and outcomes of community development, based on both statistical and process type data
- To identify external funding opening and opportunities to assist Wakefield in this work.
- To oversee the CD aspects of the District's Neighbourhood Renewal Strategy.
- To co-ordinate with other key structures and initiatives within the LSP.

Discussion Paper on "Inter-Sectoral Working for Health"
Building Health Communities Conference
21st May 2003

1. Introduction

This paper was requested by the Combat Poverty Agency for a workshop on inter-sectoral work taking place at the "Building Healthy Communities" Conference on 14th May 2003. It outlines the nature of inter-sectoral work for health and the policy context. International and Irish examples are given, together with lessons learnt and key issues raised.

The purpose of the paper is to stimulate discussion among workshop participants and serve as a catalyst for debate around key challenges and recommendations for change. The paper emphasises the need to bring inter-sectoral working to the centre of health policy and practice.

2. What is inter-sectoral work for health?

Inter-sectoral work is a process in which representatives from more than one sector work together towards a common aim. The sectors involved are generally the statutory sector, the community/voluntary sector, the private sector and the elected representatives or political sector. Sectors may also be described in terms of an area of interest such as education, food, housing or health. Inter-sectoral work is broader than an inter-agency approach where only agencies, usually from the statutory sector, are involved. The term multi-sectoral is also used interchangeably with inter-sectoral, although there may be different shades of meaning attached to each term. In Ireland, we are familiar with the concept and practice of partnerships. However, partnerships with a specific health agenda are not common, and it is only recently that those engaged in community development and anti-poverty work have started to focus on health.

Within the formal health service, a clinical, case-centred, approach, based on a medical rather than a social model, is the dominant ideology and this is reflected in much of the practice, as well as the allocation of resources. A welcome recent development has been the publication of the National Health Strategy "Quality and Fairness: A Health System for You"[1] which champions a broader perspective on health, and highlights the important role of inter-sectoral work to protect, promote and sustain health. While there are some examples of successful inter-sectoral work taking place, in terms of the health system, considerable challenges still remain for implementing this policy in a more systematic and sustainable way.

Working inter-sectorally for health does not necessarily require a stated health aim, such as an improvement in the level of a disease. It can encompass working on key health determinants, such as poverty, as long as the link to health is clearly understood by all partners.

[1] Department of Health and Children, 2002

Inter-sectoral or partnership work can encompass a range of behaviours and different levels of engagement, as outlined by in Table 1 below:

Table 1: Levels of inter-sectoral working

Level	Task	Comment
Networking	Exchanging information for mutual benefit	Simplest form of integration
Co-ordination	Exchanging information and altering activities for mutual benefit and to achieve a common purpose	More complex. Requires participating organisations to share in decisions about changes
Co-operation	Exchanging information, altering activities and sharing resources for mutual benefit and to achieve a common purpose	Requires even greater organisational commitments to cover the re-deployment of personnel, financial and technical resources in new integrative arrangements
Collaboration	Exchanging information, altering activities, sharing resources and enhancing the capacity of another for mutual benefit and to achieve a common purpose	Requires the application of sophisticated organisational linkages involving the sharing of risks, the development of shared visions, and the development of complex partnership relationships and processes

Source: O' Dwyer[2]

3. Rationale for working inter-sectorally for health

3.1 Definition of health

The broad dynamic and positive definition of "health" championed by the World Health Organisation (WHO) has received wide support in Ireland, at both community and health service provider levels:

"Health is a state of complete physical, mental and social well-being
- not simply the absence of disease or infirmity.

It is estimated that 80% of health impacts arise as a result of inter-acting and complex factors operating outside the formal health sector. The greatest gains in health worldwide over the past 100 years have been achieved through improvements **outside**

[2] O' Dwyer A, 2000. "The Conditions Necessary for Effective Inter-Agency Collaboration", Health Promotion Service, Midland Health Board, April 2000

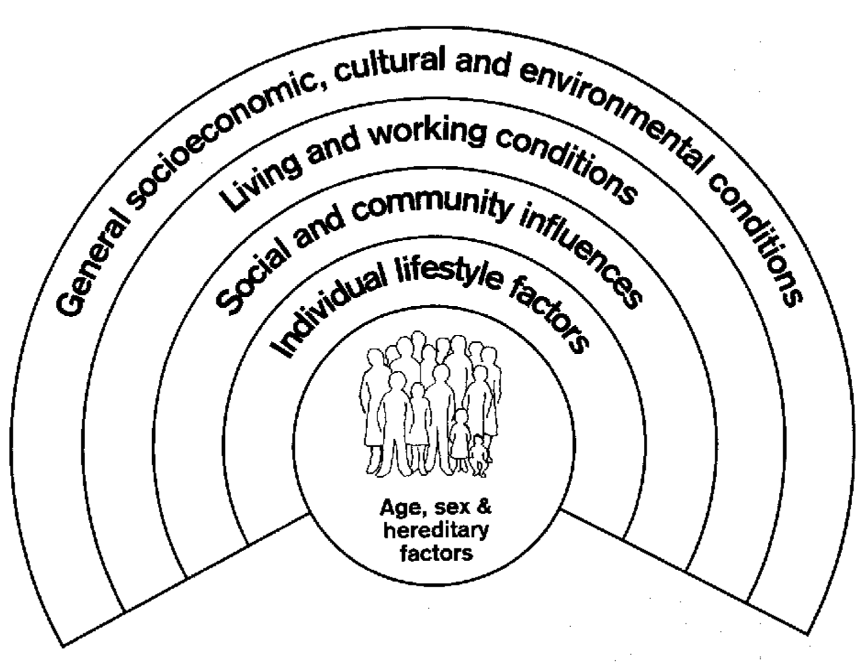
health service provision, such as education, working conditions, accommodation and housing, food safety, water supplies, waste management and the physical environment including improved transport and access. The same is true for Ireland. The overwhelming historical evidence clearly shows that health cannot be left solely to the health sector, its preventative and curative care services, and the provision of health information.

3.2 Evidence

The World Health Organisation (WHO) has published considerable research that proves health is largely determined by the social, economic and cultural environments in which we grow up, live and work and by our individual choices and lifestyles. The existence of multiple and inter-linked determinants of health highlights the need for sectors other than health to be involved in, and responsible for, activities for health; they will need to work together towards planning of policy and programmes for healthy individuals living in sustainable healthy communities.

Figure 1 illustrates broad layers of influence that affect health and well-being and the ability to realise ambitions, satisfy needs, and change and cope with the environment[3]. While the effects of age, sex and genetic factors are often difficult to change, evidence suggests focusing attention on social, community and environmental influences, in partnership with agencies outside health, is likely to have the most positive and sustainable impact on health.

Figure 1: The broad determinants of health



Source: Whitehead and Dahlgren, 1991

[3] Whitehead M and Dahlgren G, 1991. "What can be done about inequalities in health?" The Lancet, vol 338; pp 1059-63

Linking health and social and economic factors

An increasingly important area of research is around the social environment and health. Evidence is growing that social connectedness is vital for health and well-being. The more integrated we are the less likely we are to experience colds, heart attacks, strokes, cancer, depression and premature death of all sorts.[4] A review of this type of research recently reported that social integration and social support rival in strength the detrimental affects of risk factors like smoking, obesity, elevated blood pressure, and physical inactivity.[5]

Community development and participation

A community or population health approach requires us to look broadly at what makes communities healthy and in order to enhance the health of a population all the key stakeholders need to work together. Complex issues such as poverty and social inclusion require a multi-sectoral approach. Poor people get sick more often and for longer and die younger than rich people. They also find it more difficult to access the health services that they need. By tackling poverty we will automatically be influencing health status. Community participation is essential to enable communities to participate in decisions about their health and to ensure that services are responsive and targeted. The full participation of the Community and Voluntary Sector is a key component of an effective inter-sectoral approach.

Partnership

With all the different social, economic and environmental determinants of health, and the role of each individual's behaviour and lifestyle choices in determining health, multi-sectoral approaches deserve to be strengthened. This requires close collaboration and coordination with other agencies that can influence the determinants of health. Working in close and meaningful partnership with agencies and civil society to promote community development and healthy communities, as well as simultaneously ensuring the best possible health and personal social care services in the health system, will together have the most beneficial impact on health.

Positive impact of inter-sectoral work on health

There is growing evidence that the inter-sectoral approach does work. In the field of international development, there is growing emphasis on participatory methods and inter-sectoral working. An example from the U.K.'s Department for International Development (DFID) is the Sustainable Livelihoods Programme. This brings together major agencies together with civil society organisations to plan and implement programmes aimed at improving outcomes around natural resources for poor people. The fostering of new partnerships and inter-disciplinary teams is fundamental to this approach[6 7]. These sector wide approaches (SWAPs) are also operating in education

[4] Putnam, R D, (2000). "Bowling Alone – The Collapse and Revival of American Community". Simon & Schuster New York 326
[5] House J S and Landis K R, and Umberson D, (1988). "Social Relationships and Health," Science 241
[6] U.K. Department for International Development, 2000. "Inter-agency experiences and lessons" From the Forum on Operationalizing Sustainable Livelihoods Approaches, Pontignano (Siena), 7-11 March 2000

and health and are now proving successful in a number of developing countries.[8] There is no doubt that we can all contribute to achieving better health and we can all benefit as a result.

3.3 Policy

Global

At international level, the European Region of WHO has led the way since 1985 with its Health for All Strategy, which has as its central aim to ensure greater social equity in health[9]. To achieve this aim, it advocated for coordinated inter-sectoral strategies in order to address the inter-related social and economic factors impacting on health[10]. More recently, WHO's current strategic framework "Health 21: Health for all in the 21st Century" (2001)[11] again highlights the need for a multi-sectoral approach to tackle the physical, economic, social and cultural health determinants.

European

The European Commission did not have an official public health focus until 1993. Nonetheless, it has urged member governments to develop strategic approaches to health based on inter-sectoral working. More recently, there have been developments around the drafting of a health strategy for the European Community and a programme of community action using multi-sectoral approaches in the field of public health.[12]

Ireland

The National Health Strategy "Quality and Fairness: A System for You" states as its first objective:

"The health of the population is at the centre of public policy."

This objective is concerned with ensuring a joint approach, co-ordinated via one coherent strategy, to maximise impact on health of existing policies, structures and initiatives. The Chief Medical Officer's Annual Report for 2001 emphasises this approach by devoting the entire document to outlining an inter-sectoral approach to improving health and in particular tackling health inequalities. The Health

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[7] U.K. Department for International Development, 2000. "Better health for poor people: Strategies for achieving the international development targets". London, November 2000
[8] U.K. Department for International Development, 2002. "Breaking the cycle of child poverty". DFID Information Department, London
[9] WHO 1985
[10] Benzeval M, Judge K and Whitehead M, 1995. Tackling inequalities in health. An agenda for action. The King's Fund, London (p 46-47)
[11] WHO, 1998. Health 21: Health for all in the 21st century". Copenhagen
[12] Commission of the European Communities, 2000. Proposal for a Decision of the European Parliament and of the Council for adopting a programme of community action in the field of public health". Communication from the Commission to the Council, the European Parliament, the Economic and Social Committee and the Committee of the Regions on the health strategy of the European Community. Brussels COM(2000) 285 final

Promotion Strategy, the Primary Care Strategy, the Traveller Health Strategy and many more national policy documents also emphasise the importance of inter-sectoral working.

The policy document 'Investing for Health'[13] which was launched in Northern Ireland in March 2002 'contains a framework for action to improve health and well-being and reduce health inequalities. This framework is based on partnership working amongst Departments, public bodies, local communities, voluntary bodies, District Councils and the social partners.

4. Some examples of inter-sectoral working and health

The following section presents four concrete examples of inter-sectoral working for health. The places and health issues vary, as do the stage in the inter-sectoral process. These examples are given as a basis for sharing experiences and learning lessons. Ultimately, the aim is to stimulate a wider environment in which inter-sectoral working for health becomes embedded in the health system, and health is recognised as a key component in the work of other sectors.

[13] Department of Health, Social Services and Public Safety, 2002. "Investing for health". Belfast

Example 1: Iodising salt in the Swat Valley, Pakistan

Process

The spectrum of Iodine Deficiency Disorders (IDD) includes goitre, deaf-mutism (cretinism), and physical and mental retardation. IDD is a preventable nutritional disorder that affects hundreds of millions worldwide. The recommended control measure for IDD worldwide is the adequate and sustained iodisation of salt. In 1998, the people of the mountainous Swat Valley in North West Frontier Province, Pakistan, embarked on an inter-sectoral process to overcome the problem.

Results

An Inter-sectoral Swat District IDD Control Committee was formed and met regularly. The Inter-sectoral Committee involved many different sectors: the formal health, education, trade and agriculture sectors, tribal chiefs, religious leaders, community groups such as scouts and women's development, shopkeepers, magistrates, police, 11 local salt producers, and social marketing companies. The Committee lobbied for, and achieved, a Provincial Resolution banning the sale of non-iodised salt in Swat. There was intensive community awareness work with active participation from many sectors. An easy technology was supplied to iodised local salt and a packaging system agreed to identify iodised salt for human consumption. Many sectors were also involved in a decentralised monitoring process. By 2000, 100% of all salt from Swat was iodised, there was no increase in the price of iodised salt, and 97% of 1.2 million people were consuming only iodised salt. The success of inter-sectoral working in Swat for the iodisation of salt as a means of preventing IDD has become a model of best practice throughout Pakistan. The approach has been replicated in many districts, and has been widely lauded by organisations such as UNICEF and WHO across South Asia.

Lessons learnt

What helped

- High level of community-wide awareness of need for iodised salt to control IDD
- Leadership from charismatic and dynamic personalities (zero tolerance approach)
- High level of team working and the active involvement of many sectors
- Mutual respect that all had a role to play and a sense of community ownership
- System of encouragement (incentives for good practice/punishments for bad)
- Buy-in from all salt producers
- Decentralised monitoring involving many sectors
- Easy and cheap technology

What hindered/could hinder

- Contradictory media stories
- Some smuggling of non-iodised salt from other districts
- Persisting preference for non-iodised rock salt
- Supply complications

Example 2: Health action plans in County Development Board (CDB) Strategies

Process

From November 2000 to March 2002, North Western Health Board (NWHB) personnel actively contributed to the planning of the CDB Strategies in Sligo, Leitrim and Donegal. Through meaningful participatory processes, a Health Sectoral Working Group (Donegal), a Health Focus Group (Sligo), and a Health Forum (Leitrim) developed the health agenda and specific actions in all three County Strategies. All these groups were inter-sectoral in nature.

Results

- Good inter-sectoral relationships were developed
- A wider awareness and understanding of the broad determinants of health (see diagram) were generated, especially the central inter-connectedness between poverty, social inclusion, health and community development
- A shared responsibility for health was promoted among diverse CDB partners, including the health sector itself, by influencing thinking around the inter-relatedness of the broad determinants of health
- The concept of health as a key resource to maximise the potential for dynamic social, economic and cultural county development was accepted
- After the success of the inter-sectoral work achieved in the planning phase, the momentum appears to be slowing as we move into implementation

Lessons learnt

What helped
- Senior level management involvement in the process was a key factor in success
- Using participatory methods flattened hierarchies, ensuring effective involvement
- Having a nationally driven framework (Better Local Government Initiative) contributed to an environment for developing good relationships across sectors

What hindered/could hinder
- With CDBs located in Local Authorities, and perceived as part of them, the shared responsibility for implementing Strategies may become eroded
- Personnel changes at different levels detracts from sustained momentum
- So much energy went into the planning phase that there was some burn out
- Moving from planning to implementation needs sustained support from all levels
- Insufficient human resources for inter-sectoral work
- Changing economic climate is further limiting inter-sectoral work

Example 3: Traveller accommodation and health

Process

The Traveller Health Unit (THU) was set up in the NWHB in May 2000. The THU comprises 50 % Traveller representation and 50% Health Board personnel. There was early acknowledgement that the single biggest issue affecting Travellers' health and quality of life is their accommodation and living conditions, and that a partnership approach with Local Authorities in the region was essential for any substantial progress to be made. An inter-sectoral workshop was organised. Direct contact was made by the Chief Executive Officer (CEO) and Assistant CEO of the NWHB with County Managers in order to impress upon them the significance of the workshop and the importance of the attendance of key officials and elected representatives.

Results

- Workshop held (19 Feb 2003) with forty-seven participants, including Travellers, Traveller organisation representatives, local authority and NWHB officials, local authority elected representatives and health board members.
- General agreement was reached that the health status of Travellers was everybody's responsibility and that agencies and Travellers must work together to tackle issues linking accommodation and health for Travellers
- The main recommendation from the workshop was to set up a regional forum to facilitate inter-sectoral working on accommodation and health

Lessons Learnt

What helped
- The idea of holding the workshop came from all the partners on the THU
- Workshop organisation was undertaken on a partnership basis
- The workshop was supported at the highest level by NWHB management
- A respectful and honest atmosphere was created which encouraged participants to hear the realities of Travellers lives in an open and non-defensive way
- Some elected representatives are members of both the NWHB and a local authority, minimising any potential inter-agency tensions

What hindered/could hinder
- Momentum could be lost through delays in bureaucratic nature of statutory agencies
- Lack of a strong national framework for inter-sectoral working, lack of emphasis on inter-sectoral approaches in the Traveller Health Strategy, and delay in implementing national level inter-sectoral actions on Traveller accommodation and health, could all leave the process unsupported in the longer term

Example 4: AMERGE - Housing Survey to stimulate agency response

Process

The Second Chance Education Project for Women initiated a Bright Futures Education Programme with a group of 15 lone parents in St. Johnston, a small village in East Donegal. It soon emerged that housing was a key issue for the group. The group decided to do a twelve week drama training programme exploring the issues around housing and through this process, the group recognised that many lone parents and others in their area live in sub-standard, private rented accommodation and that these living conditions were negatively impacting on their lives, including health.
At this stage the group began to establish their own identity and called themselves **AMERGE**. Their first task was to carry out a housing survey to highlight their situation.

Results

Nineteen adults (17 women, 2 men) in private rented accommodation participated in the survey. 45% of these adults had required medical care in the previous year. The survey group had thirty children of whom 33% had been hospitalised in the previous year. One householder with four children has been on the housing list for fourteen years and another, with six children, for thirteen years. Ten households reported their accommodation was sub-standard but were uncomfortable talking about this as they needed the accommodation. While this survey does not provide proof that living conditions of the participants is negatively impacting on their health status, it is suggestive of this and paints a picture which it is very difficult to ignore. The women realise that these health issues have implications right across the board in relation to education, employment and at a social community level. The survey results have been sent to County Councillors and will be sent to health board officials in order to seek meetings for further discussion. Inter-sectoral structures such as the Social Inclusion Measures Working Groups of the CDB will also be presented with the findings. There is a great deal of interest in meeting with the group.

Lessons Learnt

- Such surveys, although not formally scientific, can be the catalyst for further action
- Second-chance education can empower and support individuals and groups to take action
- It can also facilitate links and networks which enable people to utilise existing inter-sectoral structures and identify key allies

5. Summary of key issues

Table 2 below summarises factors which can help or can hinder inter-sectoral work in the areas of task, process and relationships:

Table 2: Summary of factors involved in inter-sectoral working for health

	Helpful Factors	Hindering Factors
Task	• Clear agreed vision, goals, objectives • Transparency • Clear roles • Realistic timeframes • Regular progress reviews • Build on what is already there • Dedicated staff time for project work • Additional resources • Mutual benefits from start – win/win • Decision makers at the table • A leader or facilitator • Support from the top	• Each agency focussed completely on own plans and achieving own targets • Difficulty getting information from partners • Lack of data • Reliance on 'heroes' • Lack of clarity re representation • No reporting structures back to groups or agencies
Process Systems Methods	• National framework for implementation • Additional human/financial resources • Participation at all levels actively facilitated and resourced • Agreed principles/ground rules operating • Adequate information • Adequate training/capacity building • Accountability to inter-sectoral group as well as own sector • Regular evaluation/ability to learn and reset targets • Shared language developed • Good intra-agency communication • Partners must have something to give • Decisions made collectively • Support available in difficult stages • Effective conflict management procedures in place	• Linear structures of management and accountability • Power relationships not acknowledged
Relationships Attitudes Beliefs	• Intra-agency issues e.g. communication lines within agencies • Time spent building relationships and trust • Informal social contact	• Differing cultures in sectors • Differing value systems • Lack of respect for other sectors • Territoriality • Resistance to change

6. Discussion: From policy to practice

If the whole thrust of policy is in the direction of inter-sectoral working for health, why is there not more inter-sectoral work happening on the ground? Is there a mismatch between policy and practice?

The Community Development and Health Network (CDHN) in Northern Ireland has observed this situation in relation to the use of community development approaches in the health and social services[14]. In its Policy to Practice Project, CDHN observed that "traditionally, health and social service practice has been weighted in favour of individualism and a one-to-one casework approach, with little emphasis in mainstream work on supporting social action initiatives in local communities." It was felt that despite the many policy documents supporting such approaches, "the lack of strategic structures to validate and provide a framework" for such work was the cause of blocks around moving from policy to practice.

It appears that the essential ingredients for implementing policy on the ground through more inter-sectoral work for health are:

- A national framework for implementation
- Adequate additional resources to implement
- Expertise and training
- A developmental change management process.

In addition, all sectors involved in any inter-sectoral work for health also need to be aware from the start that:

- Inter-sectoral collaboration does not compensate for intra-agency gaps and deficits
- Inter-sectoral work requires a different mind-set. People will revert to the dominant modus operandi if not supported, rewarded and challenged to change
- Use of existing structures for inter-sectoral working should take precedence. Implementing policy means being practical, and this may mean working with existing partnerships structures such as CDB's, Area Partnerships, Rapid and Springboard Projects. It may even be counter-productive to set up new inter-sectoral structures under the auspices of, for example, health boards
- Vertical lines of accountability are paramount at present – this militates against effective inter-sectoral working
- The changing economic climate may further limit inter-sectoral work
- Inter-sectoral work is a subversive activity - it changes the way people work
- Expect and prepare for controversy, debate and resistance to change
- Information will not always be shared readily between sectors
- Health is not always seen as the business of all
- Look out for a tendency to fall back on the role of the health providers as "stewards of health".

[14] Community Development and Health Network/Community Evaluation Northern Ireland, (2000) "Policy to Practice Evaluation Report" Newry

Effective inter-sectoral working for health is already taking place in Ireland. Although it is sometimes unsupported and may ultimately lack sustainability, the stage is now set for effective inter-sectoral work to take place on a wide scale:

- Policy is there at inter-national, European and national level
- Effectiveness of inter-sectoral work has been demonstrated inter-nationally
- Many existing and emerging structures would facilitate the work such as the CDBs, Area Partnerships and Primary Care projects
- Interest in the area is growing from the community sector as well as in agencies, such as the Combat Poverty Agency
- The Institute for Public Health in Ireland is developing tools, such as Health Impact Assessment (HIA) to aid the process.

What remains to be done is to draw all these elements together and provide a supportive national and local framework for implementing inter-sectoral working for health. This framework would link and support existing work and would help to initiate new projects. It should also be flexible enough to allow local initiatives to develop organically.

7. Conclusion

There are some health problems for which the solution is a matter of knowledge. There are also problems for which the solution is only a matter of will. Whatever the case, those interested in protecting, promoting and improving health should now be asking some fundamental questions:

- What do we need to do to make our health better than it is today?
- What do we need to do to create a healthier future for our children?
- Who needs to take these actions?
- How can these players be supported?
- How will everyone work together?

Answering these questions will require serious, concerted, multi-sectoral efforts to tackle the social, cultural and environmental determinants of health. It can only be achieved by a renewed and dynamic commitment to a community development approach to health. Indeed, it is at the community level that the best opportunities exist for action to address inequalities in health.

"Knowing is not enough, we must apply...
Willing is not enough, we must do."

Goethe

This Discussion Paper was prepared for the Conference by:
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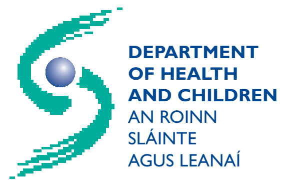
PROGRAMME



PUTTING POVERTY & SOCIAL INCLUSION AT THE CENTRE OF HEALTH POLICY & PRACTICE

BUILDING HEALTHY COMMUNITIES

PUTTING POVERTY AND SOCIAL INCLUSION AT THE CENTRE OF HEALTH POLICY AND PRACTICE

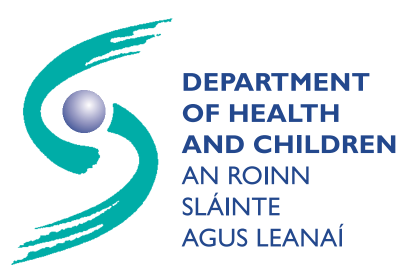
A COMBAT POVERTY AGENCY NATIONAL CONFERENCE

IN ASSOCIATION WITH
THE DEPARTMENT OF HEALTH AND CHILDREN

WEDNESDAY MAY 21ST 2003

THE ROYAL HOSPITAL, KILMAINHAM, DUBLIN

Prepared by Clare Farrell



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1. Summary of the Report

1.1 Conference Aims

Over 200 people attended Combat Poverty's National Conference on Building Healthy Communities in May 2003. The conference was supported and co-hosted by the Department of Health and Children, and aimed to:

- Highlight the gap in health between rich and poor in Ireland and internationally.
- Put the issue of a right to better health firmly on the anti-poverty agenda.
- Explore how the practice of community development can contribute to better health for disadvantaged groups and communities.
- Learn from community development practitioners about work, which has already begun to bring about changes in the delivery of health services and the development of health policy.
- Provide an overview of how the current National and EU policy context presents opportunities for tackling health inequalities.
- Bring together community development practitioners, health service personnel, researchers, policy makers and others, to exchange information and learning.

The conference also provided Combat Poverty with the opportunity to launch the *Building Healthy Communities Programme*, which has funded 13 community development health initiatives around the country (see *Appendix 1* for background information about the programme and *Appendix 2* for a list of participating projects). This programme is part of a wider programme of work focused on poverty, health and community development, which Combat Poverty is currently engaged in. The emphasis on health arises from a commitment in the current (2002-2004) Strategic Plan to develop pilot work on addressing health inequalities using community development approaches.

This programme is being carried out under Combat Poverty's statutory function to promote and evaluate innovative approaches to tackling poverty. Combat Poverty's other statutory functions - raising public awareness, promoting research and providing policy advice to Government - mean that this work programme will benefit from being situated within a strong communications, policy analysis and research capacity.

The conference heard papers from a number of speakers who addressed various aspects of the event's objectives; and involved seven separate workshops on a variety of themes, with inputs from expert researchers and practitioners. Summaries of the main speaker's presentations, and the workshop presenters' inputs are included in this report. The conference papers and workshops raised a number of issues which will inform the continued development of Combat Poverty's Programme of work, and which are relevant to a range of initiatives and policy discussions taking place in the wider health

1.2 Main Issues Emerging from Conference Contributions

Key messages, which arose from the conference papers, workshop presentations and workshops discussions were as follows.

Health, Health Determinants and Health Inequalities

- Good health is not merely the absence of disease but embraces physical, mental and social well-being.
- An individual's health is influenced by a wide range of factors – including: genetics, access to health services, lifestyle and behaviour, living and working conditions, wider environmental contexts, and access to economic and other resources.
- International and national evidence shows that in general the wealthier you are, the healthier you are likely to be, while those who are poorer have shorter and less healthy lives.
- The extent of the health gap between rich and poor is genuinely shocking and unjust - and there is a need to raise awareness of health inequalities, and the consequences of poverty, disadvantage and inequality for people's health.
- Particular groups in the population, for example Travellers, homeless people or asylum seekers, experience worsened health because of their specific experience of marginalisation and inequalities.
- Although new evidence of health inequalities in Ireland has been revealed in recent years, there is a need for more research and improved data collection to help us understand more fully the nature, extent and underlying causes of health inequalities in Ireland.

Barriers and Pathways to Better Health

- Access to health services, and opportunities to make healthy lifestyle choices are often constrained by poverty and living conditions.
- An equitable health service, provided on the basis of need rather than ability to pay, has a vital role to play in tackling health inequalities in the future.
- An effective anti-poverty strategy also has an important role to play in tackling health inequalities. Public service provision and macro social and economic policies, for instance in the areas of education, welfare, housing, employment, taxation and the environment, influence the health of the population, and in turn the gap in health between various groups.
- Various government departments and agencies, along with social partners and the community and voluntary sector, need to work together in a multi-sectoral approach to tackling health inequalities and bringing about change.

The Current National and EU Policy Contexts

- The current national and EU policy context, in particular the National Anti-Poverty Strategy, the National Health Strategy, the Primary Health Strategy and the EU National Action Plans Against Poverty and Social Exclusion, provide a positive environment in which initiatives can be undertaken and pursued; and better outcomes for disadvantaged individuals and communities achieved.
- Within the EU context, the new EU Public Health Programme offers opportunities for tackling health inequalities and health determinants.

Participation, Empowerment and Community Development

- People from disadvantaged groups and communities need to be involved in the design and delivery of health services, and other public services which impact on their health – this involvement needs to be empowering, participative and democratic and is particularly important in the area of primary care provision.
- The Primary Care Strategy, which was announced as part of the National Health Strategy, is currently being implemented, with a commitment to community involvement in the introduction and development of an initial ten community based Primary Care Teams in 2002 and 2003.
- A community development approach, based on the democratic participation and empowerment of disadvantaged communities and groups, can contribute to the reduction of health inequalities by helping to identify needs, participate in the design and delivery of services, and through models of best practice in innovative community responses.

Documentation, Evaluation and Mainstreaming

- Lessons from innovative practice (particularly inter-sectoral initiatives) should be documented, evaluated and mainstreamed in order to provide an evidence base that can contribute to the systematic improvement of services and policies, and in turn the health status of those who are less well off.
- The evaluation of initiatives to build an evidence base about the impact of community development approaches needs to encompass both process and outcome indicators; research which documents project work also needs to be both quantitative and qualitative.
- Adequate funding and resources should be provided to community development initiatives so as to achieve sustainable progress. Continuity and certainty in the funding of community-based initiatives is critical to their survival, and to the effective mainstreaming of models of best practice.

Networking, Partnership and Inter-sectoral Working

- Effective communications and networking between practitioners in the Health Services and in community and local development structures, who are involved in initiatives to improve the health of disadvantaged groups and communities, is necessary – at local, regional and national levels.
- Networking for better health is powerful because it adds value to individual initiatives, facilitates shared learning and consolidates achievements and progress.
- An integrated policy approach for better health at government level, between various departments and agencies is needed.
- Policy commitments to inter-sectoral working should be translated into action. This means addressing a number of issues: acknowledgement of power inequalities between partners; allowing time for building a process; training and capacity building of all sectors and the provision of opportunities for mutual learning.

2. Conference Presentations

The section of the conference report provides a detailed conference programme, and summaries of the papers presented to the conference which highlight the main points made by conference contributors.

2.1 Conference Programme

9.30 am **Welcome and Conference Overview**
Ms Helen Johnston, Director, Combat Poverty Agency

10.00 **Key Note Presentation: Poverty, Health and Community Participation**
Dr. Jane Wilde, Institute of Public Health (IPH)

10.30 **Building Healthy Communities – The Challenges**
Performances and Presentations
Community Drama from Longford Women's Group
Ms Sarah Flynn, Slainte Pobal
Ms Ruth Sutherland, Community Development Health Network, Northern Ireland

11.30 **The EU Context: Policy Responses to Poverty and Health Inequalities**
Mr Michael Huebel, Directorate General for Health and Consumer Protection, EU Commission

12.00 **Building and Implementing an Irish Policy Response**
Mr Charlie Hardy, Department of Health and Children

12.20 **Plenary Session**
2pm **Launch of the Building Healthy Communities Programme**
Mr Brian Duncan, Chairperson, Combat Poverty Agency.
Mr Micheal Martin, TD, Minister for Health and Children (represented by Mr Charlie Hardy)

2.15pm Workshops

1. **Working Together, Respecting Autonomy – the Experience of The Pavee Point Travellers Primary Health Care Project:**
Ronnie Fay, Pavee Point and Pat Bennett, CEO Family Support Agency/former Chairperson of the Traveller Health Unit.

2. **Community Participation in Primary Care Strategies – the UK Experience**:
Sue Perry, East Wakefield Primary Care Trust and Dr Phillip Crowley, the Irish College of General Practitioners and the Institute of Public Health

3. **Nutrition, Food Issues and Health:**
Catherine O' Meara, Northside Breakfast Club, Sian Caldwell, Community Dietician and Dara Morgan, Community Dietician

4. **Building Community Responses: Roles, Relationships and Supports:**
Photo presentation, NICHE Project, Cork and Aidan Warner, Southern Health Board

5. **Inter Sectoral Working for Health:**
Marie O'Leary and Dr. Mary Manandhar, North Western Health Board

6. **Findings from a Literature and Policy Review: Poverty, Health and Community Development:**
Dr. Margaret Barry and Dr Michelle Millar, NUI Galway

7. **Community Based Participatory Research: An Exercise in Participatory Rapid Appraisal on Health Resource Mapping**
Ms Fidelma Twomey, Quarryvale Community Development Project and Clondalkin Partnership

2.2 Conference Welcome

Ms Helen Johnston, Director, Combat Poverty Agency

This initiative by Combat Poverty emphasises the importance of the participation of those experiencing poverty in contributing to decisions about health policy and practice….

Why a conference on health?
The Combat Poverty Agency has been concerned for some time about the links between poverty and health. This concern is reflected in Combat Poverty's current strategic plan from which today's conference and the Building Healthy Communities Programme arise. The links between poverty and health were highlighted starkly by the findings of a qualitative study of families in poverty published by Combat Poverty earlier this year. This research, published in the *Against All Odds* report, showed that one third of children in the families studied had suffered ill-health.

The current policy environment contains opportunities to do something about it. The National Anti-Poverty Strategy (NAPS) contains a strong statement on health inequalities. NAPS is currently being revised to reflect the EU commitment to National Action Plans on Tackling Poverty and Social Exclusion. Combat Poverty is involved in convening consultation meetings, which in the last few weeks focused on the provision of public services. The National Health Strategy, particularly the Primary Health Care Strategy, and the EU Public Health Programme are also part of this benign policy context. Finally the Combat Poverty programme, Building Healthy Communities also provides a framework within which community development methods can be used to tackle health inequalities.

Building Healthy Communities Programme
This initiative emphasises the importance of the participation of those experiencing poverty in contributing to decisions about health policy and practice. The programme will support community development approaches, which empower and build capacity among disadvantaged groups and communities. It will also offer opportunities for networking and sharing experience, conduct research on poverty, health and community development responses and draw out practice and policy lessons from the work.

Combat Poverty is delighted that we are developing this programme with support from the Department of Health and Children. In the past few weeks over ninety applications were received from community and voluntary groups seeking support from the programme.

Challenges
In trying to build healthier communities we are faced with a number of challenges. These include the need for

- Access to health services based on need rather than ability to pay

- Developing a social model of health underpinned by a rights based approach to health
- Prioritisation of resources in a tightening economy
- Integrating responses so that agencies work together and collaborate – particularly around innovative actions such as those that will be funded by Combat Poverty's programme
- Acknowledging the role and contribution of community development to tackling poverty and health inequalities.
- Building an evidence base – and involving communities in doing that
- Responding to diversity
- Keeping the focus on improving outcomes in terms of quality of life.

Today's Event

Today's conference aims to help us understand the links between poverty and health status, to put poverty at the heart of the health agenda, to explore the role of community development in tackling health inequalities, to emphasise and hear about the contribution of people experiencing poverty and finally, to provide an opportunity for networking and sharing of experience between the many people involved in community development, health service provision or policy and the accumulation of research, who are committed to doing something about health inequalities.

2.3 Keynote Presentation: Poverty Health and Community Participation – Making the Links

Dr Jane Wilde, Institute of Public Health

'Of all forms of inequality, inequalities in health are the most inhumane', Martin Luther King.

I was confronted with vivid pictures of health inequalities over 20 years ago when I went along to a meeting with an action group in Turf Lodge in West Belfast about demolishing the flats there because there were in such a state. I went along as a public health doctor – and the pictures in my mind about that day are of a woman and her three children who all slept in the same bed in one room because of the mould on the walls in her home – and because there was nowhere to play, her 5 year old could not go out.

If we are to do anything about pictures of health inequalities, then we need to have pictures of health too. We need to understand why health inequalities exist and what needs to be done about them – that is what my presentation today will concentrate on.

Poor health in childhood casts a shadow right throughout a child's life. Poverty is a war against children, and it's a war in which children lose their lives. In Ireland child poverty is still a significant problem.

Health Inequalities

There is considerable evidence about health inequalities and the evidence is genuinely shocking. Figures for life expectancy at birth for females show that Ireland has the second lowest life expectancy in the EU.

An all Ireland report from the Institute of Public Health on inequalities in mortality 1989-1998 showed that all cause mortality in the lowest occupational group was 100 / 200% higher than in the highest occupational group. For some diseases the difference was in the order of 400%.

Infant death rates are another indicator often used to illustrate the extent of health inequalities. Data for Northern Ireland from 1996-2000 showed that infants in social class V had the highest rates of death, and that infant death rates reduced as you go up the social class scale. (Registrar General's Report, 2000 Northern Ireland.)

The Gap and the Gradient

The social gradient in disease runs right across the social scale, it is not confined to the difference between the best off and the worst off. As Martin Luther King Jnr. said,

"Of all forms of inequality, inequalities in health are the most inhumane".

The Institute of Public Health

The aim of the Institute of Public Health in Ireland is to improve health on the island of Ireland by working to combat health inequalities and influence public policies in favour of health. Our strategic objectives include

- Tackling health inequalities
- Information and research
- Strengthening partnerships
- International collaboration and
- Strengthening capacity.

Health Determinants

Why do these inequalities occur? In order to understand this, we must understand the various influences that determine our health.

"There is a chain that runs from the behaviour of cells and molecules to the health of populations, and back again, a chain in which the past and the present social environments of individuals, and their perceptions of those environments, constitute a key set of links… Nobody would pretend that the chain is fully understood, or is likely to be for a considerable time to come. But the research evidence currently available no longer permits anyone to deny its existence."
(Why are Some People Healthy and Others Not? The determinants of health of populations. Eds. R.G.Evans; M.L Barer; T.R. Marmor. Aldine de Gryter, 1994)

Clearly, the remedies are both social and economic. "The primary determinants of disease are economic and social, and therefore its remedies must also be economic and social", (The Strategy of Preventative Medicine, Rose, G. 1992.)

What are the challenges?

- Robust and clear policies
- Equity oriented targets
- Community development
- Multi-sectoral work
- Equitable and effective health services that put people at the centre, and emphasise a holistic approach.

National Targets to Reduce Inequalities

Quantifiable targets to reduce inequalities in health are really important. Having these targets is important. They can help set priorities and help us understand whether what we are doing is making a difference. Measuring progress over time on targets also means having the right information, and doing something about gaps in our information.

The National Anti-Poverty Strategy sets out three measurable targets, which emphasise the need to reduce gaps in:

- Premature mortality for heart disease, cancers and injuries
- Life expectancy for Travellers
- Low birth weight rates.

The declaration of Alma Ata on Primary Health Care from the World Health Organisation, 1978, identifies health as key to social and economic development. It says people have a right and duty to participate in the planning and implementation of health care and that all Governments should have policies and action plans to sustain primary health care. Good primary care requires building trust.

Building Trust
Opportunities for dialogue (voices heard)
Contribute to agenda (community needs)
Build on networks and alliances (innovative approaches)
Involve excluded people.

Now that we know about health inequalities, the gaps that exist and their appalling extent, it is an issue of social justice that we do something about them. Our job is to shift the balance and often this means getting out of the fields we are in. Getting out of our field can sometimes create conflict and chaos – but from this, creativity in responses can emerge.

"*It is at the edges that interesting things happen*", Evans, E. The Personality of Ireland, 1973.

2.4 Drama Presentation by Longford Women's Group.

Ms Noirin Clancy (Women's Human Rights Project), Ms Tess Murphy, Longford Women's Group, Ms Trish Rouiller, Longford Women's Group.

UN woman: Do you mean to tell me you don't have a family planning service in Ballinamuck?
Tess: (laughing…) Ballinamuck!, if we had one in Longford it would be brilliant!

This short drama illustrated in very plain (and humorous) terms the kind of difficulties rural women in particular face in accessing good health and good health care. It also highlighted Ireland's obligations under international human rights treaties which it has signed on paper, but which are not being met in the experience of many rural women. These included the Beijing Platform for Action, which the government signed: as a follow up the government said that *each health board is required to ensure that an equitable, accessible and comprehensive family planning service is available in its area and should be within easy reach, and that a choice of service provider should be available.*

The Government also signed up to the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW) in 1985, and this treaty makes specific reference to access to family planning in article 12, while article 16 states that rural women have a right of access to adequate health care facilities, including information, counselling and services in family planning. The drama highlighted how community based organisations can use these treaties and documents as lobbying tools in working for change.

2.5 Community Development Approaches to Health: Practice Issues: Opportunities and Challenges

Ms Sarah Flynn, Slainte Pobal

'Slainte Pobal trains women trainers, in communities with limited resources, in practice skills and confidence building, using a community development approach, and emphasising action, reflection, evaluation and practice'.

Slainte Pobal is about working for healthy communities, using a community development approach and holistic methodologies to help people take control of their lives.

Slainte Pobal's commitment to a community development approach to its work means a focus on

- Social change
- Collective action
- Participation and inclusion
- Empowerment
- Process
- Creativity

Change can only come about if the formula A+B+C=> X : where A= an unacceptable situation B= a vision for the future C= practical first steps – plan and X= the cost of change.

Slainte Pobal's focus is on Primary Health Care, which involves diagnosis, treatment, prevention and complementary approaches. Slainte Pobail trains women trainers, in communities with limited resources, in practice skills and confidence building, using a community development approach, and emphasising action, reflection, evaluation and practice. The outcome is a resource in the community, accredited trainers and the potential for ongoing development.

Issues, challenges and opportunities facing Slainte Pobal in its work are achieving local involvement, working in partnership, building capacity, supporting networks, assuring quality and a valuing of complementary health.

2.6 Supporting People Developing Healthy Communities

Ms Ruth Sutherland, Community Development Health Network, Northern Ireland

'Networking is the process by which relationships and contacts between people or organisations are established, nurtured and utilised for mutual benefit', Gilchrist 1995.

The Community Development Health Network emphasises the importance of support and leadership in relation to community development practice, and how that practice is really about contributing to the personal and social support that is important to people's health.

The strategic aims of the Community Development and Health Network, Northern Ireland, are to

- develop and sustain a network of community groups and organisations active on health highlight the links between poverty, inequality and health and how community development works for change
- develop tools for practice and
- organise around issues.

The network aims to work together for health through supporting people supporting communities. This means working to

- effect change at policy, organisational and practice levels
- promote and support community activity on health issues and
- promote action to redress poverty and inequalities in health.

The case for networking is that it strengthens:

- information exchange
- support and solidarity
- common purpose, shared values
- forums for debate and discussion
- negotiating and articulating a collective view.

The use of networks is both an expression of the values of community development and a means by which community development is achieved.

The constraints that have been experienced by the CDHN include:

- bureaucracy
- pressure on resources
- conflicting models
- dominance of the medical model
- deficiencies in education, training and professional development
- initiative overload
- low morale.

The core skills for Community Development health work are;

- knowledge of practice, principles and policy
- link to health
- identification of local needs
- networking and partnership working (multisectoral approaches)
- multi-disciplinary working
- group work skills
- organisational development skills
- funding
- monitoring.

The CDHN has been involved in the following range of activities working together for health;

- community education and information
- arts and health work
- working with Partnerships
- influencing policy
- self help and social support
- targeting inequalities
- health rights/accessing services
- community action and research
- environmental issues.

In speaking to her notes at the conference, Ruth Sutherland said that sometimes community development is like a bunch of flowers – beautiful to look at and wonderful in itself; but when it fades, it doesn't leave anything behind that shows how wonderful it has been. The power of networking she said, was that it could transform community development into a garden – in which community development projects can be nurtured, and things can grow and blossom as part of a greater whole– and in which agencies and services, such as the Combat Poverty Agency, can be the garden sheds from which projects can get tools or resources to sustain that growth. In this way the difference networking makes is that it sustains learning and progress.

2.7 The EU Context: Policy Responses to Poverty and Health Inequalities

Mr Michael Huebel, Directorate General for Health and Consumer Protection, EU Commission

'Socio-economic factors are to be considered in all actions aimed at lifestyle related health determinants …' EU Public Health Programme.

Introductory Comments

It is very encouraging to know that in thinking through the issues of healthier communities, you are taking a European perspective. Public health is a new area of policy developing at the EU level over the last ten years – before 1993 the EU had no competency in this area. We are conscious of the need for social policy and public health policy to be more integrated to tackle social exclusion, poverty and its consequences. Within the activities that are part of the EU Public Health programme are a number of projects related to inequalities in health. From a strategic point of view, there is recognition that a lot of health work does not take place in the health sector.

Poverty and Health

There are substantial differences in health between richer and poorer population groups, including differences in:

- Life expectancy (up to 5-10 years)
- 'healthy' / disability-free years of life
- general health status
- patterns of smoking, drinking and obesity levels
- environmental risks and housing conditions.

There are also substantial differences in the engagement with health services experienced by richer and poorer population groups, such as

- access to services
- health insurance coverage
- levels and quality of services and treatments
- specific concerns e.g. mental health services.

Tackling Health Inequalities

In order to tackle these health inequalities we need joint approaches across sectors, in particular across

- Health policy (targeting of health services, public health, risk factors, determinants)
- Social policy (social inclusion, social care, living conditions)
- Employment policy (secure jobs, working conditions) and
- Co-ordinated approaches across communities.

Since 1993 there has been a specific Treaty Article (129 – Maastricht) on public health. This provided a framework for action in eight public health programmes.

In 1999/2000 a new role for the EU on Health emerged. This involved a new commission – the Health and Consumer Protection portfolio and Directorate General. Important factors in this development were health concerns related to enlargement; new health threats and new challenges to health systems, some of which arose from European Court of Justice cases.

The ***May 2000 Health Strategy*** has two components

- A new public health framework – which includes the new programme
- An increase in coherence and co-ordination on health issues across Community policies and actions.

Other Community policies have an impact on health and health systems – the internal market which refers to standards for medical devices, food, pharmaceuticals etc; the free movement of health professionals, citizens seeking health care and health services; environmental policy including rules on water, air and emissions; social policy covering social protection, health and safety at work; research and preparing for enlargement.

The new treaty contains a commitment to a high level of health protection, and tools are being developed to provide for this. These include; developing a more powerful department; developing the use of Health Impact Assessment; Joint Actions; Instruments of coordination and an interface between health and social policy.

The New EU Public Health Programme

The new EU Public Health Programme was adopted in September 2002, replaces eight existing programmes and runs from January 1st 2003 until 31 December 2008. The initial budget is €312m. There are three strands of action:

- Health information
- Rapid reaction
- Health determinants.

Strongly related to today's themes are the need to have comparable information and data across the EU, and the need to tackle the determinants of health at a European Union level.

Key points in the new Public Health Programme are;

- integrated approach to public health
- 'enabling mechanism' to support policy development
- actions to be substantial, large-scale, wide coverage and multi-annual
- covers 15 member states, applicant countries and EEA/EFTA countries.
- Tackling health inequalities as a priority in programme decisions.

The Programme Calendar

September 2002	- Programme formally agreed
March 2003	- Call for Proposals for 2003
July 2003-06-13	- Second Committee Meeting Selection of Projects
Autumn 2003	- Funding decisions
Autumn:	- Call for Proposals
Spring:	- Funding Decisions

Priority Areas and Cross Cutting Themes

The ***workplan for 2003*** identifies a number of priority areas and cross-cutting themes. These are:
Health impact assessment
Health in the applicant countries
Inequalities in health (reporting, experience, best practice and networking)
Implications of patient mobility for health services
Promoting best practice and effectiveness
Ageing

Health Information has also been identified as a priority area. This will include developing mechanisms for reporting and analysis of health issues, producing public health reports, improving access to and transfer of data and e- health.

Health determinants have also been prioritised. Socio-economic factors are to be considered in all actions aimed at lifestyle related determinants.

Involving Stakeholders – the EU Health Forum

This is an open and transparent information and consultation mechanism that contributes to health policy development and provides networking opportunities. There are three complementary elements

Open Forum – platform for general exchange of information and discussion (from 2004)
Health Policy Forum – for European umbrella organisations (since 2002)
Virtual Forum- information, discussion and interactive consultation (started in 2002)

A ***new communication*** is due in the second half of 2003 to review progress and plans for the coming years.

Health and Social Inclusion

There is a history of programmes on poverty and social ex-/inclusion at EU level. The social inclusion process involves the Open Method of Co-ordination and the Social Inclusion programme.

This process means having common objectives (including access to resources and services, including health), agreed indicators (including health related data) and National Actions Plans on poverty and social exclusion, which were forwarded in 2001 and are due again in July, and Joint reports on progress from member states.

Three broad strategies arise from the NAPS/incl to provide better access to healthcare for all:

- Developing disease prevention and health education
- Improving adequacy, access and affordability of mainstream provisions
- Launching initiatives to address specific disadvantages

Specific groups mentioned in the NAPS/incl are the elderly, immigrants and ethnic minorities, people suffering from physical or mental disability, homeless, alcoholics, drug addicts, people who are HIV positive, ex-offenders and prostitutes. Mental health was also an issue that was raised by a majority of NAPS/incl plans.

Conclusions
Addressing health determinants requires actions and building coalitions

- across traditional policy boundaries
- across different levels of government
- involving stakeholders and communities.

Linking the health and social policy agenda is particularly important. The EU can help, but will not solve the problem.

Further information: www.europa.eu.int/comm/health/index_en.htm

2.8 Building and Implementing an Irish Policy Response

Mr. Charlie Hardy, Planning and Evaluation Unit, Department of Health and Children

'The Planning and Evaluation Unit at the Department of Health are to engage external assistance to reconvene the NAPS health working group …'

NAPS Health Targets

Under the National Anti-Poverty Strategy (NAPS) a number of key targets were agreed. These are also incorporated into the wider National Health Strategy, which spans 110 actions, 90 of which have been activated to date. The NAPS health targets include:

- Reducing differences between socio-economic groups in
  - premature mortality
  - low birth weight
- Improving Traveller life expectancy

Specifically these targets set out to

- To reduce the gap in premature mortality between the lowest and highest socio-economic groups by at least 10 % for circulatory diseases, for cancers and for injuries and poisoning by 2007
- To reduce the gap in low birth weight rates between children from the lowest and highest socio-economic groups by 10 % from the current level, by 2007
- The gap in life expectancy between the Traveller Community and the whole population will be reduced by at least 10 % by 2007
- Life expectancy of Travellers & of Refugees & Asylum Seekers should be monitored so that targets can be set for Refugees & Asylum Seekers & revised for Travellers by 2003.

Measures and actions which were identified as important to achieving progress on these targets included improved access and eligibility for services, at a wider public policy level, health impact assessment and inter-sectoral work and finally monitoring and research to strengthen data collection around targets and indicators.

Policy Measures

NAPS also identifies a number of policy measures, which are required to achieve progress on the targets. These include

- Increased equity of access to:
  Primary Care
  Acute Care
  Interventions for Cardio Vascular Diseases and Cancer
  Community Supports for continuing care

- An Injury Prevention Strategy
- Integrating an equality dimension into health services.
- Medical Card – income threshold & barriers to uptake

Increased equity of access to effective primary care is an important element and refers to
- Multi disciplinary working
- Local case management
- More diagnostics and treatment services at/through GP, e.g. minor surgery, shared care, MRIs, CAT Scans
- GP support for adolescent mental health problems
- Springboard in 12 additional areas
- Tackling youth homelessness; prevention, emergency response and reintegration

A community development approach in the area of primary care involving participation in:
- needs assessment
- planning,
- implementation,
- monitoring and evaluation.

Equality - Major issues
An equality dimension is an important aspect of NAPS. This involves;
- Strategic Approach
- Mainstreaming and targeting
- The integration of equality proofing with other proofing
- Training

A number of reports and policies provide the context in which progress on the equality dimension can be achieved. These include the Task Force on Travellers, the Report on the Status of People with Disabilities, Equality Authority Reports on Implementing Equality, the National Action Plan Against Racism and the National Plan for Women.

Poverty Proofing
Poverty Proofing is an important component of NAPS and provides the mechanism for an assessment of impact of policy on poverty and inequalities which may lead to poverty e.g. gender, age, disability, ethnic minority, sexual orientation, family status and membership of the Traveller community. (NAPS target groups were women, children and older people).

In relation to conducting the assessment of policies, the key questions to be answered are whether the proposal
- (i) reduces poverty
- (ii) has no effect on poverty
- (iii) increases poverty

(iv) impacts on target groups under nine grounds in Equality Legislation in a way likely to lead to poverty.

The NESC Report on Poverty Proofing said that it was an important aspect of evidenced based policy making, and it was integral to the Strategic Management process within government. It identified two key objectives of poverty proofing – awareness raising among policy makers, and more in-depth study of major policies. There was a need to distinguish between policies, which were self evidently anti-poverty, and those, which were not anti-poverty but could have an impact on it. Both kinds need indicators and data, which allow measurement against time-defined targets. Training is important so that proofing becomes embedded in all policy and delivery processes.

Poverty and Equality Proofing
- are both linked
- but there are some differences
- socio-economic status is not one of the nine grounds named in the equality legislation
- there are economic objectives in NAPS
- Equality agenda also includes objectives in political, cultural and affective arenas.

NAPS Monitoring and Research
The NAPS Working Group Health Report outlined a clear programme in relation to monitoring and research, which proposed an indicators programme, a research programme, a monitoring system and a review and revision process in relation to targets. The Planning and Evaluation Unit at the Department are about to engage external assistance and reconvene the NAPS/Health working group. In the wider NAPS context some relevant initiatives on the issues of research and monitoring include the work of the Steering Group on Social & Equality Statistics, the EU Survey on Income & Living Conditions (EU SILC), the EU NAPincl indicators, the Combat Poverty study on NAPS Indicators and the National Health Information Strategy recommendation on geo-coding.

Wider Public Policy Measures
The NAPS health report also proposed that there should be 'multi-sectoral' working for health, and that Health Impact Assessment (HIA) should be introduced. There is also an emphasis on community participation in working for health. HeBE has now published community participation guidelines; communities are involved in the first primary care projects under the Primary Health Care Strategy, the Community and Voluntary Pillar specifically in four of these. There is also the welcome initiative of Combat Poverty, Building Healthy Communities.

Summary

Key health status targets

Policy measures

- equity of access
- public policy
- monitoring/research
- Recognise focus on NAPS target groups as best opportunity to achieve health & social gain
- Striving for situation where, throughout system, in all we do we ask question *“how can this help reduce health inequalities?”*

2.9 Plenary Session - Morning

The main points which were raised in the open forum by conference participants were as follows:

- It can be very difficult, if not impossible, for community and voluntary groups to obtain insurance to cover the work they do, particularly in the area of health.
- The evidence on health inequalities seems to indicate that it is not just being poor that is bad for your health – evidence on income inequality and health seems to suggest that the rich are bad for your health – therefore a more equal distribution of income, through the taxation of those who are wealthy is necessary to narrow the health gap.
- There needs to be a distinction made between a 'consumer' oriented model of consultation on the design and delivery of health services and more democratic models, which engage with communities rather than simply consult them. Commitments in the current policy context to the involvement of local communities have not successfully distinguished between these approaches.
- There are anxieties among community groups about the absence or shortage of resources to fund or support community-based initiatives. Asking for participation from communities is unfair, if it is not going to be matched by resources. There is a need for clarity on how the Primary Care Strategy will support or resource community involvement for instance.
- Data collection can be resource intensive – and often there is duplication with a number of groups collecting similar data. There needs to be a strategic direction to drive the improved collection of data.
- In the midst of idealistic plans and discussions, there is anxiety at the direction of government policy, particularly in relation to addressing educational disadvantage and cutbacks in the health area.
- Among the social changes that have taken place is the increase in women's participation in the labour force – one side effect of this has been the erosion of much family support that was available in the community on a voluntary basis in the past – this needs to be replaced.
- Socio-economic disparities in society need to be addressed – and the need to include discrimination on the grounds of socio-economic status in the Equality legislation was raised.

Although time was limited, a number of speakers responded to points made by conference participants. In particular it was pointed out that the projects in the Primary Care Strategy were emphasising participative approaches to community involvement and that that funding for health had increased in recent years.

3. Launch of the Combat Poverty Agency Programme – Building Healthy Communities

3.1 Introduction from Chairman of the Combat Poverty Agency, Mr Brian Duncan

Under Combat Poverty's strategic plan, a programme of work on tackling health inequalities in disadvantaged communities had been developed. There are four elements to the programme:

- Innovation – provision of seed funding for innovation and capacity building in community development responses to poverty and health inequalities
- Networking – facilitating a space for dialogue, exchange and building relationships at policy and practice levels
- Evidence – supporting accessible research, documentation and analysis on poverty and health and community development health work
- Policy – contributing lessons at policy and practice arenas.

The funding initiative was targeted specifically at encouraging the community development/anti-poverty sector to develop community development responses to poverty and health issues. Combat Poverty received over 90 applications and funding decisions would be issued within the coming weeks. The Department of Health and Children would fund a small number of applications. The Department's support for this programme of work, its involvement in co-hosting this conference and its commitment to the funding initiative was very welcome, and a very important aspect of the programme was this partnership approach.

3.2 Launch of the Programme, by Mr Charlie Hardy, Department of Health and Children, on behalf of the Minister, Mr Micheal Martin TD.

'The document (the Health Board Executive guidelines on community participation) states that the aim of the health services in Ireland should be to move the level of community participation in health up the ladder from mere consultation to actual involvement in determining priorities, assessing local needs and decision-making.'

Introduction

I am very pleased to be here this afternoon to launch this important *Building Healthy Communities Programme: tackling poverty and health inequalities through community development approaches*. I would like to commend the Combat Poverty Agency for the initiative they have taken in coming forward with this programme and to say that the Department of Health and Children is very pleased to co-host this launch with the Agency.

The Department of Health and Children very much endorses the approach of the programme which is to build knowledge and understanding on both the linkages between poverty and health and the potential of community development approaches in tackling health inequalities.

Timeliness of Initiative

The initiative is timely. Targets to reduce health inequalities are firmly embedded in the National Anti-Poverty Strategy and in the National Health Strategy *Quality and Fairness: A Health System for You.* Both the Report of the Working Group on the National Anti-Poverty Strategy and Health and *Quality and Fairness* recognise the varied nature of the social determinants of health and highlight the importance of a multi-sectoral approach if we are to effectively improve health and social gain and reduce health inequalities.

The *Building Healthy Communities* initiative is also particularly timely in the context of the preparation currently underway of the National Action Plan on inclusion (NAPincl) for 2003-2005. NAPincl has four objectives:

- to facilitate participation in employment and access to all resources, rights goods and services
- to prevent the risks of exclusion
- to help the most vulnerable

to mobilise all relevant bodies.

This Building Healthy Communities initiative is particularly relevant in the context of the NAPincl objective "to mobilise all relevant bodies." This objective is concerned to:

- promote, according to national practice, the participation and self-expression of people suffering exclusion, in particular in regard to their situation and the policies and measures affecting them.

- mobilise the public authorities at national, regional and local level, according to their respective areas of competence
- promote dialogue and partnership between all relevant bodies, public and private.

In my view this Combat Poverty Agency initiative is a very good example of the type of synergies that can be generated with cross-sectoral working. Combat Poverty Agency is bringing to the project its very considerable experience in working with people in poverty or experiencing social exclusion and this can help build on and strengthen initiatives already underway in the health sector.

We very much welcome the opportunity for collaboration in the on-going development of Building Healthy Communities: through this conference, through supporting the funding of innovation in community development responses and through on-going linkages through the National Anti-Poverty Strategy and the Primary Care Steering Group.

We are keenly aware of the multi dimensional nature of the factors, which affect health and of the potential added value to be gained by having targets to reduce health inequalities set in the wider Government National Anti-Poverty Strategy. The need for this whole system approach is emphasised in the National Health Strategy *Quality and Fairness.*

Primary Care Strategy
The National Anti-Poverty Strategy health consultation process highlighted the important role poor and marginalised groups see for primary care in reducing health inequalities. In that context considerable emphasis was placed on the participation of communities themselves in assessing their own needs and in planning, delivering, monitoring and evaluating services.

Because of the emphasis placed on primary care in the National Anti-Poverty Strategy consultation process I would like to say a few words about developments in this area. It is recognised in the National Health Strategy that Primary Care has a central role to play in the delivery of health and personal social services in a modern health system and that the health needs of the vast majority of people should be capable of being met by primary care services. The primary care strategy *Primary Care: A New Direction,* published in late 2001, sets out a model, which aims to bring a wide range of service providers together in primary care teams so that integrated services can be delivered in the community in the most appropriate and accessible way. The model envisaged is based on multidisciplinary working, with 24 hour cover, key workers to link islands of service for groups such as people with disability and the elderly and with mechanisms for the involvement of the community. As stated in the new national partnership agreement *Sustaining Progress* the Government is committed, within resource constraints, to advancing the implementation of the Primary Care Strategy in accordance with the Action Plan for the Strategy.

Initially, approval has been given, together with the necessary funding, to the establishment of an implementation project in each of ten locations. This will allow the model to be rolled out in a manner that draws on experience gained and enables all relevant professional and user stakeholders to participate in shaping its more detailed aspects. The model will be refined and developed by agreement through the joint learning that these initial implementation projects will allow for. The development of further teams in the future will be informed by the experience gained in the initial projects. In the medium-to-long term, it will be necessary to adapt existing services and structures to enable the new team-working model of primary care to be applied on a more widespread basis. Total funding of €8.4 million is being provided for the 10 implementation projects in 2002 and 2003.

Community Involvement

A key input to the successful implementation of the Primary Care Strategy will be the involvement of communities and a number of initiatives are underway to facilitate this. In the delivery on a commitment in the previous partnership agreement - the *Programme for Prosperity and Fairness* - the Community and Voluntary Pillar is specifically involved in the monitoring and evaluation of 4 of the primary care implementation projects. The Pillar and the Combat Poverty Agency are represented on the Steering Group for the Primary Care Project.

As stated in the National Health Strategy a responsive health system must develop ways of engaging with individuals and the wider community receiving services. While there are some community participation initiatives already operating in discrete areas of activity at national and regional level, the National Health Strategy recognised that a more structured approach to community participation is required and set out a range of actions to be implemented in this regard. I would like to mention one of these in particular.

The Health Board Executive (HeBE) has recently published *Community Participation Guidelines,* which sets out the spectrum of ways of engaging individuals and communities and proposes a progressive movement towards more participative approaches. The document states that the aim of the health services in Ireland should be to move the level of community participation in health up the ladder from mere consultation to actual involvement in determining priorities, assessing local needs and decision-making. Central to this is community development in relation to health matters leading to empowerment of communities. The Guidelines are not prescriptive but provide a useful framework for developing an approach to community participation at local level. Their implementation will facilitate the delivery of a more people-centred service.

In accordance with the commitment given in the new national partnership agreement *Sustaining Progress* the learning from community participation in the context of the Primary Care Strategy will be used to inform models of participation appropriate to the wider Health Strategy.

I am aware that many communities are already involved in needs assessment and indeed several reports of this work have been published in recent months. Also the model of primary care delivery pioneered in the Travelling community, with Travellers themselves trained to engage in this work, has much to teach us.

In relation to community development it is of interest to note that the UK summary of the Cross Cutting Review on Tackling Health Inequalities - a joint Treasury and DoH report – in its key findings on successful interventions, highlighted the importance of local community involvement in action if interventions are to have a long lasting and sustainable impact. I believe that such an approach is not only important in helping us to develop more responsive and quality conscious health services but also has a role to play in creating the type of health supporting communities where people are sufficiently engaged in their society to care about what is going on and to feel empowered to try to influence it. Such participation also serves to highlight the many and varied influences on health, for example, access to quality health services, other public policies and individual behaviour. Such involvement by local communities also serves to assist the public service towards the achievement of greater coherence, coordination and integration, which is key for the Government's Strategic Management Initiative.

Conclusion

The *Building Healthy Communities* Programme which we are launching today will, I am confident, be a catalyst to considerably expand the involvement of communities with the health sector and other sectors in reducing inequalities in health. It will also add to the store of knowledge on what works best in this area. It is for this reason that I am pleased to launch this programme today on behalf of Minister Martin. We look forward to a fruitful collaboration with the Combat Poverty Agency in the roll-out of the programme.

4. Workshops

4. 1 Workshop 1: Working Together, Respecting Autonomy – The Experience of the Traveller Primary Health Care Project

Presenters:

Ronnie Fay, Traveller Primary Health Care Project/Pavee Point
Pat Bennett, Chief Executive Officer, Family Support Agency/former Chair of the Traveller Health Unit

The Experience of the Traveller Primary Health Care Project
Ronnie Fay, Brigid Collins, Kathleen McDonnell, Pavee Point

1.Traveller Health Statistics

- 4,790 families (i.e approx 24,000)
- 80% under 25, 50% under 15
- 50% in 4 counties, 8% Cork, 23% Dublin, 11% Galway & 7% in Limerick

(Source: Department of the Environment 1999)

- 1,128 Traveller families are living on the side of the road with no toilets, water, electricity
- Only 1% of Travellers are over 65 years
- 90% of adult Travellers are illiterate
- Exclusion from a range of services is a common experience for Travellers
- *Health Research Board 1987 showed….*
- Infant mortality (death in year 1) 18.1 per 1,000 Travellers 7.4 for national population
- Traveller men live 10 years less than national population of men
- Traveller women 12 years less
- Traveller life expectancy now that of national population in 1940's
- 1% over 65 years

2. Contributory Factors (General)

- Unacknowledged as a minority ethnic group
- Inappropriate policies and provision, particularly by statutory services
- Lack of coordinated approach within government departments, to service delivery
- Racism within health service structure

Contributory Factors (Accommodation)

- Forced to live in appalling conditions
- Local authorities failure to implement plans for suitable accommodation
- Objections by local residents to the development of Traveller sites

Contributory Factors (Health Services)

- Lack of access to health promotion materials and prevention services
- GPs refusal to take Travellers as patients
- Medical cards not recognised by different Health Boards
- Ineffective record keeping by Health Boards
- No health statistics or disaggregated data.

Contributory Factors (Lack of Culturally Specific Services)

- Lack of inter-cultural and anti-racism training for health professionals
- No Traveller representation on policy making fora, as a standard of good practice
- Lack of trained Traveller health professionals
- Travellers blamed for causing own ill health

3. What is Pavee Point?

Pavee Point is a voluntary non-government organisation which is committed to human rights for Irish Travellers. The group comprises of Travellers and members of the majority population working together in partnership to address the needs of Travellers as a minority group which experiences exclusion and marginalisation.

4. Work based on 4 key premises

Travellers as a Minority Ethnic Group
Travellers self determination
Racism
Community Development approach

5. Health Work

a) PHC Project: Aims & Objectives

- Establish a model of Traveller participation in the promotion of health
- Develop the skills of Traveller women in community based health services
- Liaise and assist in creating dialogue between Travellers and health service providers in the area
- Highlight gaps in health service delivery to Travellers in CCA6 and work towards reducing inequalities that exist in established services

b) Levels of Work

- National
- Regional
- Local
- International

c) Types of Work

- Direct work with Travellers

- Training
- Resources
- Policy
- Networking

6.Challenges and Conclusions

- Acknowledgement of role & expertise of NGO's
- Informed Traveller participation is critical
- Role of Traveller organisations
- Independent / Accountable / Resourced
- Individual Travellers protected
- Dual strategy of targeting and mainstreaming
- Need for disaggregated data
- Policy development versus policy implementation
- Role for NGO's at both levels
- W orking in partnership
- Respect respective roles (and constraints)
- Institutional knowledge vs. sympathetic individuals
- Organisational culture
- Power differentials
- Development of common understanding/approach
- Need to engage at senior level
- On going and structured and resourced participation of NGO's
- Funding routes independent of the partnership process

The Traveller Health Unit – Eastern Regional Health Authority

Pat Bennet, Chief Executive Officer, Family Support Agency and formerly, Chairperson of the first Traveller Health Unit (THU) set up in the Eastern Regional Health Authority.

The THU was set up in December 1998 with a committee comprising representatives of the Health Board, local Travellers, Traveller Organisations, Voluntary Health Providers, including hospitals, and a GP.

Setting the Context

- Training and Orientation
- Acknowledgement of Expertise and Interdependence

The first important step was a joint training programme. The initial emphasis was on understanding the mutual perspectives of Travellers and of the Health Board. Committee members received a copy of the Task Force on the Travelling Community Report.

Two half day orientation sessions were arranged for members, the first session related to Traveller culture issues and the next to health services issues and the various disciplines

represented on the committee. As a follow up staff arranged to visit Traveller halting sites in order to get an insight into the difficulties experienced by Travellers.

Community Development Approach

- Interface with community
- A role for NGOs
- Strategy and ownership

The involvement of NGOs plays a vital role, particularly in relation to advocacy, and capacity building.

Funding

- Decision making role
- Transparency criteria

The THU drew up a list of guiding principles for initiatives, which could be funded. Criteria for funding were developed. Initiatives had to have a partnership approach, be culturally appropriate, demonstrate additionality, and planning/outcomes. Initiatives carried out by the Unit since 1999 included a Trainers Training course in primary health care, research on the provision of health services to Travellers, research on the use of hospital facilities by Travellers, research on access to General Practitioner services, a video on Traveller's children's health, education on mental health, a men's health initiative, consanguinity, a parent crafts training initiative and an environmental health impact study.

Personal Perspective

- Commitment to the issues
- Willingness to earn
- Team approach

Strengths/Achievements

- Team participation
- Multi-disciplinary approach
- Partnership approach
- Valuable initiatives have been piloted
- Criteria developed for budget allocation

Weaknesses

- Accountability of HB staff to own disciplines
- Staff changes

Challenges

- Need for capacity building and new supports for Travellers
- Monitoring and evaluation of initiatives

Looking to the future

- The development of performance indicators for Traveller Health
- Policies in relation to areas such as childcare, anti-racism and equality proofing on service provision.

The shift from curative to preventative services, was also better for the community, was more cost effective and led to better outcomes. The PP Primary Health Care project provided a model of good practice and an evidence base for a community development approach.

Issues Arising from the Workshop Discussion

The challenges, opportunities and issues for a community development approach are:

- Building knowledge of *diverse* community needs that are delivered in a culturally appropriate way, among health service providers.
- Ensuring communities are *involved in shared decision making* processes re services/ policies, and not just consulted.
- *Managing expectations* amongst communities that are consulted/ involved in service/ policy development. Where people are consulted but there is no follow up action, this can seriously undermine the process.
- *Lack of genuine political will*
- As many community groups are often engaged in fire fighting little time is left for the development process reducing their *time/ capacity to undertake practice to policy work.*

Supports and resources are needed include:

- *Networking* opportunities, especially intercultural and inter sectoral networking.
- *Information sharing* between sectors/ communities.
- Resources for community *needs assessments.*
- Resources for *training/ capacity building of statutory staff* in understanding/ implementing community developments approaches within their work.
- Increased use of accessible language.

The two concluding messages from the workshop were:

- Participation of communities is required, rather than simply consultation with them; timeframes for *strategy development and implementation need to be realistic* and in line with community capacity.
- Resourced *training for statutory staff re community development and* consistency/ coherence of approach between departments.

4.2 Workshop 2: Community Participation in Primary Care Strategies

Presenters:

Sue Perry, Head of Health and Community Development, East Wakefield Primary Care Trust, England.

Dr Phillip Crowley, Irish College of General Practitioners and the Institute of Public Health, Ireland

Community Development and Primary Health Care
Dr. Phillip Crowley

The Irish Context

- About 30% of population have the medical card which provides free primary care
- 40% or more of the population have medical insurance
- General Practices are independent businesses often single handed
- Acute Hospitals receive more than 50% of total health budget
- There is no tradition of links between general practice and communities

Recommendation 19 of the Primary Care Strategy proposes that

'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 role of primary care teams in ensuring that local and national social and environmental health issues, which influence health, are identified and addressed'.

Ten Pilot Primary Care Teams supported

Virginia, Co. Cavan
Lifford, Co. Donegal
Ballymun, Dublin (RAPID area)
South Inner City, Dublin (part of RAPID area)
Dingle Penninsula, Co. Kerry
Portarlington, Co. Laois
West county Limerick
Erris Peninsula, Co. Mayo
Cashel, Co. Tipperary
Arklow, Co. Wicklow

The Importance of General Practice Linking with Communities

- Need to tackle causes of ill-health
- In partnership can influence population health

- Can seek solutions to non-medical problems
- Can ensure general practice is meeting local needs

Potential for Community Health Through Primary Care

- GP contact with 80-85% of population in one year
- Accessible, non-stigmatised – all problems present
- The possibility for inter-referral with the voluntary sector
- The possibility to deliver other services at premises
- General Practices as groups/collectives
- Action on population health determinants through partnership approaches

Spectrum of Participation

- Public meetings
- Postal questionnaires and surveys
- Health panels
- Focus groups
- Practice patient participation groups (PPGs)
- Citizen's Juries
- Rapid appraisal
- The community representative on committees
- A Community Development Approach

The spectrum reflects the differentiation between consumer-oriented models of participation and democratic models.

Best Practice

- Community representatives need support to be accountable to the wider community
- Any approach must involve marginalised minority groups- community development is particularly suited to this task
- Financial support is necessary to ensure access – crèche, carer support, interpretation, sign language
- Decision-making bodies need to be responsive to community's view

Some Questions to Ask

- Is the approach top down or bottom-up?
- Is it aiming to consult or to involve?
- Does the approach allow people to have adequate information?
- Is the agenda set by professional or by the community?
- Are there mechanisms for ensuring views are taken on board, or feeding back?
- Is the approach likely to involve a reasonable age/gender/race/class spread of participation?

Community Development Influencing Primary Care Strategies
Sue Perry, Head of Health and Community Development, East Wakefield Primary Care Trust

The Catalysts for Change

- Single Regeneration Budget – funding to develop CD approach in health arena
- Health Action Zone – grass roots CD work supported plus organisational change agenda
- Neighbourhood Renewal Funds – provided additional funding to work in areas of highest deprivation

Policy Context

- Acheson Report on Health Inequalities
- Community Involvement at the heart of government plans for regeneration
- Focus on Social Inclusion
- Local Strategic Partnerships
- Inequalities in Health –Cross Cutting Spending Review

East Wakefield Primary Care Trust Health Strategy

EWPCT Management Structure
Community Development Initiatives

- Tenants and residents groups – lobbying, campaigning etc.
- Environmental projects – on derelict pit sites
- Support groups – bereavement, stress, benefits advice etc.
- Participatory research
- 'Pathway to Health Action' - training

Issues and Challenges

- Long term nature of process – no quick fixes
- Performance management systems
- Future changes in policy
- Level of appointment of CD staff
- Shortage of experienced CD staff
- The need for effective evaluation
- Culture change in a predominantly clinical environment

Issues Arising from the Workshop Discussion

- There may be a tension between what disadvantaged communities want, and the development of Primary Care Teams under the Primary Care Strategy.
- It can't be assumed that health board managers or the Department of Health and Children understand the reality of community development, and there is a need to develop this understanding.
- Primary Care Teams are demonstration projects, so must include full support to community development actions in order to demonstrate best practice. There is a need for meaningful participation at an early stage.

The key challenges and opportunities identified were:

- The need for resources and supports for community development approaches
- The emerging role of County/City Development Boards in improved health at local level
- Acknowledging that participation and partnership take time.
- The need for primary care to address the determinants of health
- How to champion community development approaches to involving disadvantaged communities in the evolution and development of Primary Care Teams from the outset.

The two concluding messages from the workshop were:

1. Time and resources for community development are required, for meaningful structures to be set up within the new Primary Care Strategy, for community development approaches to be used effectively and for a greater understanding of what this means for community involvement and participation.
2. Dedicated people and supports for communities to build a voice – and support for Primary Care Teams to understand the community development approach - need to be provided.

4.3 Workshop 3: Nutrition, Food Issues and Health:

Presenters:
Catherine O' Meara and Siobhan Donoghue, Northside Breakfast Club and a Dara Morgan, Senior Community Dietician, South Western Area Health Board, Eastern Regional Health Authority.

Breakfast Clubs – a partnership that works
Catherine O'Meara

'the initiative worked because it involved the school, the parents and the children working together in partnership'.

Catherine outlined the history and work of the Northside Breakfast club, which provides breakfast and lunch for pupils in schools on the Northside of Dublin. The initiative was undertaken by the community for the community, and got off the ground through the voluntary work of parents, supported by Home School Community Liaison Officers.

The initial aims were to encourage children to attend and stay at school, to improve their concentration during the school day and to provide a nutritious meal in a convivial and social context at school. In the beginning the initiative was funded by parents. As the need increased, the St Vincent De Paul supported the project, and in more recent years the Department of Social and Family Affairs have funded it. Parents receive training over 40 weeks as part of the project, and parents run the clubs. There is a waiting list for parents who wish to become involved.

Catherine said they believed the initiative worked because it involved the school, the parents and the children working together in partnership.

Community Development Approaches to Nutrition
Dara Morgan

Health Promotion

' the process of enabling people to increase control over and to improve their health '
World Health Organisation (WHO)

The Ottawa Charter outlines 5 pillars of health promotion

- Building healthy public policy
- Creating supportive environments
- Developing personal skills
- Strengthening community action
- Reorienting the health services

Approaches to Health Promotion

1. Key settings – community, schools, health services, workplaces
2. Population groups – children, women, disadvantaged, older people, young people
3. Topics – nutrition, smoking, physical activity, mental health, oral health, accidents, alcohol

Incidence of diet-related diseases is higher in low-income groups – why?

- Lack of availability of healthy foods
- Lack of transport
- Limited kitchen facilities and cooking equipment
- Lack of confidence in cooking skills
- Family food preferences
- Other financial pressures taking precedence

Lack of information in <u>not</u> the main issue

Why use a Community Development approach*?*

In the past community dieticians have used an educational approach to food and health issues and health promotion – this has not been successful

- By focusing on individual responsibility there is a failure to recognise the many influences on food choices
- Professionally defined needs often fail to consider or reflect the wants and needs of the target population

Community Development – guiding principles

- Promoting a holistic view of health, by acknowledging the emotional, social and economic influences
- Working with groups to redress inequalities, by building on existing knowledge and skills and increasing self-confidence
- Ensuring community participation in identifying food and health needs
- Promoting inter-agency working and the development of healthy alliances.

Examples of Food Related Projects

- Food Co-ops
- Community Cafes
- Healthy Food Made Easy – peer led project
- Nutrition Programme for Travellers
- Being Well
- Breakfast clubs

What makes a Successful Food Project?

- Flexibility
- Community involvement from the outset
- Patience
- Committed back-up and access to funding that is not short-term

'Each point of arrival turns out to be a stepping stone rather than a destination..'
Seamus Heaney

Issues Arising From Workshop Discussion

- The high cost of fresh food.
- Insufficient funding for food related projects.
- Need for Department of Education to become involved and provide resources.
- Older people and nutrition is a big issue – they are often not spending money on food – room here for good work.
- Community development approach is new to health services arena.
- Training and capacity building is needed within the community.
- Community development approaches take time and money – they are a good option, but not a cheap one.
- Access to reliable multi-annual funding for projects is critical.

The two concluding messages from the workshop were:

1. An integrated approach at government level, between various departments and agencies is needed – often integration at local delivery level is not reflected higher up.
2. A dedicated funding scheme for community food and health projects is needed, and a mechanism for mainstreaming effective initiatives – rather than tried and tested projects have to piece together funding from year to year.

4.4 Workshop 4: Building Community Relationships: Roles, Relationships and Supports

Presenters:
Mary Byrd, Rosarie Coleman, Paula Casey, Carmel Murphy, Northside Initiative for Community Health (NICHE) Cork
Aidan Warner, Southern Health Board

The Story of NICHE
Mary Byrd, Rosarie Coleman, Paula Casey, Carmel Murphy, Northside Initiative for Community Health (NICHE) Cork presented a short photo presentation on health inequalities and a community response which outlined the history of Knocknaheeny (the community in which the project is based), the impact of policies on the environment and people's health, the inadequacy of services, community action and community achievements in providing services and how NICHE demonstrates a community development approach to health.

Health Board Involvement with NICHE;
Aidan Warner, Southern Health Board

'To develop innovative programmes that enable growth and creative solutions to emerge from within communities in response to health and social issues – through a process that is participative, consultative and respectful of individuals and their communities and involves the mobilisation of public, voluntary, private and community based interests to undertake tasks at different levels…'
SHB Community Work Department Mission Statement.

This short presentation will focus on the Southern Health Board's involvement with the NICHE project, in particular during the initial stages.

NICHE has been and continues to be a partnership arrangement (both formally and informally) so it is important to acknowledge the important and critical role played by those other partners who have been involved in different ways over the years, especially the Knocknaheeny Family Centre.

The timeframe is important (mid1990s onwards). We are looking at a period of time where there were interesting developments in the health services sector both externally to the Southern Health Board (the National Health Strategy) and also internally (organisational change and development, local area sector based initiatives in relation to services integration, services delivery, research etc.).

Outside the health services sector there were a plethora of projects/initiatives in communities affected by social exclusion focusing on community development, family support, combating educational disadvantage and addressing infrastructural deficiencies

in the physical environment –issues that could be argued were as, or more, relevant to the health and well being of individuals as the health services themselves.

The Southern Health Board was involved in the Knocknaheeny area through the delivery of its various health services programmes but also through its community development work with a range of projects focusing on family support, youth services, etc. There was an acknowledgement that there was a need to address individual and community health and well-being issues from an innovative perspective. The URBAN programme provided this opportunity.

The URBAN programme, an EU initiative aimed at improving living conditions for people in designated urban areas affected by social exclusion provided initial funding to the project. This was very important because URBAN (in Cork) with its focus on regeneration and the physical infrastructure, in this instance acknowledged health issues as in important aspect of the quality of life in local areas.

Furthermore the importance of taking the community itself as a starting point for local actions on health was important – the Southern Health Board supported the core approach of the project – the need to ‘recognise and build on the strengths that exist within the community as well as acknowledge and respond to the barriers which impede both individuals and communities from availing of health enhancing options’.

Whilst acknowledging the well known and well documented lifestyle issues and their impact on health, the Southern Health Board supported an approach that emphasised the importance of social support / social networks in promoting individual and community health/ well being. An initial priority for the work of the project was to engage with people around health and well-being. The role of the Community Health Worker has been vital to this process.

Another important aspect of Southern Health Board support to the NICHE project has been to initiate and support the development of strategic alliances with Southern Health Board services (Mental Health, Customer Care, Maternity Services, Health Promotion etc.) and University College Cork. Project staff themselves have developed effective local alliances with relevant groups, schools etc. This has helped to link local actions with wider regional/national strategies (providing a context for the work) and also to provide a conduit to help influence policy in terms of the experiences gained on the ground feeding back to a wider audience both regionally and nationally.

These relationships have developed and evolved over the life of the project and are ongoing as opposed to the very often ‘once-off’ nature of involvement by institutions in communities/projects.

The support to the project also included support to key staff and ongoing work with them vis-à-vis ‘vision work’ and innovative programme development ideas. It was

important to establish visibility for the project locally.

After the initial funding from URBAN ceased the Southern Health Board took over the funding of the project (€300,000 per annum approx). Being involved with the project at various levels was a key aspect of the initial Southern Health Board support.

The project is currently being evaluated. Other models are being developed and of course in a situation of tightening resources there is pressure to focus on health service delivery provision. The issue of competing agendas and the difficulties very often associated with partnerships need to be recognised.

Both the Southern Health Board and NICHE have benefited from each other's involvement.

- SHB has offered support to the project in terms of funding, administration backup and technical support from its Community Work Department as well as access to the range of services/resources.
- The Southern Health Board has benefited from its involvement with NICHE in terms of being part of innovative locality based work focusing on engaging with people in relation to the promotion of their own and their community's health and well-being.

Issues Arising From The Workshop Discussion

- Experience gained in local projects needs to be fed to County Development Boards, Health Boards etc.
- It is essential that local knowledge be applied to local situations.
- Community projects focusing on a single issue e.g. health, have the potential to break down other barriers, for example the NICHE project organised swimming for community groups in the university. This gave people a familiarity with a third level institution.
- There can be a mismatch between the 'work plan' of a statutory body and what the target community actually needs.
- The medical model of health is not the only model of health. Social models of health need to be developed and communicated.
- Health is a wider issue. " We need houses, not hospital beds." Local statutory services need to be aware of this link and build structures accordingly.
- Funding needs to be steady, generous, easily accessible and reliable
- Value needs to be placed on working in this sector. A system of accreditation for example is necessary.

***The two concluding messages from the workshop were*:**

1. Statutory bodies need to begin demonstrating an understanding of issues on the ground and a willingness to collaborate. Issues, which can be a barrier to access or communication, need to be dealt with, e.g. language, cultural, gender (men have a tendency to be more resistant to getting involved), financial or childcare. Barriers between the community and the statutory sector will need to be broken down. This is critical but it is difficult and time consuming
2. Information from community project's work needs to be recorded and communicated. Data gaps need to be filled.

4. 5 Workshop 5: Inter-sectoral Working for Health

Presenters:

Ms Maire O'Leary, Health and Social Policy Officer, Donegal Community Services, North Western Health Board and Dr Mary Manandhar, Senior Research Officer, Department of Public Health, North Western Health Board

Inter-sectoral Working for Health
What is it, why do it, what are examples of it in action in international, Irish regional and North Western contexts? What are the key issues?

What is it?
Inter-sectoral working for health is

A process in which representatives of different sectors come together to work for a common aim (e.g. planning actions to protect, promote and improve health).

What sectors are involved?
Statutory bodies, community and voluntary sector / civil society, private sector, elected representatives / politicians, academics and others.

Inter-sectoral working can also be called multi-sectoral or partnership working. It is broader than 'inter-agency' working, which mainly refers to co-operation between statutory agencies.

Why do it?

- International, EU and national policies emphasise it.
- There is a substantial evidence base of links between health, social exclusion and poverty and the contribution of community development.
- There is a growing evidence base of the beneficial impacts of inter-sectoral working on these.

Health is everyone's responsibility - alliances ensure a shared commitment.

But isn't it all too …

Difficult
Long term
Aspirational
Population focused rather than individual
About social justice and social action
Complicated ….

***Yes, but there are no excuses for inaction*.**

Challenges in inter-sectoral implementation
Partnership is a subversive activity – it changes the way people work
Expect controversy, debate and resistance to change
Information is not always readily shared between sectors
Health is not always seen as the business of all
Falling back on the role of health providers as 'stewards of health'.

Issues:
Resources
Policy into practice
Implementation
Sustainability
Capacity building
Change management

'Knowing is not enough, we must apply … Willing is not enough, we must do ..'
Goethe

Issues Emerging From Workshop Discussion

- Lack of structures and a budget can be a deterrent to getting involved in inter-sectoral working
- It's important that duplication does not occur
- The issue of unequal power can create difficulties – power can be difficult to give up and to take up
- It is important to acknowledge what different partners can bring to the table
- There needs to be some incentive for becoming involved in inter-sectoral initiatives
- Capacity building and mechanisms that resource relationship building are required

***The two concluding messages from the workshop were*:**

1. There is a need for a framework that moves policy to action and includes a number of elements: acknowledgement of power inequalities between partners; allows time for building a process; trains and builds the capacity of all sectors and has opportunities for learning (including job secondment), monitoring and incentives for inter-sectoral partnership.
2. Local structures need to mirror national structures, to ensure that all relevant stakeholders are at the table.

4.6 Workshop 6: International Literature and Policy Review on the Links between Poverty and health, and of Community Development Approaches to Tackling Health Inequalities

Presenters:

Dr Margaret Barry, Dr Michelle Millar and Pamela Mahony, Centre for Health Promotion Studies, Department of Health Promotion and Department of Political Science and Sociology, NUI Galway

"the process of organising and/or supporting community groups in identifying their health issues, planning and acting upon their strategies for social action/change, and gaining increased self-reliance and decision-making power as a result of their activities" (Labonte, 1993)

Aims and Objectives

This research was commissioned by the Combat Poverty Agency. The research aims of the project include the following:

- Review of current international literature concerning the relationship between poverty and ill health.
- An analysis of existing policy initiatives concerning the promotion of community development approaches in addressing health inequalities.
- Document approaches to implementing community development in the health area.
- Case study investigation of selected community health development initiatives in order to identify characteristics of successful initiatives and examples of good practice.
- Critically examine available research on the impact and effectiveness of community development approaches in reducing health inequalities.
- Make recommendations, based on pertinent policy, research and practice findings, for future strategic development of community development policies and practices in the health inequalities area.

Methodology

The Research was conducted using the following methodologies:

Review of published literature

Inventory of unpublished reports and initiatives

Case studies of good practice

Review of existing policy documents

The Nature and Extent of Health Inequalities

Health inequalities can be defined as "differences in health status which are unnecessary and avoidable and judged to be unjust and unfair" (Whitehead, 1990; 6).

Research in Ireland
Though there remains a notable lack of research about poverty and its impact on health in Ireland, we can ascertain from studies available that poverty is widely accepted as a risk factor for health.

Defining Community Development
As a public health practice community development has been defined as;

"*the process of organising and/or supporting community groups in identifying their health issues, planning and acting upon their strategies for social action/change, and gaining increased self-reliance and decision-making power as a result of their activities" (Labonte, 1993, p.237).*

Confusion surrounding over-lapping meanings of a community development approach:
Community development: the process, by which a community identifies its needs, develops an agenda with goals and objectives, then builds the capacity to plan and take action to address these needs and enhance community well-being.

Community Organisation: the process of involving and mobilizing major agencies, institutions and groups in a community to work together to coordinate services and create programs for the united purpose of improving the health of a community.

Community Based: the process of agency development of solutions for health problems which incorporate community consultation and input thus allowing adaptation of the implementation to suit local needs/circumstances (Robinson & Elliott, 2000; 221)

What differentiates a community development approach in health from others is the following:

- The importance of a broad-based definition of health; where good health is not merely the absence of disease but includes physical, mental and social well-being.
- The need for participation and collective working. Often this involves forming partnerships with others, crossing professional boundaries and working with people who are often excluded from participating in and/or influencing mainstream activities.
- A community development approach recognises the socio-economic influences on health and also recognises that the context in which people live directly influences health status and affects the way decisions are made regarding health.

Evaluation of Community Health Development Projects
Evaluation Issues

- Process-oriented approaches employ largely qualitative methods
- Needs assessments- variable

- Lack of baseline data
- Project reporting – variable
- Time constraints
- Tension between external demands for project outcomes and internal concerns with process
- Small scale focus
- Selecting indicators of project success
- Tracking change prospectively- documenting observable gains
- Absence of data on cost-effectiveness
- Documenting generic processes that feed into wider policy and practice
- Community controlled process evaluation and external programme evaluation

Overview
- Programmes demonstrate benefits for individuals, communities and services.
- balance between process and outcome
- analytic frameworks that link process and outcome data.
- Detection of intermediate level changes - indicators of project success.
- Clear and demonstrable outcomes as well as process indicators.

Convincing the Sceptics
Community development approaches can create the conditions where:
true participation in health in disadvantaged communities, a genuinely empowering experience, a positive impact on health status, a positive impact on health services, leads to a reduction in health inequalities.

Researching Health Inequalities
- Large body of research - nature and extent of health inequalities
- Paucity of policy and practice focused research
- Effective dissemination of existing data in an accessible format
- Need for research from the perspective of those most affected

Researching Community Level Determinants
- Interface between society and health micro and macro level studies
- links between people, place and health
- Pathways by which social structures affect health status at the community level
- What are the building blocks for healthier communities?

Bridging the Gap
- Vital link between theory, research, practice and policy
- Reflecting and theorising about community health development participation and empowerment - theories versus realities?
- Grassroots engagement by academics and policy makers
- National network- merging of perspectives

Issues Emerging From The Workshop Discussion

- Baseline data provides the foundation on which to build developments and programmes. Research, both quantitative and qualitative, allows us to see what the issues are and gives people the chance to voice their needs
- Evaluation helps determine what has been done and achieved. The development of both process and outcome oriented indicators are important for projects.
- Training on research methods and approaches and in understanding quantitative data are needed.
- The issue of how to reconcile the gaps between theoretical developments, research findings, policy articulation and the reality of practice is very important.
- The Combat Poverty Building Healthy Communities initiative offers an opportunity to document and evaluate the contribution of community development approaches to achieving better health.

***The two concluding messages from the workshop were*:**

1. There is a need for effective evaluation of initiatives to build an evidence base about community development approaches – this need to encompass both process and outcome indicators, and research documenting project work needs to be both quantitative and qualitative.
2. Combat Poverty need to articulate a concern around building an evidence base using methodologies appropriate to the community development process.

4.7 Workshop 7. A practical workshop on Community Based Participatory Research – Using Participatory Rapid Appraisal to Map Health Resources

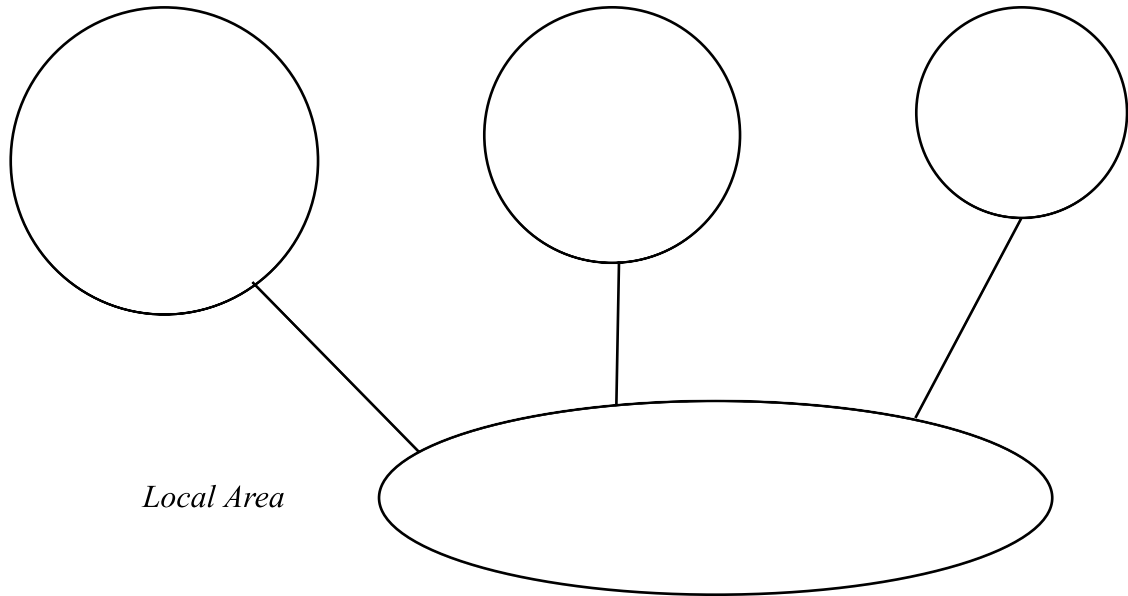
Presenter:

Fidelma Twomey and Margaret Maher, Clondalkin Partnership
Bernie Farrell and Helen Marjoram Quarryvale Community Development Project

Requirements: 1 facilitator; 1 notetaker; 4 roundtables; 2-5 persons per table.
Flipchart paper, variety of coloured markers.

Part One: The group was given 15 minutes to work together to draw a chart showing all the main players involved in better health, at local, regional and national levels.

Draw big circles to show active groups and smaller circles to show less active groups, with lines indicating linkages – the stronger the line, the stronger the link. This map indicates what current services look like.



Part Two: Repeat the exercise, this time mapping how the picture from part one could look better, what an ideal picture of services would be like.

Identify what the challenges / difficulties in doing this are?

What are the opportunities?

Issues arising from the workshop exercise

- Participatory Rapid Appraisal demonstrates the strengths of using pictorial methodologies.
- The lack of links between all levels and across levels was striking
- Health is clearly an issue of concern to a number of players – and should be addressed in a number of ways by a number of key stakeholders

***The two concluding messages from the workshop were*:**

1. Health is a crosscutting issue and needs to be addressed by multi-sectoral responses which need to be developed with the real participation of all stakeholders
2. The voice of local communities needs to be heard using processes and methodologies such as Participatory Rapid Appraisal, which demystify health structures and give a sense of ownership to communities (both geographic and of interest) about identifying their own needs.

5. Conference Closure and Final Plenary Session

Ms Anna May Harkin, Department of Health and Children, chaired the final plenary session of the conference, during which workshop rapporteurs presented brief reports. The two concluding messages are documented under each workshop section. A number of final issues were also raised from the floor although time to discuss these was limited. Issues raised included:

- There seems to be an under-representation of Irish NGOs participating in the EU Public Health Programme.
- The National Council for Older People is putting together a database of health related activities or projects involving older people.
- There is great concern that at a national level community development organisations that are part of the Community Platform are being excluded from decision making and the partnership arena through their rejection of the new partnership document, Sustaining Progress – despite the C&V sector's commitment to the partnership model.
- Mental Health and mental health services are very important issues about which the conference heard very little today.

Ms Harkin thanked the contributors and the participants, and formally closed the event.

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