

THE  
COMMUNITY  
WORKERS  
CO-OPERATIVE

# Community Work Approaches to address Health Inequalities

*'Health is a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity... health is a resource for everyday life, not the objective of living: it is a positive concept emphasising social and physical resources as well as physical and mental capacity.'*

*The enjoyment of the highest standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition...'*  
(World Health Organisation)



STRATEGY GUIDE 7

## Community Work Approaches to address Health Inequalities - A Strategy Guide

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# Community Work approaches to address Health Inequalities

Strategy Guide 7

**Community Workers Co-operative**



Community Work  
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Health Inequalities

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## The Community Workers Co-operative

The CWC is a national organisation whose members are committed to promoting and supporting community work as a means of achieving radical social change. It was formed in 1981 and it seeks to influence economic and social policies to ensure the inclusion of, and to bring about equality of outcome for, those who experience exclusion and inequality. It works to contribute to the creation of a more just and equal society through promoting a policy agenda drawn from local action and experience.

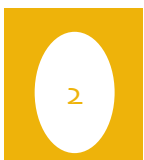
The CWC services its membership through the provision of a range of information and skills development resources. It has developed important campaigns, based on member participation in relation to EU Structural Fund investments, the role and organisation of the community sector, local government reform and the local social partnership arena, rural development, urban regeneration, educational disadvantage and gender issues. Members participate in regional networks that address regional issues and provide support mechanisms for members. They also participate in working issue-based sub-groups. These are:

- A Community Sector subgroup
- An Equality subgroup
- A Local Government subgroup
- A Global Development subgroup
- A Health Inequalities subgroup
- An Educational Disadvantage subgroup
- A Rural subgroup.

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## Introduction

The Community Workers Co-operative (CWC) is committed to the promotion of Community Work as an intervention for social change. A key element of its work has been, and continues to be, the active promotion and advancement of an equality agenda and the promotion of Community Work approaches to equality issues within the various arenas within which the CWC operates at national, regional and local levels. One of the areas in which the CWC is involved is health inequality.

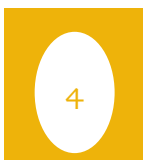
In 2000, a number of members of the CWC came together to explore why health issues are a concern for Community Work. Their work developed into establishing a Health Subgroup consisting of individual members of the CWC who are involved in Community Development Work, and interested in Community Work approaches to addressing health inequality. Since that time the Subgroup has made submissions promoting Community Work approaches to addressing health inequalities, including a submission to the NAPS Health Working Group. The Subgroup has also been active in setting health priorities for national negotiations, and promoting Community Work in the National Health Strategy and the Primary Care Strategy through its membership of the Health Linkage Network. Over the course of this work, the Subgroup has identified a need for a strategy guide for locally based Community Workers to support them to incorporate health into their Community Work agenda, but also to support them to promote Community Work approaches to addressing health inequalities at a local level.

The Strategy Guide is being produced by the CWC in order to highlight best practice and to form a basis of practice guidelines for locally based workers regarding Community Work and health. The production of the Strategy Guide is opportune at a time of developing interest in health inequalities, and at a time when a major restructuring of the health service is beginning to take place in line with the commitments under the National Health Strategy 2001 *Quality and Fairness - a Health System for You*. The Health Strategy puts a focus on health, not just on health services and acknowledges that peoples health is affected by socio-economic, environmental and cultural factors. The Strategy which emphasises the non-medical aspects of achieving full health and recognises the formal and informal role of the community in improving and sustaining social well-being in society, has '*Strengthening Primary Care*' as one of its Frameworks for Change.

Health inequality refers to "*the differences in the prevalence or incidence of health problems between individual people of higher and lower socio economic status*" (World Health Organisation 1998).

Because of the prevailing medical definition of health, Community Workers and Community Development initiatives often do not recognise the health outcomes that arise from Community Work. Community Workers are engaged in work that both promotes and produces good health, though they might not have a clearly defined health agenda. They work with the most marginalised groups and communities. They work to empower and enable them to identify needs and to develop confidence, knowledge and skills to work collectively to bring about change in the central conditions of their lives. Their work is focused on building healthy communities free from poverty, exclusion and discrimination. It is focused on ensuring that marginalised groups are enabled to move from an experience of powerlessness to a sense of well-being and a realisation of their potential, and the realisation of their right to enjoy and fully benefit from the fruits of social and economic development.

This Strategy Guide is produced specifically to generate an analysis of Community Work approaches to health inequalities at local level and to share experiences of work to date through the presentation of case studies of Community Work approaches to addressing health inequalities. The Strategy Guide is also intended to help develop a focus on influencing policy with a view to achieving more healthy communities. Four case studies have been chosen for inclusion in the Guide. These detailed case studies reflect the core elements of good practice from a range of different perspectives.



# The Health Debate

## *Moving to a Social Model of Health*

Health is a Community Work concern. Much Community Work being undertaken with marginalised communities and groups has positive health outcomes. In discussions on health this is not usually acknowledged and the health outcomes of Community Work are not usually explored.

Given the crisis in the health system, it is understandable that a discussion about health can quickly focus on funding and budgets and big strategies; on the long waiting lists and waiting times for hospital procedures; the long waiting times in accident and emergency departments; the centralisation of the system and its infrastructure for the treatment of illness and disease. Given the systemic inequalities which the Irish health system perpetuates, discussion can quickly focus on the two tier system of care; on the huge power of particular professionals within the hospital and health system; on the public funding of the private health system and the extensive use of private beds in public hospitals. Frustration can also focus discussion on the inefficiencies and bureaucracy in the public health system which has been under-resourced for so many years.

Health problems, the symptoms of being unwell or ill are often medicalised, individualised and privatised in the doctor/consultant/patient relationship and defined as problems that require the attention of experts, or that require a quick fix in the form of new and more powerful drugs produced and marketed by the pharmaceutical industry. Inequalities and problems that give rise to increasing stress, illness and lack of well being are accepted as part of everyday life. Stark inequalities, including the fact that mortality rates in the lowest occupational class are 100-200% higher than in the highest occupational class for all major causes of death, are somehow considered normal in Irish society.

Furthermore, attempts to make sense of how the health system works is frustrated by a knowledge deficit about its structures, and about how it is organised and operated and the different processes and operational procedures within and across the myriad of systems, boards and agencies that define the health service. The public health system is not focused on public health but on disease management. Health promotion, which was given much momentum with the cardiovascular disease strategy and the development and expansion of health promotion units in each of the health board areas, is often mistakenly perceived as a limited concept, as a non-smoking campaign or as a campaign to get people to do more exercise or to change dietary habits and reduce fat intake in order to have more 'happy' hearts.

The social, economic, political and cultural systems and processes in Irish society, and the inequalities that these systems generate and reinforce, have until recently, been neglected in discussions of health and in the health debate. The factors that cause poor health and health inequalities are complex and interrelated, but it is proven that people who are poor, who are disadvantaged and socially excluded, have the poorest health and die younger than those who are well off and can choose their lifestyle and living environment. It is therefore important for Community Workers to develop an analysis of inequality, to understand how inequality is generated and sustained, how inequality impacts on peoples health so that they can contribute to the vision and strategies for a healthier more equal society, and to the development of institutions and processes and programmes that will promote equality and greater health outcomes for the people with whom they work.

We will look at this in section 3, but firstly we will look at what determines good health and examine what the World Health Organisation considers to be the key determinants of health.



## What Determines Good Health?

In the context of Community Work and Community Development practice at local, regional and national level, we need to be ever mindful of the **key** determinants of health and well-being, in particular, when we are:

- identifying and developing our analysis of health inequalities at local level,
- developing our health agenda within the Community Development project and the community sector networks, and
- engaging in health partnerships with a view to negotiating real and meaningful change in the health status of marginalised communities.

The improvement in people's health must be a major objective of social and economic development. Health policy cannot be isolated from other development policies. A focus on the link between health policy and other policy sectors such as employment, income maintenance and social welfare, housing and education is therefore crucial, in all efforts to promote and achieve better health. Health Impact Assessment is an important tool in the health proofing process.

It is common practice to review a long list of determinants of health, such as: genetic and individual factors, lifestyles, environment, and the availability and effectiveness of health services. Until the 1950s, it was generally believed that most of the dramatic increase in life expectancy seen in the Western World during the 19th and 20th centuries was due to improving medical care. Since then, however, it has become clear that while modern healthcare has been very important in improving the health status of people, the majority of the improvement in life expectancy has been due to improved economic and social conditions.

The great differences in health status observed across countries and among groups within countries have highlighted the fact that all these determinants are linked to social and economic factors that are at the core of political and societal development.

The World Health Organisation (WHO) in its European Health Report 2001 states that while genetic and lifestyle factors clearly affect an individual's susceptibility to disease, their role in the differences in health at population level is much less evident. Individual lifestyle and risk factors explain only a portion of variations in the occurrence of disease. The WHO European Health Report also states that, *"the failure of individually focused health services to achieve the goal of universal access to effective health services of reasonable quality will contribute to unnecessary suffering and morbidity, but there is little evidence to suggest that this failure contributes substantially to the gross imbalances in public health seen across the European Region"*.

### World Health Organisation: Key Determinants of Health

Many factors combine to affect the health of individuals and communities. Whether people are healthy or not, is determined by their circumstances and environment. The determinants of health include:

- the social and economic environment,
- the physical environment, and
- the persons individual characteristics and behaviours

The WHO defines the following as the key determinants of health:

- **Poverty**
- **Psychosocial factors**
- **Education**
- **Unemployment/Employment**
- **Housing**
- **Transport**
- **Gender**

Wealthier members of society live longer and tend to be healthier while doing so!

*The differences in health status among the countries of the European Region have thrown into sharp focus, factors - beyond health services, genetics and individual lifestyles - that affect health at population level. The evidence has been much clearer that the differences in health status are substantially a manifestation of social, economic, environmental and institutional determinants.*

(WHO European Health Report 2001)



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## Poverty - the single largest determinant of ill health

Poverty and ill health form a vicious circle, poverty being both a determinant of poor health and a potential consequence of it. Whether defined by income, socio-economic status, living conditions or educational level, poverty is the single largest determinant of ill health.

Living in poverty is associated with lower life expectancy, high infant mortality, poor reproductive health, a higher risk of contracting infectious diseases (notably tuberculosis and HIV infection), higher rates of tobacco, alcohol and drug use, a higher prevalence of noncommunicable diseases, depression, suicide, anti-social behaviour and violence and increased exposure to environmental risks. Evidence for these associations is provided and outlined in the report *Poverty and Health: evidence and action in WHO's European Region*<sup>1</sup>.

The WHO report cites particular groups at risk of poverty i.e. the unemployed, the urban poor, ethnic minorities and homeless people.

In the United Nations 2001 World Development Report, Ireland rated second bottom in its record on poverty among the industrialised countries (16th of the 17). A look at some of the poverty statistics in Ireland give clear indications of those at risk of ill health in Irish society.

- 65% of lone parents are below the poverty line<sup>2</sup>.
- 54% of households headed by an ill or disabled person are living below the 60% median<sup>3</sup>. The average risk for consistent poverty is 22%<sup>4</sup>
- The proportion of elderly people living below the poverty line rose from 10% to 30% between 1994-1998<sup>5</sup>. Between 1994 and 2000 the risk of poverty for those aged 65 and over rose from 6% to 43%<sup>6</sup>.
- In developed countries according to the WHO<sup>7</sup>, health is more related to relative rather than absolute poverty. An analysis of the taxation policies of the Irish government over 1987-99, reveal that budgets boosted the incomes of the richest one-third by 18% but the poorest one-third by only 4%. For the top 20%, incomes rose 19% but for the bottom 20% they declined minus 1.2%. Such policies also work to reproduce the unequal distribution of resources and pass privilege from one generation to another.
- Ireland has the second highest rate of child poverty in the EU.
- The official figures for homelessness doubled between 1996 and 1999 (At 5,234 the 1999 figure is considered a vast underestimate by NGOs working with homeless people). The poverty associated with homelessness has alarming consequences in terms of overall mortality, prevalence of chronic respiratory diseases, mental ill health and alcohol and drug dependence.
- There is growing poverty amongst ethnic minority communities.

*In Ireland the gap in health between rich and poor is substantial. Mortality rates in the lowest socio-economic groups are over 100% higher than in the highest socio-economic groups for all major causes of death.*

(Report of the Working Group on the National Anti-Poverty Strategy and Health 2001<sup>8</sup>)

*In both North and South, the all causes mortality rate in the lowest occupational class was 100%-200% higher than the rate in the highest occupational class.*

(Inequalities in Mortality 1989-1998. Institute of Public Health in Ireland. May 2001)

- 1 Poverty and Health: evidence and action in WHO's European Region. Copenhagen, WHO Regional Office for Europe, 2001
- 2 Rights and Justice Work in Ireland: A new baseline. Brian Harvey 2002. The Rowntree Charitable Trust
- 3 Living in Ireland Survey. ESRI 2000
- 4 ibid.
- 5 Income, Deprivation and Well-being among Older Irish People. ESRI 1999
- 6 Combat Poverty Agency Poverty Briefing No 13, 2003
- 7 European Health Report 2002 WHO
- 8 Report of the Working Group on the National Anti-Poverty Strategy and Health 2001. Institute of Public Health



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### Psychosocial Factors

Low self esteem, anxiety, insecurity, social isolation, lack of control over work or home life produce stress. Psychosocial stress is increasingly recognised as a key factor in a number of conditions, including heart problems and hypertension, alcoholic psychosis, neurosis, homicide, suicide, accidents, ulcers and cirrhosis of the liver. According to WHO these tend to increase in importance in countries undergoing accelerated social and economic transitions that are not adequately supported by social policy.

According to the National Economic and Social Forum (NESF) there are *“increasing inequalities of outcome between social classes, between other marginalised and more powerful groups, between the disabled and the non-disabled, between Travellers and settled people. New pockets of inequality have also been created, especially among asylum seekers and refugees”*<sup>9</sup>.

Although Ireland has undergone huge social and economic transitions in the last decade and has had the highest rate of economic growth in the EU throughout the last decade, public expenditure is the lowest in Europe.

Factors which cause psychosocial stress include unanticipated rise in unemployment, employment turnover and job insecurity, erosion of the family, mounting distress, migration and rising social stratification. In Ireland, unemployment and job security may have not been perceived as highly significant factors in relation to psychosocial stress until the restructuring of the economy over the past two years with consequential lay-offs, redundancies and a rise in unemployment. However erosion of the family, mounting distress, migration and rising social stratification have all been highly significant in an Irish context. In relation to rising social stratification in Ireland:

- The richest 20% earn six times as much as the poorest 20%. This is twice the ratio of the best performing OECD country, Finland, and 20% worse than the EU average<sup>10</sup>.
- The income gap between the richest and the poorest has been widening
- From 1994-2000 the numbers experiencing income poverty increased from 16% to 22% in the percentage below a central relative income poverty line of 60% of median income<sup>11</sup>.
- 35.17% of the unemployed in 2000 were long-term unemployed, typically men over 40 who have been without work for a very long time<sup>12</sup>.

According to the WHO, *the positive and negative impacts of social and economic policies on social capital, social networks and social cohesion need to be closely monitored, as there is increasing evidence that such issues can have a protective or destructive effect on population health.*

## Education

Education is an important determinant of health. According to the World Health Organisation (WHO), educational levels produce a gradient in mortality (death) and morbidity (illness and disease) similar to that produced by income.

- *What is most disturbing in the available research is the extent to which social class of origin is so strongly related to the participation and performance of a child within the Irish education system ....substantial class differentials .... despite the overall increase in participation rates (NESF). The percentage of students who left school without qualifications, 9.1%, contrasts with less than 1% from the higher professional, lower professional and salaried employees<sup>13</sup>.*
- Approximately 47% of lone parents has no formal education or primary level only. The lack of affordable accessible and flexible childcare means that lone parents can make very limited choices regarding education and training. 65% of lone parents live below the poverty line and feel hopelessness due to being stuck in a poverty trap. The participation rate of Irish lone mothers in the labour force is the lowest in the EU. Private childcare costs on average 20% of the average industrial wage compared to 8% in the EU.
- The material and cultural resources of a family have a major influence on a child's educational attainment. 14% of the children of unskilled manual workers attend college compared to 89% of the children of professionals. Children who attain higher levels of education or technical training have much better chances in health, as well as in occupation and income.

*Educational attainment is a more powerful predictor of differences in mortality than income inequality.*

(British Medical Journal 2001)

## Employment / Unemployment

Amongst employed people, there is a clear association between the grade of employment on the one hand and the morbidity (including rates of absence due to illness) on the other. The relationship remains when adjustment is made for factors such as level of education and tenure of housing. According to the WHO it seems to be explained by higher levels of control, challenge and support enjoyed in higher grades of work.

Both unemployment and work insecurity have detrimental effects on health, increasing the risk of psychological and physical disorders and suicide. Unemployment as a cause of poverty and ill health was a major issue through the 1980s and early 1990s and is now again on the increase. The impact of unemployment and poverty on young people is of particular importance, in view of its association with health and social problems such as violence, suicide and substance misuse. According to the WHO, in the younger age groups, work insecurity is associated with poor health, irrespective of any relationship between social class and unemployment. The methods through which these trends affect health and well-being are complex and difficult to disentangle. Nevertheless there is little doubt that they are related to various kinds of health risk and damage and a high incidence of psychological and mental health problems.

13 NESF Report No 24 on Early School Leavers



## Housing / Accommodation

The housing environment is one of the main settings that affect human health. The quality of housing plays a decisive role in the health status of residents, directly or indirectly.

- In 1999, 14% of Irish homes for older people lacked either a bathroom/shower, indoor flush toilet or hot water. When it came to older people living alone, 19% of homes lacked these amenities, the second worst record in the EU.
- 48,000 people are on the housing waiting list<sup>14</sup>. At the current rate of builds by the local authorities, it will take 12 years to clear the housing waiting list<sup>15</sup>.
- Exacerbated by the housing crisis, the official homeless figure of 5,235 last published in 1999 was double that of 1996<sup>16</sup>. 75% of homeless people have mental health problems<sup>17</sup>.
- There were 939 Traveller families on the roadside at the end of 2002<sup>18</sup> without basic facilities including sanitation and running water. Traveller infant mortality rates are three times higher than the national rate. Traveller men live on average 10 years less than settled men and Traveller women live an average 12 years less than settled women. Traveller health problems are linked to their social and economic exclusion exacerbated by issues of appropriate accommodation provision.
- Panel block buildings and high rise flats were constructed between the 1960s and the 1980s to meet housing needs. The poor living conditions in prefabricated buildings, caused by outdated construction methods and a lack of maintenance, have posed and continue to pose major problems in many areas and also represent an unevaluated health risk. While regeneration projects are currently underway in a number of areas, families still live where such accommodation was constructed. The vast majority of newly constructed buildings in large housing estates were built according to a fixed construction pattern.

There is currently no policy by which housing investment is 'indexed' with health gain. In the field of housing, the 'economic' and 'engineering' issues, rather than the health aspects have prevailed in the decision-making process. There are significant gaps in knowledge in the area of housing and health, and research has not focused on integrated approaches that deal with housing and health in a holistic way, or on acceptable approaches for risk assessment.

14 Quarterly Bulletin of Housing Statistics, September 2002

15 Prof. John Monaghan, Secretary St Vincent de Paul Society, November 2003

16 Department of the Environment Homelessness Survey

17 Mental Illness - The Neglected Quarter Amnesty International 2003

18 Department of the Environment and Local Government, Traveller Accommodation Unit



## Transport

The accessibility, affordability and suitability of transport systems are key factors that have an impact on people's health and well-being. Transport policy including investment in public transport, has a significant impact on health and well-being, both positive and negative.

- Health gains can include increased opportunities for physical activity, through safe walking and cycling, as well as access to employment opportunities, education, health care and recreation.
- Health losses can include higher accident rates, more air pollution and noise, the isolation of and the separation of communities that are not serviced by public transport, most especially those communities that are already socially and economically marginalised. Health losses can also include more sedentary lifestyles.
- Vulnerable groups and those socially and economically marginalised and excluded in both urban and rural areas, the elderly and children, tend to be the most severely affected by under investment in public transport.
- People with disabilities are excluded from accessing a range of services, development opportunities and employment opportunities due to a lack of accessible transport.

Health impact assessments should be undertaken in relation to transport planning and design. An integrated multisectoral approach involving all the relevant authorities and stakeholders needs to be employed, and more attention paid to health considerations in decisions on transport and land use.

**Health Impact Assessment (HIA)** of all public policy must be introduced. In the EU, legislation under the Amsterdam Treaty makes provision for HIA in policy making. The new Public Health Action Programme will facilitate the development of HIA across the EU.

HIA is a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population and the distribution of those effects within the population (WHO 1994). HIA of non-health policies are increasingly seen as a tool to facilitate cross-sectoral action, and as a means to promote health and reduce inequalities.

The introduction of HIA will impact on the role of the health sector and other sectors, including local authorities and government departments. It involves a more proactive role with sectors promoting health as part of their policy and addressing how the issue of HIA fits into their strategic planning cycle.

*Age, sex, and hereditary characteristics inherited from parents are the basic determinants of health status. These are factors over which individuals have no control. However an analysis of social, economic, environmental and cultural factors that determine health and well-being give us an understanding of the cause of health inequalities.*  
(World Health Organisation)



## Gender

Gender has been recognised as a determinant of health, and gender inequality contributes to the risk of ill health.

Major differences exist with regard to the roles and status of women.

- In Sweden the proportion of women in government is about 50%, in Ireland the proportion of women in government is 13%. The percentage of women elected to the Dáil rose by 1% in the 10 years from 1992-2002.
- The number of women appointed to the Cabinet decreased by 7% for the current government, while the number of women appointed as Ministers of State decreased by 11%.
- Women's representation on Health Boards ranges from 10% in the North Eastern Health Board (3 women 27 men) to 30% on the South Western Health Board (7 women 16 men)<sup>19</sup>.
- Women are over-represented amongst the poor.
- Women's average industrial hourly earnings are on average only 70% of men's earnings. The gender pay gap crosses all sectors in the Irish economy<sup>20</sup>.

Gender roles may determine different patterns of disease in women and men, varying types of behaviour in seeking health care and varying responses by service providers and researchers.

There are gender differences in health that have a biological basis, and there are socio-economic factors that affect the magnitude of these differences.

Women live longer than men, but the burden of work at home and in the workplace takes a heavy toll in terms of morbidity. Women are more likely than men to suffer from depression and anxiety. On the other hand men are more prone to accidents.

Differences between and amongst women that include socio-economic status, ethnicity, sexual orientation, responsibility for dependants, require consideration of need and appropriate responses and efficient interventions in health promotion and protection.

*There is a developing knowledge base that relates disease patterns to the organisation of society and the way it invests in its human development. Health policies need to aim at reducing the overall burden of disadvantage. In attempting to reduce health inequalities and create better conditions for population health, health policy cannot be isolated from other development policies. Thus the link between health policy and other policy sectors such as employment, income maintenance and social welfare, housing and education is crucial in all European member States.*

(European Health Report 2002, World Health Organisation)

### **Income, Income Distribution and Social Status:**

*Research indicates that income and social status is the single most important determinant of health. Studies show that health status improves at each step up the income and social hierarchy. In addition, societies which are reasonably prosperous and have an equitable distribution of wealth have the healthiest populations, regardless of the amount they spend on health care.*

(The Population Health Template, Health Canada Population and Public Health Branch Strategic Policy Directorate July 2001)



19 Irish Politics - Jobs for the Boys. National Women's Council of Ireland. 2002

20 Study of the Gender Pay Gap at Sectoral Level in Ireland, prepared for the PPF Consultative Group on Male/Female Wage Differentials. INDECON International Economic Consultants 2002

## Responding to Health Inequalities in the Community - Responses from the State

In recent years we have seen an increase in statutory agency delivery of care and services from a base or centre in the local community. The Health (Amendment) (No 3) Act 1996 confers a statutory obligation on health boards to develop *“health promotion programmes having regard to the needs of people residing in its functional area and the policies and objectives of the Minister in relation to health promotion generally”*.

The policies and objectives of the Minister and government are outlined in the National Health Promotion Strategy 2000-2005 which defined health promotion as *“making the healthier choice the easier choice or the process of enabling people to increase control over and to improve their health”*. The emphasis is on enabling individuals to take more responsibility for their health.

The Strategy outlines the Minister’s five chosen settings for health promotion. These are schools and colleges; youth sector; community; workplace; and health services. Within the community setting *“the strategic aim is to support the development and implementation of community-based approaches”*. The topics prioritised for health promotion initiatives and activity are positive mental health; being smoke free; eating well; good oral health; sensible drinking; avoiding drug misuse; being more active; safety and injury prevention; sexual health. A strategic aim and the specific objectives to be achieved by the health promotion strategy are set out under each topic.

It is the responsibility of the health promotion departments in each of the health boards to plan, implement and evaluate at a regional level the objectives. To successfully implement the strategy, there has been an increase in the number of professionals employed in the health promotion units. Existing regional health promotion structures in all of the ten health boards have been developed and strengthened.

Community based Health Programmes, Health Promotion Projects, Healthy Lifestyles Projects, Health Education Programmes, Nutrition Initiatives targeting Disadvantaged Groups, Feeling Fruity Projects, Healthy Eating Projects, Healthy Communities Projects, Health Action Zones are increasingly being conceived and developed, with the health promotion and health related activity targeted and focused on a defined geographic community or town, or located and based in a local community setting.

A number of local communities have themselves initiated discussion and research on local health needs as part of a regeneration strategy.

Under the National Health Strategy *Quality and Fairness, A Health Strategy for You* ten demonstration Primary Care Units have been established by the Health Boards. These Primary Care Units are required to consult with the local community in relation to the piloting and development of the Primary Care Programme. This experience is intended to influence and present a model of community participation in the implementation of the National Health Strategy. There are also Drug Task Force initiatives, self-help groups, numerous projects that work with individuals within communities that involve the provision of education, information and advice on health matters, there are interagency initiatives, and there are collaborations between various agencies and local actors in order to enhance and ensure better health service delivery at local level.

*Community Development work requires specific skills, understanding and experience and it is not an 'add on, to other duties and tasks of health service workers.*  
(Community Development and the Tyne and Wear Health Action Zone)



The term 'Community Development' is often loosely used in relation to health work at local level and used in a way that promotes confusion. A number of the new community based initiatives in the health area, similar to those defined above, are often mistakenly defined as Community Development. The term 'Community Development' is often used to merely define the intersectoral approach being adopted at local level to address health issues. It is sometimes used to define the process or an expected outcome of a health initiative, or indeed to describe elements in the approach that is being used in the health work being undertaken. Sometimes Community Development is loosely applied to a whole range of health service practice where a health service agenda is being progressed.

It is important to define Community Work and Community Development from the outset. Being clear about the definition of Community Work that underpins an approach to tackling health inequalities is crucial to long term outcomes and progress.

**Community Development** is about actively enabling people to enhance their capacity to play a role in shaping the society of which they are a part. It works towards enabling groups and communities to articulate needs and viewpoints, to work collectively to influence the processes that structure their everyday lives and to take part in collective action that will contribute to making real, positive and lasting change. Given that the opportunity and the resources required to participate fully in society are more open to some groups and individuals, the priority, for those engaged in local social and economic development and Community Work, is to work with the most marginalised groups and communities - those experiencing poverty, inequality and social, cultural and economic exclusion<sup>21</sup>.

**Community Work** is a developmental activity composed of both task and process. The task is the achievement of social change linked to equality and social justice, and the process is the application of the principles of participation, empowerment and collective decision-making in a structured and co-ordinated way.

Community Work is focused on:

- the creation of opportunities which facilitate a social analysis of needs and appropriate responses;
- the development and delivery of actions which elevate the socially excluded;
- enabling groups and communities to develop consciousness, analysis and understanding of the issues to be addressed so that they can take part in collective action
- the strengthening of organisational capability which will facilitate excluded groups and communities to impact on local and national policy.

This requires dedicated staff with a specific remit to work with named groups.

**Community Workers and Community Development Projects are already promoting and producing health and well-being within marginalised communities.**

Even though many Community Development and Equality Projects may yet have to consciously develop their health agenda, the causes and determinants of ill health and Health Inequalities are already a focus of much Community Work and Community Development.



Community Work approaches to address Health Inequalities

CWC 2004

# How does Community Work differ from Community Based Work?

Community Work differs from community 'based' work such as service delivery, health promotion projects, local development, community-based inter-sectoral health partnerships, in that it is consciously, actively and specifically focused on bringing about social change in favour of those most marginalised or excluded in society, both geographic communities and communities of interest, and enabling them to address the social, political and economic causes of this marginalisation. It is concerned with challenging existing power relations and addressing power inequalities.

Community Work is premised on the belief that inequality is structured and is generated in the major institutions and systems that have been established to organise society, institutions and systems that are changeable and changing, including the health system, the education system, the economic system.

## Community Work principles

### Why community work produces health and well-being...

Community work

- **is collective.** It is based on working with and supporting groups of people, enabling them to develop their consciousness, analysis and understanding of the issues to be addressed so that they can take part in collective action. People enduring multiple disadvantages tend to experience them as personal and disabling. The collective and participatory approach of community work provide opportunities to recognise commonality in problems and the motivation and opportunity to affect change. Through collective activity people come to see common problems as objective and open to remedy.
- **is participatory.** Its focus is to socially include, it advocates and claims the right of excluded groups to come in from the margins. It values, stimulates and encourages marginalised groups to become involved in defining their real needs and developing responses to the problems they experience. In this collective process individuals overcome demoralisation, low self esteem, social isolation.
- **is empowering.** It provides opportunities for people to become critical, creative, free, active human beings allowing and enabling them to take more control of the direction of their lives, their community and their environment.
- **is about power-sharing.** It aims to effect a sharing of power to create structures that provide genuine participation and involvement. It is a process based on mutual respect and equal and genuine partnership between all those involved to enable a sharing of talents, experience and expertise.
- **is concerned with both the task and the process of development.** Importance is attached to the task which is social change linked to social justice and equality and the process by which change is achieved, promoting a collective process which is inclusive.
- **is committed to developing innovative and creative approaches.** It aims to address the economic and social problems that arise from deprivation. It recognises that with adequate resourcing a community work approach can unlock a huge reservoir of talent and ideas that can contribute to social change. It seeks in a dynamic way to test new approaches which ensure the involvement of local communities.
- **is about gaining concrete improvements in the quality of life of marginalised communities.** These improvements reflect real needs as identified by these communities themselves.
- **is involved in devising strategies which confront prejudice, racism, sexism, and discrimination** on the basis of class, socio-economic status, gender, disability, age, ethnicity, skin colour, nationality, responsibility for dependants, marital status, sexual orientation.
- **is about celebrating achievements, showing off, sharing lessons and promoting good practice.** Its achievements can often be forgotten or attributed to public authorities, when new amenities are created or existing ones saved through public pressure or when new groups successfully engage in partnership arrangements after a lot of pre-development work and capacity building.



Community Work consists of an analysis of social and economic situations and collective work for social change. It should lead to improved individual circumstances, but the target is positive change for the whole group. It is based on a set of principles that involve not only building capacity to participate, but also the development of consciousness, analysis and understanding of the issues to be addressed. It goes beyond consultation to participation and focuses on how things get done as well as on what is to be done, in ways that are empowering for all concerned, particularly the target groups. It is primarily concerned with the promotion of a just, equal and inclusive society at local, national and international levels.

## Health Promotion and Community Work

*“Health promotion is now a world wide movement concerned with improving individual and population health. It is now considered an umbrella term for a wide range of activities that seek to enhance physical, mental and social well-being and prevent ill-health. It is increasingly referred to as a mechanism for delivering on a health improvement agenda”<sup>22</sup>.*

Health promotion, guided by the principles of the Ottawa Charter for Health Promotion (WHO 1996) offers possibilities to promote Community Work approaches to health inequalities and to address the social and economic determinants of health and well-being and the causes of health inequalities. (For details of the Ottawa Charter, see the section in the Guide on ‘The Policy Context that Supports the Community Work Agenda’, p. 22)

While Community Work principles underpin much health promotion activity, concern exists that within the broader policy context, blame for health choices is too often focused on the individual and not on the broader situation of poverty, inequality and social exclusion.

The National Health Promotion Strategy poses particular challenges. The strategic emphasis in this Strategy is on *“how we as individuals influence our own health”*. The Strategy prioritises particular topics on which health promotion should be focused. Furthermore it suggests a particular emphasis on the monitoring of health promotion activity. These core elements of the Strategy all pose challenges for community health workers in the health promotion field, who want to adopt the social model of health and to address in their work practice the social and economic determinants of health and well-being and the causes of health inequalities. If health status is viewed in single issue terms, then the structural causes of health inequalities are in danger of being ignored.

The Ottawa Charter mandates those engaged in health promotion to work from the social model of health and to engage in action to build healthy public policy which would include legislation, fiscal measures, taxation and organisational change. They are also mandated to strengthen community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. There is a general welcoming of health promotion initiatives and their usefulness in placing emphasis on promoting health gain.

The National Health Promotion Strategy does offer opportunities for effective community based work to address health inequalities. In particular, it clearly offers and defines an important role for community based health workers in addressing structural inequalities and in influencing policy development when it states that *“The challenge for health promotion is to bring about health and social gain in a comprehensive and equitable manner by responding to the evidence presented from social, economic and environmental factors, lifestyle behaviour and illness patterns. This can only be achieved via an inter-sectoral and multi-disciplinary approach”<sup>23</sup>.*



<sup>22</sup> National Health Promotion Strategy 2000-2005 p. 66 Department of Health and Children July 2000

<sup>23</sup> ibid. p.61

## Structural Inequality

refers to the inequality which is structured into and is generated, sustained and reproduced by the dominant institutions and systems that we have established to organise our society e.g. economic system with its free market, the welfare system, the two-tier health system, the education system, representative government, the mass communications systems, and by the influence that these institutions have on peoples attitudes, preferences and prospects.

The persistence of inequalities through the generations is an indictment of the educational system. Education is often presented as a neutral exercise, giving credentials to those who have the greatest ability and work hardest. The question needs to be asked:

*Why is it that children who are bright, with a range of different intelligences, who have great ability and enthusiasm **but** who grow up in impoverished families, in families who have no choice but to live in poor housing or accommodation, who have poor food and diet, who have no choice but to go to under-resourced schools, with their fair share of disruptive pupils, primary schools with the highest pupil-teacher ratio in the OECD, why do they have a minimal chance of escaping via education into better paid employment? Why is it more likely that they will have a life of poverty and insecurity, ill health and poor quality of life not unlike their parents?*

This is in contrast to the children who grow up surrounded by all the comforts that money can buy, who are educated in 'good' schools with low pupil teacher ratios, or increasingly in private schools that are highly subsidised by the public education budget, whose parents can buy additional educational and development opportunities, extra curricular activities, summer schools, grind schools, travel, student exchanges and who can use their contacts, their social networks and know-how to help their children into successful and well-paid careers.

Community Work is an essential methodology for bringing about a more equal, just and sustainable society and for any strategy or programme aimed at achieving these goals to be effective. The Case Studies presented in this Strategy Guide are case studies of Community Work and Community Work as a methodology in addressing health inequalities.



## A Framework for Understanding Inequality

The National Economic and Social Forum (NESF) which brings together the social partners and the state has given us a framework for understanding inequality<sup>24</sup>.

**Inequality is experienced and evident in the:**

- **Economic,**
- **Political,**
- **Socio-cultural,**
- **Human interaction (caring) spheres of human activity.**

The systems and structures within these spheres generate, sustain and reinforce inequality which impact on the health and well-being of communities. Of course what happens in one of these arenas has an impact on others, they are interlinked. Inequality is also generated and reinforced through the connections between and across these arenas.

It is important for Community Workers and Community Activists to develop their analysis of inequality and the causes of inequality in each of these different but interdependent contexts. Community Workers must understand impacts on health and well-being in order to come up with a vision and the strategies for a more equal society, including institutions and systems that will promote equality and greater health and well-being.

Policy actions are necessary in these arenas if health inequalities are to be seriously addressed.

### The Economic Sphere

Economic injustice refers primarily to the unequal distribution of material resources and inequality in their ownership and control.

There are substantive wealth and income disparities and a sizeable number of people living in poverty. Ireland ranked second bottom in its record on poverty in the UN World Development Report 2002 (16th of the 17 industrialised countries). There is little or no attempt to change the structures that enable and generate the inequalities. There is a widening of the gap between the rich and the poor since the 1970s.

For the past decade Ireland has had the fastest growing economy in the EU. Gross Domestic Product<sup>25</sup> (GDP) per head does have a significantly positive correlation with life expectancy, however this relationship works mainly through the impact of GDP on (a) the incomes of the poor, and (b) public expenditure, particularly in health care<sup>26</sup>. Much therefore depends on how economic wealth is distributed and organised. One of the most striking features of the Irish taxation system when compared to other countries is that there is no wealth tax or property tax in Ireland. Ireland has one of the most lenient capital tax regimes in Europe<sup>27</sup>.

24 NESF, A Strategic Policy Framework for Equality Issues Forum Report No 23, 2002. The Equality Studies Centre in UCD has for the past number of years actively contributed to developing a framework for thinking about equality and has contributed substantially to advancing a Strategic Policy Framework for Equality Issues. The Framework has been adopted by the NESF and the Equality Authority amongst others.

25 Gross Domestic Product refers to the total output produced in the Irish economy regardless of the residence of the owners of production. It includes output by foreign-owned producers located in Ireland, but does not include output by Irish-owned producers located abroad.

26 Wilkinson, R.G. Unhealthy Societies: The Afflictions of Inequalities. Routledge, 1996

27 NESF, A Strategic Policy Framework for Equality Issues. Forum Report No 23, 2002

There has been no commitment in the past number of budgets to the introduction of progressive tax policies that could be employed to redistribute the excess wealth of some citizens into programmes that benefit the others. An analysis of taxation policies over 1987-99 reveal that budgets boosted incomes of the richest one third by 18%, but the poorest one-third by only 4%. For the top 20%, incomes rose 19% but for the bottom 20%, incomes declined by 1.2%.

In Ireland, public expenditure is the lowest in Europe. There is evidence that health spending in the private sector in Ireland is above the EU average, while spending in the public sector continues to lag behind the EU average<sup>28</sup>. There is also evidence that unless medical care is targeted appropriately, that it may contribute to widening of differences between socio-economic groups because of a the greater capacity of well off people to obtain medical care. There are many kinds of resources, not just income and wealth, but also family connections, educational credentials, access to health services, environmental conditions.

## Political Sphere

Political inequality occurs when and wherever power is enacted e.g. in decision-making, including policy-making, and in power structures generally. It can take different forms e.g. political exclusion, political marginalisation, political trivialisation or political mis-representation (Baker 1998).

Often people feel that they can vote for those that will govern them but rarely for the policies by which they will be governed. The equal right to vote does not guarantee an equality of influence on political decisions, for the resources we bring to politics, (money contacts, education, time) disproportionately favour certain groups, while the economic and bureaucratic power of non-elected bodies, e.g. private companies, and the civil service, is such that major decisions are made on their terms.

It is assumed that through the party system men can represent all women's needs and interests, that middle class people can represent the interests of working class people, that settled white people can represent the needs, interests and concerns of Travellers and other minority ethnic groups.

Those who are marginalised in our political system are subordinated and highly dependent on services over which they exercise little choice or control, such as housing, health, education, or welfare.

Currently, Health Board directors are political appointees, VEC members are political appointees and it is highly likely that the members of the schools boards of management are the most vociferous, settled and well off parents of the school going children.

The farther you are from the decision-making the less chance you have to have your needs and interests heard and accommodated. *The democratic participation of marginalised groups needs to be strengthened both inside and outside of formal decision-making structures, in a way that is likely to be comfortable to existing power holders. Political equality is about empowering those currently marginalised in terms of political influence* (NESF<sup>29</sup>).

Currently health goes with wealth and the redistribution of income and resources seems to be the best route to redistribution of well-being, even it is not on the political agenda.



Community Work  
approaches to address  
Health Inequalities

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28 OECD Health Data 2000

29 NESF, A Strategic Policy Framework for Equality Issues. Forum Report No 23, 2002

**Community work** is about working with the most marginalised groups, those routinely disparaged, and patronised, subjected to insult and violence. It is about enabling and allowing them to become critical, creative, free, active human beings, allowing and enabling them to engage in collective action so that they can take more control over the direction of their lives, their community and their environment in all its forms.

This is a claim for a political voice so that those currently marginalised can be involved in devising the appropriate policies for change, for their recognition as members of a particular group, political actors in their own right with their own specific concerns, insights and objectives. In this process they do not see themselves or refuse to be treated as a 'problem' for other social groups to resolve. In the process they are enabled to shake off the external perceptions of what they are or ought to be and claim the right to define themselves. This is a profoundly democratic vision. People are seeking a place at the table, a chance to articulate their own, possible different, perspectives and priorities and a guarantee that they too will be acknowledged as equals.

### **Socio-Cultural Sphere**

*Socio-cultural injustices are injustices that are rooted in patterns of representation, interpretation and communication. They take the form of cultural domination, symbolic misrepresentation or non-recognition all which can lead to and result in a lack of respect.*

The core concern here is with the mutual respect and recognition that is due to all members of society independent of their class or socio-economic background, their gender, their age, national or ethnic origin, their skin colour, their sexual orientation, their religious or political beliefs, their family status and responsibility for dependants, their marital status, their physical or mental capabilities.

Inequality of recognition is a failure or refusal to recognise certain sorts of people as our equals and perhaps more commonly, a tendency to view them through disparaging stereotypes or to refuse to recognise the legitimacy of their different way of life. If your identity or your way of life is not recognised as of equal value to that of others, this will be experienced as a form of oppression. It is another kind of inequality in which certain groups of people are treated as of lesser significance than the rest. This has major negative health impacts. The effects accumulate and the longer groups experience marginalisation and exclusion, the less likely they are to enjoy good health in older years.

The manner in which politics, the economy, communications networks and the law are operated and organised are all significant in reinforcing or denying respect and recognition. The right to acquire and enjoy property is considered legally enforceable, but the right to have a roof over one's head in the first place is not, all human rights are not equally regarded and equally enforceable.

The education system is one of the most powerful systems for cultural production, transmission and legitimisation. Yet it is still possible for most children to go through the Irish education system with little or no exposure to the experiences or points of view of Travellers, religious minorities, ethnic minorities or young people with disabilities.

Cultural institutions and systems for cultural production including TV and print media regularly stereotype women, asylum seekers and refugees, Travellers, and minority ethnic groups.

Groups that are ignored, misrepresented, trivialised, or otherwise negatively portrayed in institutions such as the media or education are generally not granted political acceptance in other social contexts. As a result they may be excluded from consultative arrangements, decision-making processes, or other relevant political engagements.

In promoting equality of recognition and respect, the objective is not that these 'different' groups are tolerated, but that difference and diversity is acknowledged and accommodated, and indeed celebrated. This will involve the affirmation and the practical accommodation of difference and diversity in the development of policies, practice and provisions. It also requires that structures, systems and institutions change to allow for, and accommodate the different norms, values, ways of living and needs. In this way real choices are offered that reflect and have relevance to the various groups who currently experience inequality and discrimination.

## Human Interaction

Inequalities arise in the emotional domains of human relations. The importance of love/care/solidarity relations of human life are central to human development. Like economic, political and socio-cultural relations, they relate to human existence and activity over which the State exercises both direct and indirect controls, through constitutional and legislative provisions and policy measures. Although love, care and solidarity relations are sometimes defined as private matters, in policy terms, they are publicly regulated and facilitated and are, therefore, open to policy changes and developments<sup>30</sup>.

Inequalities in this sphere exist when a person is deprived of the emotional nurturance they need to develop and / or maintain intimate, trusting, and solidarity-based human relationships.

The high levels of child poverty in Ireland which have clear implications for children's emotional development and well-being, are echoed by specific instances of neglect and an absence of state services. In 1999, Focus Ireland found that between a third and two-thirds of children leaving care subsequently became homeless.

People on the housing waiting lists, in B&Bs with no fixed abode, wander the streets during the day with little chance of developing proper relations of love, care and solidarity, as individuals, as a family or community.

Those involuntarily institutionalised for reasons of mental illness or because of a disability may also lack opportunities to develop friendships, relationships of intimacy or personal attachment or to develop friendships and bonds of solidarity in the context of their community.

The inequalities in the sphere of love, care and solidarity are well known to older people and disabled people who have to leave friendship ties in their communities because of a lack of appropriate services and accommodation provision within their own geographic community, this is especially the case in rural areas.

A person's social integration into a community can affect their health. Poor social support, marginalisation and isolation can make people more vulnerable to physical and emotional health problems. But high levels of trust, mutual respect, effective collaboration and strong personal support networks within communities can improve people's health and well-being and protect against the effects of poverty and other trauma.

Promoting equality in the spheres of human solidarity and love involves recognising the complex ways and contexts in which deprivations can occur as well as promoting conditions for a quality of life that includes intimacy, solidarity, trust and care.



## The Policy Context supporting the Agenda of Community Work

There is a very strong policy context which supports adapting community work approaches to address health inequalities.

### Acknowledging Health as a Human Right

**The International Covenant on Economic, Social and Cultural Rights**, a legally binding treaty that Ireland has ratified states: *The State Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Art. 12).*

The International Committee which monitors the implementation by State parties<sup>31</sup>, have criticised Ireland for not adopting a human rights framework in the Health Strategy 2001 *Quality and Fairness - A Health System for You* and have recommended that they do so. *Quality and Fairness - A Health System for You* merely acknowledges equity as a principle i.e. that “everyone should have a fair opportunity to attain full health potential and, more pragmatically no-one should be disadvantaged from achieving this potential, if it can be avoided” (p.17). Furthermore the International Committee has been highly critical of the fact that there is still not a common waiting list for treatment in publicly funded hospital services for publicly and privately insured patients. Private patients get preferential treatment in public hospitals and the committee strongly recommended that this be changed.

**The World Health Organisation** states that *Health is a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity ... The enjoyment of the highest standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition ...*

**The Good Friday Agreement 1998** includes a commitment by the Irish Government to take steps to further the protection of human rights within its jurisdiction. The agreement requires that the measures taken in Ireland will ensure at least an equivalent level of protection of human rights North and South.

Health is one of the areas for North/South co-operation under the Good Friday Agreement. Health is defined as a fundamental human right in Northern Ireland. The Health Strategy 2002 for N. Ireland, *Investing for Health* adopts the following values:

- Health is a fundamental human right
- Policies should actively pursue equality of opportunity and promote social inclusion
- Individuals and communities should be involved fully in decision-making on matters relating to health;
- All citizens should have equal rights to health, and fair/equitable access to health services and health information according to their needs.

In addition, the social model of health and the health and well-being of marginalised communities is promoted in Northern Ireland, because there is a Statutory Duty imposed on public authorities (i.e. an imposed legal requirement) to promote equality and an enforceable duty to eliminate discriminatory structures, processes and actions. In carrying out its functions the public authority must have due regard to the need to promote equality of opportunity and is obliged to prepare an Equality Scheme setting out the equality impact assessment, monitoring and consultation procedures with the groups that may be affected.



<sup>31</sup> the states that are legally obliged to enumerate the rights because they have signed and ratified the Covenant

All bodies operating under the Health umbrella must undertake an equality impact assessment of health strategies and resource allocations to ensure that they promote equality and address any discrimination that might currently exist on the basis of religious belief, political opinion, racial group, age, marital status, gender, sexual orientation, disability, responsibility for dependants. The demand of the community sector is for at least the equivalent level of protection of human rights North and South as is required by the Good Friday Agreement.

The Seventh **Conference of European Health Ministers** in Oslo, June 2003 called on the Council of Europe to intensify its work on the social, ethical and human rights dimensions of health care and related services. The Ministers requested the Council of Europe to propose measures aimed at reducing inequalities in access to high quality health care both within and between countries.

WHO and the Council of Europe affirmed their commitment to co-operation and the tools provided by the World Health organisation can help the Council of Europe and its member states to assess how far health policies are consistent with human rights.

### **Acknowledging Social and Economic Health Determinants**

The **World Health Organisation** defines health as “*a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity...*” According to the WHO “*Age, sex, and hereditary characteristics inherited from parents are the basic determinants of health status. These are factors over which individuals have no control. However an analysis of social, economic, environmental and cultural factors that determine health and well-being give us an understanding of the cause of health inequalities*”.

### **Ottawa Charter for Health Promotion (WHO 1996)**

In 1978 the **Declaration of Alma Ata** (outlined in the introduction to the case study on Traveller Primary Health Care Project on p. 62) was an important milestone in the promotion of world health and provided the blueprint for ‘Primary Health Care’ and ‘Health For All by the year 2000’. In 1986, the WHO held its first International Conference on Health Promotion in Ottawa, Canada and produced the **Ottawa Charter for Health Promotion**. The charter builds on the Declaration of Alma Ata and calls for action on five fronts by:

- Building Healthy public policy
- Re-orienting the health services
- Creating supportive environments
- Strengthening Community Action
- Developing personal skills

Guided by the *Charter*, the practice of health promotion aims to develop innovative, practical approaches to promote health and well-being and to address health issues.

The **EU Public Health Programme** was adopted in Dec. 2002 and runs from January 2003 - Dec. 2008. One of the three strands of action of this new Programme is Health Determinants. It will concern itself with tackling determinants of health at EU level and has prioritised *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*. There will be an emphasis on involving stakeholders in the European Health Forum and a key element of the work of the Programme will be the support of initiatives exploring inequalities in health with a focus on reporting experience and best practice and networking.

The **National Health Promotion Strategy 2000-2005** highlights social, economic and environmental factors as the main determinants of health.



**Health Strategy 2001 Quality and Fairness - a Health System for You** puts a focus on health, not just on health services and acknowledges that peoples health is affected by socio-economic, environmental and cultural factors. *“People from the lower socio-economic groups suffer a disproportionate burden of ill health. The equity principle recognises that social, environmental and economic factors including deprivation, education, housing and nutrition affect both an individual’s health status and his or her ability to access services”* (p.18). The Strategy emphasises the non-medical aspects of achieving full health and recognises the formal and informal role of the community in improving and sustaining social well-being in society.

**The National Anti-Poverty Strategy NAPIncl** (July 2001-June 2003) describes the present situation of poverty and social exclusion in Ireland and the main challenges for poverty reduction and social inclusion and presents a national action plan. It facilitates reviews every two years of national anti-poverty policies within the context of the NAPS 1997-2007. In relation to promoting health and well-being, NAPIncl is important as it highlights the past failure and current and future need, to acknowledge poverty as a major health determinant, and poor health as a major cause of poverty. It provides political sanction, as well as a strategic framework for the social model and broader, dynamic and positive definition of health. It provides the context for closer cross-sectoral collaboration around the shared responsibilities for health. Health targets have been established with a view to reducing the gap in health between rich and poor, promoting equity of access to health services and developing new ways of working to address the main factors which link poverty and ill health.

### **Putting Health at the Centre of Public Policy**

As part of the process of strategic management in Government Departments and Offices, each is now obliged to prepare a Strategy Statement covering a three year period. It is an opportunity to consider how the organisation needs to respond in terms of its structures, systems and resources to meet its goals. It also offers the possibility for greater transparency and accountability in the implementation of social policy. According to the Guidelines for Secretaries General and Heads of Office on the Preparation of Strategy Statements<sup>32</sup> *all relevant Departments should incorporate an explicit commitment to sustaining and improving health status in accordance with Objective 1.2 of the National Health Strategy which considered of primary importance that the health of the population is at the centre of public policy.*

One of the strands of the Strategic Management Initiative (SMI) is Quality Customer Service. Equality Diversity is one of the key principles underpinning Quality Customer Service. A support pack on Equality Diversity Aspects of Quality Customer Service for the Civil and Public Service has been prepared by the Equality Authority.

Health Impact Assessment Guidelines are currently being developed on behalf of the Department of Health and Children by the Institute of Public Health. Work on the development of HIA is being undertaken on an all-island basis.

The Implementation of the **EU Strategic Environmental Assessment Directive** provides another way to ensure that health impacts are carefully considered across all sectors. The Directive will require an assessment of certain plans and programmes which are likely to have significant effects on the environment. This will include an assessment of the impacts on human health. The Directive must be implemented by 2004.



## The Right to Participate

**The Alma Ata Declaration 1976** made participation a central feature of Primary Health Care. It stated that people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

**The Harare Declaration of 1987** outlined community involvement in health as a process of direct public involvement in health systems, not only strengthening people's organisations and skills, but also reorienting political and health systems to support such participation.

**The Ottawa Charter for Health Promotion 1986** highlighted the importance of strengthening community action and empowering communities. According to the Charter, health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of the process is the empowerment of communities, and their ownership of their own endeavours and destinies.

**Health Strategy 2001 Quality and Fairness - a Health System for You**, emphasises the non-medical aspects of achieving full health and recognises the formal and informal role of the community in improving and sustaining social well-being in society. The National Health Strategy contains a specific commitment to community participation and states that *"provision will be made for the participation of the community in decisions about the delivery of health and personal services"* (Action 52).

**Community Participation Guidelines** (Health Board Executive 2002). The guidelines can be used by all health service providers to ensure that *"the principle of 'people-centredness' which is at the heart of the strategy becomes an increasingly important feature of how we plan and deliver services"*. The guidelines define the term community participation as *"A process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change"*.

**Primary Care Strategy** (recommendation 19) states that Mechanisms for active community involvement in Primary Care Teams will be established: *"Community participation in primary care will be strengthened by encouraging and facilitating the involvement of local communities and voluntary groups in the planning and delivery of primary care services. Consumer panels will be convened at regular intervals in each Health Board"*.

**Government White Paper 'Supporting Voluntary Activity'** recognises the role of Community Work and Community Work organisations - *"An active Community and Voluntary sector contributes to a democratic pluralist society, provides opportunities for the development of decentralised and participative structures and fosters a climate in which the quality of life can be enhanced for all"*.

**EU National Action Plan against Poverty and Social Exclusion (NAPSInc)** agreed in Nice in 2002 has as one of its objectives *"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"*.

**United Nations Development Programme (UNDP) report Overcoming Poverty 2000** acknowledges that *"The foundation of poverty reduction is self organisation of the poor at the community level - the best antidote to powerlessness, a central source of poverty. Organised, the poor can influence local government and help hold it accountable. They can form coalitions with other social forces and build broader organisations to influence regional and national policy-making. What the poor most need, therefore, are resources to build their organisational capacity"*.

The term 'community participation' can be defined as *'A process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change'*

(Community Participation Guidelines: Health Strategy Implementation Project December 2002, p.3)



Community Work approaches to address Health Inequalities

CWC 2004

## Initiatives to support Community Work Approaches to Addressing Health Inequalities

**The Combat Poverty Agency**, under its Strategic Plan 2002-2004 has developed work to support disadvantaged communities to tackle health inequalities. Following on its consultations, and the findings and recommendations of a Round-table with community sector and local health interests, and recommendations in research paper, the Combat Poverty Agency launched its **Building Healthy Communities Programme** at a national conference in Dublin in May 2003. Designed to support community participation in tackling Poverty and Health Inequalities, it is aimed at groups / organisations from the Community Development / anti-poverty sector especially those who want to work with other health interests. Funding for the Programme in 2003 is €150,000. Thirteen initiatives have been grant aided in 2003 (individual grants to Community Groups was not to exceed € 15,000).

The Building Healthy Communities Programme aims to:

- Promote the practice of Community Development in improving health and well-being outcomes for disadvantaged communities;
- Inform and support policy initiatives relating to poverty and health;
- Explore mechanisms for effective, meaningful and sustainable community participation in decision-making relating to health issues;
- Build the capacity of community health interests to draw out practice and policy lessons.

**Traveller Health - A National Strategy.** Under the National Strategy 2002-2006 it is proposed that *“positive steps will be taken to encourage the active partnership and participation of Travellers and their representative organisations in determining health priorities for their community and in the decision-making that accompanies the allocation of resources”* (Chapter 3). *“Funding will be allocated to Traveller Health Units to be used to resource Traveller groups to participate effectively in the units. For example the funding may be used to employ a Community Worker, engage in capacity building, health training or primary health care training and provide transport and childcare allowances”* (Chapter 6).

**Department of Health Pilot Programme in support of Health Board Community Development and Health Initiatives.** In 2001 funding was allocated for Community Development initiatives to be undertaken over the three year period 2001-2003 by each of the Health Boards in their areas. Health Boards were invited to submit their proposals to the Health Promotion Unit of the Department and monies were allocated accordingly. A variety of projects and initiatives have been supported and include: Initiative focusing on Asylum Seekers (Southern Health Board); Community Health Action Zones (Midland Health Board); Appointment of a Health Promotion Officer to engage in health promotion initiatives with the residents of Fatima Mansions (South Western Area Health Board); Primary Research into the needs of particular population groups (Northern Area Health Board).

Each Health Board is required to undertake an evaluation of the initiative. An interim report on the Projects will be produced and made available by the Department of Health in November 2003.

# Role of Community Work in advancing the health and well-being of marginalised and excluded communities

The key objectives are:

**1. To advance and influence social and economic policy and programme development that both promote equality and address the inequalities that currently exist.** There are commitments to promote equality and also a commitment to put health at the core of development. However to make these commitments real a range of strategies is required to promote health and well-being including:

- **equality mainstreaming** i.e. incorporating equality considerations into all policies, programmes, practices and decision-making, so that an analysis is made of the effects of the policy, the programme, the practice or the decision on those experiencing inequality. The purpose of the mainstreaming is to ensure (a) that appropriate action is taken to redress the inequalities that exist and (b) to ensure that the policy, programme, resource allocation promotes greater equality for marginalised and excluded groups and builds a more equal and healthy society.
- **the adoption of a human rights framework in the National Health Strategy** and a guarantee to every person in its territory without discrimination, the right to the enjoyment of the highest standard of physical and mental health. Ireland is legally obliged under international law to honour this right. It is the right provided for in Article 12 of the International Covenant on Economic, Social and Cultural Rights, which Ireland ratified on 8 December 1989.
- **integrated intersectoral responses to tackle inequality**, to promote a more healthy and equal society, locally, regionally and nationally. This poses a challenge to those who work within the public service in systems that are highly centralised and historically have operated in compartmentalised and hierarchical ways.
- **health proofing and the undertaking of health impact assessments** of policy, social, economic and environmental projects and programmes, and resource allocations. It implies the adoption of responsibility by the Department of Health and Children, health authorities, the health promotion unit and health promotion departments and their officials nationally, regionally and locally to actively promote the health proofing of all policies, resource allocations and programmes beyond the health sector and particularly in sectors dealing with employment, income maintenance and social welfare, education, housing/accommodation, transport;
- **placing a statutory duty on all public and private bodies** to equality proof and health proof all policies, resource allocations, projects, structures and procedures established in the carrying out of their functions.

**2. To ensure that health policy, resource allocation, Primary Care and personal services delivery are equality proofed as a priority**, to ensure that they promote equality and redress the health inequalities that currently exist. Medical care shall be targeted appropriately on the most marginalised and vulnerable communities.

Equality proofing will require:

- an assessment of the impact of the health plan, investment decision, programme or project on groups experiencing inequality
- resourcing the participation of those groups affected by inequality and their organisations so that they can participate effectively in the process
- focusing attention on equality outcomes.

Positive action and specifically targeted policies, programmes and resource allocations will be an essential part of the equality proofing process.



**3. To ensure the active participation and involvement of marginalised groups and their organisations in the decision-making in relation to Primary Health Care**, at national and local levels:

→ in the identification of needs, in the design and development of Primary Care Initiatives in the decision-making about resource allocation and how services are delivered.

→ in the evaluation of health service delivery.

This participation of community groups must be acknowledged as part of the necessary democratisation of the health system and to ensure that the voice of marginalised groups is clearly heard at all levels in the decision making structures and processes.

These objectives need to be advanced and addressed simultaneously. A statutory duty to promote equality could go some way towards addressing health inequalities.



## What is the Role of Community Work at local level?

- 1. By adopting a social model of health**, which acknowledges that health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity and working from the perspective that the enjoyment of the highest standard of health is one of the fundamental rights of every human being without distinction of socio-economic status, gender, age, national origin, ethnicity, race, religion.
- 2. By building the organisation of marginalised groups and communities**, both geographically based communities and communities of interest, and enabling them to identify needs and priorities for action, and supporting them in their acquisition of skills, knowledge and confidence to engage in collective action to influence and impact on decision-making and policy development at local and national level.
- 3. By enabling local communities, local community platforms and equality networks to develop an understanding and analysis of how inequality is generated and sustained in Irish society and how it impacts on health and well-being particularly of the most marginalised communities.**
- 4. By enabling local communities to develop their health agenda and action plan so that they can influence development in relation to:**
  - **Health and well-being** i.e. a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity. This implies
    - ⇒ Acknowledging the human right to such a state of well-being.
    - ⇒ Developing a vision for a more equal and healthy society and a vision and sense of what that would mean at local level e.g. in 5 years within a 10 year timeframe.
    - ⇒ Identifying and defining needs that require to be addressed.
    - ⇒ Defining and agreeing priorities for action.
    - ⇒ Exploring and considering the ways in which the community's priorities for action could be put on the agendas of the relevant agencies and partnership arrangements at local level and defining where the community group could influence policy development. e.g. the Local Development Partnership, the County Development Board (CDB), Social Inclusion Measures Groups (SIMs) and the Strategic Policy Committees (SPCs) of the CDBs.
    - ⇒ Defining and agreeing a programme of action and indicators that could clearly indicate if progress is being made in achieving the immediate objectives within a 6 month and a 1 year period.
    - ⇒ Agreeing a process for reviewing progress in the light of the communities action plan and objectives.
  - **Primary Health Care delivery.** This will involve:
    - ⇒ exploring and identifying the needs of the most marginalised and excluded groups in relation to health and personal service provision at the first point of contact, e.g. GP services, dental services, pharmacy, public health nursing services, physiotherapy, occupational therapy, mental health services, home help services, social work services;
    - ⇒ engaging in an impact assessment of current health service provision;
    - ⇒ exploring and identifying what the marginalised communities would consider appropriate responses, processes and procedures to address their needs and to deliver the highest standard of health care;
    - ⇒ identifying and outlining the communities priorities and agenda for action so that it can be presented through the marginalised groups voice at the planning table.



**5 By attaining the right to participate in the decision-making process** in relation to the development and delivery of Primary Health Care at local level, articulating the experience of excluded and marginalised communities and negotiating and advancing their priorities and agenda for action. This means:

→ Being resourced to identify needs, to develop the communities own health agenda, to develop knowledge, skills and capacity to effectively engage in any partnership process.

→ Asserting the independence and autonomy of the community sector and the right of the marginalised communities to nominate their own representatives and those who will speak on their behalf.

**6 By ensuring that the Primary Health Care planning and delivery is equality proofed at local level.** This implies equality proofing policies, programmes, resource allocations and implementation plans, operational procedures and decision-making structures. It also implies targeting positive action on the most marginalised and excluded communities to redress inequalities that currently exist.

**7 By bringing the communities' health agenda into the social and economic development intersectoral partnership arrangements** e.g. the Local Development Partnership, RAPID, the Social Inclusion Measures (SIMs) Group of the City or County Development Board (CDB) and ensuring that all policies, programmes, resource allocations are health proofed and equality proofed.

**8 By developing links** with the national Community Platform, Public Health Alliance and the Health Linkage Network to build alliances with groups and organisations working to promote equality and address health inequalities; and to develop understanding of collective strategies to advance social and economic development that ensures greater equality outcomes and health gain for marginalised communities.



# CASE STUDIES

CASE STUDIES  
CASE STUDIES



## Introduction

Four detailed case studies are offered in this section to facilitate exchange of experience and ideas, and approaches and methodologies to address health inequalities. They are also presented to stimulate reflection and discussion on the objectives of our own work, and on the perspective that we have/are adopting in our work practices.

The case studies that have been chosen for inclusion in the Strategy Guide reflect different contexts and scenarios and reflect different agendas being pursued to address health inequalities by four different projects. But what the Projects have in common is their commitment to address inequality and social exclusion, the rights based approach and the use of Community Work principles in their interventions for social change.

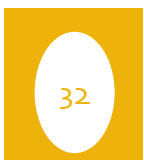
**The South Tyrone Empowerment Project** is a partnership of Community Development groups that was originally established *“To address the absence of a basic framework in which the most marginalised, vulnerable and therefore most excluded groups in the rural region of South Tyrone could develop confidence, social and organisational skills; and access the resources necessary to afford more equitable participation in the formulation, development, decision-making and delivery of projects”*. STEP *“doesn’t do health”*, nor is it involved in the delivery of health services, but its focus on Community Work takes it into the health arena and it supports local community organisations to develop their health agenda. STEP’s health agenda takes it into many partnership arrangements to advocate, pursue and ensure equality outcomes for the most marginalised target groups and communities.

**Women’s Health Action, a project of Cairde.** Cairde is a Community Development project, located in Dublin, and working with ethnic minorities to enable them to address issues which affect their health. The particular piece of work chosen as a case study focuses on how particularly vulnerable and marginalised women have been facilitated to engage in a collective process of personal development, of identifying needs, to develop skills as a group to undertake a research piece, analyse their findings, develop their leadership skills, develop an agenda and action plan and begin to impact on policy at local and national level.

**A Voice for Older People** is a pilot Community Development Project in Donegal, supported by the North Western Health Board. It was established to enhance the capacity of older people to identify and articulate their quality of life needs, to develop a collective voice in relation to these issues and to play a lead role in creating the change necessary in order to achieve equity, social justice and improved quality of life. Older people experience social, economic and cultural exclusion in the area which has an impact on their health. This project is specifically designed to engage older people in an exploration of the nature of social exclusion of older people, ageism, changing social structures and economic and development policies that impact on their lives, and to engage them in articulating and implementing a collective vision for the future, with clear agendas and local action plans for change.

**The Traveller Primary Health Care Project** is now in its tenth year. It is a project of Pavee Point, an NGO committed to the attainment of human rights for Travellers. The Project developed a model of service delivery to one of the most marginalised and excluded groups in Irish society, a model which has been replicated and is promoted in Traveller Health - A National Strategy. The case study explores the history of the project, the principles and approach which have underpinned the Project in its development, consolidation and expansion. It outlines a number of the targeted initiatives that were designed to address needs identified, and the outcomes of the project including its impact on policy development and the challenges which currently face the project.

The contribution of the Projects, their co-ordinators and staff to the presentation of the case studies is warmly acknowledged. The case studies draw on documents, reports and evaluations that have been written and prepared by and for the different Projects as well as conversations and interviews with representatives of the Projects.



# The South Tyrone Empowerment Project

## A Community Development Project with a Health Agenda using Community Work approaches to address health inequalities

### What is STEP?

The South Tyrone Empowerment Project (STEP) is based in grassroots communities and at the same time is actively engaged in attempting to inform and influence policy development and practice at various levels and in various partnership arrangements at regional level.

It is located in the southern part of the western rural region of Northern Ireland, running along the border with the Republic of Ireland. It is a scattered rural community pop 45,500 approx. (1991). The area has one district town (pop 9,500) and several scattered villages. STEP defines the features of the area as peripheral, fragmented, with poor infrastructure, uneven socio-economic development, high population growth, high level of out-migration, high unemployment, high dependency levels, a low level of sustained participatory socio-economic development, low level of self employment. Very high proportion of community segregation (percentage of enumeration districts with 80% + from one section of traditional community) and highest number outside of Belfast/Derry city area of persons per thousand killed/injured/imprisoned in the past thirty years.

STEP was established in 1997 *to address the absence of a basic framework in which the most marginalised, vulnerable and therefore most excluded persons and groups in the community can:*

1. *Develop confidence, social and organisational skills;*
2. *Access the resources necessary to afford more equitable participation in the formulation, development, decision-making and delivery of projects.*

### Why was STEP created?

The stark reality in 1997 was that those in the local community for whose benefit the European Structural Support Programme for Peace and Reconciliation had been devised, had little or no capacity, process or infrastructure through which to relate, or effectively benefit from the programme.

The problems identified in 1997 were:

1. the poor economic infrastructure, the absence of community infrastructure, the lack of access to information, training and expertise which would enable grassroots and marginalised communities to participate in socio-economic development
2. mainstream labour market was unable to keep pace with the growth in the labour supply
3. the background of sectarianism and community mistrust

An innovative integration approach was adopted by a number of diverse community based groups sharing a participatory ethos. They were determined to address the problems they had identified. These stronger local community groups in the district formed a partnership (STEP). These diverse community groups agreed a very clearly defined agenda. STEP was created to provide a supportive conduit to the most marginalised and excluded groups:

- to assist such communities to access, interpret, evaluate and utilise information in identifying their own needs;
- to assist groups and individuals to develop organisational skills and access opportunities and training to address identified needs;
- to develop local capacity to act independently of the district-wide community partnership, and
- to develop a network and infrastructure which would simplify and sustain the interaction between community groups and individuals across the district.



## Working Collectively to Combat Exclusion

The eight partners (diverse community groups) pooled their resources, and created a team of eight workers dedicated to creating an empowerment programme. The intensive nature of the project and the location of the workers in the marginalised communities enabled those most excluded to be actively involved at all points of development. The development was co-ordinated by an overall programme co-ordinator. Each worker had three elements to their role they concentrated on:

- a specific aspect of 'exclusion' e.g. disability, women
- a particular geographic location, and
- developing a specific area of vocational competence.

Each of the partners in the project

- nominated a person to the partnership Board which determined policy and was responsible for the STEP project
- hosted a STEP worker, providing physical space and resource support
- undertook internal monitoring and evaluation responsibilities
- co-operated in the delivery of the project.

The Board met every 4-6 weeks. A sub-committee (management committee) met between meetings and liaised with the co-ordinator. The co-ordinator and eight workers met weekly ensuring an organisational and strategic approach to their work.

Each worker's tasks had three elements:

- district-wide theme based team work, led by the Community Worker specialising in the field e.g. Disability, Youth, Women
- local grassroots Community Work and capacity building and training work in the geographic area in which they were based with the assistance of their 'host'
- accessing information from existing sources within and beyond the district to meet the needs identified

The project has achieved very significant success since its inception in 1997. STEP's commitment to the empowerment of the grassroots communities and to informing and influencing policy development, its commitment to be accountable for the investments by the project, means that emphasis is placed on monitoring and evaluating its work and its impact, and sharing the lessons from its work. Much of their work is documented.

### ***"We don't do health, but Community Development takes us into health"***

STEP first got into health in 1998 when the London-based *'Fit for the Future'* consultation was being undertaken. It was prior to the establishment of the Northern Ireland Assembly and Executive. Consultations were taking place across Northern Ireland. However, STEP's target groups, like the other communities that lived in areas of proposed hospital closures, were not invited to a consultation.

STEP's target groups had a lot to say about their health needs, about health services and about the proposed closure of the hospital. So STEP organised, with the help of the Community Development and Health Network, a consultation in their area. They put particular effort into consulting with young people and people with disabilities. Anxious to take forward the issues that were identified in the consultation, they sought advice from the Belfast Economic Forum about any health initiatives that they could tie into.

STEP discovered that although Health Action Zones (HAZ) were being widely promoted and developed in England, no application for a HAZ was made by any of the Health Boards in Northern Ireland.

### Key elements in the framework that facilitated development within the most marginalised communities

- community partnership of 8 strong groups established to build and support new community groups (geographic communities and communities of interest)
- pooling of resources and expertise to benefit the weaker more marginalised areas
- intense nature of the project
- clear elements in the role of each staff member
- weekly meetings to exchange information and experience and to ensure strategic approach in the work
- an active Board



STEP decided to go for a grassroots needs assessment with a view to finding out what could be done differently and to influence health policy and practice developments. For the purpose of the Project, STEP formed a partnership with the Southern Health and Social Services Board (SHSSB). Nexus Research were contracted to do the needs analysis. The report was published and the SHSSB used elements of the analysis and findings of the report to put in its bid for a HAZ. Community Groups were not eligible to apply for a HAZ.

The SHSSB was successful in its application and STEP then defined its organisational strategy towards HAZ. STEP is represented on the Strategic Alliance Group, the intersectoral group that oversees the HAZ Programme with state agencies that include the Housing Executive, Education, Environment. The STEP Co-ordinator represents the organisation at the second tier (HAZ Support Group) and currently chairs this advisory group that co-ordinates the three priority programmes of the HAZ: Rurality; Housing; and Youth. Staff members represent STEP on each of these three programme groups and the organisation is actively involved in developing seven of the nine initiatives that are being developed under the HAZ umbrella. An evaluation and impact assessment is currently being undertaken on the HAZ by the Institute of Public Health.

### **Helping Communities Develop their Health Agenda**

STEP as part of its capacity building and support to grassroots communities then facilitated five communities to design and develop proposals for Healthy Living Centres funded by the New Opportunities Fund. Again the approach to the development of the centres and the funding proposal was a strategic one and sought to integrate. **The strategy was to support the development of each healthy living centre in a way that would maximise the efficient use of resources and develop each centre in a way that it would compliment, support and reinforce the effectiveness of the work of the other four centres. It collectivised community effort and sought to collectivise community benefit.** The needs in five projects differed: in one the challenge was to meet the needs of a predominantly older population; in another the challenge was to find ways to address male suicide. Each project was designed to address its key needs, and, also to provide its expertise and support at a regional level to each of the other four projects, to pool their staff and resources of a specialist nature for the benefit of all.

### **Developing Local Expertise in Community Work Approaches to Health**

**STEP recognised that many of the people who are key to the development process in local communities are not necessarily those with formal qualifications. Enhancing the skills, knowledge and expertise of grassroots community leaders is a key element in STEP's work to address health inequalities.** Initiatives undertaken include:

- The development of partnership arrangements with the Health Board and others to support grassroots community leaders with the information and skills they need to work within communities on issues such as child protection, drug use, and to use effective Community Work approaches to address health inequalities.
- Training for Trainers in Community Development and Health - a course in Health Awareness and Good Development Practice for local community activists and appropriate STEP staff.
- A pilot study to improve participation in training especially in relation to addressing women's health issues. This programme had a number of very successful outcomes, including the development, extension and delivery of the programme in a number of new areas in South Tyrone; the adaptation of the Community Development and Health Network's Training Course to take on board the lessons and findings of the pilot; the successful negotiation by STEP for accreditation of the course by the NW Institute of Further and Higher Education, many of the trained local community activists are now contracted as tutors by the NW Institute of Further & Higher Education to deliver the course.



## Addressing Inequality in the Mainstreaming Process

Community Work approaches to health and health inequalities were piloted, programmes and courses were designed, developed and implemented. Many were deemed successful and worthwhile and decisions were made to mainstream the work. However, when the Community Development and health work was mainstreamed and the paid jobs were officially created, the community experts, whose expertise and unique experience was acknowledged as being at the core of the successful delivery of such programmes were left outside the mainstreaming process.

At the moment SHSSB Community Development related positions are advertised as requiring a degree or equivalent (Community Work experience is not required). And so those with no expertise in Community Work, or those who have none of the Community Development experience which was deemed so crucial to the success of the pilot programme in the first place, are employed to advance the work developed by local activists often working in a voluntary or unpaid capacity. For STEP it is a clear equality issue.

STEP is engaged in discussions in the Community Development Strategy Panel of the SHSSB to address this inequality. STEP feels very strongly that

- When Community Work approaches to health and health inequalities are deemed successful and worthwhile and a decision is made to mainstream the work, then the person(s), the way of doing the work, and the process of doing the work should also be mainstreamed.
- Community Health workers once employed should be facilitated to acquire professional qualifications as part of their staff development.

## Engaging in Partnerships to Influence Policy Development

STEP's core belief is in its independent strategy. However its health agenda and its commitment to influencing policy and practice engages it in many partnership arrangements with state agencies. The nature and level of involvement varies from one initiative to another. In some cases, a member of STEP staff is directly involved in a partnership arrangement or working group with other sectoral interests. In other cases, STEP is supporting the involvement and self-representation of 'grassroots' community activists in partnership arrangements.

As a result of the strategic and Community Development work of the past number of years, STEP now engages with over 150 community groups. There are now Community Forums across the district that have grown organically as a result of the STEP empowerment strategy.

STEP staff meet fortnightly as a team, this facilitates an organisational and strategic approach to their involvement in influencing policy and to their grassroots work in relation to Community Development and health.

STEP also engages with a number of different cross-sectoral and NGO networks to access and exchange information, for support, to contribute as appropriate, to raise awareness of concerns and issues expressed at grassroots level. Some of the networks work strategically, others do not.

## Supporting the Self-Organisation of Migrant Workers

Currently featuring on STEP's health agenda is the health and well-being of migrant workers, the lack of appropriate responses to their health needs and the need to inform and influence policy and practice in relation to Primary Care and effective and appropriate health service provision.

Many migrant workers have arrived into the area in the past year brought into Northern Ireland by local employment agencies to work in a particular section of the food industry i.e. in the chicken factories and abattoirs in the general area. The agent is the employer of the migrant worker, the location of his /her employment can vary and s/he can be moved without notice from one place of employment to another. Accommodation is provided by the agent and provision is tied into the terms and conditions of employment. The contracting process, and the terms and conditions of migration and employment have a negative impact on the workers health and well-being. The migrant workers are in the main EU citizens, being Portuguese and Portuguese-speaking migrant workers from former Portuguese colonies.

STEP has established a Migrants Rights Centre in Dungannon and uses Community Work approaches in its advocacy work, provision of information on rights and entitlements, support and capacity building initiatives to build the self-organisation of the migrant workers. The Community Work with the migrant workers, supports them to identify and analyse their needs, explore and identify appropriate responses to meeting their identified needs, set their own agenda and an action plan to be advanced, including linking into wider networks that promote equality and social inclusion.

Informing and influencing policy and practice in relation to addressing the health needs of the migrant workers is currently undertaken by STEP staff. The strategy employed by STEP ensures that an opening is created by the co-ordinator to put the health of migrant workers on the agenda of the health sector. The co-ordinator presents an analysis to inform policy makers of the issues, STEP staff then participate in working groups or follow up meetings to ensure that the needs are appropriately and adequately addressed by way of new policy and practice or changes to current policy and practice. The workers hold these negotiating positions until there is sufficient capacity building done to enable the marginalised group to represent its own interests.

The process to date has involved meetings with the health sector and the health professionals and health service providers to:

- Inform them of the experiences of migrant workers and their difficulties in engaging with the health system, in registering with GPs, dentists, in accessing services, in finding out how the Northern Irish health services work.
- Inform and sensitise them to the impact of the employment contract and the working and living conditions on the health and well-being of migrant workers. Many GPs complained that migrant workers are only willing to attend in emergencies and do not keep follow up appointments. Health professionals are unaware of the vulnerability of migrant workers, of their fear of losing a job, of being considered 'not up to the job' should they appear 'sickly' or ask for time off to go to a doctor.
- Make them more aware and conscious of the need to take on board the social model of health and of their obligations as health professionals to give leadership in promoting the health proofing of employment practices.
- Explore ways of appropriately accommodating the needs of migrant workers in the Primary Care area, including the many different practical ways in which services could be offered bi-lingually, particularly regarding the provision of information, when and where health assessments should be undertaken. These meetings have also provided the opportunity to define the flexible arrangements, procedures and practices that would characterise a more responsive health system and meet the needs of minority ethnic groups in an increasingly multi-ethnic and multicultural society.



## Community Development is very good for your health

### ... STEP would like to prove it

The differences in the health and well-being of individuals when they are first met by the project workers and then after a while when they are engaged with others in an empowerment process is very obvious and apparent to those who work in STEP. It is also very obvious to the individuals and groups who participate in Community Development programmes and projects. *“People want to get out of bed in the morning, they feel valued as human beings, they develop confidence, speak for the first time, walk differently, they acquire new skills, knowledge and competencies, develop social networks, they engage wholeheartedly in contributing to change in their own communities”.*

A question regularly posed in STEP is: **Does our organisation have a bigger impact on people’s health through (a) our independent Community Development work, or (b) through the energy we apply and the big investment of time and human resources that is required to work with the SHSSB in its various and vast range of committees, meetings and partnership arrangements?** According to STEP, evidence would suggest that its independent Community Development work is having a much bigger impact on people’s health and well-being than the health promotion campaigns and many of the healthy communities initiatives.

STEP would like to measure the health impact of its work over a period of time and has applied for funding to monitor the health impact of the community development work and to undertake a health impact assessment over a five year period.

Is Community Development good for your health? STEP feels it would be very easy to measure the impact of its work on people’s health and well-being. STEP already gathers data from participants of STEP programmes, it is a requirement of funding. *“We are in a position to invite participants to answer a few more questions, if they wish, in relation to their health status e.g. do they smoke, what would they consider to be their current stress level on a scale of 1-10? Do they self medicate with drugs? How often do they see the GP? If people fitted certain profiles e.g. blood pressure, they might be willing to participate in the monitoring of that category”.*

STEP would then monitor changes in participants health and well-being. Participants themselves would also be monitoring, evaluating and acknowledging these changes.

The application under the *Investing in Health* Programme, for the cost of administering the monitoring system, is currently being considered. *“We have always wanted to know how much we save the health service in terms of visits to the doctor, in medication, in treating illness. Research shows that people with the poorest health have the lowest self esteem, the lowest levels of literacy and educational attainment and are the least active in their own lives. They are also the poorest, it’s a vicious circle”.*

STEP has long acknowledged the links between literacy and health inequalities. All STEP Community Workers have trained as literacy workers, they have an appreciation of literacy and therefore do literacy training.

## Key lessons from the Community Development work to date and the work of STEP in advancing its health agenda

### 1. Community Groups should not rush into health projects.

This is the first lesson that STEP draws from its experience. The Project acknowledges that there has been a shift in the community role and a push to move community organisations into service delivery on behalf of the state - and sometimes cut-price service delivery. ***“There is a need to get back to Community Work and to be very clear about the focus of Community Work and Community Development”***. Community Work is an intervention for social change. It is about empowering the most marginalised, vulnerable and excluded groups and communities so that they can have a say in decisions that impact on their lives. It's about community organisations informing and influencing policy development and promoting social change. That is the business of Community Work. *“In an odd way our job now is to get the community to mind its own business and get back to doing its own job properly”*.

### 2. Community groups should not be encouraged to sit on partnership boards

Community groups should not be encouraged to sit on partnership boards with an array of health professionals when they have little confidence and have no strategy or agenda of their own and when they have little understanding of health strategies. State agencies or the health professionals, may claim to have the community on board, and their plans and proposals can be perceived to be legitimised by the presence and co-option of individuals from the community, but community groups can be easily abused and patronised in these circumstances. When fledgling community groups wonder if they should engage in a partnership STEP believes that there is a need to be honest with groups and say, *“as things currently sit, ‘No’ is a good answer”*. STEP acknowledges that the lack of health service provision is a huge problem for community groups and for marginalised communities. *“But we need to say to the community group ‘It’s neither your responsibility or within your ability to solve the problem. Consider instead what you need to say to others to get the problem sorted, to get those with responsibility to move and focus on the problem?’”*

### 3. Need to be strategic

The role of organisations like STEP is to teach people to be strategic in relation to working for a healthy and more equal society, to work out *‘What they want; Why they want it? How they intend to get it? What might be the difficulties and challenges along the way? How they could meet these challenges and overcome the difficulties as they arise?’* When a community group has worked out what it wants and why it wants it and has worked out all the angles, then the community group is confident, is prepared and has a greater chance of being successful in progressing its objectives.

### 4. Need to understand & appreciate the agenda of funding bodies

It is most important that community groups understand and fully appreciate the agenda of the funding bodies and the state agencies that offer grants to promote community health. *“Community groups need to always ask ‘Do we want that agenda and money? Is there room to negotiate or re-negotiate additional or alternative objectives? Can we really negotiate different terms of reference for the worker, or for the project?’ Too often groups identify their real needs and then distort their needs to get the money. This gives rise to all sorts of tensions and problems”*. The community group should have its own core objectives developed before it engages.



### **5. Need for real consultation**

A presentation of the opinions and views of a Community Worker does not represent a consultation with local communities. Often when Community Workers meet with the state, they are asked for their opinion. Community Workers should not allow themselves to be used as an alternative to a consultation with marginalised communities for their views, most especially when the state is unwilling to resource the participation of marginalised communities in the development process. Community Workers can offer to facilitate a survey of the community views, through focus groups, meetings, and should enquire about and request the resources to do so. The state should acknowledge its responsibility to consult appropriately.

### **6. Achieving Change**

Making change is not dependent on individuals. **A critical mass is necessary to make change in any partnership arrangement.** The right individual in the right place at the right time shortens the process. Real change can only be sustained through hard work and when there are people engaged beyond the partnership structure.

### **7. The State needs to contract Community Work / Community Development expertise**

The Community Work and Community Development expertise within the community sector should be contracted by the state to provide staff development within its departments and agencies. Community groups are often trying to explain Community Development at meetings. There is a responsibility on the state to develop its staff's knowledge and understanding of Community Development. There is a role for the community sector in this staff development process. It needs to be formally invited and engaged to deliver training.

### **For Further Information Contact**

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Co-ordinator

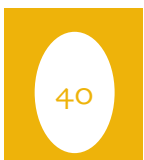
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## KEY ACTIONS

### We don't do health, community work took us into health

- When the project's target groups were excluded from a health consultation, they organised their own
- With a health agenda they then pushed for policy development and the creation of a Health Action Zone

### The Project:

- supported local grassroots communities to develop proposals for Healthy Living Centres
- created training and development opportunities for local people to develop knowledge, skills and competencies so that they could give leadership in the community work process to address health issues and health inequalities
- put women's health issues on agendas
- got accreditation so that local trainers can be contracted as tutors on outreach college courses
- engages in a range of partnership arrangements with the state and in regional health network of statutory and community organisations, to keep the health and well-being of marginalised groups on their agendas; engagement in equality network with community, equality and human rights groups
- advocates on behalf of migrant workers and their health needs while simultaneously supporting the self organisation of migrant workers so that they can represent themselves.

### Elements of Good Practice

- Strategically focused
- Two pronged approach: it is based in grassroots communities and at the same time is actively engaged in attempting to inform and influence policy at a range of different levels and in different arrangements.
- Sees opportunities, creates opportunities, seizes opportunities to put issues on the agenda of stage agencies and development bodies
- Clear in its community work and equality focus
- Solidarity is its starting point
- Works with grassroots communities and targets and empowers the most marginalised communities and groups
- Collectivises community resources, effort and expertise to ensure maximum benefit
- Develops local leadership, local skills and expertise - builds social capital and sustainable communities
- Builds and supports the self organisation of particularly excluded and marginalised groups and advocates at the policy table on their behalf until such groups can represent themselves.
- Works from the perspective of the social model of health, but also challenges structural inequalities in the health service and in health service delivery.



# A Voice for Older People

## A Community Work approach to working with Older People

### Introduction

The Project was established in January 2002 by the North Western Health Board following the successful submission of a proposal by the Community Development worker to the Department of Health and Children's *New Communities* Projects. *A Voice for Older People* is one of **eight pilot** projects focused on innovation in Community Development and Health and financed by the Department of Health and Children for a three year period. The project is being developed and co-ordinated by the community development worker. It has a European dimension with partners in France and Estonia. It is expected that the Project will contribute a model of good practice that will be transferable, and that *A Voice for Older People* will become a strong, independent autonomous network with strategic links, including a strategic link to the Choice Programme<sup>33</sup> of the North Western Health Board.

### The Project Vision

Donegal is a large county, vast in territory, but poor in terms of infrastructure and services to link local communities. Many people are impoverished in both the populated areas and towns. Those who are not well-off are not able to readily access services. The infrastructure and the provision of services is particularly poor in very isolated areas where the population is more scattered. Older people especially experience social, economic and cultural exclusion and marginalisation which has a major impact on their health.

**A Voice for Older People aims to enhance the capacity of older people in Donegal to identify and articulate quality of life needs, to develop a collective voice in relation to these issues and to play a lead role in creating the change necessary in order to achieve equity, social justice and an improved quality of life.**

The Project is placed in the social, cultural and economic reality of older peoples lives in Donegal. It explores the present situation by examining the history and nature of social exclusion of older people, the present forces - ageism, changing social structure, economic and social policies as well as articulating and implementing a collective vision with actions for the future.

### Adopting Community Work principles and a social model of health

#### Acknowledging the Diversity amongst Older People

The Project takes as its premise the heterogeneity of older people and recognises that cohorts or groups of older people who share the same birth year do not necessarily share the same experience of ageing. It also considers that ageing does not occur merely as a consequence of chronology but is shaped by society and social structures and that inequalities of gender, class and ethnicity existing throughout the life cycle do not dissipate in later life but continue to decree access to resources such as income, health and services.

Ageing therefore cannot be considered in isolation as a purely biological process but must also be viewed as an experience, which is socially constructed and therefore needs a holistic and rights based approach to meeting the quality of life and health needs of older people.



<sup>33</sup> The Choice Programme is a Strategy of the North Western Health Board with a full-time Co-ordinator. It has a philosophy of care, giving older people a choice about their care and decisions about their care needs and how the Health Board could respond to their needs.

## Capacity building for social change

**The Project builds from the bottom up** - taking as its starting point the diverse needs of older people living in different settings: at home, in the community, in private nursing homes, in hospital, etc. **It is older people themselves who collectively decide on relevant issues for action.** An essential feature therefore is the emphasis on participation, issue exploration, discussion, analysis and subsequent group development. It encompasses a creative approach to social analysis using drama, creative writing stories, video, role playing. It is from this analysis that ownership, collective thinking and active citizenship is fostered and that the target group - older people - become investors in their own development becoming part of the process of change. **Older people are actively involved in the participatory action planning and either directly and/or indirectly in implementation and evaluation.** Other key elements in the empowerment and social change process are general and specific skill development and the creation of structures and networks that maximise community involvement to ensure greater equality outcomes. **Within and throughout this approach and way of working, the threads of active community participation, partnership, equity and social justice are woven.**

What makes this project different is that it was designed and is being developed to be older people owned and older people led. **A Voice for Older People.**

## Being strategic - a two-pronged approach to affecting social change

The Project acknowledges that to be successful in achieving its objectives, it will require the development of a service sector that is open and willing to listen and willing to act on identified issues. Only then will there be more effective health care and health related policies. The Project therefore adopts a two-pronged approach to effecting social change. The strategy for engaging with the state entails a capacity building programme with the Health Board sector and capacity building with the other statutory and non-statutory agencies and bodies that provide services to older people. Statutory and non-statutory service providers are also encouraged to engage in the intersectoral partnerships and collaborations developed by the project to achieve its aim.

The Project has four key objectives:

- Development of a representative and recognised forum of / for older people in Donegal (with clearly identified roles)
- Development of five local working groups based in identified geographical areas (with clearly identified roles)
- Development of a community based education and development strategy and leadership training strategy for older people. This is key to the sustainability of the Project and to ensure that A Voice of and for Older People is older people led and owned
- Development of a project evaluation framework, which can be used as a research action tool using the principles of Community Development

The following four stages have been identified as core to a Community Development approach and are incorporated into each objective:

- Pre-Development
- Development
- Community Action and
- Evaluation

It is planned that this forum will be the collective voice of / for older people in the county from a local and county level and will become an invaluable two way resource for linking, networking, gathering, inputting, channelling and disseminating information on issues that have been collated from local, county, national and European level.

Elected representatives from this forum will link directly at policy making level to various bodies i.e. Area Partnerships, Vocational Education Committees, County Development Board Community Forum, 'Choice' in North Western Health Board etc.



## Stage 1: Pre-Development Stage

### Establishment of ad-hoc steering group to support the development of the Project

The Community Worker invited a number of people active on older people's issues and the commune workers of each of the three local development partnerships in the county to participate in an Ad-hoc steering group to support the development of the Project.

### Collection of data and the development of a baseline

Work began on the collection of data and information, internationally, nationally and locally, and on the development of a mapping process which would provide a baseline and assessment of where older people live, the different settings in which they live; the agencies providing services; the types of services, the location of the services and an assessment of services that are provided; the gaps in service provision, who is linked in and who is not linked in; how power is defined and where power is located; and where leadership lies at local and county level. This is an ongoing process which is added to at each consultation and with each piece of work that is undertaken at local level.

Interesting discoveries were made. While many perceived that there was little information on the situation of older people in the county, there was very clear data available but it had not been previously accessed or collated by community groups. The Health Board, Public Health Department has all sorts of population statistics, data and information for each District Electoral Division (DED) in its catchment area, e.g. the population of the DED, broken down by age and gender, numbers of lone parents, mortality and morbidity rates, numbers of medical card holders, breakdown of types of housing and accommodation etc. The information is not readily available for a particular housing estate, or a village, or a townland, but if people ask for information for specific DEDs (they will need to know the relevant DED or the DEDs for which they require the information) - all sorts of valuable information is available. Having this information allows groups to see exactly what the population density is in a particular DED, how close that population is to hospitals and other services including transport routes etc. It can be very helpful in developing an analysis of inequalities and inequity in service provision or in access to services. and in campaigning and lobbying for change. The county council also has valuable information with deprivation index. A comprehensive County Profile has been produced by the CDB and a County Atlas is also now available which gives comprehensive information in a range of key areas. The atlas is available for reference in the library, educational institutions, and with community networks in the county.

The mapping exercise facilitated a process engagement with service providers and a process of networking with voluntary service providers and groups working with older people and reinforced an understanding of the need to develop strategic linkages and affiliations with appropriate agencies and groups. It also reinforced the view that to promote a social model of health, the project would need to promote and develop an understanding of the links between health and well-being, social inclusion and development and promote collaborations, with those in education, especially those in the VEC, second chance education, the arts workers, the library service, the county council, the transport sector, social and family affairs, the health board, the Gardaí and the voluntary organisations working with older people - Care of the Aged, Community Alert and the St. Vincent de Paul.

### Dynamic and open-ended consultations - a defining feature of the Project

An important part of this pre-development stage was the initiation of the consultation process, which continued into the development stage. This consultation is key to the energy, ownership and success of this project. Exploration and analysis of issues took place at both local and county levels-at local level at open meetings and with the emerging working groups as well as with representatives and stakeholders at county level and at national level.

### Work of the Pre-Development Stage

Establishing an ad-hoc steering group to support the development of the project;

Commencing the Mapping Exercise, developing the baseline data;

Developing strategic linkages with appropriate agencies

Promoting the social model of health;

Consultation with older people, naming some of the real issues;

Preparing for the development of Local Groups and the County Network;

Capacity building for the development phase.



Community Work  
approaches to address  
Health Inequalities

## Local Consultations.

Local consultations were organised in a series of locations. They were promoted and advertised with a very clear and simple outline of what the consultation was to be about. *What is it like to grow older in this area? What are the issues? How can we move these issues forward?* Members of the ad-hoc group identified and targeted those actively working with older people in the different locations and letters were sent to formally invite them to a half day meeting. The consultations were advertised on local radio, and posters and notices were posted in the Local Day Centres, shops, Post Office, and churches inviting people to come along. Tea, coffee, soup and sandwiches were provided.

The consultations were very well attended by older people and by people connected to the Local Development Partnerships, CDPs, service providers, community arts, voluntary and statutory service providers, and many older people who were not connected to any organisation came to the consultation. Many issues were raised and discussed. After each consultation, people volunteered to form a local working group to help move the project forward. These emerging local working groups documented and analysed all of the issues that were raised in the consultations, this contributed to the development of local profiles and the mapping exercise and also fed into the county mapping process.

At the same time the ad-hoc county group continued with its analysis of issues with stakeholders at local and national level and with the emerging local working groups.

## Designing and Developing the Education and Leadership Development Strategy: Establishment of a Working Group

A working group of relevant partners including the VEC, the Library, Second Chance Education for Women Initiative, Hollywell Trust, the Arts Officer with older women and men was established with a view to advancing the community-based education and leadership development strategy for older people. A Mapping process was begun with regard to resources and provision and information was gathered about other initiatives, nationally and in a European context, that would be of interest to older people.

## Outcomes of the pre-development phase

This process of dynamic and open-ended consultations throughout this stage has enabled real issues to be identified and real trust to be developed; for example sensitive issues such as elder abuse, violence, relationships, loneliness as well as education and training needs, for stories and voices to be heard about poverty and fear *for* in many circumstances the first time. The use of guided facilitation, video, creative writing, group discussions, poems, dance greatly enhanced this process.

The process of animation and capacity building and the building of partnerships was key to this process resulting in the development of one county steering group and five local working groups. For the first time in the county the Gaeltacht areas aligned themselves strategically with non-Gaeltacht areas.



## Stage 2: Development Stage

The second stage of the project is interlinked with the first, however in this phase, at local and county level, a more developmental approach was being adopted to emerging issues from the mapping, the linking and the consultations.

### Development of the Local Groups

In this phase the local groups continued with the mapping exercise, the community profiling and audits; continued their consultations and networking; developed their understanding and analysis of the issues and needs being identified; fed into the development of the county plan for *A Voice for Older People*. They began the process of prioritising the issues and needs identified at local level and that would define the basis of local action plans.

Concurrently ongoing developmental work was undertaken with the local groups. They were facilitated by the project development worker and outside facilitators in sessions that focused on personal development, team building, social analysis, the development of appropriate structures to advance and represent the agenda being developed and representation on the County Network.

**A County-wide Steering Group** was established which includes older people, members of the voluntary, community and statutory sector, as well as organisations / individuals working with older people.

The steering group consists of 70% older people and 30% agencies and defines itself as an umbrella group of groups and individuals working with older people for the development and advancement of issues affecting older people in Donegal. Twelve of the nineteen places on the Steering Group are designated for older people and one place is designated to the organisations of older people. Each of the local groups are represented on the County Steering Group.

The group were facilitated to do a SWOT analysis (Strengths, Weaknesses, Opportunities and Threats) to help it define the potential, the weaknesses, the strengths and the opportunities for advancing older peoples agenda for change, and to help them to develop a good two year strategic plan. As a result of the group doing the SWOT analysis, and much discussion, it identified and agreed four roles for itself. These were to:

1. facilitate the exchange of information, communication and co-ordination between groups in the county.
2. advocate the needs of older people.
3. influence decision makers with respect to the needs of older people.
4. develop new projects as identified by local groups.

The Project worked with a clear Community Work perspective - as needs were identified - skill development was introduced - representation and how to get your message across, negotiation, advocacy, information dissemination etc. Developmental work and training is ongoing - team building, developing a recognised structure with clearly defined roles etc.

### Advancing the Education and Leadership Development Strategy

The group discussed the preparation of a Programme of Work that would be specifically targeted on older people who are not actively engaged in activity at local level. This action would require a two pronged approach: the design of events that would attract and not intimidate such older people; and having the support of others and projects such as the CDPs who could encourage the older people to attend. *'Old Age is a Privilege not Given to Many - Enjoy it'* was designed as the first event that would focus on enhancing the self-esteem of older people, as a celebration of the individual. It was not designed to focus on issues but it was expected that issues would be raised in the process. Twelve two-day workshops were planned to take place in particular areas in Donegal that were specifically identified via the county and local working groups.

### Work in the Development Phase

Deepening analysis and understanding of needs and issues

Capacity building of Local Groups

Establishment of the County Steering Group

Preparing Action Plans

Advancing the Education and Leadership Development Strategy



Community Work approaches to address Health Inequalities

Other actions that were undertaken or begun in this phase included: an exploration of needs within day centres; acquisition of old computers for day centres and active age groups; the development of an Active Age Handbook. Work also began on the development of modules on leadership and advocacy; moving from individual to collective working - needs and actions, celebrating diversity among older people and inter-generational working. These were designed to be part of the capacity building programme for the local and county groups.

A training programme to train older people as facilitators and researchers was designed with the Dept. of Public Health in the North Western Health Board. Unfortunately the training programme had to be curtailed due to budgetary readjustments in the Department, however, two sessions for facilitators have so far taken place.

### **Outcomes of the Development Phase**

Five Local Groups were consolidated in North West Donegal; North Donegal; Inishowen; East Donegal; South West Donegal / South Donegal. They had agendas for action and would meet monthly.

The Steering Group was formally established and work begun on the development of a two year action plan to advance *The Voice of Older People*.

### **Stage 3: Community Action**

This stage involves moving needs into actions, ensuring the active involvement of older people in any developments, in partnership arrangements based on equality, and focused on targeting poverty and social disadvantage, reducing health inequalities, lobbying, influencing policy and making real change.

#### **County Group Action Plan developed**

The county group established four sub-groups to advance a series of actions which it had prioritised under each of its priority action areas heading:

- Facilitating the exchange of information, communication and co-ordination between groups in the County.
- Advocating the needs of older people.
- Influencing decision makers with respect to the needs of older people.
- Developing, in partnership with relevant actors, new projects as needs arise.

Actions that have taken place or are planned include:

- **Linkages and access to decision making.** The County Group are now represented on board of two of the three Local Development Partnerships and within various sub-groupings, on the Community Forums of the County Development Board and on the management group of the Community Development Project. At a national level the group is represented on the Senior Citizens Parliament, Age Action and AGE Platform Brussels
- **Linkages and information dissemination to local level.** The group have disseminated information to local level via the open days, media and working group.
- **A media group has been established** with representation from each of the working groups and county group. A Newsletter is planned and will be launched in 2004. Media training skills incorporating radio, newspaper has been designed and will commence in 2004, this training will be open to interested older people, membership of an existing group is not a pre-requisite for participation in the training.
- **Associated Workshops with relative agencies.** A number of workshops have been organised and have taken place with relevant agencies and the community and voluntary groups e.g. VEC, Day Centres, County Council, Local Development Partnerships.
- **Applications have been made by the Steering Group for funding** to support the development of the work, of particular importance is securing funding to employ older people as co-workers on the project.



### Follow up on the initial Consultations at local level

Two full day events were designed and organised at local level by the Inishowen group and the local group in East Donegal. They were hugely successful and attracted a phenomenal level of participation with 390 people attending the Inishowen event and 320 attending the event in East Donegal. A huge effort was made by the local groups to encourage participation in the event with posters, in churches, post offices, health centres, day centres; visits to nursing homes, day hospital and other residential settings; the use of personal contacts to older people living alone; and promotion of the event on local radio and in newspaper. This ensured that both the work of the local groups and the event were well advertised. For the local groups who organised the events, the turnout and level of participation in the days programme was an affirmation of the effort made to organise a successful and worthwhile event. Keynote speakers addressed the topics that were prioritised by the local group following the initial consultations. There were workshops to further explore the issues raised. There were a series of plenary and workshop style events to meet the objectives of the day including a presentation of *Age Rage*, the drama on ageism designed and developed with two Active Age Groups and performed by older actors, creative workshops on money matters, making a will, on rights and entitlements, on active citizenship, advocacy, health promotion, story telling workshops, and the celebration of older people in music and song. Refreshments were provided and transport was organised by the local development partnerships, with specially designated bus and car pick up points. 26 information stands were exhibited at the Inishowen event.

A questionnaire was circulated at each event to help the local group in its work, to help to further define issues, areas of concern and how and where people would like follow up. Participants were asked to return the completed questionnaires to their local day care centre. The managers of the local day care centres were publicly introduced to the participants and were offered as points of further contact for information and follow up in the interim. There was a 70% return of questionnaires.

Two more full day events will be undertaken by other local groups and will draw on the lessons of the first two days.

### Local Groups current Priorities for Action

Each of the Local Groups has prioritised the key issue(s) identified through the consultation process and the process of engagement with older people to date. Action plans have been developed to advance work in these areas.

- ➔ **Inishowen** has prioritised Social Isolation, Availability of information, Active Citizenship, Celebrating Older People, and is currently following up on big consultative event and preparing a six month action plan.
- ➔ **East Donegal** has prioritised Information, Social Isolation, Elder Abuse, and Celebrating Being Older. Elder abuse was named in the first consultation, it was addressed by one of the key note speakers at the open day. It is a highly sensitive issue for many people and the group are considering exploring a piece of work, perhaps using drama initially to publicly raise and explore the issue. The group is encouraged by the success of **Age Rage** the drama developed with two of the Active Age Groups about ageism. It has been a very powerful tool for raising the issues and defining strategies for action.
- ➔ **The North West Area** Group which takes in Tory Island have prioritised Accommodation and Housing, They are focusing on choices and rights about where you want your long-term care and where you get it. Their concern is with *The Voice of the Voiceless*.
- ➔ **South/South West Donegal** local group has prioritised Housing and Accommodation and they are currently exploring the organisation of a Conference in 2004.



→ **North Donegal** are still in the process of prioritising, however there is a major concern in the group arising from the consultations and their research about the lack of opportunities for personal development, developmental education and opportunities for social interaction for older people in care and in private nursing homes. The big question that is being given attention by the group is *Whose responsibility is it? The Health Board or the Community? How have we created dependency?* These are the issues currently being explored by the group and that may lead to it defining a programme of action.

A huge issue for all of the local groups is the lack of transport and the difficulty that poses for people who want to attend but who are unable to get to meetings. One of the local groups has re-organised itself and its meeting times and locations. Three more localised centres / meeting points have now been defined within the geographic area the monthly meetings of the local group now rotate across the local centres. It has facilitated a greater attendance at meetings. It is expected that the other local groups may follow the example.

**The Community Arts Strategy is currently being developed.** The Arts work has been tremendously important to date from a Community Work perspective. It has helped fuel the enthusiasm, and the enjoyment of engaging with others in the change process. It has a collective focus and has produced collective outcomes. It has been key in facilitating the identification and exploration of issues and in deepening analysis of the issues that need to be addressed. To date community arts workshops have taken place in nursing homes and day centres, there have been a series of dance, music and story telling and creative writing workshops and programmes of events.

*Age Rage* a drama on Ageism - The play has been developed with two Active Age groups and is being used as an educational tool with four schools, fourteen day centres, five Active Age Groups, Women's Groups and the local theatre. It has been performed at all of the local consultations. The drama designed and developed with older people and performed by older actors deals with pertinent issues e.g. health, relationships, anger, isolation, carers, transport, rural degeneration, post offices, family life etc. The drama has been filmed and will continue to be used as a training and awareness raising tool by the Project.

#### **Local projects that have been developed**

- A Cross border project based on a telephone networking service with a telephone link line for older people to combat fear and social isolation
- A Video on 'Using your own Voice' - this has been used as an educational tool and to support effective participation at workshops and conferences
- Information pack on '*Who is doing what where?*' in the local area
- Community Arts Programme covering the county and being implemented in various settings where older people meet or reside
- Development of a drop-in centre in association with a local community platform group
- An access project with the County Council who are tidying up roadways and bushes along pathways and sand dunes making them safe and accessible
- The formation of new Active Age Groups, encouraged and supported and peer led by older people who are currently organised in Active Age Groups
- Active Age Handbook
- Links to the Sports Partnership

#### **Education and Leadership Development Strategy**

A series of 'exploring issues' life long learning education days were undertaken at local level with high attendance - up to fifty at each session. This intersectoral approach is proving to be extremely successful - highlighting and linking issues, and offering and making it possible to develop alternative approaches e.g. the provision of education and training in Day Centres.



Leadership Training Workshops are currently being planned for Local Groups. Five two-day workshops will deal with ageism, pre-development issues, working together and working creatively and will address the specific skills requirements that each of the local groups have defined as a priority.

A training programme is also currently being prepared for the Steering Group. It will involve training sessions with outside facilitators focusing on skills that are required to advance their work plan e.g. working with people, advocacy and lobbying, effective decision-making, negotiating skills, power and power-sharing, project management, funding and sustainability.

The education and leadership development strategy supports the initiatives in drama and community arts, the peer mentoring and the media skills development programme. The participative research training and the training for facilitators is ongoing and is a key element in the education and leadership development strategy (15 more sessions are planned).

A Healthy Ageing Programme is also being planned for 2004 which will emphasise the social model of health. It will be concerned with health determinants and promoting health and well-being.

### **Capacity Building for the Health Board Sector**

A training programme is currently being prepared for health board staff on Community Work with older people. It will be delivered in the autumn of 2003 by the Community Worker and a number of the sessions will be co-chaired by one of the older participants of the Project. The health professionals in the Health Promotion Unit clearly want to work with people in community but they do not know how to do it. They have no experience or training in Community Development and come from very different backgrounds and disciplines. It is important to clearly acknowledge that, and respect where they are coming from. Exploring the meaning of the principles common to health promotion and Community Development e.g. participation, power-sharing and empowerment, health inequalities, intersectoral working, provides a good starting point to help promote good practice. An exploration of who carries and holds power, who decides on the priorities and the agenda for action, what level of participation or power-sharing is on offer can clarify what Community Work means in practice. and colleagues can also be supported to target their work. The modules being prepared deal with these and other issues.

### **Stage 4: Evaluation**

Aims of the project with regard evaluation are to:

- develop an evaluation framework for the project
- develop a model of work that has been tried and tested and that can offer transferability of good practice

Monitoring, reviewing and evaluating progress in advancing the aims, objectives of the *Voice for Older People* is an ongoing process. The experience of the project is being documented. A formal evaluation will be undertaken with the support of the Health Board Health Promotion Unit and by an external independent evaluator. The evaluation model chosen is a combination of a participatory and a critical qualitative approach, which as the process develops, integrates a bottom up / top down approach (*'Community Capacity Initiative'*).

The **bottom-up approach** with a focus on locally defined priorities and perspectives facilitates a process of mutual learning and analysis, which takes place throughout the project, where people are brought into the process as owners of their own knowledge and empowered to take action.

The **top-down approach** acknowledges the need to incorporate the views, perceptions and culture of agencies and the process of change, which will occur in their movement and shift towards power sharing and active involvement of the community in decision making in achieving equity and social justice for older people.

## Findings and lessons to date

A **Voice for Older People** has begun to give a voice to older people, it has encouraged them to identify their real needs and issues, to collectively engage in development opportunities and to engage in a process of social change. Many have seized the development opportunities with gusto. The older people are enthusiastic about the Project, *they don't beat about the bush, they have been around for a while, they know their issues and they are glad to get a chance to become actively involved in changing things and enjoying themselves at the same time.*

The Project has challenged views of ageing, has confronted ageism and has begun to introduce what Community Work with older people is really about and to show what positive things happen when Community Work principles are applied in practice.

The Project has raised the expectation of older people for a better quality of life, and has raised capacity to help make that happen. It has brought new energy into local communities. There has been huge learning and sharing from the process across the local groups in the county and into and through the county group.

Drama and community arts have had a major impact and are a contributory factor to the success of the project to date.

Targeting particularly vulnerable groups needs strong positive action and is done with the support of existing projects with a clear social inclusion and equality focus.

There has been a very noticeable increase in the level of attendance at day care centres, however this is now coupled with a demand and the challenge for more exciting developmental programmes and activities in such locations. In one centre, an Active Age Group was formed and then many of the day care participants left to join in the more interesting Programme of the Active Age Group.

Since the inception of the Project, there is only one full time worker dedicated to its development. There are as yet no resources to employ others, especially older people as co-workers on the project.

### **Working as a Community Worker within an organisation whose systems and personnel are focused on service delivery has presented a number of challenges to date:**

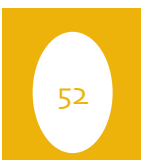
- *“You can get isolated from other Community Development workers in the field because they feel that you have ‘sold out’ by going within the system to work”. There is a belief that Community Work can only be done outside the system.*
- The lack of appreciation of the developmental process in Community Work, the lack of flexibility in the administrative system and reporting arrangements undermine energy and the Community Development process. In the first year of the project there was constant concern and criticism that the budget was not being spent on time, that spending was not on target for the quarter. *“As you see issues being identified and the process unfold you are reluctant to report on what is happening because the action that might be prioritised by the older people may not be that which was specifically named and costed in your original action plan”.* Community Workers need to find allies within the system and work with them, their support is needed and helpful to raise the credibility of Community Work in the early stages.
- The Community Work process has provided a big challenge and a huge learning for the Health Promotion Department. The Health Board provides grants to small local groups under the ‘Community Development’ heading. There was a particular perception of what Community Work is about and probably a view that *A Voice for Older People* would be a relatively insignificant project. *“But the Project had a very different understanding of what participation means and of course power-sharing is another value at the core of the Project’s practice”.* There was no expectation that the Project would mushroom or have such an impact. It has provided huge opportunities for learning for everyone.



- There is a need for Community Development training for health practitioners in the Health Board, especially those in the Health Promotion Department who engage with local communities.
- There is a need for Community Development workers working within a culture and an institution of service delivery to have a place for support, to have a space to discuss the challenges they face, to bounce ideas, to maintain their vision and clarity, so that they can engage effectively as Community Workers in surroundings that are not always supportive. The Community Workers Co-operative needs to continue to provide that space and act as a catalyst for new ideas, analysis and strategies.

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## Elements of Good Practice

Clear strategic focus to the project: vision, approach, values.

Project is placed in the social, economic and cultural reality of older people's lives.

A two pronged approach to affecting change is adopted. The Project

- is designed to be older people owned and led, they engage in the social analysis of needs and issues and in action planning to ensure change
- it acknowledges that change requires a service sector willing to act on identified issues

The stages in the community development process are clearly acknowledged

The importance of a baseline, data collection and assessment of needs and issues are recognised and addressed in the project

Progress indicators are established, there is ongoing evaluation, participatory appraisal and ongoing review of progress.

## Findings and lessons to date

A **Voice for Older People** has begun to give a voice to older people.

It has challenged views of ageing.

It has raised the expectation of older people for a better quality of life, and has raised capacity to help make that happen.

There has been a very noticeable increase in the level of attendance at day care centres but with an expectation of more developmental programmes and activities.

## Challenges for community workers working in the health sector

*"You can get isolated from other community development workers in the field because they feel that you have 'sold out' by going within the system to work".*

The lack of appreciation of the developmental process in community work, the lack of flexibility in the administrative system and reporting arrangements undermine energy and the community development process.

The community work process has provided a big challenge and a huge learning for the Health Promotion Department.

There is a need for community development training for health practitioners.

There is a need for community development workers working within a culture and an institution of service delivery to have a place for support, to maintain their vision and clarity.



## Women's Health Action, Cairde: Minority Ethnic Women Researching and Analysing their Needs

Cairde is a non-government organisation working to reduce health inequalities among ethnic minorities and is committed to supporting the participation of minority communities in enhancing their health. Cairde works within the WHO definition of health which states that "...Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition..."

Cairde currently operates two programmes to achieve its overall aim.

1. **Healthwise Community Impact** is an information and capacity building programme which seeks to build the capacity of ethnic minority communities and organisations to respond to the health needs identified by their communities.
2. **Women's Health Action** is a Community Development programme working with women from ethnic minorities to enable them to address issues which affect their health.

Core components of both Programmes include outreach and liaison with ethnic minorities, capacity building and development work with ethnic minority communities and organisations, advocacy and support to individuals and community organisations, lobbying and policy development. A Resource Centre offers a vast range of supports to the work. The staff team are multi-lingual. Cairde's own literature and information is available in English, Arabic, Russian, and French. Ethnic minority organisations are supported to adapt and translate the resource centre's materials to meet their own communities needs

### What is Women's Health Action?

The aim of Women's Health Action is to enable women from ethnic minorities to address health inequalities.

The objectives set out to achieve this aim are:

- To support women from ethnic minorities to identify their health needs
- To build the capacity of women from ethnic minorities to collectively address their health needs
- To raise awareness of the issues affecting the health of women from ethnic minorities
- To support women from ethnic minorities to influence policies which impact on their health
- To support women from ethnic minorities to build solidarity with other groups experiencing inequality.

### The analysis underpinning the approach adopted by the Project

Women's Health Action is built on the premise that health is an equality issue (equality in terms of outcome/condition) and it adopts Community Work as a tool to enable women to address inequalities in the area of health. Women's Health Action works with a structural analysis of health inequalities and with the understanding that policies, procedures and practices, or lack of, set out by institutions and policy makers cause, contribute to, and/or exacerbate inequalities which impact on health inequalities.

Cairde established an Ethnic Minority Health Forum in the past year to build the collective capacity of ethnic minority organisations. Its membership is open to grassroots ethnic minority organisations and they collectively identify health needs in the networking process. The Forum's successful application for a grant from the Combat Poverty Agency *Building Healthy Communities Programme* will enable it to develop its capacity building programme focused on building the capacity of the membership organisations to participate more effectively in a collective way in the health forum. The Programme includes developing understanding of community development, understanding of health policy and the Irish health system, the determinants of health and the causes of health inequalities in Ireland, policy and lobbying skills.



## The Project is strategically focused on three areas:

### 1. Outreach and Advocacy Work

- Outreach to hostels, churches, community centres, through other organisations
- Drop-in resource centre
- Advocacy and support work in the areas of accommodation, education, welfare rights, immigration, asylum, work permits, health
- Documenting issues, analysing the issues that need to become the cornerstone of policy development

The outreach work provides the first point of contact with ethnic minority women. It also provides opportunities to build trust, identify issues, invite individuals to combine with others to address the needs identified and it provides insights and identification of the needs and issues that need to be addressed in policy formulation.

### 2. Group Development / Capacity Building Work

#### Women's Fora

- Women's Support and Development Group
- Developmental and capacity building work in: Clondalkin; Blanchardstown; Kimmage/Walkinstown/Crumlin/ Drimnagh; Tallaght
- Developmental work with Ethnic Minority Cultural Centres and Projects (Islamic Cultural Centre, Russian Speaking Women's Group Slavianka)

#### Information

- Welfare Rights Sessions and Welfare Rights Fora
- Production of materials on Rights and Entitlements

The development and capacity building work provides the opportunity to identify needs, to make a social analysis of issues, to establish priorities for action and to develop the knowledge, skills and capacity of ethnic minority women to act collectively to address needs identified. It also provides the opportunity for leaders to emerge who will participate in policy development and lobbying, other working groups, networks and fora.

### 3. Lobbying and Policy Development

#### Developing an analysis of Health Inequality

- National Consultative Committee on Racism and Interculturalism - Women's Committee
- Platform Against Racism
- Community Workers Co-operative Health Sub-Group
- National Women's Council of Ireland

#### Building Solidarity and collective action about issues

- Integrating Ireland
- Ethnic Minority Health Forum
- Inner City Organisations Network / North West Inner City Network / RAPID / Dublin City Development Board - Community Forum
- Ireland En Route

#### Influencing policy

- Women's Health Council
- Eastern Regional Health Authority
  - Social Inclusion
  - Ethnic Minorities
  - Women's Health Unit
  - Sexual Health
- Women's Health Advisory Committee
- Dept of Health and Children - Women's Health Policy Unit
- Reception and Integration Agency.

In the initial stage of the project the lobbying and policy development was staff led with women who were engaged in the projects being supported to participate and enhance their skills and confidence in the process.



## **Shifting the Focus of a Health Promotion and Prevention Programme to a Community Work Project focused on Addressing Health Inequalities**

Women's Health Action grew out of a HIV prevention programme. There are two aspects to Women's Health Action's programme. The first focuses in general on the health needs of ethnic minority women per se. The second aspect, the focus of the case study, is the Women's Support and Development Group which is a forum for minority ethnic women living with HIV.

Cairde wanted to bring a Community Work approach to the work of the Programme, to build the capacity of women to identify and analyse their own needs and the needs of other HIV positive women, and to build the confidence and organisational capacity of women to impact on policy development.

### **Identifying an approach to the work**

Work began with the need to look at Community Development responses to the needs of HIV positive women, with a need to make an assessment of what the real issues were for women, and to explore how best to respond to the needs identified.

In discussions with women who were using Cairde services, ethnic minority women identified that they were having difficulty accessing HIV services, were experiencing racism within the Irish hospital system and society, they were having difficulty registering with GPs, they had poor accommodation or had problems finding accommodation. Many were living in poverty. There were a whole range of different issues impacting on their overall lives rather than just HIV.

A review of the research in the UK indicated that given the stigma experienced by Africans, HIV projects per se can experience difficulty, people would just not come to a clearly identified project. Most of the women with whom Cairde had contact would have had direct experience of a relative being isolated or rejected by their communities because of their HIV status. They feared disclosure of their own HIV status.

To appropriately respond to needs, Cairde would have to broaden its perspective. The real challenge in reality was to address health inequalities, women's health and health related issues, one of which might be HIV. All the issues faced by the women were of exclusion and poverty, and issues pertaining to health and health inequalities rather than about one illness.

From the outset therefore, the Women's Support and Development Group was conceived and designed as a Community Work intervention with women from ethnic minorities living with HIV to address their health and health related needs. HIV was a health need of women.

### **The Initial Stage of Forming a Group**

A Women's Health Development worker was employed. Work began with a group of seven to eight African women who had met for a couple of coffee mornings. No women's group existed and no developmental work had been previously undertaken with the women. Each woman was invited to participate in the setting up of a Women's Support and Development Group. It became very apparent that there were huge issues about the stigma of HIV, each of the women was living in terror of being seen by others, of disclosure. An enormous amount of work therefore was required to build trust and in getting to know the women before they would even agree to meet in a group. When the group met, they discussed experiences. They met weekly. There were huge issues about fear, stigma.



### **Personal Development and the many barriers to participation**

After six months of meetings it was decided to organise a personal development course. Concern was expressed by the project director that the group were in effect reinforcing their fears in the discussions. The course ran for twelve weeks but it was necessary to provide an extension to the course, in effect a second six week personal development course, to facilitate women who found it difficult to attend all of the original sessions as organised. A lot of the women were in crisis situations and there was endless disruption in their lives. Women were moving house every six to eight weeks, because they were being evicted. Other women who had been in direct provision and had been told that they could move out, were looking for accommodation and were finding it difficult. External factors had a major impact on women's ability to organise their time.

The level of stigma that the women experienced continuously manifested itself in the early stages of the Programme. All of the women were extremely cautious even of the facilitator of the course. A lot of the personal development programme focused on their own reaction to their own HIV diagnosis which was a barrier to them participating in a lot of other activities. None of the women had ever discussed their positive HIV diagnosis before, they had never shared their experience with any other women, ever.

Many women perceived themselves as inferior and perceived other HIV positive women as inferior, the level of self-stigmatisation was high.

Apart from the fears and stigma felt about HIV, the women's self-esteem was damaged by the amount of time that they spent in their lives managing poverty and crisis. The success in creating a space where seven or eight women were comfortably sitting in a room and laughing and joking, had a very powerful impact. It was a first time experience for many of the women.

### **The different and diverse needs of local Irish women and Minority Ethnic Women**

The discussion in the personal development sessions identified the different and diverse needs of local Irish women and minority ethnic women. An intercultural project for women was initially considered but the experiences of the women and a number of the issues raised in the discussions cast doubts about the appropriateness of such a project in addressing the different and diverse needs between and amongst a very mixed group of women.

A lot of the HIV services in Ireland, especially for women, are particularly targeted at women from particular socio-economic backgrounds with a drug using history. Post diagnosis counselling is generally targeted, the assumption is that you are a drug user. The counsellors based in the community are addiction counsellors. HIV services are all based in drug treatment clinics. HIV Community Welfare Officers are also located in the drug treatment clinics. None of the women participating in the Women's Support and Development Group were drug users. Many of the African women were in monogamous relationships and would have been infected with HIV by their husbands or partners.

Racism was a constant experience for the African women and the level of racism directed at them by many Irish women was experienced as very high. The African women had very clear concerns, preoccupations and priorities focusing around asylum, immigration, family reunification, issues that would not be a priority for Irish women.

### **Identifying the Needs of Minority Ethnic Women**

It was decided to undertake a participative action research project on the needs of HIV positive women from ethnic minorities in Ireland. Much of the research on the needs of HIV positive women in Ireland indicates that HIV is related to drug use, and indicates low levels of education amongst women, poor housing and accommodation, long-term unemployment. These indicators / factors are not automatically applicable to minority ethnic women in Ireland.



### **Skills development in project planning, research and social analysis**

Training objectives and research objectives were established for a Participative Action Research Project that would be undertaken over a six month period. The women trained and they developed research skills. They designed the questionnaires, they did a lot of role play on how to interview people, they piloted the questionnaire, coded the questionnaire, they inputted the data into the database and then analysed the findings. While a wide range of issues and findings arose with the pilot questionnaire, the women acknowledged that further issues would emerge when the research would be undertaken.

To effectively analyse the findings and prepare recommendations that would impact on policy it was proposed and agreed to undertake training in social analysis. Such training would support and enable the women to more effectively develop an analysis of the issues arising and focus the findings from their research. Eight workshops were organised with an external facilitator on different themes, the main themes were power, racism, gender. It was important that the women could make a social analysis of incidents of racism and be able to relate that to a policy context: that they would be able to explore and understand sexism, globally and locally, how it is manifested, how it affects and impacts on women, why and how unequal relationships and partnerships are constructed, developed maintained and sustained.

### **Selecting the interviewees for the Research**

The eight women interviewed 49 women over the six month period of the Participatory Action Research. The women spend a lot of time sitting in waiting rooms. Over the course of a year they may get to know others and eventually they might share information. That is how friendships or contacts between women develop. Some of the interviewees were women known to the participants of the Women's Support and Development Group in these circumstances. Some of these women in turn introduced them to another woman. A number of the women took the risk of opening up to other women previously not known to them. Most of the women interviewed three or four women, one interviewed eight women, they were not allowed to interview each other.

### **The Expected outcomes of the first and second stage of the Project**

That whole process was about building up a women's group to start off with, creating a space for minority ethnic women to explore their needs. It was about developing their capacity: to meet other women and to systematically explore with them their needs and their experiences; to collate and analyse all of the information and data gathered in the research; to prepare a report / strategy document that would document and present the reality of life for HIV positive women who don't fit into the Irish drug using background; and then finally to use that strategy document to develop and outline a plan of action for the next number of years.

By participating in the research process and the social analysis skills training, the women would understand where the findings were coming from, they would own the findings and they would have defined and owned the agenda for action.

The Action Plan will cover the following areas:

- Health Services;
- Accommodation;
- Racism;
- Education and Training;
- Employment and Finance;
- Immigration.
- Safety and Living Environment;
- Spiritual Life;
- Access to Support Services; and
- Childcare.

The first five action areas were identified at the beginning of the project. However during the preparation of the questionnaire the women identified the latter four areas for research questions and as key areas for action.

The Action Plan will outline, under the key headings above, a series of actions and sub-sets of actions that will need to be undertaken by each of the following:

- The Women's Support and Development Group,
- Cairde
- Government Departments.

The main activity of the Women's Group in the future will be to implement that Action Plan, and based on the findings of their own research.

### **Some indications of the types of actions to be undertaken by the Women's Support and Development Group**

The report is currently being prepared, the findings will then be analysed and the Action Plan drawn up. There are some indications of the types of actions that the women will identify for themselves arising from the findings of their research.

In relation to Racism, women feel that there is a lot of mis-information about the needs of asylum seekers, that they are continuously being disparaged by rumours being spread about them being given cars by social welfare, and by press articles suggesting that African women are bringing HIV to Ireland: that all women are infected and are spreading the infection. They feel they can highlight their stories in booklets and use that to inform and make others more aware of the reality of living with HIV in Ireland.

They are concerned about institutional racism. They wish to engage with the Reception and Integration Agency who appear to have a public health agenda which may reinforce peoples prejudice about ethnic minorities and health status so that when people think of health and ethnic minorities they think of malaria, TB and disease control.

They see themselves engaging with service providers and health officials, having meetings with social workers and being able to suggest how HIV clinics can be made more accessible to non-Irish people, meeting with Public Health Nurses, and meeting with Community Welfare Officers about the inappropriateness of providing services in drug treatment clinics.

Another practical project resulting from the findings of their research is the provision of health information. Many women interviewees were not aware that HIV medication is free in Ireland, others were not aware of the benefits of taking treatment: that it reduces the transmission of infection to a partner, or in pregnancy, and that you live longer. The women will prepare an information leaflet, encouraging women to test, advising on the availability and the benefits of treatment and telling their experiences of the benefits of medication to them and what changes taking medication has made to their lives.

The Women's Group are clear about the importance of their own programme of work arising from the research and of the importance of the action plan and the project based work that can be undertaken with the support of Cairde. They also know that they will continue to strategise so that their lobbying work can be effectively undertaken.

The Action Plan is strategically focused. The actions that will be undertaken by the Women's Group will be reinforced by the Actions to be undertaken by Cairde. The issues which it raises will be named and recommendations will be reinforced at all levels. The issues and recommendations will also be presented to practitioners and policy makers in state agencies and departments where they can be supported and pushed from the bottom up and the top down to initiate change and effective policy development.



## Lessons learnt to date at the local/community level

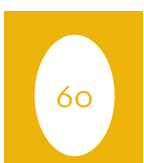
- **Using Community Development as a tool** to enable women to address inequalities, and being committed to working clearly and openly with Community Work principles was key to the success of the project to date.
- **A belief in the women and their ability to move from a situation of powerlessness to one where they could be agents in a change process** was held by staff and facilitators and was the essential element in the process.
- **Keeping an eye on both the process and the task at all stages was crucial** - this was evident through this phase in the process
  - the personal development,
  - the capacity building and formation of the group,
  - the social analysis,
  - the participatory research and
  - the development of an agenda and strategic action plan that the women will take forward over the next few years so that the work can impact on policy and policy development & produce greater health outcomes.
- The extensive capacity building for the women is viewed as a critical factor of the projects success to date. In a lot of ways, the pre-development phase and **doing the personal development course was crucial**. The level of stigma that the women have and do experience should never be underestimated.
- The **social analysis training** allowed and facilitated the women to make more sense of their world and to question and challenge accepted ways of viewing the world, it allowed and facilitated them to develop their critical consciousness in a context of respecting difference and diversity amongst people and cultures.
- The **capacity building** through the personal development course and the social analysis skills training provided the women with the personal skills and the confidence base to undertake the research. Furthermore, it equipped them with the critical and analytical skills necessary to identify, articulate and analyse the issues and problems presented in the research, to define the responses which could most effectively address these needs, and make recommendations that could impact on policy development that would produce better health outcomes.

## Lessons to date at the policy level

- There is a constant problematising of the health needs of ethnic minorities i.e. starting from the perspective that there is a problem.
- There is a predominance of negative stereotypes regarding health care among ethnic minorities, usually focusing on disease control rather than broad health needs. This stereotyping is manifesting itself in direct and indirect discrimination and racism, often within the health system and in Irish society.
- There is a very poor understanding of equality, of the concept of equality, of how inequality is generated and sustained in institutions, or of what a strategy to promote equality might entail.
- Health inequality is not seen an equality issue.
- There is a lack of recognition of Community Work or the legitimacy of Community Work in addressing health inequalities. The medical model of health is dominant.
- There is a lack of data pertaining to the ethnic minorities.

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Community Work  
approaches to address  
Health Inequalities

CWC 2004

## Actions

- Outreach and advocacy work
- Group development and capacity building work
  - ➔ Personal development
  - ➔ Skills development in project planning, research and social analysis
- Agenda setting, action planning
- Lobbying and policy development
  - ➔ Developing an analysis of health inequality
  - ➔ Building solidarity and collective action about issues
- Influencing policy

## Elements of Good Practice

- Clarity of vision, values, approach and methodology. Clear emphasis on community work as a tool to enable women from ethnic minorities to address inequalities in the area of health. Emphasis on both the process and the task of community work.
- Focus on development and capacity building opportunities that enable ethnic minority women to identify needs, make a social analysis of issues, establish priorities for action and act collectively to address needs identified. The process encourages and facilitates leaders to emerge who will participate in policy development and lobbying and networking in other fora.
- Emphasis on documentation and analysis of needs and issues that need to become the cornerstone of policy development. Project works with a structural analysis of health inequalities.
- Starting point is solidarity, and the project further supports women from ethnic minorities to build solidarity with other groups experiencing inequality.
- Strong policy focus.
- Connections and networks within the community sector locally and nationally to deepen analysis, share experience and strengthen the community sector.



# The Traveller Primary Health Care Project

## Using Community Work Approaches within a Model of Health Service Delivery to Marginalised & Disadvantaged Communities

**Pavee Point** is a non-governmental organisation committed to the attainment of human rights for Travellers. Pavee Point has been involved in direct work with Travellers since 1985. Innovation has been a key feature of the work done based on a Community Work approach on an intercultural model and on a Traveller/settled community partnership. The group seeks to combine local action with national resourcing, and direct work with research and policy formation.

### What is Primary Health Care

Primary Health Care has been identified and used as an approach to health care in the developing world. In the past 20 years there has been a growing interest in and a demand for such a service in the developed world as evidence from studies indicate that the expanding marginalised populations here are suffering disproportionately from poor health and have less access to health care services. The concept of Primary Health Care (PHC) was established at the joint WHO/UNICEF conference in Alma-Ata in 1978. It acknowledged the need to reform the conventional health systems. Health was no longer regarded as a matter for health bureaucrats but the concern of society as a whole.

*“Primary Health Care (PHC) is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country’s health system, of which it is a central function and main function and main focus, and of the overall social and economic development of the community.*

*It is the first level of contact of individuals, the family and community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process”.*

(Alma-Ata Declaration 1978)

Primary Health Care is a statement of health philosophy, it is not a package, or a complete defined methodology. It is a flexible system which can be adapted to the health problems, the culture, the way of life and the stage of development reached by the community.

Primary Health Care in communities means enabling individuals and organisations to improve health through informed health care, self help and mutual aid. It means encouraging and supporting local initiatives for health.

Successful primary health care projects have emphasised a process that values empowerment, partnership and advocacy when designing and implementing health care interventions. This allows the partners to highlight inequity and negotiate solutions with their relevant partners. Community participation and inter-sectoral collaboration are key to the success of Primary Health Care.

### Background to the Traveller Primary Health Care Programme

Capacity building and empowerment have been core factors in the early development of the Primary Health Care approach to Traveller health care. In 1992 a group of Traveller women undertook a personal development course in Pavee Point. The course which was supported by FÁS, was designed to introduce and sample skills which would enable Traveller women identify areas for further training with a view to employment possibilities.



The younger women who completed the course were particularly interested in further training in childcare. However, the older women, many of whom had reared large families and were grandmothers, identified health as a priority area that they wanted to tackle. They indicated that they wanted to improve the health status of Travellers, and were interested in developing skills and acquiring information, particularly on the cause and prevention of illness among their community. To facilitate the development of an appropriate response to this request and the serious health needs of Travellers, Primary Health Care was identified as an approach that could be piloted to facilitate Traveller participation in health.

At the completion of the course a proposal for a Health and Childcare Promotion for Traveller Women was submitted to FÁS. The proposal noted that the experiences and skills developed as participants on the New Opportunities for Women (NOW) Programme enabled the Traveller women to identify health and childcare promotion as areas for further skills development and in the long-term for income generating possibilities.

The course was supported and 16 women undertook the course for a 30 week period. Following the course a submission was made to the Eastern Health Board for funding for a Primary Health Care Initiative for Travellers. Funding was not available at the time and FÁS agreed to fund a further 30 week training programme under the NOW Programme.

### **Influencing the Policy Context**

In 1993, the Department of Health began a review of the Health Services with the objective of developing a National Health Strategy which would identify and target certain groups who are known to be disadvantaged in various ways and whose health is shown to be adversely affected. Pavee Point prepared a detailed submission *Towards a Health Strategy for Irish Travellers* and presented it to the Department of Health. The submission was drawn up in consultation with Travellers through a number of workshops and discussions and it was also based on research which set out to identify and document key issues and make recommendations to the proposed strategy. Among the recommendations made was the development of a primary health care service where Travellers themselves are trained as primary health care workers. It noted that a proposal to establish a Traveller Health Promotion Service was under discussion with the Eastern Health Board.

The National Health Strategy report was published in 1994. The commitments that it contained in relation to Travellers health facilitated Pavee Point's preparation and submission of a proposal for a Primary Health Care Project for Travellers to the Eastern Health Board.

### **Rationale for a Travellers Primary Health Care Project**

Travellers require special consideration in health care because:

- They are a distinct minority ethnic with different perceptions of health, disease and care needs
- The Health Status Study 1987, has shown that Travellers have different health and disease problems to settled people. Infectious disease control, accident prevention, ante-natal care and childspacing, genetic counselling, health behaviour and health service utilisation are all priorities that must be addressed. The study also showed that:
  - ➔ Traveller infant mortality rates is three times higher than the national average
  - ➔ Traveller men had a life expectancy of 65 years - 10 years less than that of settled men
  - ➔ Traveller women had a life expectancy of 12 years less than settled women
  - ➔ Travellers have higher death rates from all causes of death among the settled community.

These distinct characteristics imply that innovative approaches to service delivery are required if health conditions are to be improved.



**The Primary Health Care for Travellers Project** was established as a joint partnership initiative with the Eastern Health Board and Pavee Point with technical assistance initially being provided by the Department of Community Health and General Practice, Trinity College Dublin. The project began as a pilot initiative in October 1994 in the Finglas/Dunsink area of Community Care Area 6 and with funding from the Eastern Health Board. It had the following objectives:

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

### **Partnership Model**

The project which was carried out as a partnership between the Travellers, Pavee Point and the Eastern Health Board was the first of its kind in the country. It was acknowledged early as a model of good practice. It facilitated significant consultation between Travellers and service providers, greater information collection and sharing and improved access and utilisation of services. The different strengths and resources of the statutory and the community sector, brought together in a constructive way on an agreed agenda, had more impact than if either operated in isolation.

Each partner brought different skills to the project: Pavee Point provided the channel of communication and established trust with Travellers, an arena for Traveller participation and a Community Development approach to working with Travellers; the Health Board provided the funding, the health knowledge and the health professionals.

### **Co-ordination and management structure**

The partnership model of working was reflected in the co-ordination and management of the project.

A public health nurse was assigned to the project by the health board and a Community Worker by Pavee Point. The range of skills that each brought to the project contributed to its success. A balance between health and Community Development was reflected in the staff backgrounds and was particularly appropriate in the development of the Primary Health Care approach to health issues. The co-ordinators were jointly responsible for the co-ordination and delivery of the project on a day to day basis and they were responsible for convening and resourcing Steering Group meetings.

The project was managed by a Steering Group which included representatives of the Eastern Health Board, Pavee Point, the Project Co-ordinators and two Traveller Community Health Workers one permanent and one rotating. A crucial ingredient for this partnership was the willingness to dialogue, as equals, while respecting each others roles, responsibilities and ethos.

## Outcomes and conclusions at the end of the Pilot Initiative

On a practical level, project reports record that significant progress was made in relation to:

- The capacity of the Traveller women who were employed as CHWs and the development of their skills in relation to health needs assessment; health planning and prioritisation and health promotion work;
- The gathering of information by CHWs on the health status; the causality of the poor health of Traveller families on the seven project sites; on the health service personnel and services used by these families and on disease pattern and uptake of health services.
- The development of an intersectoral collaboration in the co-ordination and management of the Programme.
- A considerable impact was made on Travellers and Traveller organisations around the country about the potential of health initiatives among the Traveller community
- Greater awareness was created among health service practitioners and policy makers about Traveller culture, the specific needs of Travellers and the possibilities regarding service improvements.

In June 1995, the Department of Health published a discussion document *'Developing a Policy for Women's Health'* which acknowledged the impact of poor accommodation on premature mortality and morbidity among Traveller women, and stated that Travellers should be provided with houses for those who wanted them and that serviced sites should be provided for those who wished to retain their traditional way of life. It also stated that Health Boards should ensure that health services are provided to Traveller women and children.

In 1995, the Report of the Task Force on the Travelling Community was published. In the chapter on health, recommendations were made on a range of Traveller specific services. Overall the Task Force recommendations were an affirmation of the PHC project's work and in particular of the contribution it was making to an overall development of Traveller health services.

In the light of positive evaluations the project was continued for four years. Following its implementation report 1996-1999 the Primary Health Care Project moved into a new phase of development and innovation. Now in its tenth year the Project in a dynamic way continues to respond to needs, using Community Work approaches, developing an intercultural model, a partnership approach and combining national action with national resourcing, and direct work with research and policy formation.

### **In 2002, *'Travellers Health - A National Strategy 2002 - 2005'* was launched.**

As recommended by the Task Force in 1995, a National Travellers Health Advisory Committee was established in 1998. This committee is representative of the Department of Health and Children, the regional health boards and the national Traveller organisations. This committee worked on the production of the National Strategy for four years.

*'Travellers Health - A National Strategy'* is highly significant in that it represents a change in national policy towards Travellers. It firstly recognises Travellers as a distinct minority ethnic group in Irish society with a health status far below the majority population and having specific health needs. It also recognises that social exclusion, racism and living conditions have an impact on health status. This report and its recommendations are welcomed by Travellers and Traveller organisations nationally, who participated and contributed significantly to the development of this strategy.

The strategy contains 122 actions which are to be implemented over a four year period, from 2002 to 2005. € 8.3 million has been allocated for the implementation of these proposed actions.



## **The Interventions and Outcomes from the Project include:**

### **1. General:**

- The Project has continued for nearly 10 years. It has expanded to cover the Blanchardstown area and now works with over 250 families in the Finglas and Blanchardstown area.
- Currently there are 14 women and 2 men employed as Community Health Workers (CHWs).
- Training continues on an ongoing basis to ensure a flexible response by CHWs to the communities needs.
- The PHC Project for Travellers model has been recommended by the National Traveller Health Strategy where there is a significant Traveller population. Twenty eight projects are currently replicating the model around the country with support from Pavee Point Health Team. CHWs from the Project have been involved in visiting or receiving other Projects to share experiences and have been part of interviewing process for some projects.

### **2. Research**

- The first Traveller needs assessment survey carried out by the Traveller CHWs, identified the health needs of the Traveller community in Community Care Area 6. The results of the survey and focus group discussions with the Traveller community and service providers resulted in amongst other things, the planning and implementation of culturally appropriate interventions in public health nursing; oral health; nutrition; audiology; environmental health.
- A further survey was carried out seven years later. The new survey allowed a detailed analysis of current and new needs and an impact assessment of the work and the outcomes of the Project over the past five years in addressing the needs identified in the last survey. It also informed the work currently being undertaken by the Project.
- An All-Ireland Traveller Health Needs Assessment and Health Status Study, is currently being designed and will commence in mid 2004. This major North/South initiative is being specifically designed to engage Traveller organisations at all levels of the research and in the data collection. A consultation process regarding the design of the study has been completed with all stakeholders, and the PHC for Travellers Project input was incorporated.
- Research has been undertaken on Traveller women's reproductive health, mental health and the environment where the PHC Project for Travellers were key informants.

### **3. Production of culturally appropriate training materials.**

- Culturally appropriate health education materials are been designed by the Project on an ongoing basis.
- Posters have been produced covering topics such as: Travellers Health Status, breast feeding, care of burns, nutrition and oral health. The posters provide key messages in a culturally appropriate way, they increase visibility of Travellers in education materials. These materials are displayed in surgeries and clinics nation-wide, and are used as training tools by replicating projects.
- Two videos, with accompanying training booklets, have also been produced by the Project: Pavee Beoirs '*Her Reproductive Health*' and Pavee Gailles '*Traveller Children's Health*'. These initiatives developed through training courses organised for CHW training on women's and children's health. The learning was used to produce culturally appropriate videos which were then piloted and seen to be culturally acceptable.

- Given the low literacy levels of adult Travellers, the PHC for Travellers Project, produced an information video on the National Traveller Health Strategy. The aim was to ensure Travellers and local Traveller Groups, but particularly those with literacy problems were informed about the recommendations of National Traveller Health Strategy and how it proposed to improve of Travellers health. The video facilitates an analysis by Travellers themselves as to the issues facing their community and will enable them to collectively campaign for the full implementation of the Health Strategy and its proposed actions.
- Health education sessions are prepared and delivered by the Community Health Workers on site. The regular presence of CHWs on site, has made health information more accessible and culturally appropriate, allows space for discussion and explanation, and addresses the language and culture gaps that exist.

#### 4. Targeted initiatives

- Well-women clinics specifically targeted at Traveller women have been organised. These clinics facilitated access for the first time for Traveller women to breast screening and family planning facilities. These special clinics are supported on an interim basis while Traveller women build up confidence and knowledge of the service. Community Health Care Workers make block bookings for groups of Traveller women and accompany them to the clinic. Many women are now independently accessing the service. The Project continues to lobby for this level of service in the local area.
- The Project liaises with Breast Check to ensure that all Traveller women in the target age group are included in the invitation for screening. Clinics dates are arranged if necessary.
- Traveller men's health is the focus of a number of pilot initiatives in response to the identification and exploration of men's participation in their health care. The recent inclusion of two men training as CHWs means that the Project will be able to take more initiatives around men's health.
- Other targeted initiatives include: Audiology services, dental services, speech and language therapy, child development clinics, where CHWs identify and accompany families, facilitate sessions with health service providers and provide follow up and support.

#### 5. Increasing Awareness of Traveller health needs

- There is much greater awareness about the needs and entitlements of Travellers in the Health Service as well as the difficulties in accessing services that should be available.
- In many Health Board areas Public Health Nurses (PHNs) have been specifically designated to work with Travellers, they are engaged in direct service provision to Travellers of all ages and both sexes including Primary Health Care, and interventions such as advice, nursing diagnosis and referral. In areas where there is a Primary Health Care Project, PHNs are engaged in the delivery of health promotion/prevention services in partnership with the Community Health Worker. Regular co-ordination meetings are held.

#### 6. In-service training

- The provision of in-service training to a range of health professionals aims to encourage health personnel to offer a more culturally appropriate service and work towards an increase in the utilisation of essential services. The training provided by the CHWs, provides a mechanism to challenge racism and discrimination at both individual and institutional level with in the health service, as well as cultural awareness raising. In service training is provided in health environments such as hospitals, and Universities, to a range of service providers (approximately 300 per year) including GPs, physiotherapists, family therapists, medical students, public health nurses and student nurses.
- Each year there are on average 12 student nurses on a one week placements.
- The project also accommodates placements for Community Work students from Maynooth, NUI, on a regular basis.



## 7. Representation

- Presentations have been made at a number of local, regional, national and international conferences by the Project.
- The Project has used its networks and solidarity work with other community sector and equality interests to raise further awareness of Traveller health needs and to disseminate the lessons from the Primary Health Care Project.

## 8. Extension of the model

- The work of the Project has been replicated. There are now 28 Primary Health Care Projects throughout the country, some well established, others are in early stages of development.
- *Traveller Health A National Strategy 2002-2005* outlines Dept. of Health and Children policy and proposed that:
  - ➔ Primary Health Care for Travellers Projects should be developed in conjunction with Traveller organisations in all health board areas where there is a significant Traveller population by 2005. The Department of Health and Children will provide funding to allow for the freeing up of staff and other resources on the part of appropriate organisations in order to implement a suitable strategy for replication of the Projects in relevant areas.
  - ➔ Each Primary Health Care for Travellers Project will have two co-ordinators, a relevant health professional, employed by the Health Board and a Community Health Worker employed by the Traveller organisation.
  - ➔ In developing the Primary Health Care for Travellers Projects there will be an emphasis on flexibility and innovation in order to respond to differing circumstances and differing health needs as identified by Travellers in each area.
  - ➔ The Projects will be periodically evaluated and progress reports made available to the Traveller Health Advisory Committee of the Department of Health and Children
  - ➔ As they are developed the Projects will be used as a resource to train Health Board professionals in anti-racism skills, Traveller culture and good practice in addressing Traveller health needs.
  - ➔ The Department of Health and Children will support an annual conference to share experience and learning of Health Care for Travellers Projects. The first conference, on Traveller Health Units is being planned for 2004.

## 9. Advocacy and Lobbying

- Advocacy and lobbying are core actions of the Primary Health Care Project. In order to lobby for the policy changes needed and to promote the recognition of the special needs of Travellers and their inclusion in all mainstream provision, numerous submissions, policy papers and reports have been prepared by the Project.
- At international level the Project links with Roma Gypsy Groups through the SASTIPEN Network, Council of Europe Roma Rights projects, International Roma Women's Network and Scottish Travellers. The Project is involved in a number of trans-national initiatives, which provide opportunities to work with, share ideas and develop analysis with Roma, Gypsy and Sinti organisations. These initiatives also facilitate the expression of solidarity between groups and provide opportunities to advance equality, inclusion and health agendas at EU level.
- The Project is represented by its *co-ordinators* and Community Health Workers and participates on a range of national and regional advisory committees and working groups:
- At national level there is representation on: the National Health Advisory Committee and its subgroups Traveller Ethic and Research Information Working Group (TERIWIG), the Ethic Working Group, the Ethnic Identifier Working Group, National Traveller Health Status and Needs Assessment Working Group and the Traveller Consanguinity Working Group. It also resources and participates in the National Traveller Health Network.

- At regional level the project is represented on the ERHA Traveller Health Unit and the Eastern Regional Traveller Health Network.
- At local level, there is representation in the recently set up Traveller Area Health Committee in Community Care Area 6.
- Regular seminars, conferences, roundtables and workshops are organised with health service providers and policy makers to highlight the situation of Travellers health and to create a space to discuss challenges and mechanisms to address these issues with a view to increasing equality of outcome for Travellers in relation to their health status.

#### **10. National networking and support to Traveller Health projects nationally**

As a response to a demand for information and support from the PHC project in Pavee Point by the Traveller organisations around the country, a number of steps/supports were put in place.

- Regular workshops/ training days were provided to orientate new co-ordinators.
- The PHC project, responded to requests around the country to make presentations on its history and development to support the establishment of PHC projects in other areas. Health team members have responded to requests to become technical advisers on steering committees for Primary Care projects around the country.
- Due to demand for specific technical support to PHC co-ordinators, and the concern that projects were beginning to replicate the outcomes of the projects and not the process, Pavee Point developed a Primary Care Trainers Training Course for PHC Co-ordinators, based on the experience of the PHC project development and accredited at Post Graduate Certificate level by the Equality Studies Centre in UCD. The course was developed to train co-ordinators to facilitate the replication of the Primary Health Care for Traveller projects nationally. The course was designed in recognition of the fact that the project co-ordinators were from both Community Development and health service backgrounds, therefore a shared analysis needed to be developed. The course participants of the first course were existing or potential co-ordinators of the PHC projects i.e. Community Workers from Traveller organisations, including one Traveller CHW, and public health nurses from the Health Boards from around the country.
- A National Traveller Health Network, which is resourced by the health team in Pavee Point was established for all Traveller organisations, interested in developing a health agenda. Initially there were 20 members, this has increased to approx. 70 members, from Traveller projects all over Ireland as the number of PHC projects and funding opportunities have increased. The network meets about 7 times a year, the Irish Traveller Movement and National Traveller Women's Forum are members of this network and it is used as a mechanism for the national Traveller organisation representatives on the National Traveller Health Advisory Committee (NTHAC) to give feedback on developments at National level and to get information to feed into the national committees.
- Due to the expertise that Pavee Point has developed in health at local, regional and national level, the Department of Health funded the health team in 2003, to assist them with the implementation of the National Traveller Health Strategy. This has allowed Pavee Point to get involved in and facilitate a number of new initiatives. This has resulted in more regional support, a training needs assessment has been completed and a number of training workshops and materials and information were developed to prepare the Traveller organisations for the consultation process for the new National Traveller Health Status and Needs Assessment Study; a video has been made on the National Traveller Health Strategy; participation in the design and training of staff for the 'ethnic identifier pilot project' has also been facilitated.

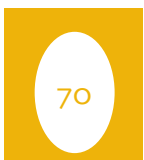


## Outcomes from the perspective of the Traveller Community

- The Project has been highly successful in establishing Primary Health Care service delivery by Travellers to Travellers.
- The Project has won 2 major awards: a WHO award in 1998 for community participation and a Guinness *Living in Dublin* Award 2001 for Community Development.
- In the Community Care Area 6, accredited training for 16 Traveller women as Community Health Workers was provided and the Project demonstrated a successful model of employment for Travellers in health care provisions. The training is a continuous and dynamic process, new competencies, skills and knowledge are acquired as new needs are identified, in an ever evolving policy context and as the Community Health Workers engage in a representational role in regional, national and international committees.
- Networking with Traveller organisations at national and local levels has facilitated the passing on of information and resources on the health issues facing Travellers and has promoted and facilitated the desire for the extension of the Primary Health Care Programme. There is a growing realisation of the potential of health initiatives among the Traveller community.
- The provision of in-service training to a range of health professionals aims to encourage health personnel to offer a more culturally appropriate services, and work towards an increase in the utilisation of essential services. The training provided by the CHWs challenges racism and discrimination at both individual and institutional level.
- Presentations have been made at a number of local, regional, national and international conferences.
- The Project has been replicated and there are now 28 Traveller Primary Health Projects in existence throughout the country and it is recommended as a model of good practice by the National Traveller Health Strategy.
- The process of facilitating community participation in the project has resulted in the empowerment of Travellers and led to them taking more control of their health needs. Attitudes to the health system has changed, through the provision of information, training and resources. This in turn has brought about a change in their ability to access the system. Travellers are making greater demands on the health services and have greater expectations for the health services to be provided in culturally appropriate ways.
- The success and impact of the Project to date has enhanced Traveller confidence and confidence of Traveller organisations in their ability to impact on policy development and in securing better equality outcomes for Travellers. There is pride in the professional service that is being provided by the Community Health Workers, they are role models for other Travellers and the PHC Project provides a vision of what is possible for the next generation of Travellers.

## Community Health Workers

- CHWs are employed by Traveller organisations, this allows them to work in a safe environment, where they can continue to challenge and be challenged and develop their skills in an ongoing way. They are not employed solely to deliver a service, their remit is much broader than that, it is as much about the ability to influence national policy development and the social determinants of their health status as it is about delivering health education messages locally.
- CHWs within projects are given as much opportunity to develop their skills and education as they want, some CHWs have taken subjects at Junior and Leaving Certificate level, some have trained to be literacy tutors, some have got FETAC certification and some have done advanced computer courses. Opportunities also exist for promotion to supervisor, assistant co-ordinator, or co-ordinator posts within the project.
- One of the CHWs participated in the Trainers training course, which allowed her to be accepted for the post-graduate diploma in Equality Studies, which may then lead her to undertaking her Masters.



- Two of the CHWs have been promoted to posts on the National Support Programme within Pavee Point.
- Development opportunities arise and come up in other programmes for those who have trained as CHWs. Two CHWs have moved on to develop a new programme on 'Women and Violence', another moved on to support the development of an initiative on addiction. Others have moved out of the area and brought their experience and expertise with them to other organisations or PHC projects. Another two CHWs now work as crèche workers within the settled community, another is employed as a home help.
- Due to the fact that the project targets women who prefer to work part-time because of child care commitments, it was deemed necessary to facilitate this by allowing women to work at rates of pay, which did not infringe upon their welfare payment and secondary benefits, particularly their medical card which is invaluable. To make the job attractive, and once training is completed, hours of work are decreased in order to maintain a generous hourly rate. The project feels if it tried to give CHWs parity with other health care staff, they would run the risk of losing their secondary benefits and this could not be compensated for. The Project has approached the Department of Social Welfare to seek support for a scheme which would make it more attractive for Travellers to move from welfare to work without loss of secondary benefits.
- As the numbers of qualified CHWs increases in the country, the Project is exploring the possibility of supporting CHWs to establish a professional body to look after their professional interests, development and remuneration.

### **Challenges being addressed by the Project**

Due to the increase in the numbers of members in the National Traveller Health Network, and the demand to support representatives on regional Traveller Health Units (THUs) it has become difficult to effectively discuss and resolve all the current issues arising in the work, particularly with the challenges in implementing the NTHS. Pavee Point are now planning to work with regional Traveller Health Networks and deliver training and support at regional level. National meetings will be held twice yearly. There are some very well established networks like the EARTH in the Eastern region, there is also one in the Western Health Board region.

There is a need for ongoing support and for specific technical support to PHC co-ordinators given the expansion of the work in new locations. However there is an urgent need to ensure a clarity of purpose and clarity in the understanding of the Community Work focus and the Community Work principles that have been fundamental to the success of the work to date. There is a concern that as the number of projects expands, some are beginning to replicate the outcomes of the Project and not the process. The Community Work practice needs to be strengthened and supported.

Ensuring the recognition of CHWs as professional workers poses particular challenges and raises equality issues for the Project. The role of the CHW needs to be fully appreciated. The Project acknowledges that opportunities need to be provided for CHWs to acquire qualifications and credentials, for those who wish to work both on a part-time and a full-time basis, and to allow them to be properly remunerated and with real opportunities to move from welfare to work.

The standardisation of training courses delivered to CHWs nationally and the development of an agreed system of external evaluation and accreditation of that training has also been the focus of attention of the Project for some time. Currently there are discussions taking place between FÁS, Pavee Point and the Department of Health and Children to agree funding the development of 'core curriculum' and accreditation of training for CHWs nationally.



## Lessons from the Project to date

**Much work still needs to be done in terms of improving the health of the Traveller community.** The Primary Health Care Project has made a significant contribution to improving health service delivery to Travellers, but given the nature of the health problems that Travellers face, a variety of responses are needed to the variety of difficulties and problems that Travellers face within and beyond the health service. The Traveller Health Strategy is an acknowledgement of this fact. Traveller organisations and the Community Health Workers are in no doubt however that unless there is a concerted effort to address the social, economic and environmental determinants of Traveller health, real health gain and health outcomes cannot be realised. For Pavee Point, while the Traveller Primary Health Care Project has demonstrated a model of health service delivery to Travellers, it is an integral and an integrated element in its overall work to attain civil, political, economic, social and cultural rights for Travellers.

**The Community Work Approach has been Key to the success of the Primary Health Care Project.** A Community Work approach focuses on social change and social justice for those experiencing social exclusion. Such an approach:

- is based on a set of Community Work principles that involve not only building capacity to participate, but also the development of consciousness, analysis and understanding of the issues to be addressed.
- focuses on how things get done as well as what needs to get done in ways that are empowering for all concerned, particularly the Travellers. It focuses on power sharing.
- works to develop a collective understanding of concerns and issues, to work collectively and above all to achieve collective outcomes for the Traveller community.

The approach and the set of Community Work principles underpinned the design of the Project. The long-lead in the Project was crucial. It allowed sufficient time and resources to enable the women to develop the personal and technical skills (confidence, teamwork, communications and analysis) which are core to the Project implementation. The fact that key elements of the pre-training are the informed insights into Traveller health issues means that Traveller organisations must play a core role in this training.

The principles continue to guide and underpin the research, the analysis, the networking, the advocacy and lobbying work.

The principles were applied to the rules of engagement in the partnership arrangements with the Health Boards and the State Agencies and Government Departments - especially in the expectation and the assertion of the right to dialogue as equals while respecting each others roles, responsibilities and ethos. Mutual respect for the different perspectives represented a core principle of the operation of the Primary Health Care Project.

The Traveller Primary Health care model has been widely identified as a particularly useful one that has now been mainstreamed across all Health Boards. **The ability to lobby nationally has been seen as a crucial factor in this mainstreaming process.**

The Primary Health Care Project model has been an inspiration to other NGOs and organisations working with excluded and marginalised groups, the principles have been taken on board and elements of the Project have been transferred and replicated in other areas and with other target groups. **Replication of the project must be based on the application of the principles, not the outcomes of the project.**



**The role of Community Health Workers needs to be carefully defined in the service delivery model to ensure equality outcomes.** Serious consideration needs to be given by the community groups and organisations who choose to engage in service delivery for the state to: the terms and conditions of employment of Local Community Health Workers, to their career path options, to how their personal and professional development needs will be met.

**For Further Information Contact**

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## Key Actions

- Development of a model of Traveller participation in the promotion of health.
- Establishing a partnership arrangement, based on parity of esteem between the partners
- Targeted initiatives.
- Development of culturally appropriate materials, programme approach and methodology.
- In-service training for those in the management and the delivery of the programme.
- Promotion of Traveller health needs and the social determinants of health.
- Influencing the policy context.
- Research, data collection, publication of reports.
- Lobbying.
- Advocacy.
- Regional, national and international networking. Promotion of the model. Enhancing solidarity with other groups experiencing inequality.
- Regional and national networking and support to Traveller Health Projects

## Elements of Good Practice

- Strategically focused
- Clear community work, equality and human rights perspective underpins all aspects of the work.
- Project developed as a partnership based on clear commitment to dialogue, to equality, and on a mutual respect for the contribution and expertise that each partner would bring to the partnership.
- Travellers define the priorities for their community.
- Social model of health was the perspective adopted from the outset.
- Starting point is solidarity, locally, nationally and internationally
- Focus of the Project is on:
  - ⇒ Equality outcomes for the Traveller community
  - ⇒ Influencing policy
  - ⇒ Building the capacity of others to expand the model and develop appropriate responses in new areas
  - ⇒ Emphasis on research, analysis, evaluation and documentation of the issues which empowers and supports the Projects lobbying and advocacy work.

## Challenges

- Continuing to raise the health status of Travellers
- Ensuring a community work focus in the health projects as they expand in number under the Traveller Health Strategy. Ensuring that they are guided by, and work from a community work, equality and a human rights perspective. Maintaining an emphasis on the process as well as the outcomes of Projects
- Standardisation of training and the core curriculum for CHWs
- Ensuring the recognition of Community Health Workers as professional workers, with career paths, ample opportunities for acquiring qualifications and credentials and remuneration.
- Providing support to the increasing number of members of the National Traveller Health Network, and meeting the demand to support representatives on regional Traveller Health Units in ways that will facilitate an exchange of experience, ideas, and analysis in order to promote good practice and influence and contribute to policy formulation locally, regionally, nationally and internationally.

# Should Community Development Projects be engaged in the delivery of Health Services and Health Projects?

The ultimate goal for Community Development workers, Community Development projects and the community sector, is structural change which results in a more equal and healthy society and the highest standards and quality of health service provision that can be accessed on the basis of need, not on one's ability to pay. It does not mean or imply that a Community Development project or the community sector engages in the provision or the delivery of health services.

The role of the Community Worker and Community Development project does imply however that they:

- build organisation,
- develop an understanding of the relationship between poverty, inequality and social inclusion and provide a context within which local communities can relate and examine their experiences to a structural analysis of poverty, inequality and social exclusion
- enable marginalised communities to explore and identify their health needs and to develop their own health agenda, and facilitate the development of consciousness, analysis and understanding of the issues to be addressed within policy and decision-making arenas,
- strengthen the voice of marginalised groups, and their skills, knowledge and competence to negotiate, to advocate for social change, and to impact on decision-making and on policy development
- ensure that the health of the communities with whom they work is acknowledged as a complete sense of physical, mental and social well-being and not merely the absence of disease or infirmity, and that that health is a resource for everyday life.

**Many community groups are invited and encouraged to engage in health partnership arrangements, to become involved in community based health promotion initiatives, to be seen to be committed to achieving the National Anti-Poverty Strategy (NAPS) health targets.**

It is important to be strategic when making decisions. Experience to date suggests that community groups should be very clear, and should have considered and agreed their objectives and their own agenda before embarking on a health promotion initiative or before becoming involved in the development of a health service project which they have not fully designed, negotiated, or proposed. Community groups can be tempted to engage in initiatives, or to refocus their own practice in order to get their hands on much needed resources.

Good practice would also imply that they should also be very clear and agreed on their own objectives and their own agenda before entering into a formal partnership arrangement to deliver a health service. The community group needs to acknowledge that unless it has formally negotiated and agreed the objectives, methodology and expected outcomes of the partnership project, it is of course committing itself and is obliged to deliver the agenda of the proposed project/partnership.

**The role of Community Health Workers needs to be carefully defined in the service delivery model to ensure equality outcomes.**

Community Health work can be considered low-paid service work and this provides an equality challenge for (a) the workers - in the main women, (b) the organisations engaging in the service delivery, (c) the community to whom the services are delivered and (d) the community sector that advocates for the highest standard of service delivery to already deprived communities.



Inequalities can be generated and reproduced when local community health workers are not respected for the experience and expertise they have acquired, and for their commitment and work in advancing the health and well-being of their communities.

At the same time, inequalities are generated for the workers and their communities, if they are not facilitated as part of their employment to acquire the skills and knowledge and the credentials that would enable and allow them to have equality outcomes from employment opportunities and to provide quality health services to their communities in community based health initiatives.

Serious consideration needs to be given by the community groups and organisations who choose to engage in service delivery for the state to: the terms and conditions of employment of Local Community Health Workers; to their career path options; to how their personal and professional development needs will be met.

**When considering engagement in health service provision or in the implementation of a health project, it may be helpful to pose and answer a number of questions with the local community group or Community Work project. e.g.**

- ➔ Is this what is good for the community and for the people with whom we work? Is investing energies in the project the most appropriate way to achieve our objectives and advance our agenda?
- ➔ Is the initiative guided by Community Work principles, what are the expected equality outcomes for the community and groups? Is this good Community Work practice?
- ➔ How much is the possibility of accessing additional, and much needed resources influencing the decision to get involved? Has the agenda, or the project being proposed already been defined as a priority with the most marginalised and excluded groups locally? Would it be considered a priority strategically for the Community Work practice?
- ➔ If the community group is not clear about the value of the project as proposed and does not have a 100% commitment to the project or partnership arrangement as outlined, is it confident that it can successfully negotiate changes in the focus of the proposed project and /or partnership arrangement? and, that the lead agency is open to its proposal being influenced and changed? What is and how much is negotiable?
- ➔ Will the resources available for the project be sufficient to develop and sustain the initiative and make an impact? Will a shortfall in resources to implement the project mean that existing limited human and financial resources already allocated to the community projects work will need to be re-deployed? Is this really in the interests of the community group or project. Is this the most appropriate way to achieve our objectives and advance our agenda?
- ➔ If local Community Health Workers are to be employed has enough consideration been given to the terms and conditions of their employment? to their career path options? to how their personal and professional development needs will be met?

Some projects having made an assessment of the potential and the expected health outcomes of a proposed initiative have either engaged wholeheartedly or chosen to re-focus their work.

*"We were really keen to incorporate a health agenda in our work locally. We did a needs assessment, we fed back the findings and held a number of workshops in the local community to get agreement on the way forward. We put a proposal to our health board for support to employ a Community Development worker to help the community to develop its health agenda within the social model of health. Needless to say we were very disappointed when the health board would only support the health board's employment of a community health worker, with a clearly pre-defined and narrowly focused health promotion brief.*

*The worker is grand, is very enthusiastic, but has no experience in Community Work approaches or in Community Development. It really limits what is now possible. More serious than that though is the fact that there is no developmental process and we are carrying a worker and an agenda that we never really wanted".*

(Workshop participant, and co-ordinator of a local CDP Project)



### Good Practice implies ...

- Clarity of vision (definition of health and well-being, understanding of the social, economic and environmental determinants of health, a rights based approach to the highest standard and quality health service)
- Analysis of needs, with an underpinning analysis of the causes of poverty, inequality and social exclusion
- A strong policy agenda that is based on identified need, where there is strong ownership and where it is developed independently of the state
- Commitment and ability to advocate and lobby, to negotiate change and engage in policy, decision-making and partnership processes
- Connections and networks between the community sector, locally, regionally and nationally that can link experience, deepen analysis and strengthen the community sector.

### Meaningful partnership arrangements or good working relationships with the statutory sector implies:

- That those mandated by the community group / community sector to represent their interests at the partnership board, are acknowledged for their expertise, skills and experience in the area of social inclusion and equality and the empowerment of the most excluded communities to engage with processes and decision-making that impacts on their lives.
- That the community sector is adequately resourced for its advocacy role, and to enable the sector to develop its own agenda and to strengthen its capacity to advance its own policy positions within the partnership structure.
- There is parity of esteem for the partners.
- The partnership arrangement is transparent in its operational and organisational procedures and practices, that it develops an equality policy, codes of practice and a set of principles that guide and underpin its work and to which its partners are held accountable.
- There is an acknowledgement that partnership is a difficult, complex and challenging relationship because it brings together people and organisations with different backgrounds, different interest and concerns. Agreeing the collective objective can often entail a process of negotiation. Delivering on the collective objective implies a pooling of resources to achieve the agreed collective objective, and a commitment to adopting a collective approach and a collective process, which will lead to a collective outcome.
- All partners in the process should engage in a process to enhance their understanding and appreciation of their role in the partnership process, to develop an appreciation of the culture of partnership, to explore and address issues that may arise in the management and implementation of partnership initiatives, and to enhance skills and understanding that will maximise the potential of the partnership to impact on policy development, locally, regionally and nationally.

*"I feel we got really distracted away from the real health issues - income, facilities for all ages but especially the young people, education, decent and meaningful jobs for women and men in this area, decent housing and quality health services for people in the community when they are ill. There is no point in cutting the Community Development Project funding and then pushing health promotion. It just doesn't make sense"*  
(Health Workshop participant)



## Facilitating Local Communities to develop their Health Agenda - A Checklist

### Promoting the social model of health and enhancing understanding of what determines health and well-being

- ⇒ Is my work to address health inequalities in the community or group with whom I work linked to my Community Work agenda? Am I aware of the health outcomes of the Community Work that I am currently engaged in?
- ⇒ Am I aware of the social, economic, and environmental determinants of health? Do I acknowledge and promote the achievement of health and well-being as a basic human right?
- ⇒ Am I enabling the community with whom I work, to develop its understanding and analysis of how inequality is generated and sustained in Irish society and how inequality impacts on health and well-being, particularly in the most marginalised communities?
- ⇒ Am I promoting discussion on health inequalities in the local Community Platform / Equality Network?
- ⇒ Am I promoting the equality proofing of all health initiatives and the health proofing and equality proofing of all social and economic development plans and resource allocations that impact on the community with whom I work?

### Facilitating the community to develop its health agenda

- ⇒ Am I exploring the social model of health with the community with whom I work and enabling them to
  - develop a vision of what a more equal and healthy community would look like in five years time
  - define the health and well-being needs of the community that require to be addressed
  - define the communities health agenda and agree priorities for action
  - explore where the communities health agenda can be taken to be addressed e.g. the Local Development Partnership, the County or City Development Board (CDB), the Social Inclusion Measures Group (SIMs), the Strategic Policy Committees (SPCs)
- ⇒ If a health initiative is being planned by the health board am I
  - aware of the initiative, its objectives and expected outcomes?
  - ensuring that resources are being allocated to resource the local community to define and analyse its own needs and priorities with regard to any proposed health initiative?
  - ensuring that adequate resources are made available to develop knowledge, skills and capacity of marginalised groups to effectively engage in any partnership process and to resource community participation in the planning, decision-making, management and review of the health initiative?
  - ensuring that any partnership arrangement that engages the community, formally adopts the social model of health, an equality policy, code of practice and agreed principles that will underpin and guide the operation and day to day workings of the partnership and its programmes/initiatives?

### Contributing to policy formulation and policy implementation

- ⇒ Am I promoting equality proofing of all health initiatives and the equality proofing and health proofing of local development initiatives?
- ⇒ Am I ensuring that the findings of any local research and the health agenda of the communities with whom I work are brought and presented to the appropriate agencies and inter-agency partnership arrangements, where they can be discussed and shape appropriate responses to the needs identified?
- ⇒ Am I developing links between the, for example, local Project, Community Platform and the National Community Platform to develop and deepen the understanding and analysis of health inequalities and collective strategies that will ensure greater equality outcomes and health gain for particularly marginalised communities?

# Best Practice Guidelines for Community-based Health Workers and other Health Workers within Statutory Agencies

Communities must be included in decisions that effect their well-being (Lessons drawn from practice to date in projects).

## 1. Part of the problem that communities suffer is that they are excluded from an active and meaningful involvement in influencing decisions that affect their well-being.

Health workers, and those in the statutory sector need to get a commitment from the top of their organisation or agency that they will be supported to actively engage the community in the project or initiative. They need commitment that

- The community will be engaged at all levels in the decision-making structures of the project.
- An individual(s) will be named who has responsibility for leading on the development of the community involvement.
- There will be clarity on the purpose of community involvement, i.e. a collaboration with the intention of tackling health inequalities and promoting equality.
- Health workers and the locally based health care professionals will be mandated to work with local communities agendas around health.

## 2. Adequate Resources

Addressing inequalities must ensure that the voices and the experiences of the most marginalised communities are heard - geographic communities and communities of interest, and that the needs of these communities and their analysis of solutions are central to the process of designing, developing, implementing and monitoring the health care service and new initiatives. Resources must therefore be provided

- To support existing Community Development organisations to develop their own health agenda as part of their core work.
- To support and resource particularly marginalised groups e.g. ethnic minority groups, to identify and articulate their needs, and to build their capacity to engage in decision-making fora to develop responses to the needs identified.
- To support the advocacy role of the Community Development projects and local equality networks and to strengthen their capacity to advance their own policy positions within intersectoral partnership arrangements.
- To enable the participation of particularly marginalised groups will require that participation is enabled childcare, interpretation, transport.
- To build community infrastructure using a Community Work approach which can sustain the work.

## 3. The development of real and meaningful Partnership arrangements demands a long-term commitment.

- Partnerships should develop and outline their own equality policy, codes of practice and set of principles that will underpin the work of the partnership.
- Developing relationships with marginalised communities takes time and trust must be developed.
- Effective community participation comes about through a period of Community Development.



#### **4. The health sector must be mindful of the determinants of health and**

- Promote health proofing of all social and economic and environmental development plans and influence investments in other sectors.
- Promote and support interventions that address health in an integrated way and positive actions targeted on reducing health inequalities.
- Equality proof all health initiatives, Primary Care Initiatives.

#### **5. The health sector is mandated by the WHO Ottawa Charter for Health Promotion**

The National Health Promotion Strategy 2002-2005 is premised on this WHO Charter and sets out the broad policy framework within which action can be carried out by the health sector. While health promotion programmes may be designed locally to promote healthy eating or to encourage people to be more active, it must be remembered that the Ottawa Charter calls for action on five fronts Building Health Policy; Re-orienting the health services; Creating supportive environments; Strengthening Community Action; Developing personal skills. Community - based health workers are therefore mandated and have responsibility to promote action on all five fronts.

#### **6. State Agencies and Department of Health and Children**

State Agencies and Department of Health and Children must be lobbied by the health sector itself, to adopt a human rights framework in health policy and service delivery in line with Ireland's legally binding obligations under the International Covenant on Economic, Social and Cultural Rights, and to ensure that there is an equivalence with regard to health protection and human rights North and South in line with the Good Friday Agreement 1998, another international legally binding agreement signed by the Irish Government.

# Am I Adopting a Community Work Approach within the Health Project?

## A Checklist for health workers whose work is focused on local communities or communities of interest or who are employed in local community settings

### In my work ...

- ⇒ Am I being guided by, and operating out of the set of Community Work principles?
- ⇒ Am I focused on addressing inequality, poverty and social exclusion and promoting equality, human rights and social inclusion?
- ⇒ Am I adopting a collective approach to change as opposed to a focus on the individual?
- ⇒ Is my starting point the local communities' health priorities? Am I working with **their** agenda and facilitating **their** collective action on that agenda?
- ⇒ Am I concerned with issues of power and empowerment and relationships between decision makers and users of services?
- ⇒ Am I advocating that positive outcomes are only possible when structures and decision-making processes are appropriate and are based on equality of participation?
- ⇒ Am I promoting real and meaningful partnership arrangements between the local community and state agencies i.e. partnership arrangements that are based on real dialogue, that facilitate mutual learning and mutual understanding through the sharing of knowledge and expertise of each of the partners in relation to health inequalities and the sharing and discussion of ideas on potential solutions?
- ⇒ Am I supporting participatory research in the community and gathering and collating the evidence presented from social, economic and environmental factors locally, not just lifestyle behaviour and illness patterns so as to ensure health and social gain for particularly marginalised communities?
- ⇒ Am I taking on a leadership role, taking responsibility for promoting integrated approaches in the development of policy and practice within the health service? Am I engaging with others to draw lessons from the implementation of the National Health Promotion Strategy to date, in order to influence the orientation of future health promotion strategies?
- ⇒ Am I actively promoting inter-sectoral and multi-sectoral approaches that focus on the social and economic determinants of health in order to address the causes of health inequalities? or am I stuck and confining myself to my own agency's 'patch' and remaining narrowly focused on the health targets of the agency with whom I work?

## Am I effectively engaged and focused on the development of opportunities for the most marginalised groups and communities to effect change ?

### Am I facilitating ...

- ⇒ their identification and social analysis of health and well-being needs, their identification of health priorities and of the most appropriate responses to promote greater health and well-being appropriate responses?
- ⇒ the development of their self esteem?
- ⇒ the development of consciousness, analysis and understanding of the issues to be addressed so that they can take part in collective action?
- ⇒ the strengthening of their organisational capability in order to enable and facilitate them to influence decision-making in relation to their health and well-being and enable them to impact on local and national policy ?
- ⇒ linking the health work and the communities health agenda into other agendas for social and economic development and for social change at local level. Am I promoting the incorporation of the community's health agenda into the agenda of RAPID, the Local Development Partnership, the Social Inclusion Measures Group (SIMs) and the Strategic Policy Committees of the County Development Board?



# How do we know that Community Involvement is successful

## A checklist for the Statutory Agencies and Local Health Workers

(The checklist was first presented in *Delivering Health in the New NHS: the role of the Public. A Discussion Paper* Community Action on Health, Newcastle Upon Tyne. Autumn 2000. Author Philip Crowley)

The checklist helps assess the relevance of the health project to the local community and outlines success criteria for judging community participation (and the relevance) in the Health Initiative / Project.

### Is there:

- ➔ Evidence of minority group involvement (race<sup>34</sup>, gender, sexuality, disability)<sup>35</sup>
- ➔ Clear working class focus and input (not middle class people speaking for working class community participants)
- ➔ Evolving community leadership, personal development and confidence for community participants
- ➔ Evidence that the communities agendas are being pursued
- ➔ Evidence of community impact on decision-making or on policy
- ➔ Evidence that working in partnership with the community has become the norm across all the local system's way of working (Organisational development)
- ➔ Evidence that it is properly resourced
- ➔ Evidence that there is some shift from the medical model to the social model of health
- ➔ Practice and policy that is to some degree directed at the root causes of ill health not the symptoms
- ➔ That individuals that represent their community are not isolated but are supported to be linked to and be accountable to a wide community network
- ➔ There is clear focus on inequality and redistribution of resources
- ➔ Evidence that discrimination is being highlighted and challenged
- ➔ Successful work should be evidently challenging to the system
- ➔ There should be evidence that the health service and its professionals are being called to account
- ➔ Evidence that links are being created between communities

What is most interesting about the checklist is how easily values, principles and good practice transcend national or local boundaries.



34 We need to also acknowledge difference and diversity in relation to ethnicity, ethnic or national origin, skin colour, membership of the Traveller community, differences in cultural or religious beliefs and practices.

35 Given the equality focus of community development work, older people, and homeless people or their organisations, would also be included in this classification of minority group given the extent of their exclusion from social, economic and cultural life.

# APPENDIXES

## APPENDIXES

### APPENDIXES



# Appendix I

## The National Health Strategy

### **Quality and Fairness - A Health System for You**

A brief overview of the key elements of the National Health Strategy

#### **The National Health Strategy Quality and Fairness - A Health System for You**

- focuses on health, not just on health services
- acknowledges that peoples health is affected by socio-economic, environmental and cultural factors
- emphasises the non-medical aspects of achieving full health and recognises the formal and informal role of the community in improving and sustaining social well-being in society
- views health expenditure as an investment, both for the social value of improved health and well-being but also for its 'direct economic benefits' including lower absenteeism, greater life expectancy thus a longer span of productive working life in the formal economy or care work.

The Strategy is underpinned by four key principles:

- Equity
- People-Centredness
- Quality
- Accountability.

The four goals of the Strategy are

- Better access for everyone
- Fair access
- Responsive and appropriate care delivery
- High performance

However the Concluding Observations of the Committee on Economic, Social and Cultural Rights in May 2002 stated:

*"The Committee notes with regret that a human rights framework encompassing, inter alia, the principles of non-discrimination and equal access to health facilities and services, as outlined in paragraph 54 of the Committee's General Comment No. 14 on the right to health, was not embodied in the recently published National Health Strategy. The committee also regrets the State parties failure to introduce a common waiting list for treatment in publicly funded hospital services for publicly and privately insured persons".*

The Committee recommended in May 2002 that Ireland review the National Health Strategy with a review to embracing a human rights framework in the strategy in line with the principles of non-discrimination and equal access to health facilities and services. The Committee furthermore urged the State to introduce a common waiting list for treatment in publicly funded hospitals for privately and publicly insured patients.

Contrary to the recommendations of the UN Committee on the International Covenant on Economic, Social and Cultural Rights, and in spite of the ongoing demands of the community sector, the government refused to adopt a human rights approach to the Health Strategy.



## **Strengthening Primary Care is one of the six Frameworks for Change outlined in the Health Strategy.**

The Strategy (Chap 5 p.93) defines the function and the role of Primary Care:  
*“It is concerned with developing a properly integrated system, capable of delivering the full range of health and personal social services, appropriate to this setting. Primary care must become the central focus of the health system so that it can help achieve better outcomes and better health status”.*

Ten Pilot Primary Care Projects were approved in October 2002

*“The government is committed within resource constraints, to advancing the implementation of the Strategy Primary Care: A New Direction”*

## **Commitment to Community Participation**

The National Health Strategy contained a specific commitment to community participation and stated that *“provision will be made for the participation of the community in decisions about the delivery of health and personal services”* (Action 52).

**Community Participation Guidelines** were published by the Health Boards Executive in 2002. The guidelines are to be used by all health service providers to ensure that the principle of ‘people-centredness’ which is at the heart of the strategy becomes an increasingly important feature of how services are planned and delivered.

The concept and practice of community participation in the Health Strategy Implementation Project is clearly defined on page 3.

Community participation can be defined as

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

In Section 5 *Framework for Participation*, the guidelines state *“The aim of the health services in Ireland should be to move the level of community participation .. from mere consultation to actual involvement in determining priorities, assessing local needs, and decision-making. Central to this issue is Community Development in relation to health matters, leading to empowerment of communities”* (p.6).

However for the purpose of engagement the term ‘Community’ is clearly focused on the traditional ‘consumer’ model rather than on the model of participation and social partnership that has been at the centre of social policy for the past 15 years and that has supported social inclusion and equality. The proposed framework for social partnership which purports to be based on the people-centredness principle of the Health Strategy seeks to draw upon and be concerned solely with the consumer of market goods, the clients of health services, rather than with a concern with social inclusion and equality i.e. the designation of spaces for women, minority ethnic and anti-poverty and equality groups. It is market driven rather than driven with a concern for social inclusion and a greater democratisation of decision-making at local, regional and national level with regard to health service delivery.



The structures proposed for involvement of the community are:

- **Regional Advisory Panels/Co-ordinating Committee**

Advisory Panels should represent the needs of individuals across the spectrum of care including those enjoying good health, in acute care and continuing care settings. The Advisory Panel should act as a resource to service planners and providers, in shaping and designing services which are appropriate and acceptable to the specific community.

- **Consumer Panels**

Randomly selected Consumer Panels will be convened at regular intervals in each health board area to allow the public to have a say in health matters that concern them locally.

With regard to membership, the guidelines state *“selection should favour advocates not aligned to special interest groups specified in the Strategy, such as children or asylum seekers”, “Health professionals and political representatives should not be debarred but should not be favoured either”*. The guidelines also say that *“efforts should be made to invite participation reflecting geographical, social and age profile of the population”*.

The role and functions envisaged for the Consumer Panels are wide ranging and varied, as advisory to the board, mediatory between board and public and consultative with the public. Possible functions for the consumer panel have been defined as including

- ⇒ participation in board-led service reviews, as guardians of equity and accessibility and
- ⇒ assessing incoming reports and requests from the community and voluntary sector

- **The National Consultative Forum**

This broadly based consultative forum is to be convened annually to consider progress reports on the implementation of the Health Strategy and to comment in the light of progress and emerging trends. There is no indication given as to the desired membership of this forum.



# Appendix II

## Useful Contacts

### **Combat Poverty Agency**

Bridgewater Centre, Conyngham Road, Islandbridge, Dublin 8.  
Tel 01 6706746 / Fax 01 6706760 /  
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### **Community Development and Health Network**

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E-mail [kathymcardle@cdhn.org](mailto:kathymcardle@cdhn.org) / Url [www.cdhn.org](http://www.cdhn.org)

### **Community Platform**

c/o Community Workers Co-operative, 1st Floor, Unit 4, Tuam Road Centre,  
Tuam Road, Galway.  
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E-mail [info@cwcc.ie](mailto:info@cwcc.ie) / Url [www.cwcc.ie](http://www.cwcc.ie)

### **Department of Health and Children**

Hawkins House, Hawkins Street, Dublin 2.  
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### **Equality Authority**

2 Clonmel Street, Dublin 2.  
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E-mail [info@equality.ie](mailto:info@equality.ie) / Url [www.equality.ie](http://www.equality.ie)

### **Health Promotion Unit**

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### **Institute of Public Health**

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## Other Publications of the Community Workers Co-operative

### **Building Sustainable Communities: Community Participation in the RAPID Programme**

This publication outlines the negotiation of the RAPID programme in 1999 through to its current implementation and documents the experience of five local anti-poverty organisations in engaging in the RAPID process since it came on stream.

2003 / €7.00

### **Developing Methodologies and Strategies to Combat Social Exclusion**

Documents the efforts of NGOs and local authorities in four EU member countries to develop local social inclusion strategies and lays down a foundation to further develop this important area.

2001 / €5.00

### **Equalising Outcomes in Education**

Using community development approaches to tackle educational inequality.

2002 €3.00

### **Organising for Change**

A handbook for women participating in local social partnership.

2003 free

### **Strategies for Mainstreaming (Strategy Guide No. 5)**

A series of case studies outlining practical actions taken to mainstream equality.

2000 / €5.00

### **Strategies for Social Partnership (Strategy Guide No. 6)**

Experiences, lessons and insights to guide the development and practice of local & national social partnership.

2001 €5.00

### **Strategies to Address Educational Disadvantage (Strategy Guide No. 4)**

A series of case studies on how best to address educational disadvantage.

1999 / €5.00

### **Strategies to Encourage Tenant Participation (Strategy Guide No. 3)**

A series of case studies outlining strategies and actions used to encourage tenant and resident participation.

1998 / €5.00

### **Violence Against Women - An Issue For Community Work**

Why is violence against women an issue for community work? This publication is intended to act as a practical resource to community groups in developing appropriate responses.

1999 €3.50

### **Wealth, Power, Inequality: challenges for community work in a new era**

Proceedings of a Community Workers' Co-operative Conference in Kilkenny in 2001.

2003 / €7.00

*For a full publications list check out [www.cwc.ie](http://www.cwc.ie) or contact  
the Community Workers Co-operative at 091 779030 / E-mail: [info@cwc.ie](mailto:info@cwc.ie)*



Community Work  
approaches to address  
Health Inequalities

CWC 2004

# Community Work Approaches to address Health Inequalities



This Strategy Guide is being produced by the CWC in order to highlight best practice, and to form a basis of practice guidelines for locally based workers regarding Community Work and health. The production of the Strategy Guide is opportune at a time of developing interest in health inequalities, and at a time when a major restructuring of the health service is beginning to take place in line with the commitments under the National Health Strategy 2001 *Quality and Fairness - a Health System for You*. The Health Strategy puts a focus on health, not just on health services and acknowledges that peoples health is affected by socio-economic, environmental and cultural factors. The Strategy which emphasises the non-medical aspects of achieving full health and recognises the formal and informal role of the community in improving and sustaining social well-being in society, has '*Strengthening Primary Care*' as one of its Frameworks for Change.

Health inequality refers to "*the differences in the prevalence or incidence of health problems between individual people of higher and lower socio economic status*" (World Health Organisation 1998).

Because of the prevailing medical definition of health, Community Workers and Community Development initiatives often do not recognise the health outcomes that arise from Community Work. Community Workers are engaged in work that both promotes and produces good health, though they might not have a clearly defined health agenda. They work with the most marginalised groups and communities, they work to empower and enable them to identify needs and to develop confidence, knowledge and skills to work collectively to bring about change in the central conditions of their lives. Their work is focused on building healthy communities free from poverty, exclusion and discrimination. It is focused on ensuring that marginalised groups are enabled to move from an experience of powerlessness to a sense of well-being and a realisation of their potential, and the realisation of their right to enjoy and fully benefit from the fruits of social and economic development.

This Strategy Guide is produced specifically to generate an analysis of Community Work approaches to health inequalities at local level, to share experiences of work to date through the presentation of case studies of Community Work approaches to addressing health inequalities. The Strategy Guide is also intended to help develop a focus on influencing policy with a view to achieving more healthy communities. Four case studies have been chosen for inclusion in the Guide. These detailed case studies reflect the core elements of best practice from a range of different perspectives.

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