RESOURCES

COMMUNITY DEVELOPMENT AND HEALTH

guidance on the application of community development approaches to different aspects of anti-poverty and social inclusion work

Siobhán Lynam

Combat Poverty Agency
working for a poverty-free Ireland
20th Anniversary 1986 – 2006

First published 2007
Combat Poverty Agency
Bridgewater Centre
Conyngham Road
Islandbridge
Dublin 8

© Siobhán Lynam

ISBN: 978-1-905485-41-3

The views expressed in this publication are
those of the author, and do not necessarily
reflect the views of Combat Poverty Agency.

COMMUNITY DEVELOPMENT AND HEALTH

Siobhán Lynam

CONTENTS

ACKNOWLEDGEMENTS

Siobhán Lynam would like to warmly thank the many individuals who have contributed to the publication through the sharing of their insights and experiences.

Combat Poverty Agency is also pleased to acknowledge and thank Siobhán Lynam and a number of independent readers for their expertise and contribution in bringing the publication to completion.

May 2007

PREFACE

Community Development and Health is the second title in a new Combat Poverty Agency publication series *Community Development and ….* The series promotes practical illustration, and guidance on the application of community development approaches to different aspects of anti-poverty and social inclusion work. It is intended to enhance readers' understanding of community development and to promote this approach across sectors.

The publication was developed as an educational resource under the *Having Your Say Programme*, launched in November 2005 by Combat Poverty Agency. The Programme is focused on strengthening the voices and practices of people and communities living in poverty in the development and implementation of anti-poverty policies and programmes – see www.combatpoverty.ie/havingyoursay. The *Having Your Say Programme* is a supporting action to Combat Poverty's Strategic Plan 2005-07, *Working for a Poverty-Free Ireland.*

The four objectives of the *Having Your Say Programme* are:

- To promote the right of people in poverty to influence, and participate in, public policy decisions that affect them
- To initiate or support work that enhances the policy skills and capacities of groups of people experiencing poverty, their representatives or organisations supporting them
- To work in partnership with policy-makers to increase their understanding of the issues related to, and implications of, involving people in poverty in policy making
- To strengthen the integration of anti-poverty practice by community and voluntary organisations into the policy advice role of Combat Poverty.

Community Development and Health is one of a range of educational resources published under the Programme's second objective. It is complemented by two other titles – *Community Development and Public Policy* and *Integrating Policy into Work Planning*, both also written by Siobhán Lynam.

A companion publication, *Finding your Way around the Health Services*, and *A Guide to Community Participation in the Health Services* are also available from Combat Poverty www.combatpoverty.ie/publications.

Structure of the publication

Community Development and Health is presented in five sections.

Section 1 gives an overview of why health is a concern of community development and anti-poverty organisations. It defines health and outlines some of the key factors that determine a population's health.

Section 2 defines a community development approach to health and outlines the benefits of adopting a community development approach to promote health and address health inequalities.

Section 3 outlines and explores the key tasks in facilitating communities to develop and advance their health agenda. Examples from practice are presented. Guidelines are offered to support the development of meaningful partnership arrangements for the implementation of primary care. A checklist is provided to support the health sector's engagement of community organisations.

Section 4 outlines aspects of the current international and Irish policy context for promoting and advancing health. It outlines the key characteristics of a population health approach – the approach that has been adopted by the Health Service Executive (HSE). It refers to the policy initiatives to reduce health inequalities and promote social inclusion and how community development approaches to health have been formally acknowledged.

Section 5 provides further reading suggestions and useful contacts.

SECTION 1: WHY HEALTH MATTERS

'Of all inequalities, health inequalities are the most inhumane.'
Martin Luther King Jr

Irish people die younger because they tolerate an inequality between them that breeds ill health, and they accept a health-care system and a view of health care that implicitly places lesser value on the lives of those with lesser means.[1]

1.1 Why health matters

Health is understood to be a capacity or resource for everyday living that enables us to pursue our goals, acquire skills and education, grow and satisfy our aspirations.[2]

International and national evidence shows that, in general, the wealthier you are the healthier you are likely to be, while whose who are poorer have shorter and less healthy lives. People experiencing poverty become sick more often and continue to die younger than those who are better off.

- Between 1989 and 1998 the death rates for all causes of death in Ireland were over three times higher in the lowest occupational class than in the highest.
- The death rates for all cancers among the lowest occupational class is over two times higher than for the highest class; it is nearly three times higher for strokes, four times higher for lung cancer, six times higher for accidents.[3]
- Perinatal mortality is three times higher in families in the lower socio-economic groups than in higher groups.
- The scale of the differences in death rates between those in the lowest and highest socio-economic groups appears to be greater in Ireland than in other European countries.[4] Even on the island of Ireland, the difference in mortality rates between the groups at each end of the social spectrum appears to be greater in the South than in the North.[5]

Health services are not the main cause of health inequalities, but they are very important for people who are sick, for children, women of child-bearing age, those with chronic illnesses and disabilities, and older people.

1.2 What determines health?

A lot has been learned in the past several decades about what determines health. Much of the research indicates the need to examine factors both inside and outside the health-care system.

At every stage of life, health is determined by complex interactions between social and economic factors, the physical environment and individual behaviour. These factors are referred to as the 'determinants of health'. They do not exist in isolation from each other. It is the combined influence of the determinants of health that establishes health status, i.e. the level of illness or well-being of an individual or a population.

Seventy-five per cent of what determines health and well-being is due to socio-economic factors.[6]

A number of elements interact to impact on the health of a society. These include:

- socio-economic and environmental factors
- social and community networks
- individual lifestyles
- genetics.

This interaction is often represented in the 'rainbow model' that was developed in the early 1990s.[7]

Evidence indicates that a number of key factors influence health. They include:[8]

- Income and social status
- Social support networks
- Education
- Employment/working conditions
- Social environments
- Physical environments
- Personal health practices and coping skills
- Healthy child development
- Biology and genetic endowment
- Health services
- Gender
- Culture.

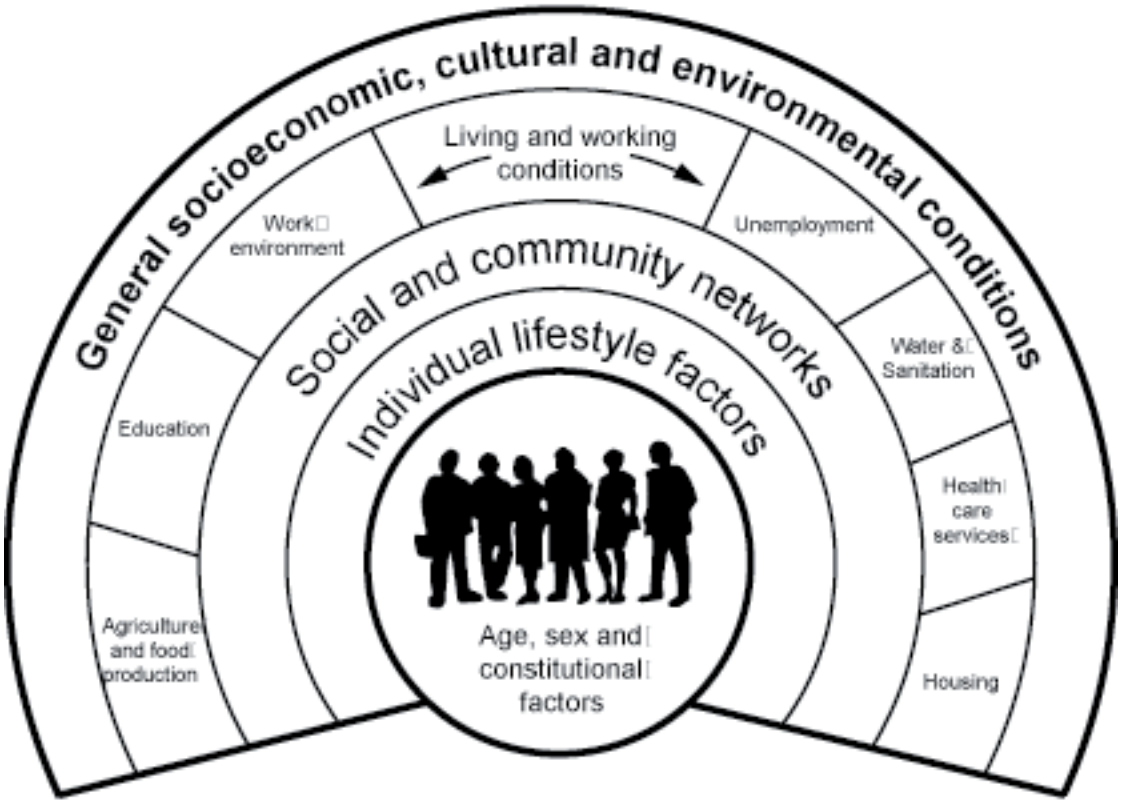


Fig. Dahlgreen and Whitehead, 1991

These key factors are now examined in more detail.

1.2.1 Income and social status

Poverty and ill health form a vicious circle. 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 non-communicable diseases
- depression
- suicide
- anti-social behaviour and violence
- increased exposure to environmental risks.

Research indicates that the higher people's income the better their health status.

The incidence of chronic physical illness has been found to be two and half times higher in the lower socio-economic groups as compared with the higher groups.

The rate of hospitalisation for mental illness is more than six times higher for people in the lower socio-economic groups as compared with those in the higher groups.[9]

1.2.2 Social support networks

Support from families, friends and communities is associated with better health. These social support networks can be very important in helping people solve problems and deal with adversity, as well as in maintaining a sense of control over life circumstances.

Low self-esteem, anxiety, insecurity, social isolation, lack of control over work or home life, all of these 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.

1.2.3 Education

Health status improves with education level, which in turn is closely tied to socio-economic status. Effective education for children and lifelong learning for adults are key contributors to health and prosperity for individuals, and for the country. Education equips people with knowledge and skills for problem solving, and helps provide a sense of control over their lives. It increases opportunities for job and income security, and for job satisfaction.

According to the World Health Organisation[10] low educational levels produce a rise in mortality (death) and morbidity (illness and disease) similar to that produced by low income.

1.2.4 Employment/working conditions

Unemployment, underemployment, stressful or unsafe work are associated with poorer physical, mental and social health.

Paid work provides not only money, but also a sense of identity and purpose, social contacts and opportunities for personal growth. When a person loses these benefits, the results can be devastating to the health of both the individual and his/her family.

Conditions at work (both physical and psychosocial) can have a profound effect on people's health and emotional well-being.

Participation in the wage economy, however,

is only part of the picture. Many people (most especially women) spend almost as many hours engaged in unpaid work, such as doing housework and caring for children or older relatives. When these two workloads are combined on an ongoing basis and little or no support is offered, an individual's level of stress and job satisfaction is affected.

> Unemployed people have a reduced life expectancy and suffer significantly more health problems than people who have a job.[11]

1.2.5 Social environments

Social support in the broader community is reflected in the institutions, organisations and informal practices that people create to share resources, build attachments and show solidarity with others.

Social stability, recognition of diversity, safety, good working relationships, and cohesive communities provide a supportive society that reduces or avoids many potential risks to good health.

Those who experience poverty, exclusion, marginalisation and discrimination are very well aware of the role and the social support provided by, for example, community development projects, community arts projects, youth projects, women's education and development projects, intercultural drop-in centres, family resource centres, asylum-seekers support groups, migrant rights centres, or refuges for women. These networks not only generate a supportive environment but also contribute to producing health outcomes.

> Social or community responses can add resources to an individual's range of strategies to cope with changes and foster health.

1.2.6 Physical environments

The physical environment is an important determinant of health. At certain levels of exposure, contaminants in air, water, food and soil can cause a variety of adverse health effects, including cancer, birth defects, respiratory illness and gastrointestinal ailments.

Factors related to housing, indoor air quality, and the design of communities and transportation systems can significantly influence our physical and psychological well-being.

The housing environment and the quality, affordability and suitability of housing and accommodation have a decisive impact on health.

The accessibility, affordability and suitability of transport systems are key factors that impact on people's health and well-being. Vulnerable groups and those who are socially and economically marginalised in 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.

> The 'economic' and 'engineering' aspects of housing, rather than the health aspects, prevail in decision-making processes relating to housing policy.

1.2.7 Personal health practices and coping skills

Personal health practices and coping skills refer to those actions by which individuals can prevent disease and promote self-care, cope with challenges, develop self-reliance,

solve problems and make choices that enhance health.

Definitions of *lifestyle* include not only individual choices, but also the influence of social, economic and environmental factors on the decisions people make about their health. There is a growing recognition that personal life 'choices' are greatly influenced by the socio-economic environments in which people live, learn, work and play.

These influences impact on lifestyle choice in at least five areas: personal life skills, stress, culture, social relationships and belonging, and a sense of control.

1.2.8 Healthy child development

Poverty damages children's health and can have detrimental, lifelong effects. Nearly one in ten Irish children lives in consistent poverty, while one in four lives in income poverty.

New evidence[12] on the effects of early experiences on brain development, school readiness and health in later life has sparked a growing consensus about early child development as a powerful determinant of health in its own right.

A young person's development is greatly affected by his or her housing and neighbourhood, family income and level of parents' education, access to nutritious foods and physical recreation, genetic make-up and access to medical and dental care.

1.2.9 Biology and genetic endowment

The basic biology and organic make-up of the human body are a fundamental determinant of health. This is called genetic endowment – the genetic profile we inherit from our parents.

Our genes can provide an inherited predisposition to a wide range of individual responses that affect health status. Although socio-economic and environmental factors are important determinants of overall health, in some circumstances, genetic endowment appears to predispose certain individuals to particular diseases or health problems.

1.2.10 Health services

Health services, particularly those designed to maintain and promote health, to prevent disease, and to restore health and function, contribute to the health of the population.

In Ireland, private patients access both in-patient and day facilities in public hospitals faster than, and in disproportionate numbers to, patients who do not have private insurance.[13]

In May 2002 the UN Committee on the Convention on Economic, Social and Cultural Rights criticised the Irish situation where there was not a common waiting list for treatment in publicly-funded hospital services for publicly and privately insured patients. The ESRI has estimated that the cost of each private patient stay in hospital is subsidised by the taxpayer by up to 50 per cent.[14]

Ireland is unusual in Europe in not providing primary care services without charge to the majority of the population.

In Ireland, our health system is fundamentally unequal, allowing those who can afford it to get more rapid access to a better service.

1.2.11 Gender

Gender refers to the array of socially-determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis.

Both women and men on lower incomes are more likely to die at a younger age than those in better-off groups.[15] Women, on average, live longer than men (life expectancy for women is 78.6 and for men is 73 years). However, they are more likely to suffer depression, stress overload (often due to efforts to balance work and family life), chronic conditions such as arthritis and allergies, and injuries and death resulting from family violence.

The circumstances of different groups of women impact on their well-being. For example, women migrants in Ireland, who are originally from countries outside the EU, may experience vulnerabilities if they are dependent spouses. The dependent spouses of workers with work permits are not entitled to Irish residence or work in their own right. If they leave their spouse, they may face deportation. Women who are dependent spouses and who experience domestic violence are in a particularly vulnerable position. When/if they leave their spouse, they have no 'legal' status. This may have consequent implications for their health and well-being, e.g. stress, lack of financial independence, personal autonomy.

1.2.12 Culture

Some persons or groups may face additional health risks resulting from a socio-economic environment that is largely determined by *dominant* cultural values. This contributes to lack of access to culturally appropriate health care and services, loss or devaluation of language and the perpetuation of conditions such as the marginalisation and stigmatisation of minority cultures or cultural groups.

The self-reported quality of life of asylum seekers is much poorer than that reported by the general population. In one study only 22 per cent of asylum seekers rate their quality of life as good or very good.[16]

Many foreign nationals and members of minority ethnic groups experience a lack of translation facilities in Irish GP clinics, although there is provision for a telephone translation service for GPs and patients who do not have a common language.

Because of the absence or limited availability of rurally-based female doctors, many refugee and asylum-seeking women may not have access to adequate and appropriate health care in rural areas, where they have been located under the dispersal programme.

For many recognised refugees and migrant workers from outside the EU, their professional qualifications, obtained in their country of origin, are not recognised in Ireland. Therefore they work in areas other than those in which they were trained. Such employment is invariably lower paid. A resulting shortage of money can have further detrimental effects on well-being.

The Traveller Community, as an indigenous minority group, has always suffered disadvantage and discrimination in all fields of life, including education, employment, and access to public and private services. Travellers are commonly denied access to public services such as hotels, restaurants and pubs. They are also victims of violence and harassment, including arson attacks against their property.[17]

Utilisation of a community development approach in which all ethnic minority communities are actively engaged in planning, design, development and implementation of health programmes is crucial to effective management of ethnic minority health needs.[18]

SECTION 2: HOW COMMUNITY DEVELOPMENT PROMOTES BETTER HEALTH AND ADDRESSES HEALTH INEQUALITIES

Community development seeks to tackle the root causes of health inequalities. It recognises that health is determined by complex interactions between social and economic factors, the physical environment and individual behaviour and that these factors do not exist in isolation to each other

2.1 Introduction

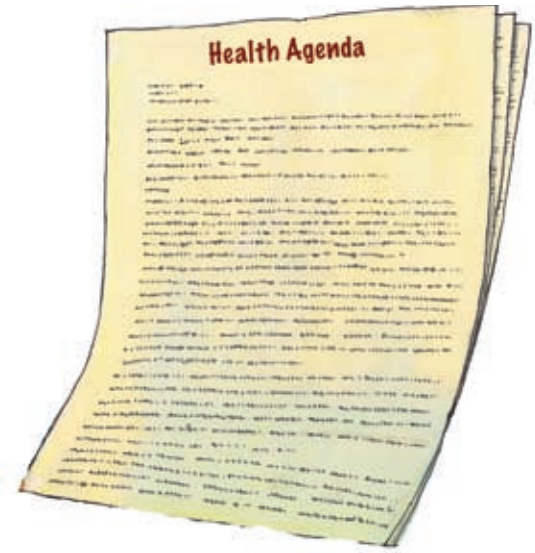
The principles and processes at the core of community development approaches distinguish it from other forms of work in, and with, local communities.

Community development is characterised by:

- a focus on empowerment and participation of marginalised groups in decision-making that impacts on their lives and communities
- a collective rather than an individual approach to tackling problems
- a social analysis and understanding of the causes of poverty and disadvantage
- a commitment to equality and social justice.

A community development approach to health is focused on:

- addressing health inequalities that are generated and sustained by the dominant institutions and systems that have been developed to organise society, e.g. the economic system, the welfare system, the education system and the health system
- advocating and working for change in these systems, in their structures and policies



- promoting and working to advance equality of access, participation and outcomes in health service utilisation
- working for positive action to address inequalities in health status.

A community development approach to health acknowledges community development work as a developmental activity composed of both task and process.

- The **task** is the achievement of social change, linked to equality and social justice.
- The **process** is the application of the principles of participation, empowerment and collective decision-making in a structured and coordinated way.

2.2 Benefits of adopting community development approach to health

- **It ensures a genuine involvement of currently marginalised groups**

Health strategies and service delivery are much more likely to succeed if people and communities towards whom they are targeted are involved in how these strategies and services are designed, and monitored and evaluated for their impact on the health of communities. A Government statement on the National Anti-Poverty Strategy acknowledges that:

> Health care services should be centred on people's needs. This requires consultation and a community development approach involving people and communities in assessing their own health needs and in various stages of design, delivery, monitoring and evaluation of health and personal social services. This issue is particularly relevant to primary care services.[19]

Community development facilitates the inclusion of people experiencing poverty, inequality and exclusion in the decision-making process, not as target groups, but as strategic partners with their own specific concerns, insights and objectives. It genuinely engages people in needs analysis, in the design and development of health strategies and in the formulation of health policy.

The participation of community organisations allows policy decision-making to be informed by 'local reality'. Insights into the community's health and 'insider expertise' of health inequalities and the impact of existing health policies and programmes can improve the quality of decision-making.

- **It adopts the social model of health**

In many countries, including Ireland, the medical model of health is the dominant model. It focuses on eliminating illness through medical diagnosis and treatment.

Community development challenges the dominance of the medical model of health. It promotes a wider understanding of health and the causes of ill health. It recognises that health and well-being are significantly determined by the social, economic, physical and cultural environments and that these environments are created and shaped by public policy.

Because the community development approach prioritises addressing the causes of poverty and inequality (including health inequality), it focuses on changing the economic, social, political and cultural structures and systems in society that produce and reproduce poverty, inequality and ill-health.

Much community development activity, although it may not have a direct focus on health inequalities, contributes to the well-

being of people and community. This is because community development:

- creates social networks
- builds personal skills and self-esteem and reduces social isolation
- enables people to act and work for change in their own lives and the life of their own communities
- enables people to have an impact on policy.

- **It promotes integrated approaches**

Community development seeks to tackle the root causes of health inequalities. It recognises that health is determined by complex interactions between social and economic factors, the physical environment and individual behaviour and that these factors do not exist in isolation to each other (see Section 1). A community development approach is therefore concerned with promoting and advancing integrated approaches and strategies that will effectively address health inequalities and promote the health and well-being of marginalised groups and communities.

This engages the community sector with different organisational and sectoral interests in a range of relationships, including partnership relationships, to address health inequalities. These include statutory agencies, national and local government, health professional bodies and institutions, and the other social partners.

2.3 The role of community development in advancing health and addressing health inequalities

Community development work is focused on the most marginalised groups and communities in society. Community development deliberately sets out to target and bring together individuals and groups who are affected by poverty and who are excluded from participation in society because of prejudice, discrimination, lack of resources or lack of power.[20]

Community development	**approaches to health**
Builds capacity	of community organisations and individuals to work together to identify their own health and well-being needs.
Builds understanding and analysis	of the structural inequalities in Irish society, including health inequalities.
Involves people collectively	in designing, developing and implementing responses to issues affecting the health and well-being of communities, including health service provision at local level.
Builds awareness	of the health policy context in which decisions are made, how resources are allocated and services that impact on people's lives are planned and delivered.

Community development	approaches to health
Enables groups	to analyse and acknowledge those health-related issues or problems that are neither their responsibility nor within their ability to solve. It enables groups to consider and agree on how they will activate and get those with responsibility to move and focus on the problem and get the problems addressed.
Builds confidence, knowledge and skills collectively	to enable marginalised groups to move from an experience of powerlessness, to develop a strong and effective voice, and to engage and negotiate with statutory agencies, governmental agencies and in social partnership arrangements at local and national level to advance their health agenda for change
Strengthens organisational capability of excluded groups and communities	to enable and facilitate them to effectively impact on the development and implementation of local and national health-related policy.
Develops innovative and creative approaches	to address the economic and social deprivation that impacts on health and well-being and to enable a sharing of talents and skills in the process.
Advocates for policy change	relating to the economic, social, physical and cultural environment that largely determine health and well-being.
Articulates rights	including the right to health.
Promotes networking	at local, national and international levels to bring about social change and greater health outcomes in favour of the most marginalised in society.
Devises strategies	to promote equality, interculturalism and an acknowledgment of diversity.

SECTION 3: FACILITATING COMMUNITIES TO WORK FOR CHANGE TOWARDS GREATER HEALTH EQUALITY

> Community development facilitates the inclusion of people experiencing poverty, inequality and exclusion in the decision-making process, not as target groups, but as strategic partners with their own specific concerns, insights and objectives. It genuinely engages people in needs analysis, in the design and development of health strategies and in the formulation of health policy.

3.1 Introduction

This section outlines the key tasks that need to be undertaken to support marginalised communities to advance their health agenda and to engage in the formation, delivery and evaluation of health policy and health services. Key items pertaining to advancing health and well-being are suggested for national and local development agendas.

This section also offers some particular guidelines for the health sector to support the inclusion and well-being of marginalised communities.

A related title, *A Guide to Community Participation in the Health Services*, is also available from Combat Poverty.

3.2 Facilitating communities to develop and advance their health agenda

A community development approach involves empowering people to work together for change that creates a fairer, more equal and healthy society.

Creating a 'health agenda' is essential for local communities who want to work for greater health equality. This helps the community to be clear about naming and pursuing what it wants to change in order to improve people's health and well-being.

Nine key tasks are summarised below and then discussed in detail.

1. Keep a focus on the job of community development, which is the pursuit of social change through collective action, and ensure that the work is underpinned by community development principles.
2. Acknowledge the diversity within and between marginalised communities.
3. Acknowledge the impact of institutionalised racism on minority ethnic groups including Travellers.
4. Develop an understanding of health inequalities and the determinants of health.
5. Identify needs and define priorities with the communities in the first instance. Define and agree a programme of action and indicators that would clearly indicate if progress was being made within a six-month and a one-year period.
6. Develop a policy agenda.
7. Promote awareness of health impact assessment tools and processes. Ensure that all county/city and local development plans make reference to population health and health inequalities and set targets for health gain.
8. Link and network nationally with other community organisations and NGOs focused on changing policy and practice change to tackle health inequalities.
9. Engage in an ongoing review and evaluation of the work.

1 Keep a focus on the job of community development, which is the pursuit of social change through collective action, and ensure that the work is underpinned by community development principles

A community development approach:

- Involves not only building the 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. A key characteristic of a community development approach is the use of creative ways to overcome the traditional barriers to formal inclusion and participation, e.g. literacy, or language, educational background, responsibility for dependants, participation costs.
- Challenges existing power relations and addresses power inequalities. It aims to effect a sharing of power and to create structures that provide genuine participation and involvement, in a process based on mutual respect and equal and genuine partnership between all those involved, to enable a sharing of talents, experience and expertise.
- Promotes social analysis and works to develop a collective understanding of the structural inequalities in Irish society and the persistence of health inequalities.
- Above all works to achieve collective health outcomes for the community.

Community development principles should guide and underpin all aspects of the community organisation's work, at all levels. These principles should guide and underpin training, research, analysis, networking, and advocacy and lobbying work.

They should be applied to the rules of engagement in partnership arrangements with government departments, state agencies and the health service, especially in the expectation and the assertion of the right to dialogue as equals while respecting different roles, responsibilities and ethos. Mutual respect for the different perspectives should represent a core principle of the operation of any health initiative.

CASE STUDY

Community Development and Health Pilot Initiative (2005-2007) – Cáirde

The achievement of health gain for minority ethnic communities will be determined by the extent to which minority ethnic communities are genuinely engaged in needs analysis, design and implementation of health strategies. In essence, this requires adopting a legitimate participative and community development approach to enhancing minority ethnic health. – Cáirde

Cáirde's Community Development and Health Pilot Initiative (2005-2007) is a phased initiative incorporating the following:

- **Capacity building** to engage in primary care. This includes knowledge and skills training in primary care strategy, health needs assessment, population health, community development, primary health care, health education, health policy development, outreach skills, communication and information technology (IT). Experiential learning and the use of creative methodologies as tools for learning characterise the approach to training. Participants have completed a community work placement, which raised their awareness of the issues affecting disadvantaged communities in the inner city and outer suburbs.
- **Health needs assessment** and analysis using a range of participative methodologies. The project's comprehensive computerised database allows for a filtering of findings and specific issues across a range of themes, e.g. Immigration and health; Accommodation, housing and health; Employment, education and health; Access and experience of health services; Racism, discrimination and health.
- **The establishment of a community health action team** that will work in partnership with a range of stakeholders in response to the needs emerging from the assessment. These stakeholders include health service providers, minority ethnic groups and other relevant bodies.
- **Mainstreaming the learning**. In each stage of the project there is a documentation and sharing of the experience and learning, highlighting and disseminating best practice to the HSE Primary, Continuing and Community Care, Dept of Health and Children, Primary Care Steering Group and Task Force, and NAPS/incl and Health Working Group. The findings, recommendations and evidence base will feed into the HSE Intercultural Strategy.

2. Acknowledge the diversity within and between marginalised communities

Acknowledge the range of different health issues and the experience of health and well-being, the differences in concerns and in the situation and experience of exclusion and discrimination that are influenced by or may be a consequence of:

- gender
- class
- age
- sexual orientation
- ability/disability
- educational background
- ethnicity including membership of the Traveller Community
- nationality
- skin colour
- religious beliefs
- marital status
- family status and responsibility for dependants
- legal status (of migrant workers and their families, of asylum seekers, of refugees, and of international students).

3 Acknowledge the impact of institutionalised racism on minority ethnic groups including Travellers

Institutional racism impacts on the health status of ethnic minorities and reinforces health inequalities. Institutional racism or structural racism has been defined as:

the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people.[21]

The Traveller Primary Health Care Project, which began as a pilot initiative in 1994, produced a model of health care that could begin to address the specific health needs of Travellers as a minority ethnic group. This model has now been mainstreamed across the health service.[22]

CASE STUDY

Consultation process – Lifford/Clonleigh Resource Centre

To allow the different groups in the local communities to consider and voice their own needs, and to ensure and facilitate their meaningful engagement in defining how the Primary Care Centre and its team practice should be developed to meet their needs, the Lifford/Clonleigh Resource Centre in east Donegal engaged in an extensive consultation process.

Seventeen focus groups were conducted with children, adolescents, women, men, unemployed people, people on low incomes, disabled people, Travellers, older people, people parenting alone and people living in isolated rural areas.

A mission statement was agreed by all those consulted:

> Our mission is to act as a strong voice for groups and individuals from the communities of Castlefinn and Lifford in order to address the issues that affect the health and well-being of every person in our community from pre-natal care to death, with a particular emphasis on the issues that affect those who are most vulnerable and excluded in our communities.

The launch in 2002 of *Travellers Health – A National Strategy 2002-2005* was highly significant in that it represented a change in national policy towards Travellers. Firstly, it acknowledged them as a minority ethnic group in Irish society with a health status well below the majority population and with specific health needs. It also recognised that social exclusion, racism and living conditions have an impact on health status.

The Traveller Primary Health Care model has been an inspiration to other community organisations and non-governmental organisations (NGOs) working with excluded and marginalised groups. The principles have been taken on board and replicated in other areas to address the health inequalities experienced by other excluded and minority ethnic communities.

The National Action Plan Against Racism acknowledges that:

> Institutional racism and the failure to accommodate diversity is often unintentional and can come about through a lack of understanding, lack of adequate planning or the persistence of the 'one cap fits all' approach. The outcome of these processes can contribute to failure in or weaker service provision to cultural and ethnic minorities.[23]
>
> 'It is clear that an immediate improvement to the living environment of Travellers is a prerequisite to the general improvement in health status.' – National Health Strategy for Travellers

4 Develop an understanding of health inequalities and the determinants of health

Section 1 of this publication explains the key determinants of health. Please refer to this. Also consult the reading list in Section 5 to further enhance understanding of health inequalities and health determinants.

Developing an understanding of health inequalities and the determinants of health can be done in formal and informal ways. It can become an integral element of the social analysis that is undertaken as part of the ongoing work and planning of the organisation.

For organisations planning to develop a health agenda, it becomes a core module in community development and health training programmes.

> Health Impact Assessments can focus on and raise awareness of the determinants of health and health inequalities.
>
> The Galway Travellers Movement is currently examining accommodation poverty as a cause of ill-health. The organisation will use the findings of a Health Risk Audit of temporary accommodation to raise awareness of the determinants of health and an understanding of health inequalities. See Case study, p.24

5 Identify needs and define priorities with the communities in the first instance. Define and agree a programme of action and indicators that would clearly demonstrate if progress was being made within a six-month and a one-year period

Acknowledge and name the health dimension in the work of the organisation. It is important to acknowledge that community organisations that work with community development principles are addressing the health and well-being of marginalised communities. However, they may want to advance this work more specifically and this can be done by promoting and facilitating a community health needs assessment. This is a central element in development of the Primary Care Strategy. Different models and different approaches can be adopted. Groups such as Cáirde,

NICHE, Clondalkin Partnership, Fatima Groups United, Lifford/Clonleigh Resource Centre have undertaken peer-led community health needs assessment using a range of community development methodologies. (See Section 5 for contact details of these projects.)

Plan for an ongoing monitoring and review of the community's progress in advancing its health agenda and its health priorities. Local health fora can provide ongoing support to the community representatives who are nominated to present and advance the community's health agenda at the partnership table.

6 Develop a policy agenda

Link and integrate the health work and the community's health agenda into other agendas for social and economic development and for social change at local and national level.

For example, promote the incorporation of the community's health agenda into the agenda of:

- RAPID
- the Local Development Social Inclusion Measures Group

CASE STUDY

Creating the conditions for community participation in primary care development – Lifford/Clonleigh Resource Centre

Lifford and Castlefinn are two isolated rural border towns in south-east Donegal with high levels of socio-economic disadvantage and unemployment. The area of east Donegal was one of the ten sites for an initial Primary Care Team, funded by the Department of Health and Children. New resources were made available for health and an onus was placed on the health board and the general practice including the GPs and other primary care providers to engage with the local community.

The Lifford/Clonleigh Resource Centre received funding in 2003 and 2004 from the Combat Poverty *Building Healthy Communities Programme* to facilitate the meaningful participation of the Castlefinn and Lifford communities in the Primary Care Implementation Project. This participation was facilitated by a working group comprising membership from the Community Development Project, the Primary Health Team and the health services.

It was achieved through the organisation of a series of specifically targeted focus groups that acknowledged the diversity of needs within and between population groups.

The Community Health Forum identified and continues to identify the priorities for the community representatives to feed into the Primary Care Team. These include issues that directly affect the health service alongside non-medical priorities, e.g. benefits advice, childcare, and environmental issues relating to some of the other social, economic and environmental determinants of health.

The project has generated a big debate about health, raised a series of issues pertaining to the health of the local population, defined a community health agenda and has been particularly successful in including minority groups and generating a greater understanding of minority groups' perspectives.

- Strategic Policy Committees
- City or County Development Boards.

Fatima Groups United successfully incorporated their health agenda into the Regeneration Plan. See Case study below.

Engaging in social partnership arrangements provides an opportunity to advance the health agenda of the community. However, there are many ways to influence policy. Some may be more effective than others, depending on the issues the organisation wants to progress. A range of factors will influence the organisation in the choice or combination of strategies that it will adopt.[24]

7 Promote awareness of health impact assessment tools and processes. Ensure that all county/city and local development plans make reference to population health and health inequalities and set targets for health gain

Health Impact Assessments (HIAs) are a way of assessing policies and programmes for their potential impact on the population's health. Promote training for both community and statutory agency staff in HIA and call for health impact assessments to be carried out on all local social and economic development plans and on health service plans.

CASE STUDY

Developing a residents-led community health agenda – Fatima Health Initiative

The Fatima Health Initiative, Fatima Groups United, is currently building on previous community development health initiatives to ensure that the social regeneration of Fatima Mansions in the area of health is community led and driven.

Initiatives and projects undertaken in the process to date have been supported by the Health Service Executive, Combat Poverty's *Building Healthy Communities Programme* and FÁS. The group has used community development approaches that reflect the social determinants of health. This has ensured:

- the integration of social regeneration to the overall regeneration of Fatima Mansions
- the empowerment of the local community in the development of a health and well-being centre in the area
- the engagement of local community representatives with the Coombe Hospital, two local health practices and the HSE in complex negotiations involving many different agendas with a view to building relationships and common ground in relation to the development of a primary care centre
- development of a community development and health training course, capacity building through participation in the course, and the employment of local women as part-time community health workers to drive a resident-led community health agenda within the regeneration
- collectivising local groups in the Rialto and Donore Avenue areas of the Dublin South City area into a Community Health Forum, with a view to developing a Community Development Health Strategy for the area that will directly influence and feed into the planned Dolphin's Barn Health and Well-being Centre.

Little information is available on the impact of socio-economic factors on health in Ireland.[25] The absence of high-quality information 'contributes to official inertia in dealing with both the causes and consequences of health inequalities.'[26]

It is important to ensure that the health status and health inequalities in the local area are referenced in the Strategic Plans of City/County Development Boards, RAPID, CLAR, Local Development Partnership Boards, LEADER Companies, Community Development and Family Resource Centre Projects. Actions should be outlined, aimed at developing systems and processes for collecting information and disaggregated data. This material can then be used as a baseline to determine actions to address health inequalities and to measure the outcomes of initiatives and investments.

CASE STUDY

Examining accommodation poverty as a cause of poor health – Galway Traveller Movement

The Galway Traveller Movement (GTM) has been concerned for the health of 20 families who have been living in very poor conditions for four years on an official transient site in Galway city. The Travellers are living with no electricity, no running water, and without flush toilets or washing facilities. Galway City Council agreed in June 2005 to place the families in temporary accommodation on an emergency site, pending provision of permanent accommodation.

GTM proposed to undertake a Health Impact Assessment (HIA) of the temporary site to which the families were to be moved and of the plans for permanent accommodation. They formed a steering group to oversee the HIA process. Membership included two social workers, two public health nurses and two environmental health officers; a representative of the Traveller Health Unit, local Travellers and the GTM community health worker. Funding was sought and received from the *Building Healthy Communities Programme*.[27]

GTM intended to record the process and the outcomes and to share and make available to other Traveller and community organisations the learning from their experience of conducting a health impact assessment of an accommodation plan. They were also in contact with the Institute of Public Health (IPH) to share the learning and experience of conducting a health impact assessment. One of the community workers of the GTM had undertaken a HIA training course with the IPH.

In July 2006, it became necessary to refocus the initiative. There was still no plan for the permanent accommodation on which to undertake a HIA. It was agreed by all the stakeholders to focus on the health of the Travellers who were still on the transient site and to undertake a health risk audit of their accommodation and living conditions. A health risk audit, it was felt, would raise awareness of the links between accommodation standards, poverty and health and would not only raise key health and safety issues for the 20 families on the Galway site but would shed light on the health risks faced by Travellers who are forced to live on the roadside and in other non-serviced sites in other parts of the country.

In the process of defining the specific focus of the audit, many health and safety issues were raised with regard to the installation of electricity generators and their use; wiring in mobile homes, home heating and the use of gas in confined spaces; the use and maintenance of portaloos, the lack of water supply and water collection, water hygiene; waste management and collection; the impact of irregular power supply and risks associated with re-freezing foods; the impact of poor or no electricity on school children and their home study/ homework; the impact of no running water and the washing of school uniforms.

The findings and recommendations from the audit are expected to have implications for service providers. They will also serve to enlighten Travellers and to point to changes in practices that will be required to avoid health risks in the home.

The Institute of Public Health's website **www.publichealth.ie** provides information on HIAs. The Institute also offers training on health impact assessments.

> **The Donegal Community Forum successfully completed a health proofing of the strategy of the County Development Board and had health targets incorporated into the ten-year strategy for social, economic and cultural development.**

8 Link and network nationally with other community organisations and NGOs focused on changing policy and practice to tackle health inequalities

Linking with other community groups and NGOs is a necessary step for community groups engaged in developing and advancing their health agenda. Such links provide a forum of solidarity and support. Additionally, comparisons of efforts help to deepen analysis, and ensure a greater equality in outcomes.

Collective effort has been shown to result in more effective action.

9 Engage in an ongoing review and evaluation of the work

Ongoing review and evaluation is a critical component of developing and advancing a health agenda. It enables the community organisation to assess the impact of its investments.

For further information on this point, refer to the Combat Poverty Agency publication *Community Development and Public Policy,* Section 3, 'How Can Community Organisations Influence Public Policy?'

3.3 Putting health on national and local development agendas

Lessons from work to date suggest that the following items need to be placed on national and local development agendas if the health and well-being of marginalised communities is to be advanced and health inequalities tackled.

- Poverty and equality proofing of policy, resource allocations, and programmes
- Health Impact Assessments (HIA). At local level HIAs should be promoted through the City/County Development Boards. Statutory agency personnel can avail of and undertake training in HIA that is provided by the Institute of Public Health
- A focus on the social and economic determinants of health
- Inter-sectoral working
- Research, data and information gathering on the health of people on low incomes and on the causes and consequences of health inequalities to ensure the establishment of realistic targets, to promote health and address health inequalities, and to ensure proper targeting and accountability for investments
- Use of ethnic identifier as a routine feature of health information systems. Collecting information on ethnicity (including Travellers and other ethnic groups) of hospital patients, users of services in local health centres etc., should done for the sole purpose of planning to meet the needs of the community and to ensure that everyone has equal access to health care.

3.4 Promoting meaningful health partnership arrangements and good working relationships in the implementation of Primary Care

As a result of the commitment in the National Health Strategy to strengthening Primary Care, the Health Service Executive is directed towards addressing health inequalities and to adopt a population health approach. New partnership arrangements are being called in order to meet these challenges. The experience, to date, in national and local partnership arrangements has provided many lessons for this type of engagement.

> **'Primary care must become the central focus of the health system so that it can help achieve better outcomes and better health status.' – National Health Strategy**

Experience suggests that good partnership working arrangements are characterised by a number of core principles:[28]

- Those mandated by the community group/community sector to represent their interests at partnership level 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.
- The community sector is adequately resourced: for its advocacy role; 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. It develops an equality, anti-racism and diversity policy, codes of practice and a set of principles to guide and underpin its work and to which all 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 interests and different concerns. Agreeing the collective objective can often entail a process of negotiation. Delivering on the collective objective implies a pooling of resources and a commitment to adopting a collective approach and process.
- All partners engage in a process to enhance their understanding of their role in the partnership process, to develop an appreciation of the culture of partnership, to address issues that may arise in the management and implementation of partnership initiatives, and to enhance skills that will maximise the potential of the partnership to impact on policy development, locally, regionally and nationally.

Checklist: Good practice to support the engagement of community organisations in the health sector

- Acknowledge that those who are disadvantaged, powerless and marginalised in society need support and the resources to be empowered and to identify and be involved in the necessary changes to improve their lives and the lives of their communities. Provide adequate resources for capacity building and participation, including the development of confidence, knowledge and skills to engage in the design of health strategies and in policy formulation.
- Acknowledge the dominance of the medical model of health and its negative impact on devising and designing health strategies to tackle health inequalities. Create opportunities to develop an understanding of population health approaches and an appreciation of health as a resource for living, which is very much determined by social, economic and environmental factors and their interactions.
- Acknowledge the importance of local knowledge and expertise and the key role of communities of interest as well as geographic communities in the design of health strategies and policy formulation. There is a contradiction when the development of health and social inclusion initiatives and policy to address health inequalities does not include those for whom they are targeted. Consultation should not be mistaken for participation in decision-making.
- Promote partnership building that is based on real dialogue, that facilitates mutual learning and mutual understanding through the sharing of the knowledge and expertise of each of the partners in relation to health inequalities and the sharing and discussion of ideas for potential solutions.
- Take a leadership role in promoting integrated approaches in the development

of policy and practice in the health service at local level.

- Promote inter-sectoral and multi-sectoral and multi-dimensional approaches that focus on the social and economic determinants of health, in order to address the cause of health inequalities. Promote the use of health impact assessments across the public and private sectors.

- Provide supports and training for health service personnel in community development approaches, intercultural practices, equality and anti-racism. Develop equality policies and codes of practice that will guide health service personnel in their work with local communities.

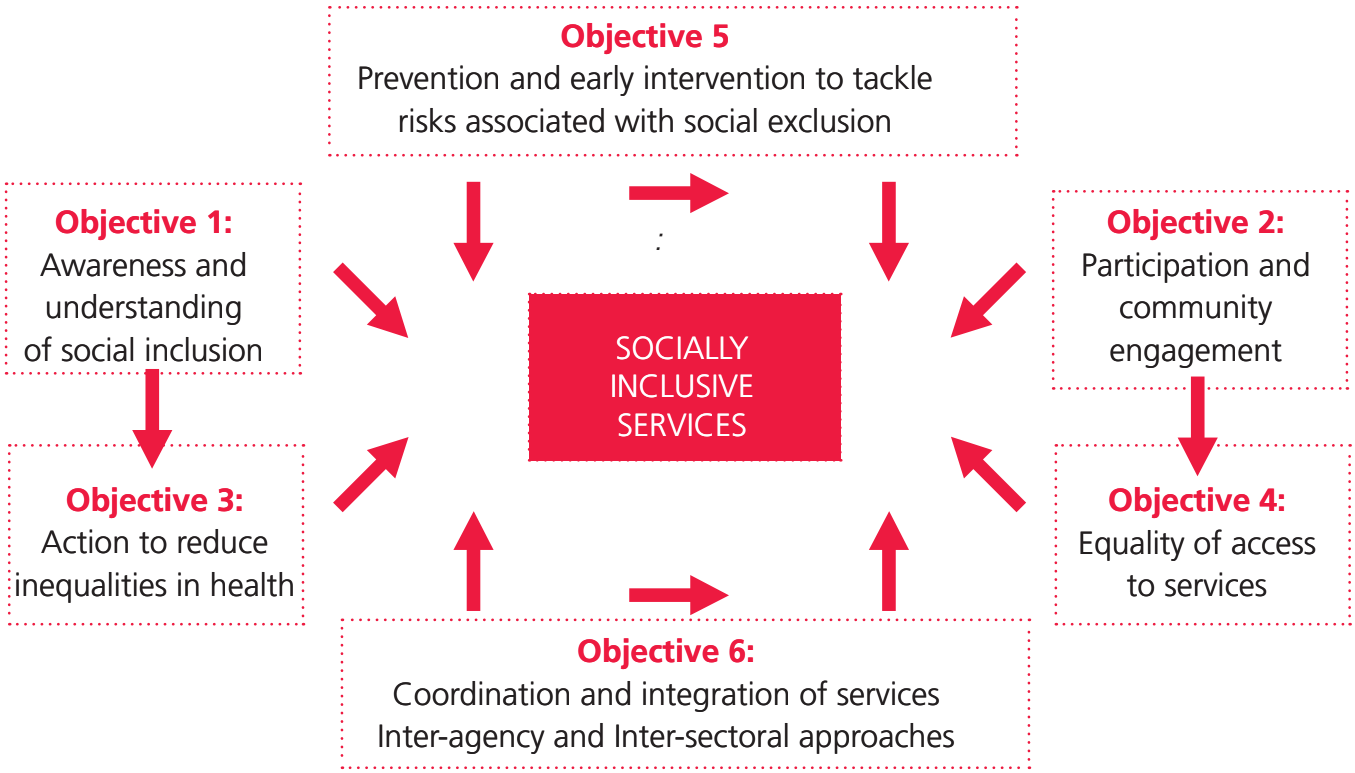
A model for social inclusion in the health service

Below is an example of a model for social inclusion in the health service. It was developed by the HSE North West Area.[29] (See Section 5 for contact details.)

The model for social inclusion is based on six key objectives:

- Awareness and understanding of social inclusion
- Participation and community engagement
- Action to reduce inequalities in health
- Equality of access to services: linking equality and social inclusion
- Prevention and early intervention: addressing the risks associated with social exclusion
- Coordination, integration and partnership.

Fig: Model for social inclusion (Draft Social Inclusion Action Plan HSE North West 2004)



SECTION 4: THE CURRENT HEALTH POLICY CONTEXT

> The right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health. ... [It is] an inclusive right extending to timely and appropriate health care but also to the underlying determinants of health .... A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels – CESCR General Comment 14, paras 9 and 11

4.1 Introduction

This section outlines key policy contexts for working on health issues. They include international documents from bodies such as the World Health Organisation (WHO) and the United Nations (UN). These give high priority to asserting and working for people all over the world to enjoy the highest possible standard of health.

This section also refers to the Good Friday Agreement, which provides a significant foundation for all-island work to improve health outcomes.

Lastly, it refers to the current national policy context, including some relevant legislation. Policy contexts change over time. It is always useful to pay attention to new policy statements of the Government or the Department of Health and Children and statements that update or change existing policy commitments. The website **www.irlgov.ie** provides a link to all government departments.

In addition, a companion publication, *A Guide to Influencing the Health Services*, is available from publications@combatpoverty.ie.

4.2 Health as a human right – internationally acknowledged

Individuals and groups have well-defined non-negotiable health-related entitlements, and governments are legally responsible for ensuring that those entitlements can be enjoyed effectively.

4.2.1 World Health Organisation

The right to health is a universal entitlement, based on the dignity and integrity of all individuals. The World Health Organisation

(WHO) articulated the first specific international health and human rights provisions in the preamble to its Constitution (written in 1946). It declares that:

> ... the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic, or social condition – WHO Constitution Preamble

4.2.2 Universal Declaration of Human Rights (UDHR)

Soon after the WHO Constitution was formulated, the right to health was affirmed by the Universal Declaration of Human Rights which states that:

Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. – Universal Declaration of Human Rights art 25(1)

4.2.3 UN International Covenant on Economic, Social and Cultural Rights (ICESCR)

The International Covenant on Economic, Social and Cultural Rights was the first human rights treaty to require states to recognise and realise progressively the right to health, and it provides key provisions for the protection of the right to health in international law:

The States parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

Until recently there was considerable lack of clarity within the international human rights community as to the specific obligations that the right to health places on governments. The wording of the treaties usually does not spell out in sufficient detail the obligations it places on governments. However, this situation has now changed significantly with the adoption by the UN Committee on Economic, Social and Cultural Rights (CESCR) of its General Comment 14 on the right to the highest attainable standard of health.

The General Comment elaborates in detail on the content of ICESCR Article 12, and emphasises that:

> The right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health. ... [It is] an inclusive right extending to timely and appropriate health care but also to the underlying determinants of health .... A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels – CESCR General Comment 14, paras 9 and 11

The General Comment of the CESCR provides the most detailed interpretation to date of state obligations and internationally accepted standards and principles arising from the right to health. It is an authoritative document that sets out clearly, for Ireland and other states, who have ratified the ICESCR, their obligations in the context of the right to health. Furthermore, it serves as a point of reference that the community sector and NGOs can use for internationally accepted standards, principles and norms.

4.3 The Good Friday Agreement 1998

The Good Friday Agreement is an international legally binding agreement. It includes a commitment by the Irish government to take steps to further the protection of human rights within its jurisdiction and to ensure at least an equivalent level of protection of human rights as will pertain in Northern Ireland.

Health is defined as a fundamental human right in Northern Ireland.[30] The commitment in the Good Friday Agreement of 1998 by the Irish government to equivalence with regard to human rights standards means there is a need to review the provisions and the interpretation of our equality legislation, and to introduce positive duties to promote equality in line with Section 75 of the Northern Ireland Act.

Health is one of the areas referred to for North/South co-operation under the Good Friday Agreement.

4.4 Northern Ireland statutory duty to promote equality

In Northern Ireland 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.[31] In carrying out their functions, all public authorities, including those operating under the health umbrella, must have due regard to the need to promote equality of opportunity 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, and responsibility for dependants. They are obliged to prepare an equality scheme setting out the equality impact assessment, monitoring and consultation procedures with the groups that might be affected.

This results in a focus on work to address health inequalities and promote the health and well-being of marginalised communities.

As already mentioned, the commitment in the Good Friday Agreement of 1998 by the Irish Government to ensure equivalence with regard to human rights standards has led to a review being undertaken of the provisions and the interpretation of Irish equality legislation, and to introduce positive duties to promote equality in line with Section 75 of the Northern Ireland Act.

4.5 The National Health Strategy, *Quality and Fairness: A Health System for You* (2001)

In 2001 the Irish Government launched the National Health Strategy: ***Quality and Fairness: A Health System for You***. For community organisations working to advance health and address health inequalities, the National Health Strategy is significant for the following reasons:

- It puts a focus on health, not just on health services, and acknowledges that people's health is affected by socio-economic, environmental and cultural factors.

- It acknowledges that '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 concept of 'health services' is seen to include 'every person and institution with an influence on or a role to play in the health of individuals, groups, communities and society at large'.

- It reiterates the commitment to multi-sectoral and inter-disciplinary work in the National Health Promotion Strategy (NHPS) 2000-2005 and incorporates many of the themes identified in the NHPS.

- It states that health impact assessments 'will be introduced as part of the public policy development process… it is a means for all sectors to determine the effects of their policies and actions on health', (Obj1.1).

- It contains a specific commitment to community participation. 'Provision will be made for the participation of the community in decisions about the delivery of health and personal services' (Action 52).

4.6 *Primary Care – A New Direction*

The aims of the Primary Care Strategy are to provide:

- a strengthened primary care system which will play a more central role as the first and ongoing point of contact for people with the health-care system
- an integrated, inter-disciplinary, high-quality, team-based and user-friendly set of services for the public, and
- enhanced capacity for primary care in the areas of disease prevention, rehabilitation and personal social services to complement the existing diagnosis and treatment focus.

The inter-disciplinary primary care team will include GPs, nurses/midwives, health-care assistants, home helps, physiotherapists, occupational therapists, social workers and administrative personnel. A wider primary care network of other primary care professionals such as speech and language therapists, community pharmacists, dieticians, community welfare officers, dentists, chiropodists and psychologists will also provide services for the enrolled population of each primary care team.

The number of primary care teams and the ratio of team members will depend on needs assessment, location and population size. In the long term, approximately 600-1,000 primary care teams will be required nationally.

The Primary Care Strategy recognises the need to develop mechanisms for active community involvement in primary care teams.

Community participation in primary care will be strengthened by encouraging and facilitating the involvement of local community and voluntary groups in the planning and delivery of primary care services. Consumer panels will be convened at regular intervals.

At local level, primary care teams will be encouraged to ensure user participation in service planning and delivery. Consumers will also have an input to needs assessments initiated by individual health boards.

The Primary Care Strategy recognises that a greater input from the community and

voluntary sector will enhance the advocacy role of the primary care teams in ensuring that local and national social and environmental health issues, which influence health, are identified and addressed.

4.7 Population health at the centre of public policy

As part of the process of strategic management of Irish Government Departments and Offices, each is obliged to prepare a Strategy Statement covering a three-year period.[32]

According to the ***Guidelines for Secretaries General and Heads of Office on the Preparation of Strategy Statements:***[33]

> **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.**

The restructuring of the health system that led to the establishment of the Health Service Executive (HSE) has resulted not only in new operational and organisational arrangements but the adoption of a population health approach.

The population health approach builds on a long tradition of public health, community health and health promotion, and reflects the shift in thinking about how health is defined and the evolution of thinking related to health. A population health approach is characterised by the following elements:

- A focus on the health of populations based on an assessment of health status and health status inequities, over the lifespan at the population level. It recognises and acknowledges health as a capacity or resource for everyday living that enables us to pursue our goals, acquire skills and education, grow and satisfy our aspirations
- Addressing the broad determinants of health and their interaction. Population health measures and analyses the full spectrum of factors – and their interactions – known to influence and contribute to health
- Evidence-based decision-making, i.e. identification of priorities and strategies to improve health based on evidence of health status, the determinants of health and the effectiveness of interventions
- Directing increased efforts and investments for protection, prevention, health promotion and action on the determinants of health in order to maintain health and address the root causes of health and illness
- The application of multiple strategies and the integration of activities across the wide range of interventions
- Collaboration across sectors and levels, partnership building processes and shared responsibility and accountability for health outcomes with multiple sectors and levels whose activities directly or indirectly impact on health or the factors known to influence it
- The employment of mechanisms for public and local community involvement in the development of health priorities and

strategies and the review of health-related outcomes. This element outlines how the public is involved at different stages of the initiative (e.g. needs identification, planning, delivery, evaluation), including their roles (e.g. advisory committee members, peer helpers) and the processes by which they are engaged (e.g. surveys, focus groups, community fora)

- The identification of accountability tools and the demonstration of accountability for health outcomes. This element identifies the accountability tools needed to capture and report on changes (both intended/actual and unintended) in the health status of populations and in the determinants of health.

Current developments at national level and the lead that the HSE is taking on equality and social inclusion initiatives offer new possibilities for integrating lessons from local initiatives into the development of national strategies. These include:

- The establishment of a National Equality and Diversity Programme and the development of an Equality and Diversity Framework for the HSE
- The development of an Intercultural strategy for the health services. This is being led by the national Social Inclusion Team
- The development of an Ethnic Identifier. This is a Social Inclusion Action for 2006, which will facilitate the collection of data pertaining to ethnicity that can be utilised to enable the development of culturally appropriate services.

4.8 Other policy initiatives to reduce health inequalities and promote social inclusion

A number of targeted policy initiatives have been designed to directly address health inequalities. Other initiatives are intended to impact on health inequalities:

- *Travellers Health: A National Strategy* 2002-2005, Dept of Health and Children (DHC)
- *National Action Plan for Social Inclusion* 2007-2016, Office of Social Inclusion, Dept of Social and Family Affairs. The main themes reflect the socio-economic determinants of health and the Plan includes specific targets to reduce health inequalities
- *The Homeless Prevention Strategy* 2002, Dept of the Environment and Local Government
- *The National Drugs Strategy* 2001-2008, Dept of Community, Rural and Gaeltacht Affairs
- *The Youth Homelessness Strategy* 2001 (DHC)
- *The National Children's Strategy: Our Children, Our Lives* 2000 (DHC)
- *National Plan for Women* (2001) Department of Justice, Equality and Law Reform (DJELR)
- *Planning for Diversity: The National Action Plan Against Racism* (2004) (DJELR)

4.9 The right not to be discriminated against in accessing health services

4.9.1 Equal Status Acts 2000 and 2004

This legislation requires the promotion of equality and outlaws discrimination (direct and indirect) in the provision of goods and services on the grounds of:

- Gender
- Marital status
- Family status
- Age
- Race
- Religion
- Disability
- Sexual orientation
- Membership of the Traveller Community.

4.9.2 Disability Act 2005

This legislation provides a statutory basis for the provision of accessible public services. Sections 26, 27 and 28 of the Act place obligations on public bodies to make their services and information accessible to people with disabilities.

The Department of Justice, Equality and Law Reform have charged the National Disability Authority (NDA) with developing a Code of Practice to guide public bodies to meet their obligations under the Act (Section 30).

4.10 Other policy recognition of community development approaches

A number of government health strategies have prioritised community development approaches, acknowledging that such an approach is ***critical to the successful delivery*** of health strategies.[34]

Initiatives to support community development approaches include:

- the appointment of community development workers in the HSE
- the *Building Healthy Communities Programme* of Combat Poverty Agency, established in 2003 and including funding support by the Department of Health and Children
- funding through the social inclusion sections in each of the HSE areas for local health and social inclusion projects and initiatives
- initiatives supported by the Department of Community, Rural and Gaeltacht Affairs, under the Community Development Support Programme
- local initiatives supported by the Family Support Agency.

SECTION 5: FURTHER READING AND USEFUL CONTACTS

5.1 Further reading

Acheson, D., 1997, ***Independent Inquiry into Inequalities in Health*** Report, 1997, London: Stationery Office.

Asher, J., ***The Right to Health – A Resource Manual for NGOs***, Online at http://www.huridocs.org/poprthea.htm.

Balanda, K. and Wilde, J., 2001***, Inequalities in Mortality 1989-1998: A Report on All-Ireland Mortality Data,*** Dublin: Institute of Public Health.

Balanda, K. and Wilde, J., 2003, ***Inequalities in Perceived Health – A Report on the All-Ireland Social Capital and Health Survey***, Dublin: Institute of Public Health. Online at http://www.publichealth.ie/index.asp?locID=10&docID=-1

Barrington, R., 2004, ***Poverty is Bad for your Health***, Dublin: Combat Poverty Agency, Online at http://www.combatpoverty.ie/downloads/publications/Poverty&Policy/PovertyIsBadForYourHealth_

CESCR, General Comment No.14. On the Right to Health, Online at http://www.ohchr.org/english/bodies/cescr/comments.htm

Combat Poverty Agency, Briefings on Health and Homelessness can be downloaded from http://www.combatpoverty.ie/pub_catalog_index.htm; key papers can be downloaded on Poverty and Health Poverty Briefing http://www.cpa.ie/facts_briefings.html

Frankish, C.J. et al, 1996, ***Health Impact Assessment as a Tool for Population Health Promotion and Public Policy***, Vancouver: Institute of Health Promotion Research, University of British Columbia.

Health Canada, 1998, ***Taking Action on Population Health: A Position Paper for Health Promotion and Programs Branch Staff***, Ottawa: Health Canada. On-line at: http://www.hc-sc.gc.ca/hppb/phdd/pdf/tad_e.pdf.

Irish Travellers Shadow Report, 2005, ***A Response to the Irish Government's First National Report to CERD under the UN International Convention of the Elimination of All Forms of Racial Discrimination***, Dublin: Pavee Point.

Kirby, M.J., 2002, ***The Health of Canadians: The Federal Role,*** Ottawa: Standing Senate Committee on Social Affairs, Science and Technology. Online at www.parl.gc.ca/37/2/parlbus/commbus/senate/Com-e/SOCI-E/rep-e/repoct02vol6-e.htm.

Lynam, S., 2006, ***A Strategy Guide to Support the Implementation of the National Action Plan Against Racism***. Dublin: National Consultative Committee on Racism and Interculturalism.

Lynam, S., 2006, ***An Exploration of Strategies for the Inclusion of Migrant Workers and their Families***, Dublin: POBAL.

Lynam, S., 2006, ***Community Development and Public Policy***, Dublin: Combat Poverty Agency.

Lynam, S., 2004, ***Community Work Approaches to Address Health Inequalities, Strategy Guide No 7***, Galway: Community Workers Cooperative. Online at http://www.cwc.ie.

NGO Alliance Shadow Report, 2004, ***In Response to the Irish Government's First National Report to CERD under the UN International Convention of the Elimination of All Forms of Racial Discrimination***, Dublin: Dominican Justice Office.

O'Toole, G., 2006, ***Community Development and Health Programme: An Intervention for Social Change – A Case Study of the Capacity Building Phase***, Dublin: Cáirde.

Raphael, D., 2003, 'When social policy is health policy: Why increasing poverty and low income threatens Canadians' health and health-care system', ***Canadian Review of Social Policy, 51,*** 9-28.

Raphael, D. and Curry-Stevens, A., 2003, ***The Toronto Charter for a Healthy Canada.*** Toronto: York University School of Health Policy and Management and the Centre for Social Justice. Online at http://quartz.atkinson.yorku.ca/draphael.

UN Special Rapporteur on the Right to Health, Online at http://www.ohchr.org/english/issues/health/right/index.htm.

United Nations Development Programme, 2005, ***Human Development Report,*** Online at http://www.undp.

Wilkinson, R. and Marmot, M., 2003, ***Social Determinants of Health: The Solid Facts,*** Second Edition, Denmark: World Health Organisation. Online at http://www.euro.who.int/document/e81384.pdf.

World Health Organisation, ***Health and Human Rights Project***, Online at http://www.who.int/hhr/en/.

World Health Organisation, ***25 Questions on Health and Human Rights***, Online at http://www.who.int/hhr/NEW37871OMSOK.pdf.

World Health Organisation, Commission on Social Determinants of Health, Online at http://www.who.int/social_determinants/strategy/en/.

5.2 Useful contacts

The following contacts for information on European and International News Electronic Bulletins has been taken from the Public Health Alliance website http://www.publichealthallianceireland.org

- *Commission on the Social Determinants of Health E-bulletin* To sign up, write an email to listserv@who.int Leave blank the subject line of the email. In the body of the message write: SUBSCRIBE CSDHSEC first name and last name. Send the message. You will then receive an email which you need to respond to for confirmation.

- *Peoples Health Assembly (PHA) Exchange Mailing List Discussion* Instructions on how to join the list are given at http://lists.kabissa.org/mailman/listinfo/pha-exchange. To see the collection of prior postings to the list, visit the PHA Exchange Archives http://lists.kabissa.org/lists/archives/public/pha-exchange/.

- *European Public Health Alliance News* To sign up to this monthly news bulletin, subscribe online by visiting the website http://www.epha.org/list/?p=subscribe.

- *EU Health Highlights* 'Health Highlights' is the EuroHealthNet fortnightly electronic newsletter for members and partners. Its aim is to inform national and regional agencies and their decision makers about relevant developments at EU level and from European states. For information about this service and how to obtain it contact l.coulet@eurohealthnet.org. They offer an initial 3-month 'free subscription' so potential users can decide before payment is required.

- *Publichealthnews.com* To sign up to the weekly newsletter service, visit the website www.publichealthnews.com or email: news@publichealthnews.com.

- *International Journal for Equity in Health* To sign up for free access to articles on equity in health visit http://www.equityhealthj.com/home/.

5.3 Contact list for community organisations mentioned throughout the publication

Cáirde
19 Belvedere Place
Dublin 1
Tel. 01-8552111
ceo@cairde.ie

Clondalkin Partnership
Camac House
Unit 4, Oakfield Industrial Estate
Clondalkin
Dublin 22
Tel: 01-457 6433
mail@clondalkinpartnership.ie

Fatima Health Initiative (Fatima Groups United)
185 Fatima Mansions
Rialto
Dublin 8
Tel. 01-4534722
fgu@oceanfree.net

Galway Travellers Movement
No.1 The Plaza
Headford Road
Galway
Tel. 091-562530
donncha@gtmtrav.ie

HSE North Western Area
Áras Sláinte Chluainín
Manorhamilton
Co. Leitrim
Tel: 071-9820400

Lifford/Clonleigh Resource Centre
Croghan Heights
Lifford
Co. Donegal
Tel. 074-9141773
Liffclonrc@eircom.net

Endnotes

[1] Wren, M.A., 2004, ***Unhealthy State – Anatomy of a Sick Society,*** Dublin: New Island Books.
[2] Health Canada, 2001, Strategic Policy Directorate, Population and Public Health Branch, ***Population Health Canada***. Ottawa: Health Canada.
[3] Public Health Alliance Ireland, 2004, ***Health in Ireland, An Unequal State***. Dublin: Public Health Alliance Ireland.
[4] Barrington, R., 2004, ***Poverty is Bad for your Health***, Dublin: Combat Poverty Agency.
[5] Balanda, K. and Wilde, J., 2001, ***Inequalities in Mortality 1989-1998: a Report on All Ireland Mortality Data***, Dublin: Institute of Public Health.
[6] Kirby. M.J., 2002. ***The Health of Canadians: the Federal Role***. Ottawa: Standing Senate Committee on Social Affairs, Science and Technology.
[7] Dahlgreen, G. and Whitehead, M., 1991, ***Policies and Strategies to Promote Social Equity in Health***, Stockholm: Institute of Future Studies.
[8] Health Canada, 1998, ***Taking Action on Population Health: A Position Paper for Health Promotion and Programs Branch Staff***, Ottawa: Health Canada.
[9] Public Health Alliance Ireland, 2004, ***Health in Ireland, an Unequal State***. Dublin: Public Health Alliance Ireland.
[10] WHO Commission on Social Determinants of Health. Online at www.who.int/socialdeterminants/strategy/en
[11] Ibid.
[12] WHO, 2003, ***Child and Adolescent Health and Development***. World Health Report.
[13] Barrington, R., 2004, ***Poverty is Bad for your Health***, Dublin: Combat Poverty Agency.
[14] Nolan, B. and Wiley, M., 2000, ***Private Practice in Public Hospitals***, Dublin: ESRI.
[15] Barry, J., Sinclair, H., Kelly. A., O'Loughlin, R., Handy, D. and O'Dowd, T., 2001, ***Inequalities***

in Health in Ireland – Hard Facts. Dublin: Department of Community Health & General Practice.

[16]Foley Nolan, C., Sheehan, A., Cahill, D., 2002, ***A Better World Healthwise, A health needs assessment of immigrants in Cork and Kerry***, Department of Public Health, Southern Health Board.

[17]European Commission Against Racism and Intolerance (ECRI), 2002, ***Second Report on Ireland***.

[18]Eastern Regional Health Authority, 2004, ***Regional Health Strategy for Ethnic Minorities***. Dublin: ERHA.

[19]Government of Ireland, 2001, ***Framework Document for the Revised National Anti-Poverty Strategy***. Dublin: Stationery Office.

[20]Cited in Lynam, S., 2006, ***Community Development and Public Policy***, Dublin: Combat Poverty Agency.

[21]Macpherson, W., February 1999, ***The Stephen Lawrence Inquiry*** para. 6.34. London: The Stationery Office.

[22]See Lynam, S., 2004, ***Community Work Approaches to Address Health Inequalities***, Strategy Guide No. 7, Galway: Community Workers Cooperative. This text provides a case study outlining the history and development of the model, and the active role of Traveller organisations in the design, development, implementation and evaluation of the model.

[23]Department of Justice, Equality and Law Reform, 2004, ***Planning for Diversity: National Action Plan Against Racism***, Dublin: Stationery Office.

[24] Lynam, S., 2006, ***Integrating Policy into Planning***, Managing Better Series, Dublin: Combat Poverty Agency; Lynam, S., 2006, ***Community Development and Public Policy***, Dublin: Combat Poverty Agency.

[25] Barrington, R., 2004, ***Poverty is Bad for Your Health***, Dublin: Combat Poverty Agency.

[26] Acheson, Sir D., 1997, ***Independent Inquiry into Inequalities in Health*** Report, London, Stationery Office, cited in Barrington, R., ***Poverty is Bad for your Health***.

[27] Combat Poverty Agency, 2005***, Building Healthy Communities: Supporting Community Development Initiatives (2005-2007)***, Dublin: Combat Poverty Agency.

[28] Lynam, S., 2004, ***Community Work Approaches to Address Health Inequalities***, Strategy Guide No. 7, Galway: Community Workers Cooperative.

[29] Cited in Lynam, S., 2006, ***Guidelines for the Development of a Model of a Socially Inclusive Health Centre,*** Dublin: Health Service Executive.

[30] Department of Health, Social Services & Public Safety, 2002, ***Investing for Health A public health strategy for Northern Ireland,*** Belfast: Department of Health Social Services and Public Safety.

[31] Section 75 of the Northern Ireland Act imposes statutory duties to promote equality.

[32] Cited in Lynam, S., 2004, ***Community Work Approaches to Address Health Inequalities*** Strategy Guide No 7, Galway: Community Workers Cooperative.

[33] Department of the Taoiseach***, Delivering Better Government Guidelines for Secretaries General and Heads of Office on the Preparation of Strategy Statement***, Dublin: Stationery Office.

[34]***Primary Care: A New Direction 2001: The National Health Promotion Strategy 2000-2005; The National Health Strategy: Quality and Fairness A Health System for you (2001); The National Traveller Health Strategy.***

GLOSSARY OF TERMS

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' – Community Development Brochure, ADM, 1994.

Community sector refers to the collective of community organisations that are actively committed and working to achieve social and economic change in favour of those experiencing exclusion, poverty and inequality. Their 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 and justice system. Organisations in the sector share a common set of values based on participation, a collective focus, solidarity and accountability.

Health inequality refers to 'the difference in the prevalence or incidence of health problems between individual people of higher and lower socio-economic status' – World Health Organisation 1998. Health inequality or the difference in health experiences and health outcomes between different population groups can be defined by for example socio-economic status, geographical area, age disability, gender or ethnic group.

Health status refers to the description and /or measurement of the level of illness or wellbeing of an individual or population at a particular time. It is based on an overall evaluation of an individual's degree of wellness or illness with a number of indicators, including quality of life and functionality.

Perinatal death: Perinatal deaths include stillbirths and early deaths during the first week of a baby's life. The perinatal mortality rate (PMR) refers to the number of still births and early neonatal deaths as a proportion of the total number of live births and stillbirths.

Population health is a term that describes an approach to health that aims to improve the health of the entire population and reduce health inequalities among population groups. It focuses on the health of particular target groups as distinct from the health of individuals.

design by **www.reddog.ie**

Combat Poverty Agency

working for a poverty-free Ireland

20th Anniversary 1986 – 2006

Bridgewater Centre, Conyngham Road, Islandbridge, Dublin 8

Tel: 01 670 6746 Fax: 01 670 6760 Email: info@combatpoverty.ie Website: www.combatpoverty.ie