Evaluation of the Building Healthy Communities Programme

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Evaluation of the Building Healthy Communities Programme (Phase 2)

CLES Consulting

Contents

Foreword

The Combat Poverty Agency is a State advisory agency developing and promoting evidence-based proposals and measures to combat poverty in Ireland.

In 2003, Combat Poverty launched the Building Healthy Communities programme, in partnership with the Department of Health and Children. The first phase of this programme provided seed funding to community and anti poverty groups to develop community development approaches to tackle poverty and health inequalities. Thirty-four initiatives were funded, which led to a variety of innovative approaches. Learning from this work informed a second phase of the programme, which ran from 2005 to 2008 and was supported by the Department of Health and Children and the Health Service Executive, which provided financial support to a number of projects.

The Building Healthy Communities programme supported three inter-related strands of work, all of which aimed to inform policy and practice in addressing poverty and health inequalities. These strands were supporting inclusion and innovation, networking and research and

documentation. This evaluation focuses primarily on the work of the ten projects which were funded over a three year period.

Combat Poverty would like to thank the Department of Health and Children and the Health Service Executive for their consistent support and assistance; Combat Poverty's Health Advisory Committee, which provided strategic direction, energy and active encouragement to the work; and to CLES Consulting who were responsible for the formative evaluation of the programme and the drafting of this report. A special word of thanks to the funded groups who have contributed so much within their our own communities and at a broader policy level and from whom we have drawn evidence and inspiration to inform our own work.

Combat Poverty Agency
February 2009

Executive Summary

Introduction

This is the final report for the Combat Poverty Agency on the formative evaluation of Phase 2 of the Building Healthy Communities programme. This report has been written by CLES Consulting (Centre for Local Economic Strategies), which was commissioned to undertake the evaluation from December 2005 until December 2007. The main aims of the evaluation were as follows:

- to assess the degree to which the programme's aims and objectives, and the resources committed to their achievement, were appropriate, realistic and met.

- to identify the strengths and weaknesses of the programme.

- to capture the main learning for policy and practice on community development approaches to tackling poverty and health inequalities.

- to analyse and provide evidence of the contribution of the programme to tackling poverty and health inequalities.

- to identify and elaborate the key policy issues arising from the work and make specific policy recommendations on tackling poverty and health inequalities arising from the Building Healthy Communities programme.

- to identify mainstreaming opportunities for the programme.

Background to the Building Healthy Communities programme

The Building Healthy Communities programme was established with four main objectives:

- to promote the principles and practice of community development in improving health and well-being for disadvantaged communities.

- to build the capacity of community health interests to draw out practice and policy lessons from their work.

- to inform and support policy initiatives relating to the links between poverty and health.

- to explore mechanisms for effective, meaningful and sustainable community participation in decision-making related to health.

The programme provided funding and support for 10 initiatives that addressed these objectives in their plans. The projects and their initiatives were:

- **Cairde:** Develop and establish a National Ethnic Minority Health Forum to influence policy.

- **Schizophrenia Ireland:** Establish a national network, the 'Women Together Network', for women experiencing mental health difficulties.

- **Irish Deaf Society (IDS):** Promote Irish sign language to address health inequalities experienced by the Deaf community in access to and provision of health services.

- **Fatima Groups United:** Tackle health inequalities by strengthening community development approaches to health within community and statutory organisations in the context of a broader regeneration process.

- **OPEN (One Parent Exchange Network):** Address issues of isolation and stigmatisation among lone parents through research and planning in four different areas.

- **Galway Refugee Support Group:** Work with asylum-seekers and refugees to ensure provision of appropriate services and support in health.

- **Galway Traveller Movement:** Community-led health impact assessment of official accommodation sites in order to demonstrate the link between health and accommodation for Travellers.

- **Community Action Network (CAN):** Evaluate a community development health course and a learning unit for stakeholders in this pilot programme.

- **Fettercairn Community Health Project:** Develop a community-led health response to promote the health and well-being of residents in Fettercairn, West Tallaght.

- **West Offaly Integrated Development Partnership Ltd:** Inter-agency response for rural communities in Offaly to counter disadvantage and address quality of life issues.

The timeframe across which the Building Healthy Communities programme operated coincided with some of the biggest changes in the health service and health policy in Ireland for many years. This included a complete re-organisation of the existing health service from a structure of regional boards to a much more centralised, unified service, the Health Service Executive (HSE). A number of key policy documents have provided an important context and focus for projects within the programme. These included:

- Primary Care Strategy (2001) *A New Direction. Quality and Fairness – a health system for you.*

- *National Intercultural Health Strategy, 2007—2012.*

- *National Strategy for Service User Involvement in the Irish Health Service, 2008—2013.*

- *Towards 2016:* Ten-year framework social partnership agreement 2006—2015.

- *National Action Plan for Social Inclusion 2007—2016.*

Evaluation methodology

The evaluation methodology was comprised of six main elements:

1. literature review of health policy context and the Building Healthy Communities programme

2. design and analysis of reporting templates for individual projects

3. interviews and visits with project managers

4. strategic interviews

5. attendance at Health Advisory Group meetings and networking meetings

6. reporting, including the production of a number of thematic papers.

Quantitative and qualitative outcomes

A range of quantitative and qualitative outcomes achieved through the programme were identified through the reporting template that was circulated to projects.

Qualitative outcomes

The main qualitative outcomes captured by the evaluation were:

- **building participation and democracy**
  The infrastructure generated by the programme helped raise capacity to participate more effectively both within projects and externally with outside agencies. The infrastructure ranged from opportunities for learning, training and sharing knowledge to the creation of networks and collaborative working.

  Individuals reported that learning opportunities gave them more confidence to participate and greater awareness of health inequalities.

Projects welcomed the opportunities offered to reflect on community development approaches and share good practice. As well as supporting more effective work within communities, projects reported that the programme had given them a better understanding and confidence to engage with policy development and national health structures such as the HSE.

- **development of new partnerships**
  Projects were helped build effective relationships with national and local government organisations, which led, in some cases, to ongoing partnerships for responding to health needs. Evidence showed that community development approaches had helped communities to secure better access to health services and a say in how they were delivered. Participants in focus groups felt that programme activity had improved health outcomes for local people.

- **effective community development approaches**
  Projects were enabled to develop and pilot effective community development approaches to health inequalities and poverty. They applied this approach consistently in their work. Some projects focused on policy change within their own areas while others, especially those with national lead partners, focused more on a national policy perspective.

- **new opportunities for networking, sharing of practice and reflective practice**
  Evaluation research found that the programme had increased opportunities for networking and

for reflecting on and sharing good practice. Projects reported that networking had added value to their work, connected them to the policy world and helped build a sense of community and collective action.

- **development of a networked community**
  The development of networking and the opportunities it gave for sharing experience and practice is a positive legacy of the programme and should continue to be supported. The potential benefits are likely to outweigh the staffing and resource implications that this would entail.

- **strengthening the role of the community health worker**
  The programme funded, in part, the activity of community health workers in some projects. It also supported research that highlighted both the challenges and the benefits that the presence of such a worker can bring to an area, thereby enhancing understanding of the role that the community health worker can play in addressing health inequalities.

- **shared understanding of the principles of community development and the social determinants of health**
  A major qualitative outcome was the greater awareness and understanding among projects of health inequalities and the social factors that influence health within communities. This awareness is important for the process of tackling health inequalities through community development approaches.

- **strengthening the collective voice among community health projects**
  The programme provided many

examples of projects which, individually and collectively, became better able to engage with statutory health services and develop positive partnerships with them, leading ultimately to better and more appropriate health services for disadvantaged communities. The collective activity strengthened the community voice and demonstrated the value of collective rather than piecemeal action.

Quantitative outcomes

- **people involved in or reached by projects**
  Over 900 people were assisted or involved in projects funded by or through the programme. A range of methods were used to reach people including DVDs, road shows, regional meetings and other events.

- **new primary research**
  Nine new research reports, as well as conference proceedings, briefings, information leaflets, area profiles and policy submissions, were generated through the programme. The new research builds understanding of health inequalities and provides an evidence-based approach to seeking responses.

- **number of community groups involved**
  Programme projects worked with many other local and community groups within their networks to build their capacity and level of involvement.

- **meetings and networking events**
  Projects organised a large number of meetings with existing and new partners, both regionally and nationally, to advance their work.

- **networking events organised by Combat Poverty**
  Combat Poverty organised a series of networking events, which enabled projects to share good practice, network with other projects and increase awareness of policy.

- **activities**
  A large number and range of different activities were organised to address health inequalities in communities. This included health impact assessments, targeted interventions to help a specific community, such as older people, and events such as family days, drop-in sessions and awareness-raising sessions.

Discussion of results

The programme funded 10 projects in Phase 2, all of which were successful in achieving or exceeding their original objectives, although some organisations had to amend their original plans in the light of a changing and dynamic context. However, where this was the case, the project activity that developed was in line with the programme's objectives.

Training, networking opportunities, information and links provided by the Combat Poverty Agency empowered participants by providing them with knowledge and understanding of their options and rights. This enabled them to negotiate more effectively with partners.

The development of a programme of activity provided an opportunity to promote the principles and practice of community development among practitioners who were actively involved in developing approaches to tackling health inequalities. The outcomes of the programme, which are described in Chapter 2, illustrate a much greater awareness of community development principles and practice among projects, partners and participants, particularly relating to the social determinants of health and the contribution that a community development approach can make to improving health and well-being for disadvantaged communities. There has been a strong focus within the programme on raising the capacity of community health interests both through the direct work that Combat Poverty has done with projects, for example through networking events, information and training, and within the projects themselves.

As well as drawing out lessons from the practice of community development in relation to health and poverty, the programme also succeeded in the development and implementation of mechanisms for effective community participation in health decision-making. Many individual projects saw the development within their areas of new structures that facilitate communication and participation in the design of services, for example, work done by the Irish Deaf Society to improve communication between health service professionals and the Deaf community, and the setting up by Cairde of the National Ethnic Minority Health Forum.

The programme also used mechanisms, such as Combat Poverty networking events, to encourage community participation in policy-making. These events provided a unique opportunity for projects directly working with people experiencing health inequalities to discuss health and poverty issues with senior decision-making staff in the HSE, the Social Inclusion Unit in the Department of Health and Children (DoHC), the Irish Human Rights Commission and other national organisations

such as Amnesty International Ireland and Community Development and Health Network. This allowed practitioners to talk directly to policy-makers about the realities of health inequalities for disadvantaged communities. There is evidence that this experience was important, not only for the practitioners, but for senior staff within the HSE and the Department of Health and Children.

Strengths and areas for development

There have been a number of key strengths of the programme and some areas for further development:

- *encouraging an evidence-based approach to community development*
  This programme piloted new approaches to community development in order to tackle health inequalities and poverty. This provided a valuable opportunity to test out different models, undertake further research and develop innovative ideas.

- *networking supported by the programme*
  The visits and learning within and between the projects were very beneficial to all participants of the programme. This point was raised repeatedly in all the evaluation work. Information sharing and knowledge building, as well as the training provided, made a difference to all organisations.

- *value for money*
  Considering the relatively small cost of the overall programme, the outcome achieved represented good value for money, particularly as the programme operated at a variety of levels, with national and local activity, among

some of Ireland's most disadvantaged communities.

- *influencing health policy formulation*
  The programme had an important impact in terms of influencing and informing health policy formulation. It helped to raise awareness among projects of policy developments and supported them to link with organisations like the HSE and the DoHC at local and national level. This contributed to pushing issues around health inequalities and poverty up the political agenda.

- *credibility as a partner*
  The Combat Poverty Agency's support for the programme was important for projects as it gave them a higher profile and put them in connection with players they would not normally work with. The majority of organisations felt they were 'part of a bigger structure' and that being funded through Combat Poverty gave them more credibility with partners and other funders.

- *capacity-building within the community development sector*
  The programme helped build and strengthen the capacity of the community development sector. It provided training courses and opportunities for organisations to grow.

- *partnership working*
  The programme facilitated dialogue between different organisations, thereby stimulating partnership working at local level among diverse agencies, such as the HSE, and the community sector. It also supported inter-agency working, which is needed to tackle the inter-related social factors that affect people's health.

- *flexible funding programme*
  The funding provided through the programme was only one aspect of the support offered by Combat Poverty. However, as regards its role as 'funder', project managers considered the programme to be focused but also flexible and adaptable, which is important for community development-type projects.

- *professionalism and management*
  Combat Poverty Agency staff and management were supportive, accessible and interested. They managed the programme to a high standard and with professional expertise, and were extremely helpful to projects. Combat Poverty was deemed to be 'supportive in every aspect'.

Areas for development

- *pilot nature of the programme*
  One of the main weaknesses identified by the projects was the limited funding and time scale of the programme. There is a need for long-term mainstream funding to support this type of work.

- *long-term support to projects*
  The Combat Poverty Agency provided extensive and effective support to the projects in line with the objectives of the programme. However, the programme itself was relatively short

term and, therefore, the ability of Combat Poverty to provide ongoing support after the programme will be relatively finite.

- *resource intensive*
  The community development approaches used in the programme are relatively resource intensive and require a great deal of long-term activity by project officers in disadvantaged communities, getting to know local people and working with disadvantaged communities in the long term.

- *more work on indicators for the programme*
  The programme could explore the development of impact indicators in the future. This would provide a method of capturing whether or not a community development approach to tackling health inequalities is effective and why it is or isn't working.

- *links with Phase 1 of the programme*
  Many projects felt it would have been beneficial if links with projects funded in Phase 1 had been maintained and incorporated into the network developed in Phase 2. There were attempts to involve Phase 1 projects in the programme but as these were no longer funded they may not have been able to participate.

- *connectivity with other initiatives*
  At national level, consideration should be given to how the activity supported through the programme could be integrated with other programmes to support disadvantaged communities, such as the Family Resource Centres or the Community Development Programme.

Recommendations for future policy

The programme has provided an important opportunity to pilot a range of community development approaches to tackling health inequalities. In order to ensure that the benefits of this work are sustainable, it is important that there are mechanisms to support the type of activity funded under the programme. This will require mainstreaming work on a number of levels.

- *mainstreaming of funding for individual projects*
  In most cases individual projects in the programme will require funding to enable them to continue the work that has been started through the programme.

- *mainstream funding for continuation of non-funding programme activity*
  Projects highlighted as important the non-funding aspects of the programme. Non-funding activities include networking events, assistance with developing policy submissions and dissemination of learning. It is the recommendation of the evaluation that these activities should be mainstreamed at some level through support from Combat Poverty and its funding partners at the HSE and the Department of Health and Children.

- *mainstreaming community development approaches to health*
  The community development approaches to health developed through the programme have important contributions to make to tackling health inequalities. Community development projects are able to reach individuals and organisations that mainstream services find difficult to reach. They also provide a way of understanding and responding to changing needs. Therefore within diverse communities, community development approaches used in the programme should be supported through mainstream health services.

Networking

The use of networking as a tool for widening discussion and consultation provided an opportunity for policy-makers to meet with community-based organisations. Such networking should be considered for future projects by statutory bodies that are aiming to improve the quality of life and well-being for disadvantaged communities.

Model of community development approach

The Combat Poverty Agency and its partners in the HSE and the Department of Health and Children should continue to support research into the community development approach to tackling health and poverty in order to make that approach more widely accessible to health professionals at all levels.

Continue to support consultation with community organisations

The programme supported joint submissions by organisations working with disadvantaged communities to inform policy development, including the roll out of the Primary Care Strategy, by presenting collectively and preparing for a national conference; the National Economic and Social Forum (NESF) project team on mental health and social inclusion; the Intercultural Health Strategy; and the User Involvement Strategy. This should be encouraged in the future and there should be active support for the involvement of community organisations and non-government organisations in policy formulation and implementation.

Benefits of community development approaches to health inequalities and poverty

The evaluation results have shown that a community development approach has a range of potential benefits for tackling health inequalities and poverty among disadvantaged communities. Further longitudinal research is required, however, to fully understand the impact these initiatives have on the health of people in a community, particularly given the variety of other factors that may influence health.

Development of indicators to evaluate progress

Work can be done to develop specific indicators around community development approaches to health. These would help to capture the types of impact that these projects have and to measure more clearly the outcomes that projects can achieve. Further work will be required to ensure that the methodologies used to capture information work effectively.

Maintain links to the network

The Health Advisory Group provided a useful and important forum for sharing information and good practice on community development approaches to health and the broader health and poverty policy environment. Even though the programme has ended, community development type approaches and the Building Healthy Communities Network should continue to be an important aspect of these meetings, to help maintain the link between activity in disadvantaged communities and decision-making structures and policy at a national level.

Promotion and dissemination

The programme produced a great deal of useful literature and research, both by Combat Poverty and individual projects. These outputs are detailed in Appendix 1.

The learning from the programme should be captured and disseminated. This process should help to raise awareness and support for community-based approaches and organisations trying to tackle health issues facing disadvantaged communities.

Chapter 1
Introduction

Outline of report

This report for the Combat Poverty Agency evaluates Phase 2 of Combat Poverty's Building Healthy Communities (BHC) programme.

Chapter 1 outlines the background and strategic aims of the programme and the purpose of the formative evaluation of its second phase. Chapter 2 presents feedback from programme organisations with evidence of qualitative and quantitative outcomes. Chapter 3 assesses whether the aims of the programme were met and the resources used effectively. Chapter 4 makes recommendations for future policy based on the evidence found in the evaluation, including the issues of mainstreaming and future support.

Appendix 1 lists resources generated as a result of the programme. Appendix 2a contains the questions used for interviewing projects for the evaluation and Appendix 2b sets out the questions guide for interviewing strategic stakeholders. Appendix 3 contains the reporting template for projects and, finally, Appendix 4 sets out in table format the main characteristics of community development underpinning activity carried out through the programme.

This chapter outlines the background and strategic aims of the Building Healthy Communities programme and the evaluation of its second phase. It sets out the objectives, and the mechanisms used to deliver them, both by Combat Poverty and programme-funded projects. These are presented in a table under four themes that reflect the programme objectives. A link is made between the work of the programme and the aims of Combat Poverty's Strategic Plan. The funded organisations and their project objectives are summarised. Finally, the work of the programme is set within the wider context of developments in national health policy.

Evaluation

CLES Consulting was commissioned by the Combat Poverty Agency to undertake this evaluation for the period November 2005 to December 2007. The evaluation gathered qualitative and quantitative information from projects that were funded through the programme. The key aims of the evaluation were:

- to assess the degree to which the programme aims and objectives, and the resources committed to

their achievement, were appropriate, realistic and were met.

- to identify the strengths and weaknesses of the programme.
- to capture the main practice and policy learning on community development approaches to tackling poverty and health inequalities.
- to analyse and provide evidence of the programme's contribution to tackling poverty and health inequalities.
- to identify and examine the key policy issues arising from the programme and make policy recommendations on tackling poverty and health inequalities.
- to identify mainstreaming opportunities for the programme.

1.1 Background to the development of the programme

Through their work and research the Combat Poverty Agency and its partners identified the need for a funding programme that would focus on supporting community development approaches to tackling poverty and health inequalities. The Building Healthy Communities programme was developed as a result.

Community development approaches to tackling health inequalities were defined by Combat Poverty as:

'A process whereby those who are marginalised and excluded are enabled to gain in self-confidence, to join with others and to participate in actions to change their situation and tackle the problems they face in their community.'[1]

The programme was developed through partnership between Combat Poverty, initially the Department of Health and Children (DoHC) and then later the Health Service Executive when it was established. The core funding came from Combat Poverty but the HSE and DoHC also provided financial support. The DoHC initially funded a project focused on primary care which was continued by the HSE. The HSE also provided resources for two projects working with minority groups, including asylum-seekers and refugees.

In 2003, the first phase of the programme was launched in conjunction with the DoHC. In this, 13 projects were funded on a once-off basis, two of them by the DoHC. This strand of the programme provided annual seed funding to a large number of groups to enable them to explore the links between poverty and health inequalities. Thirty-one initiatives were supported in the first year, aimed at 'developing knowledge, understanding and capacity on the links between poverty and health'[2]. A further 18 projects were funded, again on a once-off basis, in 2004, of which three were funded by the DoHC.

The second phase of the programme began at the end of 2005 and provided an opportunity to work in a more focused way with a smaller number of groups. Ten projects were funded for three years with the focus on learning and sharing models of good practice that demonstrated how community development approaches to tackling poverty and health inequalities could be effective.

The organisations funded under Phase 2 are summarised below with the project names, the name of the lead organisation and a brief description of the original aims of the project.

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1   Combat Poverty Agency (2000) *The Role of Community Development in Tackling Poverty.* Dublin: Combat Poverty Agency

2   Nexus (2004) *The Building Healthy Communities Programme, Evaluation Report.*

Table 1: Summary of projects

Lead organisation	Original BHC project objectives
Cairde	Develop and establish a National Ethnic Minority Health Forum to influence policy.
Schizophrenia Ireland	Establish national 'Women Together Network' for women experiencing mental health difficulties.
Irish Deaf Society (IDS)	Promotion of Irish sign language to address inequalities experienced by the Deaf community in access to and provision of health services.
Fatima Groups United	Tackle health inequalities by strengthening community development approaches to health within community and statutory organisations in the context of a broader regeneration process.
OPEN (One Parent Exchange Network)	Address issues of isolation and stigma among lone parents through research and planning carried out in four different areas.
Galway Refugee Support Group	Work with asylum-seekers and refugees to ensure provision of appropriate services and support in health.
Galway Traveller Support Group	Community-led health impact assessment of unofficial accommodation sites in order to demonstrate the link between health and accommodation for Travellers.
Community Action Network (CAN)	Evaluate a FETAC community development health course and a learning unit for stakeholders in this pilot programme.
Fettercairn Community Health Project	The development of a community-led health response to promote health and well-being of residents in Fettercairn, West Tallaght.
West Offaly Integrated Development Partnership Ltd.	Integrated support for rural communities in Offaly to counter disadvantage and address quality of life issues.

1.2 Objectives and delivery of the second phase of the programme

The second phase had four main objectives:

- to promote the principles and practice of community development in improving health and well-being outcomes for disadvantaged communities.

- to build the capacity of community health interests to draw out practice and policy lessons from their work.

- to inform and support policy initiatives relating to the links between poverty and health.

- to explore mechanisms for effective, meaningful and sustainable community participation in decision-making regarding health.

The four broad objectives can be summarised under the four themes that, along with examples of Combat Poverty's delivery mechanisms, are outlined below.

Theme 1: Supporting inclusion

Combat Poverty has been keen to actively support the principle of inclusion within the health services. This includes enabling the participation of communities in the design and development of health services and making the voice of communities, particularly new communities, heard within health services, so they can contribute to the development of accessible and appropriate services that meet diverse needs.

Types of activity undertaken by Combat Poverty Agency	Types of activity undertaken by funded projects
• Awareness-raising through involvement in cross-departmental groups, e.g. Health Advisory group, Primary Care Steering group • Funding support to consult and develop submissions to the Intercultural Health Strategy	• Undertaking research and awareness-raising with local partners • Development of projects that aim to widen access and participation

Theme 2: Networking and sharing experiences

Combat Poverty and programme projects have actively sought to develop opportunities for networking and sharing of good practice and experiences. This has been an extremely positive element of the programme, which has widened understanding and enabled projects to make new links with government departments and policy-makers.

Types of activity undertaken by Combat Poverty	Types of activity undertaken by funded projects
• Organisation of national networking events for programme projects • Brokering meetings between government departments and individual projects in order to raise awareness and develop new partnerships • Facilitating cross-departmental meetings to discuss issues arising from projects • Using networking opportunities to inform policy-makers of lessons from the programme • Web-links and email updates to projects on policy and best practice • Support to the CAN (Community Action Network) learning unit to document a model of community development and health involving local community health workers • Funding support to foster inter-project networking • Support to projects to develop joint inputs into conferences	• Undertaking best practice visits with other projects • Participating in networking events • Disseminating information and lessons learned from the experience of projects within the programme

Theme 3: Research, evaluation and documentation

An important element of the programme was its focus on research, evaluation and documentation of evidence around the value of community development approaches to tackling health inequalities.

Types of activity undertaken by Combat Poverty	Types of activity undertaken by funded projects
• Collating research from the programme and disseminating to government departments and agencies in order to inform policy and practice • Publishing documents, guidance and research on community development approaches to health • Evaluation of the Building Healthy Communities programme	• Primary research into the health needs of specific groups, including Travellers, lone parents, asylum-seekers and minority ethnic groups • Evaluation activity to understand the impact of the work undertaken through the programme

Theme 4: Policy work

Policy has been a crucial element of the programme. The programme sought to pilot new approaches and also to use the experience of the programme to develop and inform new policy that addresses issues being tackled by individual projects.

Types of activity undertaken by Combat Poverty	Types of activity undertaken by funded projects
• Brokering discussions with departmental representatives and projects to discuss current and future policy • Facilitating individual groups to contribute their ideas and experience to policy-makers, e.g. funding to develop the Intercultural Health Strategy • Providing a forum for discussion and dissemination of policy information at networking events • Consulting projects on the development of the health policy statement • Provision of technical support and specialist personnel to promote policy lessons from work	• Development of responses to policy including the Intercultural Health Strategy and the National Strategy for Service User Involvement • Participation in policy workshops at networking events • Working with partners to inform local and regional policy on health inequalities

1.3 Strategic importance of programme and Combat Poverty's Strategic Plan

There are three strategic objectives in the Combat Poverty Agency Strategic Plan 2005—2007[3]:

- *distribution of income and jobs*
  To promote a fairer distribution of income and employment by providing evidence-based advice on tax, welfare and employment policies.

- *access to quality services*
  To develop and promote policy proposals for people in poverty to have access to quality health and education services.

- *local and regional responses to poverty*
  To support local and regional responses to poverty, including those in border areas affected by the Northern Ireland conflict.

The aims of the Building Healthy Communities programme have a direct link to the second and third strategic objectives, in that the programme focused on developing work to support disadvantaged communities in tackling poverty and health inequalities, particularly under the goals of informing health services and the development of healthier communities. The programme delivered outcomes in line with this strategic objective through a number of important roles:

- *provision of funding*
  The programme has provided funding to groups and organisations to support the development of new approaches to tackling health inequalities and poverty.

- *capacity building and infrastructure support*
  In addition to funding, the programme supported groups and organisations working in the field of health and poverty by informing them about government policy and research; by providing opportunities for networking between groups and by offering groups the chance to inform the development of new policy. In addition, the programme supported projects in building the capacity of local groups so they could begin to tackle health inequalities themselves and, through this work, influence the work of local partners in health and social services.

- *encouraging an evidence-based approach*
  The programme has supported research into the links between health inequalities and poverty and raised awareness of the social determinants of health. This encouraged groups to carry out research and document evidence-based approaches to tackling health inequalities and poverty.

- *facilitating links and networks*
  The programme played an important role as a facilitator, helping to forge better relationships and more productive links between organisations and groups involved in the programme, other community health organisations and national statutory agencies.

- *making a positive contribution to policy debate*
  The programme has helped to empower local groups to make a positive contribution to the wider policy debate around health inequalities. A number of groups have been able to make an input into

3 Combat Poverty Agency (2005) *Working for a poverty-free Ireland: Strategic plan 2005—2007.*

various policies including the Primary Care Strategy, the Intercultural Strategy and Combat Poverty's own Health Policy Statement.

The Combat Poverty Agency set up a Health Advisory Group, which included representatives from the BHC projects as well as representatives from the Department of Health and Children, the Office for Social Inclusion, the HSE and a public health doctor. This group oversees its work on health to ensure that programmes such as Building Healthy Communities link with Combat Poverty strategic aims and objectives. The Health Advisory Group has been an important component in helping to inform the development and delivery of the Building Healthy Communities programme, supporting policy elements of the work and providing a robust level of accountability for the performance and management of the programme as a whole.

1.4 Overview of projects funded through the programme

Ten projects were funded through Phase 2 of the Building Healthy Communities programme. Some were located within a host organisation or as part of a larger initiative, whilst others were stand alone projects. Some projects operated at a local or geographic level, whilst others aimed to work at a regional or national level with a thematic focus (e.g. Travellers, ethnic minorities, lone parents or women with mental health issues). Therefore the projects belonged to two main categories, namely:

- *theme-focused*
  These operate at regional or national level, focusing on tackling inequalities within specific interest groups such as asylum-seekers, Travellers,

lone parents and Deaf people, e.g. the Galway Refugee Group, Galway Traveller Movement, One Parent Exchange Network and the Irish Deaf Society.

- *area-based*
  These are projects with a local area focus, aimed at developing a community response in specific geographic locations, including a rural community (e.g. West Offaly), the urban inner city (e.g. Fatima Mansions) and a suburban area 'on the margins of the city' (e.g. Fettercairn, Tallaght).

The varied nature of these projects provided an opportunity to test similar community development approaches in a variety of areas and issue-based contexts. This encouraged learning and understanding from the different scales at which organisations operated, all using health as a common denominator to tackle inequalities and adopting community development methods.

1.5 Health policy context for the programme

The period during which Phase 2 of the Building Healthy Communities programme operated coincided with the biggest changes in health services and health policy in Ireland for many years. In addition, there were substantial changes in the economy and society at large as the impact of economic growth and the associated property boom were felt. The health services were completely reorganised under one body, the Health Service Executive (HSE). The establishment of the HSE in January 2005 brought significant change in personnel and structures throughout the health service.

In a variety of health policy documents, the HSE placed greater emphasis on the importance of 'community', 'involvement of local community' and 'community-based approaches' to health. The Primary Care Strategy[4], for example, highlighted the lack of user participation in service planning and delivery as one of the principal inadequacies in the 'current system of primary care'. The Strategy also stated that the new primary care services would have a 'broad focus' that would include linking to community development projects. Similarly, the DoHC developed community participation guidelines and community involvement in primary care guidelines[5]. Published in 2007, the National Action Plan for Social Inclusion also recognizes the considerable inequalities present within the health service and the need to widen access and inclusion[6].

However, despite this progress, there has been less certainty among policy-makers about how commitment to community involvement should translate into delivery within the health service. This is where the Building Healthy Communities programme has played an important role in providing

policy-makers with a clear link to 'on the ground' delivery. Given the importance of these contextual changes, a number of policy documents have had particular significance for the Building Healthy Communities programme:

- *Primary Care Strategy (2001) A New Direction. Quality and Fairness – a health system for you*
  This health strategy set out the direction for primary health services and set the scene for the development of primary care teams. It recognized some of the serious shortcomings of the current system of health and recommended changes to improve the quality and accessibility of the current service. Combat Poverty played an active role in providing information, evidence and guidance as to how primary care provision might involve disadvantaged groups and communities. From this emerged the four-year Transformation Programme, which aimed to deliver more jointly-located primary and community services in an attempt to reduce the emphasis on hospital care.

One of the most important activities that focused on primary care was a national conference organised by Combat Poverty in 2007, which sought to explore community participation in the planned

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4   Department of Health and Children (2001) *Primary Care A New Direction. Quality and fairness: A Health System for You*. Page 16.

5   Combat Poverty Agency (2007) *Health Policy Statement*.

6   Office for Social Inclusion (2007) *National Action Plan for Social Inclusion 2007-2016*.

new primary care structures[7]. The BHC programme projects developed a collective presentation to the conference and developed a paper entitled *Nine Steps to Participation*. The conference was attended by a broad range of people including policy-makers, HSE personnel and individual groups and projects. It provided a valuable forum for discussion of the Transformation Programme and dissemination of information about how it might affect local areas and groups.

- *National Intercultural Health Strategy*
  This was published by the HSE in February 2008. The Intercultural Health Strategy was developed in response to huge demographic change in Ireland in the last decade. It focused on ensuring healthcare services are accessible and delivered to communities of interest in a culturally appropriate and respectful way. In conjunction with the HSE social inclusion unit, the Building Healthy Communities programme funded two organisations working with Travellers and minority ethnic communities to conduct national consultations. Reports of these consultations were made available and Combat Poverty made a submission based on them.

- *National Strategy for Service User Involvement in the Irish Health Service*
  This was published in May 2008 and aims to give users of health services in Ireland a greater say in the running and operation of health services. It was produced by the Department of Health and Children and the Health Service Executive in consultation with the Health Services Partnership. Combat

Poverty co-ordinated a response to the strategy from participants in the Building Healthy Communities programme. This facilitated groups, which otherwise might not have been aware of how to respond, to inform future policy through their thoughts, ideas and experiences. A number of projects also developed individual submissions to the strategy.

- *National Action Plan for Social Inclusion 2007—2016*
  In 2007, the Government published its plans for ensuring greater social inclusion over the coming nine years. It outlined a number of goals including reducing the level of consistent poverty and the development of 500 primary care teams by 2011, targeting medical card holders. A number of the projects were interested in influencing the roll of the Primary Care Strategy - the majority work to be with medical card holders and some of the most marginalised communities in Ireland.

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7   Combat Poverty Agency (2007) *Community Participation in Primary Care Conference Report.*

Chapter 2
Results from Evaluation

Outline of chapter

In this section we discuss the methodology used for the evaluation of the Building Healthy Communities programme and, based on the methodology, the results from the evaluation, which assess the programme's achievements. Feedback from projects and evaluation evidence of the application of community development approaches are presented. Quantitative and qualitative outcomes are discussed and examples are listed of how the collective voice was strengthened among health structures through programme activity.

2.1 Introduction

The methodology designed for the evaluation was formative, which aimed to evaluate the performance of the programme at regular intervals. A formative evaluation provides the opportunity to learn lessons, which then can be fed back into the programme to amplify strengths and address weaknesses so that the programme can be improved.

As this was also a programme evaluation, the focus was on understanding and capturing evidence about the impact of the programme as a whole rather than focusing

on capturing the learning from individual projects. CLES developed and prepared three policy papers on some of the issues and themes arising from the programme:

- *Policy paper 1* considered some of the key characteristics of the projects in Phase 2 of the programme, focusing particularly on the types of infrastructure that have been established through the programme to facilitate community development approaches to health on both a national and local basis.

- *Policy paper 2* aimed to build on the experience of the programme to highlight the situation of communities that are faced with health inequalities, both in terms of quality of life and access to primary and secondary health services.

- *Policy paper 3* sought to consider the different models of community development used to deliver the programme aims across the 10 projects.

2.2 Methodology

The methodology chosen for this work is detailed below.

Literature review of the health policy context and the programme

The first stage of the methodology was to understand thoroughly the policy and societal context for the Building Healthy Communities programme, as well as the structure and form of Combat Poverty's work. To do this, a large volume of literature including reports, research, previous evaluation work and other documents was reviewed by the evaluation team. We reviewed existing information, including web-based material, about individual projects and groups.

The literature review provided considerable insight into the policy context within which the programme operated and a comparison between the activities and outcomes of this programme and other research exploring similar issues elsewhere within the Combat Poverty Agency.

Design and analysis of reporting templates for projects

In the first year of the evaluation, a standard reporting template was developed, which went to all projects as part of their regular progress reports and financial updates to Combat Poverty. The template was customised to include a number of evaluative questions, the analysis of which was used to inform the evaluation. This analysis was achieved by aggregating the quantitative information and by identifying the key themes that arose from the more qualitative information. This was a useful way of gathering standardised information on a regular basis from the projects. The

reporting templates were circulated to the 10 projects at nine monthly intervals from June 2006 to December 2007. A copy of a blank template is provided in Appendix 3.

Interviews and visits with project managers

Interviews were conducted at the beginning and end of the evaluation (spring 2006 and autumn 2007) in order to measure performance and progress made. A standard interview proforma was used to semi-structure these interviews, a copy of which is attached in Appendix 2a. The interviews were written up and, in the case of the reporting template, analysed to identify key themes arising from this qualitative information.

The evaluation team met with four of the projects at greater length as part of the development of the area profile work that CLES had been contracted to do for Combat Poverty. The aim of this work was to look in detail at links between poverty and ill-health as experienced by people living in four different geographic communities. The area profiles provided an additional opportunity to extract learning and evidence about the programme and added considerable depth to the evaluation material. CLES was also contracted to provide evaluative support to each of the ten projects funded through the programme.

Strategic interviews

Interviews were conducted with strategic stakeholders throughout the course of the programme. Interviewees included representatives from:

- The HSE at national level
- The Social Inclusion Unit of the Department of Health and Children at national level

- Local statutory stakeholders including local authority and health service personnel
- Combat Poverty's Building Healthy Communities team

A copy of the interview proforma used is attached in Appendix 2b.

Attendance at the Health Advisory Group meetings

We attended a number of the Health Advisory Group meetings. This group is comprised of representatives from a range of professions and government departments and agencies that have a particular interest in poverty and health, including the HSE and the Department of Health and Children. It was a useful opportunity to get views on the interim findings and on the future direction of the programme.

Attendance at networking events

CLES Consulting attended a number of the early networking events held for projects. These were useful introductions to the programme and its participants. It provided an insight into the key challenges that projects faced in their activity.

Reporting

As this was a formative evaluation spanning two years, CLES Consulting produced a number of interim reports to summarise the findings at each stage of the evaluation. These were:

- an interim report summarising the main findings in November 2006
- an interim report summarising the main findings in June 2007
- a final report summarising the main findings and policy recommendations

2.3 Qualitative and quantitative outcomes achieved

Within the programme administration, projects were not required to collect and report detailed information on qualitative or quantitative outcomes from their activity. However, the evaluation was keen to capture some evidence about the types of qualitative and quantitative outcomes achieved by projects individually in order to analyse the overall impact of the programme.

This information was collected formally through the reporting template, designed to meet Combat Poverty reporting requirements and gather enough evidence from projects. This was circulated a number of times during the programme and also informally through discussions with individual projects. The findings were also informed through additional reports and research produced by the projects themselves. It is difficult to be absolute about these findings, but they provide at least an indication of the type of impact the programme had.

2.4 Qualitative outcomes

Qualitative outcomes refer to the wider effects of the programme within the target communities. The target community refers to the geographic and sectoral communities that participated in the programme. Through analysis of the reporting templates and discussions with project managers, the evaluation highlighted a number of key qualitative outcomes.

Building representative infrastructure and organisational capacity

The building of representative infrastructure among groups leading to the development of capacity for both

individuals and organisations was one of the most striking outcomes that emerged. Individuals from specific communities (either geographic or sectoral) reported that they had had the opportunity for 'learning' and 'awareness' and had experienced 'greater confidence' as a result of activities, for example, training provided through the individual projects. Building this infrastructure improved individual awareness of the social determinants of health and enabled people to participate in the projects and, in turn, to have their voice heard more clearly.

The work undertaken in Fettercairn provides a good geographic example. The model of work adopted by the Fettercairn Health Initiative was to develop local capacity and leadership in order to develop new facilities for health in Fettercairn. The project provided a group of local residents with Participatory Rapid Appraisal Training (PRA). This helped strengthen their understanding of health needs within their community and about how decisions are made locally about health services.

Organisations reported that they had benefited from the programme as the project work had enabled them to:

- receive training;
- access opportunities for reflective practice and discussion;
- access opportunities for networking and sharing of good practice.

People who were consulted described an increase in 'awareness' and 'much greater insight' into health inequalities and poverty links. This enabled them to become more active and influential. In Schizophrenia Ireland (SI), for example, the women participating in the Women Together

Network experienced much better levels of mental health and personal self-esteem as a result of being involved. The women are:

'Now able to turn up at meetings and their presentation skills have improved significantly. Their contribution to meetings is also remarkable.'

This enabled them to participate much more effectively in the organisation. Similarly, in Cairde the project worked with a range of small community organisations throughout the country. These smaller, individual bodies really benefited from being involved in the larger programme as it helped them to develop positive and effective relationships with other organisations, strengthened their governance structures and improved their understanding of policy formulation and the process of government. This directly contributed to the main output of the project, the development of an Ethnic Minority Health Forum and the emergence of a strong ethnic minority health voice.

'The emergence of an ethnic minority health voice and linking ethnic minority groups to local partnerships and non-governmental organisations (NGOs) are some of the outcomes of the regional and national work.'

Organisations running projects all reported the value of being part of the programme and said they had benefited significantly from the experience in terms of capacity building and policy influencing skills and strategies. The most commonly cited examples were:

- a better understanding of policy development;

- the opportunity to contribute to the policy-making process. Cairde and Galway Refugee Support Group, for example, had an input into the Intercultural Health Strategy;

- development of good working relationships with national partners;

- better understanding and awareness of national partners and how they operated e.g. Health Service Executive.

Galway Refugee Support Group provides another example of the way in which organisations have benefited. They played an important role in gathering evidence and lessons to make an input into the development of the Intercultural Health Strategy. They were approached also by the HSE to develop a new committee to inform the work of the HSE on issues concerning minority ethnic groups.

Feedback also demonstrated that organisations found the programme important in terms of enriching their own understanding of health inequalities. It gave them access to new opportunities for capacity building, for example, through the Action Learning Network. This was a project developed by CAN and it provided an action learning network for four other projects funded through the programme. It gave projects and their individual statutory partners space to discuss the different community development approaches to tackling health inequalities and the opportunity to share experiences and good practice. This learning was then taken back to the individual organisations.

Feedback also showed that the programme enabled organisations to further develop their infrastructure and become more effective. All of the organisations work with communities that experience considerable health inequalities and poverty and they find that staff and participants are deeply affected by their experiences of inequity. There is a need to encourage them to re-focus and re-channel their energy and sometimes their anger to positive and collective action to tackle the issues. A number of projects felt they had managed to achieve this by:

- encouraging networking among participants, which provided an opportunity to share experiences;

- raising awareness of the extent of the issues. This helps participants understand that theirs is not an isolated case. It enabled them to work collectively on certain issues, for example, the projects worked together in advance of Combat Poverty's July 2007 national conference on primary care to make a presentation to key HSE stakeholders in primary care on the health inequalities experienced by their communities;

- providing positive avenues along which to channel energy and ideas, for example informing the development of policy and facilitating links with national organisations.

Development of new partnerships

The majority of projects reported that the programme had helped them build and develop effective relationships with national and government organisations, including government departments, the HSE and the National Economic and Social Forum. The Irish Deaf Society (IDS), for example, worked with the HSE to improve access for the Deaf community to hospitals and health information. This scheme would

greatly improve communication between medical professionals and members of the Deaf community. On a regional basis, projects such as the West Offaly Partnership Community Health Planning Project provided a model for future delivery of support by the HSE in a specific area.

There were also examples of where the project helped closer co-operation and inter-agency work between partners. This occurred with West Offaly Partnership who reported that to meet the needs of the community, the project had helped to bring together partners drawn from the local authority, the community and voluntary sector and the HSE - who otherwise might not have worked together. Similarly, the Galway Traveller Movement project, although there was still much work to be done, had provided solid evidence on health issues, which was used to develop partnerships further and raise awareness.

Improved health outcomes for disadvantaged communities

The projects aimed to use community development approaches to tackling health inequalities within disadvantaged communities and to promote better access to services, in particular health services. An important question must be whether this activity resulted in improved health outcomes for disadvantaged communities. The programme itself focuses on two main groups:

- **disadvantaged communities** geographical communities who experience health inequalities because of issues of deprivation or isolation.

- **sectoral or communities of interest** groups such as Travellers, lone parents, women with mental health

issues, the Deaf community and ethnic minority groups.

The evaluation found evidence that the community development approach within the programme had led to improvements in the ability of disadvantaged communities to access health services and to have a voice in how these services were delivered. The Irish Deaf Society's work to promote awareness of Irish sign language among health professionals, and the Galway Refugee Support Group's efforts to secure better health services for asylum-seekers and refugees, were examples of this.

The programme's support for projects that were focused on a community of interest aimed to develop new mechanisms and structures to enable groups to have a much stronger voice and a subsequent input into health policy. This has important implications for health service provision both nationally and locally.

Evaluation evidence from the geographic communities within the programme also demonstrated that participants within health initiatives had really benefited from their involvement. Research carried out using focus groups of participants showed a consensus in each of the projects that the activity supported by the programme had had an extremely positive impact on health outcomes for local people. Comments such as those below were typical of the responses from these areas when they were asked how the project activity had influenced their health:

'We feel a lot better about the future'. (Local residents involved in the group)

'It makes you feel good in yourself'. (Project participant)

'You don't worry as much when you're at it'.
(Project participant)

'If you have problems, you feel that you can talk – a problem shared'.
(Project participant)

'The one big thing that came out of this is the fact that they (the children at the school) are more aware of the need to keep control of their health both now and in the future'.
(Head teacher involved in a project)

Feedback from partners within the area-based projects mirrored these comments. Typical statements about the way in which projects had benefited local health outcomes included:

'I think it (the health project funded through BHC) has been great and has let communities take a certain element of control over their own lives and let them assess what they need and let them go about it. In communities where it has been going on for a few years now, it is starting to show real results, in that it has spawned local projects and programmes and got people involved'.
(Local authority partner)

'The project provides an opportunity for people to have a say about their area and get involved in their community.'
(Local councillor)

'The honest answer is, without the Building Healthy Communities project, we would not have achieved what we have in this project as a partnership group.'
(Local education partner)

'It's known by the people now. They provide a lot of services locally on the ground for people without any kind of bureaucracy. They do practical courses as well. They've been to the GPs and done blood pressure checks for

people who never normally do such a thing'.
(HSE representative)

'Lots of people have taken up doing some sort of exercise now as a result of the project.'
(HSE representative)

These comments demonstrate that the community development approach to tackling health inequalities does start to break down some of the inequalities and give people better access to health services. It also helps people become aware of their own health condition and the social determinants of health. In addition, the projects have responded to these needs by providing assistance, either by directing participants to local provision or by working with partners to develop effective responses. These responses have helped people to feel better about their health and take positive action towards improving it.

However, although it is important, it is very difficult in an evaluation of this kind to make an assessment of positive health outcomes because of the time lag between the project implementation and the potential outcomes, and because individual responses within the communities to the projects vary enormously depending on their own circumstances, which can be very complicated.

The Building Healthy Communities programme was delivered over three years. More longitudinal research is needed in the future to study the precise impacts of these interventions on the health profile of individual people.

Effective community development approaches

The programme has provided an opportunity for projects to develop and pilot community development approaches to tackling health inequalities and poverty. The Combat Poverty Agency produced a document in 2007, Community Development and Health[8], which outlined the main community development approaches to health and the characteristics that this approach involves. Evidence from evaluation feedback demonstrates that these characteristics underpin the projects that make up the programme[9]. These characteristics are:

- builds capacity;

- builds understanding and analysis;

- involves people collectively;

- builds awareness;

- enables groups;

- builds confidence, knowledge and skills collectively;

- strengthens the organisational capability of excluded groups and communities;

- develops innovative and creative approaches;

- advocates for policy change;

- articulates rights, including the right to health;

- promotes networking;

- devises strategies to promote equality and interculturalism.

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8   Lynam, S. (2007) *Community Development and Health*. Combat Poverty Agency.

9   Lynam, S. (2007) *Community Development and Health.* Combat Poverty Agency.

If one analyses the approaches taken in each of the projects and checks them against the characteristics above, it demonstrates the way in which the programme has supported a range of community development approaches to health. However, it is important to note that this was a desk exercise based on the evaluation material and it should not be seen as empirical evidence but rather as a tool to understand how the different projects operated. Although all the projects demonstrated a range of the characteristics above, Appendix 4 has attempted to identify the main characteristics that the projects demonstrated. As Appendix 4 shows, the activity supported by the programme consistently applied a community development approach to health. The main difference within the characteristics can be seen with the area-based projects in Fettercairn, West Offaly and Fatima Mansions, which tended to focus more on policy change within their areas and less on policy change and the organisational capability of excluded groups. Other issue-based projects and those headed by national lead partners had a stronger focus on policy change as they were working from a national strategic perspective.

Development of new opportunities for networking, sharing of good practice and reflective practice

The programme increased opportunities for networking, sharing of good practice and reflective practice by organising regular networking events, supporting the action learning unit and distributing guidance and information about policy and practice at a national level. This was one of the most overwhelming positive conclusions from feedback in interviews and reporting templates.

All of the projects reported that networking gained through the programme added real value to their work and gave them a direct connection with the policy world, helping to improve their understanding of government and public policy in health. There were also a number of spin-off events, which have been taken forward by individual projects, aimed at bringing other projects together to discuss different aspects of the community development approach to health. The following comment was typical of feedback on the reporting templates:

'Networking and linking with other similar projects has helped develop the project, particularly giving participants an opportunity to meet other projects, sharing information, experience and learning, and giving a sense of being part of a wider network of groups promoting community development approaches to health.'

This comment also illustrates that networking had the affect of making projects feel much less isolated and remote, and helped build a sense of community and collective action that is fundamental to any community development approach.

Development of a networked community

Linked to the above point, an important qualitative outcome was the development of a 'networked community' of organisations that are able to share experience and practice of different community development approaches to poverty and health inequalities. This networking was led by projects that participated in a planning group, which met before and after each networking event.

In their response to the evaluation, projects talked of being 'part of the Building Healthy Communities programme'. The network has been facilitated by the involvement

of Combat Poverty, which has helped to build and strengthen this network over the programme's lifetime. Thjs was done through:

- regular networking events;
- regular policy and information briefing papers and publications;
- facilitated access to government and national organisations;
- access to funding for project work and other central support such as advice on dealing with the media.

This network is an extremely positive legacy of the programme and should continue to be supported as it can build on the research, awareness raising and networking engendered by the programme.

The specific benefits of such a network might include:

- ongoing links between groups and policy-makers;
- dissemination of new research from groups and identification of gaps in current research base;
- a supportive environment for existing groups to learn from each other and to share good practice;
- a co-ordinated representative forum of people living with health inequalities for government departments and the reformed health services to involve and consult with on a regular basis.

There are implications that flow from maintaining this type of forum, including staffing, resources, accountability and membership, but the potential advantages are likely to outweigh these operational issues.[10]

10 CLES (2007) *Succession Strategy for the Building Healthy Communities Programme.*

Strengthening the role of the community health worker

The role of the community health worker came across as an important aspect of the projects particularly in the area-based initiatives:

'In terms of getting the people to contribute back into their community, they develop community leadership skills and that is what the community needs so desperately. Even if you go out with the community health workers – as I do – I'm always amazed at how many people they know and how many people they are on first name terms with. They can persuade people to get involved with things that are happening that we wouldn't have a hope in hell of achieving.'
(RAPID co-ordinator)

The funding from the Building Healthy Communities programme supported these workers at least in part, supplemented by funding from other sources. However, not all projects had funding for a community health worker, for example, Fettercairn relied entirely on volunteer support. Feedback from project partners and volunteers suggested that having a community health worker in place to work on the initiative was extremely important for the success of the project.

Further research was undertaken by CAN into the role of the community health worker as it was recognized that more study was required. This research built on the work undertaken by CAN within the Action Learning Unit, which provided deep insight into the community health worker role and included detailed research with participants of the programme[11]. This research highlighted many of the challenges

11 CAN Action Learning Group (2007) *The Community Health Worker*.

that practitioners face in playing this role in a community, as well as the many important benefits that the community health worker can bring to an area by working closely with the community and with partners.

Shared understanding of community development and the social determinants of health

From discussions, it would appear that the programme has engendered a shared understanding among projects of the principles of community development approaches to health, and of the social determinants of health (Figure 1). The majority of projects stated that raising awareness of health inequalities for their target group was a major qualitative achievement.

Cairde feel there is now a 'strong understanding of policy formulation among participants', as well as a 'good understanding of social determinants of health'. The Women Together Network has helped in the recognition of mental health issues for women. For organisations such as the Irish Deaf Society, the outcomes have been to stimulate an understanding of health issues among the Deaf community, of the way in which medical professionals communicate with Deaf people, and of the issues of wider social welfare within the community.

Within geographic communities, several projects showed that there was much greater awareness of the social determinants of health among people in the community as a result of their contact with the project. Through the training work undertaken by Fettercairn, for example, local people had a better understanding of the factors contributing to poor health in their community.

Whitehead and Dahlgren (1996) Tackling Inequalities in Health

Key determinants of health call for an 'open' health sector

Environment, water and sanitation, education, employment, trade, tourism, agriculture, fisheries and food, transport and infrastructure, social policy and welfare, energy, accommodation and housing.

Similarly, in West Offaly, through the community health planning process, there was a greater appreciation of the factors that contribute to health inequalities in a particular geographic area, such as rural isolation, poor housing and unemployment.

This increased awareness of health inequalities is extremely important for starting the process of positively tackling these inequalities through community development approaches to health.

Strengthening of collective voice among community health projects

One of the interesting outcomes from the programme, as described by a number of projects, was a strengthening of the collective voice among community health professionals and participants. At the end of

the programme, the projects had a greater ability to engage with statutory health services and to lead on the development of positive partnerships that have helped to inform current and future health services and ultimately a higher standard of care for disadvantaged communities.

This has advantages for disadvantaged communities, in that they receive a more appropriate and higher standard of care, and for the health services, which can deliver a better standard of care that is more tailored to the needs of the whole community. Ultimately, such care will be used and delivered in a more efficient and cost effective way because it better matches the need. There are strong examples of where this kind of activity has taken place within the programme, including:

- engagement with health practitioners, including GPs and hospitals, to provide advice and guidance around the needs of disadvantaged communities.

- policy submissions on the development of an Intercultural Health Strategy for ethnic minorities.

- policy submissions to inform the development of the HSE User Involvement Strategy.

- policy submissions to the National Economic and Social Forum highlighting issues around mental health experienced by asylum-seekers and refugees and putting proposals to them about how to address the issue.

- staging of networking events for programme projects to raise awareness of health policy changes and to provide guidance to groups on how they can influence policy in the future.

- staging of national events to explore specific elements of health policy in order to raise awareness of changes being developed and to provide groups with the opportunity to discuss these issues, for example, the Participation in Primary Care Conference 2007.

- publication in print and DVD of information and advice to health professionals on the needs of disadvantaged communities.

- published information about disadvantaged communities who experience health inequalities.

- development of training and advocacy programmes to support community development approaches to health.

- closer working at local level between community sector representatives and local authorities, which helps to improve local accountability.

- examples of the programme cited in a best practice case study for the World Health Organisation on poverty and health (Resolution EUR/RC52/R7).

Some of these activities were undertaken individually but many were undertaken through collective action within the programme and co-ordinated by both programme support staff and representatives from projects who helped co-ordinate responses from other projects. This activity undoubtedly strengthened the voice of the sector in Ireland, making individual projects more aware of the policy system and how they, as practitioners, could influence the wider decision-making process. It also demonstrated the value of developing a programme of activities across a range of different communities, as it gave the opportunity for collective action and response, meaning the community development voice was 'as one' and co-ordinated.

Table 2: Summarising the main quantitative outcomes of the programme

Type	Approximate figures
Number of people assisted/involved in the projects funded by the programme	983
Number of pieces of new published primary research produced through the programme	9
Number of training events or workshops organised	15
Meetings/networking events (local, regional and national) organised by projects themselves	58
Annual networking events organised by Combat Poverty Agency to which projects and participants were invited	7
Community groups involved (in addition to 10 organisations funded through the programme)	82
Number of organisations funded through the programme	10
Number of new activities developed as a result of the Building Healthy Communities programme to tackle health inequalities in communities, including community health days, awareness raising sessions, events, drop-in sessions, family days, etc.	20–25

2.5 Quantitative outcomes

Although there are no set quantitative outcomes for the programme, the reporting framework asked the projects to identify what quantitative impacts had been achieved. The outcomes most commonly mentioned and approximate values are shown in Table 2. These are drawn from discussions with project managers and reporting templates, which have been cross-referenced with other documentary evidence produced by the projects themselves. These figures relate to outcomes directly attributable to the programme. There will also be a number of indirect outcomes such as improvement in health conditions, which, although undoubtedly they have occurred, are more difficult to quantify using this methodology.

People involved in and/or reached by the projects

A large number of people have been reached as a result of the programme, particularly through projects that have sought actively to involve local groups and communities from a national strategic perspective. A range of methods have been used also to achieve a high coverage of participants, including the development of DVDs, road shows, regular regional meetings and other events.

New primary research

Nine new research reports were completed as a result of the programme (Appendix 1). In addition, a number of conference proceedings, briefings and information leaflets were produced by Combat Poverty, which were developed in response to gaps identified by the programme projects. This new research is an important outcome of

the programme as it builds understanding of health inequalities and supports an evidence-based approach to new interventions. A number of other reports were produced also including:

- Area profiles – completed by CLES.
- The Voices of Poverty.
- Community Health Worker (CAN, 2007).
- Thematic and Policy Papers.
- Policy submissions from projects and groups.

Community groups involved

Projects funded through the programme were involved in supporting and capacity-building with other community groups within their network, for example, the Irish Deaf Society worked with many local Deaf groups. Cairde worked with many small, local, ethnic minority groups to build their capacity and involvement in the project. Similarly, Galway Traveller Movement worked with Traveller groups in their area to undertake health impact assessments.

Meetings and networking events

All of the projects held regular meetings with partners, organisations and groups to progress their projects and networks. A great many meetings took place, including a number between projects and new partners, both regionally and nationally. Many of these meetings were directly facilitated by Combat Poverty in order to encourage partnership working in the future.

Networking events organised by Combat Poverty Agency

Combat Poverty organised a series of regular networking events to which programme projects were invited. These proved to be extremely valuable for

participants in helping to share good practice, find out more about national policy, provide a space for discussion and the opportunity to meet and discuss common issues with other projects and organisations.

Activities

A large number of different activities took place, which attempted to deal directly with some of the health inequalities experienced by projects in disadvantaged communities. In the geographic communities these often involved a locally-based community development health worker working with other agencies and local partners to develop small, targeted interventions to help a community, such as older people's groups, men's health groups, women's health groups and encouraging people to be involved in health days. These workers also undertook health impact assessments where appropriate and this was particularly important for the Galway Traveller Movement project. The community development approach taken meant they were developed in a non-threatening way and tended to involve members of the community that would not otherwise access traditional medical services.

These quantitative figures aggregate figures from the evaluation and, although they are purely indicative, they give some idea of the scale of activities that have been achieved through the programme. If anything, they tend to under-estimate the work that has been done. Figures give an indication of what is possible in a small programme such as Building Healthy Communities. They also show how much can be achieved on a relatively modest budget using a community development approach that has relied on partnership working, innovation, capacity building and collective action.

Chapter 3
Discussion of results

Outline of chapter

This section discusses the qualitative and quantitative results from the programme in order to address the original objectives of the evaluation. It examines the degree to which the programme aims were met and resources used effectively. Specific strengths and weaknesses, based on feedback from projects, are outlined with examples from project work to illustrate the point. Barriers that projects faced in delivering the programme are highlighted and the main learning for community development approaches is drawn out.

Based on these points the study proposes a number of indicators that could be used in future health initiatives that would help to test the effectiveness of activity and capture evidence of links between work done and changes in health. Finally, the programme's contribution to tackling poverty and health disadvantages is assessed.

3.1 Were the aims and objectives, and the resources committed, appropriate, realistic and achieved?

The programme funded 10 projects in Phase 2, all of which achieved or exceeded their original objectives. Although some organisations had to amend their original plans in the light of changing circumstances, their project activity remained in line with programme objectives.

Training, networking opportunities, information and links provided by Combat Poverty empowered participants and gave them an understanding of their options and rights, enabling them to negotiate more effectively with partners. Combat Poverty's support also led to the development of a strong network of organisations all of which use community development approaches to health. This was important in raising standards within projects and helping expand the evidence base around health inequalities. An effective network also provides a coherent channel through which to develop new and positive relationships between good

practice and health practitioners. This can help to inform new policy and the development of new services.

The programme objectives were focused not just on supporting individual projects but on developing a coherent programme that would demonstrate all the characteristics used in a community development approach to tackling health inequalities. The programme of activity provided an opportunity to promote the principles and practice of community development among a wide audience of practitioners who were actively involved in using community development approaches to address health inequalities.

The programme outcomes described in Chapter 2 show a much greater awareness among projects, their partners and participants of the social determinants of health and the contribution that a community development approach can make to improving health and well-being in disadvantaged communities. Through supporting a range of different disadvantaged communities, the programme was able to explore how the community development approach could be adapted to suit a variety of different needs while keeping the basic principles and practice.

There has been a strong focus by the programme on raising capacity among community health interests both through Combat Poverty's direct work with projects, such as networking events, information and training, and within the projects themselves. Projects focused on particular themes and did a great deal of work with smaller and more excluded groups that represent different facets of disadvantage. Projects managed by national organisations

such as OPEN, Cairde and the Irish Deaf Society worked with communities in different parts of the country to build capacity and sought to use this experience to inform policy and good practice.

Combat Poverty provided a focus through which organisations could develop and channel their views, experience, research and ideas to influence a changing policy environment. This has led directly to policy submissions to the Intercultural Health Strategy and the HSE's User Engagement Strategy. It is unlikely that these submissions would have occurred had the programme not been in place. These policy submissions were submitted both individually by organisations and collectively through the programme co-ordinated by Combat Poverty. This helped to draw out lessons from community development work on the ground in relation to health and poverty. Organisations that made individual submissions attributed their ability to develop these submissions directly to the support they received through the programme.

The programme also succeeded in developing and implementing mechanisms for effective community participation in health decision-making. Many individual projects saw the development of new structures within their areas that facilitate communication and participation in the design of services. The following are some examples:

- The Irish Deaf Society worked to improve communication between health service professionals and the Deaf community.

- Cairde set up the National Ethnic Minority Health Forum.

- The Galway Refugee Support Group were invited to develop a new group in their area to work with the HSE to seek changes in the way in which refugees and asylum-seekers are treated within primary care.

- The West Offaly Partnership continues to work closely with primary care teams to engage with local people, based on the channels for engaging with local groups that it generated through the programme.

- The work undertaken by CAN (Community Action Network) through the Action Learning Unit, although focused on sharing learning and good practice, also contributed to new dialogue between projects and the HSE. Within the HSE itself, the work promoted awareness of the contribution that community development approaches to health could bring to health services.

Combat Poverty Agency networking events encouraged community participation in policy-making. These events provided a unique opportunity for project workers to discuss health and poverty issues with senior decision-makers in the HSE, the Social Inclusion Unit in the Department of Health and Children, the Office for Social Inclusion, and other national organisations such as Amnesty International Ireland and Community Development and Health Network. This allowed workers on the ground to talk directly to policy-makers about the realities of health inequalities for disadvantaged communities, particularly those in direct provision and the Deaf community.

For some groups, this was the first chance they had had to speak to someone within the HSE or the Department of Health and Children about their experiences. This in turn gave senior decision-makers a chance to hear about how health policy affected disadvantaged communities and the issues that needed to be addressed in the future.

3.2 The strengths and weaknesses of the programme

3.2.1 Strengths

Encouraging an evidence-based approach to community development

By piloting new approaches to community development in dealing with health inequalities and poverty, the programme provided a valuable opportunity to test out different models, undertake further research and develop innovative ideas. The Combat Poverty Agency promoted the principles and practice of community development to strengthen the projects and to show how this approach could add value to current health service provision. Combat Poverty Agency continuously emphasised the importance of evidence to show how and why the community development approach works and to demonstrate the needs of disadvantaged communities in a variety of contexts.

To this end, a number of new pieces of research were produced. Projects are now much more conscious of the requirement to provide evidence of the impact of their work and to research their communities' needs in order to support new interventions. The network created by the programme allows projects to continue to build their capacity to carry out research and provides a forum

for discussion and sharing on evidence-based approaches.

Networking supported by the programme

Contacts and learning among projects greatly benefited all participants of the programme. This point came through clearly in the evaluation. Information sharing, knowledge building and training made a difference to all organisations. Participants felt they were enabled to work with groups they were not aware of before, thus 'broadening their horizons – very empowering'.

For some participants, the impact of attending networking meetings was deeply personal, particularly people from projects who were directly experiencing health inequalities. It showed them they were not alone in finding their needs unmet by statutory services and also opened their eyes to the challenges that other communities faced, which generated a sense of solidarity among them. Such sentiments were voiced by members of OPEN, the Galway Travellers Support Group and the Irish Deaf Society. Participants from Schizophrenia Ireland said they really enjoyed the networking events because it felt like 'someone cared' about their concerns and took them seriously.

This has been a really strong element of the programme, the fact that its work, particularly the networking, has developed a sense of solidarity between projects and offered opportunities to work together on similar interests, submit joint proposals on policy and develop their own events to highlight good practice. The networking helped to engender this synergy and it developed rapidly during the course of the programme. Combat Poverty provided

central co-ordination, which helped support and strengthen the network.

Combat Poverty also played a role in directing organisations towards contacts and decision-makers in the statutory services. This provided the opportunity for new partnerships and greater input into statutory service provision. This form of support was considered just as important, if not more so, than the financial resources:

'Enormous support from Combat Poverty Agency, of which financial resources is just one aspect of the work. The access to additional support and encouragement from project staff, promotional support, access to policy arenas, profile through Combat Poverty Agency conference and publications, and networking opportunities all give added value beyond measure.'

'The funding was quite small in one way – it did not fund the worker completely. It went part way, but provided access to information, advice, networking, policy makers, new ideas and different approaches. Very practical and emotional support, as well as the link into the policy arm of Combat Poverty Agency or the research arm – wherever we needed to be.'

These quotes from the reporting templates show how networking and other aspects of the Combat Poverty Agency's support was extremely valuable for projects and was highly valued by them.

Value for money

Considering the relatively small cost of the overall programme, the outcomes achieved represent good value for money, particularly as the programme has operated at a variety of scales, national and local, among some of Ireland's most disadvantaged communities. A number

of projects mentioned an important multiplier effect, which developed through the programme. The majority of projects were able to use the funding from Combat Poverty as an initial investment to attract additional funding that supported further activity within disadvantaged communities. One project commented:

'For every €30 spent, we have been able to bring in around €160.'

This is an important element of the programme and demonstrates how even small investments in community projects can be used effectively by organisations in order to have maximum impact.

Influencing national policy formulation

The programme has had an important impact in terms of influencing and informing national policy formulation. It has helped to raise awareness among organisations like the HSE and the DoHC of issues around health inequalities and poverty and helped push these issues up the political agenda. The project work has contributed to the development of a cultural shift among organisations such as the HSE, making medical practitioners more aware of the contribution that a community development approach to tackling health inequalities and poverty can make. It also promoted increased understanding and exchange of views between different professional groups whereby practitioners have started to understand the voluntary sector and vice versa.

The evaluation has identified four ways in which the programme contributed to influencing policy formulation.

- It has helped build the capacity of organisations within the programme to influence policy. Through networking events, publications and training, the programme has enabled organisations to make their voices heard and to communicate with national and regional decision-makers. Organisations have disseminated information among their users and target groups about the way they access health services, express their views and experiences, and begin to work towards solutions. Examples of this include submissions to the Intercultural Health Strategy and the User Engagement Strategy. Although it is difficult to know exactly the extent to which policy submissions by projects have influenced the national agenda, the fact that organisations, through their involvement in the programme, were able to put together a submission is an important outcome for the programme. The programme raised awareness of the need for community participation in primary care.

- The programme helped projects to gain influence with regional and national organisations through the development or enhancement of an evidence base. The research and the contacts made through the programme gave projects better evidence about health and poverty issues that affect disadvantaged communities. The forum provided through the programme allowed the dissemination of this information and research to a wider audience through networking events, specialist media advice and circulation among the network of organisations.

- The programme allowed different agencies, authorities and community organisations a common space to talk about the reciprocal barriers each faced and to look for ways to overcome them. It also provided for greater co-operation between organisations and statutory services, which had not existed before. The funded activity enabled organisations to learn how to better deliver assistance to disadvantaged communities in partnership with statutory services. This was achieved through networking and joint meetings with statutory agencies and groups, and through publication and dissemination of information on good practice. Projects feel there is now greater acceptance by health agencies of participation and engagement by the community because the programme raised awareness and piloted different approaches.

- Discussion among government departments on issues of health and poverty was encouraged through the attendance of senior decision-makers from the HSE and the Department of Health and Children at national networking events.

Credibility as a partner

The Combat Poverty Agency's support for the programme was important for projects as it gave them a higher profile and connected them with health and policy bodies they would not normally work with. The majority of organisations felt they were 'part of a bigger structure' and that being funded through Combat Poverty gave them more credibility with partners and other funders. The link with a state agency

provided many organisations with an insight into the mechanism of government, including how policy systems worked, roles and responsibilities. Similarly, the programme enabled statutory organisations to understand more about the needs of community development projects, the health needs of excluded groups and local priorities.

Capacity-building within the community development sector

The programme has helped strengthen the capacity of the community development sector. It provided training and opportunities for organisations to develop. Organisations have started to see the value of research and evidence in order to prove the value of their work and make a robust case for lobbying.

'Recording of information was very powerful. As community workers, there is never enough time to record situations.'

The programme supported direct capacity-building with projects and supported projects to build capacity themselves with disadvantaged communities. This capacity-building was an extremely important outcome of the programme. It leaves a long-term legacy of higher skill among paid and voluntary staff, many of whom come from disadvantaged communities.

Partnership working

The programme facilitated dialogue and partnership working at local level among traditionally diverse agencies, such as the HSE, and the community sector. Projects felt that the programme allowed them to experience new ways of working with statutory agencies and to create more links with a variety of partners, including

the HSE and local authorities. The programme has seen the development of new, positive partnerships between community organisations and statutory services. Previously, many organisations had relatively difficult associations with statutory agencies, feeling that their concerns, for example, about widening access to GPs or cultural and language issues in accessing health services, had not been adequately considered or addressed. Although there is still work to be done, the more effective and beneficial relationships that have developed may, if allowed, continue to grow and deepen over time.

Flexible funding programme

Although the programme was not just about funding, in relation to Combat Poverty's role as 'funder', project managers considered the programme to be flexible and adaptable, an important consideration for community development type projects, which tend to be complex and operate in an evolving environment where changes are likely. The programme tried to support projects by not being overly prescriptive and by providing opportunities for projects to change and adapt over the course of the programme.

This approach was much appreciated by projects who consider, overall, that the programme was managed and administered in a sympathetic and knowledgeable way, which empowered groups to use their own expertise to deal with different situations and scenarios.

Professionalism and management

Combat Poverty Agency staff and management were supportive, accessible and interested. They managed the programme to a high standard, with professional expertise and were extremely

helpful to the projects. Combat Poverty Agency was deemed 'supportive in every aspect'.

From the perspective of Combat Poverty, the programme was an important investment in terms of funding and staff time because it was a means of drawing out learning about poverty and health inequalities from projects and groups across the country. This, in turn, can help inform future priorities, research and publications.

3.2.2 Weaknesses

Pilot nature of the programme

The limited nature of the programme was one of the main weaknesses identified by projects. Projects felt it was now time to mainstream programme services and funds and have a more long-term strategic view on sustainability. It is important to stress that the programme was always put forward as a pilot and projects were under no illusion that it would be anything other than that.

Effort must go into mainstreaming some of the work that has been developed and continuing to work with the network to inform future policy. However, there is a longer term need for sustainable funding that supports general community development-type activity in disadvantaged communities. At present, there does not appear to be a strong government commitment to support this activity in a coherent way, although considerable work has been done by individual departments, such as the Department of Community Rural and Gaeltacht Affairs.

The community sector needs to be formally recognized by government as an important

link with disadvantaged communities and one that requires ongoing support and assistance into the future. This assertion builds on work already done by the National Economic and Social Council (NESC), which recently reviewed the welfare state and set out a number of key areas for reform[12].

Long-term support to projects

Although Combat Poverty provided extensive and effective support to the projects, the programme itself was relatively short term and therefore the ability of Combat Poverty to provide ongoing support after the programme will be limited. This is not necessarily a serious weakness of the programme itself as it is common to all initiatives of this kind, and the projects themselves have developed their own network as a result of the programme, which may continue in the future. However, it is important to recognize that, without the galvanising presence of an organisation like the Combat Poverty Agency, some projects may find it more difficult to learn about good practice, influence the policy arena and stay informed about new research.

Resource intensive

The community development approaches used in the programme are relatively resource intensive. A great deal of long-term activity by project officers is needed in disadvantaged communities, getting to know local people and working with communities over time. Some projects found their original expectations were too ambitious and would stretch their resources in attempting to achieve the objectives. Other projects talked about a need for pre-work before the project could

12 NESC (2005) *The Developmental Welfare State*. NESC report number 113.

get started, in terms of getting to know and understand the community, building up trust and relationships and gathering evidence of the needs of the community.

It is often difficult to predict the resource needs of such work, which can be underestimated. In addition, some projects found their work was so well received and achieving such important results that they were under pressure to use the same approach with other disadvantaged communities. This led to the development of new projects to respond to those needs, which required additional funding from other sources or used the same funding but in a very cost effective way.

Developing indicators for the programme

Work could be done to explore the development of more indicators for similar programmes in the future. Indicators would provide evidence of whether or not a community development approach to tackling health inequalities is effective and why it is or isn't working. There were clear aims and objectives set out for this programme but there was a lack of quantifiable evidence in relation to qualitative and quantitative outcomes. This is explored further in subsequent sections.

Links with Phase 1 of the programme

Many projects felt it would have been beneficial if links with projects funded in Phase 1 had been maintained and incorporated into the network developed as part of Phase 2. This lesson can be applied in the development of future network organisations. Already, there are developments to involve organisations funded in Phase 1 in the future network and these links can continue to be developed.

Connectivity between Building Healthy Communities and other initiatives

At national government level, the activity supported through the programme could be integrated with other work to support disadvantaged communities. The social factors that affect health in disadvantaged communities go beyond health and social inclusion and are linked also to issues around planning, rural development, housing and economic development. The Combat Poverty Agency should continue to develop discussions with other government departments to highlight the advantages of this approach in tackling issues within disadvantaged communities.

3.3 Barriers to implementation

In a programme such as Building Healthy Communities projects operate in a very fluid environment, which requires flexibility, innovation and leadership. Feedback from projects emphasised the type of barriers to work on the ground but which, in the main, they managed to overcome.

Resources and capacity

Two of the key challenges in delivering the objectives of the programme were:

- resources available to undertake the work;
- capacity of the organisation.

Often, projects had to make the funding available from the programme work to achieve ambitious outcomes. The resources required to deliver good community development work are significant. Grassroots activity is costly and time consuming. When projects focus on a wider geographical scale, more workers are needed, and lack of resources and capacity may affect provision.

For all of the projects, the programme funding supported them in a specific initiative. However, as projects progressed, the needs within the communities tended to widen as people became aware of the support available. In many cases this put enormous pressure on projects, which wanted to help as many people as they could. Subsequently, some of this additional work had to be resourced in-house. Indeed, there was a feeling that, in order to deliver what was expected within communities and by organisations, projects had to commit more staff resources than they originally had envisaged in their application.

Participation and engagement

Maintaining and managing participation in projects by service users and volunteers has been a challenge for projects. Some projects depend heavily on attracting volunteers, which can be difficult in areas where there are high levels of deprivation and pressing economic issues and not enough development workers to maintain interest and develop capacity.

Fettercairn, for example, found that a key barrier to their development was maintaining high levels of participation and engagement of local people. Fettercairn was also one of the projects with no paid, dedicated member of staff to work on the project. Similarly, in West Offaly, concerns as regards participation and engagement were raised.

At the time of writing, projects were still responding to needs identified by local people but there was concern about long-term involvement, particularly among young people.

Other projects reported feeling overwhelmed by the scale of the challenge facing them. Often, the issues and concerns are so great that project workers can find it hard to see the impact of the work they are doing or whether it is making any difference. In some cases, local politics and tensions can exacerbate this situation. This is where the support provided through initiatives like the Action Learning Network have really helped to build solidarity and support among community development workers to reduce feelings of isolation.

Scale of intervention

Numerous projects found it challenging to balance interventions over a variety of geographic areas and scales of work, particularly those organisations working at a national level or whose project required them to work in a variety of geographic communities. Managing and organising this activity could be extremely complex and demanding. The challenges encountered involved managing:

- the communication process;
- different needs;
- different levels of developments and structures.

Schizophrenia Ireland found that supporting a new structure on a thematic basis nationally made communication more challenging. It was difficult to influence what was happening on a local level from a national perspective. West Offaly found significant difference between communities, with some areas starting from a very low level of capacity while others were more organised and structured. The key to their success was flexibility and the capacity to adapt the framework to different circumstances.

Managing unexpected changes

Many of the projects financed had to deal with unexpected external changes. In some cases, the challenge was an unexpected change in legislation. In the case of Galway Refugee Support Group, the Government announced a special scheme granting resident status to families and parents with Irish-born children. This meant that participants in this project had two years to prove they could be economically active in order to become residents; thus many either had to work or study. In addition, the group that the Galway Refugee Support Group had been working with to influence the health activity of the HSE was disbanded and so they had to explore other ways of making their voice heard at regional level.

For other projects, for example, Fatima Mansions and the Irish Deaf Society, budget cuts within the HSE led to the unravelling of commitments for funding and personnel. Many of these projects are working now within a context of significant economic change, which will continue to put pressure on their work and activity. This makes the need for future government support even more important.

The Galway Traveller Movement originally set out the need to carry out a health impact assessment on a halting site in Galway earmarked for refurbishment. However, this refurbishment work was delayed for nearly two years, which meant that the group had to refocus their health impact assessment work on the existing site.

Fettercairn had an interesting 'unexpected' event that required management. They received some funding from RAPID to pay for an event co-ordinator. The event co-ordinator

organised the launch of the community consultation report on a very big scale. The launch got significant media attention, including coverage in the national Press and radio. This was extremely beneficial to the project and also highlighted the work of the Combat Poverty Agency but it did require management by the project in terms of logistics and local politics.

'We were not expecting the publicity and this is a learning curve. When you are doing something involving the media, it is so important to be prepared for the outcomes. We are all on the voluntary board of management. We would all be in our own posts in different jobs and this publicity was taking over. This was quite big.'

3.4 The main learning for policy and practice on community development approaches

Importance of awareness raising and networking

The Building Healthy Communities programme has been successful in increasing the level of understanding and awareness of the principles of community development and practice and the social model of health. All the programme projects have a clear vision of what community development is about and what it can contribute to helping disadvantaged communities. Aspects of the approach have been explored in depth, such as the role of the community health worker. This has raised consciousness among medical practitioners and encouraged them to question their own work in order to better understand the role they play in their community.

Similarly, promotion and awareness-raising activities such as networking and

publications have enabled statutory health agencies to learn more about the needs of disadvantaged communities that are often difficult to reach through traditional service delivery. Community development-type approaches offer statutory health services a mechanism to include and inform disadvantaged communities of health services and thereby ensure their needs are considered in future planning and policy.

Finally, awareness raising through the programme has brought community organisations together to encourage effective collective action on particular issues, such as direct provision and joint submissions on policy. This networking has led to the development of a co-ordinated voice, so that projects are not isolated but have the opportunity to work together to address common concerns.

Positive partnership working can be achieved

The Building Healthy Communities programme showed that partnership working between community organisations and statutory agencies is possible. This can lead to positive working relationships, which have benefits for both disadvantaged communities and the more effective delivery of health services. It also shows that developing these partnerships takes time and needs to be supported through an organisation like Combat Poverty which can link directly into government and disadvantaged communities at the same time. Without this brokering partner, an important link in the chain is lost and future partnership opportunities to improve health service delivery are lost.

Value of a strategic approach to supporting community development

The support provided through the programme was not simply direct funding to support project activity but was much more strategic and sought to support projects in a number of other ways, including:

- networking;
- national events;
- opportunities to meet partners;
- brokering partnerships;
- referral to other agencies;
- production of publications and research.

These mechanisms have enabled the programme to promote the principles of community development to a wide audience and extract important learning from projects about community development approaches to tackling health inequalities in disadvantaged communities. It has meant the Combat Poverty Agency has been able to add value to the work of the HSE and the Department of Health and Children by facilitating policy submissions to inform the Primary Care Strategy, the National Action Plan for Social Inclusion, the Intercultural Health Strategy and the User Engagement Strategy.

It has also provided a link with disadvantaged communities, which is now available for other government agencies to use in order to inform and improve service design and delivery. In this way, organisations in the programme have a much more acute understanding of how public policy works and how evidence from their work on the ground can be used to directly influence this process.

Complexity

A key learning is that the health agenda is a complex one with no quick fixes in the short term. Community development approaches to tackling health inequalities and poverty require time, resources and patience in order to support communities to influence change that will benefit their health. In the longer term a health agenda can have significant benefits for communities and health inequalities.

The context in which the projects operate has also been complex with a range of organisations, partners, responsibilities and roles.

Importance of an evidence-based approach

The programme supported the development of an evidence-based approach on many of the project issues. This has been invaluable for projects, as it has helped give them greater credibility and influence when working with partners and communities to address health inequalities. The Combat Poverty Agency supported projects to develop their own research to better understand the issues. Projects have been interested in the research as it often confirms their own experience of inequality. It provides them with an important tool with which to develop relationships with partners and to lobby for policy changes through open discussions with decision-makers and policy submissions.

There is a continuing need for research into the needs of disadvantaged communities as there is still much to learn. This activity should continue to be supported, particularly as needs and new communities continue to evolve and change.

Combat Poverty Agency

Attribution and development of indicators

A key challenge to arise from a programme such as this is attribution – how do you attribute the improvements and benefits seen within disadvantaged communities to a particular project or initiative? Further work is needed to identify the types of indicators and outcomes arising from a community development approach to health that can show that the approach is making a difference in a disadvantaged community.

From the evidence gathered in this evaluation over the last two years, a number of themes could easily be developed into a series of indicators, which could then be tested in future work or even by the projects themselves using a variety of methodologies. These indicators could be both qualitative and quantitative, which means that 'soft' or more intangible impacts can also be captured using a blend of methodologies.

Table 3 (next page) provides an initial list of indicators that the Combat Poverty Agency may wish to explore or pilot with existing and future projects that use a community development approach to health and poverty. The indicators relate to the types of qualitative outcomes that a programme manager such as Combat Poverty might aim to achieve (and which have been achieved through the Building Healthy Communities programme). The table (on page 52) also provides examples of the

types of methodologies that could be used to capture this information.

3.5 The contribution to tackling poverty and health inequalities

As outlined in Chapter 2, there is evidence that the programme has had positive outcomes for those experiencing poverty and health inequalities. There is a high correlation between health inequalities, socio-economic factors, physical environment and individual behaviours[13]. The Building Healthy Communities programme has used a range of community development approaches to address poverty and health inequalities within different communities. The community development model recognizes that health inequalities develop through the negative interaction of all the factors above. There are a number of ways in which the programme has contributed to tackling poverty and health inequalities, which are detailed below.

Engaging with beneficiaries within communities to raise awareness

The projects funded through the programme have been able to tackle inequalities by engaging with beneficiaries, whether local residents or part of targeted marginalised groups, and encouraging

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13   Combat Poverty Agency (2007) *Community Development and Health*.

Table 3: List of indicators to explore with existing and future projects

Example of desired outcome within the programme	Types of indicators to show the extent to which the outcome has been achieved	Methodologies used to capture this information
Strengthening of community sector voice within the programme	• Level of collective activity within the programme that conveys policy and practice messages to decision makers: • Number of joint submissions to policy from the programme • Development of new networks between community organisations and decision-makers • Development of national and regional networking opportunities for community health sector • Level of new research and/or publications that provide new understanding of health needs of disadvantaged communities.	• Interviews with project managers • Feedback forms from projects • Observation at events and meetings.
Enabling of organisational capacity	• Number of people involved in an activity (e.g. training or networking) • percentage of people who feel their organisation has been significantly strengthened since their involvement in the programme • Number of new partnerships or projects developed as a result of the programme support • Types of benefits gained from involvement in the programme (e.g. skills, confidence, clearer aims and objectives, governance).	• Feedback forms from projects • Surveys with organisational staff • Discussion groups with staff.
Improved health outcomes among disadvantaged communities	• Level of new involvement among disadvantaged communities in a community development initiative • percentage of people from the community who feel they have benefited in terms of their health since being involved in the project • Types of benefits cited by people in the community and attributed to the project • Feedback from external partners about the extent to which the project has had positive health outcomes.	• Feedback form from projects • Surveys in the community (door-to-door or postal) • Discussion groups with community members • Interviews with partners.

them to get involved. In order to succeed in this, information sharing and dissemination were paramount. A variety of methods were used, including road shows, workshops, training of community participants and meetings. This engagement was extremely effective in helping to raise awareness of the social determinants of health and how these affect the most marginalised of society. It was a major contribution of the programme and raised awareness not only among communities but also among staff and volunteers from different organisations. This growing consciousness was reinforced by the networking and the information and publications supplied by Combat Poverty.

Opportunity to explore different community development approaches

Each project adopted the community development approach within their own community but the basic principles remained the same. The Galway Traveller Movement, for example, focused on providing evidence of the conditions in which Travellers on established sites live and the impact this had on their health. In West Offaly, talking about health was used as a method of engaging local people in discussions about their community and raising awareness of what makes a healthy community work. In other projects, the role of the community health worker was a key means of building partnerships and trust with local people in order to design and implement projects that would respond to their needs in an effective way.

Reducing health inequalities and poverty

The community development approach within the programme helped to awaken the consciousness of organisations as to the reasons for inequalities and poverty

in their communities. In addition, there is evidence of individual progress, with numerous reports of how individuals benefited from a reduction in health inequalities and poverty as a result of projects.

However, it is difficult to attribute improvement within communities to the activity of the programme. Also, it is important to note that the projects were not about delivering health services but about building the capacity of the group to participate more fully in a process of change in health services, in order to reduce a community's experience of health inequalities and poverty.

An example of this approach is the Galway Refugee Support Group, which involved building people's capacity to participate in the development of health strategies for ethnic minorities and refugees. The group worked locally to raise awareness of the need for a specific focus on ethnic minority health in the development of health policies. In its submission to the HSE Intercultural Health Strategy, it sought to outline the elements of such an approach. This submission was developed by asylum-seekers and refugees themselves, based on their own experiences of involvement with the HSE. Similarly, Cairde, in building the ethnic minority health forum, worked directly with minority ethnic groups that experienced health inequalities, to seek reform in the way that services were delivered to the ethnic minority community.

Chapter 4
Recommendations for future policy

Outline of chapter

Chapter 4 provides recommendations for future policy arising from the learning of the Building Healthy Communities programme identified through this evaluation. Opportunities for mainstreaming and implications for funding are looked at, including funding for non-health activities such as networking and policy submissions, and for community development approaches.

In addition to mainstreaming through funding, the adoption of community development approaches such as consultation and their promotion among health professionals is also discussed. The benefits of developing indicators of health outcomes are raised. Recommendations are made regarding specific strands of the Building Healthy Communities programme (Phase 2) such as disseminating research learning generated through the programme.

These recommendations will require further discussion and development between Combat Poverty Agency, the HSE and the Department of Health and Children to agree the best way to take them forward.

4.1 Mainstreaming

The Building Healthy Communities programme provided an important opportunity to pilot a range of community development approaches to tackling health inequalities. The programme raised awareness of the principles of community development and of the role that this approach can play in improving health outcomes within disadvantaged communities. In order to ensure the benefits of this work are sustainable, it is important that there are mechanisms to support this type of activity and approach. This will require mainstreaming work on a number of levels.

Mainstreaming of funding for individual projects

Individual projects that were funded through the programme will, in most cases, require more funding to enable them to continue the work started through the programme. In some cases, projects have secured additional funding through local partners. In other cases, work is ongoing to secure continued funding. The Combat Poverty Agency is not a mainstream funding provider and thus cannot fund ongoing

project work but it can continue to assist projects by helping them to make links with statutory bodies and to signpost any available sources of funding.

There is a need also to assist the kind of work supported through the programme on a broader scale. Consideration should be given to initiating a specific funding line to support this work. Representations should be made to partners in the HSE and the DoHC for support for mainstream funding and for views about the most appropriate location for such a funding line.

Mainstream funding for continuation of non-funding activity

Projects highlighted the importance of the non-funding aspects of the programme. These included networking events, assistance with developing policy submissions and dissemination of policy lessons. At the very least these activities should be mainstreamed at some level through support from Combat Poverty and its funding partners at the HSE and the Department of Health and Children.

The development of a networked community has been an important outcome and, while projects themselves may be able to work together to develop and maintain a network, it would benefit greatly, at least initially, from the support of national partners.

Maintaining the network of community health projects in both phases of the programme would help to continue the two-way channel between community organisations and health professionals which, in the long term, could help to enhance the current level of services provided to disadvantaged communities.

It could enable the Government to fulfil its requirements under the Primary Care Strategy, the Intercultural Health Strategy and the User Engagement Strategy, as well as the National Action Plan for Social Inclusion 2007—2016.

Mainstreaming community development approaches to health

The community development approaches to health that were developed have important contributions to make to tackling health inequalities. Community development projects can reach individuals and organisations that mainstream services struggle to engage with. They also provide a way of understanding and responding to the ever-changing needs of a transient population. Therefore, the approaches used within the programme should be mainstreamed within health services. This will require closer working between primary care teams and local community organisations and resources will be needed to support this.

Government policy needs to continue to recognize the importance of community involvement in primary care teams. It should support further research to fully understand the benefits that this type of involvement can have for meeting the objectives of positive health and well-being within communities.

4.2 Use of networking

The programme encouraged networking as a means of promoting the principles of community development and greater understanding of the social determinants of health. Networking was also used effectively to encourage joint working and synergies between projects. This approach is effective because it provides a forum for

discussion and analysis of the experiences of communities and the role that public policy can play in addressing their needs. Government departments should consider the use of networking as a tool for future projects for widening discussion and consultation and enabling policy-makers to meet with delivery organisations.

4.3 Model of community development approach

Combat Poverty and its partners in the health agencies should continue to support research into the community development approach to tackling health and poverty in order to make this approach more widely accessible to health professionals at all levels. They should be encouraged to consider using this approach when attempting to tackle health inequalities, particularly in disadvantaged communities. They should also be supported in their attempts to develop links with organisations that are working with disadvantaged communities to directly tackle health inequalities. Combat Poverty should continue to work with its partners in the HSE to distinguish between the community development approach and projects focused on health promotion activity, recognising that, despite overlaps, health promotion is a separate activity with different aims to community development.

4.4 Continue to support consultation with community organisations

A very valuable outcome of the programme has been the joint submissions by projects to inform policy development, including the Primary Care Strategy roll-out, the NESF project team on mental health and social inclusion, the Intercultural Health Strategy and the User Engagement Strategy. This gave the sector a more coherent and professional voice with which to inform decision-makers. Their contribution is important in ensuring that future policy reflects the realities of health inequalities in disadvantaged communities. This should be supported in future not only within the Department of Health and Children and HSE but by other government departments. There should be active encouragement for the involvement of community and non-government organisations in policy formulation and implementation.

4.5 Benefits of community development approaches to health inequalities and poverty

Whilst more efforts are required to develop specific indicators, evidence from the evaluation suggests strongly that community development approaches to

health have positive outcomes on efforts to reduce health inequalities. People involved in programme activity benefited significantly from this approach as it provided a non-threatening introduction to a wider discussion about health and the social determinants of health. This gradually allowed people to start taking greater control over their health and well-being. Further longitudinal research is required to fully understand the impact of these initiatives on the health status of people within a community, particularly given the variety of other factors that may affect health.

4.6 Development of indicators to evaluate progress

Work can be done to develop specific indicators around community development approaches to health. These would help to capture specifically the types of impact that these projects have and to measure more clearly the outcomes that they can achieve. Work will be required also to ensure that the methodologies used to capture information about these indicators work effectively. The development of clear indicators also would help to demonstrate the precise benefits that this type of programme can have, which could then be replicated. These indicators could be cross referenced with information about local population health data to see if they matched with any general improvement in quality of life for local people.

4.7 Maintain links to the network

The Health Advisory Group provides a useful forum for sharing information and good practice around the Building Healthy

Communities programme, community development approaches to health and the broader policy environment on health and poverty. Even though the programme has ended, community development-type approaches and the Building Healthy Communities Network should continue to be an important aspect of these meetings. This would help to maintain the link between activity in disadvantaged communities and national decision-making and policy.

4.8 Dissemination

The Building Healthy Communities programme produced a great deal of useful literature and research. The learning from the programme, particularly the detail around community development approaches to tackling health inequalities, should be captured and widely disseminated. This will help to increase awareness and support for this approach and for organisations tackling the issues in disadvantaged communities.

Appendices

APPENDIX 1 –
Building Healthy Communities
Programme Project Resources[14]

OPEN
Addressing mental health issues amongst lone parents experiencing isolation.
OPEN. 2007.

Submission to the NESF Project Team on Mental Health and Social Inclusion.
OPEN. 2007. www.oneparent.ie.

CAIRDE
Community Development and Health Programme: An intervention for social change. A case study for capacity building phase of the programme.
O'Toole, Grainne. Cairde. 2006.

Assessing the health and related needs of minority ethnic groups in Dublin's north inner city. A case study of a community development approach to health needs assessment. Cairde. 2006.

Submission to Health Service Executive on draft National Intercultural Health Strategy. Cairde. 2007. www.cairde.ie.

CAN
Evaluation Report of CAN/NICHE Community Development and Health Training. CAN/NICHE. 2007. www.canaction.ie.

A guide to influencing the health services. Community Action Network, Combat Poverty Agency. 2007.

Community development is good for your health. CAN comment. CAN. 2006.

Irish Deaf Society
Some sound advice – guidelines in improving access to and utilisation of health services for the Deaf in Ireland. Irish Deaf Society. 2007.

The Irish Deaf Society has produced DVDs on 'Introduction to Health Literacy'; 'Men's Health'; and 'Basic Signs for Doctors and Health Service Staff'. It is currently developing a DVD on maternity services. www.irishdeafsociety.ie.

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14 Some of these resources were developed by projects in the BHC programme while others were funded directly by Combat Poverty or other agencies that the projects worked with.

Fettercairn Health Project

Taking the first steps to a healthier Fettercairn. Fettercairn Community Health Project Participatory Rapid Appraisal Report. Fettercairn Health Project. 2007.

Ground Gained. A participatory action research report on mental health in Tallaght. Supported by the Special Project on Long-Term Unemployment Tallaght CDP. 2007. Email: spltu@iol.ie.

Galway Refugee Support Group

The mental health promotion of asylum-seekers and refugees in direct provision and private accommodation in Galway City. Galway City Development Board/Health Service Executive. 2007.

Conference report on emerging areas of practice. Galway Refugee Support Group. 2006. Email: refugee.galway@ireland.com.

Submission to Health Service Executive on draft National Intercultural Health Strategy. Galway Refugee Support Group. 2007.

Fatima Groups United

Things can be different: The transformation of Fatima Mansions. Fatima Groups United and CAN. 2007. www.fatimagroupsunited.com.

Building Healthy Communities projects' previous publications

The health and social outcomes of community participation in primary care. Health Service Executive. 2006.

A model for community participation in primary care. Lifford Castlefinn Primary Care Project. Health Service Executive. 2004.

Mulhuddart primary health research project. Sharon Cosgrove. 2004.

The impact of social exclusion on the health of lesbian, gay and bisexual people: Promoting a community development approach. National Lesbian Gay and Bisexual Community Development Network. (Cork Gay Community Development Ltd). 2006.

Healthy directions. Lifford and Castlefinn Community Health Forum and Primary Care Team.

Exploring and progressing accreditation options: Final report to the Advisory Group re Accreditation of Community Health Workers. NICHE. *2004.*

Health in Ireland: an unequal state. Public Health Alliance Ireland. 2004.

Combat Poverty Agency publications on health

Tackling poverty and health inequalities: Community participation in primary care conference report. Combat Poverty Agency. 2007.

Health Policy Statement, Dublin, Combat Poverty Agency. Combat Poverty Agency, 2007.

Poor prescriptions: Poverty, health and access to services. Layte, R., Nolan, A. and Nolan, B. Combat Poverty Agency. 2007.

Silent people and other stories. McKay, Susan. Combat Poverty Agency. 2007.

A guide to influencing the health services. Community Action Network. Combat Poverty Agency. 2007.

Community development and health. Lynam, Siobhan. Combat Poverty Agency. 2007.

Evolution of health services and health policy In Ireland. Harvey, Brian. Combat Poverty Agency. 2007.

Setting standards to achieve equity of access to quality of primary care services. Combat Poverty Agency. 2006.

Community development: Current issues and challenges. Lee, Anna. Combat Poverty Agency. 2006.

Community development and public policy: guidance on the application of community development approaches to different aspects of anti-poverty and social inclusion work. Combat Poverty Agency. 2006.

The role of community development in tackling poverty in Ireland. A literature review for the Combat Poverty Agency. Motherway, Dr. Brian. Combat Poverty Agency. 2006.

Community participation and primary care: Learning from the Building Healthy Communities programme. Combat Poverty Agency. 2005.

Tackling health inequalities: A community development approach. Combat Poverty Agency. 2005.

Health services and the National Anti-Poverty Strategy. Combat Poverty Agency. 2005.

Poverty is bad for your health. Barrington, Ruth. Combat Poverty Agency. 2005.

Community development and primary care in Northern Ireland and England. Crowley, Dr. Philip. Combat Poverty Agency. 2003.

APPENDIX 2a –
Interview proforma for projects

Background information about the interviewee/organisation

1. Name/address/project contact.

2. About the organisation. What does your organisation do?

3. How does it influence national, regional and local policy?

Information about the initiative funded through BHC

4. Name of project.

5. What are the project objectives (general but also key targets)?

6. How did the project come about? How was it developed?

7. What issues is the project trying to address?

8. Key beneficiaries.

9. What evidence is the need for the initiative based on?

10. Costs of the projects/budget information.

11. Any documentation/information about your work (published/online).

Project delivery

12. How is the project managed and delivered (staff, location, management, methods of engagement, accountability, etc)?

13. Who are your main project partners?

14. What are or have been the key challenges/issues in delivering this initiative?

Outcomes

15. 'At the end of the day'. What will be deemed a success for this project?

16. How will your project contribute to tackling health inequalities and poverty?

17. Key issues/problems/thoughts on projects.

Combat Poverty Agency

18. Benefits from being linked with Combat Poverty Agency.

19. Strengths and weaknesses of the BHC programme.

Self Evaluation

20. What are you doing? How are you doing it?

21. What help may you need?

22. What form could this take?

APPENDIX 2b –
Interview proforma for strategic stakeholders

Question guide for semi-structured interview

(Questions can be amended/tailored according to interviewee)

1.   What is your job title and what is your role (e.g. HSE, Combat Poverty Agency)?

2.   What is the main strategic framework that you deliver against?

3.   What is your link with the Building Healthy Communities programme?

4.   What are the key issues in health which the programme needs to address?

5.   From your knowledge and experience, what would you say are the key issues to arise from projects to date, e.g. the type of challenges they are trying to address or key themes emerging?

6.   What would you say *re* the key strengths and weaknesses of the BHC programme?

7.   At least two of the projects funded through BHC have active involvement of the HSE through HSE workers. Do you see this type of community development role within the HSE increasing or decreasing in the future?

8.   What is the current role of community development in the planning and delivery of health services in Ireland?

9.   What are the advantages/ disadvantages using a community development approach when tackling health inequalities in communities?

10.   What plans are in place to increase the role of community development in HSE planning and delivery? What needs to happen to demonstrate the value of this approach (e.g. through publicising good practice, networking events)?

11.   How can the lessons learned from BHC programme have a lasting influence in future health policy in Ireland?

12.   How well do you think the BHC programme has achieved its objectives to date?

13.   Are you producing any key strategic documents, which are relevant to the evaluation/work of the BHC?

14.   Anything more to add about the BHC?

APPENDIX 3 –
Reporting template

This is the reporting template for projects funded under the Building Healthy Communities (BHC) programme and will help us to evaluate the type of impact that the programme has had over the last few years.

This reporting template will be circulated to all projects so that we can capture the key learning from each of the funded projects.

The reporting template aims to gather information about:

- the progress that your project has made;

- the types of problems and barriers that you have encountered to date;

- your future plans for the project work.

As you answer the questions on the template, please use actual examples from your project to illustrate your answer. If you are unsure about any of the questions or would like any assistance, please do not hesitate to contact a member of the Combat Poverty Agency or the CLES team.

Combat Poverty Agency
Elaine Houlihan,
Tel: 01 602 6642.
elaine.houlihan@combatpoverty.ie.

Centre for Local Economic Strategies (CLES)
Sarah Longlands (nee Jack),
Neil McInroy.
Tel: 0044 161 236 7036.
sarahjack@cles.org.uk.

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1. CONTACT INFORMATION

Name of your Project: _____

Organisation Name: _____

Organisation Address: _____

_____

Email: _____

Name of Project contact: _____

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2. PROGRESS UPDATE

a. Please briefly summarise the progress that you have made towards achieving your original project aims and milestones.

b. Describe any problems or barriers that you have experienced and how you have dealt with them.

c. Please briefly describe what has been achieved over the life of your project in terms of QUANTITATIVE outcomes and QUALITATIVE outcomes

Quantitative (e.g. numbers of events, people involved, products, meetings, groups forming, etc).

Qualitative (awareness raising, relationships built, etc).

d. Provide an example of how you think your project has had an impact on the people you targeted in your project.

e. Please describe how your work on this project has had an impact on the wider aims and objectives of your organisation? Please give examples where appropriate.

3. TACKLING HEALTH INEQUALITIES IN YOUR PROJECT

a. How has your project helped to tackle poverty and health inequalities in your area or within your target community?

4. INFLUENCING DECISION MAKERS

a. How has your initiative involved different partners at both a regional and local level, e.g. HSE, local GPs?

b. What has your project helped to influence or change?

5. SELF-EVALUTION OF PROJECTS

a. What type of self-evaluation work has your project undertaken?

b. What have you learned from your self-evaluation work?

6. FUTURE PLANS

a. What are the future plans for your project when the BHC programme comes to an end? How will your project continue?

7. LEARNING FROMTHE BUILDING HEALTHY COMMUNITIES PROGRAMME

a. What have been the main strengths of the BHC programme?

b. What have been the main weaknesses of the BHC programme?

8. COMMENTS

Please use the space below to write any other comments you have about your involvement in the BHC programme.

Many thanks for your time in completing this survey

APPENDIX 4 -
Main characteristics of community development underpinning Building Healthy Communities programme activity

Project activity	Builds capacity	Understanding and analysis	Involves people collectively	Builds awareness	Enables groups
Develop and establish a National Ethnic Minority Health Forum to impact on policy	✔	✔	✔	✔	✔
Establish national network, the 'Women Together Network, for those experiencing mental health difficulties	✔	✔	✔		
Promotion of Irish sign language to address health inequalities in health service experienced by the Deaf community	✔	✔	✔	✔	✔
Tackle health inequalities in Fatima Mansions by strengthening community development approaches to health	✔	✔	✔	✔	
Address issues of isolation and stigmatisation among lone parents through research in four different areas	✔	✔	✔	✔	✔
Work with asylum seekers and refugees to ensure provision of appropriate services and support in health	✔	✔	✔	✔	

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Builds confidence	Strengthens organisational capability	Innovative and creative	Advocates for policy change	Articulates rights	Promotes networking	Devises strategies
✔	✔	✔	✔	✔	✔	✔
✔	✔	✔				
✔		✔	✔	✔	✔	
✔	✔	✔			✔	✔
✔	✔		✔	✔	✔	
✔		✔	✔	✔	✔	

Project activity	Builds capacity	Understanding and analysis	Involves people collectively	Builds awareness	Enables groups
Community led health impact assessments of selected accommodation sites to look at link between health and accommodation in Travellers	✔	✔	✔	✔	
Evaluate of a community development and health course and a learning unit for stakeholders in this pilot programme	✔	✔	✔	✔	
Community led health service to promote health and well-being of residents in Fettercairn, West Tallaght	✔	✔	✔	✔	
Support for rural communities in Offaly to counter disadvantage and address quality of life issues	✔	✔	✔	✔	✔

Builds confidence	Strengthens organisational capability	Innovative and creative	Advocates for policy change	Articulates rights	Promotes networking	Devises strategies
✔	✔	✔	✔	✔	✔	
✔	✔	✔	✔	✔	✔	
✔	✔			✔	✔	
✔	✔	✔		✔	✔	✔

Building Healthy Communities

Combat Poverty Agency
Agency *working for a poverty-free Ireland*