Tackling Poverty and Ill-Health: Finding Out What Works In Community Development

Combat Poverty Agency
working for a poverty-free Ireland

Introduction

Combat Poverty is a State advisory agency that develops and promotes evidence-based proposals and measures to tackle poverty. This paper outlines the key learning from the Building Healthy Communities Programme and is informed by the evaluation of the Programme.[1] It provides a background to the Programme and defines a community development approach to health. It explores the relationship between poverty and ill health and highlights some of the Programme's achievements. It concludes by identifying implications for future policy development.

Key learning from the Programme

Supporting inclusion and innovation

- Community development and health projects in the Programme supported groups who are amongst the most excluded in society to identify the causes of ill health for their respective communities. They supported groups to develop responses to specific health needs within their communities in an innovative and flexible way.
- The Programme built opportunities and infrastructure for these groups to be represented in policy and decision making settings.
- The Programme supported the development of partnerships to tackle health inequalities. These partnerships comprised community and voluntary groups and health service providers and were acknowledged by both as adding significant value to their work.

Networking and sharing experiences

- The Programme supported excluded groups to build solidarity, identify common issues and develop common policy messages.
- It provided opportunities to share experience, information and learning on health policy and practice and innovative approaches to tackling poverty and health inequalities.
- It provided opportunities for statutory bodies to hear and understand direct experiences of poverty and health inequalities and for community groups to hear and understand issues and challenges faced by health service providers and policy makers.

Research and documentation

- The Programme generated new research and evidence that highlights the link between poverty and ill health.
- Materials were developed within the Programme to raise awareness of the challenges faced by excluded groups with particular health needs and for communities in urban and rural areas of disadvantage. These included publications, posters and DVDs.

Policy and practice

- The Programme enabled projects to engage with their communities and to work collectively to inform national policy formation including the National HSE Intercultural Health Strategy[2], the National HSE User Involvement Strategy[3] and the implementation of the Primary Care Strategy.[4] Projects also participated in planning conferences and informed research and policy work conducted by Combat Poverty.

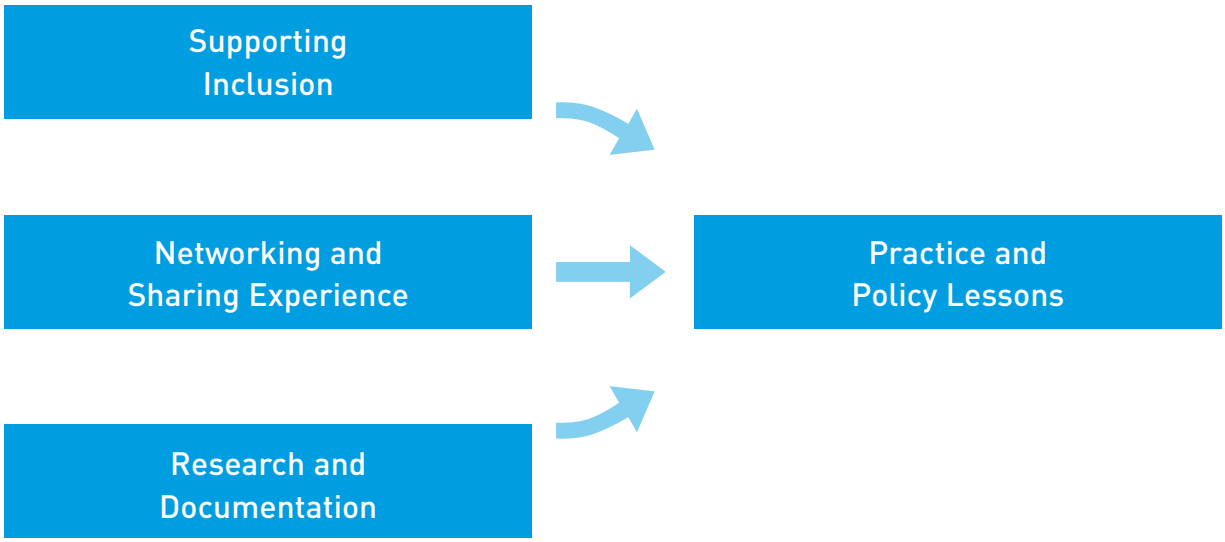
1 CLES Consulting, (2008) *Evaluation of the Building Healthy Communities Programme*

2 Health Service Executive (2008) *National Intercultural Health Strategy* 2007-2012

3 HSE and DOHC (2008) *National Strategy for Service User Involvement in the Irish Health Service* 2008-2013

4 Department of Health and Children (2001) *Primary Care: A New Direction*

Table One: Elements of the Building Healthy Communities Programme



Background

Community involvement in the planning and delivery of heath services is a commitment in the Government's health strategy[5] and primary care strategy[6].

In 2003, the Combat Poverty Agency, with the Department of Health and Children, launched the Building Healthy Communities Programme. A second phase was announced in 2005, with the Department of Health and Children and the newly established Health Service Executive. This paper focuses on this phase of the Programme, when ten community projects (see Table Three) were funded for three years (2005-2007). The Programme's aims were to:

- promote the principles and practice of community development in improving health and well-being outcomes for disadvantaged communities
- build the capacity of community health interests to draw out practice and policy lessons from their work
- inform and support policy initiatives relating to the links between poverty and health
- explore mechanisms for effective, meaningful and sustainable community participation in decision making regarding health.

A community development approach to health

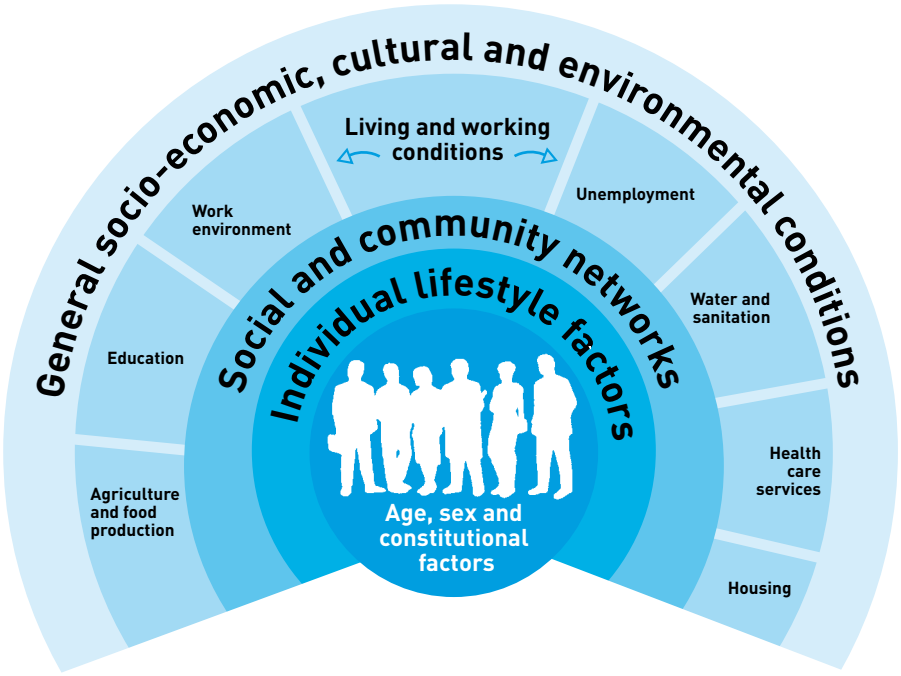
A community development approach to health is underpinned by an understanding that economic, social, physical and psychological factors impact on individuals' and communities' health. This social determinants model of health recognises that the circumstances within which people live affect their access to health services and their health status.

Community development approaches to health focus on tackling the root causes of ill health, including poverty, unemployment, educational disadvantage, poor living conditions and social isolation. Community development approaches are therefore closely linked with creating healthy communities, in which the people affected by poverty and health inequalities are centrally involved in the design of solutions to address them.

5 Department of Health and Children (2001) *Quality and Fairness: A Health System for you*

6 Department of Health and Children (2001) *Primary Care: A New Direction*

Table Two: The Social Determinants Of Health Model



Whitehead and Dahlgren (1996) *Tackling Inequalities in Health*

Poverty and ill health

Health inequalities refer to the unfair and unjust nature of heath differences between social groups, generated by social conditions, including poverty.[8]

Poverty is one of the most important factors to influence health. For example, living in damp accommodation directly contributes to poor health. Poor diet and higher stress levels also contribute to poor health. Poverty makes it difficult to afford appropriate health care and can reduce the motivation and opportunity to adopt a healthy lifestyle.

- People who are poorer are more likely to die younger and face ill health throughout their lives than those who are better off.
- The lower the socio economic status and income of an individual the poorer their health is likely to be.
- Some groups experience worse health inequalities because of other factors, such as gender, ethnic status and where they live.
- The EU Survey on Income and Living Conditions revealed that almost half (47%) of those who experienced consistent poverty[9] and 38% of those who experienced income poverty[10] reported having a chronic illness compared with 23% of the population as a whole.[11]

7 Dahlgren, G. Whitehead, M. (1991) *Policies and strategies to promote social equity in health.* Stockholm: Institute of Future Studies, 1991.

8 Farrell C., McAvoy H., Wilde J., and Combat Poverty Agency (2008) *Tackling health inequalities: an all island approach to social determinants*

9 Consistent poverty – This is also known as the *combined income-deprivation measure* of poverty. It combines relative income poverty with relative deprivation. People whose income falls below the relative income poverty line and who also experience relative deprivation are regarded as living in consistent poverty.

10 Income poverty – Income (or relative) poverty is measured by calculating the median income - the mid-point on the scale of all incomes in the State from the highest to the lowest – and setting the line at 60% of the median. People whose incomes fall below this line are said to be at risk of poverty. The most recent figures show 16.5 % of the population at *risk of poverty* and living on an income of under €227.86.

11 Layte et al (2007) *Poor Prescriptions: Poverty and Access to Community Health Services*, Combat Poverty Agency

For people participating in the Building Healthy Communities Programme the link between poverty and ill health was evident.[12] Issues included:

- educational disadvantage, literacy and language barriers leading to difficulties in accessing information on health or health services
- asylum seekers and Travellers living in inadequate accommodation
- local communities remaining without adequate primary health services
- prohibitive GP costs for those without access to a medical card.[13]

Key achievements

The following identifies some key achievements under each of the Programme objectives:

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

- Groups worked across the range of interrelated issues that impact on poverty and health inequalities, known as the social determinants of health. For example, the Fatima Health Initiative in Dublin worked to enhance access to health services within the regeneration process taking place in their community.
- Community development approaches may require flexible and experimental approaches. In some instances the planned work of projects had to be altered as the policy landscape in which the projects were operating changed. In these instances, the projects developed innovative approaches that have application across other communities such as the health impact assessment project undertaken by the Galway Traveller Movement.
- Community development approaches support collaborative and partnership working with different sectors. Many of the projects were involved in working with other sectors including the Health Service Executive (HSE), local authorities, local partnership bodies and academics. Projects that involved a broad range of stakeholders provided a 'joined up' response to tackling health issues. For instance, the West Offaly Project and the Fettercairn Health Project involved a range of local statutory service providers.
- A key achievement of all projects was that those experiencing poverty were centrally involved in planning and delivering responses at both practice and policy level.

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

- Several projects were involved in researching evidence about the nature of health inequalities experienced by their communities. In many cases this evidence was new. All of the projects involved in the Programme produced research as well as participating in research conducted by Combat Poverty. OPEN conducted research on the stress experienced by lone parents living in isolation. The Women Together Network produced a report on the barriers to participation in society by women with mental health issues. The Irish Deaf Society produced research on the issues faced by Deaf women accessing maternity services.
- Some projects were supported by academics or academic institutions. This supported evidence gathering. The Galway Refugee Support Group worked closely with the National University of Ireland Galway, documenting health issues for asylum seekers and refugees and raising awareness of these issues.

12 These issues are explored elsewhere in a paper on health inequalities faced by groups funded in the BHC Programme

13 Combat Poverty Agency (2008) Submission to the Medical Card Review group

Informing and supporting policy initiatives relating to the links between poverty and health

- Some projects worked in partnership with statutory health providers to shape health service to meet the needs of their communities. The Irish Deaf Society developed posters and DVDs to suggest ways that the health services could engage with them more efficiently. They worked closely with the health services to promote the use of Irish Sign Language to communicate with the Deaf community. The Galway Refugee Support Group worked closely with the HSE to build awareness of the impact of Direct Provision Accommodation on the health of asylum seekers and refugees. Under the 'direct provision' scheme, asylum seekers live in shared 'hostel-type' accommodation.
- Projects participated both individually and collectively in the development of a number of national health strategies including the Intercultural Health Strategy, the HSE *National Service User Involvement Strategy* and the NESF *Consultation on Mental Health*. The projects also contributed to the policy positions of the Combat Poverty Agency, including its health policy statement and its Submission to the Medical Card Eligibility Review Group.

Exploring mechanisms for effective, meaningful and sustainable community participation in decision making regarding health

- The Programme supported the representation of people experiencing health inequalities and poverty. Opportunities and mechanisms were developed where the views and voices of those experiencing the issues could be articulated to policy makers and service providers. Projects also worked collectively at national level to develop policy responses to common issues, such as access to primary health care. Cáirde developed the national ethnic minority health forum, to represent the view of new communities and develop relationships with policy structures. The Women Together Network developed a national network of women experiencing mental health issues.
- Some projects worked to influence the expansion of primary care services under the National Primary Care Strategy. Common guidelines were developed to support the participation of communities in primary care teams. Some projects are involved in supporting the establishment of local primary care teams and creating ways to ensure that people experiencing poverty are represented on these teams.
- Some projects employed community development and health workers who were recruited from their own communities. These workers had a key role in engaging the local community and acted as a bridge to local statutory services. As local people themselves, they were familiar with the issues and barriers for local people and as a result had stronger outcomes.[14] NICHE in Cork, Cáirde and the Fatima Health Initiative employed community development and heath workers and participated in the development of a Community Development Health Worker model, which was supported by Community Action Network (CAN).
- The opportunity to network with other similar projects was acknowledged by all as adding value to their work. It allowed groups to share knowledge and experience, reflect on their work and identify common issues and responses. Some projects continue to work collectively for the development of a community development and health network that could be representative of community development and health projects to inform policy formulation.

14 CAN (2009) *Model of a Community Health Worker*

Table Three: Summary of Projects

Lead organisation	Original project objectives
Cáirde	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	Tackling health inequalities by strengthening community development approaches to health within community and statutory organizations 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	Working with asylum-seekers and refugees to ensure provision of appropriate services and support in health
Galway Traveller Movement	Community-led health impact assessment of an official low grade halting site in order to demonstrate the link between health and accommodation for Travellers
Community Action Network (CAN)	Evaluation of 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 the 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.

Implications for Future Policy Development

- Because poverty and ill health are interrelated, reducing poverty is a key means to improve the health of people living in poverty. There is a need for integrated policies to be formulated, which tackle the structural causes and social determinants off ill health. These policies should be developed across Government Departments with strong inter-departmental co-ordination, underpinned by clear targets.
- Combat Poverty welcome recent commitments by the Department of Health and Children and the HSE to the participation of excluded groups in the design of health services.[15] This process will need to be actively supported and resourced. Standards of engagement should be developed and applied to ensure that this can happen in a respectful and productive way. Resources should also be made available or refocused to ensure that the participation of communities in the roll out of primary care is achieved.
- The networking strand of the Programme was useful in supporting a collective voice. The networking dimension of the Programme will continue through support for the development of a community development and health network. This can provide opportunities for government departments to consult with a range of groups who experience health inequalities. This network will require ongoing funding and support.
- The Community Development and Health Worker model, developed within the Programme, has transferability across a range of other programmes with a community development focus including the Family Resource Centre Programme, the Community Development Programme and the Local Development Social Inclusion Programme.

15 HSE and DOHC (2008) *National Strategy for Service User Involvement in the Irish Health Service* 2008-2013

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