CAN COMMENT

COMMUNITY DEVELOPMENT IS GOOD FOR YOUR HEALTH?

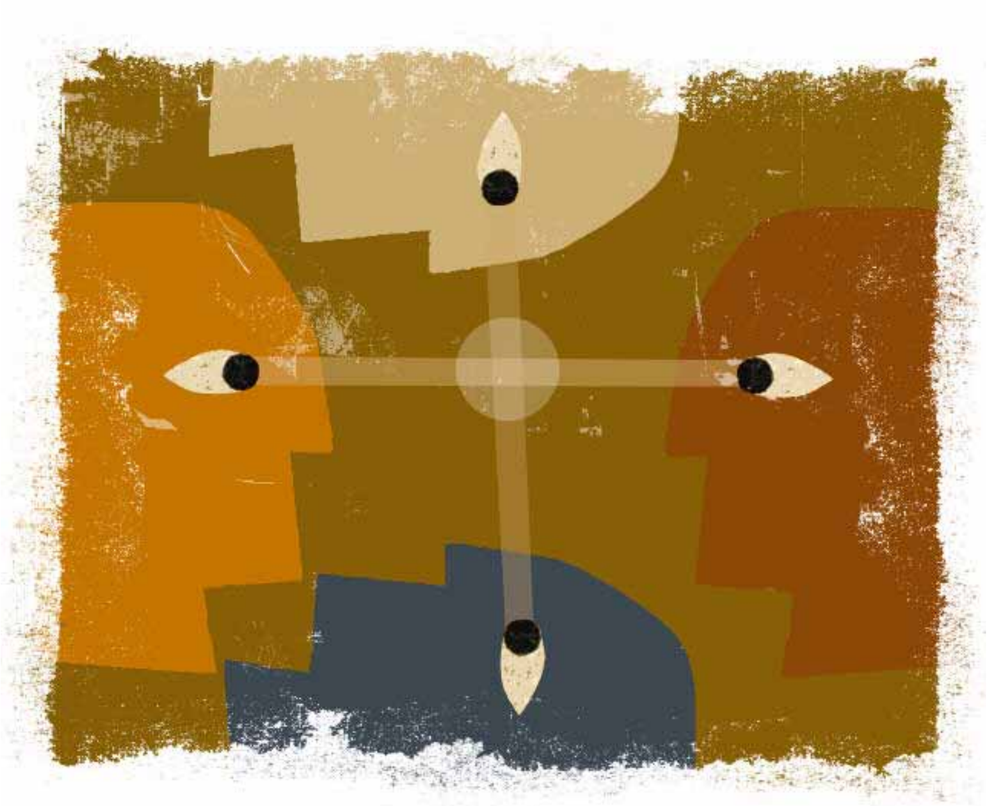
This CAN Comment explores a model of community development and health that is grounded in the experiences of four projects, all currently engaged in addressing health inequalities within a community context. These projects are the initiatives of the following four organisations:

Cáirde
CAN
Fatima Groups United *(FGU Dublin 8)*
NICHE *Northside Initiative for Community Health (Cork city)*

The Comment has emanated from the work of the Action Learning Group[1], hosted and facilitated by CAN, on Community Development and Health. It puts out for discussion the uniquely Irish challenge of visualising, developing and implementing a community development health model. The purpose of the CAN Comment is to share the learning from this Group, to promote debate and to raise issues of importance both to the community development sector and in the health policy arena. It is a first step in looking at, and spending time with, the challenges, the complexities, and the dilemmas that have emerged from this process. It does not seek to propose solutions or make policy recommendations. It does, however, present a model of community development and health currently operational in Ireland and one that is evolving and developing.

[1] *The Action Learning Group was established early in 2005. It provides a reflective space for representatives of these four community projects. The Group forms part of a wider action research programme on Community Development and Health that is supported by the Combat Poverty Agency (CPA) 'Building Healthy Communities Programme' and the Health Research Board (HRB) 'Building Partnerships for a Healthier Society'.*

can
Working for Change Through Community Development



Differing Communities – One Approach?

Cáirde works through a community development approach which is based on the concept of bringing about social change in favour of those most marginalised in society by enabling these groups to address the social, political and economic causes of their marginalisation. (Cáirde, 2006:4)

Within each of the four projects, conditions were created which allowed for the work in relation to community development and health to be initiated, to take root and to be shaped into its current forms:

cáirde: Is an organisation involved in community development activity with disadvantaged minority ethnic communities living in Ireland addressing the factors that affect their health. Cáirde is committed to supporting the participation of communities to enhance their own health and argues for a strong holistic approach. For the past five years Cáirde has implemented a range of initial capacity building initiatives with community leaders and ethnic minority community groups, seeking to realise the potential of applying community development approaches to health issues in marginalised communities. In 2004, to build on this early development work, Cáirde sought to develop a deeper capacity building initiative which would be linked to emerging community infrastructure such as the Ethnic Minority Health Forum, which it also facilitated. This approach would build the capacity of minority ethnic groups to identify their own needs, to develop an awareness of the policy context within which services are planned and delivered and to engage with statutory service providers and planners. The publication of the Primary Care Strategy, which specifically calls for health needs assessments in communities, added an additional urgency to this capacity building focus. The initiative was funded by FÁS and the HSE.

can: Is an organisation that works for change through community development. One of its stated objectives is to take action to redress the glaring inequalities in the health status of disadvantaged communities. As part of its commitment to working for a more just and equal world it has developed and delivered quality accessible and accredited training at community level over many years. For CAN, training is seen as a tool for building active empowered communities. It developed its own accredited Community Development and Leadership Course which it has delivered in partnership with community based organisations. In recent years it designed and developed new modules on community development and health and is piloting these as part of the leadership training in collaboration with the three projects documented here, each of which is pursuing a community health agenda.

fatima groups united (fgu): The regeneration of Fatima Mansions provided the driving force for much of FGU's activities in recent years. The adoption of a holistic approach to health was seen as critical to the success of this process. Those involved in the regeneration of Fatima Mansions recognised the important role played by both health and community development in ensuring successful outcomes. As part of the regeneration plan a health sub-group was established and a health strategy formulated for Fatima Mansions which included the development of a Health and Well-being Centre. There is a long history of health work within this area of Dublin 8. FGU and the Health Promotion Department of the HSE (South Western Area) have also worked together on developing community health initiatives and from 2002 a dedicated post in health promotion (funded by the HSE) was based in Fatima.

niche: The focus of NICHE is on improving both community and individual health and well-being using a community development approach. This involves recognising and building on the strengths that exist within communities as well as acknowledging the barriers that may prevent individuals and communities from availing of health-enhancing options. Its current three-year plan is to institutionalise a holistic, social model of health within the area. NICHE promotes its community development approach to health based on the Community Health Worker role and through entering into a broad range of alliances and partnerships with other organisations working in the area. Funding was accessed from Pobal under the Equality for Women Measures to put in place a training initiative.

The context within which the work on health arises in each of the three projects[2] may be very different. Yet although coming from different starting points and still evolving, all the projects embrace the social model of health; vigorously pursue community development approaches; and identify training as a key need. CAN, in collaboration with each of the three community organisations, undertook to pilot[3] its Community Development and Health training programme within the various community contexts with funding sourced by the projects from a variety of agencies.

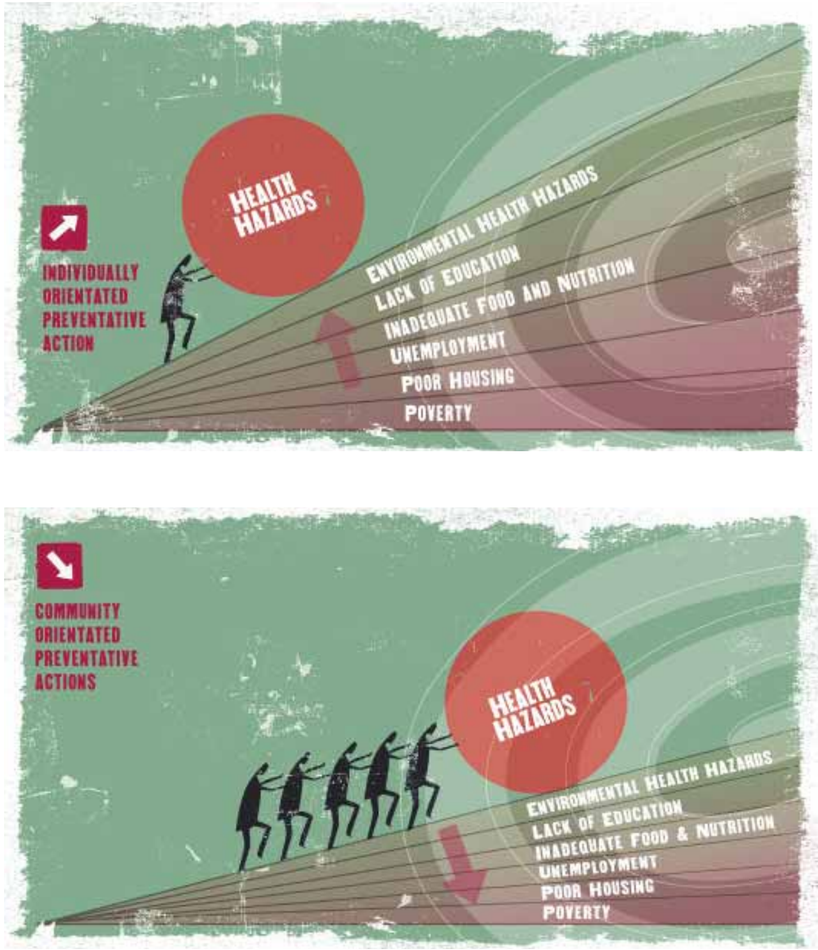
Even at this stage there is learning from the experience of pursuing a community development approach to tackling health inequalities. This approach is based on the concept of bringing about social change in favour of those most marginalised in society by enabling these groups to address the social, political and economic causes of their marginalisation and is grounded in principles of equality, participation and collective action. A community development approach to health, for example, looks at the root causes of ill health. It is not just as an individual problem but is caused by underlying structural issues in our society. Furthermore, a community development approach to health focuses on collective action on issues relating to health.

The learning from pursuing a community development approach to health as presented by the Action Learning Group is clustered around four interrelated themes:

- **Addressing the social determinants of health**
- **Facilitating community participation**
- **Training as a strategy for social change**
- **Pursuing a rights based approach to health**

[2] *Each of these has been/is also supported by the CPA 'Building Healthy Communities Programme'.*
[3] *A total of 50 participants have taken part in the piloting of the programme.*

healthy, individual and community orientated preventative actions



Intersectoral action for health WHO 1986

THE SOCIAL DETERMINANTS OF HEALTH

Imagine being told that if you live in a particular area it will mean that you'll probably get sick more often than most people' that when you do get ill, you'll have less access to decent or efficient healthcare; that you're also more likely to get more seriously ill than the average person; that you'll probably die younger than most others; that your children will also be more likely to suffer from a range of serious conditions and diseases like asthma; that they'll be more vulnerable to harmful drugs and physical danger; that they'll have to grow up in damp, unhealthy and hazardous conditions; and that your psychological health will be more vulnerable from stress, depression and mental illness.(Fatima Regeneration Board, 2005:45).

Almost every culture has some proverb about health – 'so long as you have your health'. All over the world people rank health as one of the greatest goods (Mann). Yet people experiencing poverty have poorer health and die younger than those who are better off. In no other area is the impact of inequality on society as devastating as it is on our health. Just consider the following facts:

- In the decade leading to the end of the twentieth century the death rates for all causes of death were over three times higher in the lowest occupational class than in the highest.
- The incidence of chronic physical illness has been found to be two and a half times higher for poor people than for the wealthy.
- The rate of hospitalisation for mental illness is more than 6 times higher for people in the lower socio economic groups as compared with those in the higher groups.
- Women in the unemployed socio-economic group are more than twice as likely to give birth to low birth weight children as women in the higher professional group (Public Health Alliance).

It is clear that a wide range of factors impact on the health of people and of whole communities. These factors have been described as 'layers of influence' and are very well depicted graphically in Dahlgren and Whitehead's diagram below.

This social determinants of health model recognises that the circumstances and conditions within which people live and work affects their health their health status and their access to health services (Marmot 2005:3). The recognition that social and environmental factors decisively influences people's health inevitably changes the questions to be asked and the policy responses required. The social determinants of health model forces the adoption of a broad perspective about what constitutes policies on health equality. This applies at the level of communities as well as nationally.

UNPICKING THE SOCIAL ENVIRONMENT

Within Ireland, community development practice has been active in trying to bring about change in the social environment which impacts so negatively on the health of individuals and whole communities. Some of this activity is undertaken by pursuing an explicitly 'health' agenda, while some, not so labelled, indirectly addresses health issues. The comment 'we don't do health but community development takes us into health' (STEP in CWC, 2004:33) captures this position. What matters is the content of action to redistribute resources and not particularly how it is labelled.

However, the projects involved in this CAN Comment have each endorsed the explicit goal of promoting health and well-being through using a community development approach. Furthermore, training forms a fundamental element of this wider community strategy on health. The training very quickly brings participants into reflecting on their social environment and how it impinges on the health of their communities:

I have learnt … that where we are emotionally, financially and socially can affect how we view the world and various situations. Many people can look at the same picture and may actually see things differently. The glass can be half full or it can be half empty, depending on our perspective… I'm now more aware of the 'broader picture' such as my reality is not necessarily other people's reality, that there is a very tenable link between the individual and his/her place in society. That resources or lack of them can influence a person's actions and attitude … (NICHE participant)

When exploring the issues that impact on their health and the health of the communities in which they live, participants in the training programmes identified issues such as the following and used a process of analysis to identify the root causes:

- **Anti-Social Behaviour**
- **A Concrete Jungle or a Community?**
- **Drug Use**
- **Impact of Parking and Traffic Controls on Health**
- **Food**
- **Housing**
- **Unemployment**
- **Direct Provision**
- **Isolation and Older People**
- **Depression**
- **Asthma and the Environment**

Drawing on their own lived experiences and other sources they demonstrated the impact of a wide variety of social determinants on the health of the communities in which they live and on the inequities in the system. Elements of some of their analysis are reproduced here:

health determinants model

Intersectoral action for health WHO 1986

Anti Social Behaviour

Anti Social Behaviour ranges from petty crime to outright criminal damage to people and their property. Anti Social Behaviour is after increasing rapidly in our community in the last five years. If you're a victim of A.S.B. your health would really suffer. If you are in an area with Nuisance Neighbours it becomes unbearable and as a result people have actually left their homes and deemed themselves homeless.

This has a physical and mental effect on our health. The impact this has on our community is horrendous. This effects local people's health in a lot of ways. Local people are stressed, frightened, anxious, depressed and no longer feel safe living in their own homes. As a victim of A.S.B. I can relate to this and a lot more … I interviewed 4 people who had similar experiences. They told me they were unable to cope due to the mental stress and fear of being alone in their own homes. They also lost their appetite and this brought on physical illness and severe weight loss. In my own opinion the isolation that people feel can eventually lead to depression. Some of the people have developed panic attacks and have to rely on prescription drugs to get them through each day… If the old policies are enforced and if the new measures work, our community would be a healthier place to live. People would no longer have to live in fear or be prisoners in their own homes. The community would be less stressed and our children wouldn't have to live in a tension filled community. People would be able to come and go without fear of verbal abuse or physical assaults. Peace of mind is everything and I didn't realise that until mine was taken away. (NICHE participant)

Unemployment among People from Ethnic Minority

(Refugees and Asylum seekers)

Introduction

Unemployment puts health at risk. Evidence from many countries shows that, even after allowing for other factors, unemployed people and their families suffer a substantially increased risk of premature death. Through this social analysis I will explore how the unemployment as an issue affects the individuals from minority ethnic groups (refugees and asylum seekers) and the connections between the different levels to uncover the cause and effect relationships between the different aspects of the system. I will finally identify what needs to change at each level to bring about change.

Effects of Unemployment among this Group

Personal Level

Poverty: Long term unemployment is associated with socio-economic deprivation. People from ethnic minority are likely to live on low income that comes from social welfare assistance…

Psychological consequences: The loss of structured time, social contact and status have negative effects on health. Most people from ethnic minority are likely to live on long-term unemployment for different reasons which will probably be analysed later during this work. These people are likely to get less social and emotional support as most of them experience loneliness and isolation; when these people cannot go to work or to school it becomes difficult for them to engage or to get in relation with other people and most of the time they live in the area where they don't know many people, so they prefer to stay home and try to get used to their difficult situation as there is nothing else they can do. They feel powerless on this. They are also likely to experience the loss of position; some were still at school and are not allowed to continue, maybe because of their legal status in Ireland or because they cannot any more afford to pay fees. Others were people with some qualifications but not recognised in Ireland, these people who were used to going out every day and who considered themselves to be important or useful for the society may feel unwanted when told it is not possible for them to continue their studies or to practice their work in Ireland.

All of these feelings are linked with their loss of self-esteem, self confidence and also may cause boredom and anxiety for living the same life routine every day, they are also linked to depression and can activate stress mechanisms that increase risk of disease such as coronary heart disease.

Social Level

Not Belonging to the Society: Belonging to a social network, communication and mutual obligation makes people feel cared for, loved, esteemed and valued. When people from ethnic minority, especially asylum seekers, try to get connected to others by joining them in schools and work places, they find out they are not allowed or cannot afford to pay some facilities such as child care or transport and that there are no resources available to ease this situation. Many of them feel angry about it and sometimes think that they are not considered as part of the society.

Seen as a lazy community: People from ethnic minority are seen as a lazy community that doesn't want to participate in society, just because they are looked after by the welfare offices or in direct provision centres. This is one thing that keeps people from ethnic minority down, and that has something which exposes them to the racism experience, as other communities in Ireland consider them as people who just came to keep the Irish economy down…

Cultural Level

Not recognised culturally: There is no way that you can know other people's culture or other people's way of life if you don't get alongside or involved in some thing together. The most important aspects of culture are deeper and cannot be recognised superficially. It is by joining other people in the work place or in education that a good opportunity for other communities within the Irish society to know people from ethnic minority and their way of living and doing things and vice versa…(Cáirde participant)

EXPERIENCE ON THE GROUND

The connections between the circumstances in which people live and work and their health have been well documented internationally. While we may well need more investigation to clarify the nature of the relationship between the social environment and health, we also need more social action on the basis of the knowledge we have. It is not surprising that the various national strategies relating to health, produced in the past decade, reflect and highlight the importance of the impact of social and economic factors on health status. What does such formal recognition mean on the ground for projects pursuing a community development approach to tackling health inequalities which are solidly grounded in a social model of health? There are some indications of change:

Now the whole discourse around community development and health has changed. Language around community development and health has permeated the HSE. Whether it has in practice or not, I don't know! But the dialogue and the work we are doing and what the CPA is doing has changed the discourse. It is become more mainstream (Member of ALG, Meeting January 9th 2006) .

Despite the national strategies and the changed discourse, experience on the ground by these Irish projects promoting health and well-being through a community development approach reflects considerable ambiguity:

- By working explicitly with the social determinants of health the projects are validating a model which is different to that promoted by Health Authorities or other statutory agencies. The question arises as to how such a model fits within national strategies that have as a stated aim the reduction of health inequalities e.g. National Health Strategy; NAPS, Primary Care Strategy?
- National commitments regarding the importance of the social determinants of health are not mirrored in the structures at a local level. There are, for example, no supports for health professionals at a local level to encompass a wider understanding of health , and so communities are dependent on some individuals within their local health service rather than an institutional approach addressing wider issues affecting health outcomes. This approach does not lead to sustainable outcomes at community level.
- In operationalising a social model of health there is evidence of a reluctance at local levels to cede control and ownership of 'health'. There are challenges of marrying the different philosophies of health promotion and community development together.
- While the language of social determinants of health may be more mainstreamed, often in practice statutory authorities are looking for the magic formula, the 'quick fix', rather than the sustained work required to redistribute resources and power that is demanded by a community development approach to health.

FACILITATING COMMUNITY PARTICIPATION

The formation of a coherent cadre of Community Health Workers was NICHE's principal aim … Building on this achievement, we will attempt to consolidate the role of the Community Health Workers in a number of ways. We will aim to achieve proper accreditation of the training … we will review Community Health Worker functions. And we will continue to lend support to other community health projects in Ireland striving to implement the Community Health Worker model (NICHE, 2004:13)

Community participation is integral to a community development approach to health. It is manifested in a wide variety of ways and the projects involved depict some of this diversity:

- Building the capacity of ethnic minority communities to determine their own health needs and to genuinely engage in needs analysis, design and work with and influence public service planning and delivery.
- Building the capacity of local people and of local community projects to develop and implement a health agenda that would address all of the social determinants of health.
- Through developing a wider regeneration strategy that locates health and well-being at its core and which reflects extensive community participation at all levels.
- Developing the Community Health Worker role and through this facilitating the community, and particularly vulnerable members of the community, to get involved in activities by creating a supportive environment for people to participate.
- Linking actions to a wider collective infrastructure such as Community For a or Community Development Projects.

In Ireland various national health strategies of the past decade have all signalled the importance of community participation in addressing health inequalities

- The National Health Strategy (2001) focuses on health, not just on health services, and recognises the formal and informal role of the community in improving and sustaining social well-being in society. It contains a specific commitment to community participation and states that 'provision will be made for the participation of the community in decisions about the delivery of health and personal services' (Action 52).
- The National Health Promotion Strategy (2000:66) aims to promote a holistic approach to health by focusing on the link between health promotion and the determinants of health and the importance of inter-sectoral and multi-disciplinary approaches. In particular, it clearly offers and defines an important role for community based health workers in addressing structural inequalities and in influencing policy development (CWC 2004:16).
- The importance of community participation is reaffirmed in the Primary Care Strategy. Action 19 of Primary Care - A New Direction states that: 'Mechanisms for active community involvement in primary care teams will be established. Community participation in primary care will be strengthened by encouraging and facilitating the involvement of local community and voluntary groups in the planning and delivery of primary care services'.

However, despite the rhetoric there are no formal provisions for community participation in the emerging health services structures and insofar as participation is envisaged the language relates to 'consumers' rather than citizens. Neither are there any supports or resources invested specifically for community participation at a local level, which means that community participation, where it takes place, tends to be ad hoc and reactive.

COMMUNITY HEALTH WORKER ROLE

This is not to say that there is not progress in developing initiatives and new roles that have the potential to impact on health inequalities. There is the health promotion model; cultural mediator model; peer health educator model; and the Traveller Primary Care community worker.

In promoting community participation, each of the projects that embarked on the CAN training sought to develop, in different ways, the role of the Community Health Worker. It was acknowledged in the Action Learning Group that the way in which the Community Health Worker role evolves will be influenced by the environment in which they are working, the context of the work and the issues that are pertinent to the community they serve. What remains common to all are the underlying principles of community development whereby the Community Health Worker acts in a supportive capacity to facilitate their community to identify and define the underlying issues that are affecting their health:

NICHE has been to the forefront in innovating the Community Health Worker role in the Irish context and in developing replicable examples of health promotion in a local community. It now has a coherent cadre of Community Health Workers recruited from the locality and playing a vital role as links between the community, the project and other agencies whose work impacts on health. A couple of years ago NICHE conducted a Community Health Planning process which provided a health profile of the area as seen by residents and other stakeholders. This informed the development of the NICHE Strategic Plan. The Community Health Workers address a diverse group and attempt to develop health initiatives that are responsive to the needs of the community. There are currently, for example, health programmes for women over 35, parenting support programmes, health programmes for men over 35, as well as partnership programmes with a variety of organisations - interagency mental health/disability awareness, interagency environmental health campaign, and improved access to health information. The Community Health Workers not only promote such activities but also create the supportive environment in which people can then participate.

CÁIRDE: Following the completion of the community development and health training programme, some participants became voluntary interns within Cáirde as Assistant Community Development and Health Workers. In adopting a community development approach to health needs assessment, these interns designed a research framework and conducted a health needs assessment of minority ethnic communities in Dublin's North Inner City. The needs assessment was designed to support the participation of ethnic minority communities in determining health and primary care needs, making the link between experiences in the community and health outcomes for members of the community. It is intended now to move to an action phase based on the findings, and as Community Development and Health Workers interns will design and implement actions at community level, building partnerships between service providers, policy makers and minority ethnic groups which will model community participation in primary care. This action phase will be directly connected to emerging community infrastructure, such as ethnic minority community groups and the Ethnic Minority Health Forum to ensure sustainable community participation leading to collective outcomes for ethnic minority community members.

FGU: When the HSE-SWA funded a dedicated post in health promotion based in Fatima it was interested in developing the concept of peer health education and community health worker. The concept of a course combining community development and health was attractive as it was seen as enabling community capacity building in health and facilitating increased awareness within communities of the social determinants of health and how a community might address these. It also had the potential to develop a cohort of local community advocates with the skills, knowledge and confidence to engage effectively . A number of local people who participated in the training programme are now employed as Community Health Workers in the development of two local health and well-being centres in the Rialto area.

In these initiatives to develop the role of the Community Health Workers funding partners within the health services are very different. In FGU it is Health Promotion; in Cáirde it is Social Inclusion; in NICHE it is Community Work. The role too is different in each of the areas depending on the needs and strengths in the communities concerned. It is also influenced strongly by the context within which the project is operating. In FGU it is regeneration with the wider community development project to support the emerging role; it is a community development programme supporting an ethnic minority community infrastructure in Cáirde; and in NICHE the pursuit of a holistic, social model of health using a community development approach is undertaken in the absence of other community development projects.

The Action Learning Group discussed the rationale for and the essential features of the role of the Community Health Worker (CHW) in the different communities. One of the members described the motivation to begin to develop the role:

The CHW role that we developed was based on the assumption that there was knowledge and talent in the community that could change health promotion. There was a feeling among those involved that:
- It could be done differently. Too often there were people coming in from outside and telling us what the issues are. We wanted to address our own issues.
- There was an employment issue in relation to jobs in the health arena.
- If something was to have value in the health services it had to be put in place properly and not FÁS funded.

These were vague principles. We set about putting together a team of health workers based on a social model of health… We started from what talents and interests were there in the group and what supports and training they needed…(Member of ALG, Meeting September 30th 2005).

Since the early years of 2000 NICHE has worked towards developing the role of the Community Health Worker. Community Health Workers are local, have particular skills, provide social support, promote health awareness and build individual and community capacities. However, a core element of the role is the manner in which they address the barriers that prevent participation through a gradual process of welcoming, supporting and facilitating more vulnerable members of the community to get involved in activities.

The difference between a community development worker and a Community Health Worker was also explored in the Action Learning Group. This is seen as particularly relevant where a project also has community development workers:

Health is deeply personal. The CHW needs to address the personal aspect and then move on to the collective. That's where the difference is. It starts from the personal. Engaging with people very much at the personal supportive role so that they can then begin to engage with the issues affecting them

A focus of the CHW role (in contrast with the community development worker) is in trying to get the health services to be advocates, to come on board in tackling housing or regeneration or whatever the issues are at community level (Members of ALG, Meeting September 30th 2005).

Based on the experience of the projects in developing the role of the Community Health Worker and reflecting on it in the Action Learning Group, a number of issues are raised:

- There is a question as to how the model of CHW will look if it becomes just another professional role? What of the whole process of capacity building, analysis, understanding of health and of collective action which has formed part of the current context within which they operate?
- The employment status, the basis for remuneration, the institutional attachment, are also critical and, most importantly, to whom is the CHW accountable and how will this affect their ability to be led by the community's agenda?
- The support needs of the CHW are very great and, at times, very intense. This is not always recognised by funding sources. There is also an ambivalence associated with emphasising support needs and how the role is then portrayed and perceived within the wider health arena.
- There are issues around boundaries. CHW have to work out a range of boundaries in relation to their role. One of the major dimensions is in relation to balancing personal/private and professional/work issues in relation to living and working in the same community.
- How does the role of the CHW interface with the evolving health structures, the national health strategy, the health promotion strategy and the primary care strategy?

Health and Well-being Centre for the Wider Rialto Area

One of the key objectives of the Health and Well-being Working Group of the Fatima Mansions Regeneration Board is to advance the development of a Health and Well-being Centre for the wider Rialto area.

It is planned to integrate the development of local community health initiatives with the development of a Primary Care Team for the area. The setting up of Primary CareTeams is set out in the government strategy Primary Care: A New Direction (2001) and entails the joining up of GP primary care and other ancillary paramedical services (e.g. PHN's, OT's) as part of an overall integrated team.

The model for a Health and Well-being Centre is based on the concept of Healthy Living Centres which have been established in the UK in recent years and where there is a strong focus on promoting preventative health approaches.

It is also proposed to establish a Community Health Forum. This is in order to ensure that the Health and Well-being Centre is underpinned by a strong community health ethos; to promote community participation in the identification, planning and development of community health initiatives linked to the Centre; and to promote community involvement in discussing and seeking responses to health issues which affect them.

It is envisaged that the Community Health Forum should have a broad representative base to reflect both the geographical catchment area of the Health and Well-being Centre (broadly coterminous with patient addresses in the GP practices) and to represent a wide range of health-related themes and specific communities of interest for example, age-related groups, disability, ethnic diversity. (Fatima Regeneration Board Executive).

TRAINING AS A STRATEGY FOR SOCIAL CHANGE

The community development and health training to me as a member of the minority ethnic community in Ireland was mind transforming. I experienced a paradigm shift in my perspectives around social issues in my community: quantitative and qualitative analysis, structural anomalies, collective action, participation and solidarity among vulnerable groups. Now, I feel strong and passionate about community development and health roles in my community, and I am ready to make a career in this field'. (Cáirde participant)

Pursuing a community development approach to health is empowering and health giving in itself whether at the level of the individual or the community. Community development is about change – it is about change in those that participate in it as well as in social structures and social systems. In its training programmes, community development principles and practice are pursued by CAN as a means of encouraging people to be the subjects of their own development as active informed citizens. As such they have the right to participate in the formulation, implementation and monitoring of actions that affect their lives. Communities are encouraged to challenge the structures, policies and practices that cause inequality and the denial of their rights. Training in this context is really about empowerment, analysis and collective action:

Community development made me a better person, it brought confidence in me, to stand up for my rights but in a diplomatic way; in a peaceful way; it changed my life in such a way that I could see things differently and analyse them from all angles. (Cáirde participant)

TRAINING – COMMUNITY DEVELOPMENT IN ACTION

CAN engages in training in a way that mirrors the community development approach in action. This has a number of key stages, which are reflected in the training process:

- It begins by honouring the lived experience of each person who has experienced inequality and/or a denial of rights. Encouraging people to tell their stories breaks the silence of exclusion as well as validating their ways of knowing about the issues they have lived with.
- Creating the learning group is an opportunity of linking individuals together. This creates a shared understanding of how inequalities are experienced. Patterns and similarities are highlighted. This moves the experience from the individual to the collective as well as creating a sense of solidarity and identity within the collective itself. It also provides an experience of a more equal way of being in the world, as all learning is participative, where every person's contribution is valued.
- Subjecting this shared experience to scrutiny through the process of social analysis allows the group to see the interconnection between the personal, social, cultural, political and economic dimensions of the issues. In this way the root causes of inequalities are identified while at the same time, the group has a significant experience of empowerment as the structural causes of their lived experience are understood.
- Learning the skills in planning for collective action, group dynamics and leadership that are linked to a vision of a more equal world gives groups power to take action on their own behalf.
- Networking within and across communities through visits, placements, using mentors all help to reinforce the need for and value of strategic alliances

Encouraging the practice of learning by doing is central to each stage of the training and the training is often changed significantly as a result of the joint reflection and evaluation. Participants learn that their views do count and that they can influence change.

THE CHALLENGE OF ACCREDITED TRAINING

With the formal accreditation CAN struggles with the challenge of linking two very different systems together. There is the training framework in which participative methods are encouraged and within it is also a marking system that works to agreed standards. The education system has failed many communities or, as in some cases, it does not formally recognise their qualifications and knowledge. CAN appreciates the importance of formal recognition of knowledge and the opportunities it provides to individuals for progression and personal achievement. It sees its responsibility to gather evidence of learning that reflects a variety of ways of learning – video, artwork, audio taped interviews, collages, photographs, mind maps as well as the written word. People have many ways of knowing and expressing knowledge and CAN is challenged to develop creative ways of gathering high standard evidence to reflect that and to ensure that such methods are acceptable to accrediting bodies.

When I think back I see myself a different person with very strict views and beliefs. This programme gave me the opportunity to broaden my views, to challenge my beliefs and to become a better person.

What I loved most of all was the concept of the programme, it was not meant to be another course where you have to go to take notes, the course was focused on personal development, taking personal experiences into theory, make statements and suggestions based on your personal experience, the opposite of a standard course.

I learned how to listen, actively, to others and how to communicate with others who had very different ideas than mine, I learned about different styles and behaviours in groups, I learned many things about myself, I discovered a part of me that was undiscovered which is of benefit to me and other people I come in contact with every day…(Cáirde participant)

The power dynamic that accreditation brings (for example, power over grades) is one that is worked with in the learning context. It is made explicit. The journey of human development is separated out from the accreditation, emphasising that no one can measure the former. Co-operation rather than competition is encouraged, support offered as well as the flexibility to submit and re-submit many times until the participant is happy with the final result. Comparisons are discouraged and ' class results' underplayed, while at the same time affirming personal effort.

DEVELOPING CRITICAL ANALYSIS SKILLS

In honoring the lived experience of participants, in making the connections between the personal and the political, and in developing critical analysis skills, learning tools such as 'The Social Analysis Spiral' are used widely. These are perceived by participants as extremely effective:

I learnt the effective us of the Social Analysis Spiral. It really is like the pebble in the pond. Starting with the Personal – the person and how something affects him/her. Then the Social aspect of the spiral shows us how something affects the entire community. The Cultural aspect shows us how society is affected by this issue. The Political aspect of the spiral should show us who has the power to do something about the issue. The Economic end of the Spiral will show us in what way money or the lack of it can effect an issue.

I now understand how the Social Analysis Spiral can be used as a tool to look at society and how it is constructed . The Spiral allows us to analyse things in a simple fashion. Working from the personal, social, cultural, political and economic viewpoints we can begin to penetrate more deeply into the causes and effects of problems and see how they impact on society for better or for worse and also how they are interrelated. I see the importance of taking into account the wider picture, realising that there are many elements responsible for and contributing to keeping Ireland an unequal society in spite of our Celtic Tiger status. (NICHE participants)

One participant applied the Social Analysis Spiral to the analysis of a health issue that impacted directly on her and her family. Some of her analysis is presented in the following panel:

Analysis of Depression

What is Depression?
Depression is a disorder which affects one's whole life. It is a disorder of the mind affecting ones thoughts, feelings, and view of life. It is associated with feeling sad, irritable, angry, bored, and anxious. It also causes insomnia, loss of interest in everyday activities such as work. There are also physical side effects such as panic attacks, chest pains and palpitations without a physical cause … Right now 280,000 people suffer from the disorder.

My Personal Experience
I have personally suffered from depression and it had a devastating effect on my life. It happened as a result of marital problems starting with the feeling of being sad. It felt like someone had taken a something from inside of me. I could not eat or sleep. I cried all day and night and I could not function properly. But I had three children and I had to try and keep going for their sakes. My mind was in turmoil I did not know whether I was coming or going.

I went to the doctor and he prescribed anti-depressants. I was taking them for about a year and when I did not feel any better I decided to come off them. I did not know I was supposed to ease off them slowly so I started to become paranoid. I did not trust people and I though they were watching me. Then I started to have suicidal thoughts. I was thinking this world was very bade and I did not want to be there any more. I was going to take my youngest daughter with me as I did not want her to be in this big bad world. One day I was walking down to jump in the river Liffey and for some reason I went to the phone box and I called the Samaritans. The man told me get in a taxi and go over to them. After a few hours with the Samaritan Worker I came out smiling. I could not believe that my head was so clear to be able to think of the future.

After that I went to a private counsellor. At this stage I wanted to avoid hospitals and psychiatrists since they had not worked for me before. After about 18 months of counselling I was able to go forward with my life. Now I understand depression, not only for myself, but for other people who may be suffering.

Social
This illness has a major affect on the community, as there are so many sufferers. It can start in the family and be caused by a number of factors such as bereavement, difficult childhood, marital breakdown, abuse/domestic violence, alcoholism and illegal drug taking. In ability to cope with these factors can lead to unemployment, loss of interest in life, isolation and loneliness. This can have a major affect on the family as the sufferer may have difficulty relating to their partner and children. They may end up withdrawing from all the everyday tasks that they used to do. They may have suicidal thoughts. They may be unable to care for children, which in some cases may lead to children becoming neglected and being taken into care.

People who suffer from depression need to identify these feelings, which we have discussed above. The first place that sufferers must go is their General Practitioner who will refer them to counselling or prescribe antidepressant drugs. If conditions get worse the doctor may have to refer them to a psychiatrist who in turn may refer them to psychiatric hospital for a residential course of treatment.

Access to psychiatric treatment and to counselling can be influence by how much money that you have to spend. People who have private healthcare often have a better choice of services than the public sector. They have a better choice of hospitals, shorter waiting lists. In my experience of being both a public and a private patient, I have notices that private patients have longer consultations with the psychiatrist. While in the public sector one may end up seeing junior doctors or locums for the psychiatrist and for shorter periods of time.

Cultural
People who suffer from depression are often stigmatised by their community. The community can often be prejudiced against people who suffer from depression due to a lack of understanding and ignorance about the condition. They often leave sufferers alone which leads to isolation and to cause them to withdraw from the community altogether. One common saying is 'get over it' or' she/she suffers from her nerves' or he/she is 'not the full shilling'. Some believe that depressives are weak-willed people who are simply feeling sorry for themselves. The community finds it difficult to deal with their behaviour particularly if the sufferer is engaging in anti social activities. This can lead to the sufferer feeling unwanted or unaccepted. They can loose all sense of belonging and this can often hinder their recover, as they do not feel comfortable asking for help.

Political
In my experience, Depression and mental illness has never been a big Political issue. People who have depression do not have a big major voice on the political agenda. This is evident from my experience of the public health service where there are few hospital beds, excessive waiting lists and poor conditions and quality of service for public patients.

The Government departments of Finance, Health, Justice, and Education control the purse strings in relation to funding of mental health services. They in turn give the money to the hospitals and health boards and they prioritise where the resources go. It is often the case that the money is put into acute services such as the accident and emergency and cancer units and psychiatric services are not always a major priority.

Economic
People who suffer from severe Depression are often unable to work and have to depend on Social Welfare. This means their income is low and they have the added worry of trying to make ends meet in the home while dealing with their recovery. Employers, Trade Unions and legislators lack proper training and awareness of the needs of people with depression and therefore, there are few supports in the workplace…

Addressing this Health Issue
There are plans to develop Health and Well-being Centres in the community The plan is to locate these centres in Fatima Mansions and Dolphin House. It has been proposed to have counselling services, GP, nurse, and alternative therapies available as well as inputs from organizations such as Aware. There is also a group of people being offered training in community health.

Gaps Identified
The needs of this community are large as there is a lot of poverty in the area and this brings with it problems of alcohol, drugs and general health issues. Doctors in the area have a large quantity of medical card participants on their books and often cannot cope with the volume of people. This makes it difficult for the community to access basic health services. Because doctors do not have time and resources, the quick solution sometimes is to prescribe anti depressants on a regular basis, which is leading to addiction by prescription and people swapping their medication. This means that doctors are not getting to the root of what is causing depression. There is also a shortage of counsellors in the area … Most people in the community could not afford to take counselling privately and have to wait. I have had first experience of this gap in services. *(FGU participant)*

CHALLENGES IN IMPLEMENTING THE TRAINING

In all three projects, the capacity building and training programme was linked to a wider strategy that sought to intervene in the dynamic between social inequality and health. In the two Dublin based projects it was envisaged that the participants selected would be already actively involved in their communities. The programme in the Dublin 8 area was designed for those already working in community development and with some grounding in community development work and its principles. However meeting the FÁS eligibility requirements (such as selection from the Live Register) affected participation. Some of the applicants subsequently selected had no foundation in community development while additional sources of funding had to be sought to support participants who did not meet FÁS criteria.

In Cáirde it was intended that the participants would not only be from disadvantaged minority ethnic communities who experience inequality but they would be active in their own community groups and linked to the Ethnic Minority Health Forum. In this way it was intended that the increase in community development capacity would feed into emerging structures. Here also, due to the eligibility requirements of FÁS, some of the proposed participants were not in a position to take up places.

In the NICHE programme, where funding came through Equal, all of the participants were women. While the training was geared towards women who had no formal training, all were actively involved in their communities and interested in becoming more informed about health issues.

In each of the three projects participants on the training programmes had extensive support needs. The levels of support required were often underestimated as needs could not always be identified at the outset and they also changed during the lifetime of the programme:

Our work is with disadvantaged ethnic minority groups. The distinction between these groups and immigrants is not always visible to the service providers. These are people who have not been economically active. When talking about ethnic minorities and health you very quickly get into discussions on interculturalism, anti-racism. Those type of discussions do not bring us into the poverty discussions! (Member of ALG, Meeting January 9th 2006).

Within the Action Learning Group members from the various projects grappled with the term 'support' and the many different types of activities that are subsumed within it:

We need to be documenting – if we name all the different bits that comprise support – so much of it invisible. Part of it is making it visible for ourselves.

We need to explain the extent of support to get people to a meeting and to build the infrastructure of community participation around that… A lot of it is about crisis management. People are close to crisis a lot of the time. It is really intensive work, which can last for a long time. Different levels and types of support are needed – around assignments, relationship building … (Members of ALG, Meeting January 9th 2006)

However, it is extremely difficult to quantify such support activities regardless of one's commitment

to 'measurement':

We did try to quantify that … around the number of interventions regarding training. How do you quantify that though and measure it in terms of the impact? We've only managed to count it. The issues could be an ongoing one that extends over a long period in respect of one person. There are often very complex issues – multi layered issues. How do you capture what in a report is classified as an 'intervention'?…(Member of ALG, Meeting Janaury 9th)

A number of different stages in the training process, each with its own support implications, were identified in the Action Learning Group (Meeting January 9th 2006):

ENGAGING obstacles to participation
BUILDING capacity then to participate
LEARNING how to take action

Despite the centrality of the issue of support within the training programmes, members of the Action Learning Group were uncomfortable about emphasising them, about how this was perceived and the appropriateness of the term itself. The Action Learning Group concluded that by continuing to talk about support in terms of needs the focus is maintained on the individual and on their apparent inadequacies or failures:

As long as we keep talking about people in this way we will keep them marginalised. But it is really the system that has failed individuals…(Member of ALG, Meeting January 9th 2006).

The support needs reflect on systems and statutory failures and not on the individuals. However, if we talk about rights both the language changes and the context for the support discourse changes.

There are a number of issues, therefore, which arise from reflecting on the training programmes and their implementation as part of a wider community development strategy:

- Because of the underlying structural inequalities and the failure of systems many who come into the training programme have support needs. There are challenges in the recognition of these, in responding to them and in the types of individual supports required from initial recruitment, to completion and to follow-on actions.
- Many State agencies do not realise what is involved in 'upskilling' people re community development; in ensuring they have a mandate to sit in a representative capacity; and about the types of resources required to support the person. Yet there is a huge pressure, for example, on Health Authorities and for minority ethnic communities to set up structures while the agenda has not been set nor is it owned by those invited to serve.
- There is not necessarily a history of community activism among members of minority ethnic communities involved in the programme. The assumption that collective action is a good thing may not be well founded. Neither can it be assumed that there is a common geographical area nor a common understanding in terms of language. Working cross culturally requires careful use of language in order to ensure a shared understanding of terminology in common usage.
- There are institutional barriers to accessing training. The criteria for accessing FÁS funded initiatives mitigated against many leaders active in community organisations who were interested in the training programme but who were not eligible to register with FÁS. This resulted in losing out in part on the opportunity for sustainability and wider community impact
- There is the legacy and experience of poverty and unemployment and the challenge of creating the space for participants to take their 'own journey' and keeping 'limiting' structures at bay.
- The question of identifiable progression routes, expectations of participants and what is realistic for people in terms of progression and employment opportunities.

PURSUING A RIGHTS BASED APPROACH TO HEALTH

When rights are on the table, people talk differently: then the world will be different. That's my view! (Minow, Harvard Law School).

Health is a complex policy domain given the extent of the inequalities and the powerful influences exerted on it by the social and economic environment in which people live and work. However, health is also a human rights issue. Human rights span all areas of life: civil rights, political rights, social rights (rights to social protection, housing, employment, health and education). These human rights are inherent to each and every one of us and are set out in international law. States and governments are legally bound to promote, protect and fulfil the human rights of all those in its territory. The promotion and protection of health and the promotion and protection of human rights are inextricably linked (Harvard Law School).

The right to health is given expression in and is protected by several international human rights instruments. The United Nations International Covenant on Economic, Social and Cultural Rights, a legally binding treaty that Ireland has ratified, recognises 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (Article 12). The right to health implies the right to the variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standards of health. The right to health is not confined to the right to health care. It includes both health care and the wide range of socio economic factors that promote conditions in which people can lead a healthy life. The Committee on Economic, Social and Cultural Rights (CESCR, 2000:Paragraph 4) outlines how the right to health in all its forms and at all levels contains the following interrelated and essential elements:

- **Availability**
- **Accessibility – physical accessibility, economic accessibility (affordability), information accessibility.**
- **Acceptability - respectful of medical ethics and culturally appropriate**
- **Quality**

The projects involved in this CAN Comment are working, in their differing contexts, to impact on availability, improve and increase accessibility and acceptability and to deliver quality resources to promote health and well-being in the communities concerned.

To begin to think and to talk about health and the social determinants of health in a rights based context; to use the language and tools of rights in all activities, to understand and uphold the distinctions between needs and rights, all transform the platform for addressing health inequalities at what ever level. In the health arena in Ireland the language is seldom about rights, about citizens, about participation. Where participation is mooted it is largely about being a consumer of health commodities only.

Within the four projects engaged in the community development and health initiatives while a commitment to equality, social justice and human rights underpins their work, rights based approaches as a strategy for social change have not been formulated and systematically pursued. What are the implications of embracing a rights based approach to health and how does this interface with a community development strategy? It is hoped that this CAN Comment will open up this discussion.

Some of these issues were explored a number of years ago at an interactive interdisciplinary discussion held at the Harvard Law School (HLS). It raised questions that are extremely pertinent to the conversations within the Action Learning Group as well as for community development practice in Ireland today. While there were no definitive conclusions it is worthwhile 'listening in' to the discussion which was designed to be helpful to those concerned in both practical and theoretical ways with economic and social rights and with health.

Participants point out how there is great power in the rights rhetoric and argument. Rights discourse is energizing, mobilizing, and emotive (Klare, HLS). The rights framework also has value as a conceptual tool that facilitates discussion and enables people to articulate their needs (Mann, HLS). And, significantly within the context of community development, rights rhetoric is more than aspiration. It is a commitment to some degree of action (Minow, HLS).

However, rights discourse and argument has also limitations. From the community development perspective a major one is that rights rhetoric revolve around the individual, the bearer of the right. In the discussion Anderson goes as far as to claim that the individualism of the rights rhetoric paralyses us and frustrates dialogue. Neither does it help us in allocating resources or adjudicating between competing right bearers. A similar theme is picked up by Klare (HLS) who suggests that while the 'right' signals great priority and power in this society it says little else. The application of rights requires an animating theory – political, philosophical or ethical - that is external to a rights discourse. However, others argue against abandoning the rights rhetoric:

'But I do not recommend that we discard our rights rhetoric for something new. Individuals have claims to make against society, and rights are the marks of their claims' (Nussbaum, HLS).

Of course 'rights talk' makes many economists and policy makers uncomfortable. Such people are troubled by the power of rights to make uncompromising claims on resources, to set priorities for social expenditures and the redistribution of goods regardless of the economic realities (Mandler, HLS). We saw these concerns raised in the debates on the recent Disability Legislation in Ireland.

It is clear too that the decision-making process that a rights rhetoric implies is adversarial and judicatory. We see this operating in the case of our discrimination laws and equality legislation – in the Employment Equality Acts 2000-2004 and the Equal Status Acts 2000-2004. Is there any scope for a more inclusive and communal approach?

In 2002 the U.N. appointed a Special Rapporteur on the Right to Health. As Special Rapporteur, Paul Hunt has chosen to focus in particular on poverty and discrimination and the right to health. He points out that while the 'court-based approach' to the right to health has an indispensable role to play it is only one approach. Another complementary one is the policy approach, that is bringing the right to health to bear upon local, national and international policy-making processes. He urges health practitioners to use human rights as a way of 'fortifying your work, reaching your goals and empowering people' (Hunt, 2003). One of his objectives is to identify good practices for the operationalisation of the right to health whether at community, national or international levels.

In this context there is a very interesting initiative underway in Ireland since 2001 - the *Participation and Practice of Rights Project*[4]. As part of the project, two areas, one in Dublin's North Inner City and one in North Belfast, are undertaking a feasibility study of ways of developing a rights based approach to local issues. It was initiated to encourage the communities in deprived areas to use a rights based approach to redress many of the social and economic deficiencies, which affect them. While the Irish government has signed important international Conventions and Charters such as rights to education, housing , health, welfare services, these rights are not always granted or exercised in practice This project aims to develop, in association with those affected, the means by which international and human rights standards aimed at addressing poverty and social exclusion can be accessed and used more effectively by poor, marginalised and excluded groups to affect change in their daily lives.

What would a rights based approach look like if applied to health in a community context? How would it interface with a wider community development strategy? What would the implications of this be for the Community Health Worker role within a specific community? Whatever form a rights based approach may take within a community development context, central to it is creating opportunities for participation by disadvantaged groups - participation that can shift the power relationships:

The most important tool in tackling inequality is to enable those experiencing it to remedy the power relationship, to take some control. This is a concept of rights that requires that those who are the furthest from the cabinet table to own the right that inheres to them by virtue solely of their humanity. Ownership of this kind enables them to describe their condition, then to challenge it, and then to ensure that any decisions taken in the organisation and ordering of their lives are 'by and with' them not 'about and for' them (Mary Robinson WHO, 2002)

Participation is about power – controlling it, sharing it, being aware of it. McVeigh (2005) urges us not to under-estimate its manifestations, several of which are particular relevant within a

[4] *This project operates at a number of different levels, including the local community level. It has a Shared Forum and Management Committee (Sponsoring Groups), subgroups on specific cross-cutting issues, as well as local grassroots engagement (Report on Participation and Practice of Rights Project, January 2005).*

community context:

- **The power of people and citizen's mobilisation.**
- **The power of information and knowledge**
- **The power of constitutional guarantees**
- **The power of direct grassroots experience and networking**
- **The power of solidarity**
- **The power of moral convictions.**

Discussions in the Action Learning Group (January 9th 2006) on rights based approaches focused on how the system has denied their rights to many of those involved in the training programmes. The projects, in their different contexts, attempt to secure these rights and to shift the focus from the inadequacies of individuals - individuals that have stayed within the programmes despite the statutory failures – to the systems. Some members of the Group were ambivalent that the focus on systems could result in disempowering people in the community:

> *I have very mixed feelings on this. It would certainly hold them to account but with the focus on the system would it take away the bit of power from people in the community and put it back into the system where it would be 'fixed'. If you are saying it's a system failure, as it is in education, for example, the danger is that the ownership then will go to the system (Member of ALG, Meeting January 9th 2006).*

The study by the community sector of the failure of systems was seen by others as giving power to those in a position to make such an analysis and to take action to help to rectify the situation.

The dialogue which this CAN Comment stimulates may provide an opportunity to have further conversations about the implications of pursuing a rights based approach within the health arena and to explore:

- The efficacy of such an approach, either on its own or in association with other strategies and discourses, in bringing about social change that addresses health inequalities in Ireland?
- How such strategies interface with a community development approach and what are the implications of pursuing rights capacity training as part of a community development process?
- The knowledge required in terms of an understanding of human rights law; the tools of rights based approaches; ownership of these tools, methods and skills; the development of benchmarks and indicators and their applications to health arenas?
- Operational models where rights based approaches are currently used effectively in a community context and the learning from them for health oriented change strategies

Invitation to Dialogue

This CAN Comment presents core elements of a model of community development and health that is currently operational in Ireland. It is based on the learning that has emerged over an eighteen month period from the Action Learning Group hosted by CAN. The Action Learning Group offers a shared and non-operational space in which the experiences of four community development projects involved in tackling health inequalities are subjected to critical inquiry and reflection with the support of peers. From this questioning and reflective process, issues are raised in relation to the model that provide a focus for wider conversations and deliberations. As well as sharing the learning to date, the CAN Comment is an invitation, both to the community development sector and to the health services sector, to engage in this dialogue.

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CAN is a small not-for-profit organisation working for greater equality and justice in Ireland through community development. Since 1994, CAN has tried to raise debate on issues of current relevance and importance to community groups through a series of occasional papers called CAN Comment.

CAN would like to see further debate on the issues raised in this paper and welcomes your comments and views.
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CAN Comment