# A Quest for Health

## Creating a World of Difference in Clondalkin

**North Clondalkin Health Research**

For the Health Sub-Group of Clondalkin Partnership

by
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# EXECUTIVE SUMMARY

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## Introduction and Background

The purpose of this research study is to provide a theoretical and practical grounding from which to develop an appropriate and effective intervention focused on improving both community and individual health and well being in North Clondalkin with a particular emphasis on the use of primary health care and community based models. It examines inequalities and inequities in health in its broadest sense and looks at the particular geographic area and community of North Clondalkin. It also looks at responses to health inequalities, inequities of access and to the needs and gaps highlighted by the local community, by examining the models being used elsewhere. It then goes on to draw from elements of the models examined in order to develop an operational model for community health in North Clondalkin.

An overview of recent government health policies and approaches highlights some common themes emerging which are relevant to community based responses and approaches to inequalities in health. There is an emphasis on equity and fairness as a principle underlying how health services will be delivered in the future. It is expected that people will have more of a say in how health services will be delivered. This can be seen in the new primary health strategy and in the use of peer-led approaches to Traveller health in the Traveller Health Strategy. [5] [8] The need to provide services locally and deliver them in culturally appropriate ways in order to reach particular groups is also emphasised. In addition the involvement of the community in the design and delivery of services is built into new policies and approaches including the revised National Anti-Poverty Strategy and the Government's White Paper on The Community and Voluntary Sector. [40] [50]

## Health Needs Identified

There is an established link between poverty and ill-health and higher rates of mortality are experienced by those worse off in our society. The socio-economic profile of North Clondalkin shows a high level of disadvantage in the area. The established links between poverty and ill health would suggest that the people of North Clondalkin are experiencing higher mortality rates than those in better off areas, from diseases such as circulatory disease, cancers, respiratory diseases and from injuries and poisonings. The inequalities in health are also likely to be affecting the large numbers of children and young people in the area who are exposed to the social risks that put them further at risk of ill-health.

Based on the health needs identified through surveys and consultations in North Clondalkin and the socio-economic profile, target groups in need of specific community health interventions include lone parents, young parents, women, Travellers, men, children and young people. The specific health interventions to be planned need to address the gaps in health identified in the area, in relation to the health centre, the issue of the hospital catchment area, the inequities in access to GPs clinics, dentists, pharmacists, etc. As (shown in studies of other disadvantaged areas in Dublin) there is likely to be a higher incidence of smoking, stress and chronic illnesses and a low take up of preventative screening services in the North Clondalkin area for women's health and for dental health, the need for improved health promotion and health information is crucial. There is also a need to tackle the broad impacts on health (i.e. the social determinants of health) in the area such as housing, security, educational disadvantage and environmental issues.

## Learning from Other Models

Solutions which can address many of the health needs and issues identified include improved health promotion activities, the development of a primary health care initiative and improved access to services. Using elements and approaches from other models examined such as partnerships and alliances, community development approaches to health, primary health care initiatives (involving communities) and peer-led approaches, a model for North Clondalkin can be developed. Successful

and appropriate elements to include are:

- The need to develop structures and processes which involve the necessary stakeholders in health and using the principles of partnership working, consultation, participation and involvement in decision making (by the citizen), as the health alliances and partnerships do.
- Using community development to tackle inequalities in health by using the energy and leadership of the people who live there.
- Promoting approaches to primary care which bring health care specialists and community based health promotion and prevention activities together in a local setting to meet the health needs of disadvantaged communities in a holistic way.
- Using peer led approaches to health for disadvantaged communities and for particular groups such as young people and Travellers.

## The Proposed Community Health Model for North Clondalkin

The model proposed is strategic in its approach. It recognises the need to tackle gaps in infrastructure in partnership with health service providers and health professionals in the area. It also incorporates community development and peer-led approaches to all action areas, thereby building on community involvement to date. Through its objectives, partnership structure, strategic alliances and action areas, it aims to address the broader determinants of health and recognises the importance of health promotion and prevention in reducing health inequalities, improving access to services and ultimately in improving health and reducing mortality rates for the people of North Clondalkin.

The overall aim of the proposed model is:
To address health inequalities and inequity of access to health services in North Clondalkin, through the use of community development approaches and principles, thereby achieving equality and equity of health outcomes.

The objectives are:

- To build on the consultative and participative processes to date
- To recognise the broader 'social determinants of health' model
- To compliment government health policy principles
- To tackle health inequalities and inequities

The four main areas of health that need to be addressed or tackled by the proposed model are:

- Disease reduction and prevention
- Improved child health
- Addressing broader / social health needs
- Addressing gaps in health infrastructure

The model will target five main groups through its actions and initiatives. They will consist of the groups detailed below with types of approaches to be used shown.

- Parents (targeted for parenting courses and child health promotion)
- Women (targeted for healthy living programme, screening services and stress reduction)
- Young people (targeted for drug prevention, sexual health)
- Children (play safe, safety in the home and road safety programmes)
- Men (targeted for healthy living programme, screening services and stress reduction)

It will operate to the following principles:

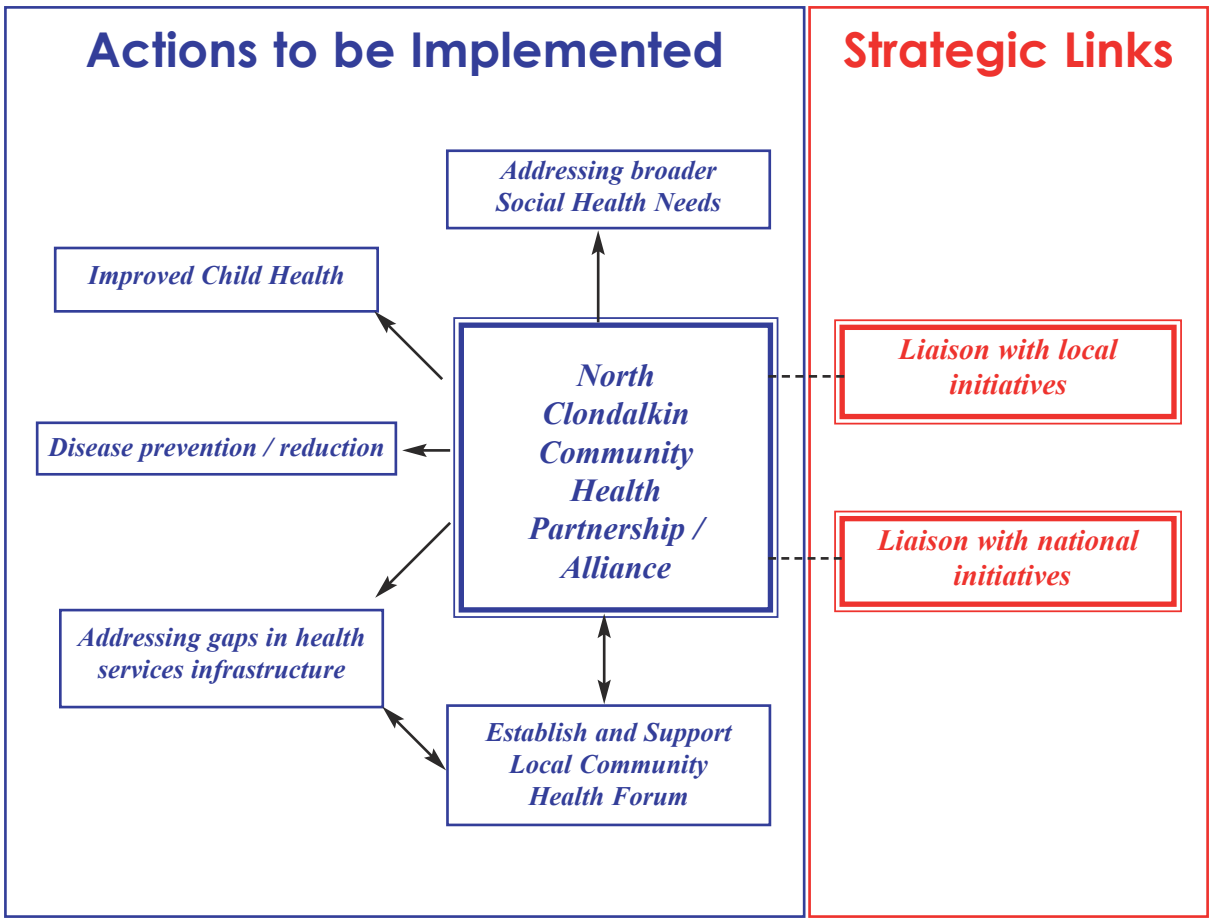
- Using community development approaches to involving communities in decision making, and in identifying health needs and priorities
- Using partnership approaches
- Using holistic approaches in order to tackle the broader determinants of health
- Working towards the development of primary health care approaches in North Clondalkin

- Tackling health inequalities and inequities in access to health
- Using peer-led approaches to health promotion activities and health needs assessments

The proposed structure for the community health model in North Clondalkin builds on the involvement of the community and of the agencies to date. In order to achieve the objectives outlined, it will broaden out the existing working group in order to establish a cross-sectoral local health partnership / alliance, made up of community sector representative, the South Western Area Health Board, Clondalkin Partnership, the Local Authority and a General Practitioner from the area. The local health partnership will develop strategic links with both local and national initiatives. It will also be necessary to establish a 'local community forum' which will have an input into the development of any future primary health care unit in the area.

The main actions and strategic links of the local health partnership are shown in Figure 1 Health Partnership Actions and Strategic Links.

*Figure 1 Health Partnership Actions and Strategic Links Summarised*



# INTRODUCTION

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## 1.1 Background to the Research

### 1.1.1 Clondalkin

In March 2001 a Health Sub-Group was formed by the Clondalkin Partnership to identify health issues facing those living in North and South West Clondalkin and to develop programmes in conjunction with the health authority to meet those needs.

A pivotal factor in identifying health issues locally was the importance of drawing from local knowledge and experience, by listening to the voices of local people. The Sub-Group subsequently decided on alternative methods of consultation and planning. A research team of local people and members of the Health Sub-Group trained in Participatory Rapid Appraisal (PRA) facilitation techniques. This innovative and creative means of gathering local information, in relation to health, captured a wide audience. The key issue identified and outlined in the report entitled *Community Planning for Better Health*, is the negative impact of inadequate services, a poor living environment and poverty on people's health. [22]

The aim of this research is to provide a theoretical and practical grounding from which to develop an appropriate and effective intervention focused on improving both community and individual health and well being in North Clondalkin with a particular emphasis on primary health care and community based approaches.

### 1.1.2 Proposed Primary Care Unit for North Clondalkin

The report *Community Planning for Better Health* as a direct outcome of the community planning process proposed the establishment of a 'Community Health Support Project for North Clondalkin'. In 2001, a submission from the Health Sub-Group of Clondalkin Partnership to the RAPID Area Implementation Team in North Clondalkin outlined a proposal to develop a Primary Health Care Unit in Quarryvale, based on the Community Health Support Project model. The proposal stated that the Unit would *"encompass a broad range of services, from health promotion and early identification of problems affecting health, to curative intervention and community-based care and support"*. The vision of the project was to *"achieve a healthier quality of life for the people of Quarryvale through a community driven service that has access to professional health practitioners and to other related services"*. The proposal referred to the service gaps and needs identified through community consultation processes. [21]

In response to the primary care strategy (launched in late 2001 and discussed in 1.3.2), each Health Board was asked to put forward up to three proposed implementation projects which the national Primary Care Task Force were then to consider. [20] At that time, the Clondalkin Partnership's Health Sub-Group asked that the proposal submitted to RAPID to develop a Community Health Support Project for North Clondalkin, be submitted to the South Western Area Health Board (SWAHB) as one of the proposed Primary Health Care Unit projects. However, the Clondalkin proposal was not selected by the SWAHB as one of the three projects submitted to the national Task Force for consideration. Informal feedback from the SWAHB indicated that due to the lack of involvement of GPs, the proposal for North Clondalkin did not meet the criteria for implementation of projects. The absence of an available premises / physical infrastructure could also have been a factor, according to a member of the Task Force interviewed as part of this research.

In hindsight and based on more recent discussions with representatives of the SWAHB as part of this research, it appears that those projects which were supported by both the Health Board and at a national level (in the first round of funding) were projects which were very much 'GP-led' and (in the case of Dublin) had significant levels of General Medical Services (GMS) patients (i.e. medical card holders). [42] The Clondalkin proposal was weak in these and in other areas required by the

criteria for funding projects. (The Clondalkin group received the criteria for implementation after the deadline for submissions.) However the strengths of the Clondalkin proposal lay in the areas of 'community focus' and 'governance issues', neither of which appear to have been given high priority in the selection of projects at either Health Board or at national level in the first round of projects selected in October 2002.

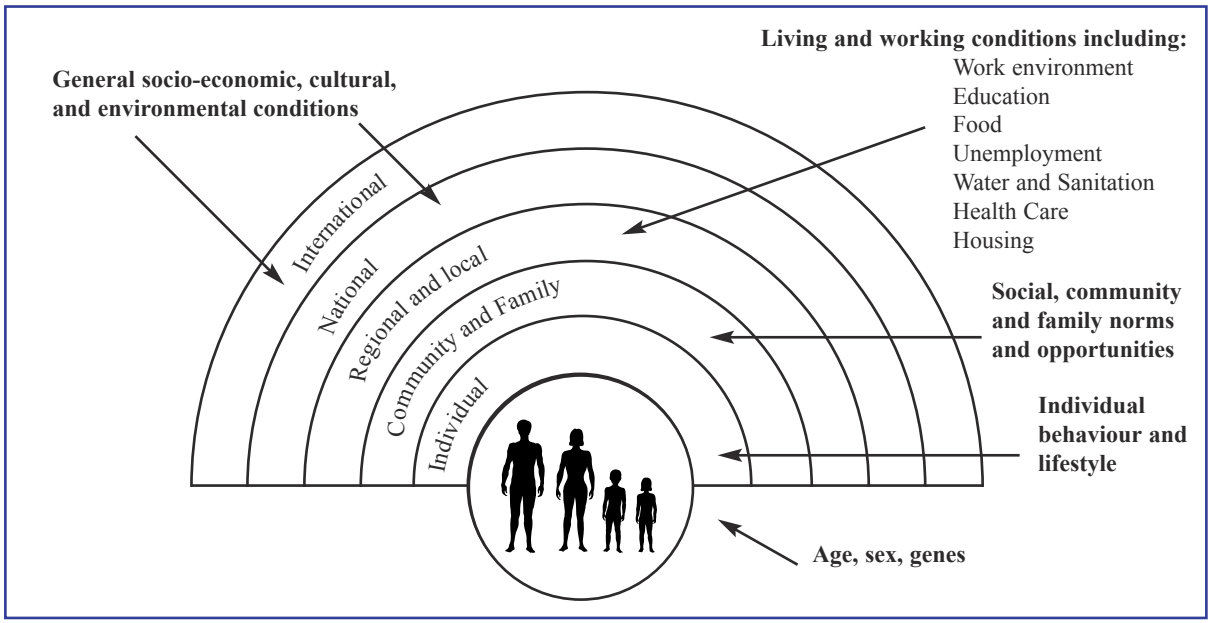
## 1.2 Social Determinants of Health

The idea that a person's health is determined or influenced by a range of internal and external factors was acknowledged by local people in the consultation processes in North Clondalkin and is well documented in the report entitled *Community Planning for Better Health.* This concept of 'social determinants of health' recognises that social, economic and environmental factors can lead to inequalities in health. The model (developed by Dahlgren and Whitehead) in Figure 2 shows that the social and economic environment in a country contains key influences on the population's health and well-being. There are very many determinants of health. Some such as age and sex are fixed, others range from individual behaviour to living and working conditions, psycho-social and community influences and the broader socio-economic environment. Such factors can include individual lifestyle behaviour but also factors such as income and social status, education, employment and working conditions.

Ethnicity can also influence a person's health, one group at significant disadvantage in health status is the Traveller community. The Travellers' Health Status Study demonstrated that life expectancy at birth for Traveller men was 9.9 years less than for settled men and 11.9 years less for Traveller women than for settled women. [4]

These factors in combination create different living conditions which impact on health. The consultation process on the National Anti-Poverty Strategy (NAPS) and Health introduced some new factors for consideration in the Irish context. They include income adequacy, levels of income inequality, accommodation, racism and discrimination, geographical location, opportunities and ability to participate in society. Policy areas such as environment, education, housing and transport are all critical to health. [7]

*Figure 2 Health Determinants Model*




*(Dahlgren and Whitehead, 1991)*

A report published in the UK known as the Acheson Report (1998) looked at determinants of health and proposed ways to tackle inequalities in health through various policy changes. It found that over the last twenty years in the UK, although death rates have fallen across all social groups, the difference in death rates between those at the top and the bottom of the social scale had widened. Differences across the social spectrum had increased for many of the major causes of death, including coronary heart disease, stroke, lung cancer, accidents and suicides among men, and respiratory disease and lung cancer among women. Life expectancy is also higher for those at the top of the social scale and the difference is increasing. People at the lower end of the social scale are more likely to have a long-standing illness. Recognising the social determinant of health the report recommends policies in many areas - poverty, income, tax and benefits; education; employment; housing and environment; mobility, transport and pollution; and nutrition. [31]

## 1.3 Government Health Policy

### 1.3.1 The Health Strategy

Over the last few years, the Government has developed new policies and approaches which are contained in recently launched Strategies. The most significant of these, relevant to this research are the National Health Strategy and Primary Care Strategy, both launched in late 2001. This Health Strategy is centred on a whole-system approach to tackling health in Ireland. It identifies overall national goals to guide activity and planning in the health system for the next 7-10 years. It also describes how the Government, the Minister and the Department of Health and Children will:

- work with everyone in the health system who has a role to play in improving health
- engage with the wider community to improve health
- evaluate services so that resources are used to best effect
- reform the way we plan and deliver services within the system
- modernise and expand health and personal social services through focused investment
- support the development and contribution of people who work in the health system. [4]

The vision of the future of the health system in Ireland is described in the National Health Strategy as follows:

- A health system that supports and empowers you, your family and community to achieve your full health potential
- A health system that is there when you need it, that is fair and that you can trust
- A health system that encourages you to have your say, listens to you, ensures that your views are taken into account

The four principles that guided the development of the Strategy are equity, people-centredness, quality and accountability. [4]

Some of these same themes and principles also emerged in the Review of the National Anti-Poverty Strategy (NAPS) and Health and consultations with stakeholders carried out in 2001. As a result, the Revised NAPS contains an overall objective which is to reduce health inequalities and there are specific objectives to reduce premature mortality. [7] [45]

### 1.3.2 Primary Health Care Strategy *(1)*

In response to some of the deficiencies of the current primary care system, as part of the Government's Health Strategy, *Primary Care - A New Direction* was launched also in late 2001. It outlined a new approach which shifts the emphasis from over-reliance on acute services such as hospitals to one-stop-shops where patients will be able to access GPs, nurses, physiotherapists, chiropodists, social workers and home helps. Wider networks of health and social care professionals, including community pharmacists, will also work with a number of primary care teams. The approach brings a wide range of service providers together in primary care teams, with the aim that

integrated services can be delivered in the community in the most appropriate and accessible way. This represents a major refocus of primary care services and the introduction of a team approach to primary care.

The new system, initially to be implemented in selected areas during the coming years, will allow members of the general public to enrol with a team and with a GP within that team. The teams will serve small population groups of approximately 3,000-7,000. The proposed membership of the primary care teams is shown in Table 1. [5]

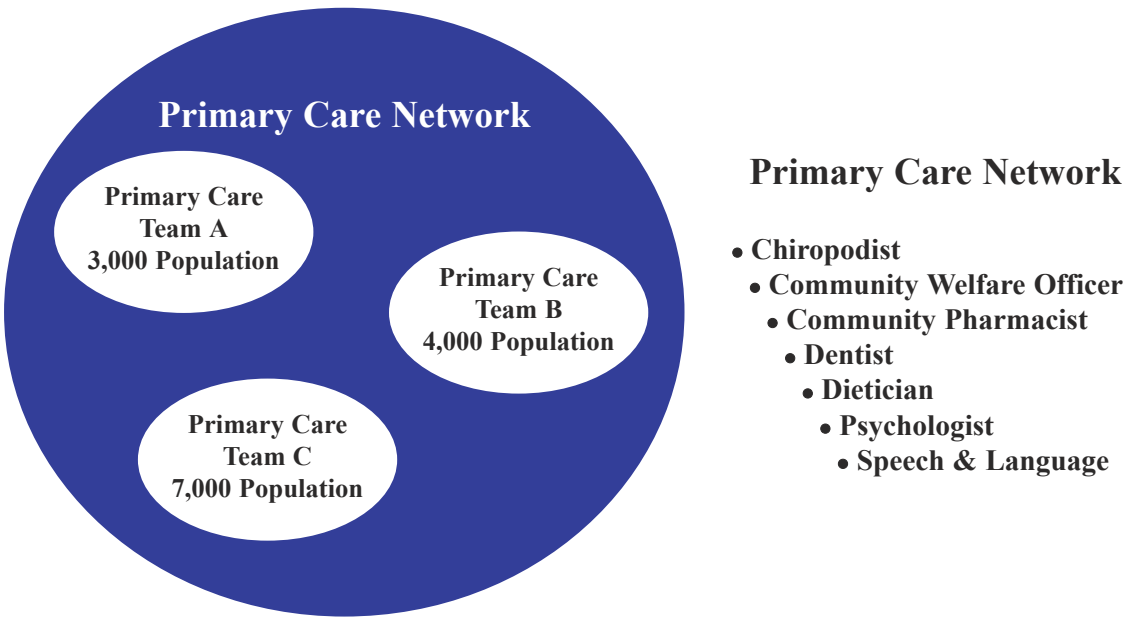
The teams will offer 24-hour cover, and because of the number of different disciplines involved, it is hoped that as a result, it will greatly reduce the demand for specialist services and that diagnostic services, which are often sourced from hospitals at the moment, will be much more easily available. The primary care teams have the potential to deliver much of the care currently provided by specialist / secondary care *(2)* services and for a more integrated and seamless health system to be created.

*Primary Care - A New Direction* also proposes the establishment of a wider network of additional professionals to provide therapy services required by a number of primary care teams. Figure 3 shows the proposed membership of the primary care network and interaction between the network and the primary care teams. [5]

*Table 1 Proposed Membership of Primary Care Team*

| Primary Care Team | Number Envisaged |
|---|---|
| General Practitioner | 4.0 |
| Health Care Assistant | 3.0 |
| Home Helps | 3.0 |
| Nurse/Midwife | 5.0 |
| Occupational Therapist | 0.5-1.0 |
| Physiotherapist | 0.5-1.0 |
| Social worker | 0.5-1.0 |
| Receptionist / Clerical Officer | 4.0 |
| Administrator | 1.0 |

*Figure 3 Primary Care Team and Primary Care Network*



In October 2002 the Minister for Health and Children announced the provision of ¤8.4m in 2002 and 2003 for the establishment of 10 primary care projects around the country, 2 of which are in Dublin - one in the Northern Area Health Board (NAHB) in Ballymun and one in the South Western Area Health Board (SWAHB), in the South Inner City.

More specifically, the Primary Health Care Strategy sets out a broad focus which states that *"primary care teams will be facilitated and funded to develop and expand cross-sectoral activities which can promote and protect the health of people and families enrolled with them, through for example, school and community based health education, counselling and classes, links to local area action plans to provide integrated information and services, as well as links to community development projects"*. [5]

In the action plan for implementation of the Primary Health Care Strategy, it lists at number 19 of its 'implementation actions' that "mechanisms for active community involvement in primary care teams will be established". It mentions the use of consumer panels as well as user participation in service planning and delivery, and having an input into needs assessments initiated by individual health boards.

**1.3.3 Traveller Health**

In recent years there has been a shift in government policy with regard to addressing Traveller health issues. In 1995, the Report of the Task Force on the Travelling Community recommended key strategies to eliminate the physical and cultural barriers that exist for Travellers in accessing health services and to develop peer-led services. The recommendations of the Task Force resulted in the establishment of Traveller Health Units in each Health Board area, in partnership with local Traveller organisations and in the establishment of Primary Health Care for Travellers Projects involving Community Health Workers who have been drawn from the Traveller community itself.[8]

In February 2002, the launch of the *Traveller Health Strategy 2002-2006* provides a clear statement of policy which focuses on the underlying problems associated with the poor health status of Travellers and sets out a clear and practical plan for specific improvements in that status and for tackling a range of health inequalities they experience. [8]

There are 122 Actions Proposed in the Traveller Health Strategy, which can be broadly summarised as follows:

- Establishment of active partnerships between Travellers, their representative organisations and health service personnel in the provision of health services.
- Provision of awareness training for health personnel in relation to Traveller culture, including Traveller perspectives on health and illness.
- Strengthening of Traveller Health Units comprising Health Board staff and Traveller representatives, with responsibility for planning and implementing the Strategy in each Health Board.
- Development of initiatives to increase Travellers´ awareness of general medical services and to make services more accessible, having regard to the Travellers' nomadic way of life.
- Provision of designated Public Health Nurses to work specifically with Traveller communities.
- A Traveller Needs Assessment and Health Status Study, the results of which will inform appropriate actions on Travellers´ health.
- Replication of the successful "Primary Health Care for Travellers Project", which established a model for Traveller participation in the development of health services.
- Establishment of an appropriate liaison arrangement between the Department of Health and Children and the Department of the Environment and Local Government and including representatives from Traveller organisations, to address issues of common concern relating

to Travellers. [8]

In order to implement the Strategy ¤9 m additional funding is being provided over the period 2002 to 2005.

### 1.3.4 The National Anti-Poverty Strategy and Health

Ireland launched its revised National Anti-Poverty Strategy 2002-2007 *Building an Inclusive Society* in February 2002. Consultation on the development of the strategy took place through thematic working groups, a national seminar and a national consultative group. The consultation process on poverty and health raised particular themes including:

- The need for a social model of health and social determinants of health
- The impact of poverty and social exclusion and health is stressed
- The provision of good quality affordable and social housing and accommodation is an essential factor influencing peoples health
- The provision of transport for marginalised communities is essential in order to access services
- Participation in decision making, particularly of the socially excluded is a critical factor for developing effective health and other public services
- Community development can play a significant role in supporting people who are living in poverty and experiencing social exclusion as a key tool for developing healthier citizens and communities
- Co-ordination of services and policies
- Equitable access to health and personal social services
- A comprehensive integrated accessible primary care service
- The importance of an information and research base for target setting, monitoring and reviewing is stressed [1]

The revised NAPS *Building an Inclusive Society* includes (for the first time) an overall objective for health which is *"to reduce the inequalities that exist in the health of the population by making health and health inequalities central to public policy, by improving access to health and personal social services for people who are poor or socially excluded and by improving the information and research base in relation to health status and service access to these groups"*. Its key target is *"to reduce the gap in premature mortality between the lowest and highest socio-economic groups by at least 10% for circulatory diseases, for cancers and for injuries and poisonings by 2007"*. [40]

### 1.3.5 Emerging Themes and Approaches in Government Health Policy

As you can see from the various government policies and approaches outlined in the previous sections, there are some common themes emerging which are relevant to community based approaches to inequalities in health in general and for the community in North Clondalkin. The main themes emerging of relevance are:

- **Equity** - the recent health policies refer to equity and fairness as a principle underlying how health services will be delivered
- **People having a say** - the involvement of the consumer is emphasised throughout, whether through costumer panels, community involvement in primary health care units or the partnership and peer-led approaches to Traveller health
- **Culturally appropriate services for particular groups** - the Traveller Health strategy, the Health Strategy and the Primary Health Care initiative refer to the need to provide training for staff and to reorientate services to ensure that health services are delivered in culturally appropriate ways
- **Primary health care** - providing services locally in an accessible way, which will take the pressure off specialist and secondary health services is emphasised

- **Community development approaches to health** are an integral part of the approaches to Traveller health and also arose out of the NAPS and Health review as a way of targeting socially excluded groups
- **Tackling inequalities in health** is an important aspect of all the national health policies outlined

## 1.4 Purpose of the Research

The purpose of this research study is to provide a theoretical and practical grounding from which to develop an appropriate and effective intervention focused on improving both community and individual health and well being in North Clondalkin with a particular emphasis on primary health care and community based models.

The objectives of the research more specifically are to:

- Investigate the nature and extent of existing services related to the people living in North Clondalkin
- Document the socioeconomic profile of the area and relate it to the local health needs established in *'Community Planning for Better Health'* 2001
- Identify a range of models of good practice at local, national and international level
- Establish how the National Primary Health Care Strategy can address the needs identified through the research
- Identify an appropriate operational model for community health in North Clondalkin that is consistent with the overall National Primary Health Care Strategy

## 1.5 Methodology

The research is based on a range of methodologies including, documentary analysis, interviews, attendance at and participation in workshops and discussions, focus groups and visits. The documents consulted include programme reports and evaluations, Irish Government policy documents and research reports. A key source of data could be the experiential expertise of existing primary health care initiatives such as that of NICHE (Northside Initiative for Community Health) in Cork, The Community Development & Health Network for Northern Ireland and the network of community health co-operatives in Glasgow. A bibliography of all documents consulted and referred to is at the end of the report and are referenced in the report numerically [in brackets].
The researcher, Sharon Cosgrove began the research study in mid-December and completed the work late-March 2003. She worked to the Health Sub Group of the Clondalkin Partnership. The methodologies used during the research in order to meet the research objectives are outlined as follows:

**Objective: To investigate the nature and extent of existing services related to the people living in North Clondalkin**

This was done through meetings, interviews / consultations with relevant stakeholders including the South Western Area Health Board, community organisations, agencies and other service providers. The purpose of this is to identify existing services, to highlight gaps in service and to begin to explore the types of models that may be appropriate. The details of those interviewed as part of the research are contained in Appendix I.

**Objective: To document the socioeconomic profile of the area and relate it to the local health needs established in *'Community Planning for Better Health'* 2001**

Using existing demographic material for the area, a current and projected socio-economic profile of the population of the area was developed. It is related to the current and future needs identified in the *'Community Planning for Better Health'* report. Using other research and literary material an analysis of the links between health and poverty / disadvantage for the North Clondalkin area is examined.

**Objective: To identify a range of models of good practice at local, national and international level**

Building on the work and contacts made by Clondalkin Partnership with other community based primary health care initiatives, a review of models was carried out. This involved some literary and web-based research and more in-depth telephone interviews with people managing the models most appropriate to the North Clondalkin context.

**Objective: To establish how the National Primary Health Care Strategy can address the needs identified through the research**

An examination of the Primary Health Care Strategy was undertaken, with specific reference to the implementation timescales for primary health care units and for a possible unit in North Clondalkin. This involved some desk based analysis of the strategy and subsequent reports and may involve explorative discussions with decision makers in the Health Board and the Department of Health and Children.

**Objective: To identify an appropriate operational model for community health in North Clondalkin that is consistent with the overall National Primary Health Care Strategy**

Through the course of the research the Researcher, Sharon Cosgrove met on a regular basis with the Sub-Group in order to report on progress and to seek direction on approaches and models. The development of an operational model concluded the research, once all other objectives had been met using the methodologies above.

## 1.6 Structure of the Report

The report begins with an executive summary of the main findings of the research. The main body of the report is divided into 5 main sections. Section 1 gives the background to the research, its purpose and methodology. It also sets the national context by introducing the government's health policy.

Section 2 gives a profile of North Clondalkin's health needs. It does this through examination of the issues and needs identified through recent consultations in the area and through health needs assessments carried out in other disadvantaged areas in Dublin.

Section 3 considers established inequalities and inequities in health and identifies some way to address these issues. Section 4 looks at best practice in the area of community based health and primary health care initiatives both here and abroad and looks at four main areas - community development approaches to health, primary health care initiatives, health partnerships and alliances and the use of peer led approaches to health.

The fifth (and last) section of the report puts forward an operational model for community health in North Clondalkin. It establishes the main aims and objectives for the initiative, and proposes a structure and some actions to take it forward.

# INEQUALITIES AND INEQUITIES IN HEALTH

# INEQUALITIES AND INEQUITIES IN HEALTH

## 2.1 Inequalities in Health

### 2.1.1 National Health and Mortality Figures

As the Acheson Report in 1998 in the UK found, there is a proven link between poverty and ill health. This has been found to be the case across the world and is supported through the findings of Irish research studies. In the words of the Combat Poverty Agency "poor people get sicker and die younger than people who are better off". An ESRI study in 1994 indicated that *"in Ireland as in other developed countries, the poor and disadvantaged experience more ill-health and have a lower life expectancy than those from higher socio-economic groups"*. [3] Those at the bottom of the social class ladder have twice the risk of serious illness and premature death as those at the top. [35]

Figures show that:

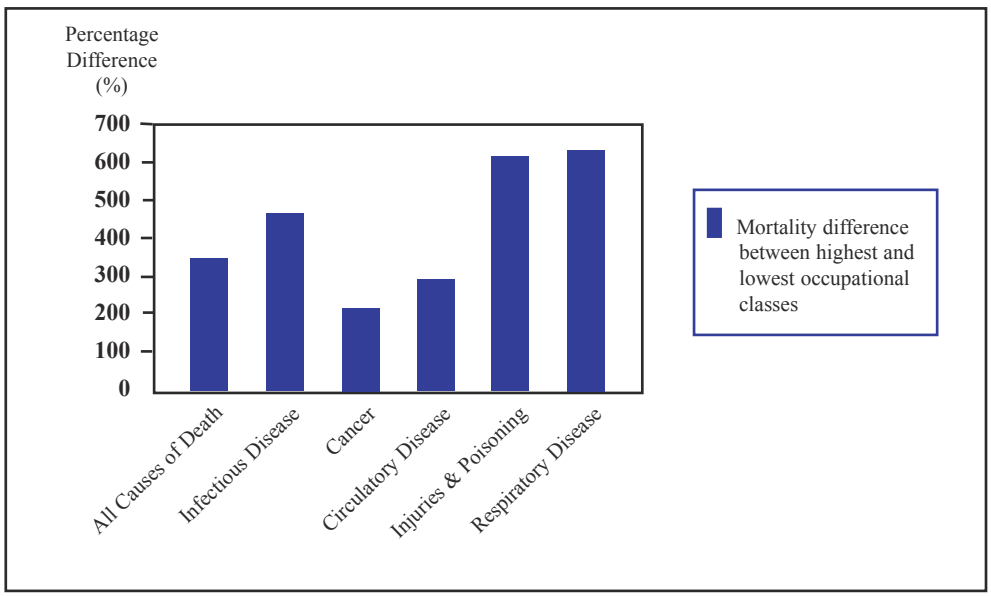
- 37% of people in unskilled manual classes smoke while 24% of non-manual classes smoke
- Babies dying at birth and low birth weight are more likely to be born in families where the father is either unemployed or in a low skilled job
- People with a disability or illness have 56.6% chance of falling below the 50% relative income poverty line
- Male Travellers' life expectancy at birth is 9.9 years less than settled men
- Female Travellers life expectancy at birth is 11.9 years less than settled women
- Infant mortality rate for Travellers is 18.1 per 1,000 births while the national figure is 7.4 per 1,000 live births
- Travellers have twice the national rate for stillbirths [3] [10]

The ESRI study also showed that the percentage of people reporting chronic physical illness rose steadily from 10% for the higher professional class to 25% for the unskilled workers. The ESRI (Nolan, 1994) has demonstrated that perinatal mortality and low birth weight are associated with socio-economic background. [4] Health inequalities are also evident in non-fatal but chronic disabling conditions. Psychiatric admissions can be used as an indicator of mental health and are more likely to be seen in the lower socio-economic groups (TCD, 2001). A recent ESRI study demonstrated that health status varies across occupational groups (Nolan, 2000). Adults in the lowest socio-economic group were twice as likely to report a long-standing illness as those in the highest socio-economic group (Nolan, 1994). The 1998 national health surveys also points to differences in health status between various socio-economic groups with less well off people smoking and drinking more, eating more fatty foods and taking less exercise. [3]

Inequalities in health can exist for a variety of reasons, including geographical location, gender, age, ethnicity, hereditary factors and socio-economic status. Poverty, unemployment, education, access to health services and environmental factors including housing and water quality, all play important roles in determining the health of individuals. Disparities in health status within the population lead to consideration of the links between socio-economic factors and health. There are clear occupational class gradients in mortality.

The report entitled *Inequalities in Mortality 1989-1998*, produced by the Institute of Public Health in Ireland established the pervasiveness and magnitude of occupational class inequalities on the island (of Ireland). In both Northern Ireland and the Republic of Ireland the all causes mortality rate in the lowest occupational class was 100%-200% higher than the rate in the highest occupational class.

*Figure 4 Mortality Difference between Classes*




*(Source: Institute of Public Health in Ireland, 2001)*

This was evident for nearly all the main causes of death:

- For circulatory disease it was over 120% higher
- For cancers it was over 100% higher
- For respiratory diseases it was over 200% higher
- For injuries and poisonings it was over 150% higher [12] [44]

In addition, the report found that the all causes mortality rate for males was 54% higher than it was for females, thus highlighting another significant inequality with respect to mortality. The main causes of death in Ireland were found to be circulatory diseases, malignant neoplasms, respiratory diseases and injuries and poisoning. [12] Poor people suffer greater psychological distress and have lower self-esteem compared to those who are better off. Low levels of literacy limit access to health information and health services. Young people from lower socio-economic backgrounds are almost five times more likely to leave school with low qualifications. This is associated with increased risk of becoming long-term unemployed and with less healthy behaviours and lifestyles. [19]

### 2.1.2 Inequalities in Children's Health

Living in disadvantaged circumstances has a direct effect on the current and future health of children. Compared with children in better circumstances, disadvantaged children are exposed to a range of risk factors including poor maternal nutrition, parental smoking, stress and emotional disturbance, all of which lead to serious long-term health consequences. In addition there are indirect effects because parental disadvantage starts a chain of social risks that put children at further risk of ill-health in the future. Poverty is the most important social factor associated with ill-health in children. [19]

Much morbidity and mortality in children is related to preventable causes such as injuries and poisonings, infectious diseases and certain congenital abnormalities. [19] *The Health of Our Children report* states that *"the most significant gains in children's health will come from tackling social, economic factors such as poverty, education, exclusion and the environment".*

## 2.2 Equity of Access to Health Services

The inequalities in health covered in Section 2.1 highlights the impact of social, environmental and other factors on health. This is also supported by the 'Social Determinants of Health' model discussed in section 1.2. Another issue which impacts significantly on health and well-being is the issue of equity of access to health services, which is set out as one of the four principles of the National Health Strategy and is contained in the Primary Health Care Strategy and the Traveller Health Strategy.

Recognising that health services make a highly significant contribution to population health, it is necessary to define health services. The Institute of Public Health of Ireland suggest that health services are defined as including those structures and personnel that work for health promotion, disease prevention, treatment and rehabilitation, using resources specifically identified and allocated for these purposes. Meanwhile researchers have been attempting to assess the contribution of health care or medical care to health and the degree to which these influence mortality trends. Most agree that medical care has contributed to reducing mortality over the decades and that the inequitable delivery in health care for the major diseases could contribute importantly to socio-economic differentials and the widening mortality gap seen between socio-economic groups. [15]

Equity is concerned about creating equal opportunities for health and bringing health differentials down to the lowest level possible. However despite the major increase in investment in the health service in Ireland and some improvements in levels of services measured to particular groups (including persons with disability, older persons, persons with mental illness, Travellers, children in need of care and protection and drug users), there still exists inequalities in access to services, which is evidenced by research, statistics and anecdotes. [15]

The requirement for equitable access to health services in terms of timeliness, waiting lists, physical accessibility and access to information was highlighted throughout the consultative process on the National Anti-Poverty Strategy and Health. Support for the development of a comprehensive, holistic, integrated and accessible primary care service was identified as fundamental to improving the health of people who are living in poverty or experiencing social exclusion. [1]

In the report Equity of Access to Health Services, by the Institute of Public Health, the inequalities in access are divided into three broad headings are follows:

- Issues related to the legislative / regulatory framework
- Issues related to organisational and operational matters
- Issues flowing primarily from resource constraints

In relation to issues related to the legislative / regulatory framework, the study found that data on waiting lists for access to acute public hospitals showed that those with private medical insurance were more likely to be sure of getting into hospital. In addition the use of public beds for private patients is not adequately monitored to ensure that this only takes place in an emergency. Neither is it validated by a consultant as originally envisaged and consultants receive financial incentives to offer public beds to private patients. [3][15]

While most media attention focuses on access to hospitals, most people's first point of contact with the health services is at primary care level. In 2001, the access without charge to primary health care was 31%, i.e. they were medical card holders. The elderly and large families are viewed as those most disadvantaged by the current income guidelines. Certain preventative screening services e.g. cervical smear tests, are not available without charge through GPs, even for persons with a medical card. [15] These are particularly relevant to the North Clondalkin area, as discussed in section 3.

In relation to issues related to organisational and operational matters, the study found that inequity in access can also arise from the way in which services are organised and operated, including the geographic distribution, for example there is considerable variation in GPs services and in access to pharmacy services. It mentions the impact of transport on access to health services, which can be exacerbated for the elderly and less able bodied and for parents of young children and can act as a disincentive to uptake of services.

Equity of access to information about health services and to health education services themselves can help people maintain and improve their health and reduce their need to access treatment services. There is evidence that people in lower socio-economic groups generally, compared to those better off, present for health services at a later stage in their illness. Studies have highlighted that Irish health leaflets had a reading age of 15-16, whereas the general population has a reading age of 9-11. The National Maternity Hospital found an information deficit most prevalent in disadvantaged women. However the barriers to access for some disadvantaged groups are not confined to literacy, but also relate to cultural attitudes to preventative services.

There are special access problems for some groups. The attitudes of the local community can also be a significant factor affecting access for drug users and people who are mentally ill, as proposals regarding the location of services for these groups are often met with strong opposition. [15] St Vincent de Paul refers to the health needs of multi-disadvantaged groups in the community and include;

- Ex-Prisoners
- Travellers
- Refugees and asylum seekers
- People with physical disabilities
- People with intellectual disability
- Health and homeless [3]

The report also highlights inequities arising from issues flowing primarily from resource constraints. These relate to for example services and supports available for people with special needs and their carers e.g. people with intellectual disability, people with mental illness, older people particularly those with Alzheimers disease, homeless people, drug users and children in need of care and protection. Efforts to expedite improvements are being hampered by constraints in the building industry and staff shortages in the health sector.

## 2.3 Addressing Inequalities and Inequities in North Clondalkin

There is a need for a broader multi-sectoral approach to reducing poverty and inequalities in health which recognise the determinants of health that lie outside clinical health care. The NAPS and Health consultations process highlighted the following needs and gaps which will address issues of inequality and inequity:

- Reorienting the health services to achieve accessible, good quality, appropriate, holistic health and personal social services that support people's health and well-being, particularly when they have specific needs. It emphasises health promotion.
- The development and support of primary care services which incorporate health promotion and community development approaches.
- Equity of access to public services for equal needs and equal quality of care
- Consultation and participation in decision making
- Meeting the needs of specific groups - setting targets and taking specific interventions

The inequalities in child health can be improved through interventions which have been tested world-wide:

- Wider family support through the development and extension of schemes such as the community mothers scheme
- Provision of quality childcare and pre-school education
- The promotion of safe environments, including housing with safe play-space and road safety
- The education of disadvantaged children
- Wider range of services for pre-school children, with emphasis on education, programmes to promote literacy and primary health care services
- The participation of children in decisions and activities which effect their health (a voice for children) [19]

Some of these issues are considered in the development of an operational model for community health in North Clondalkin together with the specific health needs identified through consultations and surveys, discussed in A Profile of Clondalkin's Health Needs in section 3.

# A PROFILE OF NORTH CLONDALKIN'S HEALTH NEEDS

# A PROFILE OF NORTH CLONDALKIN'S HEALTH NEEDS

## 3.1 Socio-Economic Profile

### 3.1.1 North Clondalkin

The North Clondalkin area includes the neighborhoods of Neilstown, Rowlagh and Quarryvale. In order to develop a socio-economic profile of the area of North Clondalkin, the RAPID area and the information contained in the North Clondalkin RAPID Action Plan, which includes the most disadvantaged areas in North Clondalkin, is used. The area of North Clondalkin designated for RAPID is made up of twelve local authority housing estates, grouped in three sub-areas: Quarryvale, Rowlagh and Moorfield and the following socio-economic profile is based on figures shown in the *North Clondalkin RAPID Action Plan, 2001.*

The figures in Table 2 show a level of deprivation and a high incidence of lone parenthood, high family dependency ratios, multi-generational long-term unemployment, ill-health and many other factors in the North Clondalkin area.

*Table 2 Summary Profile of North Clondalkin*

| Indicators | Neilstown | Rowlagh | Quarryvale |
|---|---|---|---|
| Population | 4523 | 6855 | 2516 |
| Average Household size | 4 | 4.38 | 4.5 |
| % Households with 6 or more people | 19% | 23% | 24% |
| Primary School Enrolment | 632 | 886 | 935 |
| % Lone Parents Households | 23% | 24% | 27% |
| % Private Housing | 41% | 35% | 0% |
| % Tenant Purchase | 2% | 30% | 25% |
| % on Transfer List | 18% | 22% | 32% |
| % Principal Earners | 56% | 73% | 60% |
| Average Gross Income | £123 | £122 | £132 |
| % Principal Income < £150 | 75% | 78% | 73% |
| % Principal Income < £200 | 7% | 6% | 10% |

*(Source North Clondalkin RAPID Action Plan, 2001)*

Improvements in the area of employment are questionable. It is widely recorded that any gains in employment since 1996 have been in the low-paid sector and recent figures from the Department of Social and Family Affairs show an increase in unemployment from 437 in September 2001 to 587 in January 2003 for the North Clondalkin area.

Other factors such as the relative absence of any comprehensively meaningful childcare provision in the area preclude the very high proportion of lone parents, and parents with young children, from participating in employment and training opportunities.

In Table 3, the Deprivation Score in the first column is the Haase Index of Relative Affluence and Deprivation, which provides a single measurement of overall deprivation of an area. Based on the 1996 Census of Population, the index takes into account the social class composition, the level of education, the level of unemployment and long-term unemployment, the proportion of lone parents, and the age dependency rate.

An index score of 1 indicates that an area is among the most affluent 10 per cent of areas, while a score of 10 indicates that an area is among the most disadvantaged 10 per cent. The North

Clondalkin area comprises the whole of the Rowlagh DED, but only part of Moorfield DED. Table 3 demonstrates the high level of deprivation in North Clondalkin. It also shows a very young population profile (compared to national averages) and presents significant challenges in the specific areas of childcare, education and young people's development and services. [23]

*Table 3 Summary Population Age Profile for North Clondalkin*

| Area | Deprivation Score | Total Population | < 15 years | < 15 years | 15 - 29 years | 15 - 29 years | 30+ years | 30+ years |
|---|---|---|---|---|---|---|---|---|
| North Clondalkin - Rowlagh | 10 | 5,233 | 1,737 | 33.19% | 1,659 | 31.70% | 1,837 | 35.10% |
| North Clondalkin - Moorfield | 9 | 6,697 | 2,316 | 34.58% | 1,869 | 27.91% | 2,512 | 37.51% |
| TOTAL | | 11,930 | 4,053 | 33.97% | 3,528 | 29.57% | 4,349 | 36.45% |
| National | | 3,626,087 | 859,424 | 23.70% | 891,935 | 24.60% | 1,874,728 | 51.70% |

*(Source North Clondalkin RAPID Action Plan, 2001)*

The total population of the RAPID area is estimated at about 15,000 people. Population changes for the period 1986-2002 are shown in Table 4. Between 1991 and 1996, the rate of growth in the RAPID area appears to be under 5%, compared with a national growth of 2.8%. In the period 1986-1996 the population of Moorfield grew by almost 10%, while Rowlagh declined by 6.5%. In the period 1996-2002 the population of all North Clondalkin DEDs declined. Palmerstown West, the DED which includes Quarryvale also declined by 4.1% in the same period. A detailed breakdown of the 2002 census figures are not yet available, so it is not possible to say how the decline in overall population is affecting household size or the breakdown of are profile for the area. [23] [25]

*Table 4 Population Change in North Clondalkin from 1986-2002*

| DED | Total 1986 | Total 1996 | 1986 - 1996 | Total 2002 | 1996-2002 |
|---|---|---|---|---|---|
| Moorfield | 3,355 | 6,697 | 9.5% | 6,273 | -6.3 |
| Rowlagh | 5,605 | 5,238 | -6.5% | 4,496 | -14.2 |
| Combined | 11,720 | 11,935 | 1.8% | 10,769 | -10.0 |

*(Source: Gamma Baseline Data Report 1998 and 2002 Preliminary Census Data)*

The age breakdown based on the 1996 census show a high percentage of young people under 15 years, with over one-third of the population of the RAPID area under 15 years at that time. This huge proportion of young people is counterbalanced by the very low numbers of people aged 65 or more, with less than 1% in Rowlagh, compared to 11.4% nationwide. The measure of "age dependency" is based on a combination of these two figures, so when aggregated it does not appear too different from the national rate of 35.1%, but there is more to age dependency than the plain economic facts of financial support - the picture shown here is one of young parents with large numbers of young children, and very few people of an older, more experienced generation to contribute to the social mix. Looking at these figures another way, five-sixths of the population in 1996 was aged less than 45 years. [23]

*Table 5 Age Profile and Age Dependency 1996, North Clondalkin*

| DED | Pop 1996 | Pop aged 0-14 1996 % | Pop aged 15-24 1996 % | Pop aged 25-44 1996 % | Pop age 45-64 1996 % | Pop aged 65+ 1996 % | Age Dep. 1996 % |
|---|---|---|---|---|---|---|---|
| Rowlagh | 5238 | 33.1% | 25.4% | 26.3% | 14.3% | 0.9% | 34.1% |
| County | 218,728 | 27.1% | 19.3% | 30.6% | 17.8% | 5.2% | 32.3% |
| Region | 1,058,264 | 22.0% | 18.6% | 30.3% | 19.1% | 9.9% | 31.9% |
| State | 3,626,087 | 23.7% | 17.5% | 28.0% | 19.4% | 11.4% | 35.1% |

*(Source: Gamma Baseline Data Report 1998)*

One of the most important indicators of deprivation is the percentage of households headed by a lone parent, male or female. In Rowlagh almost 20% of households are headed by lone parents - just less than twice the national average of 10%.

Another source of information on lone parent numbers is the more recent study carried out in 1997 by the Clondalkin Lone Parents Research Committee, which analysed available figures from the DSCFA and the Health Board. Table 6 below (extracted from that study), gives an age breakdown of people collecting single parent social welfare payments at Neilstown Post Office. [23]

*Table 6 Age and Lone Parent Payments Neilstown Post Office 1997*

| Age | Number |
|---|---|
| Under 20 | 41 |
| 20-30 | 238 |
| 31-40 | 170 |
| 41-50 | 102 |
| 51 and over | 28 |
| **Total** | **579** |

*(Source: One Parent Family Research Project 1997)*

The same study found that 41 claimants who were under age 20 in Neilstown were the largest cluster of teenage lone parents in North Clondalkin - forming 61% of the total of 67 lone parent claimants under 20. The study also gave figures for the numbers of lone parents claiming the medical card - 228 in Moorfield and 324 in Rowlagh, adding to 552, so a rough figure of about 600 lone parent families in the RAPID area of North Clondalkin is estimated. [23]

In addition to the socio-economic factors mentioned, levels of social exclusion within the North Clondalkin can be seen through the figures on Traveller accommodation and homelessness. In 2000 it was estimated that there are approximately 167 Traveller families in the Clondalkin area. An assessment of need by South Dublin County Council estimates that 240 new units of accommodation will be required to meet the existing and projected needs of Travellers in the immediate future in the whole county. To date only 19 units of permanent accommodation for Travellers has been provided since that assessment of need. Traveller issues prioritised in the RAPID action plan include: healthcare, education and supports, accommodation, childcare, youth and drugs and the Traveller economy. [23]

In 1998, more people from Clondalkin presented to the Homeless Persons Unit (in the city centre) than from any other area and in 1999, a survey of youth homelessness found that 57% of young people, aged between 14 and 23, interviewed had experienced homelessness, thus highlighting the issues of homelessness in the Clondalkin area.

Table 7 highlights the low levels of educational attainment in North Clondalkin compared to the national figures. In addition, during the consultation process on RAPID in North Clondalkin low levels of literacy were reported as the single biggest issue in terms of education.

*Table 7 Educational Attainment Analysis (%)*

| Area | | Primary Education at Most | | Lower Secondary Education | | Upper Secondary including Leaving Cert | | Third Level Education | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Men | Women | Men | Women | Men | Women | Men | Women | Men | Women |
| North Clondalkin | Total | 36% | 42% | 34% | 31% | 24% | 22% | 6% | 5% | 100% | 100% |
| | Unemployed | 50% | 34% | 31% | 41% | 16% | 23% | 2% | 2% | 100% | 100% |
| National | Total | 33% | 31% | 21% | 20% | 28% | 30% | 19% | 19% | | |
| | Unemployed | 42% | 24% | 29% | 30% | 23% | 32% | 7% | 14% | | |

*(Source: North Clondalkin RAPID Action Plan)*

### 3.1.2 Quarryvale

The Quarryvale estate lies about three miles north of Clondalkin Village in South West Dublin, and beyond the neighbourhoods of Neilstown and Rowlagh. The estate consists of approximately 705 local authority rented houses, which were built in the early eighties. The estimated population is 2,600 (1996). Based on preliminary census data for 2002, and the decrease in population in the neighbouring areas of Rowlagh and Moorfield, the population of Quarryvale is likely to have decreased by approximately 10% *(3)* to 2,340 in 2002.

In 1994 the CODAN Neighbourhood Profile report demonstrated that Quarryvale was an area with higher levels of unemployment and lower income levels than the national average. Lone parents occupied 27% of households. Educational attainment levels were also less than the national. According to a Clondalkin Partnership report in 1996, Quarryvale, like the rest of North Clondalkin had an unbalanced age structure comprised essentially of young parents with young children. More recent figures demonstrate that 120 adults signed on the live register in May 2001, which reflects a decrease of 100 claimants since December 2000. 300 people registered for the means tested One Parent Family Payment in May 2001, reflecting an increase of an additional 80 people since December 2000. [24]

## 3.2 Existing Health and Related Services

### 3.2.1 South Dublin's Health Services

As North Clondalkin is in South Dublin County it is worth noting the health services and infrastructure available in the county. South Dublin has a major hospital facility in the Adelaide and Meath Hospital incorporating the National Children's Hospital (commonly known as the Tallaght Hospital) and a range of health services are also provided in Peamount, Crooksling, Stewarts Hospitals and Cheeverstown House. There are 12 Neighbourhood Health Centres providing a range of services, along with 59 general practitioners (including group practices), 38 pharmacies, 18 chiropodists, 13 Environmental Health officers and 6 Drug Treatment Centres. There are 3 Home

Help Organisations, 8 Day Care Centres, 10 Meals on Wheels Groups, 11 Private Nursing Homes and 1 Respite Care Facility in the County. [28]

### 3.2.2 North Clondalkin's Health Services

The North Clondalkin area is in the catchment area of Rowlagh Health Centre which is managed and staffed by the South Western Area Health Board. Based in the Health Centre are many of the health board's community care services for children and families, including:

- Public Health Nursing
- Community Welfare Service
- Social Work

In addition, clinics are operated from the centre at different times during the week and they include:

- Public Health Nurse
- Community Welfare Officer
- Home Help service
- Dental service
- Speech and Language therapy
- Baby clinic
- Psychiatric clinic
- Ante-natal
- Baby food
- Doctor's referral
- BCG clinic

Community consultations have highlighted perceived problems with the Health Centre and have described it as 'uninviting', 'unwelcoming' and 'inaccessible'. Neither is the premises wheelchair friendly. Despite highlighting these issues with the Health Board, plans to refurbish the centre have not been approved due to budgetary constraints and efforts are being made to give the centre a minor 'face-lift' by redecorating the internal parts of the centre and erecting a notice outside the centre showing times of the clinics. Staff working from the centre report a high level of DNA 'did not attend' for clinics and appointments and are keen to improve the situation for both the community and for staff based in the centre.

For the purposes of accident and emergency treatment and other secondary health care needs of the people of Quarryvale, patients must use the James Connolly Memorial Hospital in Blanchardstown, despite the fact that the Tallaght Hospital is accessible via public transport and Blanchardstown is not.

North Clondalkin which has a population of approximately 17,000 does not have a dental practice operating and there is only one pharmacy in the area.

There is also a Local Drugs Task Force and a number of community based addiction projects in the area.

A small number of General Practitioners are based in the area. They include:

- Dr Linda Barnes, 20 Glenfield Avenue
- Dr Liam Quigley, 20 Glenfield Avenue
- Neilstown Private Medical Centre
- Dr Liam Lynch, Neilstown

## 3.3 Health Needs Identified Through Surveys and Consultations

### 3.3.1 Quarryvale Needs Analysis

The consultation processes for Clondalkin Partnership's Area Action Plan 2000-2006 and the

Quarryvale Needs Analysis (carried out under the RECITE programme) identified health as a key issue for the area. Service gaps and needs were identified locally through needs analysis carried out by local women in Quarryvale in 2000, together with public consultation and participatory planning processes in 2001. The key findings from these consultation processes are captured in *Community Planning for Better Health* and *Building a Community's Future on Answers - Assessment of Needs in Quarryvale.* Conclusions from these findings suggest *'that health in Quarryvale is not just about 'medical' issues; it is about the physical, psychological, emotional and spiritual well-being of the people living in the area. Simply treating the symptoms of poor health without dealing with the root causes is therefore insufficient.'* [21]

The main service gaps and needs identified through the consultation processes were:

- **Social factors:** Characteristics of Quarryvale which have a negative effect on health are listed as: above average levels of unemployment, low incomes, low educational attainment, bleak environment, social fragmentation, isolation and lack of basic services, lack of new housing, overcrowding and homelessness. [22]
- **Gaps in health service:** Most people in Quarryvale believe they are in the wrong hospital catchment area. They are in the Blanchardstown hospital catchment area, whereas the Tallaght hospital is accessible via public transport. There are long waiting lists for addiction clinics. The local Health Centre is understaffed, dreary and unwelcoming. Three of the biggest barriers to the use of the Health Centre cited during consultations were, lack of information on services, long waiting times in clinics and lack of evening clinics. [22]
- **Housing services and environmental issues:** The most basic facilities are not available to people living in Quarryvale. There is no affordable supermarket, pharmacy or post office. There is a lack of affordable housing and serious deficiencies in sports and recreational facilities. Quarryvale is poorly serviced with public transport. There is an absence of appropriate street lighting and traffic calming measures, which means that parents are reluctant to let children play outside their homes. [22]
- **Education issues:** Early school leaving, low educational attainment and adult literacy are issues for Quarryvale. While some initiatives to encourage young people to stay on at school locally are in place, the level of early school leaving still continues to be an issue for those living in Quarryvale. [22]
- **Crime and policing issues:** Drug related crime, vandalism, joyriding, disputes between neighbours and a lack of Garda presence means that people do not feel safe in their community. [22]
- **Specific health issues identified for women, men and teenagers in Quarryvale:** [22]
  - Health issues for women include stress, depression, domestic violence, breast cancer, cervical cancer, smoking-related diseases and the menopause
  - Health issues for men include drug addiction, alcohol misuse, heart disease, ulcers, skin diseases, premature ageing, sexually transmitted diseases, prostate cancer, bowel cancer and testicular cancer
  - Health issues for teenagers include smoking, drinking, drug misuse, bullying and poor nutrition

- The five most requested health services in Quarryvale by local people were as follows: [24]
  - Well women centre 69.8%
  - Child development clinic 66.2%
  - Counseling service 58.6%
  - GP service 52.6%
  - Positive parenting service 42.8%

### 3.3.2 RAPID

The Minister of State launched the RAPID Programme in February 2001. RAPID stands for

Revitalising Areas by Planning, Investment and Development. This Programme targets the 25 most disadvantaged urban areas in the country and is aimed at improving the quality of life of the residents of these communities. North Clondalkin is one of those areas.

The RAPID Area Implementation Team (comprising local Statutory Agencies, residents of the local community, Clondalkin Partnership, Clondalkin Drugs Task Force and local Community Development Projects) went through a process of consultation with communities and service providers in order to assess needs and to develop actions contained in the North Clondalkin RAPID Action Plan, January 2002. Many of the projects and initiatives contained in the Action Plan are either directly or indirectly related to the health of the community. One of its objectives is *"to improve access to and availability of primary and secondary health services and involve the community in planning and delivery."* The plan states that RAPID will have *"as a function the exploring of links with local community-based primary health care models"*. It also has broader 'health related' objectives related to childcare, substance abuse prevention, employment and training, youth activities and community development.

The health needs and proposed health projects in the North Clondalkin RAPID Action Plan reflect the needs and issues expressed in the Quarryvale Needs Analysis, in section 3.3.1, including the need to improve service delivery in Rowlagh Health Centre and change the hospital designation for Quarryvale. Other actions include teenage health initiatives, positive parenting, improved Traveller health programme and dissemination of health information. [23]

**3.3.3 South Dublin County Development Board's Strategic Plan**

As part of the South Dublin County Development Board's 10-year economic, social and cultural development strategy - *South Dublin: a Place for People*, the needs of the county were assessed and an implementation plan for the period 2002-2005 was put in place. The main conclusions which impact on health and well-being of the population include:

- There is evidence of higher than average levels of young mothers, higher birth rates and lower levels of marriage than the national averages. There is also a high demand for childcare which is not being met. This would suggest the need for greater support and services to target the needs of parents, children and young people in the County.
- There remain areas of high unemployment and long term unemployment in areas including North Clondalkin as well as lower levels of educational achievement, young populations, high dependency rates and a concentration of lone parents. The deprivation scores support these figures. Other indicators of social exclusion in the County identify particular groups including elderly people living alone, refugees and asylum seekers and Travellers.
- There is an inadequate public transport system, a lack of affordable housing in both urban and rural areas, inadequate provision of Traveller accommodation to meet the need.
- Of the 95 primary schools in the county, 5 primary schools have early start programmes and 31 schools have designated 'disadvantaged' status with a home-school liaison service.
- Of the 31 second level schools in the County, 9 have designated 'disadvantaged' status.
- In 1996, 23.8% of the population of South Dublin County had no formal education or primary education only; 32.2% of its population had ceased education before the age of 15 and only 19.9% of the population had a third level education. Educational attainment levels in the county are relatively low, especially when one takes into account the youthful age profile of many of the districts.
- Education and training for young people and for adults is provided by FAS, the County Dublin Vocational Education Committee, the local development agencies and a range of community organisations. [28]

In the 2002-2005 implementation plan, health goals and objectives are set. They include actions in

relation to health. The actions outlined include:

- Health promotion and early intervention projects and initiatives - some targeting vulnerable groups
- The creation of a health network involving service providers and the community
- Substance misuse prevention programmes
- Development of a sports and recreation strategy which promotes exercise, physical activity, sport and recreation [27]

### 3.3.4 Traveller Health Needs in North Clondalkin

A baseline health survey was undertaken by the Clondalkin Travellers Development Group in 2001 as part of the Primary Health Care Initiative. The findings demonstrate that Traveller families suffer a level of ill-health which precludes them from a range of life's necessities, produces shorter life expectancies and co-exists with high levels of poverty. They are more likely to suffer ill-health and less likely to receive good health care. The Clondalkin Travellers Primary Health Care Initiative aims to address the survey outcomes on a number of fronts. With the support of the Health Board, Environmental Health Officers and Local Authorities it seeks to address the environmental and accommodation conditions which are the cause of many of the high incidences of chest infections (71% of families), colds and throat infection (62% and 59% respectively), and asthma (21%). Depression levels are high with 27% of families referring to the isolation, poor living conditions, poor health and discrimination as some of the contributory factors. The report identified seven key areas where interventions should be targeted as a matter of urgency: [10]

- Women's Health
- Family Health
- Mental Illness
- Medical cards and GP services
- Mobile Clinic
- Health Education and Promotion
- Environmental Health

### 3.3.5 Youth Consultations

Recognising the high level of youth in the North Clondalkin area and the issues that face many young people, such as early school leaving, education, low paid employment, facilities for young people, drugs, etc. the Youth Working Group of the Clondalkin Partnership had developed a Youth Action Plan as part of the development of the Clondalkin Partnership's Area Action Plan 2000-2006. As part of this process extensive consultations took place with young people and with service providers and agencies working with young people in the North Clondalkin area. Though this process many issues were highlighted which are relevant to this research. The key issues that emerged for young people were:

- Lack of leisure, sports, club facilities and personnel
- Healthcare, including suicide
- Homelessness
- Support for families of drug users
- Area image - low self-esteem and poor educational achievement [29]

The needs and gaps in service identified through the consultation process were:

- Improved area image
- Social amenities - a safe place
- Health - pregnancy, detox / treatment, counselling centre in North Clondalkin
- Shelter for young homeless persons
- Parenting skills [30]

### 3.3.6 Health Needs in Other Disadvantaged Areas

In order to highlight how inequalities in health affect disadvantaged communities in the Dublin area, two studies are worth referring to. They are health needs assessments carried out in both the Dublin Docklands and the Tallaght area. These studies highlight the types of health statistics and health needs of disadvantaged areas, with similar social, economic and environmental characteristics as North Clondalkin. For this reason some conclusions can be drawn from the studies which supplement the studies and consultations already carried out in North Clondalkin about health. Table 8 shows the high levels of smoking, stress and chronic illnesses in both communities. Other issues highlighted include women's health and the low take up of screening services such as breast examinations and cervical testing. The low take up of preventative health screening is also apparent in relation to the low level of dental examinations.

*Table 8 Health Studies in Tallaght and Dublin Dockland*

| Factor | Dublin Docklands | Tallaght |
|---|---|---|
| Experienced stress in the year prior to the survey | 53%<br>26% consulted GP about stress<br>12% had prescribed medication | 59%<br>35% consulted GP about stress<br>19% had prescribed medication |
| Worried about teenagers socialising | 60% | 60% |
| Smoking | 31% of households members, 17 years or over smoked | 40% of household members, 18 years or over smoked |
| Household members over 14/15 years with drug/alcohol problem | 1% | 2% |
| Households with chronic illness | 27% | 22% |
| Household members with a disability | 3% | 3% |
| Family planning for women of child-bearing age | 46% of women using method of family planning | 56% of women using method of family planning |
| Cervical smear levels of women aged 18-65 in last 5 years | 54% of women had cervical smear | |
| Breast examination aged 18-65 in last 5 years | 43% | |
| Smoking during their last pregnancy | 29% | 41% |
| Unplanned pregnancies | 48% of the women's most recent pregnancies were unplanned | 54% of the women's most recent pregnancies were unplanned |
| Population visited a dentist in the 12 months prior to the survey | 12% | 15% |

## 3.4 Summarising the Health Needs to be Addressed in North Clondalkin

The socio-economic profile of North Clondalkin shows a high level of disadvantage in the area. The established links between poverty and ill health would suggest that the people of North Clondalkin are experiencing higher mortality rates than those in better off areas, from diseases such as circulatory disease, cancers, respiratory diseases and from injuries and poisonings. The inequalities in health are also likely to be affecting the large numbers of children and young people in the area who are exposed to the social risks that put them further at risk of ill-health.

Based on the health needs identified through surveys and consultations in North Clondalkin and the socio-economic profile, target groups in need of specific community health interventions include lone parents, young parents, women, Travellers, men, children and young people. The specific health interventions to be planned need to address the gaps in health identified in the area, in relation to the health centre, the issue of the hospital catchment area and the inequities of access in relation to GPs clinics, dentists, pharmacists, etc. There is also a need to tackle the broad impacts on health (i.e. the social determinants of health) in the area such as housing, security, educational disadvantage and environmental issues.

Having examined the health needs of other disadvantaged areas in Dublin, it can be assumed that in Clondalkin, like the Docklands and Tallaght, the incidence of smoking, stress and chronic illnesses is likely to be high. There is also likely to be a low take up of preventative screening services in the North Clondalkin area for women's health and for dental health.

Solutions which can address many of the health needs and issues identified include improved health promotion activities, the development of a primary health care initiative and improved access to services. The ways that the health needs and issues identified in this section can be addressed are developed in section 5, which puts forward an operational model for the North Clondalkin community health project.

# EXAMINATION OF MODELS

# EXAMINATION OF MODELS

## 4.1 Introduction to Models

Section 2 of this report highlights the need to address inequalities and inequities in access to health care and identifies some of the ways that these can be addressed through broad actions. Section 3 examines the socio-economic profile of the area and identifies the health needs of North Clondalkin arising from socio-economic factors and from recent consultations and surveys undertaken in the area. This section of the report highlights some models of good practice in relation to community health and primary health initiatives both here and abroad which are worth considering in light of North Clondalkin's needs, issues and gaps identified previously. As you will see from the approaches and case studies contained in this section, it is necessary to consider or 'cherry-pick' some elements of these models in order to develop a suitable model that meets the North Clondalkin needs and takes account of the local structures.

For the purposes of dividing types of models and approaches, this section categorises approaches and case studies into the following broad categories:

- Partnerships and alliances
- Community development approaches to health
- Primary health care initiatives (involving communities)
- Peer-led approaches

In some instances, the examples given are not clear cut and there is some overlap, where examples and case studies have elements of more that one category. For example, some of the health partnerships and alliances have aspects of community development approaches to health in the way that they work. (Many case studies have been sourced from websites during March 2003. The details of the websites used to develop case studies are contained in Appendix II.)

## 4.2 Partnerships and Alliances

In an attempt to develop structures and processes which involve the necessary stakeholders in health and using the principles of partnership working, consultation, participation and involvement in decision making (by the citizen), different countries are developing health alliances and partnerships. The health alliances and partnerships take account of health inequalities and of the social determinants of health and involve not only health providers and health consumers, but also local authorities (responsible for housing), education and training authorities, regeneration agencies and the community and voluntary sector. The concept of health partnerships and health alliances has not been developed at a local or regional level in Ireland (other than within the City and County Development Board (CDB) process). So it is necessary to look at where they have been established, how they work and whether the model or the practice can be used in North Clondalkin.

Health alliances and strategic partnerships are being used as the vehicle for addressing the broader social determinants of health in the UK. Case studies showing the way that the Strategic Partnership in England, the Health Alliances in Wales and the Glasgow City Health Partnership operate are shown below. In Northern Ireland, the new public health strategy *Investing for Health*, seeks to minimise inequalities in health and social wellbeing in Northern Ireland and to address the determinants of health. An important element of work in this area is the development of alliances between statutory, voluntary and community groups and the empowerment of individuals, groups and communities to become actively involved in decision making which impacts on their health and environment. [47]

## *Case Study 1: Local Strategic Partnerships in the UK*

*In the UK, there is recognition that improving people's health can not be achieved by the National Health Service alone and a process has been put in place to establish effective partnerships between health and local authorities, with the commercial sector and with voluntary sector organisations. The key to reducing inequalities lies in much more effective collaboration between health authorities, local authorities, voluntary and community groups and commercial organisations. This process of collaboration is brought together in the Health Improvement and Modernisation Programme (HIMP).*

*The Government has called on health authorities to lead the development of local HIMPs and this development may be seen as a three-fold process:*

- *Raising corporate awareness of those inequalities that exist.*
- *Increasing inter-agency planning for health improvement.*
- *Making such initiatives part of the mainstream agenda of statutory bodies, rather than being seen as peripheral.*

*Every Health Authority is responsible for developing, with local organisations, a Health Improvement and Modernisation Programme (HIMP). The purpose of the HIMP is to co-ordinate action to improve health and to reduce health inequalities in the local population.*

*The HIMP includes an agreed statement on the most important issues locally, a commitment from all of our partners to share information and work together to improve our knowledge of problems and how they can be tackled, and a framework for the service and financial arrangements in the NHS and between the NHS and social services.*

*The HIMP also brings together the NHS, local government and the business sector. This multi-level process will increasingly enable partners (individually and collectively) to use the HIMP as a strategic vehicle for health improvement and as a set of performance management indicators and tools by which to measure and demonstrate progress.*

## *Case Study 2: Health Action Zones in the UK*

*Health Action Zones (HAZs) are trailblazing new ways of tackling health inequalities in some of the most deprived areas in England. The HAZ initiative brings together organisations within and beyond the NHS to develop and implement a locally agreed strategy for improving the health of local people. The HAZ programmes are expected to address inequalities in health and develop services that are more responsive to patients and users.*

*HAZs are partnerships between the NHS, local authorities, the voluntary and private sectors and local communities. The HAZ partnerships are taking forward challenging work programmes which represent a new approach to public health, linking health, regeneration, employment, education, housing and anti-poverty initiatives to respond to the needs of vulnerable groups and deprived communities. A central aim for HAZs is integrating the services and approaches they are developing into mainstream activity.*

*Each HAZ focuses on addressing its major health and service priorities. HAZ plans allow for greater flexibility in the way that services are provided, for example in testing out joint working and pooled budget arrangements. Altogether more than £274 million was made available to assist HAZs*

*in the three years from April 1999. This funding has also been used to leverage change in the more substantial budgets of health and local authorities. The 26 HAZs (established in 1998 and 1999) range in population from 180,000 to 1.4 million people and cover over 13 million people in total. HAZs are located in some of the most deprived areas in England. All the HAZs are based on 7 key founding principles:*

- *Engaging communities*
- *An evidence-based approach to service planning and delivery*
- *Equity: in resource, allocation, in reducing health inequalities and promoting equality of access to services*
- *Partnerships/multi agency working*
- *A whole systems approach to taking forward change engaging stakeholders across the local health and social care systems*
- *Staff involvement*
- *Person centred services*

*Armagh and Dungannon HAZ in Northern Ireland was launched in April 1999, and comes under the administration of the Northern Ireland Assembly. It serves a largely young and rural population. Its bid document, 'Together, We Can Make a Difference', sets out the HAZ's aim as: '...combining the efforts of all our agencies with the involvement of local people to measurably improve the health and wellbeing of all in the Armagh and Dungannon areas'.*

*It also outlines the HAZ's main themes:*

***Rurality -*** *Projects concerning rural transport, healthy living on farms and healthy food and local regeneration*, and together address the health and social wellbeing of communities and individuals living in rural areas.*

***Housing -*** *The HAZ is working to enhance the community infrastructure, and improve the sense of community spirit and relations among residents of housing estates, rural settlements and isolated dwellings. Projects are addressing energy efficiency, environmental improvement and sustainability*, and creation of Community Houses.*

***Young People -*** *Projects here include health promoting schools, promoting citizenship, and developing life skills and building self-esteem.*

*The HAZ is made up of a strategic alliance group, and a support group and programme team for each of the programme themes. You can view membership on Armagh and Dungannon HAZ's website.*

## *Case Study 3: Local Health Alliances in Wales*

*The concept of Local Health Alliances has been developed as a means for bringing together all those who have a part to play in influencing the health of communities in Wales. In July 1999 the National Assembly for Wales published guidelines, 'Developing Local Health Alliances', which urged each local authority in Wales to establish an alliance in its area. By convening a partnership of local interests local health alliances can help ensure that all those things that have an impact upon health and inequalities in health are considered together and not as separate policies.*

*The Assembly recognises that many factors influence our lives and ultimately our health. Local Health Alliances can provide a focus for addressing these broader social, economic and environmental determinants of health.*

*Local Health Alliances are developing in ways that reflect local circumstances, but generally have a core membership, or Steering Group, that includes at least:*

- *key members and officers of the local authority;*
- *the Health Authority;*
- *the Local Health Group;*
- *the County Voluntary Organisation;*
- *the Community Health Council.*

*Local Health Alliances have been established in most local authority areas across Wales.*

## *Case Study 4: Glasgow Healthy City Partnership*

*Glasgow Healthy City Partnership is the city's main formal alliance for health. It is part of a European Network of Healthy Cities operating under the umbrella of the World Health Organisation. The Partnership brings together Glasgow City Council, Greater Glasgow NHS Board, the city's three universities and statutory, voluntary and community organisations to support a range of activities.*

*The aim of the Partnership is to "secure improvements in health for everyone living and working in Glasgow and reduce health inequalities within the city in a way which supports sustainable urban regeneration"*

- *Glasgow City Council*
- *NHS Greater Glasgow*
- *Glasgow Council for the Voluntary Sector (GCVS)*
- *Glasgow Community Health Projects*
- *Greater Glasgow Primary Care NHS Trust*
- *Greater Glasgow Health Council (which represents the patient's interest in the NHS)*
- *Communities Scotland*
- *Glasgow Community Council's Forum*
- *Glasgow Caledonian University*
- *University of Glasgow*
- *University of Strathclyde*
- *The Scottish Executive*
- *Poverty Alliance*

*8 community health projects are supported and funded in the partnership area. Greater Easterhouse is discussed as a community development approach to health case study.*

The case studies above demonstrate the way that health partnerships and alliances operate in the UK. There is an emphasis on cross-sectoral working in the identification of needs, priorities and actions. There is also a concentration on tackling inequalities and the broader determinants of health which can be seen through their membership structure and through the actions. Finally the involvement and support of the community and voluntary sector and of community based health projects is also an element in the partnership and alliances approach.

## 4.3 Community Development Approaches to Health

Community development is a way of tackling a community's problems by using the energy and leadership of the people who live there. A community development approach to health recognises the central importance of social support networks. It is a process by which a community defines its own health needs to bring about change. The emphasis is on collective action to redress inequalities in health and access to health care. [32] Community development practitioners use an approach which combines a set of methods and principles that recognise the views of members of communities as valid and their perspectives are privileged. This differs from the approach traditionally employed in the health sector where specialist knowledge of professionals is most privileged. [32]

Community development approaches to health are quite new in this part of the world. Some have been used in Northern Ireland and in Ireland through the 1990s and over the last couple of years. The NAPS refers to the need to use community development approaches to tackle inequalities in health and the government's recent policies also refer to involving communities in planning and delivering health services, as does the Government's White Paper on the Community and Voluntary Sector. For this reason it is necessary to examine some of the different models which use community development approaches to health and to consider these approaches in the development of a model for the North Clondalkin area. It is also important to draw on the lessons from these projects and from the traditional community development sector, in particular, those lessons about the emphasis placed on 'time and process' and on developing 'reciprocal and symbiotic relationships with communities'. [32]

The Community Development and Health Network Northern Ireland suggest that the following practical outcomes can be achieved through using community development approaches to health:

- Strengthen community networks, relationships and supports
- Participate and benefit from interagency partnerships
- Promote a stronger sense of community spirit and solidarity
- Develop self esteem, confidence and personal skills
- Better access to information about health, social and other community issues
- Identify and articulate their own health and social needs
- Start and manage their own organisations and groups
- Set up and run community facilities, events and activities
- Campaign or negotiate for health improvements in an area [38]

Community health development is a process (according to the Welsh Health Promotion Authority) which:

- Uses community approaches to health such as community participation and community development;
- Helps facilitate the effective interface between policy and practice;
- Focuses on local needs and priorities in partnership with others;
- Works with communities not for them or to them;
- Aims to develop healthy sustainable communities.

A key element of the Welsh Assembly Government's strategy for promoting health and well being is the focus on community health development, which may be defined as the promotion of health and well being in and with the community, and in partnership with others.

### *Case Study 5: NICHE (North Side Community Health Initiative)*

*The North side Community Health Initiative is a partnership involving Knochnaheeny Family Centre and the Southern Health Board. The project is based in the Knochnaheeny Family Centre and serves the Knochnaheeny / Hollyhill area of Cork City (population 6,000 approximately). The focus of NICHE is on improving both community and individual health and well being with a particular emphasis on the use of community development approaches. NICHE aims to:*

- *Explore effective mechanisms of consultation in relation to promoting individual and community health and well-being*
- *Develop innovative health promotion initiatives in conjunction with local people through the use of Community Health Workers whilst acknowledging and drawing on existing resources*

*The project views health promotion as broader than disease prevention and health education and recognises the influence of environmental and socio-economic factors, which are beyond the individual's control.*

*NICHE is funded by the Southern Health Board and has a board made up of Health Board and community representatives. NICHE has adopted 11 key strategies which underpin the work of the project some of which include:*

- *Developing alliances based on shared vision*
- *Building on existing strengths of the community*
- *Using research and models of good practice*
- *Promoting healthy living centre concept*
- *Exploring locally an equity and social inclusion agenda for health*

*NICHE has undertaken many projects and research in order to engage with particular groups in the community and has undertaken research into health needs of the community. It has had some success in influencing ways that health services are delivered to people from the area. [38] [49]*

Arguments for using community development approaches are that *"social integration and social support rival in strength the detrimental contributions of well established biomedical risk factors like smoking, obesity, elevated blood pressure and physical inactivity"*. Evidence from the US and Japan suggests that *"people who are disconnected are between 2 and 5 times more likely to die from all causes, compared with matched individuals who have close ties with family, friend and community"*. [38] This backs up the social determinants of the health model discussed in section 1.2 and give a rationale for using community development approaches to health.

In a study of community development activities in Northern Ireland, undertaken by Community Development and Health in Northern Ireland entitled Tales from the Field, *"there was consensus that the community development process assists in promoting the social model of health"*, that it "helped liberate people". Some of the UK's Healthy Living Initiatives have projects and activities within them that use community development approaches and principles. Examples are shown in the case studies below. The UK's Healthy Living Initiative is discussed in section 4.4.2.

## *Case Study 6: Cardiff Local Health Group Llanrumney Healthy Living Centre*

*The Llanrumney Healthy Living Centre has been funded for five years by the New Opportunities Fund to target five broad areas in relation to young people's health:*

- *nutrition & physical activity*
- *substance misuse prevention*
- *general sexual health*
- *advocacy & empowerment*
- *education and training.*

*Activities and services will be based in the community in locations where young people already meet, bringing health to their doorstep and ensuring that services are accessible.*

*An important part of the service which the Healthy Living Centre project will provide will be to continue with the organisation of The Health Joint, which has now been running at Llanrumney Youth Centre for some years. The Health Joint is a meeting place for young people held every Monday at lunchtime between 12.30 - 1.30pm to discuss health related topics and give free contraception and advice.*

*Over the coming months, the project will meet with young people across the estate such as school pupils, students, young people excluded from school and young mothers, to find out which services and support are needed. The project aims to work in partnership with agencies who already support young people in Llanrumney so that projects are multi-faceted and existing services are enhanced. The project's objective is to help young people to access the information and services they need to make informed choices, so that being healthy becomes a way of life.*

## *Case Study 7: Greater Easterhouse Community Health Shop*

*The Greater Easterhouse Community Health Shop is one of the community based projects supported by the Glasgow Health City Partnership discussed in Case Study 4 in sections 4.2. It was established in September 1999 in response to a local campaign to relocate a GP's surgery from a rundown Portacabin. As the name implies, the Health Shop is housed in two previously vacant shop units on Hallhill Road making it highly accessible to the local community.*

*It has brought together 25 different health related services including the GP's surgery, addiction support, nurse and health visitor services, money and benefits advice, parenting classes, healthy cooking classes and a range of healthy lifestyle initiatives.*

*The project is an excellent example of innovative, successful partnership working between the local community, health providers and agencies in the Greater Easterhouse area, brought together through the Pathfinder. It won a prestigious award for best practice in regeneration. It was one of 13 Pathfinders in Scotland. It is based within the Greater Easterhouse Social Inclusion Partnership which is part of the Glasgow Alliance network of SIPs in the city. After two years of operation, the health shop successfully secured future funding as a Healthy Living Centre*

*Along with GP and other primary care services, the health shop provides a range of new services promoting health and well-being, including cookery, personal development, alcohol and drug*

*counselling, parents groups, sexual health for young people, massage, pre-employment and training advice, money advice, a benefits surgery, and a milk token initiative. This case study is based on the views of partner agencies and community representatives.*

*The idea for a community health shop originated from local residents in the Barlanark area. A multi-agency steering group was established in 1998, including community representatives from an estate action group, tenants associations and housing co-ops.*

*The range of services introduced involves several voluntary organisations, the Benefits Agency and Greater Easterhouse Development Company. Due to their presence in the same building, GPs are aware of other services to which to refer patients. Availability of facilities e.g. a kitchen in the same building made possible integration of services. Numbers accessing services weekly rose from 100 in 2000 to over 300 in 2001.*

*The health shop has brought the mainstream agencies and local people together in joint planning and management, with local people being given a leading role in decisions about the operation of the CHS. It is based on the principle of services being planned locally. There are three aspects to community involvement - they are community vision and planning, community management and community consultation. (Like Clondalkin a participatory appraisal approach was used to explore local needs and priorities at the outset, including training for community representatives to lead the consultation.).*

## 4.4 Primary Health Care Initatives

For the purposes of the Health Strategy, primary care is defined as *'an approach to care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services. The services provide first-level contact that is fully accessible by self-referral and have a strong emphasis on working with communities and individuals to improve their health and social well-being.'* [4]

*Primary Care: A New Direction* refers to primary care models in other countries including New Zealand, Canada, United Kingdom, Australia, Sweden, Norway and the Netherlands. In the successful models examined, common themes were highlighted which have been incorporated in the Irish primary care model discussed in section 1.3.2. [4]

### 4.4.1 Health Co-operatives

In an increasing number of countries women and men are seeking to improve their health by establishing health co-operatives. They do so where there is inadequate provision by public health services and where non-co-operatively organized private practice is not available or is too costly.

In Canada and the United States user or client-owned health co-operatives are set up by individuals in the same community to help them meet their own health care needs. Member-users determine goals and practices, thereby enabling ordinary citizens to empower themselves with respect to health care. Members and owners each contribute shares of capital and subsequently contribute to operating costs, usually by prepaid premiums, and appoint managers to negotiate contracts with health insurance and health care providers. Often these co-operatives purchase and operate hospitals and other facilities, and hire professional and other staff. Services range from simple preventive care and basic insurance to advanced curative and rehabilitative interventions. Institutions and organizations, such as trade unions, and co-operative movements, may also set up user-owned health co-operatives. [43] [46]

In Scotland a health care co-operative structure is used to deliver primary health care needs. The Eastern Glasgow and the Anniesland, Bearsden and Milngavie Local Health Care Co-operative case studies are shown below.

## *Case Study 8: Eastern Glasgow Local Health Care Co-operative (LHCC)*

*The Eastern Glasgow Local Health Care Co-operative is the largest LHCC in Glasgow, providing primary care services to 117,000 patients over a wide geographical area and to diverse cultural and socio-economic groups. The LHCC comprises 74 General Practitioners operating from 24 GP practices together with all their attached Practice Nurses and practice employed staff, Community Nursing Staff & Professions Allied to Medicine. It also represents 33 Community Pharmacies and 60 Dentists. The LHCC area includes Parkhead Hospital, 3 Mental Health Resource Centres, 4 Health Centres, Eastbank Health Promotion Centre, various individual practice premises and community premises.*

*The Co-op works closely with the local acute hospital and the local children's hospital.*

*The aims and objectives are to provide an integrated multidisciplinary approach to the provision of Primary Care within the LHCC area and to identify health inequalities and address these to improve the health of the local population. This will support Primary Care Health professionals in better planning, managing and monitoring of services. The LHCC Clinical Priorities have been identified through wide discussion, consultation and needs assessment.*

*Health Promotion is an integral part of any clinical work undertaken and the LHCC will work closely with the Health Promotion Department at Greater Glasgow Health Board to carry this out.*

## *Case Study 9: The Anniesland, Bearsden and Milngavie Local Health Care Co-operative*

*The Anniesland, Bearsden and Milngavie Local Health Care Co-operative came into existence in April 1999 and covers the Bearsden and Milngavie areas of East Dunbartonshire, together with an area centred around the Anniesland suburb of Glasgow. It includes a wide range of professionals including, GP's, Practice Nurses, District Nurses, Community Nurses, Pharmacists, Social Workers and Managers and it is also engaged in ongoing discussions with local optometrists, voluntary bodies and the Acute Sector.*

*There are 38 GP's within the LHCC. They are supported by 7.2 WTE Practice Nurses and a number of administrative and management staff, District Nurses, Health Visitors, Nursing Auxiliaries, community PAM's and CPN's.*

*The LHCC mainly uses the Western Infirmary/Gartnavel General for the provision of acute services. Referrals to these hospitals accounts for approximately 75% of the total LHCC referrals. These sites are just beyond the boundary of the LHCC area. They are accessible by road from the furthest point in the LHCC within 30 minutes. The LHCC also accesses the services provided by Stobhill General Hospital, The Royal Hospital for Sick Children, Glasgow Royal Infirmary and The Southern General.*

### 4.4.2 Healthy Living Centres in the UK

Healthy Living Centres, funded in the short term from Lottery grants, are the vehicle for a supposedly new and positive approach to health, building the self-confidence, self-esteem and self-reliance which is the bed-rock of good health. Instead of picking up the prescription that they expect, patients could be referred to health and fitness clinics, physiotherapy and chiropody services, or arts projects to improve their health.

The HLCs are an important component of New Labour's health strategy, complementing its more conventional health improvement programmes, and welfare strategy, which is to be targeted at the most needy and delivered in a mixed economy of provision. The aim was that one fifth of the UK's population would be within an HLC catchment area by the end of 2002. The common purpose of healthy living centres will be to promote health, helping people of all ages to maximise their health and well being, whatever their capacity for 'fitness' in the traditional sense. Their focus will be on health as a positive attribute which helps people to get the most out of life, embracing both physical and mental well-being.

The concept has two parents: the holistic approach embodied in the pre-war Pioneer Health Centre in Peckham (the Peckham Experiment see Appendix III); and the contemporary American experience of 'senior centres'. Healthy living centres could become the UK equivalent of senior centres, but open to the whole age range, from single parents with toddlers to pensioners on low incomes. Their defining feature will be the relative poverty of their clientele, for no-one is suggesting that HLCs are needed in affluent areas, where people already have the disposable income to use leisure centres, the education to make good use of existing health services and enough control over their work and daily life to seek and achieve a healthy, balanced existence.

This focus on the poor is likely to attract widespread support because there could be so many beneficiaries from these centres' development. Local communities and users are expected to be involved in all aspects of design and delivery of a project. Projects are likely to cover a range of activities including, for example, smoking cessation, dietary advice, physical activity, health screening programmes, training and skills schemes, arts programmes and complementary therapy. Healthy Living Centres focus on tackling the wider determinants of ill health and address factors such as social exclusion, mental health and poor access to services and diet and fitness. Examples of Healthy Living Centres and the types of work they do are shown below in the case studies from Hackney in London and Newcastle.

### *Case Study 10: The SHARP End (Seniors Health and Active Retirement Project) in Hackney*

*It aims to:*

- *provide a resource centre focusing on health promotion for older people;*
- *actively involve users in the management and running of the centre;*
- *target people over 50 from all ethnic groups.*

*Users, older people's groups, local voluntary groups, the CHC, the local authority and the health authority are all involved as partners in the project.*

### *Case Study 11: The West End Health Resource Centre*

*The West End Health Resource Centre Newcastle is located in the heart of the most deprived area of the city. It provides an integrated approach to improve health, especially for the most vulnerable groups, through:*

- *health and fitness facilities - including structured programmes for people with chronic conditions;*
- *community health services, e.g. physiotherapy and chiropody; preventative initiatives;*
- *information on health and social services, health rights and welfare benefits;*
- *projects linking arts and health;*
- *a meeting place and focus for links between local people and statutory agencies.*

*It is based on a partnership between the voluntary and statutory sectors and local people*

## 4.5 Peer-Led Approaches

Behavioural science research suggests people are more likely to hear and personalise messages resulting in changing attitudes and behaviours if they believe the messenger is similar to them and faces the same concerns and pressures. Peer-led approaches first developed in the developing world where they have been used successfully in relation to health, Aids and HIV, nutrition and teenage sexuality. More recently peer-led approaches are being used in the developed world to tackle similar issues and are being used as a means of engaging with young people and disadvantaged communities.

Numerous studies show that peer education is an effective way to help youths develop healthy behaviours not only in sexual health but also in violence prevention and substance abuse prevention. Peer education draws on the credibility people have with their peers, leverages the power of role modelling, and provides flexibility in meeting diverse needs. Given escalating rates of HIV/AIDS, other sexually transmitted diseases (STDs), and unintended pregnancies among adolescents, peer education can create positive group norms of behaviours, decreasing risk for HIV/AIDS, STDs, and unintended pregnancies.

There are many examples of where peer-led approaches to health have been successful in both primary health care settings and in community development and health projects. In Ireland, the Traveller Primary Health Care Initiative (see case study below) and the NICHE health project in Cork detailed in section 4.3 use community health workers recruited from the target community in question.

### *Case Study 12: Clondalkin Traveller Primary Health Care Initiative*

*The recommendations of the Task Force on the Travelling Community resulted in the establishment of Traveller Health Units in each Health Board area, in partnership with local Traveller organisations. Another recommendation was the establishment of Primary Health Care for Travellers Projects involving Community Health Workers who have been drawn from the Traveller community itself. The Clondalkin Traveller Primary Health Care Initiative was established as part of this initiative.*

*The Clondalkin Traveller Primary Health Care Initiative is a programme developed to address the health needs of Travellers in Clondalkin. It is a partnership between Clondalkin Travellers Development Group and the South Western Area Health Board and implemented in cooperation with the Department of Community, Rural and Gaeltacht Affairs.*

*Its aims are to contribute to the improvement of Travellers through informed care, self-care and mutual aid, to develop an outreach and localised service where primary health care workers are of the same culture as the recipients, to work towards the elimination of the barriers of access to health services that exist, to liaise and assist in creating dialogue between Travellers and health service providers in the area, to develop the skills of Traveller women in providing community based health services and to impact on health policy development at local and national level [10]*

*Since the beginning of the project the health workers have undergone pre-training which involved capacity building, an introduction to health, some personal development, team dynamics and outreach skills and approaches. The training programme built on the pre-training and covered in detail aspects of health, the health service and as part of the programme the participants carried out a baseline health survey of Traveller health needs in the Clondalkin area. The participants became qualified as Community Health Workers in June 2001 and since then 5 have worked part time with the Clondalkin Traveller Development Group. Through outreach approaches the Community Health Workers are implementing actions in relation to women and children's health, environmental health and in service delivery, training with health services providers and in policy development. [10] [11]*

## *Case study 13: Peer Led Youth Initiatives in the UK*

***Acland Burghley School, Camden** - Anti-Bullying Campaign (ABC)*
*The ABC peer support scheme has been in existence since 1993. It includes approximately 40 students from across the whole age range. Not all are counsellors, some help with publicity or the drama workshops for feeder schools or for new Year 7 students. They are trained and receive supervision and they meet every Monday to review, reflect on and plan their work. Their campaign is an important factor in creating a safe atmosphere in the school. The (then) DfEE filmed the work of the ABC as part of their anti-bullying strategies video.*

***Blackheath Bluecoat School, Greenwich** - A peer counselling system, called BIONIC (Believe It Or Not I Care). Students are linked to Greenwich Youth Council as part of an attempt to actively engage in the democratic process.*
*This was Stephen Lawrence's school and has a long tradition of Citizenship Education within the Christian ethos of the school, although the students are mixed in terms of ethnicity, economic, religious and linguistic background.*
*They have a peer counselling system called BIONIC (Believe It Or Not I Care). Students are linked to Greenwich Youth Council as part of an attempt to actively engage in the democratic process. They are represented on the local council and involved in decisions about, for example, social inclusion, rapid response to racism and building communities as well as providing a strong voice for young people. The school liaises with local police for, among other things, a Junior Citizen Scheme and Do the Right Thing awards. Students took part in the BBC 2 See You In Court series about the justice system in the UK. Community Service is encouraged. The PSHE programme is full of Citizenship work/activities.*

***Peer mediation - Sheffield/Ghana*** *- Long-standing peer mediation programme*
*High Storrs secondary school in Sheffield set up a peer mediation programme in 1998. Groups of students volunteer to be trained as mediators and are then available to help their peers resolve conflicts including bullying, in school. Two of the feeder primary schools (Greystones and Hunters Bar) have also started peer mediation programmes.*

*Ten partner schools in Zebilla, Ghana are able to share their expertise, having been involved in peer mediation schemes for years. The programme there was started by Action Aid as part of a peace education initiative. They have established peace clubs and students stay after school to learn about mediating, which parents have supported.*

*Teachers from Ghana visited Sheffield in 1999 and staff from the UK made a return trip to Ghana in March 2000. The results in all schools are promising*

## *Case Study 14: Peer Led Street Cred, Sunderland, UK*

*A major education objective of drug prevention work in the City of Sunderland, is to minimise the adverse consequences associated with the misuse of substances. As part of the City's drug strategy, Peer Education was identified as a feasible methodology to empower young people. It was decided that a multi-agency approach would be beneficial to incorporate the wide wealth of skills and expertise needed to implement, and run a peer education project. Education and Community Services, Priority Healthcare Wearside's Health Promotion and Education, Tyneside Youth Theatre and workers from Priority Healthcare Wearside's Community Addiction Team all participated in partnership with each other.*

*A target area was identified and the wheels of a pilot project were set in motion. Through face-to-face workers in six youth centres, twelve young people, (two representing each centre) were invited to learn more regarding drugs and alcohol, and become educators in their peer groups which had been formed. A residential training weekend was organised to ensure group cohesiveness, establish support networks and of course to deliver the training and practice the skills required to educate other young people. During the weekend inter-active sessions using drama, games, videos and participatory learning were utilised to cover knowledge and skill based learning. Drug and alcohol education was covered in-depth, with young people using self directed learning to establish what information young people need, and want to know regarding drug issues.*

*The young people identified and prioritised the information they felt would be most useful to them in their area, and that their participation in the programme involved them having the power to determine in which direction the group would head. Once the group had completed the weekend they were confident in relation to basic drug and alcohol knowledge. Issues around communication and reflexive listening skills had been explored and the young people were clear of their role and support network. Upon their return to their youth centres, the trained young people could pass on factual information to their peers through an 'informal grapevine' approach, as well as give drug education leaflets and cards out with local drug agencies numbers on. The peer educators are not counselors, advisors or 'drug experts', they are information givers, who aim to empower other young people to make an informed choice when dealing with decisions regarding drugs and alcohol.*

*Initially, monthly support meetings were held so the group could feedback any information they had passed on, and to offer support/supervision to each other. It was decided that a tool for recording*

*and monitoring information was required, so a diary was designed, enabling the peer educators to write down in a simple format the age of the person asking for information, what drug they asked about, the information given and how the peer educator felt after being asked. The pilot group grew stronger and developed into an enthusiastic, committed and keen to learn group, who began to challenge the more traditional methods of drug education.*

## 4.6 Elements of the Models to Use in North Clondalkin

As mentioned it is necessary to consider or 'cherry-pick' some elements of these models and case studies examined in order to develop a suitable model that meets the North Clondalkin needs and takes account of the local structures. Partnerships and alliances, community development approaches to health, primary health care initiatives (involving communities) and peer-led approaches have been discussed. It is clear from these successful projects and initiatives discussed that the community health project in North Clondalkin should try to incorporate the following approaches and elements drawn from the case studies and models examined:

- There is a need to develop structures and processes which involve the necessary stakeholders in health and using the principles of partnership working, consultation, participation and involvement in decision making (by the citizen), as the health alliances and partnerships do. This should take account of health inequalities and of the social determinants of health and involve not only health providers and health consumers, but also local authorities, education and training authorities, regeneration agencies and the community and voluntary sector.
- Community development is recognised as a successful way to tackle inequalities in health by using the energy and leadership of the people who live there. It recognises the central importance of social support networks and allows the community to define its own health needs to bring about change. The use of community development approaches to health will enable people to have a say in how health and other related services are planned and delivered in North Clondalkin, which will meet the needs identified by the community.
- The approaches to primary care in Scotland through the Local Health Care Co-operatives and the Healthy Living Centres in the UK, highlight the value of bringing health care specialists and community based health promotion and prevention activities together in a local setting to meet the health needs of disadvantaged communities. They also recognise the need to tackle the broader determinants of health and of the need for multi-disciplinary and multi-agency working at a local level. The North Clondalkin approach to primary care should incorporate these elements and build on the Scottish and UK experience.
- Peer led approaches to health for disadvantaged communities and for particular groups such as young people and Travellers has been shown to be successful in the case studies examined. Using peer-led approaches to health promotion and health information are likely to be successful in North Clondalkin and will build on the community involvement in the project to date.

These four elements and the approaches outlined above have been used to develop a community health model for North Clondalkin in section 5.

# PROPOSED OPERATIONAL MODEL FOR COMMUNITY HEALTH IN NORTH CLONDALKIN

# PROPOSED OPERATIONAL MODEL FOR COMMUNITY HEALTH IN NORTH CLONDALKIN

## 5.1 Introduction

This section of the report proposes an operational model for community health in North Clondalkin. It draws together the main findings of the research and sets out specific health needs of the area, the main objectives of the model, the principles by which the model will operate, as well as the actions to be implemented and outcomes and indicators to be measured. A structure detailing the membership/involvement of groups and organisations in the model and showing its relationship with external agencies/bodies is also proposed.

## 5.2 Aim and Objectives

### 5.2.1 Aim

The overall aim of the proposed model is:
To address health inequalities and inequity of access to health services in North Clondalkin, through the use of community development approaches and principles, thereby achieving equality and equity of health outcomes.

### 5.2.2 Objectives

The four 'important objectives' of the model have been developed using the findings in section 12.3 (which details how to address the health inequalities and inequities in North Clondalkin) and section 3.4 (which summarises the main health needs to be addressed in North Clondalkin). The main elements of the model build on the consultative and participative processes to date in the area and take cognisance of the national health policy context.

1. **To build on the consultative and participative processes to date**
   As already discussed in the report a great deal of consultation and participation has been done in North Clondalkin in order to assess health needs in the area. Community involvement and the use of participative techniques and approaches have been very successful and highly regarded as a model of good practice. It is important that the community health model that is developed and implemented builds on community involvement to date through the use of consultative and participative approaches to health needs assessments, to health promotion activities, to service delivery and to the implementation of actions and initiatives (whether solely or in partnership with others). The use of community development approaches and peer-led approaches will ensure that community involvement is sustained.

2. **To recognise the broader 'social determinants of health' model**
   In the work and consultations to date the broader determinants of health, such as housing, environment, education, etc. have been identified through consultation processes. In addition the 'Social Determinants of Health Model' highlights the impact of the social, environmental and economic factors on health that can lead to inequalities in health. In order to address these broader issues and to have an impact on health inequalities, those agencies and groups responsible for these areas of work must be involved in developing strategies and actions, with the community. A multi-agency and partnership approach will be necessary involving the local authority, the local community, service providers involved with children and youth, education, training and employment.

3. **To compliment government heath policy principles**
   Recent government policies and approaches have some common themes emerging which are relevant to community based approaches to inequalities in health in general and for the community in North Clondalkin. The model proposed for North Clondalkin will compliment the main themes emerging which are:

- **Equity** - the recent health policies refer to equity and fairness as a principle underlying how health services will be delivered.
- **People having a say** - the involvement of the consumer is emphasised throughout, whether through costumer panels, community involvement in primary health care units or the partnership and peer-led approaches to Traveller health.
- **Culturally appropriate services for particular groups** - the Traveller Health Strategy, the Health Strategy and the Primary Health Care initiative refer to the need to provide training for staff and to reorientate services to ensure that health services are delivered in culturally appropriate ways.
- **Primary health care** - providing services locally in an accessible way, which will take the pressure off specialist and secondary health services is emphasised.
- **Community development approaches** to health are an integral part of the approaches to Traveller health and also arose out of the NAPS and Health review as a way of targeting socially excluded groups.
- **Tackling inequalities** in health is an important aspect of all the national health policies outlined.

4. **To tackle health inequalities and inequities by doing the following:**
   There is a need for a broader multi-sectoral approach to reducing poverty and inequalities in health which recognise the determinants of health that lie outside clinical health care. The NAPS and Health consultations process highlighted the needs and gaps which will address issues of inequality and inequity. It is important that the North Clondalkin model tackles health inequalities and inequities in the following ways:

- By having an input into reorienting health services locally and regionally in order to make them accessible for the people of North Clondalkin.
- By having an emphasis on health promotion - through the use of peer-led approaches and by having an input into the Health Board's Health Promotion Strategy and Health Promotion Committee.
- By facilitating and supporting consultative and participative approaches to health in the area.
- By promoting equity of access to health services for people of the area.
- By targeting particular groups in North Clondalkin who are experiencing health inequalities and inequities. Particular emphasis should be placed on targeting minority groups including Travellers, minority ethnic groups and people with disabilities.
- By addressing child health inequalities and health needs through the promotion of safe environments, education, childcare, etc.

## 5.3 Health Needs to be Addressed by the Model - The Main Action Areas

As the research highlights, there are many health needs in North Clondalkin which have been highlighted through consultations with the community and through other initiatives. There is statistical information which highlights the main causes of the higher mortality rates in disadvantaged groups. Finally, the health needs assessments of other disadvantaged areas raise additional health issues which could be addressed in order to tackle inequalities and inequities in the North Clondalkin area.

Using all of this information, this section develops four main areas of health need to be addressed or tackled by the proposed model. They are as follows:

1. **Disease reduction and prevention**
   These are the main causes of death and higher mortality rates in less well off people. *'In Ireland as in other developed countries, the poor and disadvantaged experience more ill-health and have a lower life expectancy than those from higher socio-economic groups"*. [3] The 4 main causes of death which are significantly higher for the less well of are:

- Circulatory disease.
- Cancers.
- Respiratory diseases.
- Injuries and poisonings.

For this reason the model will use health promotion and health information approaches and peer-led education programmes in order to improve early detection, to increase uptake of screening services and to improve equity of access to screening and treatment for these diseases.

2. **Improved child health**
   Aspects of child health are more appropriately targeted at parents for such things as vaccinations, developmental matters, screening, disease prevention, etc. Others are more appropriately targeted at the children themselves using appropriate techniques. The health needs in relation to children to be addressed by the model will be the prevention of accidents and injuries, by developing and using programmes in relation to improving safety in the home, play safety and road safety.

3. **Addressing broader / social health needs**
   In recognition of the social determinants and the needs expressed particularly in *Community Planning for Better Health*, the model will address broader health needs of the community in partnership with relevant agencies such as the local authority, education providers and the Garda Síochána in the area. Broader health needs to be addressed / influenced are:

- Accommodation (including homelessness and overcrowding)
- Environment (traffic, pollution, litter, etc.)
- Safety (including policing and crime)
- Education (pre-school, early school leaving, etc.)

4. **Addressing gaps in health infrastructure**
   There are four main health needs for North Clondalkin which can be categorised into 'gaps in health services / infrastructure', which the model can address. They are:

- Development of a Primary Care Unit for North Clondalkin, which incorporates community involvement in design and delivery of services (through a local community health forum).
- Supporting the development of a GP network for the area, which will mean greater access to specialist services for people from the area.
- Greater use and access to Rowlagh Health Centre.
- Attracting specialist clinics to the area, e.g. local well-woman, well-man and teen-health clinics.

## 5.4 Target Groups

In order to address the health needs detailed above, the model will target five main groups through its actions and initiatives. They will consist of the groups detailed below with types of approaches to be used shown.

- **Parents** (targeted for parenting courses and child health promotion).
- **Women** (targeted for health living programme*(4)*, screening services and stress reduction*(5)*).

- **Young people** (targeted for drug prevention, sexual health).
- **Children** (play safe, safety in the home and road safety programmes).
- **Men** (targeted for healthy living programme, screening services and stress reduction).

## 5.5 Principles

The model will adhere to the following principles which take account of the objectives, the health needs and the models of good practice (discussed in Examination of Models in section 4).

- Using community development approaches to involve communities in decision making, and in identifying health needs and priorities.
- Using partnership approaches.
- Using holistic approaches in order to tackle the broader determinants of health.
- Working towards the development of primary health care approaches in North Clondalkin.
- Tackling health inequalities and inequities in access to health.
- Using peer-led approaches to health promotion activities and health needs assessments.

## 5.6 Implementation Structure

The proposed structure for the community health model in North Clondalkin builds on the involvement of the community and of the agencies to date. In order to achieve the objectives outlined in 5.2.2 it will be necessary to broaden out the existing group in order to establish a local health partnership / alliance. It will also be necessary to establish a 'local community forum' which will have an input into the development of any future primary health care unit in the area. Each group is discussed below. A graphical representation of how the structure will work with the main actions, activities and strategic links of the partnership is shown in Figure 5.

### 5.6.1 Local Community Health Partnership / Alliance

The main partners in the local community health partnership / alliance will be:

- Quarryvale Community House
- Clondalkin Traveller Development Group
- Local health community forum representative (described in 5.6.2)
- Clondalkin Area Partnership (Community Development and Youth representatives)
- The South Western Area Health Board (Social Inclusion Manger)
- Rowlagh Health Centre (Public Health Nurse)
- South Dublin County Council (Community Department)
- General Practitioner from the local area
- North Clondalkin RAPID AIT

The partners in the model will form the Steering Group / Board of the partnership / alliance and can decide whether to establish as a company limited by guarantee (with charitable status) or to be an unincorporated entity, once it has been formed. The partnership Steering Group / Board can establish sub-groups once it has agreed an action plan. Sub-groups could be formed to take actions forward. For example, if a community safety programme is being developed, the involvement of the Gardaí will be required and for targeting children, the school and childcare providers will need to be involved.

### 5.6.2 Local Community Health Forum

The objective of this part of the structure is to establish a community health structure which will fulfil the 'community representation / involvement' requirements of the Primary Health Strategy. It will bring community representation together from the North Clondalkin area and will be supported by the local community health partnership / alliance. There will be a two way flow of information between the forum and the proposed Primary Health Care Unit and between the forum and the

community health partnership / alliance. This is to ensure that any health research, consultations and peer-led approaches (to health information / health needs assessment / health promotion) are shared with the community forum.

Membership of the local community health forum will be drawn from the Community Development Projects (CDPs) in the area including:

- Quarryvale Community CDP
- North Clondalkin CDP
- Ronanstown Women's Group
- Clondalkin Traveller CDP
- Women's Network Core Group

**5.6.3 Strategic Links**

The local community health partnership / alliance should aim to develop communication links and working relationships with the both local and national initiatives involved in supporting and developing community health initiatives.

Local initiatives in South Dublin to link with include:

- South Western Area Health Board Health Promotion Committee
- North Clondalkin RAPID
- South Dublin County Development Board
- The Youth Working Group of Clondalkin Partnership
- Clondalkin Drugs Task Force

It is possible that a national network of community health projects will be developed over the forthcoming period. The involvement of the North Clondalkin health partnership in this network will be of value in terms of sharing of information and experience. In the meantime, informal links with NICHE and Glasgow are advisable.

National initiatives to link with include the following:

- CAN - developing resource pack
- Combat Poverty Agency - building healthy communities programme
- Health Linkage Group - national community and voluntary pillar
- Community Workers Co-operative
- National Primary Health Care Initiative, Steering Group
- Public Health Alliance

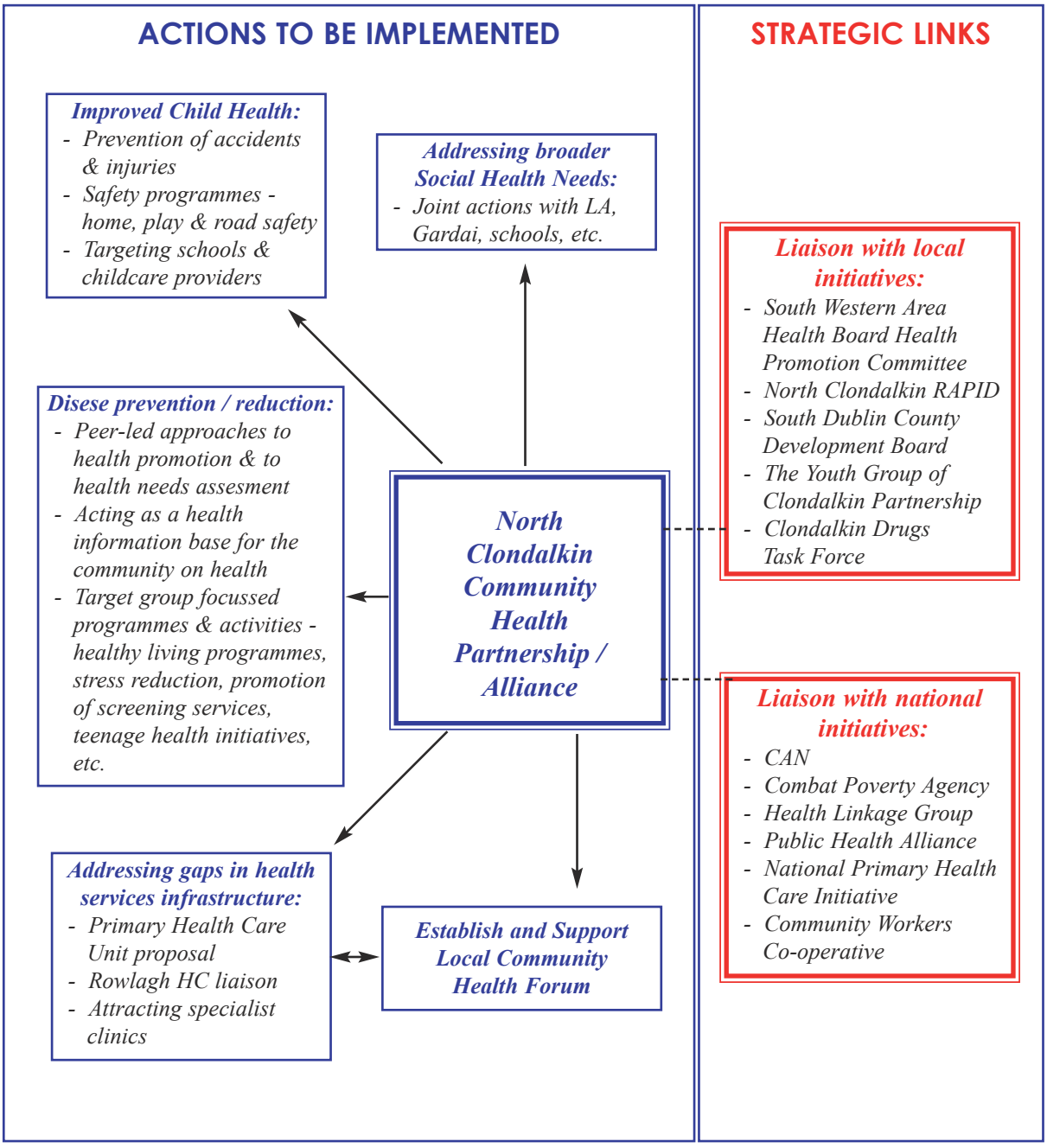
## 5.7 Making the Case for Implementing the Model

This research report is lengthy and in parts quite 'technical' and complex. It examines inequalities and inequities in health in its broadest sense and looks at the particular geographic area and community of North Clondalkin. It also looks at responses to health inequalities, inequities of access and to the needs and gaps highlighted by the local community. Having examined models being used elsewhere, it applies successful and appropriate elements of these models to the proposed operational model for community health in North Clondalkin

The model proposed is strategic in its approach. It recognises the need to tackle gaps in infrastructure in partnership with health service providers and health professionals in the area. It also incorporates community development and peer-led approaches to all action areas, thereby building on community involvement to date. Through its objectives, its cross-sectoral partnership structure, its strategic alliances and through its action areas, the operational model aims to address the broader determinants of health. In addition, it recognises the importance of health promotion and prevention

in reducing health inequalities, improving access to services and ultimately in improving health and reducing mortality rates for the people of North Clondalkin.

*Figure 5 Health Partnership Actions and Strategic Links*



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# GLOSSARY

| | |
|---|---|
| CAN | Community Action Network |
| CDB | County/City Development Board |
| CDP | Community Development Programme |
| CPA | Combat Poverty Agency |
| DED | District Electoral Division |
| ESRI | Economic and Social Research Institute |
| FÁS | Foras Áiseanna Saothair - National Training and Employment Authority |
| GMS | General Medical Services |
| GP | General Practitioner |
| HAZ | Health Action Zones |
| HIMP | Heath Improvement and Modernisation Plan |
| NAHB | Northern Area Health Board |
| NAPS | National Anti-Poverty Strategy |
| NHS | National Health Service |
| NICHE | Northside Community Health Initiative |
| NICHE | North-side Initiative for Community Health |
| PRA | Participatory Rapid Appraisal |
| RAPID | Revitalising Areas by Planning, Investment and Development |
| SWAHB | South Western Area Health Board |

*(1)* For the purposes of the Health Strategy, primary care is defined as 'an approach to care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services. The services provide first-level contact that is fully accessible by self-referral and have a strong emphasis on working with communities and individuals to improve their health and social well-being.' [4]

*(2)* Secondary care refers to specialist services which may be either community or hospital based. [5]

*(3)* The population of Clondalkin - Moorfield changed by -6.3% in the period 1996-2002 and by -14.2% in the Clondalkin - Rowlagh area. Applying the average decrease of -10% for the 2 neighbouring areas it can be assumed that the population of Quarryvale has decreased by a similar amount between 1996-2002 and that the population of Quarryvale in 2002 was in the region of 2,340.

*(4)* Healthy living programmes could include smoking cessation, healthy eating (diet and nutrition), exercise programmes.

*(5)* Stress reduction programmes should incorporate alternative therapies appropriate to particular needs.

# APPENDIX I
# Interviewee List

*Table 9 Interviewee List*

| Name | Organisation |
|---|---|
| Colin Thunhurst | UCC, Department of Epidemiology |
| Professor Ivan Perry | UCC, Department of Epidemiology |
| Margaret Maher | Clondalkin Area Partnership |
| Aileen O'Donoghue | Clondalkin Area Partnership |
| Rosetta Dempsey | Quarryvale Community House |
| Pauline Farrell | Quarryvale Community House |
| Angie Daly | Combat Poverty Agency |
| Maeve O'Sullivan | North Clondalkin RAPID Co-ordinator |
| Therese Howley | Clondalkin Traveller Development Group |
| Padraig Rehill | South Western Area Health Board |
| Peter O'Neill | South Western Area Health Board |
| Enda Barron | Clondalkin Drugs Task Force |
| Fidelma Twomey | Clondalkin Area Partnership |
| Eifion Williams | South Western Area Health Board |
| Siobhan Murphy | South Western Area Health Board |
| Pauline Bryan | South Western Area Health Board |
| Brigid Quirke | Pavee Point |
| Dr Liam Lynch | GP, Neilstown, Clondalkin |

# APPENDIX II
# Web Based References

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http://www.himp.net/2001-4/welcome.asp?about=about

Case Study 2: Health Action Zones in the UK
http://www.haznet.org.uk/`

Case Study 3: Local Health Alliances in Wales
http://www.hpw.wales.gov.uk/wahpdlha_e/scripts/fe_lha/lhadetails_details/lhadetails_list.asp

Case Study 4: Glasgow Healthy Cities Partnership
http://www.glasgow.gov.uk/healthycities/
http://www.glasgow.gov.uk/healthycities/com_health_pro/devmap.htm

Case Study 6: Cardiff Local Health Group Llanrumney Healthy Living Centre
http://www.wales.nhs.uk/lhg/page.cfm?orgid=262&pid=1383

Case Study 7: Greater Easterhouse Community Health Shop
http://www.glasgow-alliance.co.uk/news-printme.asp?ItemID=67
http://www.scotland.gov.uk/cru/kd01/blue/imss-10.asp

Case Study 8: Eastern Glasgow Local Health Care Cooperative
http://www.show.scot.nhs.uk/ggpct/coop/eastern.htm

Case Study 9: The Anniesland, Bearsden and Milngavie Local Health Care Cooperative
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Case Studies 10&11: Healthy Living Centres
http://www.nhsetrent.gov.uk/ph/hlc/hlc3.htm

Case Study 13: Youth Peer education Initiatives in the UK
http://www.citfou.org.uk/local/cs_cat13.php4

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http://www.advocatesforyouth.org/publications/iag/peer_led.htm

# APPENDIX III
# The Peckham Experiment

In 1935, two pioneering doctors opened the Pioneer Health Centre in Peckham, South London. Their aim was to conduct a huge experiment into the effect of environment on health. The Pioneer Health Centre (usually known as the Peckham Health Centre) was a bold departure in the medical field in the 1930s, concentrating on a preventative, rather than a curative approach to health. In order to facilitate their grand project, the two doctors housed their centre in a purpose built Modern building, creating an early example of how new architectural techniques could help further bold new social experiments.

George Scott Williamson and Innes Pearse were a husband and wife team who believed that an individual's social and physical environment could decisively affect his or her long-term state of health.

Nine hundred and fifty families signed up to be part of 'the Peckham Experiment'. For one shilling a week, they relaxed in a club-like atmosphere: physical exercise, games, workshops, or even simple relaxation were all encouraged. All the time they were observed by Williamson & Pearse, and their team of doctors. There was no set programme of exercise at Peckham, and members were obliged to attend a thorough medical examination once a year. [48]

"Health in Quarryvale is not just about 'medical' issues; it is about the physical, psychological, emotional and spiritual well-being of the people living in the area. Simply treating the symptoms of poor health without dealing with the root causes is therefore insufficient."

*Mission Statment - Clondalkin Partnership*
*Health Sub-Group*