A partnership approach to health promotion: a case study from Northern Ireland

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SUMMARY

In recent years there has been a renewal of interest in community development and partnership approaches in the delivery of health and social services in Northern Ireland. The general thrust of these approaches is that local communities can be organized to address health and social needs and to work with government agencies, voluntary bodies and local authorities in delivering services and local solutions to problems. Since the Ottawa Charter was launched in 1986, government in Northern Ireland has stressed that community development should no longer simply be added on to key aspects of Health and Social Services, but should instead be at the core of their work. There is increasing consensus that traditional approaches to improving health and well-being, which have focused on the individual, are paternalistic and have failed to tackle inequalities effectively. Partnerships within a community development setting have been heralded as a means to facilitate participation and empowerment. This paper outlines the policy background to community development approaches in health promotion and delivery in Northern Ireland. Drawing on evidence from a case study of a community health project it highlights the benefits and difficulties with this approach. The findings suggest that partnerships can positively influence a community's health status, but in order to be effective they require effective planning and long-term commitment from both the state and the local community.

Key words: community; empowerment; health promotion; partnerships

INTRODUCTION

Since the early 1990s, community development has been reinvented and is now depicted as having the potential to play a key role in welfare intervention policies. At the heart of this resurgence is the belief that if social intervention of any form is to have a chance of success, it must take into account the views and opinions of the communities in which the intervention is taking place. Traditional, individualistic methods of delivery of health care have failed to tackle inequalities effectively. It is now widely accepted that strategies that are imposed on reluctant communities are doomed to failure (Davies, 1999). The Alma Ata declaration of 'Health for All' (WHO, 1978) claimed that new approaches were needed to achieve complete health globally by the year 2000. It was suggested that these approaches should be based on a re-orientation of the health services towards primary care and the development of collaboration between statutory, voluntary and community sectors. Since these principles were reiterated in the Ottawa Charter for Health Promotion (WHO, 1986), there has been increasing emphasis on developing approaches to health promotion that tackle the broader social, economic and environmental determinants of health (Gillies, 1998). Approaches that aim to empower communities to identify their own health needs and facilitate ways to address those needs have gained broad acceptance (Drennan, 1988; Webb, 1994; Davies, 1999). This paper begins

with a brief outline of the structure of health care delivery in Northern Ireland and then sets out the policy culture that has led to the re-emergence of community development approaches. It then reports the findings from a case study of a community health project based in the Creggan area of Derry City in Northern Ireland. The main aim of the study reported was to identify the key issues that emerged during the establishment of a partnership between statutory health providers and the community and voluntary sectors, and to assess how they could inform future initiatives.

Delivery of health care in Northern Ireland

In 1972, 4 years after the beginning of the most recent period of 'troubles' in Northern Ireland, the British government removed power from local politicians and imposed direct rule from Westminster. Control over social services such as health, housing and education was taken from local government and placed in the hands of centralized administrative bodies. The Department of Health and Social Services (Northern Ireland) is responsible for the provision of health, personal social services and social security. Four area health and social services boards are responsible for the administration of both health and personal social services, unlike the system in Britain where local authorities are responsible for personal social services. These boards were designed to distance statutory health and personal social services from violence and sectarianism, and to ensure that services were delivered in an impartial, fair manner (Pinkerton, 1998). Hospital and community services are provided by 19 health care trusts and five health care agencies (see Figure 1).
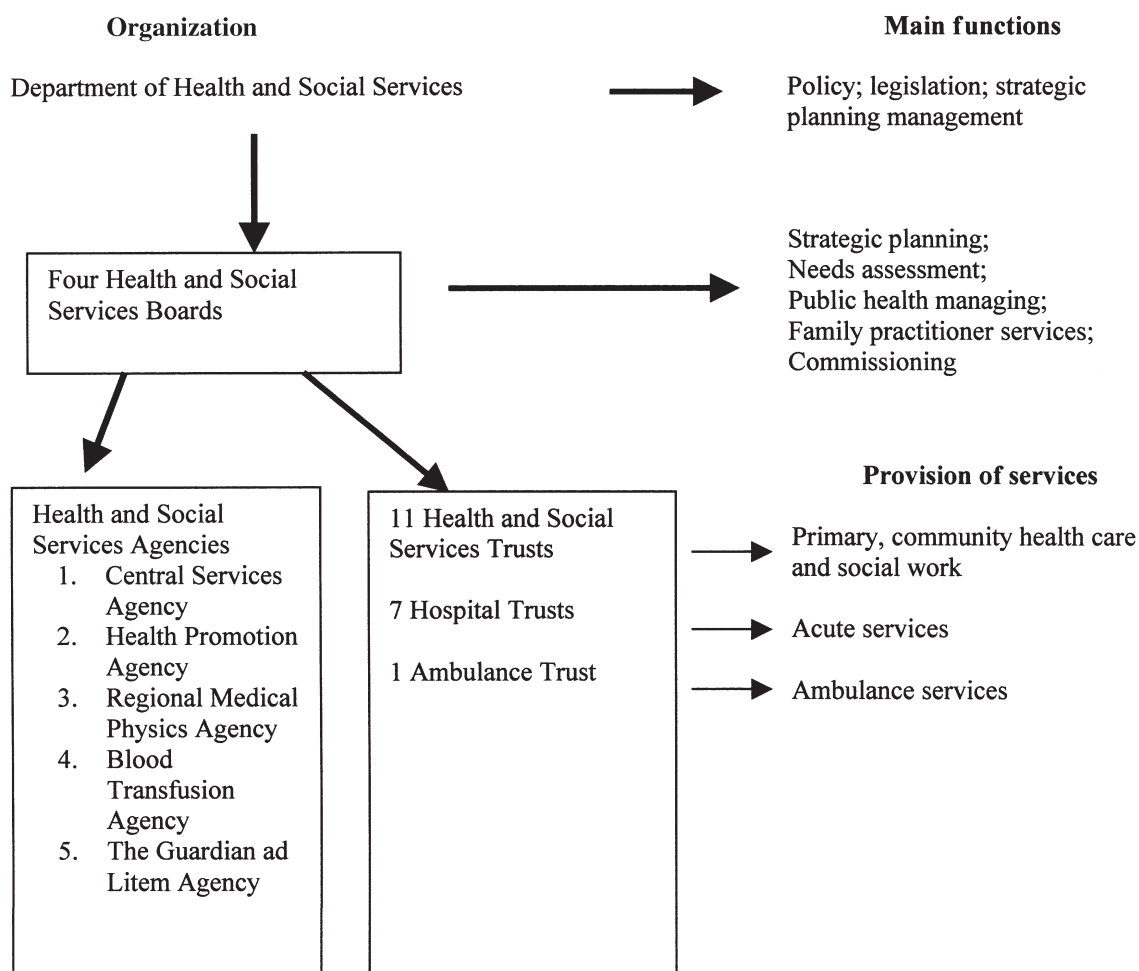
The centralized and bureaucratic organization of statutory social services in Northern Ireland has led to health care work within communities becoming an extremely marginalized activity, afforded a very low priority. This administrative system has been widely condemned as technocratic, remote and divorced from local communities (Caul and Herron, 1992; Campbell *et al.*, 1995; Traynor, 1998). In the last decade, however, there has been a resurgence of community development approaches within statutory health and social services, and a focus on partnerships with voluntary and community groups. The impetus for this change has come from a range of influences and these are briefly discussed in the next section.

The policy context

Within the UK, partnerships have been heralded as a new model for local governance as they reflect the changing relationship between the state, the market and civil society (Geddes, 1997). In the context of Health and Social Services, government in Northern Ireland has explicitly stated its desire to see community development, through partnerships, encouraged and supported. In 1993, the Voluntary Activity Unit was established with the Department of Health of Social Services to promote community development. At the launch of this unit, government stated that community development had the potential to make a major impact on a wide range of policies and programmes delivered by both statutory and voluntary agencies.

Attempts to mainstream community development approaches in the core work of the Department of Health and Social Services (DHSS) derive from policy changes in the late 1990s. In 1997, the DHSS regional strategy included a policy and plans to include community development methods in the remit of Health and Social Services. It stated that, where possible, the Health and Social Services Boards should promote and employ community development approaches to target social and health needs. It emphasized the importance of partnerships with local people in the planning, development, delivery and evaluation of social services. This report stressed that community development should be mainstreamed into health programmes and not added on as an afterthought (DHSS, 1996).

This commitment to community development approaches was reiterated in the DHSS document entitled *Mainstreaming Community Development in the Health and Social Services* (DHSS, 1999), which stressed the government's commitment to see community development 'extended, strengthened and promoted' throughout Northern Ireland. It was claimed that a rigorous application of a community development approach would advance social justice goals and social inclusion. This document highlights the importance of a culture change to ensure that community development is embedded into mainstream health and personal social services planning and the service delivery process. It stresses the need for a reorientation in senior management away from a process of 'providing for' towards a process of 'working with' local communities.

Organization   **Main functions**

Department of Health and Social Services   →   Policy; legislation; strategic
                                                 planning management

Four Health and Social   →   Strategic planning;
Services Boards   Needs assessment;
                               Public health managing;
                               Family practitioner services;
                               Commissioning

                               Provision of services

Health and Social   11 Health and Social   →   Primary, community health care
Services Agencies   Services Trusts   and social work
  1. Central Services
     Agency   7 Hospital Trusts   →   Acute services
  2. Health Promotion
     Agency   1 Ambulance Trust   →   Ambulance services
  3. Regional Medical
     Physics Agency
  4. Blood
     Transfusion
     Agency
  5. The Guardian ad
     Litem Agency

Fig. 1: The structure of the national health service in Northern Ireland.

METHODOLOGY

Given that the statutory and community sectors working in partnership in the area of health promotion is unusual in Northern Ireland, the main aim of this study was to assess the dynamics of this method of working and identify issues that may inform future projects. In order to set the study in context, a wide range of secondary sources (see Table 1) was consulted. As the research was largely exploratory in nature, a qualitative research method was considered to be most appropriate as it enabled the researcher to ascertain the views and perceptions of those who had been directly involved with the project (Janesick, 1994). Semi-structured interviews were

Table 1: Main secondary sources

No.	Source
1.	Townsend *et al.*, 1988
2.	Murtagh and Maginn, 1995
3.	Creggan Neighbourhood Partnership, 1996
4.	CHIP, 1997a
5.	CHIP, 1997b
6.	Lazenbatt, 1997
7.	CDWG, 1999
8.	CDHN, 2000
9.	McShane, 2000

undertaken with 16 key players in the project, from a range of statutory, voluntary and community backgrounds. These individuals were contacted by the researcher and all agreed to

participate in the study. All of the interviews were undertaken by the researcher, and were tape-recorded and transcribed immediately afterwards. The interviews lasted on average 45 min. The participants were asked to reflect on their involvement in the project and to discuss the main advantages and disadvantages of the model, and to identify lessons for future projects. The respondents included the Director of Social and Health Care in the Western Area Board, the Director of Social Care in the Foyle Trust, the Programme Manager of Health Care in the Trust, the health visitor who was the driving force behind the project, two other health visitors, the manager of the Creggan Health Information Project (CHIP), two nurses working part-time in CHIP, and seven community and voluntary workers. The data were analysed using thematic analysis, which involved identification of themes and categories from the interviews (Lincoln and Guba, 1985). Findings are reported through summaries of themes illustrated by direct quotations.

Background to community development approaches in the Foyle Trust

Foyle Health and Social Services Trust provides health and social services to a population of 160 000 in the Western Area Health Board. Neither the Health Board nor the Trust has a written commitment to advancing community development approaches. The majority of references to community development are in the context of health promotion, yet work in this area has been described as largely based on the medical model, focusing on individual issues such as immunization, smoking and tackling ill health. Notwithstanding this lack of a formal policy, the board has a long-established history of work with community and voluntary groups [Community Development Health Network (CDHN), 2000]. Following the World Health Organization identifying the movement of health care into the community as a key objective, in 1993 the then Director of Health Care decided to re-designate responsibilities for a number of the Trust's health visitor posts. Five of the Trust's 40 health visitors were moved out of their traditional health visiting roles and became community-based. This was a move designed to represent a shift away from a traditional mother and child focus, which had dominated health visiting, towards a more participatory view of health promotion (CDWG, 1999). One of these health visitors was allocated to the city side of

Derry, where she was given responsibility for a number of deprived inner city areas. Her main focus, however, was on the Creggan area as this was where she had contacts and felt that she could make the biggest impact.

The Creggan area of Derry has been identified as one of the three poorest wards in Northern Ireland (Townsend *et al.*, 1988). It is one of the largest and oldest public housing estates, with a population of ~11 000 people. The three main electoral wards of St Peters, Creggan Central and Creggan South are ranked the first, second and third of the most deprived areas, respectively, with respect to extent of deprivation out of a total of 5666 wards in Northern Ireland. Male unemployment ranges from 44% to 58% across the electoral wards for the area (Lazenbatt, 1997). Similar to many other areas in Northern Ireland marked by severe levels of deprivation and poverty, a vibrant community development ethos exists. The number and variety of community groups that exist in the area evidence this tradition of self-help [Murtagh and McGinn, 1995; Creggan Neighbourhood Partnership (CNP), 1996]. Following several public meetings to address health concerns, a cross-sectoral partnership, which became known as the Creggan Health Information Project, was formed in 1993. At these initial meetings it was very apparent that there was much hostility amongst the local population to the idea of a partnership with the statutory health authorities. They were sceptical about the health authorities' motives or their commitment to working at a local level. Interestingly, the local community perceived their problems to be social and economical, but had not really considered how they could be addressed from a health perspective (CDHN, 2000).

Despite this inauspicious beginning, ~30 people agreed to form a working group to take the project forward. The overall aim of the project was 'to put health on the agenda for the community'. The following key principles were identified by the community as central to the project:

- active community involvement in the giving and receiving of information;
- empowerment of local people through capacity building;
- a commitment to training and the sharing of skills;
- community management and ownership of the project; and

• partnerships between statutory services and the community.

CHIP was designed to create a core group of local people with knowledge or expertise in health issues. Skills are acquired through capacity building and training programmes, and rather than simply provide their skills, experts trained and supported others (McShane, 2000). The project was based on a partnership between the health and social service professionals, and community and voluntary workers. There are currently ~150 core members with expertise in a wide range of health issues. The project has stressed the need for the community to take ownership of their own health needs; individuals are no longer passive recipients in their health care, but can actively direct and influence the delivery of services.

Over 1000 people have attended CHIP information sessions, conference health festivals and courses. Many of the courses have been described as stepping stones to enable further development as they have enabled the community to identify their health needs (CDWG, 1999).

RESULTS

From the interviews and examination of secondary sources, three key themes emerged: the need for strategic planning, the contested nature of partnerships and sustainability.

Strategic planning

Despite the fact that the DHSS have stated their commitment to a radical change in how services are delivered, within the Foyle Trust there were no strategies designed to facilitate this shift. The management of the Trust described their part in delivering this needs-led service as moving the five health visitors into the community and giving their support to community initiatives. It was claimed that giving the health visitors the freedom to develop strategies, which incorporated a focus on community health, was tangible evidence of a shift in emphasis. The Director of Health and Social Care noted that this was a radical move, which was unprecedented in Northern Ireland:

The health visitors were freed up from their traditional roles to explore the possibilities of developing health projects within the community. It was a bold move that demonstrated a willingness to change.

The health visitor involved in this project agreed that in many ways it had been an innovative move, but claimed that the lack of an overall strategy or any training for this fundamental change had initially obstructed progress.

We were just told to go out and be innovative. There was no strategic thinking and during our first year in the community we realized that we knew nothing. What was clear was that we would have to tap into other networks already working in this area.

One of the community workers from the Creggan area also stressed that the Trust had no long-term vision and had approached this development in a very haphazard way. He acknowledged that the development was a welcome one, but one whose success depended on it being driven by the interested parties in the community.

Initially there had been some scepticism amongst the local community; many were reluctant to be seen as a testing ground for the latest idea. There was real resistance to the idea they were simply passive and dependency orientated, waiting to be drip-fed the latest idea from the State.

One of the volunteers stated that initial discussions were difficult because on the one hand they liked the idea and had been calling for more community involvement for years, but on the other hand there was a fear that they were being used. The fact that this seemed to be a way for the Trust to be addressing health targets rather than a clear strategy for enabling marginalized communities to become involved in decision-making did cause some concern.

There was a feeling that enabling the community to identify their own health needs was just pie in the sky. They had no aims, no objectives; they didn't have a strategy, they just parachuted in a health visitor and hoped for the best.

Whilst senior management in the health and social care sector had supported staff to refocus their activities on community work, there was some degree of scepticism within the community that they were fully committed to this approach. There was inevitable tension between the two groups and whilst those in the statutory sector claimed that the existence of this project was proof of their commitment within the community and voluntary sector, it was suggested that there was a lack of visible support for a change in direction.

As one voluntary worker quipped 'They can talk the talk but won't walk the walk'.

The contested nature of partnerships

Many of the difficulties encountered by the project surrounded the different expectations of the groups who had formed this health partnership. The concept of partnership was central to the development of local community health strategies and it underpinned this initiative. Yet as the project progressed some of the community groups began to question the extent to which the statutory sector was serious about this partnership approach. The manager of CHIP explained these doubts:

There was a belief in the community that we had entered into a partnership, there was a real feeling of ownership, but no real sense of having control or power.

On the one hand the statutory sector claimed that they had actively promoted user involvement and participation, and on the other hand those in the voluntary and community groups suggested that much of the power and control had remained with the Trust; consequently the partnership was not equitable. Both the community groups and the practitioners had a stake in local health planning and practice, but each had their own particular agendas. Fairly quickly it became apparent that partnership itself was a contested term. At a community level, partnership was seen as a collective response to addressing problems of social exclusion and poverty. At a Trust level it was seen as an opportunity to involve the community in addressing local health needs, but within the constraints of their legal obligations. The tensions surrounding this partnership also caused difficulties for the professionals involved with the project. As one of the nurses explained, accountability was an issue:

For the first time there was a sense of actually achieving something, you know making a difference. But it was also frustrating, you are answerable to the management of the Trust and to the local community, and it is not possible to please everybody. I just ended up as piggy in the middle.

This issue was also commented on by a health visitor:

Sometimes it was a no-win situation. I was either a traitor in the community or my colleagues in the health service were accusing me of having gone native.

The inherent tensions in this new partnership were particularly evident during a health needs assessment. In order to identify fully the health needs of the community, CHIP undertook a participatory action research programme, which involved research being conducted, produced and presented by local people, supported by a small number of community, voluntary and public sector representatives. A key component of the research method was the identification of those households with children under the age of 5 years. It had been agreed that the Trust would provide this information from their social services database. At a late stage in the research design, the steering group were informed by telephone that data protection requirements meant that the information could not be provided. The way in which this situation had been handled led to a good deal of anger and frustration amongst the local community. It was felt that senior staff from the Trust should have been aware of their limitations. However, it was not simply a matter of the Trust being irresponsible; promising something that they could not deliver proved to be the difficulty. The way in which the situation was dealt with was deemed to be indicative of senior management's attitudes towards their partnership with the community and voluntary workers. As one voluntary worker explained:

The way they handled the whole issue made it clear that there was a lack of mutual respect. All of our plans for the needs assessment had been based on the belief that we would be able to access the data; we had been assured by the Trust that it was no problem.

Another simply noted:

So much for all the talk of joint planning, we were informed without consultation over the phone.

The practical difficulties surrounding the issue of identifying families with children under 5 years of age were resolved when those undertaking the research decided to knock on every door and ask about family structure so that the sample could be identified. This issue was highlighted by many of those who were involved with CHIP as a way of comparing the commitment at community level with the commitment at Trust level. Within the management of the Trust it was suggested that some of those within the community had unrealistic expectations and would inevitably be frustrated and disappointed. It was

clear that many of the difficulties encountered in the partnership were the result of different understandings of what the term 'partnership' actually meant.

Unsurprisingly, there was tension between the theory of working in partnership and the practice of power sharing. The partnership was not something that could simply be set in motion; it required a significant amount of work and negotiation between all the parties involved. In this project there was a commitment to investing a considerable amount of time into building the relationships required for a productive consultation process. Whilst the community and voluntary groups were extremely wary of becoming involved in a token consultation process, the Trust could not delegate authority to an extent that it would encroach on their statutory responsibilities.

Sustainability

The success of this project was dependent on individuals volunteering their time and their skills. The project was well supported by local people and local groups, but inevitably motivation began to decrease. Some of those involved described the 'burn-out' they experienced after 6 months of involvement. Although the local population was enthusiastic about the work and willing to support it where possible, it was difficult to sustain momentum. Many felt that the effort did not produce tangible results quickly enough. This is well illustrated by the following quotes:

When we were getting the project off the ground, I seemed to there night and day.

Eventually I had to let go; I just could not maintain that level of commitment.

The irony was I was working so hard on the project, my own health began to suffer.

Within the community, the needs assessment report had instilled a sense of achievement in many of those involved, as it demonstrated what was possible at a local level. Despite this some people were disappointed by the lack of tangible outcomes from this report and felt that more action was required from the Trust. This frustration was commented on by one of the community workers:

We had done all we could. We identified needs and we wanted action and there was none. I began to wonder why we bothered.

There was a sense of disappointment that the community had produced this detailed information, but that it had not been followed up with specific action.

I suppose on reflection there was an expectation of some clear strategy to address the needs we had identified, but nothing really happened.

There was a suspicion amongst some of the volunteers that partnerships were simply a way of the state saving money, and that there was no real commitment to user participation and power sharing. Others however were less sceptical, but felt that further development work was required before communities were equipped to enter into partnerships.

You can't really expect people to just keep on going, it is human nature to want some outcomes. The project was never going to be a quick fix, but some positive feedback would have been welcomed.

It is significant that this partnership took place against a backdrop of cost cutting and financial constraints; it was therefore inevitable that it would be seen by many as health promotion 'on the cheap'. Popple has warned previously that community work could be used by some to offer low-cost solutions to tackle problems that require significant resources (Popple, 1995). The participation of disadvantaged community members is fundamentally different to that of privileged community members, who have resources at their disposal (Boyce, 2002). Financial and support mechanisms are prerequisites to community participation by excluded individuals. Given that few resources were available to support this move towards partnership, goodwill was at times stretched to breaking point. As Mayo (Mayo, 1994) noted, community initiatives have the potential to have a huge impact on health and well-being, but the limits of this type of work must be clearly acknowledged. In community health projects, it is essential to renew the pool of activists and avoid becoming a self-perpetuating clique. The transformation of the delivery of health services is not possible if it is not accompanied by resources and training.

CONCLUSION

What this case study reveals is that local communities can be empowered by community-based

health promotion projects. The major success of this project has been the continuing and increasing involvement of local people in the partnership. Training local people to facilitate courses and programmes is an integral part of the project and has led to increased levels of self-confidence and self-belief. The sense of ownership of the process of health promotion has encouraged and promoted a belief that health awareness can positively influence communities. This project provides evidence of how local people can actually be encouraged to take control of their lives. It demonstrates that professional boundaries can be transgressed, and a more open and flexible approach to health and social needs can be adopted. What is clear though, is that those working in this type of collaboration must ensure that aims and objectives have been clearly articulated by all parties involved. Unrealistic expectations of what can be achieved can lead to demoralization and disillusionment. Health promoters in the community must recognize that the community's greatest resources for health are its members (Kemm and Close, 1995). The process of building a partnership can be time-consuming, demanding high levels of commitment, therefore it crucial that those involved feel that their input is acknowledged and valued. The government's commitment to community development is meaningless rhetoric unless it is supported by education programmes, research, training, resources and long-term commitments. If it is to be an effective, vibrant, creative method of engagement, community development must be embedded in the planning and delivery of services, and not an isolated marginal activity driven by committed individuals.

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