AN OVERVIEW OF GOOD PRACTICES FROM THE HEALTH FIELD

PROMOTING SOCIAL INCLUSION
AND TACKLING HEALTH INEQUALITIES IN EUROPE

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This project has received funding from the European Commission within the Framework of the Community Action Programme to Combat Social Exclusion 2002-2006. The European Commission is not liable for any use that may be made of the information contained in this document, which reflects the views of EuroHealthNet.
This report of findings from the project is a timely contribution to wider debates being undertaken at European Union level in 2005.

The good practices that follow have been collected in the context of the EU Social Inclusion Strategy, as part of its Open Method of Coordination. This is, in turn, part of the wider goal to achieve the Lisbon Objective of making Europe ‘the most competitive and dynamic knowledge-based economy capable of sustainable economic growth with more and better jobs and greater social cohesion.’

Many of the good practices reflect that advancing health can improve quality of life and be a pathway towards employment, thereby enhancing personal and collective productivity. The good practices therefore support broader Lisbon Objectives in the areas of employment and economic growth and cannot be seen in isolation of these. Investing in health, and developing structures that stimulate people to take up healthier lifestyles provides the foundation for strong and stable societies.

The field activities and the conclusions that may be drawn from them, whether transferable across borders or applicable in certain states, add to the growing evidence that health promotion and education can make a significant contribution to the well-being of not only the people who need it most but also the communities and societies whose sustainable development is crucial to the future of Europe.

In itself the work involved in identifying, gathering and analysing the examples has been valuable to participants and will provide practical sources for practitioners and policy makers to take forward and use.

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We believe that the defined purpose has been achieved and our task remains to build on that through practical exchange, policy and practice development and dissemination. The outcomes so far are only the beginning of a partnership that we hope will continue in fields such as health literacy and social inclusion or capacity building to address inequalities.

Clive Needle
Director, EuroHealthNet
EuroHealthNet is a not-for-profit organisation, established under Belgian Law, linking national and regional agencies across Europe with responsibilities for health promotion, disease prevention and public health policies. Its mission is to contribute to a healthier Europe with greater equity in health between and within European countries.

Member agencies prioritise work on addressing health and social inequalities, building the evidence base for health promotion interventions, advocacy for integrated health policy approaches and liaison with other networks, organisations and EU institutions concerning public health issues. Participation is open to organisations that meet the membership criteria. For more information contact the office at the following address:

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EXECUTIVE SUMMARY

Background:
This publication presents an overview of evidence gathered from 52 good practices that reveal how the health field can foster social inclusion. It reflects the outcome of a project involving twelve public health agencies and institutes across Europe, as well as the European Health Management Association and a Primary Care Trust in England. The participating organisations engaged in a cross-national exchange and comparison of transferable good practices in this area and identified concrete examples of the contribution that the health sector is making to social inclusion.

Context:
This collection of good practices took place in the context of the EU Lisbon Strategy, which aims to make the EU ‘the most competitive and dynamic knowledge-based economy capable of sustainable economic growth and more and better jobs and greater social cohesion.’ The objectives of Lisbon constitute a ‘virtuous’ policy triangle, where economic policy, employment policy and social policy interact in a mutually supportive manner. The Commission funded the project as part of the EU Social Inclusion Strategy, which is part of the effort to achieve the Lisbon goals.

The EU does not have the competency to legislate in the area of social protection, but can play an important role in encouraging Member States to learn from one another and monitor progress with respect to self-established goals. This exchange of good practices is therefore meant to provide practitioners working in the health and social policy fields with new ideas and inspiration to tackle social inclusion. It can also serve to raise awareness amongst decision makers about the significant role of the health field and the importance of inter-sectoral collaboration in efforts to promote social inclusion.

Range:
The 52 good practices vary with respect to funding structures, scale, scope, target groups and methodology. They range from very small projects with narrow aims relating to single target groups, to broad based community projects. Most are financed through national programmes and strategies, although a number also receive funding from regional municipalities or local authorities, or a combination of these. A few were funded through outside grants. Most of the good practices focus on providing information or services to specific or general target groups at risk of social exclusion. Some are research oriented and aim to contribute to more effective projects and policies in this area.

Methodologies:
While there are a great deal of differences in the nature, scope and scale of the projects and programmes, most of them adopt similar core approaches to directly or indirectly tackle the problem of ill health and social exclusion. The methodologies aim to address the determinants of health, or the behavioural, material and psychosocial factors that can lead from ill health to social exclusion and vice-versa. They involve improving health, empowering participants, providing training and work opportunities and contributing to the development of more cohesive and health-supporting societies. Most projects incorporate more than one of these methodologies.
Target Groups:
Many of the good practices are target group specific. They address needs of, for example, people in poverty, (single) parents with young children, children and youth, elderly people and migrants and ethnic minorities. Since the nature of the problems that these groups face varies, the projects and programmes have been established to meet their specific requirements. Good practices therefore range from providing parenting and coping skills to single parents, to coordinating service providers to optimise the assistance to groups such as prisoners, drug addicted mothers, Roma gypsies and homeless people, to providing specialized support services to at risk youth and elderly people.

Access to Health Care
Socially excluded people experience many complex and interacting problems with respect to accessing health care, such as inability to access services as a result of legal status, poor literacy, cultural beliefs and prejudice on the part of service providers. Health care services, however, represent important points of intervention to address the needs of socially excluded groups. A number of good practices therefore aim to overcome these difficulties and contribute to social inclusion by providing health services that supplement mainstream services. They involve services and interventions that contact people directly in their environments (home care, intercultural mediators and experience experts) or the establishment of low threshold centres and/or specialized clinics. Ensuring that people get access to treatment is not simply about improving health; it is also about restoring dignity, since physical or mental impairments often exacerbate the experience of being excluded.

Common principles:
A number of common principles and values underlie the good practices and contribute to their effectiveness. The good practices build on and respect the judgements and capabilities of people and are often based on needs that have been identified by the target groups themselves, and implement effective means of meeting these needs, in many cases also with the participation of the target groups. The interventions thereby aim to empower people and communities to advance their health and interests. The involvement of committed and enthusiastic main actors is also of central importance to the success of these projects and programmes. They focus on alleviating prejudice and stigma and are sensitive to, and in many cases have developed on the basis of cultural and gender sensitivity.

Impact and sustainability:
One of the common problems that many projects face is that they are based on short term funding and thereby lack sustainability. This makes it difficult for them to have a long-term impact on the lives of the individuals involved and to influence social and political change. Many good practices in this compendium, however, illustrate and/or suggest how this can be overcome. One important method is to develop strong links with other sectors (professionals, private and education sector, etc), to generate supporting resources and funds. Another important means is to mobilize and streamline efforts to achieve common goals across agencies. Projects and programmes can build sustainability by demonstrating the effects and contribution that they can make to meeting larger policy goals, which increases their chances of becoming embedded in existing government or organisational structures.
1. INTRODUCTION

1.1. Background
This publication presents an overview of the evidence gathered from 52 good practices that reveal how the health field can foster social inclusion.

The report is based on the outcomes of the project ‘Tackling Health Inequalities and Social Exclusion in Europe’ that was funded by DG Employment and Social Affairs (DG EMPL) under strand 2 (trans-national exchange) of their Action Programme to Combat Social Exclusion. EuroHealthNet coordinated the project in close collaboration with NHS Health Scotland, who was the EC contract holder. It follows from a Phase I project that EuroHealthNet successfully completed in 2003, on ‘Health and Social Exclusion in Europe: a European Perspective’, which resulted in a literature review investigating the links between health, social exclusion and poverty. This Phase I project also involved a health analysis of the first round of National Action Plans for Social Inclusion (NAPs/inclusion), which led to a series of recommendations to ensure that health promotion strategies and improved access to health services contribute more positively to the fight against poverty and social exclusion.

The literature review on ‘Health, Poverty and Social Inclusion in Europe’ outlines the strong relation between health and social exclusion, and demonstrates that the health field can play an important role in promoting social inclusion. There is however limited awareness of the contributions that the public health, health promotion and health care sectors can make to tackling social exclusion, despite the fact that investing in health and establishing stronger links between health and the social care are important ways to address this problem. Health practitioners and those working in the social field have a common agenda, and increased coordination, cooperation and integration between the two can be mutually beneficial to achieving common objectives.

Project partners decided to take this forward by identifying concrete examples of the contribution that the health sector is making to social inclusion, and engaging in a cross-national exchange and comparison of effective policies and transferable good practices in this area. The partners represent 12 public health and health promotion agencies, covering nine countries, including three new EU Member States, as well as a primary care trust in England and the European Health Management Association. The aim of this report is to provide an analysis of the good practices submitted by project partners, which contribute to efforts to tackle social exclusion in Europe.

1.2. EU Lisbon Strategy and the Open Method of Coordination
The project must be seen in the broader context of the EU Lisbon Strategy. The European Council drew up this Strategy in 2000, with the aim of making the EU ‘the most competitive and dynamic knowledge-based economy capable of sustainable economic growth with more and better jobs and greater social cohesion.’ The Lisbon Strategy is based on the recognition that economic and social developments are tightly interlinked. Economic growth is a prerequisite to sustainable progress and social protection, but economic progress cannot be achieved without a healthy, well-educated workforce. The objectives of Lisbon therefore constitute a ‘virtuous’ policy triangle, where economic policy, employment policy and social policy interact in a mutually supportive manner. The Lisbon European Council of March 2000 also agreed, in this context, to take steps to make a decisive impact on the eradication of poverty by 2010.
The EU Social Inclusion Strategy was developed as part of the effort to achieve this goal.

Achieving the Lisbon objectives will mean that EU Member States should coordinate their policies in order to arrive at common goals. The European Union has limited competencies when it comes to regulating Member States economic, employment and particularly social policies. It has therefore developed the Open Method of Coordination (OMC), which stimulates EU Member States to develop National Action Plans to establish common goals and share information. EU Member States drew up the first of their tri-annual National Action Plans for Social Inclusion (NAPs/inclusion), which indicate how they will take forward the common objectives in the area of social inclusion in 2001. The Commission also implemented an Action Programme (2001-2005) as part of its Social Inclusion Strategy. Based on the Open Method of Coordination, it aims to encourage cooperation amongst Member States, to strengthen the effectiveness and payoff of policies combating social exclusion. The Action Programme has three objectives: to improve the understanding of social exclusion, to organize co-operation and trans-national exchange in the context of the NAPs/inclusion, and to develop the capacity of players to address social exclusion effectively.

1.3. Good practices

This project and the process of exchanging good practices is part of the effort to achieve these objectives. The EU does not, as noted, have the competency to legislate in the area of social protection, since this is the responsibility of Member States. It can however identify common problems, encourage Member States to learn from one another and monitor progress with respect to self-established goals. Looking abroad to see what other governments have done can provide social actors with new understanding of shared problems; it can point towards new solutions of those problems, or to new mechanisms for implementing policy and improving the delivery of public services. International examples stimulate ideas and creativity, and can provide invaluable evidence of what works in practice.\(^4,5\)

The aim of this compendium of good practices is, consequently, to provide practitioners working in the health and social policy fields with new ideas and inspiration to tackle social inclusion. Indeed, some of the good practices that have been included are based on and/or have been inspired by projects in other countries. The *New Perspectives* project in Germany is part of the Socially Integrative City Programme,\(^6\) which has been inspired by similar programmes taking place throughout Europe. Other good practices, such as the *Thurrock Community Mother’s Parent Support Programme*, have already led to similar initiatives in other regions in the UK and countries. (Full details of these projects can be found in Part II.)

The good practices can also serve to raise awareness amongst decision makers about the significant role that the health sector can play, and the importance of inter-sectoral collaboration in efforts to promote social inclusion.

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\(^4\)\(^5\)\(^6\)
In today’s competitive global economy, there is a tendency for policy makers to focus primary on economic and employment policy. It is therefore critical that health and social care work together to highlight the importance of investing in health and well-being.

There is a general concern regarding good practices that highlighting a few success stories may be a way of distracting attention from real policy needs – namely, the need for structural changes and larger investments to address the problem of poverty and social exclusion. Many of the good practices are relatively small scale, and may not address the underlying causes generating poverty and social exclusion. Exchanging good practices may therefore be considered a ‘smokescreen’ that does not address larger underlying issues and does not contribute to the broader measures often needed to address social problems. The process of exchanging good practice must however be seen within the relevant EU policy context outlined above.

3 In the EU, the relative poverty threshold is fixed at 60% of the national median equivalised income. Poverty is thus a relative concept defined in relation to the general level of prosperity in each country and expressed with reference to a central value of the income distribution, taking into account the size of the household. Using this definition, poverty concerns 15% of the population in the EU-15 countries, or close to 60 million people, and a similar share in the eight new Member States for which comparable figures are available. The lowest rate of relative poverty in the new Union is found in Slovakia (5%) whereas the highest occur in Ireland, Greece and Portugal, with about 20% of the population living below a 60% threshold.

Among the EU-15, perceived social exclusion ranges from 7% in Denmark and the Netherlands to 15% in Portugal. More people in the new Member States say they feel excluded, useless and left out of society than in the EU-15 countries. The highest rate is found in Slovakia, where more than a quarter of the population report that they lack a sense of belonging. Of the new Member States, only Slovenia and Poland have a smaller proportion of respondents who report social exclusion than the EU average of 12%. (The European Commission, DG Social Affairs. The Social Situation in the European Union, 2004 Overview. European Communities, 2004, pgs 12, 14 and 15)


5 It may be easier for organisations within a country to cooperate and to borrow good ideas from abroad, rather than nationally, where they must often compete against one another for funds. Looking abroad enables them to cooperate without the fear that a particular organisation will get the credit. De Boer, Nico. ‘Verschepen? Nee: transcultureel vertalen’. Tijdschrift voor de Sociale Sector. April 2001. pg.13

6 This programme was developed in 1999 by the federal and regional governments. Its goal is to address the widening social and economic disparities in cities. The programme fosters participation and cooperation and represents a new integrative political approach to urban district development. For more information see: http://www.sozialestadt.de/en/programme.
1.4. Method of collecting the good practices

The good practices were chosen on the basis of a framework document containing selection criteria, which were established by EuroHealthNet following internal discussions and a general literature search on the topic. Project partners discussed the framework document during the first project working group meeting in Edinburgh in March 2004. They agreed that good practices could be projects or programmes that would be backed, where possible, with information about policies related to and/or supporting these interventions. The projects or programmes should be ones that are currently being implemented or that ended no more than two years ago and which have proven to be innovative and/or particularly effective.

Project partners identified the best practices by drawing on their own expertise and consulting other organisations, databases and experts with contacts in the field. They then contacted and distributed the templates to the relevant project coordinators. Full descriptions of the good practices were sent to EuroHealthNet, who presented an overview of the projects during the second working group meeting in November 2004.

Full details of the projects referred to in this overview can be found in Part II of this publication, which contains abstracts of the reports of the good practices submitted by project partners.
2. DESCRIPTION OF THE RANGE OF GOOD PRACTICES

The 52 good practices in this publication all demonstrate how the health care, public health and health promotion sectors are contributing to social inclusion. There are, however, differences in how projects achieve this, their funding structures, scale, scope, target groups, and methodology.

National programmes and strategies financed most of the good practices, although many also received funding from regional municipalities, local authorities, or a combination both. A few projects, e.g. the Healthy Living Centre which is part of the Bryncynon Community Revival Strategy in Wales, have also been (initially and partly) funded through EU structural funds. Many were financed as part of government programmes to reduce poverty and unemployment levels, improve the situation of the elderly, or to ensure that all children have the same initial opportunities. Other projects were funded through health and/or health promotion programmes that aim to achieve policy goals and targets in the areas of, e.g. diet and obesity, drugs, mental health, coronary heart disease and HIV/AIDS.

A few projects were financed by outside grants to address government shortfalls in the area of provision of the health and social services. Some small pilot projects, such as the Social Help Centre in Latvia and the Immigrant Health Information Desk in Italy began in this way and subsequently helped to shape national policy and/or were taken over by regional governments.

A number of the good practices are community-based projects that incorporate many different components and aim to improve the health and well-being of a wide range of people. Cottoning On – Improving Health in Oldham (England), which is comprised of six different projects is an example of a broad-based community project that is being implemented in a community of 217,273 people. Most community development projects are based in areas facing economic decline or restructuring and experiencing significant levels of poverty and social exclusion. Others are set in bigger cities that are amongst the most deprived in their countries, e.g. Glasgow (Glasgow Braendam Link) where rates of poverty, ill health and mortality remain high, despite an extensive city regeneration programme. The budgets of these projects can range from 300,000 to 500,000 euro per year.

Many projects focus on the needs of specific target groups. These can be relatively large scale with respect to budget and number of person’s reached. From Fellow Country Man to Fellow Country Man, provides services to approximately 870 immigrants in Spain who do not yet have their legal residency papers, while the Adazon Mozaïek Centre in Belgium, which offers information and services to male prostitutes, reached 183 people. Such projects have budgets that range from 200,000 –300,000 euro a year.
Other projects manage to reach a relatively large number of people in a specific target group on comparatively much smaller budgets. Incomplete Family Stress in the Czech Republic provided training and support to 260 single mothers, while Clocking on to Men’s Health in England offers information and screening services to a total of 12,500 men. These projects operate on budgets that range from 2,000 - 10,000 euro per year. A few projects included in the compendium are very small scale. The SomeBuddy project pairs a handful of individuals with mental health difficulties, who are in need of companionship, with volunteers who visit them on a regular basis. The New Perspectives project in Germany provides training and counselling sessions to a group of ten long-term unemployed people.

Some of the good practices do not focus directly on providing information or services to specific or general target groups, but on ensuring that efforts to do so are as well-coordinated and effective as possible. The Health Impact Assessment project in Wales aimed to ensure that an initiative to address the needs of a deprived community has the intended effects. Programmes such as the development of a Merseyside Healthy Living Centres Network encourage networking amongst organisations to reinforce common objectives. A number of good practices such as Health and the Roma Community and Healthy to Work! are predominantly research oriented or have research components and aim to contribute to more effective policies and interventions.

The time frames of the good practices also vary considerably. Some, such as Programme for Promoting Health in Minorities (Spain), the Thurrock Community Mother’s Programme (England) and the Aurora Project (Italy) date back to the late 1980’s or the early 1990s, and have developed considerably. Roughly one third of the projects and programmes began in the 1990’s. A number, however, are very recent and were only initiated in the last two years. Approximately half of the interventions are continuous, a third are expected to continue but on a reduced budget, and the rest of the projects and programmes have a fixed time frame.
3. GENERAL METHODOLOGIES FROM THE HEALTH FIELD THAT CONTRIBUTE TO SOCIAL INCLUSION

Although there are a great deal of differences in the nature, scope and scale of the projects and programmes, most of them adopt similar core approaches to directly or indirectly tackle the problem of social exclusion. These methodologies aim to address the determinants of health, or the behavioural, material and psychosocial factors that can lead from ill health to social exclusion and vice-versa. They involve improving health, empowering participants, providing training and work opportunities and contributing to the development of health-supporting societies. Most projects incorporate more than one of these methodologies.

3.1. Promoting healthy lifestyles

A crucial first step in addressing the problem of social exclusion is to improve the mental and physical health of those experiencing or at risk of this problem. Good health ‘equips’ people to address their difficulties and is therefore an important aspect of social integration. Many good practices include direct actions to promote a healthy lifestyle amongst socially vulnerable groups. They are therefore based around, or incorporate elements of the following health promoting themes:

**Healthy eating:** Projects such as Krok Gezond and Delicious Life, Health 4-Life focus on providing information about the relationship between diet and health and issues like ‘food and mood’, and basic nutritional requirements. The projects aim to raise awareness of food habits and teach participants how to purchase food and prepare healthy and inexpensive meals.

**Physical activity:** An important means of promoting health is to stimulate people to engage in physical activity. Eighty but Strong aims to instil a culture of exercise in elderly homes, while Exercise in Day Care Centres for Children provides children with the opportunity to participate in exercises that support physical and psychological development and improve health, and informs parents and educators about the importance of exercise. In a number of projects, e.g. Healthy to Work! and Physical Activity as Warming up to Reintegration, exercise is regarded as an important mechanism to improve health, impose structure and develop social contacts, thereby helping to integrate unemployed and/or minority groups into society and the labour market. Fun and beneficial activities such as walking, swimming, aqua aerobics, circuits and team sports are an important part of all community development projects.

**Stress management:** Projects such as Incomplete Family and Stress, Community Based Parent Education Programme, Bryncyon Community Revival Strategy focus on or contain components that address the impact of stress on daily life and coping mechanisms. These interventions are often targeted at young parents, since their stress-related behaviour can have important consequences on children’s well-being.

**Drugs/alcohol prevention:** A number of projects focused on providing information about drugs to hard to reach and/or particularly vulnerable groups. Accessing the Inaccessible provides drug awareness advice and guidance to hard to reach members of the Asian community. There is also a project for prisoners in Spain that provides a Health Education Workshop to reduce harm and risk related to HIV-AIDS and the use of injectable drugs. The Aurora project focuses on the rehabilitation of drug-addicted mothers.
Projects like Adzon Mozaïek and the DIA LOGS (HIV & AIDS) Centre in Latvia convey information about drugs and provide clean syringes to drug users, to control the damage that they are doing to themselves and others.

**Sexual health programmes:** Projects such as Healthy Parenthood, DIA LOGS (HIV & AIDS) Centre, Adzon Mozaïek, Miges, Penumbra Youth Project focus on, or include modules that concentrate on promoting responsible sexual behaviour. These projects address issues such as safe sex and contraception amongst vulnerable or particularly difficult to reach groups such as minorities, youth and male prostitutes.

**Stop smoking and other ‘lifestyle challenge’ initiatives:** These Initiatives are incorporated into programmes such as Health 4 Life and Northside Community Health Initiative. These community projects include programmes that discuss the relationship between smoking and health and support people in their efforts to tackle bad habits and change their lifestyles.

Courses on health-related issues can stimulate social inclusion by conveying information that can contribute to behavioural changes that improve physical and mental well-being. The information and discussions can also help change self-perceptions and attitudes. If people feel better they are more likely to make efforts to engage with society. An important aspect of engagement in health promoting activities is that they also provide opportunities to make social contacts and to feel less socially isolated. Activities such as gym and aqua aerobic classes bring people in contact with other local community members, and thereby foster integration.

### 3.2. Empowerment

Another important methodology employed by many of the good practices is to empower participants. The life experiences of those facing poverty and social exclusion can generate feelings of alienation, lack of hope, vision and self-respect. Encouraging people to adopt more healthy lifestyles also involves raising (coping) skills, self-effectiveness, confidence and self-esteem. The term ‘empowerment’ refers to this process; it enables participants to recognize their ability and capacity to improve their personal circumstances.

**3.2.1 Encouraging people from the target group to become more actively involved in the intervention and their communities**

In many cases participation in health promoting activities give participants the self-confidence to take this a step further and to share this information and become more engaged in their communities. A number of projects actively encourage this process. The Miges project reports that participants were eager to receive follow-ups to health related courses and workshops that they had completed. They disseminated the information that they learned amongst their friends and families, reflecting an increase in their sense of responsibility towards themselves and others. Muslim women participating in activities organised under the Barefoot Health Workers programme were encouraged to become proactive and to take their own initiatives. The Bangladeshi Women Only Swimming Group, as a result, evolved into a ‘Women in Action’ group and organised fundraising activities for community initiatives that promote health and stimulate social inclusion. The group now has a management committee that applies for funding to initiate activities that will promote inclusion and enhance the well being of women in the community.
3.2.2 Providing training opportunities and/or on the job training

Another important step is to encourage participants to engage in formalized training to pursue their education and use their newly acquired skills to provide assistance and care to others. The health sector is an important economic actor that can contribute to social inclusion by providing people with training and work opportunities. This can range from engaging people on a voluntary basis, to supporting them in efforts to receive training and employing them as health care professionals.

Some projects encourage those who have completed a health-related course to become mentors to others. A number of community projects, e.g. Thurrock Mother’s Community Project and Cottoning On – Improving Health in Oldham offer college accredited training programmes to enable participants to develop a career in health and social care. These and other projects use the concept of ‘experiential learning’, or learning on the job, to integrate people into the labour market by providing them with skills to work in the health and social sector. The Work & Caring Programme provides long term unemployed people with little or no work experience and few prospects in the labour market with hands on training in caring for elderly people. Involvement in these projects and programmes has, in many cases, given participants the confidence to re-embark in formalized education. A participant in the Barefoot Health Workers Project, for example, noted “... being involved in running the group is a really good experience and has encouraged me to join a course in college”. The report from Accessing the Inaccessible notes that many volunteers, after taking part in the accredited training on drug awareness, which forms the basis of this project, embarked on university studies.

The health sector in this way provides opportunities to develop new skills and to re-engage in the job market, processes that are critical to increasing self-esteem and consolidating the process of social inclusion.

3.2.3 Employing ‘Experience Experts’

People who have experienced and/or are familiar with socially excluded groups, and have received training can go on to become ‘paraprofessionals’ who act as mediators between the health and the social field. The combination of personal experience and new skills place such persons in an optimal position to help others. This concept is particularly applicable and effective with respect to intercultural mediators. These individuals play a crucial role in overcoming linguistic barriers and acting as a bridge between two cultures. Projects like Experience Experts and Promoting Health in Minorities in Spain employ this concept. These ‘experience experts’ can provide direct, personalized assistance and ensure the application of culturally sensitive approaches, which take into account the participant’s socio-economic circumstances. The support offered is often primarily practical and focuses on all aspects of life associated with rearing children and introducing and accompanying families to the different regulatory services available to them. People from a particular social or cultural group are more likely to trust and to accept information from someone who understands their culture and situation. The benefits extend to all; those trained and working as experience experts gain formalized employment opportunities, while recipients gain a better quality of care and access to services.
3.2.4 Facilitating local (self-help) groups

Another method to empower people and to improve their well-being is to facilitate self-help groups. These groups provide participants with opportunities to identify common problems, express themselves, share experiences, discuss difficulties and, using their personal and collective resources, arrive at solutions to these problems.

An interesting example of this process is that of a support group that was established under the Phoenix Community Health Project, which comprised of a group of men who were unemployed, several as a consequence of poor health. The group started a walking club. A common problem the men faced was a sense of a ‘lack of purpose’. The men found that there were few good walking trails in the area, and therefore set out to discover more. They then applied for funding and developed and published a guide to local walks, and also undertook a training event that enabled them to become walk leaders. Their lack of sense of purpose was thereby replaced by pride in having developed the booklet and at having contributed to the well-being of their community. This illustrates how involvement in such groups can set in motion a positive chain of events that can break the self-perpetuating cycles of poor socio-economic and poor health status.

Some good practices employ techniques that enable people to express themselves creatively through drama and role-play. These techniques provide participants with the opportunity to identify, raise and discuss issues without having the activity personalized. In the Miges project, migrant parents use role-play to practice how to best respond to their children’s questions about sexuality.

In the Glasgow Braemham Link project, children, young people and adults are encouraged to write plays, based on their own experiences of, for example, poverty. They also employ media such as digital film, photography and art to express themselves and to share and raise awareness about their experience. In the Penumbra Youth Project, participants can take part in an Art Group, a Creative Writing Group or in Jammin’ Workshops. The project has also facilitated the establishment of an Eating Disorder’s Group, a Young People’s Forum, a Young Men’s Group and a Young Women’s Group. Participants in such projects have stated that it has improved their self-esteem and sense of well-being. The social aspects of groups and the sense of accomplishment that these activities generate are key to building confidence and fostering inclusion.

3.3. Building social capital

Many of the problems that people experiencing poverty and social exclusion face are generated and reinforced by the settings and communities in which they live. Poor living conditions (housing, environment) and social environment can affect health and health related behaviour which in turn, influences self-perception or sense of control over work and lives. These factors impact the ability or desire to implement the personal and collective changes required to improve well-being. The concept of social capital embraces the notion that strong community ties, community participation and social trust are beneficial for individual health and behaviour. Social capital thus refers to the establishment of networks, norms and social trust amongst people and facilitates coordination and cooperation for mutual benefit.
Community based interventions involve many methodologies that contribute to the larger goal of building social capital. These and many of the smaller scale projects achieve this through:

- Interventions that bring groups together (rather than individual consultations or therapies). These can include events such as cooking classes or excursions to the zoo and one-to-one pairings to provide people at risk of social exclusion with companionship (SomeBuddy project).
- Establishment of community cafés, e.g. a Parent’s Café (Guardian Angel), healthy food cafés that are part of a number of Healthy Living Centres, the International Women Café (Miges), and Luncheon Clubs for over 50’s (Bryncynon Community Revival Strategy).
- Food co-ops, which develop community resources and provide a place for community members to come together.
- The establishment of Healthy Living Centres, which offer a variety of activities to promote healthy lifestyles amongst different target groups, e.g. workshops and training events that address health issues (healthy eating, stress management, exercise, drug and alcohol abuse), facilitating and supporting activity groups, and housing Healthy Living Café’s. The Bryncynon Community Revival Strategy incorporates a Healthy Living Centre, while the Merseyside Healthy Living Centre Network project aims to generate cooperation amongst Healthy Living Centres as part of the larger effort to reduce health inequalities in the region.

The Stockholm based Community Intervention Programme to Prevent Alcohol and Drug Related Problems (STADT) is another example of a project that builds social capital and thereby promotes social inclusion. The project aims to decrease the number of injuries, crimes and other alcohol related problems at licensed premises in Stockholm, using strategies such as community mobilization, responsible beverage service (RBS), policy development and stricter enforcement of existing regulations. Improving community safety affects people’s sense of security and quality of life and generates a stronger sense of social cohesion.
4. TARGET GROUPS

Many of the good practices focus on improving the health and fostering the inclusion of one or more specific target groups. The following will consider how initiatives from the health sector can fulfill the needs of certain groups and promote their social inclusion. This involves, for example, teaching single mothers how to cope with stress, designing and promoting exercise classes for the elderly, or developing health promotion activities that take into account cultural and ethnic backgrounds.

4.1. Children, young people and (single) parents

Some of the good practices focus specifically on the needs of children, young people and (single) parents. It is particularly important to address physical and mental health issues amongst children and adolescents, especially those that come from a disadvantaged background, quickly, since failure to optimize physical and mental development when young can lead to intergenerational cycles of poverty and social exclusion. *Physical Exercise in Day Care Centers for Children*, in this respect, aims to generate awareness of, and to stimulate children to engage in more physical activity. Failure to do so not only affects physical development, but also social activities, which in turn influences confidence and self-esteem. *The Penumbra Youth Project* aims to provide support to youth in difficult situations in order to improve their resilience and coping skills and to generate greater confidence and self-esteem.

An important way of improving children’s well being and stemming intergenerational cycles of poverty and social exclusion is to develop parent’s coping and parenting skills and to expand their knowledge of health enhancing behaviours. Many projects and programmes therefore focus on improving the well-being of parents who are at risk of, or facing social exclusion, e.g. ethnic minorities, very young mothers and/or single mothers.

The multiple pressures that parents with a low socio-economic status face (financial difficulties, uncertainty and social isolation) make them susceptible to stress, low self-confidence and depression. While these groups are in most need of additional medical care, advice and support services, they are often least likely to have access to such resources. *Healthy Parenthood, Experience Experts, Guardian Angel, and Thurrock Community Mother’s Parent Support Programme (CMP), and the Community Based Parent Education Programme (COPE)*, e.g. provide information regarding parenting and coping skills and/or nutrition and general health to parents.

4.2. Ethnic minorities and migrant population

The largest numbers of good practices focus on ethnic minorities residing in the country for a significant period of time, or illegal or newly arrived migrants. In most European countries illegal immigrants do not have the right to access national health services. Projects such as *From Fellow Country Man to Fellow Country Man* in Spain and *Immigrant Health Information Desk* in Italy address this salient need to health care and ensure that people are granted this basic right.

The main challenge with respect to ethnic minorities and legal immigrants is to promote healthy lifestyles amongst these groups, since their health tends to be much worse that of the general population. The report from the *Cottoning On – Improving Health in Oldham* project notes that the rate of coronary heart disease (CHD) in some groups of people of South Asian descent in the UK has been found to be approximately 40% greater than amongst the white population in the UK.
Other good practice reports note that the life expectancy of Roma populations in countries such as the UK and Spain tends to be 10-15 years less than that of the rest of the population. Efforts to improve the health of these groups can only be achieved if health related services and information are imparted in culturally sensitive ways, using methods that can be understood by the target population. It is especially important to appreciate how different ethnic groups perceive both health and ill-health, and to ensure that informative sessions and/or promotional materials are culture-specific. Projects from Germany and Wales that are targeted at ethnic minority communities employ methods such as incorporating verses from the Koran to deliver health promoting messages and holding activities in Mosques, to using pictorial guides to convey information to the Roma Community. Most projects that address the needs of ethnic minorities and legal immigrants, such as From Fellow Country Man to Fellow Country Man also involve inter-cultural mediators or experience experts to help bridge any cultural gaps that may exist. These projects and programmes can serve to empower immigrants to become more aware of, and to take more responsibility for their health and in the process bring them into closer contact with their host societies.

4.3. Older people
Aging is characterized by a diffuse loss of physical capacity and reserve. This process can also lead to a decrease and/or change in social contacts and relations and the related risks of passivity, loneliness and social isolation. The good practice report on Preventive Home Visits to Elderly People in Nordmaling notes that seniors in contemporary Europe are much more likely to live apart from their families. Approximately 31% of the elderly lived alone in 1995 in comparison to 18% in 1960. The fact that seniors are not able to engage in society to the extent that they did when younger means that many are at a high risk of becoming isolated, or are already socially excluded. The Work and Caring project report cites results from a study in a district of Amsterdam that found that 72% of those over 75 were on a low or minimum income. 17% didn’t leave their homes more than twice a week, and as many as a quarter suffered from chronic depression (De Ceuninck van Capelle, 1995). Seniors with a low socio-economic status are particularly vulnerable, since research indicates that this is one of the most important factors contributing to risk of social isolation and loneliness amongst the elderly. The fact that the percentage of elderly people in Europe is increasing means that even larger numbers face the risk of exclusion.

Although getting old is a natural and unavoidable process, it is possible to influence its course and to maximize levels of physical and cognitive capacity. The projects Delicious Life, Eighty but Strong, Preventive Home Visits to Elderly People in Nordmaling are based on the concept of ‘healthy’ or ‘active’ aging. This means that efforts to improve the health of elderly people should go beyond disease prevention and also ensure that they maintain their functional capacities. The projects aim to help older people feel that they are meaningful and able to participate. They contribute to social inclusion by providing information and engaging the elderly in activities that promote physical and mental health and enhancing their independence, thereby maintaining or improving their general sense of well-being.

4.4. Long-term unemployed
Work is central to the lives and well-being of most people and is important to maintaining and promoting mental health. Quality employment provides social identity and status, social contacts and support, a means of structuring and occupying time, activity and involvement and a sense of personal achievement.
Unemployment or underemployment (low quality, low skill jobs that under-utilise abilities and generate a low sense of responsibility and control) are often linked to general health problems, mental health difficulties, and premature death. The results of a survey about unemployment in Europe have revealed that in Germany the loss of job is considered a personal defeat and stigma, which can lead to social isolation (Kieselbach & Beelmann, 2003).

Existing interventions to help unemployed people tend to focus primarily on job-mediation, rather than on providing psychosocial help. Success will however also be largely determined by the mental and physical health of jobseekers and their ability to cope with health problems and the process of looking for a job. Projects like Healthy to Work, Work and Care and New Perspectives recognize and aim to stem this cyclical relationship between poor health, unemployment and consequentially social exclusion. The good practices focus on improving unemployed people’s physical and mental health and providing training in coping as well as work-related skills.

While work is important for everyone, it is particularly crucial for people who have mental health difficulties, since they are more sensitive to the negative effects of unemployment and the loss of structure, purpose and identity that it entails. People with mental health difficulties are already excluded as a consequence of their condition – an exclusion that is aggravated by unemployment. Employment can have beneficial effects; it increases self-esteem, alleviates psychiatric symptoms and reduces dependency. Most people with mental health problems are not, however, given the opportunity to engage in work. While as many as 90% of people with mental health problems in England have indicated that they would like to go back to work, only 24% are in employment (Exclusion Unit in England, 2004). The User Employment Programme was therefore developed to provide people with a history of mental health problems with employment opportunities and to advocate for their interests.

4.5. People living in poverty

‘People living in poverty’ represent a very broad target group with wide ranging needs. Many people living in poverty also experience food poverty, a term that refers to the inability to choose, buy and prepare an adequate quantity of good-quality foods. Thirty percent of life-years lost in early death or disability are related to poor diet (WHO, 2002). Those most likely to be affected by food poverty are older people, people with disabilities, households with dependent children or containing someone who is unemployed, and members of minority ethnic groups.

The main determinant of the kind of food that people with low incomes will buy is cost. Additional factors that determine whether people consume healthy foods are access to good quality produce, knowledge about nutrition, cooking skills and cultural background. Projects such as the West-Lotian Food Co-op Network, Delicious Life and Krokoz Gezond address these factors in different ways. Local food projects improve the availability of good food at low prices as a route to improving diets within communities. A number of other projects improve awareness of health and nutrition issues and develop participant’s cooking skills.

4.6. Additional groups

Many of the good practices also addressed the needs of various other social groups, e.g. people with disabilities and chronic illness, people with mental health problems, prisoners, substance abusers, prostitutes and homeless people. Please see Part II for details.
5. IMPROVING ACCESS TO HEALTH INFORMATION AND SERVICES

An important way that the health field can contribute to social inclusion is to improve access to health care. The discussions above indicate that the health field can make contributions that extend beyond the provision of health care services, such as promoting healthy behaviour, empowering participants and building social capital. Facilitating access to health care nevertheless remains a very important issue. Failure to access necessary and adequate care, or the inability to pay for medical treatment can exacerbate poverty and social exclusion. In addition, health care services represent important points of intervention to address the needs of socially excluded groups. Socially excluded people experience many complex and interacting problems with respect to accessing health care. These include service factors (site provision), poor literacy, cultural beliefs and prejudice on the part of the service providers. A number of good practices therefore aim to overcome these difficulties and contribute to social inclusion by establishing health services that supplement mainstream services.

5.1. Contacting socially excluded people directly in their environments

An important method employed by many projects to improve access to care is to provide people with care in their own environments. Several good practices used home visits, home assistance and family support interventions. The Guardian Angel project and Experience Experts project use inter-cultural mediators and/or midwives to visit clients in their own homes. The CHD and Gypsy Travellers project use travelling vans (mobile health units) to access this hard to reach target group, which provide gypsy travellers with a safe, private space in which to talk about their problems. Some projects also employ outreach workers to provide information and care to hard to reach groups and to groups that are immobile.

Preventative Home Visits to Elderly People employs nurses to provide information about, e.g., diet, exercise, age related illness and cultural activities in order to improve the health and functional independence of the elderly. The use of personal advisors that provide individually tailored support is of particular importance when accessing groups with multiple needs. These advisors help individuals understand what services and benefits are available to them and how to access these.

The project Clocking on to Men’s Health also provides health information and services to men in locations that they are most likely to frequent, rather than traditional health care settings. The project was designed in response to the fact that men are much less likely to access health services and receive health promotion advise than women, a situation which is exacerbated amongst those with a lower socio-economic status. The project therefore attempts to improve access by providing preventative information and screenings in places where men work and/or spend time, e.g. barbershops, construction sites, ports, docks, bus depots, banks, leisure centres, colleges and fire and police stations. This has extended coverage to a wide cross section of the male population. The project Accessing the Inaccessible also aims to provide information on drugs to members of minority ethnic groups who are not reached by general national programmes or campaigns. Volunteers work with local landlords, businessmen, as well as event promoters, social clubs and leisure centres to provide information on beer mats, posters etc., which are distributed in pubs, clubs, temples, mosques and other religious and community venues.

Three projects go further and have established protected environments for people facing social exclusion.
The Aurora project in Italy is a semi-open residential centre that aims to rehabilitate and integrate drug-addicted mothers into society. Camphill Village enables people with mental disabilities to live in sheltered settings that are suited to their needs.

5.2. Establishing low-threshold centers
A large number of projects improve access to health and health care services through the establishment of various types of low threshold centres that provide social and health support to vulnerable groups.

• **Drop-ins:** The Penumbria Youth Project offers ‘drop-ins’ for young people and offer counselling on mental health issues. These take place in designated locations or in self-selected informal settings, e.g. local café’s, where young people can feel comfortable.

• **Information desks (help lines)/Service and information Centres/Reception Centres:** An important way to improve access to health care is to establish specialized low threshold centres that combine a variety of services and provide preventative or curative health care to numerous different target groups. From Fellow Countryman to Fellow Countryman, Immigrant Health Information Desk, and Road Sweet Home offer health care as well as legal and social services to groups who cannot otherwise access these services. DIA LOGS (HIV & AIDS), the Social Help Centre and Adzon Mozaïek also serve as ‘one stop shops’, which provide a variety of services to specific groups of people at risk of, or facing social exclusion.

• **Specialised Clinics:** Dental clinics or medical practices established especially for homeless people in Sweden. Several of the Centres above also provide clinical services.

People suffering from social exclusion are more likely to access low threshold community based centres, than formalized clinical interventions. This is because they remove many of the psychological barriers to assistance and are often less intimidating or confrontational than traditional health services. Community based projects are also easier to access since many remove the logistical barriers to participation by providing accessible venues, covering transportation costs, providing child-care facilities at no or low cost and where necessary, providing access to interpretation. Such features are often cited as important factors that contribute to the success of the good practices, since they make it easier to involve people who may not otherwise have sought assistance.

While many of these services provide specialized care that is suited to the needs of specific target groups, it is important to make sure that they do not become lower quality alternatives to mainstream care, which would exacerbate the experience of being excluded. They should be designed to supplement or facilitate access to normal health services.

Ensuring that people have access to treatment is not simply about improving health, it is also about restoring dignity, since physical impairments often exacerbate the experience of being excluded. This is well illustrated by the project in Sweden that provides dental care to the homeless. Dental treatment has served to restore not only the homeless person’s teeth, but also their sense of self-respect. In many cases this has sparked a path of further change; some have started drug rehabilitation programmes, resumed interrupted university studies or made renewed efforts to get work. This good practice shows how a single intervention can contribute to a more extensive rehabilitation process.
6. COMMON VALUES AND PRINCIPLES

Many of the good practices in this compendium are based on similar underlying values and principles, such as the participation and enthusiasm of those involved. A number of the interventions also focus on addressing discrimination, which often fuels social exclusion and take gender sensitive approaches. These common principles, discussed in further detail below, ensure that projects are successful in tackling social exclusion and promoting health.

6.1. Participation

An important principle is respect for individuals and their capabilities. The Camphill Village and Housing Programme for People with Mental Problems initiatives take into account the physical and mental aptitudes of people with mental disabilities and create environments that maximize their capabilities. Other projects have taken this even further, as participants become instrumental in the running of the projects themselves. In some projects, e.g. Healthy Nutrition of Pregnant Czech and Romany Women, implementation might be top-down, but programmes evolve and develop on the basis of user feedback. In many of the community-based initiatives, community members identify their needs and help to design and implement projects to meet these needs. This ensures that interventions are tailored to local priorities and assets and enhances sense of ownership. The intention is to empower communities to act on their own health agenda.

A number of good practice reports note that their success can, to a large degree, be attributed to high levels of enthusiasm and motivation amongst all those involved. Participation and a sense of ownership are important to maintaining the interest and commitment of those concerned. Some of the good practice reports also cited trust between project participants and staff as one of their strengths. This is both a pre-requisite to and an outcome of successful participation.

6.2. Overcoming stigma and prejudices associated with groups facing social exclusion

Another important principle underlying many projects is to overcome stigma and/or prejudices associated with groups facing social exclusion. Some projects aim to reduce stigma by bringing different communities of people into direct contact with one another in order to break stereotypes. This can be done by encouraging children to visit people with mental health problems (Malta), or by creating opportunities for people with a history of mental illness to participate in the workforce, as in the User Employment Programme. This challenges preconceptions regarding mental illness and in the words of the report, “breaks down the walls that separate them from us”. Other projects such as the Glasgow-Brenham Link provide socially excluded people with platforms that enable them to express, and others to learn about, their experiences. Community projects also bring people from different backgrounds together through various sport and activity groups, which provide people with the opportunity to learn about one another. Health4me, part of the Cottoning On – Improving Health in Oldham project, tackles racism and all forms of discrimination by encouraging people from different backgrounds and ethnic groups to visit theatre performances that addressed issues of diversity. This project also enabled people from the project target group (young people and black and ethnic minorities) to interview and assess candidates for project staff positions. In the words of one participant: “It gave us the opportunity to fully understand the role of the workers. It allowed us to mix with people from different backgrounds and cultures who were also involved in the recruitment which we have not had the opportunity to do before.”
6.3. Gender sensitive approaches

Many good practices are based on gender sensitive approaches and/or incorporate a strong awareness of the importance of gender sensitivity. A number of the projects are targeted primarily at women, since they are generally the main caretakers and responsible for the health of their families. The Aurora project focuses exclusively on the rehabilitation of drug-addicted mothers. Women, in many cases, are more likely to be affected by the multiple disadvantages associated with social exclusion. The report on the Community Mother’s Parent Support Programme in Thurrock, England, states that women there face a number of personal and institutional barriers that are associated with and lead to social exclusion. These include low income, low levels of basic skills, family stress, low confidence, motivation and awareness of opportunities, social isolation, lack of affordable transport and language barriers. Interventions such as Miges focus on providing women with information relating to vaccinations and nutrition. More importantly, such projects also focus on empowering women, providing training and employment opportunities and coping skills. The aim is to instil in women the confidence to stand up for, care and feel better about themselves, thereby increasing their ability and capacity to care for their families.

In order for such interventions to be successful, they incorporate practical measures that take into account the personal situation of women, (e.g. provide transportation and child care facilities). They also take into account cultural differences with respect to gender. Many women may for example, find it uncomfortable to bare their arms or legs or to talk about personal issues in the presence of men.

Two projects, Clocking on to Men’s Health and Adzon Mozaïek, focus specifically on the issue of men’s health and on the fact that different approaches are needed to reach this target group.

The first project was designed in response to the fact that men are less likely to utilise traditional health services and to receive health promotion advice in comparison with women. In the UK men are half as likely to attend their GP surgery and do so at a more advanced stage of illness. This is believed to contribute to their higher rates of mortality and morbidity compared to women. The under-utilisation of both services and information is attributed to a number of physical and social factors. These factors include machismo, traditional masculine characteristics such as being physically and emotionally strong, independent and self-contained, which impedes the ability to ask for help, show vulnerability and confront health issues. In addition, the opening hours of health services, which conflict with regular employment activity, and the female orientated environment of these services (i.e. colour schemes, available literature, and the predominantly female staff) can also inhibit access. It is therefore important to ensure that the styles and methods of conveying and delivering health information and services are gender specific.

Adzon Mozaïek offers gender-specific assistance to male sex workers. Their situation is often extreme, since they are excluded on a number of fronts. Most are illegal immigrants of North African or Eastern European decent, who are often homeless, have health problems and addictions, and lack education. Most also face multiple problems of a financial, administrative, and judicial nature and consequently mistrust any kind of social service that they associate. Often male sex workers lack the assertiveness to utilise their right to medical treatment. Many also lack knowledge on sexual health care, since general preventative campaigns do not reach them. Adzon Mozaïek therefore provides easy access, one-stop and outreach services that address the multiple and specialized needs of this particular group.
One of the common problems that many projects and programmes face is that they are based on short term funding, and thereby lack sustainability. This makes it difficult for them to have a long-term impact on the lives of the individuals involved and to influence social and political change. Many good practices in this compendium, however, illustrate and/or suggest how this can be overcome. One important method is to develop strong links with other sectors (professionals, private and education sector, etc), to generate supporting resources and funds. Another important means is to mobilize and streamline efforts to achieve common goals across agencies. Projects and programmes can build sustainability by demonstrating the effects and contribution that they can make to meeting larger policy goals, which increases their chances of becoming embedded in existing government or organisational structures.

7.1 Inter-sectoral collaboration
Health is based on and determined by a combination of different behavioural, material and psycho-social factors. Single interventions to improve health status must be supported and reinforced by other changes if they are to lead to real and continued improvements. This is the underlying rationale of many of the community projects, which are strongly based on building relationships within the community and building partnerships with agencies from other sectors that address the determinants of health. Many of the good practices involve such inter-collaboration or joined-up working.

While it is beyond the scope of this paper to address this issue in detail, the policies underpinning the good practices indicate that countries have different traditions regarding efforts to promote and even institutionalise inter-sectoral collaboration at government level. This is dependent on the nature of the historical development and structure of governments.

Whether encouraged at national level or not, a number of projects take a holistic approach to health at the local level. Work and Care reflects the collaboration between the social sector and the health sector, while many projects and programmes also establish partnerships with the education sector in order to develop and offer suitable accredited training courses. Health 4 Life provides examples of partnerships between the health and voluntary or private sector, and has approached local restaurants to provide cooking courses and the relevant department of a local college to give beauty treatments. Some Healthy Living Centres incorporate banks that offer very low-cost loans, while the Penumbria Youth Project works together with service providers including social work,
housing, criminal justice and voluntary sector homeless projects. *Clocking on to Men’s Health* also works in close collaboration with the private sector, who facilitate the provision of health related information and services to men. Other projects, such as the *Aurora Project, Programmes of Assistance for Drug Addicted Prisoners* and those providing care to the homeless involve and coordinate various different professionals such as legal specialists, psychologists and psychotherapists and educators. These initiatives aim to improve the quality of assistance provided to specific target groups. The *Health Impact Assessment* project is based on the concept of inter-sectoral collaboration. It involves assessing the effect (negative and positive) that a particular plan to open additional health services will have on health inequalities (by investigating, e.g. whether all communities will have equal access with respect to location and transportation and whether all will benefit in the same way from the nature of the services provided.)

Many projects cite inter-sectoral collaboration as one of the underlying reasons for their success and sustainability. Such collaboration has many positive effects: it relieves individual institutions, increases the effectiveness of work, improves the image of participating organisations and reduces organisational and communal costs. Many projects and programmes also note that developing effective and efficient partnerships is not easy. Amongst the difficulties raised were delays in progress due to bureaucratic processes in some of the larger organisations and differences in working culture.

### 7.2. Networking

The principle of networking is closely tied to that of inter-sectoral collaboration, since it involves collaboration amongst actors and organisations to achieve common goals. The *Merseyside Healthy Living Centre Network* was established to ensure that those applying for funding to establish *Healthy Living Centres* work together to improve their chances of obtaining funding, and coordinate their activities to ensure maximal results for the community. Some countries have very sophisticated national networks, where projects and programmes are part of umbrella organisations that support one another’s work and efforts to achieve broader policy goals. All community projects from the UK appeared to be part of such networks, as part of the effort to achieve and help shape national policy initiatives related to social exclusion, poverty and health inequalities. The good practices from Scotland were part of networks e.g. the *Community Health Exchange (CHEX), Voluntary Health Scotland* and *Scottish Diet Action Programme*. The aim of these networks is to share good practices, respond to consultations, engage directly with policy makers and politicians, provide evidence and thereby press for changes that will have an impact on poverty and health improvement. Community based programmes in the UK were also part of nation wide *Community Health Partnerships and Community Planning Partnerships*, which are divided into thematic groups such as Health and Well-being, Improving Neighbourhoods and Education and Life-Long learning. Here, project representatives meet at either the management or officer level to share experiences, coordinate activities and influence policies.
7.3 Sustainability
While the interventions included in the compendium can make important contributions to efforts to foster social inclusion, a common problem that many face is that they are dependent on (relatively short term) programme funding, which threatens their sustainability and thereby their long term impact. The constant need to apply for funding often distracts attention from project delivery. A number of the projects and programmes have, however, managed to build in sustainability in numerous ways. One of the main ways is to ensure the involvement of participants and the local community at every possible level to encourage them to take ownership. An important element of this is to provide formal and informal training and education opportunities. In the words of the Health 4 Life good practice report; “as more people filter through the programme, potentially more can be trained to assist delivery, thereby making it sustainable.” Another important method employed by many of the interventions to build sustainability has been, as noted above, to develop links with other organisations and networks and to gain the support of government structures, like local health boards. Perhaps the best way of ensuring project or programme continuity is to embed them in existing governmental or organisational structures. Krok Gezond, the Community Based Parent Education Programme and the STAD programme in Sweden have all become incorporated in municipal government structures, while Migrant Women and Physical Activity in Delftshaven has been integrated into different organisations.

7.4 Transferability
As noted in the introduction, the good practices in Part II of this report help generate new ideas and stimulate change. All good practices indicated that the projects and programmes were transferable to other countries ‘in theory/spirit’. While the specific circumstances with respect to social exclusion may vary per setting and social group, the general nature of the problem remains the same. A number of the good practice reports, however, point out that good practices cannot be transposed completely and that local and national contexts should be taken into account. The good practices may therefore need to go through a process of ‘cultural transformation’, which implies understanding the ‘simple model’ of the policy or programme being examined, while at the same time examining the ‘complex context’ within which it functions. The aim is to learn from the experience of other administrations and to apply those lessons, not simply to transfer a policy or programme from one country to another.

The project on gypsies in Navarra, Spain reflects what many good practice state with respect to transferability: “we consider that this experience can be transferred to another place, although obviously not in an identical way. The basic philosophy and the principles of action are applicable anywhere, as long as there is a minimum budget, the political desire, the sensitivity of the professionals and the involvement of the target group.” Important is that the projects and programmes respond to an established need and that initiatives are taken from ‘bottom up’. The report from the Northside Community Health Initiative states notes that “the danger in transferring (community based approaches) is that it would become agency led and community involvement would be diminished.”
This compendium provides an overview and analysis of 52 good practices, ranging from large community based programmes to small-scale projects that address the needs of a specific target group. They illustrate that the health sector, in particular the public health and health promotion sector, can make an important contribution to fostering social inclusion. People who are in good health are more able to cope with and to address their difficulties than those who suffer from health problems.

The good practices indicate that the field of health can help to promote social inclusion in a number of different ways. Firstly, it can take direct measures to improve health through for example the provision of outreach services and low threshold care to those who may not otherwise want or be able to access these services. The health field can also improve health indirectly, through training courses or health promotion campaigns that encourage people to adopt healthier lifestyles.

Secondly, many public health and health promotion activities involve social activities and group work, as well as elements of empowerment, which get people out of their houses and involved. Events and activities that address health related issues often provide opportunities to make social contacts and to feel less socially isolated. In addition, they bring different population groups in contact with one another, which can help reduce stigma and discrimination that in other cases would lead to and perpetuate social exclusion.

Thirdly, the good practices indicate that the health sector can play an important role in facilitating access to employment and by providing employment opportunities. This not only serves those who obtain training or employment, it also generates more health professionals within the community, who can provide further assistance to those at risk of or facing social exclusion.

The good practices employ many common methods that have proven effective in fostering social inclusion. These include, amongst others:

- Training courses and group work which, as mentioned above, enable individuals to expand their knowledge and develop new self-management and practical skills
- The use of experience experts and intercultural mediators who provide personalised assistance that is sensitive to both cultural background and/or social status.
- The establishment of low threshold centres to address the needs of socially excluded groups. Healthy Living Centres, which have been established in deprived areas, are an interesting example of centres that provide support to a broad range of people and help to generate social cohesion.

These methods all involve the provision of individual guidance and attention, suited to the specific needs of different target groups, which give individuals the sense that others care and can stimulate them to help themselves.
A number of common principles and values have been identified that contribute to the effectiveness of the good practices. They address real needs that are, in many cases, identified by people themselves through bottom up approaches and apply effective methods to meet these needs, again in most cases with the participation of the target groups. The involvement of committed and enthusiastic main actors is also of central importance to the success of these projects and programmes.

Many of the good practices are target group specific. They take into account the specific situation of different target groups (culture, gender, social status, etc) and ensure that information and services are accessible and conveyed or delivered accordingly. Single parents and parents experiencing poverty are, for example, often under a great deal of stress and can benefit greatly from learning coping techniques and new parenting skills. These skills ultimately advance the well-being of children and can help stem inter-generational cycles of social exclusion.

The good practices that follow are meant to provide practitioners working in the health and social policy fields with new ideas and inspiration to tackle ill health and social inclusion. They are also intended to stimulate ideas and creativity and to provide practitioners and policy makers with an indication of what works in practice.

Many of the interventions are relatively small-scale and intended to improve the well-being of specific groups, rather than to address the underlying structural problems that lead to poverty and social exclusion. Having said this, a number of good practices that began as relatively small-scale pilot projects have managed to generate broader social change. These good practices managed to survive and grow because they addressed real social needs, in many cases doing so in a multifaceted manner by developing links with other sectors (service providers, the private sector, the voluntary sector, education sector, etc).

A number of the good practices also network amongst public health and social organisations to mobilize and streamline efforts that aim to achieve common goals and to increase their larger policy impact. They were able to demonstrate their contribution to larger policy goals, thereby increasing their chances of being embedded in existing government or organisational structures. This has made it possible for them to have a sustained positive affect on the lives of the individuals and to influence social structures.

The initiatives that follow illustrate how investing in health can improve the quality of individual’s lives and generate more socially inclusive and stable societies.