Wijkgezondheidswerk: een studie naar 25 jaar wijkgericht werken aan gezondheid in Den Bosch-Oost
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SUMMARY

Community health work

A study of 25 years community based health approach in Den Bosch-Oost

The community based approach for healthcare and health promotion is considered a hopeful strategy, especially to diminish social economic health differences in poor neighbourhoods. Some important concepts are mentioned in literature, such as accessible institutions, cross-sectored collaboration, participation and empowerment. The community approach is used by primary health care, health promotion and social work. However, it is difficult to measure the results and effects of the community based approach. There is a lack of a broad theory and research about community based health approach that covers the three domains or explains the relationship between health and community.

The purpose of this study - a qualitative case study- is to unravel a more than 25 years existing practice of health community work in Den Bosch-Oost to get an insight in the important elements, its possibilities, impossibilities and results.

This study contains a theoretical framework of the ideas and activities in primary health care, health promotion and social work on the principle concepts of the health community approach in poor neighbourhoods. In addition the study contains a review of the policies in health care, health promotion and social work concerning the community health approach during the last 25 years. The different ideas about health-- i.e. the medical approach, the lifestyle approach and the social approach- are explored in the relevant literature.

Income, work and most of all education influence health. In disadvantaged neighbourhoods people’s health is worse and there is a lack of possibilities for people to improve their health themselves. To stimulate the improvement of health in poor neighbourhood there should be collaboration between health care, health promotion and social work. Nevertheless theory shows us that those domains have different views, different scales and different approaches and that policy divides them even more. (De Haan and Duyvendak, 2002)

The historical exploration of Den Bosch-Oost shows that different authors have different ideas. Some call it a conflicting community, some a disadvantaged neighbourhood and others a united community. Different ideas lead to different portraits. Social work and its community approach were very important between 1975 and 1987. Volunteers and grassroots of the community raised a lot of activities for care and welfare in this period. The health centre Samen Beter was raised in 1980 by professionals and volunteers. Samen Beter and the social work start a collaboration to support the community based activities related to care and health; this is called the network Hulpsector Oost. Social work almost disappears in the nineties and Samen Beter becomes more important to the community activities.
However the professionals of Samen Beter increasingly adapt the medical approach and disengage from the community. Nevertheless Samen Beter and Hulpsector Oost manage to improve the community based health approach by several projects and with extra financial support from different sources. This empirical study reveals that the workers (= professionals and volunteers) share a variety of knowledge about the community, about health and health care and about the approach of social economic health differences. There seems to be a difference between knowledge based on experiences or based on scientific information. As we see in Den Bosch-Oost professionals of different disciplines and volunteers share a large quantity of knowledge of their community. By working in the community they augment their knowledge by exposure. Baart’s theory of presence teaches us that exposure is the radical experience of the clash between the theoretical world, the world of the community and the professional who has to deal with those two worlds and with his own values as well. (Baart, 2001) Professionals and volunteers who are working in the same neighbourhood can share their experiences and knowledge. The experiences of volunteers and professionals are very important to choose the right approach in contacting the people of the neighbourhood. They can connect with the daily way of living and thinking of the people in the neighbourhood. By knowing what is needed in the community the workers can set up new services and activities for the neighbourhood. Working together in those services and activities they provide a lot of networks in the neighbourhood. Putnam calls this social capital with bonding, bridging and linking networks. People get support in bonding networks and have access to new opportunities by bridging and linking networks. (Swann and Morgan, 2003) In Den Bosch-Oost Samen Beter and other community based organizations are sources of social capital and also of a public familiarity as Blokland says. (Blokland, 2006) People meet each other by visiting those institutions; especially the people with infirmities are able to meet others in Samen Beter and in other meeting points in the neighbourhood. In meeting people -especially vulnerable people- Baart and van Heijst teach us that it is not the intervention that is the most important, but the attitude; to be present for those people; to keep contact with vulnerable people as long as it is needed. (Baart, 2001 and Van Heijst, 2005)

In some cases it is explored how social networks in the community contribute to the health of people. We see that social contact makes people stronger and influences their mental and physical health. Research of the ‘Health Development Agency’ in London shows the relationship between health and social capital. They say that the relationship is nuanced and they think that trust and endeavour to the community are noteworthy elements. The ‘Health Development Agency’ considers social capital a useful concept for health promotion. (Swann and Morgan, 2003)

Long lasting relationships –intensive and superficial– between professionals, volunteers and the community are important to gain trust and confidence from the inhabitants. Those relationships, accessible health services and social networks can influence health in a positive way; also the health of people in poor neighbourhoods. The modification of aspects
in a broader social environment for the time being is one of the least founded strategies for health improvement. We may conclude that within this field many benefits are still to be gained.

Another important element in the relationships between professionals and people in the community is the double actorship. People in the community are not passive objects, but active persons who are able to improve their health themselves; sometimes a tiny bit, sometimes in a substantial way. By working together in the neighbourhood professionals and volunteers show their double actorship and share their responsibilities.

Analyzing the strategies of the professionals and volunteers we find different combinations of strategies: an orientation on deficiencies or potencies in combination with either an orientation on solutions or processes. These four strategies refer to the values of the workers which are justice, compassion, empowerment or autonomy.

Justice is related to the ‘People’s Charter for Health’ (WHO, 1978) “Health is a fundamental human right and [that] the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector […].

Compassion is related to the theory of presence: to keep contact with vulnerable people and not to resign. (Van Heijst, 2005)

Empowerment is a process in which people gain health by learning to understand their situation and to change their life. They improve their situations by contact with companions (in distress) and to participate in the community. The empowerment process can take a long period of time especially for vulnerable people. Professionals should be able to make possible these long processes. As Tonkens says they need discretionary space to make decisions for the strategies that are needed. (Tonkens, 2003)

Autonomy is seen as relational autonomy. People can identify themselves as autonomous persons in relation to others. Volunteers consider autonomy essential because of the building of their own community organization in a way they think is important. It is a bottom up process based on a situational logic as Tops says. (Tops, 2002)

The inspiration and commitment of the workers in Den Bosch-Oost is driven by their values and that is why they continuously devote themselves to the community based health work for many years. This is also the main aspect in judging their results. The workers do not mention input-, throughput-, output- and outcome-evaluations. (Goumans en Koornstra, 1998; Boer en Peltenburg, 2003) They speak of the outcome or lack of outcome in complex and difficult situations. Those are their challenges. The results are nuanced and refer to their values. It is important that there is for example an accessible health service for refugees, to get in touch with a multi problem family, to inspire a woman to learn to bike or to raise a new community-activity. The results are clearly mentioned by some volunteers. Their stories reveal that the improvement of health through community based health work primarily has
a positive outcome on social health, which subsequently influences mental health and occasionally improves or eases physical health. So therefore we ought to listen to these stories. We need the stories of the people to know what the results of the health community work are. Only facts and figures will not tell us about the complexity of these results.

The case study of Den Bosch-Oost does not provide us a blueprint of the community based health approach. The way this practice is studied arouses curiosity about the way other neighbourhoods deal with the complexity of community based health work.