Competences for Poverty Reduction

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"The biggest enemy of health in the developing world is poverty."
Kofi Annan

Introduction

Capacitating for change requires a particular kind of practitioner. Scaling up the benefits of this way of working points to the need for a curriculum that equips service providers, practitioners and citizens with competencies for combating poverty and social exclusion. This paper will report on lessons learnt from COPORE (competencies for poverty reduction); a consortium of health, social and educational networks tasked by the European Commission to develop curriculum 'tuning' guidelines for poverty reduction strategies and application across a range of disciplines. Relevance of 'tuning' processes to the South African context will be highlighted (TUNING May 2012).

Background and Involvement

The European Commission dedicated 2010 to the European Year for Combating Poverty.
Since the enlargement of Europe poverty and cohesion problems have increased, 16% of the EU population currently live at risk of poverty. The number is rapidly rising, not least as a consequence of the financial crisis and the effects this has on the labour markets and the society (EAPN report, July, 2012).
The European Network of Occupational Therapy in Higher Education (ENOTHE) together with 14 other Health, Educational, Social Sciences and Clients' networks applied in 2010 successfully for a European wide project-"Competences for Poverty Reduction" (COPORE). This consortium has drawn the attention on health inequalities, related to disadvantaged groups and aimed to develop competences and approaches in higher education following the TUNING methodology focusing on affordable and accessible health care, health literacy and empowerment of clients and their community.

Aim and Objectives of the Project

COPORE has addressed several of the most burning issues in Europe related to poverty and cohesion problems and refers thereby to the WHO (World Health Organisation)'s report on Social

Determinants for Health (CDSH, 2008), that links those problems to health and well being.

Three different linkages between poverty and health – poverty as a cause of poor health, poor health as a cause of poverty and improved health as a way out of poverty – need comprehensive active inclusion strategies together with integrating health equity strategies to reduce poverty, which are described in the European Report on Social Protection and Social Inclusion 2009 in short as follows:

- Comprehensive active inclusion strategies combine and balance measures aimed at inclusive labour markets, access to quality services and adequate minimum income. Sustained work is required to tackle homelessness as an extremely serious form of exclusion, and to promote the social inclusion of migrants.

- Strategies to reduce health inequalities should focus on increased attention to primary care, prevention, health promotion, better coordination and rational use of resources. These strategies need to be more vigorously pursued, in particular where healthcare systems are under-resourced. This also implies addressing potential staff shortages in health care by measures to recruit, train, retain and develop health care professionals at all levels.

- Strategies to establish and strengthen systems for quality long-term care should include a solid financing basis, improvement of care coordination and ensure sufficient human resources as well as support for informal carers (EC 2009).

These Strategies have been incorporated in the formulation of the competences.

Thanks to the participation in the TUNING process (Conzalez J 2007) of most of the participating Thematic Networks and the discussions and reports on quality and curriculum design, the partners have been able to create appropriate tools for defining outcomes in terms of competences. They wished to use their ability to elaborate such tools and reference points to give clear recommendations, useful for educators, students, practitioners and service users on the targeted issues.

This project complied with the aims for the European year 2010 in promoting one (Higher Education Area) HEA as well as combating poverty. The overall objective of the project was to furnish guidelines and to provide reference points which would be useful in European higher education for developing poverty reduction competences.

The specific project objectives were to:

- Increase awareness about the relationship between poverty, disability, health inequalities, occupational deprivation and social exclusion

- Develop a shared set of understandings on social determinants of health and indicators of poverty
- Increase knowledge and experience of possible approaches to action
- Involvement of communities
- Develop a shared set of competences, specific learning outcomes and teaching, learning and assessment approaches
- Relate education to research
- Relate education to society
- Present recommendations defined for the competences of health, social and educational workers

Strong emphasis has been placed on involving those that experience poverty first hand in the different phases of the project.

Project Approach (What has been done)

The multi-disciplinary structure of the project tackled the multi-dimensional aspects of poverty through integrated approaches.

The following actions have been undertaken:

- Definition of a grid of good practice
- Identification of projects of good practice in social inclusion
- Encouraging students all over Europe to develop projects in poverty reduction
- Organisation of a conference (April 2010) to disseminate and discuss the value of those projects
- Recommendations for competences of health, social and education workers in poverty reduction

In the COPORE project five themes have been selected in line with the expertise of the partners and the priorities as mentioned in the following policy documents:

- Joint Report on Social Protection and Social Inclusion (EC 2009),
- Strategic Framework Document - Priorities and Guidelines for 2010 European Year activities (EC 2008)
- Health21 (WHO 1998)
- Closing the Gap in a generation (WHO 2008)
- WHO Social Exclusion Knowledge Network on understanding and tackling social exclusion (Popay J, Escorel S, 2008)

Furthermore the three basic health-related values (WHO 1998), which form the ethical foundation and underpinning for all the competences concerning poverty reduction, were applied:

• Health as a fundamental human right;

• Equity in health and well-being and solidarity in action between and within all countries and their inhabitants

• Participation and accountability of individuals, groups, institutions and communities for continued health and development.

Working groups consisting of representatives of different networks each took an important stance related to the selected themes:

1. Transdisciplinary approach in Social and Health care to prevent and/or combat poverty
2. Community development and client participation approaches to addressing health inequalities
3. Preventive and outreach approaches
4. Eradicating disadvantages in Education – (Decrease School Non-Attendance)
5. Work and worklessness

A brief explanation of what a thematic work group could entail was sent to each participant beforehand and the members of each working group were then asked to write a short statement (2 pages max.), addressing the specific theme from the point of view of the Network he/she was representing as well as his/her personal view point.

The working groups consisted of representatives of higher education institutions, from social, health and educational networks and representatives of associations concerned with poverty reduction/ or directly representing those who experience poverty or social exclusion themselves.

The leaders of the different groups summarised the submitted statements. These statements were varied and reflected different academic and professional disciplines; different geographical contexts; and different personal approaches. Such variety enriched the discussions and project outputs.

The summary consisted of the following parts:

1) Statement related to the theme
2) A short description of good practice from group members
3) Key aspects related to the theme
4) Core competences/specific competences related to the theme
5) Approaches to teaching learning and assessing competences

The summary was used to help structure the discussion at two workshop sessions in the COPORE conference. A paper that summarised competences drawn from all statements also helped to inform the discussion.

Each working group was asked to discuss and report on their specific topic, as well as to discuss and develop statements about the competences needed for poverty reduction and approaches to teaching/learning and assessment that are/would be useful for forming and assessing those competences, using the interdisciplinary expertise of the networks.

After reviewing literature and policy documents, reflection, debate and consultation in the form of working groups, which has proven to be a successful methodology in Tuning projects (2000 - 2008) and analysis of the results of the group discussions of the conference the core competences have been divided in 5 domains:

Knowledge, Strategies, Collaboration and partnerships, Research and quality improvement, Management and leadership. Close cooperation with and consultation of experts (including those who experience poverty) in the field of poverty reduction and (in) formal learning at national and international level has been essential for achieving the description below.

CORE COMPETENCES for POVERTY REDUCTION (COPORE pg 41-44)

Domains	The professional is able to:
Knowledge	Analyse the multifaceted phenomena of poverty, and its interrelationship with social exclusion, social determinants of health and health inequalities.
	Critically analyse conceptual frameworks for understanding social exclusion in the context of health inequalities, in order to critically review existing policies and actions.
	Recognise that exclusionary processes create a continuum of inclusion/exclusion characterised by an unjust distribution of resources and unequal access to capabilities and rights.
	Recognise the underlying relationship between social inclusion (including social determinants of health) and human rights (action to promote and protect human rights will reverse exclusionary processes and promote social cohesion and health.)
	Develop conceptual and methodological frameworks to work on improving social determinants of health according to the needs of the actors involved, taking into account the cultural diversity of the population
	Understand that the complex and multidimensional nature of exclusionary

	processes require structured and formal mechanisms to manage political processes and action responses which cut across sectors (health, education, social, financial) Recognise the limitations of professional education and knowledge and give greater status to 'lay' and indigenous knowledge. Critically analyse the ethical dilemmas inherent in poverty, including issues of power, sustainable environments, and legality.
Strategies	Work to provide universal access to living standards which are socially acceptable to all members of society Attend to all the dimensions of exclusionary processes - social, political, cultural and economic – and the interactions between them when developing, implementing and evaluating policy and action. Promote and support community empowerment, for example through community development and capacity building, such as technical skills and competences for problem solving Use a community oriented approach which has a local, universal, and comprehensive focus and respects cultural diversity Promote and advocate for societal change through mass media and the general public Develop strategies to extend the current limits of practice, for example towards an integrated intersectoral approach Employ a dynamic ethical framework to critically reflect on and respond to ethical dilemmas
Collaboration, partnerships	Demonstrate respect for individual, group and community rights to freedom of choice, equality, confidentiality and cultural diversity Identify and collaborate with partners in different sectors to address poverty and social determinants of health Establish and maintain networks with key stakeholders Proactively seek and build sustained and meaningful engagement with clients and communities to shape services and improve health and well-being Engage with clients, their families, carers and communities as partners in the management of change Collaborate with community partners to promote the health of the population Recognise the complexity of communication and work to identify and overcome communication barriers (for example communication in different

	languages or making use of translators), resolve conflict, and promote successful communication within networks and between sectors
Research and quality improvement	Use both quantitative and qualitative data, indicators and stories, recognising that the nature and impact of exclusionary processes can only be adequately 'represented' from both angles
	Undertake research and utilise research findings on all dimensions of exclusionary processes – social, economic, cultural and health
	Obtain 'evidence' on the impact of all aspects of exclusionary processes on health status and health inequalities.
	Describe and evaluate the action of social movements and community groups in addressing exclusionary processes.
	Appraise policy and action-research to tackle social exclusion
	Explore and develop creative research methods, such as photo voice, digital storytelling, that are led by and include the community
Leadership and management	Manage and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements
	Lead ongoing and meaningful engagement with partners to inform strategy, and drive quality, service design and resource utilisation
	Contribute to the design and implementation of policies that transfer real power to the targeted people
	Adopt a participatory approach to leadership, including shared responsibility
	Manage resources, and design and implementation of strategies, in support of social change

The specific competences for poverty were divided in 5 themes or approaches towards poverty reduction which have been mentioned at the beginning of this paragraph (See further COPORE 2010)

Identification of Good Practice

A survey on the latest research and best practice in poverty reduction through health and social care was conducted in order to publish, present and disseminate, as well as to analyse, the required competences for health and social care workers and policy recommendations for practice.

The COPORE project called for examples of services/projects/programmes in Europe, that address poverty reduction at different levels (e.g. system level, practice level), either directly or indirectly. Poverty, social exclusion and health inequalities are linked. Projects addressing health and poverty

issues in education, social and health service provision or, preferably, in combination, were invited to send a description of their work.

Nine such projects demonstrating good practice were invited to present their experiences at the conference in April 2010. The selection committee based its' selection on the criteria mentioned in the annex 1-Grid of criteria for good practice-. In addition to these criteria, the selection committee also tried to assure, as far as possible, to have a regional balance that meant; the inclusion of good practices from regions in Europe where poverty reduction practices are not as common as in other parts of Europe.

The nine selected good practice projects were:
- The Bromley Bow Centre
- Creating a centre of excellence in the delivery of integrated services: Ruse Complex for the Social Support of Children and Families
- Empowering Learning for Social Inclusion through Occupation (ELSITO)
- Empowerment and linking against poverty
- General qualification strategies for integrated health and social-coordinators exemplified via the poverty reduction project "Herzwerk"
- Miquel Marti I Pol project
- Prevention and Poverty
- Reducing youth worklessness through building bridges between university and labour market: the case of social work student practices
- Safety house

As an example here a short description of one of the projects of good practice will follow: *ELSITO* (Empowering Learning for Social Inclusion through Occupation) emerged from the identified need for occupational therapists to develop those competences that enable them to address the needs of the large number of persons within the European Union facing exclusion due to social and health factors. Although the central importance of participation in community-based occupations for all persons is recognised, it was perceived that for many occupational therapists, working within the established services and institutions, there was a gap between this knowledge and practice.
Learners in this partnership were all those involved in the projects, including service users, staff, occupational therapists and occupational therapy students.
The partners learned about the process and the experience of social inclusion through sharing lived experiences, both during international visits to each other's organisations and through local projects.

The partners learned about good practice in social inclusion through descriptions of good practice and through the narrated experience, the stories of learners, both from the partners and from projects throughout Europe (Bruggen 2011)

Conceptualizing the strategies

At the core of the COPORE project there are two strategies:

Firstly for developing the competencies and learning strategies- the TUNING methodology

The Tuning methodology includes a continuous involvement of all stakeholders in feedback groups, what was used in this project before, during and after a COPORE conference in order to achieve a high quality set of competences, that will be accepted in the higher education area as well as in practice and by the community.

Tuning is a collaborative, consultative process involving academics working in subject groups with employers and other stakeholders in curriculum development to enhance student competences.

The Tuning methodology has been designed to understand curricula and to make them comparable.

Five lines of approach have been distinguished to organize the discussions in the subject or thematic areas:

1) generic (general academic) competences,

2) subject-specific competences,

3) the role of credits as an accumulation system

4) approaches to learning, teaching, and assessment and

5) the role of quality enhancement in the educational process (emphasizing systems

based on internal institutional quality culture).

Each line has been developed according to a pre-defined process. The starting point was updated information about the state of the art at European level. This information was then reflected upon and discussed by teams of experts in the subject related areas. It is the work of these teams, validated by the respective European networks, that has provided understanding, context and conclusions which can be considered valid at European level. All together, the five lines of approach allow universities to "tune" their curricula without losing their autonomy and at the same time stimulate their capacity to innovate (Conzalez J 2007)

Second strategy is for poverty reduction- An inclusive community development approach with the idea that participation of all people in community is possible.

The role of health and social care workers needs to go beyond the traditional role of working with individuals with impairments and (occupational) needs in the health care sector to facilitating inclusive communities and improving Social Determinants of Health like living situations, self

employment, education and leisure. The development of collective approaches in which all individuals find their place is an essential step towards combating poverty and developing the concepts and practices necessary for an inclusive community (van Bruggen 2008). Four strategies inherent in implementing community development approaches have been included in the poverty reduction competences: establishing partnerships (Tennyson 2003), capacity building (Morgan 2006), facilitating inclusion, and managing for impact. Working with communities implies that the individual is considered as a citizen within the community with rights as well as responsibilities and obligations. Working in this way will constantly challenge and confront therapists, social workers and educationalists. However, all of them will be encouraged to be pro-active and become involved at all levels to ensure that community issues of marginalisation, poverty and mainstreaming are effectively tackled (van Bruggen 2008).

Recommendations for scaling up

Since this was only a one year project, the results have been widely disseminated among the different networks and they have been encouraged to stimulate their members to implement the competences.

Continuous partnerships

COPORE has intensively worked together with several of the projects of good practice like ELSITO (Empowering Learning for Social Inclusion through Occupation), EEE4ALL (Euro- Education-Employability for All), Martin I Pol Garden.

These projects will continue to demonstrate the sustainability in partnerships between Universities and community that will be a way forward for students to acquire competences for poverty reduction in an interdisciplinary team with the community.

Tuning Africa

The 2007 Joint Africa-EU Strategy and First Action Plan (2008-2010) emphasized the importance of cooperation with Africa in higher education to build high-quality tertiary capacity through networking, mobility of students and scholars, and institutional support and innovation.

In September 2009 a feasibility study started to investigate the appropriateness and the possible contribution which could be made by the Tuning project to the development of the different strategies developed by African authorities and experts (Final Report April 2011).

As from December 2011 a pilot project has started with the aim to develop in 5 disciplines (competences for the whole of Africa. It can be expected that also themes like poverty reduction will be tackled in the future.

Further research

Research is in progress on the process and the sustainability of this kind of partnership-projects, and the effect on the empowerment of the people. The COPORE project is exchanging their results with a research project in South Africa called: 'People Informing Policy: Power & Progress'.

The research partners have been building occupational therapy theory and practice by investigating core professional constructs associated with occupation and learning how to engage marginalised communities including people with disabilities in working towards social inclusion. Poverty in the Mpoza district is shaped by remoteness, underdevelopment, de-agrarianization and adverse incorporation (Du Toit & Neves 2007), providing a case study context for unprecedented occupation centered social inquiry into disability dynamics. The research has created opportunities for gathering information pertinent to the principles of community based rehabilitation (CBR 2010) and comprehensive COPC (Maeseneer 2007) in under-resourced areas. The academic partnership continues to inform social inquiry methods in the context of language and cultural difference and occupational therapy curriculum and practice through professional associations. The Competencies for Poverty Reduction (COPORE 2010) have been helpful in guiding the profession in benchmarking its role in improving the social determinants of health (Duncan 2012). However it is important to research the African SDH to better tackle the root causes of health inequality, and for supporting and promoting the global effort for achieving a better health for all (Eshetu 2011).

The COPORE project intended to be pro-active, proposed tools to deal with the situation, not simply to criticise it. Not only are health and social care students given very few opportunities to collaborate in real situations and at higher levels of study (i.e. up to and beyond the PhD) to do together research, but often are complex situations reduced to one discipline. Once again this project has produced concrete guidelines in the area of poverty reduction, and working together may develop new insights.

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Annex 1- Grid of Criteria for good practice in poverty reduction within social and health services at community level

Objective:

- To identify best practices for the COPORE (Competences for Poverty Reduction) project; a survey on the most up to date best practices in poverty reduction through health and social services at community level

Below are the criteria for a ''best practice'' in community centred social and health service provision according to the COPORE project:

1) **Access to services**: Is adequate health, social and psychological service provision available without any barriers for the entire population served by the social and health service at community level?
   a) **After-hours access to services**: Has the social and health service at community level made organisational arrangements to provide access for clients to services during the evening and weekend?
   b) **Close-to-client setting**: Is the social and health service at community level located in close proximity and direct relationship to the community?
   c) **Accessibility**: Is the setting easily accessible, both physically and mentally?
   d) **Affordability**: Does the service provided remain financially sustainable for the population served by the social and health service at community level?
   e) **Proactive**: Do the social & health services undertake action to reach citizens who do not find their way towards the resources themselves?
2) **Comprehensiveness**: Does the delivery of social and health service at community level consist of a comprehensive range of resources including health promotion and prevention interventions, as well as diagnosis and treatment or referral, chronic and long-term home care, and related to social, educational, occupational and other services/ centres?
   a) **Risk assessment**: Are risk assessments used to keep track with a) the needs of the population involved or b) the survival strategies of the clients in their environments?
   b) **Adapting services**: Does the social and health service at community level adapts its' service provided according to the changing needs and preferences of society and individuals?
   c) **Monitoring services**: Is the service provided monitored to prevent it from stagnating or ending prematurely?

3) **Continuity of services**: Does the social and health service at community level use a consistent and coherent approach to the management of a client's health, social and occupational status over time that exceeds single episodes of service delivery?

   a) **Regular point of entry**: Is the social and health service at community level a regular point of entry into the service system, which results in an enduring relationship of trust between providers and their clients?

   b) **Integrated services**: Are the different aspects of comprehensive social and health service delivery integrated?

   c) **Integrated into other levels of the service delivery system**: Is the social and health service at community level able to cooperate with other service providers at other levels like secondary and tertiary health care, residential care, care in prisons, etc?

4) **Coordination of services**: Does the team working at the social and health service at community level coordinate the services for their population?

   a) **Responsibility for a well-defined population (listed clients residing, legal or illegal, in a certain geographical area)**: Is the social and health service at community level entrusted with the responsibility for a well-defined population (in its entirety: the sick and the healthy, those who choose to consult the services and those who choose not to) and do they accept this responsibility?

   b) **Gate keeping role**: Does the social and health service at community level and its' team function as a gatekeeper for clients entering the service delivery system?

   c) **Proactive role**: Do the organisation and the team make an effort to find those who do not access the system by themselves?

5) **Effectiveness and safety**: Is the service provided effective, morally justifiable and safe?

   a) **Measuring quality of services:** Does the social and health service at community level regularly measure and undertake actions to improve the quality of their provided service or part of their services?

   b) **(Multidimensional) evidence-based services:** Do practice staff in the social and health service at community level have clinical or methodological guidelines at their disposal which are frequently used?

   c) **Efficacy:** Are the goals identified and achieved by the service providers also perceived as priorities by beneficiaries

   d) **Ethical and moral issues**: Are ethical and moral issues weighed carefully and discussed regularly to ensure politically and humanely justifiable care?

   e) **Creativity**: Is the project original, fun and unorthodox as well as effective?

6) **Multi-professional and inter-sectoral service delivery**: Are different professionals involved in the service delivery?

   a) **Inter-professional collaboration**: Is inter-professional collaboration between these different professionals present at the social and health service at community level?

   b) **Inter-sectoral collaboration**: Does staff at the social and health service at community level collaborate with professionals from other sectors like education, police, housing-agencies, etc?

   c) **Less obvious collaborations**: Is there (attention to) collaboration with less obvious partners who can make a valid contribution?

7) **Person/people-centred service delivery**: Are people at the centre of service delivery in the social and health service at community level?

   a) **Community orientation**: Does the social and health service at community level have structured connections with the community (e.g.: regular meetings with local authorities, representatives of the community / civil society / local trades' people, volunteers, client-run organisations, social networks, etc?

   b) **Client/community-participation**: Do clients, families and/or communities actively participate in gathering information, planning actions/interventions and monitoring outcomes?

The criteria above can be used at three different levels:

-   System level
-   Social and health service at community level
-   Specific project (Innovation) level

At all three levels indications can be given if certain criterion is present or not present with a sliding scale between these two outer limits.

Depending on the scores at the first level (system level), a social and health service at community level can be a best practice in one system whereas it might be just average in another system.

The same can be valid for certain pilot projects in social and health service at community levels: in one centre or care system it can be a huge innovation but in another centre it might be seen as average for the standards in such a centre and/or care system.