Amsterdam; 7th of january 2010

- To whom it may concern -

Collection of good practices:

Descriptions of good practices must be submitted by **1 February 2010**.

Selection of 20 best projects for the booklet will be by – **1 March 2010**

The 5-10 best projects will be invited (and receive financial support) to attend and/or present their projects at the COPORE conference on the **23rd and 24th** of April in Amsterdam.

Poverty is often associated with developing countries, where a lack of food and clean water can often be a daily challenge. Europe is also affected by poverty and social exclusion. It may not be as severe, but is nonetheless unacceptable. The European Union is one of the richest areas in the world, but still 17% of EU citizens have such limited resources that they cannot afford the basics.
There is no miracle solution to put an end to poverty and social exclusion. However, one thing is sure: we cannot win the fight without collaboration with different stakeholders.
COPORE (COmpetences for POverty REduction), a collaborative of different networks in education and social- and health care wants to identify and describe competences for poverty reduction for education in both social and health area. We feel that a lot can be gained on poverty reduction via for example inter-professional collaboration and training of future professionals.

The COPORE project is calling 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, are invited to send us a description of their work. Those practices will be collected in a booklet that will be distributed among the networks of project-partners and other stakeholders. The benefit for you is to raise the profile of your work within an international context and to enable you to share good practices with your colleagues in Europe.

Selected practices will:

- get the opportunity to attend the conference
- be listed in the final report

Five good practices will be invited to present their experiences at the conference (23/24 April 2010). The selection committee will base its' judgement on the criteria mentioned in the annex. On top of these criteria, the selection will assure as much as possible a regional balance, an attempt to include as much as possible also good practices from regions in Europe where poverty reduction practices

are not as common as in other parts of Europe. Please note that even if your project/service does not meet all criteria mentioned in the annex, but you feel it is working towards poverty reduction please feel free to send in your description of your work.

Descriptions of good practices within services, projects or programmes should outline the following key-aspects:

- Title
- Context of the practice (at micro, meso & macro level if applicable)
- Description of the good practice
    - In relation to the items mentioned in the annex
    - In relation to competences needed
- How does your practice address poverty reduction
- What are the key-words for your success
- Contact information

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An appeal process is in place if you disagree with the judgement.

We hope to receive many good practices showing that Europe has a high level of poverty reduction which is ready to be disseminated throughout the different regions and countries involved. Looking forward to your response!

The COPORE team

more information is to be found at : http://www.enothe.hva.nl/projects/docs/copore_webside.pdf

Annex:

1) **Access to services**: Adequate health, social and psychological service provision is 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**: The service provided remains 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 don't 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 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 overtime 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 intersectoral 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) **Intersectoral 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?