



Capacity building in health promotion, Part 2: whose use? And with what measurement?

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ABSTRACT *Capacity building has been a topic in health promotion literature for several years. In our previous article, we discussed community capacity building as both means and end in health promotion work, and reviewed seven theoretical and empirical models of community capacity which provide a total of nine separate capacity domains. In this article we discuss the parallel tracking of community capacity building in health-promotion program planning, implementation and evaluation, and describe workshop methodologies for incorporating capacity assessments within health-promotion program planning. We conclude with a discussion of measurement options for community capacity building.*

Introduction: Community capacity as a parallel track

The idea behind community capacity building as a parallel track in health promotion programming and evaluation rests on several points covered in part one of this article, which are summarized below:

- Community capacity building is unlikely to be undertaken as a program in its own right. Besides the risk of such a program being patronizing, capacity exists only in relation to specific groups, activities and issues. It is around these groups, activities and issues that capacity is built or increased in a way that allows group members to generalize it to other activities and issues.
- Health-promotion programs are funded around specific groups, activities and issues. These may be defined in more conventional, health behaviour terms (e.g. heart health and individual risk factors), or in more structural health determinants terms (e.g. poverty, unemployment, racism, pollution and other risk conditions). As well as being ends, these also become the entry, or means, around which community capacity as a separate end can be enhanced.

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- Data on risk conditions (population health determinants) should be monitored as part of the program, and some evidence-based argument for how the program contributes to their amelioration should be developed as part of program evaluation.
- Data on specific program goals/objectives should be collected as part of program evaluation, with the caution that, if community members are involved in establishing such goals, it is probable goals may change as people learn in action.

Our first article (Labonte & Laverack (2001), this issue) reviewed several models of community capacity. The model first developed by Laverack (1999) was used as a template, and embodied nine separate capacity domains. Using these nine domains, the additional question community capacity-building poses for program planners is this:

How can the program in which they are involved, from its planning, through its implementation to its evaluation:

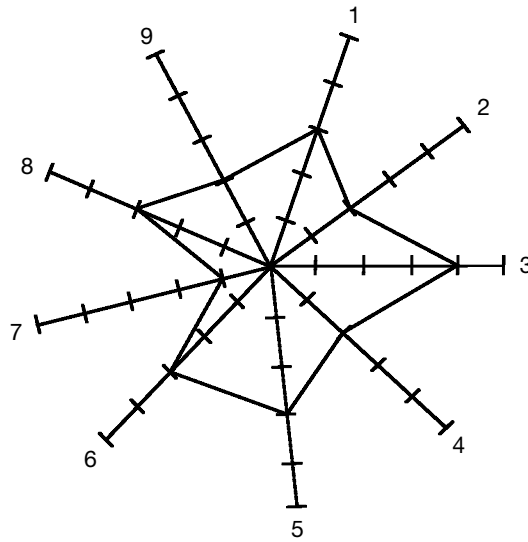
- improve community participation;
- develop local leadership;
- build empowering organizational structures;
- increase community members' problem assessment capacities;
- enhance community members' ability to 'ask why';
- improve community resource mobilization;
- strengthen community links to other organizations and people;
- create an equitable relationship with outside agents;
- increase community control over program management.

The remainder of this article deals with methods and measurement issues associated with use of these community capacity domains.

Methods and measurement

Methods for assessing change in these domains are multiple: key informant interviews, focus groups, surveys, program plans, other forms of documentation (practitioner logs, minutes of meetings, etc.). There may also be opportunities to gather information that are integrated as program activities, e.g. using sociograms to measure changes in social support and networks, or network analyses that inform people of existing relationships along which resource flow might be increased. Such techniques are part of the program itself—they are *critically educational*—as well as being sources of information for evaluating change. (Have the sociograms changed? Have the networks increased in density and resource flow?) Incorporating such techniques into program activities also fits well with capacity building as a parallel track.

A 'spider-web' mapping technique, based on a summative ranking of selected domains, has been used with some success in evaluating community participation



Legend

1. community participation
2. local leadership
3. empowering organizational structures
4. problem assessment capacities
5. ability to 'ask why'
6. resource mobilization
7. links to others
8. equitable relationships, outside agents
9. community control over program

FIGURE 1. An Example of a Spider-Gram of Community Capacity Domains

in health services (Bjaras *et al.*, 1991). It is also one used or urged by several of the community capacity models (Bopp *et al.*, 1999; Laverack, 1999; Hawe *et al.*, 2000). (See Figure 1 for an example.) Its strengths are its visual presentation of change in multiple domains that is quickly communicated. But three methodological questions immediately arise: How is the ranking determined, who assigns it and how is it empirically validated?

Determining the rank

The three community capacity models that have moved into measurement all suggest some form of ordinal ranking (Bopp *et al.*, 1999; Laverack, 1999; Hawe *et al.*, 2000). Bopp *et al.* (1999) provide numerous prompting questions to guide assigning a summative rank for each domain. Hawe *et al.* (2000) provide a number of statements that require independent ranks, though the elements of their domain, and how they should be scored, are still being field-tested. Laverack (1999) developed full statements for each rank in his scale, for example, his scale for participation:

- Not all community members and groups are participating in community activities and meetings.
- Community members are attending meetings but not involved in discussion and helping.
- Community members are involved in discussions but not in decisions on planning and implementation; they are limited to activities such as voluntary labour and financial donations.
- Community members are involved in decisions and planning and implementation; mechanisms exist to share information between members.
- Participation in decision making has been maintained; community members are involved in activities outside the community.

This is a useful improvement over wholly subjective rankings, especially if the intent is to monitor changes in the domains over time. Otherwise, how would one interpret the assigned scores? It also has problems. Foremost among them is the assumption that development of the domain is linear, or that a linear development leading to the highest ranking is desirable. Bjaras *et al.* (1991), for example, assume that community control over a health program is superior to an agency/community partnership. But given the need to maintain external resource flows, such a partnership may be more desired than community control.

In field testing, Laverack found that pre-defined rank ordering led answers and was experienced as imposing. The domains and descriptors were not always relevant, and he now argues convincingly against pre-determined rating schemes (Laverack, 1999). He transformed the ranking system into a workshop methodology and built it into the process of program planning itself. This methodology is similar to that proposed and field tested by Bopp *et al.* (1999).

Assigning the rank

Bjaras *et al.* (1991) base their method on repeat interviews with community leaders/informants. This is similar to the methods used by Eng & Parker (1994) to evaluate community competence. Hawe *et al.* (2000) do not indicate who should rank community capacity, but their complete indicator set is oriented to health promoters and their agencies. Laverack (1999) and Bopp *et al.* (1999) suggest the ranking should be made by both health promoters and community members for whom the program is targeted. There is no simple guide for choosing which community members to invite (inclusive is not a helpful instruction), or when to workshop the rankings (ideally, before a program starts, but that requires some reasonable relationship between the health promoter, his/her agency and the community group to have already developed). Much has been written on stakeholder identification and community outreach that can guide practitioners and agencies in this area. Their ability to engage community members in such a process might again be considered an indicator of their capacity to develop programs in a capacity-building way. Methodologically, involving the same people in assigning

ranks is preferred if ranks are to be used to assess change over time. Subjectivity in assessing community capacity can never be eliminated, but its magnitude can be constrained.

Validating the rank

The inherent subjectivity of measuring community capacity reflects a dilemma common to social indicators. Objective indicators, such as those for health-determining conditions, represent expert opinion that may not be shared by community members. Subjective indicators, or people's perceptions of such conditions and outcomes, may reflect the well-known tendency of persons living under objectively awful conditions to think that things are not that bad (Hancock *et al.*, 1999). Including both types of indicators in an evaluation scheme allows engaged community members to question any apparent dissonance between them. This questioning is another example of *critical education*, the results of which form more evidence useful in program evaluation.

With specific reference to community capacity, the validity of the ranking is strengthened if the assessors are required to offer some defense for it. This is where checklist or prompting questions, such as those developed and Bopp *et al.* (1999), or the descriptors for different values developed by Laverack (1999), are helpful. They define a context in which assessors can reflect on their ranking. As we stated earlier, this also risks imposing assumptions not shared or relevant to community members. Laverack, in his workshop methodology, overcame this problem by including the descriptors, but detaching them from a rank value. It was up to the workshop participants to assemble the descriptors for each domain into a ranking scheme that made sense to them.

A workshop methodology

The workshop methodology is, essentially, a planning meeting in which health promoters and key community representatives meet to reach agreement on:

- the capacity domains: Do they understand them? Do they capture an important quality for that community? Is the description of the domain relevant? Laverack, working in an inter-cultural context (European–Fijian), found that considerable prior effort was needed to determine conceptual equivalencies. This does not render the domain selection 'radically relevant', changing with each group or context. The addition, deletion or amendment of a capacity domain needs some well-defended argument;
- ordering the descriptors into a ranking scheme;
- discussing where their community ranks, providing reasons *why* the rank is assigned. Differences might arise at this point, and obtaining a consensus rank may be difficult. Subtle power relations within the group can distort individuals'

personal preferences to a forced agreement. Both Laverack (1999) and Bopp *et al.* (1999) elaborate on ways to overcome these difficulties, which would be familiar to experienced group workers/facilitators;

- discussing where the community *should be* and, in broad terms, some actions that could begin to move it in the desired direction;
- identifying resources required to take actions, including the health promotion program as a potential resource.

Additional rigour can be added by gathering an additional number of individual informant ratings, using the domain amendments and ranking scheme adopted by the rating workshop members.

Planning on the health promotion program follows the capacity assessment. The question posed at each step in the program cycle (planning, implementation, evaluation) returns to the community capacity assessment: How can the program help to increase capacity in each of the different domains? (See Laverack & Labonte 2000 for more discussion on this point.) The same rating workshop group and additional individual raters can repeat the assessment from time to time over the program life. The question for the program then bifurcates:

- How *has* the program helped to improve capacity in a given domain (and how do we know this, what other documentation or evidence can we cite)?
- How *can* the program improve it even further?

Experience with both methodologies suggests an assessment of all domains can be made during a single day-long workshop.

Thought experiment

The thought experiment below speculates on how a program might change by parallel tracking community capacity outcomes. Imagine a community heart health program, one aware of the direct effects of risk conditions (poverty, unemployment) and psychosocial risk factors (isolation, self-blame) on heart health, as well as their indirect effects on health behaviours (smoking, diet, fitness). Consider how their program planning might take into account each of the community capacity domains:

Participation: Urging people to attend classroom-style education sessions is less likely to attract participation than organizing events based around community members' interests. The program organized people around outdoor picnics and neighbourhood tours (what was liked/not liked in the area).

Leadership: Developing local leaders means working with their existing strengths and providing positive rewards for their efforts. The program used local women volunteers with good networks, cooking, organizing and child care skills to plan

the picnics and neighbourhood tours. They became new local leaders for what eventually became a broader health-promotion project aimed at a variety of issues, including housing, environment and employment.

Organization:

It may not be necessary to create a new organization. A sufficient number with good internal processes and ample citizen participation might already exist in the neighbourhood. If this is the case, they should be strengthened by a heart health program, not competed against. The program realized the locality lacked strong community structures, and used heart health, the picnics, the tours and other initial activities to lay the framework for a new organization. The organization would not be restricted to a heart health mandate.

Assessment/analysis:

Most people are aware of health behaviour risks. They are also aware of the impact of their living conditions on their health. Rather than an 'education and awareness' approach to heart health information, the program organized different educational events. These included *some* information on heart health. But they were also designed to engage community members in assessing both *capacities* and *problems* in their neighbourhood (what makes people in this area healthy? what makes them ill?). This information became the basis of planning new activities, both short term (to keep participation active) and long term (to work on underlying risk conditions).

Resources:

The program came with some resources. These were largely tied to conventional heart health outcomes. Health promoters attempted to co-opt what they could of their own time and funding to support the broader-based organizing they had helped initiate in the community. More importantly, they accepted the responsibility of working with the new organization to attract both internal and external resources for issues that fell too far afield of the funders' ideas of what were legitimate risk factors for cardiovascular disease.

Links:

It is easy to link heart health programs with one another. The program did this, but was more interested in linking the new group to those undertaking similarly broad-based, local organizing. This included brokering ties with politicians and policy makers (especially around health-determining risk conditions), and supporting their advocacy on these issues through their own health agency statements.

Outside agents:

Health promoters, and their program, were the primary outside agents in this case. They maintained critical

self-reflection on their own roles: Were they imposing? Facilitating? Empowering? This ongoing self-assessment was supported by their agency managers.

Program control:

Over time, and as additional resources were obtained, the new organization took on more direct control over their activities. Heart health was only one component, a useful one on which to cut their teeth. But control here generalized to the broader range of issues and organizing efforts. The health promoters and their agency did not pull away when these issues fell outside of the conventional heart health risk factors.

Conclusion

Several models of community capacity exist, as do many approaches to its measurement. Several models are now testing measurement more fully (e.g. Goodman *et al.*, 1998; Jackson *et al.*, 1999a, 1999b; SDH & Labonte, 1999), or are applying initial measurement field-tests to other situations (e.g. Bopp *et al.*, 1999; Laverack, 1999; Hawe *et al.*, 2000). None of these models necessarily seeks to know the 'truth' of community capacity, nor to render it into a simple set of numeric expressions. Community and its capacities are social phenomena too changeable to understand in the way we might decode, path analyze or render into discrete variables the genetic, pathogenic and behavioural bases to certain diseases. If we are seeking to fix community capacity in amber, and then provide funders and agencies with its precise metrics, we should desist now. Such an approach risks more political harm than good to the processes of healthy (socially just, environmentally sustainable) social change.

Nonetheless, there is a logic to community capacity as a constitutive element of human development to which health promotion programs make a small, but not trivial, contribution. There are also several qualities of community capacity around which, for the moment at least, there is some theoretical, empirical and pragmatic agreement. This agreement is largely, but not exclusively, Eurocentric. Laverack's work was field tested in Fiji; Bopp *et al.* (1999) base their model, in part, on work with First Nations communities in Canada. There are also useful and usable methodologies for incorporating an assessment of community capacity into health-promotion program design. It is also helpful to recognize that the workshop methodologies field tested by Laverack (1999) and Bopp *et al.* (1999) are not only means to the end of assessing community capacity building. They can also actively build capacity in their own right, as vehicles for participation, venues to develop leadership, starting points in new organizational development, means to increase peoples' abilities to assess problems and analyze contexts, and so on.

But there is a larger-order issue here that cannot be left unstated. Improving community capacity is not a panacea to complex social problems arising from unregulated economic globalism. Neither is it a substitute strategy for the

re-creation of strong and democratic states, and their legislative and programmatic commitments to wealth redistribution and environmental sustainability. These points have been made strongly in the UK by the Acheson Report (among many others) (Acheson, 1998), and internationally by no less than the United Nations in its recent Millennium Report (United Nations, 2000). Community development (capacity building) approaches to health promotion need always to keep their eye on the national and global policy ball, or risk an ultimately inconsequential and disempowering localism. So, too, evaluation of such work needs always to monitor objective trends beyond those of the more capable community. It is partly for this reason that this paper does not argue that capacity measures should supplant others now used in health-promotion evaluation. Rather, capacity indicators join two others: those measuring program-specific goals or objectives, and those measuring population health determinants at the deepest, broadest and most important levels.

Not only should this approach improve health-promotion program evaluation. It should also improve its practice.

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