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INCREASING COMMUNITY CAPACITY AND
EMPOWERING COMMUNITIES FOR PROMOTING HEALTH
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EXECUTIVE SUMMARY

This technical report addresses the subject of community capacity building and empowerment of communities for promoting health. It reflects greatly the current situation of health promotion development in Latin America.

If the desired outcome of Health Promotion (HP) is equity, its main objective should be to implement participatory strategies. It is not possible to develop a convivial and healthy environment without the participation of individuals and communities. Unfortunately, the health sector has been unprepared to assume a leadership role in responding adequately to the expressed needs of the people through policies and decisions that improve their quality of life. Understanding the relationships of HP with social change, social capital construct, and power distribution is essential for orienting work towards community involvement to achieve health goals and better quality of life for all.

Building Community Capacity (CC) and empowering communities oriented to improving living conditions are complex and difficult social and political processes. It is not possible to implement them in a vacuum, people need incentives to participate. The best incentive is to provide individuals with opportunities to resolve situations that affect their daily life. However, CC is based on bottom-up movements with top-down political support of governments. Having governmental support is not always possible, resulting in frustration of professionals, leaders, and community members. Also, working with communities require a great deal of commitment to social excluded groups. It also requires listening to people and having respectful attitudes towards their rights and values. In working with communities to promote health, several abilities and skills from diverse disciplines and fields are needed. Examples include advocacy, negotiation, policy formulation, strategies for the development of social networks, and participatory techniques. A revival of Freire's theories on popular education for the liberation and consciousness of individuals is linked to empowerment concepts and action. Concentrating in the problem-solving capacities of communities is essential for obtaining success in participatory work.

The utilization of new technologies and strategies for communication is a powerful instrument to strengthen community organizations and groups. A key factor is to identify and involve important stakeholders at each level. Stakeholders from different sectors, organizations, institutions, voluntary and professionals associations, need to be invited and motivated toward the goals of CC building and community empowerment. Health workers need to redefine their role to facilitate the participation of community organizations and local communities. HP projects that stimulate CC building have great potential for local development. Current Health Sector Reforms in Latin America need to be evaluated to determine if they are affecting negatively participatory processes, and increasing inequities. The measurement of changes in social capital, CC and community empowerment that modify health status and quality of life are urgently needed. Showing the beneficial outcomes of increased CC is a challenge for HP in the near future.

Despite the existence in Latin America of inspiring experiences of community participation and empowerment of powerless groups, there is still a desperate need to encourage strategies of CC and empowerment given the persistence of inequities in health.
TECNICAL REPORT: INCREASING COMMUNITY CAPACITY AND EMPOWERING COMMUNITIES FOR PROMOTING HEALTH

Introduction

Introduction

Within the concept of Health Promotion, social justice and equity are prerequisites for achieving better health and well-being of populations. Democracy and respect for human rights are inherent qualities of the building blocks of social justice and equity. Hence, it would not be possible to develop a convivial and healthy environment without the participation of individuals and communities. Unfortunately, those who develop policies and make important decisions regarding the health and quality of life of communities do not always bear this consideration in mind. There are great difficulties in the health sector for assuming the necessary leadership to respond adequately to the felt needs of groups. The great challenge is to listen to people and to avoid manipulating the participatory processes for reasons other than responding to the priorities identified by the community. If we are pursuing Equity as health promotion's desired outcome, the implementation of participatory strategies should be our main objective.

This technical report addresses the complex subject of building community capacity for actions oriented at changing living conditions, producing more health and improving the quality of life at the individual and collective levels. Community participation is not possible in a vacuum, people need incentives to participate and the best incentive is to provide the opportunity to work for resolving problems and issues that affect their daily life.

Emphasis is placed on the interrelationships between issues of power and politics as well as among social participation, social capital, and public policies. All issues are of importance in processes and actions directed at the empowerment of communities. However, anyone seeking for a unique formula or prescription will not find it here. The reader is encouraged to creatively search for substitutions that more adequately fit the collective mind and spirit of each community.

This report reflects the development of health promotion in Latin America over the last two decades.
I. Community Participation in Public Health Programs. Community Involvement in Health Promotion.

I.1 Background

To better understand the importance of community participation and community capacity (CC) in promoting health, a brief historical review is presented. For the ancient Greeks, who created the concepts of democracy and citizenry, the ideal “healthy life”, as a goal for all peoples, was supported by participatory processes (Guthrie, 1947). This concept, added to the one on democracy, is core values of the health promotion doctrine of today. Unfortunately, the absence of disease and/or illness as synonymous with health distorted the Greek conception of healthy people, and resulted in a significant loss for the scope of public health (Renaud, 1994) and the dominance of individual-oriented medicine. Health promotion (HP) as it has been conceived over the last twenty years, expands the concept of health and the meaning of "healthy".

Health education made an important contribution to community participation for health, by sharing knowledge about health and disease (Cardaci, 1997, 1998; OPS, 1995a). However, not all of the health education movements promoted genuine social participation. Most of them had a vertical, top-down educational approach to learning and a strictly biomedical understanding of health. It was the Brazilian Paulo Freire who developed the most progressive theories of popular education for the liberation and consciousness raising of the oppressed (Freire, 1973; Wallerstein & Sanchez-Merki, 1994). Freire's “popular education” pedagogic methods that reinforce self-assurance and self-determination are applied to health education and communication today. ¹

Successful experiences have been reported in developing countries where population-based Primary Health Care (PHC) programs and grass-root groups' participation were involved. In the Region of the Americas the involvement of communities in immunization campaigns has been exceptionally successful. However, as stated by Malher (1986), the concept and practice of PHC suffered great distortions when it lost its people-oriented philosophy.

More recently, women’s movements have made remarkable contributions to many participatory efforts and empowerment strategies for promoting health in poor communities as is illustrated by several experiences like the one of Villa El Salvador in Peru.

In the Latin American context, it is important to recognize the Santafé de Bogotá Declaration on Health Promotion and Equity (PAHO, Ministry of Health of Colombia, 1986).

¹ Dialogue is the center of Freire's philosophy. Through dialogue and relationships with others, human beings understand their existence. Every human being is capable of critically engaging in a dialogical encounter with others. He conceived human beings always interconnected in a permanent dialogue that becomes the essence of liberation and solidarity. On the contrary, conquest, manipulation, division and cultural invasion are characteristics of the oppression.
In this Declaration twenty-one countries reaffirmed the theoretical and practical proposals of The Ottawa Charter, and committed themselves to: "Strengthen the ability of the people to participate in the decision-making that affects their lives, and to choose healthy lifestyles" (p.4).

I.2 Understanding community capacity for promoting health and achieving equity.

For practical purposes we shall use the definition of community that appears in the Health Promotion Glossary of the World Health Organization (1998) which is:

"A specific group of people, often living in a defined geographical area, who share a common culture, values and norms, are arranged in a social structure according to relationships which the community has developed over a period of time. Members of a community gain their personal and social identity by sharing common beliefs, values and norms which have been developed by the community in the past and may be modified in the future. They exhibit some awareness of their identity as a group, and share common needs and a commitment to meeting them" (p.5).

Irrespective of how we define community, working with and for communities in health promotion demands the establishment of a strong identification with the socio-ecological characteristics of the group, and social inclusion in a shared locality. Both are preconditions for the search of equity through participatory processes.

It is difficult to find a more complete and comprehensive report on Community Capacity (CC) than the one of Goodman et al. (1998) based on a symposium convened by the Centers for Disease Control and Prevention (CDC). This Symposium stated: “There is no question that the concept of community capacity requires clarification” (p.260).

Public health literature has many different names for community involvement, resulting in confusion among health workers, other professionals, community leaders and lay persons. The Symposium participants concluded that “community capacity is a complex, multidimensional, and dynamic concept that requires precision for assessing community assets and for developing appropriate interventions”. The ten dimensions of community capacity noted in this report were: community participation, leadership, rich social networks, ability to articulate values, sense of history, sense of community, critical reflection, ability to bring in resources, skills, and ability to exert power.

We would like to emphasize that CC is diminished or weakened when we exclude from its assessment and development of interventions the realism that can only be provided by the participation of people in their own milieu.

Is CC a prerequisite or an outcome of health promotion? For some, the issue suggests that community strength is a result and not a precondition of health promotion. The experts at CDC, considered that CC is both part of the community development processes and an outcome that could result in gain or loss. They also considered that CC is built through social participation, leadership, community power, and a sense of community. But, CC
building is not an easy issue. The whole process of changing decision-making from top-down to bottom-up demands a great deal of effort and time for all concerned including the community members themselves. The frustration of leaders and citizens can run so deeply that the process can fail. The ideal is to count on the top-down support policies from high levels of government. However, there is enough evidence that bottom-up movements can influence positively the development and improvement of health in communities. One example is the experience of Zamora, Venezuela, a small town in which a community movement pressured local, state and national authorities to stop environmental contamination by a cement factory (OPS, Ministerio de Sanidad y Asistencia Social de Venezuela, 1999). Negative experiences are difficult to find in the literature, but not always bottom-up efforts end in successes, and frustration of professionals and leaders is common in HP practice.

The concept of equity is also a complex and difficult one. There are multiple interpretations even within a given language. The issue of equity in health continues to worry governments and international health organizations. Involving communities is one of the recognized strategies for achieving more equitable societies, and therefore it is important to discuss some concepts of equity.

In 1989, Ron Draper from the World Health Organization (WHO) defined the difference between equity and equality:

"If you live longer than I do, or if you suffer of less sickness and disability, our health status is unequal. There is inequality between us, but not necessarily inequity. The difference may not result from our living conditions, which may be essentially the same, but from accidents, genetics, or lifestyle choices. If however the differences in our health status result from different living conditions, mine being less satisfactory than yours, a question of inequity arises. I may have less access to nutritious foods, difficulty in finding decent housing or high quality health care sensitive to my particular needs. My income may be lower and my work stressful and demoralizing, punctuated by frequent periods of prolonged unemployment. In this case, inequalities in health status are the result of inequities in life" (Maltrud, Polacsek, Wallerstein, 1997, p.1).

Murray, Gakidou and Frenk use the term "health inequalities" to refer to composite measures of the variation of health status across individuals in a population, and "social group health differences" "are considered to be the differences across subgroups of the population" (1999, p.537). The authors opened a debate about these two kinds of measurements that will probably show which is the most important to orient policies and actions to reduce inequities in health. We believe that for HP purposes the utilization of social group health differences seems more appropriate.
Equity has also been defined as “life opportunities, or life-chances” by Kadt and Tasca (1993). This concept is based on experiences of urban areas in Brasil. It is a sociological approach that takes into account the needs of different social groups - other than specific health needs - in terms of services and risks of diseases. This particular notion has deep implications for developing countries where the right to have minimum conditions for survival is, more often than not, denied to groups suffering from all kinds of social exclusion.

For us, social inequity is the term that we should use to refer to the inadequacy or lack of income, housing, food, social services, education, security, recreation, power distribution, etc. - that determine health, and wellness levels. Inequalities not always show the profound inequities and exclusions of different groups in society. Inequality is disparity but it does not have the ethical and moral implications that inequity has.

Accomplishments in bridging the equity gap in health or in any other social sector require from governments the enactment of enlightened public policies, and, from the society at large a greater sense of solidarity and new social covenants. Health promotion attempts to close equity gaps by supporting social networks, advocating healthy public policies, and strengthening community capacity (Contreras, Restrepo, 1997).

1.3 Health Sector Reforms and community capacity building

The current movement for establishing new models of health care systems known as Health Sector Reforms (HSR), is adversely affecting the processes of CC building. HSR is part of the so called State Reforms or Structural Adjustments promoted by the International Monetary Fund (IMF) and the World Bank (WB).

The 1993 WB Report recommends that developing countries (low-and middle-income) formulate a health agenda that responds to neo-liberal economic policies. Such policies require the subordination of “health policy to the priorities of fiscal adjustment, which requires reducing and restructuring public social spending, including spending on health” (Laurell, Lopez-Arellano, 1996, p.2). The movement towards privatization and market competitiveness amongst health care providers is subjecting health rights to market laws. This is, to put it mildly, a grave error in judgement (Stocker, Waitzkin and Iriart, 1999). The establishment of an indiscriminate minimum of health care to make social corrections to cover the most marginal population groups is now causing serious ethical and operational problems.

Principles that are indispensable to achieving equity - such as solidarity, and impetus for community participation - are more difficult in an environment of dissatisfaction of users and providers of health care. Broad public health approaches and initiatives are disappearing and management of health services by technocrats is the priority. As of this writing, the evidence resulting from HSR is that inequities are still tearing up the social

2 Note: The author of this report is responsible for the free translation into English of some of the original Spanish texts
fabric, the people’s health is rapidly deteriorating and support to CC processes is very hard to obtain. Those of us who are interested in HP have the obligation to assess the new models of HSR and determine if they are contribute to developing CC for health and, therefore, closing the equity gap. If, on the contrary, they are found to be a hindrance, we should find the courage to criticize them.


Many groups and communities throughout our planet are struggling to simply survive, and are nourished by hope and very little else. The number of such groups and communities is increasing, thus broadening the gap between the privileged and the excluded. The United Nations Economic Commission for Latin America (ECLA) has evidence that the quality of life in most Latin American countries is deteriorating rapidly. The new report of the WB for the year 2000 refers to the increasing poverty in developing countries and the decreasing investment in health and education in countries under crisis. This phenomenon is observed not only in underdeveloped nations but also in population sectors of the more developed nations of the Region.

II.1 Social change

The approach of social change is considered by Naidoo and Wills (1998a) as “radical health promotion”. They term it radical because it recognizes the importance of socio-economic environment as a fundamental determinant of health. "Its focus is at the policy or environmental level, and the aim is to bring about changes in the physical, social and economic environment which will have the effect of promoting health"(p.90). This radical or non-traditional HP approach involves a top-down method and requires, as the same authors describe, new skills such as lobbying, policy planning, negotiating and implementation, "a way (that) may be interpreted too political or someone else's remit" (p.91). Freire's approaches towards raising political consciousness in the poors through appropriateness of their own values and autonomy (bottom-up) would complement the radicalism of HP.

Social participation strategies clearly establish strong linkages with social change and therefore with bottom-up CC building and empowerment processes. The development of healthy public policy is both top-down and bottom-up movements for securing political commitments that address the needs and priorities of the community. It would appear obvious that healthy public policy, as part of a comprehensive social policy, is one of the outcomes of CC. A goal of social change is to have communities that are able to control their own health with the support of governments.

Social change at the present time is influenced by globalization. Globalization treats as urgent the need to encourage and facilitate relationships between persons, groups,
communities and nations engaged in the search for solutions to eliminate inequities from the global scenario. Unfortunately, whereas the engines of globalization are moving rapidly to run the macroeconomics of nations, the ones routed at reversing the course of inequity in the “Global Village” seem to be running way behind.

The mass demonstrations during the World Trade Organization (WTO) Meeting in Seattle, (November 1999) and the IMF and WB meetings in Washington, D.C. (April 2000) alert us to its likely failure. Hence, those who are still moved by a social conscience are finding it extraordinarily difficult to redress the grievances of poor local communities and socially excluded urban conglomerates

Globalization also presents us with many other issues that need to be addressed. One important one that comes to mind is that of consumer protection. We must find strategies to empower communities to protect themselves against the dumping of marketable goods and the transference of cultural practices that may be harmful to their health and that may endanger their wellbeing. In developed countries consumer movements have been very successful. It would be very useful to imitate them in developing countries as part of HP infrastructure.

II.2 Social capital

Putnam (1994) defines social capital as the “aggregate of norms, networks, values and organizations which enable actors and groups to access and influence power and resources for decision-making over common interest”. For Fukuyama (1996), social capital is related to people’s capacity to associate and work together towards common objectives and goals. Social capital is considered today as one of the most important characteristics of democracy and good governance and there is an increasing interest in analyzing its relationship with health. According to Kawachi (2000), social capital variables (trust, norms of reciprocity, membership in voluntary associations) "explain a significant portion of the cross-sectional variations of in mortality rates across the states of the U.S"(p.2). He also affirms the documented relationship of social capital and crime prevention.4.

An inverse relationship between social capital, poverty and health has been documented; the more social capital within an area of poverty, the better the health outcomes. While social capital has gained prominence because it focuses on the social relationships in a community that can be strengthened to improve health, quality of life and longevity, the concept is still quite limited in its explanation of what constitutes the community's social fabric. Social capital is often conceptualized as the horizontal relationships between neighbors and people's participation in civil society. Social capital has not been clearly defined to include the ability of communities and organizations within communities to leverage power from the external society to improve their health conditions. These dimensions of power within networks and organizations are found in the concepts included in this report of community capacity and community empowerment.

The measurement of social capital is one of the current problems. Wallerstein considers that current measurement of social capital variables have primarily focused on horizontal relationships. Important research by Robert Sampson and colleagues, however, who have defined social capital as collective efficacy—or the belief that the community can effect change (1999), has begun to incorporate empowerment of people and organizations to change unhealthy conditions\(^5\).

Kawachi (2000) raises some important questions about the relationship between social capital and health: "How can social capital promote health? What is the relevant setting in which society should invest in social capital to promote health? What are the potential 'downsides' of the connection between social capital and health?" (p.3-4). These questions raise important issues for discussion among HP workers.

Deterioration of participatory initiatives is affecting social capital building in large urban areas and its correlation with homicide and trauma rates is notorious. Violence, in all its forms, including war, are powerful forces of destruction of social capital and therefore, a public health concern of the highest priority in today’s world. Social contracts are the best means for social cohesion, solidarity, and new avenues for reducing violence and restoring social capital.

In the city of Cali, Colombia, a study by the “Universidad del Valle” (1999) showed that neighborhoods with high violence rates also show high social exclusion levels and faulty participatory and social capital construction processes. (Social Policy Proposal for Cali of Foro Nacional por Colombia, Capítulo Regional, Valle del Cauca).

Social exclusion, inequity, and oppression preclude social cohesion and are responsible for the reduction of social capital. We need strong statements about government's responsibilities in stimulating the development of social capital.

### II.3 Power and politics. Empowerment concepts.

Power structures affect people’s lives at all levels. According to Hancock (1994), HP as part “of a rich public health tradition, recognizes the relationship between health, politics and power” (p.351). But, what are the implications of these relationships for community capacity and empowerment? We might find an answer by reviewing the political power influence in participatory processes.

We must begin by affirming that the legitimacy of political power is based on social consensus. Power attained in a vacuum of social consensus results in authoritarianism. According to Aristotle’s definition of politics, political power is exerted over free persons of the same category. The paternalistic and coercive powers are opposed to the development of communities (Bobbio & Bovero, 1985\(^b\)). Therefore, if we want to enhance groups and communities for health improvement, we must abolish those kinds of powers. Also recognized as a truism today is the fact that for political power to be recognized as

\(^5\) Nina Wallerstein's contribution to this paper.
such, it must first pass the legitimacy test: to be freely accepted by subordinates through consensus, and built without the use of any coercive measure (Bobbio & Bovero, 1985b).

Labonte (1994) distinguishes "power over" from "power with" relationships. Power over represents coercive or ideological power that is exercised over groups of people to keep them marginalized, whereas power with is the power to influence change with others. Therefore, empowerment processes need to be oriented both toward challenging oppressive structures as well as nurturing relationships that enable people to strengthen control of their own lives for the benefit of all.

For the Peruvian anthropologist Ponce-Alberti a type of "egalitarian power" opposed to "state coercive power is characteristic of primitive societies like indigenous cultures of America" (1995, p. 84). The egalitarian power facilitates shared governments obtaining consensus in matters that affect community life like clean water, housing, food, etc., as is the case in the Lima settlements of migrant populations.

Intimately linked to power and politics is the concept of empowerment. Understanding and applying empowerment strategies is today a clear goal for promoting health of populations. There is still great discussion about the term "empowerment", at least in Spanish-speaking environments, seemingly owing to a language prejudice based on lack of information (for some the term does not exist in the Spanish language and the use of an Anglicism is an objectionable practice). However, according to linguistic research done by Leon (1997), the term exists and has a very old origin.

The Health Promotion Glossary of WHO (1998) states: "In health promotion, empowerment is a process through which people gain greater control over decisions and actions affecting their health" (p. 6).

Lack of power has long been recognized as a burden for the health of peoples. However, only in the last two decades has the positive side of the power concept been incorporated in the theory and practice of health. The definition given by Wallerstein (1992) is clear and facilitates the use of a common language in HP. It states: “A social-action process that promotes participation of people, organizations, and communities towards the goals of increased individual and community control, political efficacy, improved quality of community life, and social justice” (p. 198).

In addition to this expert concept, Bernstein et al (1994) in the publication "Empowerment Forum" contributed to a greater understanding of empowerment through several other expert views.

Empowerment of individuals versus collective empowerment is a controversial issue. The already cited HP Glossary of WHO, makes the distinction between individual and community empowerment as follows:

6 This is a recomended reading for interested in the subject of empowerment, reference 2.
A distinction is made between individual and community empowerment. Individual empowerment refers primarily to the individuals' ability to make decisions and have control over their personal life. Community empowerment involves individuals acting collectively to gain greater influence and control over the determinants of health and the quality of life in their community, and is an important goal in community action for health (p.6,7).

Empowerment of the individual is accepted by some in the health field as referring to the personal ability to control his/her own health. In HP, changing personal behaviours is considered a goal. However, this kind of empowerment does not imply a real power gain in changing living conditions and environments (determinants) for significant wellness. Empowerment seen only as individual in nature is a dangerous concept. Personal transformation is a collective product.

Individual transformation as a result of participating in social action processes is what Zimmerman (1995) calls "psychological empowerment", or a combination of beliefs and behaviors that people can have influence in their worlds. According to Murphy (1999), the two individual and collective are interrelated. I.e. you cannot have one without the other. His approach to behavioural changes links very much in over coming lack of desire for change and the psychology of inertia. I.e. he is tackling the first level of consciousness identified by Freire.

In the health field we can identify two trends of thought about empowerment. Some hold the belief that the most important use of the empowerment concept is to emphasize individual behavioral changes for improving health levels of peoples—a very strong notion in individualistic cultures. It focuses on behavioral modifications for healthy lifestyles as the essential purpose of HP. Some of the advocates of this trend of thought are those who place greater emphasis on the reduction of risk factors than over the more difficult and complex task of modification of socio-cultural and political environments. Some HP "fanatics" subscribe to the notion that to change communities and groups, it is necessary first to change each individual. Yet, there is sufficient evidence to affirm that collective behavior is not the sum of individual ones. There is also evidence that individual behavior is shaped by social forces and to change individual behavior, social conditions must be changed. Fanatics of individual life-style changes always end up “blaming the victim”.

From the perspective of most experts who have published a great deal on the issue of empowerment, the collective understanding predominates, which has important implications for CC building, considering itself as synonymous with empowerment. Wallerstein (1999) proposes a provocative argument when she says that individual empowerment is really not empowerment, and that empowerment per se is truly a social process. Psychological empowerment will be reinforced through participating in collective action, but also through effective strategies such as Freire’s educational methods,

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participatory-research, other participatory strategies to increase personal knowledge and awareness about health rights and duties, strengthen self-care and develop personal abilities and healthy lifestyles.

We would like to close this section by reiterating that community participation for health is part of the political power and that the empowerment of individuals and groups is a matter of politics. The goal is, as Hancock stated, for people to gain power in the good sense of the word.

III. How to Work with Communities: Strengthening Community Capacity for Health and Well-being.

The mechanisms for strengthening communities are based always on the basic principles of respect for community values, knowledge, culture and decisions. The input of community leadership is essential to the whole process, and cannot be left exclusively to the technical staff.

There is an overwhelming amount of literature on the subject of community participation, which can provide a great deal of useful and practical approaches and skills to develop community participatory processes in health. In this section we will briefly summarize some of the mechanisms and practices that facilitate CC building to achieve broad health objectives. Ultimately what is important is that communities acquire the skills to negotiate health matters and participate actively in decision-making processes.

As was mentioned already in this paper, community participation cannot occur in a vacuum, it is nourished by common problems and issues that affect people's lives. This is the key for "how" to make communities get involved and develop their own capacity. Whatever techniques (e.g., focus groups, Delphi, consensus development, participatory planning, logic framework, etc.) are used to stimulate community participation, the focus to be maintained is the assessment of the situation and prioritization of needs and problems made by the citizens. The exercise of identification of problems and needs is the best starting point for CC building, and the goal is to have the participation of those who have never had the opportunity of being heard. Health administrators, leaders and politicians should listen to the problems identified by the community in order to gain the trust and confidence of the communities.

An example of a wrong practice seen frequently in Healthy Communities Projects is to ignore a very important problem commonly identified by communities: secure environments and control of violence. Many times this is the first issue that a community identifies. It is frustrating because local governments, including health authorities consider that it is not their responsibility to modify it, because it is considered a "police" matter. If violence is the first public health problem in many places over the world, all societal actors should commit themselves to focus their interventions on violence reduction. Community capacity building is one of the best strategies to apply in this scenario.

III.1 Community assets
A new strategy, “asset-based community development”, has been proposed by Kretzman and McKnight (1993). The authors developed an innovative methodology that “leads toward the development of policies and activities based on the capacities, skills and assets of lower income people and their neighborhoods” (p.5). The map of community assets provide a tool for discovering individual and collective capacities and talents, as opposed to the usual practice: making an inventory of deficiencies of individuals or communities. It recognizes that each individual has talents, abilities, interests, and experiences that constitute a valuable arsenal that can be used for community development. The authors criticize focusing only on the list of problems and needs of communities for the provision of resources. The “alternative path of asset-based, internally focused, and relationship-driven” map developed by these authors is a comprehensive inventory of all possible capabilities of a local community. The community assets map includes not only individual’s strengths but also citizen associations like churches, clubs, cultural groups, and local institutions like schools, libraries, hospitals, universities, parks, etc. Internally focused refers to concentrating on the problem-solving capacities of the community. Together they provide answers for building or rebuilding relationships between and among individuals, local associations/organizations and institutions.

We welcome the special value that is given to youth and seniors in this methodology because of its strong presence in HP. There are examples of the potential of young people for changing hazardous environments and creating innovative proposals for their own development when they find the opportunities to develop their creativity. Adolescents and elderly groups are good partners for health and development projects because they frequently are victims of social exclusion in many societies (underdeveloped and developed). Unemployment, lack of educational opportunities, violence, ethnic and gender exclusion, mental and psycho-affective disorders, family conflicts are common problems of both groups.
CALI, COLOMBIA: Experiences with Youth Organizations

Youth organizations from depressed neighborhoods (comunas) of Cali, Colombia are working together to build a better life for themselves and their communities. Their own initiatives to address prioritized problems are the means to gain confidence, self-assurance and to find alternatives of solution to their needs. "Corporación El PARCHE" is a group of 25 young persons with 5 years experience in working with the following main objective: "To promote their own integral development, increasing cohesion and community sense through cultural and artistic activities". They implemented four lines of action: education, culture, participatory research and social networks formation. Among their achievements are: improved relationships with family and peers; recognition by diverse governmental and non-governmental organizations; support for organizing new youth groups in others comunas; teaching rap music to 40 youngsters, and video design and elaboration to 15 others; organization of health festivals. The most important of all for them has been recognition by inhabitants of the Comuna, which lead to their inclusion in the Local Planning Committee and to the creation of "El Frente Común para Jóvenes" (The Common Front for Young Peoples). Violence and delinquency rates have been significantly reduced.

Mujeres Activas para un Futuro Mejor, MAFUM (Active Women Association for a Better Future).

This organization has also 5 years of experience and its objective is: "To work for comprehensive education of women, free and active participation in decision-making on important matters for their community and country". They are young women and men who share needs and wishes. They used the formulation of projects on issues such as sexual and reproductive life, health promotion, citizen culture and environment improvement, as a participatory methodology for their own development. Among their achievements are: negotiation with governmental institutions to obtain financial support; organization of a series of education and training courses in sexual and reproductive health, prevention of drug addiction and domestic violence. MAFUM also participate in the Planning Committee of the Comuna.

(Written by Sandra Torres).

These two Youth Organizations are supported by FUNDAPS (Fundación para asesorar Programas de Salud), CISALVA (Research Institute on Violence and Health of University Valle), and Secretary of Health of the City of Cali.

III.2 Community epidemiology

A group interested in Community Epidemiology in Latin America (Tognoni, 1997) has developed a work approach "with the groups themselves". Their experiences consist in identifying small groups/communities (e.g. neighborhoods or small towns) as the starting point to build larger and multicentric aggregates, where the individuality and cultural characteristics of a given group is not lost or subsumed. This approach allows to move progressively towards greater integration between communities. The community epidemiology approach has been implemented in several countries: Bolivia, Ecuador, El Salvador and Nicaragua.

In San Roque, a community of San Salvador city, a partnership between three NGOs, the municipal government, the "Italian International Cooperation Agency", the Catholic church, one public and one private University, the local health center, and the community members, implemented a project for supporting this marginalized community in the health, productive and education fields during the period of 1989 to 1996. The community epidemiology approach was applied with remarkable results. All partners reached consensus and committed themselves to achieve four health goals: 1. That no child would die during the first four years of life. 2. That no woman die of cervical-uterine cancer. 3. That no elderly person shall be lonely or abandoned and 4. That no adolescent will have an unwanted pregnancy before the age of 20.

(Dorotea Cecchetto in Tognoni, 1997, p.p.75-110)

III.3 Development of community partnerships and healthy alliances
A methodological approach is presented by Wallerstein and Sheline (1998) for implementing Primary Health Care strengthening community partnership development. The authors develop five tasks of community participation for PHC workers: "1. Assess your own resources as a health professional and your interest in becoming partners with the community. 2. Engage the community by identifying the relevant social networks and leaders. 3. Prioritize health problems using consensus-building techniques. 4. Develop strategies to enlist community involvement in the intervention. 5. Evaluate outcomes involving the community from the start" (p.92). To accomplish these tasks they also discuss available methods.

De Roux (1993) indicates that approaches to participation are not recipes but should clearly explain the procedures to be followed and the commitments to be made for establishing “co-partnerships” in health. This approach implies community involvement at high decision-making levels in health services administration, in quality control activities, and in establishing transparent financial resources management procedures at institutional levels. At the community level, the author recommends training and education activities for improving community organization and support, technical assistance for community groups, and the provision of appropriate spaces for discussions, negotiation and consensus building. We want to stress here the concepts of transparency and accountability in CC building. Corruption is a social disease that affects the world community. It is probably the most serious constraint in social capital construction and community confidence in governments and institutions. Politicians who are disloyal to community aspirations make vulnerable the participatory processes.

The term "healthy alliances" has been proposed by several authors to emphasise the need of working together to create conditions that allow people to improve their health and quality of life. Naidoo and Wills (1998b) describe healthy alliances as the intersectoral, multi-agency, inter or multi-disciplinary working, joint planning groups, and teams that work together with a "broad view of health encompassing social and environmental factors" (p.139). Here we should include the inter-institutional groups belonging to governmental, private, and mixed institutions involved in health and other activities on social development who share a common philosophy. As stated by aforementioned authors, a healthy alliance is a means not an end. They consider eight essential characteristics for obtaining a successful alliance:
- A common task or purpose;
- Members are selected because they have specific expertise;
- Members know their own roles and those of other members;
- Members support each other in the task;
- Members support each other in their skills and personalities;
- Members have a commitment to accomplishing the task;
- There is a leader who will coordinate and take responsibility, and
- The team may have a base.

Identifying important stakeholders for HP actions and community involvement in each place and country is a key factor. Despite their diversity, some known stakeholders should
be invited to participate in all CC and empowerment initiatives to improve the quality of life and health of communities. Among the most recognized stakeholders are local governments, health and education authorities, public health workers, community organizations, civic leaders (formal and informal), mass media, non-governmental organizations, health professional associations, academic institutions, business and private corporations, consumers, etc.

III.4 Strategies, skills and resources for working together

Working together at the community level requires innovative strategies, specific skills of the teams as well as resources of different kinds.

The role of the Health Sector in supporting community participatory processes should be revised and clearly established. Health workers need to understand that they have the obligation to help community organizations to mobilize their own resources. Health care institutions like hospitals and health centers, should invite community organizations to join partnerships as described earlier. Health workers should be trained in community participation methods and strategies as a way to improve the health of communities. They must learn that listening to people is the most useful skill in working with communities (Brieger, 1999).

Among the skills, some already mentioned in this paper were those coming from the political field such as advocacy, negotiation, policy formulation, abilities in resolving interests conflicts, and consensus building. Other skills are inherent to the HP theory and practice and include information, communication, social marketing, participatory research, social network formation, and organizational management.

The incorporation of modern communication and information technologies to the public health field are innovative strategies incorporated to the “new public health” based on HP theory and practice. Social communication is a great instrument for promoting health but needs serious responsibility and commitment by communicators and the media. According to the concepts of Beltran (1998), the process of true communication is implemented with a “horizontal communication model” for democratic interaction, for establishing a reciprocal communication, not—as many health workers believe—only for influencing the behaviors of others. There is a need to develop these kinds of models to support communities and their organizations. In developing countries, health communication is relatively new, and until very recently, programs were developed by outside experts with different cultural backgrounds. One of the more difficult aspects of community development work is precisely to help groups acquire and adapt modern communication/information technologies and develop culturally appropriate programs. Innovative strategies are needed, such as using of soap operas to deliver health messages and convey healthy behavior models. The initiative of organizing local communication centers, like those existing in some Healthy Municipalities projects in Latin America could be an excellent instrument to stimulate community participation.
The use of mass media in health promotion is a complex subject that deserves a deeper analysis than is possible to cover in this paper. Controversy still exists between health educators and health communicators. Many think that the role of mass media in HP needs to be redefined. However, the powerful effects of media should be taken into consideration for the purposes of community capacity building and community mobilization in public policy formulation.

Besides technical and other experts, other resources are essential in working with communities. Funding for strengthening community capacity is necessary. Experience shows the wrong belief, very common among managers, that community work does not need resource allocation. Precisely, one justification for developing alliances and partnerships is funding community development projects during an appropriate time. Time is another important resource in CC building and empowerment of communities. Even under the best of conditions, it does not happen overnight. Positive outcomes require the maturation of community participation processes. The experience of Versalles, one of the most successful healthy municipalities projects in Colombia illustrates this point. This community participatory process began in 1987 and has continued without interruptions until today. Community participation in Villa El Salvador in Peru is another example of a long and mature experience.

According to Springett, is important to notice that there is also the issue of "projectism" throughout the world. Too often community-based projects are given short-term funding and insufficient length of time to develop the groundwork. Just as the seeds for change are beginning to be established the project money is withdrawn. So a proliferation of small projects that never come together to form a coherent whole is the result. Potential therefore is not realised. On the other hand small-scale projects are required to change the world and the pattern of disease when inappropriate criteria of evaluation are placed on them.

Finally, CC processes need accountability. Community leaders, funding agencies, participant organizations and health workers should be accountable. Success or failure of projects and initiatives must be appropriately documented.

III.5 Support to community organizations and local communities

Milio (1997) emphasizes support for community organizations in order to make effective connections between public policy, health and community well-being. Support should include funding, services and information. Information support is crucial to enable communities to transform their living conditions; many times, information makes the difference between an active, participatory community and a passive manipulated one. The same author (1996) presents several fascinating case studies on the utilization of modern information technology to support and strengthen community organizations and marginal groups. For Milio, to extend innovations of information technology to disadvantaged
communities is a great challenge: “extending the benefits to all who need them never seems to get done, often because spreading good things equitably requires leadership in public policy, and political courage requires public support” (Preface, p. X).

The health sector has the obligation to organize community surveillance of its own performance. While this is one of the positive proposals advocated by Health Sector Reforms, it is necessary to encourage and implement it through mechanisms that guarantee genuine community participation. Citizen groups for surveillance and control of health care providers need to be implemented in full. One example is the "Veedurías Ciudadanas" of National Social Security System in Health of Colombia, within the HSR of 1993, not yet fully implemented; very recently, the government had approved a new law --563/2000--to establish rules for their functioning.

Local communities are suffering the adjustments of the globalization process more than any other level of governance. The current economic model imposes an overwhelming load on local and small communities to compete for goods and services in a market environment. Paradoxically, such communities are more isolated in a globalized world because they are not the targets of socioeconomic development initiatives, and are often seen as disposable consumers.

A challenge for HP in developing countries is to come up with new ways to effectively support local communities. Four findings in this sense should be highlighted: 1) local communities have incredible creativity and a great will to survive; 2) development of healthy public policies at the local level is more successful than at the national level; 3) a new epidemiological approach like “community epidemiology” already cited in this paper is a strategy tested in Latin American countries that allows for the humanization of statistical data on morbidity and mortality; 4) Communities know which are the best choices for improving their health and quality of life, when opportunities are given to them by power structures.

The Healthy Municipalities movement in Latin America is one of the most inspiring and promising developments of local community strengthening. The model has proved its powerful potential for achieving important goals and contributions to Health For All (HFA). The results in creating healthy environments, lifestyle modification, intersectoral actions, strengthening local health services, empowerment of disadvantaged groups, innovative projects to improve social conditions and well-being are new hopeful possibilities for local communities in this region (Restrepo et al. 1996).

Despite the above statement, national and local governments should give the necessary support to local community organizations to encourage and facilitate the healthy municipalities movement in every Latin American country.

IV. Evaluation of Community Capacity and Empowerment in Health Promotion.

The evaluation of CC and empowerment processes is as complex and difficult as is the evaluation of any socio-political interventions. This subject has been and continues to be the focus of debates in fields concerned with human development.

Several key aspects need highlighting here. First, evaluation of HP should be based on the contextual situation of each place where the project is implemented. In other words, there is not a unique list of indicators for evaluating socio-cultural-political processes. Second, evaluation should be participatory. Communities should be involved in the evaluation process and in the identification and definition of indicators—here stories are important. Third, there is general agreement that evaluation should be both quantitative and qualitative. Several authors stress that qualitative indicators are very important and need to be developed according to the context. The traditional quantitative health indicators, like morbidity and mortality, are too limited to measure community involvement in the solution of health problems and social support building. Evaluative processes should focus on the “why and how” and not only on the “what and how many”. Fourth, evaluation of community processes require multidisciplinary or transdisciplinary approaches. This means that disciplines need to develop a common framework for explaining problems and solutions in order to adjust their measuring methods. Fifth, participatory processes should be sustainable. It is important to search for indicators of sustainability in CC and empowerment.

Measurement of changes in social capital, community capacity, and community empowerment are still in many ways in their infancy. These can be viewed as important health promotion changes in and of themselves, similar to other community-level system changes, such as policy change, or as intermediate outcomes leading to improved health status. Mato (1996) has proposed five assessments of community participation which illustrate enhanced community capacity: 1. Extension: who participates and who does not? 2. Depth or intensity: In which type of activities do they participate? 3. Modalities; in what ways do people choose to participate? 4. Impact; what are the impacts of achieving health goals? 5. Sustainability- how is better participation assured for the future?

Recent evaluation measurements of community empowerment include collective efficacy, perceived individual control, organizational and community context, perceived social influence, as well as actual changes in practices, policies, norms, resources, and social conditions (Becker et al, submitted; Burdine et al, submitted). Despite the goals of identifying standard measurements for capacity and empowerment, contextual and qualitative assessment must always accompany these processes. Each community has its own facilitators and barriers to change, which are critically important to understand if the goal is to develop community capacity.

We believe that the main consideration in evaluating CC and empowerment to keep in mind, above all, is that such processes are political in nature.
SUMMARY AND CONCLUSIONS

This report has reviewed community capacity building and the empowerment of communities for promoting health while taking into account the current social situation of low income and marginalized populations. The interpretation of all topics in this paper is highly influenced by the author’s work experience in Latin America and commitment to contributing to a more just world. If it results in promoting debate on all or some of the issues, its main purpose will have been well served.

Understanding the interrelationships of politics, economic models, and power distribution in a given context is a must for all engaged in HP work. Such an understanding will make clearer the path to follow with respect to approaches, strategies and their timeliness. Health promotion is not the property of any particular sector. Therefore, all sectors are responsible for improving the health and well-being of the population. Actions and policies that contribute to this goal should be recognized and made visible by health sector.

Social exclusion is on the rise worldwide. It is mostly responsible for the continuing presence of inequities in health. We see in the application of HP participatory strategies a powerful weapon to reverse such a trend. Excluded groups need to gain power in order to influence key changes in the next decades. Youth and elderly groups are priority targets for empowerment.

CC and empowerment strategies are concrete mechanisms to energize social changes. The most practical approach to success is to stimulate and support participatory movements at the community level. Leaders and health workers interested in enhancing communities for health should create the right opportunities for participation, negotiation and consensus building. But government actions, such as social policy development and implementation, are the best way to reduce the burden of poverty and other causes of social exclusion. Communities should be empowered to demand -through non-violent means- the adoption of such policies and their continuous application from all levels of government.

Governments at all levels have the responsibility for supporting a people-oriented philosophy as the basis for achieving the goal of HFA, and public health workers have the obligation to reject any distortions of HFA that detract from its true purpose and intent. They also have the obligation to monitor the impact of their policies and programs. Citizens should commit themselves to demanding the development of democratic processes to make their voices heard and their opinions count. In the contemporary world, where governments are weakening due to an increase in the power of large corporations, genuine democratic participation is the only means people have to defend equitable life opportunities. Solidarity, respect for diversity, and trust between individuals and communities are part of the building blocks of peaceful and equitable societies.

Local communities in a globalized world need, more than ever, support from development agencies. HP projects at the local level, such as healthy cities/municipalities, are among those that have shown the greatest potential for health development and should receive continuous encouragement and support from public and private sources.
Despite Latin America's inspiring experiences of community participation and empowerment of powerless groups for achieving better health and quality of life, there is still a desperate need to stimulate the implementation of these strategies and mechanisms, given the deterioration of public health policies and programs. The evaluation of Health Sector Reforms is an urgent matter. We must know, sooner rather than later, if such reforms are contributing to equity in health or if, on the contrary, they are aggravating the situation. Which are the advancements in the world in terms of private sector contributions for improving health of less developed populations? A debate on this issue is timely to confront privatization movements in health and other social sectors.

While it is important to recognize that community work is political and it has been, at times, valued and supported by enlightened governments, it has been also repressed by sectors within governments. Threats against the life of community leaders or their family members, and their assassination have been tragically commonplace in some countries. Therefore, defending, protecting, and supporting community work and community leaders are the greatest challenges of the next century.

Community capacity building and empowerment of individuals and groups require a careful selection and application of strategies to avoid coercive interventions. Those who do not care about the rights of people should not manipulate social participation, nor should involvement be used to mask the imposition of healthy lifestyles.

Opening for discussion the subject of measuring CC dimensions is highly provocative and timely. It is likely to engage the audience and promote vigorous discussions about the evaluation of concrete experiences of community participation as a powerful mechanism for changing the determinants of health in different socio-cultural settings. Universities should take an active role in helping local communities perform this task and at the same time record and publish the wealth of knowledge derived from such experiences. This is extremely pertinent for Latin America.

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