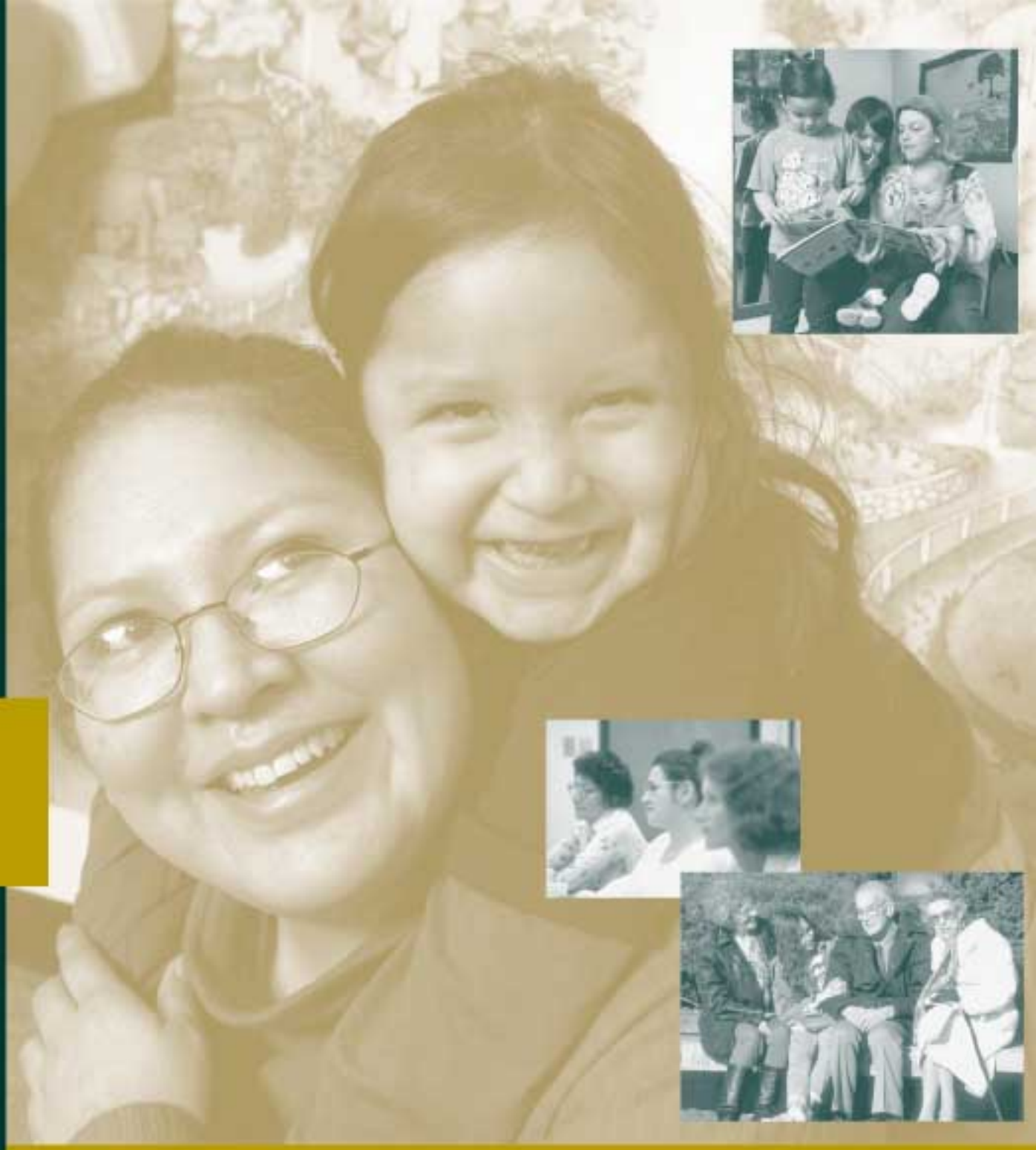

How our programs affect population health determinants: A workbook for better planning and accountability

Population and Public Health Branch
Manitoba and Saskatchewan Region

Health Canada Santé Canada

Canada

In Manitoba:
Health Canada, Population and Public Health Branch
Suite 420, 391 York Avenue • Winnipeg, Manitoba R3C 0P4
Tel: 204-983-2833 • Fax: 204-983-8674

In Saskatchewan:
Health Canada, Population and Public Health Branch
18th Floor, 1920 Broad Street • Regina, Saskatchewan S4P 3V2
Tel: 306-780-6846 • Fax: 306-780-6207

PUBLICATION DATA

Prepared by Ronald Labonte, Director, Saskatchewan Population Health and Evaluation Research Unit for Health Canada

How our Programs Affect Population Health Determinants: A Workbook for Better Planning and Accountability. June 2003

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ACKNOWLEDGEMENTS

Some examples in Section 2 are taken from the following reports:

Donner, L. and Leclair (2000) Community Action Programs for Children: A Population Health Analysis, Health Canada.

Lilley, S. (1998) A Look at Projects through a Population Health Lens, Health Canada.

FORWARD

We've known for a long time that people's health and illness are determined by a complicated web of factors and conditions:

- their family histories
- the quality of their relationships
- where and how they live
- the political and economic forces that shape the healthfulness of their communities
- their workplaces, their environments

Much health promotion works at an individual level: improved health behaviours, increased knowledge. Sometimes this work broadens to a "community-based" approach, where a larger network of community groups, agencies and citizens are organized around the particular health problem. The intent is to reach out to even more people so that their knowledge increases and their behaviours become healthier. Other strategies are added in, such as providing resources or even legislative incentives to "help make healthy choices the easy choices." Providing food supplements to encourage participation in pre- and post-natal courses, or changing tobacco taxation and smoking policies, are examples of trying to make people's environments more supportive of healthier living.

Health promotion is also beginning to dig deeper beneath the surface level of health determinants. Health behaviour is still very important. But people's behaviours, and even their understanding of their own capacities for change, are shaped by their social histories and circumstances. We have a new phrase to describe this re-discovered knowledge (population health determinants), and a new emphasis on a community development approach to working with individuals and groups. (See the Box: "From Community-Based to Community Development and Back Again")

Health promotion work on population health determinants can be challenging. Population health determinants cover everything from social justice to sustainable development. These "population health determinants" aren't simply the territory of health departments or programs. They crisscross all sectors of our society. No single program, agency or sector can make much of a dent in inequality, discrimination or climate change. But each program, agency and sector *can* make a contribution, a small chip that, alongside others, becomes a larger dent.

From Community-Based to Community Development and Back Again

A lot of health promotion work starts out as community-based:

- *organized around a specific health problem usually defined by professionals*
- *emphasizes education and personal change*
- *often time-limited (so many educational sessions or activities)*

It can easily lead into community development:

- *problem defined by community members*
- *emphasizes social action on deeper health determinants*
- *often open-ended (minimum of 2 or 3 years of development support from community health workers)*

For example, in one poor community, health workers found it easier to organize people around nutrition and exercise (planning community picnics, fun-runs and other activities) than around more complex and depressing problems of poor housing, unemployment and poverty. But when these "deeper" issues started to come up in their conversations with community residents, as eventually they always will, the community health workers asked themselves and the local residents: "What can we, and our health agency and other organizational networks, do to work with you on these problems?"

In another poor community, sole-support mothers did not want to be taught "how to cook nutritiously on a shoe-string budget." They knew they weren't eating well, and that it was affecting their children. But the problem wasn't lack of knowledge. It was lack of control, including lack of money.

With help from community health workers, some women organized a community garden, collective dinners and food buying clubs. Other women organized lobbying efforts aimed at improving welfare and public housing policies. Along the way, the community health workers helped to bridge the links between the people, resources and networks the women needed to be successful in their own work. And not too far along the way, the women went back to health professionals and asked for help in setting up a program on "how to cook nutritiously on a shoe-string budget."

Effective work on population health determinants requires a broad range of strategies. One of the most important is the ability of the health worker and her/his agency to weave in and out of the community-based program and the community development process. This requires an ethical commitment to empowerment: Acting in ways so that others gain more power, where power means their capacity to act and choose. In both stories above, local citizens gained more power precisely because they were supported in their own choices. As their knowledge and interests changed, so did the nature of the support provided by community health workers and agencies.

The Population Health Determinants Workbook

Community members, funders and health workers are interested in knowing more about *how* their health promotion activities contribute to change in population health determinants. This workbook is designed to help all three "stakeholders" to do this.

There is no "tick the box" form allowing us to show how our work is changing health determinants that are embedded in complex social structures and relationships. But we can simplify this complexity so that, *right from the moment of our program planning*, we can document how our work is leading us in this direction.

The simple framework developed for this workbook is designed like a spreadsheet. The elements of the framework can be used as a planning tool before one begins a program. Documenting each of the elements as the program progresses, in turn, can be very useful for:

- improving your own work in the future
- accounting for your work to your communities
- demonstrating to funders that health promotion can help make a difference on population health determinants
- advancing health promotion knowledge for other practitioners

TABLE 1
Introducing the Framework Elements

The Basic "flow" of the framework goes like this:

1	2	3	4	5	6	7	8	9	10
INTRODUCTION	**DETERMINANTS**	**OBJECTIVES**	**STRATEGIES/ ACTIVITIES**	**EVIDENCE**	**COMMUNITY CAPACITY BUILDING**	**EVIDENCE**	**PARTNERSHIP DEVELOPMENT**	**EVIDENCE**	**EXTRODUCTION**
Provide some background context to your program, the "what?" and "why?".	Select the most important determinants that your program intends to influence.	Your program will have a number of specific objectives, partly shaped by the funding received, and partly by your own interests and those of the communities you work with. List those program objectives that address in some way the determinants you hope to influence.	Program objectives guide the selection of strategies and activities. Strategies and activities are what lead to changes in determinants. List the strategies and activities that will lead to changes in determinants.	Evidence means more than just numbers. It means rigorously collected documentation of change. Indicate the types of evidence you will gather to examine how your strategies and activities affect the determinants you hope to influence.	Much of our work can, or should, involve "Community capacity-building" – increasing the powers and abilities of people in more general but still definable way. Indicate how your program is building community capacity.	What types of evidence will be collected to demonstrate that the program is building community capacity?	Since the Health sector cannot change population health determinants alone, it needs to partner with other key "stakeholders". Identify the partners you will work with, and why the partnership work will have a greater impact on the population health determinants than your program working alone.	What types of evidence will be collected to demonstrate that the partnership work is making a difference on health determinants?	This is the final word on your program: "so what?" did you learn from your work, and "now what?" might you do differently next time.

OK, We Know It Looks Like a Lot of Work . . .

But it shouldn't be, really. The intent of the workbook is twofold:

- To make your own accountability work back to Health Canada on population health determinants easier.

- To help you continue to move in a "health determinants" direction in your own work.

We don't want the workbook to be a burden. We want it to be a useful tool.

The workbook walks you through each of the different framework elements. Simply follow the advice it offers, and fill out each section as you work through it.

Introduction	*Determinants*	*Objectives*	*Strategies/Activities*	*Evidence*
Community Capacity-Building	*Evidence*	*Partnership Development*	*Evidence*	*Extroduction*

1. INTRODUCTION

A lot of program evaluation focuses on what was done, and what changed in the doing. This is important information. But it doesn't tell us *how* the program came to be in the first place:

- Who identified the problem?
- Why is it important? (And to whom?)
- Who got involved early on, and why?
- What did they contribute to the planning?
- What initial goals and objectives were selected, and why?

Health promotion programs usually "target" certain groups or issues. The introduction should also tell us:

- Who in the community is expected to benefit from the program and its activities?
- How were they involved in defining the problem or issue, and the program goals and objectives? (e.g. formal or informal consultation, formal or informal "needs" assessment)
- If barriers to their involvement existed (e.g. resources, time, comfort or trust levels), how were these addressed in the planning stages?

2. DETERMINANTS

Pick which of the key health determinants your work hopes to influence. To make this easy, consult the following chart. This chart uses the "official" list of health determinants used by Health Canada described briefly in the *Population Health Fund Guide*. It provides some examples from actual programs that help to address each determinant. Additional comments are made about some of the more complicated things with each determinant.

Table 2

DETERMINANT	DETERMINANT DEFINITION	EXAMPLES OF PROGRAM STRTEGIES ADDRESSING DETERMINANT	ADDITIONAL COMMENTS
Income and Social Status	This is the single most important determinant of health. Health status improves at each step up the income and social hierarchy. Higher income levels affect living conditions such as safe housing and the ability to buy sufficient good food.	• Hiring program participants and other low-income people • Providing or brokering free services (e.g. free clothing, laundry facilities, office equipment or resources, transportation) • Providing individual advocacy around welfare entitlements, subsidized housing, bank or other debts • Assisting in community economic development initiatives. • Anywhere your program activities generates *new income* for participants, or reduces the *old income* they would otherwise have to spend	But money isn't everything. How people *feel* about the adequacy of their income – how it *compares* to a broader social standard – is also important. It is a measure of one's social status or rank. The psychological impacts of being low on a social hierarchy can be as health damaging as lack of money itself. It links directly into people's sense of their own self-worth, their self-esteem. Ensuring that all program participants are valued for their differing contributions is another important action programs can take on this health determinant. For example: In La Casa Dona Juana, a social space for Latin American women in Toronto, participants identify the different skills or 'gifts' that individual members bring to the collective and to its activities. Women who are skilled in writing prepare the grant application, and teach other women in the process. Women who are skilled in cooking take a leadership role in the collective kitchen and pass skills to other women during the process. Women who are skilled in budgeting plan the menus or purchases for the collectives, again transferring their knowledge to other collective members. Women who are skilled in sewing techniques take leadership in the sewing collective. In the "outside" world, budgeting and grant-writing skills may be highly valued, and those who have them may be given more social status and power over others. But in La Casa Dona Juana, budgeting and grant-writing are merely one set of social skills no more or less important than those involved in cooking, menu planning or sewing. (Labonte 1996)

DETERMINANT	DETERMINANT DEFINITION	EXAMPLES OF PROGRAM STRATEGIES ADDRESSING DETERMINANT	ADDITIONAL COMMENTS
Social Support Networks	Support from families, friends and communities is associated with better health. The health effect of the support of family and friends who provide a caring and supportive relationship may be as important as risk factors such as smoking, physical activity, obesity, and high blood pressure.	• High quality of group facilitation • Opportunities the program creates for informal conversation and friendship formation • Peer-support initiatives • Intentionally created support groups for people with shared issues • Increase participants access to broader social networks	Social networks are what some people now call "social capital" – the web of relations and ties that bind people together into communities. Networks are different from friendships or relationships. They are more impersonal. People can move in and out of them with reasonable ease. They are the larger pot from which friendships and relationships might be ladled. They are also the range of groups, affiliations and loose connections through which potential opportunities and resources flow. Connecting participants to other groups, organizations and neighbourhoods are all ways in which programs can broaden participants' social networks.
Education	Health Status improves with level of education. Education increases opportunities for income and job security and gives people a sense of control over their lives – key factors which influence health.	• Opportunities for critical learning • On-site education facilities (something many children's programs or shelters already offer) • Referrals to literacy, ESL and other programs • Opportunities for participants to improve their own reading, numeracy and other skills in the context of program work, • Increasing peoples opportunities to make choices	This does *not* mean the "education and awareness" approach to health where we teach people what we, as community workers or health professionals, consider important. It is a matter of "critical learning". The content and style of education is based upon increasing all persons understanding of how health issues and concerns arise, how these are shaped personally and socially, and what can be done about them. Related to education is the sense of control people experience over important conditions in their lives. The key question here is: How does a program increase people's capacities to choose?
Employment and Working Conditions	Unemployment, under-employment and stressful work are associated with poorer health. Those with more control over their work and fewer stress-related demands on the job are healthier.	• Providing opportunities for employment to program participants • Offering services or referrals that improve participants employability, for example, providing skills training, interview assistance, access to information on employment opportunities • Providing training in health-promoting workplaces for participants who have jobs, and helping them to make sure their workplaces are healthy • "Practicing what we preach" internally by increasing income equality and control over conditions experienced by people working in our programs, creating a flat hierarchy in decision making levels and reducing workplace stress	It is important to create a healthy, health-promoting workplace for people employed in our programs.

DETERMINANT	DETERMINANT DEFINITION	EXAMPLES OF PROGRAM STRATEGIES ADDRESSING DETERMINANT	ADDITIONAL COMMENTS
Social Environments	The values and rules of a society affect the health and well-being of individuals and populations. Social stability, recognition of diversity, safety, good relationships and cohesive communities provide a supportive society which reduces or removes many risks to good health.	• Advocating for health-promoting changes in the social environment • Helping participants increase their own policy advocacy skills • As staff and organizations, participating in broader coalitions or other collective efforts to influence policy • Increasing public understanding of the needs and capacities of people whose health is compromised by their social and economic marginalization • Improving people's abilities to interact more effectively with their existing social environments	1. Assisting people to engage with their existing social environments will vary by the group(s) a program targets and the particular risks they might face in their social environment. Some examples might include personal safety training for women and children, assertiveness training to overcome prejudice or fear around HIV/ AIDS, mediation between participants and institutions with which they are encountering difficulties and building support networks for immigrants and refugees. 2. There are differing social values in our "mass culture". Some are more health promoting than others. Discriminatory or victim blaming prejudices (the "-isms" of racism, sexism, agism, heterosexism and so on) can be internalized by people creating poorer health. How are programs countering these stereotypes? Dominant cultural values also include "meritocracy" (people get what they deserve and deserve what they get) and notions of "deserving" and "undeserving" poor (opinion polls reveal support for spending more to reduce child poverty, but not to help out poor adults who, no longer children, have ceased to be "deserving"). How are programs engaging in public discussions about these belief systems? 3. It is important to raise public awareness of issues affecting program participants that have not received much attention. But it is even more important to portray people as capable and competent even as they experience difficulties and needs. Portraying marginalized people as "victims" of social and economic circumstances reinforces helplessness no less unhealthy than holding people individually responsible for their marginalization.

DETERMINANT	DETERMINANT DEFINITION	EXAMPLES OF PROGRAM STRATEGIES ADDRESSING DETERMINANT	ADDITIONAL COMMENTS
Physical Environment	Physical factors in the natural environment (e.g. air, water quality) are key influences on health. Factors in the human-built environment such as housing, workplace safety, and community and road design are also important influences.	• Reducing environmental threats to human health • Reducing people's (and especially children's) exposure to environmental tobacco smoke (ETS) • Supporting a healthier "intra-uterine" environment during pregnancy (alcohol-free, smoke-free, good nutrition) • Reducing toxics and toxins in the home environment, making home and local community environments safer for children (and adults) • Promoting safe activities (bicycle safety, bicycle helmet programs) • Promoting safer toys and play materials • Lobbying for more equitable access to recreational green space for people in poorer neighbourhoods, reduced traffic risks and so on • Increasing access to healthy, affordable housing	It is also important that our programs help to reduce human threats to environmental health. How are programs reducing their own "ecological footprint" (e.g. creating a green workplace with full recycling, non-toxic cleansers, low-energy lighting and heating technologies, car-pooling or other forms of transportation for staff and program participants that reduce fossil fuel use)? How are programs promoting or lobbying for green community practices, such as recycling programs, reduced air or water pollution, use of non-chemical weed management programs in parks or private lawns and so on?
Personal Health Practices and Coping Skills	Social environments that enable and support healthy choices and lifestyles, as well as people's knowledge, behaviours, and coping skills for dealing with life in healthy ways, are key influences on health	• Objectives and activities on personal health practices • Tangible supports for behaviour change, such as free food, physical fitness classes, stress reduction/ management sessions, smoking cessation courses	
Healthy Child Development	The effect of prenatal and early childhood experiences on subsequent health, well-being, coping skills, and competence is very powerful. For example, a low weight at birth links with health and social problems throughout a person's life.	• Nutrition, home visiting and parenting programs • Peer supports for parents • Infant stimulation programs • Recreational programs for parents and children	Children live in families, and families live in communities. The challenge for many programs, where the primary focus is healthy child development is developing activities on other health determinants at a broader community level.

DETERMINANT	DETERMINANT DEFINITION	EXAMPLES OF PROGRAM STRATEGIES ADDRESSING DETERMINANT	ADDITIONAL COMMENTS
Culture	Culture and ethnicity come from both personal history and wider situational, social, political, geographic, and economic factors. Multicultural health issues demonstrate how necessary it is to consider the interrelationships of physical, mental, spiritual, social and economic well-being at the same time.	• Incorporating concepts from aboriginal, Métis or other non-European cultures • Staff training in cultural sensitivity and anti-racism • Providing culturally appropriate content to newcomers (immigrants, refugees) • Offering interpretive services when required	Culture is a determinant of health to the extent that *cultural roles* shape health-promoting (or damaging) behaviours, *cultural biases* create stereotypes that influence physical and mental well-being or access to health-promoting services, and *cultural discrimination* (racism) prevents equitable access to other health determinants (income, social status, education, employment and working conditions) on the basis of one's ancestry. Some health promotion programs are specific to certain cultural groups (e.g. aboriginal, francophone). For health promotion programs generally, the most important questions here are: • How does the program support healthful cultural roles and challenge those that are not? • How does the program break down damaging cultural stereotypes? • How does the program contribute to overcoming systemic cultural discrimination? • How does the program ensure it is culturally-sensitive in its own design, content and implementation?
Gender	Gender refers to the many different roles, personality traits, attitudes, behaviours, values, relative powers and influences which society assigns to the two sexes. Each gender has specific health issues or may be affected in different ways by the same issues.	• Programs for boys in shelters to teach them alternative to violent male behaviours they have witnessed • Programs to reduce violence in dating relationships • Programs to increase father's nurturing abilities with their infants and young children • Programs to break down gender stereotypes	Gender is a determinant of health to the extent that *gender roles* shape health-promoting (or damaging) behaviours, *gender biases* create stereotypes that influence physical and mental well-being or access to health-promoting services, and *gender discrimination* prevents equitable access to other health determinants (income, social status, education, employment and working conditions) on the basis of sex. For health promotion programs, the most important questions here are: • How does the program support healthful gender roles and challenge those that are not? • How does the program break down damaging gender stereotypes? • How does the program contribute to overcoming systemic gender discrimination? • How does the program ensure it is gender-sensitive in its own design, content and implementation?

DETERMINANT	DETERMINANT DEFINITION	EXAMPLES OF PROGRAM STRATEGIES ADDRESSING DETERMINANT	ADDITIONAL COMMENTS
Health Services	Health services, particularly those which maintain and promote health, prevent disease and restore health, contribute to population health.	• Ensuring participants have access to required medical and primary health care • Educating health care providers on the issues or concerns particular to program participants about which they may be unaware • Participating in community discussions on health system reform	It is important to recognize that all health promotion programs are a health service
Biology and Genetic Endowment	The basic biology and organic make-up of the human body are fundamental determinants of health, inherited predispositions influence the ways individuals are affected by particular diseases or health problems		Few health promotion programs are involved directly in changing biological or genetic health determinants. Indirectly, any program that improves other health determinants in this list is improving a biological pathway to health. Programs improving pre- and post-natal health (for parents, for infants) are more clearly helping to shape a healthier biological pathway for children. Some programs, such as CAPC and CPNP, have specific objectives related to this pathway. Other programs aimed at reducing tobacco or drug use also affect biological pathways to health.

Summary

Almost everything we do that improves people's capacities to act can have *some* effect on every determinant. But narrow down your choices. Choose those where your program is making **a conscious, deliberate** and **substantial** effort to influence change in a health determinant.

3. OBJECTIVES

Your program will have a number of specific objectives, partly shaped by the funding received, partly by your own interests and those of the communities you plan to work with. Often, these objectives will be more "community-based" in nature, such as changes in behaviours, knowledge, local resources that support healthier living. They may even be quite technical or specific to certain groups, problems or outcomes. Identify those program objectives that you think relate to the key health determinants your program hopes to influence.

Again, it's challenging not to jot down **all** of your program objectives, since almost everything your program does can probably be connected in some way to at least some determinants. But, again, try to narrow down your choices. Choose those program objectives where it reflects a **conscious, deliberate** and **substantial** effort to influence change in a health determinant.

4. STRATEGIES/ACTIVITIES

The Workbook uses a model of health promotion strategies adapted from Canadian research and sources (Labonte 1993, 1998). Examples of several activities are given for each strategy. Indicate here which strategies and activities you use that you think relate to the key health determinants your program hopes to influence.

The strategy model used here includes in it community capacity-building and partnership development. Because these are new and important health promotion strategies, they are included as separate components in the framework in Sections 6 and 8.

PERSONAL SERVICES	SUPPORT GROUPS	PUBLIC AWARENESS	ADVOCACY/ LOBBYING	COMMUNITY CAPACITY BUILDING	PARTNERSHIP DEVELOPMENT
• one to one counseling and education • direct service (primary care) • individual advocacy • referrals to other services, groups	• organizing new peer support or educational groups • leading educational groups • facilitating educational/ support groups • Providing specific skills training programs (e.g. in self-esteem, assertiveness, literacy, lobbying and advocacy) • facilitating leadership development in groups	• organizing meetings/ consultations/ public events • developing mass education or awareness programs • using "free" mass media access (newspapers, radio, television, internet)	• making presentations and policy submissions to government bodies • meeting with politicians and senior officials • helping to create new policies for public or private sector organizations • organizing/ participating in public demonstrations	• see Section 6	• see Section 8

Summary

Not all of your work might fall in the six strategy categories above. Nor are the activities listed for each exhaustive. But the categories serve as a simple guide you can use in **planning health determinants work** and **documenting health determinants work**.

5. EVIDENCE

Health promotion is about change: Change in individuals, change in health determinants, change brought about partly by the strategies and activities used in health promotion programs. How do we document these changes? What kind of evidence do we need to collect? In general, *the greater the variety of evidence we use, and the greater the number of viewpoints we seek*, the better our documentation, and the more likely the lessons we draw from our experience are "truthful" and useful ones.

Table 4 below provides a list of the usual types of evidence programs can collect. It does not tell you *how* to collect this evidence, or *how* to use it in evaluation. Several good and easy-to-read books on program evaluation are listed in the Appendix.

Health promotion also tries to be "empowering" in its work, increasing people's capacities to choose and act. This creates special ethical concerns about what we gather about people, how we gather it and how we use it. Table 4 below lists Ten Evidence-Gathering Pointers to consider.

Table 4
Sources of Evidence

OBSERVATION/FIELD NOTES	● determine the key points about what to look for ● keep practitioner logs or diaries ● everyone has bias; check with people about your interpretation of what you observe
INTERVIEWS (TELEPHONE OR IN-PERSON)	● structured (closed questions, forced answers) ● semi-structured (mostly open questions but the same ones asked of everyone) ● unstructured (a few open questions but mostly a "conversation")
FOCUS GROUPS	● like a group interview, about 6 to 10 participants ● structured around a few "focus" questions
DOCUMENT ANALYSES	● minutes of meetings, reports, etc.
SURVEYS/QUESTIONNAIRES	● can use open/closed questions ● pre/post group education questionnaires ● questions about participants' satisfaction or feedback on programs ● routine statistics on "bums on seats"– how many came to each activity ● routine statistics on all the activities that have taken place, educational materials produced, media releases or any other indicators of activities
MATERIALS FROM PARTICIPANTS' ACTIVITIES	● reports, notes, or whatever else project participants might create or complete themselves
PEER REVIEW	● questioning and comments from people not part of the project, but sympathetic to its aims ● includes people in community and partners ● seeks other people's opinions on the impact of the program on key health determinants

Introduction	*Determinants*	*Objectives*	*Strategies/Activities*	***Evidence***
Community Capacity-Building	*Evidence*	*Partnership Development*	*Evidence*	*Extroduction*

Table 5
Ten Evidence-Gathering Pointers

1.	People need to know how the information gathered on and from them will be used. They have the choice not to provide it, and the option to review, add to and comment upon it.
2.	People should consent to information gathered on and from them for any of its public use, such as published reports, articles or other documents, tape-recording, video-recording and so on.
3.	Asking questions that provide quantitative measures (counting up the numbers) are helpful in documenting change, but they can also intrude in people's lives. They only give us answers to the questions we ask. When we use quantitative measures, we should ensure that the people we ask understand the meaning and importance of the questions we pose. They also have a right to pose questions that interest them.
4.	A great deal of evaluation evidence might be in the form of observations we, and others, make of certain behaviours or events that occur. But we need to know what we're looking for in order to make sure we "see" it.
5.	Each activity may have many important features we would like to evaluate. We need to discuss these with participants before choosing which ones to focus on.
6.	Asking people directly what they think of the activity is important. It can also be misleading because of peoples' relationships with us. They may want to please us, and please themselves.
7.	Asking people in groups what they think of an activity is also important. It can also be misleading. Group pressure might cause most group members to answer like the first two or three people, or like persons in the group who speak loudly or forcefully. Some group members may want their answers to please or avoid offending others in the group.
8.	The longer we work with people, the more likely they will be honest with us in their answers and the better able we will be to interpret accurately what they say and how they act.
9.	Combining some measures and some direct questions with some observations from a more detached viewpoint adds more rigour to an evaluation than any of the approaches used alone. Bring in a sympathetic outsider from time to time.
10.	Using three or more points of view or sources of evidence helps to ensure that the conclusions reached are good ones, in the sense of not being simply what we *wanted* to see happen.

6. COMMUNITY CAPACITY-BUILDING

Community capacity-building describes a general increase in community groups' abilities to define, assess, analyze and act on health concerns of importance to their members. It is a very important strategy to increase community action on population health determinants. Table 6 below describes 9 key categories of community capacity (Laverack and Labonte 2000, Labonte and Laverack 2001a, 2001b). A longer discussion of how these categories influence health is in the Appendix.

It may not be important to create change in all of these categories. That is something you, and your program participants and other stakeholders, need to decide first.

The question you need to answer here is, how has your program:

- Improved stakeholder participation
- Increased problem assessment capacities
- Developed local leadership
- Built empowering organizational structures
- Improved resource mobilization
- Strengthened links to other organizations and people
- Enhanced stakeholder ability to 'ask why'
- Created an equitable relationship with outside agents
- Increased stakeholder control over program management

Table 6
Nine Key Categories of Community Capacity

CATEGORY	DESCRIPTION
PARTICIPATION	Participation is basic to community capacity. Only by participating in small groups or larger organizations can individual community members better define, analyze and act on issues of general concern to the broader community.
LEADERSHIP	Participation and leadership are closely connected. Leadership requires a strong participant base just as participation requires the direction and structure of strong leadership. Both play an important role in the development of small groups and community organizations.
ORGANIZATIONAL STRUCTURES	Organizational structures in a community include small groups such as committees, church and youth groups. These are the organizational elements which represent the ways in which people come together in order to socialize and to address their concerns and problems. The existence of and the level at which these organizations function is crucial to community capacity.
PROBLEM ASSESSMENT	Capacity presumes that the identification of problems, solutions to the problems and actions to resolve the problems are carried out by the community. This process assists communities to develop a sense of self-determination and capacity.
RESOURCE MOBILIZATION	The ability of the community to mobilize resources both from within and the ability to negotiate resources from beyond itself is an important factor in its ability to achieve successes in its efforts.
'ASKING WHY'	The ability of the community to critically assess the social, political, economic and other causes of inequalities is a crucial stage towards developing appropriate personal and social change strategies.
LINKS WITH OTHERS	Links with people and organizations, including partnerships, coalitions and voluntary alliances between the community and others, can assist the community in addressing its issues.
ROLE OF THE OUTSIDE AGENTS	In a program context outside agents are often an important link between communities and external resources. Their role is especially important near the beginning of a new program when the process of building new community momentum may be triggered and nurtured. The outside agent increasingly transforms power relationships between him/herself, outside agencies and the community, such that the community assumes increasing program authority. A basic question here is: How has the program and its activities changed as a result of input from participants, over time?
PROGRAM MANAGEMENT	Program management that empowers the community includes the control by the primary stakeholders over decisions on planning, implementation, evaluation, finances, administration, reporting and conflict resolution. The first step toward program management by the community is to have clearly defined roles, responsibilities and line management of all the stakeholders.

Introduction	*Determinants*	*Objectives*	*Strategies/Activities*	*Evidence*
Community Capacity-Building	***Evidence***	*Partnership Development*	*Evidence*	*Extroduction*

7. EVIDENCE

Refer to Section 5. What types of evidence will you use to document changes in the categories of community capacity-building your program is trying to improve?

8. PARTNERSHIP DEVELOPMENT

Partnerships can assist programs in a number of ways.

The question here is, how does your partnership work:

- avoid duplication
- identify and address service gaps
- share resources
- help partners out in their own programs
- increase access to other communities, people and networks
- increase willingness to discuss differences openly
- create new activities?

It's helpful to distinguish between different types of inter-organizational work:

- Networking: Networking is a way of people sharing information. It can be very useful, but it sometimes consumes more time and resources than groups or organizations derive back as benefits.

- Cooperation: Cooperation is the time limited assistance different organizations give to another ("We're running a program on Wednesday nights and could use some help organizing space, content, better reaching our target group" etc. etc.). It grows out of networking, but is short-term and doesn't require much more than enough trust to give and receive help from one another.

- Collaboration: Collaboration describes the longer-term and more deliberate efforts of organizations and groups to undertake new, joint activities. Collaboration, or partnership development (the two terms mean the same), is labour intensive.

Before embarking on the collaborative path, it's useful to consider what research tells us about effective partnerships (Table 7).

Table 7
Effective Partnerships

PRE-CONDITIONS FOR EFFECTIVE PARTNERSHIPS	*PROCESSES FOR DEVELOPING EFFECTIVE PARTNERSHIPS*	*OUTCOMES* OF EFFECTIVE PARTNERSHIPS
• a problem we can't fix on our own (we know this, or others tell us this) • a problem no one else can fix on their own • partners out there with enough overlap in values and attitudes towards the problem that we can work together • partners out there with resources (skills, knowledge–both "expert" technical and "lived experience"–materials, finances) necessary to resolve the problem	• creating a common purpose or intent • hiring neutral facilitators or "midwives" whom all can trust • building trust by sharing differing beliefs or analyses of the problem (why it exists, what can be done about it) • being open about one's own (personal and organizational) interests or agendas about acting on the problem	• endurance (lasts for several years) • shared resources (partners contribute towards a common resource pool) • multiple new activities generated • partners demonstrate willingness to put some individual organizational objectives (their own interests) on hold to achieve partnership goals • formalized structures (become transparent and rules-based rather than ad hoc) • partners demonstrate understanding that injuring other partners is not in their own interest

In documenting your program's partnership work on health determinants, you need keep only a few questions in mind:

1. Who do you work with? (the types of organizations and groups)
2. How do you work with them? (networking, cooperation or collaboration)
3. What evidence of processes and outcomes of a maturing partnership/collaboration are there?
4. What new activities has the partnership generated?
5. How do these activities increase your program's ability to influence health determinants?

9. EVIDENCE

Refer to Section 5. What types of evidence will you use to document changes in partnership development your program is trying to improve?

Introduction	*Determinants*	*Objectives*	*Strategies/Activities*	*Evidence*
Community Capacity-Building	*Evidence*	*Partnership Development*	*Evidence*	***Extroduction***

10. EXTRODUCTION

An extroduction is the other book-end to the introduction. It's a conclusion but, since health promotion is an on-going learning process, "extroduction" is a better word to use. It describes a way of reaching some conclusions without saying, "And that's all, folks!"

The extroduction is where you describe important lessons about acting on health determinants. These lessons should arise from the time-line of your program's activities/milestones (your descriptive chronology), and from the information you record in the framework.

These lessons can apply to many different things, but at the least should describe what was learned:

- about your own practice (what you do and how)
- about building community capacity
- about building effective partnerships
- about changing health determinants

and some reflection on:

- what would you do differently and why?
- what would you recommend to other health promoters, community members, our health organizations, our funders, and why?

Finally, you should be able to comment on a summary question of great importance to the empowerment/social justice ethic of health promotion:

How did your program decrease inequalities in health status?

It is one thing to document how the health of particular people may have been improved. It is another to show that this improvement is reducing the gap in health status between rich and poor, top and bottom; and not the reverse.

APPENDIX

Resources for Program Evaluation

Evaluating Collaboratives: Reaching the Potential, Program Development and Evaluation, University of Wisconsin – Extension, 1998. Available online at *http://cf.uwex.edu/ces/pubs/pdf/G3658-8.PDF*

Guide to Project Evaluation: A Participatory Approach, Health Canada, 1996.

Making a Difference: Program Evaluation for Health Promotion,
Tammy Horne- WellQuest Consulting, 1996.

Measuring Program Outcomes: A Practical Approach, United Way of America, 1996.

Work Group Evaluation Handbook: Evaluating and Supporting Community Initiatives for Health and Development, S.B. Fawcett, University of Kansas, 1993. Some available online in the Community Tool Box – *http://ctb.lsi.ukans.edu/*

Building Community Capacity: A Description of the Nine Categories

Participation

Participation is basic to community capacity. Only by participating in small groups or larger organizations can individual community members better define, analyze and act on issues of general concern to the broader community. Peoples' participation in groups, organizations and activities with others promotes health through several pathways: increased social networks and support, improved self/social esteem, decreased isolation. Citizen participation is associated with better forms of public governance, which is associated with improved quality of life. This relation could be the result of
improved income and non-income public transfers (reduced material inequalities), and better health, education and environmental protection services.

Leadership

Participation and leadership are closely connected. Leadership requires a strong participant base just as participation requires the direction and structure of strong leadership. Both play an important role in the development of small groups and community organizations. The pathways between leadership and health are not immediately obvious or frequently studied. Leaders themselves may experience personal health gains from their increased sense of control/authority (positional leaders) or self/social esteem and social networks (reputational leaders). Leaders nurtured through organizing efforts usually gain materially and psychologically from the experience. The health benefits of leadership to the larger group of community members are less direct. Without leaders, community members may be less able to mobilize internal or access external resources, speak their voice with authority, or otherwise influence health-determining policy debates and decisions.

Organizational structures

Organizational structures in a community include small groups such as committees, church and youth groups. These are the organizational elements which represent the ways in which people come together in order to socialize and to address their concerns and problems. The existence of and the level at which these organizations function is crucial to community capacity. Participation in activities (the first category) requires organizational structures to plan activities. Organization can come from outside the community, but this can be paternalistic. It can also impose ideas or issues that do not appeal to local people and so fail to motivate their participation. Organizational structures are the "hardware" (infrastructure) that runs the "software" (interactions) of healthy participation. Organizations can be healthy or unhealthy for their members, depending on their levels of hierarchy, decision-making styles, development of cliques, management of conflicts and so on (i.e. on the type of interpersonal "software" they allow to "run"). Areas with few or ineffective internal organizations will generally be less able to mobilize internal or access external resources, provide opportunities for social support or network development or otherwise influence decisions affecting health-determining conditions.

Problem assessment

Capacity-building presumes that the identification of problems, solutions to the problems and actions to resolve the problems are carried out by the community. This process assists communities to develop a sense of self-determination and power. Research finds that programs with the highest rates of citizen participation, and the longest sustainability over time, are those that start on issues identified by community leaders.

"Asking why"

The ability of the community to critically assess the social, political, economic and other causes of inequalities is a crucial stage towards developing appropriate personal and social change strategies. Problem assessment and "asking why" (analysis) are two aspects of learning. In broad terms, people with higher education enjoy better health through a variety of pathways: more money or material security, healthier personal behaviours, better self/social esteem and efficacy, greater social network access, more experience of control; and perhaps through improved sense of coherence, less self-blame, and a greater ability to influence decision-makers and mobilize personal and external resources. Internationally, investments in education, particularly for girls, is strongly associated with improved population health. Education in these instances is usually measured as formal learning. It can also be informal or "critical" learning. Such learning often occurs in, and appears to be essential to, sustained group action. Such learning might also be health-promoting by overcoming the surplus powerlessness that often characterizes poorer groups. This term, similar to learned helplessness, describes how people internalize objective conditions of relative powerlessness as personal deficit alone, reducing further their power to act. Success in such learning is not based on factual retention, but on peoples' increased capacity to think critically.

Resource mobilization

The ability of the community to mobilize resources from within and to negotiate resources from beyond itself is an important factor in its ability to achieve successes in its efforts. The pathways between resource mobilization and health are multiple. External resources can decrease absolute and relative poverty, and may contribute to some local employment. Tapping into internal resources can improve the self/social esteem of community members ("we are more capable than we thought"), and build their social networks and support. It might also identify where some people under similar social and environmental disadvantages manage to do better (in health or any other terms) than their neighbours. Whatever they are doing differently becomes a knowledge resource that can be shared with the larger community. Health promotion programs, and any other form of government or non-government program or service, also represent a non-income form of wealth re-distribution. It translates indirectly into income because it represents a service or resource that community members do not have to pay for.

Links with others

Links with people and organizations, including partnerships, coalitions and voluntary alliances between the community and others, can assist the community in addressing its issues. The older truism here is "strength in numbers." At a personal level, health expectancy is associated with reasonably large and densely layered social networks. Such networks are also considered elements of social capital, with generally health enhancing effects.

Role of the outside agents

In a program context outside agents are often an important link between communities and external resources. Their role is especially important near the beginning of a new program, when the process of building new community momentum may be triggered and nurtured. The outside agent increasingly transforms power relationships between herself, outside agencies and the community, such that the community assumes ncreasing program authority.

Program management

Program management that builds community capacity includes increased control by the primary stakeholders over decisions on planning, implementation, evaluation, finances, administration, reporting and conflict resolution. The first step toward program management by the community is to have clearly defined roles, responsibilities and line management of all the stakeholders. Program management

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Labonte, R. and Laverack, G (2001) "Capacity Building in Health Promotion: For Whom? And For What Purpose?" Critical Public Health 11(2).

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Laverack, G. and Labonte, R. (2000) "A planning framework for the accommodation of community empowerment goals within health promotion programming," Health Policy and Planning 15 (255-62).

INTRODUCTION	DETERMINANTS	OBJECTIVES	STRATEGY/ ACTIVITES	EVIDENCE

COMMUNITY CAPACITY-BUILDING	EVIDENCE	PARTNERSHIP DEVELOPMENT	EVIDENCE	EXTRODUCTION