

## CAPACITY BUILDING

# Community capacity building and health promotion in a globalized world

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### SUMMARY

*In this paper, community capacity building (CCB) is seen as part of a long-standing health promotion tradition involving community action in health promotion. The conceptual context of the term CCB is presented, and compared with other community approaches. The usage of the term is variable. It is submitted that its common features are (i) the concepts of capacity and empowerment (versus disease and deficiency), (ii) bottom-up, community-determined agendas and actions and (iii) processes for developing competence.*

*A brief literature review looks at some of the main contributions from the 1990s on, which reveal an emphasis on building competencies, the measurement of community capacity and the attempt to break CCB down into operational components. Academic research on the impact of*

*CCB on health is lacking, but multiple case studies documented in the 'grey literature' suggest CCB is highly effective, as does research in related areas, such as community empowerment.*

*Five contemporary case studies submitted by the contributing authors show both the range and efficacy of CCB applications. The concluding synthesis and recommendations say that what is needed for health promotion in a globalized world is a balance between global macro (policy, regulatory, etc.) actions and those of the human and local scale represented by CCB. It is concluded that action centred on empowered and capable communities, in synergistic collaboration with other key players, may be the most powerful instrument available for the future of health promotion in a globalized world.*

**Key words:** community capacity building; community development; community health promotion; global health promotion

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### CONCEPTUAL FRAMEWORK OF THIS PAPER

This paper has two aims. One is specifically to consider the concept of community capacity building (CCB) in health promotion and to look at current international examples of its application. The second aim is the more general one of keeping the community dimension of health promotion on the agenda when the

macro considerations of globalization are occupying centre stage. We argue that although macro determinants, policy and regulatory perspectives are obviously crucial for health promotion in a globalized world, so too are the more 'meso' and 'micro' perspectives of community and 'people'. Each level is equally important, and harmonization and balance between these levels is required. However, it is asserted that, global considerations

notwithstanding, the community dimension is the one that most embodies the quintessence of health promotion, since it directly pertains to the Ottawa Charter ideal of people having control over their own health and its determinants. The structure of this paper follows that asked for by the WHO conference organizers.

The term *community capacity building* came to attention in the 1990s, the latest in a long-standing tradition of health promotion concepts with 'community' as a prefix, where *community* refers to any medium-sized grouping of people united by social connections, a common identity and common goals. (In particular, 'community' relates to people living in a common locality). Associated concepts are community development(CD)/organization/action/empowerment.

The usage of *community capacity* seems to come from the wish to emphasize an 'assets' or 'strengths' approach to conceptualizing community health promotion, versus a deficits or pathology approach, and to emphasize empowering or bottom-up approaches, versus those where professionals or others in power impose their own agendas. However, if the academic research literature is anything to go by, top-down, pathology approaches are still dominant. Arguably, the term CCB gives more emphasis to cognitive, behavioural and political *competency* dimensions than to social relationships, although a number of leading authors do explicitly emphasize the social relationship aspect, represented by terms such as networks, support, social cohesion, social capital and sense of community. It is suggested here that the term *community development* be retained to represent those situations where the competency and social relationship dimensions are given equal attention. However, in practice, the term CCB seems to be currently a fashionable one used by many to cover almost any activity in the community health promotion domain, so it becomes somewhat academic to be too precise about terminological boundaries. In this paper, we opt to use the term CCB quite generally, the key aspects being a focus on (i) the concepts of capacity and empowerment (versus disease and deficiency), (ii) bottom-up, community-determined processes and agendas (versus top-down/externally determined) and (iii) processes for developing community competence.

Various concepts are associated strongly with CCB. The most important, already mentioned, are *empowerment* (relating to both political and psychological power), and *community control*. Others are *participation* ('real' versus token) and *self-determination* (agendas set by communities, not outsiders). To the extent that social processes are also important in CCB, a variety of terms prefixed by 'social' are used, such as *social connectedness/capital/cohesion/belonging/inclusion/support/networks*. The concept of *civil society* is also associated with CCB, usually meaning organized society other than government or the military, especially the non-governmental organization (NGO) component.

*Equity* and *equality* are central concepts, implying primacy for CCB processes involving the most disempowered, an emphasis on dignity, justice and respect for all, and attending to political, economic and other societal structures that result in inequity. *Marginalized, excluded* and *poor* communities are prioritized. The concept of *development* is relevant here, and indeed most case studies of successful CCB and CD come from the less 'developed' parts of the world. However, CCB principles are also applicable in highly developed settings. Some CCB examples involve an activist political dimension, others not. The organizational aspect of CCB is important. Concepts here include *planning models, capacity domains, needs/wishes assessment, asset-mapping, governance, sustainability* and *evaluation*. The American term *community organization* has overtones of CCB.

Although the core of CCB is community-determined process, there are frequently professionals and others in authority (such as local government) involved, a reality likely to increase in the current environment of across-government and intersectoral action, and perhaps more corporate involvement in health promotion. Here, concepts such as *partnership* and *collaboration* come to the fore. Where health promotion professionals are involved, their role includes *facilitation, consultancy* and *advocacy*. (A criticism of the term CCB is its implication that experts 'teach' communities what to do. It is emphasized here that 'true' CCB is where communities are in control of their own capacity-building processes, only using professionals as it suits them).

Contextually and philosophically, CCB in health promotion (CCB-HP) has *ecological* and

public health perspectives, seeing communities as *human systems nested in wider systems*, influenced by many *internal and external inputs*, and having *outputs* that are *global and positive* (e.g. ‘overall well-being’), rather than just specific disease impacts. This ‘holistic’ and human-system view readily encompasses dimensions such as *spirituality, qualitative experience, traditional healing, folk wisdom and indigenous culture*, often neglected in more reductionist and positivist approaches. CCB-HP shares public health’s *population and social determinants* perspectives, its valuing of *social justice and healthy policy*, and its emphasis on *research and evaluation*.

Finally, aiming for *synergy* between communities and all other relevant sectors of society, which influence health and well-being is recommended. This acknowledges that although communities are central to the health promotion enterprise, they cannot act alone. Wallerstein (2005) says: ‘Multiple case studies have shown that synergy between all elements (anti-poverty strategies, NGO-government collaboration, empowerment and participatory development and active health programs) is probably most effective at improving health and development outcomes’.

## LITERATURE REVIEW

Since this review has to be brief, for a more comprehensive background, the reader is referred to previous reviews and position papers: the paper on CCB written for the fifth Global Health Promotion conference in Mexico (Restrepo, 2000), a major American conference on the topic (Goodman *et al.*, 1998), a comprehensive Canadian report on CCB measurement (Smith *et al.*, 2003), a technical report written last year for WHO on CCB and community mobilization (Raeburn, 2004), a forthcoming WHO report on empowerment and health promotion (Wallerstein, 2005) and various books on theory and practice (e.g. Laverack, 2005). Here, we summarize some highlights.

Restrepo’s (2000) paper has a Latin American perspective and emphasizes the political and power dimensions of CCB, placing it in a context of equity, social justice, democracy and respect for human rights. There are many good examples of effective CCB projects in Latin America. It is stressed that CCB is a collective

and political activity, and that coercive or manipulative citizen participation has to be avoided. Partnerships with stakeholders are crucial. Social exclusion and poverty are priorities, and socio-economic development is intrinsic to CCB-HP. Essentially, the starting point for all CCB action is the ‘prioritization of problems and needs made by the citizens’.

The Goodman *et al.* (1998) publication is based on a symposium organized by the US Centers of Disease Control and Prevention on community capacity (CC) from a measurement perspective. They define CC as: ‘The characteristics of communities that affect their ability to identify, mobilize and address social and public health problems; and the cultivation and use of transferable knowledge, skills, systems and resources that affect community- and individual-level changes consistent with public health-related goals and objectives’. They see CCB as having both social and organizational aspects. Ten capacity dimensions that can be ‘built’ in a community are: participation, leadership, skills, resources, social and inter-organizational networks, sense of community, understanding of community history, community power, community values and critical reflection.

Likewise, Laverack (2005) provides an analytical approach to the components of CCB. He outlines nine domains of CC: stakeholder participation, problem assessment capacities, equitable relationship with outside agents, organizational structures, resource mobilization, links to other resources and people, stakeholder ability to ‘ask why’, control over programme management and local leadership. He also emphasizes the concept of ‘parallel tracking’, where top-down and bottom-up approaches can be harmonized in situations where agendas are initially set by outside authorities.

Smith *et al.* (2003), in their report on measuring CC, cover dozens of papers on the topic. They also point out how variable the definition of CC can be, outlining five major variations. This of course affects how the concept is measured.

Australians Arole *et al.* (2004) give a social relationship emphasis to CCB, though this is done by regarding social process as a means rather than as a goal. They say: ‘Improving capacity is about strengthening the ability of a community through increasing social cohesion and building social capital’.

Jackson *et al.* (2003) did a 4-year participatory qualitative project on measurable indicators of CC in four 'problem' Toronto neighbourhoods. They found these 'poor' communities were 'rich' in community resources and activities, especially fairs and celebrations, with residents having a positive view of their communities. They conclude 'Community capacity builds over time ...', as successes accumulate and barriers are surmounted.

Finally, in this brief review, a Hong Kong study by Tang *et al.* (2001) of 3381 professionals identified three main factors to do with CC: participation and commitment, community resources, and health literacy. For professionals to assist CCB processes in their communities, the key was seen as building workforce capacity.

In spite of the emphasis on measurement, there is as yet little formal academic research on the effectiveness of CCB in terms of randomized control trials or systematic evaluative or qualitative studies. However, related academic literature reviews show health improvement with empowerment programs (Wallerstein, 2005) and CD (Raeburn and Corbett, 2001). Outside the academic literature, strong support for the effectiveness of CCB comes from hundreds if not thousands of documented 'grey literature' case studies from around the world. A recent example is an overview publication by the Voluntary Health Association of India (Mukhopadhyay, 2004), which shows dramatic gains from CCB in the health and capacity of hundreds of the poorest and most 'backward' Indian rural communities from 1993–2003.

Such examples could be multiplied many times, with a sample being given in the next section. Collectively they provide an impressive picture of a very powerful approach to health promotion.

## CASE STUDIES

The followings case studies were contributed by the participating authors and are listed alphabetically by country of origin. They illustrate not only the principles discussed earlier, but also the wide diversity of interpretations of the concept of CCB.

### **Africa: Effective participation by the very poor**

A core component of CCB is meaningful participation by community people. Although this

first case (Box 1) is perhaps more treatment than health promotion, it uses a health promotion approach, showing the power of such participation, and its ability to benefit large numbers of people in a highly effective way.

#### Box 1

Onchocerciasis (River Blindness) is a highly prevalent disease in Africa affecting millions of people. It leads to misery, loss of productivity and social ostracism in affected people in their most productive years of life.

A major challenge for controlling the disease is how to deliver annual ivermectin treatment to all target communities and sustain high treatment coverage over a very long period. Past efforts using health workers to treat most of those affected by the disease in rural communities have led to low therapeutic coverage.

This study uses a participatory approach to develop a community-directed treatment with ivermectin (mectizan), including tools for recording and reporting. The African Programme for Onchocerciasis Control has adopted and used this approach since 1995 in 19 African countries.

Evidence from field evaluation confirmed that the strategy is appropriate and cost-effective and has led to significant reduction in symptoms, thereby contributing to improvement in the welfare of the poorest people.

### **Brazil: Partnership and power-sharing**

Partnership was a theme of the Bangkok Conference and is a critical factor for the future of CCB. Here the issue is policy development. Although the Brazilian experiment (Box 2) is not strictly speaking a health promotion project, its implications for health both directly in terms of funding priorities relating to determinants of health and indirectly in terms of citizen empowerment should be obvious.

#### Box 2

An innovative experiment in urban governance has been taking place for the past 16 years in the city of Porto Alegre, Southern Brazil. This involves a 'participatory budget' (PB) process. Instituted by the City government in 1989, PB is defined as a process designed to promote sound, transparent management of municipal affairs by involving city residents in decision-making on budget allocations. The PB allows populations of different neighborhoods of the city, within a well-defined process of citizen participation, to debate and set municipal investment priorities. The process is gradually gaining credence as an urban governance model based on cooperation and partnership between local governments and civil

society. It provides a model for direct popular participation and is now being tried in 70 other Brazilian cities and in many other countries. 'It is truly the citizens who set the investment priorities for the municipal budget' (Cabannes, 2004).

### **Honduras: El Guante and 11 communities: community participation for health promotion in Honduras, Central America**

This case illustrates well the power of community-initiated action and the building of capacity to enhance health in poor and isolated rural communities. The constructive partnership with health authorities is also a feature here (Box 3).

#### **Box 3**

El Guante and 11 other villages surrounding it are poor rural communities typified by their strict agricultural activities. They are located in Cedros, district of Francisco Morazán, 72 km north of Tegucigalpa, the capital of Honduras.

With a total population of 3559 living in harsh social and economic conditions, these inhabitants cope with geographical dispersion and a high incidence of sanitation and hygiene problems that impact directly on their health.

Two years ago, they gathered under the shade of a tree and discussed their problems. Everyone, including children, took part in this discussion, and the entire community initiated the task of establishing their own health clinic.

This impressive community participation was supported by the Ministry of Health, which was willing to help these communities improve the quality of and access to health services. On 30 March 2004, the Ministry and the communities signed an agreement in which a new model of primary health services was to be implemented. The purpose of this model is to offer complete medical attention to the inhabitants of the 12 communities, and also develop a model based on an integrated family-community approach, using health promotion strategies and actions to help achieve changes towards healthy lifestyles.

The project is centred on community participation, which is articulated through community organizations in each of the 12 communities. These community organizations develop educational programmes based on improving health and nutritional lifestyles, personal and domestic hygiene and awareness of the environment. The organizations also develop training courses and make health promotional visits to high risk inhabitants. They have organized an adolescent club that provides information on topics such as reproductive and sexual health, activities promoting a clean environment and various others.

With the aid of visionary and proactive guidance by local leaders, effective social development programme management is being achieved in these communities.

Important strategic alliances have also been established with other communities and organizations that help define plans for community improvement.

With this union between government and civil society, the inhabitants of these communities are improving their health and lifestyles. Simultaneously, they have managed to establish a frontline healthcare clinic that provides high quality, efficient and highly humane medical treatment to all the population.

### **New Zealand: Community houses and empowering resource centres**

New Zealand (NZ) is the most highly developed of the countries cited here, but is also the world's 'newest' country in terms of significant human settlement, including Maori, European, Pacific and Asian. There is a strong valuing of community and 'fairness' in NZ, and many examples of CCB projects and partnerships. This case is based on one such project (Box 4).

#### **Box 4**

In 1973, NZ's first Community House (CH) opened, a collaboration between the University of Auckland and the new, low-income suburban community of Birkdale in Auckland, NZ's biggest city. The overall aim of this project was 'community well-being', and it was modelled generally on self-determined CD projects in developing countries. There are now some 300 CHs in NZ, with over 40 in Auckland. In one region of 300 000 people, an associated organization is the Empowering Resource Centre, which runs on Ottawa Charter principles. It is a community/health authority partnership and provides a wide range of human and practical resources to assist with CCB and self-help groups. Although the various CH projects vary in style and aims, the ideal is a project completely under community control and governance, with maximal participation by all residents. The original Birkdale project achieved a participation rate of 10 000 of its 14 000 residents (all ages), with significant increments in health and well-being on multiple measures. This project still survives 30 years later. At the heart of this is a simple community-controlled organizational approach called the PEOPLE System (Planning and Evaluation of People-Led Endeavors). Capacity-building is intrinsic to this, with many leadership and other skills being acquired by literally hundreds of people in each community. Over the years, this approach has been tried successfully in many settings, and various formal evaluations have shown its positive impact on health, well-being and sense of community. A current application is in Glen Innes (GI), one of the poorest and most ethnically mixed communities in Auckland. At the time of writing, 40 highly motivated residents are out in the streets of GI doing a random needs/wishes household survey as part of establishing their own

community-controlled project dealing with many dimensions of community well-being.

### Thailand: 'The new paradigm of health and community capacity'

The host country for the Bangkok conference, Thailand is a leader in innovative health promotion practice in Asia. The recently instituted nationwide exercise programme, which was able to involve 30 million voluntary participants within two years, is one striking example. Equally, the rural community development programme in Khon Kaen province outlined here is a dramatic example of CCB in action (Box 5).

#### Box 5

Ubonrat District is a rural community in Khon Kaen province, 445 km north-east of Bangkok. Most farmers there have been in a crisis involving high expenditure, low income, debt, no savings and environmental degradation. However, one group of farmers has reassessed the concept of farming for money and riches, and now pursues physical and mental health, warm families, strong community, security and a good environment, plus pride, freedom and living in harmony with nature.

The Sustainable Community Development Foundation (SCDF) has worked for 10 years to bring these successful farmers together into a large network that covers five provinces and 2650 families. As a result of pooling such local wisdom and resources, the Foundation has been able to create a learning curriculum that enables north-east farmers to learn how to be self-sufficient. They also learn how to form strong groups to solve difficult social problems and lead to community well-being. The network has recently created a project based on small-scale, well-planned intensive farming. This aims to enable farmers to focus their own resources onto a small piece of farmland (1 *rai*) to produce self-sufficiency, income for debt relief, a life pension in the form of large timber trees and, most importantly, 'all four dimensions of health and well-being'.

Within this district, Kam-pla-lai Village was the poorest. It is now a self-sufficient and resource-rich community. Forty years ago, Kam-pla-lai was in the middle of a very fertile forest, which was cut down. The villagers then turn to mono-cropping by growing sugarcane, cassava and jute. Within a few years, they were faced with high debts, low income, poor soil and labour migration. They also found themselves in very bad health. For instance, there was 25% child malnutrition, 95% liverfluke parasite infestation, depression, insomnia and other anxiety disorders. Socially, the community was in complete disorder with widespread gambling, crime (cattle rustling, robbery) and alcoholism.

Ten years ago, the SCDF and Ubonrat hospital staff chose Kam-pla-lai as one of the pilot villages in an attempt to improve the health and lifestyle of the villagers. By relying on good community leaders, positive participation from villagers and a highly effective learning process, the situation in Kam-pla-lai has dramatically improved. By facilitating regular meetings, the villagers have gradually learned how to rely on their own resources in order to rebuild their way of life. The Foundation does not directly support specific agricultural activities. Rather it provides the opportunity for villagers to learn on an ongoing basis how to solve the problems of their community. Now Kam-pla-lai is much different. Debts are lower and incomes are higher. Villagers have savings and some welfare benefits. Soil and water resources are much better. Pollution has been reduced through organic farming. Now there is no child malnutrition, no liverfluke infestation, less labour migration, no crime, no gambling and no drugs. The villagers are much happier and less stressed, and there are many strong groups and community leaders who can operate effectively both inside and outside the government system.

### SYNTHESIS

These cases represent the diversity of understandings of the concept of CCB. Each shows the power of participation and partnership, and the impressive role of grassroots action, especially when this is supported by high quality agencies and governments. The sense of growing capacity, of visionary goals, of community ownership of agendas and action and of self-respect and dignity, in addition to the attainment of positive health and well-being outcomes, is testimony to this kind of approach. Ideally, any health promotion of the future will need to look for a balance between the macro policy and regulatory requirements of a globalized world and this more human level of action. The synergy of community action with all other significant players, large and small, who influence determinants of health, is also of great importance. Empowered, self-determined community action in a balanced, collaborative environment of supportive governments, agencies, corporations and policies may be the greatest weapon at health promotion's disposal. The potential of human capacity at the community level cannot be underestimated, when people work together on common goals. The Worldwatch Institute once concluded, 'Grass-roots groups are our best hope for global prosperity and ecology' (Durning, 1989). The

same could also be said for the future of global health and well-being. CCB and its associated community development processes, together with wise global policy and regulation, may well provide the most important forces at our disposal for promoting the world's health in the future.

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