

Welcome to the Swamp: Addressing Community Capacity in Ecohealth Research and Intervention

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Abstract: The standpoint from which this article is written is that of development practitioners who work fairly continuously with community transformation processes, and with their peers in many disciplines who are trying to stimulate and support such processes. Drawing on three case examples, the authors put forward four lessons for an ecosystems approach to health development work. First, health and natural resource management professionals, and the technical solutions they create, cannot, by themselves, solve many of the problems communities face. To be effective, solutions have to address a complex set of variables that may be largely invisible to professionals from outside the communities. Creating a map of the human and natural systems within which a particular human health issue arises is often an important first step. Second, another reason why professionals cannot solve complex health challenges on their own is that, in the end, many of the solutions must be implemented by community people from the inside out. Therefore the “map” needs to include human dynamics and community capacity. Third, identifying and assessing the specific capacities that a community needs to address particular health determinants is therefore an important part of health development work. It is critical that community capacity assessment is not undertaken in the abstract, but rather in a way that links capacity assessment with real, ongoing work and through a participatory process that builds understanding and commitment within the community, and identifies clear pathways for future action. Finally, outside professionals working with a community contribute to its capacity to address critical health challenges, not only because of the technical knowledge and skills they bring, but also through the characteristics and attitudes they exhibit. It is therefore important that professionals build their own capacity to role model effective community practice.

Key words: community capacity, participatory action research, community development, health determinants, participatory development, health promotion

INTRODUCTION

For many professionals in such fields as health promotion and natural resource management, an ongoing challenge

is the reality that they do not hold many of the pieces of the puzzle required to achieve their goals. Those “missing” pieces are hidden within the thinking, choices, patterns of behavior, and relationships of a wide variety of stakeholders operating at many levels. What often appears to be a relatively obvious, neat, and straightforward problem proves to be complex, messy, and intrac-

table when attempts are made to implement technical “solutions” in real communities of people. In his classic study of professional practice, Donald Schön talks about what happens to professionals when they cross the bridge from the familiar territory encompassed by their training, competencies, and mandates into a universe of messy and uncontrollable variables.

In the varied topography of professional practice, there is a high, hard ground overlooking a swamp. On the high ground, manageable problems lend themselves to solution through the application of research-based theory and technique. In the swampy lowland, messy, confusing problems defy technical solution. The irony of this situation is that the problems of the high ground tend to be relatively unimportant to individuals or society at large, however great their technical interest may be, while in the swamp lie the problems of greatest human concern. The practitioner must choose. Shall he remain on the high ground where he can solve relatively unimportant problems according to prevailing standards of rigor, or shall he descend to the swamps of important problems and non-rigorous inquiry? (Schön, 1987, p 3)

When our goal is the actual improvement of the health and well-being of specific populations, we as professionals cannot deliver that outcome to communities. We can only work together with communities to build that outcome from within. As they say in southern Louisiana, “Welcome to the swamp!”

PURPOSE OF THIS ARTICLE

The standpoint from which this article is written is that of development practitioners who work fairly continuously with community transformation processes and with their peers from educational and research institutions, government, and the nongovernmental organization (NGO) sector who work in a wide variety of disciplines and who are trying to stimulate and support such processes. Drawing on three case examples, we will put forward four lessons that we have found critical for an ecosystems approach to health development work.

1. Health and natural resource management professionals, and the technical solutions they create, cannot, by themselves, solve many of the problems communities

face. One reason this is so is that these solutions have to address a complex set of variables that may be largely invisible to professionals from outside the communities within the ecosystem. Creating a map of the human and natural systems within which a particular human health issue arises is often an important first step.

2. Many Ecohealth solutions must be implemented by community people themselves. Unless community people and the local institutions and organizations they create have the capacity to implement the solutions, the desired improvements will not occur.
3. Identifying and assessing the specific capacities that a community needs to address particular health determinants is therefore an important part of health development work. It is critical that community capacity assessment links capacity assessment with real, ongoing work through a participatory process that builds understanding and commitment within the community, and identifies clear pathways for future action.
4. Who we are and how we carry ourselves as professionals can have a profound impact on our capacity to conduct effective Ecohealth research and to assist communities to translate the findings of our research into community-applicable solutions.

In discussing these four lessons, we draw on our experience providing training and other types of technical support to multidisciplinary research teams, government agencies, and the nongovernmental sector in their efforts to stimulate and support development initiatives aimed at making substantive improvements in the lives of community people. Concrete project examples from Kenya, Uganda, and aboriginal Canada have been chosen to illustrate the themes, because they possess the following commonalities: 1) challenging and complex health conditions creating unacceptable levels of ill health; 2) teams of health and development professionals focused on finding sustainable solutions to the tangled web of problems; 3) extremely messy processes of intervention through which professionals tried to engage communities in solution building; and 4) common themes and lessons.

WHAT COMMUNITY CAPACITY IS AND WHY IT IS FUNDAMENTAL TO ECOSYSTEM APPROACHES TO HEALTH

The following example from Kenya illustrates why professionals cannot solve critical health challenges on their own

and why building the capacity of communities to address the complex nature of many real-world health promotion research and intervention challenges is so vitally important.

Case Example 1—Mwea Rice Scheme Anti-malaria Program

In the lowland area of central Kenya, at the base of a low mountain range some 90 minutes from Nairobi, lies the district of Mwea, which holds one of the largest flooded rice schemes in East Africa. For 6 months out of the year, a large portion of the land in this area is under water, which, among other things, contributes to a greatly accelerated anopheles mosquito count, making it a very high-risk zone for malaria in a country that the World Health Organization (WHO) calls the “epicenter” of cloriquine resistance in Africa.

For the past several years, a group of Kenyan researchers and Ministry of Health partners have been searching for solutions to what can certainly be considered a malaria epidemic. Worldwide, it is estimated that 300 to 500 million people become sick with malaria each year, and about 2 million die of the disease. In Kenya, malaria accounts for some 30% of all outpatient visits to health facilities. Currently, in this country alone, between 75 and 100 children die *each day* from the disease (usually cerebral malaria) and another 14,000 require hospitalization (Republic of Kenya, 2001).

The Kenyan research team was funded by Canada’s International Development Research Centre (IDRC) to explore an “ecosystem approach to human health.” This approach brings together natural resource management and human systems change in a search for practical interventions that will address both the impacts of a human health problem (in this case malaria) and its root causes (Forget and Lebel, 2001).

On the surface of the malaria problem in Mwea, it would seem that a combination of technical solutions such as insecticide-impregnated bed nets, pyrethrum cattle strips, window screens, biological agents for killing mosquito larvae, community education, and making treatment more accessible would solve the problem. And these strategies might work, *if* the community could even begin to approach the level of capacity required to afford and sustain such solutions.

In their efforts to find out why these technical solutions were not working, the Mwea research team had to begin constructing a “map” of the agro-ecosystem

dynamics (related to the malaria parasite, disease vector, host behavior, etc.) and as well of the dynamics of the relevant human systems (farming systems, family systems, community systems, wealth distribution, etc.). This map-making was only possible when community members became real partners in the research process. It is community members who have the inside knowledge of the actual agro-ecosystem dynamics, such as the stressors that farmers face, who gets malaria most often and most severely, household caloric intakes at different seasons of the year, and factors that are impacting farm productivity and income (such as the rising costs of inputs such as fertilizer; the lack of access to high quality rice seed stock, due to the failure of government controllers of the rice scheme to manage or distribute seed stock effectively; or the rising frustrations and militancy of farmers, as rice rots in the fields for lack of transportation to market because of government tactics to force farmers to accept lower prices).

In fact, most of this sort of knowledge was contained within the community system, but it was not known systematically. It was held in bits and pieces (like an unsolved jigsaw puzzle) by many different actors (or groups of actors) within the community system. Community members tended to view most of this multitude of seemingly disconnected factors as being beyond their control, simply part of the world “as it is,” and until a thorough participatory analysis was undertaken, researchers, too, were not able to see the connections between these sorts of social and economic factors and the problem of malaria.

In their mapping of the situation, the research team was able to uncover a very familiar causal web of factors that influence malaria prevalence in Mwea. Figure 1 illustrates part of this web, gleaned from analysis provided by various community-level players at a stakeholder meeting. It is in this context, only partially described here, that technical solutions to the problem of malaria (such as bed nets and medical intervention) will have to be implemented, and it is precisely because the real world of Mwea rice farmers and their families is complex, multifaceted, and not easily changed, that the research team needed to carefully map the situation before attempting to test technical solutions.

So, in essence, researchers found that, despite the fact that a battery of technical solutions were known (even by community people) for how to reduce malaria and its impact, those solutions: a) are not implementable within the general population because of their cost relative to worsening levels of poverty; and b) are, in any case, not

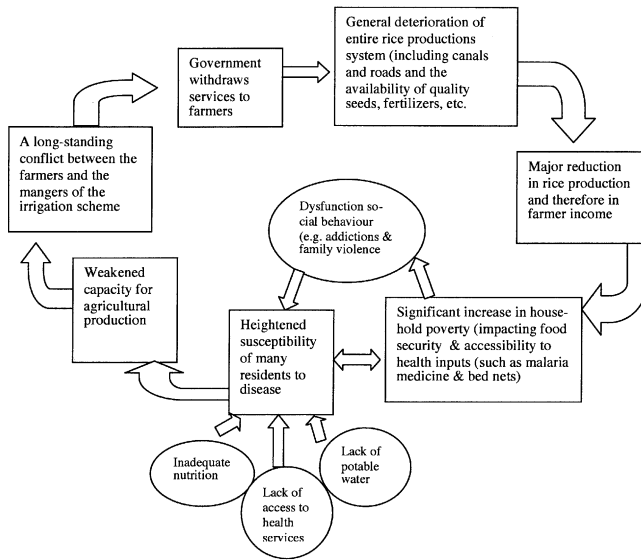


Figure 1. Schematic representation developed by grassroots community coresearchers in Mwea, Kenya, depicting the analysis of the web of causal factors and impacts contributing to chronic malaria.

enough to really solve the problem of malaria in Mwea, primarily because malaria strikes hardest at people who have compromised immune systems and generally weakened conditions that come about from such factors as inadequate nutrition (i.e., hunger) and persistent chronic sickness. These factors are further compounded by a weakened capacity for hard work (because of chronic sickness) that then leads to poor agricultural productivity, which, in turn, leads to even greater poverty, and downward the cycle goes. As it turns out, the research shows that it was not those who live closest to mosquito breeding areas (i.e., standing water) where anopheles mosquito population is the highest who have the most malaria. In fact, those groups have the least malaria in the district. Those with the most malaria and the worst impact from malaria are the poorest—and they happen to be the people who live on the margins of the rice scheme (furthest away from mosquito breeding sites), but who are earning the lowest levels of income from the scheme.

Let us take a few steps back and consider this problem from the standpoint of health professionals. First, the battery of technical solutions generally known to reduce both the incidence and impact of malaria will not work in Mwea unless a complex web of other factors is also addressed. Second, epidemiologists, malariologists, and other health experts working on the problem would have never known that their pat technical solutions could not work in Mwea, given its current realities, if they had

not engaged the community in a process of participatory analysis. When they eventually did so, they learned that the problem of malaria is imbedded in a web of inter-related causal factors. So, this research team stumbled on a fact of life in health-related community intervention, namely, that single-issue health campaigns are often unsuccessful because they try to abstract a problem from its context by dealing only with “the problem” while ignoring other factors that are correlated through common dynamics within the socioecological system that generated and sustains the problem.

What Will It Take to Solve the Problem of Malaria in Mwea?

As they contemplated moving toward solution building, it became critical to ask the question, “Who needs to do what?” in order to begin to transform the web of conditions now producing high levels of chronic malaria in Mwea. Through the process of participating as coresearchers, the capacity of the community residents to read the “text” of their own lives was significantly increased (consciousness-raising and analysis). Eventually, a very enthusiastic group of community stakeholders emerged which was subsequently able to produce a five-pronged plan of action, based on an analysis of key determinants of well-being, involving: making clean water accessible to every household; improving household income and nutritional intake; addressing critical social problems, such as alcoholism and violence against women and children which are increasing household vulnerability to disease; improving agricultural productivity and profitability, which will require resolving the ongoing dispute with the farmers union; and implementing a community-driven anti-malarial campaign linked to a revolving fund to cover input costs (Republic of Kenya, 2001).

Basically, there is very little for professional providers to “provide” in this plan, in terms of delivering actual solutions to the community. However, technical support will certainly be needed related to every one of those strategies. What is most fundamental about this set of solutions is that they all depend on the community’s capacity to actually implement them. If the community does not spearhead and sustain each of these, nothing will really change. What is absolutely certain is that no outside benefactor is going to come and deliver these solutions to the community, least of all the cash-strapped Kenyan government.

Which Community Capacities Will Be Required?

We now come to the nub of the implementation challenge. In this case, a team of professional researchers and health providers have worked with a fairly broad range of stakeholders in Mwea and have identified a five-pronged strategy for reducing both the incidence and the impact of malaria. For each of these five strategic lines of action, community members will probably require education and training, technical support, encouragement, monitoring for effectiveness, and assistance to support the costs of interventions.

Nevertheless, the metaphor of a team and its coach can help to describe the true nature of this problem. It is the team that must play the game. The coach can cajole, educate, challenge, encourage, and support. He or she can prepare the team for the big game, but ultimately, the game will be won or lost on the performance (Knowledge, skills, perseverance, etc.) of the players themselves, both as individuals and as a coherent team. Good teams usually have good coaches, and their contribution can make an enormous difference to athletic success. But what makes a good coach? Certainly a big part of good coaching is knowing which capacities the players will need in order to be effective, and also knowing how to develop those capacities in their players and teams.

What Is “Community” in Community Health Development?

For our strategic purposes, a “community” can be defined as any sizeable grouping of human beings “who enter into a sustained relationship with each other for the purpose of improving themselves and the world within which they live” (Bopp and Bopp, 2001, p 13). While this is certainly not an adequate sociological definition, it does recognize that communities are not homogenous, and that within any particular aggregate of people (geographic or relational), interveners are most likely to be working with a somewhat representative subgroup. Who exactly is, and is not, represented by community working-groups must be made an explicit part of any comprehensive problem statement. Nevertheless, the messy strategic reality is that outside helpers, trying to assist communities to transform health conditions from within, find themselves working with some kind of more or less representative group which is acting on behalf of “the community.”

What is important, in the context of work aimed at transforming the web of relationships and conditions that

give rise to any particular health problematic, is that there are some parts of the work that individuals must do (such as learning and adapting new health behaviors), but there is also collective work to do that lies beyond the capacity and influence of individuals. The socialcultural world within which a person lives (like a fish lives within water) can have a tremendous influence on attitudes, behavior and, ultimately, on health outcomes. Some communities create opportunities for their members that greatly enhance personal levels of well-being, such as access to goods and services, recreation, education, arts, and cultural experiences, high levels of trust and mutual aid, economic opportunities, etc. Other communities provide a hostile environment in which individuals are left to fend for themselves and to fight over scarce resources, and are discouraged from cooperation and mutual aid by a climate of dependency-thinking, suspicion, mistrust, and an absence of nurturing and supportive social networks.

What Is Community Capacity?

Community capacity refers to what community insiders need *to have, to know, to do, and to be*, in order to effectively influence the primary determinants of health that are affecting them. As in the Mwea case, much of the work to be done in achieving health for all cannot be done by professionals and then handed to the community like a package of pills. Improvements in many of the fundamental determinants of health require that people learn and change—and this is something that happens from within. Table 1 summarizes examples and definitions of some of the fundamental community capacity requirements for managing change.

These eight generic capacities are by no means a complete list of capacities required by communities in transformation. Lists such as these are merely indicative of what to look for in specific community contexts. In community development processes, there is usually a cluster of specific capacities and health determinants that converge to define every specific problem. Many examples of generic capacity domains (such as Goodman et al., 1998; Bopp et al., 2000, Labonte and Laverack, 2001a, b) all reflect very similar domains of capacity. The following section will argue, however, that measuring these or any other community capacities will not advance the process of Ecohealth development unless the link is made between capacities and specific health determinants.

Table 1. Fundamental Community Capacities for Managing Change

1. Participation	The community's capacity to engage its own diverse membership in constructive processes of consultation, collective analysis, and decision making
2. Vision	The capacity to systematically develop, articulate, and adapt a picture of sustainable health, well-being, and prosperity toward which the community can work
3. Community cohesion	The capacity to work together, to develop common aims, purposes, and methods; to manage and transcend conflicts and differences; and to incorporate diversity and complexity into evolving community systems
4. Resilience	The capacity to absorb shocks while maintaining function (Gunderson and Helling, 2002; Berkes and Folke, 2002). The opposite of resilience is vulnerability. The adaptive capacity is critical in complex socioecological systems (i.e., systems in which people and nature are interdependent). Resilience moves beyond trying to control systems assumed to be stable to managing the capacity of human beings in relationship with natural systems to absorb shock and surprise, and to respond with creativity, novelty, and innovation (Folke et al., 2002, p 4).
5. Ongoing learning	The capacity to learn from development processes while they are underway, and while participating in them (see Schön, 1983, and Bopp et al., 2000). The capacity to reflect on what worked and what did not, and what is now needed, is fundamental to a culture of learning within development processes. For such a culture, "mutual support, commitment to learning, and appreciation of a diversity of action are the prevailing norms" (Universal House of Justice, 2002).
6. Leadership	The capacity to engage the diversity of sectors and levels within community life in processes of learning and action for health.
7. Partnership building	The capacity to create and maintain strategic alliances with relevant individuals, organizations, and departments of government that can in some way support and enhance the ongoing development work at the community level.
8. Accessing and managing resources	Management is the capacity to organize people and resources so that their full potential is effectively utilized. The ability to identify and access resources that already exist within the community (knowledge, skills, human energy, natural capital, social capital, money, etc.) is critical and often overlooked (Kretzmann and McKnight, 1994). It is also important to learn to utilize existing resources in novel and creative ways in response to surprising and shifting circumstances. Sometimes however, it is critical to be able to locate, access, and wisely manage resources (money, technical assistance, allies, etc.) that originate outside the community.

LINKING COMMUNITY CAPACITY TO SPECIFIC HEALTH DETERMINANTS

The following case study illustrates why it is critical that community capacity assessment work not be undertaken in the abstract, but rather through a participatory process involving community stakeholders and a linking of capacity assessment with ongoing community transformation work.

Case Example 2—Tororo Sleeping Sickness Epidemic

In another IDRC Ecohealth project in Southeast Uganda (near Tororo), "Links Between Sleeping Sickness and Natural Resource Endowments and Use: What Communities Can Do." Principal Researcher: Dr. John McDermott;

International Sponsor: International Livestock Institute, Nairobi (ILRI); Funder: IDRC Ecohealth, Project No. 100106. researchers are trying to head off an impending epidemic of trypanosome-induced sleeping sickness. (Trypanosomiasis causes sleeping sickness in humans, and nagana in cattle.) In the past several decades, well over a million people and untold numbers of cattle have died. (The carriers of trypanosomiasis to both humans and cattle are tsetse flies.) The last epidemic ended in 1993, and now the disease is making an unsurprising comeback as government tsetse control and disease prevention programs have crumbled under the weight of disintegrating public sector services across Uganda.

Recognizing that government is no longer able to carry the burden of anti-"tryps" programs, international NGOs and research groups are working hard with com-

munities to develop community-based responses. Across the study area, six villages were selected for pilot work, based on a range of disease-vector-related ecosystem features (i.e., tsetse fly breeding and habitat conditions), as well as related to each area's history of sleeping sickness epidemics.

In an evaluation an IDRC-sponsored evaluation (see Bopp, 2002) the following issues came to light. First, researchers and health providers working on the project began with a fairly well-established (generic) knowledge base about what works and what does not in reducing the incidence and impact of trypanosomosis. What they did not know was how to implement control and prevention measures *through* community systems. While they were also very unclear about the specific ecosystem linkages between health, poverty, and natural resource management in the study area, the most critical challenge was that they had no idea how to move past current social patterns of dependency, disintegrated social capital, and grinding poverty to develop community-led solutions that will be sustainable and effective in the study area.

Second, the program proceeded with the assumption that engaging community representatives in an analysis of disease, natural resource management patterns, and social and economic issues related to poverty, would eventually lead to the formation of community action plans that would systematically address trypanosomosis. What actually happened was that the participatory action research approach did, in fact, lead to considerable community learning, and even mobilization for health action, but very little of that action focused on sleeping sickness *per se*, because other issues, such as clean water and income generation, loomed a great deal larger on the community's own horizon.

Conclusions Based on These Observations

The project is in the first of three phases, and a great deal of work remains, but from this initial set of observations, several conclusions can already be drawn:

1. When communities are encouraged and assisted to analyze the socioecological dynamics of particular health problems, they are most likely to see a complex web of interdependent and mutually reinforcing factors that touch many aspects of life. As in the Mwea malaria project, Ugandan communities see their general susceptibility to disease, and their vulnerability to

its impact, to be directly related to poverty. Their conclusion is that unless poverty is addressed, along with other important health and social issues, the community's capacity to carry a specifically targeted sleeping sickness control and prevention program would be almost nil.

2. In a focus group session with community leaders in Bugwera village in Uganda, six community capacities were discussed as being critical to carry off long-term community driven initiatives: (i) appropriate learning and knowledge development; (ii) social capital development (defined as the strength of networks of cooperation, trust, and common purpose); (iii) people's participation and empowerment; (iv) accessing and managing resources; (v) leadership and organizational capacity; and (vi) appropriate stakeholder engagement (particularly stakeholders such as government policy makers beyond the community level). (The language used here to talk about these capacities is not the language the community itself used. In capacity building effort it is, of course, important to incorporate the community's own language and analytical framework.) It would certainly be possible to develop a capacity-building program for community action core groups that addressed these six domains of capacity (and, in fact, we recommended that the Uganda team do exactly that). However, unless community capacity is actually invested (i.e., applied) to the specific cluster of determinants that are the most likely to influence the health outcome the community and its partners wishes to address, the building of capacity will most probably not lead to changes in health outcomes.

Figure 2 (developed as an example of a monitoring tool) graphically illustrates the strategic convergence of specific determinants of health with specific community capacities. Please note that the health determinants shown here are those considered by researchers and the community to be most likely to influence outcomes related to trypanosomosis.

There are, of course, many possible ways to actually measure both community capacity and progress in key health determinants, but the most effective of these approaches are, in and of themselves, net contributors to the building of sustainable solutions to community health challenges. In other words, the process of taking the measure should contribute significantly to the community's development.

Learning and Knowledge Development							
Social Capital Development							
Participation and Empowerment							
Accessing and Managing Resources							
Leadership and Organizational Capacity							
Appropriate Stakeholder Engagement							
Community Capacity Development							
	Key Determinants of Health						
	Natural Resource Management						
	Disease Vector Control						
	Health Measures Implementation						
	Poverty Alleviation						
	Community Capacity Investment						
	Appropriate Public Policy						

Figure 2. Linking community capacity development with key determinants of health related to sleeping sickness.

DEFINING AND MEASURING COMMUNITY CAPACITY

The problem with most attempts to measure the conditions and processes that comprise a living community, especially when undertaken by outside professionals, is that the meaning of any one measure, or group of measures, can only really be understood in relationship to the context from which it is derived. A community is a relational universe, nested within even larger systems that influence it. Health and development professionals who do not have a fairly rich and deep understanding of the community “story” (that is, its living web of relationships, processes, conditions, and needs) are usually unable to understand what the measurements they take actually mean, particularly related to the central problem of all professional development intervention—how to help the community transform its conditions and processes so that sustainable prosperity and well-being is the outcome.

Domains of community capacity such as those listed earlier (participation, vision, community cohesion, resilience, etc.) are reified theoretical constructs with no more than a vague academic relevance to any *particular* community and its health challenges *until* the community generates its own capacity domains, rooted in its own analysis (which may indeed be supplemented by the knowledge and experience of outside helpers). In most communities, until such a process is undertaken, what is known about present community realities, past circumstances that shaped them,

and future hopes and possibilities is known in scattered bits and pieces by many different individuals and groups. The process of developing a collective “story” is really like fitting the pieces of a complex jigsaw puzzle together, and seeing the whole picture it makes for the first time. (See Bopp and Bopp [2001] for a description of the Community Story Framework, a tool for community participatory analysis designed to assist communities to assemble a comprehensive “story” describing community conditions and their historical roots.) Once this “picture” emerges, it becomes possible to reflect on the capacities needed by this community to achieve its desired health outcomes.

When community capacity assessment is situated within process of ongoing community transformation, it becomes a dynamic curricular component of ongoing learning (i.e., the process of learning your way toward your goals), and it can then be a very powerful tool for both community insiders and the professionals who are working to support them. However, unless such capacities as participation, vision, and leadership are properly contextualized within an inside-out analysis of community realities and dynamics, their measurement will likely be seen as an academic diversion from “the real work” in the eyes of community people struggling to make a difference in their own lives. It is only when those same community insiders begin to understand the linkages between their own capacities (or the lack thereof) and their ability to foster the changes they want in terms of development outcomes, that introducing community capacity assessment (linked seamlessly to capacity building) is likely to be strategically effective as an approach to enhancing community development processes. It is difficult to justify the cost, in community time and energy, of carrying out a systematic community capacity assessment unless community capacity will be directly enhanced in and through the process of measuring it.

Assessment Methodology

The conventional wisdom on how to measure community progress (whether related to health determinants or community capacity) is to define categories and develop indicators, the status of which can then be assessed through observation and the collection of various types of data. This type of approach can be quite elaborate, technical, professionally driven, and time-consuming (see Bopp et al, 2000 and Conner et al., 2002). However, there are other ways people “know” things.

Case Example 3—Canadian Aboriginal Communities

In 1999–2000, we assisted a Canadian aboriginal reserve community of about 1000 people to make a comprehensive community healing and development plan. The process involved a series of community assessment and planning retreat, and consultation, that took almost a year to complete. (For an example of this type of participatory community planning work, see “The Nuxalk Nation Community Healing and Wellness Development Plan” [2000], prepared by Michael Bopp and Phil Lane, Jr., of Four Worlds International, in consultation with the Nuxalk Chief and Council and community. Available from Bill Talio, Wellness Coordinator, Nuxalk Nation, Bella Coola, BC, Canada.)

At one point in a similar process in another community (which asked to remain anonymous), a discussion arose as to how much problematic alcohol consumption was occurring.

“What do you mean, how much?” one health committee member asked. “We don’t need to count. We Know.”

“How do you know?” we asked.

“How do you know it’s raining?” she said. “We know’ cause we’re in it. We see it and live it everyday.”

“OK,” we said, “how much problem drinking is there? If you don’t know how much there is now compared to how much there was last year, how can you tell whether or not your alcohol program is working?”

She thought for a moment. “Sixty-five percent of households, 80% or more of youth under 25. That’s about what it is,” committee members said after they discussed this in their local language. “Maybe older youth is closer to 90%.”

—from the author’s field notes

We subsequently conducted an anonymous survey in the community school (codesigned by the health committee) which, among other things, asked some 200 students ages 12 to 18: a) whether there was ongoing drinking that caused harm happening in their homes, or in the homes of relatives; and b) whether they or their friends used alcohol or drugs regularly, and whether that use brought harm. The tabulated results were almost identical to the “estimates” made by health committee members.

We take several lessons from this example. First, while it is always valuable to triangulate data, the cost of doing so (in time, money, and technical know-how) must be weighed against what level of validity criteria is required for which purposes. Institutions usually require scientific research criteria, but for community members, it is often

sufficient to estimate based on experience. Second, in assessing community capacity levels, it is primarily the community itself that needs to know both which capacities are needed and which capacities are now extant in community practice. However, outside helpers also need to know, particularly if they are to contribute to capacity building. So what is needed is a common set of definitions and a common language to talk together about them.

While a formalized process can be very valuable (see Bopp et al, 2000), such processes need to be situated within a larger process of development learning and action in order to be effective. Generally, effective practitioners working on the ground with community processes are constantly “reading” community capacity as a prominent theme, and in this way assessing who needs to learn what, in order to advance the process. In its simplest form, community capacity assessment is no more than that.

PROFESSIONAL CAPACITY AS A KEY COMPONENT OF COMMUNITY CAPACITY

To return to the metaphor of a coach and a team, a good coach has at least four characteristics: 1) technical competency (knowing the game well enough to anticipate the knowledge, skills, and attitudes his or her players need, in order to succeed under any given set of circumstances; 2) an intimate knowledge of each player’s current capacity and the capacity of the team as a unit; 3) the ability to promote continuous and sometimes rapid learning and capacity development; and 4) the ability to inspire and motivate the players and the team to peak performance.

This metaphor appears to transfer well to the role of professionals in community health development processes. In both the Kenyan and Ugandan examples described earlier, health professionals placed very high performance expectations on communities, believing that struggling rural African communities with low levels of literacy would somehow absorb technical “solutions” into the pattern of everyday life because it was reasonable (from the point of view of professionals) to do so. This assumption, though common enough in development research, misses several very large steps related to testing interventions within the real world they are meant to benefit, and related to building the capacity of communities to adapt and sustain new patterns, given the tremendous burden of complex factors with which they are already coping.

With this sort of problem, there is a critical role for a “coach.” i.e., a development facilitator that works behind a community “team,” which is, in turn, working to address fundamental determinants of well-being within their socioecological system. If developing communities already knew what to do in order to solve critical problems such as poor water supply, malaria, or chronic poverty, they would have long ago done so. Therefore, the important question for professionals is what sort of help can they provide that will truly assist communities to develop and strategically apply community capacity in order to bring about the health and development outcomes they want? If measuring community capacity can help to answer that question, then it is important to measure. It is not only the capacities of the intellect but also of the heart that need to be applied to the solving of critical human problems. Indeed, a common theme in shamanistic stories is exemplified in one part of the Navaho creation story.

Monsters stalk the land. They are devouring the people. Brave warriors try to kill them with a newly acquired weapon (bow and arrow) but no matter how often they are struck, the monsters never die. Then a magic woman whispers a secret. The monsters have no hearts. They have hidden their hearts beneath a nearby bush. To kill them, it is necessary to pretend you will attack them directly, but at the last minute, you must attack the hidden heart.

The monsters of poverty and disease that stalk the earth today are also difficult to kill. The old stories contain powerful transformational keys, however. Not only must we be technically competent (by applying the right theory, model, principle, or tool), but we must also be spiritually competent, reaching out from our hearts with love and courage to the hearts of the communities we seek to uplift. We need to be able to inspire hope, and to foster forgiveness and unity. Such “software” qualities are at least as essential to success in community transformational work as are capacities such as effective leadership and sound management. Whatever other capacities that communities may need, they also need to stay connected to their own spiritual foundations, and if we want to be of any real help, we as professionals need to stay connected as well.

Résumé: Cet article est rédigé du point de vue des professionnels du développement placés constamment devant des processus de transformation communautaire et qui s'efforcent avec leurs pairs de nombreuses disciplines de stimuler et d'appuyer

ces processus. En s'inspirant de trois études de cas, l'auteur dégage quatre leçons en faveur d'une approche écosystémique de la promotion de la santé. Premièrement, les professionnels de la santé et de la gestion des ressources naturelles, ainsi que les solutions techniques qu'ils conçoivent, ne peuvent, par leur seul apport, résoudre bon nombre des problèmes auxquels les collectivités font face. Pour s'avérer efficaces, les solutions doivent prendre en compte un ensemble complexe de variables qui peuvent être indiscernables aux yeux des professionnels qui interviennent de l'extérieur. Dresser une «carte» des systèmes naturels et humains dans lesquels s'inscrit un problème spécifique ayant trait à la santé humaine est souvent un premier pas important. Une deuxième raison pour laquelle les professionnels ne peuvent relever par leur seule intervention des défis complexes en santé tient au fait qu'au bout du compte, la plupart des solutions doivent être mises en application par les membres mêmes des collectivités et s'imposer de l'intérieur. Ainsi, l'«état des lieux» doit tenir compte des dynamiques humaines et des capacités communautaires. Troisièmement, identifier et évaluer les capacités qu'une collectivité doit déployer pour influencer certains déterminants de la santé est done une composante importante des actions de promotion de la santé. Il est essentiel que l'évaluation des capacités communautaires ne soit pas entreprise dans l'abstrait mais plutôt d'une façon qui relie l'évaluation des capacités au travail concret en cours, au moyen d'un processus participatif éclairant et engageant permettant de tracer les voies propices aux actions futures. Enfin, les professionnels de l'extérieur qui coopèrent avec une collectivité contribuent à sa capacité de relever des défis importants en matière de santé, non seulement en raison des connaissances techniques et des compétences qu'ils apportent mais encore par les caractéristiques et les attitudes qu'ils adoptent. Il convient donc que les professionnels développent leur propre capacité de se poser en modèle d'une pratique communautaire efficace.

Mots clés: capacités communautaires, recherche-action participative, développement communautaire, déterminants de la santé, développement participatif, promotion de la santé

Resumen: Este artículo está enfocado desde el punto de vista de personas del campo de desarrollo que trabajan constantemente en procesos de transformación comunitaria y también con profesionales de otras disciplinas que, al igual que ellos, tratan de fomentar y apoyar esos procesos. Los autores se valen de tres ejemplos de caso para proponer cuatro lecciones de un enfoque ecosistémico aplicado al trabajo de desarrollo en salud. Primero, los profesionales de los campos de salud y gestión de recursos naturales, así como las soluciones técnicas que crean, no pueden por sí solos solucionar muchos de los problemas que enfrentan las comunidades. Para que las soluciones sean eficaces, tienen que abordar un complejo conjunto de variables que, en gran medida, pueden ser invisibles para los profesionales de fuera de las comunidades. A menudo, un primer paso importante en esta dirección es la creación de un mapa de los

sistemas humanos y naturales dentro de los cuales surgen problemas específicos de salud. Segundo, la otra razón que explica que los profesionales no puedan resolver por sí solos desafíos complejos a la salud es que, en última instancia, la gente de la comunidad es la que debe poner en práctica muchas de las soluciones, desde adentro hacia afuera. De ahí la necesidad de que este mapa incluya la dinámica humana y la capacidad de la comunidad. Tercero. De lo anterior se desprende que una parte importante del trabajo de desarrollo en salud consiste en identificar y evaluar las capacidades específicas que necesita una comunidad para abordar determinantes específicos de salud. Es vital que la evaluación de la capacidad de la comunidad no se haga de forma abstracta, sino vinculándola con el trabajo real en curso y mediante un proceso participativo que propicie la comprensión y el compromiso dentro de la comunidad, identificando a la vez vías claras para la acción futura. Finalmente, los profesionales de fuera que trabajan con una comunidad dada contribuyen a la capacidad de la misma para abordar desafíos críticos en materia de salud, no sólo por el conocimiento técnico y las habilidades que aportan, sino también por las características y actitudes que manifiestan. Por ello es importante que los profesionales desarrollen su propia capacidad de convertirse en modelos de una práctica comunitaria eficaz.

Palabras clave: capacidad de la comunidad, investigación en acción participativa, desarrollo comunitario, determinantes de la salud, desarrollo participativo, promoción de la salud

ACKNOWLEDGMENTS

The authors extend their heartfelt thanks and appreciation to Dr. Clifford Mutero and the Mwea Project research team; the community stakeholder team in Mwea, Kenya; Dr. John McDermott and the Uganda Sleeping Sickness Research Team; the community partners in Bugwera, Uganda; the IDRC Ecosystem Approaches to Human Health Program Initiative Team in Ottawa; Dr. Don Peden of ILIRI in Ethiopia; Lori Baugh Littlejohns and the David Thompson Health Unit in Red Deer, Alberta; and Phil Lane, Levi Southwind, Brenda Rivers, Bill Talio, Julian Norris, and Dr. Lee Brown, all of whom contributed significantly to our understanding of participatory processes in the context of indigenous peoples' development.

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