A planning framework for community empowerment goals within health promotion

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Health promotion often comprises a tension between 'bottom-up' and 'top-down' programming. The former, more associated with concepts of community empowerment, begins on issues of concern to particular groups or individuals, and regards some improvement in their overall power or capacity as the important health outcome. The latter, more associated with disease prevention efforts, begins by seeking to involve particular groups or individuals in issues and activities largely defined by health agencies, and regards improvement in particular behaviours as the important health outcome. Community empowerment is viewed more instrumentally as a means to the end of health behaviour change. The tension between these two approaches is not unresolvable, but this requires a different orientation on the part of those responsible for planning more conventional, top-down programmes. This article presents a framework intended to assist planners, implementers and evaluators to systematically consider community empowerment goals within top-down health promotion programming. The framework 'unpacks' the tensions in health promotion at each stage of the more conventional, top-down programme cycle, by presenting a parallel 'empowerment' track. The framework also presents a new technology for the assessment and strategic planning of nine identified 'domains' that represent the organizational influences on the process of community empowerment. Future papers analyze the design of this assessment and planning methodology, and discuss the findings of its field-testing in rural communities in Fiji.

Introduction

The empowering discourse of health promoters, legitimized by the Ottawa Charter for Health promotion (WHO 1986), has evolved as a bureaucratic response to progressive social movements and to contemporary health discourses of the 1960s, 1970s and 1980s (Stevenson and Burke 1992; Labonte 1994). This has contributed to one of the major tensions in health promotion today: many health promoters continue to exert power over the community through 'top-down' programmes whilst at the same time using the emancipatory discourse of the Ottawa Charter. This tension between discourse and practice continues because there has been little clarification of how to make the concept of empowerment operational in the more conventional, or top-down, programme context within which many health promoters still work.

Many health promoters are genuinely concerned about community empowerment, which we define generally as the means by which people experience more control over decisions that influence their health and lives. This is sometimes an explicit goal of health promotion programmes, expressed in terms of increasing personal control over health behaviour change, or in relation to more underlying health determinants such as poverty, housing or environmental threats. More commonly, this concern arises indirectly in health promotion programmes as a consequence of efforts to mobilize, organize and educate a population (Feather and Labonte 1995). Community empowerment, which we more

specifically define as shifts towards greater equality in the social relations of power (who has resources, authority, legitimacy or influence), is an unavoidable feature of any health promotion effort. It arises as an effect of which health issues are 'targeted' for action, how resources are allocated, what strategies are selected and, most importantly, which stakeholders retain or share authority over these decisions.

Health promotion and health promotion programming

There is no singularly accepted definition of health promotion. The term's more conventional usage is as a multifactorial process operating on individuals and communities, through education, prevention and protection measures (Tannahill 1985). This rather technocratic concept, in which health authorities rationally plan for health needs 'objectively' determined through epidemiological study, has been criticized by others as failing to account for more structurally determined health risks (such as economic inequalities, environmental degradation or social discriminations) or for quality of life outcomes not captured by relying upon morbidity and mortality rates alone. Labonte (1994), among others, argues that health promotion remains an open and somewhat contested term that partly represents the health system's response to the 'knowledge challenges' of progressive social movements, such as the environment, women's rights and social justice movements of the past two decades. In this sense, health promotion is more concerned with

community empowerment than changes in particular disease risks or unhealthy lifestyles.

The concept of empowerment has been championed by the 'new health promotion movement' which emerged in the early 1980s and which focused on achieving equity in health and increased public participation in health programme decision-making (Robertson and Minkler 1994). The concept has been further legitimized by numerous World Health Organization strategic position papers and declarations (WHO 1978, 1992, 1998).

In effect, two seemingly different health promotion discourses have evolved and co-exist. The conventional discourse emphasizes disease prevention through lifestyle management or, in the case of infectious disease, vector control. The more 'radical' discourse emphasizes social justice through community empowerment and advocacy. Likewise, health promotion programming predominantly utilizes two seemingly different approaches, top-down and, to a lesser extent, bottom-up. We have intentionally used the terminology 'top-down' and 'bottom-up' because this clearly puts into perspective the way in which the tensions in health promotion programming have been viewed. Each approach has different and distinct characteristics which make them somewhat exclusive, at least in theory or as 'ideal types', and certainly problematic in practice for many health promoters (see Table 1) (Feather and Labonte 1995).

Top-down programmes follow a predetermined cycle. Cycle stages and terminology may differ between agencies but generally consist of the following elements: overall design, objective setting, strategy selection, strategy implementation and management, and programme evaluation. Examples of top-down health promotion programmes include the North Karelia Project on cardiovascular disease, the Multiple Risk Factors Intervention Trial (MRFIT), the Community Intervention Trials for Smoking Cessation (COMMIT) and numerous other chronic disease prevention programmes. In

bottom-up programming the outside agents act to support the community in the identification of issues which are important and relevant to their lives, and enable them to develop strategies to resolve these issues. The programme design and management is negotiated with the community and there is, or should be, a much longer time frame. Examples of bottom-up programmes include the Alcohol and Substance Abuse Prevention Programme (Wallerstein and Bernstein 1988) and the Tenderloin Seniors Organizing Project (Minkler 1997). Much of the work in this area remains anecdotal or unpublished, and includes community development initiatives ranging from anti-poverty or housing development projects, to community gardens and policy advocacy support (Labonte 1996).

Health promoters have conventionally viewed community empowerment as a part of bottom-up approaches. The tension they experience in practice is how they might include the concerns and issues of the community in the top-down programming approach that usually characterizes their own job descriptions or funding mechanisms. The dichotomy between top-down disease prevention/lifestyle change and bottom-up community empowerment approaches is not as fixed as it is sometimes portrayed. Feather and Labonte (1995) argue that many health promoters, in their community work, shift between the options of marketing and managing lifestyle programmes, and efforts to organize and support community efforts to change more systemic health risks in their physical and social environments. One heart health project found that community organizing in a poor neighbourhood was easier around 'one-off' community picnics, fun runs and collective dinners than around more complex problems of poverty, unemployment or housing. But, over time, community members on the heart health organizing committee began to raise these more systemic concerns. Rather than worrying that these 'competing problems' were outside their heart health mandate, practitioners instead examined how they, and their health department, could support the group's organizing efforts on these more difficult problems (Labonte and Robertson 1996). Similarly, case study reports show that

Table 1. Key differences between top-down and bottom-up approaches (based on Felix et al. 1989, Labonte 1993 and Boutilier et al. 1999)

	Top-down	Bottom-up
Root/metaphor	Individual responsibility	Empowerment
Approach/orientation	Weakness/deficit Solve problem	Strength/capacity Improve competence
Definition of problem	By outside agent such as government body	By community
Primary vehicles for health promotion and change	Education, improved services, lifestyle	Building community control, resources and capacities toward economic, social and political change
Role of outside agents	Service delivery and resource allocation	Respond to needs of community
Primary decision makers	Agency representatives, business leaders, 'appointed community leaders'	Indigenous appointed leaders
Community control of resources	Low	High
Community ownership	Low	High
Evaluation	Specific risk factors Quantifiable outcomes and 'targets'	Pluralistic methods documenting changes of importance to the community

health groups structured around the immediate concerns of lower-income women (such as body image, parenting, managing food budgets) contribute to improve social support, self-esteem and perceived power, as well as providing a reward structure to their days, creating a context in which self-expressed concerns over smoking or other health behaviours often arise (Labonte 1996; Kort 1990).

One could argue that this simply represents a more subtle way of 'targeting' behaviour change programmes for 'at risk' groups, but there is a difference. The practice here is concerned more with the group members' experiences of empowerment in terms of the quality of their social relationships and self-identities than with changes in specified health behaviours. Health authorities may still retain considerable control over programme planning and resources, and may not act upon all the issues raised by the community, but the priorities are no longer the same as they would be if the programme used a strictly top-down approach.

If top-down and bottom-up approaches are not mutually exclusive in practice, programme planners still have difficulty

accommodating them, and the permeability between the approaches is more by chance than by design. We argue that to ensure community empowerment goals become more integrated within the context of top-down programmes, it is best to view such goals as a 'parallel track' running alongside the conventional 'programme track' (see Figure 1). The health promotion programmer's concern now becomes one of ensuring the programme and empowerment tracks become linked during the progressive stages of programme development. The tension is no longer simply between the top-down and bottom-up interests of the stakeholders, but becomes a series of problems which are presented as questions at each stage of the programme cycle.

The framework is intended to assist health promoters to systematically accommodate community empowerment goals within their normal approaches to programming. However, it can apply equally to more bottom-up community development programmes aimed at health-damaging social and environmental conditions, since, regardless of programme goals or objectives, the act of planning is still one of determining activities that lead towards certain ends.
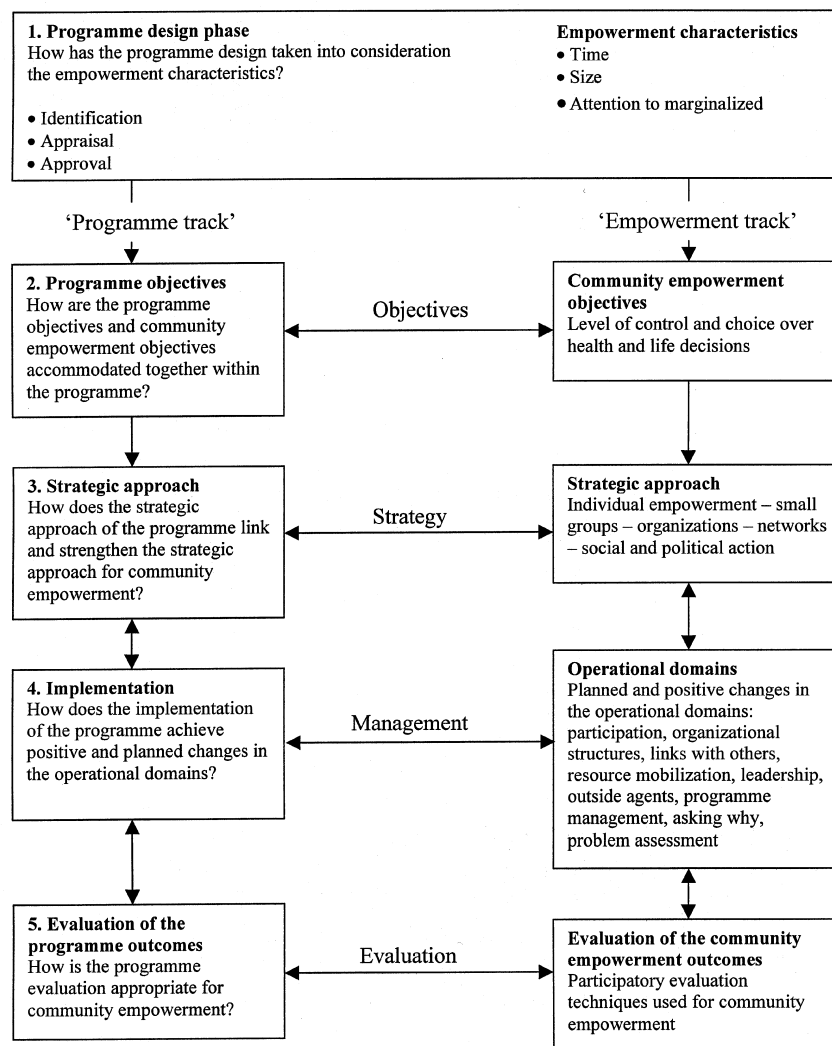

Figure 1. A planning framework for the accommodation of community empowerment into top-down health promotion programmes

Stage 1. Overall programme design

The first opportunity where the top-down and bottom-up tensions can begin to resolve is in the design characteristics of the programme itself. Specifically, programme design, regardless of its content, can be made more empowering by using strategic and participatory planning approaches. Such approaches allow the involvement of the participants and help to resolve conflict that may arise later during implementation and evaluation. In this empowering context, the concept of the programme itself changes. Rather than being a time-limited or one-off educational or marketing activity, the programme becomes essentially a vehicle through which longer term relationships between the health authority or NGO and community members are built, via the health promoter. Through this relationship, various financial, material, human and knowledge resources become available to community members that help to enhance their capacity to act on the specific issues of shorter term educational or marketing activities, or to organize to change specific public policies that determine more underlying health determinants such as housing or poverty. This capacity, in turn, generalizes to other issues of interest to community members.

Planners should consider particularly how the programme takes into consideration the time frame, size and the attention given to marginalized groups.

Programme time frame

Programmer planners need to appreciate the gradual developmental process of both personal and community empowerment. Community empowerment is concerned with effecting social, economic and political changes that improve the quality of life for whole communities. This takes considerable time, and may not even occur until long after the completion of a conventional health promotion programme. Experience suggests that the idea of longevity should be built into the design of conventional health promotion programmes that wish to achieve community empowerment goals (Tonon 1980; Bakhteari 1988; Rody 1988; Eisen 1994; Kelly and Van Vlaenderen 1996). Well-established communities may require a commitment of only 6–12 months, whilst non-established communities may require no less than 2 years and sometimes even 7 (Raeburn 1993). Too short a programme time frame runs the real risk of initiating healthy community changes, only to end before such changes have reached some degree of sustainability.

Programme size

Any community empowerment process should start with realistic community issues which are achievable and that can produce small visible successes in the short term. This helps to sustain interest and promote the progression on to more complex initiatives (Eisen 1994; Shrimpton 1995; Korsching and Borich 1997; Larson 1997). The programme may be designed to initially look inwards critically at interpersonal power relations and dynamics, which can best be achieved through small groups. Later these groups will need to develop and grow into partnerships and networks (Labonte 1993) if

they are to effect change in their external environments. The size of a programme should allow it to be managed and controlled by the community, many members of which may have little experience and initially few skills. This can be better achieved by focusing on relatively small numbers of people in small programmes, thus avoiding some of the problems associated with large impersonal organizations and institutions (Gruber and Trickett 1987; Barr 1995).

Community has both spatial dimensions (geographic, the city, town or neighbourhood) and non-spatial dimensions (affinity, shared interests based on class, gender, race or specific concerns). There is no 'community' in a totalized or abstract sense. Practically, community is best considered to be organized groups that are important enough to their individual members that they identify themselves, in part, by that group membership. This implies that within any geographic 'community', multiple communities actually exist; and that each individual may belong to several different communities at the same time. It also infers that programme planners need to be clear on which groups are organized or supported (racist, non-democratic or exploitative groups, for example, generally are not supported) and why (how will organizing or supporting marginalized groups improve population health?).

Attention given to marginalized populations

Planners should take particular account of whatever marginalized populations exist in the context of a programme during the design phase. The key to working with members of such groups is a clear understanding of what marginalization is, and how objective material powerlessness often leads to internalized psychological powerlessness. Marginalization is a complex socio-historical process, but we define it here in practical terms by its effects: those most in need, not already able to meet their own needs, with limited access to resources or who exist outside power structures. Such people are less likely to participate in programmes unless actively involved in their design and implementation, and actively supported in that involvement. The paradox of empowerment approaches is that the most marginalized populations are often unable to articulate their needs or interests, and are excluded from the programme. The ethical dilemma for health promoters is which groups, at the expense of others, should get priority for the limited resources that programmes might offer.

Stage 2. Objective setting

In conventional health promotion programming, objectives are developed during the design phase and are usually centred around disease prevention, a reduction in morbidity and mortality and lifestyle management such as a change in specific health related behaviours. The issue is how to give empowerment objectives equal priority with disease prevention objectives. Empowerment objectives are usually centred around a gain in control over decisions influencing the health and lives of the community. The specific nature of a programme's objectives will vary according to its purpose but should also be reflected in the empowerment objectives and outcomes. An example of a somewhat fictionalized account of smoking behaviours in Latin American men serves to illustrate how

Box 1. Smoking behaviour in Latin American men

During the 1980s, a large Canadian city saw an influx of immigrants and political refugees from Latin America. Often fleeing repression in their homelands, these families experienced the stresses of finding housing and work in a foreign culture, with a different language, often under the uncertainty of whether they would be able to stay permanently. They also smoked a lot, particularly the men. This caught the attention of a health department that, at that time, was flush in anti-tobacco grants money. Conventional programme objectives concerned education and awareness campaigns, designed in culturally and linguistically sensitive ways and marketed through channels, such as church and refugee assistance groups. But health workers also knew that smoking was hardly a 'burning' issue for these men. These workers knew that, until their lives and living conditions settled down, smoking would never be much of an issue for these men. Spanish-speaking health workers, still working to develop smoking awareness programmes, also asked the men about their greatest health worries. Consensus developed that it was less about them and more about their children. Their teenagers had nowhere to go once school was over and before they returned home from the sundry menial jobs they took to get by. They feared that, alienated and unattended, their children would turn to the 'street life', becoming seduced by drugs and petty crime. They wanted to create a drop-in centre for Hispanic youth, with programmes that would help their kids adjust to their new world. Along with other social agencies, health workers and anti-tobacco grants money were put to work helping these men establish just such a centre.

Conventional programme objectives concerned increased awareness of tobacco-related health risks; as one example, there was no smoking during planning meetings to develop the youth centre. They extended to efforts to prevent smoking among their children, and health-related courses became part of the structured programmes in the drop-in centre. Programme objectives also incorporated the different steps involved in planning for the drop-in centre. Empowerment objectives, in turn, concerned the quality of men's participation in the planning group, the degree of leadership that arose within the group, their ability to mobilize resources both internal (amongst themselves and their community) and external (from outside agencies and funders), and the extent of decision-making authority over programme planning and implementation the men experienced.

Achieving these empowerment objectives would improve the quality of their social relations with each other (social support), their collective and individual experience of capacity (self-efficacy, self-esteem, perceived power) and their perception as an important group by other institutions and social actors (political legitimacy, social status). Each of these psychosocial domains is independently associated with improved health. They are also associated with greater programme sustainability, and there is a rich case study literature indicating that, as such groups are supported in their immediate concerns and interests, lifestyle behaviours rise in importance in their lives (Labonte 1998).

programme and community empowerment objectives can be accommodated together to be mutually beneficial (Box 1).

Stage 3. Strategy selection

Health promotion programmes employ diverse strategies such as awareness raising campaigns, provision of information and advice, influencing social policy, lobbying for change, and training, often in combination in complex interventions (Speller et al. 1997). It is important that whatever strategic approach is used links and strengthens the strategic approach for community empowerment. Community empowerment can be viewed as a process along a five-point dynamic continuum or strategic approach: (1) empowerment; (2) development of small mutual groups; (3) development or strengthening of community organizations; (4) development or strengthening of inter-organizational networks; and (5) political action (Labonte 1990; Rissel 1994). The role of the outside agents in such as process is essentially to contribute towards some strategic integration along the continuum, partly by attending to the dynamics that underpin its different points (Labonte 1993).

Continuing with our example in Box 1, this would include ensuring that individual men were encouraged to participate in mutual support groups (which means that such groups are supported to exist in the first place which, in our example, often occurred under the auspices of refugee support services), that these groups employed strategies to establish and build the capacities of community organizations (an independent

organization to develop and administer the drop-in centre was created), and that these organizations used strategies to develop coalitions and partnerships leading toward social and political change, for example in policy and programme resources for Latin American refugees (the new organization engaged in lobbying and media efforts).

Stage 4. Strategy implementation and management

Our argument has been that the shift in health promotion discourse towards empowerment has not been accompanied by a corresponding clarification of how to make this concept operational in a programme context. We believe that health promoters require practical methodologies for assessment and strategic planning of community empowerment during their more routine programme management and implementation.

One of us (G.L.) has developed and field-tested a new methodology for this purpose. The methodology is implemented as a 1–2 day workshop and involves a number of simple exercises allowing the participants to make an independent self-assessment based on their own experiences and knowledge. The participants assess nine 'operational domains' (Table 2) that represent the areas of influence which maximize the utilization and effectiveness of the process of community empowerment. These domains have been corroborated by the work of other authors involved in the identification of the dimensions of community capacity (Goodman et al. 1998), community

participation (Rifkin et al. 1988; Shrimpton 1995) and community competence (Eng and Parker 1994). The domains do not include the social elements of community empowerment such as relationships, trust, social capital, community connectedness and a sense of community history. Rather, the domains are the organizational elements of community empowerment and in themselves act as a proxy for such social elements. For example, the existence of functional leadership, supported by established organizational structures with the participation of its members who have demonstrated the ability to mobilize resources, would indicate a community that already has strong social support and cohesiveness.

To strengthen the process of community empowerment, health promoters need to question, and answer, how programme implementation:

• improves stakeholder participation,
• increases problem assessment capacities.
• develops local leadership,
• builds empowering organizational structures,
• improves resource mobilization,
• strengthens stakeholder ability to 'ask why',
• increases stakeholder control over programme management,
• creates an equitable relationship with outside agents.

A detailed description of the operational domains, the design of the methodology and the experiences of the field testing is the subject of a separate paper.

Stage 5. Programme evaluation

The final stage of the planning framework is determining how programme and community empowerment outcomes might be evaluated. Community empowerment can be a long and slow process, and is one that, almost by definition, never fully ends. Particular outcomes in the community empowerment process may not occur until many years after the time frame of the programme has been completed. Thus, evaluation of community empowerment within the limited time frame of a programme context more appropriately assesses changes in the process rather than any particular outcome. In effect, the process becomes the outcome.

To return to the example of the Latin American men in Box 1, the empowerment outcomes for the men in the group would be determined by the men themselves. Success in this particular programme was not counted in terms of changes in smoking behaviour, though the funders accepted that such work might increase the 'stage of preparedness' in these men to consider behaviour change. It was not even marked by the opening of the drop-in programme. It was judged in terms of

Table 2.　The operational domains

Domain	Description
Participation	Participation is basic to community empowerment. 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 that 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 empowerment.
Problem assessment	Empowerment 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 from within and 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 programme context outside agents are often an important link between communities and external resources. Their role is especially important near the beginning of a new programme, 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 programme authority.
Programme management	Programme 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 programme management by the community is to have clearly defined roles, responsibilities and line management of all the stakeholders.

how these men, and their families, experienced a greater sense of control over important conditions in their reality, and the contributions the health department made to that process, including the men's abilities to define their own project outcomes, and to evaluate their accomplishment in terms that make sense to them.

More importantly, empowerment objectives are likely to change for programme participants as their own experiences of capacity and power increase over time. This 'learning-in-action' is what typifies more bottom-up or empowering approaches to health promotion. Broad health concerns that might be expressed initially by groups (e.g. reducing poverty in a given locality) may change as the group engages in activities towards this long-term goal. Through outreach, dialogue, problem analysis and so on, the group may decide to narrow its focus towards more immediate and resolvable issues, such as improving public housing conditions. Or the group may plan some community economic development initiative to create local employment opportunities only to discover later that finance capital is unavailable. The group then selects an alternative task or activity. This process of community empowerment work is why the development of generic outcome indicators for empowerment is difficult and inappropriate. A universal measure may confuse our understanding of empowerment by construing its effects as static outcomes rather than as dynamic experiences (Zimmerman 1995).

The methodology mentioned above assesses the organizational areas of influence of the process of community empowerment during the programme period. As such, it allows for clearer articulation of how a particular health promotion programme, and its funders or agency initiators, contribute to the broader empowerment concerns of community members participating on the planning group.

Finally, the concept of empowerment is concerned with the experiences, opinions and knowledge of people. It is a construction of individual and collective local beliefs and 'truths'. The selection of an appropriate evaluation methodology for community empowerment should account for different subjective experiences and allow these to be accessed as a part of the assessment. As previously noted, the programme design can be made more empowering when using participatory planning and evaluation approaches. Programme planners similarly have the opportunity at the design phase to include evaluation techniques that will actively include the community. This requires an adequate budget and a suitable time frame for training in the use of qualitative evaluation techniques, and the design of an evaluation approach that, in itself, meets some of the capacity-building goals of community empowerment.

Conclusions

At the beginning of this article we argued that one of the major tensions in health promotion today is that many health promoters continue to exert power over the community through 'top-down' programmes whilst at the same time using an emancipatory 'bottom-up' discourse. This tension between discourse and practice persists, in part, because

health promoters lack clarity about the influences on the process of community empowerment, and because the shift in health promotion towards empowerment has not been accompanied by the means to make this concept operational within a conventional programme context. Many health promoters do not have a clear understanding of how community empowerment can be practically accommodated within health promotion programming.

The framework outlined in this article is a first step towards clarifying and understanding how community empowerment goals can be systematically accommodated within health promotion programming. Although the framework refers to the more conventional top-down lifestyle and behaviour orientated programmes, it can be equally applied to bottom-up approaches. The framework is intended to be used by all stakeholders but would normally be initiated by the change agent such as an NGO or health promoter.

This article also mentions the design and utilization of a methodology for the assessment and planning of community empowerment in health promotion programmes. This is a second and probably most important step towards integrating community empowerment goals within health promotion programming. The methodology is situated within the framework and specifically addresses the issue of how to make this concept operational within a programme context. We believe that together, the framework and methodology will assist many promoters to better understand how community empowerment can be practically accommodated within health promotion programming.

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