A Synthesis Paper on the Conceptualization and Measurement of Community Capacity

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ONE-PAGE SUMMARY (ENGLISH)

This synthesis paper reviews and critically assesses the available evidence base on the conceptualization and measurement of community capacity, and discusses the implications of this for policy, research, and action. The research was based on two main data collection methods, a review of the existing evidence base (documents) and three focus groups (February – April 2003). In addition, we produced an annotated review of resources such as guidebooks and tools that people could use to understand and build "community capacity." In an effort to promote discourse on community capacity, we also convened a community forum on this topic in December 2002. We developed a framework of community capacity based on our document review and focus groups. Our framework encompasses characteristics of community capacity at one of three levels (individual, organization and community) across four dimensions of the theories of change approach (context, resources, activities and outcomes). Our framework shows that community capacity has been broadly conceptualized *overall*. A total of eighty-three specific characteristics of community capacity were identified in the documents. The characteristics were grouped into *themes*. In our document review, fourteen of the sixty-five documents (22%) were found to include indicators of community capacity. A wide variety of indicators have been proposed or used to measure community capacity. The data from the focus groups were superimposed onto the data from the document review, to observe the degree of overlap between the two sets of data. A total of thirty-seven (45%) of the eighty-three characteristics identified in the document review were also observed in the focus group data. No apparent pattern or trend, in terms of either dimension or level or theme, was observed among these thirty-seven characteristics. Only four characteristics identified in the focus groups were not found in the document review. The number and variety of participants that attended the community forum showed a wide interest in community capacity in our local area. Some themes emerged from the discussion groups at the forum; these themes are similar to those found in our document review and in the focus groups. At the end of this report, we discuss the implications of our research findings. Our document review also showed that most definitions of community capacity refer to the potential to effect change for improved health, quality of life, or community. Community capacity appears to be a process that is re-iterative and cyclical. There is no actual end because communities are not static entities. At this point in time, the framework and list of the types of indicators is exploratory and descriptive, rather than prescriptive or predictive. The framework needs to be developed further and tested for validity and for its usefulness as a tool in aiding in the conceptualization and measurement of community capacity. In addition, relationships between different characteristics and what influences the intended outcomes need to be elucidated. Who is responsible for building community capacity? Based on the prominent themes of public participation and collaboration found in the literature on community capacity, and on the different levels (individual, organizational, community) identified in the literature, in the focus groups and by the research team, it may be concluded that we are all part of the process. We suggest three major strategic directions and next steps around the conceptualization and measurement of community capacity and its use in population health efforts. First, there is a need for a national-level effort to validate the constructs of community capacity to achieve a core, consensus definition and "core" indicators of community capacity as it relates to federally-funded projects. Second, there is a need to fund demonstration projects that can reliably collect data on the above "core" indicators of community capacity. Finally, federally-funded projects that purport to use a community-capacity approach (as either a process or a significant outcome) should be subjected to an "evaluability" assessment.

ONE-PAGE SUMMARY (FRENCH)

Ces revues de papier de synthèse et évalue d'une manière critique la base de preuve disponible sur la conceptualisation et la mesure de capacité de communauté, et discute les implications de ceci pour la politique, la recherche, et l'action. La recherche a été basée sur deux méthodes de réception de données principales, une revue de la base de preuve existante (les documents) et trois groupes de focus (le 2003 février – avril). En plus, nous avons produit une revue annotée de ressources telles que guides et les outils que les gens pourraient utiliser comprendre et construire “le capacité.” de communauté Dans un effort pour promouvoir le discours sur la capacité de communauté, nous avons convoqué aussi un forum de communauté sur ce sujet dans le 2002 décembre. Nous avons développé une structure de capacité de communauté a basé sur notre revue de document et les groupes de focus. Notre structure entoure des caractéristiques de capacité de communauté à celui de trois niveaux (l'individu, l'organisation et la communauté) à travers quatre dimensions des théories d'approche de changement (le contexte, les ressources, les activités et les issues). Notre structure montre à cette capacité de communauté a été globalement conceptualisé en général. Un total de quatre-vingt-trois les caractéristiques spécifiques de capacité de communauté ont été identifiées dans les documents. Les caractéristiques ont été groupées dans les thèmes. Dans notre revue de document, quatorze des documents de soixante-cinq (22%) ont été trouvé pour inclure des indicateurs de capacité de communauté. Une variété large d'indicateurs a été proposée ou a été utilisée pour mesurer la capacité de communauté. Les données des groupes de focus ont été superposées sur les données de la revue de document, observer le degré de recouvrement entre les deux séries de données. Un total de trente-sept (45%) des caractéristiques de quatre-vingt-trois identifiées dans la revue de document ont été aussi observé dans les données de groupe de focus. Aucun modèle ou aucune tendance apparentlemee, dans les termes de dimension ou nivelle ou le thème, a été observé entre ces caractéristiques de trente-sept. Seulement quatre caractéristiques ont identifié dans les groupes de focus n'ont pas été trouvé dans la revue de document. Le numéro et la variété de participants qui ont assisté le forum de communauté ont montré un intérêt large dans la capacité de communauté dans notre domaine local. Quelques thèmes ont émergé des groupes de discussion au forum; ces thèmes sont similaires à ces trouvé dans notre revue de document et dans les groupes de focus. A la fin de ce rapport, nous discutons les implications de nos conclusions de recherche. Notre revue de document a montré aussi que la plupart des définitions de capacité de communauté se réfèrent au potentiel pour effectuer le changement pour la santé améliorée, la qualité de vie, ou la communauté. La capacité de communauté a l'air d'être un procédé qui est réitératif et cyclique. Il n'y a pas de fin véritable parce que communautés sont entités pas de statiques. A ce point dans le temps, la structure et la liste des types d'indicateurs est exploratoire et descriptif, au lieu de préscriptif ou predictive. La structure a besoin d'être plus développé et essayé pour la validité et pour son utilité comme un outil dans aider dans la conceptualisation et la mesure de capacité de communauté. En plus, les relations entre les caractéristiques différentes et ce qu'influence les issues projetées a besoin d'être expliqué. Qui est responsable de construire de capacité de communauté? Basé sur les thèmes éminents de participation et de collaboration publiques trouvées dans la littérature sur la capacité de communauté, et sur les niveaux différents (l'individu, confessionnel, la communauté) a identifié dans la littérature, dans les groupes de focus et par l'équipe de recherche, il peut être conclu que nous sommes toute partie du procédé. Nous suggérons trois directions stratégiques majeures et les étapes prochaines vers la conceptualisation et la mesure de capacité de communauté et son usage dans les efforts de santé de population. Premier, il y a un besoin pour un effort national-égal pour valider les constructions de capacité de communauté pour atteindre un noyau, une définition d'accord

et “le noyau” les indicateurs de capacité de communauté comme il relate aux projets fédéralement-subventionnés. La seconde, il y a un besoin de subventionner les projets de démonstration qui fiablement peuvent recueillir des données sur l'au-dessus “le noyau” les indicateurs de capacité de communauté. Finalement, les projets fédéralement-subventionnés que prétend utiliser une approche de communauté-capacité (comme un procédé ou une issue significative) sous réserve d'un “l'évaluabilité” l'évaluation.

EXECUTIVE SUMMARY

"Community capacity" has been widely recognized as an interesting and potentially useful concept. However, what "community capacity" is, and how it can be measured, remains elusive. The first step toward some answers is a synthesis and analysis of the current status of research and evidence related to this concept. What is the available knowledge on theoretical frameworks, statistical analyses and the evidence base on measuring community capacity? What indicators of community capacity have been tested, and where are the gaps? The research was based on two main data collection methods, a review of the existing evidence base (documents) and three focus groups (February – April 2003). In addition, we produced an annotated review of resources such as guidebooks and tools that people could use to understand and build "community capacity." In an effort to promote discourse on community capacity, we also convened a community forum on this topic in December 2002. This was an exploratory descriptive study, and therefore no statistical analyses (e.g., hypothesis testing) were performed.

We developed a framework of community capacity based on our document review and focus groups. Our framework encompasses characteristics of community capacity at one of three levels (individual, organization and community) across four dimensions of the theories of change approach (context, resources, activities and outcomes). Our framework shows that community capacity has been broadly conceptualized *overall*. A total of eighty-three specific characteristics of community capacity were identified in the documents. The characteristics were grouped into *themes*. Some themes were present across all four dimensions of the theories of change (context, resources, activities and outcomes), including: *public participation* (individual level); *normal organizational operations not specific to community capacity* (organizational level); and *community infrastructures* and *shared interests and working together towards common goals* (community level). Other notable themes that appeared across three dimensions were *knowledge and skills* (individual level), and a *general orientation towards community capacity* (organizational level). At the individual level, the characteristic that was conceptualized most frequently in the documents was the outcome of an increase in, or application of, knowledge and skills (n=29). At the organizational level, the most frequently conceptualized characteristic (n=41) was the activity of investing in human resource development in staff and/or community members. At the community level, the most frequently conceptualized characteristic (n=44) was the outcome of increased health, social conditions, well-being and/or quality of life.

In our document review, fourteen of the sixty-five documents (22%) were found to include indicators of community capacity. A wide variety of indicators have been proposed or used to measure community capacity. Some of the indicators appear to be "borrowed" from other areas of interest, such as social capital, sense of community and organizational or collaborative capacity. Although a wide variety of indicators have been used, some were used to measure different characteristics throughout our framework. For example, people's participation in elections were proposed or used to measure individual-level context, activities and outcomes, as well as a proxy measure of an increase in the quality of life in the community.

The data from the focus groups were superimposed onto the data from the document review, to observe the degree of overlap between the two sets of data. A total of thirty-seven (45%) of the eighty-three characteristics identified in the document review were also observed in the focus

group data. No apparent pattern or trend, in terms of either dimension or level or theme, was observed among these thirty-seven characteristics. Only four characteristics identified in the focus groups were not found in the document review: an understanding of the roles of formal structures, organizational development and the media were identified as a resource; and information availability and discourse were identified as a context. Over one half (54%) of the thirty-seven characteristics had overlapped with data from one focus group, while under one third (30%) had overlapped with data from two focus groups. Six characteristics had overlapped with data from all three focus groups. Five of these six characteristics were outcomes, both individual-level (increased public participation and increased awareness understanding of community issues) and community-level (increased health, social conditions, well-being and/or quality of life, ability of the community to focus on and work collaboratively to resolve issues or towards common goals, and increased resources or resource mobilization). The other characteristic that overlapped with data from all three focus groups was information dissemination and advocacy relevant to community capacity at the organizational level.

The number and variety of participants that attended the community forum showed a wide interest in community capacity in our local area. Some themes emerged the discussions groups at the forum: community assets and strengths, participation, consensus, and community ownership. These themes were similar to those found in our document review and in the focus groups.

At the end of this report, we discuss the implications of our research findings. Community capacity is often discussed as to whether it is an end or a means to an end. Although a program may include the building of community capacity as an objective (an end), community capacity is more often thought of as a means to better quality of life and healthier communities. In our document review this was the most prevalent outcome specified for community capacity at the community-level. Community capacity appears to be a process that is re-iterative and cyclical. There is no actual end because communities are not static entities. The re-iterative nature of community capacity was mentioned by participants in the focus groups, revealed in our framework where a theme spanned more than one dimension of the theories of change, and revealed in our compilation of indicators where one indicator was proposed or used to measure more than one characteristic of community capacity.

At this point in time, the framework is exploratory and descriptive, rather than prescriptive or predictive. The framework can be used to look at examples of what resources or activities contribute to community capacity. We do not purport to understand or know the interactions between the different characteristics of community capacity or any of its intended outcomes. The framework needs to be developed further and tested for validity and for its usefulness as a tool in aiding in the conceptualization and measurement of community capacity. In addition, relationships between different characteristics and what influences the intended outcomes need to be elucidated. Our document review showed that a broad range of different types of indicators have been proposed or used to measure community capacity. No clear conclusion can be made about indicators of community capacity, except that there is no consensus on what indicators should be used. We emphasize that our research is exploratory and that the list of the types of indicators we present are descriptive and exploratory. The list is not prescriptive, and should only be interpreted as examples of the types of indicators that have been proposed or used to measure community capacity. The concept of a core set of characteristics and indicators of community capacity needs to be explored. Based on our document review and the focus groups, we found several themes to be prominent in people's conceptualization of

community capacity. These include knowledge and skills, public participation, functional organizations, community infrastructure, and collaboration. Are these themes more "important" than others in building community capacity and contributing to the intended outcomes? Are they "necessary" towards the building of community capacity?

Several other points can be made regarding the need to strengthen our understanding and appropriate use of the notion of community capacity. Ideally the building of community capacity would allow communities to initiate their own initiatives or research, or work more equitably with government and/or academic partners. Our framework includes strategies, i.e., activities, which have been proposed or used to build community capacity. Who is responsible for building community capacity? Based on the prominent themes of public participation and collaboration found in the literature on community capacity, and on the different levels (individual, organizational, community) identified in the literature, in the focus groups and by the research team, it may be concluded that we are all part of the process. The organization of the framework suggests that individuals and organizations can play a role in building community capacity.

We suggest three major strategic directions and next steps around the conceptualization and measurement of community capacity and its use in population health efforts. First, there is a need for a national-level effort to validate the constructs of community capacity to achieve a core, consensus definition and "core" indicators of community capacity as it relates to federally-funded projects. Second, there is a need to fund demonstration projects that can reliably collect data on the above "core" indicators of community capacity. Finally, federally-funded projects that purport to use a community-capacity approach (as either a process or a significant outcome) should be subjected to an "evaluability" assessment.

Efforts to build and evaluate community capacity have often involved various key constituencies, i.e., academics, service providers, practitioners, policy makers, funders and lay persons. The outcome of interest is often better quality of life and healthier communities. Building and sustaining community capacity will require three things: 1) changing knowledge, attitudes and beliefs to motivate people to engage in community-capacity initiatives; 2) enabling motivated individuals or groups to take action on building (and measuring) community capacity by building skills and providing supportive environments and resources; and 3) rewarding or reinforcing practitioners, policy makers and funders who engage in capacity-building.

The notion of community capacity has a long and respected position in relation to community development and health promotion initiatives. However systematic and rigorous process and/or outcome evaluations of capacity building efforts are lacking. This is not a condemnation of community capacity as an immensely important concept in community-based, population health initiatives. Rather, this represents a challenge to both the proponents and critics of capacity building. Funders, policy makers and community partners would be better served if they agreed, a priori, on a smaller bounded set of measurable indicators, if communities were given the needed resources and support to achieve the desired outcomes, and if communities were held accountable for measuring the identified outcomes.

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TABLE OF CONTENTS

1. PURPOSE OF THE SYNTHESIS PAPER

"Community capacity" has been widely recognized as an interesting and potentially useful concept. However, what "community capacity" is, and how it can be measured, remains elusive. The first step toward some answers is a synthesis and analysis of the current status of research and evidence related to this concept. Health Canada expressed an interest in this by announcing its first Request for Proposals (RFP) for Synthesis Research under its Health Policy and Research Program in 2001. In this RFP, community capacity was one of two policy relevant themes of interest. This synthesis paper is the product of one of the successful proposals in this competition. More specifically, this synthesis paper reviews and critically assesses the available evidence base on the conceptualization and measurement of community capacity, and discusses the implications of this for policy, research, and action. The purpose of the paper is not an evaluation of either the quality of community capacity processes or the achieved outcomes of specific community capacity efforts. Rather, the paper addresses several questions. What is the available knowledge on theoretical frameworks, statistical analyses and the evidence base on measuring community capacity? What indicators of community capacity have been tested, and where are the gaps?

Although this synthesis paper is written with Health Canada as the intended audience, community capacity is not limited to the *health* sector. Therefore this paper is relevant to anyone interested in building community capacity. In other words, it is relevant to anyone interested in helping communities to identify and address issues of concern within their community, regardless of whether or not the term “community capacity” is used, or whether the issues of concern are the perceived responsibility of the *health* sector.

2. METHODS

2.1 Setting Boundaries for "Community Capacity"

At the outset of the project, various concerns were raised with respect to how community capacity is defined and conceptualized. The research team established a set of boundaries to provide a context for the research and to guide data collection.

The first step was to agree on a working definition of "community capacity." The definition found in Health Canada's call for proposals was adapted - "the characteristics of communities that affect their ability to identify, mobilize, and address social and public health issues of concern." More specifically, the research team chose to focus on community capacity for "population health promotion" as described by Hamilton and Bhatti (1996). The population health promotion approach focuses on the full range of health determinants by means of health promotion strategies that enable people to take control over and improve their health. The population health promotion approach described by Hamilton and Bhatti (1996) considers the questions, "on what should we take action?", "how should we take action?", and "with whom should we act?"

The next step was to establish what types of "communities" would be included in the study. Two types of communities were identified, spatial (geographical) and non-spatial (communities of affinity). There is no sound reason why either of these two types of communities should be excluded, and therefore both are included in the study.

The data for this project were collected using two methods: a review of the existing evidence base (documents) and focus group sessions (February – April 2003). These tasks are described in detail below. In addition, we conducted an annotated review of resources such as guidebooks and tools that people could use to understand and build “community capacity.” In an effort to promote discourse on community capacity, we also convened a community forum on this topic in December 2002.

2.2 Review of the Existing Evidence Base

In this project, the "existing evidence base" was not limited to articles in peer-reviewed scientific publications. It was recognized that this medium reflects only a portion of research and projects on community capacity. Therefore, a search for other types of publication was also made, including books, and reports, strategic planning documents (e.g., statements of goals, visions, etc.) and program descriptions published “non-academically” by government and non-governmental organizations.

Although community capacity appears to be related to other terms such as community empowerment and community development, we limited our search to documents that specifically used the term "community capacity." In addition, we only reviewed documents that included a conceptualization (dimensions or framework) and/or measurement (indicators) of community capacity. The following search strategies were used:

1) in scientific bibliographic databases, e.g., Medline, HealthStar, ABI Inform;
2) over the internet;
3) scan of citations in publications; and
4) by word of mouth, e.g., colleagues, members of the research team.

A concern was raised that there may be (older) projects that build community capacity, but do not call it as such. Due to a lack of clear criteria for determining whether a project focuses on community capacity if it does not explicitly use this term, such projects were excluded from the study.

The review of the existing evidence base was aided by the creation of a database using the software program Microsoft® Access 2000. The following data were extracted from the documents and entered into the database:

1) the source citation;
2) the type of publication;
3) the definition of community capacity and other related terms;
4) the context, i.e., country, population;
5) the "characteristics" of community capacity, as they fit into a theories of change approach (see Section 2.3 for more information on the theories of change approach); and
6) indicators of community capacity.

Frequency tables and cross-tabulations were generated from the data in the database. This was an exploratory descriptive study, and therefore no statistical analyses were performed.

2.3 Focus Groups To "Surface" a Theory of Change for Community Capacity

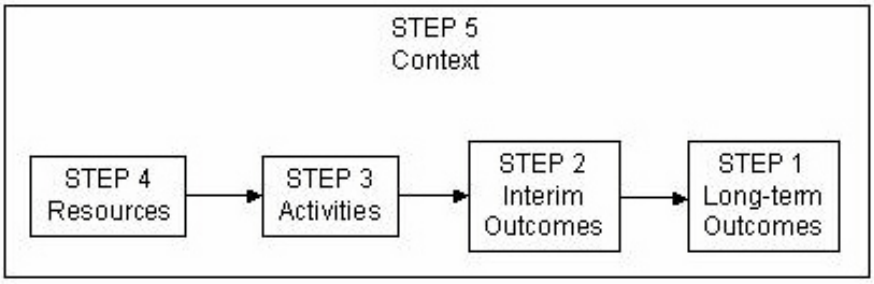
The theory of change approach to evaluating an initiative is a "systematic and cumulative study of the links between activities, outcomes, and contexts of the initiative" (Connell and Kubisch 1998). The authors point out that the theory of change is an *approach*, and not an evaluation method that stands on its own. The advantage to using the theory of change approach is that it makes explicit people's ideas underlying the initiative, i.e., what the expected outcomes are, and what needs to be done to achieve them.

Five questions were adapted for use at the focus groups, and were asked in the following order:

1) What *long-term outcomes* of community capacity does the initiative seek to accomplish?
2) What *interim outcomes* of community capacity are required to produce those longer-term outcomes?
3) What *activities* should be initiated to achieve the interim outcomes?
4) What *contextual supports* are required to achieve the interim outcomes?
5) What *resources* are required to implement the activities and maintain the contextual supports required for the activities to be effective?

Figure 1 shows both a graphical representation of the order in which the questions were asked, and a conceptualization of the relationships between context, resources, activities, interim and long-term outcomes. The first two questions make explicit the outcomes of community capacity for which people aim. The other three questions make explicit the required resources and activities to achieve these outcomes, and the context in which these occurs.

Figure 1: Theories of change approach used in the focus groups
(adapted from Connell and Kubisch 1999)



A total of three focus groups were held in Vancouver between February and April 2003. Focus Group 1 included six representatives from Health Canada, and one representative from a community capacity project funded by Health Canada. Focus Group 2 included ten out of sixteen members of the research team. Focus Group 3 included ten representatives from community capacity projects, as nominated by members of the research team.

The discussions from each focus group were audio-taped and transcribed. The results of each focus group were mapped out in the form of a chart, showing the data for each of the parts of the theories of change.

2.4 Resource Listing

To reflect the connection that community capacity appears to have with other related concepts such as community development, this resource listing was more broadly focused than our document review. The annotated resource listing (Appendix C) was based on the following questions:

1) who is the intended audience, or what audience would benefit from this resource?;
2) how is this a useful resource to the reader?; and
3) who can be contacted for further information on the resource?

2.5 Community Forum

A half-day community forum was held in Vancouver in December 2002 to promote discourse and collaboration on community capacity. The forum was co-sponsored with a community partner, the Social Planning and Research Council of British Columbia (SPARC). Invitations were sent out to locally to people on the sponsors' mailing lists.

3 COMMUNITY CAPACITY IN CONTEXT

3.1 Community Capacity For What?

The focus of the present paper is community capacity for population health promotion. We recognize that the notion of community capacity (and the building of it) is not unique to either the health field or the more narrow area of population health promotion.

In our search for documents, a scan of the Medline database yielded papers on community capacity in a variety of areas. While some of these papers can clearly be placed under the broad rubric of population health, others can not.

We found papers related specifically to health (issues) and the health system: a generic notion of community capacity in health (Baker & Teaser-Polk 1998; Francisco et al. 2001; Freudenberg et al. 1995; Gibbon et al. 2002; Goodman et al. 1998; Raczynski et al. 2001); immigrant, ethnic and international health (Chen et al. 1997; Raczynski et al. 2001; Ro 2002; Schmid et al. 2001); infectious disease control (Cline and Hewlett 1996; Molinari 1998); nutrition (Conrey et al. 2003); health policy (Dewees et al. 1996); community health (Goodman et al. 1993; Hagland 1997; Knapp and Lowe 2001); primary care (Iwami et al. 2002); public health nursing (Kang 1995; Westbrook and Schultz 2000); tobacco control (Lew et al. 2001; Tsark 2001); breast health (Meade and Calvo 2001); university engagement in health (Muramoto et al. 1997); psychiatric medicine (Reibel and Herz 1976); perinatal health (Turan et al. 2003); health disparities (Wallerstein 2002); population health infrastructure (Labonte et al. 2002; Labonte et al. 2002b; Veazie et al. 2001); and developmental disabilities (Ward et al. 2001).

We also found papers related to other areas of interest: community empowerment (Laverack and Wallerstein 2001); violence prevention (Chavis 1995); social capital and civil society (Labonte 1999; Lerner et al. 2000); healthy cities (Kegler et al. 2000); disaster management (Buckland and Rahman 1999); marine protection (Jameson et al. 2002); and technology assessment (Leidl 1994).

The existence of this broad range of applications of the notion of “community capacity” begs several questions. First, is the conceptualization and measurement of community capacity as it

relates to population health promotion the same or different from how it is thought of in other fields? Second, are these differences meaningful in terms of their research, policy and practice implications? Finally, can decision makers in population health promotion learn from the experiences and applications of community-capacity perspectives in other fields? Future work could usefully explore these questions.

3.2 Community Capacity and Related Terms

Although in the health promotion literature "community capacity" is often spoken of in relation to other terms (e.g., community participation, community competence, community empowerment, community development and social capital), it can be usefully distinguished from these terms. We provide a brief description of each of the related terms.

The concept of *"public" participation* in health-related decision making has become increasingly prevalent and appears to be driven by the doctrine of informed consent that individuals' preferences must be reflected in choices and decisions (Boyce and Lamont 1998); a public demanding greater responsiveness of professionals and policy makers to communities (Green and Frankish 1994); calls for greater accountability for resources by governments, health providers and organizations (Alexander et al. 1995; Morfitt 1998); increased interest in the role of community-level factors in generating "healthy communities" (Eastis 1998; Lomas 1998; Veenstra and Lomas 1999); and the idea that programs may be more effective if they emerge from local consensus and priorities (Morgan 2001; Zakus and Lysack 1998). Citizen involvement has been recognized as a core element of health promotion (Florin and Wandersman 1990; Green 1986). Frankish et al. (2002) provide a useful summary of some of the challenges of community participation in health-related decision making.

Community competence is a term put forward by Eng and Parker (1984) that considers community impacts and outcomes from a functional perspective. Increased community competence is an intent of many community-based health promotion programs and policies. The place of enhanced "community competence" as an (expected) outcome of increased community capacity remains open. The term "competence" refers most often to individual skills. Specific community members may be more competent in planning and decision-making tasks.

Enhanced competence may also occur at a regional or community level. Cottrell (1976) described a competent community as one in which constituencies are able to collaborate effectively, identify community needs and problems, take required actions, and achieve a working consensus on goals, priorities, and strategies. Measures of community competence are appearing in the literature.

Many community-based researchers, activists and organizers believe that a participatory effort engenders a sense of ownership and *empowerment* (Ashern et al. 1996; Zimmerman and Rappaport 1988) and is necessary for sustained success (Butterfoss et al. 1993; Murrell 1988). Empowerment, like community capacity, has proven to be an elusive concept. It has been defined as a process, an outcome, or both. Specific authors (e.g., Fettterman et al. 1996) have put forward approaches (empowerment evaluation) as a means of maximizing community empowerment and tracking its benefits. Laverack et al. (2000, 2001) have offered a planning framework for considering community empowerment goals within health promotion.

The broadest of relevant terms is *community development*. Notions and definitions of community development are more likely to have their roots in international health, public health and initiatives in developing countries. Factors such as participation and empowerment are often cited as key elements of community development (Florin and Wandersman 1990). Community development initiatives may or may not have an explicit agenda toward capacity building (Poland et al. 2000; Billings 2000). In most cases, the relations between community development and community capacity are left implicit and therefore difficult to articulate or assess.

Social capital is the newest of terms related to community capacity (Kreuter et al. 2001; Macinko and Starfield 2001; Hawe and Shiell 2000; Labonte 1999; Kawachi 1999). It refers to "those features of social relationships – such as levels of interpersonal trust and norms of reciprocity and mutual aid – that facilitate collective action for mutual benefit" (Kawachi 1999). Recent authors have written on the implications of social capital for public health and health-system governance (Lomas 1998; Veenstra and Lomas 1999). Hawe and Shiell (2000) note that social capital has relational, material and political aspects. They suggest that although the relational properties of social capital are important (e.g., trust, networks), the political aspects of social capital are under-recognized. Labonte (1999) also warns that social capital has become the

"flavour of the month" and there remains considerable disagreement over what the term means. He raises several cautions. To some, social capital is a means to economic growth, something that can compensate for a decrease in public services. Social capital may also be seen as an end requiring the defence of egalitarian intervention into market practices that create inequalities. Community development is one of many such strategies used to buffer inequalities. Labonte (1999) concludes that social capital approaches should not confuse all of the work undertaken in the name of empowerment and community capacity.

4. REVIEW OF THE EXISTING EVIDENCE BASE

A total of sixty-five documents were collected for review based on our selection criteria. See Appendix A for a list of these documents. Community capacity was a major focus in most of the documents (74%, n=48).

4.1 Types of Publication

Each of the sixty-five documents was categorized based on its publication type, i.e., the content that each contained (Table 1). These results show the breadth in the type of publications reviewed, and that the review was not limited to "academic" research publications.

Table 1: Types of Publications Reviewed

Type of Publication	Frequency (%)
"Academic" research publications	19 (29%)
"Non-academic" research publications	17 (26%)
Strategic planning documents	9 (14%)
Literature review papers	9 (14%)
Handbooks, guidebooks, tools	5 (8%)
Editorials or commentaries	3 (5%)
Program descriptions	3 (5%)
Total	**65 (100%)**

4.2 Relevant Countries

Each document was reviewed to see in which countries community capacity was relevant, e.g., the countries in which community capacity were studied, reviewed or planned (Table 2). In about one third of the documents (32%), a relevant country(ies) was not specified. A considerable proportion of the documents were relevant to Canada, the United States, or both countries.

Table 2: Countries in Which Community Capacity Were Relevant

Country	Frequency (%) [a] N=65
Not specified	21 (32%)
Canada	34 (52%)
United States	28 (43%)
Australia	12 (18%)
Other (countries in Africa, United Kingdom, Latin America, etc.)	16 (25%)

[a] Some papers include multiple countries; therefore, the numbers do not add up to 100% (n=65).

4.3 Relevant Communities

In our review, we also categorized the "communities" for which community capacity was relevant in the documents, i.e., the "communities" in which community capacity was studied, reviewed or planned (Table 3). In about one third of the documents (32%), a community was not explicitly identified. For those documents that do identify the relevant communities, about an equal number of them identify non-spatial communities (38%) and spatial communities (37%).

Table 3: "Communities" For Which Community Capacity Was Relevant

Community	[a] Frequency (%) N=65	Examples
Non-spatial community (focus on specific issues or sub-populations)	25 (38%)	Socially disadvantaged populations, specific diseases, etc.
Spatial (geographical) community	24 (37%)	Rural communities, districts, cities, etc.
Not specified	21 (32%)	Not applicable

[a] Some papers include multiple populations; therefore, the numbers do not add up to 100% (n=65).

4.4 Community Capacity and Related Terms

We were interested in whether the documents provided a definition of community capacity or of terms related to community capacity. Note that the results are based only on documents that were reviewed based on our inclusion criteria. Many papers in the literature on "community capacity" did not meet our criteria.

Of the sixty-five documents, about one half (53%, n=34) did not define the term "community capacity" (Table 4). Of the thirty-one documents that did define "community capacity," most (84%, n=26) defined it as the *ability or potential* to effect positive changes in the community; other documents (16%, n=5) defined "community capacity" as *processes or activities* that build the potential of communities to act.

Some terms related to community capacity were also identified, including community development, community empowerment, social capital, community competence and community participation. In some cases, these terms were also defined. There appears to be no clear or definite distinction between community capacity and its related terms. In general, these definitions overlap, conveying community capacity and related concepts to be both a process and an ability whereby people act together for a common community good.

Table 4: Definitions of Community Capacity and Related Terms

Term Used	Frequency of Term Used N=65 (%)	Frequency of Definition	Type of Definition
Community capacity	64 (100%)	34	Not defined.
		26	The *ability, capacity or potential* to effect change for improved health, quality of life, or community.
		5	*Processes or activities* that promote community capacity, i.e., build the potential to act.
Community development	10 (15%)	7	Not defined.
		2	Process or activities for community well-being.
		1	Process leading to community empowerment.
Community empowerment	9 (14%)	5	Not defined.
		3	The gaining of *power or influence* over decisions that affect people's lives.
		1	A dimension of community capacity.
Social capital	9 (14%)	4	Not defined.
		3	Norms and networks which enable collective action toward a common community good.
		2	Social capital, other definition.
Other (community action, community capacity assessment, community mobilization, community resiliency)	5 (8%)	3	Other terms, defined.
		2	Other terms, not defined.
Community competence	3 (5%)	1	Not defined.
		1	Process of identifying problems or needs.
		1	The skillful use of capacity.
Community participation	3 (5%)	2	Mechanisms or activities for actively involving the community.
		1	Not defined.

4.5 Conceptualization of Community Capacity

The conceptualization of community capacity was a major part of our research. Therefore we begin this section with a review of existing frameworks of community capacity, i.e., their development, and their utility. This is followed by a presentation of the framework we developed based on our review of both academic and non-academic literature.

4.5.1 Existing Frameworks of Community Capacity

To contribute to the discussion and understanding of community capacity presented in this report, we undertook a review of the literature around existing community capacity frameworks. The purpose of this review was to identify and document how community capacity frameworks were both developed and used, as well as to make a statement of how they have contributed to the conceptualization of community capacity. The following questions were used to guide our analysis:

1) How was the framework developed?
2) How has the framework been tested and/or applied?
3) How does the framework contribute to the conceptualization and understanding of community capacity?

We have summarized the information found in this review and described exemplars for each area of interest. The results are presented below.

Methods and Development Strategies

Our review found that a number of strategies were utilized for developing community capacity frameworks. Among the most frequent was some type of literature review and analysis. In these reviews, researchers clearly recognized the range of sources and documentation that provide information on community capacity. For example Brown, LaFond & Macintyre (2001) included both the published and unpublished literature in their review, and used informal discussions with practitioners to identify both theoretical and practical perspectives on community capacity. They noted that much of the practice-based documentation is found in the gray literature, including internal documents, government and other public reports, program descriptions and evaluations, and community and non-government organization reports. The range of disciplines from which the literature on community capacity were drawn reflects the inter-disciplinary nature of this concept. Jackson et al. (1999), for example, drew on work from the health field, sociology, psychology and political science in the development of their model.

A variety of consultation approaches were also used in the development of frameworks. Focus groups, key informant interviews and advisory committees were employed in a number of

projects with a range of stakeholders consulted during this process. These varied from focus groups with health unit workers (Hawe et al. 1998) to large symposia with interested groups and individuals from both academic and community backgrounds (Goodman et al. 1998). Other frameworks were developed through variations of these consultation strategies. For example, the Aspen Institute (1996) developed a guide and framework for measuring community capacity through the creation of a *community capacity-building learning cluster,* which engaged community health workers from across the country. Similarly, Labonte and Laverack (2001) used a workshop method, which brought together health promotion professionals and key community representatives to identify key elements of community capacity domains.

These strategies were also frequently used in combination, often with a preceding literature review as a basis for initiating the discussion at meetings that brought together stakeholders. For example, Goodman et al. (1998) reported on an international symposium, which brought together community health researchers with the purpose of identifying key dimensions of community capacity. This event was preceded by a sharing of articles and reports, which led to the creation of working groups to reflect on the existing literature and write various components of the developing framework. Bopp et al. (1999) also provided an example of the utilization of both literature reviews and community consultations. Their approach involved building on the literature review with the pilot testing of methods and tools for assessing community capacity.

Application and Testing

For the most part, the community capacity frameworks reviewed were noted as a starting point for capacity building initiatives and their application and testing was not described. However, a select number of these frameworks were used to some extent, often within the context of ongoing community development work in health regions. For example, the New South Wales Health Department (2001) used their framework to guide the development of effective capacity building practice in several health promotion settings. Similarly, Littlejohns et al. (2000) applied a community capacity assessment framework to a primary care initiative in a rural health region in Alberta. Frameworks were also used for capacity program evaluation in international health program development (Gibbon, Labonte and Laverack 2002). Finally, elements of capacity frameworks were also used within a broader conceptual framework for health as in the case of the National Health Performance Report from Australia, in which capacity-building was created as an additional health outcome (National Health Performance Committee 2002). In addition,

the frameworks were often discussed in relation to the measurement of community capacity. Most of the studies reviewed also discussed the implications for applying the frameworks.

Contributions

The reviewed frameworks contributed to both practical and theoretical components of community capacity. Implications and methods for the measurement of community capacity indicators were found in many of the developed frameworks. For example, Hawe, Noort, King and Jordens (1997) presented a tool for generating additional health outcomes and measuring health gains. Another model developed by Gibbon, Labonte and Laverack (2002) included the measurement of intermediate steps in capacity building programs. Brown, LaFond and Macintyre (2001) provided a review of measurement efforts, as well as a discussion of the shortcomings in measurement models.

These models also contribute on a practical level by providing a common vocabulary of community capacity concepts. This can facilitate communication between stakeholders and be a basis for better informing efforts for ongoing community initiatives (Bowen, Martin, Mancini and Nelson 2000). Similarly, frameworks can provide clear roles and outcomes for various stakeholders in community capacity initiatives. This can facilitate partnerships between stakeholders such as community residents, community agencies, non-government organizations and government (Jackson et al. 1999). Goodman et al. (1998) also noted that information from frameworks can be used by both citizen groups and community health professionals in the community development process.

Several frameworks also provide lessons and perspectives of the context in which community capacity initiatives are undertaken. The community capacity frameworks reviewed were developed within a range of community, professional and international settings and often provide a discussion of what capacity means in those different situations. The New South Wales Health Department (2001) noted the potential positive or negative impact that context can have on capacity building programs, as well as the need to be responsive to these differences. A number of studies provided a direct comparison of community capacity approaches in different settings. For example Chaskin (1999) reported on the application of their developed framework to four diverse Neighborhood and Family Initiative programs in the United States. Raczynski et al. (2001) reported on the process and provided examples of

capacity building initiatives in African American communities. Additional frameworks provided examples from Aboriginal communities, rural settings and international sites.

Finally, another valuable contribution was found in the experiences of the David Thompson Health Region in Alberta, Canada. Bopp et al. (1999) discussed the benefits and challenges of involving the community in framework development. Although increased development results in an increased feeling of ownership, this can potentially result in an inability to move forward due to lack of experience or increased time commitments. Valuable insight is provided on the roles that professionals can play in this process.

Summary

Community capacity frameworks were developed using a range of strategies from literature reviews to consultation with stakeholders through focus groups, interviews and conferences. Combinations of these strategies were frequently used. The studies that reported the application of capacity frameworks noted their use in guiding capacity efforts, evaluating programs and as an outcome measure. Frameworks contributed to the conceptualization of community capacity through lessons on context and settings, measurement and development and use among stakeholders.

The rest of this section presents the results of our literature review on the conceptualization and measurement of community capacity.

4.5.2 Description of Our Framework

As mentioned in the Methods section, we attempted to fit “characteristics” of community capacity, as found in our document review, into the theories of change approach. However for the document review we used an adapted, simplified version of the theories of change to that used in the focus groups. For our document review, we did not categorize outcomes as either interim or long-term, because the difference was often not distinguishable, i.e., not specified in the documents. Therefore our theories of change approach include the following *dimensions:* context, resources, activities and outcomes. By outcomes, we mean the results that people aim for, i.e., community capacity to what end. By activities, we mean the actions that are required to

effect these intended results. By resources, we mean the inputs required to act, i.e., financial capital, human capital and social capital. By context, we mean the surroundings or environment in which the resources are used to act to achieve the intended results.

We also categorized the document review data into one of three *levels* within each dimension of the theories of change approach. These three levels were individual, organizational and community. The levels were included in the framework based on discussions within the research team and our document review. The individual level includes those characteristics of community capacity that refer to people as individuals; this includes personal attitudes, knowledge, skills and practices or behaviour. The organizational level includes those characteristics of community capacity that refer to (formal) organizations or agencies; this includes how organizations function and the environment in which they function. The community level includes those characteristics of community capacity that are broader than either individuals or single organizations; this includes informal and formal networks between organizations and between individuals and organizations in the community, the infrastructure within the community, and networks and resources from outside (external to) the community.

4.5.3 How "Broadly" Is Community Capacity Conceptualized?

One way to look at the breadth to which community capacity was conceptualized is the number of documents that addressed the different dimensions of the theories of change approach, i.e., context, resources, activities and outcomes. The theories of change approach is used to elucidate the expected outcomes and the resources, activities and context that are required to achieve these outcomes.

Table 5 shows the number of documents that addressed each of the four dimensions of the theories of change approach. A document often addressed more than one dimension. The dimension that was found in the majority of documents is outcomes (92%), followed by activities (71%), resources (51%), and context (40%). Fourteen documents (22%, data not shown) addressed all four dimensions. By the term "addressed" we mean that the dimension was *included* in a document; however inclusion in a document does not necessarily mean the dimension was *implemented*. For example, sixty documents (92%) addressed the outcomes

dimension. These results can only be interpreted to mean that the outcomes were *included* in these sixty documents, i.e., that outcomes of community capacity were *conceptualized* in the sixty documents, but not necessarily described or measured as having been *achieved*.

Table 5: Number of Documents Addressing the Dimensions of the Theories of Change Approach

	Context	Resources	Activities	Outcomes
Number of Documents[a]	26 (40%)	33 (51%)	46 (71%)	60 (92%)

[a] Multiple dimensions of the theories of change approach are often included in the documents. Therefore the numbers across the theories of change do not add up to 100% (n=65).

The breadth to which community capacity was conceptualized can also be assessed by looking at how many documents addressed each of the three levels – individual, organizational and community – within the theories of change approach. This is represented by a three-by-four matrix of the four dimensions and the three levels (Table 6). For each dimension more documents addressed the individual and community levels, with the exception of the activities dimension where more documents addressed the organizational level.

Table 6: Number of Documents Addressing Different Levels and Dimensions

	Context	Resources	Activities	Outcomes
Individual	19 (29%)	27 (42%)	18 (28%)	20 (31%)
Organizational	11 (17%)	10 (15%)	45 (69%)	13 (20%)
Community	26 (40%)	30 (46%)	22 (34%)	60 (92%)

[a] Multiple dimensions of the theories of change approach and levels are often included in the documents. Therefore the numbers do not add up to 100% (n=65).

The breadth to which community capacity was conceptualized is also reflected in the number of dimensions/levels, out of a total of twelve (the three-by-four matrix), that was addressed in each document (Table 7). The distribution of the number of documents shows a cluster where a majority of the documents were found, i.e., from two to five dimensions/levels were addressed. Only one document addressed all twelve dimensions/levels.

Table 7: Number of Documents Addressing Total Number of Dimensions/Levels

Number of Dimensions/Levels Addressed	Number of Documents
1	3 (5%)
2	14 (22%)
3	14 (22%)
4	13 (20%)
5	9 (14%)
6	3 (5%)
7	3 (5%)
8	4 (6%)
9	1 (2%)
12	1 (2%)
Total	**65 (100%)**

4.5.4 Specific Characteristics of Community Capacity

Within each level (individual, organizational, community) and dimension (context, resources, activities, outcomes), a total of eighty-three more specific *characteristics* of community capacity were identified in the documents.

These characteristics of community capacity are shown in Figures 2, 3 and 4. Figure 2 shows the characteristics at the individual level, Figure 3 shows the characteristics at the organizational level, and Figure 4 shows the characteristics at the community level. Each box in the Figures reflects a characteristic; the frequency with which each characteristic appeared in the documents is given in parentheses. The characteristics are grouped into *themes*, shown on the far left in each Figure. The Figures also show the characteristics for which indicators were proposed or used; these are shown in *italics*. Some characteristics that were found in the documents were also found in the focus groups; these are shown in boxes with heavier lines, with the relevant focus group identified (refer to the Figures for the legend). Some characteristics were identified in the focus groups but not in the documents; these are shown as shaded boxes.

Some themes are present in only one dimension. For example at the individual level (Figure 2), the theme *networks* was only found in the activities dimension. Some themes are present across all four dimensions of the theories of change (context, resources, activities and

outcomes). These themes include: *public participation* (individual level); *normal organizational operations not specific to community capacity* (organizational level); *community infrastructures* (community level); and *shared interests and working together towards common goals* (community level). Other notable themes that appeared across three dimensions were *knowledge and skills* (individual level), and *general orientation towards community capacity* (organizational level).

At the individual level, the characteristic that was conceptualized most frequently in the documents was the outcome of an increase in, or application of, knowledge and skills (n=29). At the organizational level, the most frequently conceptualized characteristic (n=41) was the activity of investing in human resource development in staff and/or community members. At the community level, the most frequently conceptualized characteristic (n=44) was the outcome of increased health, social conditions, well-being and/or quality of life.

Figure 2: Characteristics of Community Capacity – Individual Level

FG1=Focus Group 1 (Health Canada staff); FG2=Focus Group 1 (research team); FG3=Focus Group 3 (community projects)

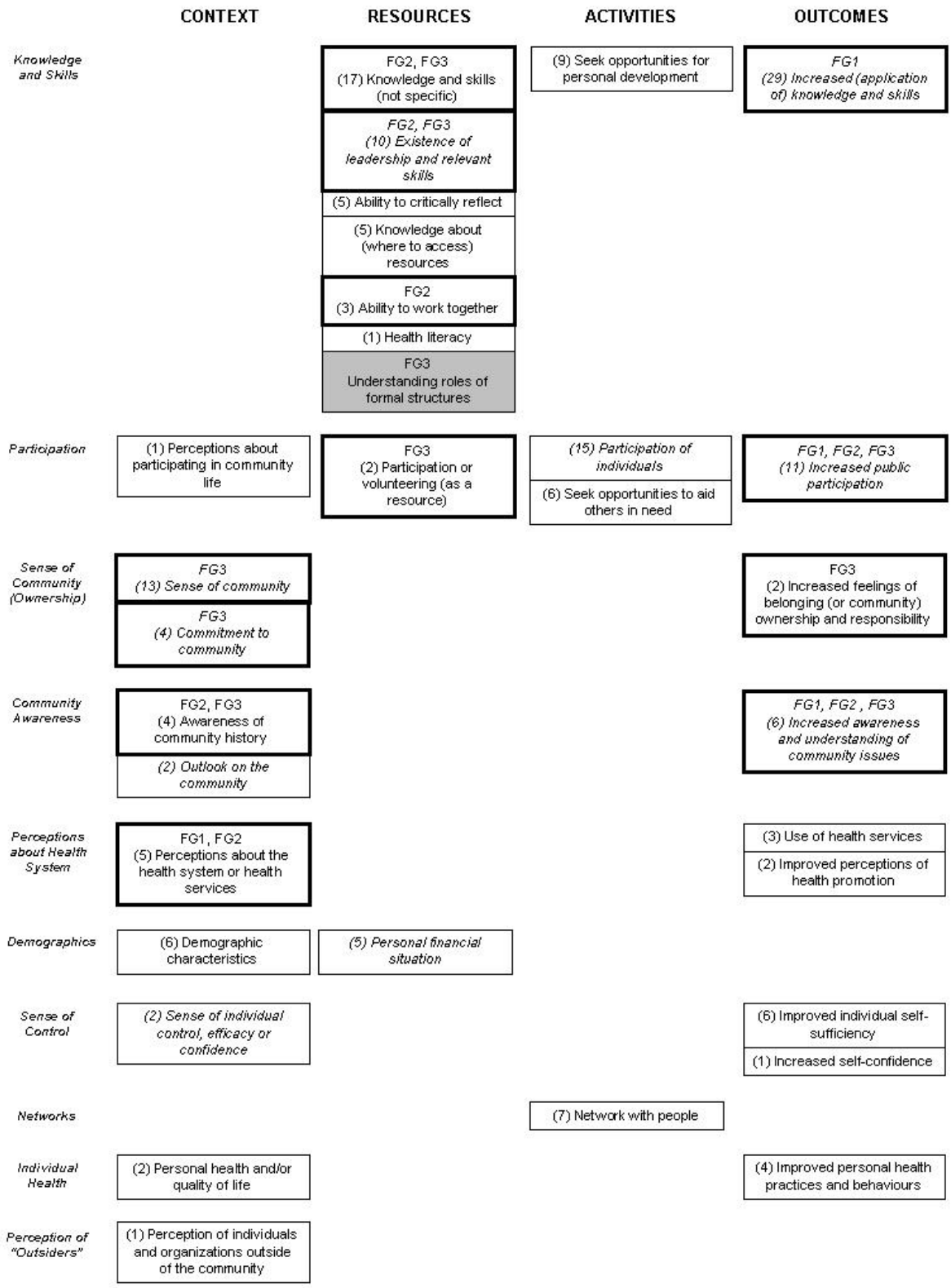


Figure 3: Characteristics of Community Capacity – Organizational Level

FG1=Focus Group 1 (Health Canada staff); FG2=Focus Group 1 (research team); FG3=Focus Group 3 (community projects)

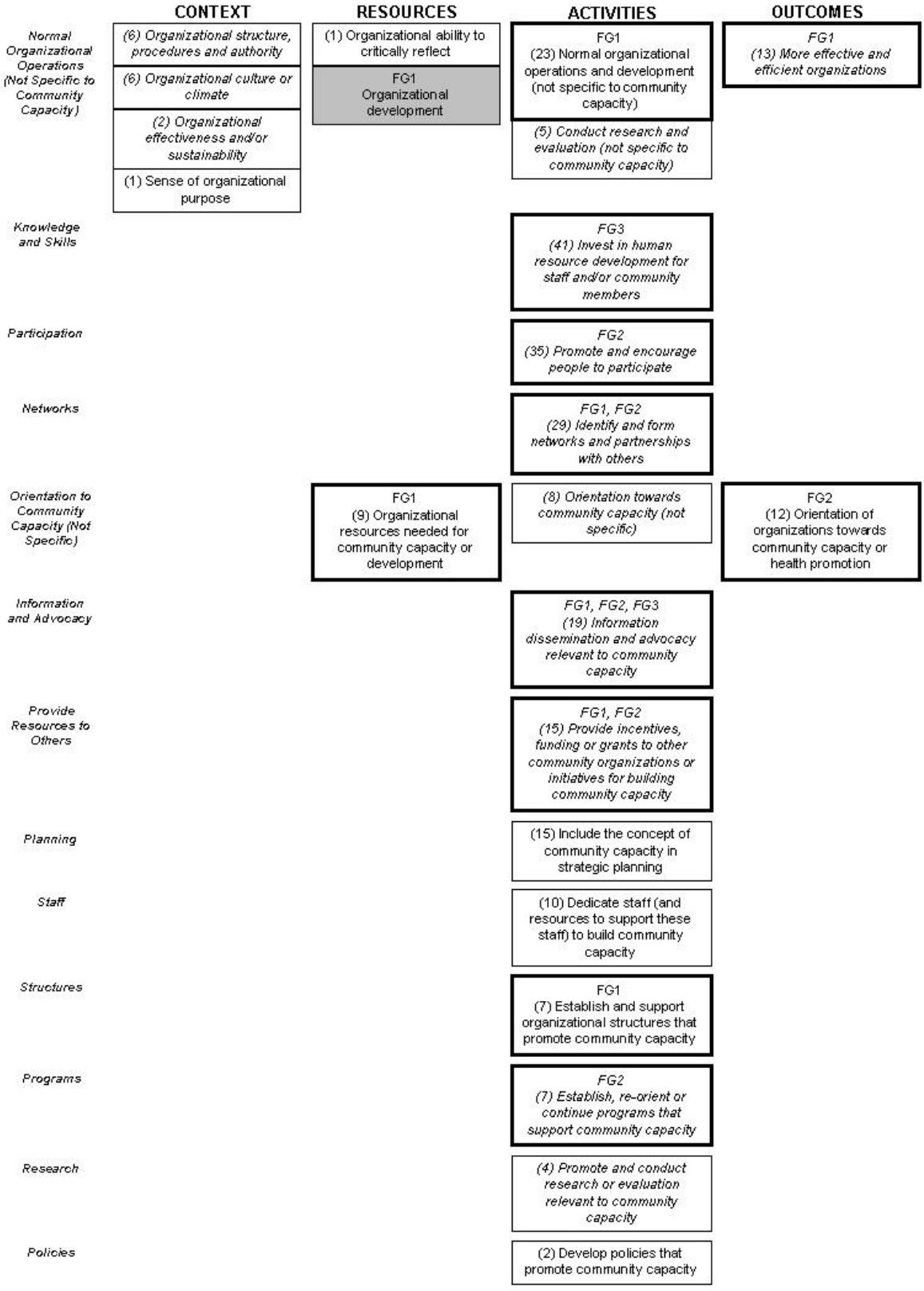
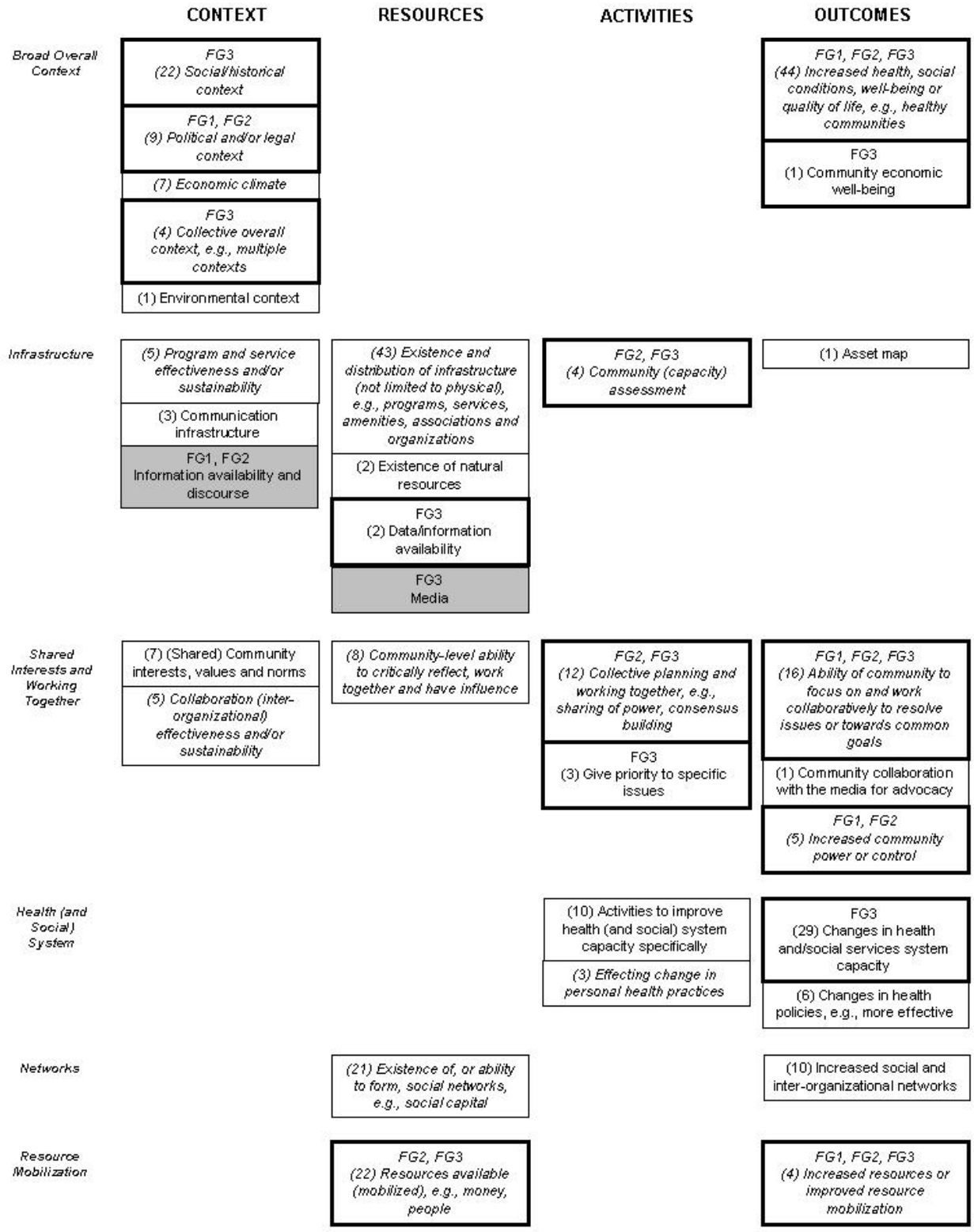


Figure 4: Characteristics of Community Capacity – Community Level

FG1=Focus Group 1 (Health Canada staff); FG2=Focus Group 1 (research team); FG3=Focus Group 3 (community projects)



4.6 Measuring Community Capacity

4.6.1 Challenges in Measuring Community Capacity

A review of the literature on community capacity suggests that there are three main challenges to its measurement (Armstrong et al. 2002; Brown, LaFond and Macintyre 2001, LaFond and Brown 2003; Hawe, King, Noort et al. 1998; Thompson, Littlejohns and Smith 2000). First, there is a lack of consensus as to what community capacity means or how it is characterized. Second, consequently there is limited research on which indicators are valid and reliable for the measurement of community capacity. Third, unlike measures of individual health status (e.g., blood pressure), community capacity appears to reflect a broader "community" or population level that is more complex than just the sum of measures at the individual level.

Lack of consensus on what community capacity is. There is no formally accepted definition of community capacity, although the definitions that do exist suggest that community capacity is viewed as the ability or potential of a community to address issues that affect community well-being and sustainability. This is a very general definition. At a more specific level, attempts have been made to develop frameworks of community capacity (as discussed in Section 4.5.1). In addition, community capacity is dynamic (not static) and multidimensional.

Valid and reliable measures of community capacity. There are different layers of difficulty in finding valid and reliable measures of community capacity. The lack of consensus on what community capacity is suggests that the constructs of community capacity have not been confirmed. Are the constructs that are claimed to be community capacity really an accurate portrayal of community capacity? Some researchers have made a distinction between more abstract concepts (societal goals and community capacity) and measures that are more specifically related to program objectives, such as the number of clients. Does the number of clients in a program actually measure community capacity? This relates to the question of what criteria are used to assess how " good" an indicator is. These criteria often appear as checklists in the literature on the use of community indicators of quality of life and sustainability, and include validity, reliability, timeliness, relevance, robustness, and manageability (Frankish 1999). Another consideration in measuring community capacity is whether a standardized core set of

indicators should be developed, or whether flexibility should be allowed. In addition, unlike clinical care, against what "gold standards" should community capacity be measured?

Community capacity – more than the sum of individuals? Community capacity appears to be a synergistic and collective application of human and social capital towards improving the lives of residents within a community. What are the relationships between the actions of individuals, the interactions between individual actions (synergistic and collective), and outcomes? This has not been elucidated, and therefore measures of community capacity are often measures of individual capacity (skills and knowledge) or organizational capacity (efficiency or effectiveness of an organization or its programs).

4.6.2 Community Capacity and Related Measures

As discussed earlier in this paper, community capacity appears to be related to other concepts. Although various taxonomies (full or partial) for conceptualizing the various individual components of community capacity have been proposed, a review of these taxonomies suggests that some of the components have been described and measured elsewhere in the psychosocial/community health literature as discrete scales or entities. In fact, a growing literature and body of measurement tools exists. Many can be found in a useful database titled Health and Psychosocial Instruments that is widely available in academic libraries.

Examples of these "competing" concepts are myriad. They include measures such as attitudes toward health and indices of community health (Champion, Austin and Tzeng 1990); capacity-building (Schwartz et al. 1994); community competence (Cottrell,1980; Eng and Parker 1994); community complexity (Mangen and Peterson 1984); community participation (Bjaras, Haglund and Rifkin 1991); community program philosophy scale (Brekke and Test 1992); community resource inventory (Cohen, Stunkard and Felix 1989); and group and/or community cohesion (Buckner 1988, 1989). Measures of the functioning of coalitions represent a particular and frequent type of measure, e.g., coalition monitoring system (Francisco, Paine and Fawcett 1993). The level of implementation (Goodman and Steckler 1990; Ottoson and Green 1987) and/or institutionalization (Goodman, McLeroy, Steckler and Hoyle 1993) are also popular. Finally, there are a number of important measures of sense of community (Chavis and Newbrough 1986; McMillan and Chavis 1986; Chavis and Hogge 1986; Davidson 1989;

Davidson and Cotter 1991; Chavis, Hogge, McMillan and Wandersman 1990; Pretty and McCarthy 1991; Davidson and Cotter 1986; Weisbrod, Pirie and Bracht 1992).

The relations between and among these various measures and our focal concept of community capacity remain to be explored and understood at several levels. First, it is not clear that the various listed concepts are either mutually exclusive or independent. It is also not clear whether they represent important constituent parts of a larger notion of overall community capacity or whether they are separate distinguishable concepts. Second, many of the above scales share common items. For this, and many other reasons it is not clear what they actually measure. Lastly, it is not clear whether any of these measures have any predictive validity. That is, can they usefully be employed to measure important aspects of program planning, implementation or outcomes. Much work remains to be done in mapping the constituent elements of community capacity, testing measurement qualities of individual items or elements, and describing the necessary and sufficient elements of community capacity for various purposes (i.e., planning, resource allocation, evaluation). The identification of these measurement issues highlight the need for further psychometric work on the measurement of community capacity and its relations to other key psychosocial and community health constructs.

4.6.3 A Detailed Review of Documents Regarding Indicators of Community Capacity

This section presents some of the discussions and conclusions found in the literature that were relevant to the use of indicators to measure community capacity. Each document is presented in terms of its contribution to the measurement of community capacity.

In their commentary, Labonte et al. (2002) suggested that community capacity building be considered as a “parallel track” to health promotion program work, such that community capacity complements rather than replaces health promotion programs. This suggests a new set of important outcomes to be measured, namely those associated with community capacity, rather than those associated strictly with program or individual goals. The authors refer to Laverack’s (1999) conceptualization of nine operational domains of community capacity as outcomes that can be tracked, in parallel with other program goals. These nine domains are: participation; leadership; organizational structures; problem assessment; resource mobilization; asking why; links with others; role of outside of agents; and program management. The

different types of indicators that are useful (and complementary) for health promotion evaluation are elaborated in a set of two papers, authored by Labonte and Laverack (2001) about the purpose of community capacity, capacity for whom, and the measurement of capacity. Three types of indicators are distinguished: 1) population health indicators; 2) program-specific indicators; and 3) community capacity (development/empowerment) indicators. Population health indicators are "measures of important health-determining characteristics in social, economic and physical environments, positive and negative health status and health behaviours." These reflect distal outcomes to which health promotion programs ought to contribute. Program-specific indicators reflect the more narrowly focused goals and objectives of a program. Community capacity indicators are discussed in terms of a spider-web mapping scheme, in which each of the domains of community capacity is based on a summative ranking of each domain. Labonte and Laverack conclude that this method appears to have been used with some success in various community capacity models (Bopp et al. 1999; Laverack 1999; Hawe et al. 2000). However three methodological questions arise. How is the ranking determined? Who assigns the ranking? How is the ranking empirically validated? To address these questions, the authors suggest a workshop methodology where health promoters and key community representatives meet to reach agreement on: the capacity domains; a ranking scheme; discussing where their community ranks and providing reasons why the rank is assigned; discussing where the community should be; and identifying resources required to take actions. The workshop process itself builds capacity.

Brown, Lafond and Macintyre (2001) published a report on the state of the art in measuring community capacity in the health sector. They suggested that there are four important and linked levels of capacity in the health sector: 1) health system level; 2) organizational level; 3) human resource (health program personnel) level; and 4) individual or community level. However, the authors conclude that the literature and measurement experience is dominated by experience in capacity at the organizational or human resources/personnel levels. Similar to our conceptualization of community capacity, the authors further delineate different levels of assessment: 1) input (resources); 2) process (activities); 3) output; 4) intermediate outcomes; and 5) ultimate outcomes. The authors reviewed existing indicators from a subset of USAID's Cooperating Agencies and from USAID missions in Africa, and reported an enormous variation in indicators used to measure capacity (the indicators were presented in their report). No indicators to measure the linkages between different levels were identified (e.g., individual,

personnel, organizational, health system). A review of different measurement methods suggested that either a combination of qualitative and quantitative methods, or quantitative methods alone, are used, and that most measurements are applied through self-assessment techniques (vs. external assessments which may be considered more objective).

Hawe , Noort, King and Jordens (1997) proposed three operational levels of capacity building in the health promotion literature, and for which indicators could be developed: 1) health infrastructure or service development; 2) program maintenance and sustainability; and 3) problem solving capability of organizations and communities. Service development indicators tend to focus on priority health problems. Indicators of program sustainability measure the extent to which a successful program's components and activities are adopted or absorbed into the regular activity of community agencies after a health intervention is withdrawn. Indicators of increased problem-solving capacity can be classified into two lines of research, program-specific context or first principles (key qualities of communities that are not program-specific). Health promotion workers engage in activities in all of the three operational levels, depending on their organizational role, the stage of development of the program, and the different opportunities that arise.

Crisp, Swerissen and Duckett (2000) present four approaches to capacity building in health: 1) top-down organizational (capacity building focused on changing institutions); 2) bottom-up organizational (capacity building focused on the training members of the organization); 3) partnerships (between organizations or groups of people who might otherwise have little or not working relationship); and 4) community organizing (working with communities to solve health issues). The authors acknowledge the challenge in finding indicators for the different approaches used, and suggest that the primary focus should be on the ultimate question of whether sustainable changes to the health of the organization or community could be attributed to an intervention. Therefore it would be more appropriate to evaluate whether capacity building processes have been implemented, and the impacts that result from these. The authors suggest some areas under which each of the four approaches could be measured, focusing on the process of capacity building.

Baker and Teaser-Polk (1998), in their commentary, suggest that the operationalization of community capacity constructs should incorporate both community member and outsider

perspectives and be locally generated. Given the flexibility needed in this approach to operationalization, the authors suggest that it would be advantageous to consider a measurement process whereby complementary qualitative and quantitative data are collected.

Maxim, White and Whitehead (2001) attempted to develop an Index of Community Capacity for predicting the potential of First Nations communities to successfully accept and maintain Federal government programs transferred to their communities. The Index is composed of two components, which the authors state are based on empirical evidence of their reliability and validity: 1) human capital (human resources); and 2) social capital (to be addressed in the future). The human capital component is assessed using a composite measure of four sub-indexes, i.e., population size, age-dependency ratio, occupational diversity, and education. In the absence of an evaluation of program outcomes, the authors suggest the average income in the community as an alternate measure of effectiveness. This suggestion is based on the assumption that investments in human resources will produce a return in the form of productivity in the population, and thus in the income that is earned. Based on their statistical analysis, the authors state that the simple combination of the indices may be considered valid. Therefore within reasonable bounds of predictive accuracy, the indices can be used to assess whether a community has the quality and quantity of human resources to successfully accept and implement programs "downloaded" from the Federal government. Furthermore, the authors state that the Index has three properties that make it useful: 1) it provides a value that allows comparability between communities that is meaningful and robust; 2) it is simple to use and understand; and 3) it is testable (i.e., falsifiable).

In a paper presented at the 2002 Australasian Evaluation Society International Conference, Armstrong et al. (2002) distinguished between "social" indicators and "performance" indicators in the evaluation of government programs in relation to crime prevention. Social indicators measure societal outcomes, e.g., reduced crime, while performance indicators measure program activity or results, e.g., number of clients. Although the research focused on "social" indicators, the authors included community capacity in the framework they developed to guide the selection of social indicators. The framework shows the relationship between strategies used by Crime Prevention Victoria and the impact of these strategies on the attributes of communities (level of dysfunction, needs, and capacity), and on crime and community well-being. The authors did not include any indicators in their paper.

Jackson et al. (1999) reported the findings of their qualitative, action research project which involved residents and community workers in three areas in Toronto in the development of a model and indicators of community capacity. The investigative team suggested some indicators based on the factors which residents identified as affecting their ability as a community to work towards and achieve their goals and aspirations: overall indicators of community capacity; inside facilitators and inside barriers (within the community); and outside facilitators and outside barriers. The suggested indicators include residents' perceptions and observations about whether certain community capacity events and activities exist. However, the authors also suggested that specific indicators would need to be developed by each community. Further areas for research were identified, such as testing the transferability of the community capacity indicators to other communities and settings in Canada, and developing robust measures that could be applicable in different settings.

Thompson, Littlejohns and Smith (2000) piloted a methodology to assess community capacity in a rural heart health project, based on seven community capacity domains that the authors had identified previously: 1) vision; 2) experience of community; 3) resources; 4) knowledge and skill; 5) participation; 6) leadership; and 7) critical learning. The assessment involves a discussion of the domains, and a ranking of whether community capacity had been built for each domain. The ranking is a visual exercise using a web-mapping technique. The authors discuss the validity of their research, using alternative constructs for assessment to reflect the qualitative nature of their research (vs. more traditional quantitative research). The four alternative constructs are: 1) credibility; 2) transferability or generalizability (application of one set of learning to another context); 3) dependability (accounts for changing conditions in the phenomenon chosen for study as well as for changes in design); and 4) confirmability (whether the data help confirm general findings and lead to implications). Credibility was established through an in-depth characterization of the data. Transferability could have been tested by asking the same questions in other settings, or by using different data collection methods in the same setting. In terms of dependability, the authors did not design their research to replicate the same results among communities, but rather to refine their understanding of and insight into how the project built capacity in each community. In terms of confirmability, the authors believe that the recurrency of themes in the data corroborates a degree of relevance for the domains in assessing the extent to which community capacity was built.

The discussions and work on indicators of community capacity show a distinction between broad concepts such as community capacity and more specific program objectives, and between different levels of community capacity, e.g., individual, organizational. However, there remains a lack of consensus on the types or levels of indicators to be used for measuring community capacity. Nevertheless there appears to be agreement that the process for the selection of indicators should involve key stakeholders (organizational staff and community members) in a discussion of, and consensus on, the constructs to be measured and the indicators to be used.

4.6.4 Types of Indicators for Measuring Community Capacity

In this section, we present the results of our document review in the search for indicators for measuring community capacity. Fourteen of the sixty-five documents (22%) were found to include indicators of community capacity. Eight hundred, fifty-one indicators were found in the documents. This vast number of indicators was found because some documents included checklists of indicators for people to use.

The indicators found in the fourteen documents have been grouped into different *types* of indicators (Table 9). Due to the limited number of documents that included indicators and that most of the indicators were derived from a limited number of checklists found in the documents, frequencies are not provided. Table 9 shows that a wide variety of indicators have been used or proposed to measure community capacity. Some of the indicators appear to be "borrowed" from other areas of interest, such as social capital, sense of community and organizational or collaborative capacity. Although a wide variety of indicators have been used, some indicators were used to measure different characteristics throughout our framework. For example, people's participation in elections were proposed or used to measure individual-level context, activities and outcomes, as well as a proxy measure of an increase in the quality of life in the community. Another example is whether an organization had clear plans and processes of operation in place (organizational-level context, activities and outcomes).

Table 9: Types of Indicators Used to Measure Specific Characteristics of Community Capacity

Dimension, Level	Characteristic	Types of Indicators
Context, individual level	Sense of community	Whether people know their neighbours
		Whether neighbours help each other out
		Whether people know the name of their neighbourhood
		Whether people feel an attachment to their neighbourhood
		Whether needs, like amenities, are accommodated within the neighbourhood
	Outlook on the community	Whether people feel proud to live in their community
		The attitudes of others about the community, e.g., media, civic employees
	Sense of individual control, efficacy or confidence	Whether people sit on the Board of Directors of local agencies and organizations
		Whether people are involved in the design and implementation of local agency programs
	Commitment to community	People's interest in voting
Context, organizational level	Organizational culture or climate	Whether the team uses clear structures and procedures
		Whether the team critically questions what goes on with the team
		Whether the team's goals are well defined and align with those of the organization
		Whether team members get feedback about their performance
		Whether the self-development of team members is encouraged
	Organizational structure, procedures and authority	Presence of (other) organizations in the community
		How the core group operates
		The degree of connectivity between people working on the (same) issues
		Whether people participate in organizations
		Whether people are satisfied with the effectiveness of organizations in dealing with issues
	Organizational effectiveness and/or sustainability	Sufficient skills within the organization
		Sufficient facilities within the organization
		The presence of an accessible decision maker in the organization
		The organization has credibility in the community
		There are favourable attitudes and knowledge about the issue the organization wishes to address

Dimension, Level	Characteristic	Types of Indicators
Context, community level	Program and service effectiveness and/or sustainability	What is included in the planning, e.g., rationale, strategies, outcomes
		Factors within the organization, e.g., how well the program fits with, or is supported by, the organization
		Factors outside the organization, e.g., how well the program fits with the community opinion
	Economic climate	Number of business establishments
		Available Job pay office space
		Cost of items, e.g., gasoline
		Corporate tax rate
		Sales figures
		Rankings of the community (by another source)
	Historical and/or social context	Housing characteristics, e.g., type of housing, cost of housing
		Diversity reflected in community events, e.g., different languages, different cultural foods and music
		Level of crime
	Collective overall context	Sense of community
		Residents who are active in the community
		Capable organizations
		Networks between organizations in the community
		Availability of resources from outside the community
	Collaboration (inter-organizational) effectiveness and/or sustainability	Strength of a coalition (an assessment)
		Processes and structures have been established
		Feeling of confidence in achieving its goals
		Sense of direction, e.g., performance indicators
		Understanding of the issue
	Political and/or legal context	Appropriate policy response (e.g., timely) that is enforced
Resources, individual level	Existence of leadership and relevant skills	Ten-point rating scale for whether leadership exists (e.g., within a group)
	Personal financial situation	Household wealth
Resources, community level	Resources available (mobilized)	Workforce, education and skills: Educational achievement, e.g., tests, graduation; Investment in education, e.g., per pupil expenditures, teaching salary; and Investment in workforce, e.g., unemployment rate
	Existence of, or ability to form, social networks	Ten-point rating scale for whether social networks exist
		Whether different sectors are reported to have good contacts with each other
	Community-level ability to critically reflect and work together and have influence	Ten-point rating scale for whether community critical reflection exists
	Existence and distribution of infrastructure	Infrastructure for travel and cargo, e.g, airport traffic
		Amenities, e.g., parks, grocery stores, public transit, recreation
		Structures, e.g., buildings
		Public utilities, e.g., sewage disposal
		Residents' satisfaction with infrastructure

Dimension, Level	Characteristic	Types of Indicators
Activities, individual level	Participation of individuals	Participation in elections, e.g., registration, turnout
		Application for volunteer positions
		Membership in organizations
		Presence at community meetings and activities
		Ten-point rating scale for whether participation exists
Activities, organizational level	Overall (collective) orientation towards building community capacity	Residents report that community workers are empowering
		Number of projects that provide opportunities for healthy environments
	Promote and encourage people to participate	Whether special celebrations are held to honour volunteers
		Ten-point rating scale for whether participation is promoted
	Provide incentives, funding or grants to other community organizations or initiatives for building community capacity	Number of organizational contacts and applications (for funding) from groups
	Promote and conduct research or evaluation relevant to community capacity	Trial implementation of community capacity indicators
		Evidence that projects address the health skills and capacity of individuals
	Establish, re-orient or continue programs that support community capacity	Effectiveness of projects for healthy communities
	Information dissemination and advocacy relevant to community capacity	Number of projects that encourage the translation of research into practice
	Investing resources for human resource development in staff and/or community residents	Number of projects that support health promotion skill development in sectors and settings both inside and outside of health
		Number of human resource development initiatives supported by the organization
	Review strategies for promoting healthier environments to see if they support priority health areas	Number of sponsorships and projects that provide opportunity for healthy environments
	Identify and form networks between organizations and groups	Evidence of collaboration of community groups or organizations with Public Health Units
Activities, community level	Collective planning and working together	Opposing or different points of view are present at community meetings
	Community (capacity) assessment	Ten-point rating scale for whether community capacity was assessed
	Effecting change in personal habits and practices	Number of sponsorships that provide opportunities for enhancing individual capacity to improve health
		Impact of sponsorship on awareness and health behaviour change
Outcomes, individual level	Increased/application of knowledge and skills	Range of skills offered in training programs
		Existence of leaders in the community
		Training aimed at recruiting “under-represented” groups
		Training program success, e.g., number of graduates

Dimension, Level	Characteristic	Types of Indicators
		Operations of training programs, e.g., publicity
		Use of specific skills to achieve tasks, e.g., data presentation
		Organizational support for training
	Increased public participation	Number of people attending meetings or events
		Number of volunteer hours
		Political activity, e.g., petitions
		Membership in organizations
		Existence of strategies that promote public participation, e.g., translation, accessible hours
		Accessibility of organizations to the community
		People's interest in voting, e.g., registration, turnout
		Number of people who donate to organizations
		Participants' perceptions about who really makes the decisions
	Increased awareness and understanding of community issues	Self-reports of awareness being a personal benefit from an initiative, e.g., knowledge of resources and collaborations
Outcomes, organizational level	More effective community organizations and institutions	Support from residents and other organizations, e.g., monetary, in-kind, volunteer hours
		Increase in the number and quality of collaborations
		Perceptions of how effective the organization is, e.g., citizens' perceptions, media coverage
		Increase in membership in the organization
		How long the organization has been around
		The organization has clear plans and processes of operation in place
		Whether the needs of residents are met
	Orientation of organizations towards community or health promotion	Number of initiatives implemented by the community committee (working on that health issue)

Dimension, Level	Characteristic	Types of Indicators
Outcomes, community level	Increased social and inter-organizational networks	Self-response to "I know who to contact to help me change things locally in: local community groups; at the Council; in other local non-governmental agencies; and among people in the neighbourhood."
	Increased community power	Number of people involved in community activity, e.g., in programs designed by and for the community
	Increased ability of the community to focus on and work collaboratively to resolve issues or towards common goals	Participation of people and organizations in implementing the strategic community plan
		Show of support for the strategic community plan, e.g., from residents (level of satisfaction), from organizations (plan is endorsed)
		Quality of the strategic community plan, e.g., range of community interests addressed in the plan, clearly defined responsibility, accessibility of the plan (readability), timeline, progress checkpoints
		Dissemination of the strategic community plan, e.g., media coverage, distribution of print copies
		Milestones reached for the strategic community plan, e.g., projects completed
		Result of evaluation are used to improve projects in the strategic community plan
	Increased resources or increased resource mobilization	Successful economic development initiatives, number and dollar value
		Businesses that are local
		Local charitable giving, amount
		Dollar value of resources from within the community and from outside the community
		Existence of a resource directory or clearinghouse
	Increased health, social conditions, well-being and/or quality of life	Environmental indicators, e.g., endangered species, watershed quality, air quality
		Availability of public services and amenities, e.g., number of physicians per 100,000 population
		Drug use
		Criminal activity, e.g., calls to the abuse hotline, crime rate
		Social assistance given, e.g., free or reduced-price lunches for students
		Morbidity/mortality indicators
		Voting activity, e.g., turnout
		Personal/household income
		Housing indicators, e.g., cost, occupancy
		Cost of living index

5. FOCUS GROUPS TO "SURFACE" THEORIES OF CHANGE FOR COMMUNITY CAPACITY

Three focus groups were conducted to develop “theories of change” around community capacity. A focus group was conducted with each of the following groups: 1) staff from Health Canada (FG1); 2) the research team advisory group (FG2); and 3) staff from community projects (FG3). Five main questions were asked at the focus groups:

1) What *longer-term outcomes* of community capacity are of interest?
2) What *interim outcomes* of community capacity are required to produce those longer-term outcomes?
3) What *activities* should be initiated to achieve the intermediate outcomes?
4) What *contextual supports* are required to achieve the intermediate outcomes?
5) What *resources* are required to implement the activities and maintain the contextual supports required for the activities to be effective?

The individual theories of change developed from each of the focus groups can be found in Appendix B. We superimposed the characteristics from the focus groups onto our framework of community capacity; this is shown in Figures 2, 3 and 4. Note that in the focus groups, outcomes were split into either interim or longer-term outcomes. However, due to challenges in identifying in the literature whether an outcome was considered to be interim or longer-term, our framework only includes “outcomes.” Thus when superimposing the focus group data onto our framework, all outcomes identified in the focus groups, whether interim or longer term, were classified as an “outcome” in the framework. As noted earlier, characteristics that were identified in both the documents and the focus groups are shown in boxes with heavier lines, and characteristics found in the focus groups but not in the documents are shown in shaded boxes.

Most of the characteristics that were identified in the three focus groups could be fit into our framework, except for four (shaded boxes in Figures 2, 3 and 4): an understanding of the roles of formal structures being identified as a resource in FG3 (Figure 2); organizational development being identified as a resource in FG1 (Figure 3); information availability and

discourse being identified as a context in FG1 and FG2 (Figure 4); and the media being identified as a resource in FG3 (Figure 4).

There was some overlap in the characteristics identified between the three focus groups and our framework. A total of thirty-seven of the eighty-three characteristics (45%) of our framework were also observed in the focus group data. No apparent pattern or trend, in terms of either dimension or level or theme, was observed among these thirty-seven characteristics. We were also interested in knowing the degree of overlap between the focus group data and our framework, i.e., how many focus groups overlapped with each characteristic. Table 10 shows the frequency of the number of focus groups that overlapped with the thirty-seven characteristics. There was some overlap in the characteristics identified between the three focus groups and our framework. A total of thirty-seven of the eighty-three characteristics (45%) of our framework were observed in the focus group data. Over one half of the characteristics (54%) had overlapped with data from one focus group, while under one third (30%) had overlapped data with two focus groups. Six characteristics had overlapped with data from all three focus groups. Five of these six characteristics were outcomes, both individual-level (increased public participation and increased awareness understanding of community issues) and community-level (increased health, social conditions, well-being and/or quality of life, ability of the community to focus on and work collaboratively to resolve issues or towards common goals, and increased resources or resource mobilization). The other characteristic that overlapped with data from all three focus groups was information dissemination and advocacy relevant to community capacity at the organizational level.

Table 10: Degree of Overlap of Focus Group Data with Characteristics in the Framework

Number of Focus Groups Overlapping With Characteristics in Our Framework	Frequency (%) N=37
1	20 (54%)
2	11 (30%)
3	6 (16%)
Total	**37 (100%)**

6. COMMUNITY FORUM

Over one hundred participants attended the community forum, including staff from health authorities, researchers, governmental staff, and staff from community-based programs. The number and variety of participants showed a wide interest in community capacity in our local area. The attendance highlights the strong level of interest in, and support for community capacity approaches in population health initiatives.

Following a panel presentation on community experiences on building community capacity, the participants broke into several informal groups to discuss the meaning of community capacity and how it can be measured. Some themes that emerged from this discussion included community assets and strengths, participation, consensus, and community ownership. These themes are similar to those found in our document review and in the focus groups. Many participants were interested in receiving the results of our research on the conceptualization and measurement of community capacity.

7. MAIN FINDINGS

This section summarizes the main findings of our document review, literature reviews, focus groups, and the community forum.

Breadth of the document review. Our document review included a broad selection of document types (academic vs. non-academic) and settings for community capacity, e.g., countries, communities. Community capacity is a concept of interest across many fields and disciplines.

Definition of community capacity and related terms. There appears to be no clear or definite distinction between community capacity and its related terms. In general, these definitions overlap, conveying community capacity and related terms to be both a process and the potential of people to act together for a common community good.

Existing frameworks of community capacity. Community capacity frameworks were developed using a range of strategies, including literature reviews, consultations with stakeholders, focus

groups, interviews and conferences. Combinations of these strategies were frequently used. The studies that reported the application of capacity frameworks noted their use in guiding capacity efforts, evaluating programs and as an outcome measure. Frameworks contributed to the conceptualization of community capacity through lessons on context and settings, measurement and development and use among stakeholders.

Breadth in the conceptualization of community capacity – our framework. Community capacity has been broadly conceptualized, with characteristics being categorized into the four dimensions of the theories of change (context, resources, activities and outcomes) and into three levels (individual, organizational and community). On the other hand, only a moderate breadth of conceptualization was found when the number of dimensions/levels, out of twelve, was counted in each document.

Specific characteristics of community capacity – the framework. A total of eighty-three specific characteristics of community capacity were identified in the documents. The characteristics were grouped into *themes*. Some themes were present across all four dimensions of the theories of change (context, resources, activities and outcomes). These themes include: *public participation* (individual level); *normal organizational operations not specific to community capacity* (organizational level); and *community infrastructures* and *shared interests and working together towards common goals* (community level). Other notable themes that appeared across three dimensions were *knowledge and skills* (individual level), and a *general orientation towards community capacity* (organizational level).

At the individual level, the characteristic that was conceptualized most frequently in the documents was the outcome of an increase in, or application of, knowledge and skills (n=29). At the organizational level, the most frequently conceptualized characteristic (n=41) was the activity of investing in human resource development in staff and/or community members. At the community level, the most frequently conceptualized characteristic (n=44) was the outcome of increased health, social conditions, well-being and/or quality of life.

Challenges in measuring community capacity. A review of the literature suggests that there are three main challenges to the measurement of community capacity. First, there is a lack of consensus as to what community capacity means or how it is characterized. Second,

consequently there is limited research on which indicators are valid and reliable for the measurement of community capacity. Third, unlike measures of individual health status (e.g., blood pressure), community capacity appears to reflect a broader "community" or population level that is more complex than just the sum of measures at the individual level. Nevertheless, research and work on indicators of community capacity show a distinction between broad goals such as community capacity and more specific program objectives, and between different levels of community capacity, e.g., individual, organizational. However, there remains a lack of consensus on the types and levels of indicators to be used for measuring community capacity. On the other hand, there appears to be agreement that the process for the selection of indicators should involve key stakeholders (organizational staff and community members) in a discussion of and consensus on the constructs to be measured and the indicators to be used.

Types of indicators used for measuring community capacity. Fourteen of the sixty-five documents (22%) were found to include indicators of community capacity. A wide variety of indicators have been proposed or used to measure community capacity. Some of the indicators appear to be "borrowed" from other conceptual areas, such as social capital, sense of community and organizational or collaborative capacity. Although a wide variety of indicators have been used, some were used to measure different characteristics throughout our framework. For example, people's participation in elections were proposed or used to measure individual-level context, activities and outcomes, as well as a proxy measure of an increase in the quality of life in the community.

Focus group theories of change. A total of thirty-seven (45%) of the eighty-three characteristics identified in the document review were also observed in the focus group data. These characteristics may offer a starting point in terms of building stronger, consensus measures of community capacity.

No apparent pattern or trend, in terms of either dimension or level or theme, was observed among these thirty-seven characteristics. Only four characteristics identified in the focus groups were not found in the document review: an understanding of the roles of formal structures, organizational development and the media were identified as a resource; and information availability and discourse were identified as a context. Over one half (54%) of the thirty-seven characteristics had overlapped with data from one focus group, while under one third (30%) had

overlapped with data from two focus groups. Six characteristics had overlapped with data from all three focus groups. Five of these six characteristics were outcomes, both individual-level (increased public participation and increased awareness understanding of community issues) and community-level (increased health, social conditions, well-being and/or quality of life, ability of the community to focus on and work collaboratively to resolve issues or towards common goals, and increased resources or resource mobilization). The other characteristic that overlapped with data from all three focus groups was information dissemination and advocacy relevant to community capacity at the organizational level.

Community forum. The number and variety of participants that attended the forum showed a wide interest in community capacity in our local area. Some themes emerged the discussions groups at the forum: community assets and strengths, participation, consensus, and community ownership. These themes are similar to those found in our document review and in the focus groups.

8. STRENGTHS AND LIMITATIONS OF THE STUDY

As with any study, both strengths and limitations exist. These are discussed in relation to several themes.

Validity of the framework. While the validity of the framework and its characteristics was not statistically tested, a strength of the framework is that it is based on an extensive review of a broad range of documents, some of which included frameworks that were developed based on the triangulation of data collected through a variety of methods, e.g., focus groups, expert opinion, literature review. Another limitation of our research is that it focused on community capacity for *population health promotion*. However our specific focus was chosen for practical purposes. In addition, the primary intended audience of our research was Health Canada. Nevertheless more research can serve to elucidate the similarities and differences between community capacity for population health promotion and community capacity for other areas of interest, such as environmental sustainability. Furthermore, four characteristics from the focus groups were not found in our document review. However, we were able to fit these characteristics into the themes that were identified. This raises the question of whether there

are other characteristics missing from our framework. We believe that any omissions would be minimal, given that we reviewed a wide range of documents, including those that included frameworks of community capacity. Finally, our framework did not include relationships or interactions between specific characteristics of community capacity. We conducted a simple, descriptive review of the characteristics of community capacity. A more robust, psychometric analysis (e.g., factor analyses, item analyses) with a larger evidence base may yield stronger themes and interrelations between and among specific elements of community capacity.

Distinguishing between different dimensions, levels and characteristics of community capacity. One of the challenges in the study was to categorize the data in the document review into the different characteristics of community capacity, given a frequent lack of specificity found in the documents. The data were categorized to the best of our ability, and where uncertainty was present, a consensus between two members of the team was used to determine the categorization. Some participants at the focus groups also had difficulty categorizing the characteristics of community capacity.

Identifying and categorizing indicators of community capacity. There appears to be a lack of agreement on what an indicator is. We understood an indicator to be a *measure* of an item of interest. However, in some documents the term indicator appeared to relate to an item of interest but not to its measurement. We critically assessed and only included those "indicators" that sought to measure an item of interest. In some cases, we felt that the indicators may not have been appropriate measures of the community capacity characteristic of interest. Nevertheless these indicators were included and categorized under the characteristic of interest. The testing of the validity of indicators was not an objective of this study.

This was an exploratory, descriptive study of, and an initial step in, understanding how people conceptualize and measure community capacity. Further research may help to address some of the limitations of the study.

9. DISCUSSION AND IMPLICATIONS

Our discussion focuses on the following themes: perspective on community capacity; community capacity as a process; usefulness of the framework and indicators; further research on community capacity; responsibility for building community capacity; and strategic directions for the conceptualization and measurement of community capacity. These themes are similar to those identified for population health, by Frankish, Veenstra and Moulton (1999) in their discussion of the issues and challenges for policy, practice and research regarding population health in Canada. Our view is that community capacity is a concept that holds great potential, both as a process for strengthening communities and as a measurable outcome of health initiatives. We believe that may of its strengths remain poorly understood and largely untapped because insufficient resources and thought have been applied to its conceptualization, measurement and surveillance.

9.1 Perspective on Community Capacity

The concept of community capacity appears to be deeply intertwined with other related concepts such as community empowerment, community development and community competence. No consensus has been reached as to how the different concepts can be distinguished from each other, although their relational aspects are recognized. Based on our review of the literature and the results of our document review, all the concepts appear to focus on collaborative action within communities for the common community good. This raises the question of the utility of a clear distinction between the concepts, given their large degree of overlap. We suggest that whichever term is used, its overlap with the other concepts should be acknowledged.

Although our document review focused mainly on community capacity for health and social conditions, we believe the concept of community capacity is broader than that. Exclusion criteria for the study were set for practical purposes. However, our background in health promotion supports the concept of the "health of communities" to include health, social, economic and environmental aspects of living, e.g., the Healthy Cities approach.

9.2 Community Capacity as a Process

Community capacity is often discussed as to whether it is an end or a means to an end. Although a program may include the building of community capacity as an objective (an end), community capacity is more often thought of as a means to better quality of life and healthier communities. In our document review this was the most prevalent outcome specified for community capacity at the community-level. Our document review also showed that most definitions of community capacity refer to the potential to effect change for improved health, quality of life, or community.

Community capacity appears to be a process that is re-iterative and cyclical. There is no actual end because communities are not static entities. The re-iterative nature of community capacity was mentioned by participants in the focus groups, revealed in our framework where a theme spanned more than one dimension of the theories of change, and revealed in our compilation of indicators where one indicator was proposed or used to measure more than one characteristic of community capacity. Although the re-iterative aspect of community capacity appears to pose some challenges in the use of the theories of change approach, we believe the approach is an important tool in the planning and evaluation of community capacity building initiatives.

9.3 Usefulness of the Framework and Indicators

At this point in time, the framework is preliminary and mainly reflects a collection of data on how people conceptualize and measure community capacity. As such, it is exploratory and descriptive, rather than prescriptive or predictive. We do not purport to understand or know the interactions between the different characteristics of community capacity or any of its intended outcomes. The framework needs to be developed further and tested for validity and for its usefulness as a tool in aiding in the conceptualization and measurement of community capacity. In addition, relationships between different characteristics and what influences the intended outcomes need to be elucidated.

We emphasize again the utility of using the theories of change approach to planning and evaluating community capacity building. The benefit to using this approach is that it aids in making explicit the expected outcomes, the activities required to achieve these outcomes, the

resources needed to implement these activities and in what context such efforts are supported. In its current state, the framework, which adapted the theories of change approach, may be used to aid people in getting started in such a process. The framework can also be used to look at examples of what resources or what activities contribute to community capacity. At the individual level, one may use the framework to identify activities to improve one's own capacity (to contribute to the capacity of the community). Organizations (e.g., Health Canada, community foundations) may also use the framework to look at activities that other organizations have proposed or used to build community capacity.

Our document review showed that a broad range of different types of indicators have been proposed or used to measure community capacity. Some indicators, such as people's interest in voting, were suggested for measuring different characteristics of community capacity. In some cases, indicators were "borrowed" from other areas of study, such as organizational capacity. Our review of the literature showed a lack of consensus on the types of indicators for measuring community capacity, although distinctions are made between program objectives and broader aims such as community capacity, and between individual, organizational and community levels of community capacity. It seems no clear conclusion can be made about indicators of community capacity, except that there is no consensus on what indicators should be used.

We emphasize that our research is exploratory and that the list of the types of indicators shown in Table 9 are descriptive and exploratory. The list is not prescriptive, and should only be interpreted as examples of the types of indicators that have been proposed or used to measure community capacity. However, these types of indicators may be of potential importance to Health Canada or others (i.e., Canadian Institutes for Health Information) who may be interested in building a Canadian consensus and credible, trustworthy measures of community capacity.

9.4 Further Research on Community Capacity

The majority of community-building initiatives have not been (empirically) evaluated. Many initiatives often lack key elements such as resources, time and personnel, that would allow for a more robust evaluation. In addition, there is little solid research (qualitative or quantitative) that

links community capacity in a causal way to improved planning, implementation, evaluation or impact of community-based efforts. Better evaluations of capacity-related efforts will require an investment of human, practical and fiscal resources.

The concept of a core set of characteristics and indicators of community capacity needs to be explored. Based on our document review and the focus groups, we found several themes to be prominent in people's conceptualization of community capacity. These include knowledge and skills, public participation, functional organizations, community infrastructure, and collaboration. Are these themes more "important" than others in building community capacity and contributing to the intended outcomes? Are they "necessary" towards the building of community capacity?

There are few, if any, well-validated indicators of community capacity. Although indicators have been proposed, there are relatively few instances where indicators were actually used to measure community capacity. We suggest that further research be conducted to test the validity of indicators of community capacity and explore the idea of a set of "core" indicators for measuring community capacity. In addition, the usefulness and validity of using indicators "borrowed" from other fields, such as organizational capacity, to measure community capacity needs to be explored.

Policy makers, program planners, service providers and other groups who work with the concept of community capacity often need to access evidence or research for a variety of purposes. We have applied a six-part taxonomy that has been useful to us in identifying different "types" of research; we have adapted it for our discussion on community capacity and the type of research that is needed. We recognize that the six research types are neither independent nor mutually exclusive.

Conceptual research examines the definition and meaning of community capacity. Considering the diversity and broad nature of community capacity, clear definitions are a vital tool for advocacy groups and policy makers alike. A lack of clarity and/or inconsistent use of definitions may result in policy difficulties. *Environmental scan* research documents the extent of community capacity, as well as issues related to community capacity. Such scans are useful but they remain primarily descriptive in nature, and there is a need to link these rich descriptions in a causal manner to concrete, measurable outcomes that can reasonably be attributed to

increased community capacity. *Methods* research focuses on the development of new tools for measuring community capacity. Our document review suggested that many different types of indicators have been proposed or used to measure community capacity. What is lacking is precise, psychometric research that evaluates the measurement qualities of each scale or tool. At present, it remains unclear as to what the indicators actually measure, whether they measure the same "thing" across different groups, and whether they are reliable. *Needs assessment* research focuses on the needs of communities as expressed by community members, policy makers, program planners or service providers. A variety of needs assessments have been undertaken in relation to community capacity. None have been linked in a systematic way to specific objectives, nor to well-evaluated interventions with measurable outcomes. *Intervention* research examines the development and implementation of programs, services or interventions for building community capacity. Implementation research is important because interventions often fail because they are poorly executed. This may be particularly true when dealing with community groups that have limited resources and capacity. Any subsequent evaluations may be misleading. Perhaps one of the most vital types of research, *evaluation* research describes the process and effectiveness of programs or services related to community capacity. Surprisingly, there are relatively few research projects of this type. In summary, each of our research "types" warrants further development. There is also a need to develop these different forms of research in concert so that one type can inform and complement the other.

Several other points can be made regarding the need to strengthen our understanding and appropriate use of the notion of community capacity. There must be significant community involvement in any work on community capacity and its conceptualization and measurement. This point was observed in our document review, the focus groups, and the community forum. The concept of involving the community is based very much on principles of public participation found in the literature, i.e., that community members should be involved in the planning, implementation and evaluation of programs and services because they are affected by them, and that community members also have expertise and knowledge to offer (they have capacity). Community members are not just passive recipients of programs and services. Steps must be taken to ensure that communities are able to contribute to, and participate effectively, in the study of community capacity and its use. Ideally the building of community capacity would allow communities to initiate their own initiatives or research, or work more equitably with government

and/or academic partners. Our framework includes strategies, i.e., activities, which have been proposed or used to build community capacity.

The issue of dissemination also remains a key challenge in relation to community capacity. The question is how can we best "capture" and communicate the lessons, experiences and best practices of community capacity. How can this information be communicated in a variety of forms and media that are appropriate to their target audiences? Again, significant barriers exist including time, personnel, research capacity and resources. On a related note, there is a need for study and development of community capacity in specific groups or populations. Vulnerable or marginalized groups warrant particular attention.

9.5 Responsibility for Building Community Capacity

Who is responsible for building community capacity? Based on the prominent themes of public participation and collaboration found in the literature on community capacity, and on the different levels (individual, organizational, community) identified in the literature, in the focus groups and by the research team, it may be concluded that we are all part of the process. The organization of the framework suggests that individuals and organizations can play a role in building community capacity. For example, individuals can seek opportunities to learn and understand the community context and issues, and increase their knowledge and skills. Government and organizations can dedicate resources to community capacity (e.g., staff, money), design programs for community capacity, include community capacity in their strategic planning, etc. There are tools available to aid in community capacity building (or community development, whichever term is used); we have compiled an annotated review of some tools in a resource listing (Appendix C).

The notion of community capacity (and capacity-building) holds a philosophical, values-based attraction to many practitioners and an increasing number of funders and policy makers. This was evidenced by the number of participants at our community forum and their expressed interest in community capacity. The adoption of a renewed focus on community capacity may contribute to a new "culture" in the health sector and greater support for health promotion and community development. It could also lead to the creation of new goals for the health sector

and to new approaches to funding population health and health promotion initiatives, and to preventing illness and promoting health. Health professionals and services providers may need to develop new capacities and skills to work with communities around capacity-building efforts. This suggests creation of new partnerships and broader inter-sectoral collaboration around the determinants of health. Thus, new and additional stakeholders from diverse sectors of government and society may become involved in the planning, implementation and evaluation of services, programs and policies.

9.6 Strategic Directions for Conceptualizing and Measuring Community Capacity

We suggest three major strategic directions and next steps around the conceptualization and measurement of community capacity and its use in population health efforts. First, there is a need for a national-level effort to validate the constructs of community capacity to achieve a consensus definition and "core" indicators of community capacity as it relates to federally-funded projects. This work could become an integral part of major measurement efforts such as the work of the Canadian Institutes for Health Information.

Second, there is a need to fund demonstration projects that can reliably collect data on the above "core" indicators of community capacity. Surveillance systems should be created around the measurement of community capacity. This data and the related systems need to be given the same attention and weight as systems that presently collect health-systems data. There is a need to renew efforts to include measures of community capacity and other community-level indicators in the Canadian Community Health Survey and similar data collection initiatives. However, the creation and collection of core data must not preclude communities from collecting additional locality-specific data of local interest and value.

Finally, federally-funded projects that purport to use a community-capacity approach (as either a process or a significant outcome) should be subjected to an "evaluability" assessment. Groups such as the Canadian Consortium for Health Promotion Research could assist Health Canada (and other relevant federal departments) in determining whether current projects and programs are evaluable. More important, it could move toward a model of program evaluation that sets realistic expectations in terms of the measurement of limited and specific aspects of community

capacity, and that provides sufficient time and resources to allow for an appropriate assessment of community capacity and its effects.

10. CONCLUSIONS

The purpose of this synthesis paper was to start answering some questions about what "community capacity" is and how it can be measured. In our document review, we found that community capacity was often defined as the potential or ability of a community to effect positive community change, or for the common community good. This suggests that there is a general *unstated* consensus on the definition of community capacity. What "community capacity" is can also be answered by analyzing how it is conceptualized, i.e., what are the characteristics of community capacity? We identified characteristics of community capacity in a broad range of documents, elicited characteristics of community capacity from focus group participants, and organized these characteristics into a framework of community capacity. The development of our framework is preliminary; it is exploratory and descriptive, rather than predictive or prescriptive. Despite some limitations in the study, the framework has some "validity" in that a broad range of documents was reviewed, and that the data from the document review and the focus groups showed considerable overlap. In addition, some themes were observed to be more prominent, e.g., public participation, knowledge and skills, etc. At this point in time, the framework may be used by both individuals and organizations as a tool that shows examples of activities and resources that may be needed to achieve intended outcomes. The question of how community capacity can be measured can be answered by observing the indicators that have been proposed or used for its measurement. Indicators of community capacity were identified during our document review. We presented a list of different types of indicators that have been proposed or used to measure community capacity. Like our framework, this list of the types of indicators is preliminary and descriptive. Little empirical research has been conducted on the validity of indicators of community capacity. Therefore at this point in time, our list of the types of indicators may be used as a resource to see what how others have proposed or tried to measure community capacity. Further research is required to understand the relationships between characteristics of community capacity and their influence on intended outcomes, and the possibility of developing a core set of characteristics and indicators of community capacity. For example, could the more prominent themes in our framework be

explored as core aspects of community capacity? If so, what indicators are valid measures of these?

Although research is often thought of as theoretical, there is a practical side to community capacity as well. Efforts to build and evaluate community capacity have often involved various key constituencies, i.e., academics, service providers, practitioners, policy makers, funders and lay persons. The outcome of interest is often better quality of life and healthier communities. Building and sustaining community capacity will require three things: 1) changing knowledge, attitudes and beliefs to motivate people to engage in community-capacity initiatives; 2) enabling motivated individuals or groups to take action on building (and measuring) community capacity by building skills and providing supportive environments and resources; and 3) rewarding or reinforcing practitioners, policy makers and funders who engage in capacity-building.

The notion of community capacity has a long and respected position in relation to community development and health promotion initiatives. There is a large body of literature suggesting that capacity-building is a core process in the development and strengthening of communities. There is also a body of largely "gray" literature on increased capacity as a key outcome of community activities. There is reason to believe that increased "capacity" may be linked in fundamental ways to improved health and quality of life at individual, organizational and community levels. However systematic and rigorous process and/or outcome evaluations of capacity building efforts are lacking. Many reasons exist for this important disjuncture. First, community groups do not have evaluation as their prime focus. Second, academics and community-based researchers have given insufficient attention to the development and testing of credible, trustworthy measures of community capacity. Finally, policy makers and funders have failed to provide appropriate resources to allow for meaningful qualitative or quantitative evaluations of most capacity building efforts.

The above points are not a condemnation of community capacity as an immensely important concept in community-based, population health initiatives. Rather, they represent a challenge to both the proponents and critics of capacity building. At present, many capacity-building efforts are being criticized for failing to achieve standards (i.e., demonstrating changes in community health status) that they were never directly designed or resourced to achieve. Equally important, funders, policy makers and their funded community partners need to develop

a more realistic approach to the measurement of community capacity. Funders and policy makers need to avoid setting unrealistic expectations around the measurement of capacity-related processes or outcomes. Alternatively, they need to fund projects and programs that are better designed (e.g., longitudinal studies) to demonstrate the desired effects. Community groups need to avoid "over-promising" that they will deliver on measurable, capacity-related processes or outcomes. It is our view that it would be far better to "do less better". Funders, policy makers and community partners would be better served if they agreed, a priori, on a smaller bounded set of measurable indicators, if communities were given the needed resources and support to achieve the desired outcomes, and if communities were held accountable for measuring the identified outcomes.

We view community capacity as a fundamental, core concept in the building and strengthening of communities. We recognize the need to improve its measurement and to create better tools for process and outcome evaluation(s) of capacity-building efforts. We encourage the investment of the needed resources toward the science and application of measurement of community capacity. Building on its traditions in health promotion and its strengths in the area of population health, Canada is well placed to become a world leader in the conceptualization, measurement and application of community capacity as a core notion and strategy for building community health.

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APPENDIX A – LIST OF DOCUMENTS THAT WERE REVIEWED

"Academic" Research Publications

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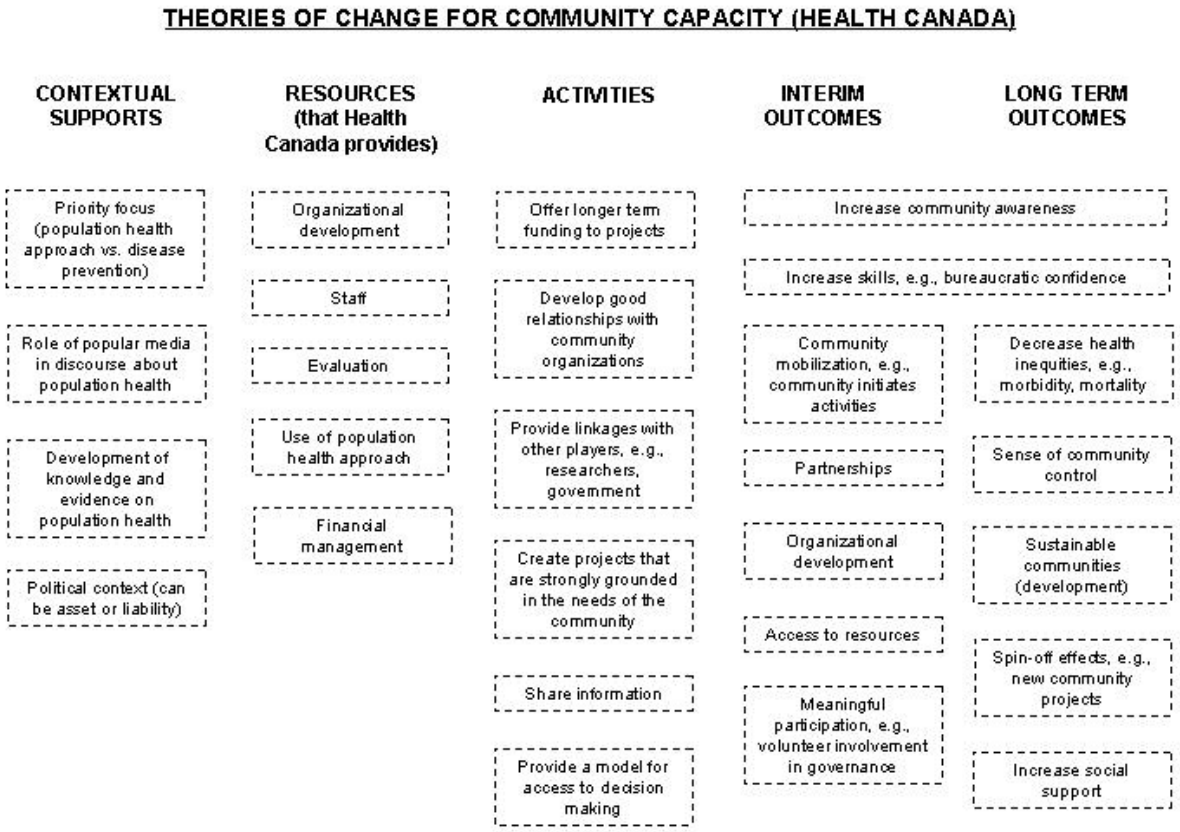
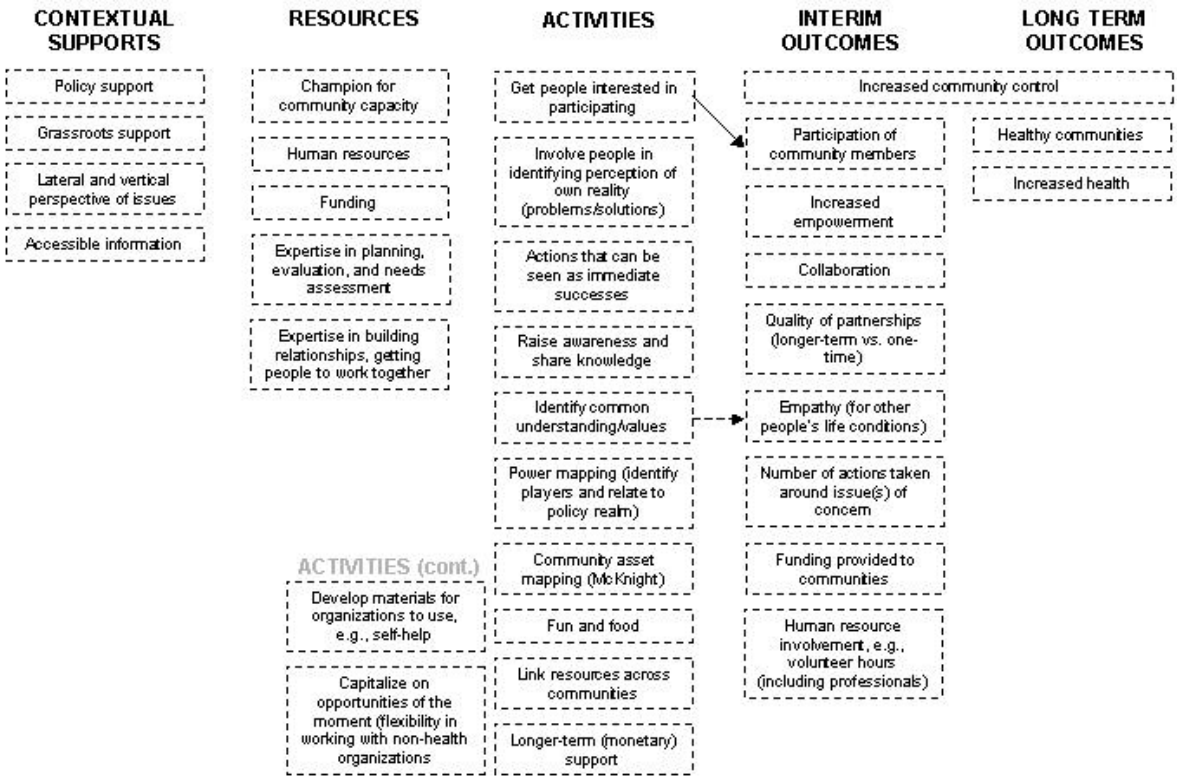
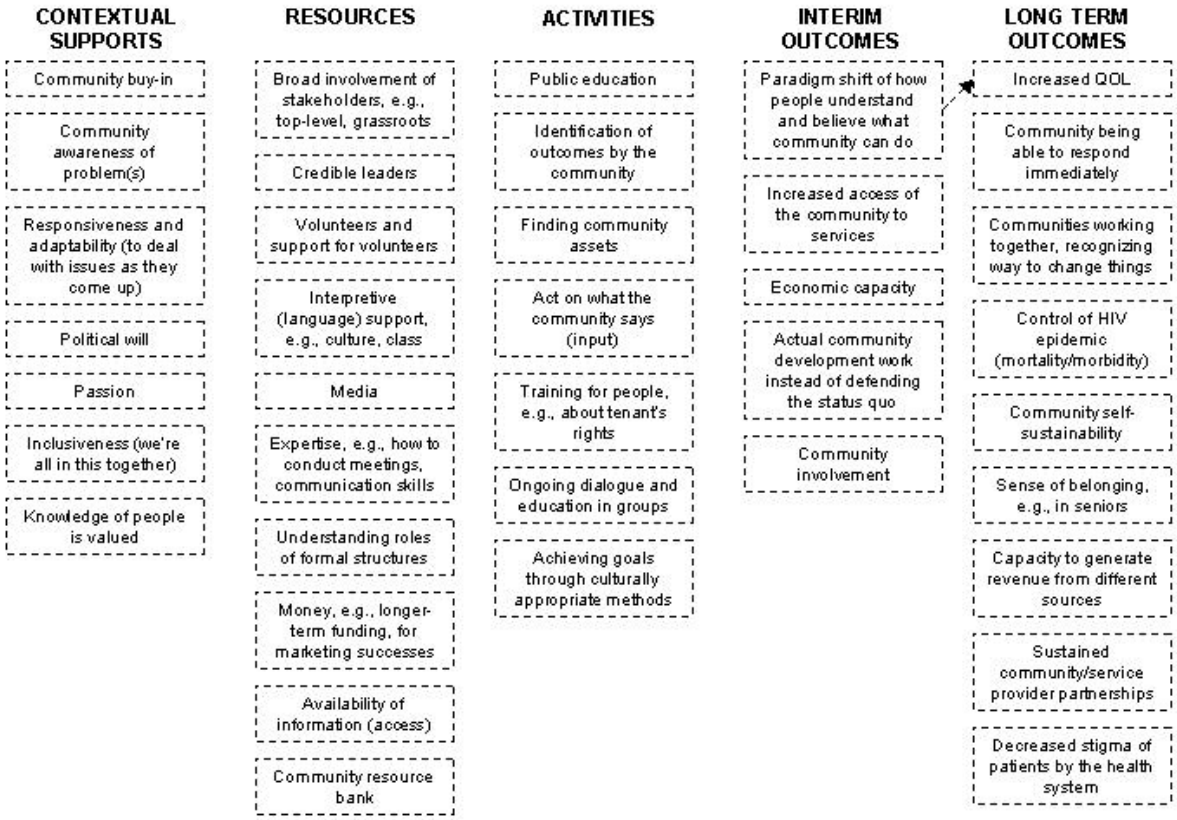
APPENDIX B – THEORIES OF CHANGE FROM THE THREE FOCUS GROUPS



THEORIES OF CHANGE FOR COMMUNITY CAPACITY (RESEARCH TEAM)



THEORIES OF CHANGE FOR COMMUNITY CAPACITY(COMMUNITY PROJECTS)



APPENDIX C - RESOURCE LIST FOR COMMUNITY CAPACITY

Australia

Title: **A Framework for Building Capacity to Improve Health**
Contact: New South Wales (NSW) Health
Address: Locked Mail Bag 961
North Sydney, NSW 2059
Telephone: 61 2 9391 9000
Fax: 61 2 9391 9101
TTY: 61 2 9391 9900
E-mail nswhealth@doh.health.nsw.gov.au
Website: http://www.health.nsw.gov.au/public-health/health-promotion/pdf/framework/Capacitybuilding.pdf
Description: This document is intended for people working on health promotion programs. It provides a guide for enhancing the capability of the system to improve health. Although the main focused is on building capacity within programs, the authors emphasize the importance of also focusing on building the capacity of the system to support change. The document emphasizes five key action areas in capacity building: organizational change; workforce development; resource allocation; partnerships; and leadership.

Title: **Indicators to Help with Capacity Building in Health Promotion**
Contact: NSW Health (New South Wales Health)
Address: Locked Mail Bag 961
North Sydney, NSW 2059
Telephone: 61 2 9391 9000
Fax: 61 2 9391 9101
TTY: 61 2 9391 9900
E-mail nswhealth@doh.health.nsw.gov.au
Website: http://www.health.nsw.gov.au/public-health/health-promotion/pdf/indicators/capbuild.pdf
Description: This project set out to clarify capacity building as a concept and to develop indicators that could determine whether or not capacity building by health promotion workers was being done well. This report contains nine checklists for capacity building which are based on specific situations and settings that are common among health promotion practitioners. For example, there are checklists for "assessing if a program is likely to be sustained" and "assessing the capacity of a particular organization to tackle a health issue."

Canada

Title: **Assessing Community Capacity for Change**
Contact: Michael and Judie Bopp
Address: Four Worlds Center for Development Learning
Box 395
Cochrane, AB T0L 0W0
Telephone: (403) 932-0882
Fax: (403) 932-0883
E-mail: 4worlds@cadvision.com
Contact: Lori Baugh Littlejohns
Address: Research & Evaluation
Regional Public Health
David Thompson Health Region
Red Deer Community Health Centre
2845 Bremner Avenue
Red Deer, AB T4R 1S2
Telephone: (403) 341-2172
Fax: (403) 341-2167
Email: llittlejohns@dthr.ab.ca
Website: This document is not available on-line. Contact the addresses above or http://www.steinergraphics.com/fourworlds/ for more information.
Description: The goal of this research was to learn and understand more about community capacity – what it is, how it can be assessed, and how it can be strengthened. This guidebook identifies seven community capacity "domains": shared vision; sense of community; leadership; communication; participation; ongoing learning; and resources, knowledge and skills. It also includes a community capacity assessment tool kit that a community can use to rate themselves against each of the seven "domains." This is a good resource for people who want to build capacity in their communities or who want a good introduction to what community capacity is and why it is important.

Title: **Assessing Self-Help Community Development Planning Tools**
Contact: Rural and Small Town Programme, Mount Allison University
Address: Avard-Dixon Building
Mount Allison University
144 Main Street
Sackville, NB E4L 1A7
Email: dwbruce@mta.ca
Website: http://www.mta.ca/rstp/shtool-e.pdf
Description: The goal of this project was to assess how communities and organizations in Atlantic Canada have made use of self-help planning tools for community capacity building, and the usefulness of such tools in developing community action plans. Four tools were selected including "Community Capacity Building for Economic Development" (from the Government of Newfoundland and Labrador).

Title: **Building Capacity in Health Promotion: More than Bricks and Mortar**
Contact: Ontario Prevention ClearingHouse
Address: 180 Dundas Street West, Suite 1900
Toronto, ON M5G 1Z8
Telephone: (416) 408-2249
Toll-free: 1-800-263-2846
Fax: (416) 408-2122
E-mail: info@opc.on.ca
Website: http://www.opc.on.ca/english/our_programs/hlth_promo/resources/capacity_building.pdf
Description: This is a tip-sheet based on literature reviews, consultations and focus groups with numerous health promotion resource centres. In this document they share how capacity building is being used in health promotion organizations and communities across Ontario. The concepts and information found in this document will help health promotion practitioners share a common language on capacity building, as well as encourage them to develop capacity building aspects to their own health promotion work. It allows practitioners to draw upon the experiences of other communities already using capacity building to sustain their initiatives.

Title: **Building Health Promotion Capacity Project**
1999 Annual Report and Capacity Checklists
Contact: Department of Community Health and Epidemiology
Address: University of Saskatchewan
107 Wiggins Road
Saskatoon, SK S7N 5E5
Telephone: (306) 966-7977
Toll Free: 1-800-667-7913 (Western Provinces)
Fax: (306) 966-7920
Email: schmidtk@sask.usask.ca
Website: http://www.usask.ca/healthsci/che/hhdis/report99.html
Description: The "Building Health Promotion Capacity" project is a five-year program funded by Health Canada, Saskatchewan Health, and the Heart and Stroke Foundation of Saskatchewan to help health districts increase capacity to plan, implement and evaluate health promotion activities and to improve understanding of the capacity-building process. The annual report lists the activities and lessons from the first year of the dissemination phase of the program. The Individual and Organizational Capacity checklists, which are explained in the annual report, can be used as a tool to assess capacity.

Title: **Capacity Building: Linking Community Experience to Public Policy**
Contact: Population and Public Health Branch - Atlantic Region
Address: Atlantic Regional Office
Suite 1525, 15th Floor, Maritime Centre
1505 Barrington Street
Halifax, NS B3J 3Y6
Telephone: (902) 426-2700
Fax: (902) 426-9689
Email: pphatlantic-spspatlantique@hc-sc.gc.ca.
Website: http://www.hc-sc.gc.ca/hppb/regions/atlantic/pdf/capacity_building_e.pdf
Description: This is a tool designed to help people in the public sector and in the community to understand how to build capacity by linking community experience to the policy-making process. It considers how policy has traditionally been made, and the opportunities and challenges facing communities and systems as they strive to work collaboratively to create meaningful and inclusive public-policy processes. One of the questions this tool considers is, "how can public policy processes help to build the capacities of all sectors to work together for more credible and inclusive policy-making and governance?"

Title: **Community Capacity Building: A Facilitated Workshop – Facilitator Guide**
Contact: Human Resources Development Canada
Address: Labour Market Learning and Development Unit
Attn: CCB Facilitator's Guide
Human Resources Development Canada
5th Floor, 140 Promenade du Portage
Hull, QC K1A 0J9
Telephone: (819) 953-7370
Fax: (819) 997-5163
Email: learning-apprentissage.lmld-apmt@hrdc-drhc.gc.ca
Website: http://www.hrdc-drhc.gc.ca/community/menu/fac_gui.doc
Description: This is a Facilitator Guide for a Capacity Building Workshop hosted by Human Resources Development Canada (HRDC). The audience for this workshop was HRDC staff involved with working with community partners. One of the messages of this package was that HRDC offices need to build their own capacity in order to most effectively assist their communities.

Title: **Community Capacity Building - Understanding It, Measuring It, Seeing It in Action - OHPE Bulletin #179.1**
Contact: Ontario Health Promotion E-Mail Bulletin (OHPE)
Address: Telephone: (416) 408-2249 extension 265
Toll free: 1-800-263-2846 extension 265
Fax: (416) 408-2122
Email: info@ohpe.ca or editor@ohpe.ca
Website: http://www.ohpe.ca/ebulletin/ViewFeatures.cfm?ISSUE_ID=179&startrow21
Description: The Ontario Health Promotion E-mail Bulletin (OHPE) is a weekly newsletter for people interested in health promotion produced by the Ontario Prevention Clearinghouse and The Health Communication Unit. This article is an introduction to understanding community capacity building, measuring it, seeing it in action in Ontario and ways to participate. It includes some helpful links to related projects and sites.

Title: **Community Capacity Mapping - OHPE Bulletin #60.1**
Contact: Ontario Health Promotion E-Mail Bulletin (OHPE)
Address: Telephone: 1(800) 263-2846 x265 or (416) 408-2249 x265
Fax: (416) 408-2122
Email: info@ohpe.ca or editor@ohpe.ca
Website: http://www.ohpe.ca/ebulletin/ViewFeatures.cfm?ISSUE_ID=60&startrow=141
Description: The Ontario Health Promotion E-mail Bulletin (OHPE) is a weekly newsletter for people interested in health promotion produced by the Ontario Prevention Clearinghouse and The Health Communication Unit. This article is an introduction to community capacity mapping. It includes a description of the Ontario Community Capacity Mapping Project as well as some helpful resources.

Title: **Fact Sheet of Healthy Community Terms: Community Capacity**
Contact: Ontario Healthy Communities Coalition
Address: 555 Richmond Street West
Suite 505 - Box 1100
Toronto, ON M5V 3B1
Telephone: (416) 408-4841
Toll Free: 1-800-766-3418
Fax: (416) 408-4843
Email: info@healthycommunities.on.ca
Website: http://www.healthycommunities.on.ca/resources/factsheets/ccb.htm
Description: This web page provides a brief, simple definition of the term community capacity. It gives an example, reasons why it is important, as well as links to helpful websites. It is intended as a starting point for people who want to learn the basics about community capacity.

Title: **Focusing on Communities - The Tool Kit**
Contact: Community Development Branch
Government of Saskatchewan
Address: 9th Floor, 122 3rd Avenue N
Saskatoon, SK S7K 2H6
Telephone: (306) 933-6937
Fax: (306) 933-7720
Email: toolkit@mah.gov.sk.ca
Website: http://www.municipal.gov.sk.ca/toolkit/index.shtml
Description: This virtual Tool Kit is designed to help build community capacity by providing easy access to information to support community and/or municipal projects, cooperation and partnerships, citizen involvement and awareness and understanding of municipal issues and challenges. The Tool Kit provides a framework for municipalities and communities to work with others to increase capacity and provide a solid infrastructure. This may increase the administrative capacity of municipalities and help maintain and enhance community services.

Title: **How Our Programs Affect Population Health Determinants: A Workbook for Better Planning and Accountability**
Contact: Saskatchewan Population Health and Evaluation Research Unit
Address: University of Saskatchewan Site
Saskatoon SK S7N 5E5
Telephone: (306) 966-2250
Fax: (306) 966-7920
E-mail: spheru@sask.usask.ca
Website: This document not available on-line, contact the address above or http://www.spheru.ca for more information.
Description: Community members, funders and health workers are interested in knowing more about how their health promotion activities contribute to change in population health determinants. This workbook is designed to help all three "stakeholders" to do this. The simple framework developed for this workbook is designed like a spreadsheet. It contains a section on community capacity building, which includes a table listing nine key categories of community capacity. The intent of the workbook is to make the accountability work for Health Canada on population health determinants easier and to help the stakeholder continue to move in a "health determinants" direction in their own work.

Title: **Profiles in Community Capacity-Building - Stories from the Leadership, Engagement and Development Program**

Contact: Vancouver Foundation
Address: Suite 1200
555 West Hastings Street
P.O. Box 12132
Harbour Centre
Vancouver, BC V6B 4N6
Telephone: (604) 688-2204
Fax: (604) 688-4170
Email: info@vancouverfoundation.bc.ca
Website: http://www.vancouverfoundation.bc.ca/AboutVancouverFoundation/Downloads/Profiles%20in%20CCB02.pdf

Description: This booklet has been created to inform and motivate community leaders to consider the practice of grant-making within the context of community capacity building. It contains a collection of relevant grant-making examples drawn from the experience over the past two years of community foundations across British Columbia that have participated in Vancouver Foundation's Leadership, Engagement and Development Program (LEAD program). This program was developed to promote the practice of community capacity building grant-making. A recent evaluation of the program generated enthusiastic feedback from community foundations and grant recipients and revealed numerous inspirational stories of community capacity building. Some of these examples are presented in this document.

Title: **The Community Development Handbook: A Tool to Build Community Capacity**

Contact: Human Resources Development Canada
Address: Labour Market Learning and Development Unit
5th Floor, 140 Promenade du Portage
Hull, QC K1A 0J9
Telephone: (819) 953-7370
Fax: (819) 997-5163
Email: learning-apprentissage.lmld-apmt@hrdc-drhc.gc.ca
Website: http://www.hrdc-drhc.gc.ca/community/menu/cdhbooke.pdf

Description: This resource is founded on the concept that community development is one of the key tools in community capacity building. This introductory handbook is not designed to be a textbook for practitioners, but as an introductory guide to community development and capacity building. It is designed primarily for those who have an interest in community development but who may not have an in-depth understanding of the concept, the process or the resources available across Canada.

United States

Title: **Building Communities from the Inside Out - A Path Toward Finding and Mobilizing a Community's Assets**

Contact: The Asset-Based Community Development Institute

Address: Institute for Policy Research
2040 Sheridan Road
Evanston, IL 60208-4100
Telephone: (847) 491-3395
Fax: (847) 491-9916
E-mail: ipr@northwestern.edu

Website: This document is not available on-line. To order, contact the publisher ACTA Publications at acta@one.org or (800) 397-2282

Description: This book is a guide to "asset-based community development." The authors summarize lessons learned by studying successful community-building initiatives in hundreds of neighbourhoods across the United States. The book outlines in lay language how communities can rediscover and "map" their local assets, how they can combine and mobilize these strengths to build stronger, more self-reliant communities, and how "outsiders" in government or the charitable sector can contribute effectively to the process of asset-based development. A six-session video training program based on the book is also available.

Title: **Community Capacity Inventory Checklist and Questions to Ask While Capacity Mapping**

Contact: Work Group on Health Promotion & Community Development

Address: 4082 Dole Human Development Center
1000 Sunnyside Ave.
University of Kansas
Lawrence, KS 66045-7555
Telephone: (785) 864-0533
Fax: (785) 864-5281
Email: Toolbox@ku.edu

Website: http://ctb.ku.edu/tools/EN/section_1002.htm

Description: The Tool Box is a website that provides over 6,000 pages of practical information to support the work of promoting community health and development. *Community Capacity Inventory Checklist* and *Questions to Ask While Capacity Mapping* are two of these tools. The *Community Capacity Inventory Checklist* is an example of how to make a list of the organizations (e.g. city/county planning departments, the chamber of commerce, volunteer placement agencies) that build the capacity of the community. *Questions to Ask While Capacity* Mapping will help is intended to aid in the collection of information about the different associations, organizations, and relationships that exist in the community.

Title: **Effective Capacity Building in Nonprofit Organizations**
Contact: Venture Philanthropy Partners
Address: Suite 420, 1201 15th Street, NW
Washington, DC 20005
Telephone: (202) 955-8085
Email: info@vppartners.org
Website: http://www.venturephilanthropypartners.org/learning/reports/capacity/full_rpt.pdf
Description: This document brings some common language to the discussion of capacity building and offers insights and examples of how non-profit organizations have pursued building up their organizational muscle. The report contributes to the growing national conversation about how to help non-profit organizations become stronger, more sustainable, and better able to serve their communities. Also included in this report is a practical assessment tool that nonrofit organizations can use to measure their own organizational capacity. The non-profit sector and funders alike might find value in this report.

Title: **Mapping Community Capacity**
Contact: Institute for Policy Research
Address: 2040 Sheridan Road
Evanston, IL 60208-4100
Telephone: (847) 491-3395
Fax: (847) 491-9916
E-mail: ipr@northwestern.edu
Website: http://www.northwestern.edu/ipr/publications/papers/mcc.pdf
Description: This document offers a blueprint for low-income urban neighbourhoods that do not have access to resources from government or private companies. It identifies resources within the community that can be tapped for internal development. These include residents, schools, associations, public institutions and services, welfare payments, and information. To help elicit information on the skills and abilities of residents that can be utilized in community building, this policy guide features a 13-page questionnaire, a "Capacity Inventory." It also contains an "Associational Map" that lists typical community organizations – from service clubs to gardening groups – around which these new activities can develop.

Title: **Measuring Community Capacity Building: A Workbook-in-Progress for Rural Communities**

Contact: The Aspen Institute
Address: Publications Office
109 Houghton Lab Lane
PO Box 222
Queenstown, MD 21658
Telephone: (410) 820-5338
Fax: (410) 827-5928
Email: publications@aspeninst.org
Website: http://www.aspeninstitute.org/bookdetails.asp?i=59&d=60
Description: This workbook is for community leaders and citizens who want to improve the ability of individuals, organizations, businesses and government in their community to come together and improve their community's capacity. This workbook will help the community to identify what community capacity is, why it is important, how to identify capacity in the community and how to measure the community's capacity as it is being built. This resource offers a "menu" of actual measures that groups of citizens can choose from to gauge their progress as they build their community's capacity.

Title: **Our Model of Practice: Building Capacity for Community and Systems Change**

Contact: Work Group on Health Promotion & Community Development
Address: 4082 Dole Human Development Center
1000 Sunnyside Ave.
University of Kansas
Lawrence, KS 66045-7555
Telephone: (785) 864-0533
Fax: (785) 864-5281
Email: Toolbox@ku.edu
Website: http://ctb.ku.edu/tools/EN/section_1002.htm
Description: The Tool Box is a website that provides over 6,000 pages of practical information to support work in promoting community health and development. *Our Model of Practice: Building Capacity for Community and Systems Change* is one of these tools. It gives definitions and describes what community capacity is, how to build it and why it is important. It provides a checklist summarizing the major points in the paper as well as ready-to-use overheads for preparing presentations.

Title: **Sustaining Community-Based Initiatives: Developing Community Capacity**
Contact: W.K. Kellogg Foundation (in collaboration with The Healthcare Forum)
Address: One Michigan Avenue East
Battle Creek, MI
49017-4058
Telephone: (269) 968-1611
Fax: (269) 968-0413
TDD on site
Website: http://www.wkkf.org/Pubs/Health/Pub656.pdf
Description: This resource is designed to improve the community's capacity for positive change by promoting citizen participation, action and leadership. This guide assists communities in engaging community leaders in designing, developing, and implementing a broad-based, community-owned action plan for improving their community's health. Since the stakes are high (financially and organizationally), by using this guide communities have the opportunity to benefit from what other leaders are learning and to avoid common pitfalls. While each community and efforts are unique, there is something to be said for learning from others' mistakes.

Title: **United Way's Community Capacity Building Stories**
Contact: Civic Practices Network (CPN)
Center for Human Resources
Heller School for Advanced Studies in Social Welfare
Address: Brandeis University
60 Turner Street
Waltham, MA 02154
Telephone: (617) 736-4890
Fax: (617) 736-4891
Email: cpn@cpn.org
Website: http://www.cpn.org/topics/community/uwaystory.html
Description: The United Way hosted a symposium in 1996 in response to their community-building initiative. At the symposium, participants benefited from the unique opportunity to learn, not only from the professional experience of experts, but also from the personal experience of their colleagues. This web-document provides readers an opportunity to learn from the professional and practical experiences of the symposium participants. Each capacity building story summarizes the challenges specific to that United Way, describes the innovative solutions to strengthen community, and offers invaluable suggestions.

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