Building the Capacity of Fijian Communities to Improve Health Outcomes

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Abstract
The purpose of this paper is to describe the experiences of building capacity toward improved health outcomes in a rural Fijian community. The paper defines the concept of community capacity situating this within the context of health programming. The tension that exists between the two key forms of health programming, top-down and bottom-up, is also discussed in terms of its resolution through the approach of 'parallel-tracking'. A practical means of visually representing the concept of community capacity is given using the spider-web configuration. The paper will be of interest to the planners and evaluators of health programmes that aim to build and measure community capacity.

Introduction

Community capacity is seen by many authors[1,2] as a process that increases the assets and attributes that a community is able to draw upon. It is 'an increase in community groups' abilities to define, assess, analyze and act on health (or any other) concerns of importance to their members'[3].

Community capacity is not an inherent property of a particular locality, nor of the individuals or groups within it, but of the interactions between both. It is also a function of the resource opportunities or constraints (economic, political and environmental) of the conditions in which people and groups live[4].

This paper addresses the issue of why some Fijian communities are more capable at accessing resources, at influencing decision makers, are better organised and are better able at mobilizing themselves to address their health concerns and needs. What are the key characteristics of these communities that make them better organised, both socially and structurally? How can they, and other Fijian communities, be systematically developed to build their capacity?

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Unpacking Community Capacity

One of the advances in recent years around our thinking of community capacity has been the ability to 'unpack' this concept into the areas of influence that significantly contribute to its development as a process. In particular the 'capacity domains' are the organisational influences of community capacity. They provide a link between the interpersonal elements (individual control, social capital and community cohesiveness) and the contextual elements (the political, socio-cultural and economic circumstances) of a community[5]. The 'capacity domains' allow communities to better organise and mobilize themselves toward gaining control of their lives. The 'capacity domains' are robust and collectively capture the essential qualities of a 'capable community'. They were developed in Fiji as part of a research project[6] and have been cross-checked against the literature to ensure their validity[7]. The community capacity domains are (a brief description of each is provided in table 1):

1. Stakeholder participation;
2. Problem assessment capacities;
3. Strong local leadership;
4. Empowering organisational structures;
5. Ability for resource mobilization;
6. Strong links to other organisations and people;
7. Stakeholder ability to 'ask why';
8. Stakeholder control over programme management;
9. An equitable relationship with outside agents.

The nine 'capacity domains' can be used in a programme context to build community capacity, to improve health outcomes and to increase sustainability. This is achieved through a learning and evaluation tool. First, I discuss the nature of health programming and how this can also influence community capacity.

Parallel-Tracking and Community Capacity

In practice, health programmes are most commonly implemented as activities set within the context of an intervention or a project (collectively referred to in this paper as the 'programme'). This is conventionally managed and monitored by, for example, a health practitioner and commonly includes: a period of identification; design; appraisal; approval; implementation; management and evaluation.

The way in which health concerns are to be addressed and are defined in a programme can take two distinct forms: 'top-down' and 'bottom-up'. 'Top-down' describes programmes where problem identification comes from those in 'top structures' who have decision making authority in the system 'down' to the community. 'Bottom-up' is the reverse, where the community identifies its own problems and communicates these to those who have the decision making authority.

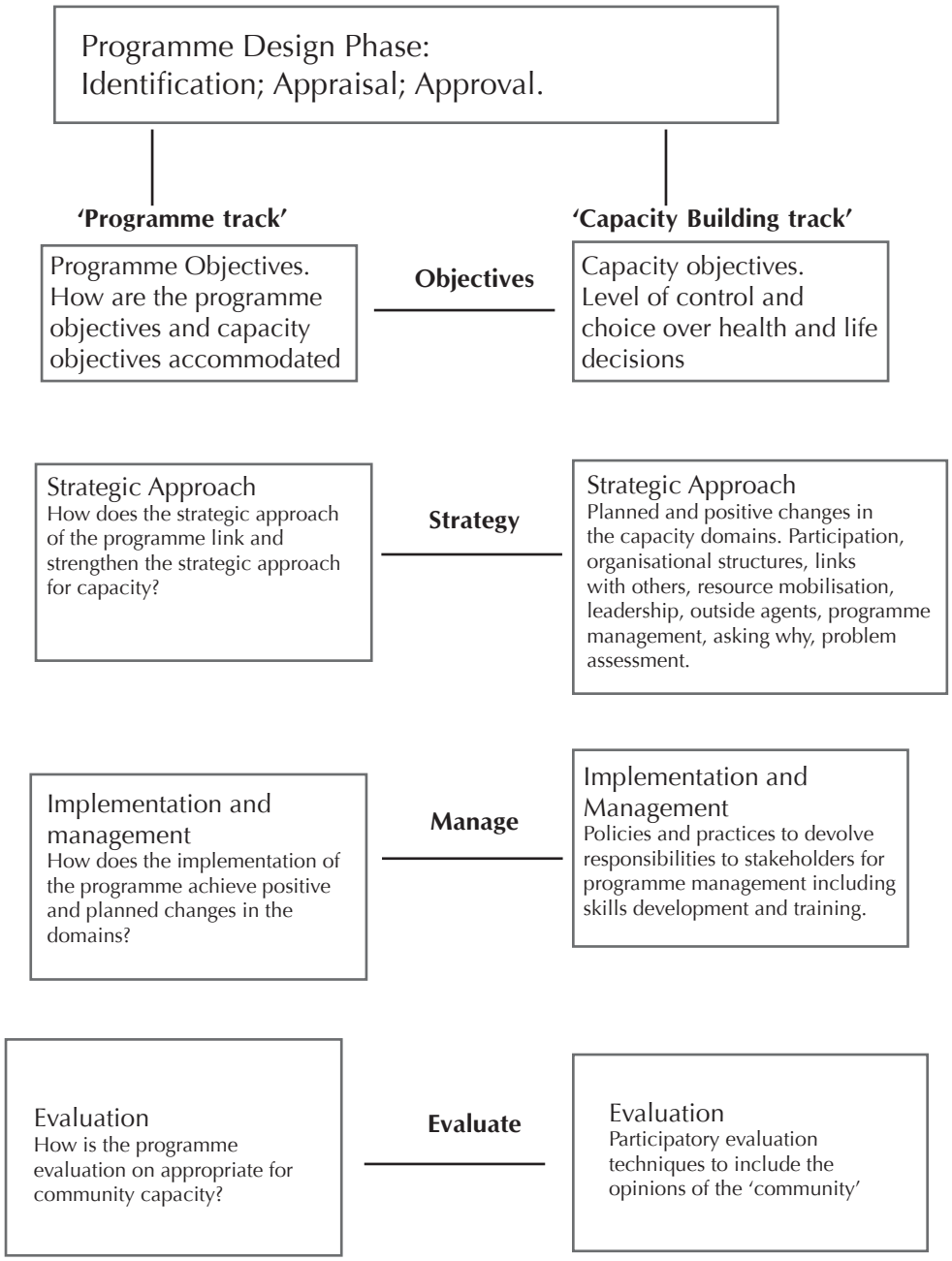
Table 1. A description of the 'capacity domains'.

Domain	Description
Participation	Participation is basic to community capacity. Only by participating in small groups or larger organisations can individual community members better define, analyse and act on issues of general concern to the broader community.
Leadership	Participation and leadership are closely connected. Leadership requires a strong participant base just as participation requires the direction and structure of strong leadership. Both play an important role in the development of small groups and community organisations.
Organisational structures	Organisational structures in a community include small groups such as committees, church and youth groups. These are the organisational elements which represent the ways in which people come together in order to socialize and to address their concerns and problems. The existence of and the level at which these organisations function is crucial to community capacity.
Problem assessment	Capacity presumes that the identification of problems, solutions to the problems and actions to resolve the problems are carried out by the community. This process assists communities to develop a sense of self-determination and capacity.
Resource mobilisation	The ability of the community to mobilize resources both from within and the ability to negotiate resources from beyond itself.
'Asking why'	The ability of the community to critically assess the social, political, economic and other causes of inequalities is a crucial stage towards developing appropriate personal and social change strategies.
Links with others	Links with people and organisations, including partnerships, coalitions and voluntary alliances between the community and others, can assist the community in addressing its issues.
Role of the outside agents	In a programme context outside agents are often an important link between communities and external resources. Their role is especially important near the beginning of a new programme, when the process of building new community momentum may be triggered and nurtured. The outside agent increasingly transforms power relationships between him/herself, outside agencies and the community, such that the community assumes increasing programme authority.
Programme management	Programme management that empowers the community includes the control by the primary stakeholders over decisions on planning, implementation, evaluation, finances, administration, reporting and conflict resolution. The first step toward programme management by the community is to have clearly defined roles, responsibilities and line management of all the stakeholders.

The two types of programming are often viewed as having different agendas that create a bottom-up versus top-down 'tension'. Top-down programmes would include almost all health education and multi-risk factor reduction interventions such as lifestyle and behaviour change. These are the predominant styles of health programming. Bottom-up programmes are fewer in design and often exist as a part of larger scale top-down programming.

Top-down programmes are conventionally managed by an outside agent, for example, the health practitioner. The community are seen as the intended beneficiaries and are expected to cooperate and contribute to the programme under the instruction of the programme management. Bottom-up approaches consciously involve the community in the management of the programme through skills training and by increasingly devolving responsibility for activities such as planning, report writing, budgeting and evaluation. The challenge to health practitioners is how to accommodate community capacity building (bottom-up) approaches within predominant top-down programming. This requires a fundamental shift in the way practitioners think about health programming. Rather than viewing the issue as a bottom-up versus top-down 'tension' the process of accommodating community capacity can be better viewed as a 'parallel track' running along side the main 'programme track' (see Figure 1).

Figure 1. Parallel-Tracking Capacity Building



The tensions between the two styles of programming then occur at each stage of the programme cycle making their resolution much easier to achieve in a practical setting. Theoretically, this helps to move our thinking on from a simple bottom-up/top-down dichotomy. Practically, this provides a systematic way in which to acc ommodate the two styles of programming. Parallel-tracking places an equal emphasis on both the bottom-up and top-down health objectives. The main purpose of the health programme remains the same but now has a clearly defined role for building community capacity. A separate set of concerns for community capacity run 'parallel' to those of specific programme objectives, strategic approach, implementation and evaluation.

Discussion

A Learning and Evaluation Tool to Build Community Capacity in Fijian Communities

I next describe a learning and evaluation tool (referred to as 'the tool') that used the nine domains developed in Fijian communities to build capacity in health programming8.

The Community Context

The 'tool' was implemented in three tikinas (Naloto, Bemana and Nasikawa) on the main island of Viti Levu between July 1997 and August 1998. Fijian villages provide a geographical boundary for the community and these are grouped into districts (tikina), the districts into provinces, the provinces into administrative divisions. The tikina typically represents three or four communities who share the same

needs and interests, geographical boundaries and have social and economic links. The Naloto Tikina Health Committee (THC) covers three rural communities and typically holds a meeting every quarter to discuss common concerns. The village of Naivicula is situated in the Naloto tikina and has a population of between 250 and 400 people. Access to Naivicula is via a narrow road approximately forty five minutes drive from the nearest town of Korovu. The village is situated in an agricultural area close to a river and farming is the main occupation of its residents. Rural Fijian life has well defined social structures and this is organised around traditional patterns and customs. The village consists of a number of extended families which form a clan, headed by a clan chief, several clans form a tribe also headed by a chief.

How was the tool implemented?

The basic question planners and practitioners need to ask themselves is: How has the programme helped to increase community capacity in each of the nine 'domains'? To address this question the tool uses four phases: 1. preparation; 2. assessment; 3. strategic planning; and 4. visual representation. This is implemented as a participatory workshop over 1 or 2 days.

In the village of Naivicula the workshop was held in the community hall and once all the participants had assembled the customary ceremony of sevusevu was completed. This involves introductory speeches by the guests and senior members of the community and the acceptance and drinking of kava. The workshop was conducted in Fijian and facilitated by a trained Fijian translator. During the workshop the summary of each activity was drawn onto a large sheet of paper and displayed at the front of the community hall to record progress. A typed summary would be later sent to the Chairperson of the Naloto THC and used as a means of further planning and evaluation.

Phase 1: Preparation prior to the implementation of the tool

A period of observation and discussion prior to the assessment of community capacity is important to adapt the tool to the social and cultural requirements of the participants. For example, the use of a working definition of community capacity can provide all participants with a more mutual understanding of the programme objectives. A simple qualitative methodology that has been used in Fiji to develop a working definition is provided elsewhere9.

Phase 2: An assessment of each domain

Using the nine domains the participants firstly make an assessment of their community's capacity. To do this they are provided with five generic statements for each domain, each written on a separate sheet. The five statements represent a description of a range of levels of capacity for that domain. The statements that were developed in Fiji are provided elsewhere10 and Figure 2 gives an example for 'Problem assessment'.

Taking one domain at a time the participants are asked to select the statement which most closely describes the present situation in their community. The statements are not numbered or marked in any way and each is read out loud by the participants to encourage group discussion. The descriptions may be amended by the participants or a new description may be provided to describe the situation for a particular domain. In this way the participants make their own assessment for each domain by comparing their experiences and opinions.

Figure 2. Statements for the domain 'problem assessment'

NA I TIKOTIKO E SEGA KINA NA KILA KEI NA VAKAVAKARAU ME QARAVI KINA NA VAKADIDIKE Community lacks skills and awareness to carry out an assessment.
E SEGA NI VAKADIKEVI NA LEQA E NA VEI TIKOTIKO No problem assessment undertaken by the community.
NA I TIKOTIKO E TIKO KINA NA KILA. NA LEQA KEI NA I TUVATUVA NI KA ME VAKAYACORI KA RA VAKARAITAKA MAI NA LEWE NI I TIKOTIKO. E SEGA NI RA VAKAITAVI KINA NA I SOQOSOQO LALAI ESO E NA I TIKOTIKO. Community has skills. Problems and priorities identified by the community. Did not involve participation of all sectors of the community.
NA LEQA , NAVEIKA E SA VAKAYACORI, KEI NA KEDRA I WALI E SA VAKATAKILAI MAI E NA I TIKOTIKO. E VAKYACORI NA VAKADIDIKE ME VAKAQAQACOTAKI KINA NA I TUVATUVA NI I TIKOTIKO. Community identified problems, solutions and actions. Assessment used to strengthen community planning
ME TOSO TIKO GA NA KENA VAKAQARAI NA LEQA, NA KENA I WALI KEI NA VEIKA E SA VAKAYACORI ENA I TIKOTIKO. Community continues to identify and is the owner of problems, solutions and actions.

2.1. Recording the reasons for the assessment

It is important that the participants record the reasons why the assessment for the domain has been made. First, it assists other people who make the re-assessment and who need to take the previous record into account. Second, it provides some defensible or empirically observable criteria for the selection. The 'reasons why' include verifiable examples of the actual experiences of the participants taken from their community to illustrate in more detail the reasoning behind the selection of the statement.

Phase 3: Developing a strategic plan for community capacity

The assessment in Phase 2 is in itself insufficient to build capacity as this information must also be transformed into actions. This is achieved by the promotion of community capacity through strategic planning for positive changes in each of the nine 'domains'. The strategic planning for each domain consists of three simple

steps: a discussion on how to improve the present situation; the development of a strategy to improve upon the present situation; and the identification of any necessary resources.

3.1. A discussion on how to improve the present situation

Following the assessment of each domain the participants will be asked to decide as a group how this situation can be improved in their community. If more than one statement has been selected the participants should consider how to improve each situation. The purpose is to identify the broader approaches that will improve the present situation and provide a lead into a more detailed strategy. If the participants decide that the present situation does not require any improvement, no strategy will be developed for that particular domain.

3.2. Developing a strategy to improve the present situation

The participants are next asked to consider how, in practice, the present assessment can be improved. The participants develop a more detailed strategy based on the broader approaches that have already been identified by: Identifying specific activities; Sequencing activities into the correct order to make an improvement; Setting a realistic time frame including any significant benchmarks or targets; and assigning individual responsibilities to complete each activity within the programme time frame.

3.3. Assessing the necessary resources

The participants assess the internal and external resources that are necessary and available to improve the present situation, for example, technical assistance, equipment, land, finance and training. This includes a review of locally available resources and any resources provided by an outside agent.

Table 2 provides a summary of a completed assessment and strategy for the domain 'problem assessment', taken from the Naivicula community. The table shows the ability of the participants to produce rational and workable strategies and to be honest in addressing the strengths and weaknesses of their community.

Phase 4: Visual Representation and Interpretation

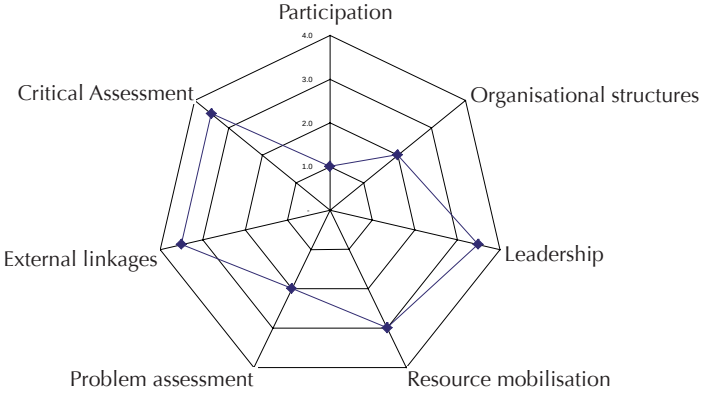
The visualization of community capacity presents an attractive option to health practitioners who want to make a representation of the analysis, over a specific time frame, and in a way that can be understood by all the stakeholders. As discussed in Phase 2, a set of statements are identified for each domain and these are ranked from 1 (weak) to 5 (strong). The qualitative evaluation of each domain then provides a set of numerical rankings which can be plotted, in this case onto a spider web configuration. Different stakeholders in the same programme use the interpretation of this visual representation to make comparisons of the domains at different times in the life of the programme.

Table 2. Baseline assessment and strategy for 'problem assessment' in Naivicula community

Domain	Baseline Assessment		Development of the Strategy		
	Baseline Assessment	Reasons why Selected	How to improve	Implementation	Resources
Problem assessment Vakadikevi ni leqa	Community lacks the necessary skills and awareness to carry out its own problem assessment.	History of petty theft in community History of conflict within village groups and unable to reach consensus.	Improve leadership skills. The delegation of tasks to every able bodied man in the community.	Training programme for leaders. Regular meetings by Tikina council. Regular visits to meetings by leaders to discuss issues raised.	Training support from outside agent. Funds or transportation for leaders to reach community.

The spider web configuration (see figure 3) illustrates how this method provides a quick picture of the strengths and weaknesses within the Naivicula community (defined by the nine domains) in a way that can be visually communicated.

Figure 3. Spider graph for Naivicuula community



Building Capacity in the Naivicula Community

The spider graph for the Naivicula community in figure 3 illustrates a range of strengths and weaknesses in capacity at that particular time[11]. Participation, given a ranking of 1.0, was identified as being weak because of the failure of local leaders to communicate information to other members of the community. Traditional protocol maintains that the approval of the village chief must be sought before holding a community meeting. Individuals may be reluctant to defer to the chief or to ask for a particular favour, such as organising a meeting, if he/she lacks respect for the chief or if he/she is not on good terms with the chief at the time. In the community this situation had led to a reduction in the number of village meetings and in a poor level of participation in decision making between its members.

Interestingly, the interpretation of the spider web gives 'leadership' a ranking of 3.5. A Fijian chief is always accorded the outward signs of respect. Even though a person may gain prominence, respect and authority within the community because of his/her personal qualities or through the acquisition of wealth, he/she would have to defer to the chief on matters of tradition and culture. Local leaders are rarely challenged and community members can be influenced by traditional views. In these circumstances it is important that the participants engage in a 'facilitated dialogue' by the evaluator to reach a consensus on the selection of each domain that represents the actual situation in their community.

To build their capacity the community members decided to firstly gain the approval of the village chief to meet on a regular basis and on predetermined dates. This overcame the difficulty of having to follow traditional protocol to obtain approval for every meeting but maintained respect for local customs in their community. Problem assessment was also identified as being weak with a ranking of 2.0. Following the assessment the Tikina Health Committee requested that a Fijian Non-Government Organisation organise skills training for community leaders. The 'tool' had engaged the community members in a process of logical thinking and critical assessment. This allowed them to identify the areas of influence (the domains) that required strengthening. In turn, this helped to improve the efficiency of the delivery of resources to areas that were felt to have the greatest need, by the community. Re-evaluation and strategic planning is carried out every 3-6 months and in this way the capacity of the community is strengthened, usually with the assistance of an outside agency. Gradually, the community members take more control of issues that were important to them and this becomes an empowering experience.

Conclusions

The purpose of this paper is to offer an approach that is workable to build the capacity of Fijian communities to address a range of health and other issues. The 'tool' for building and evaluating community capacity is designed to allow people to scrutinise the achievements that they, often in partnership with an outside agency in a programme context, have identified as being important. This enables the community to clearly define the roles and responsibilities for objective setting, strategic planning, management and evaluation. This is set within the context of top-down health programming in which community capacity is accommodated through the concept of 'parallel-tracking'.

The 'tool' enables people to participate, to better organise themselves and to critically reflect on their individual and collective circumstances. For example, being able to demonstrate success in building community capacity provides a mechanism through which communities can produce proposals to justify their access to further funds. More importantly, it enables people to strategically plan for actions to resolve their circumstances, to evaluate and to visually represent this process as outcomes that are conducive to a health programming context.

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