

Chapter 12

Capacity Building in Rural Communities

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Learning Objectives

- Define community capacity in relation to addressing rural health issues.
- Describe the dimensions of community capacity and how those dimensions may be manifested in rural communities.
- Explain strategies for building community capacity in rural communities.
- Articulate how capacity building in rural communities may differ from capacity building in urban communities.
- Specify advantages and disadvantages of using a partnership approach to building capacity in a rural community.

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In the past several decades, public health practitioners and researchers have demonstrated an increased focus on community-based approaches to health

promotion and disease prevention. This shift can be attributed to several elements, including a growing understanding of the complex factors that produce health issues (Krieger, 2008), acknowledgment of the relationship between communities and their physical and social environments (DiClemente, Salazar, & Crosby, 2007), and recognition that health improvement strategies that focus solely on individuals have limited effectiveness (Udehn, 2002).

The attention to community in public health interventions seeks to address the problems within communities through input and action by the communities where the problem is situated. However, this input and action takes a variety of forms. Differing perspectives of community result in diverse methods for working with and intervening in communities to improve health. Broadly described, community-based public health research and practice seeks to encourage collaboration among sectors of society, thus enhancing the social responsibility and capabilities of all community members while incorporating knowledge by outside practitioners (McLeroy et al., 2003; Minkler & Wallerstein, 2003). In rural areas, the importance of organizing each segment of a community to improve, promote, protect, and restore the health of the population through collective action is increasingly important.

Community-based participatory research (CBPR, also known as participatory action research) has increased its importance in the public health field for nearly fifty years (Green & Mercer, 2001). As a collaborative approach to research, CBPR "combines methods of inquiry with community capacity-building strategies to bridge the gap between knowledge produced through research and what is practiced in communities to improve health" (Viswanathan et al., 2004, p. v). Researchers and practitioners have highlighted the importance of community members' perspectives on understanding problems and successfully implementing intervention strategies (Kreuter, Lezin, & Young, 2000; Schwab & Syme, 1997; Wendel et al., 2009). Furthermore, funding agencies have increased attention because they view capacity building as essential to sustaining programs and maintaining health improvements. Through capacity-building strategies, communities, institutions, families, and individuals are strengthened long after external funding ends (Wendel et al., 2009). Nevertheless, capacity building and collaboration requires a long-term commitment. Schwab and Syme (1997) noted this process requires collaboration from many different actors, practitioners, and community members. Although effective collaboration has its challenges, the outcome of increased community capacity may yield far-reaching effects that benefit residents for generations.

Community capacity, defined as the characteristics, resources, and patterns within a community that can be brought to bear to address local issues (Wendel et al., 2009), has been identified as a key component of greater health outcomes using a CBPR approach (Wallerstein & Duran, 2010). When

communities evaluate their assets and issues, they are able to establish unique and dynamic relationships to solve systemic problems. Community capacity builds on the ecological framework that recognizes "health promotion interventions are based on our beliefs, understandings and theories of the determinants of behavior" (McLeroy et al., 1988, p. 355).

As the World Health Organization's definition of health suggests, health is not simply making sure communities are free from preventable disease and premature death, but that they are poised to solve problems that affect individuals' quality of life. This definition directs public health practitioners to community capacity building as a means of enhancing public health.

In this chapter, we will first define the dimensions of community capacity and then we provide a case study from a rural area in central Texas. In discussing community capacity, we draw on rural examples such as the shortage of health professionals, the influence of rural community values, and the participation of marginalized populations who traditionally have not had a political voice in their community.

Key Concepts

The idea of capacity building is not new. In fact, numerous programs seek to build individual capacity and organizational capacity to succeed in a variety of endeavors. The focus on community capacity hinges on understanding what characteristics of community are central to its ability to effectively address local priorities.

The Concept of Community

The concept of community capacity cannot fully be explained without first briefly discussing the notion of community. Geography is not as binding as it used to be; communities can now be defined largely in terms of what they have in common rather than just where they are located. Israel and colleagues (1998) describe **community** as a collective and characterized by "a sense of identification and emotional connection to other members, common symbols, shared values and norms, mutual influence, common interests, and commitment to meeting shared needs" (p. 178).

In examining different conceptualizations of community, one aspect that should always be considered is who is included and excluded from community membership. Also important is recognizing who has influence in the community and who has access to community networks and resources. Wendel and colleagues (2009) detailed these salient elements of community as the "social dynamics of membership" (p. 281).

Perspectives on Community Capacity

Community capacity is an integrative process that enables people to recognize and organize resources within their communities to create change. Given the complexity of communities and our ever-growing understanding of the dynamics at work, the theory driving community capacity building is always evolving.

Chaskin and colleagues (2001) proposed a definition of community capacity that also incorporates the influence of the different dimensions and understands the desired outcomes in context:

Community capacity is the interaction of human capital, organizational resources, and social capital existing within a given community that can be leveraged to solve collective problems and improve or maintain the well-being of a given community. It may operate through informal social processes and/or organized efforts by individuals, organizations, and social networks that exist among them and between them and the larger systems of which the community is a part. (p. 295)

Goodman and colleagues (1998) cautioned that capacity is used interchangeably with other, similar concepts such as community empowerment, competence, and readiness. Whereas these terms have contributed to our current understanding of community capacity, the differences in what each of those constructs contributes individually to community capacity must not be diminished (Goodman et al., 1998). To that end, they defined the dual nature of community capacity as “the characteristics of communities that affect their ability to identify, mobilize, and address social and public health problems and the cultivation and use of transferable knowledge, skills, systems, and resources that affect community- and individual-level changes consistent with public-health related goals and objectives” (p. 259)

Because of different dimensions and definitions of community, approaches to solving problems, and the contexts in which problems are analyzed, building community capacity cannot follow a one-size-fits-all approach. Given the current understanding, Wendel and colleagues (2009) posed community capacity as a set of dynamic community traits, resources, and associated patterns that can be brought to bear for community building and community health improvement, making it clear that community capacity is a value-laden concept examined through individual and structural levels of analysis.

Dimensions of Community Capacity

Stemming from these definitions of community capacity, a great deal of research has sought to operationalize the concept. Synthesizing across a substantial body of literature exploring these ideas, Wendel and colleagues (2009) extracted a set of seven dimensions critical to building capacity. These seven dimensions include the following:

- Skills, knowledge, and resources
- Social relationships
- Structures, mechanisms, and spaces for community dialogue and collective action
- Quality of leadership and leadership development
- Civic participation
- Value system
- Learning culture

Level of Skills, Knowledge, and Resources

At the core of community capacity is the goal of improving a community's ability to address an identified problem. This complex approach requires skills, knowledge, and resources from individuals as well as organizations internal and external to the community. Important skills include leadership, organization, facilitation, and collaboration as well as basic skills in planning, resource development, and evaluation. These skills also require knowledge regarding the community as well as policies and protocols and how to access information and resources outside the community (e.g., evidence-based practices). Resources cover a large range of physical capital—items that form tools to facilitate production, such as machines, equipment, or other productive materials, social capital—the connectedness of community members to each other, and human capital, which is created by “changes in persons that bring about skills and capabilities that make them able to act in new ways” (Coleman, 1988, p. S100).

Nature of Social Relationships

The nature and extent of social relationships in a community are critical to its capacity for health improvement. These relationships form social networks through which a variety of resources flow, such as information, material support, social support, identity, and access to new contacts (Israel, 1985). In rural communities, many social relationship networks go back several generations and may be founded on familial ties. Often, these historical relationships form the basis of power structures in a community; alternately, they can also be the source of long-term dissention that hinders community cohesion and collaboration.

Social networks are also integral to social capital in a community, that is, the degree to which people experience social connectedness to their community, feeling that they are valued by the community. Social capital has been recognized as important to health in a community, particularly as shown in the strength of social relationships (Kilpatrick, 2009; Trickett, 2009). Grounded

in the quality of these relationship ties, social capital includes norms of reciprocity, social trust, inter-network relationships, a sense of mutual commitment among its members, and a sense of community.

Structures, Mechanisms, and Spaces for Community Dialogue and Collective Action

Primarily highlighting the importance of relationships as a community asset, this dimension focuses on relationships and organizational networks and how they facilitate open, constructive community dialogue and action on community priorities. Networks are an important community resource because they are interwoven with other dimensions of capacity (Merzel et al., 2008). Formal and informal community structures may promote open dialogue and action, such as meetings of elected officials (commissioners' court, city council, or school board) or civic group activities, such as the Rotary or Lions clubs. Town hall meetings are sometimes held to obtain community input as well. Specific to rural communities, other social events may also provide a forum for collective conversation relative to a particular issue, for example, a Relay for Life event in a rural community may engage a diverse group of cancer survivors in dialogue about community resources needed for prevention and treatment.

The Prevention Research Center in Michigan focuses primarily on building community capacity to reduce health disparities in African American communities. Griffith and colleagues (2010) described their efforts as targeting intraorganizational, interorganizational, and extraorganizational capacity to engage and mobilize community members in systemic change. This construction of collaborative intra-, inter-, and extraorganizational structures provides a mechanism for community dialogue that can reduce the gap between those who have the greatest voice in community change as visible leaders and those who may be marginalized in their community.

Quality of Leadership and Leadership Development

Crossing multiple disciplines and held up as a cornerstone of human governance, **leadership** is a critical attribute of communities. Many dimensions of quality leadership have been identified: representation and communication, coordination and collaboration, structure and organization, accountability and feedback are all necessary for mobilizing communities for capacity building. Leadership is essential to not only mobilize and empower communities but also to promote positive relationships within and outside the community (El Ansari, Oskrochi, & Phillips, 2010).

Specific to health promotion, Goodman and colleagues have characterized quality leadership as inclusion of formal and informal leaders who provide

direction and structure for diverse participants in the future. Participation from diverse networks in the community and implementing procedures for ensuring that there are multiple voices represented is imperative for enhancing community capacity. Quality leadership also facilitates sharing of information and resources by participants and organizations shaping and cultivating the development of new leaders.

In addition to developing leadership skills in a community, another significant aspect of capacity building is the creation of new leadership opportunities. Particularly in rural communities, positions of leadership may be limited and those who fill those positions may be incumbent for extended periods. This phenomenon actually inhibits leadership development in communities; thus, the creation of new opportunities is especially important for rural communities.

Recent work focuses on youth leadership development (Sullivan & Larson, 2010). In a community youth development framework, young people are involved in engaging and challenging activities that enhance youth voice and participation that fosters community involvement and cohesion (Perkins et al., 2010). Community youth development relies on a strengths-based model in which the assets and resources of young people are acknowledged to promote positive relationships.

According to Wendel and colleagues (2009), communities with greater capacity not only draw on the quality leadership of those who are in positions of leadership but also are critically aware of the changing demographic of communities and the need to develop new leaders. As communities grow and change, leadership in communities should reflect the increasing diversity.

Extent of Civic Participation

As Robert Putnam (2000) stated, the national myth of an individualistic American society "often exaggerates the role of individual heroes and understates the importance of the collective effort" (p. 24). The importance of the collective effort or civic participation is an essential dimension in community capacity and a cornerstone of social policy change. **Civic participation** encompasses participation in voluntary associations that are community based to national organizations or institutions that extend beyond the community level. It includes voting behavior in local and national elections as well as the involvement of youth voice in policy and social change. Described by Norris and colleagues (2008) as "citizen participation," civic engagement affects community bonds, roots, and commitments that will influence the engagement and opportunities for individuals as well as the structure and relationship of their roles that contribute to community resilience.

Recognizing the variety of ways residents participate and the diversity among social networks and organizations, community leaders must establish and cultivate a mutual trust and collaboration that highlights each member's role.

Intensity of Value System

Community capacity is not a value-free construct. Understanding the complexity and the interconnected value system within communities is central to the effectiveness of capacity-building efforts. Individuals, families, organizations, and institutions that comprise communities each come with their standards, norms, values, and belief systems, which may highlight commonalities or may lead to conflict and tension. Particularly in rural settings, communities are more likely to publicly uphold more homogenous values and to engage in a system that matches their needs and reinforces their values (Kilpatrick, 2009). A community's ability to articulate a clear set of values that the community as a whole can agree on is an important goal but Goodman and colleagues (1998) cautioned that these recognized values within communities should not contradict the value of social justice. In some situations, conflict in communities may be an important part of building capacity. For example, in a rural southern community, a predominant value may be framed as solidarity but rooted in racism. To build community capacity, bringing that value to public light and engaging in dialogue around it may result in conflict but may also yield positive community change.

Learning Culture

This dimension can be explained in terms of three dynamic phases that are constantly feeding back into one another in a cyclical process. This process entails a community's ability to do the following:

- Think critically about complex problems and situations and reflect on ideas and actions
- Consider alternate ways of thinking and doing
- Determine key lessons from one's actions

Similarly, Norris and colleagues (2008) discussed community resilience as an important aspect of the reflection and learning culture of a community. In rural communities, history and tradition sometimes overrule change that could benefit local residents. A community's willingness to evaluate the impact of its efforts and incorporate that information into future planning, potentially altering its course, is a central component to improving capacity for ongoing and sustainable improvement.

By being conscious of a community's history, values, and interest, where failures and successes are used as resources for learning, communities have a greater ability to reflect on their future outcomes. Having confidence to draw on past situations in a community and identifying local and individual strengths for potential change in the future improves a community's ability to sustain and improve its health.

Capacity Building

Capacity building, particularly in terms of health improvement, is primarily done through training, technical assistance, and facilitated experience. Technical assistance has become "a popular vehicle in the prevention field to improve community program capacity and enhance outcomes" (Hunter et al., 2009, p. 810). The capacity-building process begins with the identification of specific needs and resources that can meet those needs. Those engaging in community capacity building must make a long-term commitment. Their efforts initially are focused on demonstrating and modeling for communities and then progress to facilitating experiences that provide hands-on skill building, which also improves community members' confidence in their ability to perform those actions again. The importance of having a skilled facilitator in this role cannot be overemphasized; this role requires someone who can rapidly identify learning opportunities (teachable moments) and understand social dynamics that may be capitalized on to more effectively transfer skills to the community in a relevant and appropriate way. These activities gradually shift to teaching, assisting, and advising. Capacity-building efforts can tie back to any and all of the dimensions of capacity, understanding that they are interrelated and that changes in one area inherently affects the others. By working with communities to identify areas of needed assistance and then enabling them to do for themselves, changes in community capacity have greater potential to extend beyond the original effort.

Case Study: The Brazos Valley, Texas

The Center for Community Health Development at the Texas A&M School of Rural Public Health has worked with many communities in an effort to develop community capacity. Funded by the Prevention Research Centers Program at the Centers for Disease Control and Prevention, capacity building is the center's main focus. Since its inception in 2001, one of the center's partner communities has been the Brazos Valley, a seven-county region in central Texas consisting primarily of rural communities. The region is home to Texas A&M University, with the twin cities of Bryan-College Station located approximately ninety miles northwest of Houston and a population of just over 180,000

residents (including nearly 50,000 students). Six rural counties ranging in population from thirteen thousand to thirty thousand surround Brazos County, which encompasses Bryan-College Station.

The partnership between the Center for Community Health Development and the Brazos Valley community began with the joint endeavor to plan and conduct a regional health assessment in 2001. Community response to the assessment findings resulted in the creation of the Brazos Valley Health Partnership (BVHP), composed of health and social services providers, key community leaders, academicians, elected officials, and area nonprofit organizations. The center served as the facilitator of this partnership whose mission was to increase access to care and improve health status throughout the region.

Through the collaboration between the BVHP and the center, and the center's technical assistance, four of the rural counties in the region expanded their local capacity to address their health care priorities through the development of health resource centers and county-appointed health resource commissions. Key leaders in Madison, Burleson, Leon, and Grimes Counties committed local funds, facilities, and in-kind resources to open health resource centers where providers could co-locate, share overhead costs, and simultaneously offer a wide variety of health and ancillary care to local residents. In an effort to ensure ongoing community involvement, the county commissioners' courts (the chief governing body of a county) appointed residents to serve on county health resource commissions.

As the center worked with these four rural communities to build their capacity to deal with local issues, the communities emerged as the new leaders of the Brazos Valley Health Partnership. In 2009, the health partnership reorganized as a small community-based nonprofit organization whose mission was "to support the health resource commissions and their communities in improving health and well-being. Through centralized representation, the Brazos Valley Health Partnership will develop collective strategies that, implemented locally, will leverage and cultivate resources to improve access to services in the Brazos Valley" (<http://www.bvhp.org/#!about-us>).

Since 2000, the center has provided the necessary training, facilitation, and technical assistance to support these local efforts. On behalf of the health partnership, the center secured the funding in 2003 to initiate the development of the resource centers and the volunteer-based transportation program. Once funding was obtained, the center worked as a facilitator in each community as health resource commissions were appointed. Working with the local commissions and other key leaders, the center provided technical assistance in the documentation of a health resource center development process, crafting bylaws, policies, and procedures for county-appointed health resource commissions, authoring health resource center operation protocols, creating resources for data collection, and creating facility-use agreements between service providers working in the health resource centers and the county health

resource commissions. As each county health resource commission increased its capacity, it has been able to hire executive directors or other staff. Over time, the center's support became focused on resource development, evaluation of activities, and developing the Brazos Valley Health Partnership.

Most of the literature on community capacity has been written from an academic perspective by those who seek to assist communities to improve their ability to address local needs. To provide deeper insight and an alternative perspective, this case study is written by the Brazos Valley Health Partnership board members who are leaders in their respective communities. Members include one county judge, two county commissioners, three health resource center executive directors, and two county health resource commission members.

Skills, Knowledge, and Resources

Through the regional health assessments conducted with the center, Burleson County was able to prioritize health-related needs and identify barriers inhibiting service accessibility. Prior to the first assessment in 2002, there was no convenient central location for residents to seek out available services. Instead, community members likely had to travel into the Bryan-College Station area, oftentimes hindered by a lack of transportation.

Although many groups had various pieces of information, the 2002 assessment consolidated the health status and condition of Burleson County residents into one report. The Burleson Health Resource Center (BHRC) was then opened as a single place where linkages to health and human services could be provided in an easily accessible location. The BHRC became a network of providers, through which resources were pulled together and duplicative efforts eliminated.

Numerous services and activities offered through the BHRC are available for the Burleson County community to take advantage of—services that were previously inaccessible. For example, the BHRC's transportation program offers free rides to medical services. Parent education and anger management classes are now offered at the BHRC to area residents and counselors are now providing affordable services to the population segment falling outside of the state-supported mental health and mental retardation's area of responsibility.

In Burleson County, a person with good communication skills was hired to act as an advocate and ultimately to offer a positive image of the BHRC to the community. His primary role was providing service coordination, a comprehensive case management approach that addresses each individual's multiple needs. The nature of case management requires that the service coordinator work simultaneously with multiple health and social services organizations. Eventually, he was named the executive director of the Burleson County Health Resource Commission and manages the commission and the daily operations of the BHRC.

Leon County learned how to bring together available services and people in need because they were fragmented across its perimeters. The Leon County Health Resource Commission is now able to better identify countywide current issues because its members represent all Leon County communities. The commission meetings have become a valuable forum for communication and partnering. As a result, coordination efforts have transpired that otherwise might not have happened.

The center brought many ideas from other rural communities in hopes of transferring the success to the community. Most important, through the assessment they brought focus out of an array of fragmented data for the commission to use as justification for service needs and the pursuit of funding to develop local programs.

Madison County now has access to resources from regional organizations and providers. One example is that the Brazos Valley Council of Governments Area Agency on Aging (AAA) provides funding to support a transportation program so that older adults are provided with rides to health-related appointments. AAA also contracts with the county to operate a senior congregate meal and home-delivered meal program.

Burleson County embraced the theme of **community health development** as can be seen by the center's leading many public discussions on the issues at hand. Once a focus was developed among community leaders, the commission was then able to create awareness among the community with the actual resources. This work created buy-in from the local government (county, city, and school districts), whose involvement was extremely crucial to its success.

The BHRC has been able to pull in even more services to the community and an increasingly steady amount of people have been able to access services as a result. Furthermore, resources that previously existed were given the opportunity to have a larger presence in the county through the BHRC as well as providers who were offering additional services for the first time. These were services that have been receiving funding to serve rural areas but were being conducted at a regional hub with the expectation that people needing the services would travel to the hub. Of course, transportation was often a barrier. Advocacy from local leaders and the health resource commission is what ultimately brought providers to the table to begin serving clients in Burleson County.

Quality Leadership and Leadership Development

Through the health resource commission and the executive director, Madison County now has another forum for developing leadership. There are people in the community who have stepped up and realized that community engagement is vital in addressing health care needs. These people have become leaders and are always taking care of something, often before even being asked.

Leaders like this are hard to come by but a concerted effort was made to develop these leaders through education and training. The degree to which the leaders are committed has paid off for the community substantially. As the larger community continues to witness the progress being made, there has been a stronger desire for others to participate. This led to recruiting new folks who are willing to be trained as leaders.

Civic Participation

County participation is essential in establishing and maintaining a health resource center. As evident in local communities, citizens of small rural areas throughout Texas often engage through volunteering, sharing knowledge, and advocating for interests. One example is the transportation programs operated through all five health resource centers. Volunteer drivers' donation of time makes this vital resource possible.

Another example of civic involvement is the county health resource commissions, which are the groups that set the priorities of the health resource centers. These commissions are made up solely of citizen volunteers who represent different interests within the county, and who not only attended scheduled meetings, but also promote services and advocate for the well-being of the health resource center in their free time. In Madison County, the executive director periodically has to present progress reports to the county commissioners' court as a key step in annually securing local funds to support the center.

The Burleson County Health Resource Commission members do a very good job of distributing knowledge of activities and services within the community, which has led to increased civic participation. The local government took the lead in the implementation of the health resource centers and the community followed its lead. The office managers of two BHRC locations have gone above and beyond their job responsibilities and have contributed many extra hours of volunteer time to lead local health fair efforts, organize outings for seniors, and promote the resource center.

The Leon Health Resource Center has the largest health resource commission of the four counties. The twenty-three-member commission strategically represents each pocket of Leon County, and there is a quorum at every meeting. These members have recruited volunteer drivers for the transportation program and for local health fairs. They have donated their time and their money in promoting the health resource center.

Community Values

Each community has core values that influence how a community collectively responds to opportunities and adversity. The values of a community are

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often evident in the activities citizens engage in and the initiatives they support. Values common among all of our communities include personal responsibility and self-reliance.

One value exemplified by Burleson County citizens is charity. Community members donate their money and time to reach out to the less fortunate through the health resource center as well as through local faith-based and social service initiatives. This value is balanced, though, with the value of self-reliance and personal commitment. As citizens donate money and time toward the cause of the center, they expect that their contributions be used in a way that furnishes people with skills and resources that will expedite their path to self-sufficiency. These donors trust in the mission of the health resource center and never question if their donations are being misused in a way that promotes dependence.

Madison County values education as a tool for encouraging personal responsibility among all residents regardless of age, race, or socioeconomic status. They embrace access for all and promote the resource center as benefit not only for the disadvantaged residents but rather the entire community. This had led to the Madison Health Resource Center's educational seminars being standing-room-only events at times.

Social Relationships

A great example is found in Leon County. Once they had the resource center and commissioners on board, the center took on the role of being a coach and providing support. The center helped find resources. A \$540,000 federal grant was received as a direct result of this support. The county has a large commission that brings people together to discuss priorities. These meetings have resulted in strong relationships. Leon County is divided by I-45 and by design it is a challenge for one area to share the needs of another point in the county. Health professionals have to work through the churches if they want to get information out but that strategy still does not reach everyone.

Structures and Mechanisms for Community Dialogue

In Burleson County, the establishment of the health resource centers and the health resource commission has shifted community perceptions. For example, individuals with mental health issues are increasingly more aware of the purpose of the BHRC and are beginning to view the health resource center as a place where they can be ensured of advocacy and assistance. There is also more openness in the community in dealing with people experiencing mental health issues.

The health resource centers and commission have also provided a common thread among the cities, the hospital district, and the school districts. There is a communitywide recognition across sectors that the BHRC functions to integrate a multidisciplinary response to the health-related needs of county residents. Once the awareness was there, there was a good deal of cooperation among the city, the county, and others. The county and the hospital district collaborated to purchase the building that would become the resource center's new home and worked together to promote the new location and services available. Purchased the building that would become the resource center and the city and county worked together to get the road to the center and the parking lot paved.

The county and the hospital district collaborated to purchase the building that would become the resource center's new home and worked together to promote the new location and services available.

Learning Culture

In Madison County, there has been a big change in how the county commissioners' court views the county health resource commission. The health resource commission's main purpose is to oversee the operations of the health resource center but the county commissioners did not realize the full value of the health resource commission beyond their primary responsibility. Eventually, however, the commissioners' court recognized that the commission and the executive director can advise on how to maximize opportunities to the benefit of Madison County. For example, when the county had the opportunity to subsidize the health resource center transportation program, the county judge sought advice from the commission's executive director prior to signing an agreement that stipulated the number of rides that must be given in order to receive the funding.

Lessons and Challenges

Despite the many stops and starts throughout the process and challenges in gaining and sustaining momentum at times, the communities are experiencing real change. The relationships in these counties have been strengthened through the health assessment process—particularly community discussion groups that brought schools, county and city officials, and others into a room together. It helped to acknowledge the fragmentation within the community and helped the community conclude that they must unite in their efforts to improve the well-being of its residents. They realize that they must seek assistance from the whole community because no one group can take care of this on its own. That is a huge step forward. Now new networks of folks are

addressing problems in their communities. There is also increased awareness that there are problems and that the health resource centers can help.

Members of the BVHP have been able to learn about best practices and see what has worked or has not worked elsewhere. Fellow board members provide each other with great support and advocacy. Board members know that they can go to the other members for support and advice.

Board members also have designed services so they can measure effectiveness to justify continued support. The implementation of the health resource centers, service coordination, and the volunteer-based transportation system in the communities are tangible services that are improving access for its citizens. This also means the commission has to continue to build and use advocacy skills and keep the resource centers and their impact at the forefront; the partnership with CCHD is so critical in this aspect. Without them the commission would not have been able to build a case for developing health resources the way it has. Leaders have become more willing to consider investing now in order to achieve a more long-term payoff. The commitment of these leaders has been tremendous to the network. The counties are light years away from where they were in 2004 and 2005. There is much left to be done, but they have laid a good foundation to continue the work.

Conclusion

Communities are increasingly recognized as appropriate places and partners for health improvement strategies. Through community-based participatory research and practice, advances are being made in prevention and health promotion. Because communities are complex, their activities must take into account their unique characteristics, history, structures, assets, and challenges. One aspect of communities that can enhance effectiveness of health-promotion activities is local community capacity. Building capacity should be a goal of any community-based work, leaving the community better off than it was before and better able to address its own needs. This provides the best chance for lasting improvements in a community.

Summary

- Communities are complex systems with unique characteristics that must be considered when attempting to implement health interventions and programs.
- Community capacity refers to a community's collective ability to address its own issues.
- Elements of community capacity include knowledge, skills and resources, leadership, structures for community dialogue, social

relationships, civic participation, community values, and a learning culture.

- Capacity building in communities is largely accomplished through training and technical assistance.
- Community capacity is an input and an outcome of community-based efforts for health improvement.
- Building local capacity offers considerable promise for sustainable change in communities.

For Practice and Discussion

1. With a colleague, discuss the nature of community in the place where you live. What characteristics stand out to you as being important in relation to efforts for health improvement?
2. With a small group, discuss how a rural community may differ in dimensions of community capacity compared to an urban community. How would those differences affect implementation of a health program or intervention?

Key Terms

civic participation

community

community capacity

community health development

leadership

social networks

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