Highlights from the Literature:

- Communities can be defined by sociological systems or individual perspectives (Manitoba Family Service & Housing, 2008).
- Vulnerable populations are groups that are not integrated well into the health care system due to ethnic, cultural, economic or health characteristics (The Urban Institute, 2010).
- There needs to be a focus in bottom up approaches, such as engagement to improve the health of the community.
- Community engagement is an important factor to improve the health of disadvantaged communities (Warr, Mann, & Kelaher, 2013).
- Community engagement is core approach to improving the health of the population (Fraser Health, 2009).
- To achieve successful community community engagement, there needs to be organizational capacity building, local area development, consumers/family and intersectoral networking.
- Involving community organizations are an important part of any approach to engaging a community (Jabbar & Abelson, 2011; Zhu, 2011).
- Some of the benefits of community capacity are empowering individuals and groups in the community, developing skills, and knowledge (Verity, 2007).
- “Strategies to build capacity should be responsible to the context and needs of the community, sensitive to the skills of the worker, the organizational situation or ‘sphere of influence’ and the history of intervention” (Verity, 2007 p.20).
- “Communities should be supported in such as way that problems and solutions from the community, rather than being identified from outside the community, with solutions being ‘given to’ the community” (Durie & Wyatt, 2013, p.184).

Introduction

To inform on how to foster engaged communities and build community capacity in communities that receive services by Nova Scotia Health Authority (NSHA) Central Zone, Primary Health Care (PHC) community sites, a literature review was conducted to review building community capacity with communities and how to engage vulnerable populations (priority populations).

This literature review is being used for NSHA, Central Zone, PHC Community Sites, including Community Wellness Centres and Community Health Teams working with engaged communities on building community capacity and engaging priority populations. This literature review is intended to provide information that can aid PHC community sites and Teams on building community capacity with engaged communities and engaging priority populations.

Through the synthesis of the literature, this literature review aims to:

- Define communities
- Describe vulnerable/marginalized populations
- Define community engagement
- Community Engagement Approaches
  - Cooperative Approaches
  - Community Involvement
  - Community Participation
  - Community Capacity Building
  - Community Empowerment

This literature review includes peer-reviewed articles, systematic reviews, and grey literature. A literature search was performed using the following databases: Google, Google Scholar, CHINAL, ProQuest,
and Pub Med. A combination of the following key terms was used: engagement, engaged communities, communities, community capacity, capacity building, and community capacity building, vulnerable populations, vulnerable communities, high deprivation communities, approaches and vulnerable populations, community engagement, engaging vulnerable populations, engaging vulnerable communities, and engaging high deprivation communities.

Communities

The majority of individuals belong to more than one community (Fraser Health, 2009; Manitoba Family Services & Housing, 2008). Community can mean different things to different people (Manitoba Family Service & Housing, 2008). Communities are diverse (Banks & Shenton, 2001). In communities, boundaries and memberships are always changing (Manitoba Family Service & Housing, 2008). Communities can be defined by sociological, systems or individual perspectives (Manitoba Family Service & Housing, 2008). The sociological perspective of community, can describe a community

as a group of people united by at least one common characteristic i.e. location [geographical boundaries], connectors [shared interests, activities, values, experiences, motivating forces, or traditions], or people [socioeconomic and demographics, health status and risk profiles, cultural and ethnic characteristics (Manitoba Family Services and Housing, 2008, p.10).

In the systems perspective, a community is described as a system of interrelated perspectives (Manitoba Family Services & Housing, 2008). In this perspective “healthy communities are those that have well-integrated, interdependent sectors that share responsibility to resolve problems and enhance the well-being of the community (Manitoba Family Services & Housing, 2008, p.10). This view is important in the building of community capacity (Manitoba Family Services & Housing, 2008). The individual perspective of community recognizes that a person’s sense of membership in any community may vary over time depending on the factors such as whether one feels an emotional, cultural, experiential tie to a community, whether one believes they have a contribution to make within a community, or whether one views membership as a way to meet their own individual needs (Manitoba Family Services & Housing, 2008).

According to Fraser Health (2009) there are two categories of community: internal and external. An internal community is made up of staff, volunteers, physicians, and service providers (Fraser Health, 2009). There can be several categories of an external community (Fraser Health, 2009). There are geographical communities, which can be defined neighborhoods or municipalities (Banks & Shenton; Fraser Health, 2009; Manitoba Family Services & Housing, 2008; Verity, 2007). Non-geographical communities can be based on gender, ethnicity, age, or disability, such as new immigrants or older people (Banks & Shenton, 2001; Fraser Health, 2009; Manitoba Family Services & Housing, 2008). A third category is individuals who use a service, such as primary care clients (Fraser Health, 2009; Manitoba Family Services & Housing, 2008; Verity, 2007). The last category is the general public, which can be individuals or organizations (Fraser Health,
If individuals do not feel that they are members of the community, they will not participate in an engagement activity (Manitoba Family Service & Housing, 2008).

Draper et al. (2010) identified three ways communities can participate in health programs:

1. Medical Approach, where individuals do what is advised by professionals and health is defined as the absence of disease (Draper et al., 2010). This approach may be seen as mobilizing communities (Draper et al., 2010).

2. Health Services Approach is “in which health is defined by the WHO definition as ‘the physical, mental, and social well-being of the individual’; and the participation as contribution of the community time, materials, and/or money” (Draper et al., 2010, p. 4). This approach can be viewed as collaboration (Draper et al., 2010).

3. Community Development Approach defines health as a human condition and participation of the community is involved in managing of the health activities and the professionals act as a facilitator and resource (Draper et al., 2010). This approach can be seen as empowerment (Draper et al., 2010).

**Priority Populations**

In our communities, there may be subgroups of the population who are disadvantaged in terms of their health outcomes (Region of Waterloo Public Health, 2009). “Priority populations are defined as specific populations that may require targeted approaches where evidence points to health inequalities or where a sub-group of the population is disadvantaged in terms of their health outcomes” (Nova Scotia Department of Health and Wellness, 2011, p.28). Priority populations would be defined in the community based on the surveillance and epidemiological data (National Collaborating Centre for Determinants of Health, 2013). Other terms used are marginalized populations or vulnerable populations.

According to Laverack & Labonte (2000) marginalized populations are “those most in need, not already to able to meet their own needs, with limited access to resources or who exist outside power structures” (p.258). Alberta Health Services (2011) define marginalized populations as “populations that are not fully integrated into all aspects of society” (p. 9). These population groups may not participate in society due to “lack of economic resources, knowledge about political rights, recognition and other forms of oppression” (National Collaborating Centre for Determinants of Health, 2013, p.4).

Vulnerable populations are groups that are not integrated well into the health care system due to ethnic, cultural, economic or health characteristics (The Urban Institute, 2010). Alberta Health Services (2011) defines vulnerable populations as “populations that have increased susceptibility to adverse health outcomes as a result of inequitable access to the resources needed to address risks to health” (p.13). Vulnerable populations will have difficulties accessing care (Benoit, Shumka, Barlee, 2010; Grabovschi, Liognon, Fortin, 2013). Subgroups of the population that suffer burden of illness higher than general populations are characterized as vulnerable populations (Beiser & Stewart, 2005; Grabovschi et al., 2013).
Vulnerable populations in Canada include aboriginal peoples, immigrants, refugees, the disabled, the poor, the homeless, people with stigmatizing conditions, the elderly, street youth, individuals with physical and/or mental disabilities, sexual minorities, people with low literacy skills, and people with substance use problems (Beiser & Stewart, 2005; Benoit et al., 2010).

Vulnerability can stem from both a lack of socioeconomic and environmental resources (Grabovschi et al., 2013). Socioeconomic resources refer to education, jobs, income, social connections and social status (Grabovschi et al., 2013). Environmental resources are the resources that are needed to access health care, community characteristics, and availability of health care professionals (Grabovshi et al., 2013). Most marginalized populations are not able to articulate their needs or interests (Laverack & Labonte, 2000).

Community engagement is an important factor to improve the health of disadvantaged communities (Warr, Mann, & Kelaher, 2013). Some of the other key factors to reduce health inequalities are community participation and empowerment (Warr et al., 2013). Community participation and community empowerment can be part of the community engagement (Manitoba Family Services and Housing, 2008). “The social outcomes of community engagement may be particularly important for ‘at-risk’ population groups, such as residents in poor social and economic circumstances, and older people, who tend to be less ‘well-connected’ socially” (Attree et al., 2011). “Prevention interventions that fail to engage with deprived populations may actually serve to widen health inequalities” (Harkins et al., 2010, p.392).

Top Down and Bottom Up Approaches
In bottom up programs, outside agents support the community in the identification of issues, which are important and relevant to their lives and enable them to develop strategies to resolve these issues (Laverack & Labonte, 2000). “Bottom up locally based approaches permit policies to be more socially inclusive and help to ensure that social stability and cohesion without which economic growth and structural adjustment will be obstructed” (Simpson et al., 2003, p.277). Community empowerment is one bottom up approach (Laverack & Labonte, 2000). The focus is on the “group members experiences of empowerment in terms of quality of their social relationships and self-identities that with changes in specified health behaviours” (Laverack & Labonte, 2000, p.257).
Table 1: Differences between Top Down and Bottom Up Approaches

<table>
<thead>
<tr>
<th></th>
<th>Top Down</th>
<th>Bottom Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Root/Metaphor</td>
<td>Individual responsibility</td>
<td>Empowerment</td>
</tr>
<tr>
<td>Approach/Orientation</td>
<td>Weakness/deficit/solve problem</td>
<td>Strength/capacity/improve competence</td>
</tr>
<tr>
<td>Definition of problem</td>
<td>By outside agent such as government body</td>
<td>By community</td>
</tr>
<tr>
<td>Primary vehicles for health promotion and change</td>
<td>Education, improved services, lifestyle</td>
<td>Building community control, resources, and capabilities toward economic, social and political change</td>
</tr>
<tr>
<td>Role of outside agents</td>
<td>Service delivery and resource allocation</td>
<td>Respond to needs of the community</td>
</tr>
<tr>
<td>Primary decision makers</td>
<td>Agency representatives, business leaders, 'appointed community leaders'</td>
<td>Indigenous appointed leaders</td>
</tr>
<tr>
<td>Community control of resources</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Community ownership</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Evaluation</td>
<td>Specific risk factors Quantifiable outcomes and 'targets'</td>
<td>Pluralistic methods of documenting changes of importance to the community</td>
</tr>
</tbody>
</table>


Community Engagement

**Definitions of Community Engagement**
Various organizations have variety of definitions for community engagement. The World Health Organization defines community engagement as:

a process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing, and delivering services and in taking action to active change (Fraser Health, 2009, p.3).

Manitoba Family Service & Housing (2008) defines community engagement as “a process that involves the building of a relationship between government and the citizens it serves. It encompasses a spectrum of activities from consultations with the public to community development and community capacity building” (p. 1).

Fraser Health (2009) defines community engagement as a:

dialogue that focuses on a particular topic that lays the groundwork for a shared sense of direction, resources, and responsibilities; long term effort to surface communities’ insights questions and concerns about issues; a means of helping citizens understand the issues confronting their community and possible solutions (p.4).

**Community Engagement Frameworks**
The study by Jabbar & Abelson (2011) examined the development of community engagement framework for the Local Health Integration Networks (LHIN) in Ontario. Six categories were identified as part of the framework for effective community engagement:

1. Collaboration: working together to improve health
2. Accessibility: ensuring people have a voice
3. Accountability: LHIN responsibilities to the community
4. Education: supporting transparency and information
5. Principles: making engagement meaningful
6. Organizational Capacity: prioritizing community engagement within the LHIN

“If existing public engagement frameworks are to be used in the health care context they need to consider a broader range of health system actors, those that are generally represented, including lay-citizenry, health service providers and community service organizations” (Jabbar & Abelson, 2011, p.68).

Community engagement is a core approach to improving population health (Fraser Health, 2009). There is evidence to suggest that community engagement can impact health and lead to substantial health gains (Milton et al., 2011; Simoes & Sumaya, 2010). Community engagement is a process that evolves over time (Fraser Health, 2009; Manitoba Family Services & Housing, 2008). The effectiveness of community engagement will depend on the target behaviour and the community of interest (Zhu, 2011).

Individual’s capacity will be built through community engagement (Manitoba Family Service & Housing, 2008).

There are four main components for achieving successful community engagement. These four components are organizational capacity building, local area development, consumers/family and intersectoral networking. Please see Appendix A for the diagram of the main components for achieving successful community engagement.

All of these components need to be considered in order to achieve successful community engagement (Fraser Health, 2009). The Winnipeg Health Region (2015) defines organizational capacity building as the work that strengthens and enables an organization to build its structures, systems, people and skills so that it is better able to define and achieve objectives while engaging in consultation and planning with the community, and taking part in partnerships. It includes aspects of training, organizational development and resource building. (p.2)

Intersectoral Networking is “providing resources for intersectoral/interagency network development and building of alliances” (Fraser Health, 2009, p.7). Local Area Development is “providing the resources and support for grassroots work” (Fraser Health, 2009, p.7). Each of the components supports the other components, which are need in order to achieve successful community engagement (Fraser Health, 2009).

In the report by Zhu (2011) on community engagement recommended that:

1. A community engagement approach should be tailored to the population of interest and the target health behaviour.
2. Potential adverse effects of a community engagement initiative must be considered and mitigated.
3. Community based organizations must be involved in any engagement initiative.
4. The inclusion of diverse stakeholders should not be at the expense of consensus building.
5. Community engagement approaches should be evaluated. (p.2)

**Individuals**

Individuals will define themselves by the communities they feel they belong (Fraser Health, 2009). If individuals do not feel they
are part of the community they may not participate in the engagement (Manitoba Family Services & Housing, 2008). Individuals that participated in the community engagement initiatives were found to have positive benefits in their physical and emotional health and well being, self-confidence, and individual empowerment (Attree et al., 2011).

**Community Organizations**

Involving community organizations are an important part of any approach to engaging a community (Jabbar & Abelson, 2011; Zhu, 2011). Community engagement was found to have benefits for the information flow between the community and service providers (Milton et al., 2011). Part of community engagement involves building the trust and ongoing relationship with various stakeholders (Cohen, Fiarclough, Jass, 2011).

Community partnerships, for the purpose of reducing health disparities, should be established at the conception of the project, involving diverse groups, and engaging health workers, as they often act as referral sources, advocates, recruiters, connectors, navigators, coaches and data collectors (Zhu, 2011, p.14).

**Community Engagement Benefits**

There are benefits of community engagement for government and for communities. Some of the benefits of community engagement for the government are identification and better understanding of the communities needs; dispelling myths about a program or issue; building trust with the communities; and fostering community capacity and healthy communities (Manitoba Family Service & Housing, 2008; Milton et al., 2011). Some of the benefits of community engagement for communities are empowerment of citizens and community organizations, building capacity at the organization level, sharing knowledge and experiences with the community (Manitoba Family Service & Housing, 2008; Milton et al., 2011).

**Community Engagement Barriers & Challenges**

According to the review conducted by Zhu (2011) found the barriers to community engagement include “short –term funding, lack of infrastructure, lack of trust from community/voluntary sector organizations, and propensity for some organizations to monopolize coalition groups” (p.5). In addition to barriers, there are also challenges to government and communities in community engagement. Some of the challenges for government are lack of awareness about involving the public, fear of the outcomes from the community engagement, and raising public expectations (Manitoba Family Services & Housing, 2008). Some of these challenges for communities are that public participation activities are one-offs, frustration the views of the community are not taken seriously, high expectations, mistrust and cultural barriers (Manitoba Family Service & Housing, 2008).

Zhu (2011) discussed the twelve recommendations for community engagement that were developed by the National Instituted of Health and Clinical Excellence (NICE). The NICE recommendations are

1. Coordinate implementation of relevant policy initiatives.
2. Commit to long-term investment.
3. Be open to organizational and cultural change.
4. Be willing to share power, as appropriate, between statutory and community organizations.
5. Develop trust and respect among all those involved.
6. Support training and development of those working with the community (including members of the community).
7. Establish formal mechanisms that endorse working in partnership.
8. Support implementation of area-based initiatives.
9. Utilize community members as agents of change.
10. Facilitate workshops in the community.
11. Consult residents of the community.

Community Engagement Approaches

A variety of approaches can be used to engage communities and individuals to take action on their health. Community engagement can involve a variety of approaches, from information sharing, to involving communities in their own health through community development, capacity building activities, and planning of services (Attree et al., 2011; Fraser Health, 2009; Jabbar & Abelson, 2011; Manitoba Family Services & Housing, 2008; Milton et al., 2011; O'Dwyer, Baum, Kavanagh, & MacDoungall, 2007). Some methods that can be used to involve communities in initiatives include “citizen juries, rapid appraisal techniques, neighborhood committees, community forums and community champions” (Attree et al., 2011, p.251). Community engagement encompasses “different approaches to involving communities of place and/or interest in activities which aim to improve health and/or reduce health inequalities, ranging from simple provision of information to full community control” (Attree et al., 2011, p.251). “Communities should be supported in such a way that problems and solutions from the community, rather than being identified from outside the community, with solutions being ‘given to’ the community” (Durie & Wyatt, 2013, p.184).

Community Empowerment

Community empowerment has been defined as “means by which people will experience more control over decisions that influence their health and lives” (Laverack & Labonte, 2000, p.255). Community empowerment provides a shift towards greater equality in the social relations of power, such as who has the resources, authority, legitimacy, or influence (Laverack & Labonte, 2000). Community empowerment is concerned with influencing social, economic and political change that will improve the quality of life for the whole community (Laverack & Labonte, 2000). Community engagement has an impact of empowerment of communities (Milton et al., 2011).

Cooperative Approaches

Cooperative approaches are “ground in a commitment to local people, seeking to understand community values, and a willingness to listen to community concerns” (Warr et al., 2013, p.99). These types of approaches involve various activities that provide various forms of information through engagement with the local community (Warr et al., 2013). In this type of approach the priorities are identified based on the community and the local circumstances (Warr et al., 2013). “That engaging the community in health promotion was about ‘slow, attitudinal change’ that required beginning with issues broadly related to health before moving to
address more specific health issues” (Warr et al., 2013, p.102). Cooperative approaches involve community engagement and orientation to local experience and contexts (Warr et al., 2013). These cooperative approaches are built upon relationships of trust and respect (Warr et al., 2013). In the study conducted by Warr et al. (2013) found that having personal contact with the residents was critical getting individuals out of their homes and getting them involved in different experiences. These types of approaches provide an opportunity for local perspectives to be incorporated into the process where problems are identified and resolved (Warr et al., 2013). “Cooperative ways of working with communities are able to bring together insights into local contexts with wider experiences of effective health promotion processes and practices” (Warr et al., 2013, p.107).

Community Involvement
Community involvement could encompass consolation events, local surveys, needs assessments and representation on decision-making bodies (South, Fairfax, & Green, 2005). Involving communities will enhance the delivery and uptake of the health intervention (Draper, Hewitt, & Rifkin, 2010). “Community involvement in the design, governance and delivery of services can improve health and make initiative more sustainable” (Milton et al., 2011, p.317). Involving the community has many benefits, such as having a healthy community (Interior Health, 2010). As individuals become more involved with the health system, they will become more aware of the steps they can take to improve their health (Interior Health, 2010). A second benefit is having health care services that meet the needs of users and stakeholders (Interior Health, 2010). A third benefit is communication between partners, public and clients (Interior Health, 2010). A fourth benefit is building the foundation of collaboration between various partners (Interior Health, 2010). “Initiatives that aimed to promote community involvement were attributed with gains in social capital, social cohesion, and fostering partnership working” (Milton et al., 2011).

Community Consultation & Participation
Community interventions organized to increase participation in and use of these preventive measures are essential to reach the entire community, particularly marginalized, poor, and undereducated groups” (Simoes & Sumaya, 2010, p.24). Community participation is “the involvement of consumers in the development of health services. This can include involvement in policy development, strategic planning, service planning, service delivery, and evaluation and monitoring” (Jolley, Lawless, & Hurley, 2008, p.153).

Organization and community capacity are key factors for community participation (Jolley et al., 2008). Community consultation and participation play a significant role of the success of the initiative because of the role they play in the meeting the needs to the individuals in the community (Simpson, Wood, & Daws, 2003). Participation can be seen as an empowerment tool where communities can take responsibility for identifying and working to solve their own health and development problems (Morgan, 2001; Rifkin, 2014). “Public participation in the assessment and prioritization of health needs allow organizations to target services more effectively in response to felt and expressed needs” (South, Fairfax, & Green, 2005, p.65). Participation cannot be assumed, it needs to be encouraged in order for it to be effective (Morgan, 2001). “Community/organizational capacity building is a process of strengthening and developing of both the capacities of
individuals and the capacities of the entities” (VicHealth, 2003, p.9).

### Table 2: Principles of Community Participation

<table>
<thead>
<tr>
<th>Principles of effectiveness</th>
<th>Principles of inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Engage early enough to make a difference</td>
<td>• Build in ethno-cultural diversity</td>
</tr>
<tr>
<td>• Resource it properly (skills, staff, time, funds)</td>
<td>• Eliminate physical, psychological and socioeconomic barriers to participation</td>
</tr>
<tr>
<td>• Pay attention to the results</td>
<td>• Pay attention to the results</td>
</tr>
<tr>
<td>• Monitor and evaluate the effectiveness of the participation process</td>
<td>• Monitor and evaluate the effectiveness of the participation process</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Principles of clarity</th>
<th>Principles of respect</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ensure transparent purpose and communication</td>
<td>• Be the community's partner, not its master</td>
</tr>
<tr>
<td>• Be transparent about how results will be used</td>
<td>• Use participation tools acceptable to the participants</td>
</tr>
<tr>
<td>• Develop a clear but flexible planning strategy</td>
<td>• Hear what people say, not what you want to hear</td>
</tr>
<tr>
<td></td>
<td>• Allow realistic timeframes</td>
</tr>
</tbody>
</table>


**Community Development**

In the definition used by the World Health Organization (1999), community development is “a way of working underpinned by a commitment to equity, social justice, participation and empowerment that enables people to identify common concerns and that supports them in taking action related to them” (Winnipeg Health Region, 2015, p.1). Banks & Shenton (2001) define community development as the "active involvement of people issues that affect their lives, and as a 'process based on sharing of power, skills, knowledge and experience” (p.289). There are differences between community development and community capacity building. The first difference between community development and community capacity building are that capacity building is a means to an end, it is enabling groups to achieve objectives, manage projects and participate in partnerships (Banks & Shenton, 2001). The second difference is capacity building is planned and systematic, while community development is informal and open ended (Banks & Shenton, 2001). Capacity building is a preparation stage to community involvement and participation (Banks & Shenton, 2001). “Capacity of a community is developed so that its members can participate in regeneration schemes which in turn lead to improvements in their neighborhoods” (Banks & Shenton, 2001, p.290). “‘Community capacity building’ and ‘community development’ may both be about enhancing the abilities and confidence of individuals and groups to achieve change in their communities, but capacity building, as defined by Skinner is narrower in focus” (Banks & Shenton, 2001, p.291). Community development is viewed as the old term and community capacity building is viewed as the new term (Banks & Shenton, 2001; Verity, 2007).

**Community Capacity Building**

“Community capacity building has greater potential than clinical-or behavioural-based services to generate long-term, sustainable improvements to health of the community as a whole” (Collins, Resendes, & Dunn, 2014, p.17). Capacity Building is a strategy that is used to create supportive environments (Liberato, Brimblecombe, Ritchie, Ferguson, Coveney, 2011). Community capacity building "involves identifying, bringing together, and enhancing these
existing skills and abilities in order to enable communities to take action to help resolve community problems and develop their communities” (Manitoba Family Services & Housing, 2008, p.12).

Community capacity building can be seen as a way to develop healthy and active communities (Atkinson & Willis, 2005). Capacity building is an approach to development that builds sustainability and independence” (Victorian Healthcare Association, 2012a, p.1). This approach is narrower in focus and a more strategic way to work with communities (Banks & Shenton, 2001). Capacity building is seen as a process that can influence health (Simmons, Reynolds, & Swinburn, 2011).

Community capacity building has been used to identify and address community health problems (Atkinson & Willis, 2005). Community capacity building builds on the strengths and abilities of the community assets and capacities (Manitoba Family Services & Housing, 2008; Simoes & Sumaya, 2010). There needs to be a development of the capacity of communities in order to support the community engagement process (Manitoba Family Services & Housing, 2008).

Please see Appendix B for the Framework for Building Capacity to Improve Health. This framework has four domains: network partnerships, knowledge transfer, problem solving, and infrastructure (Verity, 2007). This framework explores the different levels of capacity within each of the different domains.

Definitions of Capacity Building
Simmons et al. (2010) define capacity building as the development of knowledge, skills, commitment, structures, systems, and leadership to enable effective health promotion. It involves actions to improve health at three levels: the advancement of knowledge and skills among practitioners; the expansion of support and infrastructure for health promotion on organizations; and the development of cohesiveness and partnerships for health in communities (p.196).

VicHealth (2003) defines capacity building as a process that enhances the ability of the individual entity or a broader social system to perform effectively in the functions for which they exist, identify, and address new challenges or improve control over their practices in a sustainable manner within dynamic contexts (p.5).

Gibbon, Labonte & Laverack (2002) define capacity building as an “increase in community groups’ abilities to define, assess, analyze, and act on health [or any other concern to their members]” (p.485).

Atkinson & Wilis (2005), define community capacity building as “local solutions to local problems which enable communities to deal with problems, ultimately without relying on external resources” (p.2).

NSW Health (2001) defines capacity building as “an approach to the development of sustainable skills, structures, resources, and commitment to health improvements in health and other sectors to prolong and multiply health gains many times over” (p.3).
Banks & Shenton (2001) define community capacity building as development work that strengthens the ability of community organizations and groups to build their structures, systems, people and skills so that they are better able to define and achieve their objectives and engage in consultation and planning, managing community projects and take part in partnerships and community enterprise (p.289).

Liberato et al. (2011) defines community capacity as “those initiatives that may or may not be embedded in community organizations and that concentrate on specific health or social contexts” (p.851).

Simmons et al. (2011) propose that “capacity building can be defined as the identification and leveraging [or similar verb] of <insert identified characteristic> for the purpose of …<insert rationale>; context dependent>” (p.198).

There are three dimensions to capacity building practice: health infrastructure or service development, program maintenance and sustainability, and program solving capability of organizations and communities (Labonte & Laverack, 2001; NSW Health, 2001). Please see Appendix C for a diagram of levels of capacity building.

In health infrastructure, the focus is developing the capacity to deliver a specific program to address a specific health problem (Labonte & Laverack, 2001; NSW Health, 2001). The second dimension is program maintenance and sustainability. This focuses on the if the program can be continued to be delivered through partner organizations once the funding from the initiating agency ceases (Labonte & Laverack, 2001; NSW Health, 2001). The third dimension is capability of the organizations and communities to problem solve (NSW Health, 2001). In this dimension, the focus is on the capacity of the community groups to increase their ability to identify the health issue and develop ways to address them (Labonte & Laverack, 2001; NSW Health, 2001). Sometimes the importance is on sustaining the capacity of individuals, communities, “to mobilize themselves, when required to initiate a new action for a health challenge” (NSW Health, 2001) then sustaining the program.

**Actors in Capacity Building Relationship**

There are three actors within a capacity building relationship: health agency, the individuals implementing the programs, and the community members/groups (Labonte & Laverack, 2001, p.113). Please see Appendix D for a diagram of the actors in the capacity building relationship. The players for capacity building are governments, organizations, health systems, and communities and capacity building will differ depending of the context and where it sits (Simmons et al., 2011). The health agency has the capacity to delivery the program (Labonte & Laverack, 2001). The health agency also has capacity to build the relationship between the health agency staff and community groups/members. The Community Groups/Members have the capacity to sustain a program (Labonte & Laverack, 2001). The health agency staff has the capacity to build the sustainability of the program (Labonte & Laverack, 2001). The health agency staff also has the capacity to build the relationship with the community and group members (Labonte & Laverack, 2001).

**Community Capacity Domains**

Labonte & Laverack (2001) have identified nine domains of community capacity:

1. Participation
Participation is basic to community capacity (Labonte & Laverack, 2001). Only when individuals participate in small groups or large organizations can they act on issues of concern to the broader community (Labonte & Laverack, 2001).

2. Leadership
Leadership needs to have strong participation and it plays an important role in development of small groups and community organizations (Labonte & Laverack, 2001).

3. Organizational Structures
This can include small groups such as committees (Labonte & Laverack, 2001). The existence of these groups is important to community capacity (Labonte & Laverack, 2001). Organization structures provide the infrastructure to run the interactions of public participation (Labonte & Laverack, 2001).

4. Problem Assessment
“Capacity building presumes that the identification of problems, solutions to the problems, and actions to resolve the problems are carried out by the community” (Labonte & Laverack, 2001, p.120).

5. Asking why
This domain focuses on the community’s ability to assess the social, political, economic and other causes of inequality (Labonte & Laverack, 2001). This domain is important to development of personal and social change strategies (Labonte & Laverack, 2001).

6. Resource Mobilization
The focus is on the community to mobilize resources within and to look at resources external to the community (Labonte & Laverack, 2001). Focusing on internal resources can improve the self-esteem and the community members and build social networks (Labonte & Laverack, 2001).

7. Links with others
Linking with other partnerships, coalitions can assist the community in address its issues (Labonte & Laverack, 2001).

8. Role of outside agents
Outside agents are the important link between communities and external resources (Labonte & Laverack, 2001). These outside agencies can transform power relationships between the individual, outside agency and the community (Labonte & Laverack, 2001).

9. Program Management
“Program management that builds community capacity includes increased control by the primary stakeholders over decisions on planning, implementation, evaluation, finances, administration, reporting, and conflict resolution” (Labonte & Laverack, 2001, p.124).

Strengths and Abilities of Communities
In capacity building, there is an emphasis on building on existing strengths and abilities (Manitoba Family Services & Housing, 2008; Verity, 2007). Capacity building involves bringing all of the strengths together to take action and resolve the problem (Liberato et al., 2011; Manitoba Family Services & Housing, 2008). One idea that underpins
community capacity is that “improvements and solutions to ‘community problems’ can, and should be ‘unleashed’ from within communities rather than imposed from outside” (Verity, 2001, p.10). Capacity building provides the skills to members of the community to respond to challenges in their communities (Manitoba Family Services & Housing, 2008; Simmons, Wood, & Daws, 2010; Verity, 2007). Capacity building is strengthening the skills and abilities of the individuals in the community and community groups to take action and lead roles in developing their communities (Verity, 2007). It provides a means to empower individuals and communities (Simmons et al., 2010). Capacity building at the community level focuses on “developing capacities are the level of an organization or community” (VicHealth, 2003, p.6). It is important for communities to identify their own agendas for capacity building (Atkinson & Willis, 2005).

Advantages of Community Capacity Building
Some of the advantages of community capacity building are “better reach of the target population, better use of resources, increased local competence and commitment for health action change and increased community ability to respond to emerging health issues” (Liberato et al., 2011, p. 851). Some of the other advantages to communities are “better use of resources, increased local competence and commitment of for health action and change and increased community ability to respond to emerging health issues” (Liberato et al., 2011, p.851).

Some of the benefits of community capacity are empowering individuals and groups in the community, developing skills, and knowledge (Verity, 2007). Other benefits include increase social relationships, providing service and policies that are responsible to the needs identified by the community, and community involvement (Verity, 2007). Additional benefits of community capacity building are the acceptance of the programs by the communities, because they have been involved in the development (Verity, 2007). “Key factors supporting community action include: a positive social environment [caring neighbours, strong sense of community, celebratory events]; and the ability to work together, link tone another and participate” (Liberato et al., 2011, p.. 5).

Principles of Capacity Building Practice
NSW Health (2001) identified five key practices that underlie effective capacity building practice:

1. Respect and value pre-existing capacities
   Pre-existing skills, structures, and partnerships need to be identified prior to beginning capacity building (NSW Health, 2001). This pre-existing skills and partnerships need to be respected and worked with as part of the capacity building (NSW Health, 2001). In capacity building, local people are linked with individuals that have content expertise (NSW Health, 2001).

2. Develop Trust
   Trust is very important in building capacity (NSW Health, 2001). Capacity building is underlined by trust and respect (NSW Health, 2001).

3. Be responsive to context
   Context refers to the environment in which the program sits (NSW Health, 2001). Context can have a negative or positive impact on the program or the initiative and practitioners need to be ready to respond to the change in context (NSW Health, 2001).
4. Avoid pre-packaged ideas and strategies
There is not a single way to build capacity (NSW Health, 2001). Capacity building is an approach, not a set of pre-determined activities (NSW Health, 2001). The strategies that are developed need to identify “each situation separately to identify pre-existing capacities and develop strategies particular to a program or organization, in its time and place” (NSW Health, 2001, p.6).

5. Develop well-planned and integrated strategies
Capacity building needs to use a variety of strategies from a variety of areas such as organizational development, resource allocation, partnerships and leadership (NSW Health, 2001).

Capacity Building Strategies

In community capacity building, community assets, capacities and issues need to be identified (Atkinson & Willis, 2005). “Strategies to build capacity should be responsible to the context and needs of the community, sensitive to the skills of the worker, the organizational situation or ‘sphere of influence’ and the history of intervention” (Verity, 2007 p.20). Strategies to build capacity at the community level include partnership building, governance, leadership development, and developing the skills and resources of communities (NSW Health, 2001; Verity, 2007; VicHealth, 2003b; Victorian Healthcare Association, 2012a). Additional strategies for building community capacity are the use of self-engagement and relationship building; consciousness raising and education; responding to needs; strengthening local networks, skills, and increasing the confidence of community members (Verity, 2007; Victorian Healthcare Association, 2012a).

Table #3: Community Capacity Building Action Areas

<table>
<thead>
<tr>
<th>Community</th>
<th>Institutional</th>
<th>Linking</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Asset Mapping</td>
<td>• Policy Support for community capacity building</td>
<td>• Advocacy</td>
</tr>
<tr>
<td>• Training</td>
<td>• Balanced holistic and participatory social planning</td>
<td>• Bridge building (relation and systematic)</td>
</tr>
<tr>
<td>• Community Profiles</td>
<td>• Resource allocation</td>
<td>• Collaborative strategies</td>
</tr>
<tr>
<td>• Needs Assessments</td>
<td>• Investments (financial, human resource services)</td>
<td>• Shared planning</td>
</tr>
<tr>
<td>• Appreciative Inquiry</td>
<td>• Organization development</td>
<td>• Communication flows</td>
</tr>
<tr>
<td>• Community Organization Building</td>
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<td>• Policy feedback loops</td>
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</table>

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skills and Abilities</th>
<th>Resource mobilization/Transfer</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Leadership development</td>
<td>• Leadership development</td>
<td>• Asset Mapping</td>
</tr>
<tr>
<td>• Critical thinking skills</td>
<td>• Conflict resolution</td>
<td>• Funding</td>
</tr>
<tr>
<td>• Bridges between practical and experiential knowledge and ideas</td>
<td>• Problem solving</td>
<td>• Social Infrastructure</td>
</tr>
<tr>
<td>• Consciousness raising</td>
<td>• Mentoring</td>
<td>• Community bases and structures</td>
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<td></td>
<td>• Skills in governance and community action</td>
<td></td>
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</tbody>
</table>


As part of the process it is important to engage the willing participants from the wider community (Atkinson & Willis, 2005). Individuals need to be involved from the beginning before any action is taken (Atkinson & Willis, 2005). There needs to be
time and resources put into participation (Atkinson & Willis, 2005). Projects need to have a long-term vision. If there is not a long-term vision, the project is not likely to be effective (Atkinson & Willis, 2005). “Community/organizational capacity building is a process of strengthening and developing of both the capacities of individuals and the capacities of the entities” (VicHealth, 2003, p.9).

Other Approaches
Focus groups have been found to be effective in encouraging participation from disempowered and excluded patient groups (Harkins et al., 2011). Social networks are effective means of communication and for dispelling mistrust and misunderstanding of new services in the area (Harkins et al., 2011). Having an event to listen to residents has been identified as a way to understand resident’s experiences of what it is like to live in the community (Durie & Wyatt, 2013; Warr et al. 2013).

Conclusion

Based on this review, there are a variety of strategies that can be used with communities to build their capacity and approaches that can be used to engage vulnerable communities. Bottoms up approaches have been found to be effective in engaging vulnerable communities. Individuals in the community need to be engaged as part of the process. Listening to the community, going to their community, and engaging the communities are important in the approaches that are used by community sites within Primary Health Care.
Appendix A: Main Components for Achieving Successful Community Engagement

Appendix B: Framework for Building Capacity to Improve Health

<table>
<thead>
<tr>
<th>Domain 1</th>
<th>Domain 2</th>
<th>Domain 3</th>
<th>Domain 4</th>
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</thead>
<tbody>
<tr>
<td>Network partnerships</td>
<td>Knowledge transfer</td>
<td>Problem Solving</td>
<td>Infrastructure</td>
</tr>
<tr>
<td>Levels of Capacity</td>
<td>Levels of Capacity</td>
<td>Levels of Capacity</td>
<td>Levels of Capacity</td>
</tr>
<tr>
<td>1. There is capacity to identify the organizations and groups to implement and sustain a program.</td>
<td>1. There is capacity to develop a program to meet local needs.</td>
<td>1. There is capacity in the network to work together to solve problems.</td>
<td>1. Policy Investments</td>
</tr>
<tr>
<td>2. There is capacity to deliver the program through a network of organizations and groups.</td>
<td>2. There is the capacity to transfer the knowledge in order to implement/sustain the program within the network.</td>
<td>2. There is the capacity to identify and overcome problems/barriers to implementing/sustaining within your own organization.</td>
<td>2. Financial Investments</td>
</tr>
<tr>
<td>3. There is sustainable network established to maintain and resource the program through a network of partnerships.</td>
<td>3. There is the capacity to integrate a program into the mainstream practices of the network partners.</td>
<td>3. There is the capacity to sustain flexible problem solving over time across the network.</td>
<td>3. Human Investments</td>
</tr>
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</table>

Appendix C: Level of Capacity Building

Health Promotion Practice

Within programs

Build Capacity
- Infrastructure
- Program sustainability
- Problem solving

Within systems

Greater capacity of people, organizations and communities to promote health

Appendix D: Capacity Building as Series of Relationships

References


