University of Southern Denmark

PhD Thesis

Evaluation as a tool for community empowerment

- a study on three community initiatives in Rapla, Estonia

Dr. Anu Kasmel
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"In the varied topography of professional practice, there is a high, hard ground overlooking a swamp. On the high ground, manageable problems lend themselves to solution through the application of research-based theory and technique.
In the swampy lowland, messy, confusing problems defy technical solution.
The irony of this situation is that the problems of the high ground tend to be relatively unimportant to individuals or society at large, however great their technical interest may be, while in the swamp lie the problems of greatest human concern.
The practitioner must choose. Shall he remain on the high ground …, or shall he descend to the swamps of important problems and non-rigorous inquiry?"

Schön, 1987

CONTENTS

ABBREVIATIONS

IE – individual empowerment

ICRE – individual community-related empowerment

LE – life expectancy at birth

ODCE – organizational domains of community empowerment

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SUMMARY

Empowerment is identified as a principal theory of community psychology and a key concept for communities in reducing health inequalities and achieving a better quality of life. This study is aimed to investigate how empowerment concept is understood in newly independent Eastern European country Estonia and how the expansion of the empowerment perceived and changes in empowerment measured by its community members. The thesis investigates the application of the empowerment expansion model within three health promotion initiatives in Rapla County.

The primary objectives of the thesis are: (i) to clarify the understanding of the concept of empowerment in given context; (ii) to identify the organisational domains of the community empowerment concept in Estonian communities context; (iii) to develop a measurement tool for determining the state of affairs in empowerment; (iv) to assess changes in organizational domains of community empowerment (ODCE) after the intervention, and; (v) to evaluate the changes in individual community-related empowerment (ICRE) among the participants of community health programs networks.

The thesis is built on three articles and is formulated in eight chapters.

Article 1 aims to identify and systematize empowering domains and activities perceived by community members during the empowerment evaluation process. Semi-structured interviews were undertaken with sixteen participants from three health promotion programs The findings suggest that there are four key organizational domains that characterize the community empowerment process in Rapla: activation of the community, competence

development of the community, program management development, and creation of a supportive environment.

Article 2 aims to describe how a context-specific community empowerment measurement tool was developed and changes measured in three health promotion programs. An empowerment expansion model was compiled and applied. The consensus workshop method was used to create the measurement tool and collect data on the ODCE. The study demonstrated increases in the ODCE among all three programs networks, however, in different extent. The use of empowerment expansion model has proven to be an applicable and relevant tool for the evaluation of community empowerment.

Article 3 assessed changes in community members' ratings of the dimensions of ICRE before and two years after the implementation of an empowerment expansion framework. Five dimensions of ICRE, *self-efficacy*, *intention*, *participation*, *motivation* and *critical awareness*, emerged from the factor analysis. The levels of ICRE dimensions measured after the application of the empowerment expansion framework were significantly more favorable for the dimensions *self-efficacy*, *participation*, *intention* and *motivation* to participate.

The studies have demonstrated that understanding and measurement of empowerment concept is complex and context-specific. The model elaborated and utilized by local communities may be benefitial for expansion of ODCE and can have positive impact to community members ICRE.

Keywords: community empowerment, health promotion, Eastern Europe, Estonia.

RESUMÉ

Empowerment kan identificeres som en teori om mægtiggørelse og myndiggørelse i lokalsamfund og anvendes ofte som et kernebegreb til at reducere social ulighed i sundhed og til at skabe bedre trivsel og livskvalitet. Hensigten med dette projekt er at undersøge, hvordan empowerment som koncept anvendes og forstås i det tidligere Østeuropæisk land, Estland og undersøge hvordan indførelsen af empowerment og empowerment- værktøjer ændrer på opfattelserne af empowerment blandt borgerne i tre lokalsamfund. Ph.d. afhandlingen undersøger indførelsen af empowerment tiltag i tre sundhedsfremmende initiativer i lokalområderne, Rapla, Estland.

De primære formål med afhandlingen er: (i) at afdække og forstå konceptet empowerment i en specifik kontekst; (ii) at identificere de organisatoriske faktorer som er relevante for udvikling af lokalsamfunds empowerment i lokalområderne i Estland; (iii) at udvikle en måleværktøj til at determinere aspekter og processer omkring empowerment dannelse; (iv) At bedømme forandringer på organisations niveau ved indførelsen af empowerment på lokalniveau (ODCE) efter igangsættelse af interventioner og; (v) at evaluere forandringer i empowerment på individ niveau (ICRE) blandt deltagerne i de sundhedsfremmende programmer i lokalområderne.

Afhandlingen bygger på tre artikler og er sammenskrevet i otte kapitler.

Artikel 1: Formålet er at identificere og systematisere empowerment domæner og aktiviteter, som de er oplevet af borgerne i lokalområderne gennem evalueringen af processerne omkring empowerment dannelse. Analysen bygger på 16 semi-strukturerede

interviews med deltagere fra de tre sundhedsfremmende programmer. Resultaterne viser, at der er fire organisatoriske domæner, som kendetegner processerne omkring empowerment dannelse i Rapla: Aktiviering af lokalsamfundet, kompetence- udvikling i lokalsamfundet, udvikling af programledelse, og skabelse af et støttende miljø i områderne.

Artikel 2 Formålet er at beskrive, hvordan et kontekst – specifikt måleværktøj til at måle lokalsamfund empowerment er udviklet, og hvilke ændringer der forekommer i den proces indenfor de tre sundhedsfremmende programmer. En empowerment- udfoldelses model (ODEC) danner baggrund for dette studie. 'The consensus workshop method' blev anvendt til at måle og indsamle data om ODCE. Dette studie demonstrerer skabelse og stigning i empowerment i relation til ODCE blandt alle de tre deltagende programmer, dog med forskellig styrke. Anvendelsen af empowerment- udfoldelsesmodellen (ODEC) har på den baggrund vist sig at være et anvendeligt og relevant redskab i evaluering af lokalsamfund empowerment.

Artikel 3 Formålet er at vurdere og rangere forandringer i borgernes individuelle empowerment (ICRE) før og to år efter implementeringen af empowerment-udfoldelsesmodellen (ODEC). Ud fra en dybdegående analyse af borgernes individuelle empowerment (ICRE) fremkommer seks punkter; tro på egne evner (*self-efficacy)*, mening (*intention)*, deltagelse (*participation)*, motivation (*motivation)* og kritik opmærksomhed (*critical awareness)*. De individuelle empowerment dimensioner (ICRE) var signifikant mere favorable når det gjaldt dimensionerne; tro på egne evner (*self-efficacy)*, deltagelse (*participation)*, mening (*intention) og* motivation (*motivation)* til at deltage efter igangsættelse af empowerment- udfoldelses værktøjet i områderne.

Afhandlinge har demonstreret, at forståelsen og måling af empowerment er komplekst og kontekst specifikt. Udbyggelse og anvendelse af empowerment- udfoldelses modellen i lokalsamfund kan være gunstig for fremtidig sundhedsfremmee arbejde, da det kan have en positiv effekt på dannelse af individuel empowerment (ICRE) blandt borgere i lokalsamfund.

Nøgleord: Lokalsamfund, Empowerment, Sundhedsfremme, Øst Europa, Estland.

CHAPTER I

INTRODUCTION

1.1 Background

Empowerment is a widely used concept in developing policies and programs in many societies. Approaches that aim to empower communities to assess their own needs and facilitate ways to address those needs have gained broad acceptance in the health promotion world (Minkler, 2005; Wallerstein, 2006). Importance of empowerment has been highlighted in the Alma-Ata Declaration (WHO, 1978) and the Ottawa Charter (WHO, 1986). Empowerment is identified as a central theme of quality of life discourse (Germann and Wilson, 2004) and is understood as the expansion of assets and capabilities of people, specifically from disadvantaged groups, to participate in, negotiate with, control, and hold accountable institutions that affect their lives (Narayan *et al*., 2000). Furthermore, empowerment has been suggested as offering the most promising approach to reducing health inequalities (Wallerstein, 2006; Marks, 2002; Pickett and Wilkinson, 2010; Hurst, 2007). The central idea of community empowerment is that local communities can be mobilized to address health and social needs and to work inter-sectorally on solving local problems (Laverack and Wallerstein, 2001).

Community empowerment approaches have been used successfully not only for tackling inequalities in health (Stuckler *et al.,* 2009; Wilkinson and Pickett, 2009), but also for prevention of many health-related and social problems, including injury prevention (Day *et*

al., 2001; Huitric *et al*., 2010), cardiovascular disease prevention (Torrance *et al.,* 2008; Dewi *et al.,* 2010), drug and alcohol abuse prevention (Tracy *et al.,* 1996), and for inducing and promoting social capital (Janssens, 2010; Andersen *et al.,* 2011).

Although the concept of empowerment has met with widespread acceptance in the scientific community and has proven successful in many Western countries (Diether, *et al.*, 2006), it has not been demonstrated whether the same level of success can be attained in the newly independent Eastern European countries. Only a few studies exist to highlight the empowerment processes in countries in transition (Makara, 1994).

In Eastern European countries, the populations have been socialized in the spirit of a "closed society" (Gebert and Boemer, 1999). In accordance with the closed society model, personal initiatives, community participation, autonomy or open dialogue and other community development processes were not permitted in these societies. Some scientists have even hypothesized that empowerment, in the sense of fostering the subject status, may thus prove less successful in Eastern Europe and may even turn out to be dysfunctional (Diether, *et al.*, 2006; Gebert and Boemer, 1999).

With the changes of the political and socio-economic systems in the Eastern European countries in the 1990s, the health and quality of life of their populations changed dramatically, improving in some indicators and deteriorating in many others (Leinsalu *et al.*, 2009). The dominant aspect of these changes lies in the individuals' and communities' access to choices in all facets of their lives and in the freedom and power to control their own lives. As a result of the changes during the transitional stage of the societies, social inequalities increased suddenly (Mackenbach 2008). The social fabric eroded, disempowering many groups. Rapid increases in poverty, morbidity and mortality followed (Leinsalu, 2003).

Considering the remarkable inequalities in health, especially its socio-psychological and socio-economic determinants, between Western and Eastern European countries, empowerment approaches are indispensable in countries in transition. Health promotion policy and practice in these countries could benefit from the community development work through a focus on enabling individuals and communities to identify their needs, develop solutions, and facilitate change. Such changes could expand empowerment and foster health development. For health promoters, the support of the expansion of empowerment in communities and among individuals could be the main aim and task.

Empowerment is a complicated concept - it may vary across cultures (Wallerstein, 2006) and socio-political contexts (Laverack, 2005). In Western countries, community empowerment is understood as a process of capacity building towards greater control over the community's quality of life and wellbeing. It is argued that empowerment may be interpreted quite differently in non-Western countries (Laverack, 2005). Indeed, little is known about how community members in transition countries understand empowerment in community development processes and, furthermore, about how they interpret and operationalize empowerment domains.

The identification of the operational definition, domains and indicators of community empowerment is necessary for the evaluation of an empowerment process before planning community approaches and initiatives. Health promotion organizations and practitioners play crucial roles in activating and facilitating community health promotion programs. They act as initiators, motivators, and coaches for different teams within communities. It is important for health promotion practitioners to understand how communities are being empowered by the process and how to measure its outcomes. If health promotion practitioners are to facilitate

the expansion of empowerment in communities, they have to be able to understand and describe precisely how particular programs act, how communities became empowered and what factors of community empowerment they must work with.

The operationalization of community empowerment process helps enable community members to initiate and sustain activities leading to changes in the health and quality of life of the community. A range of factors or organizational aspects that affect a program's empowering influence on community members have been suggested by Laverack and Wallerstein (2001) and are known as Organizational Domains of Community Empowerment (ODCE). Currently, researchers emphasize that changes in ODCE can be used as proxy parameters in the evaluation of community initiatives (Smith *et al.,* 2003; Labonte and Laverack, 2001a; Robertson and Minkler, 2010). Furthermore, changes in the domains may contribute to solving health problems in the community and therefore can be seen as determinants of health.

In spite of the vast amount of available literature on community empowerment, there is no common understanding or agreement on unified ODCE. Little is known about what is really happening in different communities when health promotion practitioners facilitate and coach empowerment processes. How is empowerment understood and perceived in a newly liberated society? How can empowerment be expanded? What organizational domains create and increase empowerment in a community? And what are the measurement indicators for assessing changes in community empowerment? Many health promotion practitioners in transition societies ask themselves these questions before starting their work in communities. These questions therefore impelled us to conduct the current study.

1.2 Antinomy in theory and practice

Understanding of the concept of health promotion is guided predominantly by the main document in health promotion world, The Ottawa Charter for Health Promotion (WHO, 1986)**,** which establishes the core values, principles and action strategies for health promotion. The concept of health promotion is defined as a "… process of enabling people to increase control over, and to improve their health" (WHO, 1986). Expansion of the empowerment in communities is assumed as a paramount and ultimate task for achieving improvement in peoples' health. However, many health promotion practitioners have expressed their confusion concerning contradictions between the essential nature of health promotion and the requirements of the politics, administrators and financers primarily for traditional, medically oriented goals and objectives in community health promotion programs. The resources for community health initiatives are mainly provided by the state budget and the health promotion foundation for the predetermined initiatives, and these frequently are not in harmony with professional's understanding of effective approaches and moreover – with local needs, concerns and interests. The need for simultaneous empowering approach and pre-determined issue-specific approach and furthermore – the need for the concurrent evaluation of the both approaches during the implementation of the community initiatives has been the real mystery and puzzle for health promotion practitioners. How to manage with the antinomy in theory and practice has been health promotion professional's dilemma since they started to work in their communities. Do we really empower our target groups while trying to achieve changes in behaviour or in environments? How is empowerment understood in society, experienced lately totalitarian regime? Can we expand empowerment in newly independent countries when using the tool as in welfare states? How to know whether empowerment is

expanded? During empowerment approach how to guarantee the evaluation of the issue-specific process? How to satisfy the financer's requirements for evaluation of the issue-specific process concurrently with professional's needs for empowerment approach? These questions have been asked numerous times by the local health promotion practitioners from the author of the current research during her work with the national health promotion network. These questions are undoubtedly the main inducements of the present study.

1.3 Study context

As part of the health promotion structural development in the middle of the nineteen nineties**,** health promotion practitioners were appointed to the counties governments in Estonia. One of the first tasks for most of the professionals was to compile the health profile of their county and identify the health problems of local people (Kasmel *et al.,* 2003). A number of different concerns and needs emerged through discussions, focus-group studies among many community groups, and from the analysis of health statistics and surveys. In response to these concerns many health promotion programs and projects were initiated in different counties (Health Promotion in Estonia, 1993 – 1996 (1997). Several of these programs mobilized local citizens to collaborate and form different community partnerships. Most of the initiatives or programs were guided and managed by a core-group (workgroup) of community members. Health promotion practitioners were working with all community workgroups acting as enabling or support teams, contributing to knowledge and practice related to empowerment and capacity building of local communities. Their main tasks were to initiate, stimulate, support, facilitate and coordinate local health promotion initiatives targeted

at different groups in the community. Community programs workgroups were acting as main engines in their programs – trying to solve the problems they face.

The current study was carried out in Rapla County in Estonia in the years 2002-2004. Rapla County is a small inland region with 37400 inhabitants. It is mainly a rural area with a small central town. There were limited employment possibilities, and the relative poverty of the population in comparison to other regions in Estonia was higher in comparison to the Estonian average (Rapla Maavalitsus, 2002). Rapla has a clearly defined geographical location; the people have a strong common identity and share common communication channels (local radio, newspaper).

In 1997 the Rapla County government appointed a health promotion practitioner. Since then, several health promotion efforts have been initiated, and several nationwide health programs and projects were expanded into the county (Heart Health, Healthy Schools, Health Promoting Kindergartens programs) (Rõigas, 2002). There were multiple community workgroups and networks within the Rapla community, which focused on different community initiatives and problematic issues. Until the current study, previous assessments of health promotion initiatives were mainly focused on measuring changes in health outcomes. In 2002, the health promotion practitioner expressed the community´s desire to acquire information about empowerment approaches.

As a response to the Rapla people request to the national centre for health promotion an empowerment evaluation study was decided to carry out in collaboration with the University of Southern Denmark, to assess the empowerment process and its outcomes within Rapla community initiatives. The local health promotion practitioner and author of the current study as a researcher formed a practitioners' team and worked together with Rapla community

people on three health promotion initiatives, *Safe Community*, *Drug Abuse and AIDS Prevention* and *Elderly Quality of Life* programs, which expressed their interest to be involved. It was assumed that if community initiatives participants are provided with adequate support for conducting an evaluation, they are motivated in finding out whether they are making a difference, and how they could improve their program.

This evaluation study is the result of many discussions with health promotion practitioners` team. There were two wishes expressed by the community members and practitioners to the empowerment evaluation study: 1) it should be collaborative and local citizens should be involved as much as possible in each stage of the research and; 2) it should be knowledge enhancing for community health promotion programs participants. As community workgroups members represented different organizations, sectors and groups, they brought different experiences and perspectives to the evaluation process. It was agreed that the evaluation of a community empowerment process should itself contribute to the empowerment and capacity development in this particular community.

1.4 Theoretical considerations

In order to understand how the empowerment approaches are applied, and how programs perform, it was necessary to examine and clarify at first, how empowerment concept is understood by local community members. The precise analysis of the empowerment process was planned to identify empowerment domains and indicators and to elaborate the methodology for the measurement of the changes in community empowerment in Rapla County context.

The theoretical framework – empowerment expansion framework - what we constructed for simultaneous evaluation and community empowerment, is based on the models of empowerment evaluation (Fetterman, 1996) and the 'parallel tracks' in program planning (Laverack and Labonte, 2000). The theoretical framework – in current study called as empowerment expansion framework - has the community's perspective – development of the empowerment in the whole community through several issue-specific programs and projects, which were planned in response to a number of community needs.

In contrast to traditional external evaluation, empowerment evaluation is explicitly designed to become an ongoing, sustainable part of the community's planning and action. The process and findings of the evaluation are used to empower the community (Coombe, 1997). By participating in the actual evaluation as information providers, gatherers and interpreters, community members gain personal skills, insights and better understanding of community resources and needs. According to Eng and Parker (1994) increasing the competence of individuals and mobilizing community members empowerment evaluation was expected to build the community's capacity across a spectrum of levels ranging from individual to organizational to inter-organizational to community and society. While concerns for accountability and outcomes were part of our current interventions, evaluation was assumed not be a disempowering process. It was presumed to be 'the process of enabling people to increase control over and to improve their health' (WHO, 1986).

The main features of the evaluation approach in Rapla were: a) focus on the whole programs networks; b) focus on community empowerment rather than input delivery or transfer of knowledge; c) focus on the participatory model to enhance local capacities; d) focus on multiple perspectives in program evaluation.

1.5 The goal and objectives of the study

The main goal of this study is to seek clarity in the empowerment expansion process in Estonian communities and to elaborate and provide methodology for health promotion practitioners who start their work in communities full of needs and concerns.

The specific objectives of the current study are:

i) to identify the organizational processes and activities that community workgroup members perceived as empowering, using an empowerment evaluation approach within the health promotion programs` context in Rapla County, Estonia;

ii) to operationalize the concept of *community empowerment process* as defined and understood by the interviewees and to elucidate which ODCE and indicators the interviewees acknowledged as appropriate within the study context;

iii) to elaborate framework for evaluation of health promotion initiatives for communities with multiple needs and concerns, which simultaneously expands empowerment in community and allows to measure changes in empowerment process;

iv) to elaborate a community empowerment measurement tool appropriate and suitable for community members to use;

v) to assess the changes in the empowerment domains within Rapla community's three health initiative workgroups after two years of application of the empowerment expansion framework;

vi) to assess the changes in individual community-related empowerment (ICRE) indicators of the among Rapla community's three health initiatives' workgroup members.

The following questions needed clarification during current evaluation study:

1) What are the empowering activities practiced and perceived by the community health promotion programs participants during the community empowerment process, and what kind of domains do these form?

2) How could community health promotion programs participants measure their organizational domains of empowerment?

3) Were there changes in the organizational domains during the application of the empowerment evaluation model within three community programs?

4) Did individual empowerment indicators change among the community health promotion programs participants as result of the application of empowerment expansion model?

1.6 The structure and outline of the thesis

The research reported in this thesis is a multi-stage and multi-method study and has resulted in three articles[1]:

1) Kasmel, A. and Tanggaard Andersen, P. Conceptualizing organizational domains of community empowerment through empowerment evaluation in Estonian communities. *Societies* **2011**, *1*, 3-29.
2) Kasmel, A.; Tanggaard Andersen, P. Measurement of Community Empowerment in Three Community Programs in Rapla (Estonia). *Int. J. Environ. Res. Public Health* **2011**, *8*, 799-817.

[1] Further a chapter for the following book has been resulting from the research, but not included in this thesis: Kasmel, A. Hindamine kui võimestav kogemus. (Evaluation as an empowering experience). In Laverack, G. (ed.). *Power, empowerment and professional practice*. Tallinn: Tervise Arengu Instituut, 2011.

3) Kasmel, A.; Tanggaard Andersen, P. Evaluation of Changes in Individual Community-Related Empowerment in Community Health Promotion Interventions in Estonia. *Int. J. Environ. Res. Public Health* **2011**, *8*(6), 1772-1791.

The thesis is composed of two parts. Part one contains chapters II, III and IV, which focus to the context, concepts, methodology and methods. In chapter II an overview of the study context and community is provided. In chapter III an overview of the concepts utilized in current thesis is provided and the contemporary discussion on empowerment concept is presented and the term community is discussed. Chapter IV describes the methodology of the study, and demonstrates the design and five stage process of the application of the empowerment evaluation model in the three health promotion initiatives and methods utilized during these stages of the study.

Part two contains findings emerged in current research, discuss the results, its limitations and implications. chapter V summarizes *Article 1*, which was the first stage of the study, aimed to identify and systematize empowering domains and activities perceived by community members during the empowerment evaluation process, predominantly focusing to the results. Chapter VI summarizes *Article 2*, which explores how the empowerment expansion framework composed (seacond stage), context specific community empowerment measurement tool was developed (third stage) and the changes emerged in three health promotion programs (fourth stage). The findings, demonstrating changes in the ODCE among all community workgroups however in different extent, are discussed. In chapter VII the *Article 3* is summarised. Chapter investigates changes in community members' ratings of the dimensions of individual community related empowerment (ICRE) before and two years after

the implementation of an empowerment expansion framework in three community health promotion initiatives (fifth stage).

Chapter VIII summarises the main findings of the study and discusses the limitations and implications of the study.

CHAPTER II

CONTEXT – HEALTH PROMOTION DEVELOPMENTS IN ESTONIA AND RAPLA COUNTY

2.1 Introduction

The social and political contexts in which the health initiatives are carried out determine significantly the process of community initiative (Christiansen, 1999).

The aim of this chapter is to outline contextual conditions in which community empowerment processes were initiated and facilitated in Estonia and in Rapla. The overview of the macro-context including a short historical retrospect is outlined, condensed overview of the health situation and health promotion and policy developments at national level is provided. Second, the social environment and health situation in Rapla County is provided. Third, the formulation of the organizational structures, community coalitions and other partnerships in Rapla County are outlined. And finally, description of three community health promotion initiatives involved in current study – *Safe Community program; Drug Abuse and AIDS prevention program* and *Elderly Quality of* Life program is provided.

2.2 The macro context

Estonia is the smallest of the Baltic States that lie on the east coast of the Baltic Sea. Bordered by Finland to the north, Sweden to the west, Latvia to the south and Russian federation to the east, Estonia covers an area of approximately 45215 km2. Administratively

Estonia is divided into 15 counties. The population rate is declining and currently there is 1,3 million inhabitants. The most obvious change has been a decrease in the number of children. At the end of the 1980´s, after the "singing revolution" baby boom the birth rate declined sharply over the next decade. Another noticeable change is the growth in the pension-aged population – the present 65–74 year old male and female generation is larger than that of the previous census (Social Sector in Figures, 2003). The population is ageing.

Since 1995, after the recession, caused by the transition from a planned to a market economy, the developments have been generally characterized by growth and sound performance. (Joint Inclusion Memorandum, Estonia, 2003). GDP per capita in Estonia increased during 1995-2002 from 32% to 42% of the EU average. With the annual mid-term economic growth rates of about 5-6%, per capita GDP, Estonia reached the threshold of 50% of the EU average by 2010. The inflation rate, which was very high in the first years of the transition, decreased rapidly during 1992-1999 and reached its lowest level (3.3%) in 2006.

One third of the population is living in the capital. Administratively there are 15 counties, 39 towns and 198 rural municipalities. About 65% of the populations are Estonians, 28% Russians, and 7% other. The dominant religion is Lutheran. The unemployment rate by the Labor Force Survey among 15 – 64 year old population in 2004 was 7.3%.

2.3 Trends in health situation

Life expectancy at birth (LE) in Estonia is low in comparison to European Union average. It has been influenced and mirroring political changes in society: before the Second World War life expectancy matched that of Scandinavian countries, decreased drastically during the war and stagnated during occupation years. During half of century, from 1950 to 2000 male

LE increased about one year and among female four years LE at birth was at its highest in 1988 (70.7 years), after which it fell to a low of 67.0 years in 1994. The pre-independence and pre-reform peak of 1988 was not overtaken until 2000 (Kasmel, 2005). LE stabilized until 2002, after which it started to increase steadily, reaching 78.5 years in 2009 (Estonian Statistics, 2011). In the year 2003 life expectancy was 71.2 years (Thomson, 2004). For males 65.7 and females 76.5 years. Infant mortality rate (deaths under 1 year of age per 1000 live births) decreased during 1995 to 2002 from 14,8 to 5,7 (Koppel et al, 2008). As in developed countries, causes of death in Estonia are primarily cardiovascular diseases (46%) out of all causes of the annual statistics of death. Cancer (20%) is in the second place and death from the external causes (17%) is the third (Health in Estonia 1991 – 2000, 2002).

Injury death rate (22.1 in 2001) in the age group 1 – 14 years per 100,000 in Estonia was one of the highest in the world (WHO, 2002). Injury death rate among men in the age group 40 – 64 years was five times higher than among women of the same age group (Kaasik and Uusküla, 2003). The past decade has shown a light increase in the occurrence of communicable diseases (tuberculosis and hepatitis B and C) and significant increase in HIV infections (Health in Estonia 1991 – 2000, 2002).

During the last decade in Estonia, as in most societies, increasing discrepancies in health indicators between different social groups have become evident. The gap between the average life expectancy of different social groups is wide and steadily increasing. Morbidity, mortality (Leinsalu *et al.,* 2003), health related behaviors (Kasmel *et al*., 2003) and patterns of health care utilization strongly vary between subgroups of the population. People from lower socio-economic groups have shorter lives, more often suffer from health problems, engage in health damaging behavior and have less favorable health care utilization pattern. Moreover, large

differences in some outcome indicators are observed between men and women, non-ethnic and ethnic Estonians and by place of residence (Kunst *et al.,* 2002). During the 1990's social inequalities in mortality and most types of health related behavior have widened. For example, the average life expectancy of men with higher education is 13.5 years higher than for men with lower education; for women the corresponding indicator is 8.6 years.

2.4 Socio-economic situation in Estonia

During the transition period, in the nineteen nineties, poverty increased rapidly. Using the EU-agreed indicator on relative income poverty (60% of median income with equivalence scales 1:0.5:0.3), the risk-of-poverty rate in Estonia, 25.9% (2009) is higher than the EU average of 25,1% (2009) (Estonia Statistics, 2010).

Even though the poverty rates are declining each year, when one measures the nationally agreed upon indicator on absolute poverty, it is apparent that in 2009 25% of the population was still living below the absolute poverty line. The most worrying fact is that about 20% of children up to 16 years old are living in households with incomes below the absolute poverty line, meaning that they had only a minimal standard of living.

2.5 Political developments in health system

Since Estonia regained independence in 1991, three major reforms of health care have been completed - decentralization of planning and provision of health care services' and implementation of health insurance in financing were carried out during 1992 – 1994. The third reform, development of family practitioner and public health services is in the process.

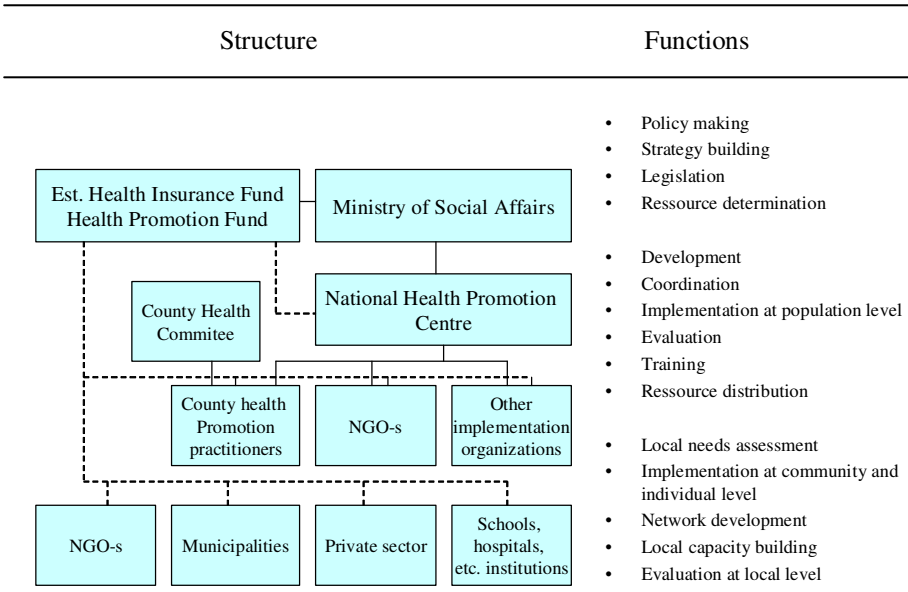
Since 1992, the Health Insurance Act created a financing system, based on solidarity, which covers approximately 95% of the population. (Health in Estonia 1991 – 2000, 2002).

Health promotion, as it is known today, started in Estonia in 1993 when the Department for Public Health was established in the Ministry of Social Affairs with the aim of accomplishing a transition from an illness-centered health policy to a health-centered policy. The Estonian Centre for Health Education was founded in the same year with the principle of implementing the national health strategy, coordinating health activities nationwide and developing innovative health promotion methods (Kasmel *et al.,* 2003). With support from the International Bank for Reconstruction and Development, the Centre for Health Education began putting the three priorities of the health policy document into practice nationwide (programs for the prevention of cardiovascular diseases, injury prevention and tobacco control). Program managers and team members were given health promotion training in several countries outside Estonia. In order for the activities to reach the target groups it became necessary to create a regional structure with the county governments. The health promotion network in counties got started in 1995 and consisted of specialists with a medical or pedagogical based education who received basic knowledge in health promotion and action strategies and also primary skills in planning, implementation and evaluation of health promotion work with support from the Health Education Authority of England and the PHARE cooperation program. The County Health Promotion Practitioner's Network has three main roles in the health development process. First, the support of the creation and empowerment of local networks. Second, the introduction of the evidence-based health promotion approaches to local communities and networks. Third, the training and education

of the county and local authority institutions in the issues of health promotion (Health Promotion in Estonia 1993-1996, 1997; Annual Report 1998, 1999).

The first Health Policy Document was approved by the Government in the year 1995 and the Public Health Law, which for the first time defined the structures and responsibilities in the health promotion field, was adopted by the Parliament and came into force in the same year (Kasmel *et al.,* 2003). The structure and functions of the health promotion system is described in the figure 1.

Figure 1. The structure and functions of the health promotion system in Estonia.



A goal for the future is to develop a health promotion structure in local authorities, which would fulfill the tasks of maintaining and improving people's health at a local level. A goal of the new health policy accepted by the Parliament in 2007 is also to move in that direction.

According to point 5.01 in the ratifying law for the loan agreement between The Republic of Estonia and the International Bank for Reconstruction and Development accepted on 24. May 1995, The Ministry of Social Affairs and Estonian Health Insurance Fund reached an

agreement that a certain percentage of the funds from the health insurance tax will be annually given to the Ministry of Social Affairs for implementing programs for health promotion and disease prevention. The agreement specifies that i.e. annually financing local health promotion programs and nationwide campaigns in five key fields: anti-tobacco campaigns, cardiovascular disease prevention, injuries control, women's health and family planning. Support from the health insurance budget to civic initiative health promotion projects was planned in 1995 in the amount of 1% to 3% (2002). From the Estonian perspective it was a political decision, which determined one certain source for funding public health programs. However, the size of the funding has decreased systematically each year, currently forming only 0.3% of the health insurance tax (Jesse and Kasmel, 2005).

2.6 Social inequalities in health

Social inequalities in health as an issue came to the policy arena in Estonia at the end of the 1990s, after a period of the extensive and profound societal changes. Rapid political and economical changes, which followed the transition, caused in the initial period of transition, a wide loss of control and disempowerment of many sectors of society (Estonian Statistics, 2010).

As a result of the publication of the first health inequalities study, which revealed large and growing inequalities between different social groups, discussions began. Since then discussions concerning health policy have been focused more on the social determinants of health and the most vulnerable groups in society (Kunst *et al.,* 2002).

What the most influential interventions and policies are, and what could best contribute to reducing inequalities in health, was the main question for the health promotion community.

The growing interest to the community empowerment and community capacity building issues emerged. Since 1997 in first counties, programs were initiated focusing on community empowerment approaches (Kasmel, 2005). However since then, evaluation of these processes have been occasional and focused mainly on the quality issues of the implementation process.

2.7 Rapla County and its people

The territory of Rapla comprises 6,9% from the whole country territory, and hence classified as a middle-sized county, with a north-south diameter of 50km and east-west diameter of 70km. The density of Rapla population is low, it comprises 2,7% from Estonian population, and population is steadily decreasing. In between the years 2000 and 2004 number of male inhabitants decreased from 17961 to 17717 and the number of female inhabitants decreased from 19710 to 19378. As of 1 January 2003 Rapla County has a population of 37 319 inhabitants. The county is one of the most sparsely populated counties in Estonia and it has a small county center town (Rapla County and its people, 2002).

The population of Rapla County is aging. Number of children is low (Figure 2). Crude birth rate per 1000 population in 2002 was 9,6 and number of death rate 13,50 (Rapla County Health Profile, 2005).

The county consists of ten rural municipalities and is made up of 1 town, 3 urban and 201 rural settlements (10 small country towns and 191 villages). As of 1 January 2003, Rapla town had 5742 inhabitants, which is 15.4% of the population of the Rapla County. Rapla County is quite homogenous in its ethnic composition – the percentage of Estonians in the beginning of year 2000 was 88% (Estonian Statistics, 2003).

Rapla is an inland county without access to major bodies of water, and no shipping. However it acts as an important link of the north-south highway and railroad. The county's economic structure is dominated by agriculture, forestry and wood, paper, chemical, glass and food products industries.

In rural areas there are low employment possibilities and the relative poverty of the population in Rapla in comparison to other regions in Estonia is high. In 2002 the average income of a household unit member per month in the county is substantially smaller than the Estonian average.

Figure 2. Rapla County, Estonia. Source: www.maakonnad.ee

The local people believe that a weakness of Rapla is the runoff of brain potential. The capital-city Tallinn with its possibilities is close-by and many people from Rapla County commute to work in the capital each day. The problem lies in the unevenness of development and settlement: the local municipalities are not equal – there are several small ones with poor

income – the county is mainly agrarian. Also the county lacks special points of interest; it has no sea or a beach (Rapla County and its people, 2002).

What raises concern is the passiveness of the inhabitants, the fear of change, the discordance of training and job structure, and the relative poverty of the population in comparison to other regions. As of 1 January 2003 there were 1029 registered unemployed in Rapla County, which is 4.7% of the entire county workforce. Average income of a household unit member in Rapla County in 2003 per month was 2477.7 Estonian crowns, which is substantially smaller than the Estonian average. Food and housing expenses made up 47.6% of expenditure (Estonian Statistics, 2004).

The vicinity of the capital city may induce growth of the lag in development compared to Tallinn and other surrounding regions. Remote villages have the danger of becoming empty and the social level of their inhabitants may decrease. Rapla County is feared to become a suburb/sleeping quarters for the capital, which would turn it into a "backyard" which might in turn cause further lumpiness, decrease in birth rates, low population growth and aging of the population.

2.8 Health promotion developments in Rapla County

2.8.1 How it started

With the initiative of the Estonian Centre for Health Education, the national health promotion network was founded in 1995 as a part of the national health promotion action strategy, which included the structural changes in health promotion. Health promotion practitioners began to work in every county as an integral part of the county government, consequently also in Rapla. The first health promotion practitioner was appointed to Rapla

County government in the 1st of October, 1995. A county doctor, with the task of managing and coordinating the healthcare system at a county level, had passed training in health education in Brighton, England, as part of a cooperation project between Health Education Authority of England and the Centre for Health Education of Estonia. Its support to the health promotion practitioner and expertise at the beginning of the actions was vital and natural.

The county health promotion practitioner characterizes the starting period of her work as a five-stage process:

1) formulation stage (when several interest groups were formed and shaped);

2) learning stage (focus to information search, professional knowledge in health promotion);

3) puzzlement stage („All of sudden we really did not know what to do and where to start – we were overwhelmed with problematic issues);

4) clarification stage („We had number of discussions and tried to prioritize actions") and

5) action stage.

A number of different concerns and needs have emerged during the first years of the work of the health promotion practitioner through discussions, focus-group studies among many community groups, and from the analysis of health statistics and surveys. In response to these concerns many health promotion programs and projects were initiated (Kasmel *et al.,* 2003).

2.8.2 Collaboration with local stakeholders

Since 1995 several health promotion projects have started in Rapla County and also several nationwide health programs (*Heart Diseases Prevention* program, *Healthy Schools* program, *Health Promoting Kindergartens* program, etc.) have expanded to the county. "In the framework of the program for the *Prevention of Cardiovascular Diseases*, a *Heart Week* has taken place annually, and with such great popularity that during a festival of the previous

campaign in a local sports building, the building was so packed with people that the pool literally started flooding…"

All these programs have mobilized local citizens to collaborate, and form different community partnerships. There are generally three types of partnerships. Some of them are formed as coalitions of different sectors and organizations, initiated by the health promotion practitioner to expand national health promotion programs within a community – so called top-down initiatives. Some partnerships are formed on the grassroots' level by initiatives of local people and local interest groups concerned with specific health issues, so called bottom-up initiatives. The third type of partnerships is bottom-up initiatives as well, mainly consisting of specific vulnerable people and related stakeholders. All partnerships have larger or smaller collaboration networks all over the county. Among collaboration partners there were members on the county government, municipalities, local media, non-governmental and private organizations, several networks, and interested individuals.

2.8.3 Cooperation with national organizations

The health promotion network of counties was financed by the Estonian Health Insurance Fund since its creation. This rather unusual system existed because of an agreement between the Estonian Government and the International Bank for Reconstruction and Development. The Bank agreed to finance the building of the Biomedicum of the University of Tartu on the condition that the Estonian Government invests in health promotion (Thomson, 2004). According to this agreement the Health Promotion Fund was created under the Estonian Health Insurance Fund with the initial aim of investing 1% of the annual turnover of the Health Insurance Fund into health promotion. As of now, this deal has turned out to be invalid as the amount of money invested in health promotion has decreased from the initial 1% to

0.3% in the year 2003. The staff budget and minimal resource for the implementation of the action plan were to come from the Health Promotion Fund as stipulated in the agreement between the Health Insurance Fund and county governments. In addition to the noted agreement, the county health promotion practitioners had the chance of applying for extra funding to implement projects from the Health Insurance Fund through public competition. The relationship with the Health Insurance Fund was limited to fulfilling contract duties from the one side and imposing financial control from the other.

With the Estonian Centre for Health Education, the entire counties' network developed a team spirit. The network got together regularly, almost every month, for meetings and refreshment courses organized by the Centre. For the counties, the Centre acted as the main competence center for getting resources, counseling, information and also professional and social support. The Centre also searched for and found plenty of possibilities for further international training and education for county health promotion practitioners. Connections developed with several non-governmental organizations e.g. Planned Parenthood Association, Cancer Association, Heart Association, etc. With the Estonian Centre for Health Education several action overview compilations have been published e.g. Health Promotion in Estonia 1993-1996, Annual Reports of Health Promotion 1998, 2000, 2002 (Kasmel *et al*., 2003). In 2003, according to the decision of the Ministry of Social Affairs, the Estonian Centre for Health Promotion was reformed and unified with the Research Institute for Experimental and Clinical Research and Training Centre for Health and Social Issues. The new institution – the National Institute for Health Development was created.

The relations between the counties' health promotion network and the Ministry of Social Affairs "turned out to be problematic". The main reason is considered to be the frequent

changes of officials at the Department of Public Health. There was no assumed support from the Ministry. The counties' problems were not heard and were not dealt with. The Ministry attempted to abolish the health promotion network twice, in 1997 and 2000, but its position and the need for it had become so clear by that time, that the county governments did not agree with the Ministry's plan and in 2000 decided to finance of the network themselves.

2.8.4 Collaboration with international organizations.

International contacts were initiated shortly after the first health promotion practitioner started working. Collaboration began with Swedish colleagues from the Karolinska University in 1995 when the practitioner took part in a Safe Community traveling seminar. At the county health conference she brought up the serious problem of injuries in the county and in Estonia as a whole. She also introduced the principles of Safe Community with which several foreign communities had achieved positive results. As a result of this presentation a deep interest in finding solutions to this problem in Rapla formed in several people. They got together and decided to take steps to avoid injuries in the community. At the same time a tragic event occurred in Rapla as a small girl drowned in sewage well that was missing its lid. This resulted in a big media discussion, in the course of which, the majority of people agreed that this kind of an accident could have been easily avoided if they were more attentive and caring towards their surroundings. A workgroup of active locals formed whose actions can be described as a typical so called bottom-up approach. The workgroup made good connections with the Karolinska Institute in Sweden and Finnish colleagues from the Finnish Ministry of Health and Social Affairs and a South-Finland County. Strong positive regard for the actions of the *safe community* workgroup has been received from multiple visitations to international partners, learning from their practice. They participated in Safe Community conferences,

initially as listeners, later as sharers of experience, and as of 1 October 2004, as equal partners: WHO Safe Community banner carriers. What is characteristic of Rapla health promotion workgroups is that they try to make international experiences attainable to a large group of people. As an example: in the course of years several trips to conferences have been organized where a large number of participants have traveled on a bus across Europe, attaining superb team-building outcome, a sense of togetherness and substantial increase in social bonds and bridges.

2.9 Organization of implementation

2.9.1 Structure

Structurally the county health promotion practitioner is affiliated to the county government, which in turn, operates under the Ministry of Internal Affairs. The main documents, which administratively and politically guide the health promotion practitioner's everyday work are their occupational guidelines certified by the county governor, and the county development plans (which includes health development chapter). Health promotion practitioners work in the social and healthcare department of the county and by hierarchy are subordinate to the department director and county governor. Their closest colleagues are other employees of the social and healthcare department including the county physician (with administrative tasks) and specialists responsible for social work, youth affairs and public sport. By profession however, county health promotion practitioners belong to the national health promotion system structure, which is under the administration of the Ministry of Social Affairs. In decision making, county health promotion practitioners are quite independent and

assemble their action plans, keeping in mind the larger county development plan based on two criteria: according to the needs of the target group and available resources.

A county centred health promotion team also consists of health promotion projects managers countywide and members of the county's health board, who together make political decisions, agree upon strategies, and largely stimulate the implementation of health promotion activities.

2.9.2 Resources

County health promotion programs are mainly financed from two sources (Table 1). Most of the finances are available through Health Promotion Fund, and are applied on a yearly basis by health promotion practitioner. Resources for implementation of the national programs are available to the county through contracts between Minister of Social Affairs and County Governor.

Table 1: Resources for implementation of the health promotion activities.

Year	Health Promotion Fund (EEK)	State budget (EEK)
1999	97 000	
2000	196 000	
2001	197 000	8 000
2002	549 200	70 000
2003	685 500	120 000
2004	669 500	75 000

Limited amount of finances are available from another funds and from the local municipalities, who however invest quite remarkably through *in kind* form of investments.

2.9.3 Approaches

The professional competence of a health promotion team in a county was often limited to the experience and training of the health promotion practitioner. That was however, enriched

by the individual expertise, skills and experience of the wide ring of team members. Several teams repeatedly expressed their wish and need for training in health promotion, which in 2002 was still unavailable in education sector in Estonia.

Since 1998 more and more community development approaches have practiced inclusion, mobilization, activation and empowerment of stakeholders. The shift from the 'old' problem solving paradigm to the 'new' began to appear and, according to the health promotion practitioner's opinion, from the beginning of the new century most stakeholders in Rapla were more or less familiar with the importance of community participation. However, empowerment terms and approaches were largely unfamiliar.

2.9.4 Community workgroups and target groups

Collaboration with different organizations and sectors began shortly after employing a health promotion practitioner. Cooperation manifested itself in various forms: There existed several interest groups (group for the physically active elderly, kids schooling "Look for Ott" group, etc.), different groups for the involved (e.g. safe neighbourhood work group), workgroup of representatives from different sectors (e.g. coalition for drug use and AIDS prevention), a network of student councils of county schools (deals with several school-centered health problems e.g. prevention of drug use, school injuries, bulling etc.), network of health teachers, health network of social workers, health network of care homes for the elderly, health network of kindergartens (active in preventing child injury) and many other networks and workgroups.

The first health workgroup of representatives from the county government, local authorities, different organizations, networks and sectors was founded in 1998 for AIDS and drug use prevention. Cooperation groups have formed initiatives from the grass-roots level,

with the initiative, stimulation, motivation and encouraging of the health promotion practitioner, and several now have their own "lives" and continue their activities. Inclusion of the local people has been a relatively enjoyable process. One of the reasons might be the general interest towards local health problems. On the other hand, people have expressed their satisfaction for having been invited to participate, that they have been regarded as relevant and acknowledged. At the end of a meeting/brainstorm of elderly women, an older lady, a former school teacher, came up to me and said: "You health promoters, are the first to come to us, retired folk, to ask what could be done for the community health. I'm so glad that our opinion is asked and our recommendations wanted. We have a lot of life experience, there's so much we can do."

Community workgroups are a combination of representatives of the target group and decision makers. With every year the amount of community people who are involved in local activities has increased and it has become easier for them to get involved. At present, involvement in health programs has become desirable and favourable. Community programs have several different target groups that are defined in the beginning of the programs by the locals themselves.

2.10 In conclusion

The context chapter has attempted to highlight the processes, context and problems inherent to study community. The health promotion development in Estonia and in other Eastern Europe countries differ from the developments in stable societies, as it has been influenced by the turmoil of transformation period in the end of last century. The foundation of the new health promotion system, health policy, strategies, structures, professional

requirements and approaches were felt as requiring shift from the medically oriented preventive model towards the empowerment focused socio-ecological model. The reforms have proceeded through constant reconsiderations using international experiences and developing local expertise, and have created a unique context both for whole society and similarly for the Rapla County.

In Estonia, as in all Eastern European countries, the populations had to live and communicate during more than half of century in the spirit of "closed society" (Gebert and Boerner, 1999). Constant fear and disempowering atmosphere due to autocrat ruler system allowed merely limited socialization. In accordance with the closed society model, personal initiatives, community participation, autonomy or open dialogue and other community development processes were not permitted in these societies. Some scientists (Diether *et al.,* 2006; Gebert and Boerner, 1999) have even hypothesized that empowerment, in the sense of fostering the subject status, may thus prove less successful in Eastern Europe and may even turn out to be dysfunctional. Author argues that social movement during the liberalization period demonstrates the potential and hidden resources and existing power for participatory approaches.

Although the concept of empowerment has met with widespread acceptance in the scientific community and has proven successful in many Western countries (Diether *et al.,* 2006), it has not been demonstrated whether the same level of success can be attained in the newly independent Eastern European countries. Only a few studies exist to highlight the empowerment processes in countries in transition (Makara, 1994). Therefore to initiate participatory approaches in implementation and also in research in such a dynamic, constantly

changing, economically unstable and historically vulnerable context was complicated and challenging.

Considering the remarkable inequalities in health, especially its socio-psychological and socio-economic determinants, between Western and Eastern European countries, empowerment approaches are indispensable in countries like Estonia. Author argues that health promotion policy and practice in these countries could benefit from the community development work through a focus on enabling individuals and communities to identify their needs, develop solutions, and facilitate change.

PART 1:

Theoretical background and methodology

CHAPTER III

COMMUNITY EMPOWERMENT - THEORETICAL CONSIDERATIONS

3.1 Introduction

The current health promotion policy and practice place a high value on community development work (Robinson and Elliott, 2000) because it aims to enable communities to identify problems, develop solutions and facilitate change (Blackburn, 2000). Community development has been suggested as offering “the most promising approach to reducing health inequalities” (Labonte, 1990) and as a key strategy to mobilize citizens, organizations and communities for health action and to stimulate conditions for change. It is an approach aimed at facilitating community groups and individuals to "*empower* themselves", one that seeks "to recognize and value the health experience and knowledge that exists in the community and to use it for everyone's benefit" (Minkler, 2005). Empowerment is identified as a principal theory of community psychology (Rappaport, 1981, 1984, 1987), and a key concept for communities to remedy inequalities and to achieve better and fairer distribution of resources for communities (Tones and Tilford, 2001, Braithwaite and Lythcott, 1989; Breslow, 1992; Minkler, Thompson, Bell, & Rose, 2001; Wallerstein, 2006). The author’s interest in empowerment theory is based in the understanding that effective health interventions require empowerment-related processes and outcomes across multiple levels of analysis.

In this chapter, first I provide an overview of the empowerment concept both at the level of the individual, organization and community, but focusing predominantly on community

empowerment. Empowerment both, as a process and outcome indicator is discussed and power issues outlined. Second, I describe the overlapping concept of community capacity. Finally, I demonstrate how community concept is understood by different authors and in the current study.

3.2 The concept of empowerment

Empowerment is a construct shared by many disciplines and arenas: community development, psychology, education, economics, studies of social movements and organizations. Recent literature reviews of articles indicating a focus on empowerment, across several scholarly and practical disciplines, has demonstrated that there is no clear definition of the concept. Zimmerman (1984) has stated that asserting a single definition of empowerment may make attempts to achieve it formulaic or prescription-like, contradicting the very concept of empowerment. However, for health promotion practitioners, making empowerment operational in health promotion contexts is a crucial issue.

Empowerment, in its most general sense, refers to the ability of people to gain understanding and control over personal, social, economic and political forces in order to take action to improve their life situations (Israel *et al*., 1994). It is the process by which individuals and communities are enabled to take power and act effectively in gaining greater control, efficacy, and social justice in changing their lives and their environment (Solomon, 1976; Rappaport, 1981, 1985; Fawcett *et al.,* 1994; Israel *et al.,* 1994; Minkler, 2005). Central to empowerment process are actions which both build individual and collective assets, and

improve the efficiency and fairness of the organizational and institutional context which govern the use of these assets.

According to Rappaport empowerment is a construct that links individual strengths and competencies, natural helping systems, and proactive behaviors to social policy and social change (Rappaport, 1981, 1984). He has noted that it is easy to define empowerment by its absence but difficult to define it in action as it takes on different forms in different people and contexts.

Czuba (1999) suggest that three components of empowerment definition are basic to any understanding of the concept: empowerment is multi-dimensional, social, and a process. It is multi-dimensional in that it occurs within sociological, psychological, economic, and other dimensions. Empowerment also occurs at various levels, such as individual, group, and community. Empowerment is a social process, since it occurs in relationship to others, and it is a process along the continuum. Other aspects of empowerment may vary according to the specific context and people involved, but these three remain constant. How empowerment is understood also varies among perspectives and context.

3.3 Power and empowerment

The essence of the concept of empowerment is the idea of power. According to Lukes (1974) power may occur in several levels and this clarifies the understanding of the term and also its relationship to community organization. At the level of individual, power refers to the ability to make decisions, at the organization level power involves the shared leadership and common decision making. The possibility of empowerment depends on two things – empowerment requires that power can change and expand (Czuba, 1999). Empowerment is

assumed to be a process that fosters power (that is, the capacity to implement) in people, for use in their own lives, their communities, and in their society, by acting on issues that they define as important. Power is often related to our ability to make others do what we want, regardless of their own wishes or interests (Weber, 1946). Traditional social science emphasizes power as influence and control, often treating it as a commodity or structure divorced from human action (Lips, 1991). However, in health promotion power is mainly understood and exercised in a positive manner, as sharing of control with others (Laverack, 1999).

The second requirement - concept of the empowerment also depends upon power that can expand. Understanding power as zero-sum, as something that some get at others expense cuts most of people off from power. A zero-sum conception of power means that power will remain in the hands of the powerful unless they give it up. Although this is certainly one way that power is experienced, it neglects the way power is experienced in most interactions.

Grounded in an understanding that power will be seen and understood differently by people who inhabit various positions in power structures (Lukes, 1994), contemporary research on power has opened new perspectives that reflect aspects of power that are not zero-sum, but are shared. Feminists (Miller, 1976; Starhawk, 1987), members of grassroots organizations (Bookman and Morgen, 1984), racial and ethnic groups (Nicola-McLaughlin & Chandler, 1984), and even individuals in families bring into focus another aspect of power, one that is characterized by collaboration, sharing and mutuality (Kreisberg, 1992). Researchers and practitioners call this aspect of power "relational power"(Lappe & DuBois, 1994), “generative power” (Korten, 1987), "integrative power," and "power with" (Kreisberg, 1992).This aspect means that gaining power actually strengthens the power of others rather

than diminishes it such as with domination-power. Kreisberg has suggested that power, defined as "the capacity to implement", (Kreisberg, 1992) is broad enough to allow power to mean domination, authority, influence, and shared power or "power with." It is this definition of power as a process that occurs in relationships, that gives the possibility of empowerment and it is a process that fosters power (that is, the capacity to implement) in people, for use in their own lives, their communities, and in their society, by acting on issues that they define as important.

In Eastern European societies the long-lasting occupation period was characterized by accumulation of power to the hands of small group of politically powerful leaders. Authoritarian systems were disempowering for population, excluding community participation, social mobilization and delegation of power to anybody outside the loyal party members. After regaining independence the democratization processes remarkably influenced to the power distribution in Eastern European countries and also in Estonia. However, the ultraliberal policies have again its eroding influence to social fabric disempowering many groups.

3.4 Levels of empowerment

Israel et al., (1994) makes the distinction between individual, organizational and community empowerment. Whereas individual empowerment is concerned with individuals gaining mastery over their lives, the organizational empowerment focuses to collective capacities and community empowerment on ‘the social contexts where empowerment takes place’ (Wallerstein and Bernstein, 1994).

The concept of empowerment has different meanings within the context of health promotion work (Israel *et al*., 1994; Labonte, 1994; Robertson and Minkler, 1994; Labonte and Laverack, 2001b; Smith *et al*., 2001) as empowerment may appear on different levels (Zimmermann, 1990; Bracht and Tsouros, 1990; Bernstein *et al*., 1994; Israel *et al*., 1994; Labonte, 1994; Robertson and Minkler, 1994; Robinson and Elliott, 2000; Smith *et al*., 2001), but all these levels are closely connected: in empowered communities there are empowered organizations and the level of organization empowerment depends on the empowerment level of its members (Robertson and Minkler, 1994; Wallerstein and Bernstein, 1994). Although it has been suggested that the three levels are interdependent, the aims of each may differ (Robertson and Minkler, 1994) and this may impede practice (Laverack and Wallerstein, 2001).

Several researchers have identified somewhat different scales for the measurement of individual empowerment depending on the context and/or specificity of study group.

Zimmerman (1995, 2000) has defined three components of IE: intrapersonal, interactional and behavioural. The intrapersonal component includes community-specific self-efficacy, motivation and intention to take action and control in an individual's community. The interactional component refers to critical awareness and understanding of a given context. The behavioural component includes participation in collective action. In the context of ethnic identity, Gutierrez (1995) specified group identification as a psychological component of empowerment for individuals. Parsons (1999) identified characteristics of empowerment in the context of mental health services. One characteristic identified was the degree to which clients develop a critical awareness or critical thinking regarding system dynamics within the family or community with relation to power. McWhirter (1991) described skill development,

a characteristic that stresses skills in decision making and socialisation. Akey *et al*. (2000) utilised data from 293 parents of children with disabilities living in three states in the USA and participating in family support programs aimed at empowering parents. The scale developed by these authors originally contained three subscales: attitudes related to control and competence, critical skills and knowledge, and participatory behaviour. Speer and Peterson (2000) elaborated a 27-item scale for the measurement of IE and reported psychometric properties of a scale from a sample of 974 randomly selected people. They identified cognitive, emotional, and behavioural dimensions in community-organising contexts. The applicability of their measure was broad. However, they all recognised that modifications need to be made on the basis of the variety of contexts and settings in which empowerment may be applied.

Wilson (1996) pointed out that recently, more researchers, organizers, politicians and employers recognize that individual change is a prerequisite for community and social change and empowerment (Speer and Hughey, 1995; Florin and Wandersman, 1990; Chavis and Wandersman, 1990; Wilson, 1996). This does not mean that we can point the finger at those with less access to power, telling them that they must change to become more "empowered" in order to be successful. Rather, individual change becomes a bridge to community connectedness and social change.

To create change in organizations and communities, individual empowerment endeavors to enable people to become partners in solving the complex issues facing them. In collaborations based on mutual respect, diverse perspectives, and a developing vision, people work toward creative and realistic solutions. This synthesis of individual and collective change (Speer and Hughey, 1995; Wallerstein, 2006) is an empowerment process. The

inclusive individual and collective understanding of empowerment is crucial in programs with empowerment as a goal.

Organizational empowerment refers to organizational efforts that generate psychological empowerment among members and organizational effectiveness needed for goal achievement (Peterson and Zimmermann, 2004). In simple terms, an organizational empowerment is its potential to perform - its ability to successfully apply its skills and resources to accomplish its goals and satisfy its stakeholders' expectations. The aim of organizational empowerment is to improve the potential performance of the organization as reflected in its resources and its management. Performance is the ability of an organization to meet its goals and achieve its overall mission.

Empowerment at the community level of analysis - community empowerment -includes efforts to deter community threats, improve quality of life, and facilitate citizen participation. The community empowerment model suggested by Wallerstein (1992, 2006) is multi-dimensional and includes the dimension of improved self-concept, critical analysis of the world, identification with the community members, participation in organizing community change. She defines empowerment as follows: it is a social-action process that promotes participation of people, organizations, and communities towards the goals of increased individual and community control, political efficacy, improved quality of community life, and social justice. The outcomes of community empowerment may emerge as actual socio-environmental and political changes in community. Furthermore, in several studies it is found that increased empowerment in community will lead to an increase in social capital (Zhou and Bankston, 1994; Harpham *et al.,* 2002; Higgins and Nohria, 1999; Lomas, 1998; Hawe and Shiell, 2000; Wallerstein, 2006). These findings suggest us to consider the indicators of the

structural (participation, institutional linkages, collective action, links to groups, etc.) and cognitive (social support, trust, reciprocity, etc.) components of social capital as the outcomes of community empowerment. However the assessment of the changes in the indicators of social capital is beyond the current study.

In practice, the distinction between individual empowerment and collective empowerment is not so clear. Studies have indicated that stronger individuals with greater belief in their own efficacy often initiate actions to improve the collective situation, but they are encouraged by, and sometimes depended on by less confident groups for help and moral support. The author's conception of empowerment takes this interdependence to be an essential aspect of empowerment.

3.5 Process and outcomes of empowerment

The many interpretations of community empowerment are based on the understanding of this concept as either a process or as an outcome (Swift and Levin, 1987; Bernstein *et al.*, 1994; Rissel, 1994; Laverack and Wallerstein, 2001). As an outcome, community empowerment is an interplay between individual and community change with a long time-frame, at least in terms of significant social and political change (Raeburn, 1993). An example of this type of outcome would be a change in government policy or legislation in favor of individuals and groups who have come together around programs and community actions (Zimmerman and Rappaport, 1988; Laverack and Wallerstein, 2001; Fetterman, 1996), evidence of pluralism in community (Zimmerman and Rappaport, 1988, Fetterman, 1996) or existence of coalitions in community and accessible community resources (Zimmerman,

1992; Israel *et al.,* 1989; Kawachi and Kennedy, 1997; Jenson, 2010). Zhou and Bankston (1994) have demonstrated that empowerment in community will lead to increase in social capital. Therefore it may be possible to measure the indicators of social cohesion, social trust, reciprocity, networks and community involvement as outcomes.

At an individual level, as immediate outcomes, people may feel an increase in self-efficacy or -confidence, motivation and intention to participate in community problem solving, which evolved from collective action (Kieffer, 1984; Bandura, 1989; Zimmerman, 1992; Zimmermann and Rappaport, 1988; Labonte, 1998). Therefore individual empowerment dimensions and social capital dimensions could be considered as potential outcome characteristics to monitor before and after the health promotion interventions. While community related individual empowerment indicators are relatively credibly attributed to the community health promotion intervention, the attribution of the social capital indicators to specific health promotion intervention is impugn able. What makes community empowerment outcomes even more confusing is that these may be different in different contexts, settings or time (Laverack and Wallerstein, 2001).

Most authors have defined empowerment mainly as a process (Swift and Levin, 1987; Wallerstein and Bernstein, 1988; Rissel, 1994). It is understood as a process of increasing the ability of individuals, groups, organizations or communities to (1) analyze their environment, (2) identify problems, needs, issues and opportunities, (3) formulate strategies to deal with these problems, issues and needs, and seize the relevant opportunities, (4) design a plan of action, and (5) assemble and use effectively and on a sustainable basis resources to implement, monitor and evaluate the plan of actions, and (6) use feedback to learn lessons

(UNDP,1995). As a process it may be defined as capacity building, competence and skills development and critical awareness in community issues.

Community empowerment as a process is best considered as a continuum representing progressively more organized and broad-based forms of social and collective action (Laverack, 2004). Jackson *et al.* (1989) and Labonte (1989) developed at the same time an almost identical five-step continuum model (Figure 3) consisting of the following developmental stages: personal action, small mutual groups, community organizations, partnership organization, and social and political actions (Rissel, 1994; Labonte, 1994).

Figure 3: Stages of community empowerment (Jackson *et al.,* 1989, Labonte, 1989).

The process is best considered as a continuum representing progressively larger forms of social organization and collective action. This continuum is dynamic - if one step is achieved, progression moves on to the next point. In this way each step can be viewed as an outcome and if this is achieved the process towards next goals goes on (Laverack, 1999). The author argues that programs themselves can, and should be viewed as a means of increasing community empowerment.

3.6 Organizational domains of community empowerment

To understand the empowerment process, health promotion practitioners require a thorough operationalization of the community empowerment concept in health promotion

interventions. The operationalization of community empowerment process helps enable community members to initiate and sustain activities leading to changes in the health and quality of life of the community. A range of factors or organizational aspects that affect a program's empowering influence on community members have been suggested by Laverack and Wallerstein (2001) and are known as Organizational Domains of Community Empowerment (ODCE). Currently, researchers emphasize that changes in ODCE can be used as proxy parameters in the evaluation of community initiatives (Smith *et al.,* 2003; Labonte and Laverack, 2001a; Robertson and Minkler, 2010). Furthermore, changes in the domains may contribute to solving health problems in the community and therefore can be seen as determinants of health.

Laverack (1999) argues that ODCE demonstrate the potential ability of a network to develop an empowering and democratic partnership with a community, through which the community's capacity to identify and address its priority health concerns is enhanced. These are the organizational domains that present a straightforward way to define and measure empowerment construct as a process. Based on review of literature, with focus to group research, and broader consultations with experts, several authors have constructed different but somewhat overlapping domains of empowerment (Table 2 article 1). None of the literature makes a strongly compelling case for one schema above any other.

While working in two rural Fijian communities, Laverack (1999) has identified nine ODCE: participation, leadership, problem assessment, organizational structures, resource mobilization, links to others, asking why, program management and the role of outside agents.

Smith *et al.* (2003) found that most referenced ODCE were participation, knowledge, skills, resources, shared vision, sense of community and communication. Hawe *et al*. (2000) identified a more general set of domains. The ODCE were comprised of three main activities: (i) building infrastructure to deliver health promotion programs; (ii) building partnerships and organizational environments which ensure sustainable programs and health gains; and (iii) building problem–solving capability. Bush *et al*. (2002) elaborated on a *Community Capacity Index*, in which they distinguished four domains: network partnerships, knowledge transfer, problem solving and infrastructure development. Domains identified by Gibbon (2002) and Bopp *et al*. (1999) overlapped almost entirely with those determined by the abovementioned researchers. These operational domains represent those aspects of community empowerment that allow individuals and groups to organize and mobilize themselves towards commonly defined goals of political and social change (Laverack and Wallerstein, 2001)

Researchers have suggested that community empowerment is a context and program-specific process (Smith *et al.* 2003; Bush *et al.,* 2002; Laverack, 2005). This idea presumes that communities may be guided by general sets of organizational domains but that the interpretation of domains may differ in different communities (Hawe *et al.,* 2000). Indeed, most authors admit that ODCE have not been tested in relevant settings and the context of different communities.

The ODCE are the organizational areas of the empowerment, which can cause the expansion of empowerment if these domains are addressed by communities. These are activities which may be planned thoroughly and collectively by a community and may be measurable and changes evaluated. In that kind of understanding the domains like *shared vision* (Bopp *et al.,* 1999) or *sense of community* (Smith *et al.,* 2003) are not qualified as

organizational domains but rather as psychological domains supporting community empowerment, but not actively expanding empowerment. Furthermore, the domains *links to others* and *role of outside agents* (Laverack, 1999) and *linkages* (Gibbon, 2002) represent domains, which in some conditions may support empowerment expansion, but not ultimatively required for the expansion of empowerment in a community. Author of the current study argues that ODCE are activities which may cause the expansion of community empowerment and that identification of context-specific ODCE in study communities is a prerequisite for further analyse of the expansion of community empowerment.

3.7 Community capacity building

The importance of community empowerment as a central theme in health promotion has been overshadowed since the mid-1990s by discussions about community capacity. Community empowerment and community capacity building both refer to the problem-solving capability among individuals, organizations, neighborhoods and communities (Hawe *et al.* 1994). According to Hawe it is helpful for practitioners, program planners and evaluators alike to regard the concept of community capacity not as something new, but as a refinement of ideas found within the literature and practice of community empowerment. Both terms (community empowerment and community capacity) describe a process that aims to increase community abilities, assets and attributes (Laverack, 2001; Gibbon *et al.,* 2002). However community capacity is concerned mainly with the organizational aspects of empowerment (Laverack *et al.,* 2001).

Fawcett *et al.* (1996) connects these two terms and defines 'capacity for empowerment' as the ability to influence community conditions, such as programs and policies, and outcomes related to the mission.

According to Jupp (2000) real capacity building involves giving groups the independence to manage resources. Capacity building takes on a wider meaning than just training and development of individuals as its long term aim is to take control and ownership of the process. Community capacity building is understood as a part of a wider policy agenda supporting civic participation, decentralization and local service delivery, the modernization of local government structures and community planning frameworks. Research evidence links capacity building and community empowerment to the concept of social capital and explains how networks, trust, community values and participation provide a powerful force in the regeneration of disadvantaged communities (Taylor, 2000).

Wilkinson (1997) argues that community capacity term lacks the dimension of transforming power relations. Laverck and Wallerstein (2006) emphasize that it is only by being able to organize and mobilize oneself that individuals, groups and communities will achieve the social and political changes necessary to redress their powerlessness. And they conclude: "This remains the domain of community empowerment as a political activity, which enables people to take control of their lives".

Many authors see capacity as something that is dynamic, multidimensional, and directly or indirectly influenced by contextual factors (Brown *et al*. 2001). Also capacity is seen as task specific, and capacity constraints are specific as they relate to factors in a particular organization or system at a particular time (Milen, 2001). Capacity building is defined by Brown *et al.* (2001), and Labonte and Laverack (2001) as a process that increases the ability

of persons, organizations or systems to meet their stated purposes and objectives. It can also be seen as a process to induce, or set in motion, multi-level change in individuals, groups, organizations and systems seeking to strengthen the self-adaptive capabilities of people and organizations so that they can respond to a changing environment on an on-going basis (Morrison 2001). The capacity of a group is also dependent on the resource opportunities or constraints (ecological, political and environmental), and the conditions in which people and groups live (Gibbon *et al.,* 2002).

Like several researchers, (Mayer, 1994; Labonte and Laverack, 2001a) the author of the current study considers building community capacity fundamental to the concept of community empowerment.

3.8 How is community understood?

The term 'community' has many contradictory definitions. Different actors - practitioners, financers, politicians and community members understand community in different ways. As a result, the concept of community is often contested causing confusion for policy makers when considering who benefits from community empowerment and capacity building.

Napier (2002) defined community as a term associated with existing formal and informal community networks and local community organizations. Nutbeam (1986) considers community as a specific group of people living in a region, who are arranged in a social structure and exhibit some awareness of their identity as a group. According to Laverack (2003) the concept of 'community' includes several key characteristics: 1) a spatial dimension, that is, a place or locale, 2) interests, issues or identities that involve people who otherwise make up heterogeneous and disparate groups, 3) social interactions that are

dynamic and bind people into relationships with one another, 4) identification of shared needs and concerns that can be achieved through a process of collective action. The notion of community does not necessarily imply homogeneity and there are likely to be competing and conflicting interests. Bell and Newby (1978) emphasize that albeit community can include many components, social relations are crucial. Communities consisting of heterogeneous individuals may collectively take action toward attaining shared and specific goals (Ward, 1987; Israel *et al.,* 1994). This author supports the idea of Ward (1987), Israel *et al.* (1994) and Laverack (2003) that people from different sectors, having common needs, can work together towards program goals and objectives, may bind and connect stakeholders, create a community identity, and create social cohesion in a locality.

In the current study heterogeneous groups in Rapla County, who have been involved and actively participated in each health promotion program – *Safe Community, Drug Use and HIV Prevention* and *Elderly Quality of Life* programs, both workgroups and networks around these programs are considered as communities. Through program planning, shared interests, aims and needs in given locality they worked together towards common goals, searching solutions for common problems. They have certain common geographical location, common identity, needs and interests, and they communicate and interact socially with each other. There are multiple community workgroups and networks within the Rapla community which are collaborating in certain community initiatives or programs, and each individual may belong to several different community groups at the same time. Within this study thee community groups and networks, focusing on specific program objectives, are involved and mobilized. The main aim of the health promotion practitioner's daily work was to involve, activate and mobilize as many community members, groups and networks as possible – to expand

empowerment in Rapla community through several programs integrating both, top down and bottom up approaches.

Heterogeneous groups in Rapla have formed several program workgroups through the process of program planning, as the program's aims and objectives reflect their shared interests and needs in a given locality. Involving program participants in the identification of issues and concerns is therefore crucial to ensure that the aims and objectives are relevant, and people are capable of working to overcome other divisions. The members of the formed 'program workgroups' organize and mobilize themselves around the program which, in turn, facilitates the means by which they empower themselves. This is enhanced when communities have shared needs, social networks and the desire to gain power. The role of the health promotion practitioner is to ensure that there is equality in both opportunities, and inclusion of the marginalized people.

3.9 In conclusion

Health promotion practitioners do not bring or give empowerment, but intervene into empowerment processes, which already exist (Taylor, 2000). It is essential for the practitioner to be aware where the individual, the organization, or the community is located on its own path of empowerment development. To know where it has come from, how it has changed and shaped.

A process of community empowerment begins along a continuum as a result of a personal action taken by individuals with an assumption that there is a deficit of power to influence a community (Laverack, 1999). From the health promotion practitioner's perspective this is a

baseline level of empowerment - individual, community related empowerment, characterized by psychological attributes. As a next step, development of several action groups, which are focusing on different community issues may be stimulated, enabled and encouraged by a health promotion practitioner (Labonte, 1989; Jackson *et al.,* 1989; Taylor, 2000). It is not just delivering resources and services to those in need, but rather initiating processes which result in people exercising more control over the decisions and resources that directly affect the quality of their lives. Support and facilitation of the forming and establishment of community organizations, consisting of core workgroup and several diverse surrounding networks, are characterized by organizational domains of community empowerment. Health promotion practitioners have an influential position in the activation and mobilization of several community groups and community coalitions for expansion of the empowerment in community through planned social endeavor.

Community workgroups are empowering engines in community – these serve as community organizations, having leadership, a system for communication, and an agreed upon structure. Community workgroups are able to mobilize new groups and networks, to search for new information, to search for knowledge required for problem solving, to manage problem solving, and to influence the political and social environment in order to achieve a more supportive environment for social/political action and change.

CHAPTER IV

METHODOLOGY AND METHODS

4.1 Introduction

Current research is a multi-stage study. To accomplish the objectives of this research, the study was formed as a logic process of five stages, which resulted in three separate articles. In previous chapters I have informed reader about the Rapla County communities` health promotion situation and communities` members` willingness to find an empowering approach for the evaluation of their health promotion programs. Also I have demonstrated, using literature analysis, that understanding of empowerment concept and its` organizational domains are largely culture-, and context-specific. Therefore, as stage 1, we started with clarification of the concept of community empowerment and its organizational domain in Estonian health promotion context. The results of the first stage is summarized in chapter V and more precisely discussed in *Article 1*. In stage 2 the framework for empowerment evaluation was developed. In stage 3 we focused to the elaboration of a measurement tool for the evaluation of ODCE. In stage 4 internal evaluation of changes in OCDE was carried out. This stage is more precisely presented in *Article 2* and summarized in the chapter VI. In stage 5 an external evaluation of individual community related empowerment (ICRE) was conducted. The study is summarized and discussed in chapter VII. *Article 3* reflects the study process in details.

This chapter focuses to the methodological issues. According to Haase and Myers (1988) there are three distinct research process levels: (i) paradigmatic level, (ii) research approach and (iii) method or technique. I first present the paradigms research is based on. Thereafter I give an overview of study communities, and present and discuss the study design, methods utilized and analytical procedures used during the stages of the study.

4.2 The research paradigm

The term "paradigm" refers to a systematic set of assumptions or beliefs about fundamental aspects of reality (Kuhn, 1970; Guba and Lincoln, 1989). Paradigms provide philosophical, theoretical, instrumental, and methodological foundations for conducting research and provide researchers with a platform for interpretation of the world (Morgan, 1983). Although the 'traditional' positivist paradigm is still dominating in evaluation research - in relation to health promotion the use of the post-positivist and constructivist approaches has been gathering strength in recent years (Labonte and Robertson, 1996). According to Guba and Lincoln (1989) evaluation approaches have changed during time and the approaches, using constructivist paradigm is the sign of new generation in evaluation - the fourth generation. The ontological and epistemological differences distinguish two main paradigms – constructivism and positivism (Guba, 1990). The basic ontological assumption of constructivism is relativism - that human sense-making is an act of constructions and is independent of any foundational reality. Reality is contextual and depends on the persons who assess it. The basic epistemological assumption of constructivism is transactional subjectivism, that is "reality" and "truth" depend solely on the meaning sets and degree of

sophistication available to the individuals engaged in forming those assertions (Cheadle *et al.,* 1997; Rosenau, 1994). The researcher and the "object" of investigation interact to influence one another, the knower and the known are inseparable. The basic ontological assumption of positivism is a belief that there is a single tangible reality and universal truth, which exists independently. According to the positivist epistemology the researcher investigates and controls the reality. However reality is constructed by the context and people socializing in the context.

Frequently discussions concerning research paradigms are barely distinguishable at the level of methods – in particular, on the subject of “quantitative” versus “qualitative” methods. In the empowerment evaluation approach Fetterman *et al.* (1996) support the importance of the use of both, qualitative and quantitative data. They argue that use of different paradigms within an evaluation process could take place in parallel - constructivist paradigm allows reckon with community member’s opinions and views, and positivists paradigm allows to examine data collected externally in the same time. Both types of methods may be and often are appropriate in all forms of evaluative inquiries. Moreover, the qualitative participatory approaches to health promotion and evaluation have been designed to empower people, often evoke a real social change (Fetterman, 1996; Fawcett *et al.,* 1996; Springett, 2001). For health promotion practitioners, the art of assessing effectiveness is not to what extent it can approximate a randomized controlled trial, but whether it achieves the ultimate purpose in population health, which in authors´ view is to enhance the health and wellbeing of the community members and to do this in a way that is empowering.

Current thesis is a multi-method research. Both qualitative and quantitative methods are utilized in different stages of the study. However, constructivist paradigm formed the

worldview of the current evaluation research and directed predominantly the data analysis, with and exception of the stage 5 (Chapter VII), what is based on positivist paradigm.

Health promotion techniques that aim to listen more attentively to the views of community members, by using interviews, workshop methods, participant observation or other qualitative methods, penetrate into the lives and mind of subjects (Nettleton and Bunton, 1995). Participation means engaging in dialogue at all stages of the research and shifting power in favour of those being researched. This is in contrast to the positivist models of research that have dominated in evaluation in the past and where the voice of the community was not often being heard. This is what led to a whole new paradigm of action and was also taken into consideration in current study.

4.3 Settings and people involved in study

In the current study heterogeneous groups in Rapla County, who have been involved and actively participated in three health promotion programs – *Safe Community, Drug Use and HIV Prevention* and *Elderly Quality of Life* programs, both workgroups and networks around these programs are considered as communities. Through program planning, shared interests, aims and needs in given locality they worked together towards common goals, searching solutions for common problems. They had certain common needs, interests and goals, and they communicated and interacted socially with each other. The members of the program workgroups organized and mobilized themselves around the programs. These three initiatives in the Rapla County received a grant in the year 2002 from the Health Promotion Fund to implement county-wide approaches for preventing injuries, drug and alcohol use among young people, and unsafe sex and to promote safety, security, and quality of life among the

elderly. The initiatives shared the mission of involving stakeholders from a variety of sectors in addressing issue-specific health concerns. The participating community programs are described as follows:

The *Safe Community* program was initially a *bottom-up* initiative, started four years before the study, guided by a community workgroup. It later involved representatives from municipalities and decision-makers from different sectors and had a large network in the county. The mission of the program was to reduce injuries among the Rapla population and to support the development of safe community principles by modifying policies and practices related to the perpetuation of an unsafe environment. It comprised a combination of *top-down* and *bottom-up* initiatives financed on a yearly basis by a health promotion fund. There were many activities, the program workgroup together with larger network were implementing: organizing safety campaigns, teaching school-children traffic behaviour, publishing printed materials for mothers of newborn babies on the prevention of babies' injuries, organizing swimming courses to prevent drowning, implementing safe school campaigns, publishing printed materials for elderly persons to prevent falls, distribution of grants to stimulate small prevention projects.

Drug Abuse and AIDS prevention program was a *top-down* program initiated and planned nationally and expanded into the community three years before the current study was conducted. It had national goals and objectives and an action plan. The objectives were to prevent drug and alcohol use and unsafe sex among young people in the community. This program was financed by the state budget and guided by a local coalition that comprised representatives from different organizations, authorities and sectors in the county.

The Elderly Quality of Life program was a *bottom-up* initiative developed by a group of elderly people. The workgroup consisted of women who were interested in improving the quality of life of elderly citizens in their community. The program's aim was to avoid exclusion of older people, and the group made efforts to keep elderly citizens involved socially. The program workgroup was formed and activities initiated three years before the current study was conducted.

The workgroups and networks which participated during the intervention period consisted of members with different background, education, specialities and affiliations. The mobilization of community members was continuous and expansive. The more precice description of participants who were involved in different stages of the study is given below.

4.4 Study design

As mentioned above there are five stages to this research: conceptualization of the community empowerment process, elaboration of a measurement tool for the evaluation of ODCE, development of the framework for empowerment evaluation, internal evaluation of changes in OCDE and an external evaluation of ICRE. The different stages of current study are based on integration of different worldview and paradigm. Consequently different stages apply different strategies of inquiry. Integration of the qualitative and quantitative research was utilized in the study. Qualitative research is a naturalistic interpretive approach that seeks to describe and explain how participants perceive action, understand concepts and make decisions. Quantitative research seeks to identify factors or indicators in a sample that can be assumed to be true of the population from which the sample was drawn. The qualitative

research designs were implemented in the 1-3 stages of the study. In stage 5 the quantitative approach was implemented. In the stage 4 the integration of these two approaches were utilized. The choice of study design in current research was influenced by both, theoretic and pragmatic issues, predominantly by participants` considerations.

In the beginning of the study more inductive-oriented design was selected as the concept of empowerment is highly complex and was relatively unfamiliar to participants, and as many authors have declared that the empowerment concept is a context- and culture-specific. The study design consisted of combination of following designs:

1) Explorative research – refers to making efforts to clarify an unclear problem from multiple perceptions and opinions (Stage 1);

2) Participatory action research - empowerment evaluation – refers to the participatory use of evaluation concepts, techniques, and findings to foster community improvement and self-determination (Stages 2 and 3);

3) Descriptive study – refers to description of a possible social change or a condition (Stage 4).

4) Cross-sectional study – refers to a snapshot at a particular time looking at the presence or absence of indicators (Stage 5).

4.5 Study process

4.5.1 Stage 1: Conceptualization of the community empowerment process.

As a first step in the multi-stage study the clarification of the community members' context-specific understanding of empowerment process concept was agreed with three

community health promotion programs workgroup members in order to identify measurable organizational domains and indicators of community empowerment.

After several discussions and review of different empowerment approaches, the principles of empowerment evaluation were agreed upon as the most suitable and acceptable approach for local people to experience empowering process and simultaneously acquire knowledge and skills in evaluation techniques. According to Fetterman (1996) empowerment evaluation is defined as the use of concepts, techniques, and findings to foster improvement and self-determination. Self-determination, defined as the ability to control one's own life and/or community life, forms the theoretical foundation of empowerment evaluation. It consists of numerous interconnected capabilities, such as the ability to identify and express needs, establish goals or expectations and a plan of action to achieve them, identify resources, make rational choices from various alternative courses of action, take appropriate steps to pursue objectives, evaluate short- and long-term results (including reassessing plans and expectations and taking necessary detours), and persist in the pursuit of those goals (Grills, 1996; Fetterman, 2002).

The approach was appreciated by the participants as it explicitly rejects the paternalistic and patronizing characteristics of the previous traditional evaluation approaches, allows community members collectively to evaluate the program and simultaneously develops community empowerment. The decisive aspect in selecting this model was that according to Laverack and Wallerstein (2001) the approach contains the capacity development component for the local people, what means that the acquired knowledge and skills remain in the community after the official end of the evaluation. It is a process through which community

members themselves, in collaboration with health promotion practitioners, work toward the improvement of the quality of their common program.

Empowerment evaluation is a relatively new approach to evaluation in health promotion community. The model has been adopted in higher education (Fettermann *et al.*, 2010), government institutions (Keller, 1996), non-profit corporations (Andrews, 1996) and community health promotion (Fettermann, 2010) primarily in North America. Until now, it has been relatively modestly used in Europe and, to author knowledge, never in Estonia.

The empowerment evaluation model applied to the Rapla health promotion initiatives consisted of four steps (Figure 1 in *article 1*):

i) Agreement on mission.

During this step, discussions on the issue-specific mission in each workgroup took place separately. This was a democratic process where a myriad of opinions were considered, but final consensus was required and reached. Thus, the participants of each program agreed on a common issue-specific mission.

ii) Taking stock.

The program's accomplishments to date were assessed. A list of activities was composed and priority activities selected and analyzed. Each activity was rated on a 10-point scale that allowed community members to assess their actions' quality, effectiveness, appropriateness and relevance. An evaluation matrix was created and summative grades calculated.

iii) Planning of the future.

The workgroups' members focused on establishing their program goals and objectives and determining where to go in the future, with an explicit emphasis on program improvement and achievements. The outcome indicators were identified and evaluation tools agreed upon.

Strategies and actions to accomplish program goals and objectives were developed, and measurement indicators for process evaluation were identified. Tools for evaluation were identified, time schedules composed and responsibilities distributed. The implementation and evaluation plans were drafted.

iv) Implementation and monitoring.

During the implementation period, the continuous recording of the planned activities, assessment of the quality and appropriateness of the activities, continuous feedback from the workgroup members and evaluation of the outcomes at the end of implementation period took place. In parallel, a number of consultations, training courses, workshops and supportive activities were offered to meet community members' needs for program planning, implementation and evaluation.

The application of the empowerment evaluation was agreed in the year 2002 in order to plan and internally evaluate their interventions. A year after, in 2003, semi-structured interviews were undertaken with sixteen participants from three health promotion programs, *Safe Community, Drug Use and AIDS Prevention* and *Elderly Quality of Life* programs members in order to identify what transpired in the community during the empowerment process, how participants perceived empowering activities, and what empowering domains and activities were focused on by the practitioner and workgroups. *Article 1* in chapter V provides an overview of current qualitative research. As the result of the study the ODCE were identified by the community participants (see chapter V).

4.5.2 Stage 2: Elaboration of the measurement tool

The ODCE used in the following stage of the study, were constructed using Rapla community members' perceptions and views on the health promotion empowering and

enabling activities during community empowerment evaluation process by three programs (*Safe Community*, *Drug Abuse and AIDS prevention* and *Elderly Quality of Life* program) workgroups. Based on interviews with community members in Rapla, four empowerment process domains were formed: 1) activation of the community; 2) competence of the community in solving its own problems; 3) program management skills and 4) creating a supportive environment (political and financial) (Chapter V).

Among the domains formed, the third domain, program management skills, coincided almost completely with that developed by Bush *et al.* (2002). However, when analysing the indicators of the concurrent domains with the community workgroup members using the consensus workshop method, it appeared that questions characterizing indicators, developed by Bush *et al.* (2002) were difficult to understand and often irrelevant to Rapla community members. Before the testing of this third domain, the definitions of domain indicators were translated into Estonian and retranslated back into English to avoid a translation bias.

The community workgroup members from the *Safe Community* initiative were asked to express their understanding of each indicator, discuss it, and to reach a consensus on its characteristics. During the testing, several statements describing indicators were redefined, specified and adjusted to Rapla's context by the community workgroup members. Considering the elements of the domain, and enabling activities of the community workgroup, a new set of questions had to be developed to provide description of the types and levels of the community capacity. This process reaffirmed the statements of Laverack, (1999), Hawe *et al.* (2000), Foster-Fishman (2001), Gibbon *et al.* (2002) and Bush *et al.* (2002) that community capacities are context specific.

Community workgroup members identified three levels of each domain. A similar number of levels were suggested by Bush *et al.* (2000), but the content of the levels was predominantly context specific. The actual activities were recorded to show evidence that determined the ODCE by matching the activities against the indicators listed in the questionnaire. A ranking for each indicator, 1 (not at all/very limited), 2 (somewhat), 3 (substantial) and 4 (almost entirely/entirely), was agreed upon. The validation of a set of domains and indicators was tested by two other community workgroups, Drug Use Prevention and Elderly Quality of Life programs` workgroups (The measurement tool is presented in Annex II).

4.5.3 Stage 3. Development of the framework for empowerment evaluation.

Although Fetterman *et al.* (1996) demonstrates the evaluation process, which is supposed to empower participants, he do not discuss the development of a practical methodology or ‚tool' for the measurement of community empowerment, nor do he assess whether the application of the model has resulted changes in community empowerment. This aspect has allowed his opponents to criticize his approach. Patton (1997) argues that Fetterman never demonstrated whether community member's empowerment expanded as a result of evaluation process.

Laverack and Labonte (2000) have elaborated a 'parallel tracks' program planning model where he integrates an empowerment approach in parallel with an issue-specific approach, ensuring focus on both, empowerment development process and an issue-specific problem-solution process. The advantage of this model is that by clarifying and distinguishing empowerment domains, participants are able easily to assess changes in empowerment during an intervention course and measure empowerment domains and indicators. The limitation of

the 'parallel tracks' model is that it does not clearly demonstrate the precise steps for the empowerment process. For searching solution, in collaboration with community workgroups, the an empowerment expansion framework was constructed to achieve and assess changes in empowerment and health in the three different programs that were implemented The framework integrated models of empowerment evaluation, as suggested by Fetterman *et al.* (1996) and the *parallel tracks* model elaborated by Laverack and Labonte (2000) (Kasmel and Andersen, 2011). The empowerment expansion framework, which adopts the distinct implementation steps from the empowerment evaluation model, and measurement of the ODCE from 'parallel tracks' model, creates an opportunity to simultaneously expand empowerment in a community, achieve expected outcomes related to community needs, and similarly evaluate changes in both tracks. The framework of the empowerment expansion is presented in Figure 1 article 2.

4.5.4 Stage 4: Implementation of framework in three community health promotion programs

The workgroups of the *Safe Community, Drug Use and AIDS Prevention* and *Elderly Quality of Life* programs separately implemented the framework of empowerment expansion in the year 2003 and 2004. Implementation started with assessment of ODCE in January 2003. Consensus workshop method was used to identify, discuss and reach consensus in the extent of each domain and indicator of community empowerment (further described in methods section and in chapter VI). In the same workshop, in phase II—planning of community empowerment - goals and objectives for the empowerment expansion were defined, measurable indicators and measurement processes were identified, and action and evaluation plans agreed upon. Phase III—comprised two parallel implementation processes:

a) issue-specific processes, in which the guidelines for empowerment evaluation (Fetterman, 1996) were used. An issue-specific mission was discussed in each workshop and agreed. Thereafter activities undertaken so far were listed, prioritized, analyzed, and rated, and an evaluation matrix was developed (an example in Annex III). Further issue-specific goals, expected outcomes (an example in Annex IV), and action plans were formulated (an example in Annex V). This step also included the selection of measurement tools, indicators (an example in Annex VI) and time-schedules for the issue-specific evaluation, *i.e.*, creation of a system of processes and outcomes monitoring. During the course of the year the action plan was implemented, including constant feedback and monitoring of issue-specific processes. In parallel, b) the empowerment expansion processes: these included numerous activities targeted on the development of the four ODCE domains - the activation of community groups and networks, undertaking actions in order to improve community members` knowledge, skills and supportive environment. These processes were debated on and formulated by the community workgroups members that was being supported, facilitated and mediated by the health promotion practitioner and researcher.

The fourth stage of the empowerment evaluation framework includes the evaluation of changes in the outcome level: the changes in ODCE. As a complementary process, the measurement of ICRE was carried out.

Empowerment expansion process in Rapla health promotion programs workgroups was based on the following assumptions: 1) community groups should be involved in each step of the evaluation; 2) community people should make all the decisions and share the ownership of the program; 3) everyone were expected to agree that both process evaluation and outcome evaluation are important to undertake; 4) community people themselves should carry out the

evaluation; 5) the evaluation should be done in conformity with the local people's needs and concerns; and 6) all stakeholders should be equal in the process. The agreement in above mentions assumptions were reached before intervention was started.

The researcher acted as supporter, facilitating, assisting, enabling and mediating the process and worked as an equal partner in solving local problems during first four stages of the study with all three above mentioned workgroups in the community, in order to empower and enable community groups. During the fifth stage the researcher acted as an external evaluator.

4.5.5 Stage 5: Evaluation of Changes in Individual Community-Related Empowerment

In the preparatory stage of the study agreement was made in between community health promotion programs workgroups participation and the researcher that in parallel the external evaluation will be undertaken by the researcher. The process is summarized in chapter VII.

4.6 Methods, data collection procedure, sample and data analysis

In current research we have used both qualitative and quantitative data to provide a more complete picture of the issue being addressed - the stakeholders` perceptions and opinions and effectiveness of the intervention itself. Three methods were utilized in this research:

Method 1: In the first stage where we focused to the clarification of the empowerment concept in given context the qualitative grounded theory method was used (*Article 1*).

Method 2: In the second study, internal evaluation of the ODCE, the consensus workshop method was used, which is combination of the qualitative and quantitative research. The consensus workshop method is a participatory method that can be used as both a research and empowerment tool in health promotion programs. It involves each group member, gets all the

ideas into the mix, focuses the group's consensus, and builds an effective team partnership (*Article 2*).

Method 3: In the third research, external evaluation of ICRE, the quantitative cross-sectional pre-and post-study was undertaken (*Article 3*).

4.6.1 Method 1: Qualitative grounded theory method

This research method was developed by Glaser and Strauss 1960s. The research begins with the raising of generative questions, which help to guide the research. It is complex iterative process. The utilization of the qualitative grounded theory method enables to construct theories in order to understand phenomena (Corbin and Strauss, 2008).

Data collection procedure. Individual interviews, guided by a semi-structured questionnaire, were used to help the community members to describe their experiences and understandings of organizational domains of community empowerment. The interviews were guided with semi-structured questionnaires (Annex VII). To develop a clearer picture of the participants' understanding of the organizational domains of community empowerment, more detailed questions were subsequently asked.

The interviews were carried out in the local administrative centre where workgroups usually had their meetings. The data collection was continued until saturation was achieved, that is, no more new information was received and the number of interviewees was considered sufficient (Morse, 1995). Each interview lasted from 45 minutes to 2 hours (average length = 80 minutes). Each interviewee was contacted before the interview. The details of the study were explained, and verbal assent to participate was requested.

Sample. Purposive sampling was used, and interviewees were selected according to research needs. The criteria for inclusion were being a community member and participating

in one of the three health promotion programs from its start. Altogether, sixteen interviews (six from the *Safe Community,* five from the *Drug Abuse and AIDS Prevention* and five from the *Elderly Quality of Life* programs) took place. There were seven male and nine female participants ranging in age from 29 to 68 years (mean age = 47 years) with different backgrounds: medicine (n=2), social work (n=4), education (n=3), agriculture (n=2), economics (n=1), retired (n=3), and rescue (n=1). Six had completed university education, seven secondary education and three primary education.

Data analysis. The interviews were taped, and verbatim transcripts were made in Estonian. To test their validity, the typed interviews were sent to the interviewees for confirmation and adjustment. Eleven participants out of sixteen commented on and confirmed the recorded information. Whole data were not translated into English to avoid misinterpretation of data due to translation. Only those parts of the text that are quoted for the purpose of reporting were translated into English. Data analysis was conducted using the constant comparative methods described by Corbin and Strauss (1099). Once data collection was complete, a thorough inductive coding was conducted line by line by two researchers separately. Everything was coded to find statements illustrating interviewees' understandings and perceptions about the organizational domains of community empowerment in their context. Each perception, opinion, view, idea and/or action recorded in the transcript was labelled. Names of codes were derived from the actual words of interviewees. Thereafter, the two researchers' codes were compared and discussed until consensus was achieved. The duplicate coding was undertaken to address issues related to the trustworthiness of the research findings. When agreement on codes was attained, the categories were identified by comparing the codes and interpreting their content. Hence, four steps were undertaken: first,

the data were reviewed; second, the data to include were identified. Third, the categories were formed. Categorization provided working concepts that facilitated further comparison. Finally, the emerging conceptualization was discussed, first between the two researchers, and thereafter with interviewees. The contexts, attributes, conditions, and consequences of the categories were examined carefully.

4.6.2 Method 2: Consensus workshop method

The consensus workshop method was utilized to elaborate the measurement tool by the participants of the safe Community workgroup and to test the tool and develop a framework for empowerment expansion by the Drug Use and AIDS Prevention and Elderly Quality of Life workgroups in the study year 2002. Similarly consensus workshop method was used to measure changes in all three study workgroups in the year 2003, 2004 and 2005.

The consensus workshop method is derived from a set of participatory group facilitation methods. These methods have been used since the 1960s in communities, corporations, and governments in both developed and developing countries (Stanfield, 2000) for planning, problem solving, decision-making and research. The method encourages active participation from everyone in the group, and allows use of information and ideas for the enhancement of the program.

There are several reasons why the consensus workshop method is useful in empowerment evaluation research and the follow-up. Firstly, it encourages everyone to participate and is a relatively easy method to discuss and with which to reach a consensus. The method can be used both in formative research and as a follow up tool to stimulate discussion with community members`, therefore it was appropriate to employ in elaboration of the measurement tool. It leads to personal responsibility and action, so it is useful as an

empowering and a capacity building tool. It is valuable as it respects the knowledge and experiences of everyone in the group. Similarly, the method is good for gathering large amounts of data and organizing it relatively rapidly. Consensus workshop is a method which allows to use in parallel both quantitative and qualitative components. Recently, the integration of qualitative and quantitative components has been frequently utilized. Steckler *et al.* (1992) have delineated four possible models of integrating qualitative and quantitative methods in health promotion research. In the first approach, qualitative methods contribute to the development of quantitative instruments, such as the use of focus group in questionnaire construction. Second model consists of a primarily quantitative study that uses qualitative results to help interpret or explain the quantitative findings. In the third approach, quantitative results help interpret predominantly qualitative findings, as when focus group participants are asked to fill out survey questionnaires at the session. In the fourth model, the two methodologies are used equally and in parallel to cross-validate and build upon each other's results. Researchers may operate under one or more of these models. The approaches are not mutually exclusive.

In current research, in development of the measurement tool, the first approach was applied – using qualitative method the quantitative instrument was developed - the questionnaire was constructed. The numerical ranking was discussed by participants, and in parallel, the opinions and experiences of workshop participants were recorded. For measurement of changes in ODCE in all three study workgroups the second model suggested by Steckler *et al* (1992) was used - primarily quantitative study (consensus-based ranking of ODCE and its indicators was complemented with qualitative results to help interpret, explain and confirm the quantitative findings.

Data collection procedure. The workshops started by setting the context. The facilitator outlined the process, topic, purpose and timeline for the workshop. The focus question, assessed by each domain separately, was introduced. Workshop participants were provided with the propositions of each indicator, asked to characterize a domain, and then asked to rank it using Likert-like measurement tool, from 1 (not at all/very limited), 2 (somewhat), 3 (substantial) or 4 (almost entirely/entirely). Every participant assessed the indicator individually at first. Rankings were then written on the board, and the group discussed them until a consensus was reached. The aggregation of the different levels of indicators were discussed, assessed and ranked thereafter, means and range of scores were calculated. After the proposition of each aggregated indicator, participants were asked to verify the evidence. At the end of the ranking procedure, the community workgroup discussed potential measures and opportunities to enhance each empowerment domain during the next program cycle. The next two evaluations of ODCE were carried out one and two years later, in January 2004 and 2005. They preceded the new empowerment evaluation planning cycles.

During the first data collection, additional four interviews were conducted these workgroup members who were not able to participate in workshop, to collect empowerment domains and indicators data. Both methods allowed the identification and ranking of ODCE and its indicators in the community, and also to supply further examples of evidence to reconfirm it. Occasionally, long discussions accompanied the ratings before the group reached a consensus. After the proposition of each aggregated indicator, the evidence to verify it was asked from participants and recorded.

Sample. There were seven male and nine female participants in the Safe Community program in the year 2003, eight male and 12 female in 2004 and eight mail and nine female

participants in the year 2005 ranging in age 29 to 68 years (mean age = 42.5 years in 2003, 44.8 in 2004 and 44.1 in 2005) with different backgrounds: medicine, social work, education, agriculture, economy, rescue system and two retired community members. Fourteen members of the Drug Abuse and AIDS Prevention program participated in the workshop in the years 2003 and 2004, and fifteen in the year 2005 (Table 3). Mean age of participants was ranging

Table 3. Distribution of the gender and age characteristics of the workshop participants.

Initiative	**Safe Community**			**Drug Abuse and AIDS Prevention**			**Elderly Quality of Life**		
Year	**2003**	**2004**	**2005**	**2003**	**2004**	**2005**	**2003**	**2004**	**2005**
Male (N)	7	8	8	8	8	8	0	0	0
Female (N)	9	12	9	6	6	7	15	18	17
Total (N)	16	20	17	14	14	15	15	18	17
Age range y	29–68	30–69	31–69	24–52	25–53	26–54	48–72	49–73	49–74
Mean age y	42.5	44.8	44.1	32.4	32.4	36.1	62.2	62.8	63.4

from 32.4 in 2003 to 36.1 in 2005. The workshop consisted of representatives of county government, local municipalities, schools, leisure centre, sport institution and health care system. Fifteen workgroup members in Elderly Quality of Life program participated in the workshop in the year 2003, eighteen in 2004 and seventeen in the year 2005. Twelve of participants were retired, three were working in education sector and two in health care sector.

Additionally, document analysis (reports of the program and additional documents) and continuous feedback was used to register the evidence within each program. During the next assessments, solely the consensus workshop method was used.

At the end of the ranking procedure the community workgroup discussed potential measures and opportunities to enhance each empowerment domain during the next program cycle.

4.6.3 Method 3: Quantitative cross-sectional pre-and post-study

Data. Two sets of were collected. Ethical committee approval was not sought because in Estonia, studies that involve the voluntary participation of adults and have informed consent are exempt from further ethical approval.

The first dataset was used to investigate the multidimensional nature of the ICRE construct in the Estonian context and to assess the content validity and reliability of its dimensions. Questionnaires to be self-completed were mailed by regular post during April-May 2003 to a cross-sectional random sample of 1000 inhabitants from Rapla County (selected from the National Population Register). Two reminders were subsequently mailed to those individuals who did not respond. The response rate was 67.1%. Respondents' (n = 671) ages ranged from 17 to 71 years (Mean=42; SD = 14.18). 392 (58.42%) female and 279 (41.58%) male respondents were included.

The second dataset was employed to assess changes in participants' ratings of the dimensions of the ICRE. This sample consisted of all 120 voluntary participants from the three community programs who were involved in at least two program activities during the first intervention year of any of the three programs before the implementation of the empowerment expansion model. Two waves of the same self-administered questionnaire that was utilised for the first dataset were sent electronically: the first wave was sent one month before the first workshop related to application of the empowerment expansion framework in each community program separately (pre-test, 2003); and the second wave was sent after the last (third) workshop of the programs (post-test, January 2005). Additionally, two electronic reminders were sent to non-respondents, and phone interviews were undertaken with three individuals who did not respond electronically.

The pre-test was undertaken in 2003 (response rate 100%). Respondents' (n = 120) ages ranged from 24 to 65 years (Mean=43; SD = 10.9), and the sample comprised 78 (65%) women and 42 (35%) of men (Table 4). Of these participants, 22% had attained a primary level of education, 61% a secondary level, and 37% of the participants had a university education. With respect to the employment and affiliation of these individuals 19,16% were retired community members; 14,6% were people from the non-governmental sector; 10,83 worked in agriculture; 9,16% worked in the preschools and the same percentage in social work; 7,5% in the education system; 6,6% worked in the service and the same percentage in recreation sector; 3,33% were civil servants and students; 5% worked in the health care system; 2,50% were unemployed during the first measurement. In 2005, the post-test was

Table 4. Selected socio-demographic characteristics of respondents.

Characteristics	**Year 2003**		**Year 2005**	
	N	**%**	**N**	**%**
Total	120	100	115	95,8
Gender				
Male	42	35,00	42	36,52
Female	78	65,00	73	63,48
Age				
Range y	24-65		25-65	
Mean y SD	43 (10.90)		45 (10.51)	
Education				
Primary	22	18,33	19	16,52
Secondary	61	50,83	61	53,04
University	37	30,83	35	30,43
Affiliation				
Retired	23	19,16	21	18,26
Non-governmental sector	17	14,16	19	16,52
Agriculture sector	13	10,83	13	11,30
Pre-school	11	9,16	11	9,56
Social sector	11	9,16	11	9,56
Education sector	9	7,50	9	7,83
Recreation	8	6,66	8	6,96
Service	8	6,66	8	6,96
Students	7	5,83	5	4,35
Health care sector	6	5,00	6	5,22
Civil servants	4	3,33	4	3.48
Unemployed	3	2,50	-	-

undertaken. A total of 115 completed questionnaires were received during the post-test, which represented 95.8% of the pre- test participants. Five of the respondents who completed the pre -test had subsequently moved away from the community or were not available and, hence, were excluded from the current analysis. The mean age was 45 (SD = 10.51), and the sample consisted of 73 (63.48%) women and 42 (36,52%) of men.

Instruments: Questionnaire (Mobilization Scale – Individual)

There are few instruments that measure ICRE. For instance, Israel *et al.* (1994) developed a 12-item *perceived control scale* to assess empowerment at individual, organisational and community levels (internal consistency $\alpha = 0.63$). Similarly, Oman *et al.* (2002) proposed a 6-item *community involvement scale*, and Reinigen *et al.* (2003) suggested a *youth empowerment scale* (both with $\alpha = 0.78$). Likewise, Spreitzer (1995) developed a tool to evaluate IE in the workplace environment (12 items) that had a reliability coefficient 0.72. The present study utilised the *mobilization scale – individual* (Jakes and Shannon, 2002). This scale was selected because most of the scale's items emphasized participants' perceptions of having the requisite abilities and motivations to make a difference in their communities. The original scale consists of nine subscales and 49 propositions. Five subscales (self-efficacy, participation, motivation, social assets and human capital) were selected as most appropriate for study context (Annex VIII). The questionnaire was translated from English into Estonian language by two translators independently. Thereafter, the method of back-translation (Lin *et al.,* 1975) was employed to determine the equivalence between the primary and secondary language tools. After the back-translation, the original and back-translated questionnaires were compared, and points of divergence were noted. The scale components were modified

during a workshop in which Rapla community members were invited to respond to the items and discuss their cultural understanding and relevance to their community.

The content validity of the translated questionnaire was assessed by an expert panel of six health promotion experts. Each item in the questionnaire was discussed and rated as 'essential' (1) or 'not necessary' (0), and the content validity ratio (CVR) was calculated using the formula developed by Lawshe (1975).

The final questionnaire consisted of 20 items rated on a Likert-type five-point scale (1 = 'strongly agree', the most favourable perception, to 5 = 'strongly disagree', the most unfavourable perception). The questionnaire considered the multidimensional nature of empowerment and allowed the assessment of the five dimensions of ICRE: *self-efficacy* related to an individual´s attitude toward social change in the community (7 items, e.g., "I have confidence in my capabilities to make the changes needed in my community"); *participation* in community activities (3 items, e.g., "I participate in community activities"); *intention* to become involved in community change (4 items, e.g., "I intend to take action in my community"); *motivation* to be involved (3 items, e.g., "I am motivated to get involved in my community"); and *critical awareness* that community issues are serious (one item, "I think that the problems in my community are serious"). Collectively, these dimensions provided a broad picture of ICRE.

Data Analysis. The software package SPSS 12.0 was used for the statistical analysis of the data. For the first objective of the study, to assess the construct validity of the ICRE scale, we employed Lawshe's (1975) formula: CVR = (n < item > e +n < item >e) / (N x n), where ne= number of experts rating essential, and N= number of items. To investigate the multidimensional nature of the ICRE construct within the Estonian context, the first dataset

was used, for which factor analysis was employed to extract the factors by applying principal components analysis (varimax rotation). To assess the reliability of the ICRE scale, we used internal consistency coefficients measured by Cronbach's alpha, which were undertaken twice: collectively for the total empowerment scale and individually for each of the five empowerment dimensions. To assess the changes in the participants' ratings of the dimensions of the ICRE before and after the application of the empowerment expansion framework, we compared the pre-test and post-test results using an independent sample t test (one way ANOVA). Significance level was set at $p < 0.5$.

4.7 Ethical considerations

Each interviewee was contacted before the interview. The details of the study were explained, and verbal assent to participate was requested. Participants who attended in interviews were informed that by agreeing to be interviewed, they were providing verbal informed consent. A confidentiality statement was provided in written form. Participation was voluntary, and data protection procedures were observed throughout the study.

Ethical committee approval was not sought because in Estonia, studies that involve the voluntary participation of adults and require informed consent are exempt from further ethical approval requirements.

PART 2:

Results, discussion and conclusions

CHAPTER V

RESULTS of stage 1

CONCEPTUALIZATION OF COMMUNITY EMPOWERMENT

This chapter summarises the focus, logic and findings of the *Article 1* "Conceptualizing organizational domains of community empowerment through empowerment evaluation in Estonian communities".

5.1 Summary of the *article 1* background

The study aimed:

1) to identify the organizational processes and activities that community workgroup members perceived as empowering using an empowerment evaluation approach within the health promotion context in Rapla County, Estonia; and

2) to operationalize the concept of *community empowerment process* as defined and understood by the interviewees, and to elucidate which ODCE the interviewees acknowledged as appropriate within the study context.

The paper first argues that empowerment is widely used concept in development policies and programs in many societies and that empowerment approaches have gained broad acceptance in the health promotion world. Community empowerment approaches have been used successfully for tackling inequalities in health, prevention of many health-related and social problems and for inducing social capital. The concept of empowerment has met with

widespread acceptance in the scientific community and has proven successful in many Western countries, however it has not been demonstrated whether the same level of success can be attained in the newly independent Eastern European countries. Article states that only a few studies exist to highlight the empowerment processes in countries in transition. Some scientists have even hypothesized that empowerment, in the sense of fostering the subject status, may thus prove less successful in Eastern Europe and may even turn out to be dysfunctional.

Article states that with the changes of the political and socio-economic systems in the Eastern European countries in the 1990s, during the transitional stage of the societies, the health and quality of life of their populations changed dramatically, improving in some indicators but primarily deteriorating in many others, social inequalities increased suddenly in all Eastern European countries, rapid increas in poverty, and morbidity and mortality followed. It is hypothesised that health promotion policy and practice in these countries could benefit from the community development approaches through a focus on enabling individuals and empowering communities to identify their needs, develop solutions, and facilitate change.

Article presents an overview of the different understandings of empowerment concept and argues that concept is complex and its operationalization may vary across cultures and socio-political contexts. A range of factors or organizational aspects that affect a program's empowering influence on community members are known as ODCE, which can be used as proxy parameters in the evaluation of community initiatives. Article demonstrates diverse versions of the ODCE, elaborated by several authors, and illustrates the similarities and variations. All authors OF these studies admit that concepts defined by them are not tested in different community contexts.

Some authors have argued that empowerment may be interpreted quite differently in Western and non-Western countries, as little is known about how community members in transition countries understand empowerment in community development processes and how they interpret and operationalize empowerment domains. Article states that the identification of the operational definition, domains and indicators of community empowerment is necessary for the assessment of an empowerment process success during the planning of a intervention and before the implementation of community approaches and initiatives in certain context.

In 2002, three health promotion initiatives workgroups in the Rapla County - *Safe Community*, *Drug Abuse and AIDS prevention*, and *Elderly Quality of Life* programs were involved in study. As an empowering approach, the empowerment evaluation model was applied in each program separately and year later qualitative interviews with sixteen participants were undertaken to identify local people understanding of the domains and indicators of community empowerment.

5.2 Findings: Communities members understanding of the ODCE

The analysis of interview data resulted in the identification of four ODCE. Findings are reported in terms of types of empowering activities, which are described by the indicators of the activities that the interviewees reported were perceived as empowering. Findings are illustrated by quotations.

The ODCE that emerged were the following: 1) community activation; 2) community competence development; 3) program management skills development; and 4) creation of a supportive environment (Table 5). The order of the ODCE was perceived as important. The interviewees pointed out that a community's first need in order to become empowered to be

mobilized to take responsibility for health concerns and to make decisions. Second, a community should have adequate knowledge to identify and assess critical health and social situations. Further, the community members should have relevant skills to make changes happen. Finally, most interviewees emphasized the importance of support from policy makers, financers, experts and other groups for a community to be empowered and act to improve its quality of life.

Table 5. Organizational domains of community empowerment and corresponding activities identified by Rapla community members.

Domain	Activities
Community Activation	- Activities to support community members' participation in community problem solving processes - Involvement and engagement of more stakeholders - Motivation of new leaders - Creation and encouragement of new networks - Initiation and stimulation of new community groups
Community Competence Development	- Training to improve community members' awareness and knowledge of how to solve community problems - Distribution of information on good practices and evidence-based approaches - Information sharing to improve community members' understanding of concepts, determinants and theories in health promotion
Program Management Skills	- Teaching of program management and team-building skills - Training for planning, implementation and evaluation techniques - Instruction about information use and dissemination and communication skills - Improving community groups' abilities and expertise in the use of evidence-based techniques in identifying, solving and managing their problems
Creation of a Supportive Environment	- Training community members in lobbying skills - Advocating for political support and financial resources - Promoting better access to different foundations and expert resources - Improving participants' abilities to maintain and sustain political changes and achieve widespread social support

ODCE: organizational domains of community empowerment

5.2.1 Community activation

According to the interviewees, the activation and mobilization of the community was perceived as the most important domain. Actions to (i) activate people, get community members interested and willing to participate, (ii) involve and engage stakeholders, (iii) find and motivate

new leaders, (iv) create and encourage new networks, and also (v) initiate and stimulate new community groups were assessed as essential for the community to be empowered. The indicators of the empowering activities identified by the interviewees are presented in table 6.

5.2.1.1. Activities to support community members' participation in community problem-solving processes.

The active participation of community members in solving community problems was perceived as a fundamental indicator of program success. It was expressed that an active attitude and involvement are crucial to getting changes to happen. Participation in a community workgroup was perceived as imparting feelings of safety and security that decisions concerning community issues would not happen against the community's will. Interviewees noted that community members' active attitudes about community life create opportunities to influence what happens in the community. The activation of the community was influenced by peer support, by organizing encouraging and convincing meetings for community members and by listening to their concerns and needs.

> "…if we ourselves do not participate in making decisions about our own community, then others will do it …"
>
> "… health promotion practitioner was so motivating and inspiring that we couldn't resist showing up when the next meeting was announced …"
>
> "….Health promotion practitioner visited me and we had a long discussion on teenagers' problems in Rapla, so in the end I felt that I certainly had to come to the next meeting. During the first meeting she was so convincing and supportive, and had such a positive effect on us that it created a feeling that it was natural to come. From the very beginning she bound us together, so nobody wished to leave the workgroup…"

Table 6. Activities and indicators of activities expressed as empowering by the interviewees within the domain of *Community Activation*

Activities	Indicators of activities expressed by the interviewees
Activities to support community members' participation in community problem-solving processes	¤ convincing local people to participate in community health and social problem-solving programs ¤ motivating and inspiring community members to commit themselves to solving local health problems ¤ approaching community members personally and convincing them to become actively involved in community problem-solving activities
Involvement and engagement of more stakeholders	¤ identifying the stakeholders and bringing them together to discuss and deal with common issues ¤ contacting stakeholder organizations and sectors and stimulating collaboration ¤ appreciating and acknowledging stakeholders for their involvement, commitment, efforts and progress
Motivation of new leaders	¤ supporting and motivating active local people in taking leading and coordinating role ¤ activating, encouraging and stimulating local people to take leadership positions in core activities ¤ appreciating and acknowledging new leaders for their initiatives and commitment ¤ initiating and mediating the process of sharing responsibilities within workgroups
Creation and encouragement of new networks	¤ initiating the coordination of activities between different groups, sectors and institutions ¤ facilitating and stimulating discussions between local groups to create or enlarge networks ¤ supporting collaboration within existing networks at local, national and international levels to encourage and motivate these networks' members in issue-specific interventions ¤ seeking collaboration from outside of the community and introducing networks with similar interests
Initiation and stimulation of new community groups	¤ encouraging community members to commit to and initiate new workgroups around different important health issues ¤ stimulating and supporting initiation of new and innovative community health initiatives ¤ making efforts to support new initiatives and community groups by supporting social cohesion and motivation to attend ¤ functioning as a skillful team builder and team member

The following positive characteristics were used to describe activities that encourage and support participation: personal contacts, personal invitations, making the health issue attractive, creating a willingness to do something within one's own community, and creating a feeling of usefulness and belonging. More than 200 people participated in different training courses over a period of one year, and over 4000 have attended campaigns, public health days and information sessions.

5.2.1.2 Involvement and engagement of stakeholders.

According to the interviewees, the community was activated when important stakeholders became involved and engaged in the community's issue-specific networks. Many potential stakeholder groups were considered and thereafter convinced to join. Together with the health promotion practitioner, small teams visited most of the rural municipalities, where they contacted a number of stakeholders from various NGOs and institutions and invited them to participate in the *Safe Community* program.

> "… Can you imagine that the County Governor really came to a seminar when we invited him, and participated actively in discussions on young people's alcohol problems …"

Stakeholders from different sectors– workers from the non-governmental and private sectors, municipal governments, and organizations as well as some retired and unemployed persons joined each of the three initiatives. The *Drug Abuse and AIDS Prevention* program involved a workgroup that consisted of about eighty people. The *Elderly Quality of Life* program engaged people from town and rural areas, elderly people living in their homes and in care homes for aged people, and many elderly who still were active in work life.

5.2.1.3 Motivation of new leaders.

According to the interviewees, there was initially a leader, the community health promotion practitioner, who encouraged the people to come to the workgroups and participate in community initiatives. During the program implementation period, new active persons became evident who inspired local groups, networks and the whole community.

> "… yeah, I am responsible for a school safety network. In the beginning I thought that I have a lot to do in my ordinary work, so I was not very eager to take a leading role and take on additional tasks, but the health promoter invited me to several meetings with fantastic people from our County and we always had fun together, so it really motivated me to stay and contribute and enjoy good company …"

The leaders filled their groups with enthusiasm and were convincing and capable of motivating the people to cooperate in the community workgroups. The charisma of leaders was perceived as an important factor for the empowerment of the community.

5.2.1.4 Creation and support of new networks.

At first, a group of active community members made efforts to involve more people. Later, in collaboration, many new networks were created, for example, networks of health-promoting schools, kindergartens, student unions, and elderly networks. Representatives of most networks belonged to the leading workgroup and played active roles in the functioning of the networks.

> "…By now, several networks have been formed in Rapla - the kindergartens share experiences and cooperate to prevent injuries, and so do schools and day-care centers for the elderly. Recently student unions of schools came together to discuss and deal with drug use prevention problems…"

According to the interviewees, the development of the networks initiated a snowball effect – the expansion of the networks continued and reached the schools, villages, kindergartens and organizations.

5.2.1.5 Initiation and stimulation of new community groups.

The group of activators initiated and facilitated discussions and group conversations to identify local people who have common concerns and are interested in becoming involved and cooperating to handle the problems. The workgroup has played a significant role in encouraging the emergence of local groups focusing on the specific local health and social problems. The workgroup has motivated emerging groups to cooperate with each other, with other regions and internationally.

> "… for example the injury prevention workgroup has taken decisive steps towards joining the WHO Safe Community movement, and an elderly group dealing with physical activity organized a visit to Latvia to meet peers and share experiences..."

Each event in the community attracted new participants and people willing to take part in the workgroups' activities. Creating an interest in community health and well-being issues has been a motivating factor for many local groups.

5.2.2 Community competence development

The following characteristics were used by interviewees to describe the activities that they perceived as empowering during the community competence development process: (i) training sessions to improve community members' awareness about the community health situation and opportunities to improve it; (ii) distribution of information on good practices and evidence-based approaches; and (iii) information sharing to improve understanding of determinants of health and concepts and theories of health promotion (Table 7).

5.2.2.1 Training sessions to improve awareness and knowledge of community members to solve community problems.

Interviewees described that several seminars, courses and community *open health days* were organized to increase community members' knowledge and awareness of community health issues. A broad overview of the community problems was given, pointing out the statistics and analyzing the problems that are apparent in the community. Training seminars consisting of information delivery as well as brainstorming on community issues were perceived as enriching.

> "… We have learned a lot about causes of injuries and what other countries have done to avoid them, and we also learned from each other …".
>
> " … You know, this knowledge, received through the collaboration in the community, is somehow universal. You can use it everywhere, and you look at your surroundings differently now…".

Some interviewees emphasized that the workgroup members, each having different backgrounds, contributed by finding information concerning local health determinants. It was

felt that the program workgroups act as competence sources in the community, facilitating access to relevant domestic and international information for community members and making available information concerning relevant funds and application procedures. Several interviewees revealed that the topics of the training courses were so universal that their outlook on life had broadened and their general competence on community health issues extended.

Table 7. Activities and indicators of activities expresses as empowering by the interviewees within the domain of *Community competence*.

Activities	**Indicators of activities expressed by the interviewees**
Improving community members' awareness and knowledge concerning community problems	¤ sharing community health data with community workgroups and community networks ¤ facilitating access to relevant local, national and international health information for community members ¤ facilitating acquisition of information from relevant local and national databases and from other sources ¤ mediating the delivery of local health information to local people
Information sharing to improve understanding of concepts, determinants and models in health promotion.	¤ organizing seminars and workshops to community members to improve their knowledge of health determinants and the models of social change ¤ preparing, sharing and delivering verbal and written information concerning factors affecting community health and solving the problems ¤ organizing campaigns, 'open days' and conferences to introduce risk factors for diseases and injuries
Distribution of information on good practices and evidence-based approaches	¤ increasing community members' knowledge of theories and methods relevant to community problem solving ¤ introducing evidence-based approaches to the issues relevant to workgroups and networks ¤ distributing information about basic principles of health promotion

5.2.2.2 Distribution of information on good practices and evidence-based approaches.

The positive aspects brought up by interviewees included meetings and seminars focusing on good practices and evidence-based approaches to health promotion. During these seminars with different community groups, comparisons to other regions and information about methods and approaches were presented, which can be helpful in solving problems most effectively. The health practitioner and other invited lecturers described their experiences of solving similar problems in other countries and demonstrated evidence-based efficient activities in other

communities. A literature review of good practices was carried out by some workgroup members and distributed to all participants.

> " … It has been an enriching experience to participate in the *Elderly Quality of Life* program, as we had many valuable seminars and many good lecturers talking and discussing what to do to achieve changes in our own health and in our community in the most effective way…"

Community workgroups acted as information centers and as facilitators between the community and other resource centers at the national and even the international level. The health promotion practitioner acted as a counselor in the field of health promotion and has created a feedback system within programs.

5.2.2.3 Information sharing to improve understanding of concepts, determinants and theories of health promotion.

Interviewees pointed out that having an understanding of the main concepts of health and health promotion has been useful and also that the information concerning health determinants has been extremely valuable for identifying goals and objectives and for clarification and selection of the actions needed. Lectures describing health promotion theories were perceived as illuminating and worthwhile.

> "… Several seminars have been organized to introduce the basics of health promotion, to discuss concepts of health and introduce health determinants in the community. Lecturers have been invited from the national health promotion center and also from abroad. They have demonstrated the use of health promotion theories..."

5.2.3 Management skills development

The interviewees stated that management skills development has been a consistent focus as an important activity for expanding community empowerment since the start of the programs. The

following aspects were mentioned: (i) teaching of program management and team building skills; (ii) training in planning, implementation and evaluation techniques; and (iii) improving community groups' abilities and expertise in the use of evidence-based techniques for identifying, solving and managing their problems (Table 8).

Table 8. Activities and indicators of activities expressed as empowering by the interviewees within the domain of *Management skills*

Activities	**Indicators of activities expressed by the interviewees**
Teaching of program management and team-building skills	¤ training in management skills and assisting in the management of the programs ¤ assisting and guiding in program documentation administration ¤ training skills in different methods of group work and team building ¤ teaching presentation skills, reporting skills and accounting skills to community members ¤ training program application skills for both national and international funds ¤ acting as a stress-buster for group members and as a good method of conflict resolution
Training for planning, implementation and evaluation techniques	¤ organizing training in mapping of local problems and resources ¤ delivering training sessions and assisting in the identification of goals and objectives, priorities and target groups ¤ teaching skills for project planning and implementation ¤ training in how to use different approaches in specific contexts ¤ introducing, guiding and assisting in evaluation of the programs and assessment of the quality of the programs ¤ increasing members' skills in creating feedback systems between workgroup and network members
Instruction in information collection, use, dissemination and communication skills	¤ developing skills for community health situation analysis and facilitating the analysis process ¤ delivering skills in data collection and facilitating access to data ¤ facilitating the delivery of skills for conducting local surveys and monitoring, data collection and data analysis ¤ using focus-group analysis to acquire qualitative information for situation analysis ¤ delivering skills for working with press, politics, groups and individuals ¤ assisting and facilitating in the preparation of press releases and in organization of program press conferences ¤ providing assistance and training for the program dissemination process
Improving community groups' abilities and expertise in the use of evidence-based techniques for identifying, solving and managing their health problems	¤ conducting seminars to introduce evidence-based approaches and illuminating how to apply and modify the approaches in specific community contexts ¤ carrying out training workshops to demonstrate and practice models that have been effective in other communities ¤ inviting experts to teach community groups about new models and helping to adjust these models to the present community setting ¤ assisting community workgroups in adopting effective models for the specific community context.

5.2.3.1 Teaching of program management and team-building skills

The interviewees stated that the program workgroups had systematically improved their skills in program management techniques and team building. The skills development training sessions were organized to teach the health needs analysis, know-how and techniques necessary for preparing, conducting, and analyzing surveys and focus groups. In the workgroups, team-building methods were used to bring participants together, to improve collaboration, to teach conflict resolution skills and to encourage teams to act efficiently.

> "….An important part of workgroup activities has been the organizing and binding of the team. The workgroup was able to hold meetings in a way that makes social life an intrinsic part of it…"
>
> "… Several workgroup members acquired good skills in writing project applications and managing networks…"

The interviewees mentioned that one of the important activities of the community health promotion practitioner was teamwork training for the community workgroup. The above-mentioned skills also included training in conflict and stress management issues.

5.2.3.2 Training for planning, implementation and evaluation techniques.

Training skills, which are needed for defining objectives, planning strategies and action plans, and implementing and evaluating community programs, were perceived by the interviewees as important for expanding community empowerment. According to the interviewees, the abilities to assess local needs, discuss priority issues, set objectives and goals and establish action and evaluation plans facilitate decision making and give community members a feeling of security.

> "…For example, our workgroup launched a full-scale action plan on the safety problem in the kindergartens in the whole county…".
>
> "…The planning of the health-promoting school activities has been much easier and clearer after in-depth training where we had opportunity to discuss it with experts and adopt an approach that was best suited to our own community…"

Instruction in information use and dissemination and communication skills was given. The interviewees revealed that a media expert was invited to conduct a training day on communication issues, share information about communication methods and train community members in communication skills. Guidelines were introduced for how to write press releases, and practical training on this topic was conducted. Access to and analysis of information was discussed, and dissemination methods were introduced.

5.2.3.3 Improving community groups' abilities and expertise in the use of evidence-based techniques for identifying, solving and managing their problems.

The interviewees emphasized that workshops were carried out where different concrete methods and techniques were practiced, including how to identify and solve different problems. This training had a significant impact on the quality of approaches chosen by the workgroups and allowed them to identify and select evidence-based approaches during the planning of each stage of their respective programs. The increased abilities and expertise enhanced the empowerment of the community.

5.2.4 Creation of a supportive environment

The interviewees stated that the creation of supportive environment is important for expanding community empowerment and achieving goals and objectives as planned. The following aspects were mentioned: (i) developing community members' lobbying skills; (ii) advocating for political support and financial resources; (iii) promoting better access to different foundations and expert resources; and iv) improving participants' abilities to maintain and sustain political and broader social support (Table 9).

Table 9. Activities and indicators of activities expresses as empowering by the interviewees within the domain *Creation of supportive environment.*

Activities	Indicators of activities expressed by the interviewees
Training of community members in lobbying skills	¤ assisting community workgroup members in lobbying local decision makers to influence municipal government in health-related decisions ¤ conducting workshops to practice lobbying skills ¤ inviting policy makers to share their knowledge and skill in policy-making and to deliver recommendations on how to get support for decisions ¤ teaching verbal and written presentation skills
Advocating for political support and financial resources	¤ advocating and negotiating with local policy makers to achieve more political support for the community programs ¤ initiating, supporting and facilitating contacts and meetings between community groups and politicians and local decision makers ¤ mediating community needs at the national level and national needs within the community ¤ facilitating access to financial resources through information dissemination about local, national and international funding sources ¤ negotiating with different sources (e.g., municipality, private and business sectors) to get additional finances and other resources for community programs
Promoting better access to different expert resources	¤ making available information concerning different experts required and requested by community workgroup members ¤ inviting experts to share their knowledge and skills with community members ¤ finding researchers to assist in data collection, analysis, assessment and evaluation ¤ searching for opportunities to acquire international expert support for community programs ¤ assisting community members in finding and attend In 2002, three initiatives in Rapla - *Safe Community*, *Drug Abuse and AIDS prevention*, and *Elderly Quality of Life* international conferences dealing with issues of interest to the community
Improving participants' abilities to maintain and sustain political changes and achieve widespread social support	¤ convincing local organizations and municipalities to invest in health programs ¤ negotiating with institutions and organizations to get space and facilities for training and other initiatives for community workgroups ¤ creating a local small projects funds system to support network activities ¤ using local media channels to achieve public support for the community programs and initiatives ¤ engaging media to cover workgroup activities

5.2.4.1 Developing community members' lobbying skills

The interviewees stated that during several workshops, the importance of lobbying decision makers was discussed, and lobbying skills training was provided. An expert on lobbying skills was invited to give a workshop on communication with policy makers and other decision makers.

5.2.4.2 Advocating for political support and financial resources.

The interviewees pointed out that for the *Safe Community* and *Drug Abuse and AIDS Prevention* initiatives, workgroup meetings were arranged with local politicians and decision makers from other organizations to get their support for the programs. The County Governor and municipality leaders were informed of the course of the programs, and their support was gained by bringing them into cooperation.

> "... Really influential is that the County Governor is supportive. He is informed about our program and he has attended some of our events, fox example, he made a wonderful opening speech at the beginning of the county Drug Abuse Prevention Conference ..."

5.2.4.3 Promoting better access to different foundations and expert resources.

During several seminars, information concerning different foundations and resource sources was introduced by the health promotion practitioners and other participants, and training sessions were conducted to improve the workgroup members' skills in acquiring resources for community programs and activities. The interviewees pointed out that the *Safe Community* and *Drug Abuse and AIDS Prevention* programs have been successful in applying for resources from the Health Promotion Fund. Also, the *Elderly Quality of Life* program received good feedback from the foundation but did not receive resources as the target was not a priority for the foundation.

5.2.4.4. Improving participants' abilities to maintain and sustain political changes and achieve widespread social support.

The interviewees stated that workshops have been conducted to discuss potential effective approaches to maintaining sustainable resources for their programs and getting the programs' issues onto municipal agendas. A strategy was devised to convince the Union of Local Authorities to acknowledge health issues as a concern and to integrate health issues into their long-term action plan.

"…The program workgroup has done good work with municipal leaders to persuade them to include several health issues in the municipality agenda. Several municipality governors have confirmed their interest in joining the *Safe Community* movement and their municipalities have action plans for injury prevention. We hope to convince the whole Union of Local Authorities to do it.…".

"… for example, in the local authority council a approval was won to limit sales of alcohol at night time in the county…"

The plans have been compiled to increase public awareness of important health concerns in the county and to achieve support from citizens throughout the county.

5.3 In conclusion

Study has revealed that the four domains of community empowerment, Rapla County three health promotion inititives workgroups identified, were following. The *activation and mobilization of the community* is a domain that includes the participation of the community members in community activities, the emergence of new potential leaders, and the formation of new groups and networks. The *competence development* domain includes increasing the workgroup members' knowledge, critical assessment of causes of problems and assessment of potential resources. Acquiring relevant information concerning the community health situation, determinants of health and evidence-based ways to influence health are prerequisites for achieving social change. The *management skills development* domain consists of skills in community situation analysis, goal setting, planning, implementation and evaluation. The *development of a supportive environment* domain includes the ability of the community to search for and acquire political and financial resources and support.

The findings are discussed in chapter VIII.

CHAPTER VI

RESULTS of stages 2,3 and 4: MEASUREMENT OF COMMUNITY EMPOWERMENT

This chapter summarises the focus, logic and findings of the *Article 2* " Measurement of Community Empowerment in Three Community Programs in Rapla (Estonia)".

6.1 The background of *Article 2*

The study aimed:

i) to elaborate a community empowerment measurement tool appropriate and suitable for community members to use, and;

ii) to develop a framework for evaluation of health promotion initiatives for communities with multiple needs and concerns, which simultaneously expands empowerment in community and allows to measure changes in empowerment process;

iii) to assess the changes in the ODCE within Rapla community's three health initiative workgroups after two years of application of the empowerment expansion framework.

The paper argues that that ODCE offer a straightforward way in which to view, measure, and assess changes in community empowerment, and that organizational domains present an explicit lane to evaluate community empowerment as a process.

As described in chapter V, using qualitative interviews among community health promotion programs participants, four organizational domains of community empowerment (Table 3 in article 1) were constructed based on Rapla community members' opinions and perceptions

(Kasmel and Tangaard, 2011): *activation of the community*, *competence of the community* in solving its own problems, *program management skills* and *creating a supportive environment*. The article illustrates how based on ODCE identified, the measurement tool was elaborated for evaluation of the changes in community empowerment, and how the study framework was composed.

6.2 Elaboration of the measurement tool

For the measurement of the ODCE and its indicators, the consensus workshop method was utilized by the participants of the *Safe Community* program workgroup and tested by the *Drug Use and AIDS Prevention* and *Elderly Quality of Life* programs` workgroups in the study year 2002 (see also paragraphs 4.5.2 Stage 2: Elaboration of the measurement tool and 4.6 Methods, data collection procedure, sample and data analyzes).

The consensus-based discussions resulted with a questionnaire, which includes a total of thirty-six indicator and twelve aggregated indicator measures, with nine measures for each domain (community activation, community competence, program management skills, building a supportive environment) in three levels. Aggregated indicators served as controls to confirm the reliability of indicators assessment. Community workgroup members identified three levels of each domain. A similar number of levels were suggested by Bush *et al.* (2000), but the content of the levels was predominantly context specific. The actual activities were recorded to show evidence that determined the ODCE by matching the activities against the indicators listed in the questionnaire. A ranking for each indicator, 1 (not at all/very limited), 2 (somewhat), 3 (substantial) and 4 (almost entirely/entirely), was agreed upon.The questionnaire is presented in Annex II.

The questionnairse was constructed for the measurement of the ODCE before and after communities health promotion initiatives.

6.3 The framework for empowerment expansion

The empowerment expansion framework, constructed in collaboration with community participants using consensus workshop method, integrates models of empowerment evaluation, as suggested by Fetterman (1996) (Figure 1 in article 2), and the *parallel tracks* model elaborated by Laverack (1999) (Annex I). The framework adopts the distinct implementation steps from the empowerment evaluation model, and measurement of the ODCE from 'parallel tracks' model and creates an opportunity to simultaneously expand empowerment in a community, achieve expected outcomes related to community needs, and similarly evaluate changes in both tracks. The framework comprises four phases:

Phase I – internal evaluation of the ODCE and assessment of ICRE (external evaluation - described in detail in Article 3 and summarized in chapter VII).

Phase II – planning of community empowerment. This includes the formulation and statement of the empowerment expansion (in this stage goals and objectives for the empowerment expansion are defined; measurable indicators and measurement processes identified; and action plans agreed upon).

Phase III – consists of two parallel implementation processes:

a) Empowerment expansion processes: includes activities to target at the development of the four ODCE domains, and;

b) Issue-specific processes: during which the four steps of empowerment evaluation are undertaken (see paragraph Stage 1 and figure 1 in article 1):

(i) agreement on an issue-specific mission;

(ii) taking stock;

(iii) future planning;

(iv) implementation.

Phase IV– evaluation of changes in community members' ICRE (described in more detail in Article 3 and summarized in chapter VII).

The empowerment expansion framework development process was a collaboration process between community health promotion programs workgroup members, local health promotion practitioner and researcher. Author (researcher) of current study acted as a facilitator and mediator, enabling and supporting stakeholders throughout the empowerment expansion framework construction process.

6.4 Findings of the measurement of the ODCE

In the first phase, during the implementation of the empowerment expansion framework, the measurement of ODCE was undertaken by the workgroups of the *Safe Community, Drug Use and AIDS Prevention* and *Elderly Quality of Life* programs separately. Consensus workshop method was used to identify, discuss and reach consensus in the extent of each domain and indicator of community empowerment (see paragraph 4.6 Methods, data collection procedure, sample and data analysis). The first measurement of ODCE was carried out in January 2003, following with measurements in January 2004 and 2005.

Each indicator, aggregated indicator and level of indicators was determined after discussions and consensus among community members. For the purpose of visualization, rankings were calculated in numerical terms, and tables were developed for each initiative to include data from three measurements. The rankings used in the evaluation are not suitable for comparison of the

three initiatives, but they do describe changes within each initiative over time. Furthermore, the evidences to describe changes were collected to illustrate and confirm the numerical findings.

6.4.1. The measurement of the ODCE in Safe Community program workgroup

Table 6 in article 2 demonstrates that a remarkable increase in all four ODCE has taken place during the three year observation period. Domain levels demonstrate that the community has substantial ability to profit not only from local, but also from national and international knowledge and experience. The workgroup's capacity to collaborate with partners on all levels has increased considerably. The data indicate that many new community members and influential leaders have joined the program. The Safe Community program network has expanded remarkably during three years and stakeholders maintained a commitment to the initiative. The most prominent change has occurred in the community competence domain—the awareness and knowledge on safety issues had increased remarkably. Significant change took place in the program management domain; workgroup members were able to collaborate as equal partners on national and international levels acquiring required skills and competencies to manage program implementation. Moreover, the indicators demonstrating capacities in building politically and financially supportive environments have increased substantially. At the end of the third year of the measurement, the program had sustainable finances and good support from decision-makers. The completed questionnaire by the workgroup is presented in Annex VIII.

6.4.2. The measurement of the ODCE in Drug Abuse and AIDS Prevention Program

The evaluation of the ODCE in the *Drug Abuse and AIDS Prevention* program demonstrated that ODCE have substantially expanded and were highest within the first three domains - community activation, community competence and program management (Table 7 in article 2).

The program during its first year made efforts to involve more stakeholders, among them young people directly endangered by the problem. Active leaders appeared among schools-children and youth organizations. Numbers of discussions were organized by the program members to raise the awareness and concerns and search solutions. Several training courses were implemented to improve management skills of stakeholders to be able to apply evidence based approaches. The fourth domain, the supportive environment, showed that political and financial support on the national and international level is easier to achieve if an issue is of national priority—the program was supported both by local and national decision-makers.

Although all of the ODCE were characterized by a steady and rapid increase, the discussions within consensus workgroups revealed that three years is a relatively short period for community development if the issue is not initially the local concern and that more time is needed for a community to create large networks and initiate external collaboration to prevent the newly appeared problem to expand. The completed questionnaire is presented in Annex IX.

6.4.3. The measurement of the ODCE in Elderly Quality of Life Program

Results revealed that during the first study year program had a charismatic leader, who was able to mobilize new program members and motivate new leaders to take responsibility in community actions (Table 8 in article 2). The program members gathered regularly to discuss issues concerned. Lots of events were organized and social life was activated. However, the program was unsuccessful in securing further financial support from the Health Fund. In second study year, when the program lost most of its finances, some organizational domains still increased, though more slowly. The workgroup was no longer as effective in mobilizing new groups and in recruiting new members into the program, but the activation domain still had slight increase. Although the competence development domain was perceived as being at a standstill,

program management skills were increased through several training and the group was activated to focus to the application writing skills. However, the communication and collaboration with outside partners was limited and had slowed down. Despite the efforts in working with media and policy makers, the results were modest, and the capacity to influence policy makers and financers was assessed as weak. The completed questionnaire is presented in Annex X.

6.5 In conclusion

The use of the empowerment expansion model within different community programs demonstrated development of the ODCE in all three community health promotion programs. The evaluation of the programs indicated that the ODCE were increased most considerably among the community workgroups, which were initiated by community members and equally involved the municipality's decision-makers, and which has existed for a longer period - the *Safe Community* program. The ODCE were increasing significantly in the program with the strongest political and financial support from the government institution - the *Drug Abuse and AIDS Prevention* program. In the *Elderly Quality of Life* program the expansion of empowerment was relatively slow but still evident.

CHAPTER VII

RESULTS of stage 5: CHANGES IN INDIVIDUAL EMPOWERMENT

This chapter summarises the focus, logic and findings of the *Article 3* "Evaluation of changes in individual community-related empowerment in community health promotion interventions in Estonia".

7.1 The background of *Article 3*

The main aim of the current study was to assess changes in ICRE in a sample of community members two years after the application of the empowerment expansion framework in the community of Rapla, Estonia. The specific objectives were as follows:

1) to assess the construct validity of the ICRE scale;

2) to investigate the multidimensional nature of the ICRE construct;

3) to assess the reliability of the ICRE scale; and

4) to assess changes in participants' ratings of the dimensions of the ICRE before and after the application of the empowerment expansion framework.

The paper first argues that individual community-related empowerment (ICRE) is viewed as the ultimate foundation for community empowerment, and that community empowerment emerges from a process of determination and inspiration of the individual (Reinigen *et al.,* 2003). This inclusive individual and collective understanding of empowerment is crucial in health promotion programs where empowerment is frequently an explicit goal. In this

viewpoint, the development ICRE becomes a bridge to community empowerment and social change. In order to achieve change in community health and well-being, community members must be individually empowered in order that they are enabled to be equal partners in finding and implementing solutions to the complex issues that they collectively face (Wowra, and McCarter, 1999). Therefore, in assessing the empowering processes, the evaluation of the community empowerment might be supported by and might benefit from the measurement of the ICRE. Thus, the use of an empowerment expansion framework described here could assist communities in focussing on particular ICRE dimensions, which might then become essential and integral parts of a given community health promotion programs.

The article demonstrates that the development of a universal measure of individual empowerment has not been possible as empowerment differs among individuals, contexts and times (Zimmermann, 2000) and may manifest in different forms of perceptions, behaviour, competencies and actions, and moreover, it may fluctuate over time (Wallerstein, 2006). Several researchers have identified somewhat different scales for the measurement of individual empowerment depending on the context and/or specificity of study group. Several of these are introduced in the *article 3*. All authors recognized that modifications need to be made on the basis of the variety of contexts and settings in which empowerment may be applied. The definition of ICRE employed in the current study combines multiple components: *self-efficacy* with self-confidence (Israel *et al*., 1994; Kieffer, 1984; Zimmermann, 1990); involvement in collective action (*participation*); *motivation* to be involved in community action (Zimmermann and Rappaport, 1988); willingness and *intention* to take action in the public domain (Zimmermann and Rappaport, 1988); and *critical*

awareness that community issues are serious (Spreitzer, 1995; Dimidriades and Kufidu, 2004).

As the scale used for the measurement of ICRE (ANNEX VIII) has been modified by community participants, the validity and reliability control of the scale was an ultimate prerequisite before its utilization.

The concept of ICRE employed in the current study was combination of multiple components: *self-efficacy* with self-confidence; involvement in collective action (*participation*); *motivation* to be involved in community action; willingness and *intention* to take action in the public domain; and *critical awareness* that community issues are serious.

S*elf-efficacy* is an individual's confidence in their personal capability to organise and execute the course of action required to deal with prospective situations and belief in their capability to regulate their motivation, thought processes, emotional stages and the social environment, as well as behavioural attainment (Rappaport, 1984; Florin and Wandersman, 1990; Zimmerman and Rappaport, 1988). It is the belief that one has the skills and ability to achieve goals accompanied by perceived improvements in knowledge and skills through participation in community problem-solving processes (Eklund, 1999). Perceived self-efficacy with regard to dealing with community issues is associated with a sense of community (Davidson and Cotter, 1989; McMillan *et al.,* 1995) and with social action on community issues (Chavis and Wandersman, 1990; Florin and Wandersman, 1990; Zimmerman and Rappaport, 1988). Perceiving that one can solve community problems is a prerequisite for community involvement (Hirsch, 1990).

Participation is the involvement in any community action that an individual attends without pay to achieve a common goal and/or social change (Zimmerman and Rappaport, 1988; Bracht and Tsouros, 1990).

Motivation is the belief that one should participate in community problem-solving processes as a responsibility to others (Zimmerman and Rappaport, 1988; Wallerstein, 1992). Thus, people are motivated by a sense of moral responsibility to redress practices or change conditions that they perceive to be unfair (Horvath, 1999).

Intention to participate is an anticipated outcome that is intended or that guides one's planned action (Zimmerman and Rappaport, 1988).

Critical awareness is the sense of the importance of community issues and understanding of the purposes of community action (Eklund, 1999). Critical comprehension and knowledge of social and political contexts is a prerequisite for the cultivation of both individual and collective resources and skills related to social action (Kieffer, 1984).

7.2 Findings in the cross-sectional measurement of ICRE

7.2.1 Study Objective 1: Construct Validity of the ICRE scale

Employing the formula suggested by Lawshe (1975), the content validity ratio of the ICRE scale was .98, which is acceptable according to Davis (1992) and Lawshe.

7.2.2 Study Objective 2: Dimensionality – the Multidimensional Nature of the ICRE

The dimensionality of the scale was evaluated by factor analysis (Table 5 in article 3) using Kaiser's criterion (eigenvalue >1) (DeVellis, 2003). The Kaiser-Meyer scale was .93, which is defined as very good (DeVellis, 2003). Table 5 shows that five ICRE dimensions

(factors) (i.e., *self-efficacy*, *intention*, *participation*, *motivation* and *critical awareness*) emerged relatively clearly. However, two items (*intention* – "I pitch in when there is work to be done", and *critical awareness* – "I feel that community issues are important") exhibited fairy low loadings on their associated factors and relatively high loadings on other components. All remaining factors presented relatively strong loadings on their individual components. The factors consisted of three to seven items each (though only one item for the factor *critical awareness*). Collectively, the five dimensions explained 62.91% of the variance in ICRE. With respect to each of the individual dimensions, *self-efficacy* explained 20.37% of the variance, *intention* 16.96%, *participation* 11.97%, and *motivation* 7.22%. Their corresponding Eigen values (a common criterion for a dimension to be useful) were 8.52, 1.91, 1.25 and 1.02 (Morgan and Griego, 1998).

7.2.3 Study Objective 3: Reliability of ICRE

Cronbach alpha coefficients were used to assess the reliability of the scale (Table 5 in article 3). The internal consistency (Cronbach's α) of the total scale was 0.859, which is very good (Sekaran, 1992). Likewise, the internal consistencies of the three sub-scales comprising three dimensions (Self-efficacy 0.883; Intention 0.834; Participation 0.808) were very good. The Motivation dimension had a lower α (0.69), which is considered satisfactory. Critical awareness comprised only one item, and hence, α was not applicable.

7.2.4 Study Objective 4: Comparison of Pre- and Post-Test Ratings of ICRE Dimensions (Before and After the Application of the Empowerment Expansion Model)

Table 6 in article 3 presents the means and standard deviations of the empowerment scale at the beginning of the application of the empowerment expansion framework and two years

after its application. Generally, the means of the post-test (2005) for the five dimensions of empowerment and for total empowerment were more favourable than their pre-test means (2003). These changes were statistically significant for four of the five dimensions (*self-efficacy*, *participation*, *intention*, and *motivation*).

These findings suggested that respondents' perceptions of their *self-efficacy* related to community problem-solving had increased in 2005 in comparison with the 2003 data. Participants' confidence in their capabilities to undertake the required changes in their communities had increased, as respondents felt they could influence their communities to take action on important issues. Furthermore, respondents' *motivation* to participate, *intention* to participate and actual *participation* in community activities had all increased. Similarly, respondents' *critical awareness* of the seriousness of the community issues also exhibited a moderate increase, although the increase was not significant. Nevertheless, the 2003 data indicated that the *critical awareness* component of empowerment already presented a high value during the pre-test period, suggesting that for these three programs, respondents' baseline awareness of community problem seriousness was already high before the initiation of the programs.

7.3 In conclusion

Comparison of the scores from pre- and post-tests revealed that all dimensions of ICRE were improved in the post-test. Our findings demonstrated a significant increase both in total empowerment and in four (of the five) dimensions of perceived ICRE, as well as a slight non-significant increase in one item, *critical awareness*. To clarify the concept of ICRE, the empowerment scale was adapted to the community context, and factor analysis was utilised to

identify its dimensions. A five-dimension ICRE scale emerged from the factor analysis, which was congruent with results reported in the literature, confirming the usefulness of ICRE characterised by the context-specific dimensions of perceived *self-efficacy*, self-reported *participation*, *intention* and *motivation* to participate in community actions and *critical awareness* of the seriousness of community problems. The internal consistency of the ICRE scale was very good.

CHAPTER VIII

DISCUSSION

This chapter illustrates in compact manner the main findings of current study and includes discussions of separated stages of the study. Thereafter the methodology, strengths and limitations of the study are considered, and criteria for assessing adequacy and quality of the study discussed. The chapter ends with consideration of the broader implications of the study and brings some recommendations for future research.

8.1 Main findings of the study

The **c**urrent study was planned as an evaluation research of community empowerment of three community health promotion programs in a small Estonian county Rapla, where relative poverty was higher than Estonian average. When we started our study, little was known about how community members in a transition country understand empowerment in community development processes, and how they interpret and operationalize empowerment domains. We were looking for answers to the following questions: What are the ODCE perceived by the local health promotion programs members, what are the measurement indicators for assessing changes in community empowerment, and how the empowerment expands in a newly independent country`s communities.

During the first stage of the study we found that first, in order to become empowered, a community needs to be mobilized to take responsibility for health concerns. Second, a

community should have adequate knowledge to identify and assess critical health and social situations. Third, the community members should have relevant skills to make changes happen and finally the support from policy makers, financers, experts and other groups for a community were felt as important.

The assessment of ODCE, named above, demonstrated the expansion of the empowerment in all three community health promotion programs, however the change was more positive among the program, which was initiated by community members and equally involved the municipality's decision-makers, and which has existed for a longer period - the *Safe Community* program. The external evaluation confirmed the results of the internal evaluation – the most favourable changes in the ICRE became evident in the same program. The ODCE were increasing significantly also in the program with the strongest political and financial support from the government institution - the *Drug Abuse and AIDS Prevention* program. In the *Elderly Quality of Life* program the expansion of empowerment was relatively slow but still evident.

Hence, given that expansion of empowerment is frequently the primary objective of community health promotion programs, the positive change in ODCE and ICRE among the participants of the programs investigated in this study is gratifying. Studies focusing on organizational aspects of community empowerment can lead to interventions that expand community empowerment to achieve goals and improve quality of life in communities, and it also revealed in our study.

Several researchers have argued that efforts are necessary to focus the empowerment process in a community to achieve the competencies, skills, supportive environment and power needed for health enhancement (Smith *et al.,* 2003; Laverack, 2009; Labonte, 2010).

Not surprisingly, numerous health promotion efforts have employed empowerment as a vehicle for their programs to combat a range of health and social problems. The types of such programs in which empowerment strategies have been used are diverse and are related to, e.g., violence against women (Kalaca, 2010), promotion of mental health (Taylor *et al.,* 2010), maternal and reproductive health among internally displaced communities (Mullany *et al.,* 2010), and the reduction of sex workers' vulnerability to HIV/STDs (Swendeman *et al.,* 2009). Similarly, empowerment has been successfully utilised in decreasing the burden of lymphatic filariasis (Rajendran *et al.,* 2009), in dengue prevention (Sanchez *et al.,* 2009) and in the Healthy Cities movement (Heritage and Dooris, 2009). However, few studies on this topic have previously been reported from Eastern European countries, and there remains a gap in the empowerment literature in terms of research undertaken in countries that have experienced political and economic transition. The current study tries to bridge this gap, and while Estonia is classified economically as a high-income country (World Bank, 2010), the current study was undertaken in a mainly rural area of Estonia where the relative poverty of the county's population was high in comparison to other regions of Estonia (Rapla Maavalitsus, 2002). In such settings, the empowerment of community members through program participation has been shown to be particularly important (Smith *et al.,* 2004).

Below we will discuss the results of different stages separately.

8.2 Conceptualization of the ODCE

Hence, the findings of the interviews with the Rapla Health promotion initiatives participants indicated that empowerment process comprises four domains – community activation, community competence development, management skills and the creation of a

supportive environment. The domains identified during the empowerment evaluation process are largely similar to domains identified by Bush *et al.* (2002). In the *Community Capacity Index* elaborated by Bush *et al.* (2002), they distinguished four domains: network partnerships, knowledge transfer, problem solving and infrastructure development. However, the activities and indicators identified by their community differed. Likewise, the domains found by Laverack (1999), Gibbon *et al.,* (2002) and Smith *et al.* (2001) were largely overlapping, but they included domains that were not mentioned by the interviewees from the current study community, such as the role of outside agents or understanding of community history.

The community activation domain, comprising participation, involvement, leadership, and group and network expansion, is consistent with concepts defined by all authors in the literature and, hence, represents a universal domain of community empowerment. The domain of community competence as an ODCE is separately pointed out by Bopp *et al.* (1999) and by Bush *et al.* (2002) as the capacity of *knowledge transfer,* comprising development, exchange and use of information. The activities that the interviewees in this study perceived as empowering within the management skills domain support Laverack (1999) and Gibbon *et al*.'s (2002) suggestions that management of programs increases community members' control over planning, implementation, evaluation, finances, administration, reporting and conflict resolution. The fourth ODCE – creating a supportive environment – marks the most significant difference between the current model and others. It comprises the organizational practices directed to the development of political, social and expert support and the acquisition of financial support.

The findings indicate that organizational domains of community empowerment are context specific. The phenomena observed in the present study support the universal understanding of the concept of ODCE, though the evidence from different cultural settings yields somewhat distinct definitions and understandings of domains than do the data in this study. The authors of the present study believe that the ODCE identified by the actual community under investigation are most suitable for quantification of community empowerment in that context. Likewise, Wallerstein (2006) has emphasized that domains of community empowerment, such as those the community members in the present study constructed, reflect the community members' understanding and perception of empowerment processes.

Bopp *et al.* (2004) have argued that ODCE are refined theoretical constructs with no more than vague academic relevance to any community other than the one in which they were identified. It is therefore crucial that the community itself be engaged in a process of refining, adapting, changing and adding to generate its own empowerment domains rooted in its own analysis, which may indeed be supplemented by the knowledge and experience of outside professionals. The empowerment approaches assume that community members typically understand their own needs better than others do, and it is optimal for communities to have the greatest possible control over decisions that may influence their quality of life.

According to Gibbon *et al.* (2002), organizational domains of community empowerment capture the halfway point between desired program changes, whether such changes involve individual behaviors or broader social policies and practices, and what actually happens in the community. Indeed, the clarification of the concept allows the community to establish explicit goals and objectives and set distinct directions for future empowerment expansion and for specific health issues.

Cronbach and Meehl (1955) indicated that once the concrete operations and processes in a model are made explicit, the validity of a construct can be empirically tested.

The aim of empowerment evaluation is to optimize community outcomes through empowerment of a community. We used this model to build community competence in evaluation techniques, but also to clarify the community members' understanding of the domains and activities involved in empowerment in order to elaborate an evaluation tool for the assessment of potential changes in ODCE. The application of the four steps of the empowerment evaluation model helped community members to notice and distinguish empowering activities. Fetterman (2010) asserts that, during the evaluation process, stakeholders gain knowledge, skills and experience critical to the technical aspects of conducting program evaluations while simultaneously developing an appreciation for the usefulness and meaningfulness of the data generated. The evaluator's role as trainer and facilitator can allow him or her to gradually disengage from the program's evaluation as the community members become more competent and empowered in the ongoing evaluation. This was the reason why an empowerment evaluation model was well suited to the community context in which the authors were asked to work.

Empowerment domains are not static and may change over time as political or economic contexts change (Wallerstein, 2006). This changeability reinforces the need to continually evaluate and assess the scopes of domains and to rethink the goals and objectives of a program. Once a community is empowered, it is productive and capable of handling its problems.

The expansion of empowerment is a continuous process that consists of several interrelated components, policies, strategies and tools. A health promotion practitioner, together with

community members, can modify ODCE within the program context to expand community empowerment. Having a planned empowerment approach from the very beginning of community work is a prerequisite for effective issue-specific outcomes. The action plan of the empowerment expansion presumes that the focus of the actions will be on community activation and mobilization, required competence, skills and a supportive political, social, professional and financial environment. The process should be continually internally evaluated and feedback provided.

Hawe *et al*. (2000) stated that the focus on the organizational domains of community empowerment in health promotion is being undermined, first, by a lack of visibility and, second, because health promotion funding is tied mostly to direct activities with population groups in relation to specific disease entities or national targets. Planning and implementing empowering activities can mobilize a community, increase its competence and management skills and develop its ability to acquire resources needed to improve quality of life.

The identification of processes in the community or in the broader society, hindering the expansion of empowerment, was not planned within the current study. However, several aspects were mentioned by interviewees. The frequent changes in the political arena and replacement of decision makers created the need to repeatedly lobby new policy makers. Furthermore, the changes in ideology that took place when the government changed from left- to right-wing brought with them changes in the decision makers' priorities. The scarce time factor and stressful nature of project work were also noted as impairing aspects. Some elderly interviewees noted that the burdens and fears from occupation times have made people cautious about collaboration, so organizers need more time to engage older people in networks and to convince them to join.

8.3 Measurement of ODCE

The use of the empowerment expansion model within three different community programs demonstrated development of the ODCE in all three community health promotion programs. The study demonstrated the framework elaborated in cooperation with the community members for simultaneous empowerment and evaluation of the community process, combining the advantages of the empowerment evaluation (1996) and the 'parallel tracks' (Laverack, 1999) models. Laferty and Mahoney (2003), and Wallerstein (2006) have argued that successful empowerment interventions cannot be fully shared or 'standardized' across multiple populations. Therefore, no one theory could be applied in its entirety to other populations but must be created within or adapted to local context. Also Smyth and Schorr (2009) suggest that people must be seen in their real context. The current study has made efforts to consider these suggestions.

Although Fetterman *et al.,* (1996) have elaborated the simple and clear empowerment evaluation guide, he does not discuss the development of a practical methodology or ‚tool' for the measurement of community empowerment, nor does he assess whether the application of the model has resulted changes in community empowerment. Combination with the model developed by Laverack (1999), which suggests a tool to measure ODCE in program development, was found a proper approach by the communities to evaluate the changes in empowerment expansion. The ODCE has presented an explicit lane to evaluate community empowerment as a process.

Crisp, Swerissen and Duckett (2000) have argued that evaluation of the empowerment process is complicated because each community may identify and use a unique set of domains and empowerment strategies. The current approach confirms the argument as community

identified and adopted the ODCE as they perceived it. The main strengths of the model were that it was developed, discussed and analyzed by the community and adapted to their context, so it was for community members understandable and easy to apply. The measurement of the ODCE was understood by the participants as an explicit and logical way to determine the required domains for the needed empowerment goals. Furthermore, the identification of existing domains assisted in the planning process of the empowerment expansion.

Community health programs are initiated by local people in response to local needs (bottom up approach), by government requirements to solve national or municipal health problems (top to bottom approach) or by combined approaches. The evidence-based research has demonstrated that the most effective strategies are those that expand empowerment of local people and communities (Wallerstein, 2006). In current study in all three programs the ODCE were increased. However, evaluation of the programs indicated that the ODCE were increased most considerably among the community workgroups, which were initiated by community members and equally involved the municipality's decision-makers - the *Safe Community* program. Local interest and initiative, the importance of the issue, and political, financial and expert support from decision-makers are crucial for community empowerment and further achievement of its goals. This argument is supported by Fawcet *et al.* (2001) in his evaluation of community coalitions for the prevention of substance abuse.

The ODCE with the strongest political and financial support from the government institution was the *Drug Abuse and AIDS Prevention* program. The results demonstrated that the relevance of this issue among local people was critical. The dependence on a funding body and/or political requirements is important but not enough to result in sustainable expansion of empowerment.

In the *Elderly Quality of Life* program the expansion of empowerment was relatively slow but still evident. The community was unable to achieve no political nor financial support from decision-makers. However, most empowerment domains, such as community activation, community competence, and program management skills were still in steady increase. For the socially vulnerable groups, it was problematic to achieve both political and financial support. However, to acquire social and expert support was attainable. Likewise, Crisp, Swerissen and Duckett (2000) have found that it is difficult for program participants to achieve change or develop without external and/or political assistance or support.

The consensus workshop method, used for internal evaluation, is a deceptively simple and yet powerful way to engage people and capture diverse ideas within community groups. According to Stanfield (2002), consensus workshops promote inquiry; their intent is transformation. They allow people to respect and understand each person´s viewpoint and experience. Additionally, a consensus workshop method is transparent and serves and protects the interest and concerns of the group. The workshop's inclusive consensus-building allows groups to have a high degree of consciousness in relation to the decisions it makes. Several researchers have emphasized the importance of this method in assessing community empowerment domains (Gibbon *et al.,* 2002; Bush *et al*., 2002; Foster-Fishman *et al.,* 2001; Krupka and Noonan, 2009).

8.4 Measurement of ICRE

Tools for the measurement of ICRE are still under development. This study undertook an initial step towards examining ICRE in the Estonian context. The post-test findings indicated that the employed empowerment processes were associated with enhanced feelings regarding

self-efficacy related to social change in the community, *participation* in community activities, *intention* to become involved in community change, *motivation* to be involved, and *critical awareness* that community issues are serious.

The scale, a *mobilization scale – individual* (Jakes and Shannon, 2002), we adopted, measures individual community-related empowerment. We validated the scale, which demonstrated a satisfactory five-factor solution, confirming five specific dimensions of ICRE. Factor analysis indicated that the first factor, *self-efficacy,* was one of the strongest and most consistent. This is in agreement with findings reported in the USA by Rogers *et al.* (1997), who studied the individual empowerment of 271 participants in self-help groups in six states. Our results are also in support of the findings of Wowra and McCarter (1999), who validated an empowerment scale in an adult outpatient mental health population in South Carolina among 283 patients and similarly reported that self- efficacy was the strongest dimension.

Likewise, the dimensions *participation* and *intention* to participate in community actions imply the ability and willingness to participate, which is in agreement with the results of a study by Eklund (1999) among two Finnish communities where she found increased *participation* and *intention* to participate in community initiatives after utilising empowerment strategies. The results of Bejerholm and Björkman's (2010) research among people with mental illness entering supported employment in Sweden demonstrated a higher level of engagement in daily activities. In a study undertaken by Röger *et al*. (2010) among disadvantaged women in Germany, participation in community initiatives was found to be better among empowered individuals.

Our findings related to the dimension *motivation* to participate in the community, as an important component of ICRE, are in line with those of Mok *et al.* (2004), who studied

individual empowerment among Chinese cancer patients in Hong Kong. They found that the *motivation* dimension was critical for IE. Similarly, our findings regarding the dimension *critical awareness* are in agreement with the results of a study by Champeau and Shaw (2002) in which they examined critical consciousness in the dynamics of a public health community collaboration around an HIV prevention media campaign for women in the USA and observed its importance in ICRE.

In our sample, the five factors described above emerged sufficiently clearly. Although the factor *critical awareness* comprised only one item, the ICRE scale proved to be valid and appropriate for the measurement of its dimensions. The reliability coefficient for the total empowerment scale ($\alpha = 0.859$) demonstrated very good internal consistency (Sekaran, 1992).

Our findings confirmed that the framework for ICRE adapted and utilised in the current study is consistent with the definitions of ICRE offered by Zimmerman and Rappaport (1988) and Bracht and Tsouros (1990). The features constituting ICRE included community members' *self-efficacy* and confidence in their personal capability to organise and execute the course of action required to deal with community problems; *participation*, *motivation* and *intention* to participate without pay to achieve a common goal and/or social change in their community; and *critical awareness* as the sense of importance of community issues and understanding of the purpose of community action. Our findings are consistent with those of Bejerholm and Björkman (2010), who studied people with mental illness entering supported employment and found that the use of multilevel empowerment approaches to health are required to support individual empowerment.

Comparison of the pre- and post-test scores for the five dimensions revealed that all dimensions were improved in the post-test. The findings demonstrated a significant increase

both in total empowerment and in four (of the five) dimensions related to perceived ICRE. A somewhat unexpected finding was the absence of a significant change in the fifth dimension, *critical awareness* of community issues. A likely reason for this might be the relatively high score for *critical awareness* already prevalent in the pre-test, or alternatively, the provision of insufficient focus on this particular dimension in the intervention. Nevertheless, a slight increase was also observed in the dimension *critical awareness*. Thus, the ICRE scale was shown to allow the researchers and community members to determine the levels of ICRE as perceived by community members before and after the implementation of an empowerment expansion model in three community programs. Furthermore, it provided members of the community workgroups with valuable information about factors that could be modified to achieve even more favourable ICRE among participants in the community programs.

8.5 The strengths and limitations of the study

The advantage of this type of multi-stage and multi-method study is that it allows step by step identify context-specific understanding of concept and its utilization in a way, which is relevant to community stakeholders. Also it provides in-depth information on the facts, opinions and perceptions of the interviewees; it makes it possible to link up a group of elements, thus producing a relatively exhaustive study on a given subject. A well-conducted interview may provide insight into the mechanisms of implementation and the causal links peculiar to a given program. The parallel internal and external evaluation confirm the findings and gives an opportunity simultaneously assess the ICRE and identify the expansion of empowerment in a community.

However, studies like the current one have their limitations. When data are obtained through in-depth interviews (as in the first stage of the study), the sample size is usually smaller and does not use random methods to select the participants. Subsequently, the results cannot be generalized. Moreover, an individual interview takes into account situational and individual factors, making it difficult to draw general conclusions. Individual interviews may allow for an exhaustive identification of effects and possible causes, but they cannot be used to measure impacts or grade causes. Furthermore, the literature of the area under study may give a researcher preconception about what is likely to be found, and the researcher may be distracted by borrowed concepts. Also, the study is limited by its focus on a small number of communities from one county in Estonia. It is not clear whether data from other communities and contexts would result in similar perceptions and concept identification. However, the perspectives of the community members participating in the current study add richness and existential meaning to the abstract conceptualization of the ODCE.

In the second stage of the study the findings are limited by the fact that the workshop's participants were not necessarily representative of all community members. According to Bopp and Bopp (2004), passive members are less likely to attend community development processes. In future research, these groups should be studied to fully understand the impact of empowerment strategies in larger groups in the community. Also the small number of the participants on workshops limit the ability to generalize the findings. The results of this study are restrained by the inclusion of participants who are proactive, as they joined the workgroups voluntarily. The community workgroups and network members who participated in the current study consisted of individuals with a heightened sense of social responsibility and social activity, as suggested by the fact they were already involved in a range of

community development processes. Further studies are needed to apply the framework in more and different communities. Similarly, individuals may be greatly influenced by the context and other unanticipated events in their communities, which might influence their ICRE. Although this study affirmed that ICRE became more favorable during the intervention period, it is not possible to conclude that this materialized due to the health promotion interventions that we assessed. Furthermore, due to the cross-sectional nature of the current study, the observed trends are associations and should not be viewed as causations. Respondents from three health promotion programs from only one county in Estonia participated in the study. This geographical limitation means that similar assessments in other regions and with larger sample sizes would be required to confirm or refute the present findings. The extent to which these results reflect changes in empowerment on other regions groups is not known. There is a need for further research to clarify the results.

8.6 Criteria for assessing adequacy and quality of qualitative part of the study

The qualitative stages of this research are based on constructivist paradigm, which assumes a relativist ontology (existence of multiple realities), and a subjective epistemology (researcher and researched create data in collaboration). To ensure trustworthiness of the research this position requires the criteria as transferability, credibility, dependability and confirmability (Guba and Lincoln, 1989). Transferability refers to that knowledge generated from one context can be transferred to another. Transferability is always relative and depends entirely on the degree to which salient conditions overlap or match. So it is crucial that the researcher is detailed about describing the context he or she is studying so other researchers

can make qualified judgement whether study is transferable or not. The major technique for establishing the degree of transferability is thick description (Greets, 1973).

In current study author have made efforts to accommodate this criterion by providing as many details as possible of the context and settings and of the participants of the study. In both, methodology chapter and discussion chapters, it has been an ongoing process comparing findings to other relevant studies and findings to see if these make sense in other study context. The process of comparison has illustrated that ODCE are largely context-specific and suggest that before an evaluation of a community the clarification of the context is an ultimate proposition, which confirms the appropriateness of the selection of design utilized in current study.

Dependability is concerned with the stability of the data over time. Dependability specifically excludes changes that occur because of overt methodological decisions by the researcher or because of maturing reconstructions (Guba and Lincoln, 1989). The technique for documenting the logic of process and method decisions is an example of dependability audit. In current study the study process is established, agreed and presented as detailed it was as possible. It is trackable in collaboration with participants of the study and documented by the community members and reflected to each other systematically.

Confirmability is concerned with if assuring data, interpretations, and outcomes of inquiries are rooted in context and persons apart from the researcher and are not expression of researchers` imagination (Guba and Lincoln, 1989). The techniques to consider the criterion and confirm the data and interpretation is the confirmability audit. The data were assured asking interviewees to have double check of the transcribed data, and having two researchers to interpret data and thereafter to compare the results.

The credibility criterion refers to the isomorphism between constructed realities of respondents and the reconstructions attributed to them. That is how much researchers` realities match with realities participants have been produced. The techniques to avoid such error probability are prolonged engagement (Guba and Lincoln, 1989), peer debriefing, persistent observation and member checks. In our study the qualitative data, produced by the interviewers were sent back to them for confirmation of adequacy, similarly the interpretations of the data and categorization has been introduced and discussed with the people producing the data.

An another method of judging adequacy control of evaluation research is to look within the process itself (Guba and Lincoln, 1989). The evaluation based on constructivist paradigm is conducted via hermeneutic, dialectic process. Data inputs are analysed during the process of data collection. Continuous feedback during the consensus workshop method application, corrections, revisions, additions, elaboration of comments characterised data collection systematically. Collaborative reconstructions emerged as process. Using hermeneutic, dialectic process the opportunities for production of incorrect data is relatively small.

8.7 Criteria for assessing adequacy and quality of quantitative part of the study

The adequacy of a quantitative data are controlled by the criteria of validity, reliability and objectivity. Internal validity is defined as the extent to which variations in and pendent variable can be attributed to controlled independent variable (Cook and Campell, 1979). Internal validity is a crucial measure in quantitative studies, where it ensures that a research design closely follows the principle of cause and effect. For many studies pretest-posttest designs are the preferred method to compare participant groups and measure the degree of

change occurring as a result of interventions. However the threat to the validity in such design, which utilizes open public intervention, is that there are many other social influences to the study group and the design cannot confirm the causality of intervention. Similarly are threats to internal validity events like community history and maturation.

To assess the construct validity of the ICRE scale, we employed Lawshe's (1975) formula: CVR = (n < item > e +n < item >e) / (N x n), where ne= number of experts rating essential, and N= number of items. To investigate the multidimensional nature of the ICRE construct within the Estonian context, the factor analysis was employed to extract the factors by applying principal components analysis (varimax rotation). To assess the reliability of the ICRE scale, we used internal consistency coefficients measured by Cronbach's alpha, which were undertaken twice: collectively for the total empowerment scale and individually for each of the five empowerment dimensions.

The external validity is understood as a process of generalization. Generalizability refers to the extent that the account can be applied to other people, times and settings other than those actually studied. The external validity is also problematic in community context. The pre- and post-test as single method design cannot guarantee the external validity as in communities the context is continuously fluctuating. Furthermore, the context, settings and people, participating in the study may differ in community health promotion programs, and make the adequacy and suitability of quantitative methods in evaluation questionable. Nevertheless, the process of multi- method and multi-stage study design is a way to control the adequacy of the current study.

8.8. Concluding remarks

8.6.1 Outcomes of the study

This thesis is founded in raising critical questions of the understanding and application of ODCE concept in communities experienced lately authoritarian regime and large political and economic transition period. Considering the remarkable gap and inequalities in health in between Western and Eastern European countries, the need for empowerment approaches in countries in transition is notable. Therefore, the empowerment expansion within the health promotion community programs in Estonia in current study was perceived as a positive outcome.

The main goal of this study was to seek clarity in the empowerment expansion process in communities and to elaborate and provide methodology for health promotion practitioners who start their work in communities full of needs and concerns. The thesis investigated the application of the empowerment expansion model within three health promotion initiatives in Rapla County, *Safe Community*, *Drug Use and AIDS Prevention* and *Elderly Quality of Life* programs. In Rapla County the relative poverty of the population was high during study period in comparison to other regions of Estonia (Rapla Maavalitsus, 2002). In such settings, the expansion of empowerment of community members through program participation has been shown to be particularly important (Smith *et al.,* 2004).

Hence, the current study identified the ODCE and employed the empowerment expansion framework elaborated by the community members. Using this framework, program participants from three community health promotion initiatives were empowered through: 1) a range of empowerment activities (e.g., community activation, competence building and skills training, in addition to the creation of supportive environments) and 2) a variety of issue-

specific actions (agreement on missions, taking stock, planning of the future, implementation and monitoring). The use of the empowerment expansion model within different community programs demonstrated expansion of the empowerment in all three community health promotion programs. The current study suggests that, at least under some conditions, community program workgroups can empower themselves using contextually clarified ODCE and evaluating their implementation process. The community workgroup members agreed that this type of evaluation is a useful and flexible way of understanding and measuring the community empowerment process. It is also an applicable, rapid, simple and inexpensive tool that can be used in the measurement of the organizational domains of community empowerment.

As a parallel, external evaluation, the assessment of changes in community members' ratings of ICRE after two years of application of an empowerment expansion framework in Rapla County, Estonia was conducted. Comparison of the scores from pre- and post-tests revealed that all dimensions of ICRE were improved in the post-test. Our findings demonstrated a significant increase both in total empowerment and in four (of the five) dimensions of perceived ICRE, as well as a slight non-significant increase in one item, *critical awareness*. We conclude that for the investigated the Rapla community workgroups and networks, ICRE was rendered more favorable after the implementation of the empowerment expansion framework among the three health promotion programs. However, the cross-sectional study design employed here does not allow the demonstration of a cause-and-effect relationship between the intervention and ICRE outcomes.

8.6.2 Broader implications of the study

Hence, we found that there are several implication of this study. First, implicit in our model is the notion that the processes and activities within any ODCE may have effects on both empowerment and issue-specific outcomes within the community program context. Furthermore, the identification of ODCE allows a health promotion practitioner, together with community members, to identify the goals and objectives for certain domains of empowerment and thereby to identify prerequisites for effective program implementation. An empowered community with good knowledge and management skills, combined with an active and extensive network and also with political, expert and social support, could produce more health-enhancing results and outcomes, acquire more funding and consistently create, initiate, and implement new, important community interventions and actions.

Expansion of empowerment programs in communities is a powerful tool to help improve peoples' health (Laverack, 2009). However, many health promotion practitioners have expressed their confusion concerning contradictions that exist between the essential nature of health promotion and the requirements of the politics, administrators and financiers that have evolved, primarily for traditional, medically oriented goals and objectives in community health promotion programs. The resources for health initiatives are mainly provided by the state budget and health promotion foundation for the predetermined initiatives, and usually, these are not in harmony with professionals' understanding of effective approaches or local needs, concerns and interests. There is a need for a simultaneous empowering approach, its organization, and a pre-determined issue-specific approach. Furthermore, there is a need for the concurrent evaluation of both approaches. Health promotion practitioners, in collaboration with community members, can utilize the suggested approach to gain power and assess their

own achievement in empowerment expansion. The second implication of the current study is that it suggests to practitioners another possibility to measure the results of their health promotion program and gives another opportunity to be accountable. More and more financiers accept empowerment variables as targets that help health promotion practitioners focus directly on the main determinant of a community's health status, the expansion of community empowerment and its organizational domains.

Health promotion practitioners working with community networks might benefit from scrutinising the ICRE dimensions in the specific community contexts in which they work in a precise manner. Furthermore, asserting community members' individual empowerment status (and its dimensions) prior to a planned intervention could be beneficial for needs assessment exercises in terms of the dimensions of ICRE that might require strengthening to ensure effective program planning to meet the particular needs of the community members. Thus, another implication of current study is that the use of an empowerment expansion framework described here by communities could assist them in focussing on particular ICRE dimensions, which might then become essential and integral parts of a given community health promotion program. The findings of the present study suggests that to empower community members as part of a planned effort, community workgroups, together with local health promotion practitioners and evaluators, could direct their efforts to deliberately planned activities that would increase community members' *self-efficacy*, *participation*, *motivation* and *intention* to participate in community actions, as well as *critical awareness* of community issues.

8.6.3 Rapla County today

Due to several reasons the intermission in between current study, carried out in 2002-2005 and writing of this thesis has been six years. Looking to the Rapla County health profile in

2010, we find remarkable changes in health and health determinants, also in social mobilization of the communities in the County. Large number of health promotion initiatives has been initiated and health workgroups and networks have extended enormously. Significant decrease in injuries death rate has taken place during these years. Life expectancy has increased and relative poverty of the county's population in 2009 was lowest in comparison to other regions of Estonia (Rapla Maavalitsus, 2010). Rapla has acquired the image of friendly county, where people are collaborating together, where social cohesion is high, and where is good to live. To the authors` knowledge, the use of methodology, elaborated during current study, is used in Rapla by health promotion programs often and in large programs systematically. However, as numerous of processes are ongoing in each society, we cannot attribute these positive changes in the county to the empowerment evaluation processes initiated during current study six years ago.

8.6.4 Recommendations for future studies.

The focus on ODCE has gained increased prominence in health promotion over the past decade. The interest in ODCE has grown because health promotion practitioners and researchers increasingly see that effective action requires empowerment of communities in ways where meaningful decision making power is shared. Author believes that measuring ODCE is useful not only for assessing the expansion of empowerment to take action on health determinants but also for assessing generically the health status of the community.

This study has raised several questions which seek answers in future studies. Are domains identified during current study applicable also in other cultures and among other nations? Do domains differ in communities with different history and ideology? What are the

preconditions, within a range of community contexts, necessary for value-added ODCE assessments? What is about the effectiveness and efficiency of ODCE measurement methods and tools from a practical point-of-view? For addressing these questions I recommend in future studies to focus on potential transferability of the ODCE indicators developed. There is a need to test the same tool among more workgroups and communities in other cultures. This would involve a comparative study design. An analysis of how the presence or absence of key conditions within various community contexts affects the outcomes of ODCE assessment. Also a description of how the measures of ODCE are used I other contexts. This would require longitudinal studies or follow-up studies of previous projects. Author is confident that the measurement of the organizational domains of community empowerment as a determinant of health is the primary purpose of the programs directed to the health enhancement in communities.

In conclusion, this study has shed some light on the empowerment processes in a country in transition in Eastern Europe and demonstrated how community members in a formerly 'closed society' understand empowerment in community development processes as well as how they interpret and operationalize empowerment domains. The study adds Estonian community members' perspectives on empowerment to other perceptions of ODCE in the literature.

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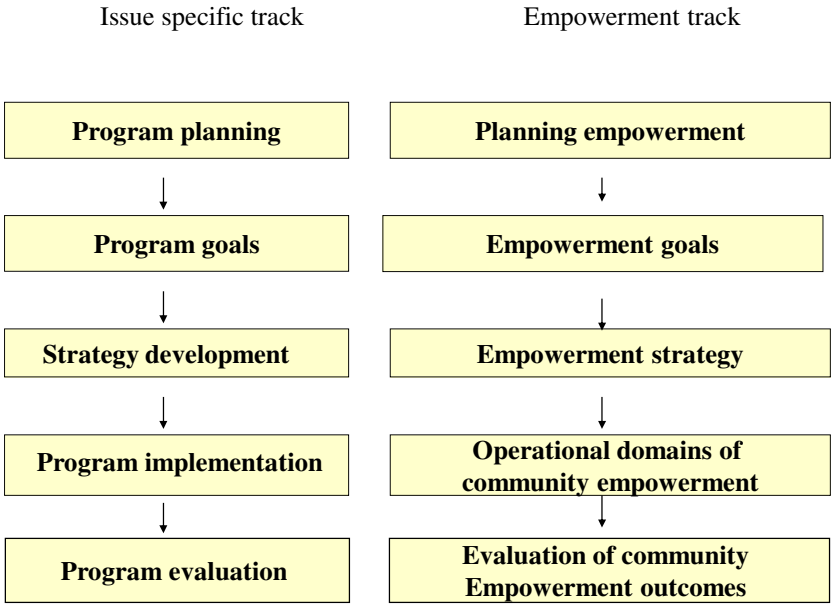
ANNEX I

The planning framework for incorporating community empowerment into top-down health promotion programs (Laverack and Labonte, 2000)



ANNEX II

The measurement tool of the ODCE

I Community activation

Level 1	Not at all/Very limited 1	Some-what 2	Sub-stantial 3	Almost entirely/ Entirely 4
1. There exists a group of community representatives that meets regularly to work on community goals and desired community outcomes.	□	□	□	□
2. The community group has an active leader, who motivates and engourages members of group.	□	□	□	□
3. The community workgroup is committed to solving local problems and is motivated to collaborate as a team.	□	□	□	□
I A community workgroup, which cares for community problems and is committed to collaborate in solving community problems is constituted.	□	□	□	□

Evidence describing the above mentioned assertions: .....

Level 2	1	2	3	4
4. Community workgroup members are proactive in assessing community needs and solving problems.	□	□	□	□
5. The community workgroup includes potential leaders who are able to overtake leadership if needed.	□	□	□	□
6. The community workgroup activates community members, new groups outside the community and also supports network development outside the community.	□	□	□	□
II The community workgroup is proactive in assessing community needs and solving its problems and is able to activate groups and networks inside and outside their community.	□	□	□	□

Evidence describing the above mentioned assertions:.....

Level 3	1	2	3	4
7. The community workgroup has initiated and created new community groups and extended networks in community.	□	□	□	□
8. The community workgroup has a strong identity and ownership of program.	□	□	□	□
9. Community workgroup collaborates with groups and networks outside of the community and internationally.	□	□	□	□
III There exists a constant group, which has created collaboration networks within and outside the community and initiated collaboration with international groups.	□	□	□	□

Evidence describing the above mentioned assertions:…….

II Community competence development

Level 1	Not at all/Very limited 1	Some-what 2	Subs-tantial 3	Almost entirely/ Entirely 4
10. Members of the group share information and knowledge within their group.	□	□	□	□
11. Members of the group are actively seeking new information and knowledge and building links between other sectors specialists.	□	□	□	□
12. Members of the group are seeking opportunities for further training to improve skills and knowledge from outside sources.	□	□	□	□
IV The group is seeking information and further training to improve knowledge and skills to handle community problems.	□	□	□	□

Evidence describing the above mentioned assertions:.....

Level 2	1	2	3	4
13. Members of the group get local and/or national training according to their needs.	□	□	□	□
14. Members of the group are able to train and educate other groups outside the community.	□	□	□	□
15. Members of the group have competence, which allows them to apply evidence based methods for solving local problems.	□	□	□	□
V Group has the competence to use evidence-based methods in solving local problems and to train and educate other groups.	□	□	□	□

Evidence describing the above mentioned assertions:.....

Level 3	1	2	3	4
16. Members of the group are able to conduct trainings outside the community and share information concerning their programs internationally.	□	□	□	□
17. Members of the group are able to conduct program analysis, and evaluation to improve their programs.	□	□	□	□
18. Members of the group have created a continuous feedback system to achieve overall quality assessment by the group members of the programs.	□	□	□	□
VI Group members have good knowledge and skills for educating and training community members and outside community networks members in health promotion.	□	□	□	□

Evidence describing the above mentioned assertions:.....

III Program management skills

Level 1	Not at all/Very limited 1	Some-what 2	Sub-stantial 3	Almost entirely/ Entirely 4
19. Members of the community workgroup are able to carry out local community needs assessment.	□	□	□	□
20. Members of the workgroup are able to compose a program implementation and evaluation plan using expert assistance.	□	□	□	□
21. Members of group are able to implement programs in collaboration with an expert.	□	□	□	□
VII Group has the capacity to identify local needs, compose a program implementation plan together with outside assistance.	□	□	□	□

Evidence describing the above mentioned assertions:.....

Level 2	1	2	3	4
22. Members of the group are able to analyze local needs, identify priorities, and also collaborate in problem solving at national level.	□	□	□	□
23. Members of the group are able to independently identify goals and objectives, plan activities and implement these.	□	□	□	□
24. Members of the group are able to flexibly reassess the situation and needs and replan the program if needed.	□	□	□	□
VIII Group has the capacity to independently assess local needs and implement programs, also participate in national problem solving.	□	□	□	□

Evidence describing the above mentioned assertions: .....

Level 3	1	2	3	4
25. Members of the group have initiated and implemented programs involving groups outside their community.	□	□	□	□
26. Members of the group participate in international collaboration programs in solving wider problems.	□	□	□	□
27. Among members of the group there are experts who are invited outside the community to assist or train members of other networks.	□	□	□	□
IX Group has the capacity to design and implement international programs and act as local and international experts.	□	□	□	□

Evidence describing the above mentioned assertions:.....

IV Creation of supportive environment

Level 1	Not at all/Very limited 1	Some-what 2	Sub-stantial 3	Almost entirely/ Entirely 4
28. The workgroup has received financial resources from foundations or state.	□	□	□	□
29. The workgroup has gained support from their institutions and organizations.	□	□	□	□
30. Members of the group collaborate with local policy makers and the media.	□	□	□	□
X Group has the capacity to achieve financial support and political support at local level.	□	□	□	□

Evidence describing the above mentioned assertions:.....

Level 2	1	2	3	4
31. The workgroup has gained more sustainable resources from sources outside the community	□	□	□	□
32. The workgroup has gained support from local policymakers and is collaborating systematically in influencing decision-making process.	□	□	□	□
33. The workgroup is collaborating systematically with the local media and has involved media representatives into their work.	□	□	□	□
XI The group has the capacity to achieve more sustainable financial resources and systematic involvement of politicians and media.	□	□	□	□

Evidence describing the above mentioned assertions:.....

Level 3	1	2	3	4
34. Members of the group have achieved sustainable resources for their initiatives from their own community organizations or national sources.	□	□	□	□
35. Members of the group have contributed in advocating policies at national level.	□	□	□	□
36. Members of the group have achieved reflections to their initiative from national media.	□	□	□	□
XII Group has the capacity to develop political and media support to their initiative and sustainable financial support for solving local health problems from international sources.	□	□	□	□

Evidence describing the above mentioned assertions:

ANNEX III

Evaluation matrix of the *Drug and AIDS Prevention* programme, 2004 (an example)

Activities 2004	Priorities	SV	KA	SL	TH	PK	KR	ES	LV	LMM	ÜL	Scores	Mean	Position
Feedback meetings (9)	-	10	9	8	9	6	10	9	8	7	8	84	8,4	14.
Trainings for peer support network (2)	/5	10			9	8	8		7		7	49	8,2	15.
Health Promoting Schools summercamp	/4		9		9	8			6		7	39	7,8	18.
Network for trainers of sexual health	/5		10		8	8	8		8		10	52	8,7	11.
Trainings for municipalities health partnerships network	/5	9		8			8		8		8	41	8,2	15.
Further trainings of health teachers	/5			10	9	9	8		9		6	51	8,5	12.
Lobby “Restrictions to selling of alcohol products during night time”	/4	9	10	10	8	10	9		8	8	7	79	8,8	10.
“Choice is yours” trainings	/4					9			8		7	24	8,0	17.
Campaign ‘Drug prevention week’	/8	10	10	10	10	9	10	10	10	10	10	99	9,9	II
- Camera Obscura (tent)			7		10		10	10	10	10	10	67	9,6	5.
- Church contsert		9	10		9		9			10	10	57	9,5	6.
- Drug prevention festival		10	10		9		10	9	10		10	68	9,7	4.
- Raids at tobacco kiosks			9		10		10	10			10	49	9,8	III
- Photo competition and festival		10	10		10		10	10	10	10	10	80	100	I
- Students peer trainings at high schools		10	9		8		8				10	45	9,0	8.
Training of the trainers in sexual health	/3					4					6	14	4,7	20.
Quit&Win competition		2	3	2	2	2			4		6	21	3,0	21.
Smoke-free class competition	/2	1	3	2	1	1			4		5	17	2,4	22.
Drug behaviour monitoring	/2	10	9	10	9	10	9		9	9	7	82	9,1	9.
Media	/4	8	9	8	8	6	8		9	8	9	73	8,1	16.
- Special newspaper		9	10	8	9		9		10		10	65	9,3	7.
- Media events		8	8	8	9		9		8		8	58	8,3	13.
Nation-wide collaboration									4	7	3	14	4,7	20.
Team-building					5				7		8	20	6,7	19.

ANNEX IV

Goals and expected outcomes in *Safe Community*, *Drug Abuse and AIDS Prevention* and *Elderly Quality of Life* programs, 2003 (an example)

Program	Objectives	Expected outcomes,	Measurement tools
*Safe Communi*ty program	1. To avoid children mortality in injuries in Rapla	1. The mortality in children injuries is zero (0,81 per 10 000 inhabitants in 2002)	Health statistics analyze
	2. To reduce the number of diagnosed injuries among Rapla adult population.	2. 5% of the increase in diagnosed injuries in the year 2004.	Health statistics analyze
Drug Abuse and AIDS Prevention program	1. To achieve 1% decrease in smoking among Rapla's schoolchildren in 5th, 8th and 11th grade.	1. Regular smoking (at least once in month) among schoolchildren in 5th grade 8% (9% in 2002), 8th grade 27% (28% in 2002), 11th grade 37% (38% in 2002).	Quantitative cross-sectional health determinants survey among school children
	2. To stop the increasing trend of alcohol-use among Rapla's schoolchildren.	2. The alcohol consumption among schoolchildren)once a month in 5th grade less than 33% (33% in 2002), 8th grade less than 20% (20% in 2002), 11th grade less than 32% (32% in 2002).	
	3. To slow down the increasing trend of drug use (defined as: tried illegal drug during the last year at least once) so, that the use of drugs among Rapla's schoolchildren does not exceed 5%.	3. Less than 6% of students in - 5th grade declare in April 2004 that they have tried illegal drugs at least once during last year (1% in December 2002). - Less than 14% of students in 8th grade declare in April 2004 that they have tried illegal drugs at least once during last year (9% in December 2002). - Less than 21% of students in 11th grade declare in April 2004 that they have tried illegal drugs at least once during last year (16% in December 2002).	
	4. To achieve a situation, where there is no newly diagnosed HIV infected people.	4. There are no newly infected HIV patients in Rapla by December 2004. (Altogether 7 infected persons – no one diagnosed in 2003).	Health statistics analyse
Elderly Quality of Life program	1. To achieve increase in self-assessment of health among the elderly women	1. The 2% increase is expected to achieve in self-assessment of health among the 55 years and older women for the year 2004. (15,8% in the year 2002).	Quantitative cross-sectional health behaviour survey among adult population
	2. To achieve increase in social inclusion of elderly women.	2. The increase 5% is expected to achieve in involvement in community groups or networks (45% involved in 2002).	
	3. To achieve increase in physical activity among elderly women.	3. The 3% increase is expected to achieve in physical activity at least 20 minutes twice a week among women older that 55 years (21% in the year 2002).	

ANNEX V

Planned activities, measurement indicators and measurement tools in *Safe Community* program, 2004 (an example)

Activities	Measurement indicators	Measurement tools
1. Counseling of parents of newborn children and equipping with relevant materials on injury prevention	-100% parents of children born in 2003 have received injury prevention information leaflets; - 70% of parents interviewed are aware of injury prevention measures of babies Leaflet quality indicators: - appropriateness - attractiveness - informativeness - usefulness	*-Registration of shared leaflets and counseled parents;* - phone interviews among 50 randomly selected baby's parents
2. Interactive play for pre-school children 1-4 "Know how to behave in traffic" in 20 kinder-gardens.	The number of kinder-gardens and schools where drama is played and Participation rate of children;	Feedback information from schools and kinder-gardens
3. Trainings for kinder-garden teachers, at least 40 hours	- 80% of kinder-gardens attend; - Trainings are assessed as 'good' or 'very good' - seminar's appropriateness - informativeness - usefulness - standard of organization	Checklists in the end of seminars
4. Preparation of articles for weekly magazine "Nädaline" and for municipality- and school magazines	- number of articles (at least 6 in a year) - appropriateness - informativeness - usefulness	- register of articles - readers survey carried out by magazine
5. Trainings for elderly in care center's and day care institutions to personnel and clients, 4 seminars	Participants assess trainings at least 'good' or 'very good' - seminar's appropriateness - informativeness - usefulness - standard of organization	Focus-group discussions after four seminars
6. Round table discussions with family doctors, twice in a year	70% family doctors attendance in both events	Participants self-assessment of value of the discussions
7. A leaflet "Dangers of being injured and safety needs of children during first 3 years of life" additional printing and sharing to 300 parents	100% of parents have received leaflet Leaflet quality indicators: - appropriateness - attractiveness - informativeness - usefulness	Phone interviews among randomly selected parents
8. Teacher training "Look for Ott", three stages: training: theory, practical training and survival course in forest	- Attended at least 60% of kinder-gardens teachers; - participation - training is assessed as 'good' or 'very good'	- Checklists after each training - number of trainings and number of kinder-gardens, where training took place;
9. Leaflet "Injury prevention guide II" additional printing and sharing to parents in kinder-gardens	50% of parents of pre-school children have received the leaflets. Leaflet quality indicators: - appropriateness	Phone interview of the randomly selected 50 parents

	- attractiveness - informativeness - usefulness	
10. "Ott's Day" in Rapla and Märjamaa	Assessment will be carried out by Injury Prevention Coalition members who attended	Evaluation matrix
11. Emergency trainings in gymnasiums among last year students	- Attended at least 90% of last year students;	List of students attended
12. Trainings of class-leaders and teachers and principals of gymnasiums at least 40 hours	- training is assessed as 'good' or 'very good' - participation rate - training's appropriateness - informativeness - usefulness - standard of organization	Feedback questionnaires after each training
13. Preparation, printing and sharing of the stickers "Helmet is for HEAD"	Shared 500 stickers Sticker's quality indicators: - appropriateness - attractiveness - informativeness - usefulness	Focus group assessment
14. Training of the Day Care personnel in elderly injury prevention, 8 hours	- training is assessed as 'good' or 'very good' - participation rate - training's appropriateness - informativeness - usefulness - standard of organization	Checklists after each training
15. Leaflet "Injury prevention guide III" preparation, printing and sharing to elderly	200 leaflets Quality indicators: - appropriateness - attractiveness - informativeness - usefulness	Interviews with day care center's clients
16. Sharing reflectors and counseling of elderly	500 reflectors shared	- List of shared reflectors
17. Lectures, round-table discussions, risk analysis in kinder-gardens, schools, organizations and among magazine's editors	The number of events, programs and decisions made will be registered	Records
18. Lobby among municipality clerks convincing to join WHO Safe Community movement	Municipality leaders commitment is written down in form of application to the WHO	Application
19. Team building/ Trainings for Injury Prevention Coalition members (2)	- training is assessed as 'good' or 'very good' - participation rate - training's appropriateness - informativeness - usefulness - standard of organization	Checklists after each training
20. Workshops with Injury Prevention Coalition members (4)	Documents prepared as a result of workshops (project plan, action plan, evaluation matrix, etc)	Protocols of workshops
21. Emergency-course for Injury Prevention Coalition members	Assessment of participants	Evaluation matrix

ANNEX VI

Evaluation tools and indicators of the S*afe Community* and *Drug Abuse and AIDS prevention* and *Elderly Quality of Life* program workgroups (an example)

Evaluation type	Evaluation tool	Indicator		
		Safe Community program	*Drug Abuse and AIDS Prevention* program	*Elderly Quality of Life* program
Process evaluation	Continuous process monitoring Continuous feedback	- participation - number and scope of activities - products produced - media products	- participation - number and scope of activities - products produced - media products s	- participation - number and scope of activities - products produced - media products
	Leaflets quality assessment - Phone interviews among target group (parents of newborn babies, elderly)	- appropriateness - attractiveness - informativeness - usefulness		- appropriateness - attractiveness - informativeness - usefulness
	Quantitative surveys in the end of each training seminar among participants	- seminar's appropriateness - informativeness - usefulness - standard of organization	- seminar's appropriateness - informativeness - usefulness - standard of organization	- seminar's appropriateness - informativeness - usefulness - standard of organization
	Focus-group study among children	-awareness of traffic risks - traffic behavior -visibility of the intervention		
	Qualitative interviews with 16 workgroup members	- satisfaction with management and implementation of the program	- satisfaction with management and implementation of the program	- satisfaction with management and implementation of the program
Impact evaluation	Monitoring of changes	- political decisions made through group initiation and influence - finance resources acquired - network enlargement - new sustainable structures created	- political decisions made through group initiation and influence - finance resources acquired - network enlargement - new sustainable structures created	- political decisions made through group initiation and influence - finance resources acquired - network enlargement - new sustainable structures created
Outcome evaluation	Analyze of health statistics	-injury morbidity and mortality among children and adult population		
	Cross-sectional quantitative health determinants surveys among schoolchildren and adults		- occasional smoking - regular smoking - alcohol use - occasional drug experience - drug use	- self-assessment of health - physical activity - social inclusion

ANNEX VII

Semi-structured interview guide

Mission statement

1. Describe your community program structure – how was it formed, who belongs into workgroup, what kind of networks you work with?
2. Have you contributed to the formulation of the mission of your workgroup?
3. In your opinion, what were the empowering and enabling activities accomplished and performed by the health promotion practitioners` team and workgroup members in the process of mission statement and goals definition?
4. Can you identify the most influential propositions and activities carried out during the process of mission agreement?

Situation assessment

5. Have you contributed to the process of situation analysis?
6. How local needs and concerns in your community health program workgroup were identified?
7. In your opinion, what were the empowering and enabling activities accomplished and performed by the health promotion practitioners` team and workgroup members in the process of identification of local needs and concerns?
8. Can you identify the most influential propositions and activities carried out by the health promotion practitioners and workgroup members for identification of the local needs?
9. How priorities were selected and decided in your community health programs?

Planning

10. Have you contributed to the process of planning community health program activities?
11. In your opinion, what were the empowering and enabling activities accomplished and performed by the workgroup members and health promotion practitioners in the process of program planning?
12. Can you identify the most influential propositions and activities carried out by the health promotion practitioners and workgroup members during the program planning?

Implementation

13. Have you participated in implementation of the community health program?
14. In your opinion, what were the empowering and enabling activities accomplished and performed by the workgroup members and health promotion practitioners in the process of program implementation?
15. Can you identify the most influential propositions and activities carried out by the health promotion practitioners and workgroup members during the program implementation

Monitoring and evaluation

16. Have you participated and contributed to the monitoring and evaluation of the community health program?
17. In our opinion, what were the empowering and enabling activities accomplished by the workgroup members and health promotion practitioners in the process of monitoring and evaluation of the program?

18. Can you identify the most influential propositions and activities carried out by the health promotion practitioners and workgroup members during the process of monitoring and evaluation of the program?

Participation satisfaction

19. Are you satisfied with your involvement in community health program?
20. Are you satisfied with the process of the program planning, implementation and evaluation? Why? Why not?
21. Are you satisfied with program management?
22. Are you satisfied with team work during the different stage of the program implementation?
23. Are you satisfied with your own role, responsibilities and performance?

Social, Political and financial support

24. In our opinion, what were the enabling and empowering activities accomplished by the workgroup members and health promotion practitioners for achieving social, political and financial support to the program?
25. Can you identify the most influential propositions and activities carried out by the health promotion practitioners and workgroup members for attaining social, political and financial support to the program?

Participation in health program

26. In your opinion, have your workgroup been influential in handling community health problems? In what way?

Personal

27. How long time you have been involved in the program?
28. What is the health issue your workgroup is dealing with?
29. What is our age group: 18-24, 25-34, 35 44, 45-54, 55-64, 65-and older

Thank you very much. Is there anything you would like to add?

Male/female
Place of the interview: ……
Time of the interview: …….....…

ANNEX VIII

The questionnaire

PLEASE, CIRCLE THE QUESTIONS

I GENERAL INFORMATION

1. What is your place of living?

1 urban
2 suburban
3 rural
4 village
5 countryside

2. How long have you lived at your current address?

1 less than 12 month
2 1-2 years
3 3-4 years
4 5-10 years
5 more than 10 years
6 always

3. Are you living in:

1 private house
2 private flat/appartement
3 public housing
4 Other

4. Are you renting your accommodation?

1 yes
2 no

5. What is your occupation?

1 farming, cattle-raising, forestry
2 industrial, mining, construction or other similar type of work
3 office work, intellectual work, services
4 student
5 housewife
6 pensioned
7 unemployed

6. What is total number of years of full-time education (including school, study)?

└┴┘ years

II MOBILIZATION SCALE

	STRONGLY AGREE	AGREE	NOT SURE	DISAGREE	STRONGLY DISAGREE
7. I know many people in my community by name	1	2	3	4	5
8. People work together to solve problems in the community	1	2	3	4	5
9. I know I can make difference in my community	1	2	3	4	5
10. I want to get involved in my community	1	2	3	4	5
11. I am going to get involved in my community	1	2	3	4	5
12. I Participate in community activities	1	2	3	4	5
13. I know when and where important community events take place	1	2	3	4	5
14. There is effective leadership in the community	1	2	3	4	5
15. I can influence community members to take action on important issues	1	2	3	4	5
16. I feel that community issues are important	1	2	3	4	5
17. I am willing to get involved in my community	1	2	3	4	5
18. I volunteer for community projects	1	2	3	4	5
19. I know about current community projects	1	2	3	4	5
20. It is easy to volunteer to help solve community problems	1	2	3	4	5
21. I have the ability to impact my community in important ways	1	2	3	4	5
22. I think it is important for me to get involved in my community	1	2	3	4	5
23. I intend to take action in my community	1	2	3	4	5
24. I have an active role in my community	1	2	3	4	5
25. I have the knowledge and skills to gather information relevant to community issues	1	2	3	4	5
26. There is a lot of cooperation between groups in the community	1	2	3	4	5

	STRONGLY AGREE	AGREE	NOT SURE	DISAGREE	STRONGLY DISAGREE
27. I have confidence in my capabilities to make needed changes in my community	1	2	3	4	5
28. I feel that efforts to address community issues are worthwhile	1	2	3	4	5
29. I am going to try participate in community activities	1	2	3	4	5
30. I pitch in when there is work to be done in the community	1	2	3	4	5
31. I have the knowledge and skills to influence the community	1	2	3	4	5
32. The community has the necessary resources to make community improvements	1	2	3	4	5
33. I am able to affect the area in which I live	1	2	3	4	5
34. I think that the problems in my community are serious	1	2	3	4	5
35. I am motivated to get involved in my community	1	2	3	4	5
36. I am involved in my community	1	2	3	4	5

III SUBJECTIVE WELL-BEING AND THRUST

	STRONGLY AGREE	AGREE	NOT SURE	DISAGREE	STRONGLY DISAGREE
37. It is safe to walk around the area at night	1	2	3	4	5
38. I generally thrust my neighbors to look out for my property	1	2	3	4	5
39. Children are safe walking around the neighborhood during the day	1	2	3	4	5
40. My area have a reputation for being a safe place	1	2	3	4	5
41. Most people can be trusted	1	2	3	4	5
42. I think that most people would try to take advantage of me if they got a chance, I do not think they would be fair	1	2	3	4	5

	STRONGLY AGREE	AGREE	NOT SURE	DISAGREE	STRONGLY DISAGREE
43. If I no longer lived here, hardly anyone would notice	1	2	3	4	5
44. I can get help from friends when I need to	1	2	3	4	5
45. People in my neighborhood are willing to help each other	1	2	3	4	5
46. I am satisfied with my life so far	1	2	3	4	5
47. I feel valued by my community	1	2	3	4	5
48. I feel proud of living at this street/village	1	2	3	4	5
-"- city	1	2	3	4	5
-"- country	1	2	3	4	5
49. I would assess my present health as very good	1	2	3	4	5
50. I am satisfied with my household financial situation	1	2	3	4	5
51. I often feel rushed, pressured and too busy	1	2	3	4	5
52. It is up to me to take responsibility for what happens in my own life	1	2	3	4	5
53. I am satisfied with my standard of living	1	2	3	4	5
54. I have optimistic attitude to my future	1	2	3	4	5
55. I assess my family being rich	1	2	3	4	5
56. I feel I have enough power and rights to change my life better in future	1	2	3	4	5
57. I am continuously supporting my parents/ children/relatives living with me or elsewhere	1	2	3	4	5
58. I am continuously getting support from my parents/children/relatives living with me or elsewhere	1	2	3	4	5

IV SOCIAL NETWORKS

	STRONGLY AGREE	AGREE	NOT SURE	DISAGREE	STRONGLY DISAGREE
59. I am active member of a local organization/club	1	2	3	4	5

	STRONGLY AGREE	AGREE	NOT SURE	DISAGREE	STRONGLY DISAGREE
60. My workmates are also my friends	1	2	3	4	5
61. I feel part of a team at work	1	2	3	4	5
62. I have a extended family whom I meet regularly	1	2	3	4	5
63. I have friends whom I meet regularly	1	2	3	4	5
64. I have work-mates whom I meet regularly out of work-time	1	2	3	4	5
65. I have people from my community/ neighborhood whom I meet regularly	1	2	3	4	5

V POLITICAL AND CIVIC ENGAGEMENT

	STRONGLY AGREE	AGREE	NOT SURE	DISAGREE	STRONGLY DISAGREE
66. I have voted during last elections	1	2	3	4	5
67. During last year I have participated in community meetings or in protest action	1	2	3	4	5
68. I or my family is member of the NGO	1	2	3	4	5
69. In my community/neighborhood, is it generally expected that people will volunteer or help in community activities	1	2	3	4	5
70. People who do not volunteer in community activities likely to criticized or fined	1	2	3	4	5
71. I have full confidence in my government	1	2	3	4	5
72. I have full confidence to my local government	1	2	3	4	5
73. I have full confidence to the legal system	1	2	3	4	5
74**.** People here look out mainly for the welfare of their own families and they are not much concerned with neighborhood welfare	1	2	3	4	5
75. Most people in this neighborhood are willing to help if you need it	1	2	3	4	5
76. This neighborhood has prospered in the last five years	1	2	3	4	5

VI SOCIABILITY, PROACTIVITY

	STRONGLY AGREE	AGREE	NOT SURE	DISAGREE	STRONGLY DISAGREE
77. In the past week I had several phone conversations with my friends	1	2	3	4	5
78. Yesterday I talked to many (at least 10) people	1	2	3	4	5
79. When I am going shopping in my local area, I am likely to run into friends and acquaintances	1	2	3	4	5
80. I have sometimes picked up other's people rubbish in a public place	1	2	3	4	5
81. If I disagree with what everyone else agreed on, I feel free to speak out	1	2	3	4	5
82. I sometimes go out my community to visit my family	1	2	3	4	5
83. At my neighborhood I sometimes take the initiative to do what needs to be done even if no one asks me	1	2	3	4	5

VII YOURSELF

84. Your gender?

1 male
2 female

85. Year of birth? 19 ⌊__⌋⌊__⌋

86. Marital status?

1 married or living in a partnership
2 single
3 separated or divorced
4 widowed

87. How many people live in your household?

ADULTS	CHILDREN
1	1
2	2
3	3
4	4
5	5
6 or more	6 or more

88. What is main source of income for your household?

1 Wages or salary
2 Pension or benefit
3 Other

89. What is your current income?

1 ……..
2
3
4
5

90. What are the five most important issues needing to be addressed for improvement of Horsens citizens life quality?

1 Childcare
2 activities for children 0-5 years
3 activities for children 6-12
4 activities for children 13-17
5 care for elderly
6 parks, open spaces
7 bike roads
8 access to physical activities facilities
9 speeding traffic
10 safety
11 vandalism
12 employment
13 clean air
14 clean water
15 health services
16 other, specify …….

THANK YOU VERY MUCH FOR YOUR KIND COLLABORATION!

ANNEX IX

ODCE measurement questionnaire - *Safe Community* program

I Community activation

Level 1	Not at all/Very limited 1	Some-what 2	Sub-stantial 3	Almost entirely/ Entirely 4
1. There exists a group of community representatives that meets regularly to work on community goals and desired community outcomes.			M1	M2; M3
2. The community group has an active leader, who motivates and encourages members of group.			M1	M2; M3
3. The community workgroup is committed to solving local problems and is motivated to collaborate as a team.			M1; M2	M3
I A community workgroup, which cares for community problems and is committed to collaborate in solving community problems is constituted.			M1; M2	M3

M1 3,0
M2 3,6
M3 4,0

Evidence describing the above mentioned assertions:

M1 2003 – The workgroup was constituted in the year 1998 and during these years, it has convened more than 30 times, six times during the year 2003. The meetings are recorded. The workgroup members work on a voluntary bases. They have a clear perception of the mission and are happy to participate in the community program. The members judge their collaboration to be excellent and feel that they can rely on each other. "It is a priviledge to be invited to participate and it is great to work with these people – we have become friends".
Many new members have taken part in different training programs, events and campaigns. During last year, more than 120 people participated in different training programs and meetings. Training programs are documented and participation evaluations surveys conducted.

The community workgroup has an active leader who is highly appreciated by the group. The group members have repeadedly emphasized the importance, charisma and good team-buiding skills of their leader. Several new groups have sprung up, such as groups of "Look for Ott" trainers and school health educators on school injury prevention.

M2 2004 - Workgroup members have regular planning and feedback meetings. During the year 2004 there were 7 meetings. The meetings are recorded. Workgroup members have brought a large number of participants into community activities. School-children groups and elderly groups were also formed. During the study year three new networks were formed : a network of elderly care homes representatives on injury prevention, networks of kindergardens health workers injury prevention group, and networks for prevention of infant injuries which family doctors have joined .
M 2005 – The networks formed during the previous year are working actively. A network of municipality leaders has been activated and involved into the Safe Community process.

Level 2	1	2	3	4
4. Community workgroup members are proactive in assessing community needs and solving problems.		M1	M2; M3	
5. The community workgroup includes potential leaders who are able to take over leadership if needed.		M1	M2; M3	
6. The community workgroup activates community members, new groups outside the community and also supports network development outside the community.		M1	M2	M3

II The community workgroup is proactive in assessing community needs and solving its problems and is able to activate groups and networks inside and outside their community.	M1	M2; M3	

M1 2,0
M2 3,0
M3 3,3

Evidence describing the above mentioned assertions:

M1 2003 - The workgroup made efforts to activate municipalities during the previous years, actively contacting municipality leaders, and organizing collaboration seminars and discussion groups. Several municipalities have taken an active role and are collaborating increasingly (Rapla, Kehtna, Kohila). Non-governmental organizations like the Health Promotion Association, Red Cross, Children Protection Association, etc. have been brought into the Safe Community program. Collaboration with several peer health promotion organizations from different counties was initiated (with Jõgeva, Viljandi, Pärnu and Harju Counties).

There are many potential leaders in the community workgroup who could take leadership, if needed. Currently they are acting as leaders of different groups and networks in the county. They have been proactive in building networks within and outside of the community.

M2 2004 - In 2004 a larger number of municipality representatives joined the community actions. County Schools Students Governings Union joined the community collaboration. Several school related injury prevention tasks became their responsibility. Municipality weekly newspaper editors' network agreed to join and make regular contributions to injury prevention. Municipality governors were willing to collaborate, and twice have had common meetings concerning safe community issues. In four municipalities local safe community networks were formed.

Common meetings and seminars with other counties have taken place (Põlva, Jõgeva, Harju, Tartu, Viljandi counties). A summer school was organized together with other counties for discussing common issues, exchanging experiences and learning from each other.

M3 2005 - All municipalities have joined the Safe Community movement and signed the common agreement in injury prevention. The agreement was presented to WHO Safe Community Collaboration Centre. Together an international Safe Community conference was organized. Two collaboration seminars and a summer school were organized with workgroups of other counties Safe Communities. A meeting with Viljandi County municipalities leaders was conducted.

Level 3	1	2	3	4
7. The community workgroup has initiated and created new community groups and extended networks in community.		M1	M2; M3	
8. The Community workgroup has a strong identity and ownership of program.			M1;	M2; M3
9. The community workgroup collaborates with groups and networks from outside of community and internationally.		M1	M2; M3	
III There exists a constant group, which has created collaboration networks within and outside the community and initiated collaboration with international groups.		M1	M2	M3

M1 2,3
M2 3,3
M3 3,6

Evidence describing the above mentioned assertions:

M1 2003 – The community workgroup has been proactive in creating contacts with Finnish colleagues in Safe Community program and also with Swedish colleagues. Several reciprocal group visits have taken place during previous years. Several members of community workgroup attended a Safe Community conference in Helsinki.

M2 2004 - In June 2003, members of Rapla community workgroup and networks attended an international Safe Community conference in Prague. Two people from community workgroup presented Rapla initiatives on injury prevention and safety promotion.

M3 2005 - In the year 2004 the Safe Community workgroup has submitted an application to the World Health Organization (WHO) for attaining the designation of Safe Community. An international expert committee conducted a review and concluded that all requirements for the Safe Community nomination were fulfilled. The community workgroup organized an international conference on 1st of October, which was a summit for the entire community

and bonded community people together even more. Participants from many countries (Canada, Latvia, Sweden, Finland and Denmark) attended. Six presentations introducing Rapla's injury prevention initiatives were made by community workgroup members. Also a WHO seminar was arranged during the conference days, and the Baltic-Nordic Network for Safe Communities was established.

II Community competence development

Level 1	1	2	3	4
10. Members of the group share information and knowledge within their group.		M1	M2; M3	
11. Members of the group are actively seeking new information and knowledge, and building links between other sectors specialists.		M1;	M2; M3	
12. Members of the group are seeking opportunities for further training to improve skills and knowledge from outside sources.		M1	M2	M3
IV The group is seeking information and further training to improve knowledge and skills to handle community problems.		M1	M2; M3	

M1 2,0
M2 3,0
M3 3,3

Evidence describing the above mentioned assertions:

M1 2003 – The community workgroup has acquired information about local health statistics and data from behavioral surveys conducted in region. Group members have also obtained data about injuries from the police, local hospital, family practitioners centers, traffic service and rescue service system.

Group members have conducted several training programs and workshops in order to acquire more information, knowledge and skills from different stakeholders and specialists from their community. The last training examples are first-aid training and a session devoted to drug prevention methods.

M2 2004 - An information delivery system is created between different sectors' representatives: kindergartens, schools, traffic service, rescue service, etc. Regular feedback of information is given through 1) direct contacts between the representatives of different network members and 2) through community workgroup meetings (seven feedback meetings during the year 2004). Additional information is shared through professional networks (schools networks, elderly care homes network, etc).

M 2005 - In the year 2004 four training programs were conducted. Information delivery and the functioning of the community members is assessed.

Level 2	1	2	3	4
13. Members of the group get local and/or national training according their needs.		M1; M2	M3	
14. Members of the group are able to train and educate other groups outside the community.		M1; M2	M3	
15. Members of the group have competence, which allows them to apply evidence-based methods for solving local problems.		M1	M2; M3	M3
V The group has competence to use evidence-based methods in solving local problems and to train and educate other groups.		M1	M2	

M1 2,0
M2 3,0
M3 3,3

Evidence describing the above mentioned assertions:

M1 2003 - Members of the community workgroup have carried out training on injury prevention issues for several networks: kindergarten nurses, schoolteachers, municipality representatives, parents and to the representatives of the other communities in other regions.

Workgroup members and representatives of different networks have received information and training from the national Safe Community program, the Union for Health Promotion members and university people. A three seminar cycle was requested to be carried out by the university on evaluation issues. Empowerment evaluation methodology was acquired by the workgroup members and practiced during 2003. Evaluation was carried out by community members in collaboration with Union for Health Promotion and a university evaluator. The training cycle included information on evaluation methods, data collection, data analysis and dissemination.

M2 2004 - Workgroup members have been invited to other counties to conduct seminars on safety issues. The Empowerment evaluation method was applied in the programme continuously. The feedback system is a regular part of the programme.

M3 2005 - During the year 2004, members of the community workgroup and networks have organised two common seminars with Viljandi, Jõgeva and Tartu Safe Community initiatives. A summer school was organised for sharing knowledge and experience between four counties' safe community initiatives. Rapla community workgroup members have been asked to share their knowledge at the national health promotion conference. In January 2004 they were asked by the Health Promotion Fund to introduce the empowerment evaluation approach to the health promotion programme leaders. Five members of the community workgroup have been asked to collaborate on the preparation of the safetyness Chapter in the County Developmental Plan. Three municipalities have asked workgroup members to consult and advize on their Health Action Plan preparation process.

Level 3	1	2	3	4
16. Members of the group are able to conduct training sessions outside their community and share information about their programs internationally.		M1	M2; M3	
17. Members of the group are able to conduct program analysis, and evaluation to improve their programs.	M1		M2	M3
18. Members of the group have created a continuous feedback system to achieve overall quality assessment by the group members of the programs.		M1	M2	M3
VI Group members have good knowledge and skills for education and training community members and outside community networks' members in health promotion.		M1	M2	M3

M1 1,6
M2 3,0
M3 3,6

Evidence describing the above mentioned assertions:

M1 2003 - Community members(?) have attended international conferences and presented Rapla Safe Community data to the international audience. Members of the community workgroups and networks have collaborated during last three years with the Finnish Safe Community initiative. Mutual visits have been organized annually since 1999. Contacts with Karolinska Institute in Sweden were established in 1998 since then a group of community members have attended training and field visits at several Safe Communities in Sweden, and also at the WHO Collaborating Center for safe Communities. Three members of the community networks have attended the WHO Safe Communities traveling seminars in Sweden, Bangladesh and South Africa.

M2 2004 - During the year community members attended the Finnish Safe Community Conference and performed two presentations: an oral and a poster presentation concerning the Rapla Safe Community initiative. A group of nine community members attended the European Conference on Safe Communities in Prague and made two presentations. Programme evaluation has been carried out regularly using the empowerment evaluation method. The continuous feedback process is an essential part of the evaluation.

M3 2005 - Members of the community workgroup attended the IUHPE World Health Promotion Conference in Melbourne and prepared two poster presentations concerning Safe Community issues in Rapla. On the 1st of October 2004 members of the Safe Community workgroup organised an international Safe Community Conference in Rapla, where approximately one third of the presentations were made by Rapla community people. According to the WHO expert, group results of the Rapla injury prevention efforts were acknowledged to correspond to the requirements of the WHO Safe Communities movement. Programme evaluation has been carried out regularly using the empowerment evaluation method. The continuous feedback process is an essential part of the evaluation.

III Program management skills

Level 1	1	2	3	4
19. Members of the community workgroup are able to carry out local community needs assessment.		M1	M2; M3	
20. Members of the workgroup are able to compose the program implementation and evaluation plan using expert assistance.		M1	M2	M3
21. Members of the group are able to implement programs independently.		M1	M2	M3
VII Group has the capacity to identify local needs, compose the program implementation plan together with outside assistance.		M1	M2	M3

M1 2,0
M2 3,0
M3 3,6

Evidence describing the above mentioned assertions:

M1 2003 – The Community workgroup has received training in program management skills from their own group members and from national level experts. Group members have experience in conducting several local programs independently. Outside experts have conducted training programs on several program management issues (goal definition, planning, evaluation skills) and on other specific issues (scald injuries and babies injuries prevention, etc)

M2 2004 - Community workgroup members have received training in participatory evaluation methodology and practiced empowerment evaluation in collaboration with a university evaluator and health promotion experts from the Union for Health Promotion. Workgroup members have been invited to other regions (Jõgeva, Harju and Viljandi) to introduce practical application experience in the empowerment evaluation.

M3 2005 - Community workgroup members have conducted the community needs assessment independently. Community members have designed the implementation plan with limited assistance from an outside evaluator. Implementation of the program has been almost without assistance.

Level 2	1	2	3	4
22. Members of the group are able to analyze local needs and identify priorities and collaborate in problem solving at the national level.	M1	M2	M3	
23. Members of the group are able to independently identify goals and objectives, plan activities and implement them.		M1	M2	M3
24. Members of the group are able to flexibly reassess the situation and needs and replan the program if needed.		M1	M2	M3
VIII Group has the capacity to independently assess local needs and implement programs, also to participate in national problem solving.		M1	M2	M3

M1 2,6
M2 2,6
M3 3,6

Evidence describing the above mentioned assertions:

M1 2003 - Members of the community workgroup have experience with several independently implemented community programmers. Since 1998, injury prevention program applications have been made each year to the Health Promotion Fund, and the program implemented on a yearly bases. As the program target groups (community children and elderly) are wide, flexibility is needed in engaging new actors, solving emerging problems and making changes when needed.

M2 2004 - Members of the community workgroup have come up with the idea of using participative drama for teaching traffic behaviour skills to infants in kindergardens. A show was produced and performed in all kindergartens, in which children, parents and pre-school teachers showed tremendous interest. Workgroup members have also been asked to perform it outside their community.

M3 2005 - Workgroup members have prepared and published the compact report of the health situation in Rapla County analysing behavioural, social and environmental determinants of health, and made an overview of health

statistics. The Safe Community programme has been implemented independently, continuously reassessed, and flexibly improved.

Level 3	1	2	3	4
25. Members of the group have initiated and implemented programs involving groups outside their community.	M1	M2; M3		
26. Members of the group have participated in international collaboration programs solving wider problems.	M1; M2	M3		
27. Among members of the group are experts who have been invited to assist or train members of other networks outside the community.		M1 M2	M3	
IX Group has the capacity to design and implement international programs and act as local and international experts.	M1	M2	M3	

M1 1,3
M2 2,0
M3 2,3

Evidence describing the above mentioned assertions:

M1 2003 - Community members have been involved mainly in community safety issues. A couple of seminars have been organized together with neighbouring counties.

M2 2004 - Workgroup members have somewhat collaborated with four communities outside their own county, specifically in competence building but not so much in solving common problems.

M3 2005 - There are several experts among community workgroup members who have been invited to other regions to train their community members. Some members have been actively involved into national injury prevention program preparation and implementation as experts. Community members have attended international Safe Community movement and planned and organized an international conference on safety issues. Applying for community initiatives resources from international foundations is now planned.

IV Creation of supportive environment

Level 1	1	2	3	4
28. The workgroup has received financial resources from foundations or state.		M1M2	M3	
29. The workgroup has gained support from their institutions and organizations.		M1	M2; M3	
30. Members of the group collaborate with local policy makers and media.		M1	M2; M3	
X Group has the capacity to achieve financial and political support at local level.		M1	M2; M3	

M1 1,6
M2 2,6
M3 3,0

Evidence describing the above mentioned assertions:

M1 2003 – The Safe Community programme has received some financial resources from the Health Promotion Foundation, and also some financial support from community institutions. The workgroup has some support from local policy-makers.

M2 2004 – The Safe Community programme has received substantial financial ressources from the Health Promotion Foundation. Several municipalities have invested in the programme and local policy-makers have inolved community members in some decision preparation processes.

M3 2005 – The Safe Community programme has been awarded as the best programme of the year by the Health Promotion Foundation. Finances have increased substantially. In collaboration with policy-makers restrictions on the sale of alcohol at night have been achieved, and the use of helmets for pre-school children approved.

Level 2	1	2	3	4
31. The workgroup has gained more sustainable resources for long-term activities due to high quality work and applications.		M1	M2; M3	
32. The workgroup has gained support from local policy-makers and is collaborating systematically in influencing decision-making process.	M1	M2	M3	
33. The workgroup is collaborating systematically with the local media and has involved media representatives into their work.		M1 M2	M3	
XI Group has the capacity to achieve more sustainable financial resources and systematic involvement of politicians and media.		M1; M2	M3	

M1 1,6
M2 2,6
M3 3,0

Evidence describing the above mentioned assertions:

M1 2003 - The program has been financed by the Health Promotion Foundation. Several institutions, such as the County Government, and some municipalities and organizations have occasionally invested in the program. A local weekly newspaper journalist has become a regular member of the workgroup. Some workgroup members are collaborating with policy-makers at the county level.

M2 2004 Funding is made on a yearly bases. Two applications to other foundations: the Gambling Fund and the Social Fund, have been successful. The county government has invited some workgroup members to participate in the county development strategy building process. Several municipalities have included safety issues into their development plans.

M3 2005 - More local resources have been invested into the program – several municipalities have included resources for injury prevention into their yearly budget. A local newspaper published 14 articles altogether during the year on injury prevention issues. Two workgroup members have been invited to participate in the county development plan preparation.

Level 3	1	2	3	4
34. Members of the group have achieved sustainable resources for their initiatives from their own community organizations or national sources.	M1	M2; M3		
35. Members of the group have contributed in advocating policies at national level.	M1	M2; M3		
36. Members of the group have achieved reflections from national media on their initiative.	M1	M2; M3		
XII Group has the capacity to develop political and media support to their initiative and sustainable financial support for solving local health problems.	M1	M2; M3		

M1 1,0
M2 2,0
M3 2,0

Evidence describing the above mentioned assertions:

M1 2003 - Financial resources are undependable and based on the Health Promotion Foundation's yearly decisions. National media is not interested in local issues. There is no national strategy for injury prevention.

M2 2004 – The programme is financed by the Foundation on a yearly bases. Workgroup members do not feel secure in making long-term plans. There is no national injury prevention action plan and the Safe Community movement is not supported nationally. There is considerable media interest at the local lever but not at the national level.

M3 2005 – Financial resources for injury prevention are still allocated yearly based on applications. There is no certainty, however, in the following year's resources. In spite of an international conference taking place in Rapla County, there has been no interest from the national media. Some members of the workgroup have been involved in advocating the national health strategy but with no special success.

ANNEX X

ODCE measurement - *Drug/AIDS prevention* program

I Community activation

Level 1	Not at all/Very limited 1	Some-what 2	Sub-stantial 3	Almost entirely/ Entirely 4
1. There exists a group of community representatives that meets regularly to work on community goals and desired community outcomes.		M1,	M2	M3
2. The community group has an active leader, who motivates and enthuses members of group.				M1, M2, M3
3. The community workgroup is committed to solving local problems and is motivated to collaborate as a team.		M1; M2		M3
I A community workgroup is constituted, which cares for community problems and is committed to collaborate in solving the community's problems.		M1	M2	M3

M1 2003 – 2, 6
M2 2004 – 3, 3
M3 2005 - 4, 0

Evidence describing the above mentioned assertions:

M1 2003 – The Drug/AIDS prevention program workgroup was formed during the previous year. The network consists of representatives from schools, municipalities, the police, NGO-s, hospital, and family doctors. The workgroup has agreed upon the mission and has expressed their commitment to work towards drug use prevention and safe sex education. The workgroup had four meetings this year. The workgroup has elaborated an initial work plan, and is working toward its implementation. The workgroup has an active leader, who is a charismatic and stimulating person.

M2 2004 – The workgroup had five meetings this year. The group is motivated to work together. A team-building seminar was organized to develop collaboration and to engage a larger number of groups and networks in the program. Two new networks have formed within the program – 1) the students' authority's network and 2) network of the youngster's leisure time centers.

M3 2005 – The workgroup has existed for four years. Six meetings were organized during the year. Besides the initial leader, three persons from the workgroup have been active in coordinating new networks – the students' authorities' coordinator, working with all schools student authorities in Rapla region, the Health Promoting Schools representatives' network leader – working with school administrators and health educators, and the network coordinator of the children leisure-time centers. Several new collaboration groups have been formed (in most schools the anti-smoking groups and peer-education groups).

Level 2	1	2	3	4
4. The community workgroup members are proactive in assessing community needs and solving problems.		M1	M2, M3	
5. The community workgroup includes potential leaders who are able to take over leadership if needed.	M1	M2		M3
6. The community workgroup activates community members, new groups and supports network development in and outside community.	M1	M2	M3	
II The community workgroup is proactive in assessing community needs and solving its problems and is able to activate groups and networks inside and outside their community.	M1	M2	M3	

M1- 1,3
M2 - 2,3
M3 – 2,6

Evidence describing the above mentioned assertions:

M1 2003 – The workgroup members are somewhat proactive, but mainly seek information on evidence-based methods and try to acquire some knowledge and skills for working in drug/AIDS prevention. The leader of the group is motivating and stimulating and makes efforts in team building. Some new groups have been formed, specifically in county schools.

M2 2004 - There are several members in the workgroup, who have become more active and would be able to take over the coordination of the group if needed. New groups have been activated – municipalities leaders have decided to have regular meetings on drug-prevention issues.

M3 2005 – The workgroup members have demonstrated their active attitude, while inviting workgroups from other counties to join in fighting for more financial resources from the national budget for drug prevention measures in all counties. Negotiations with the leaders of the national drug prevention program have been initiated, which resulted in an increased budget for the county's drug prevention program. More schools and municipalities have joined with program. There is close collaboration with three other counties: Jõgeva, West-Virumaa and Harju.

Level 3	1	2	3	4
7. The community workgroup has initiated and created new community groups and extended networks in community.	M1	M2, M3		
8. The Community workgroup has a strong identity and ownership of program.	M1	M2		M3
9. The community workgroup collaborates with groups and networks from outside the community and internationally.	M1	M2	M3	
III There exists a constant group, which has created collaboration networks within and outside the community and initiated collaboration with international groups.	M1	M2	M3	

M1 – 1,0
M2 – 2,0
M3 – 3,0

Evidence describing the above mentioned assertions:

M1 2003 - Five schools in the community have joined the drug prevention program. The community workgroup has "some identity, but it is early to say how strong it is". The workgroup is focused on inner relations, team-building and communication issues.

M2 2004 - 2/3 of schools in Rapla County have joined the drug prevention network. Several municipalities have established drug prevention action groups.

M3 2005 - Most schools in Rapla County have joined the drug prevention network. The community workgroup has been one of the initiators of fighting for resources from the state budget. The workgroup members have invited representatives from other counties to join into a united delegation for negotiations with governmental institutions about financial resources for drug prevention initiatives. Contacts have been made with the EU drug prevention network and colleagues from Finland and Sweden. A traveling seminar to Finland has been organized for learning of their experiences from their interventions. The workgroup members have a strong identity.

II Community competence development

Level 1	1	2	3	4
10. Members of the group share information and knowledge within their group.	M1	M2	M3	
11. Members of the group are actively seeking new information and knowledge, and building links between other sectors' specialists.	M1	M2	M3	
12. Members of the group are seeking opportunities for further training to improve skills and knowledge from outside sources.		M1, M2	M3	

IV The group is seeking information and further training to improve knowledge and skills to handle community problems.	M1	M2	M3	

M1 – 1,3
M2 - 2
M3 – 2,6

Evidence describing the above mentioned assertions:

M1 2003 – The workgroup has organized several discussions and seminars to learn more about smoking, alcohol and drug use prevalence, prevention methods, etc. Two seminars were organized with experts on drug prevention.

M2 2004 - Seminars on methodological issues of drug and AIDS prevention have taken place regularly four times a year. Empowerment evaluation methodology was acquired and knowledge on behavioral and social determinants of drug use and sexual behavior clarified. A county health conference on drug and AIDS prevention was organized and 121 stakeholders participated.

M3 2005 - Members of the community have attended seminars and workshops organized by the workgroup. They share information during the meetings and between each other individually. A second county health conference on drug and AIDS prevention was organized, 156 stakeholders participated.

Level 2	1	2	3	4
13. Members of the group get local and/or national training according their needs.		M1	M2, M3	
14. Members of the group are able to train and educate other groups outside their community.	M1	M2, M3		
15. Members of the group have competence, which allows them to apply evidence-based methods for solving local problems.	M1	M2	M3	
V Group has the competence to use evidence-based methods in solving local problems and to train and educate other groups.	M1	M2	M3	

M1 – 1,3
M2 – 2,3
M3 – 2,6

Evidence describing the above mentioned assertions:

M1 2003 - Members of the workgroup have received some training by local and national experts. The group has not done training themselves. A need for more systematic training on evidence-based methods is emphasized.

M2 2004 - Workgroup members have had several training workshops on drug/AIDS prevention issues and facilitated empowerment evaluation sessions in combination with training on needs assessment, priority setting, goal definition, implementation and evaluation issues.

M3 2005 - Workgroup members have had several training workshops on drug/AIDS prevention issues and they themselves have conducted several training sessions in county schools and for other stakeholders. Members have been invited to share their experience in other counties (Jõgeva, Viljandi).

Level 3	1	2	3	4
16. Members of the group are able to conduct training sessions outside their community and share information about their programs internationally.	M1,	M2	M3	
17. Members of the group are able to conduct program analysis, and evaluation to improve their programs.	M1		M2, M3	
18. Members of the group have created a continuous feedback system to achieve overall quality assessment by the group members of the programs.	M1	M2		M3
VI Group members have good knowledge and skills for educating and training the community and outside networks and share information internationally.	M1	M2	M3	

M1 - 1
M2 - 1,6
M3 – 2,6

Evidence describing the above mentioned assertions:

M1 2003 - No training outside the community has been conducted and no contacts with international partners made. As there is limited experience in working with substance abuse issues, group members have not evaluated their program until now. Some feedback has been asked in the end of some seminars, but there is no evaluation system.
M2 2004 – The workgroup has mainly focused on the community's internal affairs and has had no contacts with international partners until now. Members of the workgroup have received profound training in the empowerment evaluation method and are able to improve their program according to the results of the evaluation. A continuous feedback system is created to assess the process of the program. Workgroup members are substantially informed about the measures and assessment of their program. Workgroup members have been invited to Viljandi and Jõgeva counties to present their program, specifically to share experience in empowerment evaluation issues.
M3 2005 – The workgroup has contacts with partners from Finland and they have attended a training seminar on drug prevention issues making their own contributions and sharing information about their program. The Finnish partners had a seminar in Rapla. Two common seminars and two round-table discussions have taken place during the year. Regular empowerment evaluation has been conducted during the year 2004.

III Program management skills

Level 1	1	2	3	4
19. Members of the community workgroup are able to carry out local community needs assessment.	M1	M2	M3	
20. Members of the workgroup are able to compose a program implementation and evaluation plan using expert assistance.	M1		M2	M3
21. Members of group are able to implement programs in collaboration with an expert.		M1	M2	M3
VII Group has the capacity to identify local needs and compose a program implementation plan together with outside assistance.	M1		M2	M3

M1 – 1,3
M2 - 2,3
M3 – 3,0
Evidence describing the above mentioned assertions:

M1 2003 - Members of the workgroup have not carried out needs assessment independently. They asked for assistance and training from experts. The community health profile compilation is assisted by outside experts. An implementation plan is composed together with an expert from national institution.

M2 2004 – The group has collected information and data using some assistance from outside. The assessment of last year's measures is done together with an outside evaluator and empowerment evaluation skills are gradually acquired through trainings and practical experiences. An intervention and evaluation plan is composed in collaboration with an outside evaluator.
M3 2005 – The group has collected information and data using little outside assistance. The assessment of last year's measures is done together with an outside evaluator and empowerment evaluation skills are acquired through training and practical experiences. An intervention and evaluation plan is composed in collaboration with an outside evaluator. A community profile report including health determinants is published.

Level 2	1	2	3	4
22. Members of the group are able to analyze local needs, identify priorities, and also collaborate in problem solving at national level.	M1	M2	M3	
23. Members of the group are able to independently identify goals and objectives, plan activities and implement these.		M1	M2	M3
24. Members of the group are able flexibly to reassess situation and needs and re-plan program if needed.		M1	M2	M3
VIII Group has the capacity to independently assess local needs and implement programs, also participate in national problem solving.		M1	M2, M3	

M1 – 1,6
M2 - 2,6
M3 – 3,0

Evidence describing the above mentioned assertions:

M1 2003 - Members of the workgroup are not able to carry out needs assessment independently. They ask assistance and training from experts. The community health profile compilation is assisted by outside experts. The implementation plan is composed together with an expert from a national institution.

M2 2004 – The group has collected most information and data independently. They required some assistance in data analysis from outside. Assessment of last year's measures is done with an outside evaluator and empowerment evaluation skills are gradually acquired through training and practical experience. The intervention and evaluation plan is composed in collaboration with an outside evaluator.

M3 2005 – The group has collected information and data using little assistance from outside. The assessment of last year's measures is mostly done independently. Empowerment evaluation skills have enabled them to assess previous actions and evaluate current actions. The intervention and evaluation plan is developed mainly by community members. Drug prevention problem solving skills are delivered and experience shared with other counties through two seminars and a summer school.

Level 3	1	2	3	4
25. Members of the group have initiated and implemented programs involving groups outside their community.	M1	M2		M3
26. Members of the group participate in international collaboration programs in solving wider problems.		M1	M2	M3
27. Among members of the group are experts who are invited outside the community to assist or train members of other networks.	M1	M2	M3	
IX Group has the capacity to design and implement international programs and act as experts in solving local health problems.	M1	M2	M3	

M1 - 1,0
M2 - 1,3
M3 – 2,3

Evidence describing the above mentioned assertions:

M12003 - No collaboration with groups outside the community or common programs has been initiated.

M2 2004 – A couple of workgroup members have been invited by Jõgeva and Viljandi counties to share Rapla's experience in drug and AIDS prevention.

M3 2005 - Collaboration elements (common round table discussions on planning and empowerment evaluation issues and training) are initiated with two other counties. Five group members have attended international training seminars. Several workgroup members have been invited to present their skills in empowerment evaluation at national conferences and training courses. One of the workgroup members is the leader of the international drug-prevention program „Lighthouse".

IV Creation of supportive environment

Level 1	1	2	3	4
28. The workgroup has received financial resources from foundations or state.	M1	M2	M3	
29. The workgroup has gained support from their institutions and organizations.		M1, M2	M3	
30. Members of the group collaborate with local policy makers and media.	M1	M2		M3
X Group has the capacity to achieve financial and political support at local level.	M1	M2	M3	

M1 - 1,3
M2 - 2,0
M3 - 2,6

Evidence describing the above mentioned assertions:
M1 2003 – The workgroup applied for and received some financial resources from the Health Promotion Foundation. Collaboration with media is modest and occasional - there have been two press releases reflecting events of drug prevention initiatives in schools.
M2 2004 - Finances are received from the state budget through a national institution. Several institutions (schools, local pharmacies, municipality government and Youngster's Center) have expressed their concern and support to the community workgroup. Frequent contacts with county leaders have taken place. Lobbying for prohibiting the nighttime sale of alcohol was done consistently.
M3 2005 - Modest finances have been received from the state budget. Continuous collaboration with local media has been achieved. A representative of the local weekly paper is regularly attending workgroup meetings. Several round-table discussions and lot of lobbying work took place for prohibiting nighttime alcohol sales until it was achieved in County Government.

Level 2	1	2	3	4
31. The workgroup has gained more sustainable resources for long-term activities.	M1		M2	M3
32. The workgroup has gained support from local policymakers and is systematically collaborating in influencing the decision-making process.	M1, M2		M3	
33. The workgroup is collaborating systematically with the local media and has involved media representatives in their work.	M1	M2		M3
XI The group has the capacity to achieve more sustainable financial resources and systematic involvement of politicians and media.	M1	M2	M3	

M1 – 1,0
M2 - 1,3
M3 – 2,3
Evidence describing the above mentioned assertions:
M1 2003 - Finances for program implementation have been modest and no certainty for sustainable financing exists. Finances are available for a one-year intervention. There is no substantial support from local policy makers or media.
M2 2004 - An agreement within the national drug prevention program was made to achieve longer-term finance. Designated resources are still modest and inadequate for sufficient drug/AIDS prevention. More persistent collaboration with local media is achieved. A representative of the local weekly paper is permanently involved in the program as a workgroup member.
M3 2005 - Barriers appeared in financing from the state budget. The workgroup had to fight for next year's resources and collaborate with other counties in order to achieve finances. Finances of 3 mil EEK from the EU were received for drug prevention. The media has been active and supportive, and altogether 11 articles reflecting drug/AIDS prevention initiatives have been published in weekly newspaper during the year. Local policy-makers have been engaged in supporting and promoting campaigns.

Level 3	1	2	3	4
34. Members of the group have achieved sustainable resources for their initiatives from their own community organizations or national sources.	M1	M2	M3	
35. Members of the group have contributed in advocating policies at national level.	M1	M2,	M3	
36. Members of the group have achieved reflections to their initiative from the national media.	M1, M2	M3		
XII Group has the capacity to develop political and media support to their initiative and sustainable financial support for solving local health problems from national and international sources.	M1	M2, M3		

M1 – 1,0
M2 - 1,6
M3 – 2,0
Evidence describing the above mentioned assertions:

M1 2003 – The workgroup has received very limited resources from the County Government and no other local resources.

M2 2004 - Drug/AIDS prevention workgroup has received some financial resources from the County Government and municipalities for local initiatives.

M3 2005 - Workgroup representatives have been invited to collaborate in the new national drug prevention strategy building process. Workgroup representatives have attended the Societal Agreement process advocating drug/AIDS prevention. Rapla drug and AIDS prevention initiatives have been introduced in national TV broadcasts and in two daily newspapers. The workgroup has received some financial resources from the County Government and municipalities and from EU foundation.

ANNEX XI

ODCE measurement QUESTIONNAIRE - Elderly Quality of Life program

I Community activation

Level 1	Not at all/Very limited 1	Some-what 2	Sub-stantial 3	Almost entirely/ Entirely 4
1. There exists a group of community representatives that meets regularly to work on community goals and desired community outcomes.		M1	M2;M3	
2. The community group has an active leader, who motivates and engourages members of group.			M1	M2;M3
3. The community workgroup is committed to solving local problems and is motivated to collaborate as a team.		M1M2; M3		
I A community workgroup, which cares for community problems and is committed to collaborate in solving community problems is constituted.		M1	M2;M3	

M1 2,0
M2 3,0
M3 3,0

Evidence describing the above mentioned assertions:

M1 – 2003 The community workgroup dealing with elderly quality of life issues was initiated two years ago. The group leader is enthusiastic and active in engaging new members. The workgroup has the mission of improving elderly life in Rapla community.

M2 – 2004 According to group members they are more active and have involved several other groups in their activities. The group leader is highly appreciated by the group members as a charismatic and stimulating person. The workgroup is dissapointed with the financial cut off from the Health Promotion Fund and therefore express that their committment to the local problem-solving mission is somewhat weakened.

M – 2005 The workgroup is continuing regular meetings in spite of losing the main funder. Group members have their mission but their are careful in telling that they are committed to continuing their work.

Level 2	1	2	3	4
4. Community workgroup members are proactive in assessing community needs and solving problems.	M1	M2	M3	
5. The community workgroup includes potential leaders who are able to overtake leadership if needed.		M1; M2	M3	
6. The community workgroup activates community members, new groups outside the community and also supports network development outside the community.	M1	M2; M3		
II The community workgroup is proactive in assessing community needs and solving its problems and is able to activate groups and networks inside and outside their community.	M1	M2	M3	

M1 1,6
M2 2,0
M3 2,3

Evidence describing the above mentioned assertions:

M1 – 2003 According to group members they did not know very clearly what they could do, before they had empowerment evaluation training. They admitted that they had not been very active in involving more people, although there are several active potential leaders in group.

M2 – 2004 The workgroup members had two meetings outside their own community with elderly from Tartu and Harju county. Although meetings have been difficult to organize due to limited ressources.

M3 – 2005 The group has been active, more events are organised, more people engaged. Elderly from several municipalities have joined into networks. Several members have demonstrated their leadership skills in activating different new members.

Level 3	1	2	3	4
7. The community workgroup has initiated and created new community groups and extended networks in community.	M1;M3	M2		
8. The community workgroup has a strong identity and ownership of program.		M1	M2;M3	
9. Community workgroup collaborates with groups and networks outside of the community and internationally.	M1	M2	M3	
III There exists a constant group, which has created collaboration networks within and outside the community and initiated collaboration with international groups.	M1	M2	M3	

M1 1,3
M2 2,3
M3 2,6

Evidence describing the above mentioned assertions:
M1 – 2003 The programme has worked mainly with local people and mainly only the core group has been active. No contacts with outside groups have been made. Group members like to work for the community and especially for the elderly but they do not claim strong ownership to programme. „We will do what we can".

M2 – 2004 Workgroup has widened, a new network of elderly home representatives has formed. The group has developed their identity – people like to come together and continue in spite of a lack of resources.
M3 – 2005 The *Elderly quality of life* program is expanded. People from elderly care homes have also joined the community programme. Contacts have been made with similar Latvian and Finnish networks and a visit and a common seminar was organized in Riga. Identity of the group is strenghtened and workgroup members have decided to continue their work even if all finances will disappear.

II Community competence

Level 1	1	2	3	4
10. Members of the group share information and knowledge within their group.		M1	M2; M3	
11. Members of the group are actively seeking new information and knowledge and building links between other sectors specialists.		M1;M2M3		
12. Members of the group are seeking opportunities for further training to improve skills and knowledge from outside sources.		M2M3	M1	
IV The group is seeking information and further training to improve knowledge and skills to handle community problems.		M1;M2M3		

M1 2,0
M2 2,3
M3 2,3
Evidence describing the above mentioned assertions:
M1 – 2003 Workgroup members have organized regular training seminars on health issues (health determinants, disease prevention and health promotion methods, etc.), invited lecturers from national institutions and several different sectors.
M2 – 2004 Only two training seminars have been organized due to limited ressources.
M3 – 2005 Trainings and competence building have been occasional, more in the form of information delivery between members of the group. The county government has supported with resources, both financial and professional, for trainings.

Level 2	1	2	3	4
13. Members of the group get local and/or national training according to their needs.	M1	M2;M3		
14. Members of the group are able to train and educate other groups outside the community.	M1	M2	M3	
15. Members of the group have competence, which allows them to apply evidence based methods for solving local problems.	M1	M2	M3	
V Group has the competence to use evidence-based methods in solving local problems and to train and educate other groups.	M1	M2	M3	

M1 1,0
M2 2,0
M3 2,6

Evidence describing the above mentioned assertions:

M1 – 2003 Workgroup members have not organized any trainings for other groups. They need assistance in applying evidence based methods in their program.

M2 – 2004 The workgroup has organized further education trainings together with a neighbouring community, Tartu. They have shared their experience and have the courage to present their information on seminars. A programme plan was designed for the next year using assistance from health promotion professionals.

M3 – 2005 The programme plan is prepared independently by the community workgroup and the evaluation is also carried out by themselves. The workgroup has enlarged their contacts and in collaboration with three counties' colleagues common seminars have been organised and experiences shared.

Level 3	1	2	3	4
16. Members of the group are able to conduct trainings outside the community and share information concerning their programs internationally.	M1	M2;M3		
17. Members of the group are able to conduct program analysis, and evaluation to improve their programs.	M1	M2;M3		
18. Members of the group have created a continuous feedback system to achieve overall quality assessment by the group members of the programs.	M1	M3	M2	
VI Group members have good knowledge and skills for educating and training community members and outside community networks members in health promotion.	M1	M2;M3		

M1 1,0
M2 2,3
M3 2,0

Evidence describing the above mentioned assertions:

M1 – 2003 The workgroup has no international contacts. The first course on empowerment evaluation is just carried out – until now no assessment of their own program has been conducted.

M2 – 2004 Assessment of the program is superficial as there are no resources even for the proper implementation of the program. Some feedback elements are used to share information concerning events within the program.

M3 – 2005 Some seminars together with Finnish and Latvian colleagues have been organised. No regular evaluation has been carried out. Just some feedback from members to deliver information concerning the course of the programme.

III Program management skills

Level 1	1	2	3	4
19. Members of the community workgroup are able to carry out local community needs assessment.	M1	M2	M3	
20. Members of the workgroup are able to compose a program implementation and evaluation plan using expert assistance.		M1	M2;M3	

21. Members of group are able to implement programs in collaboration with an expert.	M1	M2		M3
VII Group has the capacity to identify local needs, compose a program implementation plan together with outside assistance.	M1	M2	M3	

M1 1,3
M2 2,3
M3 3,6

Evidence describing the above mentioned assertions:

M1 – 2003 Until now, workgroup members have never conducted a planned needs assessment. For two years the program plan has been designed and implemented using the help of the county health promotion practitioner.

M2 – 2004 During last year the first needs assessment was carried out within the application of the empowerment evaluation approach. Using assistance from health promotion professionals the implementation plan was designed.

M3 – 2005 Needs assessment was conducted among three elderly groups during the previous year. Implementation of the limited program was conducted independently due to limited resources.

Level 2	1	2	3	4
22. Members of the group are able to analyze local needs, identify priorities, and also collaborate in problem solving at national level.	M1	M2	M3	
23. Members of the group are able to independently identify goals and objectives, plan activities and implement these.	M1	M2	M3	
24. Members of the group are able to flexibly reassess the situation and needs and replan the program if needed.	M1	M2	M3	
VIII Group has the capacity to independently assess local needs and implement programs, also participate in national problem solving.	M1	M2	M3	

M1 1,0
M2 2,0
M3 3,0

Evidence describing the above mentioned assertions:

M1 – 2003 Needs assessment, prioritization of issues and the defining of goals have not been conducted among the members of the workgroup.

M2 – 2004 Members of the workgroup have received training the in empowerment evaluation method and are practicing it together with professionals assistance.

M3 – 2005 The programme workgroup members have designed their implementation plan almost independently with minor help from an outside evaluator. The continuous feedback system has become a part of programme regular activities.

Level 3	1	2	3	4
25. Members of the group have initiated and implemented programs involving groups outside their community.	M1	M2	M3	
26. Members of the group participate in international collaboration programs in solving wider problems.	M1;M2	M3		
27. Among members of the group there are experts who are invited outside the community to assist or train members of other networks.	M1;M2	M3		
IX Group has the capacity to design and implement international programs and act as local and international experts.	M1;M2	M3		

M1 1,0
M2 1,6
M3 2,3

Evidence describing the above mentioned assertions:

M1 – 2003 Members of the workgroup are mainly retired elderly women, who have not demonstrated any activity outside their community. However there is interest in collaborating and exchanging experience with similar groups in other regions and internationally.
M2 – 2004 The workgroup has attended seminars and a public campaign in Tartu region groups. The workgroup has initiated contacts with the Finnish elderly health promotion group, who visited Rapla and with whom the workgroup members had a common seminar and a walking tour.
M3 – 2005 The workgroup has been invited to Riga, Latvia, for sharing their experience with Latvian elderly groups.

IV Creating supportive environment (politics, resources)

Level 1	1	2	3	4
28. The workgroup has received financial resources from foundations or state.	M2;M3		M1	
29. The workgroup has gained support from their institutions and organizations.	M1	M2;M3		
30. Members of the group collaborate with local policy makers and the media.	M1;M3	M2		
X Group has the capacity to achieve financial support and political support at local level.	M1	M2;M3		

M1 2,6
M2 2,6
M3 1,6
Evidence describing the above mentioned assertions:
M1 – 2003 The workgroup has applied and received ressources from the Health Promotion Fund, which has allowed them to mobilize more people and advocate their ideas through a local newspaper. Two articles have been published during the year, which introduced the programme for the community.
M2 – 2004 Programme did not receive finances for the next year from the Fund. Some limited resources from the County Government have been received. Some policians have expressed their support but no substantial resources have been allocated.
M3 – 2005 Health of the elderly is not a local or a national priority. It has been overwhelmingly difficult to get resources from the municipalities. Politically elderly health is not supported.

Level 2	1	2	3	4
31. The workgroup has gained more sustainable resources from sources outside the community	M2	M1;M3		
32. The workgroup has gained support from local policymakers and is collaborating systematically in influencing decision-making process.	M1;	M2;M3		
33. The workgroup is collaborating systematically with the local media and has involved media representatives into their work.	M1	M2;M3		
XI The group has the capacity to achieve more sustainable financial resources and systematic involvement of politicians and media.				

M1 1,3
M2 2,6
M3 2,0
Evidence describing the above mentioned assertions:
M1 – 2003 The Gambling Fund has somewhat supported the actions of the program. Local policy makers do not care and it is difficult to get articles on elderly health published in the local newspaper.
M2 – 2004 No ressources from outside community have been received. Some policy makers have, in result of influence, expressed their interest in dealing more with elderly health issues. The local newspaper published two articles during the year concerning elderly health issues.
M3 – 2005 Support from outside and also from local policy-makers and media is modest.

Level 3	1	2	3	4
34. Members of the group have achieved sustainable resources for their initiatives from their own community organizations or national sources.	M1	M2;M3		
35. Members of the group have contributed in advocating policies at national level.	M1;M2 M3			
36. Members of the group have achieved reflections to their initiative from national media.	M1;M2 M3			
XII Group has the capacity to develop political and media support to their initiative and sustainable financial support for solving local health problems from international sources.	M1;M2 M3			

M1 1,0
M2 1,3
M3 1,3

Evidence describing the above mentioned assertions:

M1 – 2003 No sustainable resources have been received for the initiative. Members of the workgroup have made no active steps to convince policy makers at national level, also towards media.

M2 – 2004 Some limited sustainable resources have been allocated by municipalities. No actions towards policy influence and also towards media influence.

M3 - 2005 Very limited resources for workgroup activities are delivered by the local municipality. Messages concerning elderly quality of life issues have not reached the national media. National Heart Health strategy, which includes a chapter on physical activity, does not include any planned measures for the elderly.

ANNEX XII

ARTICLES 1-3

1) Kasmel, A. and Tanggaard Andersen, P. (2011). Conceptualizing organizational domains of community empowerment through empowerment evaluation in Estonian communities. *Societies, 1*, 3-29. Reproduced with permission from the journal.

2) Kasmel, A.; Tanggaard Andersen, P. (2011). Measurement of Community Empowerment in Three Community Programs in Rapla (Estonia). *International Journal of Environmental Research and Public Health,* 8, 799-817. Reproduced with permission from the journal.

3) Kasmel, A. and Tanggaard Andersen, P. (2011). Evaluation of Changes in Individual Community-Related Empowerment in Community Health Promotion Interventions in Estonia**.** *International Journal of Environmental Research and Public Health***,** 8(6), 1772-1791. Reproduced with permission from the journal.