



LEENA EKLUND

From Citizen Participation Towards Community Empowerment

An analysis on health promotion from
citizen perspective



ACADEMIC DISSERTATION

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University of Tampere,
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Leena Eklund

Summary

At the beginning of the 1990's rapid changes in the society with long-reaching consequences presented new challenges to health policy in Finland. Due to economic recession, financial difficulties of municipalities, decentralization of administration, and a greater responsibility at the local level, the ability of the state in taking care of the health of the population was expected to decrease. The move towards a greater autonomy at the local level required that citizens assume an increasing activity in managing their own affairs. Historically, Finland has a long tradition of local governments. However, when the Finnish Health for All 2000 programme (launched in 1986) was evaluated in 1991 by WHO, a low degree of citizen participation in planning and implementing the programme was pointed out. Starting from this critical comment the Finnish Centre for Health Education and Promotion (= FCHE, a national non-governmental organization representing ca. 100 other non-governmental bodies) initiated community action programmes in two towns, Somero (agricultural small town with 10 000 inhabitants) and Järvenpää (small urban town near the capital with 30 000 inhabitants) in 1992.

The goal of the Somero-Järvenpää Programme was to enhance the control over health of the community (community competence) through citizens' active participation in health policy formulation, evaluation and implementation. The Programme was implemented during 1992–1996. Regular education occasions and consultation meetings, ca. 20 in each community, using critical consciousness raising education strategies introduced by Freire (1970), were the main means. Formulation of theme groups was the first step of the intervention. The theme groups consisted of members of local non-governmental organizations, authorities and other citizens, who then selected the health promotion themes they wanted to work with. The purpose of the theme groups was to act as the first structure for action and to strengthen the sense of community, which have been discovered as essential elements in building up collaboration, and in making the people commit themselves to the process. The Programme was continuously assessed during its life in order to give feedback to the project organization and to the participants.

In the beginning of the Somero-Järvenpää programmes the original intention did not include the idea of implementing a scientific research. The development of empowerment and increasing the participation were first considered as pragmatic questions. However, as the Programme proceeded the process showed to be much more complicated than expected. Thus it was considered necessary to connect the Programme to the international experience and literature in the field. The study in hand was believed to produce understanding, concepts, and theoretical considerations applicable in the Finnish practice of health promotion and furthermore in developing empowerment and control over health. The principal objective of the present study was to develop instruments to assess empowerment both at individual and community levels, and furthermore, through using these tools in the analysis of empirical data to elaborate a model for empowerment practice, and finally to develop the theory of empowerment.

The theoretical part of the study consisted of a literature review on the development of the concepts of citizen participation, empowerment in health, and community organisation, and an elaboration of the empowerment approach and evaluation instruments used in this study. The literature review revealed that the empowerment process of the 90s and beyond is not only a political question, but also a methodological question. Empowerment approach requires action-orientation (the philosophical basis of which rises from critical theory) and qualitative research methods favouring theme interviews, observation and participatory methods. Evaluation leans on interpretivistic and constructivistic paradigms and hermeneutical understanding.

Citizen participation (Zimmerman and Rappaport 1988), sense of community (Chavis and Wandersman 1990) and empowerment (e.g. Zimmerman and Rappaport 1988, Wallerstein 1992) were selected as the main focus of the evaluation of the Healthy Somero and Järvenpää Programmes. The indicators measuring participation were:

Number of participants at training occasions, existence of a core group committed in the process, permanence of theme groups, time consumed for the Programme per year, and perceptions of the participatory tasks of different actors. The indicators measuring psychological level of empowerment were: Personality dimensions (perceived self-confidence and self-esteem, perceived feeling of control over own health and life, control ideology, i.e. belief that people in general, but necessarily oneself can influence social and political systems), cognitive dimensions (perceived change in skills and knowledge, internal and external political efficacy), motivational dimensions (desire to control environment, sense of causal importance and purposefulness, feeling of civic duty), and contextual dimensions (cultural awareness and consciousness raising).

The community level of empowerment indicators were: Sense of community, participation in decision-making and health political action, learning how to get organized for managing a community problem, ability to work with others for a common goal, ability to identify problems and solutions and analyse critically the world, increased participation in community activities, reported improved quality of community life, and a raised level of psychological empowerment among the members of the Programme. The indicators for community empowerment were limited, however, to the subjective perceptions of the informants and their descriptions of actions implemented by theme groups within the Programme. A thorough analysis of the objective reality of the modified conditions for community empowerment was excluded from the present study.

Empirical data was collected during the life of the Somero-Järvenpää Programme (observation notes, surveys [n = 100 in 1992, n = 75 in 1994 and n = 73 in 1996] and theme interviews of participants [n = 36 in 1996], and various written documents). The overall method was triangulation – combination of several theories and approaches including both quantitative and qualitative measures. Qualitative programme evaluation, content analysis, hermeneutic understanding and grounded theory were used in the analysis. The main focus was on the development of community empowerment. The major paradigms behind the study were nearest to critical science (the purpose was a social change), constructivism (the phenomenon in focus was created by the human mind) and interpretivism (in order to understand the complex world of a certain phenomena the researcher must interpret it).

The results revealed that about a "core group" of about 20–30 people participated as actors all the time during the first three years, planning and implementing different activities within the programme. In Somero the majority of the participants represented NGOs, whereas in Järvenpää a little less than a half of the participants represented authorities and the second half others. The time used for working in the Programme per year was about the length of a working week in Somero and about 60 hours in Järvenpää in 1992. According to the questionnaire in 1994, the time consumed for the programme decreased in the next years period, which shows decreasing enthusiasm and tiredness to commit to actions. In 1995 the training organized by the FCHE was finished. After this the project participants organized training on their own on actual topics.

The Programmes were successful in strengthening psychological empowerment, sense of community and decision making skills of the participants. In summer 1996 the Healthy Somero was characterized as a public health movement, the most important role of which was to initiate new projects and team groups at the local level. To some extent it had recruited more people into health promotive action. The main meaning of the existence of the programme was to function as an arena of social relations and social action. The role of health services remained minor. The Healthy Järvenpää Programme had taken the shape of a joint planning and co-operation arena of authorities and NGO's by the summer of 1994. Tasks and duties were shared and coordinated between the counterparts. The role of health services in the process had been major until the year 1994. However, the core group shrank to about 10 people by the year 1996, and no new people entered the Programme.

In the beginning the interest of the local population towards the Programme was greater than expected and there were good prerequisites for proceeding to the community level of empowerment in 1994. However, the strategy of decreasing the

consultation and education support by the organizers of the Programme in 1994 followed by an almost total withdrawal in 1995 leaving the communities to manage on their own, indicated the way to a collapse of the development of empowerment. The conclusion was that the period of 1992–1996 was too short for generating community empowerment. The process of empowerment proved to need continuous training and practice in which new roles and ways of action, as well as working as a group can be exercised for several years. Furthermore, to be sustainable empowerment must be built up step by step, strengthening the psychological level of empowerment long enough before proceeding to the next stage. Consultancy and project leaders are necessary for guiding and assessing the development process. The programme indicated that health promotion based on participation of people is possible in general, but generating community empowerment calls for long lasting external supportive mechanisms, as well as changes in the prevailing organisation structures.

The results of the study led to a theory labelled as a 'Model of Reasoned Empowerment Action'. The model was a serendipity, a discovery grounded on the data but liberated from single concrete findings. It is composition of the researchers interpretative procedures and understanding. The theory comprises a typology of four different roles, which are hypothesised to be existing and necessary elements in the empowerment process and, which characterize those supposed to be empowered and engaged as actors in the process.

I INTRODUCTION

1 Background

The debate of the 1980s around health promotion, the HFA 2000 ideology with the idea of health promotion through citizen mobilization, and several other documents by WHO (1978, 1986a, 1986b, Oakley 1989) with recommendations and initiatives of wider use of strategies for increasing citizen participation were the indications for drawing attention to citizen participation in Finland (STM 1985, STM 1986). Already in the middle of the 1970s there were several community programmes and trials to widen people's opportunities to participate in the planning and development processes in health care and the results were encouraging (e.g. Puska et al. 1979, 1981, 1985, Kumpusalo and Neittaanmäki 1987). However, the real power-sharing concerning health issues remained marginal and the participation in planning and decision making largely in the domain of experts talking to experts. (WHO 1991)

Rapid changes in the society with long-reaching consequences at the beginning of the 1990s presented new challenges to health policy in Finland (STM 1993b). Due to these changes – economical recession, financial difficulties of the municipalities, decentralization of the administration and decision making and greater responsibility at the local level – the ability of the state to take care of the health of the population was expected to decrease from the beginning of the 1990s. The move towards greater autonomy at the local level required an increasing activity of the public in taking care of their own affairs.

On the other hand, the opportunities to activate people to participate in health promotion were good. Because the general level of education of the people had increased, people's ability to follow and evaluate decision making had improved. Many examples from community health projects showed that the motivation and willingness of the people to participate and take responsibility of their own health or the health of their own community was large. The most often cited examples were probably the North Karelia Project in Finland (Puska et al. 1981, 1985) focused on the prevention of cardiovascular diseases at a regional level (community control approach) or the Healthy Cities Programme (Ashton 1991) exploited in many European cities. The latter was seen more as an example of a public health movement than a prevention programme of any particular disease.

The community based programmes have received wide attention and are believed to offer a strategy with potential for achieving substantial health gains. While community prevention programmes have used different implementation approaches, many have relied on community organization techniques to mobilize community leadership and resources, and to plan interventions. (Giesbrecht et al. 1991) However, a review of the literature reveals that the evaluation of these programmes has focused on assessing the outcomes and on documenting programme output. There is still a gap concerning the analysis of the process of programme implementation, especially where the process has required community activities and involvement of the citizens.

Health promotion in Finland has mainly been based on the centralized measures implemented by the municipality or state authorities as well as on the NGOs' activities (NGO = Non-Governmental Organization). The health legislation and the codes stipulated by authorities or the recommendations of national health prevention programmes have steered the direction of health promotion in the country. The collaboration between authorities and NGOs – especially typical for the 70s – decreased clearly in the 1980s and the NGOs concentrated on advocating measures for the patient group they represented and their particular missions. Disease orientation in health policy in the beginning of the 1980s was dominating. The planning co-operation between social and health sectors was typical of the state level authorities. The challenge of the 1990s is to find new ways of action in health promotion, which could enhance the role of citizens in health planning, implementation, decision making and evaluation. This research is trying to answer to that challenge.

2 Aims and purpose of the study

In order to develop strategies to promote the mobilization of the people in the community action and decision making, and to find factors enabling this kind of efforts, Research & Development (R&D) activities and local experimental procedures are needed (e.g. Medical Research Council 1989, Rimpelä 1992a, Rimpelä 1993, STM 1993b). An effort was made to answer this challenge by the Finnish Centre of Health Education and Promotion (FCHE), which started two local programmes Healthy Somero and Healthy Järvenpää at the beginning of 1992 (Eklund et al. 1995).

The small town Somero (10 000 inhabitants) is an agricultural community, the main source of living being farming. Somero is located in the wealthy South-Western part of the county, 110 km from Helsinki (the capital). Järvenpää (30 000 inhabitants) is a small urban town located near the capital (45 km). Most of the inhabitants earn their living in the service sector and a relatively large proportion of the working age population have their work place in the capital area.

The aims of the Programme were expressed as follows at its starting point: To 1) improve people's capabilities in taking care of their own health and the health of their community, and to strengthen the skills and knowledge needed for this, 2) create coalitions and social networks among the people, NGOs, teachers, programme leaders, researchers and authorities for health promotive action, 3) support and activate health promotive actions and participation of citizens in decision making for health and in implementation and evaluation processes, 4) make the people and health professionals to commit themselves to the health promoting and participating health policy, 5) promote intersectoral organizational collaboration and action for health between NGOs, health professionals and authorities, and 6) increase initiatives for new local programmes for health promotion.

The main idea of the Programme – developing (community) empowerment – was not explicitly expressed with these goals, but they included the essential elements of empowerment, however, like taking more responsibility of one's own and the community's health, the political action and participation. Particularly the first goal reminds of the Ottawa Charter definition of Health Promotion (WHO 1986a), which has a clear analogy to the definition of empowerment by Rappaport (1981, 1985) in the field of social psychology. However, it should be noted that when the Somero-Järven-pää Programme started (planning in 1991 and start of action research in 1992), the concept of empowerment was not well known in the health promotion or public health literature – at least not in Finland. The other argument why the Programme staff selected to express the aims of the Programme as they did was to use such phrases (as this study was considered to be a participatory process between all involved), which could be expressed with common normal language and understood by the people who were supposed to be empowered. Thirdly, the aims listed above are in their authentic form and cannot be changed afterwards.

The idea of empowering the people to take care of their own health and the health of the community was exploited e.g. in the Healthy Cities Programme (Ashton 1991), which was grounded on the HFA 2000 ideology and the principles of health promotion (WHO 1986a, WHO 1986b, WHO 1997). The same thoughts were also the basis for the local programmes Healthy Järvenpää and Healthy Somero (Eklund et al. 1995). These local projects differentiated, however, from the earlier community programmes in using a new approach, in which health professionals more clearly should be seen as consultants in the development process and the human resources of the local people themselves should be used more effectively. Health professionals were expected to recommend and give proposals but the final decision making concerning the course of the programme was planned to be the domain of the people themselves. (See Hunt 1990.)

The ultimate goal of the Somero-Järvenpää Programme was to enhance the community competence in health issues through active participation in health policy formulation, evaluation and implementation, and participation in decision making by

citizens (which is considered the most advanced stage of empowerment process). Regular education occasions and consultation meetings were selected as the main means of achieving the goal of empowering the people and the community within health matters. Formulation of theme groups was the first step in the development programme. Their purpose was to act as the first “structure“ for action and to strengthen the group feeling and sense of community (McMillan and Chavis 1986, Chavis and Wandersman 1990), which have been discovered to be essential elements in building up collaboration, and in making people commit themselves to the development process aiming at community empowerment in health.

Rissel (1994) claimed that there is some evidence that groups without power, or who report feeling of powerlessness, experience worse health. And visa versa, those who have more power are healthier (e.g. Smith T. 1990, Labonte 1992). Wallerstein (1992) claimed that the raised psychological empowerment might have an impact on physical health. Community empowerment according to Rissel (1994) might bring along health gains through the effects of structural changes following the collective political action. However, although there might be evidence of positive effects of empowerment on population’s physical health, *the health status indicators were excluded* from the present study. The reasons for this were that, firstly, to be able to show health effects, at least a 10-year follow-up should be organized and there were no resources for this. Secondly, the main interest in the present study was not in the health gains received by a health promotion intervention, but the “valued outcomes of health promotion”(Nutbeam 1998) (in this case empowerment of individuals and communities). And, referring to Nutbeam, health outcomes which are defined mainly in terms of a physical function or a disease state, are not necessarily the same as the “valued outcomes” from the health promotion perspective.

The general purpose of this research is to analyse, understand and support the development process expected to lead to (community) empowerment and find methodological tools for these procedures. The study "From Citizen Participation towards Community Empowerment" is divided in a theoretical and an empirical part. The theoretical analysis consists of a historical literature review on the development of the concepts of citizen participation, empowerment in health and community organization, and an elaboration of the empowerment approach used in this study, as well as an elaboration of the evaluation instruments. The empirical part comprises the description and analysis of the two local programmes in Finland (“Healthy Somero” and “Healthy Järvenpää”), in which the approach was used.

The aims of the study are:

- to develop indicators and evaluation methods for citizen participation and empowerment in community health promotion programmes;
- to measure and analyse citizen participation and empowerment in the process of local health promotion programme development using the evaluation tools and indicators created
- to create a model for community action for local health promotion programmes, and
- to develop (elaborate/improve) the theory of empowerment

Problems in the measurement of empowerment can be recognized to be in connection with the conceptual confusion regarding the construct of empowerment, as well as the oversimplification of the process by which empowerment might occur (Rissel et al. 1996). There have been some trials to create instruments for assessing participation (Arnstein 1969, Rifkin et al. 1988) and psychological empowerment (Torre 1986, Zimmerman and Rappaport 1988, Short and Rinehart 1992, Frans 1993, Rissel et al. 1996). The existing measurement instruments for community participation and empowerment are not directly suitable for the study in concern. Rissel et al. (1996) discovered that Frans’s (1993) as well as Short and Rinehart’s (1992) instruments were

limited to the specific use of assessing the empowerment of particular worker groups, the previous of social worker specialists, and the latter of public school teachers, and considered not being appropriate for use with the general population. The instrument used by Torre (1986) seemed to be most useful in the general health promotion context and was recommended by Rissel to be used in the evaluation of community health promotion programmes. However, it cannot be used as such in this study, because of the difference of the nature of the research approach (action research) and the type of data (qualitative data) collected for the analysis. Rissel et al. (1996) created a quantitative instrument on the basis of the work by Torre. Maton and Rappaport (1984) made an attempt to examine the correlation and contexts of empowerment among members in different religious settings by using purely quantitative measures. These quantitative instruments are out of question in this study referring to the reasons mentioned above.

Klakovich (1995) developed an empowerment scale designed to measure empowerment in the context of the leader-follower relationship in organizational settings. However, the use of the scale has been limited mostly to nursing administration research and practice. There have also been trials to investigate some limited parts of empowerment. Examples of these could be Maibach and Murphy's (1995) study in which a measurement scale for self-efficacy was developed, and Flynn's (1995) Community Ownership Scale to measure community leaders' perceived ownership of health education programmes. Flynn's measure can be applied at different stages in the life of a programme to monitor the success of efforts to foster community ownership and to test the relationships between perceived ownership and programme effectiveness and maintenance.

In spite of its complicated nature, the instrument by Zimmermann and Rappaport (1988) with the 11 items of empowerment has most inspired the development of the measurement instrument concerning psychological empowerment and participation, and has been the most important basis of the measurement development of this level of empowerment in this study.

Israel et al. (1994) created a 12 item set of questions (survey) to assess individual perceptions of control or influence at three levels of analysis – individual, organizational and community. Israel et al. themselves speculated the limitations of the instrument and emphasized that it provided only a partial measure of empowerment. The closed-ended survey instrument was not able to capture the richness and complexity of community empowerment concept lacking e.g. description of the development of conscientization, which, according to Freire (1970) is one of the key component of empowerment. The instrument was also lacking an assessment of the broader social-political-economical-cultural context which influence empowerment. Israel et al. conclude that to better assess empowerment as both a process and outcome, the use of in-depth, semistructured interviews, focus groups and community observations throughout a community empowerment intervention is required.

The main interest of this study is in the development of a conceptual framework and operationalization of empowerment that explores the relationships among different elements in the development process and makes explicit the different stages of the process. And, moreover, the idea was to *develop a method for assessing the extent to which empowerment (in health promotion) exists in the experiment communities and for documenting its development over time*. The interest is to find regularities, patterns or rules expected (hypothesized) to lead to community empowerment, control over health, and health political action.

3 Health for All 2000 in Finland – from policy to action in health promotion

To understand the philosophical basis of this research and the need for empowering approaches in health promotion, it is essential to describe in more detail the trends and development of Finnish health policy, and the roles of different actors in health promotion. The megatrend of the 1990s and beyond puts the ever-increasing emphasis on the action and process-orientation in health promotion and its research, citizen participation and human liberation, decentralized local policies, equity in health, and empowerment in health matters.

In this chapter, Finnish health policy, health promotion and community-based programmes will be discussed in more detail from the citizen perspective and participation. The main emphasis is on the development of the interaction/relationships between citizens, health professionals, and the municipality/state/official health care system.

3.1 The development of health legislation behind primary health care and health promotion

The Finnish health policy has two important turning points: the 1972 Primary Health Care Act and the 1993 State Subsidy System Reform (STM 1986, Pekurinen et al. 1987, STM 1993a, Kivistö 1994). In order to understand health policy and promotion and to assess its needs for future development, it is necessary to describe these essential features – the development of health legislation and the priorities of health care and their relationship in health care – during the past decades.

The provision of health services in Finland has been a public responsibility for over 450 years. The development of health policy has also been a public responsibility. The legislation created in the 1860s formed the basis for local administration, according to which various tasks were allocated to local authorities. According to the 1879 Statute on Public Health each municipality was to have a board for monitoring health conditions and rendering help in urgent cases (e.g. deliveries). Local authorities began to employ physicians in addition to midwives and health inspectors. From 1880, the state provided financial support for this.

At the beginning of the 20th century the priorities for health policy in Finland were similar to those in other European countries: the prevention and cure of infectious diseases. The basis for prevention and health promotion was actually created already in the 1930s when midwives and public nurses visited homes in maternal and child care.

By the mid 40s maternal and child health activities were determined by law. Centres for offering these services had been established independently by voluntary organizations in various parts of the country (family-oriented health care). The good results that followed led to the establishment of a comprehensive network of maternal and child care centres. They were created to cover all mothers and children irrespective of place of residence or financial status. Emphasis was on continuity, prevention of illnesses and health promotion. Nurses specialized in public health care (formerly midwives and public health nurses) played a particularly important role in this. The system was financed from public funds and was free of charge.

During the decades of 1950 and 1960, hospital care was stressed and the building of hospitals increased. By the 1970s Finland had a high standard of specialized hospital services. However, shortage of outpatient services, limited resources for primary health care, barriers like high costs of medical care and medicines in seeking care, and inadequate income security during illness were the major problems of the 1960s.

A turning point was the establishment of sickness insurance in 1964. Its purpose was to reimburse the fees up to 60% (costs of outpatient medical care, medicines, travel

costs and compensation for loss of earnings). The benefits were seen as improved use of services and the allowance of more freedom of choice. But it was still necessary to expand primary health care services and to direct the increase in services to areas with greatest shortages. The main instrument for this was the Primary Health Care Act 1972, which established uniform access to services. The law left the national sickness insurance system unchanged. (National Insurance Scheme had been based on legislation separate from that for National Health Planning. It was directly responsible to the Parliament and not part of the Ministry of Social Affairs and Health nor under its direct control.) The Sickness Insurance Act was not abolished and it is still the financial means for providing private medical care, too.

Changing priorities in the 1970s

The situation in the 1970s was that about 90% of the public health care resources were used for specialized medical care and only around 10% for primary health care. In the 1960s, the rate of increase of health care expenditure had been almost twice as high as that of the GNP. With the exception of infant mortality, health indicators showed that progress was slow or even nonexistent and that regional differences were still growing. It was generally admitted that the inadequacy of primary health care was the principal structural defect of the Finnish health care system. It was also understood that the defects in the system could be corrected only if a government health policy setting out national priorities could be developed for the allocation of resources between primary and specialized care.

The Primary Health Care Act was the key to the reorientation of health policy towards an integrated development of health services. The law emphasized the provision of care through health centres and required each municipality to provide primary health care for its citizens. Municipalities were requested to establish health centres either on their own or jointly with one or more neighbouring municipalities. The Act included health centres in the state subsidy system. In order to receive a state subsidy the municipality had to produce the services via the public system. Services from the private system were not acceptable under the transfer payment system. This legislation promoted a strong development of primary health care in Finland.

A health care strategic planning system was established in connection with the Act 1972 when it became necessary to shift the priorities in health policy and to organize more systematic resource allocation. Strategic planning was made possible by the introduction of a uniform planning system to cover all public health care services at the national and local levels. The system required a five-year rolling plan (first for health services and since 1984 the nationwide rotating planning system covered also social services). The national plan for health and social services was approved annually by the government. The plan included targets for main activities, requirements and instructions. Municipalities or federations of municipalities had to follow the targets and requirements of the national plan to get financial contribution from the government. This incentive was a very essential part of the planning system.

According to Kivistö (1994) the developments in the 70s and 80s of the Finnish health care system had proved to be solid, efficient and open to the introduction of new elements. The service system itself was decentralized but the central government carried primary responsibility for the strategic allocation of resources and for determining priorities and major courses of action. Local authorities had sufficient autonomy to maintain flexibility and take local initiatives.

By the 1970s Finland and Sweden had the highest per capita number of hospital beds in the industrialized world. Hospitals were traditionally owned and run by municipalities. In the 1980s the state subsidies covered about half of the hospital costs (capital and running). Subsidies were set in the same way as for primary health care, and patients paid small fees. Hospital planning system was similar to that of primary health

care: decentralized decision making structure operating with generally set priorities/targets and centrally allocated resources. This approach was effective for the implementation of government policy.

The State Subsidy System Reform in 1993

The reform entered into force from the beginning of 1993. The aim of the reform was to reduce central government control, increase the freedom of municipalities to provide services, and consequently the municipalities were expected to take a more active purchaser role instead of the old provider and producer role.

The revision of determining state subsidies to municipalities was an important part of the reform. In the old system the municipalities received subsidies according to the real costs, but in the new system state subsidies are calculated according to a formula, which included such indicators as population age structure, morbidity, population density, land area and the financial capacity of the municipality. According to the new system the subsidies are paid directly to the municipality (not to federations), and automatically, without the need to apply for them. The subsidies are not earmarked but they are a lump sum of money, the use of which the municipalities can decide themselves. Consequently they are also able to set their own priorities and have more freedom to organize primary health care and hospital services. Binding steering by the government was abolished. The municipalities no longer need to submit their plans for the execution of health care to the provincial government, nor to report on the use of state subsidies.

Financing of hospitals also changed. The federations of municipalities no longer receive state subsidies for operating costs. The municipalities pay the federations for the costs of services used.

Finland had adopted an explicit policy based on the Primary Health Care Act 1972. This policy was implemented through a powerful central planning system combined with an elaborate state subsidy system. Over a long period of time, the approach made it possible to substantially increase the proportion of aggregate health care resources allocated to primary health care and it was a good mechanism for controlling public expenditure on health. The health care planning system was simultaneously local and national in composition and it appeared to promote co-operation between local and national agencies. The national authorities arrogated themselves all strategic policy decisions. The municipalities were structurally precluded from exercising their authority in making decisions and choices. Control was almost entirely countered by the combined impact of the national 5-year plan and the state subsidy system. Finland's strategic planning system appeared to have succeeded in directing financial and human resources towards primary health care, in reducing inequities in access to services and in controlling the overall growth of the health sector. A complaint towards this system was the fact that the municipalities did not think how to use the prevailing resources more effectively, instead they made efforts to obtain new resources. Increased efficiency was an important objective of the State Subsidy Reform in 1993.

3.2 The main strategies in the Finnish health policy

The objectives of health policy were outlined by Kuusi (1961) in his book on the social politics of the 60s. Kuusi stated that the established aim of the health care policy is the "continuing improvement of the status of health of the population," and also that as a functional objective of health care "we must assume an increase in the use of medical services and in the equal distribution of these services as dictated by the need of health care. "We will not get rid of the latent diseases by means other than seeking medical care", stated Kuusi. This brought Kuusi to the logic conclusion that the economic losses

caused by necessary care needed to be shared equally. These and other opinions became the basis of the legislation as enacted in 1964 regarding the health insurance system. There was an increase in health services, and a period of building hospitals and institutions began. Such activities were naturally followed by a growing need for health care personnel and professional educational programmes.

In the next decade a workgroup was set by the Economic Council of Finland (1972), who were given the task of looking into the general aims of health policies. The group published a report in the early 70s which named the achievement of as perfect status of health as possible and its equal distribution among citizens as the general aim of health policies. As the most important tool to reach the goal, the group considered the minimizing of disturbances in the relations between the psycho-physical system of human being and the social system. Health instead was at that time seen as an intrinsic value and a part of people's welfare. The group stated in their report that the means necessary to reach the goals of health policies must not be limited to the conventional means in the health care, but the most effective means for each goal should be discovered whichever field of social policies they might belong to. Despite such statements, the nature of the report and its suggestions emphasized diseases to a notable extent. Prevention of diseases and health education were mentioned briefly, while concluding that in these areas there existed a state of undevelopment in Finland. *Health education* was at that time seen as information on the cause and prevention of diseases, and as attitude development training given in schools, maternal and child care centres, work places, and as part of the military service.

Health education in Finland has been mostly developed in connection with maternal and child care centres as well as school health services. The 1970s stressed a health education aimed at the prevention of the most important national diseases and the elimination of risk factors. In the 1980s however, the stress moved gradually towards positive health education programmes which followed the principles laid out in child care centres and school health services, and which emphasized the promotion of health rather than independent health educational programmes of certain diseases and risk factors. The report on the bases and trends of social and health politics by the Ministry of Social Affairs and Health (STM 1982) laid further stress on the activity of an individual and the health of communities. The *aim of health education* was defined as promotion of individual and community health and safety as well as improvement of health assessment. Emphasis was laid on such factors like personal activity in obtaining information on matters concerning health, in promoting one's own as well as other people's health together with environmental health and safety, and in taking active part in one's own care and rehabilitation programmes in the event of an illness. The duty of health education was thus seen to strengthen a person's self-respect and to produce experiences of success in personal and independent health care. It was further agreed that the general social policies should support an individual in making health promoting choices.

The most important long-run health political document was registered into the Finnish Health for All by the Year 2000 Strategy (= HFA 2000) in the middle of the 1980s (STM 1986). Health for All 2000 is a world-wide strategy approved in 1979 by the World Health Organization (see WHO 1985, WHO 1993), the aim of which is to improve the health of the world's population, and in particular, the health status of the most disadvantaged. *Health*, according to the programme, is defined as a resource of everyday life that enables people to live socially and economically productive lives. The strategy stresses that health is largely determined by social conditions. To achieve the targets for HFA 2000, it is necessary to change these conditions to be health promotive and preventive of illness. Finland was appointed to be a pioneer country, the obligation of which was to draw up and implement a National HFA 2000 programme and report the results to WHO. The Finnish Ministry of Social Affairs and Health (= STM) published its HFA programme in 1986 (STM 1986). Its strategies were in line with the Health

Policy Report (STM 1985), the main health policy schemes of which received wide support in the parliamentary debate.

The Finnish HFA 2000 programme was largely based on the public health research carried out in the 1970s and 1980s. Such being the case, the priorities set for research during those decades (Medical Research Council 1972, 1980a, 1980b, 1980c, 1988) were relevant for building up the Finnish National HFA 2000 programme. However, significant deficits were revealed in several crucial research areas in connection with this planning procedure. (Kankaanpää et al. 1986, Rimpelä 1987, Eklund and Rimpelä 1989, Medical Research Council 1989, Subcommittee of National Public Health Research 1988a, 1988b, 1988c).

The Finnish HFA policy was built up – according to the guidelines of the European programme – on three main policy statements: promotion of healthy life-styles, reduction of preventable health risks, and development of health services system. The emphasis was on broad policy statements instead of detailed numerical targets. According to the Finnish HFA 2000 programme, the implementation of these policies required health-oriented social policy, development of the health care system, increasing health-related knowledge and skills of the population, participation of professionals and laymen, as well as research. Support from the general public and active participation of citizens and communities were seen as crucial prerequisites for the effective implementation of the programme. However, according to the Programme for Research for HFA 2000 (Medical Research Council 1989) there was a shortage of research information concerning the participation of communities and individuals and concerning the channels through which the participation in or the practical management of this kind of procedures was or should have been realized in the Finnish society. (Eklund and Rimpelä 1989).

In 1948 WHO (Hogarth 1975) defined *health* as a state of complete physical, mental and social well-being. Accordingly, the HFA 2000 considered health as a positive and comprehensive/holistic concept. (See e.g. WHO 1986a, Ottawa Charter). However, the strategy brought two new dimensions to this definition. Firstly, health was not regarded as the goal of life as such, but as a continuously changing resource, a tool for achieving a good and satisfactory life and well-being. Additionally, the definition emphasized the importance of social conditions and the environment as determinants of both individual and community health. The increasing stress on community health was seen in several documents of WHO. One example of this kind of community approach was the Healthy City programme initiated by WHO. The ideas of Healthy City were grounded on the debate on health promotion at the end of the 1970s, when the emphasis shifted from a simplistic, reductionistic cause-and-effect view of the medical model to a complex, holistic, interactive, hierarchic systems view known as ecological model (Lalonde 1974, Hancock 1985, Hancock 1986). The ecological model took into consideration the interactions of man and human society with the environment.

The HFA strategy takes a holistic approach to the human being. Thus, focusing exclusively on a disease or health disorder is not enough. The psychosocial environment with which the individual interacts must also be taken into consideration. The model of health care in which people are seen as passive objects is not valid any more. The HFA programme emphasizes people as active subjects of their own life and health. They are expected to rely on themselves both in their contacts with the health service system and in relation to the planning of the system. The role of health care and social welfare workers is to support people's personal resources (Medical Research Council 1989).

The HFA 2000 programme lays further emphasis on health promotion in such a manner whereby matters, people or communities are taken into consideration as entities. Parallel to individual diseases or disorders, also the holistic approach to health is thus considered and with it the question of how to maintain and how to promote health (Medical Research Council 1989).

In health promotion, health care professionals should be seen as consultants. The participation of individuals and community in health related decision making, both concerning decisions on public health policy and on health services, is one of the

cornerstones in the promotion of health. The aim is to establish a collaboration relation based on two different areas of expertise: the citizen is the expert of his own life history and human resources; the health professionals are experts on the filed medical and health care knowledge. (Medical Research Council 1989.)

Constant change is a characteristic feature in the health of human beings and communities. All states, which are classified as final, are actually results of a long process. This process perspective is included when growth and development of human life span at the individual level, or historical developments or outcomes at the community level are considered. Actions and decision of individuals and communities which have resulted in a certain situation or state are essential elements in the process and an important focus for research. In order to analyse and understand actions and social change, information concerning processes is needed. (The outcome measures or descriptions of certain stages are not sufficient for this purpose).

The HFA 2000 is primarily an action programme, which aims at bringing about changes to promote health. These changes depend on people's actions and decisions at both the individual and community levels. The main lines of health research – the research on pathogenesis, treatment and risk factors of disease – provide important information about the factors influencing disease and health. However, they do not indicate how and in what conditions health-promoting changes are brought about in everyday life, in organization and society and whether or not the change is possible in general. Such being the case, a new research approach is needed, in which people's everyday life and the function of social and political systems in health terms are examined. An action-oriented research approach, which looks upon the actions and everyday life of the people and community from the health perspective, was appointed as one of the most important priority areas of research.

At the beginning of the 1990s the Finnish Health for All policy was evaluated by an international group of experts named by WHO in August 1991. (WHO 1991) The evaluation was based on the National HFA Programme of Finland published in 1986 (STM 1986). According to the expert group, the health and social policy in Finland had been highly successful in improving the health status of the population in general. Much was going towards the right direction without actually being labelled as HFA policy implementation. (WHO 1991, Sihto 1997). It was considered that the HFA strategy was generally implemented without remarkable problems and that many of its guidelines were still current. However, in some areas no progress had taken place.

Sihto (1997), however, in her study on the implementation of the HFA 2000 Programme in Finland, concludes that the way the programme was planned indicates that a rational organization paradigm was followed in which attention was paid to the formulation of the programme but not to the implementation afterwards. The method of preparation procedure of the programme, according to Sihto, was central administration oriented excluding other parties and did therefore not promote commitment to the programme, nor interest in its implementation. With reference to the opinions of the steering group, Sihto claims that the HFA 2000 Programme in Finland was aimed at strengthening the existing health policies and a separate implementation or promotion of the programme was therefore not given a priority.

A new steering group for the HFA 2000 strategy revision was appointed in Finland in 1991. The steering group decided not to change the original HFA 2000 strategy altogether, but to concentrate on fields which had received critique in the WHO's evaluation (1991). The remarks were taken into consideration when the Finnish HFA policy was renewed in 1992 (STM 1993b). One of the central messages of the evaluation was an observation that the participation of the public in the HFA policy development process – policy formulation, implementation and evaluation – had not been sufficiently wide, and the potential and resources of NGOs for the implementation of the HFA policy had been under-utilized. The strategies selected for the health policy areas were reduction of differences in the health status between population groups, maintaining and improving the coping abilities of people, co-operation supporting preventive health policy,

improving the effectiveness of health services, developing human resources and management in health care, and increasing community participation. The HFA Revised Strategy (STM 1993b) recommended e.g. to develop models for co-operation and joint activities between municipalities and NGOs where citizen participation is an essential element.

3.3 The roles of state, professionals, NGOs, and citizens in health promotion

The collaboration between NGOs, state authorities, health professionals, and the municipal health care had produced skills and know-how within health education based on everyday practice and experience by the 1970s. However, the role of the state strengthened in the shift of the decades of 60s and 70s. The strengthened role of the state was explicit at all levels of health care, even in the financing of the NGOs, in the 5-year planning and financing system of health care and in the health legislation of the 1970s. Health care was steered or rather ordered by different state directives. The state and regional authorities had a central role in this function. The state decision makers (the National Parliament and the Cabinet) and the authorities (the Ministry of Social Affairs and Health and the National Board of Health) became independent and strong actors for the health and social field. (Rimpelä 1992b, 1993).

Health education started to organize into its own professional field in the beginning of the 1970s, indicated by a separate administration (the National Health Education Office) and a particular source of funds within the state budget (Appropriation under §27 of the Tobacco Act). The differentiation of health education was seen also in the administration of the municipalities, which established separate boards of health education and appointed health education co-ordinators. In the beginning of this kind of state conducted health education the emphasis was in the co-operation between municipalities and NGOs.

In the 1970s health education was considered important, even though steered by the state, but in the 1980s it was criticized for being ineffective and, furthermore, health education was labeled as health terrorism. E.g. Illich (1976) criticized that medical care was trying to offer medicalized solutions for solving everyday problems (medicalization). Consequently, the collaboration between municipalities and NGOs decreased and the NGOs concentrated on their own specific activities and on taking care of the affairs of the groups of patients they represented. The preventive medicine of the 70s was based on the medical model approach, in which the citizen was considered purely as an object of care, the duty of which was to follow given instructions. The concept of "informed consent" reflects this approach, according to which the best results will be reached through "collaborative" behaviour by the patient, i.e. when the patient consents to the measures or care determined by health professionals.

The debate concerning patient's participation in the decision making about his own care started in the 1970s. In addition to the concepts of "compliance" and "utilization/use of health care services" the expression of community participation appeared in the general discussion. This was particularly realized in the world famous North Karelia Project, in which the emphasis shifted from an individual to the entire community. The North Karelia Project became an internationally known example of a cardiovascular disease prevention programme, the focus of which was the whole community and not only an individual and, thus, the approach used could be called as "community control". However, the disease-oriented approach was still dominant in the discussion of health policy and prevention (e.g. Economic Council 1972).

The roles of state, health professionals and citizens were facing a change when entering the 1990s. Parallel to the term "participation" came the terms of "involvement" and "control over health" at the end of the 1980s, and the term of "empowerment" in the 1990s. These new concepts and the approaches involved set an increasing demand for the

professionals to assume the role of consultant or mediator or collaborator instead of the role of expert, initiator, needs indicating or problem solving person. The aim was to increase citizens' personal responsibility and independent initiative in health care.

It cannot be assumed that changing the role of professionals is an easy task. Most of the pressure is directed to a change in the attitudes of professionals. According to Lehtinen-Drebs (1991), the major issues are the facts that, firstly, a need of a volunteer is regarded as criticism of one's own work. Secondly, the abilities of a volunteer are not trusted. And thirdly, volunteers cause extra work while on the long run they are feared to replace the professionals. Lehtinen-Drebs suggests that professionals should abandon the way of looking at their work as always being an accomplishment of a task for somebody else. Being a professional may, however – according to the line of action set out by HFA 2000 – in the future imply an ability of extensive co-operation between professionals and volunteers as well as families. Professionalism will be characterized by not only the execution of minor duties within the personal expertise but also by an ability to comprehend entities. Volunteer activities do not present a threat to professionals, instead they can form a part of an entity in for example such areas that do not require trained professional skills or where humane empathy and experience based support beyond the scope of professional work may bring better results.

At the same time, various arguments have been heard on the role of man in the 1990s. The need for a new public services culture is explained by descriptions of clients no longer neo-helpless or irresponsible but aware of themselves and of personal needs, who express their requirements differently, who do not wish to yield to subservience and standard services, but who demand individuality and autonomy (Julkunen 1991). Man in the 1990s is described as demanding and initiating, with the aim and the ability of self-help. Based on this belief, recommendations are given to "privatize responsibility", to increase the production of citizen-run services and to encourage communities (Karisto 1990). For example, the Helsinki City Social-political Programme of 1989 stresses an increase in citizen participation opportunities, being close to citizens, strengthening of neighbourhood and unofficial networks, mobilizing resident communities, and voluntary organization activities.

The health debate in the 1980s thus focused on the people's right to control their own health to as large an extent as possible (WHO 1986, Ottawa Charter). The minimum requirement was an increased understanding of matters related to individual's own health and awareness on health matters in general (Oakley 1989). The s.c. lay epidemiology appeared alongside the disease-disorder information produced by medical scientists. The "lay epidemiology" according to Rimpelä (1993) means that information is collected on the health concepts used in the interactions of people's daily lives, and on their causes and solutions.

According to Rimpelä (1993), the "control over" idea associated with health promotion calls for strategic skills and knowledge at many different levels like neighbourhood communities, schools, workplaces, health centres and municipalities, economic regions, provinces and states. The scope of responsibility of *health education* by Rimpelä comprises health related awareness, health cultures of communities, their development and possibilities of change, as well as educational and communicational methods (see also Kannas 1992).

Effort has been taken to apply the functional idea of control over health and participation to practice, in e.g. Healthy Cities Programmes (Ashton 1991, Takano et al. 1992), as well as other community projects (e.g. Hunt 1990). The same effort was apparent in the Healthy Somero and Järvenpää programmes conducted by the Finnish Centre of Health Education (Eklund 1993, Eklund and Bergström 1993, Eklund et al. 1995), and also e.g. in the School Alcohol Education Programme (Koskinen-Ollonqvist 1993). The programmes included a new approach in which health professionals remained in the role of consultants (Eklund et al. 1995). They could give recommendations and suggestions, but the decisions were eventually made by the people and the communities themselves. Secondly, the programmes emphasized improving the health awareness of

ordinary citizens. This was also one of the aims of the "lay epidemiology" (like the preparation of a "lay community diagnosis"). A more detailed description of the Programme is given in Chapter 5 of this report.

Participation does not, however, happen automatically. On the contrary, the strengthening and learning of control over health through participation requires many years of co-operation between professionals and citizens in which new roles are rehearsed and learnt not only to act as groups but also to obtain new skills and ways of action. However, there is evidence from successful efforts in other cultures (like in USA, UK, Canada, Sweden) on health care models, where the lay people are a permanent part of the decision making procedure of a municipality. (See e.g. Piette 1990). E.g. in USA, local communities are mandated by law to participate in decision making. Local health boards which are composed of laymen and NGOs have veto power over the community's professional public health system on all matters, excluding purely medical issues, however.

3.4 Earlier community programmes

Early forms of community programmes

The measures implemented by the community/municipality – like sewage and waste water systems etc. – could be considered as first forms of community programmes in which the emphasis was to find solutions to system level problems, although the own initiatives of citizens were seen important, too (see Table 1). The PH movement of the 1840s was the manifestation of this. The rapid urbanization, which took place in many places in Europe during the 19th century, created miserable living conditions for the urban poor. Consequently local governments appointed city medical officers to enforce national and local legislation aimed at tackling environmental squalor, along with problems of poor food, water and personal hygiene (sanitary idea). (Rosen 1958, Brockington 1960, Hobson 1969, Last 1987, Ashton and Seymour 1988, Hurrelman and Laaser 1996). The individual-oriented preventive health care started to develop at the end of the 1800s. The health legislation and the measures by authorities aimed at supporting and strengthening the preventive services. The prevention of tuberculosis was an example of this, participation in the x-ray screenings was obligatory for everyone.

The socio-ecological health research by Relander (1892) pioneered the regional health services research in Finland, and represented the first community study in the country. The study proved that the promotion of health in a certain community, a village for instance, requires knowledge about the condition of the population and community in concern. Such data gathering which describes community health profile has later been named a *community diagnosis*¹ which was included in e.g. the before and after surveys of the North Karelia Project (Puska et.al. 1979) and other similar programmes.

The prevention of diseases strategy was explicated in the struggle against other national diseases like breast cancer and cervical cancer. (See Tables 1 and 2) Consequently mammography screening and papa smear screenings were organized according to the state directives (Hakama et al. 1997). The strategy of preventive health services was fully developed during the 50s and 60s and materialized in the form of

¹ A community diagnosis is built by analysing the community profile of a regionally restricted community together with the health profile of the area. The community profile contains data on geographic location, demography and socio-economic features of the population, culture, religious and political systems etc. The health profile contains data on e.g. health behaviour, health risk factors, use of health and social services, health status indicators, prevalence and incidence of diseases, morbidity and mortality (e.g. Haglund et al. 1983, Kumpusalo 1988). Paronen (1993) adds to the community diagnosis also the perceived health, as well as social dimensions of health like resources to control life, focus of control, perceptions about life's meaningfulness, social support, coping with difficult situations and observations of the social rules of the community.

maternal and child care centres as well as school health services, and later in the 70s and 80s in the form of occupational health services. The Public Health Act was enacted in 1972 with the main objective to bring the entire population within preventive health care services. This policy was suggested as late as the mid 80s by the s.c. "Puska committee".

Model of the 70s

The development of a new strategy defined as Community Control of Non-communicable Diseases began in the early 1970s. Rose (1981, 1992) enlightened this strategy in relation to individual centred strategy (population strategy vs. high risk strategy). A part of this discussion concerned the participation in making decisions about care. Parallel to compliance and use of services, citizen participation on a community level was discussed. This was explicated particularly in the North Karelia Project (Puska et al. 1979, 1981, 1985), which had received international attention. It changed the focus from the individual control approach to a community control approach which meant that the preventive measures moved from a personal to a community level (community control approach). (Table 1). The aim of this primary prevention programme was to reduce cardiovascular disease incidence by reducing risk factors (smoking, high blood cholesterol, diet high in cholesterol and saturated fat, hypertension, sedentary lifestyle and obesity) in the whole community. This community control strategy could be contrasted to secondary prevention programmes directed at patients who already had a symptomatic cardiovascular disease, and to high risk strategy primary prevention programmes directed at individuals found through screening to have one or more risk factors.

North Karelia was discovered to have one of the highest ischemic heart disease mortality in the world. Consequently the North Karelia Project was initiated in response to a parliamentary petition by elected officials from the region. From the very beginning, the project was planned to be an action-oriented programme with evaluative and other research. Simultaneously the project would work in close collaboration with national health authorities and the WHO as a major demonstration project to test the

Table 1. The most important strategies of the preventive health care.

<p>1840– Community and society level structural measures: – legislation, implementation, organizations, control – sewage system – water sanitation – building operation and environment planning</p>	<p>1880– Individual focused preventive health services: – vaccinations – screenings – maternal and child health care centres</p>
<p>1970– Community level disease prevention/control programmes: – community strategy prevention: epidemiology, preventive health services, regional and municipal governmental measures, NGOs</p>	<p>1980– Community level health promotion programmes: - e.g. Healthy City Turku – e.g. Healthy Village in Kuopio</p>
<p>1990– Local level community empowerment programmes – e.g. Somero-Järvenpää programmes – e.g. The school health education (= programmes concerning use of alcohol (Koskinen-Ollonqvist 1993)</p>	

usefulness of the approach for national and international purposes. [E.g. An analogous study – Stanford Three Community Study – was planned and launched in USA (Farquhar et al. 1985)] The study was designed to compare North Karelia to a neighbouring and demographically similar reference region of Kuopio. The project chose to intervene on serum lipids, diet, smoking and hypertension. Five behavioural/social models contributed (see Table 2) to the unified theory guiding the community intervention. External input from the project was viewed as acting through mass media communication and through formal and informal opinion leaders functioning as change agents to influence both individual behaviour and various aspects of community organization. The purpose was to increase knowledge, persuade behaviour changes, teach practical skills, and provide the necessary social and environmental support for behaviour change and maintenance. Behaviour change was directed at reducing the level of cardiovascular risk factors and thereby the rate of cardiovascular disease.

The project team planned the evaluation and the intervention activities. The project field office was established within the county health department, and local project advisory boards were set up with participants from various community agencies. Contacts were initiated for community organizing, initial awareness campaigns were launched, materials and action plans were developed, and local training activities were started. The programme was integrated with the existing social and health service structure of the community.

The evaluations were designed to assess feasibility (the extent to which it was possible to implement the planned activities, like amount of resources, how they were used and how well the activities reached the populations), effects (changes in behaviours and risk factors, association to CVD rates), process (risk factor and behaviour change trends with time during the programme and changes in the intervening variables), costs (total project resources and how they were allocated) and other consequences (symptoms and subjective health) related to the project.

The role of the health service staff was e.g. to help individuals to modify their behaviour. Community organization procedures were aimed at mobilizing the community for broad-ranged changes through increased social support (by health professionals) and environmental modification to aid the adoption of the new lifestyles in the community. Concerning persuasion, the aim was to inspire “community action for change” in which people would participate not necessarily for their own sake but for the sake of North Karelia and the project that had become familiar and close to the people. The Project worked closely with the various formal opinion leaders (municipal leaders, voluntary organization leaders, health personnel, mass media and business leaders) to ensure the innovation-diffusion. Later the Project systematically identified informal opinion leaders in order to communicate the innovations through the county via this network.

The community organization approach in the project comprised the community self-development (the community initially detecting a problem, and organizing itself to cope with it) and the outside influences needed to promote the reorganization. Shortly, community organizing in connection with the North Karelia Project meant actually only collaboration with the organizations within the county.

Several other community projects similar to the North Karelia Project were initiated after the good results of the programme became famous and known worldwide. These community programmes used comprehensive interventions with the aim to reduce cardiovascular diseases in the population. (Mittelmark et al. 1986, Jacobs et al. 1986, Lefebvre et al. 1987, Nutbeam and Catford 1987, Farquhar et al. 1985). However, even though the projects labelled themselves to be community programmes in which participation was used as a tool, they should not be confused with community programmes where the main focus is on health promotion, participation and empowerment procedures. In the typical community programmes of the 70s the ultimate goal was the prevention of a disease, while in the more recent community programmes the emphasis is on the mobilization of health political action by laymen and on social change enabling this kind of efforts.

The nature of citizen participation in various community action studies was analysed by e.g. Giesbrecht et al. (1991). The analysis reveals that in a cardiovascular disease prevention project in Budapest (Kockeny et al. 1986) the participation was created by building a network of local organizations and volunteers. In the Minnesota heart health project (Jacobs et al. 1986) the community key members were assigned and invited to work in the project expert team. To assign the key members, a community diagnosis was made. Also in the North Karelia Project (Puska et al. 1979, 1981) the unofficial opinion leaders of the community were charted and then trained to lead various sectors of the project. The key members of the community were not, however, taken to the administration of the project. Local organizations were mentioned but the nature of their precise role and actions remained unclear. In the Pawtucket Project (Lefebvre et al. 1987), volunteers were recruited and trained to carry out interventions. A counseling team was gathered consisting of members of the community. The Stanford 5 City project of cardiovascular diseases (Farquhar et al. 1985) heeded community opinions when planning the interventions, and local resources were used in their completion. How the opinions and proposals were gathered remained unclear in the descriptions. The Wales Heart Programme (Nutbeam and Catford 1987) donated resources to be used in local preventive projects.

The methodological examination by Brännström et al. (1994) reveals that the two well-known community-based CVD-preventive programmes – North Karelia and Minnesota – dealt mainly with health behavioural and/or medical effects and only few papers had analysed factors that promoted or constrained community participation in health development. The conclusion was that there are very few published reports which have taken into account the views of members of the community or which have tried to analyse the process of change within preventive programmes, or to find factors in the various arenas which promote or constrain community participation.

Some partnership arrangements of citizens (usually initiated by a core group of community leaders) are combined with the knowledge and talents of vested agents for change and government experts. The North Karelia Project and other corresponding programmes recognized that behaviour is strongly influenced by a larger social environment and the underlying values and norms of community. Such basic changes in the behaviour, values and norms of the community can occur only through the active participation of community residents and organizations. However, the participation in these experiments remained limited to health inspections and check-ups planned and implemented by health experts. The participation of NGOs in these programmes was limited to their use in implementing some functions planned by the research group.

Several considerations favour the community primary prevention (community control) strategy in comparison with the other strategies (Shea and Basch 1990). However, community participation and its extensiveness was not precisely explained in these projects, typical for the 70s, despite the fact that all of these projects took special measures to attract local participation. The previously mentioned project failed to explain in particular such factors as citizens' possibilities to participate in decision making and counseling, time (length and duration) used in preparation of actions, representation of citizens in the project management or other groups, satisfaction in participation opportunities and channels, quantity of results and achievements, as well as evaluation of objectives completed. On the other hand, such factors were not the primary interest of the preventive programmes.

While a wealth of materials has been published on the mechanisms and theory of community-based health promotion programmes, the evidence linking theory, practice and outcomes is limited. Because of the conceptual overlap between theories and models, it may be impossible to accurately test specific theories with the appropriate scientific rigour, claims Fincham (1992). To understand these community programmes, more basic research is needed to investigate the relations between the process of change, the target of change and both the short- and long-term outcomes of change.

Table 2. Characteristics of typical community programmes in Finland before the 1990s and the corresponding characteristics in the Somero-Järvenpää Programme

Project Characteristics	Model of the 60s	Model of the 70s	Model of the 80s		Healthy Somero-Järvenpää Programme
	e.g. Breast Cancer Screening	e.g. North Karelia Project	e.g. Healthy Village (in Kuopio)	e.g. Healthy City (Turku and Hki)	
Back-ground	High and increasing incidence of breast cancer National instructions and directives	Extremely high mortality on cardiovascular diseases	High prevalence of lifestyle diseases Health promotion and Ottawa Charter	HFA philosophy, Ottawa Charter on health promotion	HFA philosophy, Ottawa Charter, Finnish HFA 2000 programme and its revised version
Health concept	Absence of disease or disability	Absence of disease or disability. Individualized, health as energy, physical/functional ability, connectedness to one's family/friends/community/ environment	Health is a positive and comprehensive concept	Health is a positive and comprehensive concept, a resource of everyday life, and determined by social conditions.	Health is a positive and comprehensive concept, a resource of everyday life, and determined by social conditions. It is a state of balance between man and his physical and socio-cultural environment. As the balance is a dynamic one, man has to play an active role in it, to participate in all aspects and stages of health promotion.
Theoretical basis/framework	Medicine, epidemiology	Medicine, epidemiology, a system theory based on four models: behaviour change, communication-behaviour change, innovation-diffusion, community organization	Social support, system theoretical adaptation, holistic socio-ecological approach: salutogenesis and pathogenesis in rural villages	Lalonde model about health, community health, communality	Participation theories, Freire's learning theory about conscientization and process consultation, empowerment theories, PAR
Target level	Individual (micro)	Individual (micro)	Individual and community (micro and meso)	Community and its citizens (meso)	Community (meso)
Target population	Women, certain age groups	Citizens of North Karelia county	Village citizens and local authorities	Not applicable	Not applicable
Intended change	Disease, incidence	Disease, incidence, behaviour, lifestyle	Behaviour, diseases, lifestyle	Community, several not specified intentions of change	Health policy making process, health care infrastructure
Specific indicators of change	Mortality, survival	Reduction in risk factors like smoking, blood cholesterol and blood pressure, use of lower fat products, vegetables and berries/fruits, decreased mortality and morbidity	Increased social interaction, socialization, coping, (healthy) lifestyle, health status, reduction in risk factors	Not specified Decision making in health issues	New way of action in health promotion, action model, well established channels and organization structure for participation in decision making
Interventions	Mammography	Community organization, education of health professionals, information through mass media, health inspection	Joint planning, local community organization, health inspection	Not specified, not defined in the beginning of the project	Process consultation, education for participation, action and exercises for strengthening participation skills and knowledge about decision making process, local community organization
Evaluation and experimental procedures	Time trends, follow-ups	Quasi-experimental (neighbour county as comparison group). Emphasis on outcome measures, health status indicators and cost-effectiveness	Correlation analysis, factor analysis (4 villages to compare). The emphasis on self care, social support, and health status indicators	General Healthy City quantitative indicators, action research	Process evaluation, action research, qualitative analysis, hermeneutics, participant observation, emphasis on development of empowerment

Concept describing participation	Compliance	Community control	Community involvement	Community involvement	Community participation, empowerment, control over health
Type of participation	Non-participation: Manipulation -	Non-participation: Manipulation, therapy - marginal	Degree of tokenism: Informing, consultation or placation - marginal	Degree of tokenism: placation, or partnership - substantial	Degree of citizen power: Partnership, delegated power, and citizen control - structural
Participation was used as	means	means	means	means and end	means and end
Nature of participation	People were called to a free of charge mammography examination. Participation was voluntary but highly recommended.	Informal opinion leaders of community were chartered and trained for implementing project measures. Local organizations are involved. Participation meant health check-ups, following instructions, answering questionnaires and following health education instructions	For information gathering purposes key persons in the community were interviewed. They participated in the planning of re-search organization, and had a representation in the joint planning committees. Activists of the village committee were selected to implement research measures. Participation meant health controls, following instructions, answering questionnaires and involvement in research organization.	NGOs and local people participated in activities planned and organized by local authorities Role of NGOs was not specified.	Project participants selected subjects, prepared questionnaires, conducted interviews, made analyses, reports, planned and implemented personal interventions and public campaigns, and created networks with existing institutions (businesses, schools, restaurants etc.); other city residents participated also. Participation was one element of the process expected to lead to self-awareness, psychological and community empowerment. It was a means and an end.
Political commitment	National	National, regional and local	Local	International, local	Local
Commitment of health services	Part of health services	Implemented in joint collaboration with health services	Implemented in joint collaboration with health services	Planning and implementation by health authorities and health services	No particular role at all
Commitment of citizens	Objectives of care	Participation for the sake of North Karelia and because of good results and fame of Programme	Not clear, citizens participated in health inspections	Project organization committed, others participated depending on topic	A committed and continuously growing core group of local people during entire development process. Rest of the population as supporters, or resource persons, as well as participants of activities organized by Programme or by citizen core group
Project management	Health professionals	Project researchers, project organization	Project researchers, project organization, village group, action groups	Local Healthy City Office, Project secretary, City council of health education	Project manager, consultants, local project secretaries, theme leaders, and participants of training programme

Altman (1986) emphasizes that it would be important to know how much, through which channels, and with what methods health information is diffused among community organizations and residents. To do this, qualitative analysis is required, such as tracking the use of health education materials, interviewing and observation of community health events, assessment of the salience of health among individuals and organizations, and monitoring health interactions among community members. Furthermore Altman states that there is inadequate documentation of how the programmes become a part of the community structure, how specifically they achieve their effects, and which programme implementation strategies are successful and which are not. Employment of the process evaluation strategies outlined above would foster an understanding of the programme implementation, the causal events leading to change, and the specific programme components that most influence outcomes.

Model of the 80s

Health promotion philosophy of the 1980s, HFA 2000 ideology and the related incentives by WHO (WHO 1978, 1985) brought attention to citizens' participation also in Finland in the 1980s. Improvement was suggested by e.g. foundation of planning committees with citizen representation (e.g. Kumpusalo and Neittaanmäki 1987, Kumpusalo 1988, Haukkasalo 1992, Stenroos 1992). Their task was to improve the dialogue between users and consumers of services. Such committees were viable in cases like building a hospital etc. Real citizen participation remained, however, marginal in these joint planning models. The planning units often had a short life and could not guarantee continuing participation after solving the primary problem.

The "Healthy Village" Project implemented in Kuopio Region is one example of a community programme of the 80s in Finland. (Kumpusalo and Neittaanmäki 1987, Kumpusalo 1988, Kumpusalo et al. 1991). However, the community control of a disease approach used in the North Karelia Project still formed the theoretical basis for this programme, but with the addition of a general system theory and a holistic socio-ecological approach labelled "Salutogenesis and Pathogenesis in Finnish Rural Villages". The essential elements of the latter approach were interaction, socialization, coping, lifestyle, and health status. The empirical part of the study concentrated to analyse the relationships between self-care and lifestyle and social support.

As part of the Healthy Village study, a health promotion programme was carried out. The basic idea was to integrate new health promotion practices into rural lifestyles. The key elements of the programme were to focus on positive health, people's participation and inter-sectoral collaboration. Health Promotion in the programme was based on the ideas presented in the WHO Ottawa Charter (WHO 1986, Kumpusalo 1988, Kumpusalo et al. 1991) emphasizing health as a resource for everyday life. Health promotion was understood as comprising activities to improve the possibilities of people to cope and advance their health. Self-health promotion was operationalized as self-health care and personal promotion of environmental health.

The local adult education institutes worked as links and arenas for inter-sectoral collaboration. For practical purposes, such as for local planning, co-ordination, collaboration and management of the programme, each village board selected an "action group". Twice a year this group together with the education institute, made plans for a health promotion programme for its own village. For this planning, the action groups inquired local needs and made recommendations for health promotion (e.g. village seminars and lectures, training in healthy cooking, slimming, physical exercise, walking campaigns and tests).

Actually there was an honest attempt towards some kind of participatory processes (like joint planning) in the Healthy Village Project but the main emphasis, however, was on the changes in the health status and health behaviour of the individuals, and not in the way of action concerning for example participation behaviour or political action in

health. The participation in the project remained marginal and took the form of participating activities organized by health professionals or the form of self-initiated health care.

The Healthy Cities Programme initiated by WHO was another typical example of the community ventures in the 1980s. At the same time it was a local application of the Health for All 2000 Programme. The "healthy city" of the programme was defined as a city that reacts and responds to citizens' health needs, and where citizens know how to utilize and develop their city to promote health (Duhl 1986, Vertio 1993a).

The idea of a healthy city incorporates the belief that the city, as a place which shapes human experience, has a crucial role in determining the health of those living in it. The main elements of the project were: to formulate concepts leading to the adoption of City Plans for health which are action based and which use Health for All principles and the 38 European targets as a framework; development of initiatives and processes as models of good practice; implementation and monitoring of models of good practice; dissemination of ideas and experiences between collaborating cities; and mutual support, collaboration and learning between the cities of Europe. (Ashton 1991). In practice, Healthy City was an attempt to translate the WHO philosophies and frame-works into practical and concrete health promotion work. However, every city involved in the Healthy City movement was expected to find its own way of implementing the desired 'good practices' and their evaluation.

Turku (official partner) and Helsinki were Healthy Cities in Finland. In Turku, as well as in other Scandinavian countries, the Healthy Cities Programmes were mainly conducted by the health authorities instead of the desired local community groups (like e.g. in UK). In Turku the programme organization (steering group) consisted of different health leaders from various governmental sectors in the city. However, a corporation of local NGOs supported the steering group. The general aim of the Healthy Turku was to strengthen healthy decision making and healthy social policy in the City. (Hakkala 1994.) Healthy Turku was directly based on the general principles and philosophies of WHO (see above). No specific detailed objectives were defined at the beginning of the programme in 1987. The only written document was a general action plan for money application purposes. (Hakkala, personal interview 1993.) However, there was one example of an implemented subprogramme on promotion of physical activity of the citizens in Turku. Its goal was to prevent national health diseases like e.g. the musculo-skeletal diseases.

Helsinki had an ideological objection to the disease-oriented approach. However, within subprojects disease prevention was stressed to some extent (Vertio, personal interview 1993, Eliasson, personal interview 1993). In Helsinki, a number of sub-projects involved hypotheses which underwent testing. The more general hypothesis of the Healthy Cities Programme was that the role of sense of community was seen crucial in promoting health. In Helsinki, a separate project plan was drawn.

Action research was considered an important feature based on WHO experts who had deemed such an approach necessary. In reality, Turku failed to perform any studies of this kind. According to Hakkala (personal interview 1993), the implementation of quantitative research methods remained negligible in the beginning. Later however, a lot of quantitative research on population's health status has been conducted by the city of Turku. Additional research was carried out following the outlines of WHO indicators (WHO 1992). This consisted mainly of evaluation and community diagnosis type data gathering based on quantitative measures. The proportion of qualitative evaluation remained minor in Turku. On the contrary in Helsinki some general action research as well as qualitative surveys were completed (e.g. Horelli 1992). The Helsinki Healthy City Project did not, however, call for any research, action only was considered important.

Local expertise was not particularly valued in the planning. Dr. Vertio, the Chief Physician in Helsinki, and the City Chief Medical Officer in Turku acted as kind of local experts in the project development. The significance of other local experts remains

unclear. In Helsinki, local experts were assigned to the Health Education Counseling Committee which has later been renamed the Healthy City Counseling Committee. The experts for this committee were also chosen among the vice-management level of the city.

The contribution of the state authorities to the project was mostly restricted to the availability of funds from the Appropriation under §27 of the Tobacco Act. The significance of city authorities in both locations on the other hand was big since the initiative of the project as well as the planning responsibility remained with the authorities. They were involved in every active sector of the project. Moreover, the Healthy City Office was located in the health authorities' office building, a fact that gave the project a certain identity.

Otherwise health services did not play such an important role in Healthy Turku or Helsinki as e.g. in the North Karelia Project, where the active work of the project was performed mainly by health professionals (measurements, health examinations, training, education etc.). Since the aspect of health was to be given more attention in the city management, a greater significance was held by various authorities who made decisions on health issues, on the agendas of health educational committees, and health policy.

WHO recommended that also other than health sectors should be appointed to promote health. In Turku, such an active partner was the environmental health care. There is no documented information on the nature of the collaboration, however.

Inclusion of voluntary organizations was not considered in Turku at all at the time the project was launched. In other words, the declaration of WHO on citizen participation had not been fully understood, stated Hakkala (personal interview 1993). Voluntary organizations have joined in only in the 1990s in the "second round" of the Healthy City Project. The organizations have founded their own co-operative committee to work together with the s.c. local groups (evidently subdivisions of health centres). According to Hakkala (personal interview 1993), participation and role of state organizations were not considered either. They could not find such organizations whom they could assume to support or bring any contributions to the project. By Hakkala, Turku did not implement "empowerment" or "citizens' control over health", at least not in the way it was planned in some other health promotion programmes. The planning as well as the major part of the implementation of the Healthy City Turku Programme was controlled by the city authorities.

One of the duties of the Helsinki City Board of Health was to run a healthy and safe action policy (see Tarvainen-Pääkkönen et al. 1992). As a means to reach this goal Helsinki chose the Healthy Cities Development Programme. It was based on five operational items of health promotion presented in the Ottawa Charter: health supportive public decision making, provision of healthy environment, increasing community action, improving knowledge and skills, and reorienting health services. Community participation or communality was not specifically defined in Helsinki. Reference to the Ottawa Charter issue on "increasing community activities" was perhaps a step towards it, meaning that local activities are to be intensified with various community level concrete activities. In evaluation of the order of priority matters, in making decisions, in designing and implementing action models the ultimate objective was to attain better health.

In the process of developing the Healthy Cities programme, there has been a continuing search for indicators to enable cities to follow-up the fulfilment of the programme (e.g. The visibility of the initiatives of the HFA 2000 programme in health related decision making, Tarvainen-Pääkkönen et al. 1992), and also to enable comparisons between cities. According to Vertio (1993a) the measures of a healthy city are health promotion activities, city structure from health perspective, and health status of the population. As parameters of health promotion Vertio proposes responsibility for taking care of own health, intersectoral collaboration, participation, social support, health promotive habits and behaviour, healthy environment, knowledge about health, and safety. For each parameter, detailed indicators are presented. The indicators of for example participation are the decentralization of health related decision making together

with the involvement of local health groups (e.g. voluntary organizations). The indicator system presented by Vertio was, however, not tested in Finland, at least not directly.

The community perspective and community diagnosis in the Healthy Cities programme (see footnote on page 14) was also a part of the message of Ottawa Charter and its view on health promotion. Therefore, the community diagnosis was hoped to give tools to evaluate and follow-up the fulfilment of the Healthy Cities programme. In Finland, community diagnosis has been developed by the Healthy Cities programmes, but also e.g. at the UKK-Institute (Paronen 1993) and in the City of Espoo (Saarelma 1993). Hancock and Duhl (1988) presented quite a substantial list of methods to measure the city structure and its health affecting factors. Noack and McQueen (1988) analysed a theoretical and methodological framework for developing indicators for healthy cities. These indicators are, however, incomplete in for example evaluation of citizens' participation in the Healthy Cities or other community programmes.

The discourse of health promotion is typical of the discourse of new social movements (like peace movement, environmental movements, and women's movements). "The arguments call for enhanced powers of civil society versus the state; the decentralization and democratization of the state; and a reordering of social priorities in favour of reproduction as opposed to production; equity as opposed to hierarchy, difference as opposed to unity or universality, and the mutually intelligible needs and purposes of persons freely communicating in the real communities of their life-world as opposed to the abstract preferences or interests of the mutually antagonistic classes or isolated individuals who inhabit the 19th century theoretical models of society" (Stevenson and Burke 1991). However, Stevenson and Burke do not consider the 'movement of health promotion' (including e.g. healthy city movement) as a social movement but a bureaucratic tendency; not as a movement against the state but one within it. This compounds a deficiency in the conceptualization of politics that is common to the discourse of all new social movements. Health promotion theory tends to pull away from the state as a central object of analysis to refocus on the diverse communities of civil society. In addition Stevenson and Burke claim that there are methodological deficiencies in research that stem from the bureaucratic rather than anti-bureaucratic character of the health promotion movement. As health promotion has sought epistemological legitimization for its alternative knowledge of health (e.g. as in Healthy Village in Kuopio or in Healthy City), the health promotion movements have tended to be preoccupied with search for indicators. This search invites a recapitulation of essentially positivist logics, rather than a "critical theory" that reconstitutes what needs to be indicated.

The theoretical and practical basis behind e.g. the Healthy City and Healthy Communities movements is provided by urban planners, public health professionals, bureaucrats at all levels of government, and expert consultants from different disciplines (Stevenson and Burke 1991). And consequently the community involvement has remained marginal and minimal in these movements (Stevenson and Burke 1991, WHO 1991). Actually the primary objective of the WHO's Healthy City programme was to provide information to local politicians for the purpose of policy-making (Kickbush 1989). Consequently there was a pressure on administrators to generate comprehensive (as the definition of health and health promotion expanded) indicators that could be easy to collect, use and understand and that would be available at a reasonable cost. This situation led to a contradiction: the pressure to produce quick and comprehensive results ended in a lack of results.

The hypothetical model of the 90s and beyond

The future aim of the HFA 2000 ideology is to change the relationship between health care professionals and the clients/citizens through participation (e.g. STM 1986, Medical Research Council 1989, Matthies 1991). From the health promotion point of view, health

care professionals should remain mainly in the position of consultants. Participation is finally a question of relations between the power of experts, citizens and state. The purpose is to increase personal responsibility and self-help of people in health care. This was also the intention in the Healthy Village Project as described earlier, as well as in the Healthy Cities Projects. However, these programmes placed health promotion research and advocacy in the postmodernist² discourse of new social movements and pointed out the theoretical limits that result from that location.

Stevenson and Burke (1991) emphasize that accepting post-modernism and its research strategies can be associated with a profound narrowing and depoliticizing of the conceptualization and practice of health promotion. E.g. the key concept of the 1990s, community empowerment, requires action research approach, consultative methods, naturalistic inquiry and participatory research as well as social and educational sciences. This puts the emphasis on *defining empowerment more as a methodological rather than a political question*. The Ottawa Charter for Health Promotion (WHO 1986) equated community empowerment with the community's ownership and control of its own endeavours and destinies. However, the Charter did not specify the means by which empowerment could be implemented in the communities.

Until recent years the participation of citizens in Finland is believed to have materialized in two ways: either via representative democracy or via people's direct action in protecting their own and community health (STM 1993b). Along with social development and the growth of the urban settings there has also been a need to find additional means of influence (Savileppä 1989, Saarela and Sainio 1991, STM 1993b). The HFA 2000 revised strategy (STM 1993b) proposes e.g. that the resources of the NGOs could be used more in health care planning and evaluation. To influence decision making, however, requires certain skills and knowledge as well as courage for the citizen to express his/her opinion. The ultimate goal for the process of community empowerment is to seek new ways of action and channels for citizen participation in health as well as to strengthen and increase people's capabilities for participation. The empowering approach should be the central basis for the typical community programmes of the 1990s and beyond.

Summary

The differences concerning the community programmes of different decades have been collected in Table 2. Figure 1 is a rough illustration of the different approaches used in the community programmes in different decades. North Karelia, Healthy City (Helsinki and Turku), Healthy Village in Kuopio and the Somero-Järvenpää Programme. The nearer the marks are to the left side of the column, the closer the programme is to the typical preventive medical model, and the nearer the markings are to the right column of the scale, the closer the programme is to the empowerment ideology. (In the figure, the expressions "Large" or "Important" mean that the element is of great importance for the programme. And visa versa, the words "Small" or "Not imp." mean that these matters were less important for the programme).

Concerning the scientific basis and goals in a medical preventive model, the starting point is the prevention of disease. The hypotheses testing and using earlier studies and theories were important for the research planning. Action research does not exist in a pure medical model of a programme. In the implementation, the experts' role (e.g. like experienced researchers or health professionals and WHO authorities, etc.) is crucial and the people to be investigated (called usually target groups) are the objects of the research. The people have no influence on the course of the programme. In the scale, this is marked as "local experts' role is small". The role of the state (e.g. in the form of giving national directives) and the municipalities (e.g. in the form of accepting the

² "Postmodernism is a contemporary sensibility, developing since 2nd World War, that privileges no single authority, method or paradigm" (Denzin and Lincoln 1994, p. 15).

research plan or applying for money), and the health services (e.g. in the form of implementing the health screening) is major. The expertise of global NGOs is more important than the expertise of local NGOs and voluntary organizations. "Control over health" (actually this describes the item "Whether the empowering of the people was included in the implementation of the programme") is not the main focus of a preventive medical model type of programme and is often totally lacking. The use of local coalitions (using local human resources) or networking between local coalitions (e.g. between local NGOs) is minor. The medical model type programme has usually a differentiated organization, which in this case usually means groups of researchers, universities or other organizations, Health Ministries, etc., officially committed to the programme, both in the political and financial sense. In research, the preventive model relies on quantitative measures as well as impact and outcome measures.

The empowerment model starts with promoting health, and this type of programme is not focused on a particular disease. Testing hypothesis is not so clear as it is in the preventive medical model type of programme due to the fact that the focus of the research is more abstract (empowerment). However, some kind of hypothetical ideas are included as foreknowledge to the programme staff, like planners, consultants or researchers. The programmes are usually based on the action research approach, where the study plan is rather vague, often not documented in a written form. This is assumed to ensure the flexibility during the programme and the possibility to change the course of the programme according to the needs of the people involved or in case the study circumstances need amendments. In implementation, the programme does not rely on global experts, but the expertise will be found among those to be investigated. Local people with their own experiences, skills and knowledge are the most important human resources in the programmes. The role of authorities, both state and municipality, is minor in the sense of steering, managing or implementing the programme. Instead, their political commitment (some kind of expression of a political will to support the effort) will be quite important. The role of health services is minor and not expected to produce plans or implement measures included in the programme. However, it is crucial that as participants in the programme health professionals are equal to the lay people. They provide their own skills and knowledge for use where needed and desired. Local NGOs' role in the empowerment programmes should be major. The idea of aiming at "control over health" is the core of the programme. Any differentiated official organization to implement the programme is not needed. In research and evaluation, the methods are mainly qualitative and the evaluation concentrates to describe the process and development of the programme as well as the outcome measures.

As can be seen from Figure 1, the North Karelia Programme (black point) is nearer to the preventive medicine type of programme. Healthy Village (white square) and Healthy Cities (grey triangle) are somewhere in between. Somero-Järvenpää (white point) is closest to the empowerment model. Figure 1 is based on the telephone interviews (1993) of six key persons³ of the programmes and on the literature about the programmes. (The scale used as a tool when implementing the interviews is included as Annex 1.)

Community health promotion programmes of the 90s require a shift from the emphasis on epidemiological measures and health status indicators towards the emphasis on social and educational sciences and indicators of community empowerment and competence. The direction is from positivist or post-positivist oriented

³ Pekka Puska and Heikki Korhonen (North Karelia), Harri Vertio and Marja-Kirsti Eliasson (Healthy City Helsinki), Mari Hakkala (Healthy City Turku), Esko Kumpusalo (Healthy Village).

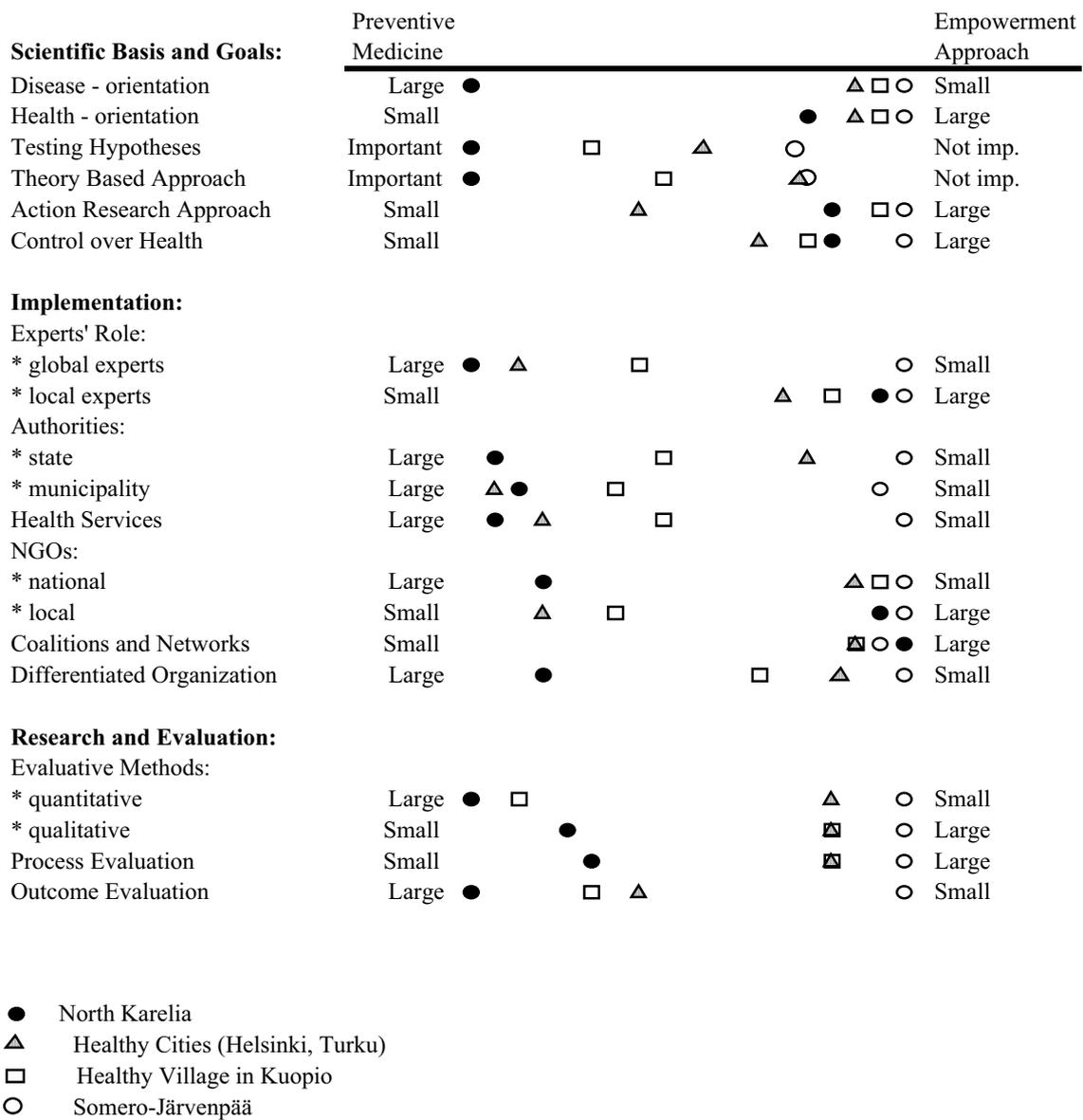


Figure 1. Types and concepts of different community programmes

paradigms⁴ towards critical sciences, interpretivistic and constructivistic paradigms, which then further direct the methodological choices (e.g. Lincoln and Guba 1985, Guba 1990, Labonte and Robertson 1996) (Figure 2).

Health status or incidence or prevalence of diseases are phenomena measurable with quantitative methods. The emphasis of health promotion in community programmes of the 90s and beyond should be on the emancipation of the oppressed groups (in this case read: people with learned helplessness) and on empowerment. As the focus of the research is abstract, it is impossible to investigate or verify the phenomena with quantitative parameters (e.g. Labonte and Robertson 1996). The researcher has to interpret the word world (e.g. the experiences of the people) and formulate an own/new construction about the abstract world (e.g. developing models). Participatory, observational, action research and qualitative approaches are needed in research and data analysis.

In Finland – particularly after the 1993 State Subsidy System Reform – the communities have become more autonomous. The local level has more responsibility in decision making and policy planning as well. Consequently, empowerment processes are needed at the community level due to the requirements of increased skills and knowledge for making good decisions and sustainable development. The community programmes of the 90s should be connected with local settings and based on the local problems defined by the people themselves.

⁴ A paradigm is defined as a world view and, as such, is generally believed to be more or less exclusive. Paradigms are composed of multiple belief categories, principal among them being the ontological (what is the nature of “knowable” or “reality”), epistemological (what is the nature of the relationship between the knower/inquirer and the known/knowable) and methodological (how should the inquirer go about finding out knowledge) assumptions (Kuhn 1970). Positivism asserts that objective accounts of the world can be given (Denzin and Lincoln 1994, p. 15). According to Comte (1864) The word “positive” refers to the actual in contrast to the imaginary, to what can claim certainty in contrast to the undecided, to the exact in contrast to the indefinite. E.g. Susman and Evered (1978, p. 583) define the positivistic science as an approach to science that considers scientific knowledge to be obtainable only from sense data that can be directly experienced and verified between independent observers. Postpositivism holds that only partially objective accounts of the world can be produced, because all methods are flawed (Denzin and Lincoln 1994, p.15). Positivist and post-positivist paradigms are often considered as “conventional”, traditional paradigms which were dominating public health discipline until the mid 80s. The ontology of the conventional paradigms seeks universal truths, cause and effect-laws and single realities. The epistemology requires value-free inquiry and subject-object dualism. The hypothesis testing and context-free variables form the methodological assumptions (Guba 1990, Labonte and Robertson 1996).

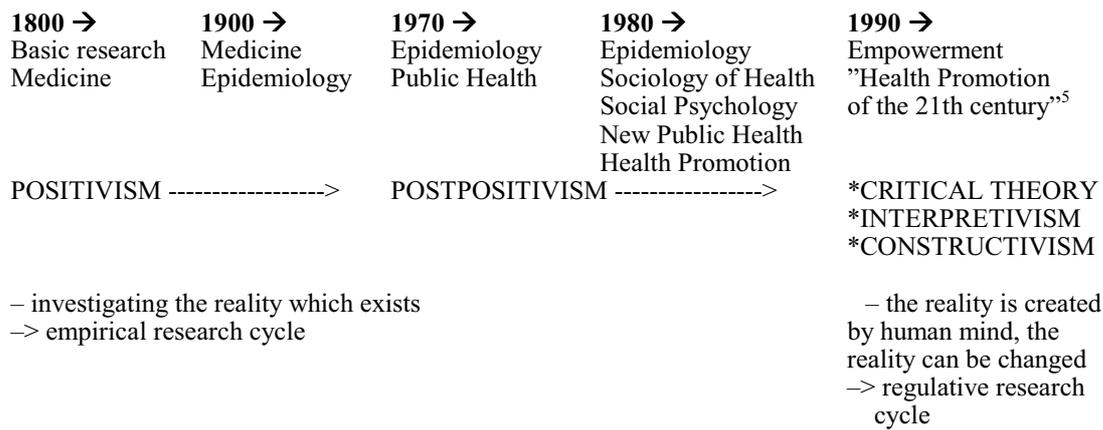


Figure 2. The sciences and paradigms of public health and health promotion

The controversy of the Healthy Village and Healthy Cities programmes lay in the fact that (when matters are considered from citizen participation and “control over health” perspectives) in these programmes the focus of the research was on a problem typical of post-modernism which cannot be measured with quantitative indicators only. For example, the Healthy Village Project aimed at building citizen participation and self-active health care (these dilemmas are created by human mind, not existing as granted), with also some kind of intervention planned for it. The results of the project were, however, measured with quantitative indicators which emphasized the health status indicators. Measurement of self-activity was made by calculating the percentage of participation – meaning, how many took part in the survey, attended the health checks prescribed etc.

Healthy Cities was in its nature rather a movement or a philosophy built around high level abstract concepts. Each pilot city was supposed to find its own methods and transform the philosophies into practice. Healthy City Philosophy emphasized a political action element. In Finland for instance, this was solved or interpreted by means of encouraging health related decision making and health debate in general, and also by the fact that in all decisions reached, health aspects had to be taken into account to a higher degree than before. There was even qualitative research to evaluate this aspect (Tarvainen-Pääkkönen et al. 1992) in Helsinki. Sense of community and participation

⁵ Macdonald (1991) speculates about health promotion’s legitimacy to be thought of as a discipline in its own rights. He notices that health promotion has been an area of a study bounded by federation of theories, perspectives and methods, the majority of which have been borrowed from other disciplines (acting as “feeder” disciplines). However, these approaches have been interpreted and reworked so that they – according to Macdonald – can be constituting a fundamental body of knowledge within health promotion. Macdonald refers to Kuhn (1970) and his theory of how disciplines develop through three different stages (pre-paradigm stage where several theories compete for dominance; period of normal science where one single paradigm emerges and gains acceptance; and a crisis stage where the paradigm is replaced by another) and claims that health promotion is in the stage where the feeder disciplines have competed for dominance but are now setting into a period of normal science characterized by limited theoretical roots and sources. Macdonald emphasizes, however, that health promotion is not only dependent on the feeder disciplines, but it also depends on the institutions that practice and teach it and the professionals in the field. Such being the case, health promotion theory development seems to be dependent on the practice. However, Labonte and Robertson (1996) argue that if health promotion is to be matured as a discipline, research-practice tensions should be reduced through “articulating better the theoretical and moral fits between our research paradigms of inquiry”. Through investigating several research issues drawn from several community based health promotion programmes, Labonte and Robertson concluded that constructivist paradigm would be the most relevant.

was encouraged by means of more extensive discussions, but the practical content of these concepts was not defined by the cities. Participation was shown in practice as an increase in self-care. And the opinions of clients were taken more into consideration as consumers of health care system (e.g. Rights of self-determination in health care and Law on patient rights). Research on participation was not carried out in the Healthy Cities experiments in Finland due to the fact that it was difficult to examine a phenomenon which was not precisely defined. The research methodology in the cities was still based on quantitative indicators. These were aimed at testing the 'city health' as defined by WHO (characteristics of healthy city, competent community).

As the challenge of the 90s was/is the people's control over health (included in the most advanced definitions of empowerment, e.g. Zimmerman and Rappaport 1988, Wallerstein 1992, Rissel 1994), a new kind of health promotion is required enclosing the growing project type action, which is consciously directed towards 'control over health' and 'community empowerment in health' in local settings and therefore also contains a political component. This is one of the factors *that differentiates participation from empowerment*: The purpose is to change the organization structure and develop a new form of operations to enable continuous citizen empowerment. The purpose is therefore not limited to changing individual (lay and professional) behaviour towards participation or to the strengthening of communities. The target of social changes includes also changing of the decision-making system regarding health matters and changing the community infrastructure to pave its way. The challenge lies in changing the existing infrastructure in such a way that participation in health decision making and its policy, as defined by empowerment, is possible.

However, the empowerment approach of the 90s and beyond is not only a political question, but also a methodological question, as stated above. The approach along the lines of the empowerment model requires qualitative and action research type methodology (critical science) (e.g. Starrin and Forsberg 1997). Data gathering should favour theme interviews, group interviews, participating and observing methods. Evaluation and research analyses should be directed along the paradigms of interpretivism, constructivism and hermeneutics in order to comprehend entities (e.g. Labonte and Robertson 1996).

Locality is required to a higher degree as empowerment cannot be directly transferred or applied from one community to another. Empowerment calls for commitment, readiness for internal growth and team work skills as well as patience to wait years for results. This sets new requirements also to the education of health care professionals. Project planning and management skills, together with a "coaching" role will be appreciated when directing efforts to a common objective – control over health and empowerment.

As a conclusion, it can be suggested that *Health Promotion of the 90s and beyond* is a process of building up empowerment in health, which requires:

- Action orientation
- Critical theory and social change
- Qualitative approaches in research
- "Verstehen" paradigms – interpretivism, constructivism – and naturalistic inquiry
- Local settings

The statements about health education presented by Minkler (1994b) fit nicely to the end of this chapter. This view is compatible with the vision on health promotion and empowering processes of the 21st century, too:

"...Start where the people are, because it reflects a respect for the rights of individuals and communities to affirm their own values and ways of living. Secondly, one should recognise and build on community strengths instead of only assessing the community needs. Thirdly, while we need to work closely with communities, to respect their capacities and rights to self determination, we must at the same time strive to live up to own ethical standards and those of our profession in not letting blind faith in the community prevent us from seeing and

acting on the paramount need for social justice. Fourth, high-level community participation must be fostered. Fifth, commitment is that one should not forget sense of humour about their work. Sixth, the role of political analysis and activism in health education must be recognized. Health problems and their solutions need to be re-framed in terms of their political, economic and social contexts. Think globally, act locally, foster individual and community empowerment and finally work for social justice.”
(Minkler 1994b)

II THEORETICAL PART – Elaboration of the empowerment approach

4 Introduction

This chapter describes the evolution of the key concepts of the study, i.e. participation and empowerment. A brief discussion is also included on the concepts related to community development/organizing and other aspects of community. The chapter ends up with a summary and conclusions on the main differences between the various concepts.

4.1 Participation

4.1.1 Defining participation

In the late 1960s citizen participation in community development emerged as a key issue in political science in USA. Arnstein said in 1969 that citizen participation effectively means the same thing as citizen power: the redistribution of power”, he maintained, “enables the have-not citizens, presently excluded from the political and economic processes to be deliberately included in the future. Citizen participation is a strategy by which the have-nots join in determining how information is shared, goals and policies are set, tax resources are allocated, programs are operated and benefits like contracts and patronages are parceled out.” Arnstein wanted to stress that participation without a redistribution of power is an empty and frustrating process for the powerless. He developed a typology (Figure 3) in which each rung corresponds to the extent of citizen power in determining the plan or programme.

The bottom rungs on this ladder describe the level of non-participation, where the real objective is not to enable people to participate in planning or conducting programmes, but to enable those in power to educate or cure the participants. Rungs 3 and 4 proceed to the level of “tokenism” that allows the have-nots to hear and to have a voice. However, they lack the power to ensure that their views will be heeded by the powerful. Placation is a higher level of tokenism where the ground rules allow the have-nots to advise, but retain for those in power the right to decide. The higher rungs involve degrees of decision-making as well. Partnership enables negotiation and engagement in trade-offs with traditional powerholders. The levels of delegated power and citizen control express the state where have-not citizens obtain the majority of decision-making seats, or full managerial power.

In the late 1970s the idea of 'citizen participation' was connected for the first time as a crucial part of the development of primary health care. The declaration of Primary Health Care at Alma Ata (WHO 1978) emphasized citizen participation as a value in itself and as a tool for promoting health in the community. Following the primary health care conference in Alma Ata, the concept of citizen participation became an established part of definitions of ‘health’ and health promotion in particular.

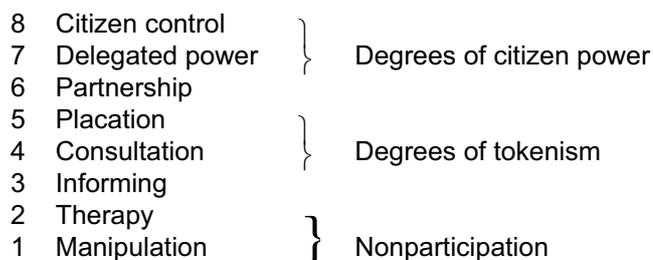


Figure 3. Eight Rungs on a Ladder of Citizen Participation (Arnstein 1969).

Härö 1987/WHO:

"Health is defined not merely as the absence of disease, but a state of balance between man and his physical and sociocultural environment. As the balance is a dynamic one, man has to play an active role in it. He can strengthen the balance by increasing his health potential or reserves, or by assuring optimal concordance between actions to meet his own needs and those to meet the needs imposed by his environment. In other words, man has to participate actively in all aspects and stages of health promotion, as he is at the same time subject and object in the process."

However, as it turned out, citizen participation remained little more than a popular catchphrase whose exact content was never precisely defined; it was used quite freely without any clear statement of its meaning (Brännström et al. 1994). The concept enjoyed something of a revival in connection with the concept of health promotion in the mid-1980s. The first international conference on health promotion in Ottawa 1986 presented a charter for action to achieve Health for All by the year 2000 and beyond (WHO 1986). Health promotion was defined as a process of enabling people to increase control over health.

Ottawa Charter (WHO 1986a):

"Health promotion is the process of enabling people to increase control over, and to improve, their health. This perspective is derived from a conception of Health as the extent to which an individual or group is able, on the other hand to charge or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living; it is positive concept emphasizing social and personal resources, as well as physical capacities."

One of the key strategies identified for the pursuit of the targets of the HFA 2000 programme was the 'strengthening of community action'. Empowerment of communities, their ownership and control of their own endeavours and destinies was considered to lie at the heart of the development process in promoting health. Health education was considered an important tool for gaining control over health:

Dhillon and Tolsma (1992):

"Health education is the combination of planned social actions and learning experience to enable people to gain control over the determinants of health and health behaviours, and the conditions that affect their health status and the health status of others."

However, as is clear from this definition, participation was still considered in individualistic terms, as aimed at gaining control over the health of an individual. At the same time, the underlying approach was still firmly anchored to the medical model of health care. The intention was to enable others, to impose measures on people according to experts' instructions. The implication is that health-enhancing activities are not initiated by the individual him- or herself but by somebody else.

Brännström et al. (1994) carried out a literature search covering the period from 1966 to 1988 in two databases, Medline and SOCA, using the key words "community involvement" and "community participation". They found that the concepts were mainly used during the latter half of the period reviewed and that the concepts were used interchangeably, with no statement as to their precise meaning. Comparison of the two databases showed that "citizen participation" was used more frequently in Medline, whereas in Soca the majority of the papers referred to "community involvement".

Researchers remained disagreed over how the concept of participation/involvement should be defined. Oakley (1989) observed in a literature review that there was still no consensus of opinion as to whether participation essentially was a process, a programme, a technique or a methodology. The terms reflect the differences in the approaches used in examining the concept.

The term participation, according to Oakley (1989), has a wide range of meanings. He refers to the WHO definition (Fonaroff 1983) where participation is seen as part of a planning procedure:

"Community involvement in health development is a process by which partnership is established between the government and local communities in the planning, implementation and utilization of health activities in order to benefit from increased local self-reliance and social control over the infrastructure and technology of primary health care."

Proceeding from this platform Oakley goes on to argue that participation means:

- * ...in its broadest sense to sensitize people and thus increase the receptivity and ability of people to respond to development programmes, as well as to encourage local initiatives.
- * with regard to development ... participation includes people's involvement in decision-making processes, in implementing programmes... their sharing in the benefits of development programmes and their involvement in efforts to evaluate such programmes.
- * participation involves... organized efforts to increase control over resources and regulative institutions in given social situations on the part of groups or movements of those hitherto excluded from such control."

Oakley also makes a distinction between participation as a means and as an end. If participation is seen as a means of achieving a set objective or goal, the results of the participation are more important than the act of participation. It is a management technique intended to benefit both provider and consumer, where the nature of participation is passive, static and a temporary feature. This is an ultimately controllable form of participation and is commonly found in rural development programmes.

Participation can also be seen as an end in itself. In this case participation is in essence a dynamic process, unquantifiable and essentially unpredictable. The process unfolds according to the participants' needs and the changing situation. This kind of participation is longlasting and usually starts in situations where a change is needed.

It is also possible to distinguish between different stages of participation. Participation is 'marginal' when it is limited and transitory and when the people involved have only little direct influence on the outcome of the development activity. Participation is 'substantial' when people are actively involved in determining priorities and carrying out activities, even if the mechanism for the activities is externally controlled. However, the substance of participation is limited to the benefits of the project activities. Participation can be described as 'structural' (the ultimate stage of participation) when it becomes an integral component of the project and an ideological basis for all project activities. People play an active and direct part in the development process and have the power to ensure that their opinions are heeded.

Participation may also be considered from the standpoint of how it was initiated: Participation is 'spontaneous' when it is based on local initiatives which have little or no external support and which from the very outset have the capacity to be self-sustaining. Participation is 'induced' when it starts through external initiatives which seek support or endorsement from the participants for these external plans or projects. Finally, participation is 'compulsory' when people are mobilized or organized willy-nilly to undertake activities in which they have had no say and over which they have no control.

Further, the concept of participation may be characterized on the basis of whether it seeks cooperation (the participants have the right to receive information, to submit protests, to make suggestions and to be consulted before final decisions are taken) or whether it is power-sharing (the participants are conceded a share in formal power, varying from the right to impose temporary or permanent vetoes to the right to participate directly in decision-making).

In 1986 Green set out to elaborate a theory of participation through a qualitative analysis of expressions of participation in national and international health policies in relation to primary health care. He discovered that the new policies had shifted the emphasis from participation in implementing to participation in planning; from centralized to decentralized planning and policies; from categorical to comprehensive programmes; from singular to diverse objectives; from changing behaviour to developing behaviour; from building motivation and skills in support of existing programmes or

services to building self-awareness, community involvement, and a variety of organizational, economic, and environmental supports for behaviour conducive to health.

The shift in policies described by Green had a major impact on further thinking within health education, which was seen as a tool for achieving control over health. The health education implied by the new policies described above had a three-fold role: predisposing (the initial comprehensive, consciousness-raising role), enabling (increasing awareness and strengthening skills to assess and use existing programmes and services), and reinforcing health education, the aim of which was to increase self-reliance, self-care, and independent functioning of individual lifestyle and community development in support of behaviour conducive to health.

Green's theory of participation is a model summarized in a figure which he labelled as "Steps requiring participation (decentralized functions), and the role of health education to achieve community development, application of appropriate technologies, evaluation, multisectoral coordination, and increased self-reliance".

As far as I can judge, however, Green's theory is a traditional multi-phase planning process with community representation. The model speaks of community actions but does not specify what is meant by 'community' or 'actions'. It provides useful tools for purposes of describing the concept of citizen participation, but it fails to fully describe the means with which citizen control over health or empowerment could be created. (Therefore it cannot be adopted as such as a frame of reference for this study.)

Green concluded his paper by setting out the following hypotheses for testing in future research: Increased level of active participation in the planning, implementation, and evaluation of health programmes or activities increases people's effective adaptation to their needs for health protection or health enhancement; Increased consensus in relation to priorities among competing needs or opportunities for health protection or health enhancement increases effective adaptation; Both active participation and consensus will increase as people receive more education and training in recognizing and assessing their needs and opportunities in health protection or health enhancement; Increased control exercised by people over decisions concerning the implementation of programmes, services or activities increases effective adaptation of the services and the people to their needs for health protection and health enhancement; Greater control will be exercised as people receive health education designed to enable them to exercise control, especially in relation to community institutions; As people receive feedback on their progress or success in achieving the goals or solving the problems they identified as their priorities, they will be more effective in their adaptation to their needs for health protection or health enhancement; Feedback will reinforce the predispositions of people to participate actively in efforts to identify needs, to set priorities, to exercise control and to evaluate programmes, services or activities related to their needs for health protection or health enhancement.

However, this set of hypotheses by Green implies an understanding of participation as characteristics of people's behaviour that shall be enhanced through health education implemented by health professionals. Furthermore, Green assumes that participation serves as a catalyst in a process leading to control over health.

Brownlea (1987) connects participation as a way of broadening the range of inputs to decision-making

participation means getting involved or being allowed to become involved in a decision-making process or the delivery of a service or the evaluation of a service, or even simply to become one of a number of people consulted on an issue or a matter.

However, Brownlea pessimistically continues, participation in decision-making may in fact represent a kind of tokenism. The input may be received but very quickly discarded as of little or no consequence. The motions have been gone through, the democratic ideal has been observed, but there is little power behind the participant's input. The participant cannot take it any further because there are resistances, impediments, a disinclination on the part of some, and no real access to the decision

arena. Even though people are participants, they may still largely be observers; they are in the game, but they are more like reserves than players.

Brownlea argues that the structures organized to carry out and facilitate participatory input are sometimes difficult to understand from the participant's perspective, but they are very easily managed from the other side. The complexity of the structure may be such that the participant is only aware of a very small part of the game.

Participation, if not invited, requires penetration. This requires a different knowledge resource: how to get into the system, who are the critical people and where are they located, how can pressure be brought to bear so that information, insights and feelings can be put into the appropriate arena and get onto the right agendas. Penetration requires knowledge of the structure of the system, its component parts, especially its committees, and the relationships between these components and committees, and how information and decisions are cycled and recycled amongst them. There is a range of practical skills and knowledge that individuals and communities need to have as a key resource for participation.

Brownlea emphasizes a key issue, i.e. that of challenging the existing power structures and acceptable role models for doctors, clients, bureaucrats and politicians. Professional mystique is no longer an adequate power base for professionals, Brownlea says: "Increasing community knowledge and awareness in health-care matters, political decision-making processes, the realities of what health care can achieve, and competitive models of health care, have placed within some communities a strong platform from which to challenge the existing medical and health-care status quo".

The political will in society has to be behind participation, so that appropriate structures and relationships can be set up to give people at the grass-roots level access to their key resources: power, knowledge, and skills.

Zimmerman and Rappaport (1988) broaden the focus of participation beyond decision-making:

Citizen participation is broadly defined as involvement in any organized activity in which the individual participates without pay in order to achieve a common goal. This includes involvement in government-mandated advisory boards, voluntary organizations, mutual-help groups, and community service activities.

According to WHO community involvement (= community participation) can be assessed by the level of involvement and the degree of decentralization in decision-making as well as the development of effective mechanisms for expression of people's needs and demands.

Rifkin et al. (1988) suggest a definition of community participation that takes into account the geographic, common interests and epidemiological meanings as well as the characteristics of participation common to all perceptions of the concept: participation must be active, it must involve a choice, and the choice must have the possibility of being effective. The definition emphasizes community and sees participation as a developmental process:

Community participation is a social process whereby specific groups with shared needs living in a defined geographic area actively pursue identification of their needs, take decisions and establish mechanisms to meet these needs (Rifkin et al.1988).

Bracht and Tsouros (1990) make a distinction between individual citizen and community participation where

Citizen participation refers to the social process of taking part (voluntarily) in either formal or informal activities, programmes and/or discussions to bring about a planned change or improvement in community life, services and/or resources (Bracht and Tsouros 1990, Bracht 1991). Whereas **Community participation** is the process by which individuals and families assume responsibility for their own health and welfare and for those of the community, and develop the capacity to contribute to their and the community's development (WHO/Alma Ata 1978, Bracht and Tsouros 1990).

Bracht and Tsouros (1990) conclude that it is not possible to offer any unique model for citizen participation, but the processes and activities leading to and maintaining participation are generalizable.

Hunt (1990) regards the needs of the community and their fulfilment as the key elements of participation and says that

issues of having people define their own needs; helping people to find and implement their own solutions; cultural invasion versus cultural synthesis; are essential in the conceptualization of **community participation** and are the rocks upon which projects either founder or find fundamental support.

Hunt concludes, however, that professional attitudes and behaviour and bureaucratic structures are significant barriers to public participation in health. Fundamental changes in the state of the public health are blocked by a medical model which emphasizes individual responsibility and treatment. Hunt argues that the public should retain 'ownership' of the problems they define and the solutions to those problems. Professionals need to share their skills, rather than impose them, and learn, in their turn, about the world inhabited by disadvantaged groups.

In a discussion of methodological considerations related to community programmes for citizen mobilization, Brännstöm et al. (1994) suggest that 'community participation – community involvement' be defined as:

"A social process which occurs in a defined geographical area, where citizens approach their health needs through active participation in practice as well as by taking part in the making of decisions about local health policy matters."

4.1.2 Measuring participation in earlier studies

Rifkin et al. (1988) were concerned in their study to find ways in which to measure two major principles of primary health care, i.e. equity and participation. With their main accent on the assessment of participation, the team developed a methodology to define indicators for participation in health care programmes. Their so-called spider-model involved five factors – needs assessment, leadership, organization, resource mobilization and management – influencing community participation. For each factor, Rifkin et al. generated a continuum with wide participation at one end and narrow at the other. The continuum was divided into a series of points, which described the level of participation in the health programme concerned.

Rifkin et al. stressed, however, that the process indicators were not used to quantify or standardize changes in participation and they did not shed any light on whether community participation was better or worse. The main contribution of this model was that it highlighted differences in community participation in a health programme over time and among different people. It also served as a point of departure for discussions about community participation, which was expected to help the actors in the programmes understand the process better and to help achieve better results by allowing for greater involvement.

According to Bracht (1991) it is possible to measure the results of citizen involvement or participation. The same goes for the variables associated with participation itself, which include: opportunity for and level of decision-making or advising; amount and duration of time devoted to goal-directed activities; representativeness of the citizen and leader groups that are formed; degree of social ownership perceived and/or achieved; satisfaction with the processes of participation; and assessment of achievement and long-term maintenance of goals.

Bracht points out that citizen participation can be taken as a dependent variable when the causes of participation are identified; or as an independent variable when the focus of analysis is on the consequences of participation. Furthermore, Bracht notes that there are distinct urban and rural forms of social change and creativity. Complex urban environments often develop more formal avenues and infrastructures through which

citizen involvement is mediated and realized. Rural villages or small towns more frequently have informal, ad hoc approaches. In conclusion, Bracht proposes structural models – coalitions, leadership board or councils, lead agencies, grassroots groups, citizen panels, and networks – for implementing and enabling citizen participation.

Brännström et al. (1994) say that the most promising approach to investigating citizen participation is Gaventa's (1980) theoretical framework, which comprises three power dimensions: i) The first is a pluralistic approach to studying the visible consequences of power, e.g. observable conflicts in decision-making (who participates, who gains, and who loses. ii) The second dimension is "power's second face", which is a managerial approach to examining how the organizational structure of society excludes certain individuals and groups from participating in community life and prevents certain questions from ever getting on to the political agenda (Bachrach and Baratz 1970). iii) The third dimensional view, power as ideology, developed by Lukes (1974), focuses on the means, e.g. language, symbols, social myths and norms, which shape, legitimize, and determine patterns of participation, not least among the relatively powerless.

The framework suggested by Brännström et al. (1994) for the assessment of outcomes of health interventions is based on a multi-method research approach. The purpose is to study community participation as a dynamic process from different points of view, using longitudinal process evaluation with qualitative and quantitative methods. The authors make a distinction between four perspectives: i) community participation study (participation, non-participation, control, initiative, and influence on local health policy and practice); ii) socio-epidemiological study (self-reported health, knowledge and attitudes about health, risk factor changes, social stratification); iii) key informants study (understanding the interaction within the community and among health professionals and decision-makers; the structural conditions of community participation connected with power, influence, and latent and manifest conflicts at the level of health and politics; attitudes and knowledge among the power-holders; conflicts in decision-making; visible and invisible in the mass media and iv) social, cultural and political description (which societal mechanisms create and reproduce poverty and low participation within certain groups; social landscape, community structure, and cultural patterns).

Stone (1992) has looked at the changes in the way that the role of culture has been analysed in relation to community health issues and particularly in relation to community participation. A review of the most recent perspectives showed that the fate of community health programmes had come to be seen as relying more on structural factors in health care systems than on cultural factors within local communities. There has also been an increasing emphasis on political factors or power relationships within and between health agencies, governments, and various levels of national health care systems. Stone claims that the new trends in accounting for success or failure in community health programmes include a greater emphasis on structural factors in health programmes than on community cultural variables, and also an increasing emphasis on political factors or power relationships.

The period of 1940–50 was, according to Stone, an optimistic era in which development, including health development, was defined as a set of problems easily overcome by the introduction of Western knowledge and technology. Local culture was considered irrelevant to the development process. This approach failed. Increasing knowledge about the complexities of international development led to a new era marked by phrases such as 'basic needs', new directions, felt needs, reaching the poor. This period extended to the late 1970s. Moreover, community participation loomed as an essential development strategy.

With regard to health development and PHC in particular, there were somewhat different views on the role of culture during this period, states Stone. One view, held by planners and health project personnel, saw culture as a set of beliefs and customs, which were potential obstacles to the introduction of new health measures and ideas. A second view, sponsored primarily by social scientists, saw culture in the realm of health as local

knowledge on the one hand, and local strategies for securing health care, on the other. Both groups, however, tended to regard local culture as fairly static.

These two views carried different implications for health interventions and for the notion of community participation. The first, 'culture as obstacle' view stressed that a particular culture needed to be understood so that a health programme could be designed in such a way that local people would be more likely to accept it. Central to this view was the notion of the superiority of modern medicine. As far as professionals and experts were concerned, local beliefs were largely 'wrong'.

The second view of culture focused on local knowledge and health care strategies. Culture was seen as a much broader ideological and behavioural context within which the old and new of health care should be integrated. In this perspective culture was viewed as a potential resource for health development. This approach was also seen as automatically promoting community participation.

The results of the research conducted in the communities have now stimulated new thinking about the role and power of culture in both health programmes and community participation.

Stone refers to Rifkin et al. (1988) and says that the projects need to specify realistically the level of participation they are aiming for rather than to phrase programme objectives in terms of vague concepts and ideas.

Rissel et al. (1995) analysed factors which explain the amount of participation in task forces (as coalitions, definition by Butterfoss et al. 1993) and conclude that the more time the participants devote to task forces, the greater the investment in and ownership of the task forces, and the greater the capacity to mobilize resources to achieve programme objectives. Furthermore, they recommend that task forces and coalitions should be organized to maximize the sense of control and ownership of members. In addition, members should agree with the direction of the task force, which might increase satisfaction with the task force and lead to increased participation. Another discovery was that to be effective, it may be necessary to recruit community members who have lived in the community concerned most of their lives in order to streamline task force efforts.

4.2 Empowerment

Questions of empowerment – what it is, how it develops, under what conditions it occurs, how empowerment at one level of analysis influences the other, etc. – have preoccupied researchers in a number of different fields, including social psychology, education, social science, social anthropology and public health. The concept of empowerment can be traced back to feminist and civil rights movements (Solomon 1976, Riger 1981, Swift and Levin 1987), to the social action ideology of the 1960s (Alinsky 1971), to the self-help perspectives of the 1970s (Gutierrez 1990, Gibson 1991, Eng et al. 1992, Wallerstein 1992, Rissel 1994), and to adult education philosophies (Freire 1970, 1973, 1996). In the 1980s the concept was promoted further as a principal theory of community psychology (e.g. Rappaport 1981, 1985, 1987, Rappaport et al. 1984, Zimmermann and Rappaport 1988, Chavis and Wandersman 1990). Empowerment became important for community psychology because it acknowledged the person as a citizen within a political as well as a social environment. In the 1990s the idea of empowerment can be seen as part of a growing general movement towards greater citizen control in many areas of life: medicine, health education, self-help movement, the physical environment, nursing homes, etc. (e.g. Israel et al. 1994, Rissel 1994, Forsberg and Starrin 1997a, 1997b).

In spite of extensive research that has been going on for several years now, we still have no clear definition or operationalization of the concept of empowerment. This applies most particularly to the field of public health/health promotion. The absence of a unique theory and definition goes a long way towards explaining why empowerment has

often been discussed but not quantified or measured. Rappaport (1987), however, argues that because it is dependent on the context, empowerment cannot in fact be measured but only considered in each case. Rissel (1994) claims that the difficulties in developing and applying empowerment theory in health promotion derive mainly from the lack of clarity regarding the focus of empowerment (e.g. Tones 1984, 1992). The lack of a clearly defined concept also contributed to misuse of the term (Grace 1991).

4.2.1 *Early practices of empowerment development*

The main intellectual and practical foundation for the development of empowerment is provided by the work of Alinsky (1971), Freire (1970, 1973), and Rothman (1971). The thread that ties together their theorizing on empowerment is the common process of personal development, participation, consciousness-raising, and social action.

Alinsky's (1971) approach to community organization and change was based on the view of low-income community as powerless and disenfranchised in relation to the "haves" and society as a whole. The goal was to facilitate a process whereby people coming together around a shared interest or concern could collectively identify and freeze targets, garner resources, mobilize an action campaign, and consequently help realign power within the community. Alinsky believed that community organizing must of necessity increase the problem-solving capacity of the community. The key ingredient of his philosophy was the fostering of indigenous leadership. The accent was on local leadership and capacity building. Furthermore, Alinsky emphasized that the outside organizer must maintain a low profile, and at the point that the outside change agent has to withdraw, he/she must ensure the continuity and the development of indigenous leadership.

In his theory of *critical consciousness* Freire (1970) set forth a view of man as an incomplete being whose vocation is to become fully human, reflecting critically on objective reality and taking action based on that reflection in order to transform his or her world. A fundamental distinction was made between the oppressed and the oppressors in society. The dialogical method upon which *conscientization*, or education of critical consciousness is based, involves oppressed groups of individuals in a process of: 1. reflecting upon aspects of their reality (e.g. health problems), 2. looking behind these immediate problems to their root causes, 3. examining the implications and consequences of these issues, and finally, 4. developing a plan of action to deal with the problems collectively identified. Freire emphasizes the elimination of asymmetrical, paternalistic aspects of the leader's role in the learning process. This is the key factor which distinguishes his methodology from the approaches of Alinsky (1971) and other social action theorists. The leader's role in facilitating conscientization is to ask questions of the group which help the trainees to see the world not as a static reality, but as a limiting situation which challenges them to transform it. The "leader" (e.g. Project Manager, Local Project Secretary, or Trainer) must clearly exhibit leadership abilities in guiding the discussion, asking appropriate questions and facilitating the emergence of a realistic plan of action. Wallerstein and Bernstein (1988) claim that community organizing has differed from empowering education in its emphasis on winnable goals rather than on a participatory process that engages people in critical analysis of root causes as the basis for social action.

According to Freire facilitators must follow a series of steps: tuning into the vocabulary of the people through a process of participant observation and where possible, living with the people over an extended period of time; working with small groups initially in searching for generative themes – key words suggestive of the hopes and concerns of the people; synthesizing the ideas of the people and codifying them in visual images, e.g. pictures and symbols; and giving these symbols and images back to the people for decoding through "cultural circles" – groups of people who, with a coordinator-questioner, look at the causes, consequences, and possible solutions of the

problems and generative themes they have identified. Freire stresses that full participation of the people through dialoguing and other similar means is essential to effective liberation and change.

Minkler and Cox (1980), who looked at applications of Freire's methodology in health care settings, suggest that "functional" (common interest) communities may constitute appropriate units that could benefit from a dialogical problem-solving methodology. The value of conscientizing around functional rather than geographic community lines should therefore be considered in efforts to apply this approach in highly urbanized and technologically advanced Western nations.

According to Minkler and Cox (1980) the philosophy and approach of Freire appear in retrospect to share with sound health education and community organization a commitment to start with the concerns of the people. By focusing on the root causes of these concerns, and helping people, through praxis, develop a plan of action for dealing with these fundamental issues, the methodology becomes revolutionary rather than reformist in character. It concentrates on helping people change the structure of society rather than simply integrating them more successfully into the existing structure. Furthermore, Minkler and Cox see Freire's theory both as an organizing tool for social change and as a revolutionary approach to improved health care.

In 1992 Minkler concluded from her Tenderloin experiment that the Freirian approach is most useful when applied in a flexible and adaptive manner in conjunction with other situationally determined techniques and methods. For instance, the codifying/decodifying stages of the Freire process, as indeed all steps in the process, must be weighed and used, adapted and omitted, according to the cultural and other realities of the group or community in concern.

Wallerstein and Sanchez-Merki (1994) demonstrated in a study on two experimental programmes that a Freirian approach can be integrated with individual cognitive change theories to create programmes directed at both individual and community change. The authors' three-stage model of change suggests that people engaged in Freirian programmes can evolve beyond powerlessness to create a sense of empowerment – that they can make a difference in their worlds.

4.2.2 Defining the concept of empowerment

The concept of empowerment was first introduced by Rappaport at the beginning of the 1980s in the field of social psychology. According to Rappaport (1981)

Empowerment means aiming at enhancing the possibilities for people to control their own lives.

The message here was essentially the same as that included in the definition of Health Promotion in Ottawa in 1986. According to the WHO (1986a):

Health promotion is the process of enabling people to increase control over, and to improve their health.

The word *empowerment* derives from the same Latin words as "power" and "freedom". Hence, if power is the ability to predict, control, and participate in one's environment (see e.g. Pinderhughes 1983), then empowerment is the process by which individuals and communities are enabled to take such power and act effectively in changing their lives and their environment (Minkler 1992, Robertson and Minkler 1994). This means that the core notion of empowerment is the concept of power. Gutierrez (1990) stated that empowerment theory is based on a conflict model which assumes that a society consists of separate groups possessing different levels of power and control over resources (see Bachrach and Baratz 1970), and power is a non-material resource differentially distributed in the society.

The new health promotion movement emphasizes that power must not be reframed as "power over", but rather as "power to" or "power with" (French 1986, O'Neill 1992).

The relationship between professionals and lay people/individuals or communities must be seen as partnership rather than as a traditional hierarchic provider/ client relationship.

In 1985 Rappaport concluded that it is very difficult to define empowerment in positive terms or terms of outcome because it includes psychological and political components. Empowerment is not consistent with any particular goal or political view. However, empowerment is easy to recognize when you see it happen; it is easy to intuit. The absence of empowerment is also easy to recognize: powerlessness, learned helplessness, alienation, loss of a sense of control over one's life could be the terms with which to conceptualize the status of lack of empowerment. Empowerment often assumes different forms in different people and contexts. Consequently the terms of empowerment will look different in its manifest content for different people, organizations and settings. (Rappaport 1985, Rappaport 1987).

The psychological dimension of empowerment appears in Rappaport's writings for the first time in the mid-80s (Rappaport 1985). Psychological empowerment logically includes beliefs about one's competence and efficacy as well as one's involvement in activities for exerting control in the social and political environment. The construct assumes a proactive approach to life, a psychological sense of efficacy and control, self-and political efficacy, perceived competence, locus of control and self-esteem as well as socio-political activity, and organizational involvement. Rappaport (1985) suggests that

Empowerment is a sense of control over one's life in personality, cognition, and motivation. It expresses itself at the level of feelings, at the level of ideas about self-worth, at the level of being able to make a difference in the world around us, and even at the level of something more akin to the spiritual. It is a process ability, which we all have but which needs to be released.

An empowered person is also thought to be one who can critically analyse the social and political environment. This enables people to make choices so that they can effectively engage in conflict and change. Consequently, according to Rappaport (1985),

Psychological empowerment may be seen as both a feeling of perceived control and the critical awareness of knowing when to confront powerful others and when to avoid them.

This definition has evolved since 1985 and now includes the idea that empowerment must come from within a group and cannot be given to a group or community. Furthermore, empowerment cannot be given, it must be taken; groups and individuals can only empower themselves. The professional's role is to nurture this process and to remove obstacles, the first being the professional's own need to define health problems for the community. (Rappaport 1985, Labonte 1989a, Hunt 1990). This idea is compatible with Green's (1986) views on the new role of health education, which should be to facilitate grassroots participation in the first place. Participation acts as catalyst in the process towards empowerment.

Rappaport observes that "people can only empower themselves". However, there are examples of interventions where empowerment is built up gradually, in an educational development process (e.g. Freire 1970). Gruber and Trickett (1987), however, point out that there is a fundamental paradox in the idea of people empowering others, because the very institutional structure that puts one group in a position to empower also works to undermine the act of empowerment. Gruber and Trickett emphasize the importance of the personal variable – locus of control – as a proxy for an individual sense of empowerment, of feeling capable of acting positively on one's environment and shaping one's future. Increasing choices or options have a meaningful role in this process of empowering people. However, Gruber and Trickett did not investigate empowerment as a phenomenon as such; they did not try to induce empowerment through an intervention, for instance. Instead, their main concern was to investigate the prerequisites for the development of empowerment, such as organizational structures. The existence of the phenomenon of empowerment was taken for granted.

Both Torre (1986) and, one year later, Rappaport (1987) characterized empowerment as a process aimed at helping people as individuals to cope with the complex world:

Empowerment is a **process** through which people become strong enough to participate within, share in the control of and influence, events and institutions affecting their lives. (Torre 1986)

Empowerment is a **process**, a mechanism by which people, organizations, and communities gain mastery over their affairs (Rappaport 1987).

According to Rappaport empowerment has a two-fold function. First of all it serves as an individual's determination over one's own life and secondly, it is a means for democratic participation in the life of one's community through mediating structures.

Random House Dictionary (1980) defines empowerment as "giving power or authority to, authorize, or to enable or permit"; and the Oxford Dictionary (1980) says it "includes the sense of investment with legal power, and the sense that persons or settings may be empowered for some specific goal or purpose". Empowerment thus refers to the process of becoming able or allowed to do some unspecified thing because there is a condition of dominion or authority with regard to that specific thing (Rappaport 1987) as opposed to all other things. This means that there are limitations as well as powers.

As early as 1987 Swift and Levin made the important distinction between the subjective experience of psychological empowerment and the objective reality of modified structural conditions for the purpose of reallocating resources. Zimmerman and Rappaport (1988) developed the concept of empowerment further and stated that empowerment can be considered as a multilevel construct that may be applied to organizations, communities, and social policies. They also observed that there is little evidence on this construct that has been verified through research. Psychological empowerment is the expression of this construct at the individual level.

Empowerment is a construct that links individual strengths and competencies, natural helping systems, and proactive behaviours to matters of social policy and social change. It is a process by which individuals gain mastery or control over their own lives and democratic participation in the life of their community (Zimmerman and Rappaport 1988).

The individual experience of empowerment is expected to include a combination of self-acceptance and self-confidence, social and political understanding, and the ability to play an assertive role in controlling resources and decisions in one's community. One way to develop a sense of psychological empowerment is to become involved in decisions that affect community life. According to Zimmermann and Rappaport (1988):

Psychological empowerment is the expression of this construct at individual level. Its elements are perceived efficacy, self-esteem, a sense of causal importance. Psychological empowerment is the connection between a sense of personal competence, a desire for, and a willingness to take action in the public domain.

The broader empowerment includes self and political efficacy, perceived competence, locus of control, and desire for control.

Psychological empowerment, then, refers to the individual level of analysis, but does not ignore ecological and cultural influences (Zimmerman 1990b). Psychological empowerment is a contextually oriented conception of empowerment that embraces the notion of person-environment fit. It includes collective action, skill development, and cultural awareness, and it incorporates intrapsychic variables such as motivation to control, locus of control, and self-efficacy.

Wallerstein (1992) says that in the public health field empowerment had been mostly defined by its absence, as powerlessness, but that in recent years a new range of usage had appeared. According to Wallerstein, in its broadest sense:

Empowerment is a **multi-level construct** that involves people assuming control and mastery over their lives in the context of their social and political environment; they gain sense of control and purposefulness to exert political power as they participate in the democratic life of their community for social change (Wallerstein 1992).

Consequently empowerment cannot be seen only as an individual phenomenon, but it must also be investigated in connection with the social setting in which it appears. This implies studying not only individual change, but also change in the social setting itself (Wallerstein 1992). Unfortunately the most common use of the term empowerment in public health has focused on change at the individual level. Although psychological empowerment is still an individual level of analysis, it is embedded in participation in the socio-political context. (Zimmerman 1990b)

Israel et al. (1994) provide a definition of community empowerment that includes individual, organizational and community levels of analysis. They describe how empowerment fits in with a broader conceptual model of stress, look at its relationship to health status, and examine a series of scales that measure perceptions of individual, organizational, community, and multiple levels of control. According to Israel et al.:

Psychological empowerment refers to an individual's ability to make decisions and have control over his or her personal life. In addition psychological empowerment incorporates the establishment of a critical or analytical understanding of the social and political context, and the cultivation of both individual and collective resources and skills for social action. (Kieffer 1984.) Thus empowerment at the individual level combines (1) personal efficacy and competence, (2) a sense of mastery and control, and (3) a process of participation in influence institutions and decisions (Zimmerman 1990b). Empowerment at the individual level is linked with the organizational and community levels through the development of personal control and competence to act, social support, and the development of interpersonal, social and political skills (Kieffer 1984).

An empowered community is one in which individuals and organizations apply their skills and resources in collective efforts to meet their respective needs. An empowered community has the ability to influence decisions and changes in the larger social system. For empowerment to be a meaningful concept, distinct from others such as self-esteem and self-efficacy, the cultural, historical, social, economic, and political context in which the individual exists must be recognized.

Community empowerment has been broadly discussed within the community psychology field. In this orientation the word refers to communities achieving equity of resources (see Katz in Rappaport et al. 1984); communities identifying their own problems and solutions (Braithwaite and Lythcott 1989, Hunt 1990); increasing participation in community activities leading to improved neighbourhoods, a stronger sense of community, and personal and political efficacy (Chavis and Wandersman 1990, Florin and Wandersman 1990); and developing a participatory social action model to increase the effectiveness of natural helping systems and supporting proactive behaviours for social change (Rappaport 1981). All these elements come close to the idea and definition of health promotion introduced in Ottawa in 1986 (WHO 1986a).

Rissel (1994) proposed several assertions about the definition, components, process, and outcome of 'empowerment', including the need for a distinction between psychological and community empowerment. He also put forward a model of community empowerment (see Braithwaite and Lythcott 1989, Breslow 1992). Rissel's definitions are as follows:

Psychological empowerment can be defined as a feeling of greater control over their own lives which individuals experience following active membership in groups of organizations (through group membership), and may occur without participation in political collective action.

Community empowerment includes a raised level of psychological empowerment among its members, a political action component in which members have actively participated, and the achievement of some redistribution of resources or decision making favourable to the community or group in question.

The above definition of community empowerment means that control over resources is redistributed, which might further mean that some people gain at the expense of others. It might be expected that groups with actual control over resources have a high level of reported psychological empowerment, although the reverse is not true. Groups

with high levels of reported psychological empowerment may not have much control over resources.

4.2.3 Theories of empowerment as a process

Kieffer (1984) studied a small number of participants in grassroots community organizations and suggested that at the individual level of analysis the process of empowerment passes through several phases. This was an exploratory study of the emergence of individual activists in citizen organizations who had succeeded in increasing their real and self-perceived sense of participatory competence. The research sought to illuminate the patterns and processes of transition from powerlessness to socio-political empowerment. Empowerment was conceptualized as an interactive and highly subjective relationship of individuals and their environment. The starting-point in Kieffer's study is powerlessness (Seeman 1959) or psychological conception of alienation (Stokols 1975), or the "role of object" and oppression as expressed by Freire (1970). The sense of powerlessness is viewed as a construction of continuous inter-action between the person and his/her environment. It combines the attitude of self-blame, a sense of generalized distrust, a feeling of alienation from resources for social influence, an experience of disenfranchisement and economic vulnerability, and a sense of hopelessness in socio-political struggle (Kieffer 1984).

There are four distinct and progressive phases of involvement as these individuals construct the skills and the insights which constitute a fully matured attainment of participatory competence: *era of entry* (characteristics: powerlessness, sense of integrity, rootedness, feelings of attachment, and support within a caring community of peers, experience of injustice), *era of advancement* (centrality of mentoring relationships, more critical understanding of social and political relations), *era of incorporation* (developed self-concept, increased strategic ability, and matured critical comprehension, improved organizing and leadership skills, and constructed survival skills), and *era of commitment* (application of new abilities to the reality and structure of every-day life-worlds, commitment to adapting recent empowerment to continuing proactive community mobilization and leadership).

Kieffer identifies two themes which underlie the movement through all phases of the development continuum: Firstly, the function of a continuing internal "constructive dialogue" or the maintenance of the creative force of internal contradiction, and the fundamental internal perception of dissonance. Secondly, she points out that conflict and growth are inextricably intertwined. It is also essential that there are constructive channels and supportive resources for resolving these continuing internal confrontations. In addition to this function of constructive conflict is the essential contribution of the dynamics of praxis. *Praxis* refers to the circular relationship of experience and reflection through which actions evoke new understandings, which then provoke new actions. Experience, then, is at the core of empowering learning. The building up of skills only progresses through repetitive cycles of action and reflection. In other words, crucial for the building up of empowerment are time and practice.

Kieffer sees empowerment as consisting in the development of empowering skills and the attainment of participatory competence. This state of being and ability incorporates three major intersecting aspects: 1) development of a more positive self-concept, or sense of self-competence, 2) construction of more critical or analytical understanding of the surrounding social and political environment, and 3) cultivation of individual and collective resources for social and political action. These are inter-connected elements. A fully established attainment of empowerment implies attainment of extensive and abiding competence in each of these areas.

Swift and Levin (1987) make a distinction between three stages in the empowerment process. At the first level people reach some critical consciousness of their *powerlessness*. At the second level people feel strongly about this inequity, and through

social interaction begin to feel comradeship with like-minded persons. At the third level of the empowerment process the like-minded group then engage in deliberate action addressed at changing the social conditions creating the powerlessness. All three stages are needed for community empowerment.

Jackson et al. (1989) and Labonte (1989b) claimed that the process of empowerment begins with the assumption that a power deficit or an unattended social problem exists despite the presence of certain competencies. These two researchers presented almost identical five-step models on the development of empowerment, which is illustrated by Rissel (1994) in Figure 4. Rissel's model was based on the development work of Jackson et al. and Labonte.

The **process of psychological empowerment** is enhanced by the sense of community, and that psychological empowerment plus collective political or social action plus an actual increase in control over resources (to some degree) constitute community empowerment (Rissel 1994).

An increase in control over resources (the attainment of actual power) or a positive change in the socio-political environment, plus an increase in the reported level of psychological empowerment, are the appropriate end-points for evaluating an empowerment programme.

In 1990 Zimmerman presented a structural model for the analysis of participation and empowerment (Zimmermann 1990a) by using a positive concept of *learned hopefulness*, which the author defined as *a process of learning and utilizing problem-solving skills and the achievement of perceived or actual control*. Learned hopefulness suggests that experiences that provide opportunities to enhance perceived control will help individuals cope with stress and solve problems in their personal lives.

Perceived control is a primary variable in both learned helplessness and learned hopefulness. According to several studies perceived control is *multidimensional, but has been typically treated as a univariate construct including* cognitive, personality and motivational elements, which then have been investigated independently (White 1959, Rotter 1966, DeCharms 1968, Bandura 1982, Zimmerman and Rappaport 1988). The function of these three elements including their subelements has been identified as psychological empowerment (Zimmerman 1990a). However, psychological empowerment differs from perceived control because it is multidimensional and it includes a theoretical link to community involvement.

The theory of learned hopefulness predicts that involvement in community organizations and activities is one way to both improve problem-solving skills and enhance one's psychological empowerment (i.e. mastery and control over the environment). However, several mediating factors such as decision-making structures, the development of social support (enhancing), or frequent organizational failure (hindering), may influence the impact of participation.

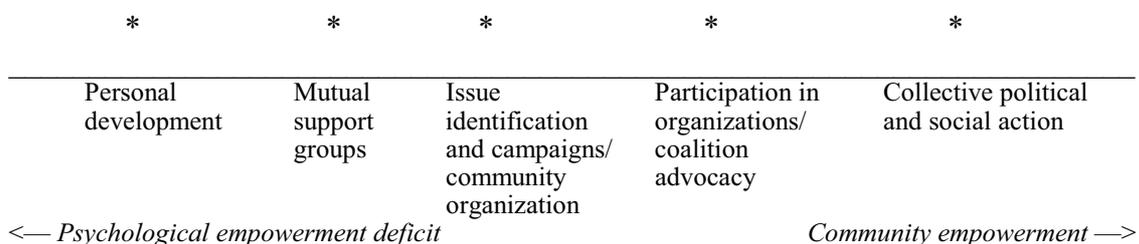


Figure 4. Conceptual stages of community development for maximizing community empowerment potential (adapted from Jackson et al. 1989, Labonte 1989b).

Psychological empowerment is expected to be a product of learned hopefulness. As individuals gain control and mastery over their lives and learn and utilize skills for influencing life events, they become empowered. Individuals may learn how to manage time, organize themselves, identify resource providers, work with others towards a common goal, or begin to understand the factors that influence decision-making processes.

Skills can be learned from fellow participants in natural settings such as mutual help groups and other forms of voluntary citizen participation (Rappaport 1987). Participation differs from traditional skills training because it is initiated and controlled by grassroots leaders, offers opportunities to benefit from reciprocal helping (Maton 1987) and provides settings for developing social support and sense of community. Involvement in voluntary organizations enhances perceived control and reduces feelings of alienation (Kieffer 1984).

Withdrawal, alienation, and depression are symptoms of helplessness, whereas the concept of hopefulness is characterized by increased psychological empowerment, proactive behaviour, and reduced alienation.

The model suggested by Wallerstein (1992) includes dimensions of improved self-concept, critical analysis of the world, identification with others as a member of a community, participation with others in organizing for community change, and actual environmental/political change. As summary she defines empowerment as follows:

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 (Wallerstein 1992).

The community empowerment model suggested by Wallerstein (1992, p. 198) includes the dimensions of improved self-concept, critical analysis of the world, identification with others as a member of a community, participation with others in organizing for community change and actual environmental/political change. Wallerstein defines empowerment as follows:

Community empowerment 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 (Wallerstein 1992).

Wallerstein's empowerment model has the following assumptions of success: Act of participating oneself in community change promotes changed perceptions of self-worth and a belief in the mutability of harmful situations, which replaces powerlessness; outcome-related assumption: the experience of mobilizing people in community groups strengthens social networks between individuals and enhances the community's or organization's competence to collaborate and solve health problems; and empowerment education interventions promote actual improvement in environmental or health conditions.

Participation in decision-making, in developing sense of community, and in gaining control over one's destiny, Wallerstein (1992) maintains, is itself enhancing.

Self-efficacy is defined as people's belief in their capability to organize and execute the course of action required to deal with prospective situations (Bandura 1977b). The domains of self-efficacy functioning include confidence in one's capability to regulate one's motivation, thought processes, emotional states, and the social environment as well as levels of behavioural attainment (Bandura 1977a, 1992). An expression of personal efficacy is an assertion of confidence in one's capability to overcome the difficulties inherent in achieving a specified level of behavioural attainment (Maibach and Murphy 1995). Self-efficacy is defined as the behaviour-situation unit of analysis. In other words, people are not self-efficacious in general, rather their sense of efficacy is tied to particular domains of functioning. According to Maibach and Murphy there are four broad processes through which efficacy beliefs operate: choice behaviour, effort expenditure, and persistence, thought patterns and emotional reactions.

4.3 Community organizing and community development

Community organizing and community development, according to Minkler (1989, 1992), are processes closely related to empowerment. In a case study on poor elderly people in the USA, she demonstrated the role of community organizing as a vehicle for enhancing individual and community-level empowerment. Building the project on social support theory, Freire's education for critical consciousness, and the principles and strategies of community organization practice, Minkler claims that the project reflects the WHO's perception of health promotion (WHO 1986a, 1986b) as a means for helping individuals and communities to take increasing control over the factors influencing their health.

Community organizing and/or community development refers, in a broad definition, to the process of purposefully stimulating conditions for change and mobilizing citizens and communities for health action(s). A key element in this process is the participation of individuals in voluntary organizations which produce collective and individual goods. Furthermore, it involves the process of engaging networks of governmental (formal) and non-governmental (voluntary) organizations including special interest groups in coordinated efforts to promote greater social control.

British and American urban reform movements and rural organizations of the late 19th century are described in many English-language accounts as representing the first systematic approaches to community development (Mayo 1975, Wileden 1970, Petersen 1994). It seems that the term 'community development' came into broad popular usage after World War II. At this time it was still primarily used in the context of programmes and interventions implemented in developing countries. Furthermore, these programmes were criticized for their high degree of government involvement and low degree of voluntary group involvement.

Dixon (1989) points out that the community development approach has been used when national interest is at stake and for the introduction of innovative ideas, practices and technologies. He says that although community development can contribute to planned social change (which is defined as the shaping of community and informal networks, rather than of economic and political forces), it is not about the redistribution of power, even within an area, even though less powerful members may benefit from the innovation or new service.

Community development was adopted by British, French and Belgian colonial administrations in Africa and Asia, especially after World War II, as a social and political as much as an economic strategy for rural areas. Hence, community development remained essentially an aspect of government policy.

Petersen (1994) identifies the following keys to empowerment in community development: gaining control over information; improved organization and links to outside supports; consciousness raising; and gaining access to resources. However, in the absence of an analytical framework of power, continues Petersen, there is no way of gauging the strength of these claims, or of knowing exactly how power relations have changed, and how enduring these changes have been.

According to Butler and Cass (1993) the changes in power relations are perhaps the most important criteria distinguishing community development from other forms of health promotion. However, in their own investigation of the success of 16 case studies in Australia, they also fail to provide any theoretical perspective on power.

Community development (WHO 1986c) refers to developing, or building up, communities to be more self-sufficient, assertive or involved... [and] includes 'community involvement', as well as movements which aim to give communities skills and knowledge to build them up.

Community development is an underlying democratic vision and it includes such values as: local group involvement in defining objectives and making decisions; a more equitable sharing of social resources and opportunities; personal fulfilment defined in terms of being contributory and creative rather than simply in terms of status and material possessions; an emphasis on the developmental process that accompanies a project rather than simply on measurable outcomes; and the promotion of the balanced

development of all the resources, physical and human, in the community or area under consideration.

Since the 1960s community development has been seen as a means of fostering participation in local area service delivery, of obtaining the views and compliance of local leaders through consultation, [and] of encouraging self-help, volunteerism and cost-saving decentralisation. (Dixon 1989, Cox et al. 1970).

Community development has traditionally been defined as voluntary cooperation and self-help/mutual aid efforts among residents of a particular locale which aim to improve the physical, social, and economic conditions of the community (e.g. Cox et al. 1970). However, Petersen's (1994) criticism is that even when adopted by NGOs, community development has been an externally imposed, paternalistic intervention, 'for the good of the community', rather than an attempt to alter established power relations.

For Florin and Wandersman (1990), community development represents an approach that facilitates individual and community capabilities, that attacks more than one problem at a time, and that fosters citizen efforts and citizen influence in decision-making.

In the 1970s Rothman (1971) presented a classification of community organizing practice which has since been widely quoted by other researchers. The three approaches to community change were labelled as locality development, social planning, and social action.

The locality development model presupposes that community change may be pursued optimally through broad participation of a wide spectrum of people at the local community level in goal determination and action. Its most prototypic form is "community development", which can be defined as a process designed to create conditions of economic and social progress for the whole community with its active participation and the fullest possible reliance on the community's initiative. Locality development includes democratic procedures, voluntary cooperation, self-help, development of indigenous leadership and educational objectives.

Social planning emphasizes a technical process of problem-solving with regard to substantive social problems, such as delinquency, housing, and mental health. Rational, deliberately planned, and controlled change has a central place in this model. The model presupposes that change requires expert planners who, through the exercise of technical abilities, can skillfully guide complex change processes. The concern here is with establishing, arranging, and delivering goods and services to people who need them. Building community capacity or fostering radical or fundamental social change does not play a central part.

The social action model presupposes a disadvantaged segment of the population that needs to be organized, perhaps in alliance with others, in order to make adequate demands on the larger community for increased resources or treatment more in accordance with social justice or democracy. It aims making basic changes in major institutions or community practices. Social action seeks redistribution of power, resources, or decision-making in the community and/or changing basic policies of formal organizations.

Rothman's three models of community organizing practice remain somewhat abstract and in this sense do not provide a very substantial contribution to developing the concept of empowerment. The locality development model does share certain features in common with the empowerment philosophy in referring to community change and democratic processes, but it fails to explain in any detail these democratic procedures or the strategies for implementing voluntary cooperation. (This model of locality development was adopted as part of the theoretical foundations of the North Karelia project, for instance). Rothman's social planning model refers to a planning process in which grassroots participation remains marginal and in which the decisions are made by experts. As far as I can judge the social action is confined to situations where an existing problem is connected to the personal life situations of particular individuals or groups of individuals and where this problem is seen as a threat to wellbeing.

The definitions proposed of community development/organizing in the 1980s show a growing tendency to move towards an understanding of empowerment, too, showing similar intentions such as that of aiming at community ownership and control over destiny.

According to Chavis and Newbrough (1986)

community development is a process that stimulates opportunities for membership, for influence, for mutual needs to be met, and for shared emotional ties and support. This process is fuelled by a hunger for community and the synergy of group empowerment.

Central to this process is the participation of community members in collective problem-solving. This is accomplished through the strengthening of mediating structures such as neighbourhoods, family, self-help groups, etc. The empowerment of people and groups through these structures leads to the *competent community*.

Bracht and Tsouros (1990) define

community organization as a planned process to activate a community to use its own social structures and any available resources (internal or external) to accomplish community goals, decided primarily by community representatives and consistent with local values. Purposive social change interventions are organized by individuals, groups or organizations from within the community to attain and then sustain community changes and/or new opportunities.

One outcome of this process of community and citizen involvement is community ownership. Communities must shape their own directions and emerge with the necessary self-help skills and resources to manage continued and/or new efforts.

Effective participation leading to ownership may be measured by the following criteria: presence of decision-making and advisory opportunities, substantial time devoted to goal-related activities, citizen and leader groups representative of the community, a high degree of local programme control, general satisfaction of groups with participation processes, and long-term maintenance of initiated programmes.

According to Wallerstein (1992) community organizing affects health by enhancing other community empowerment variables such as social supports and networks, psychological empowerment, community participation, sense of community, community competence, and control over destiny. Wallerstein describes control over destiny, or lack thereof, as a disease risk factor and as a strategy for health promotion programmes. Empowerment becomes a strategy that directly addresses lack of control over destiny. By challenging social and physical risk factors in a collective setting, people gain a belief that they can control their worlds, a sense of their communality, an ability to work together to acquire resources, and an actual transformation of socio-political conditions.

Chavis and Newbrough (1986) have presented a definition of community development from the vantage-point of sense of community:

Community development is a process that stimulates opportunities for membership, influence, mutual needs to be met, and shared emotional ties and support.

The stronger the sense of community, the greater the influence members will feel they have on their immediate environment. It is through this process that sense of community can contribute to individual and community development. The relationship between a sense of community and community competence through collective effort is reciprocal.

Community and communality

Midgley (1986) suggests that a community is a group of people living in the same defined area sharing the same basic values and organization, or a group of people sharing the same basic interests, which may change from time to time with the consequence that the actual members of the community change from time to time, or a target population or a population at risk.

According to Chavis and Wandersman (1990), a community can be identified as a place, as relationships and as collective political power.

Israel et al. (1994) consider a

community as a locale or domain that is characterized by the following elements: (1) membership – a sense of identity and belonging; (2) common symbol systems – similar language, rituals, and ceremonies; (3) shared values and norms; (4) mutual influence – community members have influence and are influenced by each other; (5) shared needs and commitment to meeting them; and (6) shared emotional connection – members share common history, experiences, and mutual support. Communitality may be geographically bounded, but not necessarily. (Klein 1968, Sarason 1974, Israel et al. 1994.)

McKnight (1987) says that the discourse is dominated by three visions of community: The *therapeutic* vision. The well-being of individuals grows from an environment composed of professionals and their services. There is a professional to meet every need. The *advocacy* vision foresees a world in which labelled people will be in an environment protected by advocates and advocacy groups. The individual's world is guarded by legal advocates, support people, self-help groups, job developers, and housing locaters. The approach conceives a defensive wall of helpers to protect an individual against an alien community. The *community* vision considers the goal to be the recomunalization of exiled or labelled individuals. It understands the community as the basic context for enabling people to contribute their gifts. It sees community associations as contexts for creating and locating jobs, for providing opportunities for recreation and multiple friendships, and for become the political defender of the right of labelled people to be free from exile.

In the search for the earliest forms of social work/social assistance in Finland, we need also to look at those local communities on which society at the local level was built (Jaakkola 1991). The earliest neighbourhood communities in historic Finland were represented by e.g. family, house and village. In Finnish practice, communitality is often used as a general label for all non-public, unofficial voluntary activities. According to Lehtonen (1988) communitality is not just any form of togetherness or intensive social relations within a group of people; Instead it is closely organized, individually binding horizontal and collective action. The earliest forms of horizontal organization, according to Lehtonen, are represented by the family relations of tribal societies and by medieval city guilds. Their communitality was tight and based on oath, rights and responsibilities. Membership was consistent and binding in nature.

Jaakkola (1991) says that communities must not be confused with free citizen action which evolved with 19th-century civil society nor with the consequent associations, because these were based on the principles of individualism and voluntariness, which are alien to communitality.

Sense of community

Communities have evolved within different settings and systems than the traditional residential locale (Gusfield 1975, Chavis and Newbrough 1986). A community should be defined as any set of social relations that are bound together by a sense of community. A sense of community is the 'over-arching' value.

Chavis and Newbrough (1986) argue that sense of community should be accepted as the basic organizing concept for the psychological study of community. They say that an understanding of the psychology of community must include the study of the evolution of territorial and non-territorial communities; the social supports and social networks that develop within various communities; the physical, social, and symbolic nature of the setting for the community; the role of boundaries; the benefits of community for human development and the quality of life; the therapeutic value of community; the developmental processes that communities undergo; the differing needs that different communities can meet for different people; and the role of leadership for a healthy, functioning community.

McMillan and Chavis (1986) propose a definition of *sense of community* which includes four elements:

membership (the feeling of belonging or of sharing a sense of personal relatedness, feeling that one has invested part of oneself to become a member and therefore has a right to belong), **influence** (a sense of mattering, of making a difference to a group and of the group mattering to its members), **reinforcement**: integration and fulfillment of needs (the feeling that members' needs will be met by the resources received through their membership in the group), and **shared emotional connection** (the commitment and belief that members have shared and will share history, common places, time together, and similar experiences).

McMillan and Chavis go on to argue that membership has boundaries (there are people who belong and who do not); that it brings about emotional safety (security that protects group intimacy and that can be more than emotional); that it is a sense of belonging and identification; and that it requires personal investment and a common symbol system.

Perception of the community environment is defined as judgements about the environment, perceived qualities, satisfaction, and problems. There are substantive relationships between the qualities of the physical environment, the social environment, and residential satisfaction (Wandersman and Giamartino 1980, Baum et al. 1981, Taylor 1982, Rohe 1985, Weideman and Anderson 1985). Perception on environmental problems can serve as a motivator to action (Florin and Wandersman 1984). As residents feel safer and more secure in their community, they are likely to interact more with their neighbours, feel a greater sense of community, and have more incentive to participate.

Social relations refer to interactions among neighbours such as borrowing or lending tools, informal visiting, and asking for help in an emergency (Unger and Wandersman 1985). Through this kind of interaction, neighbours provide each other emotional, personal, instrumental, and informational support. The social network in a neighbourhood develops, supports, and supplements the efforts to neighbourhood association by sharing information about the association, fostering the coproduction of services, such as sanitation and security, through informal social control (Rich 1979). The presence of social networks within the neighbourhood helps regulate social behaviour through normative mechanisms called informal social control (Merry 1987).

The likelihood that their own individual efforts (self-efficacy) or a group of people working together (collective efficacy) can solve a neighbourhood problem can influence behaviour (Bandura 1986). The locus of control (generalized expectatations about outcomes being related to one's own actions or to luck, chance, or powerful others) has been empirically related to participation (e.g. Florin and Wandersman 1984).

It has been suggested that there is a positive relationship between a sense of community and empowerment (Chavis and Newbrough 1986, Rappaport 1987), but this has not fully established through empirical research. Chavis and Wandersman (1990) have created a model of how the sense of community functions as a catalyst for action by affecting the perception of the environment, social relations, and one's perceived control and empowerment. They tested and confirmed their model by means of path-analytic and longitudinal techniques. Sense of community is used in the model to characterize the relationship between the individual and the social structure.

The results of the study clearly demonstrated the catalytic role of the sense of community. A sense of community was found to have a positive influence on one's perception of the environment, social relations, and the perceived control the person had over the immediate environment. The strongest path to participation was through a sense of community, through neighbouring relations, which influenced the degree to which a person became involved in the block association.

One major limitation of this study was that concentrates exclusively on participation in local organizations and on individuals. The concepts of both 'empowerment' and 'control' were poorly defined, which made it difficult to understand how they were used in the study (individual power and group power). Since empowerment is itself a process, it should not be incorporated in the model. In the second part of the study Chavis and Wandersman set out to authenticate causal relationships by means of an annual

survey in one group of people. However, since no intervention was involved, one may question the reasoning of this. The study further failed to explicate the sense of community, its origin and so on; it seemed either to exist or not to exist. The authors' decision to focus on participation in a block community also presented serious problems.

A further limitation of this study was that it focused entirely on the perception of empowerment. It failed to determine whether or not the block association was actually successful in improving the quality of life or in increasing the resident's capacity for self-determination. Indeed future research needs to distinguish perceived empowerment from actual empowerment in terms of their causes, effects, and processes (see Swift and Levin 1987). Finally, Chavis and Wandersman's study also had the problem that it was confined to variables at the individual level. In order to overcome these problems and shortcomings, future research needs also to look at at the organizational, community (microsystem) and macrosystem levels. Future research should also discard the static perspective and focus instead on the dynamic nature of community; offer more items per concept (e.g. group and individual empowerment, include more measurement points; have larger samples; incorporate objective environmental and social indicators; and include a variety of neighbourhoods for comparative purposes.

Competent community

The community experience incorporates a number of strands: capacity, collective effort, informality, stories, celebration, and tragedy. McKnight (1987) recognized that as institutions have grown in power, people have become too impotent to be called real citizens and too disconnected to be effective members of community. The key problem, according to McKnight, is weak communities.

Acknowledging this deficit, communities have put much effort into changing this trend in development. The aim of several community programmes (such as the Healthy cities movement), is to build up a competent community.

Competent community is defined as a human system that can care for its members and cope with or change external forces. Community competence can be achieved by developing the power to manage community systems for the purposes of human development. (Iscoe 1974)

According to Cottrell (1976) a competent community is one whose members can collaborate effectively in identifying problems, can reach consensus on goals and strategies, and can cooperate in the necessary actions to acquire resources to solve those problems.

The Healthy Cities Project has attempted to create measurement parameters that are similar to competent communities, such as degree of citizen participation, decentralized decision-making, and interconnected support networks (Hancock and Duhl 1988, WHO 1992).

According to Eng et al. (1992) it has been hypothesized in a range of disciplines that community competence is an effect associated with three levels of change: perceptions and behaviours of individuals, social support functions of social networks, and services and policies of institutions. Multiple levels of intervention are necessary for optimal improvement of community competence in health, an example of which is the ecological framework provided by Eng et al.

Community Coalitions

One of the key concepts in building up community empowerment is the formation of community coalitions. The purpose of coalitions is to function as a structure for action. In the development process where the aim is to build up empowerment, cohesive coalitions stand as a precondition for the more developed stages of the continuum towards the highest level of empowerment.

Coalitions are typically composed of individuals representing diverse organizations and community sectors. They develop formal working relationships, they are relatively durable, issue-oriented, structured, and focused on specific goals external to the coalition. Coalition members tend to collaborate on the behalf of the organizations they represent, and advocate on behalf of the coalition itself (Butterfoss et al. 1993, McLeroy et al. 1994).

Since coalitions consist of individuals representing diverse community organizations, there is bound to be frequent role conflict between representing one's primary organization and serving the needs of the coalition. This highlights the importance of coalition leadership in defining collective goals, as well as conflict resolution skills. (McLeroy et al. 1994).

The development of coalitions proceeds through defineable stages. The effectiveness of coalitions in implementing programmes and services and in accomplishing long-term goals is enhanced by organizational development of the coalition and influenced by member satisfaction, participation, and commitment. (Butterfoss et al. 1993). The implementation of coalition activities and the success of coalitions is partially determined by the extent to which coalitions develop an appropriate organizational structure (formalized rules, roles and procedures), and the extent to which members are satisfied, participating and committed. Other factors include leadership and member characteristics, member perceptions of benefits and costs of participation, organizational climate, member-staff relationships, decision-making processes, and problem-solving and conflict resolution strategies and skills.

An important indicator of coalition development may be the extent to which a coalition develops a separate organizational identity and organizational culture (cohesiveness), as is the case when members shift from representing their own organization in a coalition to working primarily for the coalition's benefit. Cohesive coalitions are more likely to develop clear mission and goal statements, which then, together with well-defined administrative and decision-making procedures, will promote or strengthen cohesiveness.

As soon as the coalition has succeeded to develop a formal administrative structure, roles, rules, and procedures – the prerequisites of an effective coalition – the very structure that allows organizations to work together effectively may impose a barrier to broader participation by the other residents of the community. In order to participate effectively in a complex organization, individuals must be socialized to the organizational culture of the coalition concerned and become knowledgeable about the organizational structure and procedures. People without experience in working with formal bureaucracies may find it difficult to learn effective methods of participating within the constraints imposed by the organization (coalition). (McLeroy et al. 1994.)

Another problem is presented by the role of professionals/experts working in the coalitions. Professionals are accustomed to working within a hierarchic organizational environment, and tend to develop coalitions that are hierarchically structured. (McLeroy et al. 1994.)

Social support and social network

Social support, according to House (1981) refers to the following broad classes of supportive behaviour or acts: emotional support (affect, esteem, concern), appraisal

support (feedback, affirmation), informational support (suggestion, advice, information) and instrumental support (aid in labour, money, time). Israel (1985), however, points out that instead of adhering to a narrow definition of social support, several convincing arguments by earlier research suggest that the use of a broader social network approach can be advantageous for understanding health behaviour and health status.

Mitchell (1969) defines social networks as a specific set of linkages among a defined set of persons, with the additional property that the characteristics of these linkages as a whole be used to interpret the social behaviour of the person involved. In this definition network refers to a set of relationships among individuals which has numerous characteristics that can be categorized along three dimensions: structural, interactional, and functional. By *structural characteristics*, Mitchell refers to the connections in the overall network like size and density, the percentage of people in the network who know one another. *Interactional characteristics*, then, refers to the nature of the relationships themselves, such as the frequency of interaction and reciprocity, i.e. the extent to which support is both given and received. *Functional characteristics* refer to the functions provided by network members, including affective support (caring, love), instrumental support (tangible aid), the development of new social contacts, and the maintenance of social identity.

Israel (1985) provides a list of network characteristics which includes intensity, reciprocity, affective support, size, density, instrumental and cognitive support. By intensity, Israel means the emotional closeness between the focal person and network members (operationalized by the presence of a confidant, at least one person in whom one confides). Reciprocity means the mutuality within a relationship, the extent to which support functions are both given and received within a network. Affective support means the provision of moral support, caring and love. Size indicates the number of direct contacts that an individual has. Density refers to the extent to which members of a network know one another. By instrumental support, Israel means the provision of concrete aid and services, such as loan of money, food, and technical help. Finally, cognitive support refers to the provision of diverse information, new knowledge, and advice.

The significance of the above list varies according to the situation and needs of the individual or network concerned.

4.4 Power, powerlessness, and human liberation

Effective intervention requires a knowledge of how power and powerlessness operate in human systems. Throughout life, the feeling of having at least reasonable control over one's destiny is the essential, psychological component of all aspects of life (Pinderhughes 1983). It follows that the perception of oneself as having some power over the forces that control one's life is essential to mental health. Power or lack of power then become critical issues in people's lives. Pinderhughes (1983) defines power as follows:

Power is the capacity to influence the forces which affect one's life space for one's own benefit. **Powerlessness** is the incapacity to exert such influence.

Power can be examined from the perspective of the process of interaction between the parties involved and the context in which the interaction occurs.

The 1960s has been described as a decade of "movement politics" (Friedmann 1992). By the end of the decade, however, this had seemed to have dried up and lost much of its attraction. The state had regained control, restricting the course of political action and practice to its customary channels. The return to normalcy was more deceptive than real, however. Movement politics, as it turned out, was there to stay. The only difference was the nature of the movements themselves. In an historical perspective all movements – the movements for social ecology, peace and women, the Black Power movement in the US, China's Cultural Revolution, the Paris student uprising of May

1968 – included the rise of civil society as a collective actor, working for political agendas outside the established framework of party politics. Throughout the world, social movements have helped to bring about a profound democratization of politics (Touraine 1977, 1981, Friedmann 1992).

In the mid-1970s many participants of earlier meetings on human liberation and from various social movements and projects, as well as some new contributors, came together in the establishment of the International Foundation for Development Alternatives in Nyon, Switzerland. Their purpose was to launch the Third System Project.

”This ‘third system’ was not just an analogy for the Third World. The state and the market are the two main sources of power exercised over people. But people have an autonomous power, legitimately theirs. The third system is that part of the people which is reaching a critical consciousness of their role. It is not a party or an organization; it constitutes a movement of those free associations, citizens and militants, who perceive that the essence of history is the endless struggle by which people try to master their own destiny – the process of humanization of man. The third system includes groupings actively serving people’s aim and interests, as well as political and cultural militants who, while not belonging directly to the grassroots, endeavour to express people’s views and to join their struggle. This movement tries to assert itself in all spaces of decision making by putting pressure on the state and economic power and by organizing to expand the autonomous power of people.” (International Foundation for Development Alternatives 1980 in Friedman 1992).

The Third project recognized that development occurs at local, national, global, and, somewhat ambiguously, at the Third World levels. Of these local space was regarded as the most significant for people’s creative unfolding: Development is lived by people where they are, where they live, learn, love, play, and die. The primary community, whether geographical (village, town, neighbourhood) or organizational (the factory, office, school, sports club, the association, etc.), is the immediate space open to most people, and the arena for personal and societal development.

Friedmann (1992) says that there exist some general assumptions about beliefs of alternative development: First of all, there is the belief that the state is part of the problem, and that an alternative development must as much as possible proceed outside and perhaps even against the state. Secondly, there is the belief that the people can do no wrong and that communities are inherently "gemeinschaftlich"; and thirdly, that community action is sufficient for the practice of an alternative development, and that political action is to be avoided. As the state which is considered bureaucratic, corrupt, unsympathetic to the needs of the poor – is often defined as the enemy, alternative projects are frequently designed to bypass the state and to concentrate on local communities instead. Friedmann does not agree with this and claims that even though alternative development begins locally, it should’t end there. The state remains the major power, after all. It may need to be more accountable to poor people and more responsive to their claims, but without state collaboration, the lot of the poor cannot be significantly improved. Local empowering action requires a strong state.

Nor are communities necessarily *gemeinschaftlich*, even when they take part in a moral economy based on reciprocity and trust. Many fault lines run through both rural and urban communities: religious, ethnic, social class, linguistic, etc. Each of the several social groups within a territorial community is likely to see its situation from its own perspective and contend over the same and always limited resources. Territorial communities are thus necessarily also political communities, rife with the potential for conflict.

Lastly, these conflicts cannot be contained locally. They are likely to spill over into regional and national political arenas. A politics of claiming is inherent in an alternative development, which is always about the use of common resources (often controlled by the state) and the removal of those structural constraints that help to keep the poor poor. If an alternative development is to advocate the social empowerment of the poor, it must also advocate their political empowerment.

4.5 Summary and concluding remarks

The concepts of community organization/development, citizen participation and community empowerment, as we have seen, have quite a lot in common. The roots of all three concepts can be traced back to Freirian (1970) praxis and to other liberation movements of the 1960s and 1970s (see Table 3). They share in common the idea of helping lay people to gain more power in health issues; the position that the needs of these people must be taken into consideration in local health planning; and that the voice of the public should be heeded in decision-making on health issues. The aspect of power is perhaps the most important dimension of all, distinguishing these approaches from other forms of health promotion. There are, however, also certain features which distinguish these approaches from one another.

Community organizing (for instance in the form of "locality development", "social planning" and "social action", e.g. Rothman 1971), although including elements of empowerment ideology and a requirement of social change to create conditions for democratic processes, is unable to explain, for instance, what these processes could be or to provide strategies for the voluntary cooperation that it emphasizes. To me, 'locality development' and 'social planning' remain tools for defining local needs. Rothman's third model of community organizing, i.e. that of 'social action' probably has better chances of catching the volunteers. However, this type of development requires a crisis or a threat to a group of people before it will be activated. In other words, there must exist a personal interest and a particular problem/crisis/threat connected with the life situation of the people in concern. The model, to me, seems to refer to a social movement, comprising the idea of opposing or fighting against something.

Community organizing is also distinguished from empowering procedures by the leaders' aims and intentions. Community organizing aims at winnable goals, empowerment aims at participatory processes. Secondly, the leaders in community organizing are managers or experts of the process (or planning officers) who make the final decisions, whereas the leaders in empowerment are seen as facilitators.

Definitions of citizen participation in the late 1980s and early 1990s (e.g. Oakley 1989, Hunt 1990) and definitions of empowerment (e.g. Wallerstein 1992) emphasize power relations and bottom-up approaches in health promotion. However, with the development of health promotion it seems that the concept of empowerment has taken over in the 1990s. "Empowerment researchers" have also had more success in their efforts to elaborate models for empowering processes, to develop its theoretical foundation, and to adapt these to health promotion praxis, particularly in the US (e.g. Flick et al. 1994, Flynn et al. 1994, McFarlane and Fehir 1994, Merideth 1994) and in research concerning developing countries (e.g. Gutierrez 1990, Purdey et al. 1994, Rudd and Comings 1994).

For these reasons then the focus of this study is on empowerment – even though there still is no absolute truth as to what constitutes empowerment. The approach adopted in the empirical part of the study has been mainly inspired by the work of Freire, Zimmerman, Rappaport, Wallerstein, Rissel, Chavis, and Minkler et al. The measurement tools and indicators have been developed primarily by reference to Zimmerman and Rappaport, who have also been important in the understanding of empowerment as a process comprising both a psychological and a community aspect. The adaptation of empowerment to health education and health promotion leans mainly on the work of Wallerstein. The model of empowerment and its developmental stages are based on Rissel, the recognition of the sense of community as a catalyst for empowerment on Chavis, and the applications of Freire's methodology in health care settings on Minkler et al.

Zimmerman and Rappaport's (1988) definition of empowerment was selected as the basis for defining empowerment in this study. The definition of Zimmerman and Rappaport was then complemented by the characteristics of empowerment presented by several other authors. According to Zimmerman and Rappaport *empowerment is a*

construct that links individual strengths and competencies, natural helping systems, and proactive behaviours to matters of social policy and social change. It is a process by which individuals gain mastery or control over their own lives and democratic participation in the life of their community. Zimmerman and Rappaport divide empowerment to *psychological and community levels.*

Psychological empowerment includes personality, cognitive, motivational, and contextual dimensions. The *personality dimension* of empowerment is defined as strengthened self-efficacy and self confidence, internal locus of control (referring to one's expectations that he/she can exert control over his/her environment), chance control (comprising the idea that things are not a consequence of a chance but a result of an individual's own action, which he/she can control), belief in powerful others (which in this study includes the feeling of being stronger within a group or a community than alone), control ideology (comprising the idea that people in general and particularly oneself can influence social and political systems). The definition of personality dimension of psychological empowerment was complemented in this study with characteristics as feeling of empathy and other emotional variables (e.g. feeling of such fulfilment of life, learning to know oneself through participation in groups and community life) (Wallerstein 1992).

The *cognitive dimension* of psychological empowerment defined by Zimmerman and Rappaport (1988) includes self-efficacy (comprising the belief in capability to organize and execute the course of action required to deal with prospective situations and the confidence in capability to regulate one's motivation, thought process, emotional stages and social environment as well as behavioural attainment, as well as confidence in one's capability to overcome the difficulties inherent in achieving a specified level of behavioural attainment), self- and political efficacy expectations (comprising the belief that one has the skills and ability to achieve goals including perceived improvement in skills and knowledge through participation in community action), political efficacy (comprising the belief that it is possible to influence the political process and community decision making) and sense of political efficacy (including the feeling that individual's political action does have, or can have, an impact upon political process, i.e., that it is worth while to perform one's civic duties. It is the feeling that political and social change is possible, and that the individual citizen can play a part in bringing about this change).

The *motivational dimension* includes the desire to control environment, civic duty or sense of civic obligation comprising the belief that one ought to participate in political process as a responsibility to others. It is the feeling that oneself and others ought to participate in political process, regardless of whether such political activity is seen as worth while or effective. It includes a concern for the common good and a sense of connectedness to others and a sense of causal importance and purposefulness.

The *contextual dimension* includes the person's involvement in collective action (Rappaport 1985) for exerting control in the social and political environment, perceptions of persons' ability to have ecological and cultural influence (Zimmerman 1990b), persons' raised cultural awareness (Zimmerman 1990b, Wallerstein 1992, Israel et al. 1994), and raised consciousness (Freire 1970, Hart and Bond 1995) of community problems.

Community empowerment according to Zimmerman and Rappaport (1988) *means self- and political efficacy, perceived competence, locus of control, and desire for control.* These characteristics are elements of community empowerment, which in this study were complemented with the following characteristics: Community empowerment means *achievement of equity of resources* (Katz 1984, Rappaport et al. 1984, Rissel 1994), *ability to identify problems in the community and their solutions* (Braithwaite 1989), *increased participation in community activities* (Chavis and Wandersman 1990, Florin and Wandersman 1992), *a raised level of psychological empowerment among members of community* (Wallerstein 1992), *improved neighbourhoods as a consequence of the activities of community* (Chavis and Wandersman 1990), *stronger sense of community among the members of community* (Chavis and Wandersman 1990), *ability to make critical analysis of the world* (Wallerstein 1992),

Table 3. Roots and main milestones of empowerment.

Direction of influence →

Discipline Time	Education sciences	Social sciences	Social psychology	Public Health	Health Promotion
1960s		1960 Social action and feminist movements			
1970s	Freire (1970): "Pedagogy of the oppressed"	Rothman (1971): - community development, community organizing 1970s: "self-help" perspective		Puska (started 1972): Community control programmes for disease prevention Alma Ata (1978): "Participation" concept	
1980s			Rappaport (1981): "Empowerment" concept Rappaport (1987): "Empowerment as a process" Zimmermann and Rappaport (1988): "Psychological and community empowerment"	Swift and Levin (1987): "Stages of empowerment"	Ottawa Charter (1986): "Participation" as an element in the definition of health promotion. "Healthy Cities" movement Wallerstein and Bernstein (1988): "Empowerment education adopted for health education"
1990s			Chavis et al. (1990): "sense of community"	Jackson et al. + Labonte (1989): "Model of empowerment" Rissel (1994): "Social change for community empowerment"	Wallerstein (1992): "Empowerment adopted in health promotion" Jakarta Declaration (1997) etc: "Empowerment of individuals as a goal of health promotion"
2000s					ca. 1998-> "Empowerment as the essence of health promotion" "Health Promotion of the 21st century"

identification of themselves (with others) as members of the community (Wallerstein 1992), *improved quality of community life and social justice* (Wallerstein 1992), *political action* (Rissel 1994, Minkler 1994) meaning political action in health, and ability to organize themselves for managing a community problem, initiative and participation in decision making as well as in planning or other committees, *achievements in redistribution of resources or in decision making* (Rissel 1994), as well as *control over health* (Zimmerman 1990b) and *destiny* (Wallerstein 1992). According to Zimmerman (1990b) the communities have control over health when the people have learned how to manage time, organize themselves and identify resource providers, to work with others for common goals, and to understand factors that influence decision making.

Another consequence of the choice to focus on empowerment as the key concept was that the concept of participation had to be subjected to the position of a tool or prerequisite for empowerment. It was assumed that people must, in the first instance, participate in order to be empowered. Participation is here seen not only as a means but also as a consequence, an individual characteristic: active involvement or participation (initially in the programme and its intervention and other health promotion activities and ultimately in health decision-making) becomes an integral part of the person's daily life or health behaviour. This understanding of participation was based on Zimmerman and Rappaport (1988).

In spite of having identified the theoretical foundations of my work and its main influences, I have also considered it necessary to provide a detailed overview of the evolution of the three main concepts concerned. To this end Table 3 illustrates the main milestones in the evolution of empowerment. It does not perhaps include every relevant step in this process of evolution, but it is intended to illustrate the sciences and scientists that I feel have been most instrumental in elaborating participation and empowerment as well as the disciplines within which they have worked.

The roots of empowerment can be traced back to the education and social sciences of the 1960s and 1970s and particularly to the work by Freire on the "Pedagogy of the Oppressed". Rothman's community organizing models (the "locality development" model) constituted an important theoretical basis for the community control programmes of the 1970s as well as for disease prevention. One of the reasons for this was probably that the new concept of citizen participation (let alone that of empowerment) had not yet been launched in the field of public health. The next step in the evolution was the Alma Ata conference, which for the first time explicitly highlighted citizen participation as a requirement for primary health care development.

The concept of empowerment was first coined by Rappaport in the field of social psychology in 1981. A few years later, Rappaport emphasized that empowerment is a process. Swift and Levin (see also Kieffer 1984 and Torre 1986) identified different stages of empowerment in 1987. In 1988, Zimmerman and Rappaport made an important distinction between psychological and community empowerment and claimed that one must first be empowered at the individual level before it is possible to proceed to higher levels. Jackson et al. (1989) and Labonte (1989b) were among the first to present a model or theory of empowerment. Their work has often been quoted in research concerning empowerment and health promotion in general. In 1994, Rissel elaborated the model of empowerment and also discovered that empowerment can be created through social change.

It is also important to bear in mind that 'health promotion', which comprises empowering elements, was launched as late as 1986 (WHO) in the form of a Charter in Ottawa, Canada. Wallerstein et al. have been among the pioneers in launching empowerment in the fields of health education and health promotion. The Jakarta Conference on Health Promotion stated explicitly that the empowering of individuals should be one of the goals of health promotion (WHO 1997). During the past few years empowerment has been regarded at least as the core of health promotion, sometimes as almost as the very essence of health promotion (e.g. Labonte and Robertson 1996, Nutbeam 1998).

III EMPIRICAL PART – The assessment of empowerment in local settings

5 Theoretical and methodological framework of the Somero-Järvenpää programmes

Denzin and Lincoln (1994) state three interrelated activities which define research process: articulation of the researcher's individual worldview or basic belief system, decisions on the theoretical perspective and strategies of inquiry, and thirdly, decisions on methods of data collection and analysis. Furthermore, the study design expresses the connections between these activities. This view is supported e.g. by Haase and Myers (1988) who distinguish three research process levels: i. paradigm and assumptions (the worldview or philosophies behind the study), ii. approach or research orientation, and iii. method or technique (data collection and analysis).

The presentation of Chapter 5 follows the division suggested by the above mentioned writers: paradigms behind the study, strategies of inquiry (action research and intervention), data collection and analysis methods, and a summary of the chapter.

5.1 The paradigms behind the study

According to Patton (1990), the nature of paradigms⁶ behind a study can be characterized as a paradigm of choices, which recognizes that different methods are appropriate for different situations. As such paradigms are important theoretical constructs for illuminating fundamental assumptions about the nature of reality. However, at the pragmatic level of making concrete methods decisions, the emphasis on strategic choices helps to convey the idea that there is a wide range of possibilities when selecting methods. This is a fundamental remark concerning the investigation of empowerment; empowerment is a methodological question in addition to its political character.

The paradigmatic worldview defining the nature of the "world" in the present study could be characterized as the tradition of *critical theory* (realized in the action research/participatory action research approach), while it has features typical of the paradigms of *interpretivism* and *constructivism* (realized particularly in the evaluation and data analysis parts). [E.g. Labonte and Robertson (1996) have presented convincing results on using constructivism as the leading paradigm in community-based health promotion programmes claiming that constructivism has potential to resolve some of the tensions between research and practice in health promotion, and in addition it is inclusive of knowledge generated by the conventional paradigms. E.g. Eakin et al. (1996) and Poland (1996) speak up for critical science, which, they claim, approximates more closely than conventional science what is required by the "new public health".]

Schwandt (1994) speaks about constructivism/constructivist in parallel with interpretivism/interpretivist and finds similar features to be typical of both paradigms. Yet, he claims, their particular meaning is shaped by the intent of their user. Common to these approaches is, according to Schwandt, that the constructivists and interpretivists believe that to understand the complex world of meaning the researcher must interpret it. Referring to Blumer (1969), Schwandt claims that the terms are best regarded as sensitizing concepts. These approaches are not seen as methodologies per se, but the scientific method is best characterized as an abstract, formal sense of method. They are more concerned with matters of knowing and being. Method is predicated on the elimination of personal, subjective judgement – it is an intellectual technique. The emphasis is on the world of experience as it is lived, felt, and undergone by social actors.

⁶ A paradigm (Kuhn 1970) is defined as a worldview and, as such, is generally believed to be more or less exclusive. Paradigms are composed of multiple belief categories, principal among them being the ontological (what is the nature of "knowable" or "reality"), epistemological (what is the nature of the relationship between the knower/inquirer and the known/knowable) and methodological (how should the inquirer go about finding out knowledge) assumptions (Labonte and Robertson 1996).

Although constructivist and interpretivist persuasions share the above mentioned general framework for human inquiry, they are unique in the manner in which they answer the questions concerning the purpose and aim of human inquiry, and the ways how a researcher can know about the world of human action. In the following the characteristics of the three paradigms – critical theory, interpretivism and con-structivism – forming the worldview of the present study will be shortly described.

Critical theory

Critical theory originates in Germany with the Institute of Social Research at the University of Frankfurt (Kincheloe and McLaren 1994). Marx, Kant, Hegel and Weber can be mentioned as initiators of this tradition. Habermas, Foucault and Freire are other examples of critical theorists. The feminist movement also has its origins in critical theory. Kincheloe and McLaren define a criticalist as a researcher/theorist who attempts to use his/her work as a form of social or cultural criticism. A criticalist accepts certain basic assumptions like “thought is mediated by power relations that are socially and historically constituted”, “facts are value-mediated”, “the relationship between concept and object and between signifier and signified is never stable or fixed and is often mediated by the social relations of capitalist production and consumption”, “language is central to the conscious and unconscious awareness (subjectivity)”, “certain groups in any society are privileged over others (oppression)”, and “the research practices should be implicated in the reproduction of systems of class, race, and gender oppression”.

Guba (1990) particularly emphasized the notion of the value-ladenness in critical theory, which distinguishes the paradigm from e.g. positivism requiring value freedom and objectivity. Moreover Guba discusses the dilemma of bringing the values into the human inquiry: whose and what values should be chosen? He claims that a particular value system tends to empower certain persons while disempowering others, and that in this way a research becomes a political act.

According to Kincheloe and McLaren (1994), critical theory has been best understood in the context of the empowerment of individuals or groups. The “critical” aspect of the research refers to an attempt to struggle for a better world, while traditional researcher’s intention is neutrality and their task is to describe, interpret, or reanimate the reality. Critical theorists regard their work as a first step towards forms of political action that can “redress the injustices found in the field site or constructed in the very act of research itself”. Critical theory takes often the form of self-conscious criticism (e.g. Freire 1970), which means that the researchers try to become aware of the ideological imperatives and epistemological presuppositions that inform their research as well as their own subjective, intersubjective, and normative reference claims. Critical researchers have their own assumptions about the “world”. If the researcher recognizes the assumptions not leading to desired actions he/she may change them during the research process.

Guba and Lincoln (1994) have described critical theory according to the ontological (what is the nature of the “knowable”, or the “reality”), epistemological (the question of the nature and relationship between the knower/inquirer and what can be known) and methodological questions (how should the inquirer go about finding out knowledge), according to which the paradigm can be distinguished: In critical theory the ontological question is ‘historical realism’, which means that “a reality is assumed to be apprehendable as one that was once plastic, but that was, over time, shaped by a range of social, political, cultural, economic, ethnic and gender factors, and then crystallized into a series of structures, which are taken as ‘real’”. The epistemological question in critical theory assumes that the investigator and the investigated object are interactively linked, and that the values of investigators and other participants of the research process inevitably influence the inquiry. Consequently the findings of the study are considered to be value mediated (the transactional and subjectivist perspective). The methodologies

along the critical theory paradigm are dialogic and dialectical requiring continuous dialogue between the investigator and the subjects of the inquiry. The aim of the dialectic method of an inquiry is to eliminate “false” consciousness and energize and facilitate transformation (Guba 1990, p. 25).

Interpretivism

According to Schwandt (1994) the main streams of interpretivism are based on the ideas from e.g. the German intellectual tradition of hermeneutics and the “Verstehen” tradition in sociology, the phenomenology of Alfred Schutz and Wilhelm Dilthey and from Max Weber’s theories concerning the relationship between the interpretation of meaning and causal explanations and the separation of facts and values in social inquiry. Interpretivists point out that there is a difference between mental sciences or cultural sciences and natural sciences. The latter seeks scientific explanation (Erklären) whereas the goal of former traditions is the understanding (Verstehen) of the meaning of social phenomena. Interpretivists struggle with maintaining the opposition of subjectivity and objectivity, engagement and objectification. In other words the emphasis is on drawing the line between the object of investigation and the investigator. The paradox of how to develop an objective interpretative science from subjective human experience thus arises.

There are different persuasions concerning the ways of interpretation; *Hermeneutical interpretation* of Verstehen is one of them (Schwandt 1994). The hermeneutical understanding according to Bleicher (1980) can be further divided to the i) objective/validation hermeneutics (e.g. Dilthey, Betti and Hirsch), and ii) philosophical hermeneutics (e.g. Gadamer, Heidegger, Taylor). The former is an epistemology or methodology for understanding the objectification (like language, institutions etc.) of the human mind. It assumes that meaning is a determinate, object-like entity waiting to be discovered in a text, a culture or the mind of a social actor. In this tradition hermeneutics is a particular method for identifying and explicating these objective meanings. Consequently this kind of hermeneutics is a means of inquiry in the human sciences.

The philosophical hermeneutics is concerned with being-in-the-world. The hermeneutical circle in this case is the “ontological question of understanding, which proceeds from a communality that binds us to tradition in general and to our object of interpretation in particular”. It also provides a link between theory and praxis⁷.

Schwandt (1994) considers *symbolic interactionism* (see Blumer 1969, Patton 1990, Simmons 1995, Kvale 1996), as one form of the interpretivist persuasions. Symbolic interaction was the original concept produced by Blumer (1969). According to Blumer “symbolic interactionism” is a label for a distinctive approach to the study of human group life and human conduct. Symbolic interactionism relies on three premises. Firstly, the human beings act towards the physical objects and other beings in their environment on the basis of the meanings that these things have for them. Secondly, these meanings derive from the social interaction (e.g. communication) between and among individuals. Communication is symbolic because we communicate via languages and other symbols; further in communicating we create or produce significant symbols. Thirdly, these meanings are established and modified through an interpretive process: The actor selects, checks, reforms, regroupes, and transforms the meanings in light of the situation. The use of meanings by the actor occurs through a process of interpretation.

Blumer (1969) explains that in symbolic interactionism the inquirer must actively enter the worlds of people being studied in order to see the situation as it is seen by the actor, observing what the actor takes into account, observing how he interprets what is taken into account. The process of actors’ interpretation is rendered intelligible not merely through the description of words.

⁷ *Praxis* refers to the circular relationship of experience and reflection through which actions evoke new understandings, which then provoke new actions (e.g. Freire 1970, Kieffer 1984).

Basic assumption in interactionism is that people are in constant process of interpretation and definition as they move from one situation to another (Blumer 1969, Bogdan and Taylor 1975). The research has to infer the salient features of this operation by collecting all kinds of data (by interviewing, examining personal documents, and observing) and then extracting from these records the material that is relevant to the question the researcher asks. (Tesch 1990). The end result of symbolic interactionism is the formulation of propositions about relationships among categories of data, which the researcher weaves into a theoretical scheme (Blumer 1969) through three steps: a tentative proposition drawn from the observations about the existence of a phenomenon and the relationships between the other observed elements of the phenomena. The second task is to find out whether the events that prompted the development of these propositions and their potential relationships are typical and widespread. And finally, the concrete individual findings are used to confirm, disconfirm, or modify the propositions, resulting in a descriptive model which best explains the data [the researcher has] assembled.

Constructivism

Constructivists share the interpretivists' emphasis on the world of experience as it is lived, felt, and undergone by social actors (Schwandt 1994). Constructivists are committed to the view that what we take to be objective knowledge and truth is the result of perspective. Knowledge and truth are created, not discovered, by human mind. Constructivists emphasize the instrumental and practical function of theory construction and knowing.

Lincoln and Guba (1985) use the "constructivist paradigm" as a wide-ranging eclectic framework. They originally titled their approach as "*naturalistic inquiry*". In the recent years they have used constructivism to characterize their approach as methodology. They, however, acknowledge that constructivist, interpretive, naturalistic, and hermeneutical are all similar notions. According to Lincoln and Guba the act of inquiry begins with issues and/or concerns of participants and unfolds through a "dialectic" of iteration, analysis, critique, reiteration, reanalysis and so on that leads to a unified reconstruction, which is then once more evaluated for its "fit" with the data.

The ontological question within constructivism paradigm is 'relativist', which means that "realities exist in the form of multiple, mental constructions, socially and experimentally based, local and specific in nature, and dependent for their form and content on the individual persons or groups holding the constructions, which are not more 'true' in any absolute sense, but simply more or less informed and sophisticated." (Guba 1990, Guba and Lincoln 1994). The epistemology of constructivism is transactional and subjectivist. This means that the investigator and the object of investigation are assumed to be interactively linked so that the findings are literally created as the research proceeds. The methodological question of constructivism is hermeneutical and dialectical. This means that the varying constructions are interpreted using hermeneutical techniques (see above, interpretivism), and are compared and contrasted through dialectical interchange with the aim of generating one/a few constructions on which there is substantial consensus (Guba 1990, Guba and Lincoln 1994).

Labonte and Robertson (1996), however, made an important remark noting that a constructivist paradigm can include both quantitative and qualitative methods, allowing a selection of methods appropriate to the research and evaluation questions in concern.

The paradigms from the Somero-Järvenpää Programme's perspective

Critical theory was the worldview behind the intervention and the action research parts, whereas the interpretivism and constructivism formed the worldview of the evaluation and directed the data analysis procedures of the Somero-Järvenpää case. The following explains in more detail the paradigm worldview in practice (see Table 4).

Characteristics of the Programme which were based on the critical theory

The ideological basis behind the study was assumed to promote pluralism, seeking to find understanding of the world. Diverse views of different people were supposed to be taken into consideration, and the planned actions were based on solidarity. The ultimate goal was emancipation and human liberation, in other words empowerment through social change.

“Key audiences” in the Somero-Järvenpää case comprised participants of the Programme, citizens of the communities and the Programme staff (Project Manager, Project Secretaries). The Programme was considered to be an empowering process to all involved and the intention was to grow together, (all were considered to be “sailors in the same boat”). The people involved were considered to be “powerless groups” when taking into consideration the prevailing situation in Finland, particularly at the starting point of the Programme. There was a financial recession in the beginning of 1990s, the communities had difficulties to survive with the limited budgets, and there was a threat that allowances, particularly in the field of health promotion, will be cut. This was the reason why the people in the communities were expected, to an increasing extent, to take care of their own affairs concerning health and decision making in health. As the Finnish society was through a long tradition relying on the medical model approach and paternalism concerning health matters (as described in the earlier chapters), the learned helplessness of people was the natural consequence following this kind of policy. In this respect people were considered to be “powerless”, they were lacking skills and relevant knowledge to be the virtual actors in the health policy field. Consequently, the primary task of the “enlightenment and awakening of common people” was to educate and support the lay people in the health field and also to release the human knowledge of the people to be utilized in the Programme and further in the development of the whole community.

The staff of the Programme was also considered to be a “powerless” group in the beginning of the Programme, because the course of this kind of procedure was not precisely predictable. Also the literature concerning empowerment was in the developmental phase in the beginning of the 1990s, and did not provide “the right answers” as how to cope with different situations.

The methods used in the Programme were mainly participatory and qualitative (observation, diaries, open-ended questionnaires, preparation of the lay community diagnoses, education based on dialogue etc.). Referring to Leininger (1992) qualitative approaches fit well with the action research because of their local focus and their closeness to the respondents or participants. Furthermore, action research has been located within the new tradition of collaborative research (e.g. Participatory Action Research PAR, see Starrin and Svensson 1991, Starrin 1993) and described as a resection of the empiricist and interpretivist notions of science (Meyer 1993).

Table 4. Major paradigm approaches compatible to the Somero-Järvenpää case (adapted from the presentation by Guba 1990 and Greene 1994).

Paradigms	Ideological framework/ Key values promoted	Key audiences	Preferred methods	Typical evaluation questions
Critical theory	Emancipation/empowerment, social change; reality is shaped by social, political, cultural, economic, ethnic, and gender values and crystallized over time	Programme beneficiaries, communities, other "powerless" groups	Participatory: stakeholder participation in varied structured and unstructured, quantitative and qualitative designs and methods; historical analysis, social criticism	In what ways are the premises, goals, or activities of the programme serving to maintain power and resources as inequities in the society
Inter-pretivism	Pluralism/ understanding, diversity, solidarity, the reality is existing and can be discovered by human mind	Programme consultants and staff, researchers and beneficiaries	Qualitative: case studies, interviews, non-structured questionnaires, observations, document reviews	How various stakeholders experience the programme?
Constructivism	Historical realism, the reality is created by human mind, understanding, the reality can be changed through social change, local and specific truth	Programme consultants and staff, researchers and beneficiaries	Qualitative (but allows also quantitative methods). Hermeneutic and dialectic procedures, interaction and synthesis, triangulation.	E.g. What is "participation" or "empowerment"? Can empowerment be created?

The characteristics reflecting the interpretivism and constructivism

The value orientation that promotes pluralism is typical in qualitative evaluation contexts and in case study methodologies. According to Greene (1994), a part of the tradition of interpretivism seeks enhancement of contextualized programme understanding for stakeholders closest to the programme, and consequently promotes values of pluralism as well as forges direct mechanisms to programme improvement.

This study was asking how the participants experienced the Programme (and particularly the different elements of it), how they felt about their learning, what was participation or empowerment to them, and so on. The participants – as interpreted by the interview answers and the open-ended questionnaires and the observed actions – reflected the status of empowerment through what they said and did. The researcher was continuously interpreting this world and conveying her understanding back to the people in the dialogues between the counterparts. (Along the lines of symbolic interactionism).

The constructivism in this study can particularly be connected to the ontological question of human inquiry. The phenomenon under investigation (the nature of the "knowable") – empowerment – can be considered to be created in the human mind. Moreover, there is no absolute truth as to what constitutes the empowerment. It is a matter of interpretation and additionally, as stated by e.g. Rissel (1994), context specific. Being empowered in one area doesn't necessarily mean that one is empowered in some other area (or some other period) of human life.

However, in the final critical analysis the success of the Programme from the empowerment perspective and the social change towards empowerment were considered through hermeneutical understanding and through putting together the pieces in the puzzle (all elements of the inquiry). This could be called the tradition of hermeneutical interpretation of understanding as Schwandt (1994) has described it, and particularly

nearest to the sc. objective/validation hermeneutics (see. e.g. Bleicher 1980, Kvale 1983, Patton 1990, Kvale 1996). The hermeneutic circle in this case is considered as a methodological device in which one considers the whole in relation to its parts and *visa versa*. Thus it provided a means for inquiry.

5.2 Strategies of inquiry

5.2.1 Action research

As a general strategy of institutional change action research has been practised since the 1920s. In this approach the researchers, with local help, design the outlines of a "field experiment". (Miles and Huberman 1994.) Action-oriented approaches have also been placed firmly within the long tradition of liberationist movements (Reason 1994) as well as within empowerment programmes (Starrin and Forsberg 1997). Reason explains that the primary task is the "enlightenment and awakening of common people" and the tradition begins with concerns for power and powerlessness. "The aim is to confront the way in which the established and power-holding elements of societies world-wide are favoured because they hold the monopoly on the definition and employment of knowledge". Starrin and Forsberg emphasized that when speaking about empowerment one means that someone is lacking power and resources and must be empowered through social change. Participatory research and particularly Participatory Action Research (PAR) is suggested by Starrin et al. (Starrin and Svensson 1991, Starrin 1993, Starrin and Forsberg 1997) to be an appropriate tool for this.

Starrin and Svensson (1991) distinguish two main streams of participatory research, the *utilitarian* (sc. Pragmatic-oriented action research, originally introduced by Kurt Lewin in 1946), and the *radical* tradition (represented by e.g. by Paulo Freire 1970), which is more ideological and political or feminist-oriented (see e.g. Clarke 1992, Olesen 1994).

Lewin (1946) defined *action research* as a research where the researcher him-/herself participates in all phases of the development process, thus being within the focus of inquiry. Action research involves an interplay between inquiry, action, intervention, and evaluation. Within action research the role of the researcher shifts and develops between the role of researcher, change agent and project worker over the whole life of a particular project or programme. The participants' roles and relationships change as well; an outsider may move into an insider's role at a certain moment in the programme's development, and an insider might find that conditions change so that he/she becomes defined as an outsider.

In action research the emphasis is in the process, while the outcome should not be ignored, either. Action research is a way of generating knowledge about a social system while attempting to change it. However, later Lewin referred action research to as "rational social management" which proceeded in a serial of steps, initiated by a general idea and a general objective. The first step is to examine the general idea in relation to means available. The next step is composed of a circle of planning, executing and reconnaissance or fact-finding for the purpose of evaluating the results of the second step, for preparing the rational basis for planning the third step, and for modifying again the overall plan. Rational social management, therefore, proceeds in a spiral of steps each of which is composed of a circle of planning, action, and fact-finding about the result of the action (Lewin 1946). Lewin's experiments concerning group behaviour have also shown the importance of the power of the approach in promoting attitude and behaviour changes. This influenced his later work on action research, which Lewin defined as a *planned social change*.

Starrin and Forsberg (1997) emphasize, however, that the participatory research of today is not equal to the concept of the (Lewinian, utilitarian) action research. They stress that even this type of action research requires a close contact between the researcher and

the participants of a social change process, and although the starting point in the process is formed by problems rising from those people involved, it is finally the researcher who steers the course of the process.

The action research of today and as often applied in e.g. the empowerment programmes is closer to the radical tradition and could, referring to Starrin and Forsberg (1997) and Starrin and Svensson (1991) be labelled as Participatory Action Research (PAR). This sets more emphasis upon the awareness-raising and the empowerment, and the finding of ways for researchers and practitioners to work collaboratively, and ways for practitioners to become action researchers in their own rights (Meyer 1993). The radical branch emerged from the adult education field (e.g. Freire) in developing countries where poverty and oppression prevailed and the power was concentrated in the hands of few. Starrin and Svensson (1991) define Participatory Action Research as an inquiry which leads to change by and for those who carry out research. Research, education and action form a continuum and are parts of the social change process. (see e.g. Gutierrez 1990, Flick et al. 1994, Flynn et al. 1994, McFarlane and Fehir 1994, Merideth 1994, Purdey et al. 1994, Rudd and Comings 1994).

Hart and Bond (1995) in their analysis of various persuasions of action research discovered four different orientations: the *experimental approach* (nearest Lewin's original use), the *organizational approach* (e.g. Tavistock Institute), the *empowering approach* (e.g. Freire and feminism) arising from community development, and the *professionalizing approach* recognizable within the field of education and nursing. Hart and Bond found seven criteria which distinguish these types of action research and which also distinguish action research from other methodologies. Firstly, action research is educative; it deals with individuals as members of social groups; it is problem-focused, context-specific and future-oriented; it involves a change inter-vention; aims at improvement and involvement; involves a cyclic process in which research, action and evaluation are interlinked; and finally, is founded on a research relationship in which those involved are participants in the change process.

Eakin and Maclean (1992) take a critical perspective on participatory research and knowledge development in health promotion. They address the emphasis e.g. on the importance of community participation in the research process and simultaneously on the need to broaden the disciplinary base of health promotion. The emphasis on participatory approach in research expresses an attempt to make research more relevant and accountable, but at the same time it may inhibit the theoretical grounding of research and create a strain between pragmatic and scientific interests. Furthermore the authors argue that there is a need for a critical perspective making a distinction between "research of" and "research for" health promotion.

5.2.1.1 *The Somero-Järvenpää Programme in action research framework*

Considering seven of the criteria defined by Hart and Bond (1995) in the Somero-Järvenpää case, it is possible to state that the Programme is nearest to the empowering approach, but that it has to some extent characteristics from the other approaches, too. In fact during the life of the Programme the action research approach shifted from one type to another (experimental, organizational, empowering, professionalizing) as it moved through the spiral of development cycles. The compatible criteria (by Hart and Bond 1995) of these different types of action research in the Somero-Järvenpää Programme are collected in Table 5, and in the following text the Programme is considered from their perspective:

- 1) The education included in the Programme aimed firstly at raising consciousness, which in practice meant that the people should become more concerned about their own health, the health of their families and also of the members of the community. Secondly, the intention was that they start to analyse their own community from the

health and health political perspective. It was assumed that people pay more and more attention to health issues and problems which they had not noticed before or which they had expected the municipality or the professionals to take care of. The purpose of the education was to enhance user control and to shift the balance between laymen and professionals by strengthening the skills and knowledge among the participants of the Programme and later on among as many members of the community as possible. In the long run, it was assumed that the “conscientization” process would become a part of the health care infrastructure and thus affect the planning, implementation and evaluation of health care and health policy and decision making.

- 2) Individuals in groups: At the beginning stage the groups (coalitions = theme groups) were formulated artificially by lot. The idea was that after the start of the Programme, the grouping in the Programme should be fluid, and the theme groups could be re-formulated through negotiations and according to people’s interests and own needs.
- 3) Problems focus: The most important health problems (called themes) selected as topics for the working groups (theme groups = coalitions) were prioritized through several negotiations and joint discussions with the participants (in connection with the training occasions organized and facilitated by the Project staff) and the trainers. The themes in Somero were: mental health (working name “Well-being”), drug use (“Nine-Drive”), physical activity and back (“Drop”), nutrition and health (“Light Shoe”), agriculture change and health (“Bull”), use of alcohol (“The Glancers”), men’s health (“Man Gang”), and healthy school (“Towards Healthy Habits”). In Järvenpää the themes were: mental health (working name “MieTas”= “Mental Balance”, abbr.), drugs and alcohol (“Straight into Vein”), promotion of physical activity (“Enlightenment”), nutrition and health (“Goody-Goody”), living environment and health (“Utopia”), insecurity and rootlessness (“Together”), attitudes of life (abbr. “ElAs”), civil defence (“Defenders”).
- 4) Change intervention was intended to be bottom-up led and process-oriented. The people themselves planned and implemented the interventions in the community, and the preparation of the community analysis (including small surveys and statistical research projects etc. using the Participatory Action Research -approach).
- 5) Improvement and involvement: The ultimate outcome was expected to be community empowerment. However, the desired outcomes (expressed by the people themselves) were on several occasions negotiated and discussed with the people involved in the experimental Programme. It soon became obvious that the desired outcomes in the two communities were different to some extent or at least proceeded at a different pace.
- 6) Cyclic processes: The education and action components were dominating in the process while evaluation was continuously made by the permanent staff of the Programme (Project Manager, Project Secretaries, Consultants) in collaboration with the “theme leaders” and participants. The measures taken reflected the results of the evaluation as well as the needs of the participants of the Programme and were thus process-oriented.
- 7) Research relationship, degree of collaboration: In the beginning stage, the Project Manager of the Programme (Eklund) acted also as practitioner of the Programme, change agent, trainer and researcher. The Project Secretaries acted occasionally as co-researchers, participating in the collection of data and in the continuous observation and evaluation, and as trainers, too. Outside research resources – external evaluators – were also occasionally used (e.g. Vertio 1993b, Serkkola et al. 1995).

Table 5. The criteria of the four action research types (by Hart and Bond 1995) compatible with the Somero-Järvenpää Programme.

	Consensus model of society; Rational social management <----->			Conflict model of society; Structural change
Action research type	Experimental	Organizational	Professionalizing	Empowering
Criteria				
1. Educative base		Overcoming resistance to change/restructuring balance of power between managers and workers	Empowering professional groups; advocacy on behalf of patients/clients	Consciousness raising Enhancing user-control and shifting balance of power; structural change towards pluralism; Empowering oppressed groups User/practitioner focused
2. Individuals in groups	Partly fixed membership	Work groups	Interdisciplinary professional groups and negotiated team boundaries Shifting membership	Fluid groupings, self-selecting or natural boundary or open/closed by negotiation. Fluid membership
3. Problem focus		Success defined in terms of social science / or theories of empowerment etc.	Contested, professionally determined definitions of success	Emerging and negotiated definition of problem by less powerful group(s). Problem emerges from members' practice/experience. Competing definitions of success accepted and expected
4. Change intervention				Bottom-up, undetermined, process-led. Problem to be explored as a part of process of change, developing an understanding of meanings of issues in terms of problem and solution.
5. Improvement and involvement				Towards negotiated outcomes and pluralist definitions of improvement: account taken of vested interests.
6. Cyclic processes		Action and research components in tension; action dominated. Identifies causal processes that are specific to problem context and/or can be generalized	Spiral of cycles, opportunistic, dynamic	Action components dominant Change course of events; recognition of multiple influences upon change Open-ended, process driven
7. Research relationship, collaboration	Occasionally outside researcher. Differentiated roles	Consultant/researcher, respondent/ participant	Outside resources	Practitioner researcher/ co-researchers/ co-change agents. Shared roles.

The knowledge and experience of the participants of the Somero and Järvenpää Programme were directly honoured and valued as suggested e.g. by Freire (1970) and Reason (1994).

The growing interest towards action research may also be explained by the trends towards decentralization. E.g. in Finland the health care financing reform, enforced in 1993, required decentralization and gave more autonomy to the municipalities. The understanding that health institutions must change (as in this case towards an autonomy of communities) if they are to deal with the changing circumstances of societies suggests that people at the local level, people working in the institutions in the health field, and particularly people served by these institutions should be the most appropriate change agents. In other words, the people themselves must, to an increasing extent, take care of their own affairs in the community. They are no longer expected to rely only on professionals or on the state municipality authorities. Consequently, the direction of the development process should be from learned helplessness towards learned hopefulness (Zimmerman 1990a). The social change expected in Somero-Järvenpää was that the people become empowered and that the empowerment/participatory approach or philosophy will become an integral part of the community infrastructure and local health policy.

In the Somero-Järvenpää Programme the action research approach had two objectives: Firstly, to produce knowledge and action directly useful to the group of people participating in the Programme – through consultancy, adult education, research (foreknowledge to staff through literature reading), and other social action (activities planned and implemented by the people themselves). And secondly, to empower people in health matters at a second and deeper level through the process of constructing and using their own knowledge. This was the meaning of consciousness raising (Freire 1970, 1996) within the Programme. The third starting point was the authentic commitment, genuine collaboration. The change agents (both the participants of the Programme and the staff) were expected to commit themselves to work within the values of the participants of the development process, and to honour the wisdom of the local people. A key element here was dialogue and the subject-subject relationship between the researcher/Programme leaders and the people involved in the process. Through the dialogue it was assumed to be possible to produce more profound understanding of the situation. As the emphasis of the Programme was on empowerment in health, the actual methodologies, which in orthodox research would be called research design, data gathering and analysing etc., took a place second to the emergent processes of collaboration and dialogue that empower, motivate, increase self-esteem, and develop community solidarity.

5.2.1.2 The intervention approach

The Programme was implemented as an empowering action research (inspired by Freire 1970, Starrin and Svensson 1991, Hart and Bond 1995) as described above. The researcher, acting at the same time as Project Manager of the programme, participated in all the phases of the development process during the period of 1991–1994, after

which her role shifted to that of an external researcher⁶. Process consulting approach⁷ and education (using active learning pedagogic introduced by Freire 1970) were the major means in the input of the Programme. At the beginning of the process the emphasis was on strengthening local coalitions building and networking (= structure) (Butterfoss et al. 1993) and on encouraging the people to prepare their own community health analysis based on surveys planned and conducted by the participants of the Programme (skills and knowledge, sense of community). Figure 5 illustrates the elements (and key concepts) of the development circle.

The process of community empowerment begins with an assumption that a power deficit (Kieffer 1984, Swift and Levin 1987) or an unattended social problem exists (Freire 1970, Hart and Bond 1995) despite some competencies. Psychological empowerment may require some individual personal development, such as increases in self-esteem or self-efficacy (Rotter 1966, Bandura 1977b and 1982, Gruber and Trickett 1987, Rappaport 1987, Zimmerman and Rappaport 1988, Zimmerman 1990b, Wallerstein 1992, Israel et al. 1994, Rissel 1994) to the point where that individual is willing and able to join a group and function effectively within it (Rissel 1994). Joining mutual support, self-help or action groups builds and expands social networks and provides an opportunity for a personal mentor (Kieffer 1984, Swift and Levin 1987, Rissel 1994) or a group to support a personal development process. At the same time, individuals may become critically aware of how political structures operate and affect them and their groups. This critical consciousness raising (Freire 1970, Oakley 1989, Hart and Bond 1995) may occur through participation in a group or other mediating

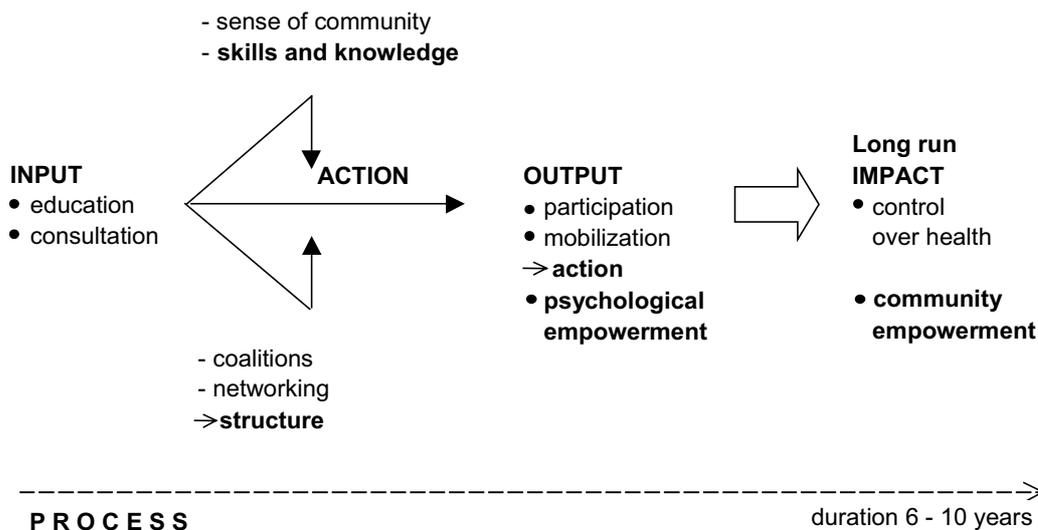


Figure 5. An illustrative model on the key elements of the development process in Healthy Somero and Healthy Järvenpää Programmes (Eklund et al. 1995).

⁶ The researcher/Project Manager (Eklund) moved to Sweden to another job in summer 1994, after which she was involved in the Programme in the role of external researcher. No new Project Manager was appointed.

⁷ The external Educators and the permanent staff (a full time Project Manager, three part time Project Secretaries, and the Executive Director of FCHE) of the Programme were acting as Process Consultants in the intervention. The “process consultancy “ in this study is defined as an approach where the education, support, and supervision were directed towards strengthening the sense of community, building up networks and collaboration between the groups and different organizations, and in general building all the enabling circumstances for the process. In the training, negotiations and discussions with the participants of the programme the process consultants must purposefully avoid providing “right answers” to the questions or matters raised by the participants. The expertise was limited to technical assistance like computer aid, assistance in implementation of interviews, lay-surveys etc.

social structure. Participation in and influence of a group or organization is an important stage of both psychological and community empowerment (Green 1986, Florin and Wandersman 1990). It is the means by which people learn skills, which they may then be able to transfer to other situations, and by which communities develop their problem solving capacity.

Participation in collective action is fundamental to the successful redistribution of resources, which is necessary before a community or group can be said to be empowered (Wallerstein 1992, Rissel 1994). The emphasis on community action as a core component of community empowerment (Brown 1991) is also consistent with the principles of health promotion (Minkler 1994a) and voluntary organizations (Rodriguez et al 1994). Issues being addressed by the group or community should be or have been identified by the group (Bracht and Tsouros 1990, Hunt 1990, Rimpelä 1993, Eklund et al. 1995).

An essential concept which is linked to community empowerment is the “sense of community” (Chavis and Newbrough 1986, McMillan and Chavis 1986, Chavis and Wandersman 1990, Wallerstein 1992), which is considered as a catalyser to increased participation and problem-focused coping behaviours (Bachrach and Zautra 1985). In the broader sense of the word community, a community and its cohesiveness seems to have some parallels with ‘group cohesiveness’. (The words ‘community’ and ‘group’ are used interchangeably in the community psychology literature, Rissel 1994.) Pressure to conform to groups or communities may be the mechanism by which groups exert influence on members to participate and act socially. McMillan and Chavis (1986), though, noticed that community members are also attracted to communities where they feel they are influential and that these forces operate concurrently. Figure 6 illustrates the key concept 'community empowerment' and the process by which it may be achieved (by Rissel 1994). The process of psychological empowerment is enhanced by the sense of community, and that psychological empowerment plus collective political or social action plus an actual increase in control over health constitute community empowerment.

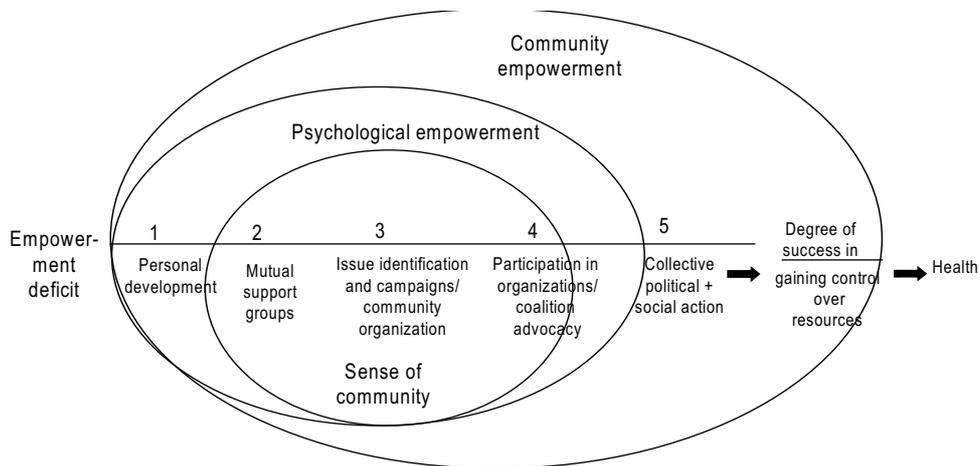


Figure 6. Model of the critical components of community empowerment and the process by which it may be achieved (Rissel 1994).

5.2.2 Evaluation

Evaluation in the form of fact-finding about the results of the action/intervention is central to action research and provides the means of establishing whether or not the action has led to an improvement. (e.g. Green and Kreuter 1991, Patton 1991, Stecher and Davis 1991, Fink 1993, Hart and Bond 1995). In the Somero-Järvenpää case the researchers were interested to find regularities, patterns or rules expected (hypothesized) to lead into community empowerment, control over health, and health political action. The prime analytic task was to "uncover" and explicate the ways in which the participants of the experimental Programme came to understand, commit themselves to, account for, take action and manage with the development procedures leading to the above mentioned goal or some optional goal defined by the participants themselves. The research was concerned with the genesis or refinement of a theory of empowerment as a developmental continuum.

There are diverse models of evaluation (Øvretveit 1998a, 1998b) and approaches to evaluation (Greene 1994, Øvretveit 1999, Øvretveit and Aslaksen 1999). Greene emphasizes that it is not the methods but rather whose questions are addressed and which values are promoted, that distinguishes one evaluation methodology from another. Green and Kreuter (1991) divide health promotion programme evaluation into three levels: *process*, *impact* and *outcome*. Process evaluation is also referred to as *formative evaluation*. In the process/formative evaluation, the potential objects of interest include programme inputs (= the strategy or theoretical tenets of the programme, the plausibility and specificity of programme goals and objectives, and the resources allocated like funds, personnel and space, and the support given e.g. consultancy or education), implementation activities [like staff performance (management, roles, support, structure, commitment), tools of intervention (consultation, action as tool, theme group formulation), measures taken by the participants], and stakeholder reactions.

According to Stecher et al. (1991) and Green and Kreuter (1991) impact evaluation normally assesses the immediate effects the programme has on target behaviours and their predisposing, enabling, and reinforcing antecedents, or on influential environmental factors.

In outcome evaluation the objects of interest have traditionally been health status and quality-of-life indicators (Nutbeam 1998). They are typically referenced in terms of mortality, disease, or disability rates for a given portion of population as in the heart health and correspondent disease prevention programmes (e.g. Puska et al. 1985, Mittelmark et al. 1986, Green and Kreuter 1991). However, even if the research has confirmed that participation and empowerment as such are health enhancing (e.g. Wallerstein 1992), the focus of this research was *not to verify the changes of the health status of the population* of the community or of the core participants/activists of the Programme. The understanding and explaining the development process leading/or not leading to community empowerment was the main focus, and whether it was possible to induce empowerment.

The emphasis of the assessment of the Somero-Järvenpää Programme was thus in the process of empowerment development, but some aspects of the outcome and impact levels were considered as well.

"Stakeholder reactions" included the follow-up of the participation among Programme recipients and their commitment to the Programme. Moreover, the responses of participants to the empowering intervention were considered as stakeholder reactions: the development of motivation to participate, of opinions about learning, of perceptions about participation and about the purpose of the Programme, and finally, by triangulating all the elements of the assessment, the development of empowerment.

In the Somero-Järvenpää case the focus was on the social change enabling the development of empowerment, as well as on predisposing and reinforcing factors promoting the process or factors hindering the process, and finally on the changes of the environmentally influential factors, social structures, networks and mechanisms enabling the creation of community empowerment.

The meaning of “community” in this study

The focus is on individuals' and citizens' perspectives and interpretations of the different aspects of empowerment and the development process as well as on their community as a setting for a programme for empowerment. However, since the process of empowerment is a synergistic interaction between different levels of analysis, it can never be an individual outcome or personality variable measure in isolation from the social setting, claims Wallerstein (1992). Individuals participate in changing societal conditions and in the process individuals also become transformed. The construct, psychological empowerment, best embodies the interrelatedness between individual variables and their social context such as one's self-efficacy about being involved in one's community.

In addition to psychological empowerment variables, a comprehensive measurement of empowerment would analyse the organizational and community settings where the intervention is taking place, which settings and historical conditions are conducive to promoting participation and psychological empowerment, or which conditions may constrain this development (Wallerstein 1992, Rappaport 1987). Measurements must also focus on the changes in the settings themselves, as to whether, as a result of the intervention, the organizations and communities are becoming empowered to exert a greater influence in the larger society. (Wallerstein 1992).

The measurement of organizational and community empowerment requires the existence of “community” as the smallest unit of analysis. Moreover, a “community” would require some shared history, values, and interdependence and mutual interest (see e.g. Butterfoss et al. 1993).

The intention of the Somero-Järvenpää Programme was to involve, step by step, the whole community (“as many of the inhabitants as possible”) during a hypothetical time period of ca. 10 years. However, to investigate the empowerment concerning the whole municipality needs data like interviews of the policy makers, review of the written documents of the community, decision making documents etc. There were no resources to expand the study towards this direction as it would have required several researchers' involvement and collaboration. The actual data (questionnaires, interviews, diaries etc.), on which the results (facts) are grounded, is the data concerning those people who were included in the Intervention and the Programme. Thus the word “Community” in the empirical part of the study comprises merely the “Healthy Somero” and “Healthy Järvenpää” Programmes and their participants (and not e.g. the whole municipality of Järvenpää or Somero).

5.2.3 Operationalization and indicators

The key concepts of the study were citizen participation and empowerment. In this chapter the operationalization and the indicators of the key concepts will be presented:

**Citizen participation*

In the present study ‘participation’ was seen both as a tool or a catalyser (Fonaroff 1983, Green 1986, WHO 1986a, Brownlea 1987, Oakley 1989) for empowerment and for implementing the development procedures, and also as an end of the development process where ‘participation’ has become a characteristic feature of the people or of the community involved (Green 1986, Oakley 1989, Bracht 1990, Bracht and Tsouros 1990).

Participation was seen as a tool for achieving empowerment, and it was a kind of management technique where the nature of participation was passive, static and temporary. In this case the intention was that the expertise, skills, knowledge and experiences of the local people could be utilized as widely as possible within the Programme, and it was expected that as many people in the community as possible should participate in the Programme. The aim of the participation was conscientization

i.e. sensitizing people (Freire 1970, Oakley 1989) towards health issues and problems in the community and to strengthen their ability to respond to these matters.

According to Zimmermann and Rappaport (1988), *Citizen participation* means: "Involvement in *any* organized activity in which the individual participates without pay in order to achieve a common goal." Bracht and Tsouros (1990) complemented this definition by emphasizing that participation of people should focus on activities aiming at a social change. Hence, in the Somero-Järvenpää case, when participation was used as a tool for conscientization, and social change for empowerment, it was necessary that the people participated in the intervention Programme in the first place, and then become, step by step, empowered.

Indicators measuring this type of participation in the study (through observation, accounting, bookkeeping and questionnaires) were:

- Description of participants (accounting, questionnaire)
- Number of participants in the training occasions (accounting)
- Existence of a core group, committed to the process for at least two years (accounting)
- Permanence of theme groups (observation, bookkeeping)
- Time consumed for the Programme per year as estimated by the participant (Zimmerman and Rappaport 1988) (questionnaire)

At the same time, participation was considered as a dynamic social process, the end point of which is the act of participation itself. Participation during the development Programme was seen as a dynamic and unpredictable phenomenon developing all the time according to the needs and interests of the people and to the continuously changing situations in the Programme. It was assumed that, at best, participation remains a permanent characteristic of the people and will be integrated as a structural part into the community life, and in the long run participation would become an ideological basis for local health policy. (Oakley 1989, Bracht 1990, Bracht and Tsouros 1990, Hunt 1990, Bracht 1991).

Indicators of participation as an end (consequence, characteristic) were limited to the Programme activities:

- Motivation for participation (questionnaire, interview)
- Perceptions about the participatory tasks of different actors (Rifkin et al. 1988, Zimmerman and Rappaport 1988) (questionnaire)
- Perceptions about participation (questionnaire, interview)
- Perceptions about the purpose of the Programme (questionnaire, interview)
- Representativeness in community planning and other community organs (observation, interviews, written documents)
- Participation in political action (observation, interviews, written documents)
- Perceptions about the participation in decision making (interview, questionnaire)

* *Empowerment*

Referring to Zimmermann and Rappaport (1988) *empowerment* is a construct that links individual strengths and competencies, natural helping systems, and proactive behaviours to matters of social policy and social change. It is a process by which individuals gain mastery or control over their own lives and democratic participation in the life of their community. *Psychological empowerment* is the expression of this construct at an individual level. Its elements are perceived efficacy, self-esteem, and a sense of causal importance. Furthermore, the *community empowerment* means self and political efficacy, perceived competence, locus of and desire for control.

In this study the indicators measuring the psychological empowerment were as follows (through interviews and questionnaires, through the questions concerning motivation, learning and understanding the purpose of the Programme):

A. Personality dimensions:

- **self-acceptance** and increased self-confidence (Zimmerman and Rappaport 1988) and strengthened self-esteem (Rappaport 1985, Zimmerman and Rappaport 1988, Zimmerman 1990b)
- **internal locus of control** (Rotter 1966, Gurin et al. 1969, Levenson 1974, Gruber and Trickett 1987, Zimmerman and Rappaport 1988, Zimmerman 1990b, Wallerstein 1992, Israel et al. 1994, Rissel 1994): According to Rotter (1966) internal locus of control refers to one's expectations that he/she can exert control over his/her environment, thus influencing rewards and punishments. Levenson (1974) added that the items of locus of control are concerned with whether one can affect what happens to him/herself, but the items do not imply that an individual will control his or her life in a positive direction.
- **chance control** (Zimmerman and Rappaport 1988, Israel 1994, Rissel 1994)
- **belief in powerful others** (Zimmerman and Rappaport 1988)
- **Control ideology**: the belief that people in general, but necessarily oneself, can influence social and political systems (Zimmerman and Rappaport 1988)
- variables of empathy or other **emotional** variables (Wallerstein 1992): learning to know oneself, mental maturation, empathy and understanding other people, etc., meaningful content of life, and fulfilment

B. Cognitive dimensions:

- **self efficacy** (Bandura 1977b, Rappaport 1985, Zimmerman and Rappaport 1988): belief in capability to organize and execute the course of action required to deal with prospective situations (Bandura 1992), and confidence in capability to regulate one's motivation, thought process, emotional states and the social environment as well as behavioural attainment (Bandura 1992), and confidence in one's capability to overcome the difficulties inherent in achieving a specified level of behavioural attainment (Mailbach and Murphy 1995). Efficacy beliefs operate through choice behaviour, effort expenditure and persistence, and thought patterns and emotional reactions. (Wallerstein 1992).
- **self and political efficacy expectations** (Tipton and Worthington 1984, Zimmerman and Rappaport 1988): the belief that one has the skills and ability to achieve goals
 - a) **sense of mastery** (Pearlin et al. 1981, Zimmerman and Rappaport 1988)
 - b) **perceived competence**: skill assessment (Florin and Wandersman 1984, Rappaport 1985, Zimmerman and Rappaport 1988). Perceived improvement in skills and knowledge through participation in the Programme.
- **political efficacy** (Craig and Magiotto 1982, Rappaport 1985, Zimmerman and Rappaport 1988): the belief that it is possible to influence the political process and community decision making:
 - a) **Internal PolEff**: one has skills necessary to influence political systems
 - b) **External PolEff**: belief that the political system is responsive to change efforts
- **sense of political efficacy**: the feeling that individual political action does have, or can have, an impact upon the political process, i.e. that it is worth while to perform one's civic duties. It is the feeling that political and social change is possible, and that the individual citizen can play a part in bringing about this change (Campbell et al. 1954).

C. Motivational dimensions:

- **desire to control the environment** (White 1959, DeCharms 1968, Zimmerman and Rappaport 1988, Zimmerman 1990b, Wallerstein 1992)
- **civic duty (or sense of civic obligation)**: the belief that one ought to participate in the political process as a responsibility to others. It is the feeling that oneself and others ought to participate in the political process, regardless of whether such political activity is seen as worth while or effective (Campbell et al. 1954, Florin and Wandersman 1984). It includes a concern for the common good and a sense of connectedness to others (Zimmerman and Rappaport 1988).
- **sense of causal importance** (Zimmerman and Rappaport 1988) **and purposefulness** (Wallerstein 1992) → **learned hopefulness** (Zimmerman 1990a)

D. Contextual/Other dimensions:

- **involvement in collective action** (Rappaport 1985) for exerting control in the social and political environment: perceiving the programme as a channel for influencing decision making

- ecological and cultural influence (Zimmerman 1990b) = contextual oriented conception → "**person-environment fit**"
- **cultural awareness** (Zimmerman 1990b, Wallerstein 1992, Israel 1994), and **consciousness raising** (Freire 1970, Hart and Bond 1995)
- **understanding of the purpose of the programme** (Eklund et al. 1995)

The following indicators were selected as indicators of the community empowerment (questionnaires, interviews, observation, local newspaper articles, and accounting lists):

- communities achieving equity of resources (Katz 1984)
- communities identifying their problems and solutions (Braithwaite and Lythcott 1989)
- increased participation in community activities (Chavis and Wandersman 1990, Florin and Wandersman 1992)
- raised level of psychological empowerment among the members of the programme (Wallerstein 1992)
- improved neighbourhoods (Chavis and Wandersman 1990)
- stronger sense of community (Chavis and Wandersman 1990), reported as "us-feeling" (Eklund et al. 1995)
- ability of communities to make critical analysis of the world (Wallerstein 1992)
- people identifying themselves (with others) as members of community (Wallerstein 1992)
- improved quality of community life (Wallerstein 1992)
- improved social justice (Wallerstein 1992)
- political action component (Minkler 1994a, Rissel 1994) = Participation in decision making and political action in health (e.g. learning how to organize themselves for managing a community problem, reported initiatives and respondents' involvement in decision making, participation in planning or other committees)
- achievements in redistribution of resources or in decision making (Rissel 1994)
- **control over health** and destiny (= CoH, Zimmerman 1990b):
 - people have learned how to manage time
 - people have learned how to organize themselves
 - identifying resource providers
 - ability to work with others for common goal, learned team-working
 - understand factors that influence decision making
- **community competence** (Cottrell 1976): ability in groups to identify problems, select goals and act for social change (e.g. ability to use local media as a tool)

Note that the indicators for the community (broader) level of empowerment were mostly limited to the subjective perceptions of the informants and their descriptions of the actions implemented by the theme groups within the Programme. Additionally, through bookkeeping, observation notes, and reviewing the Programme documents, it was possible to verify the participation in community activities organized by the programme and to calculate the actual measures implemented by the theme groups. (Achievements, campaigns, initiatives, concrete results like written reports etc.)

A thorough analysis of the objective reality of the modified conditions for the entire community empowerment was excluded from the present study.

5.3 Study design, data collection and analysis methods

5.3.1 Study design

The design of the study in concern can in a real sense be seen as analytic. According to Denzin and Lincoln (1994) choices of conceptual framework, of research questions, of samples, of the "case" definition itself, and of instrumentation all involve anticipatory

data reduction¹⁰, which is considered as an essential element of data analysis. The choices made during the life of the "Somero-Järvenpää" Programme had a focusing and bounding function, ruling out certain variables, relationships, and associated data, and selecting others for attention. These measures already required creative, analytical work.

At the beginning of the Programme a "loose" more inductive -oriented design was selected (action research) because the area (empowerment) was unfamiliar and excessively complex, a real case in authentic settings was involved, and the intent of the research was exploratory and descriptive, particularly at the early stage of the experiment (1992–1994). Getting gradually towards (inductively) a description and explanation of the pattern of relationships between the conceptual elements of the development process was the intermediate goal of the research.

The difference between the evaluation and the action research approaches is based on the extent to which the research is systematic, and the extent to which there is a special role for the researcher as distinct from the people or group being researched. (Patton 1990) Under these circumstances, in the first place, the Healthy Somero-Järvenpää Programme was considered as an action research during the period of 1991–1994. The permanent staff of the Programme acted as researchers and change agents, who naturally attended all development phases of the Programme until the summer 1994. The people in the action research period were directly involved in gathering information and assessing the process, and the results (e.g. Eklund et al. 1995, Serkkola et al. 1995) were used internally to solve specific pragmatic problems within the Programme or in the community. After 1994 the researcher was not involved in the Somero-Järvenpää Programme in the role of an inside educator/consultant or a change agent any more, but in the role of an external researcher only. Concerning the evaluation aspect of the analysis a more formal design existed, while in the action research the design and data collection were more informal.

The study design consisted of a combination of the "historical record keeping", the "periodic inventory" and the "experimental" approaches (Patton 1991) The idea was to observe two municipalities in which data was collected as in time series. (Green and Kreuter 1991). Similar intervention was implemented in both communities.

- Design 1: Action research and intervention:
– refers to the action research development circle and the education, consultation and other supportive procedures
- Design 2: "Historical record keeping" approach (Patton 1991)
– refers to collection of data – like tables, accounting lists, charts, graphs, diaries, memos - as an ongoing account of what was occurring in the Programme (e.g. The number of people who participated was counted and registered, and the impact of different activities, educational occasions, etc., could be noted as changes in participation)
- Design 3: "Periodic inventory" approach (Patton 1991)
– refers to making a special effort periodically (rather than continuously) to collect data: Participant questionnaires in 1992, 1994 and 1996, and theme interviews of the key persons of the Programme in 1996 represented this design.

Sometimes the "historical record keeping" does not incorporate the data required, and changing the system, perhaps expanding it, would be too disruptive to the programme. Hence, instead of accumulating the data on an ongoing basis only, the data was also obtained by conducting special questionnaires including a wide range of open-ended non-structured questions. Participant questionnaires were made repeatedly to

¹⁰ Data reduction refers to the process of selecting, focusing, simplifying, abstracting, and transforming the data that appears in written-up field notes or transcriptions (Miles and Huberman 1994, p. 10).

collect information about the participants' perceptions about the purpose of the Programme and about participation in general, experiences and opinions about the Programme, and about the ways of action in the theme groups during the Programme. In addition to questionnaires, theme interviews of the key persons of the Programme were made in 1996 using a tape-recorder.

In addition, "interim case summaries" (Miles and Hubermann 1994) were used to provide syntheses about what the researchers and field-workers knew about the cases indicating what procedures might have been needed and what may have remained to be found out. According to Miles and Huberman, "interim case summaries" normally present a review of findings up to that date, a careful look at the quality of data supporting them, and the agenda for next waves (Figure 7) of data collection and for measures to be taken in the Programme.

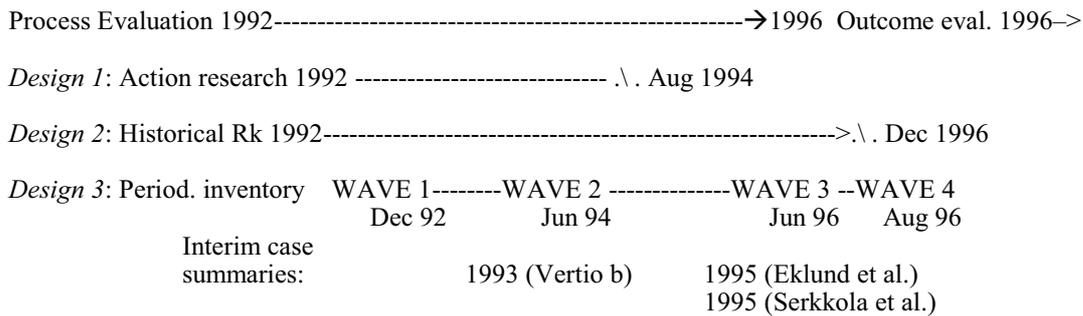


Figure 7. Research strategy.

5.3.2 Implementation and organization of the Programmes

Planning and organizing

An plan of intent was made to start the Healthy Somero-Järvenpää Programmes in which the idea of promoting citizen participation, foundations for its importance, aims, as well as general outlines were crystallized. A more detailed research and work plan was not made, because such a plan was considered as binding the people to outside conditions. When external suggestions and plans were left as open as possible, the operation was allowed to proceed and find its form based on estimations of common needs. The progress and main characteristics are described in Table 6.

The board of the Finnish Centre for Health Education and Promotion (FCHE) appointed a group of experts from the member NGOs, associations and authorities, presided by Per-Erik Isaksson from Samfundet Folkhälsan, and the Project Manager acting as secretary. The task of the group was to follow-up the fulfilment of the undertaking and to give support when necessary, and also expert advice and supervision where desired. Additionally its task was to give opinions and first hand formal approval concerning the annual application to RAY (Slot Machine Association) for a grant. In practice the meetings (which were held in Helsinki at the FCHE) were informative in their character. The group assembled four times a year on the average during 1991–93 and less frequently later on. When needed, the members of the group were consulted individually.

In 1990, a Project Manager was hired, to be in practical charge of the Programme and to develop the ideas and the education intervention. In 1991, training and consultation co-operation was agreed upon with an outside consultant. Together with the director of the FCHE they formed a working group in which the operation idea of the Programme was developed. In December 1991 a part-time Project Secretary was hired for the undertaking.

Late in the autumn of 1991, a more formal management group was named for the Programme, including Project Manager, Executive Director of the FCHE, Consultant, and the part-time Project Secretary (Figure 8). Also the local part-time Project Secretaries, hired in the spring of 1992 to Järvenpää and of 1993 to Somero, were part of the group. The task of the initial phase consultant ended in the spring of 1993 (Figure 9).

The relationship between the “management group” and the theme groups of the Somero and Järvenpää Programmes changed over time. The management group’s role shifted from one of initiator, educator and supervisor towards that of a facilitator. Furthermore, the intention was to move towards a role of a background supporter only, and withdraw totally as soon as the local people and local Project Secretaries involved would manage on their own.

The work place of the Project Manager and the first part-time Project Secretary was the FCHE located in Helsinki. The city of Järvenpää hired a part-time Local Project Secretary in May 1992, partly with their own funds and partly with funds from the FCHE. In Somero, a part-time Project Secretary was hired in spring 1993 with funds from the FCHE.

The Project Manager was in charge of the planning and evaluation of the Programme, and for co-ordination of the Programme. Towards the municipalities, her job was to act as consultant and supervisor, she made consultations and trained when necessary, rendered services (e.g. interviews assigned by theme groups), and acted as supervisor to other project workers. In these varying duties the Project Manager was assisted by the Project Secretary. Both had a wide scope job description, from the roles of expert and supervisor to running practical office routines.

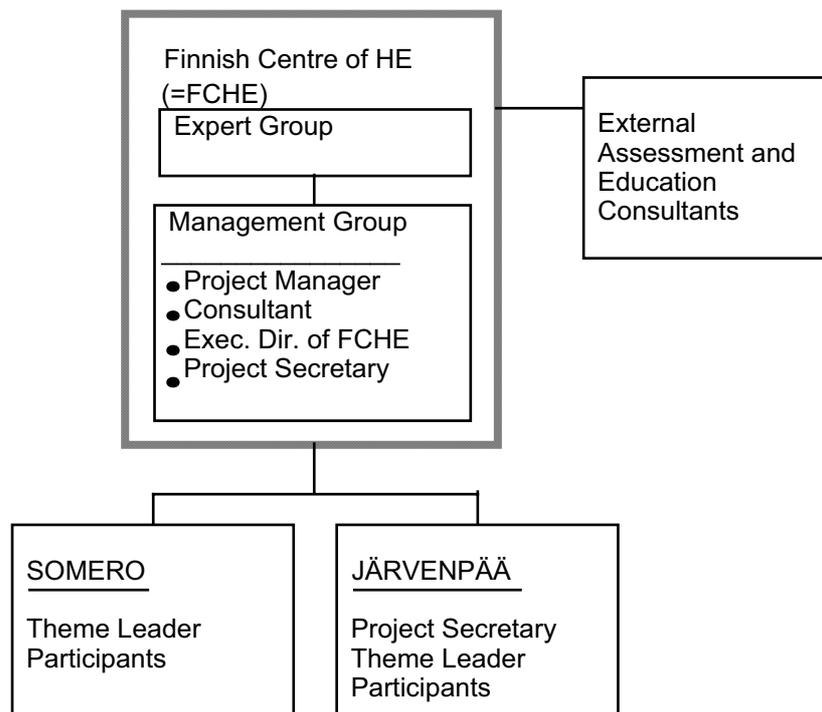


Figure 8. Project organization 1992– (summer) 1993.

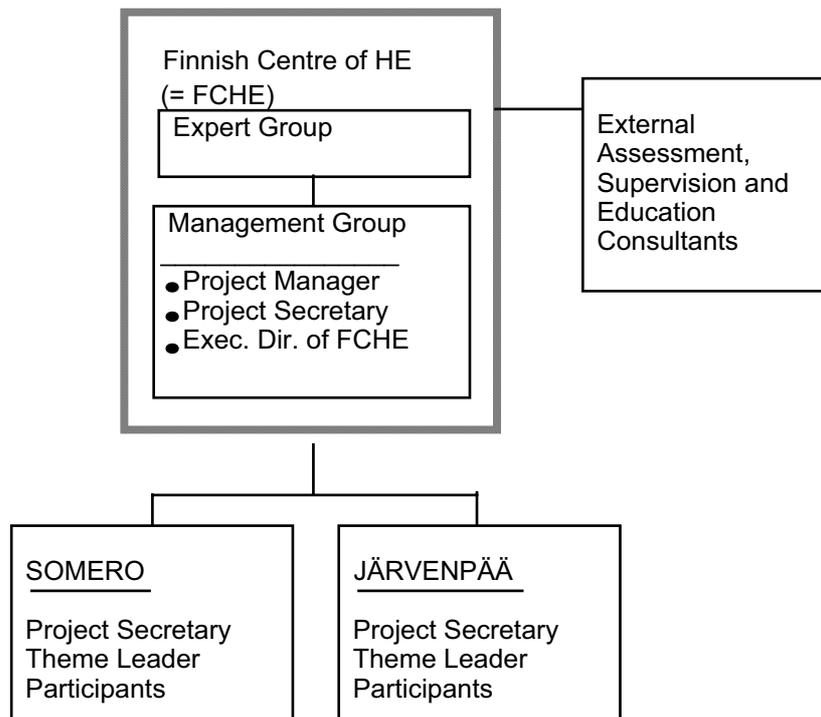


Figure 9. Project organization (autumn) 1993 – (summer) 1994.

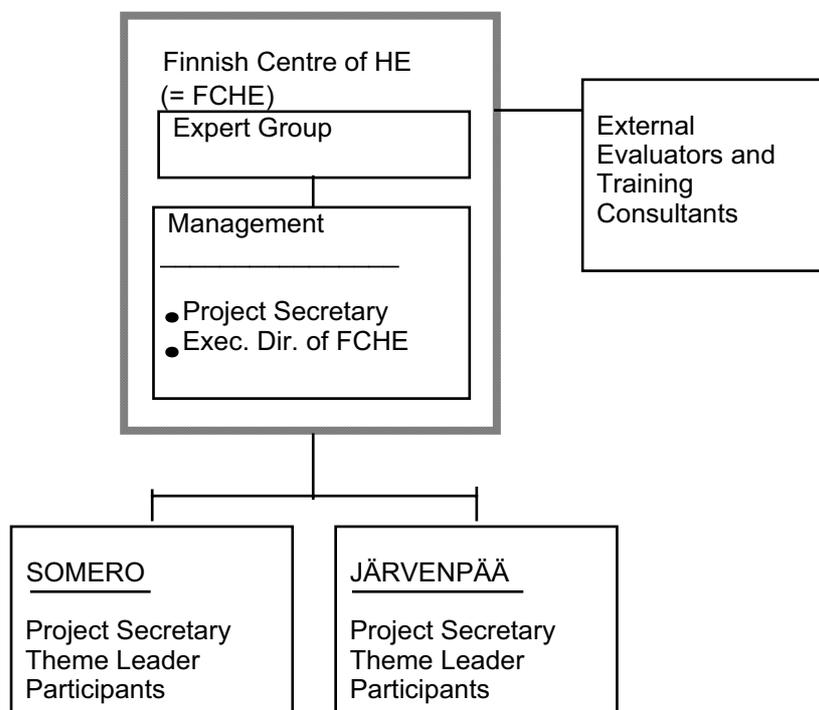


Figure 10. Project organization (summer) 1994 – end of 1994.

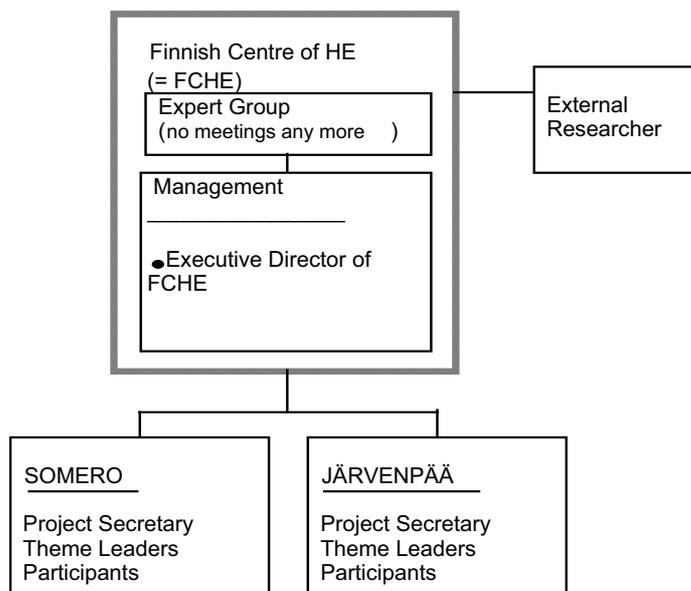


Figure 11. Project organization 1995–1996.

The Executive Director of the FCHE participated in the training sessions as a trainer and supervisor of the project staff. The outside Consultant took part in the planning and evaluation in co-operation with the FCHE employees, and he was practically in charge of the training intervention from August 1991 to May 1993. He also acted as a supervisor for the Project Manager and Secretaries. In spring 1993, another consultant evaluated the development and future of the programme (Vertio 1993b). And in 1994 a similar external interim evaluation was done (Serkkola et al. 1995).

The job of the local Project Secretaries was to create and maintain connections, support groups, render services towards the Healthy Somero-Järvenpää meaning that they did various chores according to the needs of the theme groups, and acted as assistants to groups and as local activity supervisors.

The local residents participating in the Programme had a duty to act as local experts in matters of community needs and priorities, as active planners and performers of the Programme, as data collectors and distributors, as founders and active parts of networks, and as local agents of change, etc. theme leaders were appointed by the groups themselves to be in charge of the groups. Their duty was to call the groups together, give information, act as group chairmen and participate in the fulfilment of various activities prepared by the groups jointly with other group members.

With the support of the process consultants (external consultants and the Programme staff) the groups were active in the area of health promotion, using their own ideas, skills and methods appropriate in the local context. This support was almost totally withdrawn at the end of 1994 and the groups were left under the supervision of the local project secretary and the leaders of the theme groups (Figure 11). The special training for empowerment organized by the permanent staff of the Programme ended in autumn 1995. After this the training occasions (which actually were more or less lectures or evening entertainments, or get-together events with local speakers) were planned and organized by the theme groups. The theme groups themselves selected the topics of the lectures and found the speakers.

Preparation procedures and selection of communities

The first action of the Healthy Somero-Järvenpää Programmes was to select the municipalities in the fall of 1991. Because it was supposed that the provincial governments were well informed about the municipalities in their region and had

knowledge about their modes of action and development stages, the Executive Director and the Project Manager of the FCHE contacted the provincial governments of Uusimaa, Häme, and Turku-Pori. These provincial governments were selected due to their close geographical location to the FCHE Centre. Negotiations were arranged between the Heads of the Social and Health Department, County Doctors, and Public Health Care Examiners.

The provincial governments suggested a few municipalities in priority order. Kerava and Järvenpää from Uusimaa, Somero and Ulvila from Turku-Pori, and Valkeakoski and Lempäälä-Vesilahti from Häme were the first candidates. The provincial governments also provided names of the persons to be contacted in the municipalities.

When selecting the communities the aim was to include municipalities known to be *co-operative*, and the managements were expected to have an at least somewhat *affirmative attitude* towards this kind of endeavours. Other factors affecting the selection were size, geographical location, economic structure, interest of NGOs, and readiness to commit. Because the size of the personnel in the project was small, the consideration was that the *size* of the municipality could not be very large in order to keep the project in control. A municipality with 30,000 residents at the most was considered suitable. As the planning, supervision, co-ordination and evaluation of the project would take place at the FCHE Centre, it was considered an advantage if the municipality to be included in the Programme would be *geographically close* to Helsinki. Such location would save time and expenses on travels. It was further agreed that one municipality of different provinces would be selected. Municipalities with different *source of livelihood* structure were searched. One service-trade-oriented and one agriculturally oriented were required. The aim was to include an industrial region later on if allowed by financial and personnel resources. One of the selection criteria was that the municipality itself and the non-governmental organizations (NGOs) there show sufficient *interest towards the programme*. A minimum of 30 people per location had to be available for the initial training phase of the development plan. Municipalities with enough volunteers willing *commit* to work for at least one year in the project would be included in the Programme.

The FCHE representatives contacted the municipalities in the fall of 1991 starting from the ones closest to Helsinki. It was decided that the first two municipalities that fulfill the above criteria in the best possible way and show interest in participation would be selected. The decision concerning inclusion of a third municipality was postponed to a later date.

Järvenpää with its service-trade-orientation and Somero with its agricultural domination had decided about their participation by the beginning of 1992. The management in both municipalities showed obvious interest. The towns were small in size, Somero 10,000 and Järvenpää 30,000 inhabitants. The communities were located within a reasonable distance from Helsinki (Järvenpää less than 50 km and Somero appr. 100 km). No other municipality was approached at this stage, the decision was to continue the ongoing process with these two municipalities and see whether they would be interested in and have desire to work for a longer time within the Programme, too.

The main activities, training, and other procedures

Community meetings, training, and various kinds of events and exercises (Table 6) were an important part of the intervention, serving to identify issues, to reclaim a sense of community and emphasize the potential of "liberation", to make sense of information collected by the people, to reflect on the progress of the project, and to develop the ability of the community to continue the development process.

Table 6. Main activities and occasions of the Somero-Järvenpää Programme.

Month/ Year	ACTIVITY
8-12/1990	Finnish Centre for Health Education and Promotion (FCHE) hired a Project Manager. Organising the "HFA 2000 Healthy, developing community" –seminar series.
1-7/1991	Programme interrupted on account of the 14th World Congress on Health Education.
8/1991	Project group is formed and training consultant is assigned.
9-10/1991	Negotiations with leading officers of the provincial administration in Uusimaa, Häme and Turku-Pori counties to find the experiment municipalities.
11-12/1991	Negotiations with the official management of three municipalities: Järvenpää, Somero and Kerava. Kerava showed no interest. Co-operation will commence with Somero and Järvenpää. Work plan was approved by the HFA 2000 experts group (consisting of 10 members) of FCHE. Decision was made to hire a part-time Project Secretary for FCHE.
1-2/1992	Training I - Open info sessions in Somero (Sro) and in Järvenpää (Jpää) to launch the project.
2-3/1992	Training II (1.5 days) – Series of training lectures on "Health and Health Problems of the Community" begins in both locations: Discussion on health status and problems, assignment of theme groups and theme leaders.
4/1992	Training III (0.5 days) – Report on group work, clarifications, continue planning.
5/1992	Training IV (0.5 days) – Group work in theme groups continues, introduction to planning at municipal level. Decision to arrange a joint seminar for Jpää and Sro in NAANTALI during fall 1992.
5/1992	City of Jpää hires a part-time Project Secretary.
8-9/1992	Training V (0.5 days) – Theme groups examined the data from interviews, questionnaires and other materials they had gathered, and made plans for a poster exhibition in Naantali as an interim report of community diagnosis.
11/1992	Training VI (2 days) – Somero and Järvenpää joint training seminar in Naantali, including a poster exhibition based on the materials the theme groups had collected concerning the communities.
11/1992	HEALTH-92 fair in the Helsinki Exhibition Centre (4 days), where Healthy Somero and Healthy Järvenpää poster exhibitions on display for the second time.
12/1992	Project group evaluation meeting at FCHE (0.5 days). Outside evaluation consultant is appointed to interview theme groups, theme leaders and project leaders.
12/1992	1 st Participant Questionnaire to all project members
1/1993	Project group evaluation seminar (2 days). Project management, representatives of Healthy Somero and Healthy Järvenpää Programmes, local project secretaries, training and evaluation consultants.
2/1993	Training VII - Reporting back the results (feed-back) on participant questionnaires. The theme groups present their drafts of lay community analysis to be published as Healthy Somero and Healthy Järvenpää reports. Plenary discussions concerning the participants' future visions about the Programme.
3/1993	Training VIII – "Healthy Somero 1992" and "Healthy Järvenpää 1992" reports completed. The external training consultant assignment finishes.
3/1993	A part-time Project Secretary is hired by FCHE for Somero.
3-4/1993	Poster exhibitions on display in Järvenpää and Somero. Completed lay community diagnosis reports "Healthy Somero 1992" and "Healthy Järvenpää 1992" handed over to city management.
4/1993	Healthy Somero and Healthy Järvenpää project poster exhibition in connection with the "HFA 2000 INITIATION symposium" in Hyvinkää (2 days).
4/1993	"1 st Mental Health Market" in Järvenpää. Event planned by the Healthy Järvenpää theme groups, "MieTas" –group having the main responsibility

5/1993	Training IX (0.5 days) - Discussion on the Evaluation Consultant's report. Based on the 1 st participant questionnaire and consultants' evaluation the training theme is updated as "communication and health marketing as project guiding factors". End of Evaluation Consultant assignment.
6/1993	"1 st Midsummer rowing" - City sports campaign" of Healthy Somero. Event planned by theme groups in Somero, the "Drop" group having the main responsibility.
9/1993	Training X (0.5 days) – "Brainstorming as tool for health promotion and planning".
10/1993	Training XI (2 days)– Training cruise, and excursion to Tallinn. Joint event of Sro and Jpää planned by the participants themselves. Two guest representatives from the "Healthy Dragsfjärd" project.
11/1993	Training XII (2 days) – "Communications and health marketing" - group work where the participants of the Programme prepared radio and TV programmes plus newspaper articles under supervision and in co-operation with professionals of trade.
12/1993	Training XIII (0.5 days) – Group works on communications and marketing continue. Evaluation of results and plans for 1994.
12/1993 -5/1994	Public events and campaigns planned and implemented by Jpää theme groups, such as "Together at Christmas Eve", "2 nd Mental Health Market", "Year of the Family – decision makers' and citizens' forum with public discussion -event", "Carrot sausage designed with sausage manufacturers", "Healthy food - cooking course".
1-6/1994	Public events and campaigns planned and implemented by Sro theme groups, such as "Healthy Somero - drawing and essay contest", "Healthy Somero on display at Somero Fairs", "Healthy environment in Somero - series of seminars in co-operation with the local open college", "Check your liver -campaign", "Walkingtest and sports day", "Towards Healthy Habits -school children's own health programme" starts, "Visit without invitation -how to lessen loneliness campaign", "Smokefree Somero".
5/1994	Training XIV (0.5 days) – Evaluations of completed work, planning for future. Decision made to organize joint seminar in Jpää in autumn -95. In Sro, "Smokefree Somero" was selected as main theme of the autumn.
6/1994	2 nd Participant Questionnaire to all participants of the Programme.
6/1994	2 nd Midsummer Rowing" - city sports campaign". Event planned by theme groups.
8/1994	End of Project Manager assignment. The Project Manager takes the role of an external researcher of the Programme.
10/1994	Training XVI (1 days) – Joint meeting of the participants of the Somero and Järvenpää Programmes
11/1994	Training XVII (1 days) – Training by outside consultant - Course on volunteer activities
6-12/1994	Preparation of "Healthy Somero 1993" and "Healthy Järvenpää 1993" reports. Events and campaigns planned by theme groups in Somero and Järvenpää.
10/1994	"3 rd Mental Health Market" in Järvenpää
1/1995-8/1996	End of FCHE organized training supporting empowerment. Theme groups draw up independent plans jointly with and under supervisions of the Local Project Secretary to arrange own training which are converted to lecture and public evening entertainment sessions.
6/1995	"3 rd Midsummer Rowing" in Somero.
10/1995	4 th Mental Health Market" in Järvenpää
5/1996	3 rd Participant Questionnaire to all Programme participants
8/1996	Theme interviews of the participants of the Programme
12/1996	End of project financing by Slot Machine Association (Raha-automaattiyhdistys). End of financial support by the city of Järvenpää which covered part of the salary of local project secretary. End of Project Expert Group.

Supportive procedures

Supportive procedures included also measures directed outwards from the core Programme and activities included in the main intervention. Such measures were e.g. creating enabling conditions for community empowerment, mechanisms of decision

making procedures in the community and people's possibilities to influence the direction of local health policy. Actually these measures occurred occasionally without thorough planning.

The local media was used as a tool in strengthening the participants' commitment to the process as well as a means to attract more people into the Programme. Information of the activities and development of the Programme was given to the media by the participants of the Programme through press conferences, press releases etc. Several articles and local radio programmes were prepared by the media professionals, which increased the visibility of the Programmes at the local level.

Observing and reflecting

The data concerning the development of the change process was collected during the life of the Programme and occasionally given to the "participants"/"activists" both as feedback and in preparation of the next stage of operations. E.g. the questionnaires of the participants of the Programme were implemented at 2 years' intervals, analysed and the results given as feedback to the participants. Furthermore, the results and participants' own ideas about future visions were continuously discussed on the training occasions and during various activities of the Programme (see e.g. Eklund et al. 1995, Vertio 1993b).

Financing

The Healthy Somero-Järvenpää Programmes were put into effect with support from Finland's Slot Machine Association (Raha-automaattiyhdistys = RAY)¹¹, and funds were applied separately for each year. The city of Järvenpää funded part of the salary of the part-time Project Secretary during 1992–1996. The Slot Machine Association's funding was discontinued after 1996.

5.3.3 Materials

Data consisted of material resulting from local Programmes, like written documents and diaries, minutes of Programme meetings, action plans of the local people, observation notes of the development process, notes from discussions with the participants, interim case summaries, and data collected in a more systematic way like open-ended questionnaires and the transcribed text of theme interviews.

¹¹ Finland's Slot Machine Association (RAY = Raha-automaattiyhdistys) is the only organization of its kind in the world. It operates slot machines and casino games in Finland and it has an exclusive right to engage in these activities under Finnish law (Lottery Act and Slot Machine Decree). RAY's basic function is to raise funds through its gaming operations in order to support the work of voluntary health and welfare organizations (NGOs). This Finnish method of providing care and assistance has been benefiting people since 1938. RAY is an association of 96 voluntary organizations, but each year funds are granted to almost one thousand organizations, which provide assistance to tens of thousands of people in Finland. Gaming is controlled by the Ministry of the Interior, and the distribution of assistance is supervised by the Ministry of Social Affairs and Health. RAY's Board of Administration (the members of which are either appointed by the Council of State or elected by member organizations) prepares a proposal for the distribution of assistance, but the final decision is made by the Finnish Government. (RAY 1998)

Participant questionnaires

The questionnaires of the participants (Participant questionnaire) were conducted in 1992, 1994 and 1996. A questionnaire was sent to each participant of the Programme and to all persons who had participated in at least one training occasion or information occasion of the programme. The addresses of these people were registered in the FCHE's address register and consisted of local NGOs, health and social care professionals, other officials working in the community, staffs of all schools, local pharmacies, as well as some local enterprises. The local authorities assisted in finding the addresses.

Altogether 200 questionnaires in Somero and 210 in Järvenpää were sent in 1992 (54 in Somero and 46 in Järvenpää responded, total N = 100). In 1994, 115 questionnaires in Somero and 106 questionnaires in Järvenpää were sent (39 in Somero and 35 in Järvenpää responded, total N = 75). In 1996, the questionnaire was sent to 179 persons in Somero and 178 in Järvenpää (response rate: Somero 38 and Järvenpää 35, total N = 73).

Age, marital status, size of family, and social background of the respondents (considered to be the activists of the Programme, too) in 1992 were analysed to give an approximate picture of the demographic character of the participants. In Somero, one fourth of the participants were 60 years or older, one fifth were between the age of 50–59, almost one fifth represented the age group 40–49, and one fifth represented the group '70 years or older'. The middle age of the participants was 53 years in Somero.

In Järvenpää, the majority of the respondents were in the age groups 30–39 years (25%) and 60–69 years (25%). The middle age of the participants was 49 years.

38% of the respondents in Järvenpää and about 50% in Somero were married or lived together. The persons in Somero had more children (average 2–3) than those in Järvenpää (average 1–2). The people in Järvenpää had a higher education than in Somero. In Järvenpää the majority (28%) had at least a high school level education and almost one fifth held an academic degree. In Somero, the typical education background was elementary school and some additional training. One third had a vocational school degree and only a few had an academic degree.

In Somero, almost one third of the respondents were lower clerical employees, one fifth farmers or entrepreneurs, and about 15% higher clerical employees. One third worked in the social sector in the municipality, little less than one third within agriculture and forestry. About 12% worked in the municipality administration. A half of the respondents in Somero were retired and one third worked full time. Only 15 persons had earlier experience from participation in projects or correspondent activities connected with voluntary action, working in committees, and political or trade union action.

In Järvenpää, almost 60% were lower and 27% higher clerical employees. A half of the respondents in Järvenpää worked in the health and social sector, 13% in other service sectors, 13% in commercial sector. About 60% had a full-time job, and only 35% were retired. About 15 persons had earlier experience of working in projects connected with supporting their daily work.

(The distribution of the age and social background of the activists according to the participant questionnaires in 1994 and 1996 remained about the same).

The open-ended questionnaires included questions concerning the participants' perceptions about community participation, opinions about the Programme, motivation of involvement in the Programme, perceptions about their own learning process and an estimation of time and money they have used for the Programme. Structured questions concerning the participants' social background were included as well, like education, occupation, age, marital status, number of children, earlier experience in projects, and participation in NGOs. In addition, there were questions in which the participants' opinions about the Programme in general (organization, management, activities, education, proposals for the future) were inquired. This latter information was primarily used to improve the Programme and make decisions about the next measures to be taken in the Programme.

Diaries, observation notes, notes from discussions and minutes of meetings

The data was completed by continuous discussions between the researchers and the participants as well as by observation in connection with all educational and other development occasions and activities during the action research phase of the Programme. This data was collected as diary notes and minutes of meetings. The Project Secretaries in the two communities and the team group leaders kept diary about the activities and other remarks concerning the process (topics, discussions and decisions in the group meetings, essential notes and descriptions concerning their work etc.).

Theme interviews

Theme interviews of the key persons of the Programme (Somero $n = 21$, Järvenpää $n = 14$, FCHE $n = 1$, total $N = 36$) were conducted in 1996. Eight of the interviewees in Somero were men and 13 women, the age ranged between 31–75 years, the average age being 54 years. There were 10 persons standing for the NGOs and eight for the authorities, and three represented other instances. The theme groups “Wellbeing”, “Towards Healthy Habits”, “Drop”, “Bull”, “Nine-Drive” “The Glancers” and “Man Gang” were represented. Also the local project secretary was included representing authorities, because the salary was paid by the city of Somero (although financially supported by the FCHE).

In Järvenpää four of the interviewees were men, 10 women, the ages were between 34–64, the average age being 48 years¹². Six of the interviewees in Järvenpää represented the NGOs and eight the authorities. The theme groups “Utopia”, “Goody-Goody”, “MieTas”, “Together”, “Enlightment”, “EIAs” and “Straight into Vein” were represented. The Project Secretary was included in the group ‘authorities’, being employed by the city of Järvenpää.

In addition, the part-time Project Secretary of the FCHE (who assisted both communities) was included among the interviewed, the age being 39 years. The data of this particular interview was excluded from the comparative analysis concerning the empowerment measures of participants in the two towns, because the person could not be calculated to represent either. However, the material was used as clarifying, complementary information concerning the implemented activities or the general managerial and organizing matters of the Programme in Somero and Järvenpää.

The interview-guide was based on the literature on empowerment. The themes were: motivation for community involvement, perceptions about what participation is, considerations about the aims of the Programme, opinions about the health problems and needs of the community, opinions about the Programme, description of the function and measures in the theme groups, perceptions about personal individual development, recruitment procedures, visibility of the Programme, organization of the Programme, decision making in the community, role of authorities and NGOs in the community, and several themes included in the dimensions of psychological and community empowerment, as well as visions about the Programme.

The tape-recorded theme interviews were typed word by word for conducting a qualitative analysis with the assistance of the ATLAS.ti computer programme specially designed for this (see Fielding and Lee 1991, Mühr 1991, Moilanen and Roponen 1994, Richards and Richards 1994, Kelle 1995).

¹² One person in Järvenpää did not tell the exact age -> $n=13$

Articles in media and programmes on TV and radio

The visibility and appearance of the Healthy Somero-Järvenpää Programmes was investigated by collecting the material (articles, programmes) published in the media during 1992–1994. Their amount was calculated and the content analysed.

Other written documents and “Interim Case Summaries”

- * Reports: "Terve Somero 1992" (Eklund 1993)
"Terve Järvenpää 1992" (Eklund and Bergström 1993)
"Terve Somero 1993–1994" (Aaltonen et al. 1995)
"Terve Järvenpää 1993–1994" (Sassi et al. 1995)
- * Minutes of the meetings in Somero and Järvenpää, (altogether 16)
- * Official initiatives of the groups, letters to authorities, decision documents of the "city health boards"
- * Other miscellaneous documents and correspondence

Qualitative studies tend to have a peculiar life cycle, one that spreads collection and analysis throughout a study, but one that calls for different modes of inquiry at different moments. These inquiries in this study are called, according to Miles and Hubermann (1994) and Denzin and Lincoln (1994), as 'Interim Case Summaries'. In this case they are the reports by Vertio (1993b), Eklund et al. (1995), and Serkkola et al. (1995) and the minutes of the evaluation meeting in Naantali, December 1993.

These reports and documents were reviewed several times without coding them and used in the verification of the results and triangulation.

5.3.4 Analysis methods

The approach of the analysis process could be labelled as *abduction*, including both inductive and deductive procedures: The analysis of the written questionnaires was *inductive* in character, because any pre-determined framework was not used. The categories were raised mainly from the data to be investigated.

For the analysis of the theme interviews¹³ (August 1996) an operationalized conception about empowerment and participation was developed based on the literature (see pages 76–79). And furthermore, indicators for participation and empowerment were elaborated to be used in the content analysis of the transcribed interview texts. This part of the analysis could be labelled as *deductive*.

Additionally, some small parts of the interview material were analysed in more detail through a method inspired by Grounded Theory. The distinction was that the analysis – codes, concepts, categories, and the supplementing theories – was grounded on the data without pre-knowledge of these fields. The approach of the analysis was hence *inductive*, again.

The final theory building of empowerment was done through hermeneutical approach (Bleicher 1980, Kvale 1996) combining all parts of the puzzle and separate areas of the analysis.

¹³ In the analysis of a theme interview, attention must be paid to the fact that much interpretation on the part of the interviewer occurred along the way of the interview. The interviewed person describing his or her "life world" discovered new relationships and patterns in the topics raised during the interview; The researcher who occasionally "summarized" or "reflected" what she heard, was condensing and interpreting the flow of meanings. Data was, hence, not being "collected" but rather "co-authored" (Patton 1990, Miles and Huberman 1994, p. 35, Kvale 1996).

Content analysis through induction

The evaluation of the empowerment process was implemented through content analysis (see Holsti 1969, Pietilä 1976, Bordens and Abbott 1991, Denzin and Lincoln 1994, Miles and Huberman 1994) and the categories used were raised from the data of the open-ended questionnaires (conducted in December 1992, May 1994, and May 1996). The content analysis was not limited to calculate singular words but the context was taken into consideration, too. To interpret and understand and to recognize the unit as a part of a concept, it was sometimes necessary to take a whole sentence or several sentences as the smallest unit of analysis. The ethnomethodologists claim that a word will be understood only in connection with the context, the semantic environment in which it is expressed (Manning and Cullum-Swan 1994). This is why the analysis method used here could also be labelled as context analysis (see e.g. Honkasalo 1988).

Content analysis through deduction

The interview data (transcribed text) was analysed deductively using the literature based operationalization of the main concepts – participation, psychological empowerment, community empowerment – as indicators of the evaluation. The study respondents in the theme interview conducted in 1996 (N = 36) were bothered by questions dealing with the dimensions of empowerment.

The hermeneutical procedures

The interpretation of the meaning of empowerment and its elements was implemented through hermeneutical procedures, where the understanding of the transcribed text (from the interview, describing also human action) was one step. This step involved a continuous back and forth process between parts and the whole. The analysis started with a vague and intuitive understanding of the text as a whole. The next step was to identify its different parts belonging to empowerment or to some other theme, like decision making in health in general. These interpretations of the different parts were again related to the totality. Then the researcher went back to certain themes and special expressions and looked at their meaning in more detail by using the operationalized instruments and indicators concerning psychological and community empowerment and participation. In this work the ATLAS.ti -programme was used to assist in tracing the elements of empowerment and coding them, and furthermore in creating codes and categories¹⁴.

At this point, when the researcher had reached a good picture of the inner unity in the text, free from inner contradictions, were certain parts of the interview material (like the perceptions of “health” or “way of action”) left for a more detailed analysis by using content analysis or techniques inspired by grounded theory.

The next phase consisted of looking at the first-hand interpretations against the global meaning of the text, and of returning back to the theories and literature of the issues in concern. As Kvale (1996) has stated, the researcher/interpreter must have a wide foreknowledge about the theme of the text one interprets. The carrying through of an interpretation of a qualitative research interview requires an extensive knowledge of the themes of the interview in order that the interviewer may be sensitive to the different connections they may enter, claims Kvale. The approach of this study, to use e.g. the operationalized instruments, is one evidence of this.

However, Kvale continues (1983), the interpreter cannot jump outside the tradition of understanding which he/she lives in, but the interpreter of the text may attempt to

¹⁴ E.g. “Psychological empowerment” was the main category. “Personality element” of psychological empowerment was its subcategory. And “self-esteem” one name of a code belonging to this subcategory, and so on.

make his/her presuppositions explicit, and to become conscious of how certain formulations of a question in a text already determine which forms of answers are possible. What matters here is to be as aware as possible about one's own presuppositions and modes of influence and to attempt to take them into account in the interpretation. This is one of the reasons which makes the study in hand value-laden.

Finalizing the understanding of empowerment involves innovation and creativity. The final step in the hermeneutical procedure was to understand all parts of the data analysis, interpretation of the transcribed texts, reviews of the interim case summaries and other documents, etc. without coding them. The aim was only to understand through combining all parts of the puzzle.

Grounded theory inspired inductive procedures

A grounded theory, basically developed by Glaser and Strauss (1967), is one that is inductively derived from the study of the phenomenon it represents (Glaser 1978, Strauss and Corbin 1990). The research findings constitute a theoretical formulation of the reality under investigation. The concepts and relationships among them are not only generated but also provisionally tested. The research questions in a grounded theory study – which usually tend to be action and process oriented – are statements that identify the phenomenon to be studied.

In this study only small parts of the material from the theme interviews were analysed through a method inspired by the Grounded Theory (Glaser and Strauss 1967). If a theory is to be purely grounded to the data, the researcher must be free from any foreknowledge concerning the phenomena to be investigated. In the case of the present study the researcher had become quite thoroughly acquainted with the literature in the field and consequently the method used here could not be labelled as pure Grounded Theory. However, in parts where the researcher did not use any operationalized instruments (like the analysis of the perceptions about “health” or the “ways of action”), the method could be called as a method inspired by the Theory.

Triangulation in confirming and completing the findings

Triangulation is ‘a technical term used in surveying and navigation to describe a technique whereby two known or visible points are used to plot the location of a third point’ (Knafl and Breitmayer 1989). It was first used in the 1950s in the social sciences to measure a single construct. Garner (1954) and Campbell (1956) noticed triangulation as a tool to confirm and validate the results of a study. Fielding and Fielding (1986) claim that “the important feature of triangulation is not the simple combination of different kinds of data, but the attempt to relate them so as to counteract the threats to validity identified in each”.

Denzin (1978) has described triangulation as a method of confirming findings by showing that independent measures of the research issue in concern agree with it, or at least, do not contradict it. Denzin made a distinction between a triangulation by data source (may include different persons, times, places, etc.); by method (observation, interview, documents, etc.); by investigator (researcher a,b,c,..), and by theory. This list was complemented by Miles and Huberman (1994) with a triangulation by data type (e.g. qualitative text, recording, quantitative accounting and listing of participants and actions), and by Janesick (1994) by interdisciplinary triangulation.

However, basing her claims to the earlier literature (e.g. Jick 1979, Fielding and Fielding 1986) on triangulation, Shih (1998) distinguishes another purpose for triangulation: In addition to confirming the findings, triangulation is used for completing the findings. When using this form of triangulation, one should not expect multiple sources of data to confirm one another. Rather, the expectation is that each source will

contribute an additional piece to the puzzle. Multiple strategies are selected and combined because of their unique angles in addressing the research question, and not because of their counterbalancing strengths and weaknesses. (see e.g. Bennett 1997)

In the critical analysis of triangulation Sim and Sharp (1998) conclude that triangulation raises a number of problematic methodological and philosophical issues. E.g. when triangulation is used to secure validity, it is likely to be in respect of content validity (i.e. scope of findings) rather than criterion-related validity (i.e. the 'accuracy' of findings). Sim and Sharp also doubt whether combining the qualitative and quantitative methods is meaningful at all in triangulation due to the fact that these methods come from different epistemological frameworks (e.g. the nature of know-ledge, what is knowledge).

The validation triangulation in the Somero-Järvenpää case consisted of data sources (collected from several people, and in different times and from two communities), data collection methods and data type (observation, questionnaires, interviews, accounting lists, written documents), analysis methods (the phenomenon was investigated using several types of approaches in the analysis; content analysis, grounded theory inspired methods, hermeneutical method, action research, and pro-gramme evaluation), discipline (public health, social sciences, educational sciences), and paradigm (critical science, interpretivism, constructivism, symbolic interactionism). In the final analysis of understanding the empowerment and in the theory formulation the triangulation was considered additionally as a procedure for completing the findings.

5.4 Summary of the theoretical and methodological approaches in the Somero-Järvenpää Programme

The empowerment process as described in literature aims to an improvement in individual and community health and to a competent community. The difference of the approach in this study was, however, that instead of focusing on long-term targets like health and competent community, the main emphasis was on the short-term target of building a new model of action for health promotion based on the philosophy of empowerment. The intention of the Programme was to establish both a structure and a channel that would support continuous participation in health policies. Moreover, this study was aimed at creating an evaluation method for such development programmes, and submit it to empirical testing.

Previous empowerment experiments lack intervention and induced empowerment process. As the theory or model involved here was designed for the development of municipalities, the experiments tested the feasibility of inducement, factors promoting or obstructing the process. A critical examination of the relevant theories and literature was conducted. The empirical data was used in testing the evaluation instruments. The progress of the development of the empowerment process was described while endeavouring to make the process explicit.

The models produced by previous studies further lack the element of "structure". Empowerment cannot be constructed without an attachment to a social context (Zimmerman 1990b, Wallerstein 1992). The previous models describe the development of psychological empowerment, also community empowerment elements have been described, but building a community empowerment has been the object of experimentation in only a few projects, and seldom the object of research (Wallerstein 1992).

A social change as a target intends to change existing organizational structures and prevailing action models in a municipality (Swift and Levin 1987). Community empowerment is therefore built on three cornerstones, the individuals go through personal development, the groups of individuals comprise a community which grows together, and the social infrastructure must be changed to enable and support empowerment (Figure 12):

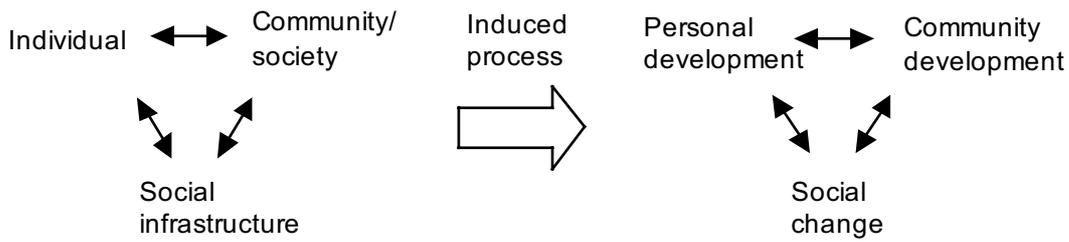


Figure 12. The three cornerstones of community empowerment development.

In evaluating the Programme, the data and the process of the project was examined, as well as the impact and the outcome from the aspect of empowerment theories. In this theory "participation" and "sense of community", "community action" etc were elements of empowerment process. The empowerment process can also be dealt with the concept of learned hopefulness (Zimmerman 1990a), which follows psychological empowerment. As community empowerment on the other hand is a group phenomenon, it cannot here be interpreted from an individual point of view, but from that of a community. The community in this study was limited to the people involved in the project, which means that a 'community' means here both the 'Healthy Somero Programme' and the 'Healthy Järvenpää Programme'.

The intervention Programme forming the basis of the empirical part was thus carried out as action research and evaluated during the development process with methods typical of this kind of approach such as observation, interviews, discussions etc. This material was evaluated interim to serve the decision making and planning concerning the advancement of the project. In the present study the material in full, including the final theme interviews, was the focus of the entire re-evaluation from the aspect of empowerment.

6 Results

6.1 Participation

6.1.1 Participants and activists of the Programme

Participation in the different training occasions, theme group meetings and other activities organized by the Programme were calculated and marked/recorded on the accounting lists, which included the name of the participant, the organization, the theme group the person represented, as well as the name and date of the occasion or activity in concern. If the person attended at least one training occasion, the person was counted as a participant of the project and included in the address register of the Programme.

In Somero almost a half of the participants who attended the training sessions of the Programme at least once, (n = 179), represented NGOs. (Figure 13). One third of the participants announced not to represent either a NGO or any organization (labelled in Figure 13 as "independent"). About a fifth represented authorities, a few worked in business (like banks, pharmacies, stores), and a couple of persons were church officials. A half of the participating authorities (n = 31) in Somero came from the health and social sector, 39% came from the school and youth sector, and the rest from other sectors. A third of the participating NGOs (n = 80) represented agricultural organizations, and about one fourth Public Health organizations¹⁵. Sports and leisure time organizations were represented with 16%, 12% were handicap and 11% pension organizations. There were also some representatives from political and other organizations.

The majority of those ca. 60 persons who participated in the Programme actively (four times or more) in Somero (Figure 14) came from the NGOs (80%), 10% were authorities and 10% "independent" or other participants.

In Järvenpää about 178 persons attended the Programme training at least once (Figure 15). From these the authorities formed the biggest group (38%), about a third represented NGOs and a little less than a third were calculated as "independent". (The person had not informed which organization he/she represented, this was done either on purpose or the bookkeeping was insufficient particularly concerning the years 1995-1996). A few persons were Church representatives.

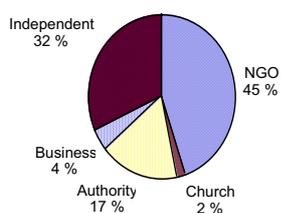


Figure 13. Distribution of participants (%) who attended at least once by the organization they represented (Somero, n = 179).

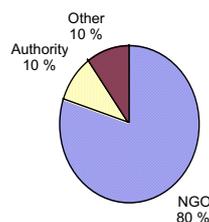


Figure 14. Distribution (%) of those who participated in 4 or more training occasions by the organization they represented (Somero n = 60).

¹⁵ e.g. Diabetes Association, Psoriasis Association, etc.

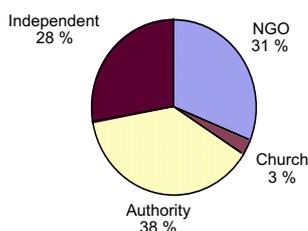


Figure 15. Distribution of participants (%) who attended the Programme at least once by the organization they represented (Järvenpää, n = 178).

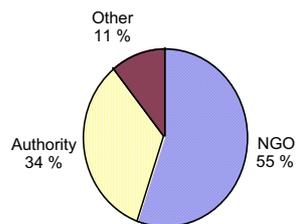


Figure 16. Distribution (%) of those who participated in 4 or more training occasions by the organization they represented (Järvenpää n = 56).

The majority (ca. 80%) of the participating authorities in Järvenpää (n = 67) represented the health and social sector, the rest was shared by school and youth and other sectors. A little less than half of the NGOs (n = 56) represented Public Health organizations. The next biggest group was handicap organizations. Agricultural (11%), pension (7%), sports and leisure time (5%), and political (4%) organizations were represented to some extent. In addition there were one or two representatives from various other NGOs in Järvenpää.

About 56 persons attended the Programme actively (four times or more) and of these little more than a half were NGO representatives, 34% authorities, and the rest “independent” or other representatives. (Figure 16).

There were almost the same number of participants and activists in both of the communities. In Somero, the NGOs were more eager to participate, whereas in Järvenpää the Programme raised more interest with the authorities. A notable remark was that in Järvenpää fairly many wanted not to represent either the NGOs or the authorities, informing themselves to be “independent”, even if in most cases they were members of either one. The reason from the NGO’s side was that their organization considered that participating in this kind of programme is not the field of NGOs, but that their task is to be an advocate of some patient group instead. The authority representatives who wanted to be registered as “independent” considered the participation in the Programme to belong to leisure time, particularly in Järvenpää, when the administration of the town decided (1995) that their staff was not allowed to use their work time to participate in the Programme. After this, a few of the authority representatives ceased to attend, but some of them continued to represent the authorities and a part informed to represent “themselves as citizens” (in the figures labelled as “independent”).

6.1.2 Participation in training

Bookkeeping was held of the attendance in the training occasions organized by the FCHE (during 1992–1995) and by the participants of the Programme (mostly during 1995–1996). The topics together with the course and content of the discussions were documented in the minutes of the meetings.

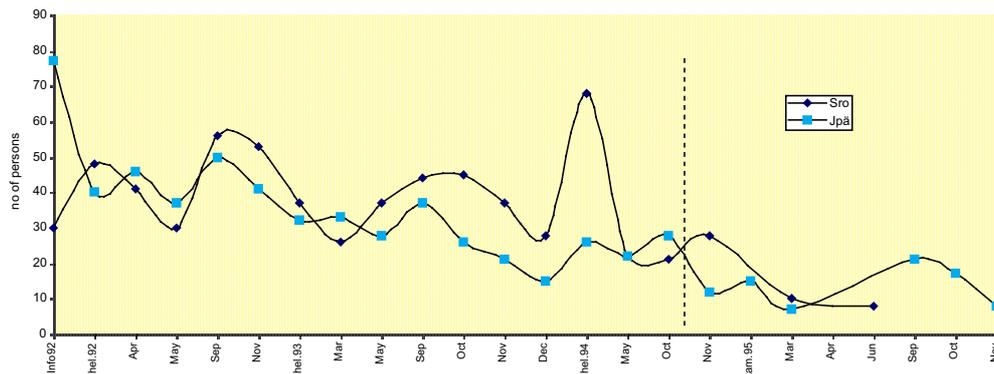


Figure 17. Number of persons participating in training occasions 1992–1995 by community.

Until the autumn of 1995, 19 training occasions were organized in Somero, and 22 occasions in Järvenpää focusing especially on skills and knowledge needed for the community action for health (topics: democracy and decision making in the community 1992, preparation of community diagnosis and local health policy 1992–93, communication and the use mass media 1994, teamworking 1995). The majority of the training took place during the period of 1992–1994 after which training by the FCHE was provided in a slowing momentum. Only two training occasions were organized in 1995 and after that the training supporting the development of empowerment was totally finished. Later the project participants organized training occasions on their own on current topics, or the “training” was limited to theme group meetings which took a form of discussions conducted by the Local Project Secretary. These meetings were informative in their character. (The vertical broken line shows the time where the empowerment training conducted by the FCHE was withdrawn).

About the same “core group” of some 20–30 people participated as actors (Figure 17) until the end of 1994, not only in training occasions, but also in planning (mostly during the theme group meetings) and implementing the different activities within the Programme. After 1994 a decreasing trend was seen in the training participation. According to the accounting lists there were less than 10 activists left in Järvenpää, while the same figure in Somero was somewhat higher – about 15 persons in 1996. The interest to participate had a slowing tendency every year, particularly towards the summer.

The peaks in the curves were connected to assignments which were considered particularly interesting, like preparation of the community analysis (“lay community diagnosis”), putting together a poster connected to the community analysis, organizing and participating in the Poster Exhibitions and joint seminars (Somero and Järvenpää together), exercises with media, or study visits like the excursion to The Estonian Centre for Health Promotion in Tallinn.

Figure 18 shows that in both communities there was a small core group, which participated actively in at least a half of the occasions organized by the FCHE. There was a group of 35 persons who participated in every fourth of the training occasions in Somero, but in Järvenpää only 15 persons participated as frequently. The number of persons who attended the training only a couple of times was a little higher in Järvenpää than in Somero.

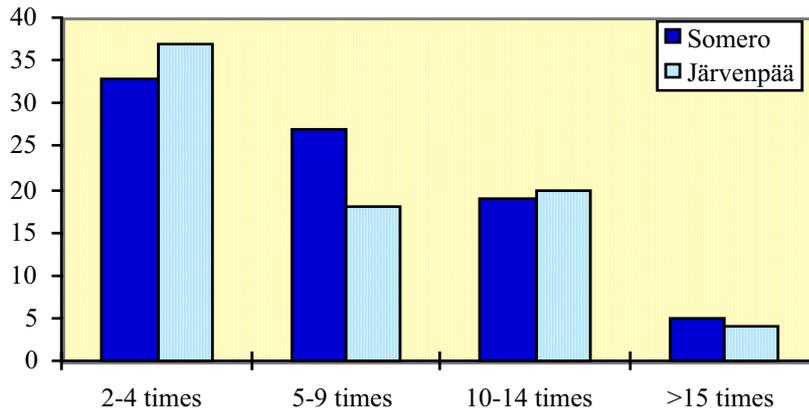


Figure 18. Activists of training occasions by town.

The distribution of the gender of participants was calculated according to the participant address register kept by the FCHE. The majority of the participants of the Programme were women (75%) and about 25 % men in both communities.

6.1.3 Use of time

The questionnaires in 1992, 1994 and 1996 included a question in which the informants were asked to estimate the time in hours they had used in participating/working in the Programme per year.

The time (Table A, Annex 5) participants used for working in the Programme per year was about the length of a normal working week in Somero (ca. 40 hours) and about 60 hours in Järvenpää in 1992. According to the questionnaire in 1994 the time consumed for the Programme decreased in the following year, indicating a decreasing enthusiasm and tiredness to commit to actions which took place particularly during 1994–96. The same trend was reported in 1996, with the distinction that Somero used twice as much total time for the Project than Järvenpää. The average time used for the Programme per person was 22 hours, but as there seemed to be more people involved in the process in Somero than in Järvenpää, the responsibility was divided between a larger group of people in Somero than in Järvenpää.

6.1.4 The “core group” and the permanence of theme groups

The establishment or development of theme groups was assessed through calculating the different activities the person took part in as well as through observing what kind of tasks the persons were assigned to. The permanence of theme groups was estimated through bookkeeping: the project secretary kept records of which group the person belonged to and marked the changes.

Figures 17 and 18 show that during the first three years the Programme had generated theme groups which proved to be particularly permanent in both communities until 1994. A moderately permanent group of about 30 people in both communities was formulated, consisting of very actively participating members, who took part in about 75% of the training and other activities of the Programme. This group, which then was labelled as the “core group” shrank to about 10 persons in Järvenpää and to about 15 persons in Somero by summer 1996. These persons were mainly acting as theme group leaders of the Programme.

6.1.5 Motivation

The motivation to participate was asked for in connection with the questionnaires of 1992¹⁶, 1994¹⁷ and 1996¹⁸ with three open-ended questions: “Can you estimate why you participated in the first occasion?”, “What was the reason for you to participate in the Healthy Somero-Järvenpää Project?”, and “Specify the thing/things, which have kept you in the project”. The first question was analysed only in 1992 and is separately shown in Figures 19–20 (marked “Beg 92” = beginning 1992), and omitted in the analyses in 1994 and 1996, because it was assumed that people have difficulty to distinguish the reason for participating in the first meeting in 1992 and remember this separately from the other motivational reasons. The answers to the two next questions were combined in the analysis referring to their similarity. The respondent had often answered only either one of these two questions, not both.

The answers were analysed with the content analysis technique, using either one word or several words or even a longer sentence as a unit of analysis. The classification was done using categories raised inductively from the data. (The explanation of each of the categories in Figures 19 and 20 is presented in connection with the text below by using examples from the quotations).

The reason/motivation for participation was asked for from the respondents in the theme interviews in August 1996¹⁹ again. The tape recorded and transcribed answers concerning this question were analysed through content analysis using the same classification framework as used in the content analysis of the questionnaires, which were completed with new categories raised from this data.

Somero

In Somero (Figure 19) the curiosity (“Curiosity” = including both curiosity and a general interest towards the Programme without being able to specify this in more detail. E.g.: “...because I was curious what this is all about”, “Well, I am interested in different kinds of activities...”) was the most often mentioned reason for participation. Many participated also because of perceived duty in 1992 (“Duty” = e.g. “I came because it was my duty as a public Health Nurse”, “...my employer sent me there”, “I felt that I have to come and represent my NGO”) but feeling of duty decreased significantly during the process. Feeling of being able to influence decision making (“Infl decis”= e.g. “... because I thought that I can influence the decision making in my community through participation in the Programme”) in the community was low at the beginning of the programme in Somero, but it increased slightly in 1994 and significantly by the summer 1996. The social function of the Programme (“Soc function” = e.g. “... because I had a possibility to meet/learn to know people”, “...because we had such a good time in the groups”, “...because we did things together”) providing an arena for meeting people was one of the most important reasons for participation in 1994 and 1996 in Somero. Being productive (“Results” = e.g. “...it was important to me to see our good achievements”, “...the results kept me in the Programme”) did not play a very important role for the participants in Somero. Personal development (“Pers devel” = e.g. “... I had a possibility to learn new things”, “...developing myself”, “...I assumed that I benefit from this by applying the things I have learned in my daily work”) reported less important than achieving results in 1994 but two years later it was the other way round. About 13% of the participants could not specify the reason for their participation in 1994 in Somero, and

¹⁶ Questionnaire 1992 (Somero: $n_{\text{pers}}=54$, $n_{\text{expr}}=44$; Järvenpää $n_{\text{pers}}=46$, $n_{\text{expr}}=46$); n_{pers} = number of persons who responded; n_{expr} = number of expressions

¹⁷ Questionnaire 1994 (Somero $n_{\text{pers}}=39$, $n_{\text{expr}}=39$; Järvenpää $n_{\text{pers}}=35$, $n_{\text{expr}}=36$);

¹⁸ Questionnaire 1996 (Somero $n_{\text{pers}}=38$, $n_{\text{expr}}=46$; Järvenpää $n_{\text{pers}}=35$, $n_{\text{expr}}=39$);

¹⁹ Interview 1996 (Somero: $n_{\text{pers}}=18$, $n_{\text{expr}}=87$; Järvenpää: $n_{\text{pers}}=13$, $n_{\text{expr}}=76$)

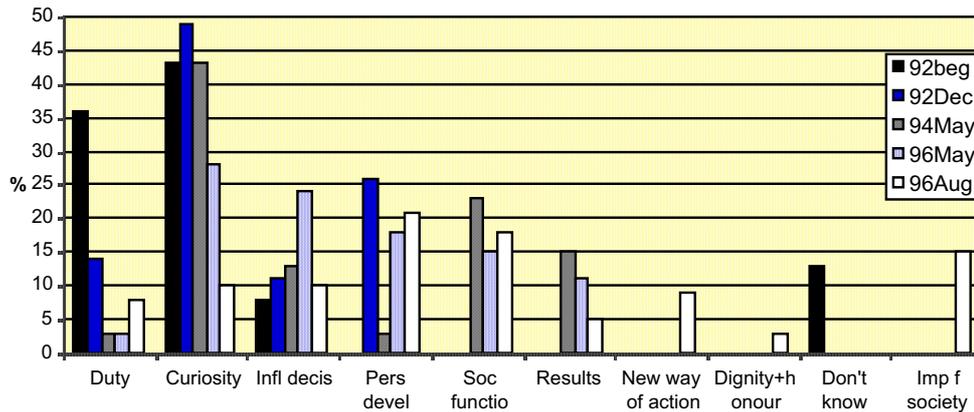


Figure 19. The motives (%) of participation in Healthy Somero Programme.

answered “I don’t know”. In the repeated questionnaires in 1994 and 1996 everyone was able to tell the reason for participation.

In connection with the 1996 interview new motivational factors arose, which had not been mentioned in the previous years at all. The respondents reported such things as “...I felt that through participation in this Programme I am able to make my town better”, or “...I really was happy to notice that the decision makers had changed their attitudes” (“Imp f society” = Felt, actual improvements or changes in the society category). Another new motivation factor was the ‘new way of action’ that the participants felt they had learned (“...this was something new, which we had not done here before, at least not consciously and in such a systematic way...”). There were also people who felt that it was an honour to belong to the Healthy Somero Programme (“Dignity + honour” = e.g.: “...It is something special, fancy,...I feel that we are part of something bigger, like the Health For All 2000 Programme”).

Järvenpää

In Järvenpää (Figure 20) the “curiosity” towards the Programme was high all the time, being the most often reported reason to be involved in the Programme. The feeling that participation is a civic “duty” decreased in 1994 but was moderately high again in 1996. The feeling of being able to “influence decision making” was high in December 1992, but decreased again in 1994 being about the same by summer 1996. The feeling of “personal

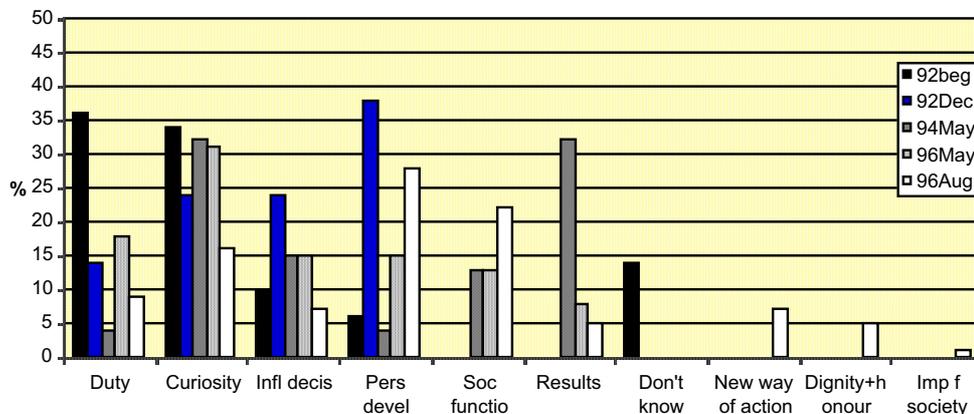


Figure 20. The motives (%) of participation in Healthy Järvenpää Programme.

development” through participation in the Programme was significantly high in December 1992 but in 1994 other motives like the concrete “results” or “Programme providing an arena for social action” (“Soc functio”) gave more satisfaction to the participants. In 1996 “personal development” as a motive played an important role again. In 1994 about 14% of the participants answered “*I don’t know*” to the question “why are you participating”. However, in 1994 and 1996 the reason for participation was clear to everyone. The answers in the interview in 1996 concerning the motivation of the Järvenpää participants showed that the “Improvements for my own society” was not so important as in Somero. However, some of them mentioned the learning of “new way of action” or the “honour” being the motivating factors to some extent.

Argumentation for participation

The different reasons for participation can be grouped to individual, social and health political arguments. Individually oriented motivation comprised curiosity, personal development and feeling of dignity and honour, because they mostly reflect personal motivational factors. The socially oriented motivation comprised the categories of “social function”, “new way of action”, “results” and “duty”. These reflected that the person was also interested in social environment, peers, other people and things happening around. It could also be a sign of the person’s loyalty towards his/her own community. “Influencing decisions” or “improving society” were considered as politically oriented reasons, because most of the expressions belonging to this category included a political action element and either reported actual or, at least, desired issues requiring social change. The motivation to participate is considered in these three dimensions in Figures 21 and 22.

In Somero (Figure 21) the individually oriented reasons were most important during the whole research period but particularly at the end of 1992 (first questionnaire). The socially oriented argumentation seemed to be quite important in the beginning stage of the Programme but was replaced at the end of 1992 by the individual benefits (belief the Programme provides possibilities for individual development and learning). As the Programme developed, the Programme’s social function became important again and the results were an important factor in keeping people in the Programme. The (new) way of action was reported as one of the reasons for participation at the end of the Programme. The politically oriented reasoning for participation showed an increasing trend towards the end of the inspection period. (Those who did not know the reason for participation are also illustrated in this picture. In the beginning of the Programme, about 13 % could not give a reason for participation, but already by the end of 1992 everyone knew why they participated).

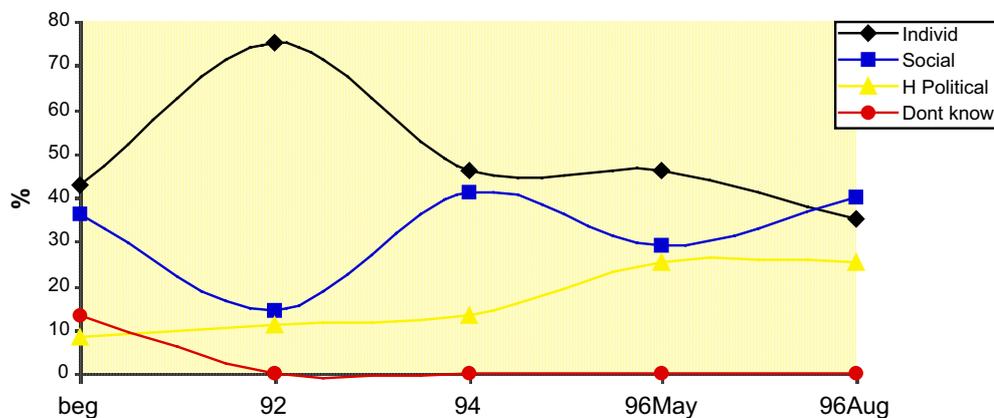


Figure 21. Argumentation for participation during the Programme by time, Somero.

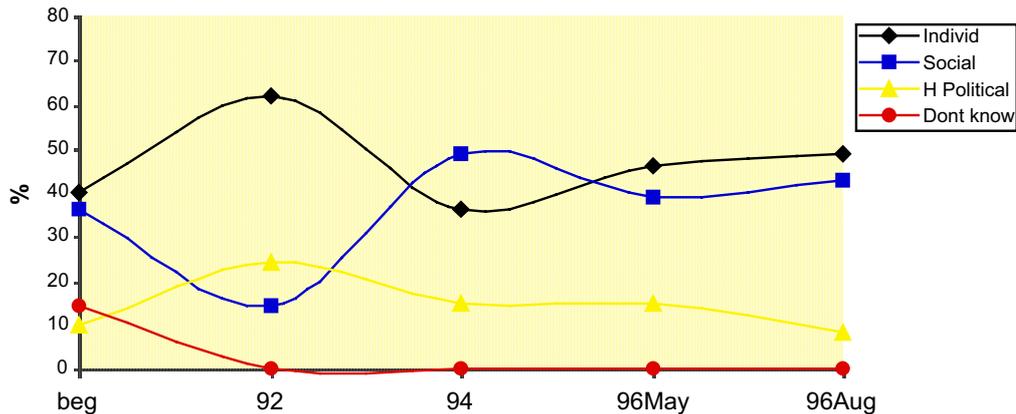


Figure 22. Argumentation for participation during the Programme by time, Järvenpää.

In Järvenpää (Figure 22) the starting point of the Programme reminds the situation in Somero but already at the end of 1992 the politically oriented argumentation for participation seemed to have a bigger role, which then decreased again in 1996 to the same level as it was in the beginning of the Programme. Participating in the Programme seemed to provide most benefit to the individual in 1992, but like in Somero, the socially oriented reasons became more important in 1994, and the importance decreased again a little in the next two measuring points. As in Somero at the last measurement point (August 1996), the participation in Järvenpää seemed to have a more individually oriented reasoning (This may, from the empowerment perspective, reflect some kind of regression, since empowerment requires the joining of mutual groups and a strengthened sense of community as stated in the literature. E.g. Kieffer 1984, Swift and Levin 1987, Rissel 1994).

6.1.6 Perceptions of the meaning of “participation”

In the questionnaires of 1992²⁰, 1994²¹, and 1996²² the perceptions about participation were asked in an open-ended question. The question was repeated in the theme interview in August 1996²³. The answers were analysed through content analysis. A unit of analysis varied from one word to several sentences and the categories were grounded on the data (i.e. to the content of the respondents’ answers). The categories were: Citizen Participation is: 1) ‘Taking care of own health or health of nearest family’, 2) ‘Decision making’, 3) ‘Mobilization of everyone’, 4) ‘Providing knowledge’, 5) ‘Co-operation’, 6) ‘Community Action’, 7) Traditional ‘prevention and health education’, 8) ‘Consciousness raising and communality’(= “Consc + Comm”), 9) ‘Purchasing actively knowledge’, and 10) ‘Healthy public policy’. The following examples of quotations characterize these categories.

Participation as ‘Taking care of your own health or health of your nearest family’:
 “...specifically, that one would have responsibility for oneself and the environment.”

²⁰ Questionnaire 1992: (Somero: $n_{\text{pers}}=54$, $n_{\text{expr}}=48$; Järvenpää $n_{\text{pers}}=46$, $n_{\text{expr}}=52$); n_{pers} = number of persons who responded; n_{expr} = number of expressions

²¹ Questionnaire 1994: (Somero $n_{\text{pers}}=39$, $n_{\text{expr}}=37$; Järvenpää $n_{\text{pers}}=35$, $n_{\text{expr}}=42$);

²² Questionnaire 1996: (Somero $n_{\text{pers}}=38$, $n_{\text{expr}}=29$; Järvenpää $n_{\text{pers}}=35$, $n_{\text{expr}}=26$);

²³ Interview 1996: (Somero: $n_{\text{pers}}=19$, $n_{\text{expr}}=62$; Järvenpää: $n_{\text{pers}}=13$, $n_{\text{expr}}=49$);

“... well, if I don't just think about this Project which is one way to take part, but participation is what you do every day; exercise, look after your own health and then, as a mother, guide the kids to the same rails, make home-made meals and such. Even being a couch potato is taking care of your health if it feels good.”

“...it is that everybody takes care of their own health and fitness so that one exercises as much as one can as long as it is a natural part of everyday life and, in every way, takes spontaneously care of oneself and, depending what information is available, takes care of the well-being and health even of one's loved ones.”

Participation as ‘Decision making’:

“... citizens' participation in health issues is that the citizens can have an impact on the health issues of a community if they want and if they have the enthusiasm... it is how to make a contribution by one's own action, not only by phoning the decision makers -- one's own action and input belong to it, too.”

“... I think the issue is that everybody feels to be an influential person/opinion leader, that I can feel that I am who I am and I can interfere in some issue and assume that it is my right and duty and I must be heard.”

Participation as ‘Mobilization of everyone’:

“...I think it is just that that there is interaction and you stay out of small circles and come out of your shell, that is when a person participates.”

“...In general, people should take part in everything that is even slightly available and which is organized for people to participate in.”

Participation as ‘Providing knowledge’:

“...citizens' participation in health issues is to keep oneself in shape plus to distribute information and give the right kind of info even to your pal.”

Participation as ‘Co-operation’:

“...it is that when we were working together over there in a house with a mold problem we did indeed try to gather the people together and go to the authorities whining and bickering and putting all kinds of pressures on them, maybe I would do the same even in other situations if I would feel the issue important to me, I'm sure that I would write in the newspapers and all.”

Participation as ‘Action’:

“...And you could yourself organize and participate and do something, everybody could take some initiatives. So that it wouldn't only be passive...not come to a ready-set table, that a thought could be provoked, that even I can do something and air my ideas.”

Participation as ‘Prevention and health education’:

“... I think ...my idea of participation is what becomes apparent maybe in this kind of an anti-smoking campaign.”

Participation as ‘Consciousness raising and communality’(= “Consc + Comm”):

“...I don't know, but there is a lot to do in the society when the safety nets are in danger of crumbling all around and we should bring security to the people when they are fearing that they are no more in control of their own lives. Security is needed and getting it in the very beginning and the very end depends on one's own activity. No other person can help and save another, a person must help him/herself. So we need this kind of an idea for this project so that we could teach people to help themselves in controlling their own lives. It is a difficult and demanding task, education is needed and I hope that we can get it. Also I wish to keep contacts with the leaders, even in the Finnish Centre for Health Education, they have got ideas and influence and knowledge of what we need. ...I want to discuss with them and

get acquainted with them and gain self-esteem and, like spiritual strength. The support we got at the starting stage was important. I do not want to be left on my own.”

“...It means exactly that we participate when an issue hits home hard enough... What is the participation – we go together and find out about issues, express opinions, ask around, find out is this issue now for real and is there cause for concern, and who should do something or should you do it yourself. It works if there is reason for it.”

Participation as ‘Purchasing actively knowledge’:

“...participation is that you actively find information and attend lectures, etc.”

Participation as ‘Healthy public policy’:

“... in a way, if the project is so inclined that we can have considerable savings, then this Healthy Sro/Jpä Project is a very good undertaking because it is aimed at influencing the public health aspect and in this way it means remarkable savings for the municipality. If people could change their habits and started to look after their health, it indeed would be a great saving for the society, think millions...but if there is nothing to show on paper, it won't have any impact on the decision makers...it goes in through one ear and comes out the other. The Healthy Sro/Jpä like all the other good things is a matter of practical problem at this time: even though research has been made to show how beneficial it is to take good care of oneself, also that if the community invests a Mark in this kind of procedures, the saving sort of will be four-fold at the end, after all.”

Somero

Figure 23 shows that in 1992 “participation” was characterized as taking care of own health and secondly, as mobilizing all citizens of the community. To some extent “participation” in 1992 was also characterized as participation in decision making, providing knowledge about health and traditional preventive measures (advice giving by health care personnel, participation in health controls, visits to public health nurse etc.) and health education.

The understanding of the word was approximately the same in 1994, but the mobilization of the people was considered as the most descriptive meaning. To an increasing extent also expressions which showed a growing awareness of health problems and issues in the community were presented in 1994 and 1996 (labelled in the figure as consciousness raising of the community problems = “Consc + Comm”).

The expressions in 1996 showed a wider range of dimensions comprising not only taking care of own health and mobilizing people or being aware of the health problems in the community, but also actions for social change and improvement in the community life and collaboration. In comparison with the earlier years participation was considered more as prevention and health education. This may be a sign of an expanded perception about the concept of health promotion and also that participation of individuals in different activities was considered to be an important part of health promotion. On the other hand, the result may indicate that the perceptions about participation turned back to a more traditional direction which includes the idea that health promotion and health education still remind of the domain of health professionals.

The role of providing and distributing knowledge had a decreasing trend towards 1996. Purchasing actively knowledge yourself was discovered as a new dimension for participation in connection with the last interview in 1996.

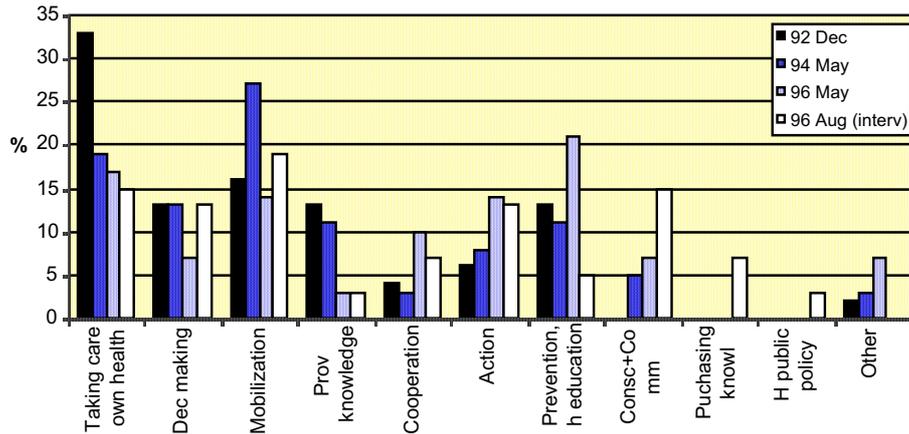


Figure 23. Perceptions of the meaning of “participation” in Somero (%).

Järvenpää

The perception about participation in Järvenpää proved to be very similar to the correspondent perception in Somero in 1994 (Figure 24). Taking care of own health was the most often expressed meaning. The word “participation” was connected with decision making more often than in Somero. The role of co-operation was, though, more important to the people in Järvenpää and the traditional prevention or health education less important in 1992. Also participation in decision making seemed to be important in Järvenpää in the two first years of the Programme, but the trend was decreasing towards 1996. There was a remarkable increase in 1994 in the expressions labelled under “consciousness raising” remaining quite high in 1996, too. The same trend as in Somero could be noticed in Järvenpää in 1996: Perception about the concept of participation was wider in 1996 than in 1992 and understanding participation as a part of health promotion was obvious.

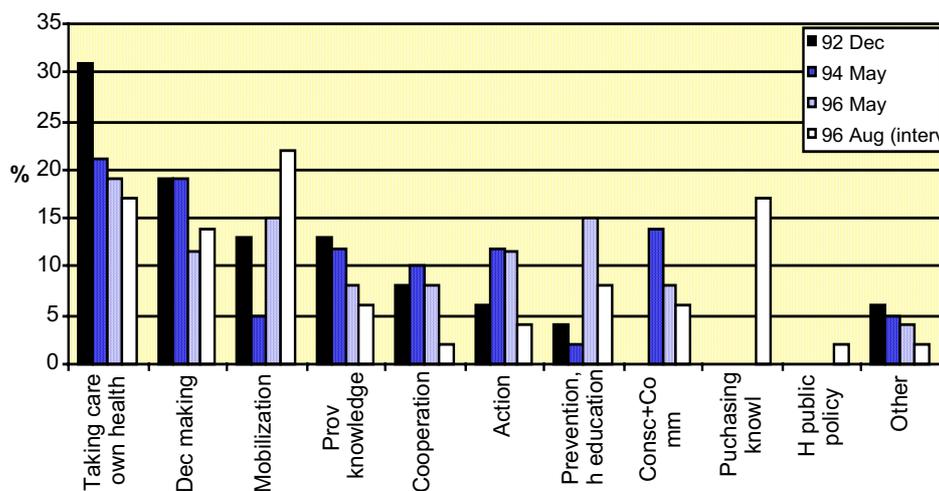


Figure 24. Perceptions of the meaning of “participation” in Järvenpää (%)

Somero and Järvenpää according to the interview in 1996

Figures 23 and 24 show a wider range of expressions in 1996. New expressions emerged which had not been used in connection with the earlier measurements in 1992 and 1994. In Järvenpää, “purchasing actively knowledge yourself” and “taking care of own health” were still considered the most important in addition to “decision making” and “mobilization of people”. However, such expressions as “participating in happenings and occasions organized by others” (10% of all expressions) could be a sign towards a passive approach. Communality (= or ‘sense of community’) and healthy public policy were new dimensions for participation in Järvenpää in 1996. The role of co-operation, which was moderately important for the respondents in the interviews in 1992–1996, decreased in connection with the interview in August 1996.

In Somero, “communality”, “taking care of own health”, “decision making” and “action” formed the most often mentioned perceptions concerning participation. “Co-operation”, “mobilization of everybody” and “participation in happenings” were a moderately important content for the word. Also in Somero “participation” was more seen as a core of health and social policy of the community.

The development of understanding “citizen participation”

The development of participation can be examined from two different perspectives: Who is in the focus of the ‘participation’ (individual/me myself = ego-oriented²⁴ or the wider community = community-oriented). The second view is: who is considered to be the producer of the action (in other words e.g. who is organizing the activities – oneself or somebody else/outsider). In this respect the categories of the results of the content analysis above can be grouped as follows: When the producer/organizer is expected to be someone else than oneself, the participation is considered to be passive. If the person himself has an important role in the action the participation is considered to be active. The categories of “participation” (see the list of categories and the examples in the beginning of this chapter) were formed, though the content analysis was placed in the following typology (Table 7).

When the development of the perceptions of the meaning of participation is looked upon the above typology, the results (Figure 25) show that in Järvenpää in December

Table 7. Categories of participation orientation and organizer.

Producer	Orientation	
	Ego-oriented	Community-oriented
Organized by others (= passive)	Providing knowledge Prevention, health education Participating happenings	Mobilizing everybody Co-operation Healthy public policy
Organized by self (= active)	Actively searching knowledge Taking care of own health	Participation in decision making Sense of community Acting, measures Consciousness raising

²⁴ Ego-oriented = ego-centric, which according to Webster’s Encyclopaedic Dictionary (1989) is defined as “having or regarding the self as the centre of all things; and having little or no regard for interests, beliefs, or attitudes other than one’s own.”

Community-oriented in this connection means regarding the ‘community’ or the wider environment as the centre of things; and having more interest towards the society and not towards oneself only.

1992 (when the Programme had run for almost one year) the perception about participation when looked upon the orientation was ego-oriented yet active, which means that the role of citizens themselves was considered to be central in participation. Community-orientation seemed to have strengthened particularly in May 1994 (two and a half years after the Programme started). Of the expressions concerning participation, 45% were considered to be community-oriented and active. However, the perception concerning participation shifted back again towards the individual in 1996, yet the role of an individual remained active.

In Somero the individuals had an active role in the beginning of the Programme, but the orientation of the activities was also ego-centric (e.g. including expressions like “...providing knowledge to me” or “...I am taking part of campaigns”. At the time of the next measurement in 1994, the community seemed to set a more important focus on the activities than the “ego” only. However, in organizing the activities the community expected action by “others” not by “myself”. Hence the approach was passive. In 1996 it seemed obvious that the people had realized that they themselves have to play an active role in organizing the desired activities. One should not just expect the official system or some other institution to make all the preparations and planning. The benefits of these different activities organized collaboratively were seen to be shared with all the citizens of the community. This community-oriented, solidary view prevailed and seemed to be even stronger in time of implementing the last measure (interview in August 1996).

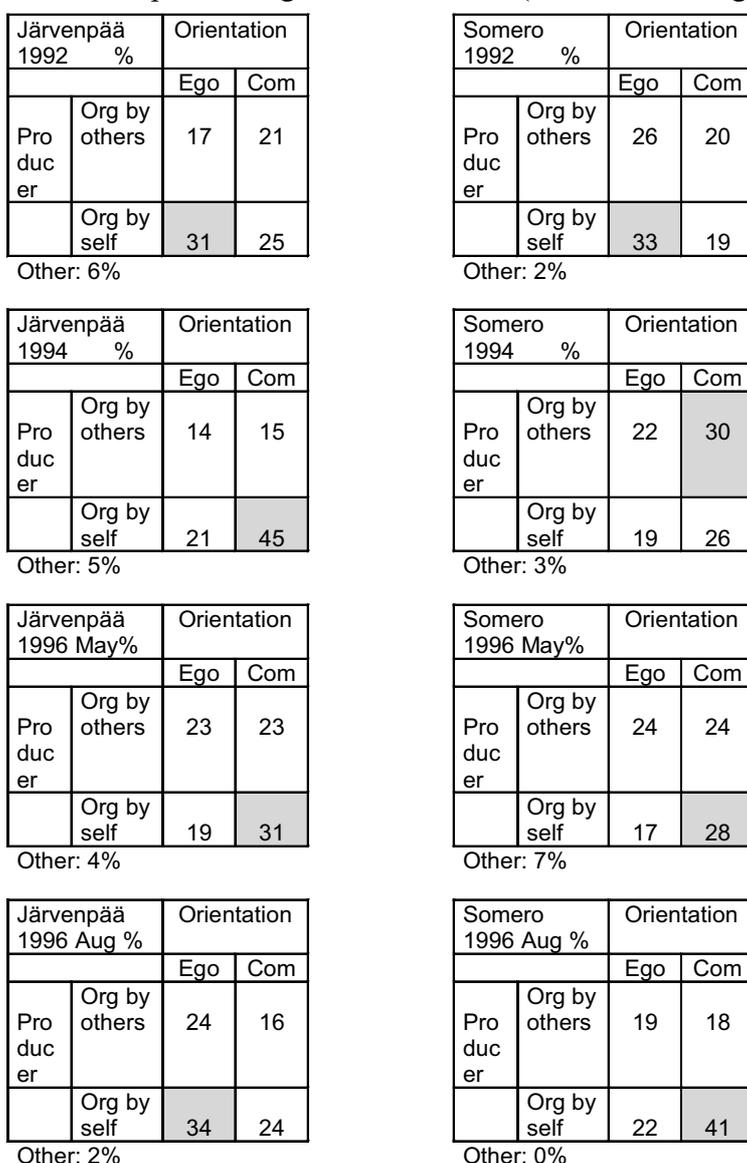


Figure 25. The development of understanding “participation”.

6.1.7 Perceptions about the purpose of the Programme

“What is, in your own words, the purpose and aim of the Healthy Somero-Järvenpää Programme?” was the open-ended question in 1992²⁵, 1994²⁶, and 1996²⁷. In addition, the theme of the Programme’s purpose was included in the theme interview in August 1996²⁸. Word/s, sentences and sometimes even a chapter (particularly concerning the interview data) were units of content analysis and the categories were raised inductively from this data. The categories in 1992–1994 were:

- ‘Health education’ (= The traditional way of seeing health education, e.g. *“the purpose to me is to affect peoples’ lifestyle...”*, *“...it’s talking about health”*, *“...to try to persuade people to eat healthier etc.”*, *“...to organize health campaigns regularly”*);
- ‘Activating citizens’ (e.g. *“...activating people”*, *“... making people take care of their own health, so they are not only sitting passively at home”*)
- ‘Decision making’ (= The purpose was to provide a channel for influencing decision making, e.g. *“...that the opinions of our citizens will be heeded in decision making”*, *“...possibility to influence”*)
- ‘Co-operation’ (= The purpose of the Programme was to increase co-operation or practice co-operation, e.g. *“...the idea is that we solve the problems together, like in the old days when we helped our neighbours”*, *“...team-working”*)
- ‘Channel for participation’ (= The Programme was seen as a tool for participation – that the Programme existed in order that people become active and participate, e.g. *“...the idea was to get people together”*)
- ‘NGO work etc.’ (= The purpose of the Programme was seen as gathering together the NGOs and take measures in the way the NGOs traditionally do, e.g. *“...it is voluntary work”*, *“...it supports the NGOs work”*)
- ‘Increasing knowledge’ (e.g. *“...that we learn new knowledge”*, *“...its purpose is to be an idea bank to the people or a place where we can do brainstorming”*)
- ‘Social change’ (e.g. *“...it means concrete achievements and results“*, *“...it means developing and changing the city environment to be a better place for living”*)
- ‘Other’ (e.g. *“...serving the FCHE”*, *“...charting volunteers”*).

The additional categories raised from the data concerned the year 1996. These additional categories were:

- ‘Own health’ (e.g. *“...that the people start to take care of their own health”*),
- ‘HP philosophy’ (e.g. *“...it means that we could learn to think that we should be active”*, *“...it is something like trying to make us look at our surroundings critically”*)
- ‘HP work’, (e.g. *“...it means replacing the Health Promotion Committee of our town”*, *“...it means organizing campaigns”*, *“...it means organizing the annual ‘Mental Health Markets’ campaign”*, *“...it means concrete actions and measures like what the health care system is normally doing”*)
- ‘Networking’ (e.g. *“...building up a network between people”*, *“...communality and knowing people”*)
- ‘Local health policy’ (e.g. *“...the purpose is to prepare our own local health policy, where our own visions are expressed....”*), and
- ‘New way of action’ (e.g. *“...this completely new way of action is a consequence of the economic recession in Finland”*, *“...that we know what to do and how to act and organize ourselves if there is a problem to be solved”*),

²⁵ Questionnaire 1992: (Somero: $n_{\text{pers}}=54$, $n_{\text{expr}}=41$; Järvenpää $n_{\text{pers}}=46$, $n_{\text{expr}}=41$); n_{pers} = number of persons who responded; n_{expr} = number of expressions

²⁶ Questionnaire 1994: (Somero $n_{\text{pers}}=39$, $n_{\text{expr}}=30$; Järvenpää $n_{\text{pers}}=35$, $n_{\text{expr}}=25$);

²⁷ Questionnaire 1996: (Somero $n_{\text{pers}}=38$, $n_{\text{expr}}=30$; Järvenpää $n_{\text{pers}}=35$, $n_{\text{expr}}=37$);

²⁸ Interview 1996: (Somero: $n_{\text{pers}}=21$, $n_{\text{expr}}=103$; Järvenpää: $n_{\text{pers}}=14$, $n_{\text{expr}}=77$);

Somero

(Figure 26) In 1992 the purpose of the Programme was to provide health education to increase the knowledge in the field and to activate people. In 1994 the participants understood that the aim was a change in the social structure, which ensures better channels for participation and co-operation. Two years later the respondents most often reported that the aim was to strengthen the health promotive linking or philosophy and to implement a social change enabling better co-operation and wider participation. Unfortunately, more than 20% of the respondents did not exactly know the purpose of the Programme, which was not the case in 1992 or in 1994.

Järvenpää

(Figure 27) Activating people, informing decision makers, health education as such, co-operation and providing channels were seen as the purpose of the Programme in 1992 in Järvenpää. Two years later the Programme was seen as a channel for participation and as a tool for introducing a social change. In May 1996 the respondents did not believe in social change or increased participation any more but they understood that the aim was to implement health promotion work through the Programme. In 1992 and 1994 all the respondents were able to describe the purpose of the Programme, while in May 1996 more than 30% did not know the purpose any more.

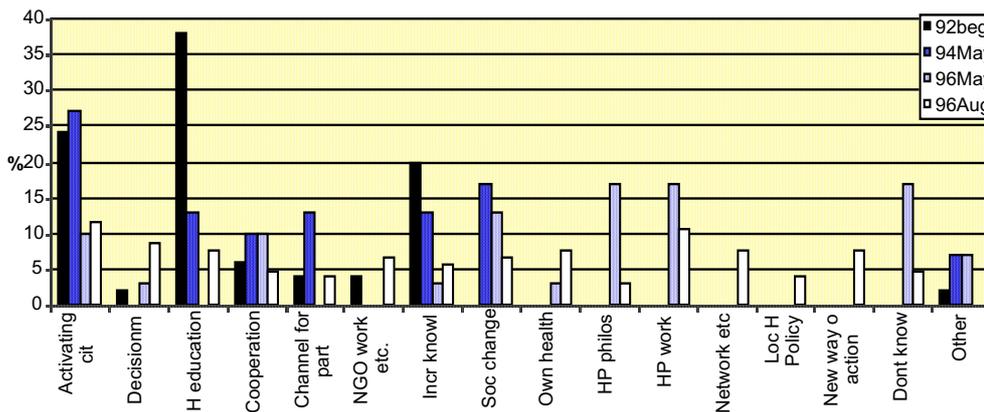


Figure 26. Perceptions (%) about the purpose of the Programme in Somero

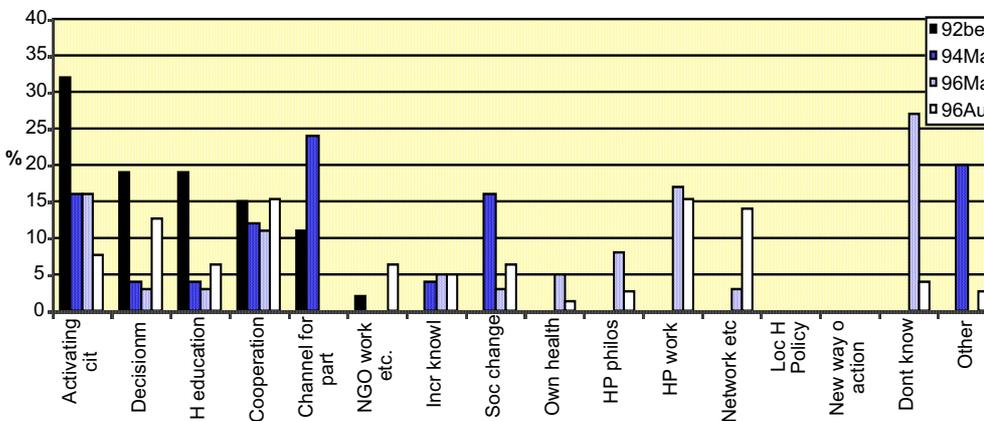


Figure 27. Perception about the purpose of the Programme in Järvenpää.

According to the interview in August 1996, the purpose of the Programme (Figure 26) in Somero was most of all “activating citizens”. The Programme was clearly seen as a way of implementing health promotion locally and in practice. Increasing people’s possibilities and skills for participation in decision making was seen as one of the most important aims. Networking with different counterparts in the community, enabling the people to take care of their own health, and creating a new way of action and social change were seen as important goals, too. The utilization of the NGOs’ work seemed to be the purpose of the Programme to some extent.

In Järvenpää (Figure 27) the four most important purposes for the Programme seemed to be health promotion work (as in Somero), co-operation, networking and decision making. In Järvenpää, according to the interview, the Programme was not understood to have a role in local health policy making, or creating a new way of action or being a channel for participation. Instead, the participants in Järvenpää gave another picture, where they freely describe the decision making concerning health issues within their municipality. Obviously, this could be interpreted so that the participants in Järvenpää had, with pleasure, seen the Healthy Järvenpää Programme as a channel for influencing decision making. However, this possibility, or challenge probably, was not explicitly enough expressed by the “empowerment consultants” when the purpose of the Programme was discussed. Moreover, the purpose of the Programme in both cities had been obscured by the summer 1996. This may be a reflection of the fact that the education and consultancy discussions conducted by the FCHE ceased totally during 1995 and the people were practically left without any leader. The course of the Programme was steered by the few charismatic key persons whose perception about the purpose and participation was projected in the actions taken by the theme groups.

6.1.8 What the participants had learned

In the questionnaires of December 1992²⁹, May 1994³⁰, and May 1996³¹ as well as in the interview in August 1996³² the respondents’ opinions about what they considered to have learned in the Programme were asked. The data was analysed through content analysis and categories raised from the data.

Somero

(Figure 28) In 1992 the participants in Somero reported that they had gained new information and learned team-working and decision making skills, and in 1994 they had also learned to know people. According to the results from May 1996, the perceived learning included also elements from strengthened psychological empowerment like feeling of better control of own health and life. In addition the respondents reported that they had learned how to use time and new approaches for managing community problems (defined as ‘learned hopefulness’ in the figure). In August 1996 the interviewees in Somero reported that they had learned new knowledge, and secondly they reported experiences which could be labelled as learned hopefulness (e.g. “...empathy”, “...equity feeling”, “...feeling of finding the right pieces of the puzzle and putting them together”, “...I am able to execute my own creativity”, “...the feeling that things are going well”, “...learned positive thinking, learned empathy and to listen to others”, “...I can see things much broader now, etc...”) and other positive feelings like “...now I understand other people better and I have learned to listen to them and have tolerance to wait with my own

²⁹ Questionnaire 1992 (Somero: n_{pers}=28, n_{expr}=34; Järvenpää n_{pers}=28, n_{expr}=38);

³⁰ Questionnaire 1994 (Somero: n_{pers}=23, n_{expr}=25; Järvenpää n_{pers}=21, n_{expr}=28);

³¹ Questionnaire 1996 (Somero n_{pers}=21, n_{expr}=35; Järvenpää n_{pers}=20, n_{expr}=29). n_{pers}= number of persons who responded; n_{expr}= number of expressions

³² Interview 1996 (Somero: n_{pers}= 15, n_{expr}= 54; Järvenpää: n_{pers}=12, n_{expr}=57)

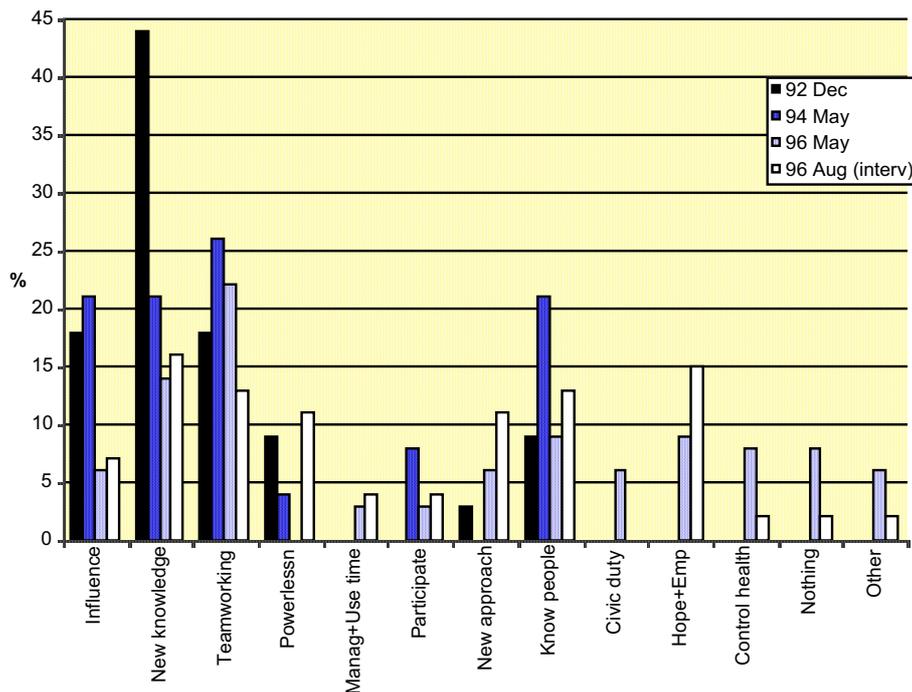


Figure 28. Perceptions about what the participants learned in Somero in 1992–1996

worries...”. They also had learned team-working and to know new people. The new approach was considered as a learning result to some extent.

Järvenpää

(Figure 29) In Järvenpää the picture of learning results was about the same with the distinction that powerlessness was experienced much more often than in Somero. New information and improved team-working skills, and getting to know people were the most important learning experiences. By May 1996, to an increasing extent, people had learned how to use time, they experienced participation as a civic duty in the positive way, and they showed hopefulness (expressed as belief like “...through participation to the Programme I feel that I have more power and I am able to have influence in my own community”), they considered to have more control over their own health. The willingness to be involved in the decision making was an important motivation factor for the people in Järvenpää, and at the same time the experienced difficulty to actually influence the community led to feelings of powerlessness. Unfortunately, the feeling that the respondent had not learned anything or that the participation in the Programme was a waste of time increased a little by 1996. The interviewees in Järvenpää in August 1996 (Figure 29) considered to have learned new skills and approaches clearly more than the respondents in Somero. Secondly, they had learned to know people in their own community, team-working, and gained new knowledge. The feeling of powerlessness (e.g. “...I have learned how powerless I really am in my municipality”, “...it certainly doesn’t matter what we tiny people think, say or do, the politicians decide according to their own will, anyway”) was expressed quite often. They expressed disappointment about the decision making system in their community (the system was unable to react to the needs of the citizens), or they were disappointed with the Programme itself – they felt that the Programme did not achieve the results the people had expected.

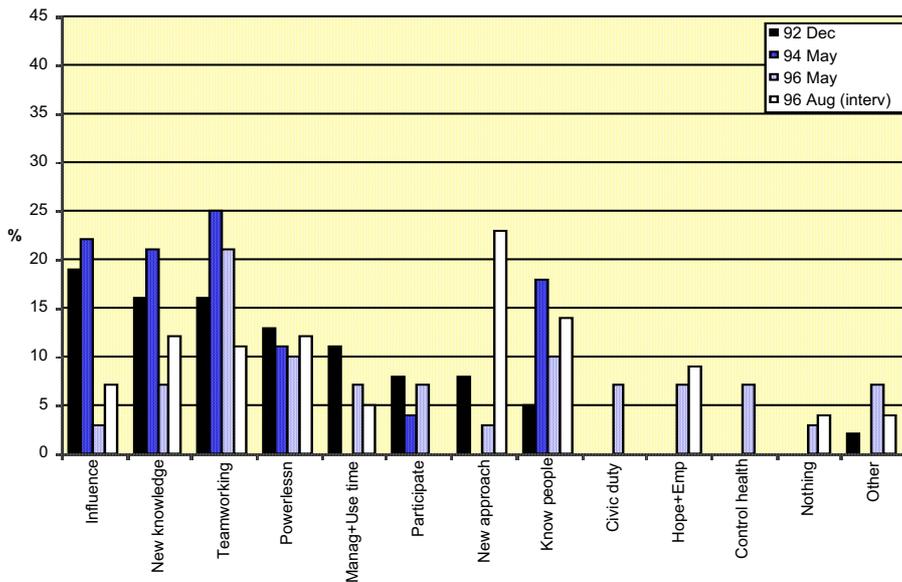


Figure 29. Perceptions about what the participants learned in Järvenpää in 1992–1996.

The results from the questionnaires and the interview were grouped in four larger categories illustrated in Figures 30 and 31. The categories were: i) ‘Individually oriented learning experiences’ (selfish reasoning for learning benefits, like “*I have gained new knowledge*”, “*I have learned how powerless I am*”, “*I have learned a new way of action or to manage time*”, “*I have learned to take care of my own health*”); ii) ‘Socially oriented experiences’ (“*...learned to collaborate with others*”, “*...to work in teams*”, “*...to know people*”); iii) politically oriented learning experiences (like “*...I have learned how it is possible to influence policy making*”, “*...I have learned that it is a civic duty of everyone to participate in decision making and other community activities*”), and iv) other learning experiences (“*...I have learned nothing*”).

In Somero (Figure 30) it was considered important to gain the benefits from the Programme to oneself in December 1992, but already in May 1994 the socially oriented benefits to the larger community were seen to be more important. However, again in May 1996 as well as in August 1996 the selfish learning experiences were reported more often than the other categories. There was a slight increase concerning the politically oriented learning experiences in 1994, but resumed a decreasing direction in 1996. Other learning experiences increased particularly in May 1996 but showed a decrease again in the next measurement time.

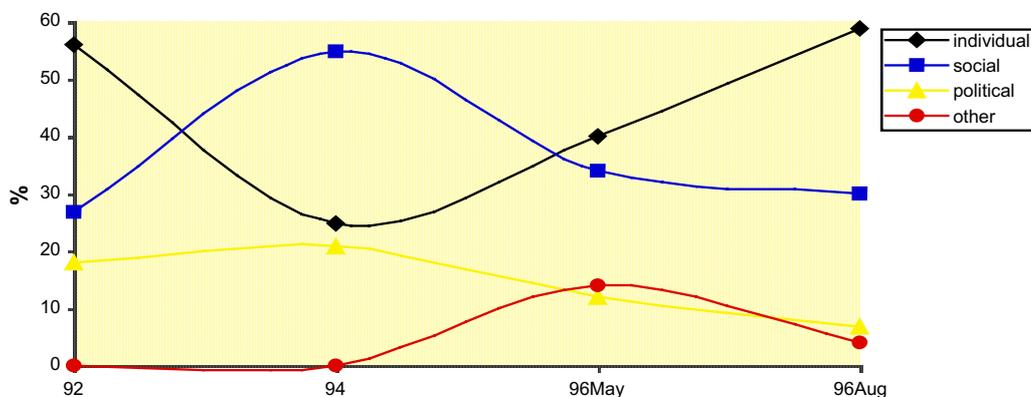


Figure 30. Perceived learning by dimensions in 1992–1996, Somero

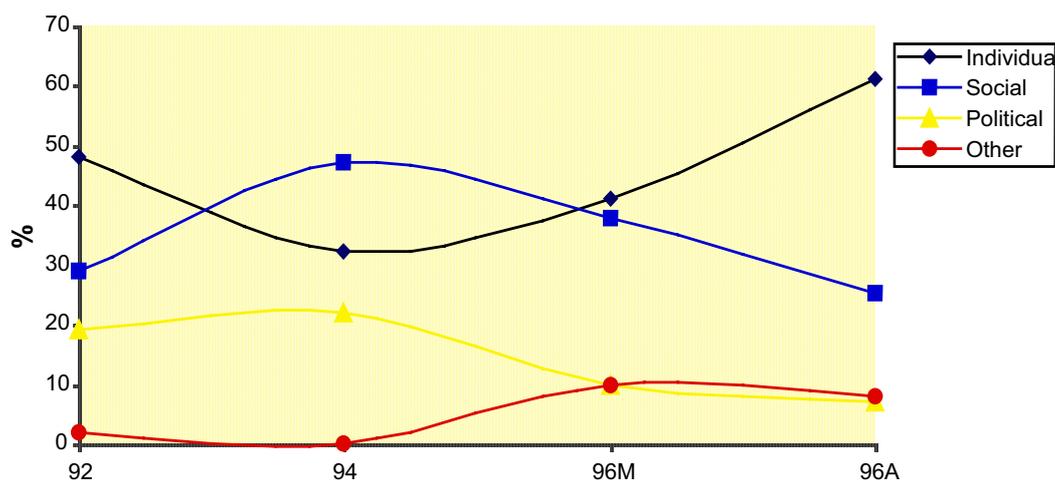


Figure 31. Perceived learning by dimensions in 1992–1996, Järvenpää

The perceived learning in Järvenpää (Figure 31) followed about the same trend as in Somero with the exception that the socially oriented learning experiences were not so significant in Järvenpää in 1994 as they were in Somero. Individually oriented reasoning remained quite high in Järvenpää even in 1994.

6.1.9 Perceptions about the tasks of different actors in the development process

Perceptions about the most important tasks of the different actors (see Tables 8–9) were included in the questionnaires implemented in 1992, 1994 and 1996. The informants were asked to mark three most important tasks for each of the actors involved in the Programme: FCHE (The Finnish Centre for Health Education and Promotion), project manager, project secretary, trainer/consultant, theme group leader, theme group members, authorities of the municipalities, NGOs, citizens in the community, and role of respondent him/herself. The alternatives for the tasks given in the structured question were: Economical support, providing prerequisites for action, atmosphere creator, management, leadership and co-ordination, planning, supervision, evaluation, keeping contacts between different counterparts, brainstorming, motivating, implementing the routine tasks within the Programme, educating, giving information (keeping people informed, communications), providing background support, expertise, taking part/passive participation, and miscellaneous.

The markings were calculated and the function with most marks was highlighted with an "x" in the tables. (Lines without any numerical figures means that the function received only solitary votes when calculating priority and is therefore not among the three most important roles.)

Somero

The role of the Centre for Health Education and Promotion (FCHE) was seen as leading, co-ordinating and financially supporting throughout the project span of 1992–1996. (Table 8). The Project Manager was expected not only to lead, co-ordinate and plan on a continuing basis, but in the beginning she was also expected to show an ability to motivate. The Project Secretary was clearly a person to maintain contacts, communications and planning. In the early stages she was expected to motivate as well as to

perform the routine duties of the project, and to put the planned functions into action. The duties of the trainer were first not ranked among the three most important ones, but in 1994 and 1996 his primary duties were considered to be training and assistance as an expert. The theme leader made contacts, motivated, had ideas, and in 1996 he/she was more clearly also a leader and a co-ordinator. The theme group was seen to perform routines, motivate and be generally present in the project (same role throughout). Authorities had the role of experts and support. Organizations were first seen to motivate, carry out routines, communicate and act as experts, but later in 1994 their task was narrower providing only background support and presence, and in 1996 the most important tasks were keeping contacts and communications. A local resident in the early phase of the project was featured to act as an expert, to perform routines and to motivate, whereas in 1994 being present was considered sufficient apart from giving ideas and performing routines. In 1996 routines were considered to belong to others than local residents, mainly to theme groups (strong groups of activists). The 'own job' of the respondents changed from the early routine work, communication and expert assistance to acting as a background supporter and in brainstorming, as well as to participating in activities arranged by others. Becoming bored, tired, or having no goals, lacking decisiveness created a sort of passiveness affecting participants' personal roles.

People who had actively joined the project at its early stage regarded their task and that of other community citizens as being one of an expert while being prepared to perform the actual functions. Later in 1996, however, the results show that the participants were prepared to take the role of a background supporter only, and that in their minds the fulfilment of functions belonged to the theme group which was already seen as a kind of "organization".

Järvenpää

The participants in Järvenpää considered the role of the FCHE (The Finnish Centre for Health Education and Promotion) as being the leader, co-ordinator, and expert in the Programme as well as giving the economical support. (Table 9). In the beginning of the Programme, the FCHE was expected to produce new (brainstorming) ideas, too. The Project Manager was expected to lead, co-ordinate and steer the programme but also to evaluate the Programme and to motivate the participants in the beginning of the Programme. In 1996 motivation and evaluation were no longer mentioned as the most important roles of the Project Manager. The Project Secretary was assumed to take care of the routines in 1992 in addition to communicating with different counterparts. In 1996 routines were not mentioned any more as the duties of the Project Secretary, but communicating and keeping contacts with different counterparts remained very important. The theme-responsible's most important role in 1992 was to do brainstorming, and to communicate and keep in contact with the participants. In 1994 and 1996 creating a good atmosphere was seen as the most important task in addition to motivation and new ideas. The theme group was mentioned as the routine task performer and expert in 1992 and 1994 but not any more in 1996. The theme group's role seemed to shift to a more abstract level like planning and involvement in general and to being a source of new ideas. In 1992, the authorities and the NGOs were expected to do the routine work, but there also was seen a trend to withdraw from the duties and stay as an expert or a background supporter for the projects. The most important role of the NGOs, the citizens of the community, and the respondents in 1996 was to be innovators or idea producers. Actually the results show a trend from an active actor towards a passive supporter.

Table 9. The most important tasks of each actor in the Programme in 1992-96 as perceived by the participants in Järvenpää

Task	FCHE			Project manager			Project secretary			Trainer, consultant			Theme leader			Theme group			Authorities			NGO			Citizen			Own role		
	1992	1994	1996	1992	1994	1996	1992	1994	1996	1992	1994	1996	1992	1994	1996	1992	1994	1996	1992	1994	1996	1992	1994	1996	1992	1994	1996	1992	1994	1996
Economical support	X																													
Prerequisites, materials etc																														
Atmosphere creator													X	X																
Management, coordination	X	X	X	X	X	X																								
Planning					X	X						X																		
Supervision	X			X	X	X																								
Evaluation				X																				X						
Keeping in contacts				X		X	X	X	X				X	X										X				X		
Making things known (communicate)				X			X	X	X				X	X		X			X			X					X			
Brainstorming	X												X		X	X	X						X		X	X		X	X	
Motivating				X						X	X				X			X			X			X						
Training, educating		X								X	X							X			X									
Implementing routine tasks							X	X							X	X		X			X			X			X	X	X	
Background supporter																			X		X									
Expertise		X	X							X	X				X			X	X	X	X	X					X		X	
Taking part, participating															X	X		X			X	X		X	X	X	X	X	X	
Other																							X							

6.2 Empowerment

The amount of expressions concerning empowerment

The interest in the theme interviews (August 1996) was to investigate the extent to which people's expressions concerning empowerment appeared, at both the psychological and the community levels.

The total amount of expressions presented by the respondents in August 1996³³ gives the impression that the participants had a lot to say concerning this issue (Table B, Annex 2). There were a few more expressions on the average per person in Järvenpää than in Somero. However, a difference could be seen between those who had participated in the empowerment training actively and those who participated only a few times. The 'activists' had about six times more to say about issues considered to belong to the area of empowerment (Tables C and D, Annex 2).

First of all, those of the respondents who participated in the Programme actively (Table C, N = 26) expressed more items which could be recognized as signs of empowerment than those called here "non-activist" respondents (n = 9) (persons who did not participate in the training but were participants of the Programme, or who had participated in the Programme less than two times, or who participated in the Programme after the training intervention i.e. after 1995) (Table D). The respondents who participated actively referred frequently to the Programme and stated that this kind of improvement would not have taken place without participation in the Programme.

There was no big difference on the average in the amount of expressions between the NGOs in Somero and Järvenpää (Table E, Annex 2). But the authorities in Järvenpää expressed two and a half times more items on empowerment per person on the average than in Somero (Table F, Annex 2).

6.2.1 Psychological empowerment

Psychological empowerment as an outcome

The level of psychological empowerment was investigated among the interviewed Programme participants in August 1996³⁴. The transcribed text material of the entire interview was analysed and elements of empowerment were identified by using the descriptions of the four dimensions (based on literature) of psychological empowerment (= operationalization, see chapter 5.2.3, pages 76–79): personal, motivational, cognitive, and contextual dimensions. Words or sentences were units of analysis and were picked up from the data by using the operationalization as an instrument. The *Personality Dimension* included such items as strengthened self-confidence and self-esteem, internal locus of control, chance control, belief in powerful others, and control ideology which consists of the belief that people in general, but necessarily oneself, can influence social and political systems. The *Cognitive Dimension* consisted of several subcategories like self-efficacy, perceived increased competence, sense of mastery, internal political efficacy (one has skills necessary to influence political system) and external political efficacy (belief that the political system is responsive to change efforts). The *Motivational Dimension* included desire to control the environment, sense of civic duty, sense of causal importance and purposefulness. Expressions concerning involvement in collective action, ecological and cultural influence, cultural awareness and consciousness raising and understanding the role and purpose of a health promotion programme comprised the *Contextual Dimension* of psychological empowerment (Figures 32 and 33).

³³ Total amount of expressions concerning empowerment: (Somero: n_{pers}= 21, n_{expr}= 360; Järvenpää: n_{pers}=14, n_{expr}=294),

³⁴ Expressions concerning psychological empowerment (Somero: n_{pers}=17, n_{expr}=163; Järvenpää: n_{pers}=13, n_{expr}=110)

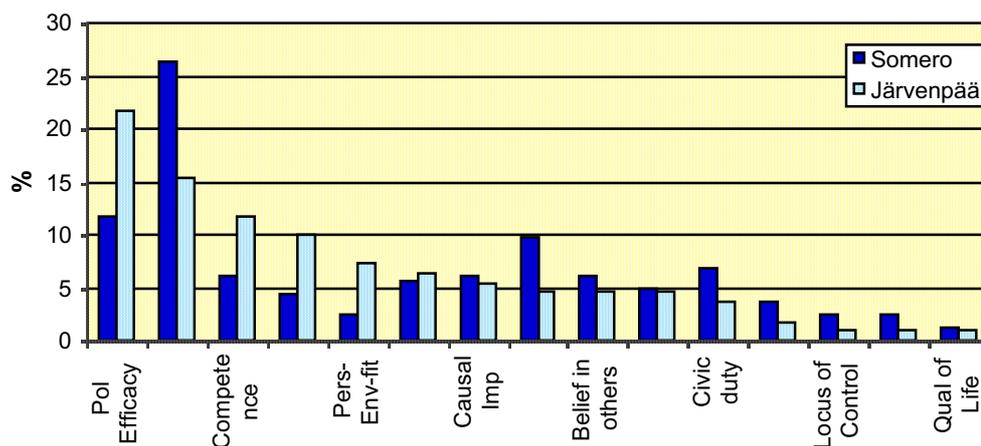


Figure 32. Reported Psychological empowerment by community (%).

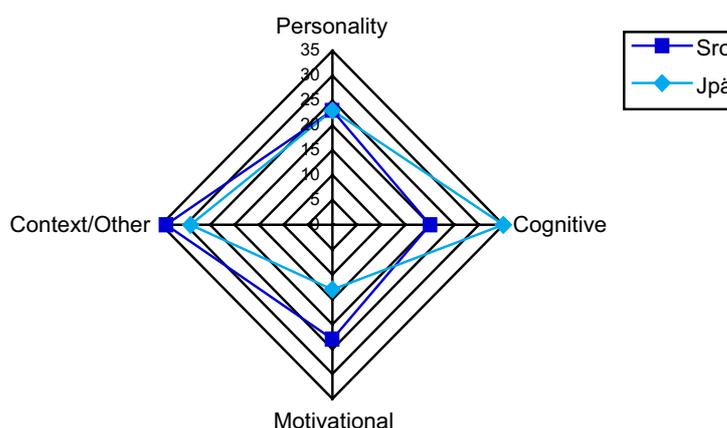


Figure 33. Reported psychological empowerment by its dimensions and by community (%).

Järvenpää

When the psychological empowerment is looked at in more detail, the following can be noted (Figure 32). In Järvenpää the respondents believed more strongly than their fellows in Somero that it is possible to influence political process and community decision making and that individual political action does have an impact:

“...in handling issues, however difficult it seems, there will be a common tune when you look for it long enough” (Female, 37 years, Jpä)

There seemed to be a better understanding or idea how to approach the decision makers in a way which could be effective. And the skills and knowledge needed for making an impact, e.g. in the health policy issues of the political system, were connected to the skills they had gained through participating in the Healthy Järvenpää Programme:

“...Well, I’ve learned that you should be very positive and have learned to be sort of positively persuasive. It has been such an education to me to learn that you do not enter anywhere walking backwards with a grimace on your face but you must, sort of, know how to sell issues and enter with sort of a broad grin on your face, but an honest grin, so that somehow you are standing behind that issue.” (Female, 34 years, Jpä)

“...yes, and when I want to make a point, I do it quite extensively in the name of the Healthy Jpä but I don’t do that in my own name. I’m sort of not a resident of the municipality so I have never thought about starting to influence personally but through the project.” (Female, 41 years, Jpä)

They were more conscious about the different health problems in their community, but clearly less than the participants in Somero. The following quotation reflects this:

“...some sort of a realization of the problems in the community, in the neighbourhood, is born and things are proceeding.” (Female, 41 years, Jpä)

It became quite apparent that the participants in Järvenpää felt themselves quite competent in this field. This actually was the case from the very beginning of the Programme and can be also explained by the fact that there were much more health care professionals involved in their Programme than in Somero.

“...these public events that have taken place have been very nice, one has learned a lot from them, so this is like” putting money in the bank” to get along with different people and all that.” (Female, 37 years, Jpä)

“...I haven’t thought of what the actual factor is, true, there was a theme every time which we dealt with so that you sort of were supposed to gain something new and then utilize it otherwise, too.” (Female, 40 years, Jpä)

The participants in Healthy Järvenpää had good self-confidence which, according to what they said, even increased. Three quotations from female participants reflect this:

“...Well, I feel sort of stronger to make connections, to believe in finding people in this village, I have a feeling that there is power in this thing so that when I sort of start crying into the woods, there will be an answer, so that my faith in this thing has become stronger.” (Female, 34 years, Järvenpää)

“...the information concerning the feeling of being more courageous comes sort of like drop by drop and, yes, the participants report that they know what they are talking about and how to act. They have received sort of an education, I have even heard opinions like this from the officials, which is nice. But also the so-called lay people all the way to the retirees they feel now more courageous and capable and know the channels, and yes, they say it is thanks to the Healthy Järvenpää that they have succeeded this way.” (Female, 41 years, Jpä)

“...many people say that through the Healthy Jpä they have learned to take a stand more courageously, and even by acting within some other organization.” (Female, 41 years, Jpä)

Several respondents reported that they had utilized the skills and knowledge in their daily work (marked in the Figure 32 as code “Pers-Env-Fit” = person-environment fit) and that they had been approached in different matters due to the fact that it was known that they participated in the Healthy Järvenpää “...*Could you take part in this planning group and represent the Healthy Järvenpää ...*”. The participants experienced to achieve a valuable result in getting to know people, which they called networks and channels:

“...and then there are an awful lot of channels, I have gotten to know lots of people, I know how to contact them, so that this network has gotten hugely wider.” (Female, 41 years, Jpä)

Somero

The respondents in Somero reported that while participating in the Healthy Somero they had become more conscious than before about health matters concerning not only their own lives but also concerning issues from a wider perspective. They reported that they became more aware about issues which they had not earlier given any notice to. And that they were more courageous to take delicate issues (like sexual life, or environmental problems and pollution) on the agenda of the debate. Almost one fourth of the quotations by the respondents in Somero were dealing with consciousness raising and cultural awareness, and clearly more so than their fellows in Järvenpää:

“...of course it has widened the horizons and, maybe, one has changed one’s attitude towards many issues that have come along.” (Male, 65 years, Sro)

“...we got a quite clear indication what people think about health issues.” (Female, 46 years, Sro)

“...the accomplishment is that there is this kind of awareness among the citizens, even individuals recognize the health issues.” (Male, 41 years, Sro)

“...and then we pay attention, like observers have a habit of doing, to the prospects what can we do and how can we be of common help to ourselves and our fellow beings.” (Male, 75 years, Sro)

The participants in Somero seemed to have better confidence or faith towards the responsiveness of the political system than in the beginning of the Programme (e.g. according to the questionnaires of 1992 and 1994, see the figures xx) yet it was less apparent than among the respondents in Järvenpää. This can be seen from the guarded two quotations:

“...far from everybody thinking of what should be done, what is the right way and such, but if an issue is brought up with sound arguments, it’ll hit home eventually.” (Male, 75 years, Sro)

“...yes, having actual influence is the most important thing, one way to influence is that the citizens have a possibility during election to vote for such people who are for change and thus things will change. I don’t think myself to be that desperate that I would think that it doesn’t matter who sits there in the city government, it would be very pitiful if just any old blockhead were sitting over there.” (Female, 57 years, Sro).

“...there is progress but it is quite slow, when knowledge on these issues increases, that does have an effect on people’s insights and attitudes, but slowly.” (Male, 75 years, Sro)

However, they felt that they had gained skills and knowledge needed for influencing the political process in their community:

“...but when I think about a regular person in the community, knowledge and such activity mean that you find out about things yourself, that’s what I’ve learned.”...and the feeling of competence, just the kind that you find out that when you act and do, you get something accomplished, something happens.”(Female, 63 years, Sro)

There was also a desire to influence the environment, however, which seemed to be stronger in Somero than in Järvenpää. The reason for this might be that the decision makers in Somero were much closer to the lay people than in Järvenpää. The politeness towards the local decision makers and the moderately strong belief in authorities was quite apparent in Somero. But at bottom they (as can be noted from the raised awareness of the prevailing health problems in the community) felt that there is much to be done in

the community to make it a better place to live, and they had an honest desire to try to make efforts for improvement towards this goal:

“...well, is there such a desire, I think there is, and I also think that we have possibilities and that depends, quite at length, on ourselves, nobody from the outside can bring in any health, and I believe in our effectiveness right on.” (Male, 41 years, Sro)

“...I’ve been of the opinion that the citizens themselves must decide about their involvement in issues, and this opinion has become stronger that through involvement you can achieve such things which have an effect and people feel that it makes sense to be involved, and that the kind of activity that comes from below makes sense when you think about village communities, everything was done together and pondered on together.” (Female, 46 years, Sro)

“...yes, and in a way at least that you point it out to the people that you can act by yourself and if you want some kind of change, you must do something yourself by committing yourself, not by thinking that I have voted them to get in there and they will take care of the issues.” (Female, 46 years, Sro)

Furthermore, the respondents in Somero believed that one ought to participate in the political process as a responsibility to others. They were convinced that although the participation in the political process would probably not be effective at the very beginning, it is anyhow worth trying for the sake of common good:

“...I think this is definitely one of those things that everybody sees themselves as an influential person, that one can feel that I am like that, and that I can interfere in an issue and consider it as a right and a duty and people must listen to me.” (Female, 57 years, Sro)

“...I’ve been thinking many times, I’ve always considered myself in a way as a saviour of the world and, you know, thought about my own life and also about the neighbours so that I try to promote common interests and so forth, not selfishly but for the benefit of all the people and the nation. So that helps me keep going when something good has been accomplished.” (Male, 75 years, Sro)

The activities of the Healthy Somero Programme seemed to have causal importance not only to the participants of the Programme but also to the entire community. They saw the Programme as an aid when trying to keep contacts to other parts of the society, too:

“...that we are not so cliquish here in Somero and do not keep just to ourselves, we must be involved in everything that takes place inside and outside Somero and everything that happens outside Somero also affects Somero.” (Female, 63 years, Sro)

“...I have tried to attend all the training events, also, because a link has been formed to Helsinki and Järvenpää, so to speak outwards from Somero so that there is a link to somewhere else, that we are not here just like in a musty mole hole, isolated. I think it has been very important. And all the information we have got during these courses has been such that it has led us to the map of the world so that we are part of something bigger, and the Health for All Programme is a part of it.” (Female, 63 years, Sro)

“...all of the themes have been important issues. It is only that we have had to make people understand, make decision makers understand that we can benefit each other and thus save a lot of common funds.” (Female, 63 years, Sro)

The following quotations reflect that the participants in Somero believed that by joining the efforts they will become more powerful. This could also be a sign of strengthened sense of community (but not too tight as seemed to be the case in Järvenpää, where the sense of community barred the “outsiders” from entering the Programme) e.g. allowing all residents to join the activities:

“...I think the biggest gain is that we now have shown that we can do, a citizen can do, but a citizen needs a framework for the job so that, over all, it is possible that the mere mortals can together do something to develop their own intimate circle.” (Female, 57 years, Sro)

In the speculations of the purpose of the Programme, it seemed that the participants of the Programme in Somero, particularly, had hit the essence:

“...well, I didn’t have any bigger fantasies, I just thought that let’s see what this involves. Just like this kind of volunteer, preventive work. ...Well, then I started to think that it cannot be official health care, that it has to be something else, when we think about psychiatric outpatient care and stuff, it has to be something different. It cannot be very profound or very problem-centered, if it goes too far, then it will become disease-centred pretty fast. So in our team, it has gradually turned into health-centered thinking and action so that the people’s social and psychological needs are a starting point, that is the safest factor or starting point in it.” (Female, 68 years, Sro)

“...I am of this opinion also in other matters that if a project responds to the needs of people – informative, know-how, whatever other needs – gives a stimulus, provokes thoughts, and effects emotions, so it will survive as long as it produces something that feeds the different needs of people. But if it is not ”satisfactory”, it will fall flat. So that if the project always brings about incentives and something new, it will live and grow...” (Female, 68 years, Sro)

The participants of Somero showed more empathy and reported more expressions on “soft values” of the society than e.g. their fellows in Järvenpää. The following quotations illustrate the meaning of this kind of expressions:

“...understanding others, increased empathy, listening to other people...” (Female, 63 years, Sro)

“...knowing better yourself as an individual, spiritual maturation, self-development like learning to see different matters from wider perspective.” (Male, 65 years, Sro)

“...Well, as far as I am concerned you cannot talk about any financial gain, it’s just a question of mental growth and development, that I want to improve myself, that I want specifically to be with the progress. The whole world is progressing, even Somero is progressing to some direction whether it is good or bad. And I feel this project has something to give me.” (Female, 63 years, Sro)

Summing up the differences between the orientation of the psychological empowerment of the respondents (participants) in Somero and Järvenpää can be done by using the four different dimensions of empowerment. Figure 33 shows the emphasis in orientation of empowerment in the two communities: The personality dimension was equally apparent in both communities. However, it could be concluded that Järvenpää was more cognitive-oriented (the importance of political matters and competence and a real possibility to influence) than Somero. The motivational (desire to influence, feelings of civic duty in the name of common good and sense of causal importance) and contextual aspects (e.g. being part of a bigger whole and understanding the advocacy role of the Programme) had more importance in Somero than in Järvenpää.

6.2.2 Community empowerment

Reported sense of community, team-working skills, and involvement in decision making (data received from the questionnaires of 1992, 1994, 1996 and the interview in 1996) as well as actual participation in the Programme activities (data from bookkeeping lists, diary and written documents of participation) were used as tracers in the development of the process of community empowerment. The operationalized indicators of empowerment (Chapter 5.2.3, pages 76–79) were used in the analysis of community empowerment as an

outcome. This part of the analysis was based mainly on transcribed interviews as well as on observation, diary and written materials.

Sense of community

According to the interview (1996)³⁵, the Programme had been able to generate a sense of community both in Somero and Järvenpää. The interviewees reported that they had a strong group feeling, and that the members of the Programme supported and encouraged each other. They felt that it was easy to be within the group, they felt themselves secure. The interviewees stated that there was a good atmosphere in the theme groups, and they were able to work effectively together. They also assumed that without the human resources and the skills and knowledge existing in the groups they wouldn't be as strong as they now felt themselves.

“... but as a team we have, so to say, more insight into it and this way we can, perhaps, see the whole picture better but also have courage and ability to inform about these things” (Male, 75 years, Sro)

“...I doubt that these environmental issues would have proceeded without our theme group. ...they say that individuals in this group would not have, for one reason or another, taken the issues to the decision-making authorities of the municipality or informed the municipality about them, but, as a group we have, so to say, more insight into the matters and this way, maybe, we see better the whole picture and, in addition as a team, we have more courage and ability to bring the matters to the general awareness.”(Male, 75 years, Sro)

Furthermore, they reported that belonging to the groups had brought not only new friends but also new other contacts within the community (like connections to the politicians, and health and other professionals in the municipality). They perceived that they had started to think more global (the ego was no longer so important) and they had a strong sense of solidarity and feeling of togetherness:

“...they think alike in the most important issues when they proceed on the same wave length and everybody agrees that this kind of issues should get attention and improvement collectively. Our team relies pretty well on each other even so that, in a way, we weigh our words and actions inside the team and we are quite solidary and reliable towards each other as well as the society.” (Female, 63 years, Sro)

However, the new members of the Programme (those who joined the Programmes after 1994) reported that they had difficulties to become accepted as members of theme groups. This was confirmed by several “old” members’ comments revealing that the old members experienced that it is “*troublesome to explain in detail all the principles, philosophy, plans, and such to the new members*”. This might be a sign that perhaps the sense of community or togetherness was too tight and did not allow or tolerate outsiders. This kind of development often leads to monopolization or pooling of the groups.

Community empowerment as an outcome

Community empowerment in this study was limited to empowerment within the communities “Healthy Somero” and “Healthy Järvenpää”. (Not meaning empowerment within the whole municipality). The issue was examined mainly on the basis of interview data collected in August 1996³⁶ Through using the indicators and operationalization of

³⁵ Expressions concerning sense of community: (Somero: n_{pers}=9, n_{expr}=58; Järvenpää: n_{pers}=10, n_{expr}=54)

³⁶ Expressions concerning community empowerment: (Somero n_{pers}=21, n_{expr}= 189; Järvenpää n_{pers}=13, n_{expr}=174).

empowerment, expressions representing community empowerment were picked up from the data and coded. (The indicators and operationalization of community empowerment are presented in chapter 5.2.3 pages 76–79.).

Somero

In Somero the majority (over 16%) of the expressions of community empowerment could be seen as signs of “control over health”. (Figure 34) This comprises the idea that the participants of Somero had learned how to organize themselves and how to manage time:

“...of course, there should be a group that gets together regularly which would know about these municipal policies and would have an attitude and would make initiatives. If there is no such group, the initiatives are not made and, because we are not political in a sense that we belong to a political party, we should have this kind of team which would contact the parties, the city council groups and thus the local government. It really would be important to have this kind of team to handle current issues, to bring them forth and keep on pushing even at every single city council meeting to give pressure constantly. It is not enough to make an initiative now and then, because it will just be filed after the issue has been handled. You must keep on making another motion and stick with it.” (Female, 63 years, Sro)

Control over health comprises also the improved team-working skills and the understanding that by joining the efforts a community can be stronger:

“...In general everybody talks only about those matters that interest themselves, you do not usually think in general terms...When people are in that kind of a group situation, they have to adopt a bigger scale, you must listen to your neighbour, too, in order to get your own issue heard. So I think that it is good to have to be with other people, because you cannot present your own issue without listening to others, that’s what I think.” (Female, 63 years Sro)

It seemed apparent that the people in Somero were aware of the factors influencing decision making and knew the mechanisms how to be heeded. This was also considered to be an important part of the feeling that one has “control over health”:

“...this Programme has had such an impact that we have basically learned about the general influencing channels, and we know where the decisions and plans are being made. We gained general knowledge, in order not to bark under the wrong tree.” (Female, 46 years, Sro)

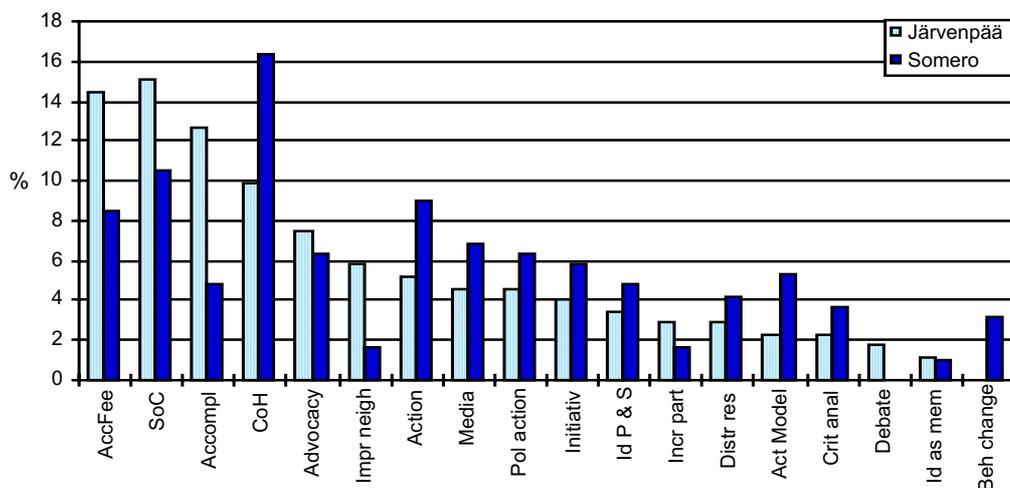


Figure 34. Community empowerment by areas and by town (%) in 1996.

“... We have a Modus Operandi now, so that we know that a petition must be made like this, it has to be in a written form, and it has to be delivered in a civilized manner so that we don't rush into any meeting to create a disturbance. This is the way it should be done.” (Female, 46 years, Sro)

Secondly, they expressed descriptions about the different actions the Healthy Somero Programme had implemented or which were going on. The respondents in Somero expressed much less both the “feeling of accomplishment” and expressions about the actual “accomplishments” than in Järvenpää, the amount of former being about a half from those in Järvenpää and the latter only a third from that in Järvenpää. The following quotations illustrate the meaning of feeling of accomplishment:

“...yes, the Project has given us confidence and a sort of faith in the future in such a way that we feel like something can be done and that support is available for our efforts.” (Female, 57 years, Sro)

“...but then I kind of realized that, to my mind, a clear change took place later on, and then this Project got appreciation and people saw that this has a meaning to Somero and that it is great to have this kind of freewill citizens' participation and volunteering to do something for Somero.” (Female, 63 years Sro).

And the following quotation reflects how a ‘real achievement’ was experienced by the respondents. The ‘real achievement’ to the participants of the Healthy Somero Programme was e.g. an established new way of action, but also some concrete improvements in the physical or social environment.

“...well, our group's true accomplishment is that people can now utilize the waste management services and are able to act the way they should concerning these matters ...and this would be the all-around benefit to the people.” (Female, 63 years, Sro)

“...The fact that we are getting a cleaner city, and benches and tables are brought to the parks is already an accomplishment. By the way, look over there, there already are benches there.” (Female, 63 years, Sro)

In Somero the Programme was more visible in the media, there were more attempts towards political action (even if they did not feel so when directly asked), initiatives, and improvements implemented, and more experiences of influence on the behaviour of the community:

“...during the first event, this group found out there really was a concrete result in effect, people changing their behaviour made this kind of change ...from the past.. .by following up the results of their work, it was obvious that maybe they have potential to act in the future, too.” (Female, 46 years, Sro)

“...yeah, we still have this alcohol issue brooding in the background but we have started to pay more close attention to the environment in its different forms, waterways, forests, the whole nature, and the issue of alcohol is a part of the social environment and a detail in these environmental issues, the enjoyment factors of the village centre and the whole municipality, littering, park maintenance, and our aim is that people would feel at home here and the environment would be taken care of so that it feels pleasant.” (Male, 75 years, Sro)

The participants of the Healthy Somero Programme were more extensive in their critical analysis of their world than in Järvenpää. The people in Somero referred more often than in Järvenpää to the “Action Model” they used in case they wanted to influence or manage some change in their community. Additionally, the “Action Model” of Somero was quite different from that in Järvenpää, which emphasized the core group and concrete actions and measures. The action model of Somero had clearly a component of political action, and moreover their model and actions were more often understood to be realized through joint efforts (e.g. notice the “we” form in the quotation.):

“...however, the pattern has been formed. The mode of operation, so that we know how to make a petition, that it has to be in writing and it will be taken by hand and it will be taken sort of in a civilized manner, so that you do not rush into a meeting and cause a disturbance, but this is the way it should be done. Should there be a real need to make a petition of the citizens like some health threat or should there be a service that would be terminated, so we would look up the pattern in the “Healthy Somero –book” and made it accordingly. There would be no extra panic but we would know this is the way to do it and take it to the decision makers at a previously agreed time and they then must handle the issue and the press would be notified and this is the way we would utilize the pattern, our Action Model.” (Female, 46 years, Sro)

Järvenpää

In Järvenpää the most often expressed indicator of community empowerment was the feeling of accomplishment (without, however, actual concrete changes) and expressions of a strengthened sense of community (Figure 34).

“...it really was the highlight of the programme when we noticed that the place was full of people. We felt that we had worked hard and succeeded. I really was a great feeling.” (Female, 37, Jpä)

However, they also spoke about the actual achievements the Healthy Järvenpää Programme had implemented. There were actions or measures taken where the participants had accomplished the work on their own, or they had influenced the authorities or other pressure groups who then implemented some concrete changes in the community:

“...and then our theme group became a municipal level drug squad. That is to say, this municipal level drug squad was hammered home all the way up to the local government, so that it must be founded and, in a way, a decision must be made who will be nominated to it.” (Female, 34 years, Jpä)

About 10% of the expressions could be attached to the concept of “Control over health”. In the category “Advocacy” (7%) there were registered e.g. activities where the Healthy Järvenpää Programme was used as an expert (representation in an experts group etc.) or a lobbyist towards politicians. They expressed also that they had been able to implement some improvements in the community life or environment:

“...I think there was a small story in the press and after that this cleaning operation of lake Tuusula was born. The lake is now being cleaned in earnest.” (Female, 47 years, Jpä)

“...and then there was this development project for the city centre area. One work team made it an issue that it is important that the mobility of old and disabled people should be made easier, now they are making the pavements lower, i.e., the pedestrian crossings are easier to pass.” (Female, 41 years, Jpä)

The participants in Järvenpää were able to implement various actions in the field of health promotion, and to “affect” media (meaning in this case articles in the local papers or programmes on the radio the participants had contributed) and the general debate concerning health:

“...thanks to the Project, such issues have been dug up that normally are not easily talked about, so that this way, via the project, we can bring them out in the daylight as one way and, of course, by direct impact as another ... just pick up the phone and call the decision makers.” (Female, 37 years, Jpä)

They were able to identify problems and speculate possible solutions for these. They also believed to have increased the people’s participation to some extent. There were descriptions concerning distribution of resources (and in addition there were e.g. plans concerning the distribution of community funds, or the community had invested in the

Programme in the form of providing facilities free of charge). Moreover, some of the participants had realized that through the kind of activities implemented during the Programme, the whole community could gain considerable savings (as noted earlier in this report the participants of the Programme had each devoted about one working week to this Programme, which could be considered as time saved from the traditional health service staff):

“...in a way, if the Project is so inclined that we can have considerable savings, then this Healthy Jpä project is a very good undertaking, because it is aimed at influencing the public health aspect and in this way it means remarkable savings for the municipality. If people could change their habits and started to look after their health, it indeed would be a great saving for the society, ...but if there is nothing to show on paper, it won't have any impact on the decision makers ...it goes in through one ear and comes out the other. The Healthy Jpä like all the other good things is a matter of practicality at this time, even though research has been made how beneficial it is to take good care of oneself, also that if the community invests a mark in it, the saving sort of will be four-fold at the end.” (Female, 40 years, Jpä)

The respondents expressed also – though in a very small scale – that they themselves had created a new way of action (“Action model”) (2%), which they could use if they wanted to e.g. influence decision making. However, the action model of the Järvenpää Programme included the idea that it was the “core group” which was in the charge, not the Healthy Järvenpää Programme in full, nor the entire population of the town, either.

“...The most important thing is the nuclear team! The ideas are coming from it, anyway, and the fact that these teams do not act the same way they did in the beginning, I think it is quite a natural change and quite good as that. The monthly meetings are held again and everybody who wants to have an impact will act in it and through it... work teams will be formed even though they still work like the previous ones. When we'll have the “Mental Health Markets”, the nuclear team is organizing it but the operation has changed. I think it is ok, nothing can go on unchanged.” (Female, 41 years, Jpä)

Furthermore, it was considered to be mostly in concrete problem solving situations where the action and the model would be utilized:

“...Whether it was thanks to the Healthy Jpä or whatever but some things have been done anyway, and the earlier set challenges will be met, and then there are the Projects own occasions and happenings, these things will roll on their own, although we don't even know about all of them. ... just concrete matters like this.” (Female, 41 years, Jpä)

“ But the truth of the matter is that being together, having something nice to do – may it be like cleaning the yard , or, in this team, we also got this here granny's yard cleaned and her berries picked.” (Female, 57 years, Jpä)”

Figure 34 shows that only 2% of the expressions were concerned with “critical analysis of the world”. However, the following quotation reflects the understanding of the way how the decision makers could be reached:

“...with such pressure and continuous contact and this kind of exhaustion battle you can reach the goals you want, i.e., the official who is there will get tired at some point and says “alright, alright, you'll get what you want. ...I would think that the bigger the hullabaloo and noise the better you can get the issue hit home, I mean that we need to make loud noises and have good grounds and have a war of attrition” (Female, 40 years, Jpä)

In Järvenpää there were no expressions of behaviour changes in the community which could be recognized as an achievement of (the participants of) the Healthy Järvenpää Programme.

Community empowerment by dimensions

The researcher combined the subcategories of community empowerment into larger categories/dimensions labelled as cognitive (actual characteristics, which had been reached through learning, including the subcategories like ability to identify problems and their solutions in the community, understanding the factors affecting decision making, ability to analyse critically the world, understanding the essence and use of “the action model” the people created), affective (emotionally laden expressions like sense of community and feeling of accomplishment, identifying oneself as a member of the community), behavioural (expressions concerning changes in behaviour, media reactions, increased debate concerning health), and actual environmental (actual changes in the community = descriptions about the real changes in the community brought about by the Programme participants).

Figure 35 shows the different orientation of community empowerment in Somero and Järvenpää. Somero was more behavioural and cognitive oriented with its reported expressions concerning community empowerment than Järvenpää. In Järvenpää the perceived feeling of achievements (affective) as well as the actual changes in the community life or environment seemed to be important.

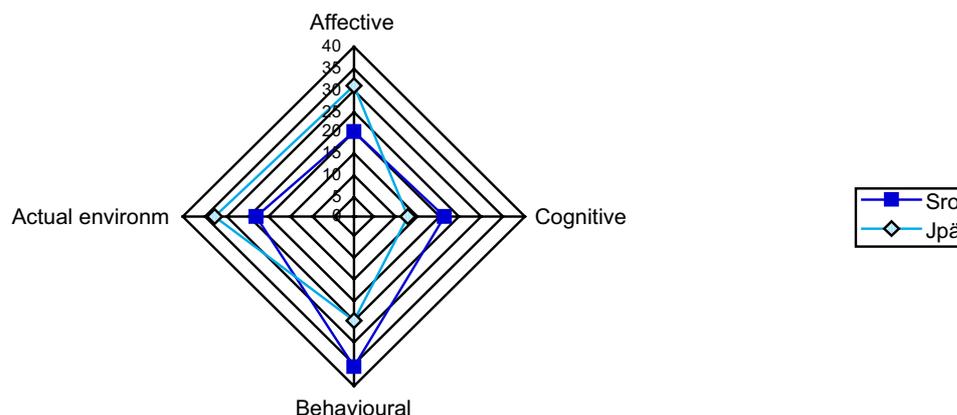


Figure 35. Community empowerment by dimensions and by town (%) in 1996.

Control over health and community life and community competence

In Figure 36 the way in which the two communities experienced to have “control over health”³⁷ is visualized in more detail. (Control over health was defined by Zimmerman (1990b) as comprising the ability to manage time and to organize themselves, the ability to identify resource providers and work for a common goal and understanding of factors that influence decision making). First of all there were twice as many expressions in this category in Somero than in Järvenpää. There was no difference concerning how the participants had learned to understand factors which influence decision making. Järvenpää considered to have improved in team-working (skills and the use of it, understanding others and taking into consideration other people’s opinions, too, democracy), whereas Somero reported more often than in Järvenpää how they had organized themselves (they systematically collected the people together, discussed the issue in concern in a democratic way listening to each other, invited experts in case their own expertise was not enough, delegated tasks, implemented them and reported

³⁷ Expressions concerning “control over health” (Somero $n_{\text{pers}} = 8$, $n_{\text{expr}} = 31$; Järvenpää $n_{\text{pers}} = 8$, $n_{\text{expr}} = 17$)

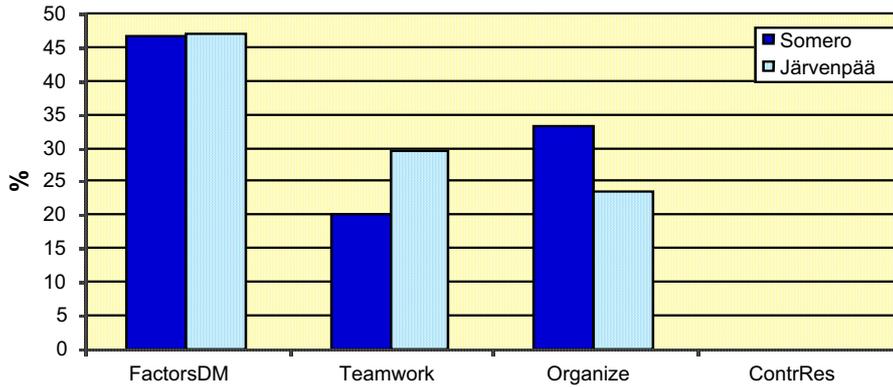


Figure 36. 'Control over health' by town in 1996.

or made an initiative) in case there was a problem or a matter to be solved or managed in the community.

None reported to have influenced the decisions concerning resources (e.g. their opinions concerning community budget were not taken into consideration). They seemed not to have gained control over resources (when thinking in terms of money), but they had improved to some extent concerning the community competence (improved skills and problem solving) (other than money matters).

There were, however, also negative feelings, opinions and perceptions about the development process, and expressions reflecting a sort of deficit of empowerment in both communities³⁸. (Figure 37). There were two and a half times more negative expressions in Järvenpää than in Somero.

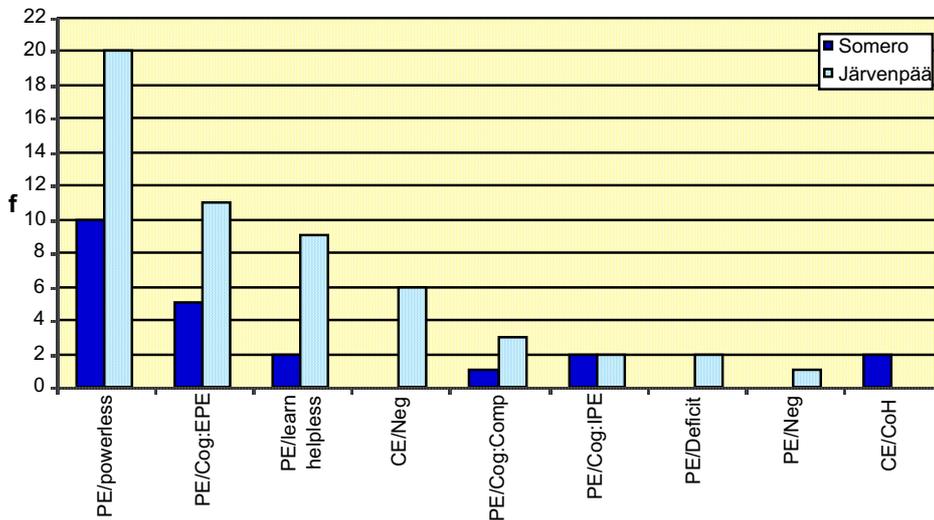


Figure 37. Negative expressions³⁹ by town in 1996.

³⁸ Negative expressions: (Somero $n_{pers} = 9$, $n_{expr} = 22$; Järvenpää $n_{pers} = 9$, $n_{expr} = 54$)

³⁹ PE/Powerless = psychological empowerment/feeling powerless; PE/Cog:EPE = psychological empowerment/cognitive dimension, external political efficacy = the belief that the political system is responsive to change efforts); PE/Cog:IPE = Cognitive dimension, internal political efficacy (= one has/has not skills to affect the policy making process); PE/learn helpless = feelings of learned helplessness; PE/Cog: Comp = psychological empowerment cognitive dimension, feeling of lack of competence; PE/ Deficit = feeling of not having control of one's world; CE/Neg = pessimistic views of community empowerment; CE/CoH = Community empowerment, the community is not having control over health.

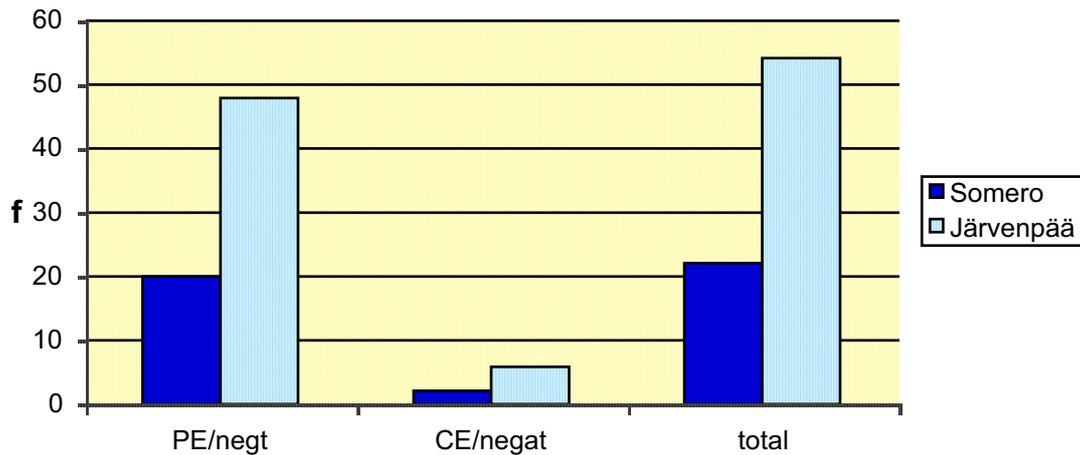


Figure 38. Negative expressions by level of empowerment in 1996.

In Järvenpää the negative expressions were mostly connected with the psychological level of empowerment and the respondents experienced powerlessness much more than in Somero. The negative expressions included such as: *“I feel powerless”, “I have not learned anything, at least not anything new”*...it is so difficult to do Gallup polls and all these exercises required in this Programme”.

The belief in external political efficacy was weaker in Järvenpää (*“...there is no response from the politicians side – it is all the same what we do...”*, *“...our municipality does not have an affirmative attitude towards change”*, *“...the decision makers were not committed to this Programme...”*, *“... our petition had too many demands and points – such a petition is impossible to take seriously”*) and in 1996 they experienced that the society had contributed to the development towards learned helplessness, more so in Järvenpää than in Somero. (E.g.: *“...it is this learned helplessness approach that makes people so passive”*) In Järvenpää the respondents reported more often than in Somero that they had not learned anything or at least not anything new or that participation in the Programme was a waste of time. More often also lack of empowerment in general (like lack of control of their lives) was expressed in Järvenpää than in Somero. Overall, the negative expressions were more concerned with the psychological level of empowerment than the community level (Figure 38).

Perceptions about the decision making channel

The participants in Somero⁴⁰ seemed mostly to rely on the traditional way (e.g. voting, parliamentary elections) of influencing decision making (Figure 39). The Healthy Somero Programme was considered to be the second best channel to influence decision making in their community. The citizens in Somero were also ready for direct action themselves rather than wait for the circumstances to change through the traditional community planning and decision making machinery. Also more often than in Järvenpää they reported to contact decision makers directly (personal contact) or to use NGOs as a channel for decision making.

The respondents of the theme interview in Järvenpää reported the most important channel for decision making to be the Healthy Järvenpää Programme. Secondly, they

⁴⁰ Expressions concerning decision making channel: (Somero $n_{pers}= 16$, $n_{expr}= 36$; Järvenpää $n_{pers}= 12$, $n_{expr}= 28$).

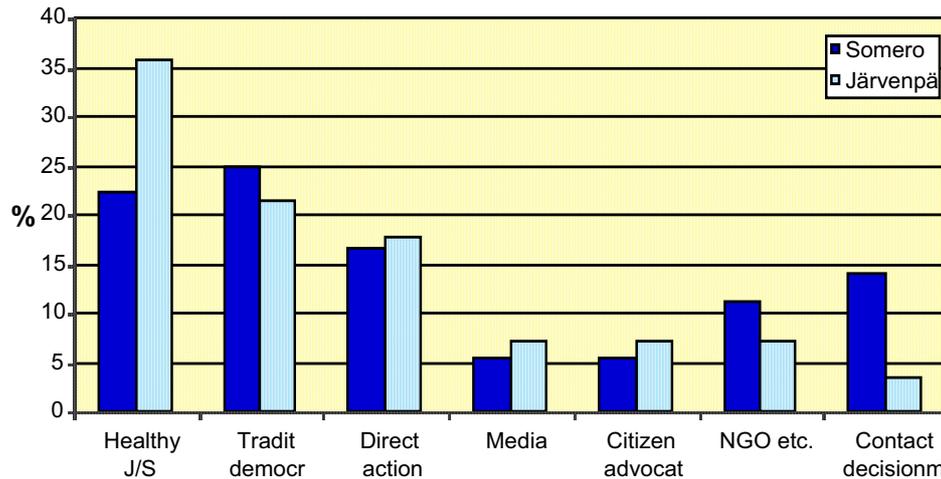


Figure 39. Opinions about the decision making channels by town in 1996.

were relying on the traditional way of influencing decisions or taking measures themselves. There was no difference concerning the use of media as a way of influencing decision making or general opinion between Somero and Järvenpää.

The appearance of the Programme in local media

The appearance of the Programme in the form of articles in local newspapers and programmes on TV and radio was followed particularly during 1992–1994. The ability of the trained people to use local media as a tool is one indicator of community competence and empowerment. The articles and programmes concerning Healthy Somero and Healthy Järvenpää, to the preparation of which the participants of the Programme contributed, were calculated and the content analysed. (After 1994 the articles and programmes were not systematically collected any more and therefore the analysis concerning years after 1994 is lacking from this study.)

In Somero the total amount of appearance in media increased significantly during the period (Table G, in Annex 2). In the first year of the Programme, 1992, only little more than ten articles were published. Already next year the amount of articles and programmes was five times more, and in 1994 the number of articles and programmes raised to 75. In Järvenpää there were no notable changes in the total amount of articles or programmes during the period of inspection (Table H, in Annex 2). There were annually about 20 articles or programmes concerning the Järvenpää Programme. This gives an impression that the people in Somero were more successful in raising the interest of the local media towards the Programme, and that they had found the mechanism how to attract the journalists to their meetings and various other activities.

In the beginning of the Programme in Somero, the newspaper articles were dealing with general information about the project, status reports about the proceedings as well as questions concerning mental health. In 1993, the articles reported on campaigns organized by the theme groups, and on a school children’s drawing and essay writing “competition” (on different topics of health promotion in Somero). In 1994, the articles and other materials were reporting on actions organized by the theme groups. One third of the materials dealt with smoking, one sixth with mental health issues and one sixth with environmental health matters. The ‘Somero Newspaper’ was the most important publisher.

In Järvenpää the Tuusula District News was most interested to follow the development of the Programme. The content of the materials dealt with general information about the Programme together with mental health issues.

6.3 Perceptions about what is Health

As it has been claimed that empowerment in the long run is enhancing health at least of those who are empowered, the researcher considered interesting to include in the theme interview in 1996⁴¹ a question of the perception the interviewees had about the concept “health”. The quotations concerning health were analysed through a method inspired by grounded theory. First, all quotations were recognized from the text, after which a detailed coding procedure followed. The codes were combined into categories shown in Figure 40, and furthermore combined to main categories (dimensions) of health illustrating the orientation of the expressions by the communities (Figure 41).

Figure 40 shows that in Järvenpää “health” meant taking care of own health, healthy lifestyle, coping, well-being and physical capability, but also such things as respecting others, social relations, developing yourself through e.g. hobbies and education (=“intellectual developm”), positive life attitude, influencing decisions, and political action seemed to be included in the concept. If the same categories are looked at in Somero, it is possible to notice that esteem and respect of others was the most often mentioned element of “health”. Secondly, well-being, social relations, and coping were mentioned as important elements of “health”. Taking care of own health and healthy lifestyle appeared less frequently in Somero than in Järvenpää as content of health. Political action was considered to be a part of “health” more often in Somero than in Järvenpää, as well as positive attitude towards life. In Somero “health” was also connected to upbringing which wasn’t the case in Järvenpää.

The perceptions of “Health” were combined to five dimensions – social, physical, mental, social political and spiritual dimensions (Figure 41), which remind the dimensions of 'health' defined by Ewles and Simnet (1992) and Naidoo and Wills (1994).

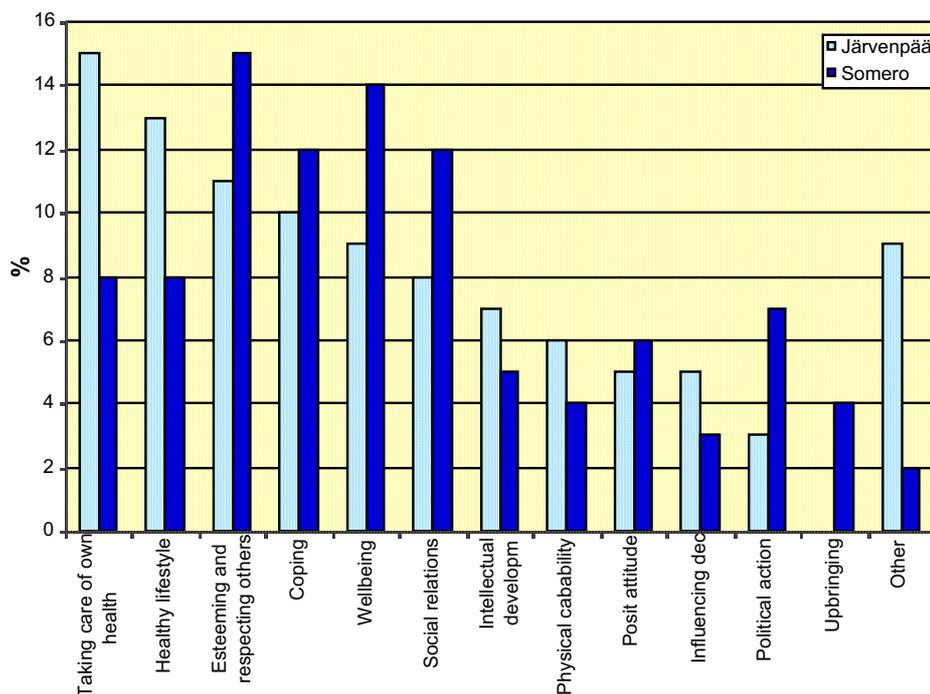


Figure 40. The participants’ perceptions about what “health” is by town.

⁴¹ Interview 1996: (Somero: $n_{\text{pers}}=15$, $n_{\text{expi}}=89$; Järvenpää: $n_{\text{pers}}=14$, $n_{\text{expi}}=94$)

Referring to the quotations of the respondents of the interview the physical aspects of health consisted of ideas like *“..it is that people should not neglect her/his own health”, “... one has to ensure and sustain a good physical condition”, “...you have to follow healthy habits, eat healthy food, do physical exercises, no smoking, etc.”, “...that you cope with your disease”, “.. physical well-being”.*

The social aspect consisted of *“.. constructive communality, feeling of belonging to the society”, “...social interaction”, “...being together with your family”, “...friends”, “...love one’s neighbour”, “...activities and social action”, “...hobbies”.*

The ideas comprising the mental aspects were e.g. *“...mental balance”, “...belief in better future”, “Positive thinking” “...positive attitude towards life”, “...to overcome one’s small adversities” “...being happy about the positive sides you have”.*

The spiritual or emotional aspects of health can be illustrated by the following quotations: *“...a man’s life is worth a song”, “to respect human life”, “to accept oneself with all weaknesses and imperfections”...”listening to the needs of human being”, “...spiritual development”, “being interested to develop oneself”, “...”...seeking spiritual and cultural dimensions of life “, “...courage to change”, “...the ‘green’ values of life”.*

“...Influencing decision making”, “...active participation in social political life”, being interested in what is happening in the world”, “..health is not a matter of sector only - it is a joint responsibility of all sectors of society”, “...seeking actively knowledge”, “..pulling all threads together to make a sustainable, robust network to support the society”, “...that all the basic prerequisites of health are in order, meaning living conditions, healthy environment, shelter, and so on” and “...this is an educational question” characterize the health political dimensions of the concept of health.

Figure 41 shows the differences between Somero and Järvenpää. It seems obvious that the “health” perceptions among the participants in Järvenpää are more oriented towards the physical and social dimensions of health, whereas the participants in Somero put stress on the mental and social political dimensions of “health”. Both communities also recognize spiritual aspects that according to the respondents belong to the “health” concepts.

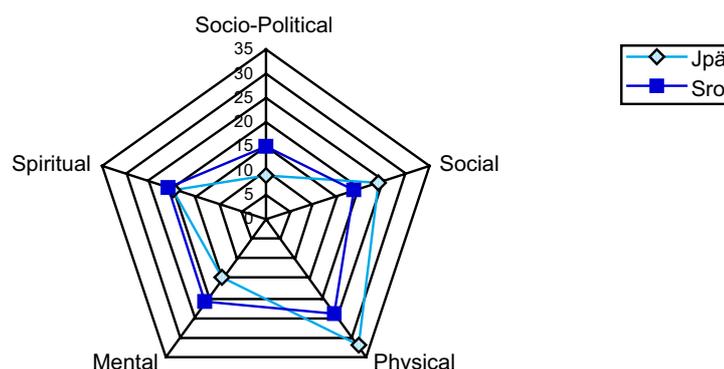


Figure 41. The perceptions about what “health” is presented by its main dimensions and by town in 1996 (%)

IV DISCUSSION AND CONCLUSIONS

7 Research strategy, validity and instrument elaboration

7.1 Research strategy

One of the main goals of the study was to understand (the process of) empowerment. Such being the case the study was built on two main elements: a theoretical part (consisting of the description of Finnish health policy from the citizen participation perspective, the description of the most significant health promotion programmes in Finland, the development of the concepts and theories of participation, empowerment and community organizing, and the paradigm perspective) and an empirical part where the understanding and methodological tools and approaches were adapted in the evaluation of the Somero-Järvenpää case. The question was not only to find out whether the programme was successful or not but also to understand the needs and requirements of a health promotion programme and its research in a wider context. The empirical data was used as a tool in forming a better understanding and a hypothetical view on how an empowering health promotion programme and its research should appear in the 21st century. This monograph was an attempt to characterize the nature of these issues and participate in the debate concerning the challenges confronting future health promotion programmes and their evaluation.

At first, the wide review of literature and the descriptive analysis of the health promotion programmes conducted in earlier years in Finland revealed that it is not possible to measure community participation and empowerment with approaches typical of the positivist and postpositivist paradigms (e.g. Labonte and Robertson 1996, Nutbeam 1998). The challenge of health promotion of the 90s and beyond, referring to the literature (e.g. STM 1986, WHO 1986a, Medical Research Council 1989, STM 1993b), was the enhancing of people's control over health and empowerment (e.g. Rappaport 1981, Zimmerman and Rappaport 1988, Wallerstein 1992, Rissel 1994). The empowerment process, as explained in the literature review, encloses a political component when attempting to increase power among the powerless (Starrin and Forsberg 1997). Enabling continuous citizen empowerment requires changes in the organization structures and development of a new form of operations.

However, as empowerment seems to be not only a political question, but also a methodological question, it makes the evaluation of empowering efforts extremely complicated. The approach along the lines of an empowerment model requires action research type methodology (and critical theory paradigms) (e.g. Eakin and Maclean 1992, Simmons 1995, Starrin and Forsberg 1997) favouring theme interviews, group interviews, participating and observing methods etc. Evaluation and research analyses should be directed along the paradigms of interpretivism, constructivism and hermeneutics in order to comprehend entities (Labonte and Robertson 1996).

This is what made this research complicated. Being on the one hand involved in a political act (at least in the period of 1992-1994) and on the other hand at the same time trying to implement an academic study and further health promotion as a discipline was the ongoing dilemma during the research process. The intention of the researcher was simultaneously to conduct a social change, understand the worlds and world view of the people involved (symbolic interaction), and create measurement tools to actually assess something which had been created by the human mind or through the discourses of different stakeholders of the process (constructivism see e.g. Kushner 1996). In addition, the issue, which complicated things even further, was the existence of *those* constructions of empowerment which the people involved (not only the researcher) had created in *their* minds. Consequently, the results of the study are in this sense value-laden at many levels.

The dilemma above – what should be known in the empirical part of the study and what should be looked for – was solved by selecting different aims for this study than those for the intervention. The researcher decided to concentrate on the elaboration of the measurement instruments and then look at empowerment through the scope of those instruments. The instruments developed here do not permit very deep considerations as to whether empowerment was sufficient, good or bad, or whether the process led to human liberation or an increase of actual health political power of powerless groups or the lay people in general.

The overall approach of this study could be labelled as “research of health promotion”(Eakin and Maclean 1992), which seeks “understanding of the nature and development of health promotion as a phenomenon in its own right”. In this case the focus was on empowerment which is seen as the core of health promotion by many (WHO 1997, Nutbeam 1998, etc.). The “research for health promotion”, which I consider the action research element belongs to, remained in my analysis a secondary task, but a necessary link between theory and practice.

The problem was that although the aim was to promote citizen power and participation, there were no tools for implementing such programmes, not to speak about evaluating such efforts. As described earlier, the available tools were not appropriate because of the ontology – the nature of the phenomenon (empowerment) to be known to be created by the human mind. And the perception of empowerment is subjective, because there is no common definition of what constitutes empowerment. This “which should be known” cannot be captured by quantitative instruments only. There is, however, good evidence about different uses of quantitative scales and measures of psychological empowerment (context specific empowerment and general empowerment) (e.g. Arnstein 1969, Maton and Rappaport 1984, Torre 1986, Rifkin et al. 1988, Zimmerman and Rappaport 1988, Short and Rinehart 1992, Frans 1993, Israel et al. 1994, Flynn 1995, Klakovich 1995, Maibach and Murphy 1995, Rissel et al 1996). The concrete instruments created in these studies have been limited in their use of assessing empowerment and focused on certain topic-specific interventions or groups of people, only. There have also been some trials to measure general empowerment. All of them have approached the issue with quantitative instruments. Rissel et al. (1996) claim that in order to assess community empowerment (as an empowered community should include empowered individuals) psychological empowerment must first be quantified.

Community empowerment has not been measured in such a systematic way (Wallerstein 1992). And to analyse community empowerment requires multiple levels of analysis. Psychological empowerment and sense of community are parts of community empowerment, but to measure community empowerment completely requires also parameters external to the intervention process.

In evaluating community empowerment, it would have been also necessary to examine the results in a wider context expanding the analysis to cover subjects like project participants’ and municipality authorities’ views on decision making on health issues as well as perceptions of their community as a health promoting setting (see e.g. Perttula 1999). What kind of hindering or enabling cultural or structural factors for empowerment could be found, perceptions of the support received from the community, FCHE or other counterparts for the process are other examples of appropriate research questions. These ideas are supported by e.g. Wallerstein (1992) and Stone (1992). However, because of time limits and the difficulty to deal with the already huge data, these issues were excluded from the present study. In Somero a separate study on the municipal employees’ perceptions of community empowerment was conducted in 1998 (Aaltonen 1998).

Pirie (1999) claims that the strongest study design would have been a control or comparison community (to compare the results to a community which was not exposed to intervention). I, however, claim that this kind of approach would not have been feasible concerning the implementation of an empowerment programme. Firstly, this would have raised an ethical dilemma of who had the right to participate and to be empowered and who had not, and who would have made this choice? Secondly, as

empowerment is claimed to be context specific (e.g. Rappaport 1981, Rissel 1994) and to be considered in particular settings and times, it would not have been appropriate to make serious comparisons between the towns (particularly concerning the *extent* to which they were empowered) in a manner required by the design proposed by Pirie. The design of the Somero-Järvenpää study was a follow up of the process of empowerment and a *description of the way* these two towns were empowered.

Why qualitative methods

Qualitative methodology of this study (not only a set of methods but a set of methodological choices from a wide range of possibilities) was devoted to see the world from the perspective of the participants within that world, and to getting closer to the participants' experience. It also assisted in locating these experiences in a wider context and earlier theories. Furthermore, I also thought qualitative methodology to be more flexible and adaptable in changing situations in the local settings than quantitative. In the research process and data collection, interaction between the researcher and respondents was evident and recognised as influencing the process. Many writers and qualitative researchers (e.g. Denzin and Lincoln 1994) have argued that it is not possible to have a completely value-free social research. In the case where empowerment is the focus of inquiry, I claim that the involvement of the researcher to as high a degree as possible in the life of those to be investigated is necessary and recommended. As the phenomenon of empowerment is still at a highly abstract level having multiple dimensions, it would be a "mission impossible" for an external researcher located in a distant office to imagine all sophisticated nuances of meanings which may take place in authentic situations.

My claims are supported by e.g. Eakin and Maclean (1992) who noticed that health promotion research involves the study of complex human behaviour in natural settings that cannot be controlled for scientific purposes. They state that qualitative methods may be attractive because they appear to promise the capacity to capture aspects of human action and social change, such as context and complex meanings. Furthermore they claim that qualitative methods are compatible with the philosophy of health promotion practice. The idea that qualitative research gives value and scientific legitimacy to individual subjective experience furthermore parallels the "people-centred" health promotion presented by e.g. Raeburn (1992). Also Wallerstein (1992) supports the idea of deepening the already existing quantitative measures on psychological empowerment with in-depth exploration of the meaning of empowerment and participation to individuals. The qualitative methods at best may elicit genuine participation of the community leaders in the research.

One of the most important disadvantages of the qualitative approach is that it is time consuming, particularly when the researcher is working alone, as it was in my case. On the one hand it would have been good if there had been a group of peer researchers to discuss the ideas and share the pressure of making scientific choices and argumentations. On the other hand the existence of peers could have disturbed my own maturation in perceiving and understanding empowerment.

7.2 Validity and reliability

According to Svensson (1996) the concept of *reliability* is placed under the concept of validity, which means that if the validity is considered as good, the reliability is good as well. However, if the reliability is good the validity is not necessarily good, claims Svensson. High reliability means that to satisfy the requirement of objectivity within the quantitative research tradition, measures and procedures must be reliable, i.e. a repeated measure with the same instrument on a given sample of data should yield similar results. Holsti (1969), when applying reliability to the content analysis method, finds reliability to be considered as a function of coder's skill, insight, and experience, clarity of

categories and coding rules which guide their use, as well as the ambiguity of the data. According to Holsti the nature of the data is usually beyond the investigator's control, opportunities for enhancing reliability are generally limited to improving coders (particularly in case there are more than one), categories (category reliability) or both.

To improve individual reliability Holsti proposes training. As in my study there was only one coder involved, this type of reliability was improved by literature reading and reading the data several times before the final coding. Referring to Holsti category reliability depends upon the analyst's ability to formulate categories for which the empirical evidence is clear enough so that competent judges will agree to a sufficiently high degree on which items of a certain data belong to the category and which do not. The category reliability was improved by checking the judgement – whether the unit of analysis (word, phrase, sentence, and chapter) belonged to the category or not – several times. This means that when the whole data was coded in full, the researcher re-examined the entire data and made corrections where needed. In doing this procedure repeatedly the coder's experience and understanding improved and the coder's ability to proportion or distinct the units between each other became easier. It was particularly in the coding of the interviews that the researcher used the foreknowledge gained through reading the literature. If necessary, the researcher returned to the theories and definitions of empowerment and other concepts. Also the operationalization of empowerment was used as an instrument, when interpreting whether the sentence, word, phrase, etc, belonged to a code or a category. It could be noted that the categories were in certain parts overlapping so that the unit of analysis (or a part of it) could be categorized in some cases under more than one category.

Svensson (1996) in his speculations on reliability concludes that reliability should be considered as encompassing a meaning, which approaches the meaning of *validity*. The reliability of a qualitative study cannot be judged without considering the validity of the study at the same time. Validity is usually defined as the extent to which an instrument is measuring what it is intended to measure (e.g. Starrin and Svensson 1994, Svensson 1996). As Svensson states (1996), there are two persuasions in the use of the validity concept in a qualitative study, some favour the use of 'validity' (e.g. Kvale), and others are ready to replace 'validity' with other terms (see e.g. Lincoln 1992, Denzin and Lincoln 1994).

Internal validity, external validity, reliability and objectivity are criteria, which the positivist and post-positivist paradigms normally apply for the inquiry (Lincoln 1992, Denzin and Lincoln 1994 pp. 479–480). The development of paradigms has led to the development of validity criteria, which would better fit in a naturalistic research context. E.g. constructivists replace the validity criteria used in the conventional paradigms with 'trustworthiness' and 'authenticity' (Denzin and Lincoln 1994). Moreover, Lincoln (1992) specifies 'trustworthiness' comprising credibility, transferability, dependability and confirmability. 'Authenticity' criteria would be fairness, ontological authenticity, educative authenticity, catalytic authenticity and tactical authenticity. Constructivism abandons a subject-object dualism in favour of an interaction between the investigator and investigated (subject-subject relationship). The values and purposes of the interpreter are thought to influence the interpretation in a much stronger way than is acceptable to an empirical study. J.K. Smith (1990) in his consideration of constructivism claims that "there is no independently existing reality of meanings that is susceptible to objective depiction, and there is no epistemological sense to be made of the dichotomy between meaning and significance".

There are also scientists who are ready to totally reject the question of validity in qualitative research (see e.g. Smith JK 1990, Hammersley 1992). E.g. postmodernists argue that the character of qualitative research implies that there can be no criteria for judging its products at all (Denzin and Lincoln 1994, p. 480). This argument contends that the very idea of assessing qualitative research is antithetical to the nature of this research and the world it attempts to study. This position doubts all criteria and privileges none.

Kvale (1996) defines validating the qualitative research, methods and analysis as controlling the trustworthiness (by controlling that empirical facts exist behind the results) and ensuring that the researcher has done reasonable/appropriate interpretation. Kvale speaks about *pragmatic validity*, which means that “truth” is whatever assists us to take actions on the basis of observations and interpretations and produces desired results, and *communicative validity*, which involves the testing the validity knowledge claims in a dialogue. Valid knowledge is constituted when conflicting knowledge claims are argued in a dialogue. Kvale further claims that the validity of an observation is decided through the argumentation of the participants in a discourse.

Maxwell (1992) emphasizes that in order to be useful, the validity in qualitative research must be considered from the researcher’s perspective and from that content and understanding which the researcher has given to a phenomenon under investigation. Maxwell states that the validity must be weighted in relation to the context, interviewer/observer and the interviewee/observed. Every situation of an interview or an observation is unique, and validity must be considered after thorough assessment of each of these situations. (Compare with the communicative validity of Kvale, above).

In my mind, the concept of pragmatic validity of Kvale approaches the perception of validity of the critical theorists: According to Lincoln and Guba (1994) critical theorists stress action, praxis, and the historical situatedness of findings. Increased importance is attached to such criteria as emotionality, caring, subjective understanding, dialogic texts, and the formation of long-term, trusting relationships with those studied. For Lincoln and Guba the inquiry enhancing the level of understanding of the participants and of their ability to take action, empowering them to take increased control over their lives are validity criteria for an action oriented research. Action research goes from descriptions of social conditions to actions that can change the conditions under investigation.

I have chosen to consider the validity of my study from the two perspectives presented by Kvale, pragmatic and communicative validity. (The perception by Lincoln and Guba supports the usefulness of pragmatic validity in an action research.) Kvale (1996) states that in practice to validate means checking (e.g. triangulating, looking for negative evidence, and getting feedback from informants), questioning (e.g. in hermeneutical interpretations the questions posed to a text become all-important, the “what”, “why” and “how”. The more multiple questions to, and readings of the data, the more likely is the crystallization of the meaning of the statements of the informants), and theorizing (deciding whether a method investigates what it intends to investigate involves a theoretical conception of what is to be investigated).

The empirical facts justify the trustworthiness of the study (see Kvale 1996, above). In my study the results are based on the empirical data (open-ended questionnaires, written reports, minutes of the meetings, diaries) collected during the Programme in focus. The trustworthiness of the data was improved when complementing the above listed material with a theme interview of the participants. The interviewed persons were selected to be a representative group; there were NGOs, authorities and “independent” citizens represented; 14 out of the 16 theme groups were interviewed; there were people who represented the activists as well as those who attended less regularly. In addition, the validity was improved by using annual reports, interim case summaries, diaries of the local Project Secretaries, diaries of the theme groups, and minutes of the meetings. They were read through without coding them. The participants of the Programme were the main authors of the annual reports assisted by the local Project Secretaries. I.e. the content and the quality of the descriptions of activities were ensured by this kind of participatory preparation procedure (the participants had a chance to check and correct/clarify what had been said about them and their activities). The minutes of the meetings were written by two persons, the local Project Secretary, who made the first drafts, and by the Project Manager (who attended the meetings) who complemented the minutes and discussed them with the Project Secretary in case clarifications were needed. The diaries of the two local Project Secretaries were also used in the validation. And, in addition, the interview of the Project Secretary working for both communities was used the same way

in confirming the findings. The negative opinions of those the interviewed were also analysed and used as one factor in validating the results.

Communicative validity was improved continuously during the interviews. The interviewer sometimes summarized what she had heard and asked the informant whether she had understood the message right (e.g. "... *by saying ... did you mean...*"). Complementary and other elaborating questions were used in order to make sure what the person wanted to convey or in case the interviewer wanted to know more. Communicative validity concerning observations was improved through a continuous dialogue between the observer/researcher and the observed/participants as well as through discussions with the Project Secretaries and the Trainers (this concerns particularly the action research period of 1992–1994).

Pragmatic validity (Kvale 1996) in this study refers to the actions taken on the basis of the interpretations and observation. The course of the action research proceeded according to the perceptions of the maturation and learning level of the participants involved. The feedback received from the participants was used in planning the next measures to be taken in the Programme. As Guba and Lincoln stated (1994) the validity of an action research is judged on the basis of how well the research has enhanced the participants ability to take action and have control over health. In this respect the study in concern was able to show at least that the psychological empowerment was strengthened and that the participants of the programme were able to use the "Action Model" they had created. However, the external circumstances (time allotted to the Programme too short in order to involve the entire municipality, and the nature of the available data) confined the pragmatic validity to concern only the Healthy Somero and Järvenpää Programmes, not the entire towns.

The validity of the study was also improved through *triangulation*. The validation triangulation in the Somero-Järvenpää case consisted of data sources (data was collected from several people, and at different times and from two communities), data collection methods and data type (like observation, questionnaires, interviews, accounting lists, written documents), analysis methods, and theory (empowerment, participation, theory of critical consciousness) and paradigms (critical theory, interpretivism, constructivism).

Theory triangulation (e.g. Bennett 1997) provides a macro view of a phenomenon allowing the researcher to discern better how it might relate to other phenomena. Bennett speaks up for theory triangulation as contributing to the solution of problems for which single theories provide only partial solutions. Denzin (1989) describes theoretical triangulation as the use of all possible theoretical interpretations in the framework of a study. Ideally, claims Denzin, competing hypotheses are developed from different theoretical backgrounds and are tested against each other. Theory triangulation in this study meant that the empowerment and health promotion programmes were approached from the perspectives of several theories and paradigms. Theory triangulation helped the researcher to understand better the phenomena encountered.

Two types of methodological triangulation, defined by Denzin (1989), – "within-method" and "across-method" – were used in the study. "Across-method" involved the utilization of both quantitative and qualitative methods with the aim of achieving convergent validity (the phenomenon was investigated using several approaches in the analysis; quantitative and qualitative; content analysis, grounded theory inspired methods, hermeneutic method, action research, and programme evaluation, together with some bookkeeping lists concerning participation, and structured questions concerning the demographic factors of the participants). The "within-method" involved combining similar data collection approaches in the same study to measure the same variable, realized in this study by using several separate questions like "Why are you participating", "What is the purpose of the study", "What do you think citizen participation means", and "What have you learned". The goal and visions of the Programme, empowerment and mobilization of the people in the community, were discussed together with all the counterparts at several training occasions and meeting. Such being the case, the answers to the above mentioned questions reflected the

maturation and development of the participants' perceptions of the meaning of the programme and about empowerment in general.

The general intention in using triangulation was not to pursue an objective truth but to add breadth and depth to the analysis (see Fielding and Fielding 1986, Begley 1996). In addition, triangulation was not only a tool for confirming the findings but also for completing the findings (giving a comprehensive picture about the phenomena) (e.g. Shih 1998).

However, the appropriateness of using triangulation is not always self-evident, states Sim and Sharp (1998). Its use should depend upon the nature and scope of the particular research question: If the research question is a specific and focused one and if it takes the form of a clearly defined hypothesis, triangulation may be redundant, Sim and Sharp say. However, as the focus of my study was ambiguous (empowerment) in character, it seemed to me justifiable to use triangulation. This is supported by e.g. Wallerstein (1992) stating that evaluations of empowerment interventions require studying a multiplicity of methods in order to cover all levels of analysis and capture the complexity of individual and setting changes.

7.3 Instrument elaboration

The primary aim of the study was to develop methods which could be used to measure and analyse participation and empowerment in local settings. As the general goal was to understand empowerment and the process leading to empowerment, it was not enough to develop single methods but to consider a more comprehensive package of methodology from which the more detail methods could be derived. Such being the case, the whole design and implementation of the study in concern can in a real sense be seen as analytic. The choices of conceptual framework (action research, education for consciousness raising, empowerment, participation, community development) and the paradigm considerations behind them, followed by instrument development, are all essential elements of the analysis. The choices made during the life of the "Somero-Järvenpää" action research part and its evaluation required also creative, analytic work. In this sense one of the measurement "instruments" was the researcher herself.

Attention must be paid to the fact that much interpretation of the phenomenon occurred all the way through the whole process, particularly including interviews and observations. The researcher was continuously condensing, reflecting back and interpreting the flow of meanings (e.g. what the people said, how they acted, what they did). In this sense part of the data was not being "collected" but rather "co-authored".

The study in concern used combination of several methods. The overall method was triangulation – a combination of several theories and approaches. The paradigmatic view the researcher had allowed the use of both quantitative and qualitative methods. The quantitative parameters, however, were limited to measure demographic characteristics of the participants and to account participation on different occasions and to estimate the use of time. The opinions of the participants of the different tasks were measured with a structured question where the respondents were able to mark the tasks they considered most important.

The main concepts measured with specific instruments in this study were citizen participation, psychological and community empowerment.

Participation measures

Participation in the study was seen on the one hand as a tool and catalyst (Fonaroff 1983, Green 1986, WHO 1986a, Brownlea 1987, Oakley 1989) for empowerment and on the other hand as an end of the empowering process – a characteristic of the people (Green 1986, Oakley 1989, Bracht and Tsouros 1990). The first type of participation comprised the idea that people have to participate in the programme and its activities in order to be

exposed to conscientization and education. For measuring this kind of participation indicators were: Accounting how many people participated (particularly in the training) and who they were. Looking (by bookkeeping) at the duration of their participation and whether they stayed in their original theme groups even when allowed to change groups if needed (permanence of groups = "coalitions"), noting the time the participants estimated have had used for participating in the Programme.

The above idea (and the instrument created) parallels with the idea of Rissel et al. (1995) who maintained that the more time contributed to the task forces (e.g. projects, NGOs etc.), the greater the investment in and the subsequent ownership of the task forces, and the greater the capacity to mobilize resources to achieve programme objectives. Based on this idea Rissel et al. created an instrument – quantitative survey - to measure factors (gender, age, occupation, time use for task forces etc.) associated with the amount of participation.

In my study, the parameters above (similar to the instrument of this study) could not be used in a statistical manner as Rissel et al. did. "Participation as a tool" parameters were measuring the participants mostly in their commitment to the Programme. They gave a picture of how the interest and commitment changed over time. Also the amount of participation reflected the interest towards different training occasions and their quality, times of the year when the interest was high or low, and whether it was connected to particular activities only. The measure showed that the interest to participate was greatest in the beginning of the Programme, had a slowing momentum towards every summer, and that the amount of participants generally decreased towards the end of the inspection period. In addition they revealed that in both communities there was a core group that participated actively and that had managerial tasks in the groups. Moreover, the measurement instruments gave an insight into whether it was the NGOs, or ordinary people, or authorities, who participated.

The measures here were quite simplistic but useful in describing the general interest to participate. In addition this tool helped the planning of the action research. There were some efforts by the organizers of the Programme to recruit more people to the programme in 1994 and 1995 (like organizing new informative evenings etc.). However, it seemed that these new candidates had difficulty to enter the "cliquish" circle of the Programme participants since they did not share the same historical experience (like participation in the education and other activities implemented earlier) and they did not find an adequate role for themselves. Consequently, most of the newcomers participated a few times but after a while did not appear any more.

An explanation of the difficulty of the new people to commit to the Programme could be that the existing theme groups (coalitions) already had formal relationships and mutually agreed shared roles within the groups. They had created their own organizational identity and culture and the members were committed to work primarily on behalf of the coalition itself. It is a paradox that this structure, while allowing the coalition to work together effectively it may at the same time impose a barrier to broader participation of other residents of the community. This observation is supported by Butterfoss et al. (1993) and McLeroy et al. (1994) in their analysis of community coalitions.

'Participation as an end' was measured, besides the above mentioned accounting, with open-ended questionnaire and theme interviews including questions like "why are you participating", "what is the purpose of the Programme", "what do you think citizen participation means", and "what have you learned". According to Zimmerman and Rappaport (1988) and Rifkin et al. (1988) the tasks which the participants perform in a programme reflect also commitment to the process and the level of participation (Arnstein 1969). The ideology of these measures comes from Zimmerman (1990a, 1990b) and Wallerstein (1992) who claimed that citizen participation itself is enhancing psychological empowerment. Participation offers opportunities to benefit from reciprocal helping and provides setting for developing the sense of community.

The above mentioned data (open-ended questions) was analysed with content analysis without any pre-formulated category framework. The categories were raised

from the data and to a certain extent they reflected the process of participation but also the process of empowerment. The issues like “self-esteem”, “participation in decision making”, “civic duty” etc. are elements of empowerment. As these questions were presented repeatedly (1992, 1994, 1996 May and 1996 August), it was possible to follow the change of these issues in time.

The researcher grouped the categories of motivation to fewer dimensions (individual, social, and health political reasoning for participation, Figures 21 and 22). The idea was to find out whether the participants thought to have obtained only personal benefit from the Programme or if they had some community centred or politically oriented reasoning for participation, and how these reasons developed in the progress of time. Empowerment requires joining mutual groups and a strengthened sense of community (Kieffer 1984, Swift and Levin 1987, Rissel 1994) and thus the measures of socially or health politically oriented reasoning could reflect the status of empowerment in this sense, too. The reader must, however, adopt a sceptic attitude towards the figures because of their qualitative character and small sample sizes.

Perceptions of what participation means, as supported by the quotations of the people, also reflected dimensions of empowerment. The development of understanding “participation” gave an impression of the same trend as above: From self-centred thinking towards community centred perceptions of what constitutes the concept of “citizen participation” and its changes in time. According to e.g. Chavis and Wandersman (1990) and Green (1986) sense of community is a catalyst in the process leading to empowerment and control over health. The measure of egocentric or community-centric understanding of ‘participation’ could to some extent provide information concerning the development of sense of community. However, this instrument, based on qualitative analysis, should also be developed further before it can be fully exploited. The researcher found the same tendency towards a strengthened sense of community in the analysis of perceived learning.

Empowerment measures

The idea was to develop a method for assessing what empowerment is like in the two towns. Empowerment was measured at psychological and community levels.

The ideas by Zimmerman (1990a 1990b), Zimmerman and Rappaport (1988), Rissel (1994), and Wallerstein (1992) were most inspiring in the instrument elaboration of the present study. The 11-item instrument created by Zimmerman and Rappaport (1988) including personal, motivational, cognitive, and contextual dimensions formed the basic framework of the operationalizing of psychological empowerment in my study. (The instrument in detail is presented on pages 76–79 of this study). The subcategories – like self-efficacy, civic duty, etc. – were further defined by referring to the definitions presented by their original authors.

Zimmerman and Rappaport (1988) and later Zimmerman (1990a) used this instrument and created a questionnaire, and further, analysed the results statistically. I.e. the instrument developed by these authors was purely quantitative. However, in my study the same dimensions were used to recognize the elements of empowerment from qualitative data. To my mind it worked well, even the recognizing procedure required interpretation and use of the researcher’s own foreknowledge on the topic. As the language of people consists of symbols which might have different meanings to different people, it probably was beneficial that the researcher participated as much as possible in the activities of the Programme. This was supportive to the researcher in trying to understand the meanings and messages conveyed by the people in the transcribed texts (based on theme interview).

The measurement instrument of community empowerment was developed in the same way by using the definitions of empowerment (Cottrell 1976, Katz 1984, Braithwaite and Lythcott 1989, Chavis and Wandersman 1990, Zimmerman 1990b, Florin and Wandersman 1992, Wallerstein 1992, Minkler 1994, Rissel 1994, Eklund et

al. 1995) as a basis for the operationalized instrument, which was then used further in the content (or rather context) analysis. The elements of community empowerment were then combined to four dimensions: Cognitive (characteristics which the people had gained through learning, like ability to identify problems and their solutions, understanding factors effecting decision making, ability to analyse the world critically, and understanding the use of "Action Model"), affective (emotionally laden expressions like sense of community, feeling of accomplishment, identifying oneself as a member of a community), behavioural (ability to positively influence behaviour of others, reporting of media reactions and own ability to use media to achieve common goals, increased debate on health) and actual environmental dimensions (descriptions about real changes in the community). This instrument had not been used as such in any other research before. It was intended for explicating the orientation of the perceptions of the interviewees concerning community empowerment issues.

The elements of community empowerment were thus mostly limited to subjective perceptions of the informants on the issue, and their descriptions on the actions implemented by the theme groups within the Programme. A thorough analysis of the objective reality of the modified conditions for the entire community empowerment was excluded from the present study.

The empowerment tools elaborated were rather complicated and multivariate in character, but with their help the items of empowerment could be recognized from the huge data of the study (qualitative open-ended questionnaires in 1992, 1994, 1996 and 36 theme interviews, average 1,5 hours each, as well as all written materials and observation notes). The researcher was able to trace items typical of empowerment by using the classification framework in the interview data analysis (content/context analysis). The analysis of questions "What have you learned", "Why are you participating", "What is the purpose of the Programme", and "According to your perception what is 'participation'" (open-ended questionnaire) complemented, as described above, the picture of empowerment as a process.

With these tools it was possible to draw conclusions concerning the character of empowerment reached, in other words to compare in which way (dimensions) the two communities were empowered. In this effort the measures of empowerment were quantified to roughly illustrate the differences between the two towns. However, a purely qualitative approach (the use of authentic quotations of participants) in describing results was needed to complement and support the findings and give them a deeper meaning. For drawing final conclusions of the patterns of rules concerning the development of empowerment, a comprehensive hermeneutic understanding approach was needed (where the researcher, back and forth, was reading the data and returning to the early theories and trying to understand the semantic meaning of the words and their connectedness to each other, and to finally create or elaborate new constructs between the elements necessary for the theory building). With the multilevel evaluation used in the study – which included several types of "triangulation" both in confirming the results and in completing the wholeness of the phenomena – it was to some extent possible to make explicit the steps necessary for empowerment (illustrated in Figures 42–45) and to find regularities, patterns and rules hypothesized to promote community empowerment, control over health and health political action.

Conclusions and generalization

The instruments developed in the study were complicated in character and it might be difficult to use them as such in another setting without adapting them to that particular new case. In addition, I want to emphasize that the measurement methodology created here required the involvement of the researcher in the everyday life of the people and thus the generalizability of the study may be questionable. I would rather partly endorse the statement by Rappaport (1981, 1987) who claimed that empowerment cannot be measured but only considered in certain times and settings. (The approach used in my

study was rather a 'consideration' supported by various qualitative measures in different parts and aspects of the development process). There is evidence, however, that empowerment can be quantified (e.g. Zimmerman and Rappaport 1988, Frans 1993). I would raise the question of who are the beneficiaries of this kind of information. Who benefits from knowing to what extent the participants or the community are empowered. This information mostly benefits the programme leaders and planners in giving an insight into how effective the programme/input has been in the mission of creating empowerment described in the literature. However, if the long term goal is the emancipation of the local people in health matters, it would be more useful to understand the process of empowerment, as well as in which way the participants experience empowerment and its sub-elements, and how empowerment is realized in the measures taken by the people. The Theory of Reasoned Empowerment Action is one attempt to illustrate this and the way empowerment can be embodied for different groups and people.

My remark is supported by Guba and Lincoln (1989) who claim that there cannot be any generalization of an inquiry, and state that "truth is a matter of consensus", "facts have no meaning except within some value framework", "causes and effects do not exist except by imputation", "phenomena can be understood only within the context in which they are studied". Hence, the meaning of evaluation shifts from making sense of the world as it is to making sense of how different individuals and groups themselves make sense of it. Kushner (1996) argues that "if research wants to work with agreed social realities, we have to negotiate, and in doing so we have to take account of how and why it is that individuals construct their own realities".

7.4 ATLAS.ti as a tool in qualitative research

The ATLAS.ti computer programme is a powerful tool/aid for the qualitative analysis of large bodies of textual (and even graphical or audio) data. In the course of qualitative analysis ATLAS.ti is supposed to help the researcher to uncover the complex phenomena hidden in the data in an exploratory way. It offers tools to manage, extract, compare, explore, and reassemble meaningful pieces from extensive amounts of data in a creative, flexible, yet systematic manner (Moilanen and Roponen 1994, Kelle 1995). The main principles of the ATLAS.ti "methodology" can be termed visualization, integration, serendipity, and exploration (Mühr 1991). Visualization means direct support of the way human beings think, plan, and approach solutions creatively, but at the same time systematically. Tools are offered to visualize complex sets of relations between codes, categories, and quotations. Integration means not to lose the feeling for the entity when working on details. Making fortunate discoveries accidentally, i.e. to find something without having searched for it, is an intuitive approach to data. Exploration comprises the idea that the whole conception of the programme, including getting acquainted with its own characteristics, is aimed towards an exploratory, discovery-oriented approach.

Coding, retrieval of quotations, writing memos, building families and networks are the functions of ATLAS.ti. The programme also calculates the frequencies of the codes if needed by its retrieval system. The graphs and code networks support subtle exploration of text via a visually intermediate interface that relates the text to the systems or theories in the world being studied (see Caven (1999) as an example of use of ATLAS.ti in theory building). Mühr (1991) emphasizes, however, the significance of the researcher as the main instrument of the analysis, reiterating that the computer programme is only an aid in this task.

In this study, however, ATLAS.ti programme was not used in the formulation of a theory ruled by the Grounded Theory procedures, which the ATLAS.ti has originally been planned for. Instead it was of assistance in coping with the huge data. The lack of time and personal experience in the use of computers in qualitative analysis limited the full exploitation of ATLAS.ti in the study. Moreover, it needs to be emphasized that

ATLAS.ti was only applied in the analysis of the theme interviews, as there was a lot of other data to be analysed manually.

For the analysis of empowerment (on the basis of the interviews) I created an operationalized instrument (see pages 76–79), which then was used in the content/context analysis procedure with ATLAS.ti as a coding assistance. Recognizing the different parts of the data belonging to different codes or categories required that the material was read through several times and interpreted before the units of analysis could be placed under different categories and codes. In other words the process proceeded as follows: First, the whole transcribed material was imported to the ATLAS.ti programme. This was followed by the reading through of the whole material (from the screen) without coding them. In the second round the researcher made an effort to recognize the main themes of empowerment from the data – parts belonging to psychological and to community empowerment. The passages of text dealing with other issues, like perceptions of general decision making and quality of health services in the community, were left out pending a more detailed analysis in a later stage. After this, the researcher worked to elaborate the details of the empowerment elements and their coding. At this stage the functions of the ATLAS.ti were helpful in allowing e.g. surfing through the data by selecting certain items already coded, and jump from code to code over other material.

The use of ATLAS.ti offers surely many advantages, but there are also some remarks of caution I wish to make. Sometimes when surfing from code to code and from one separate part to another, there is a possibility that the researcher does not discern the “forest from the trees”. This is what I felt after using the programme for several months (and after I was forced to purchase special glasses to protect my eyes). – For a while, I actually lost the feeling of the entity when working on details. In the beginning I was relieved that there was such a programme available, which, I thought, could speed up my work and make it presumably easier. I started with great enthusiasm. Since at the time of the analysis (summer) there was no expertise available whom I could consult, I had to get acquainted with the programme on my own, with the manual as my only guide. Fortunately, ATLAS.ti is one of the more consumer friendly programmes following partly the same rules as an ordinary text processing programme and it turned out to be quite easy to use. I soon came to discover, however, that the computer was only a tool, and that it is the researcher’s brains that actually need to accomplish the work. Analysing the text, making judgements about placing the text passages to different categories, marking the codes, comparing the parts, exploring and reassembling meaningful pieces from extensive amounts of data seemed to consume very much time. After seven months of work I eventually gave up using the computer in detail analysis, and proceeded to code manually those small parts (themes) of interest, which at the earlier stage I had left out from the very detail processing. Nevertheless, I claim that the ATLAS.ti was of great help in retrieving, managing and sorting the huge material, and I would probably use it again in my future study.

One of the great benefits of the ATLAS.ti programme is its ability to visualize the relationships between the concepts and categories in a form of networks, i.e. theory formulation. Unfortunately, I did not come so far in my use of ATLAS.ti. The theory (Model of Reasoned Empowerment Action) I discovered in my study was a serendipity, which resulted from the general hermeneutical understanding of the whole data (putting the pieces together), and free from any direct computer assisted or other type of detail coding or calculating procedures. I rejected the use of ATLAS.ti in assistance of the theory formulation partly because of the time limits but also because of the nature of the focus of the research. The intention was not to discover e.g. a new essence for the concept of empowerment, for that kind of theoretical considerations have already been made to a large extent without a consensus (e.g. Rappaport 1981, Kieffer 1984, Rappaport 1985, Rappaport 1987, Swift and Levin 1987, Rappaport and Zimmerman 1988, Zimmerman 1990a, Wallerstein 1992, Israel et al. 1994, Rissel 1994). (Discovering the essences of phenomena is one of the purposes of ATLAS.ti). Instead there has been a call for measuring empowerment and the process leading to it. Such being the case, the existing models and definitions of empowerment were exploited and a

measurement instrument was elaborated (operationalized conception), thereby using mostly the computer programme in the coding procedure.

The intention was also to describe in which way the two towns were empowered by clustering the codes into larger dimensions of empowerment, and by illustrating this with the help of ATLAS.ti. Since the use of distributions in reporting the results may give a quantitative impression, it needs to be emphasized that the idea was only to assist in outlining the differences between the towns as well as the character and content of empowerment of the participants. Therefore, the figures and distributions should not be understood in a quantitative manner (like judging sample sizes) but mainly as a way of visualization. Also, the changes in time can better be embodied using graphs. The intention of using quotations in the description of the results was to deepen the understanding of the meaning of the different categories of empowerment.

ATLAS.ti would have allowed the import and handling of texts in handwriting, too (like the open-ended questionnaires). However, as I purchased the programme as late as in 1997 this material had already been analysed manually. I think that ATLAS.ti would provide a great many practical functions to be used in qualitative research and not only in the procedures required by Grounded Theory. It might ease the coding procedure and formulation of theory building and in general holding the data in good order, but as I reminded above, the time consumed in the analysis does not necessarily shorten. Another benefit of the programme is the fact that the several hundred pages of transcribed texts need much less physical space than if manually handled. The material in a computer form is also much easier to take with you if needed, which in my case made life easier, as the academic part of the study was conducted in two countries.

8 From citizen participation towards community empowerment

The process of empowerment was followed by using certain “tracers” included in the questionnaires implemented in 1992, 1994 and 1996. The tracers were the questions concerning motivation, perceptions of participation, purpose of the programme, and perceptions of learning. In addition, the picture of the empowerment process was complemented by combining the results of the analysis of the theme interview and the pieces concerning the expressions on psychological and community empowerment. Furthermore, the researcher used all other written materials, observation notes, minutes of the meetings, and reports in complementing (triangulation) the results and forming the hermeneutical understanding and interpretation of the process. In this process the researcher used also the foreknowledge gained by reading literature and elaborating the empowerment approach.

The key aspects which the researcher was looking for in order to make an interpretation of the process, were feeling of sense of community, feeling of increased or strengthened personal skills, perception of the goal of the Programme, evidence concerning psychological and community empowerment, existence and permanence of theme groups, number of participants, and action and measures of participants (see Figure 42).

The Somero-Järvenpää Programme did not, at least in the beginning of the Programme, take a form of an in advance planned, time-limited project, including clearly defined objectives. In the beginning it was most important to get the people together and initiate and encourage discussion about the health issues concerning their own community (e.g. Freire 1970). The next stage was to support, strengthen and deepen this discussion, which then was expected to lead to raising the citizen consciousness regarding health problems. The discussion, the specific training, and the assignments involved were expected to ensure the skills and knowledge needed for participation and empowerment as well as for strengthening the sense of community (e.g. Chavis and Wandersman 1990), which is considered as a catalyst in promoting participation.

Furthermore, it was fundamental to understand the step by step development of empowerment (e.g. Kieffer 1984, Swift and Levin 1987, Rissel 1994). It is assumed that to proceed to the ultimate level of community empowerment, there is a need to first support individual development and psychological empowerment and then to promote alliances between the like-minded (“us” feeling). The research by Rissel (1994), though, claims that psychological empowerment as a feeling of greater control over one’s own life may occur without participation in collective political action. In this case empowerment can be assessed with the individual as a unit of analysis. However, psychological empowerment seems to be a necessary, but not sufficient, component of community empowerment (Rissel et al. 1996). As it has been suggested in this study, (parallels with Wallerstein 1992), there should always be an interaction between all counterparts of the empowerment process (along the lines of PAR, see e.g. Freire 1970, Starrin and Svensson 1991, Starrin 1993, Starrin and Forsberg 1997, Denzin and Lincoln 1994, Hart and Bond 1995), since empowerment can never be an individual phenomenon. The measurement of community empowerment requires the existence of community as a unit of analysis. (Wallerstein 1992). This is why the study in concern selected to focus on the communities in the analysis, and considered Healthy Somero and Healthy Järvenpää as the units of analysis.

External support must be sensitive to react to changes in the group processes and be able to predict the course of development, and furthermore to provide assistance where it is needed and desired. When planning the Somero-Järvenpää Programmes, the process consultants were prepared for a long lasting collaboration with the participating communities. The intention was to first build up long enough the foundations and prerequisites for action (see Figure 42), and after that to expect permanent and measurable effects. The whole process would have taken about 5–10 years depending on the available resources and support.

When the Programme started, the project leader group (the permanent staff of the Programme e.g. Project Manager, and Secretaries and the Executive Director of the FCHE, and the external trainers and consultants) had a clear idea about the consultancy approach to be applied in the mission. However, at the beginning stage of the Programme there was a prevailing confusion concerning the concepts of empowerment and participation, and the international literature about these phenomena was undeveloped within the field of health promotion. Consequently, the procedure expected to lead to community empowerment was not, after all, completely crystallized to the leader group. This study – both the theoretical considerations and the empirical part - has been of great assistance in understanding empowerment and the processes promoting or hindering its development.

One of the most important discoveries was the distinction between the psychological and community levels of empowerment. On the one hand they were considered as separate concepts, but on the other hand they were considered as one unified concept, as both levels are needed in the process through complementing each other. And secondly, it is not possible to speak about community empowerment before there first is a certain number of people who are empowered as individuals. It is not necessary, however, that all individuals of the group or community in concern are empowered to the same extent. But as the empowerment is a group phenomenon (e.g. Wallerstein 1992), it is the cumulated sum of empowerment existing or prevailing in the group that constitutes community empowerment.

Although researchers still have different opinions about empowerment, and their emphases are on different aspects of empowerment, there is some consensus over at least the following issues (that are also the key points when assessing empowerment): The importance of acquiring knowledge and skills, creating collective identity, supporting the establishment of critical awareness about one’s world, strengthening of self-concept of those who are expected to participate, and finally, adjusting the capability for reflective action and ensuring the appropriate channels and prerequisites for this .

Firstly, acquiring *knowledge and skills* is crucial in the process of becoming empowered (see Figure 42). The knowledge and skills comprise not only professional

contextual information about different topics, but also the shared lay expertise and experience (folk wisdom) within the members of the community. This resource must be released through the *critical awareness/consciousness raising* education (introduced originally by Freire and adopted in this study labelled as the *process consultancy* approach).

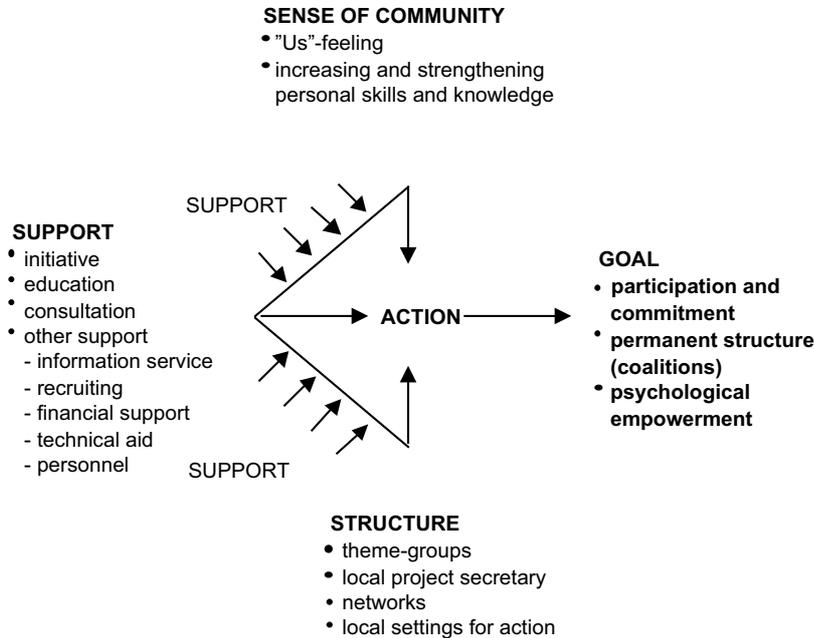


Figure 42. 1st stage (years 1992–1993) of the process.

It is believed that at least the core participants of the Programme were able to develop their power to perceive critically the world they lived in, as they expressed sophisticated judgements about their own community and society. (See Chapter 6.2.2.). However, one has to remember that this result concerned only a small experimental group, but could be a first sign that if the Programme had been given a chance to continue for some more years, the development of critical awareness could have diffused wider to the rest of the population in the communities.

The positive sense of self-confidence (included in the Personal Dimension of the psychological empowerment) is crucial to the development of empowerment. It is a prerequisite for the other dimensions of psychological empowerment – sense of control and causal importance. The enhanced psychological empowerment reflects individuals' (and the theme groups' = coalitions') willingness and motivation to collective action towards empowerment. The study gave evidence on the status of psychological empowerment, which seemed to be more explicit in the group that had been in the Programme from the very beginning, than in the group which had not been equally long exposed to the empowerment training (see Tables B and C, Annex 2).

The *collective identity* ("us" feeling and sense of community) includes the tendency that perceptions of power or powerlessness (see Chapter 6.2.2.) occur in the context of group membership. Group experience mediates the personal awareness of power, which was expressed by several members of those participants of the Programme who most felt themselves or their theme group empowered. E.g. Torre (1986) explained that primary group associations tend to link the individual to larger societal institutions, resulting in a sense of participation. The feeling of power (or powerlessness) then cumulates within the members of the community (or as it was in the Somero-Järvenpää

case, within some monopolized theme groups) and reciprocates the sense of power of the other individuals.

The component of capability to act (as individuals or within a community) reflects the community competence, which includes the perception of the ability to initiate effective action on the behalf of self or others. The expressions by the participants of the Programme gave the impression that at least to some extent a new way of action was generated. The participants themselves used the concept “action model” when they described the measures they took to manage or solve problems. The “action model” of the participants comprised several logical steps to be taken if e.g. they wanted to influence decision making concerning some issue. However the “action model” occurred quite dissimilar in the two towns and there were divergent views of how to use it. The participants in Järvenpää did not e.g. use the word “action model” at all but the existence could be realized according to the interpretation about the measures the theme groups took. The “action model” in Järvenpää meant concrete measures implemented by the “core group”, the majority of which consisted of authorities. The “action model” seemed to be the privilege of the empowered “core group”. In Somero the “action model” was more explicitly a logical pattern of measures to be taken to influence decision making (including the use of media to get their voices heeded). The participants considered the “action model” as a product of their learning process. The Somero “action model” was considered to benefit the whole community.

According to Bracht (1991) the urban and rural forms of social change and creativity are different. Bracht claims that urban environments tend to develop more formal avenues and infrastructures through which citizen involvement is mediated and realized, whereas rural environments have more frequently informal approaches. Järvenpää could be considered as an urban setting referring e.g. to its short distance from the capital of Finland and its service based source of livelihood, whereas Somero was an agricultural rural town. The strengths of Healthy Järvenpää seemed to be strong self-efficacy and feeling of competence (skills and knowledge) probably resulting from the fact that the majority of participants of the “core group” were authorities (who were highly educated, too). However, the weakness of Healthy Järvenpää was heterogeneity of the theme groups concerning the mentioned aspects followed by a tendency of the authorities to take the position of a leader more often than the NGOs or the “independent”. Consequently, the strong and skilled (empowered) “core group” realized its own action as representing the ‘more formal infrastructure’ (Bracht 1991) through which, they thought, citizen participation could be mediated. (E.g. they were represented in different city planning groups).

In the beginning of the Programme the strength of Healthy Somero seemed to be the sense of community and neighbour atmosphere, whereas the more obvious belief in authority and lack of skills and knowledge (e.g. on health issues) could be counted as weaknesses. The “action model” reported by the participants of Healthy Somero (interview in 1996) could be interpreted as a more ‘informal’ (Bracht 1991), ad hoc mechanism conducting a social change in different situations. The “action model” (the users of which comprised a broad citizen representation) was believed to be helpful when approaching the decision makers.

In the first stage (Figure 42). the most important goal was to generate as wide participation as possible and to make the persons commit to the process. In this stage the “action” (exercises, campaigns, preparation of posters, and lay community analysis etc.) as well as the “structure” (theme groups, project secretary, networks, etc.) in the process were used as tools for strengthening the sense of community and collective identity, and furthermore the development of psychological empowerment.

In the second stage (Figure 43) the elements mentioned above, as well as the commitment of the core group (those ca. 30 persons who participated actively all the time) and the interest to participate in the Programme had become stronger, so that the Programme was able to concentrate on recruiting more people to the process. The feeling of success experienced through implementing the “action” (the exercises etc.) promoted the establishment of a tradition for action (which the people at the later stage labelled as

an “action model”). In this stage (compare e.g. Kieffer 1984), it would have been of utmost importance to concentrate on the clarification of the local aims and purposes of the Programme and to come to a consensus about future visions and goals for the next stages. Referring to the minutes of the meetings, this was actually done in several occasions in both communities. This prepared the participants of the Programme, little by little, to move from the stage where action was used as tool to the stage where action is a consequence. I.e. the measures taken are planned and implemented by the participants themselves in accordance with the real priorities of the community. Kieffer (1984)

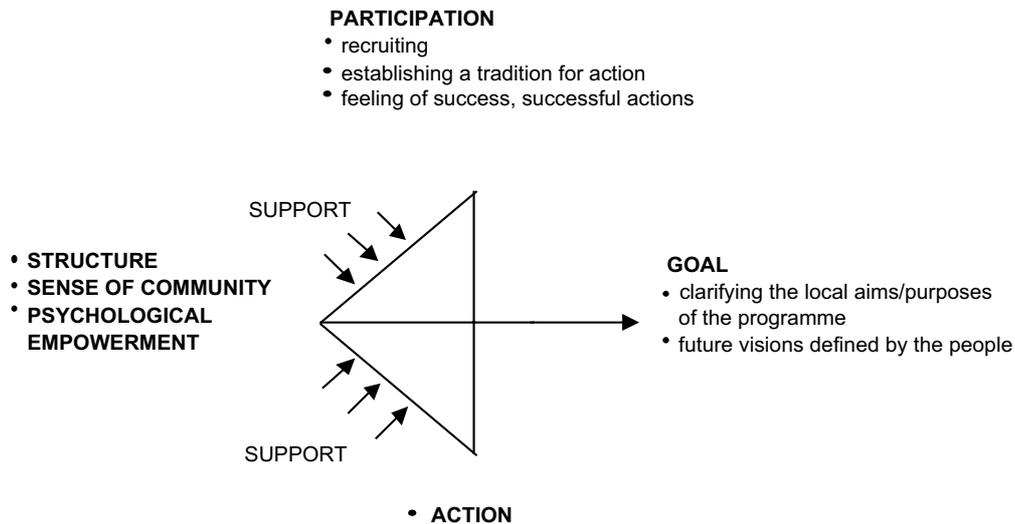


Figure 43. 2nd stage (years 1993–1994) of the Process.

emphasizes experience as the core of empowerment learning by saying that the building of skills progresses only through repetitive cycles of action and reflection. In other words, this process requires time and continuous practice. It seemed, however, obvious that as the Programme reduced the training and support in its third stage, the discourse concerning the goals and visions of the participants remained insufficient.

Somero

The Healthy Somero Programme in summer 1996 was characterized as a “*public health movement*”, the most important role of which was to initiate new projects and theme groups at the local level (Figure 44). It had recruited plausibly more people into the health promotive action. The main meaning of the existence of the programme was to function as an “*arena of social relations and social political action*”. The role of health services remained minor. In Somero, a core group existed, which, to some extent was able to draw new people into the activities of the groups. However, as the networks between the groups seemed to disappear as a result of the training meetings organized by the FCHE coming to an end, there was no regular contact or collaboration between the groups. According to the interview in August 1996, the representatives of these groups did not know what the other groups were doing or whether they even existed.

In the strongest theme groups activities continued, but with some weaker groups the members reported the action to be “*in ice*” or “*resting*”. When some new members entered the Programme in Somero, they reported difficulties to identify themselves in the group, because they were lacking, firstly, the skills and knowledge the other members had gained through the special training, and secondly, the common experiences of the groups while implementing the activities. As a consequence, the newcomers did not commit themselves to the Programme and participated only occasionally in different

activities. In other words, the objective of the 2nd stage of bringing more volunteers into the Programme and community action failed.

It was obvious that the sense of community of the core group in Somero was strong and particularly in some theme groups who continued to take measures according to the “*action model*” they generated. The psychological empowerment of the participants in Somero was “motivational” and “contextual” in character. The first characteristic comprised such elements as an experienced desire to control one’s environment, and a belief that one ought to participate in the health political process as a responsibility to

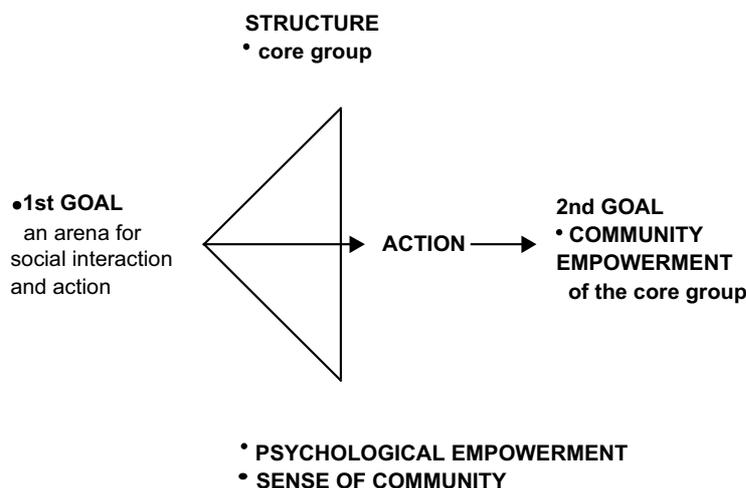


Figure 44. 3rd stage of the process in Somero, (years 1995–1996).

others, which included the concern for the common good and a sense of connectedness to others. The latter characteristics included the idea that in exerting control in the social and political environment the participants considered it necessary to be involved in collective action. They also became more aware of health issues and problems in their community. According to the results of the study this kind of development was more evident in 1994 than in 1996, which means that reducing the training and support seemed to have an effect on the direction of the development. As regards community empowerment, the participants in Somero showed to have “control over health” to some extent in some small theme groups, but in practice mostly only a couple of persons were concerned.

Järvenpää

In the very beginning of the Programme, influencing decisions seemed to be the most important mission for the Healthy Järvenpää Programme. There was also a tendency, particularly in 1994, to get rid of the perceived “steering” of the FCHE. The core group felt themselves to be psychologically empowered enough to be able to strive towards community empowerment themselves (perceived control). (This opinion was, however, limited to a couple of activists in some theme groups only. In summer 1996, in connection with the questionnaire, there seemed to be an obvious confusion about the purpose of the Programme, instead). Psychological empowerment according to Zimmerman (1990a) differs from perceived control, because it is multidimensional and includes a theoretical link to community involvement. Zimmerman, however, concludes in his research on connection between the learned hopefulness and participation among university students that one’s sense of empowerment plays a stronger role than

participation in reducing alienation and that personal feelings of control are expected to reduce perceptions of powerlessness, normlessness, and isolation.

Psychological empowerment in Järvenpää was more “cognitive” in its character. This comprised values like belief in capability to organize and execute the course of action required to deal with prospective situations, and confidence in one’s capability to overcome difficulties inherent in achieving goals and in that they have skills and knowledge for this. This kind of beliefs can be labelled as efficacy beliefs (Bandura 1977a, 1977b, 1986), and they are one of the most important foundations for proceeding to the broader stages of empowerment. Bandura claims that when individuals are empowered, their personal efficacy expectations are strengthened. However, their outcome expectations are not necessarily affected. They develop a sense of personal mastery or a “we can do” attitude regardless of hopes for favourable performance outcomes.

As the empirical example showed in both communities, efficacy beliefs cannot survive without external support and nurture (see e.g. Kieffer 1984). Community empowerment in Järvenpää remained at the level of “*illusion* of community empowerment”, where the emotionally laden expressions about achievements were typical. Even when the participants in Järvenpää reported more actual achievements and changes in the community environment caused by the Programme than their fellows in Somero, it seemed obvious that there was a discrepancy between the subjective sense of empowerment and the objective reality of modified structural conditions. I.e. the Programme was incapable of enabling the participants to exploit their skills and resources better in collective efforts.

As a summary one can conclude that the Healthy Järvenpää Programme had taken shape as a “*joint planning and co-operation arena of authorities and NGO's*” comprising a core group (Figure 45). The core group had a strong sense of psychological empowerment and perceived control. The role of health services in the process was major until the year 1994, after which it decreased. The core group shrank to about 10 people by the year 1996, and no new people entered the Programme. Tasks and duties were shared and co-ordinated between the members of the core group, which in 1996 was a union of the remaining theme groups and their most active members. The process of empowerment had thus probably strengthened the perceived power and the skills of the small core group only. According to e.g. Starrin and Forsberg (1997) there have been examples where empowerment has not necessarily led to an enhancement of human liberation and common good but to a strengthening of the positions of a limited elite only. In practice, the core group did not function any more at the time of the interview (August 1996) of this study.

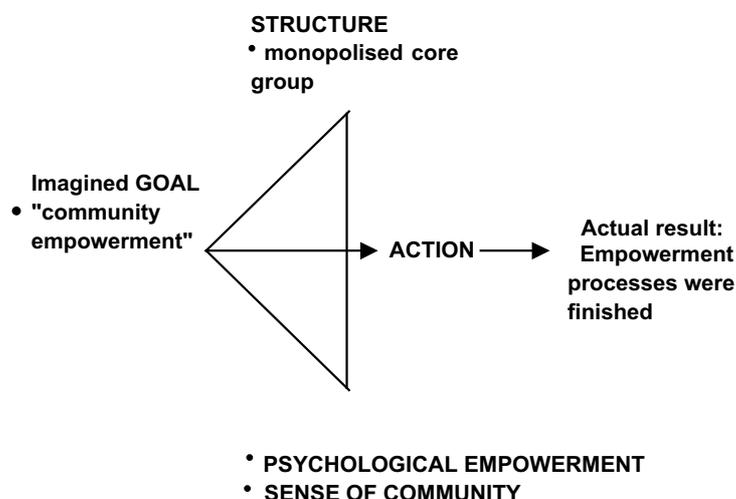


Figure 45. 3rd stage of the process in Järvenpää, years 1995–1996.

Conclusions

The concept of empowerment is still rather ambiguous and the other concepts of participation and community organization, which partly have the same meaning (particularly the most recent definitions), have caused more confusion in this area. However, the study in concern was able to show that empowerment is possible to initiate (supporting the claim by Rissel 1994 and Wallerstein and Sanchez-Merki 1994), but that in practice the development process is a complicated and multilevel phenomenaon which is extremely time consuming to establish and needs supportive mechanisms for years.

In Somero and Järvenpää a lot of activities, campaigns, interventions etc. were initiated (see Table 6) and the interest to participate in these occasions was high until 1994, after which the participation turned towards a slowing momentum. The conclusion was that during the four-year follow-up period of the Programme it did not succeed in achieving its ultimate goal – increase the participation of the entire community (whole municipality) or establish community empowerment integrated into community structure. However, the Programme was *successful in strengthening psychological empowerment, and sense of community and decision making skills of the participants of the Programme* (particularly of the core group). *Community empowerment* was strengthened only in the communities of Healthy Somero and Healthy Järvenpää, which in practice meant that community competence was monopolized by the skills and knowledge practised by the core-groups, only. Due to the fact that the support from the FCHE was withdrawn almost totally after 1994 and the communities were left alone under the supervision of a part time Project Secretary only, the Programme could no longer be called action research aiming at social change towards empowerment. The course of action was not as well predictable as it was before. The measures taken were under the guidance of charismatic persons in the groups and their perceptions of participation, purpose and future visions of the Programme.

The reasons for the collapse of the Programme can be found not only in the weaknesses of the design of the study (no precise theory basis nor a clear picture of the empowerment process at the beginning stage of the Programme, and underdevelopment and confusion concerning the key concepts, and inexperience of the project staff), but most of all in the too short a duration of intervention. The study in concern was able to show that there were good foundations for empowerment to be developed further, but that to proceed favourably these processes need external supervisors, consultancy and support for years before they could be assumed to be robust enough to be managed alone.

An other assumption for the collapse was the neglected area of raising the interest of the decision makers and official powerholders in the community towards the Programme, and persuading them to commit to the process, too. There were some efforts towards this direction in 1994 when the participants of the Programme had prepared their first exercises – lay community analysis reports (Eklund 1993, Eklund and Bergström 1993) – and approached the powerholders with their initiatives based on their own discoveries about the health of the community. After this, no purposefully planned efforts were implemented by the process consultants of the FCHE. However, certain theme groups continued to approach the decision makers by using the “action model” they created. These efforts were occasionally effective when managing a small contextually limited issue/problem, and lead to some improvements in the community environment (like starting to clean the water of the Lake Tuusula due to the efforts by the Healthy Järvenpää Programme, or persuading the municipality to organize their compost system in a better way including citizen training due to the efforts by the Healthy Somero Programme). However, this kind of action should have been extended to wider groups in the community to be more effective and sustainable. And this kind of political action to become an integral part of normal practice concerning health issues, needs support and supervision, managers for “navigation”, and assistance to overcome the problems and difficulties in the path.

Thirdly, the reason for failure could not only be found in the time question of the intervention, but also in the extent of the resources devoted to the Programme by the

FCHE and by the municipalities involved. The external input and support provided by the FCHE was approximately the same for both towns. Consequently, in both communities about the same amount of people were mobilized, even though the population in Järvenpää was three times bigger than in Somero. This gives an impression that it is essential that the emphasis is put on the width of the external support provided and not on the population size of the community in concern. A certain amount of external input brings about an anticipated volume of mobilization.

9 The Model of Reasoned Empowerment Action

The results of the study led to a concluding serendipity, a theory which was developed through procedures reminding the theory building of Grounded Theory. The discoveries are grounded on the data but liberated from single concrete findings, and are a composition of the researcher's interpretative procedures and understanding. The theory presented here could be labelled as a "Model of Reasoned Empowerment Action" (Figure 46). The theory comprises a typology of four different roles, which are hypothesized to be existing and necessary elements in the empowerment process, and which characterize those supposed to be empowered and engaged as actors in the process. The actors of the process can be divided into "Inductors", "Lobbyists", "Actors" and "Drones".

The division in the typology is based on the perceptions the actors in the empowerment process have of "health" and of "participation" – whether the perceptions are narrow (reflecting often the traditional view of health comprising first of all the physical, social and mental aspects of 'health', and "taking ego-centric care of own health" as giving the most important content for 'participation') or broad (in case where

<i>Understanding of health and participation</i>	<i>Narrow</i>	<i>Broad</i>
<i>Nature of action</i>		
<i>Long run & Indirect</i>	<p>INITIATIVE MAKERS/ "INDUCTORS"</p> <p>Groups that induce new projects, which after a while start working independently. The 'Inductors' withdraw after the new action has started and their assistance is no longer needed. The identity of Inductors is varying.</p>	<p>"LOBBYISTS"</p> <p>Health political pressure groups acting as advocates for the rest of the members of the community; advocacy-groups. The identity of 'Lobbyists' is very strong.</p>
<i>Short run & Direct</i>	<p>"DRONES"</p> <p>Groups resiganted to other groups; they act for limited time periods where assistance is needed. The identity of 'Drones' is weak.</p>	<p>"ACTORS"</p> <p>Groups maintaining a social arena for action and enabling participation for health promotion. The identity of 'Actors' is strong.</p>

Figure 46. Model of Reasoned Empowerment Action.

also spiritual and health political aspects and empathy become essential parts of “health” perceptions, and where “participation” is understood widely including such aspects as involvement in decision making in health and efforts towards common good). Actions taken can be “Short run” where some matter needs fast measures (like organizing a campaign), and the assignment is over the action terminates. Actions are “Long run” in case there are to be some real changes in the society or some activity continues to exist. When the actors implement the measures themselves, it is called “Direct”, and when they act through some organization or e.g. through professionals who then are persuaded to implement the desired task in practice, the action is labelled as “Indirect”.

The “*Inductors*” have a moderately narrow perception of the concepts of “health” and of “participation”. They often see ‘health’ as well-being of self or of the nearest family and taking care of own health including healthy habits. They see participation as taking part in action organized by others, and as mobilizing as many in the community as possible. However, the “Inductors” consider it important to enable the people to participate and for this reason they see their role as initiative makers for new projects. The identity of the “Inductors” is strong when they have innovated a new idea for a possible project and they put lots of energy to get things started and efforts to engage others into the process. As soon as the project has been started, the “Inductors” withdraw as their assistance is no longer needed. The responsibility of taking care of the project shifts to ‘others’. After the mission is fulfilled, the identity of the “Inductors” is weak and the group may terminate, unless they find a new mission. The nature of action of the “Inductors” is long run in the sense that the actions taken care of by ‘others’ will continue even when the “Inductors” have withdrawn from the process. And the action is indirect by nature, because the process needs the “other” stakeholders to be involved in the process.

The “*Lobbyists*” have a broad perception of what “health” is, comprising the idea that to have control over own health and the health of the family is not enough, but the control should comprehend the whole community. Furthermore, they include in health perceptions such items as esteem and respect of others, social relations, and influencing or being involved in the decision making of health issues. In general they consider health to be an extensive concept consisting of several dimensions, not only physical, mental, and social, but also political and spiritual dimensions. Along with the wide perception of health, the “Lobbyists” also perceive the “participation” as being a multidimensional perception. The most essential characteristic of “participation” to the “Lobbyists” is its political and context-specific meaning. They have a strong feeling that the individuals or group of individuals’ political action can have an impact upon the political process, and, moreover, that participating in the political process is a responsibility to others. The wide perception reflects the actions taken by the “Lobbyists” who see their mission to be a health political pressure group. Their task is to be advocates in health matters for the rest of the population. The identity of the “Lobbyists” is very strong. The nature of action of the “Lobbyists” is indirect, because they consider themselves to be facilitators in the dialogue between the decision makers and powerholders and the public. In other words they collect opinions from the general public and convey these further. Consequences of action are “long-run” in the sense that these could lead to actual improvements (at best) in the society.

The “*Actors*” may have as broad a perception of “health” and “participation” as the “Lobbyists”. However, they tend to rely more on traditional decision making channels than the “Lobbyists”, “letting those do the tasks who are officially assigned to them” (e.g. health professionals, members of parliament). They consider the essence of ‘participation’ is being active in general and socially oriented, and that these will then influence the health and well-being of an individual. They also believe that, the more there are active people in the community, the more likely it is that well-being prevails there (cumulated sense of well-being). The “Actors” see their mission to be in organizing opportunities for all citizens to be active and social (provide an arena for social relations and action). The identity of the “Actors” is strong, but the consequences are considered to be “short run”, having no continuity, but providing temporary pleasure and satisfaction

for those involved. When one mission is over, the “Actors” seek actively new “wild and humorous” ideas to attract more and more people in the community. However, the actions they implement have often a clear goal and they feel strongly to be “health missionaries”.

The “Drones” have a narrow perception of “health” comprising individuals’ control over own health and following healthy habits. They see participation mostly as participation in activities organized by others. The identity of the “Drones” is weak and consequently they seek support from other individuals or citizen groups. The role of the “Drones” is often to act as assistants in activities initiated by the other groups. They act for a limited time period, or for as long as is needed, and under the supervision or command of the other types of groups.

All these types and roles are needed in the process and they form a natural part of it. The level of empowerment of individuals or theme groups (or whatever coalitions are used) is reflecting the way of action and, consequently, the counterparts may move from one type to another when they develop (or regress).

I want to emphasize that it seems possible (as supported by the results of this study) to change the position of individuals and groups in this typology through empowerment education and conscientization by external facilitators/process consultants. The training and experience gained through participation in an empowerment process are expected to influence people’s perceptions of “health”, “participation”, and “mission” (goal and vision), which is then reflected further in the actual actions the groups take. The model here reminds the ‘Theory of Reasoned Action’ (by Ajzen and Fishbein 1980), which attempts to explicate the links between attitudes and behaviour, as well as the “Health Action Model” by Tones (see e.g. Tones and Tilford 1994, pp. 90-103) seeking connections between individuals’ belief system, behavioural intention and real action. However, a profound analysis concerning the connection between these theories and “The Model of Reasoned Empowerment Action” will be left as a task for further research.

10 Ideas for future research and development

The study in concern was an attempt to answer the challenge of measuring empowerment and making explicit the process of empowerment, as well as to contribute to the development of the understanding of empowerment in a Finnish context. The research was able to show to some extent, however, the development and status of empowerment in a limited community but it was not able to go further. Future research on health promotion programmes faces the need to create approaches to analyse actual community empowerment and community structures which enable or hinder the development of empowerment.

In addition, for the purpose of measuring/considering internal empowerment of a community (in my case meaning the participants of the Programme) I call for complementary measures/considerations on empowerment of entire members of the community (e.g. their sense of community). This would mean the use of complementary quantitative measures (like surveys) of quite large numbers of people, where a quantitative approach could be more appropriate allowing moderately large sample sizes.

The interview material of my study collected in 1996 included parts where the respondents described the decision making in their community and health promotion in general (like which societal mechanisms create low participation in certain groups, structural factors enabling and hindering participation, etc.). Due to the fact that the analysis of this thesis already consisted of huge data, the above mentioned items were left out from the present study to be returned back to in future research.

There would be also a need for studying non-participation, e.g. who is the audience of a health promotion programme which should participate, but which the programme does not reach, and why (see e.g. Brännström et al. 1994). Additionally, to follow the

visibility of an empowerment intervention/programme, it would be important to know how well known the programme is among the residents of a community/municipality. This would be of assistance in recruiting more people into the programme, and in giving information on whether there is a need for more effective “marketing” of the programme or other measures.

Satisfaction with experiences that participants perceive in a programme might be one focus of interest of further study (socio-epidemiological approach). However, it might be difficult to rank the satisfaction, particularly where respondents/participants have themselves been counterparts of the process. Finally, it would be interesting to include indicators on perceived health of people who attend empowerment programmes and who do not.

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Annex 1. The scale of the types and approaches of the community programmes

Importance	1	10
	Minor	-----> Major
SCIENTIFIC BASIS AND GOALS		
Disease/Dis-order	Minor	1 2 3 4 5 6 7 8 9 10 Major
Health-orientation	Minor	1 2 3 4 5 6 7 8 9 10 Major
Testing hypotheses	Minor	1 2 3 4 5 6 7 8 9 10 Major
Theory based approach	Minor	1 2 3 4 5 6 7 8 9 10 Major
Action res. approach	Minor	1 2 3 4 5 6 7 8 9 10 Major
”Control over health”	Minor	1 2 3 4 5 6 7 8 9 10 Major
IMPLEMENTATION		
Experts role:		
Global	Minor	1 2 3 4 5 6 7 8 9 10 Major
Local	Minor	1 2 3 4 5 6 7 8 9 10 Major
Authorities:		
State	Minor	1 2 3 4 5 6 7 8 9 10 Major
Municipality	Minor	1 2 3 4 5 6 7 8 9 10 Major
Health services	Minor	1 2 3 4 5 6 7 8 9 10 Major
Other municip. sectors	Minor	1 2 3 4 5 6 7 8 9 10 Major
NGOs:		
National	Minor	1 2 3 4 5 6 7 8 9 10 Major
Local	Minor	1 2 3 4 5 6 7 8 9 10 Major
Coalitions and networks	Minor	1 2 3 4 5 6 7 8 9 10 Major
Differentiated organisation	Minor	1 2 3 4 5 6 7 8 9 10 Major
RESEARCH AND EVALUATION		
Evaluative methods		
Quantitative	Minor	1 2 3 4 5 6 7 8 9 10 Major
Qualitative	Minor	1 2 3 4 5 6 7 8 9 10 Major
Process evaluation	Minor	1 2 3 4 5 6 7 8 9 10 Major
Outcome evaluation	Minor	1 2 3 4 5 6 7 8 9 10 Major
FEEDBACK TO:		
the population	Minor	1 2 3 4 5 6 7 8 9 10 Major
practitioners	Minor	1 2 3 4 5 6 7 8 9 10 Major
experts and researchers	Minor	1 2 3 4 5 6 7 8 9 10 Major

Annex 2. Appendix tables

Table A. Time (in hours) the participants consumed for the project

	Somero			Järvenpää		
Year	-92	-94	-96	-92	-94	-96
Hours total	1382	873	504	1914	919	282
Hours per pers (in average)	41	35	22	58	42	22
Used time per pers Min/Max	1,5 / 110	2 / 80	2 / 80	3 / 200	2 / 90	1 / 63
	n = 34	n = 25	n = 23	n = 33	n = 22	n = 13

Table B. Number of expressions showing empowerment of the participants by community in 1996

Expressions	PE	CE	Total Empowerm
Town	in average (total)	in average (total)	in average (total)
Somero all (n = 21)	7.8 (163)	9.4 (197)	17.1 (360)
Järvenpää all (n = 14)	7.9 (110)	13.1(184)	21 (294)
All (n = 35)	7.8 (273)	10.8 (381)	18.7 (654)

Table C. Number of expressions showing empowerment of the activists by community in 1996

Expressions	PE	CE	Total Empowerm
Town	in average (total)	in average (total)	in average (total)
Active Somero (n=14)	10.4 (n = 146)	13.0 (n = 182)	23.4 (n = 328)
Active Järvenpää (n=12)	9.1 (n = 109)	15.1 (n = 181)	24.2 (n = 290)
Active Both Cities (n=26)	9.8 (n = 255)	14.0 (n = 363)	24.0 (n = 618)

Table D. Number of expressions showing empowerment of the non-activists by community in 1996

Expressions	PE	CE	Total Empowerm
Town	in average (total)	in average (total)	in average (total)
Non-active Sro (n = 7)	2.4 (n = 17)	2.1 (n = 15)	4.5 (n = 32)
Non-Active Jpää (n = 2)	0.5 (n = 1)	1.5 (n = 3)	2.0 (n = 4)
Non-active Both Cities (n = 9)	2.0 (n = 18)	2.0 (n = 18)	4.0 (n = 36)

Table E. Number of expressions showing empowerment of the NGO representatives

by community in 1996

Expressions	PE	CE	Total Empowerm
Town	in average (total)	in average (total)	in average (total)
NGO Somero (n = 10)	7.9 (n = 79)	10.1 (n = 101)	18.0 (n = 180)
NGO Jpää (n = 6)	8.8 (n = 53)	10.8 (n = 65)	19.7 (n = 118)
NGO total (n = 16)	8.3 (n = 132)	10.4 (n = 166)	18.6 (n = 298)

Table F. Number of expressions showing empowerment of the participants who represented authorities by community in 1996

Expressions	PE	CE	Total Empowerm
Town	in average (total)	in average (total)	in average (total)
Authority, Somero (n = 8)	3.1 (n = 25)	5.1 (n = 41)	8.3 (n = 66)
Authority, Jpää (n = 7)	6.0 (n = 42)	12.7 (n = 89)	21.8 (n = 131)
Authority, total (n = 15)	4.5 (n = 67)	8.7 (n = 130)	13.1 (n = 197)

Table G. Healthy Somero – Appearance in media 1992–1994

MEDIA	1992	1993	1994
Somero-Newspaper	7	28	52
Forssa News	4	8	13
Salo District News	2	9	3
Turku News	-	1	-
Local Radio “Suomen Salo”	-	3	4
Local TV	-	1	3
Total n	13	51	75

Table H. Healthy Järvenpää – Appearance in media 1992–1994

MEDIA	1992	1993	1994
Keski-Uusimaa (Middle-Newland)	5	3	9
Tuusula District Weekly News	10	7	10
Other newspapers	2	1	-
Other magazines (e.g. published by NGOs)	3	6	6
Finnish Radio	-	1	1
Local radio “Etelän Ääni”	-	4	1
Local “Radio 10”	-	-	1
Total n	20	22	25