Chapter 13
The Application and Evaluation of an Assets-Based Model in Latin America and the Caribbean: The Experience with the Healthy Settings Approach

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13.1 Introduction

One of the most outstanding characteristics that distinguish Latin America and the Caribbean (LAC) from the rest of the world is the social, cultural and economic diversity among and within its countries. Nevertheless, while not being the poorest set of countries in the world, LAC is one of the most unequal in terms of wealth and health (World Bank 2007).

How to decrease inequities in health through the reduction of poverty and inequality is one of LAC's biggest challenges, in the face of the enormous social, economic, political, climatic and ethnic variations present in these countries. The evidence indicates that the countries have significantly advanced in many aspects, such as the reduction of people living in poverty and increases in literacy rates and life expectancy at birth. However, this progress refers to average values for all the countries together and often hides great inequalities among and within countries (PAHO/WHO 2007).

Although it is recognized that inequity in health is a direct consequence of the inequitable allocation of resources, opportunities and power, the greatest share of the resources for health in LAC continues to be invested in health care alone. Policies and interventions in LAC have traditionally focused on disease prevention and treatment, following what Morgan and Ziglio in Chap. 1 call the deficit model of health promotion, as opposed to the promotion of factors that create and sustain health and development.

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Nevertheless, as the interest in the social determinants of health (SDH) has grown worldwide, addressing their impact on population health has become a priority in many LAC countries. Over the past few years, an increased emphasis has been placed on understanding how the SDH impact health conditions in general, as well as unfair and avoidable inequalities in health. As a result, LAC countries have experienced an increase in policies and activities that incorporate a SDH approach to tackle health inequalities (Comissão Nacional sobre Determinantes Sociais de Saúde CNDSS 2008), recognizing, strengthening, and utilizing a population's capacities and resources to improve health (what Morgan and Ziglio refer to as "assets" in Chap. 1).

The creation of healthy and supportive settings (municipalities, schools, workplaces, etc.), also known as the settings approach, has been one of the most used and successful health promotion strategies implemented in LAC in the past few decades. The settings approach is based on the belief that determinants of poverty and equity, and their influence on health, can be addressed through: the creation of sustainable public policies and laws; development of supportive environments; establishment of public–private partnerships; strengthening of networks; and the promotion of active participation of municipal and local governments in health promotion and development. Healthy settings interventions and policies build strongly on community, population, economic, social/cultural, environmental and institutional assets.

While healthy settings is widely considered to be a successful approach to mobilize intersectoral efforts around health goals and to promote health at the local level, the evidence base and generalization of accomplishments to various local settings remains unclear. Currently there is no consensus on the methods or recommendations for assessing the effectiveness of healthy settings and similar health promotion programs and policies. Furthermore, demands for greater "accountability" means that health promotion programs and evaluations are often driven more by public concerns related to the allocation of health resources and generating greater responsiveness of policymakers and health professionals, than by the creation of scientific evidence (Judd et al. 2001). While there is strong pressure to generate evidence of the effectiveness of health promotion interventions, the current medical framework commonly used to define "evidence" is based on methods that are not necessarily suitable for health promotion practices. This can lead to stakeholders drawing inappropriate negative conclusions related to health promotion as a viable approach to improve community and population health.

While most practitioners and decision-makers emphasize the need for a conceptually sound evidence base for health promotion initiatives, the current methods and strategies used to build that evidence often do not correspond with the community contexts in which they are applied. As a result of the use of inappropriate methods, the evidence base for health promotion often overemphasizes data related to health status outcomes and individual behavior change. This is to the detriment of producing evidence related to capacity building (community, institutional, individuals) and the benefits of addressing the broader social determinants of health. Therefore, the advancement of health promotion and assets-based models as effective approaches to improve health and to reduce health inequalities requires an adapted and balanced evidence-base. In addition, an approach to evaluation should incorporate a saluto-

genic perspective while accommodating stakeholders' concern for both evidence and accountability.

The use of assets-mapping, as proposed by Morgan and Ziglio (2007), can help to support the advancement and implementation of programs that incorporate an assets-based model by allowing communities and practitioners to identify and build an inventory of the strengths, resources and "wealth" (in terms of people, services, material, etc.) that communities possess and that could be drawn upon. Assets-mapping offers an opportunity to bring out in the open the knowledge, skills and capacities that can be used and developed for everyone's benefit. It also highlights the web of interconnections among these assets and the potential for accessing and improving them.

This chapter will discuss the development of the healthy settings approach in LAC and the application of a participatory evaluation methodology developed by the Pan American Health Organization (PAHO)/World Health Organization (WHO) to support the evaluation of health promotion programs in the Region. The experience with the participatory evaluation shows that such methodology can be a powerful tool to support the application of assets-mapping and to demonstrate the effectiveness and usefulness to health promotion and assets-based programs.

13.2 Background

Since the First International Conference on Health Promotion in Ottawa, Canada, in 1986 and the publication of the Ottawa Charter for Health Promotion (WHO 1986), health promotion has been increasingly utilized as a central strategy in community development initiatives. Over the last three decades, governments and international organizations worldwide have significantly increased their investments in health promotion programs.

From an approach focused on disease prevention in the 1970s, the concept of health promotion has evolved and broadened. During the 1980s and 1990s practitioners recognized the need for complementary interventions (such as healthy public policies), to incorporate other sectors and to create healthy environments, in order to make health promotion initiatives effective and successful. In the past few years, the concept of the social determinants of health has been incorporated into the health promotion approach, as global movements of social change and the need to invest and strengthen leadership in health promotion have became more prominent.

Salutogenesis, or the creation of health, is also a core value for the development, articulation and implementation of health promotion programs and policies. The adoption of a salutogenic perspective in health promotion highlights the importance of understanding how health is created and maintained; it establishes a link to the notions of social capital, capacity building and citizen engagement; and it focuses on the need to implement activities that seek to maximize the health and quality of life of individuals, families and communities (Judd et al. 2001).

The Latin America and Caribbean countries have a long tradition of social mobilization and community-driven movements to improve living conditions for

their populations. Movements towards the adoption of salutogenic approaches to health have been taking place in the Region for decades. Starting in the 1950s, the concept of local development took hold in many countries as a way to improve the quality of life primarily in rural areas. These movements were characterized by efforts to organize and mobilize communities to implement health programs more effectively. However, most of these initiatives still implemented a top-down approach and assumed that communities would accept the ideas and health priorities as defined by outsiders. By the 1970s, as community resistance mounted, new integrated community development strategies that focused on promoting more active community participation and greater access to health services were introduced with varied results.

Since the 1980s, the LAC countries have experienced major democratization and decentralization processes that significantly re-shaped their social, political, cultural and economic profiles. Decentralization processes that took place in various degrees in the LAC countries have resulted in a territorial redistribution of power and resources through political-administrative reforms. This resulted in greater autonomy, decentralized decision-making power, and control of resources at the local level. Consequently, the concept of local and regional governments as facilitators of community participation and the mobilization of local resources and capacities have been greatly strengthened.

Concomitant to health sector reforms that took place during the 1980s and 1990s, a series of strategies have been put into place by countries in the Region aiming at improving health by incorporating more equitable, sustainable, participatory, and health promoting approaches. In the early 1980s, countries in the Region made a commitment to implement the Primary Health Care (PHC) Strategy, with a focus on community participation and improving access to health care by the most vulnerable population groups. By 1986, renewed emphasis was placed on strengthening Local Health Systems (known as "SILOS"), as a viable strategy to tackle health priorities among the most vulnerable populations. The SILOS strategy was characterized by a focus on decentralization and local development in order to contribute to sustainable democratization, social participation and social justice processes. It called for a shift from traditional approaches to health to one that incorporated health promotion and a focus on families and communities sharing the responsibility for their own health and their search for solutions for their own health problems.

By the 1990s, health promotion surfaced as a major strategy in the Region; one that fit the complex health profile of its countries, with feasible proposals for integral health and human development. Health promotion recuperated the importance of the social setting as a central element to achieve true equity in health by incorporating a positive concept of health and recognizing people as active participants in the process. In this context, interest in preventive and educational activities quickly spread throughout the Region, and particular emphasis was placed on promoting healthy lifestyles. Greater importance was placed on the importance of strengthening the social construction of health and the centrality of community participation in order to achieve better health (PAHO/WHO 1999).

13.3 The Healthy Municipalities, Cities and Communities Movement in LAC

Experiences from the last two decades in LAC countries demonstrate that the local level, represented by regional or local governments, constitutes an important asset when conditions are created that facilitate the implementation of health promotion actions and when other assets present at the local level (community, individual, environmental, etc.) are mobilized and strengthened. Local authorities are responsible for establishing policies for a specific territory and population (PAHO/WHO 1999), and therefore they have greater capacity to mobilize and integrate the action of the various sectors and actors present at the local level. Additionally, they can make health be a priority on their political agendas and they are strategically positioned to better adapt health programs and policies to the specific social, cultural and ethnic context of their communities.

Local governments and communities in LAC have demonstrated increasingly stronger motivation and social, political and technical commitment to initiatives aimed at promoting sustainable local development and improving living conditions of their populations. In particular, initiatives make use of community capacity, resources and potential; foster self-reliance; improve coping abilities; and raise individual and community self-esteem.

The Pan American Health Organization (PAHO) developed and introduced the Healthy Municipalities, Cities and Communities (HMC) strategy in the 1990s to improve and promote local health and development in the hemisphere of the Americas. This strategy is being actively implemented in 18 of the 35 countries and three territories of the Americas.

Based on the definition that health promotion is "the process of enabling and empowering people to take control over and improve the determinants of health" (WHO 1986), the orientation of the Healthy Municipalities, Cities and Communities Strategy is to ensure continuous improvements in the underlying conditions that affect the health and wellbeing of their members. It also focuses on improving health in the social context of people's daily lives by identifying, utilizing and strengthening communities' and population's assets. The improvements affect social conditions and life styles, which in turn have an impact on people's health and promote sustainable system changes.

Based on the notion that being healthy means having a good quality of life, the actions of the HMC strategy focus more on the underlying determinants of health than on their consequences in terms of diseases and illnesses (PAHO/WHO 2002). It also focus strongly on the notion that every community has assets and resources that, when strategically aligned around community-driven priorities, can lead to more effective change. This is achieved by facilitating joint action among local authorities, community members and key stakeholders, aimed at improving their living conditions and quality of life in the places where they live, work, study and play.

The HMC Strategy is based on the premises that (1) various systems and structures governing social, economic, civil and political conditions, as well as the

physical environment, can affect individuals' and communities' health; and that (2) health is inherently linked to an individual's capacity to take action in the community and society to which he/she belongs. HMCs strive to create a synergy between these two premises: promoting individual actions and society's response.

The HMC Strategy incorporates an assets-based approach by:

- Emphasizing capacity building through (1) community empowerment, education, and participation; (2) strengthening individual skills and fostering critical thinking among those involved in the initiative; and (3) supporting the development of leadership, agents of change, and advocates.
- Promoting action by communities, institutions, and interserctoral organizational structures for action through (1) the identification of community resources and assets (assets-mapping, community assessments, etc.); (2) and the definition of priorities, strategic planning and the development of a responsive and appropriate action plan.
- Fostering sociopolitical action by (1) guaranteeing formal commitment by local governments, (2) forming community-based, intersectoral committees, and (3) utilizing participatory, community-based methodologies.

Municipal Governments as a Strategic Health Asset: The Experience of a Malaria Prevention and Control Initiative in Central America and Mexico[1]

Between September 2003 and June 2008, the *Regional Program for Action and Demonstration of Alternatives for Malaria Vector Control without the use of DDT* (DDT/PNUMA/GEF/OPS Project) was implemented in eight countries of Mesoamerica (Belize, Costa Rica, El Salvador, Guatemala, Honduras, Mexico, Nicaragua and Panama). The goal of the project was to prove the cost-effectiveness and viability of an integrated vector control model that utilizes alternative methods and techniques to control the malaria vector without the use of DDT or other persistent pesticides. Community participation and the incorporation of municipal governments was the key strategy of the model that was established in 202 pilot communities from 52 municipalities.

The project resulted in a 63% reduction of malaria cases in the pilot communities between 2004 and 2007, and an 86.2% reduction in the cases caused by *P. falciparum*, which is the type of malaria vector that causes the highest morbidity and mortality from the disease worldwide. It was the first time in the

[1]Pan American Health Organization (2009). El papel de los gobiernos municipales y la participación comunitaria en el manejo integral del vector de la malaria sin el uso del DDT en Mesoamérica. Washington, DC (To be published).

sub-region that municipal governments were successfully incorporated into local activities to combat malaria, a responsibility that was traditionally considered to be under the pervue of the Ministry of Health's mandate.

The participating municipal governments contributed to the success of this initiative by financing important infrastructure projects such as bridges, basic sanitation systems, recovering of river banks; provision of materials, supplies and personnel to assist in community cleaning brigades; creation of permanent committees or staff positions (with proper resources allocated to it) to address issues related to malaria; the creation and enforcement of policies aimed at improving environmental management (such as the regulation of waste disposal); and advocacy for and promotion of the participatory model at national and international levels. Another great achievement was the identification and training of community leaders to serve as a link between the community and the project's technical personnel. Community leaders assisted in the coordination of activities at the local level, which in turn resulted in an increase of up to 63% of community health agents in the pilot communities.

In this project, municipal governments demonstrated their capacity to act as agents of change. They achieved this through the development and implementation of public policies and innovative management mechanisms that produced sustainable changes in the social, cultural, and physical structure of their communities in order to prevent and control malaria. They successfully mobilized other actors, sectors and resources which resulted in better coordination of activities and more rational use of resources. The project also resulted in increased knowledge and improved skills in the population related to malaria-vector lifecycle and control. The population demonstrated improved community environmental management (e.g. proper waste disposal), changes in attitudes and behaviors (e.g. improved personal hygiene), greater sense of responsibility about their and their families' health (e.g. keeping their properties clean), and less dependency on the public sector for the implementation of malaria vector control strategies (e.g. organizing and participating in cleaning brigades independently of the presence of the health department technical team).

This experience demonstrates that municipal governments can play a key role in the implementation of health promotion strategies. They are in a privileged position to act upon a variety of factors and levels, and to create the appropriate setting for the successful implementation and sustainability of such initiatives. They are also able to place health and health promotion on the local political agenda, and to generate momentum for the discussion and resolution of community issues and problems without the creation of new or parallel structures. This indicates that municipal governments can be an important health asset, and that their incorporation into health promotion initiatives can be an effective and sustainable strategy.

13.4 Building the Evidence of the Effectiveness of Interventions that Incorporate an Assets-based Approach in LAC

Evidence-based policy-making to tackle health inequalities is greatly compromised by lack of good evidence on the effectiveness of policies and interventions. As noted in Chap. 1, policies and programs designed to promote health and tackle health inequalities are mostly based on evidence built on a "deficit model," The model defines communities and individuals in negative terms and greatly disregards existing positive and health-promoting factors. The alternative is the development of an evaluation approach that builds the evidence base from a "salutogenic" perspective of health and that aims to maximize key health promotion assets. This has been recognized by the international community as key to strengthening the capacity of institutions and communities to activate solutions that are effective, coherent, empowering, and that can contribute to the reduction of health inequities.

Health promotion interventions tend to be complex, context-dependent, occur at different levels (individual, lifestyle or behavioral, community, socioeconomic, environmental, etc.) and in diverse settings and groups. They also employ multiple strategies (healthy settings, healthy public policies, community empowerment, capacity building, behavioral changes, skills development, reorientation of health services, etc.), are large in scope, have extended timeframes and require many resources (Judd et al. 2001). They also need to be flexible and responsive to changing realities.

Practitioners working in countries in LAC have long highlighted the need to develop appropriate methods, indicators, and frameworks that can measure change in such multifaceted and evolving contexts. Appropriate evaluation will help governments, as well as decision makers and policy makers, understand the benefits of investing in approaches that focus on health-promoting factors and key health assets, and that can effectively tackle health inequalities. Existing evaluation tools and methodologies do not appropriately capture changes in essential health promoting factors and assets, nor do they provide insights into the multiplying effect of working with various assets and determinants of health in a coordinated manner. Furthermore, an intervention may not be equally effective for all population subgroups. The effectiveness for a disadvantaged population may be lower due to a number of factors such as place of residence, race/ethnicity, occupation, gender, religion, economic status, sexual orientation, etc. This requires the incorporation of a health equity approach into evaluation designs, methods, indicators and domains for data analysis.

13.5 PAHO's Evaluation Initiative

In an attempt to address these gaps, in 1999 PAHO established a Healthy Municipalities Evaluation Working Group formed by evaluation experts from leading institutions in the Americas working on issues related to health promotion, evaluation and local development. The Working Group was comprised of people

from governmental, non-governmental and academic sectors from various countries in the hemisphere, including Argentina, Brazil, Canada, Chile, Colombia, Ecuador, and the United States. It developed a series of evaluation tools, among them, a *Participatory Evaluation Guide for Healthy Municipalities, Cities and Communities,* published in 2005.

Participatory evaluation was considered by the Working Group to be an appropriate methodology because of its potential to systematically generate new knowledge and social capital. Participatory evaluation recognizes the complexities of the HMC Strategy as a local development initiative, and facilitates the development of capacities for critical analysis and reflection, learning and empowerment. It is a methodology that involves key stakeholders in all phases of the process, including the design, implementation, management, interpretation, and decision-making about the evaluation and its results. As such, the process of conducting a participatory evaluation is a positive and inclusive endeavor, which stimulates autonomy and community self-determination. It can improve a community's ability to identify and activate solutions to its own problems, and it builds upon assets, strengths, and resources already in existence in the community (PAHO/WHO 2005).

The *Participatory Evaluation Guide for Healthy Municipalities, Cities and Communities* provides guidance and tools to evaluate healthy settings and health promotion efforts. The guide uses an evaluation framework that incorporates essential health promotion elements and assets such as intersectoral collaboration, social participation, capacity building, individual physical and material conditions, health determinants, and community capacity, among others. It aims to provide an alternative evaluation framework that reflects the underlying health promotion principles embedded in many long-term initiatives taking place in LAC countries while continually building on a community's assets and capacities through continued participation.

The participatory evaluation methodology proposed in the guide supports the documentation and analysis of changes and accomplishments in terms of processes, outcomes and results related to a series of domains, and it guides users on how to communicate and act upon the results to improve their initiatives. Although specific indicators are not proposed in the Guide, a compilation of possible indicators in each of the evaluation domains is included to orient the decisions about which ones are the most appropriate for the initiative being evaluated.

13.6 The Application of the Participatory Evaluation Guide in LAC

In recent four years, the Participatory Evaluation Guide has been introduced into and applied to several LAC countries. These experiences highlight some of the potential benefits that assets-based models and evaluation frameworks can generate and the challenges posed by the complex and multidimensional local and national contexts into which they are introduced. This section will present the lessons

learned by applying the participatory evaluation methodology in Brazil, Dominican Republic, Honduras, Mexico, Peru, and Trinidad and Tobago.

Given the strong emphasis of initiatives such as HMC in the involvement of local governments and authorities, political context and timing were two of the main factors affecting the implementation of the participatory evaluation methodology in these countries. Election periods and political transitions often caused major delays (if not termination) of initiatives, shortage and/or change of personnel and funds, and great uncertainty about the future of the initiatives. Constant advocacy about their purpose and benefits, and the establishment of strong coalitions and support bases among all stakeholders was often an efficient strategy to provide continuity and sustainability to the evaluation initiatives during these transitional periods.

The establishment of intersectorial collaboration posed another challenge for most evaluation initiatives in LAC countries despite its centrality to the sustainability of health promotion efforts. It was reported that lack of support from critical stakeholders, such as municipal program managers or key personnel in public institutions, resulted in serious delays or isolation of the participatory evaluation initiative. In some cases, it also jeopardized the possibility that the evaluation results would be seriously considered by all relevant stakeholders, hence threatening the likelihood that the information generated would be utilized to improve health promotion programs and policies.

Various factors accounted for this resistance by key institutions and stakeholders to applying a participatory evaluation methodology. High among the concerns reported were those related to the benefits of conducting a participatory evaluation, particularly due to the time it takes to conduct the process and reservations about the usefulness of the data it produces. Difficulties also arose related to developing indicators, and to articulating which factors and variables were relevant and would be tracked and assessed, given the diversity and breadth of health promotion policies and programs. Such programs and policies are often based on notions of empowerment, community participation, intersectoral collaboration, capacity building, and equity. This emphasis was often perceived by some key stakeholders as being in conflict with established criteria and notions of evidence-based decision making and accountability, and with funders' and decision-makers' concerns with measuring outcomes and impact.

These are valid concerns given the challenges faced by stakeholders coming from institutions with rigid and bureaucratic structures. Such stakeholders often do not have a policy that enables or facilitates coordination with other institutions or intersectorial collaboration, yet are under great pressure to produce specific results in a short period of time. The implementation of the participatory evaluation methodology often required in-depth changes in how groups, organizations and institutions functioned, and, most importantly, in their expectations about the type of data such processes would generate. The countries that utilized the participatory evaluation reported that it was critical to recognize the need for institutions, organizations and individuals to understand, adapt, and accept a new methodology and paradigm to evaluate health promotion interventions. Achieving this acceptance, particularly from public institutions and their staff, is essential in order to be able

to incorporate the evidence generated from this kind of evaluation into programs and policies. The acceptance therefore, leads to more effective implementation of health promotion practices and principles, more consistency with the communities' expectations and priorities, optimization of resources, and improvement in personal motivation among public staff and other stakeholders. Given the appropriate support, consideration and time, people from the countries involved became motivated and applied dedicated efforts to implementing the new methodology.

Coordinating the evaluation effort with public institutions also proved challenging due to lack of institutional support or excessive bureaucracy, lack of coordination among public sector institutions, strict guidelines regarding the use of funds, and conflicts among the different actors involved (federal, state, municipal level institutions). High turnover of personnel at all levels and institutions was particularly disruptive. On the other hand, most of the countries involved in this experience reported that the process of engaging public institutions in the participatory evaluation initiative improved channels of communication, resulting in other levels, institutions and sectors providing valuable inputs for the evaluation process. It also cleared the way for exploring new modes of intersectoral collaboration and provided an opportunity for involvement of institutions that could potentially have a far-reaching impact on promoting and supporting the implementation of new paradigms and methodologies, as well as the allocation of resources for them.

All experiences reported that the participatory evaluation process was lengthy and time consuming. This was due to various factors, such as bringing together a variety of stakeholders from various backgrounds, sectors and interests; reaching consensus on core concepts, indicators and paradigms; and working through institutions and organizations with rigid and bureaucratic structures and work cultures. The various levels of knowledge and literacy among those involved also affected the time it took to complete the process. The countries reported a general lack of understanding about health promotion and assets-based approaches (often considered as approaches to disease prevention), their principles (such as community participation) and the participatory evaluation methodology. This can have a direct impact on the planning of the evaluation since how people understand key concepts shape the design, data collection, analysis and presentation of evaluation results. The adoption of a participatory evaluation methodology can play an important role in addressing these issues by serving as a catalyst to engage people in a joint reflection and learning process.

It was also common for initiatives trying to apply the participatory evaluation to be confronted with the fact that their health promotion programs (objectives and definitions of success, expected results, strategies and activities employed, indicators developed and data collected) often were not operationally articulated in a transparent, measurable, or even logical manner. While most programs and policies had the stated purpose of impacting core health promotion principles and assets, accompanied by a more positive and salutogenic approach to health, the activities, strategies and indicators used often reflected disease prevention, individualistic and services-oriented approaches to community health.

As described previously, the Participatory Evaluation Guide was developed to respond to a direct need expressed by health promotion practitioners in LAC. However, once the methodology was made available and applied, most practitioners reported not being ready to implement such an innovative approach to evaluation, partly due to the disconnect between program planning and implementation described above. Primarily, stakeholders came to a realization that their health promotion initiatives had not appropriately taken into account key health promotion principles (such as intersectorial collaboration or community participation). As a result, many initiatives decided to re-examine their planning processes in order to make them more coherent with the conceptual models they intended to implement and the goals they planned to achieve. These experiences highlighted the need to address the different levels involved in these initiatives from a conceptual and planning perspective. In order to appropriately generate more useful evidence, evaluation domains that reflected health promotion and assets-based models should be used, with principles and values clearly delineated and incorporated from the outset of the process.

These experiences also indicated that conducting a participatory evaluation was an empowering and assets-building process by itself. These processes provided an invaluable opportunity to discuss and reflect on communities' experiences, challenges, assets and potentials. The experience brought to light the various interpretations that stakeholders gave to health promotion concepts and principles. It engaged them in a productive and positive dialogue to reach consensus on the various concepts and principles utilized in their health promotion initiatives and evaluation processes. They also shed light on the gaps in their efforts and mobilized those involved to confront the problems and reflect on how to address them. Merely by engaging in the planning and implementation of the participatory methodology, communities and stakeholders were more willing to and interested in participating. This in turn served as a catalyst for generating intersectoral and participatory processes.

Many countries reported that deep-rooted apprehensions arose about efforts conducted with community input, particularly in those countries in which, traditionally, decisions were implemented from the top-down with few mechanisms for meaningful community representation and participation. Concerns included an expressed fear of receiving negative comments, prejudice against actions taken with "too much" input from community members, and the possibility that the process would generate "unrealistic demands" for services and resources. In many cases, however, the process itself of conducting a participatory evaluation and having the opportunity to engage with other community stakeholders served as an eye-opener for stakeholders in these countries. The process resulted in positive changes in attitudes and perspectives related to the potential of community participation.

Having strong, sustained and dynamic leadership was central to the sustainability of a community-responsive evaluation initiative. Active commitment and engagement from institutions both at the local and national levels were key to the success of these initiatives, as well as the quality of the collaborative work among them. National and regional HMC networks effectively created and maintained such leadership, given their potential far-reaching connections to municipalities, institutions and key stakeholders throughout a country or region.

The Application of the Participatory Evaluation Methodology to the *Tai Chi in the Parks Program*, in Miraflores, Peru[2]

Since 1990, the "Tai Chi in the Parks" Initiative has been implemented in the municipality of Miraflores, in Lima, Peru. Its main objectives are to incorporate the practice of Tai Chi and its philosophy as a daily, voluntary and accessible habit in the life of Miraflores' elderly population; and to achieve physical, psychological, social and spiritual development of Miraflores' elderly population through the practice of Tai Chi.

The initiative offers free Tai Chi classes during weekdays in the municipality's parks, supports the creation Tai Chi clubs, maintains a "Tai Chi in the Parks" network, promotes community activities (such as Tai Chi championships), and trains community elderly to become Tai Chi instructors. Today, more than 20,000 elderly people practice Tai Chi in the municipality through this program.

During 2005, an Evaluation Subcommittee was formed comprised of technical staff from the municipality, the program coordinator, program participants and elderly members of the community in order to apply the participatory evaluation methodology to this Initiative. All participants received training in the participatory evaluation methodology through a series of meetings, guided by a trained facilitator, which included discussion among the group members in order to reach consensus on all of the methodology's core concepts.

Working with the elderly and mostly retired population proved to be advantageous as participants had more flexibility and availability to participate in the process. Most participants of the Evaluation Subcommittee were not involved with the health sector or were not health professionals. This was found to be beneficial because it allowed the group to more openly explore issues related to the social and psychological benefits of the program, and not focus exclusively on evaluating its health benefits in terms of disease prevention.

Based on the process and the steps proposed in the Participatory Evaluation Guide, the group developed an evaluation plan and defined key indicators, data collection methods and a work plan. During this process, the group came across some major issues which posed a challenge in applying the participatory evaluation framework: the Tai Chi in the Parks Program had not been planned and implemented in a participatory manner, and it had not fully taken into account core health promotion principles (such as intersectorial participation). However, simply engaging in the participatory

[2]Information about this experience was compiled from a report submitted by the Peruvian Network of Healthy Municipalities, Cities and Communities to PAHO/WHO (2005) that describes the application of the participatory evaluation guide to various HMC initiatives in Peru.

evaluation process highlighted these deficiencies and mobilized the group to search for solutions. The group approached its problems from different perspectives and took into account the factors that might have facilitated or hindered the participation of other stakeholders in their evaluation plan and analysis.

Among the challenges reported was the resistance by some participants to implementing a participatory methodology due to ingrained and negative preconceptions related to actions taken with community input. There were also fears of receiving excessive criticism and increased "demands" by the community if it was offered the opportunity to participate. Difficulties in coordinating the work with the technical staff from the Ministry of Health and a local university providing technical guidance, resulted in delays in the data collection and analysis phase of the process. Difficulties also resulted from discrepancies related to the various interpretations given by the group to the concept of health promotion and other core concepts related to the evaluation. This was compounded by inflexibility on the part of some group members to listening and engaging in a true dialogue. Having a good facilitator was reported as key to guiding the discussion and helping the group reach conclusions. In addition, turnover of key personnel in the municipality caused major delays in the evaluation process.

While collecting data the group observed issues that required immediate attention such as difficulties with sound systems and the need to limit the access of dogs to the parks during the Tai Chi classes. This information was quickly transmitted to the program coordinator and the issues were promptly resolved. Seeing the results of their efforts highly motivated the Evaluation Subcommittee participants to become more involved in the process, with many manifesting an interest in evaluating other aspects of the Tai Chi in the Parks Program and learning more about the participatory evaluation methodology. This resulted in a series of workshops aimed at identifying other key aspects of the program and priorities for the next round of evaluation.

These workshops were organized by the Evaluation Subcommittee itself and provided an important opportunity to bring together program managers and program beneficiaries to participate in the process. The strategies devised to broaden the evaluation initiative included: (1) incorporating the San Marcos National University to provide technical support in evaluation processes, and (2) engaging the current Evaluation Subcommittee in the evaluation of other municipal programs targeting the elderly population. As a result, the participatory evaluation brought about significant changes in how programs were planned and implemented in the municipality, particularly with respect to involving various stakeholders and sectors, and incorporating participatory planning into the process.

13.7 Discussion

Health promotion and assets-based approaches can greatly contribute to the development of programs and policies that support the preservation of health and the decrease of health inequities, rather than only the prevention of diseases. During the past few decades the implementation of the healthy settings approach in LAC countries have greatly advanced the cause for health promotion in the Region. Valuable experiences and information related to the process, outcomes, benefits and challenges of these approaches to community and population health have also been accumulated. Nevertheless, practitioners in the field are often concerned that health promotion programs and policies will not be continued due to a perception on the part of decision makers and funders that there is a lack of success and effectiveness. In order to highlight the positive results from health promotion initiatives, a new type of evidence base needs to be created that incorporates an inclusive, positive, and salutogenic orientation, while at the same time being consistent with the context and population in which such initiatives are implemented. Such an approach will help to produce arguments that might guarantee support from policy makers and funders for health promotion programs and policies.

This approach to building evidence can demonstrate how these participatory and assets-based processes help to enhance health, quality of life and wellbeing, while recognizing that health is a key asset to community development rather than just an end in itself. In order to achieve this goal, there is a need to shift from a view of evidence and evaluation based on a pathogenic, risk factor and outcomes-oriented perspective to a balanced, inclusive and positive approach to assessing change and success; one that can contribute to the production of knowledge and capacities to improve the health of individuals, families and communities.

Interest in building the evidence base of health promotion effectiveness has increased greatly in the past few years. However, these efforts have been hampered due to insufficient attention being paid to ensuring the presence of sufficient capacity, political will, resources and leadership in order to develop and apply appropriate frameworks and methodologies that will generate this evidence. The participatory evaluation methodology described in this chapter can help to generate such evidence and promote understanding of the barriers to taking effective actions that address health inequities and the promotion of more inclusive and positive approaches in LAC. It can also be a powerful tool when applied in conjunction with assets-mapping as it can help to demonstrate the value of approaching communities from a positive, salutogenic perspective, and building on their strengths and resources.

Factors affecting the successful implementation of the HMC Strategy and the participatory evaluation methodology in LAC were identified at various levels (individual, institutional, political, community, etc.). These factors overlapped and impacted each other in very complex ways. These experiences indicate that "re-dressing the balance between an assets and a deficit model evidence base", as discussed in Chap. 1, requires taking into account these challenges, which are inherent in most collaborative and participatory efforts.

When they were conducted in a truly participatory manner, HMC and other settings-based health promotion initiatives, accompanied by the use of the participatory evaluation methodology, promoted accountability, motivated continuous and active participation from all stakeholders, and created a sense of common interest among those involved. The approach encouraged community participation, the development of personal skills and the understanding of the key assets that created supportive environments for health development. It also helped to uncover hidden assets and resources in the community, as well as potential connections and possibilities for improvement and growth. As such, the participatory evaluation can be an important tool for assets-mapping as it can be implemented in various stages of an initiative and involve a variety of stakeholders.

Engaging in the participatory evaluation was highly motivating and revitalizing, concretely stimulating those involved to look at their actions more consistently and promoting interest in issues related to health promotion, community assets and equity. The participatory evaluation experience strengthened capacities among those involved, generated commitment to adhering to health promotion principles, and strengthened alliances among key stakeholders. The experience also emphasized the potential of "salutogenic approaches," such as using participatory evaluation as a decision-making tool.

There are complexities inherent in building the evidence-base of the effectiveness of these initiatives, and practical barriers for conducting evaluation studies as described by the experiences of LAC countries with the participatory evaluation methodology. Therefore it is essential to create opportunities for mutual learning, exchange of experiences and the pro-active identification and dissemination of evidence and "good practices," taking into account the complexity of communities and decision-making processes. In doing so, it is important to articulate the definition of success in health promotion initiatives, and redefine the criteria to judge the evidence generated in these efforts in order to improve programs and policies aimed at improving community health and reducing health inequalities.

Well designed evaluations can assist funders, policymakers, practitioners and communities in linking the success of specific programs and policies to broader contextual, economic, environmental and social issues. It can also help with the development of rational strategies for tackling health inequalities that can be understood by policy and decision makers and applied to policies and interventions at the national and local levels.

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