ORIGINAL RESEARCH

Social Participation in Health: A CBPR Approach to Capacity Building in Two Colombian Communities

Alexandra Agudelo Ramírez, MEd, BE[1], Melissa Katherine Sánchez Peña, DMD[1], Jorge Alexander Daza Cardona, MSSc, BS[1], Sandra Marcela Gómez Marín, MD[1], Gloria Carmona Londoño[2], Conrado Echeverry Vargas[3].

(1) Fundación Universitaria Autónoma de las Américas; (2) Local Action Board, "El Dorado", Pereira; (3) Community Action Board, "Frailes", Dosquebradas.

Submitted 1 August 2020, 11 March 2021, accepted 28 July 2021

ABSTRACT

Background: In Latin America, community participation in health issues is subject to corrupt and self-serving interest. Research recommends strengthening communities' abilities to develop actions that involve them in the co-production of their health.

Objectives: This study aims (1) to understand social participation in health based on the discourse of community leaders and institutional representatives and (2) to design and implement an educational strategy for capacity building within two communities in Colombia.

Methods: The study used a community-based participatory research (CBPR) partnership between researchers, community leaders, and institutional representatives. To understand social participation in health, 17 interviews were conducted with leaders and institutional representatives. Based on this assessment, an educational strategy was designed and implemented with residents of two communities, which resulted in 28 people taking part in 14 pedagogical workshops. The strategy was evaluated through focus groups and the results of the project were validated by all the interested parties.

Results: Interviewees' perception of participation is reduced to access to health care services. They identified that the agencies and institutions promote participation only to comply with the law. The communities stated that they had few tools to resolve situations that violate their right to health. Therefore, leaders and researchers developed an educational strategy custom tailored, so the community could acquire the capacities to confront injustices and bureaucracy in the health system and public services.

Conclusion: This participatory research empowered communities to defend their right to health. The findings are a reference for social participation in health initiatives in similar contexts.

KEYWORDS: Community-based participatory research, health promotion, social participation, capacity building, Colombia, Latin America, health education.

INTRODUCTION

Social participation is one of the most effective ways to promote health and overcome inequities.[1-3] It helps to achieve greater access, quality, and responsiveness of health services, it also stimulates the reduction of diseases and poverty, as well as the improvement of basic sanitation, among others.[4-8]

According to the Pan American Health Organization,[9] social participation in health is understood as the involvement of communities in identifying their problems, prioritizing needs, and making decisions. Likewise, it is interpreted as the social interactions of people outside the home[10-12] or as the incorporation of vulnerable populations in processes that improve some health dimension.[13-16] However, from a critical perspective, it should be understood as a condition of collective well-being that transcends the logic of the regulatory framework focused only on care services[17]. It should be deemed as the power of the subjects to decide on their own health.[17]

Some studies report that both communities and their leaders have low levels of participation and little clarity about the mechanisms that facilitate empowerment within the health system.[8,18-19] For this reason, citizens should be trained in the development of community actions so that they get involved in their own care process.[8,18]

In Latin America, participation takes place in a context of social struggles for the right to health since the countries in this region suffer from severe inequalities that have been further deepened by the application of neoliberal reforms to health systems. Therefore, people need to start seeing themselves as political subjects to transform social injustice.[20] However, in this sub-continent, participation is usually associated with institutional interests that lead to the manipulation of communities.[21] This has resulted in a less substantial role for the communities with limited achievement of their goals.[22-24] Despite this, some advances have been achieved, such as the

institutionalization of participation mechanisms in the Brazilian (participatory budget) and Cuban (community activities in primary health care) health systems.[6] Similarly, other studies show that some community leaders are perceived as agents capable of change in health services, research also makes evident that family and community networks foster participation.[25-27]

In Colombia, there have been more barriers to participation than facilitators. This include the asymmetry of power generated by the lack of technical knowledge about the health system and the legislation that regulates said participation among social leaders. Communities are prone to manipulation, have restrictive access to information[28-32] and interact with officials who are wary of oversigth.[29] Moreover, there is poor coordination between the health sector and the citizens, prioritization of political interests over a sense of community,[31] and fear of retaliations from health institutions.[28]

Despite these barriers, the theory of community capacity building proposes to overcome deficient views and focuses on facilitators to enhance social participation in health. In this sense, it is necessary to increase the inherent strength of community leaders, without which the scope of any health promotion intervention would be limited.[33] Such capacities allow communities to mobilize their resources to solve issues related to healthcare and reinforce their knowledge, skills, networks, and organizations.

In this context, health interventions have been developed using the Community Based Participatory Research (CBPR) approach to strengthen community capacities.[34-37] This approach is based on a constructivist perspective in which the actors involved are co-producers of knowledge and develop strategies to change their reality through reflective dialogue and action.[38-40] It also suggests that interventions must focus on community needs, taking into account their cultural dynamics.[41-45] Thus, the potential of this approach lies in the possibility for participants to

speak with their own voice and interact as peers with the researchers, which is one of the bases for building mutual trust and commitment.

The present research focused on two areas in the department of Risaralda, Colombia: "Frailes" in the city of Dosquebradas and "El Dorado" in the city of Pereira. Both areas are composed of low-income households with low educational attainment. Their inhabitants have maintained partnerships with the Fundación Universitaria Autónoma de las Américas for five years through health promotion and education activities. Within the framework of these partnerships, the leaders of both areas asked the University's professors to carry out a larger project, which was developed using the CBPR approach to understand the local context and generate an intervention tailored to the needs of the communities.

The purpose of the project was twofold. The first was to understand social participation in health based on the discourse of different institutional and community actors in Pereira and Dosquebradas (due to the lack of data in the region). The second was to design and implement an educational strategy for community capacity building with the inhabitants of "El Dorado" and "Frailes", based on the needs identified by the actors mentioned above.

METHODS

Setting and partnership

The CBPR approach was used to conduct this study, which involved a collaborative partnership between academics, inhabitants of the "El Dorado" and "Frailes" sectors, representatives of the municipal and departmental

health offices, municipal attorney offices[1] and health service providers[2] from the cities of Pereira and Dosquebradas. Institutional actors are the people in charge of executing public policies and health promotion programs in the above-mentioned communities according to their mission. The partnership for this project was driven by the community, as intersectoral actions were sporadic. Multiple actors and organizations were involved, each with different roles, stories, and dynamics. Table 1 shows the characteristics of the actors. Two of the challenges that this research faced were to connect the work of the partners that influenced community participation and to promote dialogues of knowledge that did not exist before.

Table 1. Number of Social Actors Participating in the Methodological Phases, Roles, and Ages.

Social Actors	Roles	Number of participants and ages	Participation in phases
Institutional representatives of the municipal health offices	Civil servant	1 representative from Pereira (woman, 46 years old) 1 representative from Dosquebradas (man, 55 years old)	1.3
Institutional representatives of the departmental health offices	Civil servant	1 representative from Risaralda (man, 52 years old)	1.3
Municipal attorney offices	Civil servant	1 representative from Pereira (woman, 38 years old) 1 representative from Dosquebradas (man, 42 years old)	1.3
Health service providers	Civil servant	2 representatives from Pereira (woman, 49 years old) (woman, 40 years old). 2 representatives from Dosquebradas (woman, 35 years old) (woman, 30 years old)	1.3

[1]Control and monitoring bodies of the territorial entities, responsible for the defense, protection, and promotion of human rights in their jurisdiction.
[2] Hospital, clinic, and health care center workers.

Academics	Researchers	4 researchers (woman, 35 years old) (man, 35 years old) (woman, 29 years old) (woman, 28 years old)	1,2,3
"El Dorado" inhabitants	Leaders	4 leaders: 2 men (average age 49 years old), 3 women (average age 50 years old). Members of different organizations (older people's association, association of people with disabilities, Community Action Board)	1,2,3
	Other leaders and residents	1 leader (woman, 65 years old, Local Action Board). 11 residents: 2 men (average age 48 years old), 9 women (average age 63 years old)	2.3
"Frailes" inhabitants	Leaders	4 leaders: 2 men (average age 53 years old), 4 women (average age 43 years old). Members of different organizations (Association of Hospital Patients*, Community Action Board)	1,2,3
	Other leaders and residents	3 leaders: 2 women (average age 28 years old), 1 man (average age 48 years old). Members of different organizations (workers' union, cultural and sports group, environmental organization). 5 residents: 4 women (average age 41 years old), 1 man (39 years old)	2.3

*According to Decree 1757 of 1994, these associations are a form of social participation in the provision of health services. Each Health Services Provider Institution (IPS) must create one. Hospitals are public IPS.

Regarding the selected neighborhoods, "El Dorado" is the name given by the community to this area according to their experiences and perceptions of the territory and is composed of four neighborhoods that are part of

commune[3] Consota in the city of Pereira, capital of the department of Risaralda. "Frailes" is the name popularly given to five neighborhoods in commune 2 of Dosquebradas, the second most densely populated city in the department.

During the period of the partnership between the residents of these neighborhoods and the Fundación Universitaria Autónoma de las Américas, contact was established with the leaders through the Community Action Boards, the Community Mothers' Associations, the "Frailes" Parish and the "El Dorado" Health Committee. There are two aspects worth mentioning about this relationship. The first was the participation of one of the researchers as a facilitator in a course on citizenship building with a group of leaders in 2016. The second were the community practices that the authors of this article have developed in these neighborhoods with the support of the University's Health Faculty students. With respect to these practices, on many occasions, students were approached by community members with concerns about how they could proceed when they were denied medication or medical appointments by their insurers. These practices also helped detect socio-economic, cultural, environmental and political situations that affected the quality of life of the inhabitants. For example, the lack of drinking water, precarious housing infrastructure, barriers to health care access, and the lack of health promotion programs, among others. In this regard, the communities asked the University to support them with a project that would allow them to defend their right to health.

Procedures

The project was developed in three phases. The first phase attempted to understand the perspective of institutional representatives and community leaders on social participation in health in Pereira and Dosquebradas. This was a

[3] According to the political-administrative division of Colombia, cities are subdivided into communes and these, in turn, are subdivided into neighborhoods.

request from the actors of the partnership given the lack of information on the subject. To this end, 17 semi-structured interviews were conducted to investigate various aspects of participation, including citizen motivation, mechanisms and strategies, barriers and facilitators, needs, and community and institutional experiences. They were conducted in the offices or homes of the interviewees (Table 1) and lasted an average of 35 minutes.

The second phase began with the involvement of the leaders of both communities in the analysis of the interviews and the validation of the results. Later, the leaders brought together other residents to form a larger group. This group designed and implemented the educational strategy for community capacity building. The research technique used was pedagogical workshops, while field diaries were used as tools to collect information. A course consisting of seven workshops was developed in each community in two-hour sessions every two weeks. In addition, the content was chosen by the participants. A total of 28 people attended the sessions, with a minimum attendance of 80 %. Likewise, planning, action, observation, and reflection cycles were developed collaboratively.

In the third phase, the educational strategy was evaluated through two focus groups with community leaders, in which the affective component of the process, the lessons learned, and the contributions made in terms of problem solving in routine activities were investigated. Each focus group lasted 45 minutes. Moreover, a systematic evaluation discussion[46] of the results of the project was developed along with leaders and representatives of public institutions during a citizen participation event attended by 48 people and carried out at the University. Intersectoral working groups were set up and the participants in the educational strategy received a certification as a symbolic gesture of recognition to their involvement in the process.

Data analysis and interpretation

First, the interviews, focus group discussions and field diaries were transcribed. A Thematic Analysis was performed[47] to identify codes, which were later grouped to establish patterns. To this end, researchers and community leaders reviewed the transcripts and added their interpretations to the most relevant fragments. Then, they discussed the results of such analysis based on the theoretical framework and coded the participants' opinions while looking for differences and similarities. The resulting codes were grouped into thematic patterns. An analysis map was generated, in which the interrelations between the topics were refined to produce the results report accompanied by the most relevant opinions of the participants.

Ethical considerations

This study followed the Colombian regulations for research on human beings. Participants signed an informed consent and the project was endorsed by the Research Ethics Committee of Fundación Universitaria Autónoma de las Américas.

RESULTS

Phase 1. Understanding social participation in health

The participants' conception about health was reduced to access to care services and focused on disease, omitting social determinants and ignoring health promotion. Since they consider that the health system is solely responsible for health, collaboration between and among sectors to foster social participation is almost non-existent. Thus, the participants considered that, despite the existence of regulations to promote it, participation is not facilitated.

Below are the perspectives of public representatives and community leaders, which are exemplified by the units of meaning in Table 2.

Table 2. Perspectives of Institutional Representatives and Community Leaders on Social Participation in Health During Phase 1 Interviews

Risaralda Health Office (man, 52 years old): "The Central Government is the one that writes the regulations. So we have a lot of norms, plans and projects, guides and protocols that the Government has defined very well, but it has not taken the time to prepare the human resources that are going to implement them in the community. This situation and corruption are the reasons of the crisis in the health system."
Pereira Health Office (woman, 46 years old): "We are immersed in an organization and profiles that have no community awareness. So, most of us are staff subject to contracts and programs fragmented by those contracts."
Dosquebradas healthcare providers (woman, 36 years old): "We don't know about the leaders, what they do, and that happens because we are separate, right? They don't know anything about the health post either, they don't know how it works, and we don't know anything about them."
Dosquebradas healthcare providers (woman, 35 years old): "Officials manipulate the community to get the municipal administration to pay the contracts because they only care about signatures on attendance sheets and photos."
Pereira municipal attorney office representative (woman, 38 years old): "What people want is to know that their rights are guaranteed in general terms. I mean, the Community Action Boards work a lot to make a court for the neighborhood, to practice sports or to put an outdoor gym, but I don't know the first Board that has addressed health issues."
Leader of an association of people with disabilities, El Dorado (woman, 41 years old): "When a person gets sick, they visit the hospital directly or through the emergency room if necessary. That's health."
Leader of an Association of Hospital Patients, Frailes (woman, 43 years old): "I did not use the *tutela* or the right to petition because there are one or two political friends around working in the hospital and the health office. So, I turned to them to help me."
Leader Local Action Board, El Dorado (woman, 65 years old): "The issue is so politicized and that is why I scrutinize the leaders, I tell them: 'what really happens is that you think more of your own interests and do not take advantage of this to join forces and work for the community'. This is the fragility of leadership."
Leader Community Action Board, Frailes, (man, 57 years old): " The community needs to be updated on the health system in order to defend their rights."

Health Offices: They stated that social participation policies in health are well defined country wise, but employees are not sufficiently trained to implement them locally. In this regard, they point out the responsibility of the academy in the training of skilled professionals in community work. At the same time, they make explicit the deficiencies in the selection of personnel for public positions since this process is largely linked to the repayment of political favors. The bureaucratization of budget execution is another issue because the resources of a year are spent in an improvised manner in a few months at the end of the administrations. This is a strategy used by politicians to show results at their convenience and to attract voters in future elections.

Health care providers: They stated that both senior hospital managers and some health professionals perceive participation as an obstacle or an attack on their institutions, so they use it to comply with the indicators required by law. However, they recognize that health committees involving social leaders have been successful in addressing community needs.

Municipal attorney offices representatives: They agreed that health is the most violated right, so they advise and support citizens to demand that it is guaranteed through mechanisms such as the *tutela* (writ for the protection of fundamental rights). In addition, they noted that collective mechanisms are barely used due to the urgent need for solving specific situations given the crisis of the health system. Nevertheless, in the case of Dosquebradas, environmental problems have been solved through *acción popular* (writ for the protection of collective rights).

Community leaders: They claimed that they do not receive effective institutional responses and that the only way to solve their needs is to make deals with "political friends", which increases clientelism and politicized participation. They said they are used to welfare dependency, which means that communities only participate if

they receive benefits. They also mentioned that citizens are unaware of their municipalities' development plans and know little about participation mechanisms and the health system. Consequently, their perception is that the only way to receive a response from the institutions is to prove that they have sufficient knowledge on these topics. Furthermore, they highlighted other barriers to participation: low educational attainment in their communities, actions focused on solving individual needs or an existing problem, and little sense of community. They also stated that community empowerment increases when they achieve results through their own work, showing as an example the increased coverage of antenatal classes for pregnant women and infrastructure improvements in two community centers. In the case of the "El Dorado" neighborhood, the sense of community has been strengthened with participation in the Health Committee and the execution of participatory budgets for the provision of the health center.

Phase 2. Educational strategy for community capacity building

First, a meeting was held with the communities of "El Dorado" and "Frailes" to develop a systematic evaluation discussion of the results of the first phase, in which participants validated the information on social participation in health. Based on the needs and interests detected, the possible topics to be addressed in the educational strategy were exposed: individual and collective participation mechanisms, project formulation, strengthening of individual capacities, and formation of community networks. Since it was not possible to reach a consensus for choosing the topic, the first one to be worked on was agreed by vote. Participants also proposed learning methods, such as analysis of argumentation of real legal cases, printed material with key messages, and discussion of community situations. For this strategy to be effective, the participants chose schedules, places and methodologies that were adapted to their context. All actors involved decided to name the strategy “Course on Social

Participation in Health" and a call was made to involve the community through announcements at the Catholic churches, word-of-mouth of leaders, flyers and social networks.

Twenty-eight people between the ages of 25 and 83 participated in the educational strategy, 16 from "El Dorado" and 12 from "Frailes", 71 % women, and 68 % over 40 years old. Other people attended some workshops, although they did not comply with the 80 % attendance requirement. Besides, participation was voluntary. Table 3 shows the topics covered in each session. As the sessions progressed, trust between researchers and participants grew stronger. Also, the leaders invited their families to the meetings, as they were increasingly interested in the contents discussed.

Table 3. Issues Discussed During the Pedagogical Workshops Within the Strategy of Community Capacity Building with Leaders.

Workshop	Issues discussed	Description of the meeting
Come and Build Social Participation in Health	Planning the course contents and methodologies to be used with the community	Icebreakers (to generate confidence and knowledge among the participants). Brainstorming of activities and teaching-learning methods for the development of the workshops. Exploration of different learning styles. Previous experiences of social participation in health.

Do you know the Colombian health system?	Monitoring bodies Fosyga (Solidarity and Guarantee Fund of the General Security System). Ministry of Health and Social Protection Municipal and departmental health offices Healthcare Providers (EPS) - Private and public healthcare providers (IPS). Levels of care (I, II, II, IV) and their services	Icebreakers. Diagrams to illustrate the institutions that make up the system and their relationships. Discussion about the experiences that participants have had with these institutions and the responses they have received. Experiences with the health system. Delivery of printed material so that each participant has a folder with notes and key aspects.
Your rights and the right to petition	Health resolutions according to the needs expressed by the community: Resolution 6408 of 2016 (Health Benefits Plan), Resolution 1552 of 2013 (medical appointments), Resolution 1604 of 2013 (supply and distribution of medicines). Right to petition: Political Constitution of Colombia of 1991 article 23, Law 1755 of 2015.	Explanation of the regulations with examples, considering the previous experiences and knowledge of the participants. Practical activity in small groups about the right to petition. Plenary session to socialize the lessons learned and the solutions of their concerns.
Tutela, do you know how to file it?	Political Constitution of Colombia 1991 Article 86 Fundamental rights Difference between natural and legal persons Structure of the judicial branch (types of judges)	Explanation of the regulations with examples, considering the previous experiences and knowledge of the participants. Practical activity in small groups about tutela. Plenary session to socialize the lessons learned and the solutions of their concerns. Legal counseling.

Acción popular to defend collective rights	Political Constitution of Colombia of 1991 Art 88 Law 472 of 1998 Terms and actions Precautionary measures	Explanation of the regulations with examples, considering the previous experiences and knowledge of the participants. Practical activity in small groups about acción popular. Plenary session to socialize the lessons learned and the solutions of their concerns. Legal counseling.
Apply your knowledge by differentiating the mechanisms of participation	Use: right to petition, *tutela* and *acción popular* in health Case studies Formats for the practice of the mechanisms	Concept matching game using boards and developed in subgroups. Plenary session to socialize the lessons learned and the solutions of their concerns.
What are the systems for regulating human behavior?	Systems for regulating human behavior: law, moral attitudes, and culture Difficulties in living together Citizen culture	Discussion group. Use of cartoons to give examples of the topic. Discussion of how this is evident in the daily life of the community. Reflection on the problems that can be solved without having to resort to the law.

The workshops were developed based on real-life situations that affected their health. The result was a satisfactory resolution of this problems. Some of the issues were disposal of debris in creeks, felling of *guadua* (American bamboo endemic of tropical regions), the refusal of a health provider entity (or EPS by its acronym in Spanish) to deliver medicines and diapers to a disabled person, the refusal of a company to compensate one of its employees, among others. Additionally, the investigators sought advice from a lawyer expert, who attended four sessions and provided technical counseling to the required cases. Table 4 presents the opinions of some people who attended the pedagogical workshops and excerpts from the researchers' field diaries.

Table 4. Participants' Opinions and Excerpts From Field Diaries in Which Doubts, Needs and Barriers to Social Participation in Health are Observed

"It would be great to go, have a meeting and invite an official that commits in front of all of us to do the job he or she is supposed to do." (Leader, workers' union, Frailes, man, 48 years old)
"To teach us a lot about law because we have the laws, but we don't know them. And I think that's the biggest flaw that we have, that we don't even know how to begin, and we don't know how to do it. We have rights, but we don't know how to enforce them." (Leader, resident, Frailes, woman 25 years old)
Some participants recognize the Legal Clinic and the Municipal Attorney Office as the places where they can ask for help to prepare the *tutela*. (Field diary)
A woman shares her experience by telling us that her son had her as a beneficiary of a Healthcare Provider Entity (EPS). Her son lost his job less than a month ago and she had to go to the emergency room, but they did not make the tests that she needed. (Field diary, resident, El Dorado, 83 years old)
One of the participants asks if a *tutela* can be filed against a neighbor who turns their sound system on too loudly, arguing her right to health and pointing out her ear. (Field diary, resident, Frailes, 69 years old)
One of the leaders said that they must overcome the fear of making the complaints, when appropriate. (Field diary, leader, Local Action Board, El Dorado 65 years old). At the same time, a woman looks away and says: "It's scary". (Field diary, resident, El Dorado, 30 years old)
One of the leaders says that she wants to advise a woman on how to gain access to public services, since she lives in a sector built on public property. (Field diary, leader, Community Action Board, Frailes, 41 years old)
One concern presented involves a young man who urgently needs inhalers, but the Health Care Provider (EPS) does not provide them. (Field diary, leader, cultural and sports group, Frailes, woman, 25 years old)
One man describes the case of his mother, who was enrolled in the contributory and subsidized regimes after she retired and is no longer clear about which regime she is affiliated to and where she should receive medical care. (Field diary, resident, El Dorado, man, 49 years old)
One of the leaders said: "I have told these people to prepare a right to petition because the waste disposal and removal service is very expensive"; however, when he saw that people did not follow his idea, he did it by himself." (Field diary, leader, older people's association, El Dorado, man, 64 years old)

Phase 3. Evaluation of the educational strategy and citizen participation event

Most participants agreed that the most important achievement of the course was acquiring knowledge to help others. They also highlighted skill development; for example, a leader stated that she learned to overcome the fear of public speaking. Similarly, the participants felt encouraged after realizing that they could now face the injustices and bureaucratic obstacles that they had suffered because of the health system and public services. One of the leaders said that she was skeptical when she received the invitation to take de course because similar initiatives had been developed in the neighborhood before to cover up politicking and manipulate the community. However, after witnessing the researchers' working methods, she became one of the most important allies of the process. Another leader said that she felt confident when she was told which university sponsored the project. Table 5 shows the remarks made by the participants on their learning and achievements during the educational strategy.

Table 5. Opinions of the Participants in the Focus Groups on Learning and Achievement Regarding the Educational Strategy

"This course provided us with a lot of information on how to deal with the needs we have in the face of health deficiencies, whether before a judge or the Office of the Attorney General, and how to guide our people so that their rights are not be trampled on. This makes you feel great." (Leader, Community Action Board, Frailes, man, 57 years old)
"I learned to file *tutelas*, thanks to God and to you. I have a very sick nephew and they didn't give him any diapers or drugs; they didn't give him anything, and thanks to the *tutela* and to your teachings, they gave him everything he needs." (Resident, El Dorado, woman, 33 years old)
"We have already started to use the *acción popular* so that they help us to repair all the sports scenarios in the neighborhood and to prevent constructions from dropping litter in our spaces". (Leader, organización ambiental, Frailes, woman, 29 years old)
"My motivation: I belong to an association of people with disabilities, and this [the course] has helped me a lot because suddenly I can help this community more and I have better tools so that they are treated as they deserve." (Leader, association of people with disabilities, El Dorado, woman, 41 years old)
"I was interested in the course because sometimes you look like you've been trampled on, you go to make a complaint in a hospital or to a doctor and you're filled with anger because you don't know how to react, whether to file a *tutela*, a lawsuit or... you're filled with rage, but learning everything legal to defend ourselves was what motivated me the most." (Resident, Frailes, man, 60 years old)

"Well, personally I learned a lot, how to defend ourselves because, as I said, you go to the EPS [Health Care Provider] and you fight with these people but you don't win anything, but you can do something through a right to petition or a *tutela*. (Resident, El Dorado, man, 37 years old)
"I have felt very happy and very content because we are more confident and more secure about everything. If we run into a neighbor who has some problem, some difficulty, we are confident to recommend them what to do." (Resident, Frailes, woman, 44 years old)
"Where does this drive come from? From what you teach us, what we can get and the things we are entitled to. The right to a healthy life is vital for everyone, isn't it? And that's what we're claiming, we're not asking for something we can't get, we're claiming what we pay for [taxes] and what we're supposed to receive for paying that." (Leader, Local Action Board, El Dorado, woman, 65 years old)

At the end of the course, almost all the participants had used rights to petition, *tutela* and *acción popular,* applying what they had learned. Some of them had used these mechanisms before but they said that they did not know how to support them based on the law and with valid arguments, so they perceived that this was the greatest gain of the process. They also expressed that they felt more confident and secure to address institutions and public servants. Some of them followed the recommendation to resort to the entities that give free advice to the citizens, such as the municipal attorney offices and the legal offices of the universities.

The emotional connection with the educational process was evident in the words of the participants. They thanked the University and the facilitators and stressed that their guidance enabled them to understand issues that are not simple for the common citizen. In this regard, one of the leaders said: "we did not go to the university, but the university came to us."

Finally, during the citizen participation event, a social dialogue working group was established that included different actors: social leaders, municipal attorney offices representatives, municipal and departmental health offices, professionals from the healthcare centers that serve these communities and the academia. The leaders had

the opportunity to make their requests and receive a response from the officials. The health offices also called on the leaders to be part of the Community Participation in Health Committee of each municipality, especially in Dosquebradas, where the Committee was just beginning. This event was unprecedented because many actors converged to collaboratively address social participation in health. In the past this global collaboration simply did not exist. Also, a systematic evaluation discussion of the results of the project was developed with all the parties involved to validate them, reflect on them and the educational strategy. To reinforce learning, a booklet summarizing the course topics was delivered to the attendees. It also included information about the health care network and the institutions that give legal advice to the citizens. At the request of the participants, the second phase of the project was developed and will be reported on in another article.

DISCUSSION

The purpose of this study was to carry out an educational intervention for the development of community capacities with inhabitants of two urban sectors of Pereira and Dosquebradas. It was based on the understanding of social participation in health from the perspective of social leaders and institutional representatives. The findings showed that politicized participation is a vicious cycle in which favors are made from the top down to obtain electoral advantages, while the influence peddling that perpetuates welfare dependency and clientelism is used from the bottom up. All this results in interventions that manipulate communities, which, in turn, lead to wasting public resources on strategies that ignore the voices and problems of the people. This context hinders medium and long-term processes articulated with public policies. Thus, a panorama of corruption and manipulation against social participation in health was found, results that coincide with other Latin American studies.[22,25,28,31] In this sense community leaders perceived that they had insufficient arguments and tools to deal with the situations that violated their rights. This was associated with their urgency to understand the participation

mechanisms to transform their realities. This need was addressed using a participatory strategy, tailored to their environment and culture.

The success of this process was associated with the use of the CBPR approach which states that the community is the starting point of any intervention. This principle embodies leaving behind the hegemonic model in which academics solely retain the knowledge and moving to a vision in which the different actors are its co-producers.[48] One of the strengths of this research was the leading role played by institutional representatives and community leaders in identifying existing participation in both towns, which served as the grounds to develop the educational strategy. It should be noted that the leaders chose the topic on which they were going to work and the learning strategies and at the end of the course they were satisfied with the results. This method facilitated capacity building for leaders to contextualize their knowledge using participation mechanisms to solve daily problems. Another key aspect was that the course did not promote any political ideologies or welfare dependency. On the contrary, independence and a freedom to criticize contributed to building trust, this is an essential idea of the CBPR approach.

The active participation of the communities was not only fostered by the initial trust framed in the historical relationship with the University but was strengthened when participants acknowledged the transparency of the researchers' intentions. Other aspects that built trust were the involvement of the participants in decision-making about the project, the perception of the effectiveness of learning in relation to their health needs, and the face-to-face dialogues with institutional representatives as requested by the community. This proves that promoting partnerships between the academia and the communities based on mutual trust leads to sustainable collaboration to improve health.[43,45]

Community capacity is a process as well as an outcome.[33] In this project, its growth was evident in the creation of a sense of community thanks to shared experiences and emotional connections. Likewise, leaders and the community strengthened their advocating abilities by improving their communication and argumentative skills. They also expanded their power to make demands to institutions, learned mechanisms to exercise their citizenship and improved their understanding of the political and institutional environment. Furthermore, the number of actively involved residents increased, social networks were strengthened and both positional and reputational leaders were involved.

This study is close to Freire's theory which highlights the inequities and injustices inherent to Latin American societies.[49] His philosophy of education, applied to the field of health, shows how critical and committed education in an equal exchange of ideas with the oppressed has the potential to generate social change.[50] Thus, praxis, understood as an indissoluble unity between reflection and action,[51] was manifested in the educational process since it did not only explain the functioning of the health system and the mechanisms of participation, but also brought about concrete transformations in the lives of the participants. So, this study can be a reference for initiatives that promote social participation to transcend the biomedical model and place health as a co-production of collective well-being.

The findings of this research have remarkable implications for social participation in health and can be generalized to similar contexts in Latin America. Firstly, it serves as a model for health promotion interventions in communities, thus distancing itself from most studies that focus on disease. Secondly, this study emphasizes the cultural and political barriers to participation based on the critical reflection of the participants taking into account

the geopolitical environment. This is relevant because many communities in the region experience similar situations. Thirdly, popular education and the CBPR approach empower communities to become participatory agents, so it is necessary for health sector institutions to adopt these approaches. Finally, research on this direction is a contribution from the Global South for the promotion of scientific and popular knowledge aimed at transforming social realities.

The study had some limitations. On one hand, intersectoral work was weak during the training phase and was hindered by the lack of political will. This aspect should be strengthened. On the other hand, the members of the community did not have any training in scientific writing, but they participated in all phases by making decisions and contributions based on their own experiences and languages. A proposal to overcome this limitation is that the funding agencies make the requirements more flexible so that they include languages and procedures adapted to communities that are less formal and bureaucratic.

In conclusion, this was a community-driven project that delivered insights on community participation in health issues from various perspectives (health offices, health care providers, municipal attorney office representatives, community leaders, and residents). This type of partnership to empower communities in the co-production of their health is virtually non-existent in the socio-political setting in which it is situated. This study is strongly linked to the environment of the participants, so it moves away from traditional interventions and recognizes the subjects and the historical relationships between communities and local institutions. The project is an example for future research on how to improve health through popular education with the stimulation of critical thinking and the strengthening of community capacities, even when conditions are adverse.

ACKNOWLEDGMENTS

This research was funded by the Fundación Universitaria Autónoma de las Américas. We would like to thank the partners collaborating on this work, specially, the inhabitants and leaders from "El Dorado" and "Frailes", we acknowledge their commitment and trust.

REFERENCES

1. World Health Organization. Shanghai Declaration on promoting health in the 2030 Agenda for Sustainable Development. 9th Global Conference on Health Promotion; 2016 Nov 21-24; Shangai, China. Geneva: World Health Organization; 2017, 44p.
2. International Union for Health Promotion and Education. Curitiba Statement on Health Promotion and Equity. 22nd IUHPE World Conference on Health Promotion; 2016 May 22-26; Curitiba, Brazil. Paris: International Union for Health Promotion and Education; 2016, 3p.
3. World Health Organization. Closing the gap: policy into practice on social determinants of health. Discussion paper. World Conference on Social Determinants of Health; 2011 Oct 19-21; Rio de Janeiro, Brazil. Geneva: World Health Organization; 201, 56p.
4. Bath J, Wakerman J. Impact of community participation in primary health care: What is the evidence? Aust J Prim Health. 2015;21(1):2-8.
5. Fiorati RC, Arcêncio RA, Segura J, Ramasco M, Serrano P. Intersectorality and social participation as coping policies for health inequities-worldwide. Gac Sanit. 2018;32(3):304-314.

6. De Andrade LOM, Pellegrini Filho A, Solar O, Rígoli F, de Salazar LM, Serrate PC-F. Social determinants of health, universal health coverage, and sustainable development: case studies from Latin American countries. Lancet. 2015;385(9975):1343-1351.
7. World Health Organization. Taking a participatory approach to development and better health. Examples from the Regions for Health Network. Copenhagen: Denmark: WHO Regional Office for Europe; 2015.
8. Gómez ME, Pastor G, Pérez O, Iriarte MT, Mena AL, Escudero MC, et al. Análisis de las buenas prácticas de participación ciudadana en las unidades de gestión clínica del Servicio Andaluz de Salud. Gac Sanit. 2017;31(2);139-144.
9. Pan American Health Organization. Evaluating and supporting processes on social participation from local health systems toward health promotion and development. Washington DC: PAHO; 1994. 183 p.
10. Naud D, Généreux M, Bruneau JF, Alauzet A, Levasseur M. Social participation in older women and men: differences in community activities and barriers according to region and population size in Canada. BMC Public Health. 2019,19:1-14.
11. Goll JC, Charlesworth G, Scior K, Stott J. Barriers to Social Participation among Lonely Older Adults: The Influence of Social Fears and Identity. PLoS One. 2018;13(7):e02015102015. Correctec and republished from: PLoS One. 2015;10(2): e0116664
12. Levasseur M, Généreux M, Bruneau JF, Vanesse A, Chabot E, Beaulac C, et al. Importance of proximity to resources, social support, transportation and neighborhood security for mobility and social participation in older adults: results from a scoping study. BMC Public Health. 2015,15:1-19.
13. Flaman LM, Nykiforuk CIJ, Plotnikoff RC, Raine K. Exploring facilitators and barriers to individual and organizational level capacity building: outcomes of participation in a community priority setting workshop. Glob Health Promot. 2010;17(2),34–43.

14. Webber M, Fendt-Newlin M. A review of social participation interventions for people with mental health problems. Soc Psychiatry Psychiatr Epidemiol. 2017;52(4):369-380.
15. Laurence, J. Youth Engagement, Positive Interethnic Contact, and 'Associational Bridges': A Quasi-Experimental Investigation of a UK National Youth Engagement Scheme. J Youth Adolesc. 2019;48(7):1264–1280.
16. Godfrey EB, Cherng HS. The Kids are All Right? Income Inequality and Civic Engagement among Our Nation's Youth. J Youth Adolesc. 2016;45(11):2218-2232.
17. Carmona-Moreno LD. Concepción de la participación social en salud: propuesta de resignificación. Rev. Cienc. Salud. 2017;15(3):441-454.
18. López E, Forcada C, Miller F, Pasarin I, Foz G. Factores que facilitan y dificultan el desarrollo de los proyectos comunitarios. Estudio observacional de la red AUPA de centros de atención primaria de Cataluña. Aten primaria. 2010;42(4):218-225.
19. March S, Jordán M, Montaner I, Benedé C, Elizalde L, Ramos M. ¿Qué hacemos en el barrio? Descripción de las actividades comunitarias de promoción de la salud en atención primaria: Proyecto frAC. Gac Sanit. 2014;28(4):267-273.
20. Borrero-Ramírez YE, Echeverry-López ME. Luchas por la salud en Colombia. Una propuesta teórica para su análisis. Rev. Gerenc. Polit. Salud. 2011;10(21):62-82.
21. Merino CE, Torres MC. Participación en salud y desarrollo territorial: experiencia sanitaria en una comuna del sur de Chile. Cienc. Enferm. 2015; 21(1):115-125
22. Ruano AL, Sebastián MS, Hurtig AK. The process of social participation in primary health care: the case of Palencia, Guatemala. Health Expect. 2011;17:93-103.

23. Santana F, Van Stralen CJ, Antunes PH. Participação social e saúde no Brasil: revisão sistemática sobre o tema. Ciênc. saúde coletiva. 2014;9(2):487-498.
24. Delgado ME, Vásquez ML. Percepciones de usuarios y líderes comunitarios sobre su capacidad para influenciar en la calidad de los servicios de salud: un estudio de casos de Colombia y Brasil. Cad. Saúde Pública. 2009;25(1):169-178.
25. Nigenda-López G, Juárez-Ramírez C, Ruiz-Larios J, Herrera CM. Social participation and quality of health care: the experience of citizens' health representatives in Mexico. Rev Saúde Pública. 2013;47(1):1-8.
26. Cueto RM, Seminario E, Balbuena A. Significados de la organización y participación comunitaria en comunidades vulnerables de Lima Metropolitana. Revista de Psicología. 2015;33(1):57-86.
27. López-Bolaños L, Campos-Rivera M, Villanueva-Borbolla MA. Compromiso y participación comunitaria en salud: aprendizajes desde la sistematización de experiencias sociales. Salud Pública de México. 2018;60(2):192-201.
28. Castañeda GI, Delgado ME. Barreras, oportunidades y tácticas para participar en salud según Asociaciones de Usuarios del Valle del Cauca, Colombia. Hacia la Promoción de la Salud. 2015; 20(2):59-76.
29. Mosquera J, Gutiérrez A, Serra M. La experiencia de participación ciudadana en el control social a la gestión en salud en Cali, Colombia. Colombia Médica. 2009;40 (2):95-102.
30. Restrepo O, Vega R. Participación social y comunitaria en Atención Primaria de Salud - APS. Bogotá: para la muestra un botón. Rev. Gerenc. Polit. Salud. 2009;8(16):153-164.
31. Cáceres-Manrique FM, Angulo-Silva ML, Vesga-Gómez C. Eficacia de la movilización y la participación social para la apropiación o “empoderamiento” (sic.) (empowerment) de las medidas de control del dengue, Comuna Norte, Bucaramanga, 2008-2009. Biomédica 2010;30(4):530-538.

32. Puerta-Silva C, Agudelo-Calle A. Modalidades de interacción en el régimen subsidiado de salud en Medellín: participación y estrategias sociales. Hacia la Promoción de la Salud. 2012;17(1):13–28.
33. Goodman RM, Speers MA, McLeroy K, Fawcett S, Kegler M, Parker E, et al. Identifying and defining the dimensions of community capacity to provide a basis for measurement. Health Educ Behav. 1998;25(3):258-278.
34. Berge JM, Jin S, Hanson-Bradley C, Doty J, Jagaraj K, Braaten K, et al. Play it Forward!: A Community-Based Participatory Research Approach to Childhood Obesity Prevention. Fam Syst Health. 2016;34(1):15–30.
35. Chang C, Minkler M, Salvatore AL, Tau Lee P, Gaydos M, San Liu S. Studying and addressing urban immigrant restaurant worker health and safety in San Francisco's Chinatown district: a CBPR case study. J Urban Health. 2013;90(6):1026-1040.
36. Tobias JK, Richmond CAM, Luginaah I. Community-based participatory research (CBPR) with indigenous communities: producing respectful and reciprocal research. J Empir Res Hum Res Ethics. 2013;8(2):129-140.
37. Griffith DM, Pichon LC, Campbell B, Allen JO. YOUR Blessed Health: a faith-based CBPR approach to addressing HIV/AIDS among African Americans. AIDS Educ Prev. 2010;22(3):203-217.
38. Wallerstein N, Giatti LL, Bógus CM, Akerman M, Jacobi PR, Ferraz R, et al. Shared Participatory Research Principles and Methodologies: Perspectives from the USA and Brazil-45 Years after Paulo Freire's "Pedagogy of the Oppressed". Societies (Basel). 2017;7(2):1-21.
39. Martínez-Toledo Y, Marroquin. L. Ambiente limpio, comunidad feliz: análisis de resultados de una campaña de comunicación para la prevención de la fiebre del dengue en las comunidades Luis XV, en Guápiles, Costa Rica. Revista de Comunicación y Salud. 2017;7(1):103-117.

40. Herrera-Giraldo SL, Panader-Torres A, Cárdenas-Cárdenas LM, Agudelo-Cely NA. Promoción de una alimentación saludable: experiencia en Tunja, Colombia. Av. Enferm. 2012;30(1):55-63.
41. Amico KL, Wieland ML, Weis JA, Sullivan SM, Nigon JA, Sia IG. Capacity building through focus group training in community-based participatory research. Educ Health 2011;24(3):1-13.
42. Israel BA, Coombe CM, Cheezum RR, Shulz AJ, McGranaghan RJ, Lichenstein R, et al. Community-based participatory research: a capacity-building approach for policy advocacy aimed at eliminating health disparities. Am J Public Health. 2010;100(11):2094-2102.
43. Jagosh J, Bush PL, Salsberg J, Macaulay AC, Greenhalgh T, Wong G, et al. A realist evaluation of community-based participatory research: partnership synergy, trust building and related ripple effects. BMC Public Health 2015;15:1-11.
44. Wallerstein N, Duran B. Community-based participatory research contributions to intervention research: the intersection of science and practice to improve health equity. Am J Public Health. 2010;100(Suppl 1):S40-46.
45. Christopher S, Watts V, McCormick AKHG, Young S. Building and maintaining trust in a community-based participatory research partnership. Am J Public Health. 2008;98(8):1398-1406.
46. Montero M. Hacer para transformar: el método en la psicología comunitaria. Buenos Aires: Paidós; 2006. 372 p.
47. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77-101.
48. Abma TA, Cook T, Rämgård M, Kleba E, Harris J, Wallerstein N. Social impact of participatory health research: collaborative nonlinear processes of knowledge mobilization. Educ Action Res. 2017;25(4):489-505.
49. Freire P. Pedagogy of the Oppressed. New York, USA: The Seabury Press; 1970.

50. Schülter IT, Sartori I, Fernandes PC, Costa C, Baeta MF, KuntzM. Reflections on Paulo Freire's research itinerary: contributions to health. Texto Contexto Enferm. 2017;26(4):1-8.

51. Masi, A. El concepto de praxis en Paulo Freire. In: Godotti M, Gómez V, Mafra J, Fernandes A (editors). Paulo Freire. Contribuciones para la pedagogía. Buenos Aires: Consejo Latinoamericano de Ciencias Sociales (CLACSO); 2008, p. 75-82.