

Evaluating community capacity

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Abstract

The aim of the present study was to examine the convergence of two approaches used to assess community capacity in health promotion interventions. One was used to examine women and men in rural communities in Fiji, and the other to study women only in rural communities in Nepal. Both approaches used a set of 'capacity domains', a ranking scale and a means of visually representing the findings. The experiences of using each approach, and the strengths and weaknesses of using rating scales and the 'capacity domains' to assess community capacity are discussed. The use of visual representations of community change, in particular the 'spider web' approach, are also discussed. The capacity building 'domains' presented in this study are robust and capture the essential qualities of a 'capable community'. 'Parallel tracking' of the domains allows programmes themselves to be viewed as a means to the end of building community capacity. These approaches provide a useful new dimension to programme evaluation.

Keywords: community capacity, evaluation, Fiji, health promotion, Nepal

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Introduction

It is helpful for practitioners, programme planners and evaluators alike to regard the concept of 'community capacity' not as something new, but as a refinement of ideas found within the literature and practice of both community development and community empowerment. All three terms (i.e. community development, community empowerment and community capacity building) describe a process that increases the assets and attributes which a community is able to draw upon in order to improve their lives (including but not restricted to their health). This process can happen for many reasons unrelated to the work of community health workers. In this study, the present authors deal with how community capacity can be deliberately enhanced through the programmes developed by health workers and their agencies. The authors could as easily apply this approach to education workers or development aid workers. The approaches they describe concern how community capacity can be enhanced through relationships between government or

non-governmental organisations, community workers (practitioners), and community members (the 'targets' of new programmes or initiatives), regardless of programme name or content (see Figure 1).

Defining community capacity building

Labonte & Laverack (2001a) defined capacity building as the 'increase in community groups' abilities to define, assess, analyse and act on health (or any other) concerns of importance to their members' (p. 114). The capacity of a group is also dependent on the resource opportunities or constraints (ecological, political and environmental), and the conditions in which people and groups live. This definition resembles past definitions of community development or community empowerment. It also has a similar tension to these terms: Is community (development, empowerment and capacity building) a means to achieving a programme end (often defined by the funding agency or practitioner)? Or is community (development, empowerment and capacity building) an end in itself?

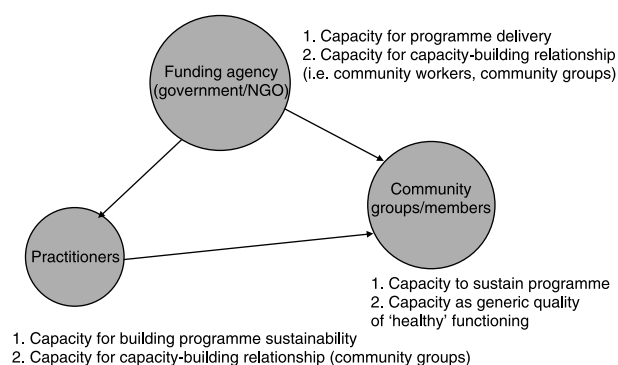


Figure 1 Capacity-building/enhancing relationship.

The present authors recognise that most agencies or funders have, and will continue to have, specific mandates and programme objectives for which they need to be accountable. These priorities sometimes overlap completely with the interests of local communities, while at other times, they do not. When they do, community members are willing to participate actively and programme activities are often sustained beyond the funding period. When they do not, agencies and funders need to be flexible in accepting the developmental nature of community work, recognising that often it is more important to build generic community capacities rather than programme deliverables. Indeed, community capacity becomes one of the programme deliverables, straddling between most health programmes' intents to change behaviours or living conditions and their actual impacts.

Community capacity building as a 'parallel track'

The present authors share the concern with funders about how programmes can be sustained over a longer term, and believe that enhancing community capacities may be a strategic 'missing link'. This is how several writers, such as Goodman *et al.* (1998) and Bopp *et al.* (2000) defined their interest in community capacity building. This approach remains an important means to the end defined by a particular programme, whether it be smoking prevention, basic sanitation or poverty reduction. Nevertheless, the present authors are also convinced that programmes themselves can, and should, be viewed as means to the end of increasing community capacity. By being more deliberate in how they think about the different elements of a 'capable community', agencies and practitioners can plan their programmes in ways which intentionally seek to enhance what they call 'capacity domains' which may be weak in a particular community. These might include a lack of local leadership, or the inability to mobilise internal and external resources.

Rather than get stuck in whether community capacity should be seen as means or as end, the present authors view it as both. It is not a substitute for programme goals or objectives, for which proper and participatory forms of evaluation should be developed, but it creates a separate set of objectives which run parallel to those of specific programmes. The present authors argue for a 'parallel track' approach to community capacity building (Laverack & Labonte 2000, Labonte & Laverack 2001a, b). The basic evaluation question practitioners and their funders need to ask themselves is: How has their particular programme, from its planning through its implementation, through its evaluation, helped to increase community capacity in particular domains where all (i.e. community members, practitioners and agencies) recognise an important gap?

Defining the 'domains' of community capacity

What, then, does community capacity look like? The present authors do not presume that community capacity 'exists' waiting to be discovered, but that it is a construct created because it captures a consensus on some important characteristics or qualities. Laverack (1999) in his research, identified and interpreted nine domains for community empowerment/community capacity. The above author included a review of relevant literature, with particular reference to the fields of health, social sciences and education, to provide an in-depth understanding of programmes which sought to achieve the same goals: to bring about social and political change. The 'organisational domains' were categorised from a textual analysis of the literature and the validity of this data was cross-checked by two other researchers using a confusion matrix approach, as discussed by Robson (1993, p. 222). The research identified the following domains such that a programme:

- improves stakeholder participation;
- increases problem assessment capacities;
- develops local leadership;
- builds empowering organisational structures;
- improves resource mobilisation;
- strengthens links to other organisations and people;
- enhances stakeholder ability to 'ask why';
- increases stakeholder control over programme management; and
- creates an equitable relationship with outside agents.

These domains were later checked against the historic literature on community development and the emerging literature on community capacity building to ensure their face-validity (Labonte & Laverack 2001a). The present authors are reasonably convinced that they adequately capture the essential qualities of a 'capable

Table 1 A brief description of the 'capacity building domains'

Domain	Description
Participation	Participation is basic to community empowerment. Only by participating in small groups or larger organisations can individual community members better define, analyse and act on issues of general concern to the broader community.
Leadership	Participation and leadership are closely connected. Leadership requires a strong participant base just as participation requires the direction and structure of strong leadership. Both play an important role in the development of small groups and community organisations.
Organisational structures	Organisational structures in a community include small groups such as committees, and church and youth groups. These are the organisational elements which represent the ways in which people come together in order to socialise, and to address their concerns and problems. The existence of and the level at which these organisations function is crucial to community empowerment.
Problem assessment	Empowerment presumes that the identification of problems, solutions to the problems and actions to resolve the problems are carried out by the community. This process assists communities to develop a sense of self-determination and capacity.
Resource mobilisation	The ability of the community both to mobilise resources from within and to negotiate resources from beyond itself is an important factor in its ability to achieve successes in its efforts.
'Asking why'	The ability of the community to critically assess the social, political, economic and other causes of inequalities is a crucial stage towards developing appropriate personal and social change strategies.
Links with others	Links with people and organisations, including partnerships, coalitions and voluntary alliances between the community and others, can assist the community in addressing its issues.
Role of the outside agents	In a programme context, outside agents are often an important link between communities and external resources. Their role is especially important near the beginning of a new programme, when the process of building new community momentum may be triggered and nurtured. The outside agent increasingly transforms power relationships between her/himself, outside agencies, and the community, such that the community assumes increasing programme authority.
Programme management	Programme management that empowers the community includes the control by the primary stakeholders over decisions on planning, implementation, evaluation, finances, administration, reporting and conflict resolution. The first step toward programme management by the community is to clearly define the roles, responsibilities and line management of all the stakeholders.

community'. Table 1 provides a brief description of each domain, and a full interpretation can be found in Laverack (2001).

Evaluating community capacity

Having defined the domains of community capacity, how might this 'parallel track' be evaluated? The present authors' emphasis is on the importance of community participation in this evaluation. Sufficient evidence exists of the failures of top-down programmes which have focused on accountability and effectiveness, and not on what the community wants or is trying to say (Boutilier 1993, Syme 1997). An example is the use of 'experts' to measure programme success using predetermined checklists of indicators. This can only serve to take programmes away from empowerment and capacity building because it does not involve the community in the process of evaluation.

The present authors now discuss the application of two approaches which have used the 'capacity

domains' in programme evaluation, the first in Nepal and the second in Fiji. Gibbon (1999) worked with seven women's groups in two districts in eastern Nepal. The evaluation approach used was undertaken with two of the groups in rural and mountainous areas with poor accessibility. Each group consisted of between 10 and 15 people. The work undertaken aimed to help the groups analyse their own health needs, consider what led to their particular health problems, and plan small projects to overcome the problems, implement, monitor and evaluate achievements.

In her evaluation of community capacity, Gibbon (1999) utilized a set of eight domains, similar to those developed by Laverack (1999) (see Table 2). A set of indicators was identified and a rank assigned for each indicator from (1) low to (4) high. In this way, it was possible to locate change as a point along a continuum. Different stakeholders in the same programme used the indicators to make comparisons of the domains at different times in the life of the programme. The indicators and the scores formed an evaluation matrix (CARE

Table 2 Community capacity domains

Laverack (1999)	Gibbon (1999)
1. Participation	1. Representation
2. Leadership	2. Leadership
3. Organisational structures	3. Organisation
4. Problem assessment	4. Needs assessment
5. Resource mobilisation	5. Resource availability
6. 'Asking why'	6. Implementation
7. Links with others	7. Linkages
8. Programme management	8. Management
9. Role of outside agents	

1996), later adapted for use by two women's groups in Nepal. An example of the matrix for the 'organisation' domain is shown below (Table 3).

Gibbon's (1999) work found that the use of a matrix can facilitate the participants' understanding and discussion of the situation, the strengths, weaknesses and areas which need improvement. It is essential for the group members to be involved in the decisions regarding indicators. The matrix for each factor in the above author's work was completed during a facilitated discussion used to identify the agreed response that most directly corresponded with what the group members agreed upon. The results can be used to facilitate the identification of further training needs or other forms of assistance.

Laverack (1999) independently used a similar rating scale (called 'empowerment assessment rating scales') approach in three rural Fijian communities on the main island of Viti Levu. The purpose was to provide a focus for the participants' on each of the nine 'domains' to identify problems and then solutions toward building

community capacity. Each scale consisted of five items which ranged from the least to the most empowering situation. Each item was expressed as a short statement derived from community discussion and the literature, and a ranking made from (0) unacceptable to (4) most satisfactory. The participants were asked to discuss the five statements for each domain and to select the one that most closely described the current situation in their community.

During the field-testing in Fiji, the pre-quantified scales were found to unacceptably influence the behaviour and actions of the participants. The use of the rating scales led to the introduction of subject bias such that they did not allow an independent assessment to be made by the participants. The rating scales were subsequently removed and the design adapted to utilise an approach in which the participants are provided with five statements, each written on a separate sheet of paper. In the field-test, each statement was written in English with a translation in Fijian. They were not numbered or marked in any way. Each statement represented an item of the range between the least to the most empowering situation, and this pattern of having five alternatives was repeated for each domain. Participants discussed each statement in turn and made a selection of the one that most closely described the current situation in their community. They repeated this pattern for each domain, with an emphasis placed on sharing experiences and knowledge. The statements could be amended or a new statement written by the participants to describe the situation in their community. Participants could discard some of the statements and spend time discussing others before reaching a consensus about any one statement.

Table 3 Matrix showing the 'organisation' domain of community capacity

Organisation	Rank			
	1	2	3	4
Does the core group meet regularly?	No, almost never	Irregular meetings	Regular meetings low participation of members (< 50%)	Regular meetings high participation of members (> 50%)
How does the core group take decisions?	No decisions made	Decisions are made, mainly by one or two members	Decisions are made by few members, but supported by majority of members	Decisions are made with consensus of all members
How does the core group communicate with general members?	No messages conveyed to members; no contact between the core group and general members	Irregular, verbal communication with general members (< 50% informed)	Regular verbal communication with general members (> 50% informed)	Good interaction between the core group and the general members all are informed
What is the understanding of the role of the group?	No perception of role	Few members have a clear idea about the role	Majority of members have a vague idea of the role	Majority of members have a clear perception of the role

Table 4 Matrix for the Naloto Tikina Health Committee

Domain	Assessment	Reasons why	How to improve	Strategy	Resources required
Resource mobilisation <i>Na kena vakayagataki na i yau bula</i>	Community has increasingly supplied resources, but no collective decision has been made about distribution Resources raised have had limited benefits	People have given resources for planned activities, but these were not carried out Resources continue to be requested from the community	Considerable resources need to be raised by the community The community should decide on the distribution that should be carried out fairly	A clear plan of action to include policy of accountability Regular meetings Provide feedback from meetings to the community Leadership and management training – to set a good example	Year planner Meeting place and small funds to hold meeting Time frame for meetings Skills training to leaders
Participation <i>Vakaitavi/cakacaka vata</i>	Not all community groups are participating in activities and meetings (e.g. women and youth groups)	There is a lack of knowledge, skills, focus and interest in the community Personal differences divide the community	Use traditional protocol, chiefly leadership and <i>matagali</i> Have a clear directive on the course of action	Develop directive with time, activities, responsibilities in follow-up meetings	Human resources to develop directive Commitment to implement

1

Table 4 shows how one Fijian community assessed the 'domains' of 'resource mobilisation' and 'participation' using this more flexible approach. Laverack (Year?) found that the successful implementation of the 'domains' for capacity building were dependant on a free flow of information between participants (access to the matrix, sharing of information between the participants and with other communities and clear expectations) and follow-up support (from the facilitator and from outside agents). This provides an important lesson: even if the methodology is correctly implemented, the transformation of the information into action will not occur unless there is also adequate communication and possible support from an outside agent. This also provides an example of how community capacity building can be worked into programme planning, since it includes actions for improvement, strategies to be used and new resources which may be required. The question of the health worker then becomes, 'How can the specific programme, or programmes if there are more than one, support the strategy to improve the situation in the local community?'

2

The present authors' experiences underscore the importance of a 'facilitated dialogue' or workshop approach to assessing community capacity domains. This is a conclusion reached by other capacity researchers, such as Bopp *et al.* (1999). It is important in these assessment sessions that participants discuss and record the reasons why the statement was selected for the assessment of each domain, and for two reasons: (1) it assists other people who make the re-assessment

every 3–6 months, and who need to take the previous record into account; and (2) it provides some defensible or empirically observable criteria for the selection. This overcomes one of the weaknesses of using qualitative statements or 'mini-stories', as in both Gibbon's (1999) and Laverack's (1999) rating schemes, i.e. that of reliability over time or across different stakeholders (Uphoff 1991). The 'reasons why' analysis needs to include verifiable examples of the actual experiences of the participants taken from their community to illustrate in more detail the reasoning behind the selection of the statement.

Using visual representations of community change

Several authors have used visual representations to map community changes. Roughan (1986) developed a wheel configuration and used rating scales to measure three areas: (1) personal growth; (2) material growth; and (3) social growth for village development in the Solomon Islands. The rating scale had 10 points which radiated outwards like the spokes of a wheel for each indicator of the three growth areas. Each scale was joined together following an assessment by the village members to provide a visual representation of growth and development. However, the approach did not promote strategic planning, and used a total of 18 complex, interrelated indicators, such as equity and solidarity for village development, which are difficult to conceptualise.

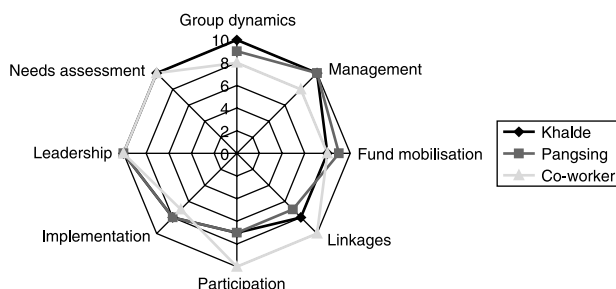


Figure 2 'Spider web' visual representation.

In a similar approach, Bjaras *et al.* (1991) developed a 'spider web' configuration for the measurement of community participation in Sweden. This approach has been used in evaluating community participation in other health programmes (Rifkin *et al.* 1988, Bopp *et al.* 1999, Hawe *et al.* 2000). Bjaras *et al.* (1991) used the approach for five factors to assess community participation, i.e. leadership, needs assessment, management, organisation and resource mobilisation, and a rating scale of narrow, medium and wide to rank each factor. However, the approach was not carried out as a self-assessment, but used an external agent and did not promote strategic planning or self-improvement.

Figure 2 provides an example of a self-assessment of two women's groups in Nepal also using the 'spider web' approach (so called because of its appearance being similar to a spider's web) to provide a visual representation of community capacity. The assessment includes Gibbon's (1999) eight community capacity domains, and adds a ninth category particular to the group and its dynamics. This assessment used a 10-point rating scale. The numbers used to assess community capacity have little cross-comparison meaning. They only make sense relative to changes in the same group or community over time, or as in this instance, similarities or differences between different stakeholders. For example, the co-worker in the Dhankuta group evaluation gives the same rating as the groups for needs assessment and leadership. She rates the groups higher for participation and linkages, and lower for group dynamics, management and implementation. The 'spider web' was plotted out on newsprint by the co-worker, and discussed with the women's groups who found this helpful when changes occurred over time and when comparing assessments (Gibbon 1999).

Graphing differences over time allows some conclusions to be drawn about community capacity building. However, differences between stakeholders at the same point in time require facilitated discussion over why different ratings were assigned. For the purposes of evaluating changes in community capacity, some

consensus amongst stakeholders (or averaging process) for ratings at any given time needs to be used.

Visual presentations of change such as the 'spider web' can be a useful tool to health promoters, but any evaluation of community capacity should make use of a range of different evaluation techniques, including process measures, observations, key informant interviews and other documentary material. Laverack (1999) encountered difficulties when applying visual representations and preferred to use the matrix approach for mapping community capacity (Table 4) in a cross-cultural context.

Conclusions

In this paper, the present authors have described the construct of community capacity in terms of specific 'domains' and 'parallel tracking'. They believe it adds a useful new dimension to the programme work engaged in by many community health workers, whether in developing or developed countries. It captures the 'half-way' step between desired programme changes, whether such changes involve individual behaviours or broader social policies and practices, and what actually happens or should happen in effective community work. The domains of community capacity which the authors cite are robust, and the participatory methods they discuss for their assessment allow for amendment, expansion and further elucidation. Therefore, the authors do not start with a blank slate called 'community capacity' onto which each group or community might inscribe its own problems or needs.

The present authors appreciate that there is evidence from numerous different cultural settings that community capacity needs to retain some contingent flexibility. Communities may share much in common, but they are never exactly the same.

The approach to evaluating community capacity allows community-based organisations to scrutinise their project achievements. In both Fiji and Nepal, the participants found that being able to evaluate project effectiveness led to a better demonstration to policy makers about changes within their communities and to access to further project funds.

The present authors do not call on community capacity evaluation to substitute for the evaluation of programme specific goals and objectives. They see community capacity and its assessment (and especially the participatory nature of its assessment) as a useful and flexible approach for community work. Community capacity is both means and an end, and the authors feel that a consideration of this construct improves the evaluation of health promotion programmes. They hope that it also leads to improvements in its practice.

References

- Bjaras G., Haglund B.J.A. & Rifkin S. (1991) A new approach to community participation assessment. *Health Promotion International* **6** (3), 1199–1206.
- Bopp M., Germann K., Bopp J., Littlejohns L.B. & Smith N. (1999) *Assessing Community Capacity for Change*. Four Worlds Development, Calgary.
- 4** Boutilier M. (1993) *The Effectiveness of Community Action in Health Promotion: A Research Perspective*. ParticiACTION 3, University of Toronto, Toronto.
- CARE (1996) *Participatory Monitoring of Community Groups Capacities*. CARE Nepal, Kathmandu.
- Gibbon M. (1999) *Meetings with Meaning: Health Dynamics in Rural Nepal*. PhD Thesis. South Bank University, London.
- 5** Gillies P. (1998) Effectiveness of alliances and partnerships for health promotion. *Health Promotion International* **13** (2), 99–120.
- Goodman R., Speers M., McLeroy K. *et al.* (1998) Identifying and defining the dimensions of community capacity to provide a base for measurement. *Health Education and Behaviour* **25** (3), 258–278.
- Hawe P., King L., Noort M., Jordens C. & Lloyd B. (2000) *Indicators to Help with Capacity Building in Health Promotion*. Australian Centre for Health Promotion/NSW Health, Sydney.
- Jackson S., Cleverly S., Burman D., Edwards R., Poland B. & Robertson A. (1999) *Towards Indicators of Community Capacity*. NHRDP Project No. 6606-6084-002, Final Report, Centre for Health Promotion, Toronto.
- 6**
- 7** Labonte R. (1996) Community organizing and 'partnerships for health'. In: M. Minkler (Ed.) *Community Organizing and Health*, pp. 88–102. Rutgers University Press, City, NJ.
- 8** Labonte R. & Laverack G. (2001a) Capacity building in health promotion, Part 1: for whom? and for what purpose? *Critical Public Health* **11** (2), 111–127.
- Labonte R. & Laverack G. (2001b) Capacity building in health promotion, Part 2: whose use? and with what measurement? *Critical Public Health* **11** (2), 128–138.
- Laverack G. (1999) *Addressing the Contradiction Between Discourse and Practice in Health Promotion*. PhD Thesis. Deakin University, Melbourne.
- Laverack G. (2001) An identification and interpretation of the organizational aspects of community empowerment. *Community Development Journal* **36** (2), 40–52.
- Laverack G. (Year?) Building capable communities: experiences from Fiji. *Health Policy and Planning* **XX**, 000–000.
- Laverack G. & Labonte R. (2000) A planning framework for the accommodation of community empowerment goals within health promotion programming. *Health Policy and Planning* **15** (3), 255–262.
- Laverack G. & Wallerstein N. (2001) Measuring community empowerment: a fresh look at organizational domains. *Health Promotional International* **16** (2), 179–185.
- Rifkin S.B., Muller F. & Bichmann W. (1988) Primary health care: on measuring participation. *Social Science and Medicine* **26** (9), 931–940.
- Robson C. (1993) *Real World Research*. Blackwell, Oxford.
- Roughan J.J. (1986) *Village Organization for Development*. PhD Thesis. Department of Political Science, University of Hawaii, Honolulu, HI.
- Syme L. (1997) Individual vs community interventions in public health practice: some thoughts about a new approach. *Vichealth Letter* **July** (2), 2–9.
- Uphoff N. (1991) A field methodology for participatory self-education. *Community Development Journal* **26** (4), 271–285.
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