Community participation and empowerment in Healthy Cities

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SUMMARY
Community participation and empowerment are core principles underpinning the Healthy Cities movement. By providing an overview of theory and presenting the relevant findings of evaluations, this article explores how cities in the WHO European Healthy Cities Network have integrated community participation and empowerment within their development. Reflecting the inclusion of public participation and empowerment within the designation criteria for project cities, the evaluation of Phase III in 2002 demonstrated that community participation continues to be a high priority in most project cities. One-third of cities regularly consulted with large parts of their populations and another third undertook occasional consultations. Nearly 80% of cities had mechanisms for community representatives to participate in decision-making; and more than two-thirds of cities had initiatives explicitly aimed at empowering local people. Subsequent research carried out during 2005 further highlighted the centrality of public participation to the Healthy Cities movement. It found that all project cities continued to support community involvement. Community participation is an essential part of the process of good local governance, and empowerment remains at the heart of effective health promotion. To be meaningful, these processes must be seen as fundamental values of Healthy Cities and so must be developed as an integral part of long-term strategic development.

Key words: Healthy Cities; community participation; health promotion; empowerment

INTRODUCTION

Concepts
A commitment to community participation and empowerment is at the heart of the WHO European Healthy Cities Network (WHO-EHCN), reflecting its origins in health for all (WHO, 1981) and the Ottawa Charter for Health Promotion (WHO, 1986). The Ottawa Charter includes ‘strengthening community action’ as one of its five action areas, stating:

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies [(WHO, 1986), p. 3].

The subsequent Jakarta Declaration (WHO, 1997) reinforces this focus, giving priority to increasing community capacity and empowering individuals. It emphasizes the necessity of participation, with actions being carried out by and with people, not on or to people.

The WHO-EHCN has also integrated the principles set out in both Agenda 21 (United Nations, 1993) and Health 21, the revised health for all policy for the WHO European Region (WHO Regional Office for Europe, 1998). The former, a major output of the 1992
United Nations Conference on Environment and Development, suggests that the active participation of communities is essential for environmentally, economically and socially sustainable development, urging local authorities to undertake a consultative and consensus-building process with citizens and local organizations and to formulate their own sustainable development strategy—a Local Agenda 21. The latter advocates a participatory health development process and one which reaches out ‘to empower individuals, local communities and private and voluntary organizations in different settings for health, e.g. homes, workplaces, schools and cities’ [(WHO Regional Office for Europe, 1998), p. 68].

A WHO publication (WHO Regional Office for Europe, 2002a) drew on key literature (Bracht and Tsouros, 1990; WHO, 1991; Smithies and Webster, 1998) to propose the following working definition of community participation:

A process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change [(WHO Regional Office for Europe, 2002a), p. 10].

The term community participation is often used alongside or interchangeably with a number of other concepts. Although clearly distinguishing between terms can be difficult, three broad categorizations are useful:

- those that imply different types and levels of participation (such as consultation and empowerment);
- those that represent methods of working that give priority to and enable participation (such as community capacity-building and community development); and
- those that seek to describe and/or map interactions and relationships within communities that are influenced by participation and related to health and well-being (such as social capital and community cohesion).

Zakus and Lysack argue that, although there is still little rigorous evidence of the effectiveness of community participation in relation to health, community participation is widely accepted to have many important benefits (Zakus and Lysack, 1998). The range of benefits is influenced by the motivation for undertaking the work—and in particular whether participation is seen as a means or an end (Jewkes and Murcott, 1998; Kahssay and Oakley, 1999; Morgan, 2001)—but these benefits are understood to be important for individuals, communities, organizations and society as a whole (Smithies and Webster, 1998). Key benefits include increasing democracy, mobilizing resources and energy, developing more holistic and integrated approaches, achieving better decisions and more effective services, ensuring the ownership and sustainability of programmes and actively empowering people (WHO Regional Office for Europe, 2002a).

The concept of empowerment, although arguably overshadowed in recent years by discussions of social capital, community capacity and other constructs, remains important in understanding the processes of social influence and transformation of power relations as unavoidable features of health promotion (Laverack and Wallerstein, 2001). Defined by Laverack (Laverack, 2006) as a ‘process by which relatively powerless people work together to increase control over events that determine their lives and health’ (p. 113), empowerment is used in a diversity of ways and remains contested in the literature, with key debates focusing on whether power is limited or limitless and whether empowerment operates at interpersonal and/or socio-political levels.

Rappaport (Rappaport, 1985) has argued that empowerment only occurs when individuals and communities take power, a perspective echoed more recently by Laverack (Laverack, 2006). He stresses that empowerment cannot be bestowed by others, but that those who have power (e.g. health practitioners) and those who want it (e.g. clients) must co-operate to create the conditions necessary to make empowerment possible. This can be done by building capacity and enabling social action to address the underlying social, structural and economic conditions that impact on health. This highlights the differing perspectives concerning power—Checkoway (Checkoway, 1995) proposes that power is an infinite resource in every person or community; and Schuftan (Schuftan, 1996) presents a ‘zero-sum’ model and contends that the empowerment of some entails the disempowerment of others, usually the current holders of power. This view is shared by Gutierrez (Gutierrez, 1990) who argues that ‘empowerment theory is
based on a conflict model that assumes that a society consists of separate groups possessing different levels of power and control over resources’ (p. 150). While important to acknowledge these different conceptualizations, discussed by Wallerstein (Wallerstein, 2006) as ‘power over’ and ‘power within’, it can be argued that public health will most often simultaneously involves zero-sum and non-zero-sum formulations of power (Laverack, 2005)—with practitioners acting as advocates, enablers and catalysts for empowerment. Key to this role has been a shift from the ‘deficit’ model, with its overriding focus on needs, to the ‘assets’ model with its focus on community strengths and capacities (McKnight and Kretzmann, 1992; Minkler and Wallerstein, 1998; Morgan and Ziglio, 2007).

In discussing the relationship between different levels of empowerment, Checkoway (Checkoway, 1995) comments that ‘empowerment at its best includes…individual involvement, organizational development, and community change’ (p. 4), while Laverack (Laverack, 2005) suggests that community empowerment is a ‘synergistic interaction between individual empowerment, organisational empowerment and broader social and political actions’ (p. 36). Exploring this further, a number of writers (Minkler and Wallerstein, 1998; Wallerstein, 2006) have highlighted the significance of ‘conscientization’ as a mediating process. As Freire (Freire, 1972/1996) argues, ‘The critical development of [people] is absolutely fundamental for the radical transformation of society… but it is not enough by itself’ (p. 6).

**Developing a coherent approach**

If community participation and empowerment strategies are to be meaningful, they must be developed coherently and at different levels (Tsouros, 1990; Smithies and Webster, 1998). In particular, they need to include:

- support for grassroots community-level development and capacity-building;
- the establishment and strengthening of networks and infrastructures for communities and professionals working to enable participation; and
- a commitment to meaningful organizational development, to ensure that grassroots action for participation feeds into and influences the mainstream.

The development of such a coherent and strategic approach requires a number of preconditions (Zakus and Lysack, 1998; WHO Regional Office for Europe, 2002a) including commitment, understanding, competencies and resources. Without these, the effectiveness of community participation will be limited and communities may be left feeling let down and cheated. Healthy Cities have the potential to provide an appropriate framework for community participation.

As highlighted earlier, community participation not only embraces a wide range of theoretical influences but also serves as an umbrella term for many different practices. Recognizing different types and levels of participation is especially important, and this has been illustrated through the development of continuums and ladders by writers such as Arinstein (Arinstein, 1969) and Brager and Specht (Brager and Specht, 1973) (Figure 1).

Healthy Cities clearly require a high level of community participation practice that promotes active and genuine involvement and empowerment rather than the more passive processes of providing information and consultation. However, achieving high-level participation is not always possible: different political, social, economic and organizational contexts may

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**Fig. 1: A ladder of community participation: level of participation, participants’ action and illustrative modes for achieving (Source: adapted from Brager and Specht, 1973).**
create different conditions, offering different opportunities and constraints (Kummeling, 1999).

Davidson’s wheel of participation was developed in recognition of this, as a model to assist community planning. Rather than a hierarchical ladder, it offers a nonlinear model in the shape of a wheel—distinguishing objectives and techniques under the four quadrants of information, consultation, participation and empowerment (see Figure 4.2 of Davidson, 1998).

Community participation and empowerment within Healthy Cities in Europe

Community participation has been a core principle of the WHO-EHCN since it was initiated in 1987. The review of cities at the end of the first phase (1987–1992) highlighted the priority given to community participation—with an emphasis on specific community-based action, community representation on steering committees and the transfer of resources and decision-making powers to communities. It concluded that:

Healthy cities projects, with their focus on local action, have made progress in increasing community participation. This meant that local people had a stronger voice in the decisions of city government that affect health, within an environment that could support change [(Draper et al., 1993), p. 71].

This commitment was formalized in subsequent phases of the WHO-EHCN. For example, a designation criterion of the third phase (1998–2002) stated that:

Cities should demonstrate increased public participation in the decision-making processes that affect health in the city, thereby contributing to the empowerment of local people [(WHO Regional Office for Europe, 1997), p. 10].

METHODOLOGY

Davidson’s wheel of participation, described earlier (Figure 2), provided the framework for evaluating the place of community participation and empowerment within Phase III of the WHO-EHCN.

In summer 2002, 44 of the 56 cities in Phase III (1998–2002) of the WHO-EHCN responded to a questionnaire distributed by WHO, which included a section on community participation (WHO Regional Office for Europe, 2002b). The questions were both qualitative and quantitative. They were designed to find out what really occurred in the cities rather than whether the city supported the theoretical principles of community participation and empowerment. The questionnaires were completed by the Healthy Cities coordinators and the replies were checked by the city politicians and/or Healthy Cities steering committee before being sent electronically to WHO. The responses were categorized under four headings which reflected the key themes of Davidson’s wheel (information, consultation, participation and empowerment).

The survey findings were supplemented by 12 one-hour semi-structured interviews held with city representatives during September 2002. The interviews were programmed during an evaluation day, at the start of an annual business meeting. The questions asked were designed to validate the written replies and obtain further details on the community participation methods used in each city.

Additional information came from the cities’ annual reports (WHO Regional Office for Europe, 2000, 2001, 2002c, 2005) and from a report on national network activity (Lafond et al., 2003). A full report of the community participation findings from the Phase III evaluation can be found in Heritage (Heritage, 2002).
FINDINGS

The evaluation of Phase III of the WHO-EHCN highlighted the continuing high priority given to community participation among member cities—covering all four quadrants of Davidson’s wheel by (i) providing information, (ii) consulting with the public, (iii) enabling participation through representation and (iv) empowering individuals and communities.

Providing information to local people

Before citizens can participate, they must be aware of what activities are occurring. Cities were asked how they kept citizens informed about health. Nearly 90% of the cities proactively informed citizens about their initiatives and/or other public health issues. A further 8% of cities occasionally provided information.

Websites were the most frequently used channel for disseminating information, followed by producing Healthy Cities magazines or newsletters and publishing articles in local newspapers (Figure 3). In contrast, when interviewees were asked to state the most effective way of keeping local people informed, the more traditional routes were the most popular. Websites were discounted, as they were not usually used to inform people on current work and the most vulnerable citizens rarely had easy access to the Internet. The most effective ways of informing the general population were seen to be the local mass media, in particular newspapers and television. The most effective way to contact specific, perhaps vulnerable, groups, however, was understood to be by direct word of mouth via voluntary groups, schools etc.

Information, awareness raising and public advocacy

The Mayor of Sandnes, Norway is proud of local peoples’ awareness of Healthy Cities principles. He has found that it does make the Municipality think carefully about difficult decisions. If a new road is planned, for example, there will be letters to newspapers from local people questioning how a road can promote sustainable development and is it appropriate for a healthy city such as Sandnes.

Consulting local people

The 2002 evaluation found that slightly more than one-third of the member cities regularly consulted with large parts of their populations and another third consulted with some groups before developing specific initiatives. In the United Kingdom, consultation about some health and social issues was a statutory requirement, but for most other cities this type of consultation was an optional activity that requires considerable financial and/or staff resources.

Questionnaires and public meetings, followed by working and focus groups, were the most...
common methods cited. Other more original ones included drama, quizzes, personal visits and rapid appraisal assessment. These approaches could be divided into those that invite people to attend (e.g. public meetings, focus groups and consensus conferences) and those that reach out to the people (e.g. questionnaires and visits to community groups). The city of Copenhagen held 16 meetings with local people as part of its health planning process and collected 1200 suggestions. Another Scandinavian city had set up a consultation using their website but was disappointed by the low number of responses, even in a country with very high Internet usage.

Consulting via an annual forum
For the past 3 years, Seixal (Portugal) has held a 2-day Health Forum attended by several hundred partner and voluntary organizations. Half the Forum is set aside for a survey and debate about health priorities in the city and the future work of the Healthy Seixal Project. The findings from the questionnaire and from the debates are carefully noted and are the focus of the subsequent coordination committee meetings. The consultation during the Health Forum drives the agenda for the Healthy Seixal Project for the coming year.

During the third phase of the WHO-EHCN, member cities were encouraged to produce a strategic city health development plan. Of those that developed such a plan, virtually all consulted with their communities—the most popular pathways being a mass questionnaire followed by focus groups and consensus conferences. Few cities (only 2 of the 44 surveyed) described providing feedback to the people involved in the consultation.

Representation: participating in decision-making
Nearly 80% of the 44 cities surveyed had mechanisms for community representatives to participate in decision-making, most frequently through membership of the Healthy Cities steering committee. An earlier Healthy Cities survey found that most of these members came from nongovernmental organizations (NGOs) rather than the general public (WHO Regional Office of Europe, 2002c). Healthy Cities personnel often selected representatives, usually from organizations with which they have had a long working relationship, although three cities organized open elections. These findings were supported by the 2004/2005 annual reports from the 41 newly designated fourth phase cities—which showed a continuing commitment to involving the community in decision-making, but indicated that the majority (76%) work with NGOs rather than directly with the public.

Some community representatives were clearly equal partners on Healthy Cities steering committees. In Belfast, United Kingdom, they had the status of director with equal rights and responsibilities. In others places this was not the case:

Nongovernmental organizations are not in an equivalent position with the municipal or other organizations. One reason is that nongovernmental organizations get the overwhelming majority of their budget from the municipalities [(Heritage, 2002), p. 60].

One-fifth of the cities surveyed had a community forum because a plethora of community organizations as full partners on a Healthy Cities city steering committee was not always practical. A community forum allows many more people to influence the development of the Healthy Cities project. Forums usually took the form of a large meeting of members of the public and voluntary sector. Most covered the whole city, but some cities had several forums covering different geographical sectors. A weakness in some cities appeared to be the link between the community forum and the main strategic steering board. Sometimes, the Healthy Cities coordinator was the only link person attending both meetings. This means that he/she had to represent both the viewpoint of statutory agencies to the community forum and the community’s concerns to the steering committee.

Supporting community members to participate in decision-making
For 8 years, Newcastle (United Kingdom) had voluntary and community sector representatives on its Health Partnership. A separate city-wide organization coordinated the annual election of four voluntary-sector representatives and the six community members are chosen by local steering groups that organize community health conferences. The voluntary and community representatives felt that the sense of equality is one of the strengths of the Health Partnership meetings. Newcastle found that the most difficult part to get right was not the selection process but rather how to support community representatives in actively contributing to the meetings.
Education for democracy
A priority for the Bosnia and Herzegovina Healthy Cities Network was to encourage young people currently growing up in segregated communities to cooperate together. It had developed a school democracy project in partnership with the Norwegian and Croatian national networks. It involved setting up mock parliaments in primary and secondary schools, with the aim of bringing about change in society by educating young people in democratic processes. Student assemblies discussed and proposed solutions to health-related problems such as the availability of drugs, playground safety or how to support children with special needs.

Empowering local people
Empowerment is characterized by local people having increased control over their own lives and being able to set the agenda (Laverack and Wallerstein, 2001). The Phase III evaluation found that just over two-thirds of cities reported supporting initiatives aimed at empowering local people. This support included funding projects run by other partner organizations, funding community grant schemes, facilitating groups and managing staff employed to work in this way. Some cities used a diverse number of locations; others concentrated their efforts through a volunteer centre, health shop or family centre.

The range of empowerment activities occurring in Healthy Cities was enormous. Examples of activities include: supporting an older people’s network; user-centred mental health projects; scout camps for children from low-income families; and enabling early retired men to overcome handicaps and to start to enjoy life again. Three cities in different geographical parts of Europe had trained community members as health promoters. They had all run a number of courses for local people who previously felt disempowered. Participants increased their self-confidence and knowledge and were encouraged to share this knowledge with their neighbours and friends.

Managing a community health project
Glasgow (United Kingdom) managed eight community health projects, all based on a social model of health, employing 50 people. One programme, East End Health Action, focused on empowering people to access training and employment opportunities (one of Glasgow’s key health issues). By using volunteering within the project, it enabled people to move on to formal training and then into the labour market. It is unlikely that many people would have been able to access such opportunities without the support of the community health projects.

Other sources of information
As well as the Phase III evaluation, other sources of information provided evidence of participation and empowerment in Healthy Cities. The 2002 evaluation findings are in accordance with annual reports from the cities compiled from 1999 to 2005 (WHO Regional Office for Europe, 2000, 2001, 2002c, 2005) as well as the findings from earlier 5 year phase evaluations (Draper et al., 1993; Kummeling, 1999). Although it cannot be easily quantified, it appears from these sources that more community participation is now occurring as an integral part of Healthy Cities activities and not as an ‘add-on’, reflecting a shift from the margins to the mainstream.

National Healthy Cities networks in the European Region had also been active in promoting and evaluating local participation (Lafond et al., 2003). For example, the Danish Healthy Cities Network evaluated its members’ citizen participation activities and found that although the extent of citizen participation varied, most municipalities were active in this field. National networks have a key role in providing training and information exchange.

The findings of the 2004/2005 annual reports of the 41 of the 79 member cities of Phase IV of the WHO-EHCN confirmed those of the 2002 evaluation. It found that local people/community groups were involved in decision-making and activities in all cities (WHO Regional Office for Europe, 2005).
DISCUSSION

Overview
Healthy Cities do appear to have been successful in promoting community participation. Community participation and the empowerment of local people are core values of the WHO-EHCN. The specification of community participation as a designation criterion for Phase III provided cities with the legitimacy to experiment with innovative approaches and encouraged cities to try new methods of supporting local people to get involved. Furthermore, the national networks have supported this approach through providing training and opportunities for cities to exchange experience.

The 2002 evaluation demonstrated that the majority of EHCN Cities are actively promoting aspects of community participation (Heritage, 2002). One-third of the cities demonstrated a very solid commitment to putting local people in control by having activities in all four areas of Davidson’s wheel of participation. Four-fifths of cities encouraged community members to participate in decision-making. The literature (Smithies and Webster, 1998; Tsouros, 1990) stresses the need to provide support at different levels: grass-roots community development; networks and organizational changes in statutory organizations (to enable them to listen to the community voices). European Healthy Cities do appear to have provided this variety of support. They have community forums and/or have representatives of the community on their steering committees. They finance local NGOs and networks that provide training and support to local people often from disadvantaged areas.

Due to the different political pasts, it is not surprising that some cities feel more comfortable promoting activities concerned with informing and consulting the community than with more advanced participation such as responsibility in decision-making. Empowerment requires those who have previously been in control to share their power (Freire, 1972/1996; Schuftan, 1996) and this change can be painful to some and difficult in certain contexts.

Limitations of this study
The main limitation to the 2002 Phase III evaluation is that the findings are based on self-completed questionnaires. Finance did not allow the researchers to observe in situ the processes described. The subsequent interviews with city representatives did allow some validation of their written replies. The fact that the findings of the evaluation were in line with other data gathered from city annual reports is positive, but the annual reports have the same weakness of being self-completed.

The questionnaire did contain definitions and descriptions of what was meant by consultation, empowerment and other terminology. Despite this effort, some cities appeared to have understood the concepts in different ways, and reported activities that were not completely appropriate to the questions that were asked. This is most noticeable in the section relating to empowerment.

Lessons learnt
Lessons can be learned from the evaluation findings. As Zakus and Lysack (Zakus and Lysack, 1998) mention, there is a need for commitment, understanding, competencies and resources in order to develop coherent community participation and empowerment processes. The majority of Healthy Cities has demonstrated commitment and has allocated resources. However, some cities do not seem to have fully understood the meaning of ‘empowerment’ as they have reported processes that probably should be classified as ‘participation’. This suggests the need for further training about the definitions and techniques to encourage effective community participation and, in particular, local empowerment of disadvantaged communities.

Although spontaneous grassroots participation can occur, it is rare in communities that
are not used to influencing political change. Resources are required to facilitate the creation of community structures that can support the involvement of local people. Considerable time can pass before people feel sufficiently empowered to recognize that they can contribute significantly to improving health. Healthy Cities should consider providing even greater financial and human investment in the future in order to improve public health.

The findings regarding effectiveness of different mechanisms for informing the public raise questions about the value of producing Healthy Cities newsletters—and suggest that developing skills to improve contact with the mass media might be a more effective investment of resources (Figure 3).

Many cities rely on members from large NGOs to represent the community viewpoint, especially on the Healthy Cities steering committee. The cities do not report awareness that such NGO representatives can be paid professionals and they may only represent one interest. Developing community forums with their much wider membership base appears to be a more satisfactory approach. Also it appears to be important that cities that do have a community forum look to strengthen mechanisms for linking the forums to Healthy Cities steering boards. It may be possible to develop a more robust model than currently exists in most cities. This could be done by ensuring that at least two statutory representatives from Healthy Cities steering committees are present at the community forum and that two community representatives sit on the steering committee, ensuring a minimum of four link people (Figure 4).

This evaluation has identified a lack of feedback to local people after consultation. Healthy Cities need to strengthen this area, so that people who have contributed to a consultation feel valued and understand how their concerns and ideas have or have not influenced decision-making. Cities also need to differentiate more clearly between strategies aimed at involving the general public and those aimed at vulnerable groups that have been traditionally excluded from decision-making. For example, broad-based communication methods and consultation via community forums can be complemented by more intensive empowerment initiatives with specific ‘hard to reach’ communities.

As mentioned in the introduction, for community participation and empowerment approaches to be meaningful, they must be developed as part of a long-term strategy. Community participation and empowerment must be fundamental values that are integrated into Healthy Cities at every stage—from assessing needs and assets, through agreeing a vision and generating ideas, to enabling action and carrying out appropriate monitoring and evaluation (WHO Regional Office for Europe, 2002a). Healthy Cities require the involvement of local politicians and other senior decision-makers. Virtually all Healthy Cities have an intersectoral steering committee. These committees are vital for effective community participation as they provide an organizational channel to hear local people’s concerns and ideas and in turn to influence the service delivery of statutory organizations.

**CONCLUSION**

Community participation is part of the process of good local governance (Carly, 2003). It can complement the established democratic process of voting at local elections and enable groups of people not connected to political parties or who have traditionally felt excluded to get involved (Stewart, 1996).

However, community participation is not a simple panacea. The process must come to be owned by local people and must follow the community’s timescales and not those of the municipality or of the WHO Healthy Cities project.
...to be both effective and long lasting, community participation must become a successful and integral part of the entire community’s common experience and not remain as a structure imposed from outside [(Zakus and Lysack, 1998), p. 9].

A key message of the Phase III evaluation and the later annual reports is that the Healthy Cities model has been successful in promoting community participation as part of the process of good local governance. Several Healthy Cities have moved further and their community action focus is now concerned with developing social capital or community capacity-building. These new fields provide important evidence of the positive health impact of participation and empowerment (Kawachi, 1999; Healy, 2001). However, successfully involving the community in basic decision-making is still a learning process for some cities. The need to build participatory community networks and, specifically, to empower socially excluded people cannot be ignored by those who wish to improve urban health.

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