ASSET-BASED COMMUNITY DEVELOPMENT FOR HEALTH PROMOTION IN CULTURALLY DEFINED COMMUNITIES

by

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ABSTRACT

As our understanding of the broader determinants of health such as socio-economic status and the social environment has matured, community development has emerged as a possible health promotion strategy. This thesis explores Kretzmann and McKnight's asset-based community development (ABCD) (Kretzmann & McKnight, 1993), a strengths-based community development strategy, as a potential method of promoting health in culturally defined communities. The specific research question is: Is ABCD a suitable strategy for promoting health in culturally defined communities? Where a “suitable strategy” reflects health promotion and population health research; addresses the specific challenges associated with promoting health in culturally defined communities; and, is of practical use in terms of helping communities identify their health issues, develop plans to address these issues, implement these plans, and evaluate the plans.

Together, these three “suitability dimensions” incorporate both theoretical and practical expectations. The evaluation is accomplished through a cross-disciplinary literature review, individual interviews, and a focus group with key informants who are knowledgeable of health promotion issues in Vancouver’s Chinese communities. The information gathered through these interviews and the focus group is incorporated into the thesis as a small case study of ABCD’s potential in Chinatown/Strathcona and Richmond Chinese communities.

This evaluation suggests that on balance ABCD may be an appropriate approach for promoting health in culturally defined communities. Although the strategy lacks clear direction in terms of evaluation processes, may not help communities identify their health issues, and faces several challenges associated with power imbalances, these weaknesses are outweighed by its strengths, which are its focus on assets, emphasis on community empowerment, and reflection of the socio-ecological approach to health. For these same reasons, ABCD also shows potential as a health promotion strategy in both Chinatown/Strathcona and Richmond Chinese communities. While these conclusions are favourable, further research on evaluation of community-based health promotion programs and on health issues in culturally defined communities would improve ABCD's suitability as a health promotion strategy.
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PART 1: INTRODUCTION

Health related issues attract a significant amount of attention these days. Nearly every newscast includes a health segment, magazines are filled with tips for healthy living, and people consume all types of health related services that promise to do everything from reduce stress to assist weight loss. We now view health as not only the absence of disease, but as an overall state of well-being, and we are interested in how we can promote and maintain good health. While most of the media has concentrated on medical innovation and lifestyle changes, evidence suggests that health is determined by much more than biophysical characteristics, by the quality of health care services or even by lifestyle choices. As our understanding of the broader determinants of health such as socio-economic status and the social environment has matured, community development has emerged as a possible health promotion strategy.

The purpose of this thesis is to explore the potential of a particular form of community development, asset-based community development (ABCD), as a method for promoting health in culturally defined communities. ABCD was chosen as the strategy of interest because it reflects current planning trends toward participatory processes, empowerment, and capacity-building. ABCD is also of interest because it is a strengths-based approach to community development, which is a novel departure from the conventional needs-based perspective. The interest in health promotion in culturally defined communities is motivated by our understanding of culture as a determinant of health, and by Canada’s growing multiculturalism. The specific research question is:

*Is asset-based community development a suitable strategy for promoting health in culturally defined communities?*
A "suitable strategy" is here defined as one that:

1. reflects health promotion and population health research;
2. addresses the specific challenges associated with promoting health in culturally defined communities; and,
3. is of practical use in terms of helping communities identify their health issues, develop plans to address these issues, implement these plans, and evaluate the plans.

Together, these three "suitability dimensions" incorporate both theoretical and practical considerations. The three criteria are interrelated, as theoretical considerations can affect the implementation of ABCD, and conversely, ABCD's practical merits can affect how closely the strategy is able to match relevant research and evidence. If ABCD is to be a suitable strategy for promoting health in culturally defined communities, it should logically reflect the latest thinking in health promotion and population health, and it should be particularly sensitive to research linking health and culture. In addition to the theoretical strengths, ABCD should be reasonably practical, and in terms of community health promotion this means that the strategy should help communities identify their health issues, develop and implement plans to address them, and then evaluate these plans.

Because this is only an exploration of ABCD as a health promotion strategy, there will be no attempt to weight suitability dimensions. Prioritizing expectations and developing measures for determining levels is left to subsequent research. Further to these caveats, the strengths and weaknesses of ABCD identified in this thesis are only anticipated strengths and weaknesses, and have not been determined through an ex-post analysis of a completed ABCD project. The set of actual strengths and weaknesses
would certainly be dependant on the specific context, but could reflect the strengths and weaknesses discussed here.

The exploration is accomplished through a literature review that pulls information from many different disciplines, including sociology, planning, epidemiology, health promotion, and population health. The literature review will be supplemented by individual interviews and a focus group with key informants who are knowledgeable of health promotion issues in Vancouver's Chinese communities. The information gathered through these interviews will ground the evaluation in a specific context and will be incorporated into the thesis as a small case study.

The exploration relies on three key working definitions. The most fundamental definition is that of health. I have chosen to adopt Frankish et al.'s definition, which is “the capacity of people to adapt to, respond to, or control life's challenges and changes” (Frankish, Green, Ratner, Chomik, & Larsen, 1996). The concept of health as a resource for living is commonly cited in the health promotion literature and emphasizes health as a determinant of quality of life and not simply end in itself (World Health Organization, 1986).

The second key term is Asset-Based Community Development, which is a specific community development strategy developed by John Kretzmann and John McKnight, of Northwestern University, that focuses on strengths rather than deficiencies or needs. Although there are certainly other community development programmes that are strengths-based, ABCD here refers to the specific strategy outlined by Kretzmann and McKnight in Building Communities from the Inside Out (Kretzmann & McKnight, 1993) and is discussed in more detail in subsequent sections of this thesis.
The third term is *culturally defined community*. For the purposes of this thesis, a culturally defined community is any group that shares common beliefs, values and behaviours. Culturally defined communities are non-spatially defined communities, meaning that they may be geographically widely spread. Culture, as a set of shared beliefs, values and behaviours, is distinct from “race”, which is genetically determined. I have used the terms *culturally defined community* and *minority cultural community* interchangeably in this thesis, since several important health related distinctions arise between the majority and the minority cultural populations.

This thesis begins with a motivation section that summarizes the reasons for exploring community development as a health promotion strategy, and for the interest in health promotion in culturally defined communities, specifically. The next section rounds out the background portion of the thesis by outlining the main characteristics of asset-based community development. This section is then followed by the methodology, which outlines the various methods employed in this thesis.

Following the methodology section is the body of the thesis, which consists of a “strengths section” and a “weaknesses section”. The strengths section examines the anticipated advantages of ABCD as a health promotion strategy in culturally defined communities, while the weaknesses section considers the anticipated drawbacks of using ABCD for such purposes. To better illustrate these strengths and weaknesses, ABCD is discussed as a health promotion strategy in two distinct Greater Vancouver Chinese communities, Chinatown/Strathcona and Richmond. By referencing two communities that have similarities, but also important differences, the strengths and weaknesses and context-dependence of ABCD will become that much clearer. The final section, the
conclusion, summarizes the findings of the thesis and discusses implications of these conclusions and offers resultant recommendations.
PART 2: MOTIVATION

My interest in studying community development within a health context, and specifically as a strategy for promoting health in culturally defined communities, reflects current trends in health promotion, population health, and planning. These disciplines have converged on complementary themes, which together, support broad based efforts such as community development to improve and maintain health, particularly in culturally defined communities. Population health and health promotion have taken on a socio-ecological approach to health, defining health in its broadest terms and as the product of a wide range of interrelated factors, and it is from this perspective that community development's relevance as a health promotion strategy, and culture's importance as a determinant of health have become evident. Planning has further reinforced health promotion and population health's upstream perspective, itself adopting capacity building, empowerment, and intersectoral collaboration objectives, all of which complement the socio-ecological approach.

This section will briefly explain why this topic ought to be of interest to planners, why community development has been chosen as the health promotion strategy of interest, and why I have chosen to evaluate this strategy in culturally defined communities.

2.1 PLANNING AND HEALTH

Why should planners be interested in health? It might seem odd that a planning student would write a thesis about health promotion, but these two fields are actually far less disparate than might be expected. In fact, planning and health promotion share a common origin, as they both find their roots in the sanitary movement of the early 1840s
when, in response to appalling living and working conditions in early industrial cities, they coalesced around common issues concerning street layout and ventilation (Ashworth, 1954; Hebbert, 1999). The link between disease and overcrowding, unsanitary conditions, and poverty were clear. It was also clear that medical interventions alone could not solve these problems—as advocated by planning and public health, these challenges called for a more holistic approach, one that recognized socio-environmental factors as well as biophysical ones (Ashworth, 1954; Hebbert, 1999).

During the industrial revolution, the link between socio-environmental conditions and health was obvious—conditions were so horrendous that the relationship was hard to miss. Today, the factors that threatened health in early industrial cities are far less common and in many cases have been altogether extinguished, but the impact of other socio-environmental factors nonetheless remains significant. The socio-environmental determinants pertinent today, however, are perhaps less obvious, and so some planners may wonder how their contemporary skills as facilitators, community organizers, or advocates might be relevant to health promotion. What these planners may not realize is that these new planning skills are the very skills warranted by the “new health promotion,” which espouses participatory processes and capacity building (Robertson & Minkler, 1994). Indeed, as health promotion has evolved beyond medical interventions and behaviour modification programs to incorporate community development strategies, planning’s relevance to health may be as strong today as it ever was.

Planners should be interested in health issues not only because their skills seem well suited to health promotion, but also because they share the same social justice
objectives as put forward in health promotion. In this planning school, notions of social justice figure prominently in our formal education and certainly among the convictions of students and faculty. Our interest in social justice would be well served by taking an interest in health, as many determinants of health are linked directly to disadvantage. Certainly promoting health has become, at least in part, promotion of social justice causes, from affordable housing, to access to care, to poverty reduction. Therefore, given both our skills and our values, it seems logical that we, as planners, should be concerned about health related issues such as those explored in this thesis.

2.2 **COMMUNITY DEVELOPMENT AND HEALTH**

Over the past thirty years, health promotion and population health have influenced the way health is defined, modeled, and promoted. The approach to health has shifted from a *biomedical* perspective, to a *behavioural* perspective, and most recently to a *socio-ecological* perspective (see Figure 1). Each has implied a distinct set of policy responses and research agendas, and now the socio-ecological approach leads us to consider community development as a relevant health promotion strategy. Since the socio-ecological approach is in many ways a response to previous approaches, and so too then is community development a response to corresponding past health promotion strategies, it is worthwhile at this point to summarize this trend.

*Figure 1: Approaches to Health*

<table>
<thead>
<tr>
<th>Biomedical Approach</th>
<th>Behavioural Approach</th>
<th>Socio-Ecological Approach</th>
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<tr>
<td>Focuses on health care services as the primary determinant of health.</td>
<td>In addition to biophysical and health care services, emphasizes individual behaviours as determinants of health (e.g. smoking, exercising, diet).</td>
<td>Recognizes broad determinants of health, including biophysical, health services, behavioural, social and ecological factors.</td>
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Until the mid 1970s, “health” was conceptualized in a physiological sense, narrowly defined as the *absence of disease or injury*. The dominant approach to health was a biomedical one, which considered health care services as the primary determinant of health, and therefore sought improvements in health by way of improvements in health services. The biomedical approach was challenged in 1974 with the release of *A New Perspective on the Health of Canadians* (hereafter the Lalonde Report) (Lalonde, 1974). The Lalonde Report called for a broader approach to health and identified four key health factors: human biology, environment, lifestyle, and health care organization (Lalonde, 1974). Although the Lalonde Report identified the environment (both physical and social) as a key element and recognized that individuals have little or no control over it, health promotion nonetheless adopted a behavioural approach, which places the responsibility squarely on individuals to make healthy lifestyle choices. Accordingly, health promotion concerned itself with lifestyle modification and health education programs for behavioural change, such as familiar stop smoking and participation campaigns (Hancock, 1994).

Although health promotion’s attention to lifestyle and behaviour as determinants of health was an improvement upon the biomedical perspective, health promotion was later criticized for adhering to the individualist approach (Labonte & Penfold, 1981). In 1986, *The Ottawa Charter for Health Promotion* (World Health Organization, 1986), and *Achieving Health for All: A Framework for Health Promotion* (hereafter the Epp Framework) (Epp, 1986), shifted the focus away from lifestyle risk factors to an even broader, socio-ecological, conceptualization of health. These documents recognized not only human biology and individual behaviour as health determinants, but also
emphasized the impact of socio-economic status, community support, and the environment on health. The Epp Framework and the Ottawa Charter clearly implied more than health education programs, calling for social justice, equity and empowerment objectives (Epp, 1986; World Health Organization, 1986). The population health concept, which recognizes the interrelated nature of a broad set of determinants of health, was introduced a few years later, arguing further the merits of a socio-ecological perspective (R.G. Evans & Stoddart, 1990).

In health promotion, the socio-ecological perspective has encouraged an increasing interest in the social environment (see for example, Patrick & Wickizer, 1995), community level analysis (see for example, Robertson & Minkler, 1994), and empowerment and capacity building (see for example, Wallerstein, 1992, 2002). Accordingly, health promotion holds not only behavioural change goals, but a much wider set of objectives: community capacity building, empowerment, partnership building and community participation (World Health Organization, 1997). And to meet these objectives, health promotion employs a wide range of strategies including health communication, social marketing, health education, social support, community action for health, creating supportive environments, and developing healthy public policies (Bhatti & Hamilton, 2002), many of which directly compare with community development strategies. The relationship between health promotion and community development is transparent.

Population health evidence, which includes evidence on both individual level and population level determinants of health, further supports community development's potential as a health promotion strategy. In 1996, Health Canada released *Towards A*
Common Understanding: Clarifying the Core Concepts of Population Health, which identified ten major determinants of health: income and social status; social support networks; education, employment and working conditions; social environments; physical environment; biology and genetic endowment; personal health practices and coping skills; healthy child development; health services; and, gender and culture (Health Canada, 1996). Given the wide range of identified factors, population health policies focus on intersectoral collaboration, a strategy widely promoted within the planning field, to reduce inequities in health across populations. Indeed, as Yen and Syme note in their recent review of research on the social environment and health, the role for planners of all types (social, environmental, and physical) in promoting health has become clearer as the evidence supporting broad determinants of health has grown (Yen & Syme, 1999).

Planning has followed a similar trend as health promotion and population health, embracing many of the same objectives and strategies as those disciplines have within the socio-ecological perspective. Planning’s current zeitgeist now favours bottom-up, community-led processes to top-down, expert-led processes, clearly placing a large emphasis on public participation, empowerment, and capacity building (Friedmann, 1993; Healey, 1992; Sandercock & Forsyth, 1992). Like health promotion and population health, planning now focuses on upstream problem-solving strategies, preferring to tackle the cause of the problem, rather than only treating downstream symptoms. Asset-based community development was chosen as the strategy of interest for this thesis specifically because it embodies the most current planning principles. The more we learn about the determinants of health and the interplay among them, the
commonalities among population health, health promotion, and planning, especially community development planning, have become unmistakable.

2.3 CULTURE AND HEALTH

Like community development, culture’s significance to health has only recently been formally recognized in health promotion circles. In 1996, Health Canada added culture along with gender to its list of determinants of health (Health Canada, 1996). Culture impacts health in a variety of ways, including the way people interact with the health care system, how they participate in health promotion programs, how they access health information, what lifestyle choices they make, their conceptualization and understanding of health and illness, and their health priorities (Health Canada, 1996; Helman, 2000; Spector, 1996). Additionally, members of cultural minorities may suffer prejudice, harassment, and isolation, all of which can have a negative impact on health. And for many of the above reasons, the impact that culture may have, directly or indirectly through the other determinants of health, may predispose entire populations to be “at risk.” Only by recognizing culture’s impact on health, and affording it the formal weight as a determinant of health, can we hope to discover better ways of promoting health in these communities.

Population health evidence shows that culture has an impact on health, and the importance of culture as a determinant of Canadians’ health becomes more apparent as Canada becomes more multicultural. In 1996, 44% of the Canadian population reported origins other than British, French, or Canadian (Pendakur & Hennebry, 1998, p.2), and over 3 million Canadians reported to be a visible minority, up from 2.5 million reported in the 1991 census (Pendakur & Hennebry, 1998, p.18). The largest visible minority
groups are now the Chinese, South Asian and Black minority groups (Pendakur & Hennebry, 1998, p.22). Indeed, Canada is one of the world’s most multicultural nations. The motivation for focusing on culturally defined communities, then, is based not only on an understanding of culture as a determinant of health, but also on the fact that as Canada’s population becomes increasingly diverse, multiculturalism issues related to health become more significant.
Identifying the strengths and weaknesses of ABCD in a health promotion context first requires that we have an understanding of ABCD. It is key to understand not only the basic characteristics of ABCD as defined by John Kretzmann and John McKnight, but to also understand something of the context within which the strategy was developed. The context reveals the novelty of ABCD’s approach to community development, and it also helps us better assess the strengths and weaknesses of ABCD as a strategy to promote health in culturally defined communities.

Most simply, ABCD is a particular form of community development that emphasizes a community’s assets rather than its needs. Kretzmann and McKnight developed the strengths based strategy in the 1970s as an alternative to the usual needs-based strategies, which they believed were severely handicapping community development efforts (Kretzmann & McKnight, 1993, 1996; McKnight, 1985). By shifting the focus from needs to assets, McKnight and Kretzmann argue that communities are better able to build internal capacity to address issues for themselves, rather than relying on outside experts or professionals. From an asset-based perspective, the glass is half full rather than half empty.

Kretzmann and McKnight developed ABCD originally to address community economic development issues in low-income neighbourhoods in the United States. They believed that not only had needs-focused community development strategies failed to bring about meaningful community change, but that the focus on needs had actually cultivated the sense of hopelessness in these neighbourhoods (Kretzmann & McKnight, 1993; McKnight, 1985). These neighbourhoods had for so long been characterized by
their needs and deficiencies that they began to believe that they were unable to contribute to their own development. Given that it was highly unlikely that these communities would receive significant outside resources, the most reasonable response was to build capacity within, by mobilizing the community’s internal strengths and assets (Kretzmann & McKnight, 1993).

By emphasizing a community’s own assets, ABCD lessens the importance of outside professionals and experts. ABCD is an application of the ideas McKnight developed throughout the seventies and eighties and later published in 1995 in The Careless Society, where he concludes that the professionalization of “care”, enabled by a focus on needs, has generated communities of clients, rather than citizens, highly dependent on outside help from experts (McKnight, 1995). Professions that profess to “care”, including the medical professions, McKnight argues, have become poor and common substitutes for caring among citizens (McKnight, 1994, 1995). Caring has become proprietary, and these proprietary interests are protected by a focus on needs since the needier a community feels it is, the more it is convinced it requires these caring services (McKnight, 1994, 1995).

McKnight’s arguments in The Careless Society are to a significant degree reflected in current community development trends, and especially in current thinking regarding the role of the expert in community development. The planner as the “expert” and “technician” has given way to the planner as “facilitator” and “mediator” (Healey, 1992; Innes, 1998). Planning has shifted from a top-down, expert driven process, to a bottom-up, community led process that downgrades the role of the “expert”. As represented by Arnstein’s ladder of participation, planning operates preferably at the top
rung, where communities take ownership of the process, rather than at lower rungs, where communities are only token participants (Arnstein, 1969). Community development planning no longer means only community-based consultation, but community ownership of the process and the outcome.

Kretzmann and McKnight define ABCD as “asset-based”, “internally focused”, and “relationship driven” (Kretzmann & McKnight, 1993). Each of these elements along with a comparison of needs-based and asset-based assessment strategies is discussed below.

3.1 ASSET-BASED

As already mentioned, the defining characteristic of ABCD is that it is asset-based rather than needs-based. This focus on assets, however, is just that, a focus, and does not disregard the fact that communities may have real needs. Lack of employment opportunities, poor housing conditions, or inadequate daycare facilities are all real needs, and it is often the case that communities initiate action precisely because of these kinds of identified needs. However, focusing on assets, rather than needs, is more likely to produce long lasting solutions (Kretzmann & McKnight, 1993).

Community development strategies usually begin with some form of community assessment before any policy or program is initiated. Often these assessments are needs-assessments that focus on identifying the needs and deficiencies in a community, such as rates of unemployment, of homelessness, or of drug addiction. Asset-mapping, the first stage of ABCD, is an asset-focused assessment method that identifies and records a community’s various assets. According to Kretzmann and McKnight, communities have individual assets, associational assets, and institutional assets, all of which can play a
role in the community’s development (Kretzmann & McKnight, 1993). For example, a local youth group may be considered an associational asset, schools and churches may be institutional assets, and seniors may be able to contribute individual assets.

Interestingly, Kretzmann and McKnight do not appear to offer any more formal a definition of “asset.” Perhaps the many examples of individual, associational, and institutional assets they provide in their guide are sufficiently illustrative. For clarity, however, it is useful to find a working definition of “asset” for this thesis. From what can be inferred from Kretzmann and McKnight’s work, an asset is any thing (which can be expressed at the individual, associational, or institutional level) that holds promise of value in the process of a community’s development. This definition implies that a wide range of skills, knowledge and resources may be mobilized to be valuable in the community development process.

These assets can be identified in any number of ways: by using local directories such as the Yellow Pages, conducting personal interviews, or simply by walking through neighbourhoods and noting assets. An asset-map for health promotion will most likely include formal health institutions, and also a variety of organizations in the informal health sector, plus individual capacities that help create and support health. Since there are no formal requirements on what qualifies as an asset, it is entirely up to the community to determine what to include in their asset-map.

Associational and institutional assets are likely more easy to identify than individual assets. Sussing out individual assets truly requires a mind shift to an asset-based approach. The biggest challenge is getting past labels and stereotypes. As Kretzmann and McKnight argue, labels reveal only deficiencies, such that the “homeless
person", the "disabled person", the "pregnant teen" are all seen as needy (Kretzmann & McKnight, 1993). A comprehensive asset-map, however, recognizes and records the assets these individuals possess—talents that usually go unnoticed and untapped.

It is key to keep in mind that asset-mapping is not an end in itself, but a tool for community development. The asset-map is only descriptive, but it is used in ABCD to infer possible relationships and lines of causality as the first step in the community building process. Community cannot be built from needs—needs can only be treated—but must be built from strengths, and therefore a community’s asset-map becomes its foundation for community development (Kretzmann & McKnight, 1993). As explained below, the community building process begins by using the asset-map to cultivate relationships among the various assets in a community.

3.2 INTERNALLY FOCUSED

Just as the section on assets began with a caveat, so too does this section. ABCD is internally focused, but it does recognize that outside resources are important and sometimes necessary for a community’s development. Kretzmann and McKnight argue, however, that relying on external solutions only reinforces dependence and does not contribute to true community building (Kretzmann & McKnight, 1993). In many instances, an external solution, which usually means capital, may not be likely.

It must also be noted that internal and external resources are not intended to be portrayed as mutually exclusive or independent categories in ABCD. The line between the "inside" and the "outside" is not as tidy as it might seem. Certainly, internal assets can be linked to external resources, which are resources that are completely beyond the control of the community, and an asset that is only partially controlled by the community
may be considered an internal resource. The operationalization of internal and external resources is highly reliant on how community boundaries are defined and how power is distributed within the community and how power is distributed between the community and the state.

ABCD mobilizes resources within the community rather than relying on an inflow of outside resources. In the case of low-income neighbourhoods, this seemed to Kretzmann and McKnight an exceedingly obvious and necessary component of any community economic development effort in these communities, since it was highly unlikely that these communities would ever be the benefactors of a large influx of resources (Kretzmann & McKnight, 1993). An internal focus serves capacity-building efforts well since it encourages the community to build on its strengths and find its own sustainable solutions. ABCD's internal focus, however, certainly should not be construed as justification for the public sector to withdraw from public programs that support community development. The argument is that by building sufficient capacity within the community, the community is better able to control and determine how outside resources can be best employed. The community takes charge of how these outside resources will affect their community, rather than passively receiving outside help (Kretzmann & McKnight, 1993).

3.3 RELATIONSHIP DRIVEN

And finally, ABCD is relationship driven. Once the assets have been identified and documented through an asset-map, the community development process begins by building connections between these assets. This step is critical; otherwise the asset-map would remain only a descriptive list and not become a community development tool.
Relationships are built between individuals and associations; associations and institutions; institutions and individuals, and so on. These relationships then become the backbone of the community’s capacity (Kretzmann & McKnight, 1993). Relationships need not be new ones, but can also be formed from existing ones. ABCD mobilizes existing relationships between close friends, just as it builds new relationships among strangers. The existing relationship would not necessarily remain unchanged, however, but would be mobilized for new and collective community development purposes.

3.4 ASSET-FOCUSED ASSESSMENT VS NEEDS-FOCUSED ASSESSMENT

In order to fully explain how asset-based strategies compare with needs-based strategies, it is useful to compare stylized versions of each (stylized versions are used for illustrative purposes only, while in practice, assessment methods combine characteristics of both strategies). This comparison serves not only to further explain what is meant by a focus on assets, but also to introduce a number of issues that are critical to the evaluation of ABCD as a health promotion strategy.

Asset-focused assessment methods are in direct response to the shortcomings of traditional needs-focused assessments. Kretzmann and McKnight identify eight drawbacks of the needs approach as it is applied in low-income neighbourhoods in the United States (see Table 1). They argue that needs based approaches emphasize survival rather than community development or change, as it reinforces the notion that only outside experts can solve the problems. These communities, based on their needs map, spend much of their energy and resources emphasizing these needs in order to secure this outside help. Worse yet, when outside resources are secured, they flow to service providers rather than residents (i.e. to the social worker rather than the single mom).
needs perspective becomes so pervasive that even residents begin to believe it, defining their own communities by only its deficiencies. Labelling a community as "needy" implies dependence (Kretzmann & McKnight, 1993).

Table 1: Comparison of Needs-Focused Assessment and Asset-Based Assessment

<table>
<thead>
<tr>
<th>Needs-Focused Assessment</th>
<th>Asset-Based Assessment</th>
</tr>
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<tbody>
<tr>
<td>• Residents begin to accept the needs map as their reality.</td>
<td>• Residents begin to believe in the assets in their community.</td>
</tr>
<tr>
<td>• Fragments efforts to find solutions.</td>
<td>• Consolidates efforts to find solutions</td>
</tr>
<tr>
<td>• Funding targeted to service providers rather than residents.</td>
<td>• Funding targeted to residents rather than service providers.</td>
</tr>
<tr>
<td>• Leaders must emphasize problems in order to secure resources.</td>
<td>• Leaders emphasize assets in order to secure outside resources.</td>
</tr>
<tr>
<td>• Reinforces notion that only outside experts can solve the problems.</td>
<td>• Internally focused—begins with available resources.</td>
</tr>
<tr>
<td>• Ensures cycle of dependence.</td>
<td>• Breaks cycle of dependence.</td>
</tr>
<tr>
<td>• Targets individuals rather than the entire community.</td>
<td>• Targets the entire community.</td>
</tr>
<tr>
<td>• Emphasizes only survival rather than community development/change—leads to feeling of hopelessness.</td>
<td>• Enables community development and change.</td>
</tr>
</tbody>
</table>

Adapted from (Kretzmann & McKnight, 1993).

Others support the arguments articulated by Kretzmann and McKnight against needs-based approaches, preferring to take a strengths-based perspective (Cowger, 1994; Hancock & Minkler, 1997; Marti-Costa & Serrano-Garcia, 1983; Saleebey, 1996). As outlined in Table 1, an asset-based or strengths-based perspective is essentially the opposite of a needs-based approach, at least as they are presented here in stylized versions. Rather than fostering dependence, asset-based approaches reinforce a community's assets in order to build towards community development and change. An
asset-based approach encourages the entire community to rally around community assets in a consolidated effort to find solutions. Outside resources are secured through emphasis of assets, and these resources, once secured, flow to residents according to the asset-map, rather than to service providers. It is worth reiterating at this point, that asset-based community development does not offhandedly dismiss needs, deficiencies or problems, but only shifts emphasis away from needs to strengths.

3.5 **ABCD PROJECTS**

To better explain how ABCD is actually employed, a brief example from Denver, Colorado is outlined below. Also included is a brief overview of two ongoing ABCD projects for health promotion.

3.5.1 *An ABCD Example: Connecting Neighbours*

A brief example from Denver, Colorado illustrates a simple application of ABCD (for more information on this case see Kretzmann and McKnight, 1993). The Southwest Improvement Council, a local neighbourhood organization, employed the ABCD technique to find a way to help homebound residents (seniors and disabled people) with their outdoor chores. Rather than drawing on professional services available only outside the immediate neighbourhood, the Southwest Improvement Council chose to capitalize on its neighbourhood’s own capacities to help the homebound residents. Using the asset-mapping approach, the organization surveyed local residents about their skills and willingness to contribute. The asset-map, which detailed what kinds of skills each individual had along with the amount of time they were willing to contribute, was then used to connect neighbourhood “helpers” with those who could use the assistance. Quite simply, the Southwest Improvement Council compiled an inventory of assets and
then used this inventory to build appropriate relationships. The "helpers" then cleared snowy sidewalks or mowed lawns as required. The ABCD method was not only effective at addressing the difficulties homebound residents had caring for their property, but also built a stronger sense of community by way of fostering new connections among residents.

3.5.2 *ABCD Projects for Health*

ABCD has been applied primarily for community economic development (Asset-Based Community Development Institute, 2002). ABCD has also been applied in culturally defined communities, again most often for community economic development. Examples of ABCD, as specifically defined by Kretzmann and McKnight, within a health context are much fewer, but growing. Although a few commentaries on ABCD’s relevance to health promotion are found in the literature (Kretzmann, 2000; McKnight, 1994, 1995; Parks & Straker, 1996), there does not appear to be any studies of ABCD employed as a health promotion strategy in the published academic literature, but we do know that ABCD is being applied to promote health. Two instances are particularly relevant to the research question posed here: Community Building Resources’ work in Alberta, and the New York State Health Department’s ABCD project in New York.

Community Building Resources is a private company in Edmonton that has developed a process called Community Capacity Building and Asset Mapping (CCB & AM), modeled after ABCD. They are currently involved in a project with the University of Alberta, Centre for Health Promotion Studies and the Jasper Place Gateway Foundation, a local community organization, to assess the efficacy of CCB & AM in creating a "Healthy Community" movement. The Jasper Place community is interested
in improving a wide range of factors including health and well-being, economic well-being, visual appeal, safety, and social connections. Community Building Resources is currently writing its final report on this project. For further information see Community Building Resources’ web site at www.cbr-aimhigh.com.

The New York State Minority Health Department is in the second year of a three-year project to promote the use of ABCD in health promotion within the state. Applicants are required to prepare asset-maps to secure funding, and to show evidence of an ABCD process. The Minority Health Department just recently evaluated the degree to which each group was able to mobilize their assets, and preliminary results of a survey of these participants and a report of the project’s progress thus far is due out later this year. For further information see the Minority Health Department’s web site at www.health.state.ny.us.
PART 4: METHODOLOGY

This thesis makes use of multiple methods including a literature analysis, key informant interviews, and a focus group. The literature review forms the basis of the exploration of ABCD's suitability as a health promotion strategy, while the interviews and focus group augment this information with specifics on health promotion in two Greater Vancouver Chinese communities.

4.1 LITERATURE ANALYSIS

Although this thesis does not include a specific literature review section, the analysis is based heavily on information gathered from the health promotion and population health literature. While the review of the literature was not an exhaustive review, several electronic journal indexes were searched for relevant information in psychology, social work, sociology, planning, and the health disciplines. Searches of PubMed, Medline, Geobase, Social Work Abstracts, and PsychInfo were conducted using a variety of keywords including health promotion, community, community development, assets, and culture. I also searched the UBC library catalogue for relevant publications using similar keywords. The most useful method of identifying key publications was the use of the Social Sciences Citation Index and the Science Citation Index to trace cited articles. Review articles were particularly helpful at leading to other references.

The internet was a key information source for gray literature, literature that is not published in academic journals or as books. I appealed to a number of gray literature sources such as government web sites, particularly Health Canada's site, and Northwestern University's Asset-Based Community Development Institute's web site. I
also conducted general internet searches using the Google search engine to find further information that does not appear in the published academic literature, such as working papers and conference proceedings.

The literature was analyzed by searching for themes that would help determine whether ABCD is a suitable strategy for promoting health in culturally defined communities. As this thesis is exploratory, I had not determined which specific themes I would concentrate on until I had become more familiar with the health promotion literature. Early in the literature review it became apparent that empowerment, the strengths perspective, evaluation, and the socio-ecological approach to health were the most relevant themes. The literature was then further synthesized according to the three suitability dimensions mentioned in the introduction: population health and health promotion research; health promotion in culturally defined communities; and practicality of the method. Once the information was grouped into these categories, I was then able to delineate ABCD's strengths from its weaknesses.

4.2 INTERVIEWS

The purpose of conducting key informant interviews was to gain expert insight into the potential of ABCD as a health promotion strategy, and also to buttress information gleaned from the literature with specific information on ABCD and health promotion in Chinatown/Strathcona and Richmond, two of Greater Vancouver's Chinese communities.

Interviewees were selected based on their knowledge of community development, health promotion, or the two Chinese communities. Most of the interviewees were already known to my supervisors, who provided me with their contact
information, or the interviewee was recommended to me by another interviewee (the snowball method). All interviewees are professionals in government, non-governmental organizations, academia, or are community leaders—no lay people were interviewed (Appendix A lists occupations of interviewees). In large part, interviewees were chosen specifically because of their professional role. A total of eight interviews were conducted as the interview process was severely limited by the dissolution of the Vancouver/Richmond Health Board in late 2001. Interviews with remaining employees under the new Vancouver Coastal Health Authority or with terminated employees was simply not permissible given the recent upheaval.

Each interview lasted approximately one hour and where possible, was conducted in person at the office of the interviewee. For those residing outside of the Lower Mainland, interviews were conducted by phone. The interview was semi-structured, and roughly followed the interview questions attached as Appendix B. The questions are all open-ended and ask basic information about the interviewee's relevant experience and their thoughts on community development and health promotion. Interview questions were modified to fit the expertise of the interviewee, such that community development experts received more community development questions, and health promotion experts received relevant health promotion questions. I did not tape record interviews, feeling that I had no need for verbatim quotations in my analysis of ABCD.

Much like the literature analysis, interview notes were scanned for information that might be pertinent to the three suitability dimensions mentioned earlier. The information, to a large extent, collected from the interviews should be considered only anecdotal since the objective of the interviews was not to systematically determine
trends or find a consensus of beliefs or attitudes, but to only explore the concepts and issues.

4.3 **FOCUS GROUP**

I also had the good fortune to sit in on a focus group led by my supervisors on the topic of ABCD and health promotion in culturally defined communities. The purpose of the workshop was to introduce the possibility of conducting a research project on ABCD and health promotion in local Chinese communities, to gauge interest in such a project, and to begin to build relationships with possible collaborators. I first met most of the individual interviewees through this focus group. Although I did not formally collect information at this focus group, the information gleaned from this meeting did provide me with a good starting point for the remainder of the thesis research.
PART 5: STRENGTHS

This thesis is an assessment of ABCD’s strengths and weaknesses as a potential health promotion strategy in culturally defined communities. The strengths identified in this section are not, in general, independent of the weaknesses identified in the following section. Rather, ABCD’s strengths and weaknesses are closely related to one another, such that a strength may directly correspond to a weakness. This arises because most of ABCD’s attributes have both positive and negative aspects.

ABCD’s anticipated strengths are identified by comparing ABCD’s characteristics to current thinking in health promotion and population health, with a particular focus on the challenges of promoting health in culturally defined communities. ABCD seems to be well suited for promoting health in a cultural context because it is amenable to the socio-ecological perspective on health; asset-based; a bottom up process that promotes empowerment and capacity building; and a process that balances structuralist and individualist approaches. Although these strengths have been listed here separately, as the following discussion reveals, these strengths are closely related, often overlapping and reinforcing one another.

5.1 SOCIO-ECOLOGICAL PERSPECTIVE

It is widely accepted that health is determined by much more than health care services. Health Canada’s list of determinants of health includes a wide variety of factors, from the most conventional, health care services and biology, to much more broad-based variables such as social support networks, gender and culture (Health Canada, 1996). This list clearly implies that not all health challenges can be appropriately addressed from the traditional biomedical perspective, but must be
approached from a broader socio-ecological perspective, which recognizes the importance of both medical and non-medical factors and the interactions among them across individual and community levels. ABCD’s principal strength is that it reflects this wider perspective, and puts into practice some of the very latest thinking in health promotion and population health.

5.1.1 From Individual to Community

One of the major changes in the approach to health has been the shift from an individual level focus to recognition of group and community level variables (Cashman & Fulmer, 1994; Patrick & Wickizer, 1995; Raphael et al., 2001; Taylor & Repetti, 1997). It is now commonly held that determinants of health operate not only at the individual level but also at the group and community levels. Although it is uncertain exactly how group and community level factors influence health, whether they influence health directly or have a mediating effect on risk factors, substantial evidence suggests that community characteristics and community processes do have an impact on both health behaviours and health outcomes (for a review see Patrick & Wickizer, 1995). Figure 2 shows the plausible connections between community and health—the relationship between community and health is clearly multifaceted and complex.

The simple series of questions posed in the Second Report on the Health of Canadians reveals how individual illnesses or disease can be easily related to factors at other levels, beyond the influence of the individual:

*Why is Jason in the hospital?*
*Because he has a bad infection in his leg.*

*But why does he have an infection?*
*Because he has a cut on his leg and it got infected.*

*But why does he have a cut on his leg?*
Figure 2: Model of the Relationship Between Community and Health

Source: (Patrick & Wickizer, 1995, p.67)

Because he was playing in the junkyard next to his apartment building and there was some sharp, jagged steel there that he fell on.

But why was he playing in a junkyard? Because his neighbourhood is kind of run down. A lot of kids play there and there is no one to supervise them.

But why does he live in that neighbourhood? Because his parents can't afford a nicer place to live.

But why can't his parents afford a nicer place to live? Because his Dad is unemployed and his Mom is sick.

But why is his Dad unemployed? Because he doesn't have much education and he can't find a job.

But why ...? (Federal Provincial and Territorial Committee on Population Health, 1999, p.vii)

What appears on the surface to be an individual problem is linked to circumstances that the child has no control over—his physical environment, community
socio-economic status, his father’s education level, and so on. The child’s physical environment, the factor that is most directly related to his injury, is nested within his parent’s and his community’s socio-economic status. Different levels of socio-economic status engender different risk factors, and in this example, low socio-economic status increased the risk that the boy would be playing in an unsafe environment. Due to the nested nature of health determinants, if the boy had lived in a wealthy community, he likely would not have been playing in a junkyard and would not have cut himself.

Setting the individual as the unit of analysis, as do the biomedical and behavioural approaches to health, disregards these types of important contextual factors that may not only be beyond the control of the health care system or the individual, but may also be beyond the perception of either. No behavioural modification program could appropriately address these issues, and the formal health care system is largely reactive, responding only to individuals who present themselves as having health care needs, and is unable to address community level factors, which fall outside this definition of need. The health care system, as a health promotion tool, is largely insensitive to community level factors.

The fundamental problem with individual level analysis is that the non-biomedical determinants of health do not reveal themselves at that level. Non-biomedical determinants are embedded in social structures at the mezzo level (i.e. family, neighbourhood) and at the macro level (i.e. provincial, national) (Frankish, Kwan, Flores, Rootman, & Hancock, 2002). An individual’s or a community’s health must be understood in terms of a multitude of factors that operate across these levels, such that improvements in individual or community health are much more likely if
interactions among these factors across levels are acknowledged (Frankish, Kwan, Flores et al., 2002).

ABCD, like all community development strategies, takes the community, rather than the individual as the relevant unit of analysis and intervention. ABCD pays close attention to context, indeed engaging the context (meaning the community and its assets) in its own development. Because ABCD is a community development strategy rather than a medical intervention or health education program, it tackles upstream causes that exist at the community level, rather than downstream symptoms presented at the individual level. By taking a community wide perspective, ABCD is sensitive to the relationships between individuals and their immediate environment (both social and physical) and the impact these relationships can have on health.

5. Broad Determinants of Health

ABCD has the potential to positively impact many broad determinants of health. Socio-economic status, social support networks, and culture are focused on here because each of those determinants of health is particularly relevant to ABCD’s strengths as a potential health promotion strategy.

5.1.2 Socio-economic status

Socio-economic status, which is usually measured as income, education and occupation, is perhaps the most well substantiated and accepted non-medical determinant of health (Brunner, 1997; Robert G. Evans, Barer, & Marmor, 1994; Yen & Syme, 1999). In Toward a Healthy Future: the Second Report on the Health of Canadians, Health Canada found that people with higher incomes generally live longer and healthier lives than people with lower incomes and that educational status and working conditions
are important determinants of health (Federal Provincial and Territorial Committee on Population Health, 1999). Furthermore, Yen and Syme in their review of epidemiologic studies of the social environment and health, note that research clearly shows that individual social and economic status has a bearing on health, and there is now growing evidence to suggest a relationship between an area's socio-economic status and mortality risk, morbidity, and health behaviours (Yen & Syme, 1999).

Medical interventions cannot, to any significant degree, influence socio-economic status, and it would be simplistic to believe that behavioural changes alone could improve social and economic conditions. Any sustainable solution must recognize context, and context that is not limited to only the health sector, but includes factors that cuts across sectors and levels, from the individual to the community. ABCD is designed to mobilize a wide variety of assets in many sectors to promote the intersectoral collaboration required to address determinants such as socio-economic status. Notably, ABCD was originally designed to tackle economic development issues in low-income neighbourhoods in the US. Given the impact that income has on health, it is likely that ABCD's influence on economic development could translate to improvements in health.

5.1.2.2 Social Environment

Social networks (Cattell, 2001), social capital (see for excellent reviews Hawe & Shiell, 2000; Macinko & Starfield, 2001), and social cohesion (Haan, Kaplan, & Camacho, 1987; Kawachi & Kennedy, 1997; Lasker, Egolf, & Wolf, 1994; Lomas, 1998), all of which stress the importance of the social environment, have garnered considerable attention as potential determinants of health. Though the distinctions between the concepts and the relationships among them is much debated and much
misunderstood (Labonte, 1999), there is certainly enough evidence to suggest that various aspects of the social environment, however labelled, have a bearing on health and warrant closer examination. Indeed, as Lomas concludes in his review of the social, behavioural, and biomedical literatures, community level interventions fare well against individual medical approaches for the prevention of deaths due to heart disease, and increasing social support and or social cohesion in a community is at least as worthy of exploration as improved access or routine medical care (Lomas, 1998).

This emphasis on social relationships, civic participation, trust, identity, and reciprocity in the health literature matches well with ABCD, as ABCD builds community by building relationships among individuals, associations, and institutions. In effect, ABCD establishes networks of caring, and not only among individuals, but also among associations and institutions. Even if the community chooses to focus its efforts on developing a healthy eating campaign, or securing funds for a piece of medical equipment for its local hospital, although these ends may have little to do with improving the social environment, the means is nonetheless focused on relationship building. Regardless of the nature of the plan the community creates, implementation of that plan involves relationship building, which positively affects the social environment.

5.1.2.3 Culture

While members of a cultural group may share biological and genetic characteristics that predispose them to certain diseases and illnesses, the impact of culture on health is certainly not limited to biomedical factors. Culture influences a wide range of factors that can have an impact on health including health beliefs, lifestyle and behaviour choices, interactions with the health care system, plus a variety of socio-
environmental factors, such as prejudice or racism, that are linked to culture (Health Canada, 1996). Johnson, in a review of macrosocial and environmental influences on the health of cultural minority groups in the US, found that for each minority, their sociocultural background was a determinant of observed health effects (Johnson, 1995). Thus, while socio-economic status, or any similar health determinant, may have an impact on health for all populations, larger structural forces may increase the likelihood that some cultural minorities suffer lower education and income levels, and therefore, diminished health.

The structural disadvantages some minority cultural communities face can include racial discrimination and social disadvantage. While discrimination and social disadvantage can affect health directly, these structural problems can also result in an unfavourable distribution of resources and inappropriate planning and delivery of health care services (Blakemore, 2000). ABCD, as a community development strategy, may be suitable for altering these types of circumstances. Again, the strengths of ABCD are its community-wide perspective and its emphasis on empowerment and capacity-building. Instead of directly treating the disease or illness, ABCD concentrates on helping communities modify underlying conditions, such that they could mobilize their assets to gain resources and influence health services delivery.

5.2 ASSET-BASED

ABCD’s focus on assets rather than needs is perhaps its defining strength as a health promotion strategy. As described in generic terms in the Motivation section, asset-based approaches are preferred to needs-based approaches because they: help communities believe in their strengths; consolidate efforts to find solutions; target
funding to individuals rather than service providers; encourage leaders to emphasize assets rather than deficiencies; focus on available resources; break the cycle of dependence; target the entire community; and enable community development and change (Kretzmann & McKnight, 1993). This section builds on that discussion to highlight the salient advantages of asset-based approaches specifically within a health context.

5.2.1 Health Needs versus Health Care Needs

Shifting from a needs-focus to an assets-focus reduces a number of difficulties with using needs as the basis of assessment and intervention for promoting health. Health needs are often misconstrued as “health care needs”, thus correlating “needs” to available medical interventions (Robert G. Evans et al., 1994). And because needs are narrowly defined by the ability to benefit from a medical intervention, many needs that either are not medical in nature, though still related to health, or are medical in nature, but for which no medical treatment exists, go unrecognized and unmet (Robinson & Elkan, 1996). The tendency to misinterpret health needs as only health care needs, much as McKnight argues in The Careless Society (McKnight, 1995), allows professional service providers not only to appropriate caring from the community, but also to manage to define caring. Thus, this medicalization of health needs serves only to reinforce the status of health care service providers and precludes citizens from contributing their strengths and abilities to health promotion efforts in their own communities.

Moreover, these health needs are shaped not only by personal experience and culture, but also by corporate objectives, as the health industry, through media and advertising, shift health expectations for increased profit. This strategy is most apparent
within the pharmaceutical industry, which participates in what Moynihan et al describe as “disease mongering” (Moynihan, Heath, & Henry, 2002, p.896) where firms sponsor and promote “treatable” diseases to widen their markets for treating them. The industry accomplishes this by: classifying ordinary processes of life as medical problems; portraying mild symptoms as indications of serious disease; construing personal or social factors as medical ones, conceptualizing risks as diseases; and framing disease prevalence estimates to maximize the size of a medical problem (Moynihan et al., 2002). Thus individuals are led to believe that they “need” pharmaceuticals even if there is little or no justification for using them. While needs are difficult enough to distinguish from wants in the absence of corporate interference, “disease mongering” makes it even more difficult to reconcile what an individual would perceive as needs, and what policy makers would judge to be reasonable and justified needs.

Additionally, not all health needs are health losses—healthy individuals also wish to stay healthy (Robinson & Elkan, 1996). Given that needs are commonly defined as health losses, focusing on only needs may disregard the importance of proactive and preventative strategies for maintaining good health, strategies that often operate outside of the health care system. Needs assessments based on health losses disregard the healthy segment of the population. Focusing on assets may be more successful at recognizing the needs and assets of both healthy and unhealthy people, thus constructing a more complete picture of a community’s health.

Due to this tendency to define and manipulate needs to match health care services, needs may not be a reliable basis for solutions. This is not to argue that by focusing on assets, these difficulties with defining needs no longer exist. ABCD still
acknowledges needs, and the challenges of measuring health needs cannot be underestimated even then, but that by focusing on assets, rather than needs, these difficulties may figure less prominently in defining the solution. Assets, rather than needs, become “the rallying point for bringing citizens together” (Sharpe, Greaney, Lee, & Royce, 2000, p.206). While needs may certainly be central and relatively well-defined in the emergency room, needs need not figure as prominently in preventative and proactive health promotion efforts such as community development. Indeed, it is argued that community can be built from only strengths and capacities, and not from needs, however defined (McKnight, 1985, 1994).

5.2.2 Identifying Assets for Health

The very process of identifying and recording assets allows communities to express their own definition of health and define corresponding assets for health. Unlike a needs focus that is predicated on largely matching needs to existing health services, a focus on assets allows communities greater flexibility to define their own unique set of assets. This is particularly important for culturally defined communities whose health assets may not conform to the Western biomedical notion of health, which validates only a narrow set of formal health care assets. Instead, an asset’s legitimacy as a “health asset” is determined entirely by the community, and is therefore much more likely to be culturally appropriate. Given that informal care giving and traditional medicine (which both lie outside the Western formal health care system) have been shown to play a significant role in health promotion in cultural minority communities (Lillie-Blanton & Hoffman, 1996; Yee & Weaver, 1994), an assessment process such as asset-mapping, which recognizes these as assets, is especially valuable and appropriate.
Furthermore, unlike traditional medical interventions, which imply that what is most important about an individual is her disease or illness (Cowger, 1994; McKnight, 1994; Saleebey, 1996), ABCD, while it acknowledges those real needs, emphasises that an individual’s assets are more important. Because an asset-map is assembled from a “glass half full” perspective, the process of identifying assets serves empowerment and capacity building objectives, which are further discussed in following sections.

5.2.3 Assets and Community Acceptance

A program that focuses on assets may be easier for the community to accept than a program based on needs. This distinction may be especially salient in cultural minority communities that have been for so long defined and stereotyped from the outside by their health deficiencies (for example the Aboriginal population). For communities that have been defined by their deficiencies, such as substance abuse or poverty, the community may not welcome yet another intervention that underscores these challenges, while overlooking their strengths. Programs that emphasize needs only serve to reinforce these negative stereotypes (Kretzmann & McKnight, 1993; McKnight, 1994).

5.3 Bottom-up Processes: Empowerment and Capacity Building

The trend in health promotion is towards the socio-ecological perspective on health and towards “bottom-up” processes that are both empowering and build capacity (Bracht, 1999; Minkler, 1997). As a community development strategy, empowerment and capacity building are central principles of ABCD, matching ABCD closely to health promotion objectives.
5.3.1 Empowerment

The shift from the biomedical model to the socio-ecological model has generated new interest in empowerment in the health field. Wallerstein in her review of empowerment and health, defines empowerment as “a social-action process that promotes participation of people, organizations, and communities towards the goals of increased individual and community control, political efficacy, improved quality of community life, and social justice” (Wallerstein, 1992, p.198). Wallerstein’s definition reveals the multidimensionality of empowerment, which is commonly conceptualized in the literature as individual empowerment, organizational or small group empowerment, and community empowerment. At the individual level, empowerment is about a sense of personal control and self-worth; at the organization or small group level, empowerment is the ability of an organization to influence policies and decisions in the community; and at the community level, empowerment is collective action to secure resources and influence larger social and political systems (Clark & Krupa, 2002; Israel & Checkoway, 1994; Wallerstein, 1992). At the individual level, empowerment outcomes are largely subjective, in terms of subjective feelings of self-worth and personal sense of control, but can also be more objective in terms of skills and proactive behaviours (Fetterman, Kaftarian, & Wandersman, 1996). At the community level, empowerment is reflected in objective measures of power such as income, housing conditions, social status, and employment (Bracht, 1999; Clark & Krupa, 2002). Although the relationships among the levels of empowerment are far from clear (Clark & Krupa, 2002), it might be expected that individual empowerment facilitates community empowerment and community empowerment, in turn, fosters individual empowerment (Bracht, 1999; Wallerstein, 1992).
Empowerment has become a central tenet of community development practice because of its link to emancipation. In health promotion, empowerment is recognized as an important objective not only because of the underlying notions of social justice, but because empowerment, and its converse, powerlessness, have been shown to have an impact on health (for reviews see Wallerstein, 1992, 2002). Powerlessness, as it is experienced through being poor, low in the hierarchy, without control, or living in chronic hardship, has been shown to be a broad risk factor (Israel & Checkoway, 1994; Wallerstein, 1992). While powerlessness may be a risk factor, research on community empowerment suggests that an empowered community can have positive impacts on health. Community empowerment enhances health by improving social support networks, community competence, sense of community and control over resources (Neighbors, Braithwaite, & Thompson, 1995; Wallerstein, 1992).

Although it is possible to implement programs that operate at only the individual level or only the community level, interventions that consider empowerment at both levels are more likely to bring about real health improvements (Israel & Checkoway, 1994; Robertson & Minkler, 1994). ABCD’s strength is that it can potentially address multiple empowerment dimensions. At the individual or psychological level, ABCD can improve empowerment by emphasizing an individual’s assets. Instead of labelling individuals by their deficits or needs, the strategy encourages individuals to contribute their strengths. ABCD also promotes community empowerment by building relationships among a community’s assets ultimately for greater political and social influence. This emphasis on mobilization of assets is what sets ABCD apart from network analysis, which, although it also focuses on relationships, does not mobilize
these relationships for empowerment purposes (Wellman, 1981). Network analysis may be thought of as an extension of asset-mapping and, therefore, a sub-set of the larger ABCD strategy.

The very process of building an asset-map can be empowering, since the asset-map is wholly owned and implemented by citizens, rather than being a technical tool accessible and understandable only to experts. Individuals can readily identify themselves and their neighbourhoods within the map. As Aberley notes of bioregional mapping, a planning method for community development based on creating maps of local regions, the process of creating maps is empowering in several ways.

In successfully searching out and integrating information about a community or bioregion citizens become more confident in their ability to understand and direct processes of governance and development. The notion that only scientists, government officials, and politicians can decide complex decisions quickly evaporates. This empowerment breeds an assurance that has great positive effect on all aspects of community life. Bioregional mapping defines an agenda for the future that has the potential to simultaneously confront threat and realize opportunity. (Aberley, 1998, p.12)

Asset-mapping, which shares a similar underlying philosophy as bioregional mapping, may be expected to have a similar positive effect on individuals and communities.

ABCD is also advantageous because of its perspective on the role of the professional or expert. There is much commentary in health promotion over what the appropriate role is for the health professional, and this debate centres on questions of power. There is now a trend towards promoting a “power with” attitude, where others’ views are not merely tolerated but respected and professionals work with the citizens, as opposed to “power over”, where professionals have control of health issues (Labonte, 1994; Laverack & Labonte, 2000; Pilisuk, McAllister, & Rothman, 1997). Generally, biomedical and behavioural perspectives promote a “power over” attitude, wherein either
services are delivered and controlled by health care professionals or programs “instruct”
individuals how to modify their behaviours for improved health. ABCD flatly rejects
these types of control by experts, allowing the community to take full control of the
process and discover its own solutions, and thereby break cycles of dependency and
paternalism (Kretzmann & McKnight, 1993).

5.3.2 Capacity-Building

Alongside empowerment, capacity-building is a defining characteristic of
bottom-up planning processes. Capacity-building arises in three different contexts in the
health promotion literature: building of health sector infrastructure to implement
programs; building capacity to sustain a program; and fostering problem-solving
capacities in communities (Hawe, Noort, King, & Jordens, 1997, p.33). Because the
impact of a health promotion intervention is dependent on not only the effect and reach
of the intervention, but also the sustainability of the effect, building capacity to extend
and magnify the impacts of the intervention should be an important health promotion
objective (Hawe et al., 1997). Capacity-building then becomes what Hawe et al. call a
“value-added dimension to health outcomes” (Hawe et al., 1997, p.38). It is beneficial to
be interested in not just which interventions will work, but for how long they will work.

ABCD’s “value-added” is that it builds community capacity as programs are
developed and implemented. Goodman et al. define community capacity as “the
characteristics of communities that affect their ability to identify, mobilize, and address
social and public health problems” (Goodman et al., 1998, p.259). Capacity is held in
the relationships among the community’s assets, and these relationships improve the
community’s problem-solving potential. These relationships are far more flexible than
any project plan that is of only narrow relevance. Furthermore, because ABCD is internally focused and relationship driven, whatever programs or interventions the community decides upon are not wholly reliant on outside resources, which, if withdrawn, may threaten the sustainability of health outcomes.

5.4 COMPROMISE BETWEEN STRUCTURALIST AND INDIVIDUALIST APPROACHES

The tension between the individualist and structuralist explanations of health has attracted much attention in the health promotion literature (Allen, 1997; Neighbors et al., 1995; Robertson & Minkler, 1994; Rutten, 1995). The debate has been over what level of responsibility should be put on individuals for their health. At one end of the spectrum, the individualist explanation places a high degree of responsibility on individuals, emphasizing the impact of individual choices and behaviours on health. Health education strategies, generally, conform to the individualist approach. At the other end of the spectrum, the structuralist explanation places much less emphasis on individual responsibility, arguing that health is the product of socio-political conditions that are not under the individual’s control (Allen, 1997).

Ever since the Lalonde Report identified individual behaviours as a determinant of health alongside biomedical factors, health promotion has concentrated on developing programs to modify lifestyle choices and behaviours for better health. While individual behaviours and choices certainly have an impact on health (i.e. the choice to smoke or to exercise), those who take a structuralist perspective would argue that focusing on only individual behaviours has significant negative (albeit unintended) implications. Most notably, because the individualist explanation assumes away all context that may influence an individual’s ability to make healthy choices, it separates social justice issues
from health issues (Lomas, 1998). Issues of poverty, empowerment, and equity are seen as quite separate and irrelevant to health issues. The powerful are then conveniently able to place blame on ill individuals for their health troubles—they were too "lazy", "irresponsible" or "neglectful"—while evading any responsibility for the larger societal conditions (which they may generate and sustain) that put the less powerful at increased risk of becoming ill (Allen, 1997). From the structuralist perspective, this amounts to victim-blaming (Ryan, 1976).

While victim-blaming may be a negative implication of the individualist explanation, system-blaming is the corresponding negative implication of the structuralist perspective. From the structuralist perspective, health is the result of structural factors, over which individuals have no control. While the socio-political environment certainly has an impact on health, placing all blame on the system can leave individuals with little agency over their health and feeling helpless and hopeless (Allen, 1997; Neighbors et al., 1995). This type of system-blaming can lead to victimhood and dependency, neither of which advance health promotion. Furthermore, because the structuralist approach supports increased state intervention to address structural forces, there is the risk that this power may not be exercised in a socially just manner and actually result in worsening of conditions (Allen, 1997).

Instead of conceptualizing the individualist and structuralist explanations as opposites, it is more helpful to emphasize the relationships between the two (Allen, 1997; Neighbors et al., 1995; Robertson & Minkler, 1994; Rutten, 1995). Both perspectives contribute to our understanding of health and how it might be promoted, and need not be mutually exclusive. As Rutten outlines, collective behaviour patterns
and collective resource patterns shape an individual's choices (some environments are more supportive of healthy lifestyles than others), but that individuals maintain a degree of agency within these larger forces (Rutten, 1995). Furthermore, according to Neighbors et al., encouraging individuals to be responsible for their behaviours and choices builds personal empowerment, which enables individuals to become socially and politically active and can eventually lead to community empowerment (Neighbors et al., 1995). Green & Kreuter and Allen argue, the individualist and structuralist perspectives can be best reconciled at the community level through community development efforts (Allen, 1997; L.W. Green & Kreuter, 1990, in; Neighbors et al., 1995).

ABCD is advantageous because, as a community development strategy, it manages to find a compromise between the structuralist and individualist ideologies, addressing structural factors while preserving individuals' agency. ABCD does this by encouraging individuals to directly contribute to a community-wide process for bringing about structural changes. Individuals are no longer seen as passive victims, but as full participants in their community's development. The agency that ABCD promotes, however, is distinct from the form of agency the individualist approach promotes. The individualist approach encourages individuals to take responsibility for their own behaviours and choices, the benefits of which are enjoyed primarily by that individual. ABCD requires not that individuals change their lifestyles for better health, but that they contribute their skills and assets to a community development process that benefits the entire community, and thereby promote health. ABCD manages to hold individuals accountable for their community, but also avoids victim-blaming, by focusing on the strengths of individuals—everyone has something valuable to contribute. In terms of
feelings of victimhood that might stem from the structuralist perspective, asset-mapping, an accessible, but powerful tool, shows individuals how they can specifically contribute to bringing about larger structural changes, thus diminishing feelings of helplessness and hopelessness.
ABCD's relevance as a health promotion strategy arises out of the socio-ecological perspective of health that characterizes health as a complex issue involving multiple factors that interact across levels and across sectors. By casting health in such broad terms, as opposed to narrower biomedical or behavioural conceptualizations, the socio-ecological perspective establishes a new and daunting set of expectations for health promotion strategies. Health promotion strategies are now expected to "build capacity", "empower communities", and "foster intersectoral collaboration", none of which are fully understood let alone easily done. While we must be mindful not to fault ABCD or other similar health promotion strategies for striving towards these objectives, which are widely supported in the health promotion and population health literatures, we should also be sure to be pragmatic about the many challenges that may impede achievement of those objectives (for a concise review of challenges facing population health in Canada see Frankish et al, 1999). Policy makers, health promoters, and communities themselves must be made aware of ABCD's limitations given the complex problem situation articulated by the socio-ecological perspective.

Indeed, it is possible to anticipate several practical challenges that would likely limit ABCD's ability to: help culturally defined communities identify health issues; develop plans to address these issues; implement these plans; and evaluate the outcomes of these plans. ABCD faces obstacles to community empowerment; it fails to incorporate evaluation into its methodology; it is not easily implemented; and finally, ABCD does not propose how health issues might be identified.
6.1 OBSTACLES TO EMPOWERMENT

A suitable strategy for promoting health helps communities implement plans to address their identified health challenges. Whether it is a plan to improve daycare facilities, provide meals to seniors, or decrease traffic accidents, plans require resources, which may have to be acquired from outside the community. Implementing a plan may require not only resources, but also modifications of socio-political structures. In either case, power is necessary to implement a community's plans. Although empowerment, both at the individual and community level, is one of ABCD's primary objectives, there are several challenges that may prevent ABCD from bringing about the changes necessary to reallocate resources and promote health in culturally defined communities.

As previously outlined, empowerment has two dimensions: psychological empowerment at the individual level, and collective empowerment at the community level, and both play a role in producing health (Rissel, 1994). While psychological empowerment, a feeling of control over one's life, may be a win-win situation where the increase in power of one group does not decrease the power of another, for community empowerment, competition for scarce resources can seem like a zero-sum game. One group's increase in community empowerment, as confirmed by a favourable reallocation of scarce resources, may imply that that group gained power at the expense of another.

ABCD may very well succeed at building psychological empowerment, but for several reasons fail to mobilize these subjective feelings of control for objective control over resources. Psychological empowerment may, itself, have a positive impact on health, but the importance of building on this psychological empowerment to attain community empowerment for the reallocation of resources cannot be understated (Rissel, 1994; Wallerstein, 1992, 2002).
Gaining power to implement community development plans to address health issues is complicated by a number of socio-political factors, all of which could potentially limit ABCD’s ability to foster community empowerment (Laverack & Wallerstein, 2001). First, as will be discussed, political trends towards neo-liberal approaches to public policy and governance may frustrate community-based efforts to reallocate resources for health promotion. Second, broader socio-political factors may defeat ABCD’s community-based efforts. Third, the biases of the biomedical and behavioural approaches to health may inhibit the adoption or acceptance of community development as a legitimate health promotion strategy. Fourth, securing resources means securing resources away from the control of service providers, the medical professions, which are undoubtedly a powerful group that may not be willing to surrender influence. And fourth, to compound all of the previous challenges, culturally defined communities generally suffer low levels of power relative to the majority population. All of the above are circumstances that may prove challenging for ABCD as a health promotion strategy in culturally defined communities.

6.1.1 Neoliberal Policy Environment

As mentioned, if ABCD is to facilitate community empowerment, it must bring about an objective reallocation of resources, which often necessitates corresponding structural changes. While a certain degree of resource allocation may occur outside of the public system (i.e. in the third sector), redistribution is primarily a government responsibility and arguably, one of its most important. However, as neoliberalism has gained popularity, governments have reduced their redistributive role on the basis that redistributive policies hinder economic growth (Navarro, 1998). These trends towards
government budget cutting, deregulation, and privatization are what one observer directly termed the "neoliberal triad of anti-health reforms" (Terris, 1999, p.1). This market ideology in public policy may prove to be a serious obstruction to community empowerment for health promotion as it becomes increasingly difficult for disadvantaged communities to capture resources or influence socio-political structures.

Furthermore, under the neoliberal orthodoxy, health promotion trends may be misconstrued as justification for minimal public sector responsibility for health. As health promotion moves towards community development strategies that promote capacity-building and empowerment, from the neoliberal perspective, this emphasis on "communities helping themselves" could be taken as justification for rolling back government support and leaving communities to address their health related issues on their own. Arguments of this sort may frustrate ABCD efforts to bring about changes in resource allocation, especially given ABCD's internal focus on assets, which could be misconstrued as further justification for the neoliberal perspective.

6.1.2 Socio-Political Factors

Health is determined not only by individual and community level variables, but also by macro socio-political factors. For example, provincial welfare programs and national tax policies influence income, which is a determinant of health. Health promotion should then focus on altering "unhealthy" provincial and national policies as well as promote healthy individual behaviours and healthy communities. While ABCD may seem suitable for building healthy communities and for developing programs at the local level, it is unlikely that ABCD could have any significant influence on macro socio-political factors that are beyond the control of the community.
Though communities can benefit to a degree from an ABCD process, in the absence of changes at larger levels it is questionable whether ABCD offers any sort of fundamental solution. ABCD may focus further upstream than medically or behaviourally based health promotion strategies, but it stops short of influencing macro socio-political health determinants. As such, ABCD may be best suited for helping communities cope with negative socio-political environments, but not to change the larger environment. ABCD's internal focus disregards the fact that some issues are external to the community and cannot, therefore, be properly addressed from within.

6.1.3 Biases of The Biomedical And Behavioural Perspectives

Although recognition of the social-ecological approach to health is growing, the well-established biomedical and behavioural approaches continue to dominate health policy. The biases inherent in these dominant perspectives may significantly challenge achievement of community empowerment objectives under ABCD. The institutions and policies that have grown out of the biomedical and behavioural perspectives fail to recognize or support empowerment or capacity building as legitimate objectives, and consequently discriminate against community development programmes such as ABCD. Although this is not to argue that ABCD should conform to the dominant perspective, these biases are potential barriers that proponents of ABCD or any similar community development strategy must recognize and anticipate.

ABCD's incompatibility with the prevailing perspective weakens its ability to compete for scarce resources against traditional interventions such as immunization campaigns and heart health programs, which arise directly from the biomedical and behavioural perspectives. While ABCD should certainly be required to prove itself in
light of other health promotion methods, it should not be held to the same type of standard as these other methods. However, it is most often the case that community development options are judged against an impact assessment standards designed for, and appropriate for, only biomedical and behavioural interventions (McQueen, 2001; Raphael, 2000; Shiell & Hawe, 1996).

These dominant evidence-based approaches favour experimental methods, quantitative analyses, identification of linear cause and effect relationships, and an individual level focus over a community level focus (Raphael, 2000; Shiell & Hawe, 1996). ABCD cannot fair very well against these standards. Community development strategies require much longer time frames for impacts to become evident, they have low trialability, meaning they are not amenable to experimentation on a limited basis, and their results are not highly observable (Frankish et al., 1999). Broad-based health promotion programs such as ABCD should be held to standards other than biomedical (scientific) standards, but it is unclear what they standards should be (Frankish et al., 1999) (evaluation issues are discussed further in subsequent sections). Regardless, ABCD cannot be judged fairly by the current biased evaluation methods.

In addition to influencing standards of evidence, ideology influences the very framing of an issue (Raphael, 2000). The same issue can be framed in entirely different ways. Take the issue of lung cancer, for example, where the problem could be framed as a cigarette-smoking problem, or it could be seen as a tobacco problem. The former warrants lifestyle changes while the latter warrants regulation of the tobacco industry (Raphael, 2000, p.361). How an issue is framed determines how it is addressed. The dominance of the biomedical and behavioural perspectives means that most issues are
framed in biomedical and behavioural terms, which preclude socio-ecological interventions such as ABCD. And even while the socio-ecological perspective has made gains, the optimism held for new scientific discoveries and technological solutions continues to deflect attention away from broad based health promotion interventions. Attention consistently turns to biomedical and behavioural elements of health.

6.1.4 Control of service providers

Despite McKnight’s argument that service providers promulgate a needs-focus (McKnight, 1995), many health service providers hold valuable skills and knowledge that if properly mobilized could support community development efforts for health promotion (Labonte, 1989). Believing that the expertise and knowledge that these professionals hold can be replaced entirely by caring within the community would be naïve; however, it would also be naïve to believe that health professionals would readily surrender their power over resources. Transforming these power relationships such that the community has greater control over these assets, both resources controlled by practitioners and practitioners’ skills and knowledge, requires a clear shift in power relations.

As cited in (Frankish, Kwan, Ratner, Wharf Higgins, & Larsen, 2002)) the potential reluctance of health care professionals to share power may be based on a number of arguments against citizen participation in health promotion planning: health professionals may make better decisions than lay citizens; quality of care may be threatened by citizens’ efforts to protect individual rights; lay decision-makers may have less skill or knowledge than those responsible for implementing the decisions; participation may be costly and inefficient; and lay participants may be less accountable
for their decisions than professionals. Community empowerment may be severely limited if communities are unable to assuage these concerns and delineate a clear and productive role for professionals within bottom-up processes. ABCD, although it emphasizes internal assets, fails to clearly define how assets held by professionals might be mobilized for community empowerment. ABCD’s failure to carefully consider professional groups may result in not only lost opportunities in terms of missed assets, but even worse, it may so alienate professional groups from the process that they become barriers to community empowerment.

6.1.5 Low Power Status of Cultural Minority Groups

Power is also an issue simply because it is generally the case that culturally defined minority communities have little power in relation to the majority. Socioeconomic status, prejudice, and the very fact that they are the minority all contribute to low levels of power in these communities. It may be presumptuous to believe that a single insight could realign the distribution of power, especially in the context of health, where, as previously mentioned, several barriers to community empowerment exist. Culturally defined minority groups are generally not in positions of power to secure resources, influence health system decisions, or challenge discriminatory policies that impact health. It is unclear whether ABCD, alone, would be sufficient to allow communities to overcome all of these barriers.

6.2 EVALUATION AND EVALUABILITY WEAKNESSES

Evaluation may be considered a weakness or challenge associated with ABCD from two perspectives. From the perspective of policy makers who must decide among health promotion alternatives and who are interested in measuring a program’s impact,
ABCD's low level of evaluability makes it less attractive than alternatives with higher levels of evaluability. Second, from the perspective of communities who have used an ABCD strategy to plan for and implement programs to promote health, it is unclear whether ABCD can help them properly evaluate these programs.

6.2.1 Evaluability Weakness

According to Smith, "a program (or a plan) is evaluable if criteria and procedures for measuring achievement of intended goals have been identified which can be feasibly implemented" (Smith, 1989, p.12). In short, evaluability judges the likelihood that a program's achievements can be measured. It is straightforward to understand why program evaluability is desirable and preferred by policy makers. A program with a high degree of evaluability allows a program's success or failure to be determined, and in cases where programs have failed, evaluable programs allow policy analysts to determine whether failure was the result of theory failure (failure due to incorrect theoretical underpinnings) or implementation failure (failure follow through with the planned activities), a key distinction that must be made in order to make decisions about improving the program (Smith, 1989). Furthermore, proper evaluation, enabled by a program's evaluability, allows policy makers to successfully replicate a program and modify it to suit changing contexts.

Referring back to the definition of evaluability, ABCD would be evaluable if it identified feasible criteria and procedures for measuring the achievement of its goals. Unfortunately, all three components of "evaluability", setting goals, creating feasible criteria (performance measures), and developing feasible procedures for comparing program outcomes to criteria, are not well developed for community based health
promotion programmes (Judd, Frankish, & Moulton, 2001). First, it is difficult to characterize ABCD's objectives because the distinction between means and ends is unclear. While community capacity building and empowerment may be ends in themselves, they are also means towards further actions. ABCD's process and its products cannot, therefore, be easily disentangled for evaluation purposes. Furthermore, evaluation of ABCD implicitly requires that an appropriate balance be found between process and outcome goals. Only a clear understanding of a community's fundamental objectives can determine the appropriate balance. The difficulty here is that there are two sets of goals that must be evaluated in light of each other.

Even if suitable objectives can be established, criteria still have to be developed for each objective. Criteria, what are often called indicators or performance measures, define objectives, which may otherwise be imprecise (Keeney, 1992). Effective criteria put goals in terms that can be evaluated. Setting criteria for objective goals, say for example, decreasing the mortality from heart disease, is relatively straightforward, but setting criteria for goals such as "to improve community capacity" or "to foster community empowerment" is complicated by their subjective nature. Many of these types of objectives focus on quality rather than quantity, and defining quality is highly dependent on values. For example, say we wanted to develop a criterion for the objective "to foster relationships within the community", of course "number of relationships" comes to mind as a suitable criterion. However, does counting the number of relationships say anything about the quality of those relationships? And should all relationships be considered of equal value? Is a relationship built between friendly
acquaintances the same value as a relationship built between two groups who have been at odds in the past? Each criterion requires a number of value judgments.

Not only are objectives and criteria difficult to define, but developing feasible procedures for comparing ABCD’s outcomes to its goals, the third evaluability requirement, is also complicated. This is not only a matter of determining whether the goals were met, but whether they were met due to ABCD. ABCD is a form of community development, and as such, it certainly does not lend itself to a randomized controlled trial format for measuring outcomes. Even the opportunity to perform randomized policy experiments, the most effective way to investigate programs implemented in real communities, is highly unlikely. It is questionable whether any procedure can definitively isolate the impact of any program like ABCD. Separating the impacts attributable to only ABCD from any number of confounding factors is challenging to say the least given the difficulties with latency and gaps in theory (Nutbeam, 1998).

Failure to demonstrate program evaluability of community development strategies is particularly risky in the health field. Program accountability has become a priority issue for those who control health and social services budgets (Hawe et al., 1997; Judd et al., 2001). As such, the politicians and bureaucrats who control scarce health care resources are under pressure to make evidence based decisions, and therefore favour programs that have been proven via randomized controlled trials. This is not to suggest that ABCD’s legitimacy as a health promotion strategy rests on its ability to conform to the scientific method, which it cannot, only that its ability to compete with these traditional strategies for attention and resources is reliant on its evaluability.
Evaluability of ABCD very much relies on setting meaningful standards for community health promotion. Part of the confusion over how to evaluate ABCD stems from the difficulty with defining evaluation criteria. Unfortunately, standards of acceptability are underdeveloped in health promotion (Judd et al., 2001; McQueen, 2001). The risk here is that if programs like ABCD do not develop their own sets of standards and articulate plans for evaluation—in short, find ways to make their programs evaluable—standards may be determined by those in political, administrative, and economic fields and thereby fail to reflect the unique nature of community health promotion (Judd et al., 2001). If ABCD does not set its own standards of evaluation, some other group may, and these standards may not fairly judge the success or failure of community development strategies for health promotion.

6.2.2 Evaluation Weakness

Policy makers are interested in the evaluability of ABCD as a general framework for community development, but for communities, the evaluability of the overall framework may not be as relevant as evaluation of the individual plans that grow out of this framework. ABCD enables and supports communities in their own plan making, and it is these specific plans that communities may be interested in evaluating. Part of helping communities address the health challenges they face is helping them implement and evaluate plans to address these issues. While ABCD sets out a strategy for implementing plans, through the identification and mobilization of community assets, it does not set out any clear methods of evaluating these plans. For communities seeking substantive change, the ability to evaluate outcomes and adjust plans is crucial.
While it is possible that communities may choose to build capacity specifically for evaluation, it is more likely that communities will use their capacity to develop specific programs for health promotion. Without a conscious and ex-ante decision to evaluate their programs, communities are unable to properly assess the success of their programs. This also means that communities are unable to learn about their programs and adapt strategies for future efforts—evaluation is not only a method of judgment, but also a method of learning. Learning, self-evaluation, and reflection foster self-determination, such that the evaluative process of taking stock, setting goals, developing strategies to reach these goals, and documenting progress can be an opportunity for empowerment—this type of evaluation is called empowerment evaluation (Fetterman et al., 1996). ABCD’s failure to clearly incorporate evaluation into its strategy means that it misses this additional opportunity to foster empowerment through empowerment evaluation.

Furthermore, ABCD’s lack of attention to evaluation may threaten the sustainability of community health promotion efforts if citizens cannot gauge whether their efforts are justified. Without evaluative feedback, citizens may lose motivation to maintain or improve a programme. The lack of an evaluation plan may not only threaten program sustainability, but it may also deter citizen participation from the outset, thereby threatening program development and implementation.

6.3 IMPLEMENTATION

While it is unquestionable that health promotion programs that are based on well thought out theoretical foundations are preferable, no matter how strong the theory, if the program cannot be implemented, then it is worth very little, especially to communities
that are concerned with finding real solutions to urgent issues. Implementation is a key consideration for decision-makers, who may very well opt for the strategy that is easy to implement over alternatives that may be more convincing or appropriate on a theoretical level. For decision-makers and communities, programs that are difficult to implement carry with them a great deal of risk—risk not only for decision-makers in terms of public perception and accountability failures, but also for communities, the risk of implementation failure may leave issues unaddressed.

While ABCD seems to exemplify the very latest thinking in health promotion, population health, and social planning, in several ways it trades off implementability for these theoretical strengths. ABCD is time consuming, potentially conflictual, and unpredictable. Of course, these implementation difficulties may not figure prominently in every case, but they must be considered at the outset to improve the likelihood of the successful implementation of ABCD in any context.

6.3.1 Time Consuming

ABCD works by fostering individual capacity, community capacity and community empowerment, all of which take time. It takes time for the community to become aware of the strategy, to learn about it, and then to actually carry through with it. Arguably, any bottom-up process is likely to take more time to implement than a top-down process because no single authority has control over the parameters of the process. The timeliness of the process can also be affected by conflict, which is especially likely in heterogeneous communities where differences among groups may stall progress at multiple points. Even communities that are relatively conflict-free may have difficulty making timely progress if they adopt overly ambitious participatory objectives that
require a lengthy and detailed process for even small decisions. Moreover, the process time frame may not only be lengthy but also undetermined.

The above are limitations shared by all community-led strategies. ABCD has an additional limitation related to its asset-mapping component. While asset-mapping is arguably the most easily understood and well articulated component of ABCD and, therefore, readily accepted by communities, it nonetheless takes time for a community to construct its asset-map. The more comprehensive the asset-map is, the more assets there are available for mobilization. While communities may be successful at identifying their assets, there is the risk that by the time the map is complete, the community may either be so exhausted by the process that they cannot find the resources to mobilize the assets, and abandon the map altogether, or that it took so long to complete the map, that the community had changed significantly in the meantime, leaving the map irrelevant. The latter scenario is particularly true in communities that have a high degree of transience so that when it comes to building relationships many of the community’s citizens have moved on, taking with them their assets. The time and energy consumed during the asset-mapping phase may never be fully realized because the initial asset-mapping phase took too long.

6.3.2 Conflictual

Implementation of ABCD may be obstructed by conflict. Conflict between an “authority” and the “community” can arise when a program or policy is developed in a top-down fashion, but conflict can arise just as readily in bottom-up processes—conflict arising from bottom-up processes might even be more detrimental to program implementation because no one authority has the power to push the program through,
despite conflict. While it would be convenient to believe that culturally defined communities are homogeneous in their values and objectives, this is an assumption that cannot be justified. In terms of implementation of ABCD, it is much more useful to assume that culturally defined communities are indeed heterogenous and that sub-groups will likely compete for control of the process. In health promotion, there is certain to be conflict over priority setting—which health issues should the community address with ABCD? As discussed below, ABCD’s lack of direction regarding the identification of issues will likely exacerbate the conflict over the selection of issues to address. It is also reasonable to anticipate conflict between the community and those health care service providers who are reluctant to become subsumed under the larger health promotion strategy.

Furthermore, a community’s asset-map may also create conflict and disappointment if community members feel they have been misled by the mapping process. Although a comprehensive asset-map is desirable, it may generate unrealistic expectations within the community. Community members may become frustrated if community development does not progress to the degree implied by the asset-map.

6.3.3 Unpredictable

Implementation is much easier when a detailed plan can be developed in full before it is implemented, but since ABCD is a community-led process, and offers only a framework for moving ahead, it is impossible to predict where the process will end up. Because ABCD is primarily a process plan, rather than a project plan, all substantive decisions are left to the community, and these decisions are unpredictable. This
unpredictability diminishes ABCD's evaluability and may frustrate community members who prefer a more predictable course.

6.4 IDENTIFICATION OF HEALTH ISSUES

In order to promote health in a community, health issues have to first be identified and understood. This does not imply that identification of health issues means that new epidemiologic studies must be conducted, but only that communities find a way to gather information on local health issues and to learn which factors interact to produce each challenge. The discussion around issues also helps communities clarify their objectives and discover what tradeoffs they are prepared to make among them so that they may prioritize the issues.

Although ABCD seems to set out a detailed process plan, the methodology gives little guidelines for how to identify and prioritize health issues in the community or how to use existing technical information. Although there may be some heuristic value in discovering assets (in general), and through this definition of assets, we might better understand health beliefs held by that community, and the local help-seeking behaviours, taking inventory of all assets related to health does not help communities identify key concerns and health issues in their community. Unlike the popular PRECEDE-PROCEED model of health promotion planning that includes five assessment phases that help define a community's health issues (Lawrence W. Green & Kreuter, 1999), ABCD provides no mechanism for helping communities first identify health issues, and second, decide which are most important and should be the focus of community development efforts.
ABCD's failure to help communities identify their health issues is particularly troublesome for culturally defined communities. As already mentioned, culturally defined communities are, as a minority group, likely to have less influence than the majority on public policy issues, including health-related policy. The risk is that if ABCD does not offer methods that help culturally defined communities identify their health issues themselves, then it is likely that health issues will be defined by some outside authority who may not take culture into account, or that the community's issues may not be identified at all.
PART 7: ABCD AND LOCAL CHINESE COMMUNITIES

This section explores the strengths and weaknesses of ABCD as a health promotion strategy in specific cultural communities: the Chinese communities residing in Chinatown/Strathcona and Richmond. Discussing ABCD within a specific context should help better illustrate the strengths and weaknesses outlined in previous sections. I have chosen these two Chinese-Canadian communities because, although it may seem that they share the same culture, these communities are quite distinct and the differences should reveal different strengths and weaknesses of ABCD as a health promotion strategy. This section may also be considered the first steps towards determining whether ABCD would be a worthwhile strategy for promoting health in these Greater Vancouver Chinese communities.

7.1 LIMITATIONS AND QUALIFICATIONS

A few limitations and qualifications must be noted at the outset. First, I recognize that although there are certain characteristics that define and unite each of the Chinatown/Strathcona and Richmond Chinese communities, I recognize that there is a great deal of heterogeneity within these communities. In no way do I wish to suggest that all members of a community share identical beliefs and behave in identical ways, since no individual's personal experience can be predicted based on cultural affiliation alone. In this case, cultural affiliation only raises the likelihood that certain factors impact health. Second, this section is not an extensive ethnographic or case study. Because I collected information only through a literature review and key informant interviews, and did not endeavour to survey residents of these communities, the information and analysis in this section should in no way be considered definitive.
Rather, the objective of this section is to only bring attention to issues that I anticipate would impact the success of ABCD as a health promotion strategy if it were to be implemented in either of these communities. The points raised here certainly deserve further analysis. And third, the quality of analysis in this section is limited by the dearth of information on health issues in these Chinese communities. Unfortunately most information on cultural minorities is limited to aggregate data on “immigrants” and is not disaggregated to the community level. Although research in this area is growing, the amount of information on local health issues in these communities is limited.

7.2 COMMUNITY DESCRIPTIONS

Chinese immigrants began settling in Vancouver in the middle of the 19th Century, when Chinese labourers who had come to work on the Canadian Pacific railway settled in what would become the second largest Chinatown in North America (Li, 1998). Since then, Canadian immigration policies have had a direct and considerable impact on immigration from China, starting in 1923 when migration from China was completely banned until 1947. In 1962, the Canadian government changed its immigration policy to a points system that rewards skills and education and relies less on national origin or race. This policy change precipitated the first major wave of immigration from Hong Kong to the Lower Mainland. A second wave of Chinese immigrants arrived throughout the eighties, after the government expanded its business immigration program in 1984. During this time, the number of wealthy migrants from Hong Kong increased, as Hong Kong residents anticipated its return to China in 1997 (British Columbia Statistics, 1998). By 1998, Mainland China had become the dominant source of immigrants to British Columbia, as increasing numbers of Chinese immigrated
under the entrepreneur and investor classes (British Columbia Statistics, 1998, p.1). Chinese immigration has, and continues to have, a significant impact on the Lower Mainland, and no less so in the neighbourhoods of Chinatown/Strathcona and Richmond.

Table 2: Select 1996 Census statistics for Chinatown/Strathcona and Richmond

<table>
<thead>
<tr>
<th></th>
<th>Chinatown/Strathcona</th>
<th>Richmond</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>7,350</td>
<td>152,531</td>
</tr>
<tr>
<td>Population with Chinese as home language</td>
<td>53%</td>
<td>25%</td>
</tr>
<tr>
<td>Population in low-income</td>
<td>56%</td>
<td>22.9%</td>
</tr>
<tr>
<td>Population with less than grade 9</td>
<td>32%</td>
<td>7%</td>
</tr>
<tr>
<td>Population with university degree</td>
<td>11%</td>
<td>18%</td>
</tr>
<tr>
<td>Population over 65 years</td>
<td>25%</td>
<td>12%**</td>
</tr>
</tbody>
</table>

Note: These statistics are for the entire populations within these neighbourhoods, including the Chinese communities.

1 Compiled from data from the City of Vancouver (City of Vancouver, 2002)
2 Compiled from data from the City of Richmond and BC Statistics (British Columbia Statistics, 2002; City of Richmond, 1998a, 1998c, 2002).
3 2001 statistic

Chinatown and Strathcona are among the oldest neighbourhoods in Vancouver. They lie adjacent to each other just east of the city’s downtown core, bordering the north side of the False Creek Flats, and notably, next to the Downtown Eastside, the poorest neighbourhood in Canada. Chinatown/Strathcona, which had once been the commercial and cultural centre of the Chinese community in Vancouver, faces a number of difficulties, most evidently socio-economic decline. In 1996, the year for which the last Census data is available, over half of Chinatown/Strathcona’s population was in the low income bracket and 32% had less than a grade nine education (see Table 6.1). Chinatown’s revitalization is hampered by a number of factors, including the settlement of new Chinese migrants in other areas of the Lower Mainland, the exodus of second and third generation families out of the community, and the crime and safety issues
generated by the illegal drug trade in the Downtown Eastside (General Manager of Community Services, 2001).

Chinese immigrants continue to settle in British Columbia, but they are now choosing to live in Vancouver's suburbs, Richmond being one of them. Richmond, like many municipalities in the Lower Mainland has very much felt the shift in immigration from European countries of origin to those in Asia. Recently (1991-1996), the top three source countries of recent immigrants to Richmond were Hong Kong (44%), China (17%), Taiwan (13%) (City of Richmond, 1998b, p.2). Nearly half of the population of Richmond is born outside of Canada, the Chinese population being the dominant immigrant group. In comparison to the Chinese community of Chinatown/Strathcona, the Chinese community in Richmond is wealthier, better educated, and newer to Canada (City of Richmond, 1998b, 2002; City of Vancouver, 2002). Indeed, Richmond has become a hub of Chinese culture and commerce.

7.3 STRENGTHS AND WEAKNESSES IN CHINATOWN/STRATHCONA AND RICHMOND

Since the Chinese communities in Chinatown/Strathcona and Richmond share some of the same challenges and issues, ABCD’s relevance to these common considerations are discussed first. The following sections discuss the applicability of ABCD within each of the two communities separately, highlighting the major issues that are likely to have a bearing on the success of this type of health promotion strategy in Chinatown/Strathcona and in Richmond.
7.3.1 Considerations Common to Both Communities

7.3.1.1 Assets for Health

ABCD may be well suited to promote health in Chinese cultural communities such as those in Chinatown/Strathcona and Richmond because the strategy allows each community to identify and mobilize a broad range of health assets. For both of these Chinese communities, traditional Chinese medicine is likely to be identified as an important asset. Indeed, the provincial government recently regulated traditional Chinese medicine and acupuncture practitioners, formally recognizing the importance of this form of health care specifically within the Chinese community, but also for all citizens of the province (Ministry of Health Planning, 2002). Given the prevalence of traditional healing practices in Chinese immigrant communities (Lai & Yue, 1990; Zhan, 1999), it seems important that this and other types of informal care are recognized as legitimate assets for health. As Chen argues, perhaps the most culturally suitable way to promote health in minority communities is through informal care, which is more culturally familiar than formal care (Chen, 1999). Noting traditional medicine as an asset then seems to be an appropriate first step for health promotion.

Both Chinatown/Strathcona and Richmond Chinese communities have numerous organizations and associations, all of which may be considered assets. Well-established and relatively powerful organizations such as SUCCESS (United Chinese Community Enrichment Services Society) and MOSAIC (Multilingual Orientation Service Association for Immigrant Communities), which act in part as advocates for culturally defined communities may be particularly useful assets for health promotion. Indeed many local Chinese organizations consider health to be a significant issue in their communities (personal interview).
The Chinese culture itself could be an asset for health. Chiu, in a study of Chinese immigrant women with breast cancer in the United States, found that these patients noted spirituality, family closeness, religion, and traditional Chinese values as resources for coping with their illness (Chiu, 2001). While medical or behavioural approaches might view culture as a barrier to health promotion (i.e. a barrier to accessing formal health care services), ABCD allows communities to view their culture as a collective strength rather than a deficiency. Culture would then be considered an asset for health, rather than a barrier to health.

7.3.1.2 The Formal Health Care System

Unlike medical interventions or health education programs, ABCD promotes community empowerment as a means for promoting health. Empowerment is likely to be important for both of these Chinese communities, especially with respect to their interactions with the formal health care system. The formal health care system may be insensitive to language barriers (Lai & Yue, 1990), differences in value-systems (Tabora & Flaskerud, 1997), the life experiences of cultural minorities, the role that the family plays in health decisions (Lai & Yue, 1990) or the impact of religion on health beliefs (Bowman & Singer, 2001). ABCD is a method by which communities can empower themselves so that they can begin to gain some degree of influence over which services are provided and how they are provided, such that the formal health care system improves its sensitivity to these types of cultural differences.

7.3.1.3 Evaluation and Evaluability, Implementation, and Identifying Health Issues

Evaluation, evaluability and implementation concerns about ABCD raised earlier apply to both of these communities. These challenges would apply in any community.
ABCD’s lack of direction with identifying health issues, however, is especially challenging in this context. The lack of basic information on the health status of either of the Chinese communities in Chinatown/Strathcona and Richmond may preclude ABCD from being of much use. Identifying, let alone prioritizing, health issues would likely require additional initiatives.

7.3.2 ABCD for Health Promotion in Chinatown/Strathcona

The Chinese community of Chinatown/Strathcona is challenged by a number of socio-environmental factors that may have health implications. As noted in the City of Vancouver’s plans for the Revitalization of Chinatown, the community faces a number of significant difficulties:

- Second and third generation families have moved out of the community to other Chinese communities in Greater Vancouver
- New immigrants choose to live in these new Chinese communities
- New Chinese business leaders have little or no connection with Chinatown
- The economic decline of the Downtown Eastside and surrounding communities
- Feelings of fear and crime associated with the illegal drug trade (General Manager of Community Services, 2001, p.3)

While most of these factors may or may not have a direct or immediate impact on health, all may very well create an environment that is unhealthy both socially and physically. As discussed earlier, these types of structural factors cannot be addressed by the formal health care system, but require more broadly based efforts, such as ABCD, that are amenable to the socio-ecological approach to health. Additionally, ABCD was developed specifically as an economic development tool, which may make it especially
useful in the Chinatown/Strathcona community where economic decline is a significant issue.

ABCD might also be an attractive strategy for promoting health in the Chinatown/Strathcona community because it emphasizes assets rather than needs. This may be particularly important for this community because of its proximity to the Downtown Eastside—the Chinatown/Strathcona Chinese community may wish to differentiate itself from the extreme negative image of its neighbour (personal interview). So instead of needs and deficiencies, which are closely associated with the Downtown Eastside, an ABCD process would highlight the community’s strengths and assets. The positive nature of this type of health promotion effort may also complement revitalization efforts, as the Chinatown Revitalization Committee endeavours to bolster the profile of Chinatown to residents in other growing Chinese communities in the Lower Mainland. Indeed, the Chinatown Revitalization Committee, and other local Chinese associations and organizations, could themselves be a rich source of assets for health.

As noted, empowerment is an important health promotion objective, which ABCD promotes. Empowerment may be an especially important variable not only because of Chinatown/Strathcona’s economic struggles (economic empowerment), but also due to the prejudice and discrimination (Li, 1998) the older citizens in particular, may have experienced over their lifetimes. Chinatown/Strathcona’s empowerment issues may not be isolated to struggles with the “majority group” but may also include struggles with newer Chinese immigrant groups such as those that settle in Richmond, especially as these communities compete to be the centre of local Chinese cultural life.
While ABCD’s focus on assets may have several positive impacts, the Chinatown/Strathcona’s proximity to the Downtown Eastside, what is known as the poorest postal code in Canada, may pose health challenges that are beyond the scope of ABCD. The difficulty here is that the Downtown Eastside’s issues transcend community boundaries to become safety and crime issues (which both impact health) in Chinatown/Strathcona. It may be the case that community development efforts in Chinatown/Strathcona would be insufficient simply because the problem is far larger than that single community. While ABCD could certainly help Chinatown/Strathcona build a safer social and physical environment, any large scale success would likely require commitments from all levels of government, plus the Downtown Eastside community itself (see for example the Vancouver Agreement (Ministry of Community Aboriginal and Women’s Services, 2002)).

7.3.3 *ABCD for Health Promotion in Richmond Chinese Communities*

The Richmond Chinese community does not face the economic or safety challenges that the Chinatown/Strathcona Chinese community faces. Although the Richmond Chinese community is wealthier and more educated than its Chinatown/Strathcona counterpart (see Table 2), it does experience social challenges that may have an adverse impact on health, and for which ABCD might be a helpful strategy.

The economic and political conditions under which many of the new Chinese immigrants to Richmond arrived precipitated transnational family arrangements called “astronaut families”. Astronaut families are families where one parent, usually the father, returns to Asia to earn a living, leaving behind his spouse and children in Canada (Waters, 2001). Although the prevalence of astronaut families is not known, this type of
familial arrangement may have important health impacts (personal interview). Waters, in her analysis of astronaut families in Vancouver, found that the arrangement has gender implications, as the separation often reinforces traditional gender roles. While some women felt liberated by the absence of their husband, others who were left to raise children on their own experienced boredom, isolation, and even fear (Waters, 2001). ABCD may be well suited to addressing the stresses that these women experience because it focuses on establishing networks of support and caring. Again, this is not likely a medical problem, but a social one, which is not likely to be addressed from a biomedical perspective.

While the Chinatown/Strathcona Chinese community may struggle with the legacy of past racial discrimination, the Richmond Chinese community, because it has been established more recently, may struggle with more issues associated with adjusting to a new culture and country, which can have a negative impact on health. And although Richmond is a diverse city with a very large Chinese population, new immigrants may still feel isolated or depressed. In some instances, immigrants may suffer significant stress when they are unable to secure employment or find jobs appropriate to their education and experience (Ley, 2000). Again, ABCD is relevant because it builds networks of support and caring, addressing the upstream causes of ill health.

7.4 CONCLUSION

On balance, it appears that ABCD could be a useful strategy for health promotion in both the Chinese community in Chinatown/Strathcona and the community in Richmond. While the two communities are quite distinct, most of the issues noted in both communities are macrosocial issues, which ABCD seems relatively well suited to
address, at least compared to medical interventions or behaviour modification programs. However, the dearth of information on health status in these cultural communities, and the even greater lack of information on the relationship between local Chinese culture and health, is likely to be a significant barrier to the success of any community development initiative for health promotion in these communities. ABCD may very well be an appropriate strategy for building a community’s capacity to address structural issues, but it may be wise to first focus on collecting basic information that the community could use in the process.

Both Chinatown/Strathcona and Richmond Chinese communities have numerous cultural organizations, and many of them already work on health related issues. In terms of preconditions for the success of ABCD in each of these communities, the existence of these organizations and associations is probably the strongest indicator that each community has the time and energy to follow through with an ABCD strategy. An ABCD strategy should not, however, replace these existing efforts, but rather build relationships between existing programmes and strategies to coordinate health promotion efforts. Chinatown/Strathcona and Richmond Chinese communities both have many assets that would be useful in an ABCD strategy.

An ABCD strategy for health promotion in these Chinese communities may garner broad support if the instrumental value of health is understood and promoted to key stakeholders. While health and quality of life are distinct concepts, they are closely related as health is an input to quality of life (Frankish et al., 1996). Individuals rely on good health to be productive members of the workforce, to enjoy family and friends, to participate in their communities, and so on. Though ABCD for health promotion may
not influence quality of life directly, its impact on health would indirectly improve quality of life, which is a widely held objective.
8.1 CONCLUSION

Is ABCD a suitable strategy for promoting health in culturally defined communities? In some ways, yes it is, but in others, no it may not be. Certainly, ABCD has its strengths, but it also has its weaknesses. To better understand how these strengths and weaknesses were established, it is useful to recall the standard against which ABCD was compared. As defined earlier, a “suitable strategy”:

1. reflects health promotion and population health research;
2. addresses the specific challenges associated with promoting health in culturally defined communities; and
3. is of practical use in terms of helping communities identifying health issues, developing plans to address these issues, implementing these plans, and evaluating the plans.

Together, these three dimensions of “suitable” incorporate both theoretical and practical considerations. Keeping in mind, though, that because this is only a first look at ABCD as a health promotion strategy, there has been no attempt to systematically determine the degree to which ABCD meets any of these suitability criteria, nor has there been any attempt to judge which expectations should weigh more heavily in the evaluation process. Further to these caveats, the strengths and weaknesses identified in this thesis are ones we anticipate ex-ante, but ex-post analysis would reveal the actual set of strengths and weaknesses, which would likely be a modified version of the set discussed here. Nonetheless, it is possible to arrive at general conclusions about ABCD’s suitability as a health promotion strategy in culturally defined communities.
8.1.1 Suitability Criterion 1: Health promotion and population health trends

On the whole ABCD reflects current research and trends in health promotion and population health. As a community development strategy, ABCD complements health promotion trends towards bottom-up, participatory approaches that emphasize community empowerment and capacity building. ABCD's principles also parallel population health evidence that suggests a broad set of socio-environmental factors determine health, factors that are beyond the control of the individual, and which may express themselves at the community level. ABCD also manages a compromise between the structuralist and individualist perspectives by preserving individual agency while at the same time promoting community wide changes. Indeed, ABCD's defining feature, its focus on assets rather than needs, reinforces each of these strengths, giving communities a way to break away from the traditional needs perspective. ABCD, however, does not address macro socio-political factors that determine health. ABCD's community level focus is not capable of addressing factors that express themselves at scales beyond the community.

8.1.2 Suitability Criterion 2: Health promotion in culturally defined communities

Largely because ABCD is suitable in terms of health promotion and population health trends and research, ABCD also seems to be well suited to address health promotion in culturally defined communities. More specifically, the asset-mapping process affords communities great flexibility to define their own, culturally appropriate assets for health despite the dominance of the Western medical model of health that may not recognize them. By virtue of its participatory nature, ABCD is also likely more culturally appropriate than any top-down process that imposes outside values and beliefs
on a community. ABCD is also designed to foster community empowerment to address structural factors such as poverty, access to the formal health care system, or even prejudice that may be correlated with culture. While ABCD is theoretically well suited to promote health in culturally defined communities, practical challenges as discussed under the third suitability criterion are nonetheless apparent. Of particular significance to cultural communities is the issue of power, which these communities generally lack relative to the majority population. Furthermore, assimilation and acculturation pressures that culturally defined communities may experience might prove challenging for ABCD, which is more likely to succeed in communities with strong identities.

8.1.3 Suitability Criterion 3: Practicality

The third suitability dimension is the most challenging. The high expectations generated by ABCD’s theoretical strengths must be tempered by its practical limitations. In practical terms, a “suitable strategy” helps communities identify their health issues, develop and implement plans to address these issues, and evaluate the plans. While ABCD seems to be quite capable of helping communities develop and implement plans (aside from difficulties associated with power)—ABCD is in effect the “process plan” for both program development and implementation—it is much less capable of helping communities identify health issues or evaluate their plans, both of which are critical for promoting health. The health promotion process can be frustrated by incomplete information on a community’s health issues. With little information, it becomes difficult for communities to not only properly characterize their health issues, but to also prioritize these issues and articulate corresponding tradeoffs among prospective programs. Similarly, lack of an evaluation process can also impede health promotion
efforts. Without an evaluation strategy, communities are unable to gauge the success or failure of their efforts. They are also unable to learn how to modify and improve their programs.

8.2 IMPLICATIONS AND RECOMMENDATIONS

Although ABCD has its weaknesses, on balance, it seems to be a worthwhile endeavour as a health promotion strategy in culturally defined communities. While ABCD may not address macro socio-political factors, it is a significant improvement over medical or behavioural interventions in terms of recognizing an individual's context. It does, however, warrant closer examination, and further thought should be given to power imbalances, identification of health issues, and evaluation strategies. Implications of these conclusions can be grouped into implications for further research, and implications for policy.

8.2.1 Implications and Recommendations for Research

The conclusions imply further research is needed in two key areas: first, in measurement and evaluation of community development efforts for health promotion; and second, in measurement of health status, health beliefs and values, and health practices in culturally defined communities, including Greater Vancouver's Chinese communities. Although measurement and evaluation issues related to community based health promotion have attracted much attention in the academic literature, there is still little consensus on how these programs should be evaluated. Certainly for communities implementing programs for the first time, evaluation is often only an afterthought. Further research is needed on basic measurement and evaluation methods, and on how communities might best employ these methods in their own evaluations. In terms of
information on health in culturally defined communities, research is needed on both qualitative and quantitative aspects of health such that communities can develop programs based on a more complete, and culturally sensitive, account of health issues in their community. These bodies of information are absolutely necessary if initiatives such as ABCD are to be successful at improving health outcomes, and if they are to be accepted as legitimate health promotion strategies.

As this thesis is only an ex-ante analysis of ABCD, the conclusions also imply that it would be useful to test these expected strengths and weaknesses by actually implementing and studying ABCD in a culturally defined community. To my knowledge there has been no academic documentation of ABCD implemented as a health promotion strategy.

8.2.2 Implications and Recommendations for Policy

ABCD and like community development efforts can play a role in health promotion and specifically in culturally defined communities. The policy implications of such a conclusion are quite straightforward—public policy and health policy in particular should support and promote these types of initiatives and related research. ABCD is at least worth consideration. Assessment policies should also begin to reflect a strengths perspective rather than a needs perspective.

However, given ABCD’s weaknesses, health policy should not support community development efforts without also requiring corresponding evaluation strategies. Communities deserve to know whether their efforts are justified, and to be given the tools to improve their efforts. Policy also need not support one type of health promotion to the exclusion of all others. Rather, policy should encourage health
educators, community developers, and medical professionals to work together in a cooperative environment to promote health.

8.2.3 Implications and Recommendations for Planning

Since this thesis is part of planning degree, I thought it would be suitable to end with implications and recommendations for planning. The conclusions certainly imply that planning is relevant to health promotion and that these two fields have significant complementarities. Physical, social, and environmental planners should endeavor to learn more about health promotion not only to strengthen their own practices, but to also share their skills and knowledge with health practitioners. Certainly, planners ought to at least be aware of the health implications of their work.

Perhaps the most significant implication concerns evaluation. ABCD, like so many other community development strategies and participatory processes, lacks attention to evaluation. The ability of planning to contribute meaningfully to other fields, including the health field, relies upon sound evaluation. Planning must concentrate on developing innovative evaluation strategies that incorporate both quantitative and qualitative information, and planners must be sure to carefully and consistently implement these types of evaluations. Communities deserve to know if their programs are meeting their objectives, and they deserve to know if their efforts are justified. Improvements in evaluation techniques can only lend credibility to widely supported planning objectives such as capacity-building and empowerment. Improvements in evaluation in planning could very well lead to improvements in health.
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APPENDIX A: OCCUPATIONS OF INTERVIEWEES

1. City of Vancouver—planning analyst
2. Richmond Chinese community leader
3. Chinese health services administrator
4. University of British Columbia—health sciences faculty member
5. Health Canada—manager
6. Canadian Mental Health Vancouver-Burnaby—mental health worker
7. Community Building Resources—community organizer
8. New York State Health Department—community developer
APPENDIX B: SAMPLE INTERVIEW QUESTIONS

Opening Questions

1. What is your professional or community leadership role?

2. How is your position related to community development for health promotion?

3. How long have you been working in your current position?

4. Do you have any other experience in community development work for health promotion?

Community Development and Health Promotion

5. How would you define community development for health promotion?

6. What are the main principles of community development?

7. Are community development strategies currently being used to promote health in Vancouver's Chinese communities?
   - If yes, how? Have these efforts been successful? How has success been defined?
   - If no, why not?

Asset-Based Community Development

8. What is your experience with asset-based community development methods?

9. From your experience, what elements are necessary to make asset-based community development methods most effective?

10. From your experience, what factors prevent the success of an asset-based community development project?

11. How have asset-based community development methods been applied to geographically defined communities?

12. How might applying asset-based community development methods in a culturally defined community differ from applying the method in a geographically defined community?
Vancouver's Chinese Communities

13. What are the main health promotion challenges in Vancouver's Chinese communities?

14. How might the local Chinese community define an "asset for health"?

15. What characteristics of Vancouver's Chinese communities might endorse the applicability of asset-based community development for health? How so?

16. What characteristics of Vancouver's Chinese communities might inhibit the applicability of asset-based community development for health? How so?