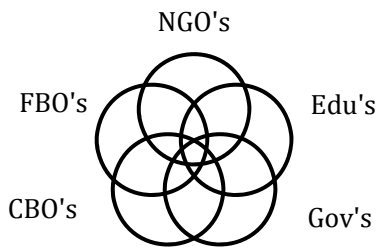


ABC^{Health}D

ASSET-BASED COMMUNITY HEALTH DEVELOPMENT WORKSHOP

Everyone Everywhere 2011. Estes Park, Colorado, USA. 15 October 2011

Contested Public Space (also called "Competitive Public Space")



"I don't concern myself about the poor ...
they have the church to take care of them.

"I don't concern myself about the rich ...
they have the government to take care of them."
~ Facundo Cabral

Poverty & Health

An operational **definition of poverty** includes five core dimensions of deprivation in human capabilities:

- economic (income, livelihoods, decent work)
- human (health, education)
- political (empowerment, rights, voice)
- socio-cultural (status, dignity)
- protective (insecurity, risk, vulnerability)

"The poor, more than any other group, rely on basic **public services**. For vulnerable families, **access to education and healthcare are important routes out of poverty**. The politics matters: services work better for the poor when poor citizens participate in reform of service delivery ..."
(UKAID, 2010)

"Health is the capacity for individuals, families, and communities to work together to transform conditions to promote, in a sustainable manner, their spiritual, physical, emotional, economic, and environmental well-being."

~ Definition of health, Pastoral de Salud, Iglesia Episcopal Dominicana

"We need to appreciate who is primarily involved in the production of healthy families and communities ... We must recognize that individuals and families in general, and mothers in particular, are truly the 'producers' of health."
(Mosley, 1990; also, WHO, 2002)

Community Health

What is a *community*?

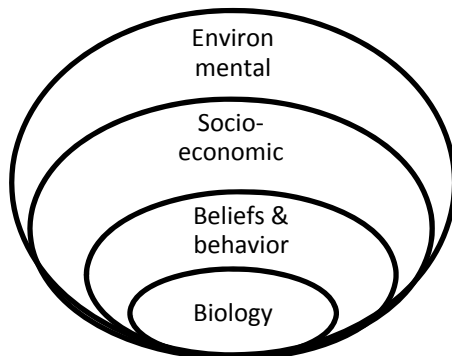
Four key characteristics of community (Wiggins et al., 2006):

- Spatial dimension (a place or location)
- Non-spatial dimensions (interest, issues, identities) that involve people who otherwise make up heterogeneous and disparate groups
- Social interactions that are dynamic and bind people into relationships with one another
- Identification of shared needs and concerns that can be achieved through a process of collective action

What are *Primary health care* and *Community health care*?

"Primary health care consists of those activities done by the health services for and with the population to improve the health of the people. Community health care consists of all the activities initiated and carried on by the community to improve the health of the people. Primary health care and community health care are complementary. But the health services must never diminish or supplant local community initiatives. On the contrary, all health interventions should be done in such a way as to motivate and strengthen community initiative." (Fountain, 1990, p 55)

Health Determinants



- **International**
- **National**
- **Regional**
- **Society**
- **Community**
- **Household**
- **Individual**

(Morgan, 2006b)

Ten major social determinants of health

(Morgan, 2006b, WHO, 2008, Halfon et al., 2010, Blas et al., 2011)

- | | |
|--------------------|------------------|
| ✓ Social gradient | ✓ Unemployment |
| ✓ Stress | ✓ Social support |
| ✓ Early life | ✓ Addiction |
| ✓ Social exclusion | ✓ Food |
| ✓ Work | ✓ Transportation |

Who is *responsible*?

"... Responsibility to address the [upstream] determinants of health rests with the whole government ..."
~ Bangkok Charter (WHO), 2005

Global action on social determinants of health (Marmot, 2011)

"Closing the gap in a generation"

"... there is a greater than 40-year spread in life expectancy among countries and dramatic social gradients in health within countries. But the evidence suggests that we can make great progress towards closing the health gap by improving, as the CSDH [World Health Organization's Commission on Social Determinants of Health] put it, the conditions in which people are born, grow, live, work and age.

"These include ensuring: equity for every child from the start, healthier environments, fair employment and decent work, social protection across the life course and universal health care. To make such progress, we must also deal with inequity in power, money and resources – the social injustice that is killing on a grand scale. At a more fundamental level, our vision is to create the conditions so that every person may enjoy the freedoms that lead to improved health – what we call empowerment."

"Assets and deficits and needs! Oh my!"

"Needs" are ***not the same*** as "deficits". These concepts are often merged or confused in asset-based development discussions.

"Deficit models tend to define communities and individuals in negative terms, identify problems and needs requiring external actors, measure risk exposure and vulnerability and ask communities to prove that they are worse off than others to justify the expenditure of resources - decreasing self-esteem." (Morgan, 2006a, p 31)

"Asset models tend to accentuate the positive ability, capability and capacity to identify problems and activate solutions, which promote the self-esteem of individuals and communities leading to less reliance on professional services." (Morgan, 2006a, p 31)

An asset-based approach to health and development adds value to the deficit model by (Morgan, 2006a, p 32):

- Promoting the population as a co-producer of health rather than simply a consumer of health care services (thus reducing the demand on scarce resources).
- Strengthening the capacity of individuals and communities to realize their potential for contributing to health development.
- Contributing to more equitable and sustainable social and economic development and hence the goals of other sectors.

Community asset mapping (Morgan, 2006a)

"**Asset mapping** reveals the assets of the entire community and highlights the interconnections among them, which in turn reveals how to access those assets."

- **Primary building blocks**
Assets and capital located inside the community and largely under the communities control (for example, skills, talents of community members, community-managed centers, community-based organizations, etc.)
- **Secondary building blocks**
Assets located within the community but largely controlled by outsiders (physical resources such as vacant land, energy and waste resources, public institutions and services [schools], etc.)
- **Potential building blocks**
Resources originating outside the community and controlled by others (for example, public capital improvement expenditures, medical care systems, etc.)

"**People as resource.** People are the primary resource for development and improvement of health."
(Fountain, 1990, p 55)

Health needs assessment (four types of "needs")

- ✓ **Normative need** (Compared to a set standard or external expert standard)
- ✓ **Comparative need** (How do we compare to those not in need? Or are others in the same position doing better?)
- ✓ **Felt need** (What people say or feel are their needs; need from the perspective of the people who have the need)
- ✓ **Expressed need** (Inferred need from observing people's behavior or demands)

"Of course, as the process proceeds, it may become clear that the individual or community **does not have sufficient assets** to address all of the needs. ... [When applying outside resources, we must ask ourselves] ... (1) Is it too early? (2) Is it too much?"
(Corbett & Fikkert, 2009, p 107-8)

ABCD – A Christian perspective

"ABCD is consistent with the perspective that God has blessed every individual and community with a host of gifts, including such diverse things as land, social networks, knowledge, animals, savings, intelligence, schools, creativity, production equipment, etc." (Corbett & Fikkert, 2009, p 106)

"ABCD puts the emphasis on what materially poor people already have and asks them to consider from the outset, 'What is right with you? What gifts has God given you that you can use to improve your life and that of your neighbors? How can the individuals in your community work together to improve your community?' " (Corbett & Fikkert, 2009, p 106)

"ABCD starts by asking the materially poor how they can be stewards of their own gifts and resources, seeking to restore individuals and communities to being what God has created them to be from the very start of the relationship." (Corbett & Fikkert, 2009, p 106)

"Indeed, the very nature of the question - What gifts do you have? - affirms people's dignity and contributes to the process of overcoming their poverty of being." (Corbett & Fikkert, 2009, p 106)

ABC Health D – A Christian perspective

- 1) "First, the ultimate performance of any health care program is only measureable in terms of improved health among the people."
- 2) "Community-based primary health care programs must be as much concerned about the process of improving health among people as they are about the [health] outcome." (Mosley, 1990, p 38-40)

Principles of community development (Hargreaves & Twine, 2006)

- Human dignity
- Participation
- Empowerment
- Ownership
- Learning
- Adaptiveness
- Relevance

The role of the "outsider" or

"What is the non-community asset-based community developer to do?"

Successful development models are generally built on a three way partnership: community, 'experts' from the outside, and government officials (Government must at least be permissive). (Taylor-Ide & Taylor, 2002)

"But of all the ills that kill the poor, none is as lethal as bad government." (Anonymous, 1999)

"The failures taught us that an outsider's good intentions are generally a bad starting point and that **community successes tend to evaporate once governments or donors assume control.**" (Taylor-Ide & Taylor, 2002, p 5)

Working in a development team (Hargreaves & Twine, 2006)

- Stakeholders
- Who has decision making power (Concentrated power? Collaborative model? Veto power? Power relationships? Transfers of decision making power?)
- How do things change over time (Participation and adaptiveness. Process of transformation: Awareness raising → Action → Reflection → Subsequent action → Etc).
- Annual reviews and networking (Taylor-Ide & Taylor, 2002)

Sustaining community programs

- Often relatively small organizations working collaboratively with communities.
- Foster and nurture partnerships.
- Pay attention to monitoring and evaluation (Is it even possible to measure impact?)
 - ***“Community development programs are notoriously difficult to evaluate since they are highly flexible and have complex, often changing goals.”*** (Hargreaves & Twine, 2006, p 159)
- Stay flexible and able to respond to change (in the community, in the contested public space, elsewhere)
- Diversify funding streams and support

Strengths of the community approach	Challenges of the community approach
<ul style="list-style-type: none"> ✓ Ensure effective uptake of new messages and technologies. ✓ Additional benefits for communities beyond the health effects (increased skills, knowledge, self-actualization, etc.) ✓ Sustainability. ✓ Promotion of health equity. <p>(Adapted from: Hargreaves & Twine, 2006)</p>	<ul style="list-style-type: none"> ✓ Labor intensive and difficult to scale-up. ✓ Highlights conflicting priorities of community members. ✓ Difficult to run. ✓ Struggle to reach the most marginalized groups in a community. ✓ Difficult to evaluate.

Political concerns and possible conflicts within the community concerning:

- 1.) Goals and results to be achieved
- 2.) Means to achieve those goals - particularly when health-related behavior has a health impact on someone else
- 3.) Economic and commercial costs (Fahy, 2006)

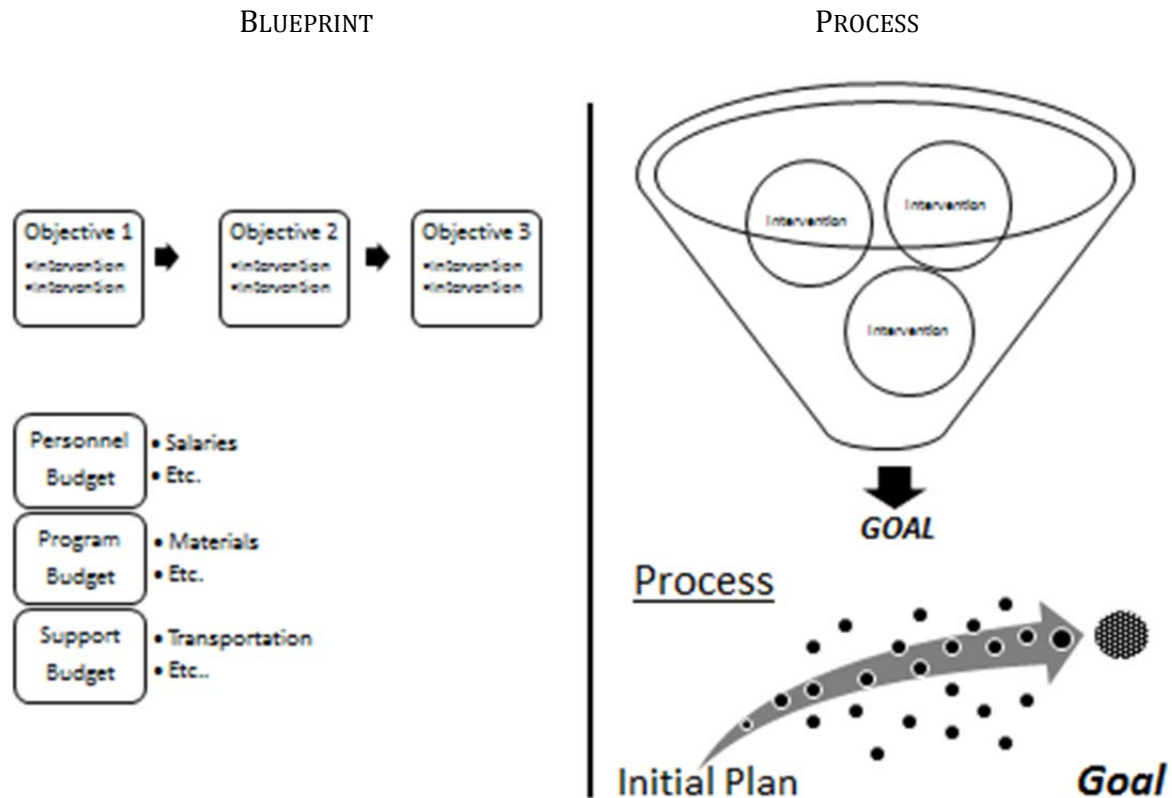
Social capital

“... high levels of social capital may act as a buffer in deprived communities, serving to shield them from some of the worst effects of deprivation.” (Speller, 2006)

Equity

“Equity is the central challenge for the future of medicine and public health.” (Farmer, 2005, p 20)

"Blueprint" projects versus "Process" projects



[Adapted from the United Kingdom Department for International Development (DFID) manual on water and sanitation development programs.]

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