How can the Capabilities Approach help to reframe Asset Based Community Development from a social justice perspective?

In this paper, I will explore the use of the Capabilities Approach as a means of critiquing and re-framing a popular policy intervention in Scotland called Asset Based Community Development, with the aim of extending its social justice potential. Drawing on research conducted for my PhD with a project piloting an Asset Based Community Development – or ABCD - approach to improving community wellbeing, I aim to show how a normative Capabilities framework can legitimise conversations about social justice with local residents and staff, side-stepping well-rehearsed project justifications and seeking out opportunities for genuine social change.

In order to explore the potential for a Capabilities Approach, I will briefly introduce the issue of health inequalities in Scotland and the failure of policy interventions to date. I will go on to discuss Asset Based Community Development and outline the hypothesised theory of change derived from the literature. Finally, I will consider the use of a Capabilities framework in generating dialogue with health policy practitioners and local residents around social justice issues, and what the Capabilities data revealed about ABCD as a policy intervention.

First, let's consider why existing policies do not appear to have worked in addressing Scotland's health inequalities. According to the World Health Organisation, Scotland's gap in male life expectancy between richest and poorest geographical areas now amounts to a difference of twenty-eight years: the widest in Western Europe. It's a stark reminder of the WHO's statement that 'social injustice is killing people on a grand scale', and those dying young are the poorest.

The *structural* determinants of health are well evidenced as key causes of health inequality[i]. UK governments repeat their pledges to address inequality and close the

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widening gap between rich and poor, but despite research evidence that the solutions are structural, the majority of social and public policy continues to focus on behavioural solutions.

Research suggests a number of reasons for this failure. The first is political. Despite a rhetorical commitment to addressing inequality, political ideologies currently at play are either unsupportive of addressing the distribution of wealth and/or disagree with the necessary level of government intervention to effect change. Linked to this is the issue of lack of popular support or understanding of the policy interventions required to address inequality. A policy focus on tackling the 'gap' rather than the 'gradient' has also found that whilst resources are targeted at the poorest, less attention is paid to the relative improvements across the gradient of society. So whilst the health of the poorest might be improving, the health of the richest is improving much more quickly. Add to this the problems of policy silos caused by the various government departments involved in addressing inequality, the issue of lifestyle drift from policy into practice, and the difficulty of translating research evidence into workable policy solutions, and we begin to see the complexity of the problem at hand.

Scotland's Christie Commission (2012) responded to this failure of public service with three key measures (whether or not these are working in practice is another question). These are: the streamlining of services to reduce overheads; a major shift in service delivery towards prevention; and a significant stepping-up of community involvement in service planning and delivery in the form of 'assets approaches.'

It's the third of these areas in which my research is located. So, what are assets approaches, and why have they become popular? Asset-based approaches began to appear

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in community engagement policy in Scotland and UK in the mid 1990s, and in health policy within the past five years. Their emergence forms part of a growing array of participation approaches that have accompanied a mainstreaming of 'exercising popular agency'[ii], a phenomenon often criticized for depoliticizing what ought to be a political process of struggle and change. In some cases, 'assets' mean material and physical resources, but more often they refer to a range of protective, non-material skills and social relationships. A health asset is seen as any resource that improves an individual or community's ability to maintain good health. These 'constituents of good health' guard against illness and minimize the costs of prevention or cure.

Asset Based Community Development (or ABCD) sees the main locus for change at a neighbourhood rather than individual level. The literature suggests three main underlying discourses to ABCD: a focus on the *behaviours* seen to promote good health; the *resources* required to live a healthy life – including 'community capital' such as social networks; and the *strength factors* enabling communities to develop resilience. This third discourse of strengths includes a long-term goal for communities to link micro and macro issues and challenge the power structures seen to produce inequalities, thereby recognising a structural analysis of inequality.

Does this recognition of the need to link micro and macro mean that ABCD has something to offer in re-politicising the acts of participation? As always, the devil is in the detail. At a time of austerity cuts across the UK, assets approaches are being promoted by government as a means of offsetting public sector capacity and dwindling services, or at best, meeting the need for local participation in service design and delivery: not as a means of re-politicising issues of social justice. However, perhaps ABCD can contribute to

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developing popular understanding of the structural nature of inequalities and the solutions required to effect change.

For the past three years, I have been working with the AHEAD Project in South West Scotland, a four-year pilot using ABCD as a means of improving community wellbeing. Beyond this broad goal, the pilot has had the freedom to develop its own milestones for success, although the absence of focused parameters has caused difficulties for staff at times. For my role in evaluating the ABCD theoretical framework in practice, I found a Theory of Change approach useful in identifying the hypothetical cycle of change suggested by the ABCD literature, including the mechanisms or activities that would effect this, and the key assumptions that underpin the ABCD theory. I took a qualitative, case study approach, including two case study sites, documentary evidence, fieldwork diary, and thirty in-depth interviews.
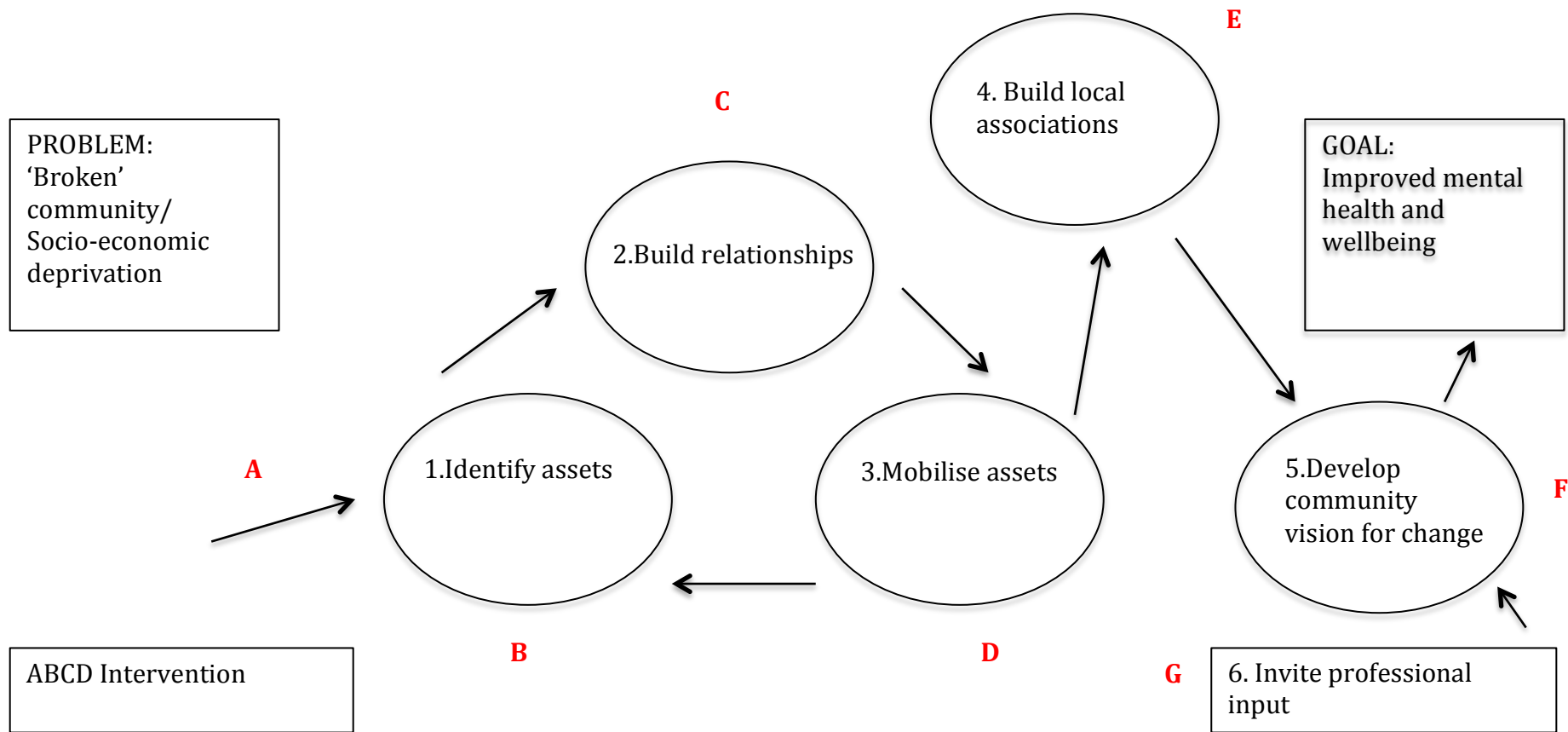
From the Theory of Change depicted in Figure 1.1, it is possible to trace the five main steps of ABCD: identifying assets, building relationships, mobilizing assets, building community association and finally, developing a local vision for change. At the end of this cycle comes a sixth step: that of inviting in professionals to take the roles designed for them by community. ADD Across this cycle I have identified seven mechanism activities, which map across the Theory of Change diagram from before the first step to after the last. A key finding that I discovered from the empirical evidence is that there appears to be a problem in moving from Step 3 (mobilising assets) through to Steps 4 and 5 (Building community association and a vision for change, respectively).

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ABCD LOGIC MODEL DEVELOPED FROM ACADEMIC & POLICY LITERATURE

Figure 1.1 Mechanism areas A-G mapped onto ABCD logic model
(From Chapter 3: Assets theory literature review - Identifying mechanisms within the ABCD logic model)

PROBLEM:
'Broken'
community/
Socio-economic
deprivation

GOAL:
Improved mental
health and
wellbeing

E

C

4. Build local associations

2.Build relationships

A

1.Identify assets

3.Mobilise assets

5.Develop community vision for change

F

B

D

G

ABCD Intervention

6. Invite professional input

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Despite the problems uncovered by the empirical evidence, it seemed to me that the ABCD approach did have something important to offer. From my fieldwork observations, it appeared that ABCD practitioners were adopting a radical approach to community work that I recognised from the work of Freire or Alinsky, but had rarely seen in practice. The work of the AHEAD Project 'Community Builders' (or grassroots workers) takes place in local streets, parks, shops and schools – any communal space, in fact - talking to residents and finding out about their interests and concerns. Whatever local people wanted to contribute, the Community Builders would try to find a way to support this. Their role is as enablers, always trying to shift the balance of power from worker to local resident; something they refer to as 'the conscious relocation of authority.' I felt that here was something of value that wasn't captured explicitly in the ABCD Theory of Change. I also wanted to find a way to free up discussion with project participants around these deep-rooted problems of inequalities, without demoralizing current project efforts and avoiding the well-rehearsed project justifications.

I turned to the Capabilities Approach (CA) in the hope that using this normative, tried-and-tested framework might legitimize questions around the scope of ABCD to address issues of social justice. Capability domains align well with the social determinants of health and allow a broad articulation of health as a state of wellbeing rather than the absence of disease, and as a moral, multi-dimensional concern[iii]. The Capabilities' focus on disadvantaged groups setting their own value domains for 'a good life'[iv] seemed in keeping with ABCD's commitment to local empowerment. The CA would also allow an examination of the conversion factors working for or against the achievement of domain freedoms, compatible with the contextual questions I wanted to explore using Theory of Change analysis.

Due to time constraints, I knew that the development of a full Capabilities

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framework with participants would not be possible, so I chose to use the Equality Measurement Framework (EMF), a Capabilities framework developed by Alkire and colleagues for the Equality and Human Rights Commission (EHRC)[v], with the purpose of monitoring human rights across a range of public policy areas in Britain. Using Alkire et al.'s domains and an approach used by Wolff and De-Shalit's to prioritise Capability Domains[vi], I asked participants to choose their 'top 5' Capabilities with most relevance to the ABCD approach. The selected domains were then used as a basis for open discussion, generating a series of functionings ('beings and doings') that I mapped onto existing EMF functionings, adding in additional areas and removing those not raised by research participants. The final functionings identified as relevant for ABCD are shown at Table 1.1.

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TABLE 1.1 CAPABILITY DOMAINS & FUNCTIOININGS OF THE AHEAD PROJECT

No.	CAPABILITY DOMAIN	FUNCTIONING	ABCD MECHANISM
4.	**IDENTITY, EXPRESSION & SELF RESPECT**	Have freedom of expression	B/C/D
		Build a sense of communal identity and belonging	E
		Engage in cultural practices, in community with other members of your chosen group or groups and across communities	D
		Have self-respect	C
		Be confident that you will be treated with dignity and respect	B/D
		Access and use public spaces freely	D
8.	**PRODUCTIVE & VALUED ACTIVITY**	Do something useful and have the value of your work recognised even if unpaid	D
9.	**PARTICIPATION & VOICE**	Make decisions affecting your own life	B
		Get together with others	C
		Participate in the local community	D
		Participate in locally-led decision-making	E/F
		Participate in non-governmental organisations concerned with public and political life	E
		Participate in the formulation of government policy, locally and nationally	F
		Form and join civil organisations and solidarity groups	E/F
5.	**INDIVIDUAL, FAMILY & SOCIAL RELATIONSHIPS**	Spend time with others	D
		Develop as a person	B/E
		Formulate and pursue goals and objectives for yourself	E/F
		Hope for the future	C/D
		Access emotional support	C
		Know that someone will look out for you	C
		Have peace of mind	C
		Form friendships	C
		Develop and maintain self-respect, self-esteem and self-confidence	C
2.	**HEALTH**	Mental wellbeing through social networks	C

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Each of the Capabilities functionings identified requires further consideration to establish the types of activity that help to promote it, as well as the contextual requirements to support its achievement. This is another area of work within my PhD. For today, what I would like to discuss is the way in which the functionings map onto the ABCD Theory of Change model depicted earlier.
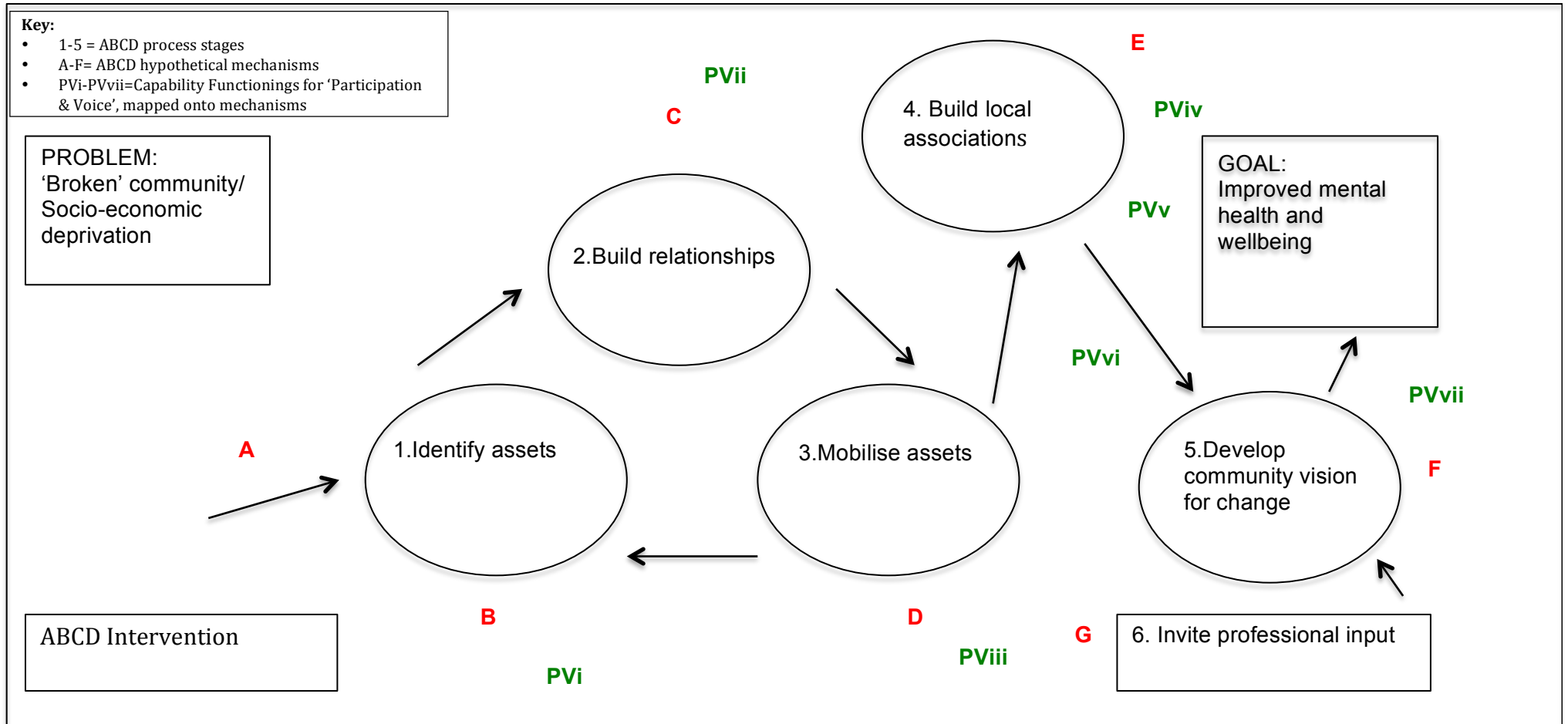
So, I mapped the capability functionings for each domain onto the theory of change diagram to show the ABCD mechanism activity in which that domain was most likely to occur. This patterning suggested that domains such as Identity (Domain 4), Relationships (Domain 5), and Productive Activity (Domain 8) pertain mainly to the building of social networks (Mechanism C) and the generation of local activity (Mechanism D). When it came to the domain of Participation and Voice (Domain 9), however, I noticed a different pattern emerging.

When I mapped the Participation and Voice functionings across the ABCD theory of change, what became clear were two things: unlike the other four domains, this one mapped across the entire ABCD cycle of change, but also, several of the functionings clustered around Mechanisms E and F: the problem area identified through previous Theory of Change analysis. The Participation and Voice domain therefore appeared to offer some focus on how to approach the problem associated with Mechanisms E and F: how best to support a community towards developing association and local visioning.

Analysis of evidence demonstrated a perception of Participation and Voice as a *temporal process* or pathway, requiring a series of steps (or mini cycles) over time to achieve the end goal of the local community being ready to 'plan a local vision' (Mechanism F).

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Figure 1.1. **Mapping the Participative & Voice Functionings PVi - PVvi onto the ABCD theory of change and mechanism model**

Key:
- 1-5 = ABCD process stages
- A-F= ABCD hypothetical mechanisms
- PVi-PVvii=Capability Functionings for 'Participation & Voice', mapped onto mechanisms

PROBLEM:
'Broken' community/
Socio-economic
deprivation

GOAL:
Improved mental health and wellbeing

PVii

C

E

4. Build local associations

PViv

PVv

2.Build relationships

PVvi

PVvii

A

1.Identify assets

3.Mobilise assets

5.Develop community vision for change

F

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B

D

G

6. Invite professional input

PViii

PVi

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This analysis of a cycle of Participation and Voice activity suggests that perhaps the ABCD theory requires a twin track of change alongside that of community activity, relating to the integration of local decision-making at every stage of the ABCD process. An integrated process, in fact, of 'the conscious relocation of authority.' For the public sector in particular, this raises serious questions over the need for power sharing and democratic empowerment, with all the challenge and dissent that healthy community activism brings. It also raises questions about the resources needed in the poorest communities, where there is little history of activism with which to gain traction for an ABCD approach. What the Capabilities analysis highlighted was the perceived value of P & V across research participants at all levels, within community and public sectors, in having the support to actively privilege local decision making within the ethos of the project. Although this principle is implicit within the third ABCD discourse, it is not made explicit in ABCD literature, and the complexities of power dynamics and temporal change therefore go unexplored. A remodelling of the theory and mechanisms for change may assist the approach in building towards Stages 4 and 5 of the cycle, and in understanding what resources are required to get there.

Moving on to conversion factors, the Capabilities Analysis also helped to uncover the differences in how resources impact on mechanism achievements across the two Case Study neighbourhoods. Today, I will briefly mention those relating to Participation and Voice specifically. Despite the very similar socio-economic profiles of my two Case Study neighbourhoods, Case Study 1 was much more effective at all stages of the ABCD process than Case Study 2, and this corresponded strongly with evidence of local participation and democratic representation across a wide range of local activities. Case Study 1 was better resourced at a meso level, with a local Community Centre and a history of local activism. This neighbourhood demonstrated a strong history of planned meso level support from the Local Authority from the inception of the neighbourhood,

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when it was built forty years ago. Despite problems due to recent austerity cuts, the strong, well-established routes to democratic involvement and a healthy appetite for dissent in Case Study 1 meant that a sense of association and coherence was already in place in the community before the AHEAD Project began. However, the research also showed that Case Study 1 was struggling to maintain this level of participation due to historical cuts to youth and community services in the previous decade, only now being felt in the lack of representation from a younger generation.

The next step for my research is to explore the role of agency, the need for re-politicization of local involvement, and the ways in which the P & V functionings might integrate within the ABCD theory of change, offering a clearer pathway that reflects change over time. I would welcome any suggestions for how to progress in this area.

What I hope to have demonstrated in this paper is the scope for a Capabilities analysis to legitimise cross-sectoral dialogue on the importance of social justice, and to make such thinking a responsibility of policy interventions in order to begin addressing health inequalities more effectively. My PhD research aims to reconfigure the ABCD process to reflect empirical experience, building a more robust theory of change that incorporates the potential for the Participation and Voice domain and its contribution to social justice, but also acknowledges the limitations of ABCD and the need for a range of additional policies to address the remaining CA domains not covered by ABCD. I would welcome any feedback and suggestions for how best to achieve this.

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Endnotes

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