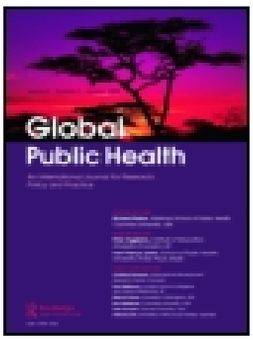

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Synthesising the shifting terminology of community health: A critiquing review of agent-based approaches

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ABSTRACT

The field of community health promotion encompasses a wide range of approaches, including bottom-up approaches that recognise and build on the agency and strengths of communities to define and pursue their health goals. Momentum towards agent-based approaches to community health promotion has grown in recent years, and several related but distinct conceptual and methodological bodies of work have developed largely in isolation from each other. The lack of a cohesive collection of research, practice, and policy has made it difficult to learn from the innovations, best practices, and shortcomings of these approaches, which is exacerbated by the imprecise and inconsistent use of related terms. This article provides a review of three agent-based approaches to promoting community health: asset-based approaches, capacity building, and capabilities approaches, noting the theoretical origins and fundamental concepts, applications and methodologies, and limitations and critiques of each. This article discusses their commonalities and differences in terms of how they conceptualise and approach the promotion of community health, including a critical consideration of their limitations and where they may prove to be counterproductive. This article argues that agent-based approaches to community health must be met with meaningful opportunities to disengage from the structures that constrain their health.

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Introduction

The role of communities in promoting health and wellbeing has long been highlighted in fields such as community development, health systems, and disease surveillance and eradication. While the notion of community has been contested (Flint & Finley, 2008; Walmsley, 2006), here we define communities by the shared conditions and constraints they face, which in turn shape access to resources and power as well as health. Community health promotion refers to a spectrum of context-specific strategies that support, build, and realise community health and wellbeing (Ewles & Simnett, 2003; Goodman et al., 2014). As an alternative to conventional top-down and deficit-based health promotion strategies that see beneficiaries as passive recipients of interventions, agentic approaches have been developed and applied to community health promotion over the last few decades (Labonté & Laverack, 2001b; Morgan & Ziglio, 2007; Ruger, 2012). These approaches present opportunities to catalyse community health work through empowering communities to meet

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their current and future health goals. However, a lack of consistency in term usage and poor consideration of how their contributions can be understood in concert has held back the development of theory as well as practical action (e.g. Merzel & D'Afflitti, 2003).

To address this gap, we conduct a critiquing review of key agentic approaches to community health promotion, and we summarise this literature for health and development professionals interested in effecting health-related change at the community level. We identify key similarities and points of departure, with the goal of providing a synthesis of overlapping but often disconnected approaches for understanding and promoting community health. We begin by summarising the background, theory, and application of community health promotion and explain a shift towards agentic approaches with a focus on asset-based approaches, capacity building, and capabilities approaches. We then discuss and critique these terms, indicating how they conceptualise and promote community health. Next, we synthesise commonalities, distinctions, and common critiques across these approaches, before concluding with ways forward.

Community health promotion

The community level, rather than just individuals, has become a focus of health promotion interventions, inspired in part by the community development movement that took root in the 1950s and was propelled into mainstream discourse and practice by the 1980s and 1990s (Craig, 2007). Community health promotion commonly aims to return the community population to a 'normal' level of functioning by focusing on needs and problems, which is also known as the deficit model. The deficit model enables a targeted approach to dealing with specific health topics, but it has led 'to policy development which focuses on the failure of individuals and local communities to avoid disease rather than their potential to create and sustain health and continued development' (Morgan & Ziglio, 2007, p. 18).

The deficit model carries potential unintended consequences, like creating clients rather than agents of change; implicitly denigrating communities as being needy; and construing communities and their behaviours as part of the problems rather than as part of the solutions. Painting communities only in terms of their deficits and failures may also introduce new constraints, including being offered even fewer opportunities to engage in development activities due to the external perception of likely further failure (Jackson et al., 2003). Another critique of the deficit model is that it often pursues solutions that rely on the provision of material resources like medical technologies and facilities to achieve certain population-level health benchmarks (e.g. Oliver et al., 2015). Such resources are assumed to operate universally across settings to achieve the desired ends and do not contextualise interventions to local conditions. Moreover, they assume that diverse and complex challenges can be addressed through simplistic solutions that do not engage with the other determinants of health; for example, increased production and distribution of food does little to ameliorate the social and political causes of famine (Sen, 1991).

Top-down approaches to community health can disregard community understandings, needs, and goals, and so they often lead to irrelevant, undesired, and unsustainable 'solutions' that may further entrench dependencies and health inequities. Rather than external actors merely tailoring interventions to the population or health challenge in question, communities may instead benefit from forging their own pathways to health by tapping into a wider array of tangible and intangible resources that they can access, use, leverage, and own. In opposition to dependency-creating approaches, agency-based or agentic approaches stemming from the fields of human and community development and psychology have been developed and employed in health research, policy, and practice.

Agency is understood as 'an actor's or group's ability to make purposeful choices' (Samman & Santos, 2009, p. 3), and it is exercised not merely in the absence of constraints but also in the ability to influence life circumstances with intentionality to achieve a desired outcome (Bandura, 2006) according to one's own systems of meaning and values (Bhattacharyya, 1995). For those previously

denied choice to pursue their goals, empowerment is conceptualised as a process of change (Kabeer, 1999) that expands agency (Ibrahim & Alkire, 2007; Samman & Santos, 2009).

While individuals are often at the core of discussions of agency, collective agency displays emergent group-level properties that have been increasingly acknowledged as central to achieving certain goals (Bandura, 2006), including increasing wellbeing (Stewart, 2005), in part through a group's enhanced ability to pressure structural social and political changes (Ibrahim, 2006). Community agency involves taking the wellbeing of the collective into account when setting goals and sharing responsibility for acting upon them (Pelenc, 2013). Health and wellbeing may be tied to awareness and knowledge as well as action that come with agency (Shankar et al., 2019). Empowered communities can take ownership over their health and self-sustain their health gains as active agents rather than passive recipients of aid (Laverack & Labonté, 2000). Agency and empowerment have been employed not only as orientations but also goals of health promotion.

Several agentic approaches to community health promotion have developed over the past few decades, notably asset-based approaches, capacity building, and capabilities approaches. While these three approaches share a common agentic lens that prioritises community-defined health goals and challenges, they have developed largely in isolation from each other. Each comes with their own strengths and weaknesses, which we explore further in the next section in order to synthesise commonalities and points of departure. These three approaches have been selected due to their shared agentic origins as well as their applications in practise. Community empowerment and mobilisation have not been included in this review, as they represent more generalised goals of agentic approaches. Additionally, related theories, such as Nordenfelt's (1987) ability theory of health, which typically feature less in policy and practice, have not been incorporated.

Agentic approaches to promoting community health

Asset-based approaches

Origins and fundamentals

Asset-based approaches focus on the strengths necessary for people to meet their own needs and goals. Asset-based approaches emerged from community development initiatives, which recognised that deficit-based approaches focused on conditions of resource scarcity and deprivation risked deepening community dependencies on external aid (Alvarez-Dardet et al., 2015; Kretzman & McKnight, 1993; Mathie & Cunningham, 2003; Morgan & Ziglio, 2007). Asset-based approaches emphasise the potential of a community and support communities to pursue and determine their own futures in accordance with their held values and collective vision (Mathie & Cunningham, 2003). Thus, interventions are implemented 'with' and not 'to' communities; the intention is for power to be transferred to communities and citizens, who are seen as capable of generating solutions for themselves (GCPH, 2012; Mathie & Cunningham, 2003).

When applied to community health, asset-based approaches highlight that all communities have strengths and assets regardless of whether and to what extent they are embedded in conditions of relative deprivation. Community health assets correspond with what people in the community believe is important for their health (de Andrade & Angelova, 2020), and can be defined as:

> any factor (or resource), which enhances the ability of individuals, groups, communities, populations, social systems and/or institutions to maintain and sustain health and well-being and to help to reduce health inequities. These assets can operate at the level of the individual, group, community, and/or population as protective (or promoting) factors to buffer against life's stresses. (Morgan & Ziglio, 2007, p. 18)

Community assets include not only physical resources and those related to formal healthcare facilities, but they also encompass all the resources people have at their disposal including psychosocial, social, governance, knowledge, and environmental factors (Springer & Evans, 2016). Some assets also function to connect, build, or strengthen other assets (Roy, 2017). Community assets can be conceptualised as primary building blocks (under community control), secondary building blocks

(under external control), and potential building blocks related to individuals, associations, and institutions (Kretzman & McKnight, 1993).

Community assets taken together have the potential to promote all the determinants of health and enable people to maintain or improve their health despite facing adverse conditions (GCPH, 2012) and reduce health inequities (Alvarez-Dardet et al., 2015). Assets are embedded in the local social context, so it is essential to acknowledge not only the presence of the assets but for whom they are important and under which circumstances (Brooks & Kendall, 2013).

Applications and methodologies

Community health interventions applying asset-based approaches centre on identifying, building, connecting, and mobilising assets (Cassetti et al., 2020; GCPH, 2012) that support the causes of health. The Scottish Government has championed asset-based approaches in light of the disproportionately poor health outcomes compared with the rest of the United Kingdom and the apparent ineffectiveness of conventional solutions in changing these trends, and non-governmental organisations have also taken up these approaches. For example, since 2000, the Columba 1400s Young People's Leadership Academy (YPLA) has provided intensive programming for youth from disadvantaged backgrounds throughout Scotland to explore and pursue their personal potentials, effect community change, and, in doing so, reduce individual and collective health inequities such as those related to drug and alcohol use and dependencies (McLean & McNeice, 2012).

Because asset-based approaches seek to empower communities to take control of their own health, initiatives facilitate the co-production of solutions through participatory methodologies, including community-based participatory action research (de Andrade & Angelova, 2020), and engage in activities including asset mapping, participatory appraisal, appreciative inquiry, asset-based community development, time banking, co-production, social prescribing, and participatory budgeting (GCPH, 2012). Through these inclusive methodologies, asset-based approaches are designed to foster relationships, priorities, and visions for the future, which themselves can be considered assets for health, and these processes can be empowering as community members recognise and appreciate the assets that already exist in their communities (GCPH, 2012). While asset-based approaches may be implemented with a particular objective in mind, the outcomes of asset-based approaches emerge from community decisions and actions, and thus are complex, long-term, and interconnected (de Andrade & Angelova, 2020).

Limitations and critiques

The presence of assets does not speak to their accessibility or usability to all or certain segments of a population due to social, political, or economic barriers, nor do they function the same in diverse contexts or under different conditions. In practice, activities like asset mapping may need to be accompanied by complementary activities to come to realistic conclusions and yield desired outcomes. The societal determinants of health are not well considered, and the neoliberal undercurrent of asset-based approaches emphasises the need for people to pull themselves out of poverty through their innate qualities rather than confronting the production of poverty and its consequences on health (Friedli, 2013). Asset-based approaches thus risk implicitly sanctioning and permitting structural inequities to persist (Brooks & Kendall, 2013; Friedli, 2013) and neutering collective agency to break dependencies and pressure social and political changes.

Overall, there is a limited evidence base for asset-based approaches (GCPH, 2012; Morgan, 2014) that assesses their effectiveness at improving health outcomes and reducing inequities (Cassetti et al., 2020), and most existing evaluation is qualitative and descriptive and often based on case studies alone (Baker, 2014). This may be partially owing to challenges surrounding the systematic collection of evidence. For example, asset-based approaches have been employed potentially for decades under different names (Roy, 2017), such as strengths-based approaches, enablement, self-management, and community empowerment (GCPH, 2011). Meta-analysis is further complicated due to some studies retrospectively labelling themselves as asset-based without applying the

theoretical foundations and/or methodologies (McLean & McNeice, 2012). Other asset-based approaches focus on poverty reduction more than on health and wellbeing (Baker, 2014).

These data shortfalls make it difficult to compare systematically short- and long-term outcomes with those resulting from different approaches, and this impedes building a cohesive body of evidence on asset-based approaches to validate and advance their theoretical and practical contributions. This lack of evidence may challenge the justification of asset-based approaches, which may be more time consuming and costly to implement and scale up compared to conventional health promotion strategies (Whiting et al., 2012).

Capacity building

Origins and fundamentals

Capacity building is rooted in community development and empowerment that took shape in the 1970s (Crisp et al., 2000) and gained momentum along with the global sustainable development agenda in the 1990s, including in the area of health (Craig, 2005). Capacity building supports communities to develop, nurture, and leverage their knowledge, skills, systems, and resources to address their own health concerns and goals (de Graaf, 1986; Goodman et al., 1998; Robertson & Minkler, 1994); enable others, such as health practitioners, to assist them in the process (Labonté & Laverack, 2001b); and sustain and multiply the effects of solutions on health gains (Hawe et al., 1997; Poole, 1997).

Community capacity was defined by Easterling et al. (1998) as 'the set of assets of strength that residents individually and collectively bring to the cause of improving local quality of life' (p. 7). Community capacities are a combination of knowledge and skills (Crisp et al., 2000; Tran et al., 2014) as they function within a particular social-environmental context (Labonté & Laverack, 2001a). In 1995, the Division of Chronic Disease Control and Community Intervention of the Centers for Disease Control and Prevention convened an interdisciplinary symposium and determined the essential dimensions of community capacity for health as follows: citizen participation, leadership, skills, resources, social and interorganisational networks, sense of community, understanding of community history, community power, community values, and critical reflection (Goodman et al., 1998). Lempa et al. (2008) found the most quantitatively robust of these to be leadership, resources, and the ability and commitment to organise action. Community capacities reflect a state of being as well as a potential or readiness (Goodman et al., 1998), and community capacities may also function to promote the development of assets (Gibbon et al., 2002).

There are helping and hindering conditions for community capacities for health, in recognition that communities alone are not responsible for their current status (Jackson et al., 2003). In the context of dementia care in Latin America and the Caribbean, Gonzalez et al. (2014) identified the following barriers for capacity building: poverty, unfavourable political environments, poor healthcare systems, inadequate information technology infrastructure, unavailability of standardised capacity building initiatives, and insufficient mentorship. To push against these structural constraints, important capacities include the knowledge and skills necessary for communities to engage in social and economic policy making (Israel et al., 2010). Not only does this advocacy capacity target the broader social and environmental determinants of health, but community participation in formal decision making also contributes to the sustainability of community health interventions and their impacts (Shediac-Rizkallah & Bone, 1998). Capacity building has the potential for positive spillover effects into other health issues beyond those specified during an intervention as well as development more broadly (Gonzalez et al., 2014), as it enhances the agency of individuals, organisations, and networks (Chaskin, 2001) to pursue their full range of goals.

Applications and methods

Community health interventions employing capacity building cultivate existing strengths and resources alongside building sustainable skills, including problem-solving and commitments to health (Hawe et al., 1999; Robertson & Minkler, 1994) to address health concerns that are important

to community members (Labonté & Laverack, 2001b) articulated through community goals and objectives (Goodman et al., 1998). Evaluation often begins by conducting a needs assessment (Jackson et al., 2003), though capacity building itself is intended to focus on building positive capacities.

In practice, capacity building often takes a multipronged approach to community health promotion. A capacity-building intervention in a rural community in Australia was designed to promote childhood healthy eating and physical activity, and it sought to change policies and strengthen community leadership and ownership of the intervention (Sanigorski et al., 2008). In a ten-year intervention aimed at promoting health for parents and their children in a disadvantaged neighbourhood in Hamburg, Germany, the health authority developed a series of activities and projects to build and sustain community capacities related to participation, local leadership, available resources, networking and cooperation, and health care (Nickel et al., 2018). Research on capacities highlights the importance of cross-scale relationships and interactions (Lempa et al., 2008), including with contextual factors and community characteristics (Minkler et al., 2008), and capacity building ideally occurs through long-term engagement rather than short-term interventions (Jackson et al., 2003).

Limitations and critiques

Conceptually, the term 'capacities' can carry many meanings (Crisp et al., 2000), but it is often used liberally in community health promotion literature without an accompanying definition or conceptual clarity. For example, community health literature often refers to the professional, organisational, and operational capacities of the formal healthcare system and facilities rather than community capacities more broadly. Capacity building for community health is difficult to distinguish from community development more broadly, and both can be manipulated to serve external interests (Craig, 2007). For instance, when health objectives do not align between a target community and health promotion practitioners, community capacity building may be adopted as a programme goal (Gibbon et al., 2002) with the intention of swaying the community to align with top-down goals and perspectives rather than reassessing or negotiating health objectives together with the community. To this end, community capacity at times has been seen as a necessary ingredient for the successful planning, implementation, and sustainability of top-down health promotion interventions (Goodman et al., 1998) as a way to ensure that communities will comply with rather than lead strategies. This subverts the goals of agentic approaches, which seek to create space for communities to take ownership over their health in accordance with their own goals and values.

As with asset-based approaches, the evaluation and measurement of capacity building has relied primarily on qualitative and participative methods (Gibbon et al., 2002; Jackson et al., 2003) based on case studies (Lempa et al., 2008; Minkler et al., 2008). While communities are differently equipped with capacities (Goeppinger & Baglioni, 1985), capacities are not entirely internally conceptualised (Lempa et al., 2008). Yet, the quantitative measurement of capacities has been evasive (Anderson-Lewis et al., 2012). While multiple studies have attempted to develop instruments to measure changes in community capacity (Shediac-Rizkallah & Bone, 1998), very little literature has offered models and indicators (Jackson et al., 2003). Beyond this, evaluation often focuses on individual capacities in aggregate and may not capture emergent capacities at the community scale (Jackson et al., 2003). Altogether, these limit the ability to evaluate capacity-building approaches systematically across contexts and interventions, conduct cross-case comparisons, and capture outcomes at the community scale.

Capabilities approaches

Origins and fundamentals

Sen (e.g. 1980, 1993, 1999) developed the capabilities approach as an alternative way of understanding and evaluating quality of life and development across varied contexts. Nussbaum (e.g. 2000, 2006, 2011) built upon and extended capabilities into a partial theory of justice. The capabilities

approach is a normative framework to evaluate and design social change mainly through focusing on individuals, though it can also be applied to groups and social structures like communities (Robeyns, 2005). For example, since 1990, the United Nations Development Programme has based its annual Human Development Reports on the capabilities approach.

The capabilities approach seeks to promote the 'capabilities of persons to lead the kind of lives they value' (Sen, 1999, p. 18) based on freedoms and opportunities, and people become responsible for their choices and the realisation of their capabilities (i.e. functionings) (Venkatapuram, 2011). Capabilities reflect all the potential alternatives that people can effectively choose (Sen, 1993) now or in the future (Poli, 2015), while functionings represent what people manage to do and be in their lives. Agency and the freedom to choose rather than being coerced into achieving functionings are at the core of the capabilities approach (Nussbaum, 2011).

Capabilities are formed from resources in combination with higher-level competencies like rational thinking and social connectedness (Hopper, 2007). Resources are not fixed: different people in different circumstances require different resources to achieve the same level of wellbeing (Robeyns, 2005), and alternative resources may be used to provide for the same or similar needs (for example, multiple types of food provide nutrition) (Sen, 1991). The capabilities approach asks whether the necessary tangible and intangible resources for capabilities are present, and it takes stock of the social and political influences and constraints on wellbeing (Robeyns, 2005). Different capabilities and freedoms are mutually reinforcing, and combined disadvantages can exacerbate constraints on capabilities and functionings (Sen, 1999). Nussbaum (2011) argues that it is the responsibility of society to promote capabilities through tangible and intangible resources and expand the range of opportunities enabled by the political, social, and economic environment.

The capabilities approach was not originally intended to be applied to public health, but several scholars have conceptually made this bridge (e.g. Abel & Frohlich, 2012; Ruger, 2012; Venkatapuram, 2011). The first three of Nussbaum's (2006) ten central capabilities relate specifically to health – life, bodily health, and bodily integrity – but Venkatapuram (2011) argued that all Nussbaum's central capabilities relate to health and that health can thus be conceptualised as a meta capability, positing that '… A person's health is most coherently conceptualized as her abilities to be and do things that make up a minimally good, flourishing and non-humiliating life for a human being in the contemporary world' (p. 20). Ruger (2012) developed a health capability approach that identifies 'central health capabilities' – namely to avoid premature mortality and morbidity – for people to remain healthy, pursue other capabilities, and flourish. The capability to be healthy is both 'intrinsically and instrumentally valuable' (Ruger, 2003, p. 678).

A capabilities approach to promote community health aims to expand opportunities and choices from the perspectives of a selected community, which may lead to more sustainable success in health outcomes than setting pre-determined and narrowly defined health targets (Abel & Frohlich, 2012). Communities are provided with resources and trainings to expand their health agency so that they can make choices that directly affect their health functionings in personally meaningful ways, and they are also guided to become active catalysts in transforming oppressive societal structures that constrain their health opportunities and freedoms (Abel & Frohlich, 2012).

Applications and methods

Mitchell et al. (2017) conducted a review of how the capabilities approach has been applied in the field of health, and the authors identified the main themes of physical activity, empowerment in health, multidimensional poverty in health groups, and assessments of health and social care interventions. The capabilities approach has also been used to inform how health practitioners understand community health needs and outcomes. For example, Ndomoto et al. (2018) employed the capabilities approach to conduct a health needs assessment in deprived communities in Kenya and the UK to understand from community perspectives how conditions of poverty and deprivation lead to poor health outcomes, and Lorgelly et al. (2015) refined an existing public health

intervention outcome measurement instrument using the capabilities approach. Other studies have identified key capabilities related to health. For example, Greco (2013) conducted participatory research with women who recently gave birth in rural Malawi to identify their values and ideas about what constitutes a 'good life', and the author quantitatively identified six areas of wellbeing: inner wellbeing, bodily strength, family and community relations, economic security, and happiness.

The capabilities approach has also been used to influence health policies. From the perspective of capabilities, health policies must be multifaceted and target all of the determinants, factors, and processes of health, while not conflating health policies with other policies like those related to poverty or unemployment (Ruger, 2004). There is a case for designing policies to deliver on functionings instead of capabilities, especially where bodily integrity is at risk of being harmed or when dealing with young children or people with severe mental disabilities who might not be able to make complex choices for themselves (Robeyns, 2005).

Limitations and critiques

Conceptually, the capabilities approach is perhaps the most ambitious of the reviewed approaches to community health, as it seeks to enhance all the determinants and processes that factor into health. At the same time, it may be the most nebulous in terms of converting the concepts into community health promotion on the ground. The nuances between capabilities, functionings, opportunities, and freedoms may not be clear to community members involved in an intervention (Lorgelly et al., 2015), which limits the utility of employing the full range of concepts in practice. Politically, the capabilities approach is aligned with mainstream human development discourse, which presumes the need for economic growth more so than human empowerment (Dean, 2009) and may not correspond with local values and goals. Because the capabilities approach is primarily designed to promote individual freedoms rather than collective solidarity, there is no discussion of how development processes like extractive forms of capitalism which may degrade or deplete natural resources, for example, could diminish opportunities and freedoms that support the health of future generations. The wide-sweeping concept of capabilities is 'vulnerable to subversion by misinterpretation', including by groups such as the World Bank (Alkire, 2005), to pursue health interventions that align with top-down objectives.

While Sen sought to create an objective means of evaluating capabilities, internal perceptions versus external views of health do not always align (Lorgelly et al., 2015). When trying to measure relative health and health equity gaps, this misalignment becomes even more problematic, as it is not clear if community health should or can be measured against standardised criteria. Beyond this, there are inherent challenges to assessing health potentialities (i.e. capabilities) versus realities (i.e. functionings), particularly when people make choices that seem out of step with achieving their stated health goals; amidst freedoms and opportunities, people may make choices that lead to suboptimal health outcomes for a variety of reasons. On the other hand, where the capabilities approach has not adequately identified constraints, suboptimal functionings may be falsely attributed to choice. Sen has not elaborated on constraints to free choices, and has not acknowledged how cultural and social influences shape preferences and choices (Abel & Frohlich, 2012). These further influences on health choices – in addition to the potential for a gap between knowledge and action – confound what the focus of a capabilities approach to health should be as well as *what* should be measured and *when* in evaluation.

Synthesis and ways forward

The reviewed agentic approaches to community health promotion emphasise that communities should be provided space and supported to define their own sense of community health, determine priorities, and design and pursue strategies to improve or build upon their strengths. These approaches adopt the perspective that there is not a one-size-fits-all approach to promoting

community health, so one of the shared challenges has been to develop standardised methodologies and quantitative means of measurement and evaluation (Anderson-Lewis et al., 2012; Baker, 2014; Lorgelly et al., 2015), if those are expected.

The starting and ending points of community health may significantly diverge between different contexts and even different groups in the same context or at different times. This is to say that the constellation of health strengths and resources at the outset of an intervention are different, and the goals and strategies developed through participatory methodologies may dramatically differ as well (de Andrade & Angelova, 2020), leading to differing outcomes. Progress toward health goals may advance at varying rates, and may produce dividends at much slower rates than expected by traditional donor funding cycles. Moreover, building assets, capacities, and capabilities may yield unexpected positive results outside of the initial scope of a given community health promotion intervention (Gonzalez et al., 2014) and thus may be challenging or problematic to capture through predetermined evaluation criteria. Alternatively, promoting specific health goals may come with significant opportunity costs or trade-offs for a community that should be taken into consideration before, during, and after the implementation of programming.

While these approaches may lead to positive health changes in communities irrespective of whether they are captured in measurement and evaluation, asset-based and capacity building approaches in particular often fall short of addressing systemic and structural constraints on health (Brooks & Kendall, 2013; Friedli, 2013). These approaches may inadvertently shift the burden of change onto the most disadvantaged groups, which may not only be unrealistic but also counterproductive when people immersed in adverse conditions are blamed for failing to 'choose' health (Dougherty, 1993; Lowenberg, 1995). These approaches have generally failed to reconcile themselves with deficit-based and top-down perspectives and build integrated approaches to community health promotion that leverage what is useful from both of them. By contrast, a capabilities approach provides more of a conceptual basis for addressing the social and political constraints on what it is possible for people to achieve and be, placing responsibility on society and government to provide resources to people and expand their opportunities (Nussbaum, 2011). Yet, the capabilities approach also falls short of challenging the structures upholding mainstream human development policies, which prioritise economic growth over resource preservation and regeneration, which may be necessary inputs for current and future community health.

The shift in discourse from top-down 'solutions' to bottom-up, grassroots strategies has not always been met with the meaningful implementation, which is a challenge common to all three reviewed approaches. Tensions may exist between internal and external perceptions of how community health is defined, pursued, and measured (Lempa et al., 2008; Lorgelly et al., 2015), and communities may be shoehorned to suit the interests of top-down actors, even if external interests are to ostensibly 'empower' or 'transform' the same communities to take charge of their own health. Agentic approaches may inadvertently serve neoliberal interests in maintaining the status quo, as well as pursuing the goals of top-down donors through the veneer of community participation.

While similar in origins and applications, the reviewed approaches to promoting community health vary in subtle yet important ways (see Table 1). Assets refer to the tangible and intangible building blocks that support community health that range from physical infrastructure to psychosocial factors and governance arrangements. Capacities broadly refer to what communities *do* with a collection of building blocks and which are demonstrated through skills or knowledge, for example. Finally, capabilities emphasise what people have the *potential to do* with a specific set of building blocks and opportunities but may or may not choose to pursue at a particular point in time. It may be useful to conceptually and practically link these approaches to better understand how to promote the determinants of community health and expand meaningful opportunities for communities to pursue their health goals (see Figure 1). Because communities are particularly suited to pressure for social and political changes, these approaches should be accompanied with a strong commitment to leverage community agency not only to strengthen internal health assets, capacities, and capabilities but also to engage with the power structures within which they function.

Table 1. Summary of the main aspects of asset-based, capacity building, and capabilities approaches.

Agentic Approach	Origins & Fundamentals	Applications & Methods	Critiques & Limitations
Assets	All communities possess assets (strengths and resources) that can support all the determinants of health Assets are material/physical as well as social, political, and environmental Assets – or the building blocks of health – may be under community or external control, or they may be a potential Assets and their functionality are specific to the local social context Asset-based approaches aspire to help reduce health inequities	Assets are identified, built, connected, and mobilised to promote health Interventions often adopt participatory methodologies to coproduce health solutions Interventions may increase community belonging and solidarity through inclusive processes Outcomes may be complex and unfold over the long term	The presence of assets does not imply accessibility or usability Approaches focus internally and do not engage robustly with the structural or external conditions imposed upon communities that also determine their health Implementation may be time consuming and costly and difficult to scale up Assets function differently under different conditions and may lead to divergent health outcomes, leading to challenges in standardisation There is a limited evidence base based primarily on qualitative data from case studies, and it does not use standard terminology
Capacity-building	Capacities are the set of assets that belong to a community Health capacities include resources, knowledge, skills, leadership, systems, and organised action Capacities include a current state and a potential Capacities and their functionality are specific to the local social context Capacities may promote the development of assets	Capacities are nurtured, built, and leveraged to promote health Interventions occur through long-term and participative engagement Interventions focus on building internal capacities and advocating for policies favourable to health	Capacity-building can be manipulated to serve external, top-down interests There is a limited evidence base based primarily on qualitative data from case studies, and it does not use standard terminology Evaluation may focus on individual capacities in aggregate and overlook emergent community capacities
Capabilities	Capabilities encapsulate the capabilities to live in ways that correspond with held values Capabilities represent the potential alternatives that people can choose based on freedoms and opportunities, and functionings represent what people manage to do and be in their lives Health capabilities include life, bodily health, and bodily integrity, as well as for people to sustain their health, pursue all other capabilities, and flourish according to their held values Key health capabilities include inner wellbeing, bodily strength, family and community relations, economic security, and happiness Capabilities emphasise choice based on higher-level competencies like rational thinking and social connectedness The resources that contribute to opportunities are specific to the local social context and may be substituted with other resources that provide for the same needs	The capabilities approach is intended as a normative framework to evaluate and design social change Interventions centre on physical activity, empowerment in health, multidimensional poverty alleviation, and assessments of health and social care interventions Interventions also target policy changes to increase opportunities and freedoms for health	The capabilities approach aspires to address all the determinants of health, but it may be ambitious and nebulous to convert into practice The vocabulary associated with the capabilities approach is highly nuanced and may be easily misinterpreted Capabilities were developed from an individualistic lens, and their effective application on a community level may require more work The capabilities approach is aligned with mainstream human development policy, which may itself undermine capabilities in the short- and/or long-term The capabilities approach can be manipulated to serve external, top-down interests There is little elaboration on constraints to free choice, including cultural and social influences that shape choices

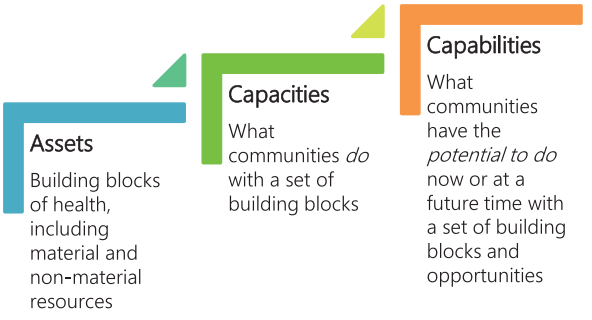

Figure 1. Linking assets, capacities, and capabilities for an integrated agentic approach to health.

Conclusion

This article has provided a critiquing review of three agentic approaches to community health promotion: asset-based approaches, capacity building, and capabilities approaches. The review covered literature central to the theory and application of the included approaches, but it was not exhaustive in part due to inconsistencies in how these concepts are applied to individual studies. While each of these terms is supported by a distinct body of conceptual and applied work, these terms are often used synonymously in the literature as well as by policymakers and implementing actors. This complicates efforts to build a clearly defined and robust body of literature that features internal agreement for each agentic approach to community health promotion.

The reviewed approaches share common theoretical roots in community and human development literature, including those related to agency and empowerment, but there is a notable lack of engagement between these distinct bodies of literature. Combined with the imprecise, inconsistent, and uncritical labelling and usage of related terms and concepts (Crisp et al., 2000; Robeyns, 2005; Roy, 2017), the lack of an integrated understanding has held back the timely maturation and refinement of agentic approaches to support the development and realisation of community agency in achieving their self-defined health goals and priorities.

There are several possible ways forward for agentic approaches to meaningfully support community health. Community agency and empowerment should be seen within the context of historical, current, and future trajectories that are partially shaped by the structural and systemic drivers of health. An explicit future orientation may be utilised to create multiple avenues for community health and pursue long-term sustainability, while taking into consideration global-to-local health challenges, such as climate change and environmental degradation, structural racism and violence, and the concentration of global wealth and economic power. Agentic approaches to community health may also engage more radically with diverse communities (including traditional societies, Indigenous peoples, and otherwise marginalised groups) to decolonise theory, practice, and policy. In doing so, these approaches together may correspond more directly with the interests and values of communities rather than top-down actors and stimulate collective agency to expand structural opportunities for community health.

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