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Applying strengths-based approaches to nutrition research and interventions in Australian Indigenous communities

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This paper provides a background to strengths-based approaches used in health and considers what these have to offer in the context of public health nutrition, with particular reference to work with Australian Aboriginal and Torres Strait Islander peoples.

Deficit, disease and dysfunction permeate approaches in health fields, including nutrition. Public health has focused on gathering evidence about 'what works' from this deficit perspective, particularly in those communities identified as vulnerable. Strengths-based approaches, on the other hand, work with the assets already existing in individuals, communities and institutions to support the conditions for health. Although strengths-based approaches are used in some health fields, they are under-utilised in public health nutrition. A strengths-based approach draws on the theory of salutogenesis to accentuate positive capacities so that nutrition professionals and clients/communities can jointly identify problems and activate solutions.

Research processes and findings from a number of participatory Indigenous nutrition health projects will be discussed. This research has identified significant social resources within Australian Indigenous communities and these assets offer points from which to work.

A strengths-based approach offers a different language with which to address nutrition inequalities. It can contribute to empowering Indigenous individuals and communities towards healthier nutrition. We propose that redressing the current imbalance between strengths and deficit-based approaches is needed in public health nutrition and would like to consider the nature and potentials of strengths-based approaches in nutrition, with particular reference to their use in Aboriginal and Torres Strait Islander groups.

We shifted ideologically in our thinking of our community, from negative assumptions to endless opportunities. We refrained from drawing assumptions around notions of "good" and "bad" communities or families – we simply started from strengths (Bond, 2009 p.177).

Introduction

The field of public health nutrition (PHN) has rapidly evolved from the fields of nutrition science, public health and dietetics. Its focus on prevention and population-based approaches to dealing with nutrition issues distinguishes it from clinical dietetics (Hughes, 2008). The Australian PHN workforce reflects its origins and is populated by people with primary dietetic or nutrition specialisations (Hughes, 2008). PHN has been shaped by a history of using epidemiology (informed by the biomedical model) to focus on nutrition problems of individuals, households, communities and populations. Common PHN terms reflect the deficit approach: 'vulnerable' populations, inadequate diets, food insecurity, poor dietary practices and associated nutritional deficiencies or excesses. These issues have defined PHN, and provide the rationale for the profession's existence and purpose, and a broad agenda for research, policy and practice.

In this paper we advance the idea that this deficit approach has pitfalls that are exaggerated if it dominates. As Shawna Berenbaum (2012) identified, it is important in Critical Dietetics to consider new perspectives and challenge assumptions about the way nutrition issues are addressed. To counteract the imbalance created

by predominant focus on deficits, we propose a critical approach which gives greater attention to a strengths-based approach (SBA) (also referred to as assets-based) in PHN, and use the example of Aboriginal and Torres Strait Islander nutrition research and practice in an Australian Indigenous Health Service, where we are currently engaged in nutrition research, to suggest how this could make a difference.

The recently established Southern Queensland Centre for Excellence in Indigenous Primary Health Care, where we are engaged in research, has a set of principles to guide its research program. Among these is the principle that, where possible, research adopts a strengths-based approach, to emphasise identification and promotion of factors that build resilience rather than simply treat disease (Southern Queensland Centre of Excellence in Indigenous Primary Health Care, 2011). At this stage of the centre's development, it is important to consider how a SBA could shape nutrition research, program development and service models.

We need to engage with identified community strengths related to particular nutrition issues, such as infant feeding or chronic disease, and assess how community nutrition issues could be better addressed through these strengths. We will also need to appreciate and harness the energy and ingenuity of the community to influence food and nutrition outcomes. This would involve strengthening partnerships with community members and organisations, using processes outlined later in this paper.

Ethical approaches are of great importance. These include accountability to the Aboriginal and Torres Strait Islander community, ensuring the cultural safety of participants, establishing meaningful roles for Aboriginal and Torres Strait Islander co-workers and the development of mutual trust between the community and any non-Indigenous nutrition researcher/worker (Pyett & VicHealth Koori Health Research and Community Health Development Unit, 2002).

While the recently articulated principle of SBA to guide research and previous research (Bond, 2009) provide precedents for a strengths approach within the Centre, it remains challenging to reframe usual approaches to research in order to prioritise strengths and develop effective ways to work with them. In the development of an infant feeding research project, for example, we immediately faced the challenge of moving from a deficit- to a strengths-perspective when deficit perspectives dominated the literature reviewed. We have had to consciously address language usage as it is easy to slide towards the usual deficit descriptions when giving background descriptions of the study population. Working with strengths is an important challenge. Community engagement in nutrition improvement has much potential, however the SBA in this area still needs to be more fully explored.

Rather than making an 'either/or' argument, we see the co-existence of strengths and deficit approaches to work together in a yin and yang-like symbiosis. At the outset, we would also like to emphasise that a strengths-approach cannot replace the essential work of addressing the structural causes of inequalities (Foot & Hopkins, 2010), such as those experienced by Australia's Indigenous peoples as a result of the hegemonic colonial disruption of their traditional bases of strength and wellness.

In the section that follows, we explore definitions and genealogy of a SBA, before moving on to make some observations of repercussions of the wide application of a deficit approach, and to address the application of a SBA in PHN, with particular reference to nutrition in Aboriginal and Torres Strait Islander settings.

Background

A SBA represents a 'way of thinking' that can encompass a variety of nutrition intervention and research methodologies, and is applicable to a range of settings and levels of implementation. Table 1 shows key characteristics of the SBA and the deficit-based approach in PHN. Although key characteristics are readily identifiable for each approach, in PHN practice and research these approaches are complementary and there is sometimes a mixing of the approaches, as we show later in this paper. A SBA lends itself to intervention approaches that are culturally sensitive and locally specific, while the deficit-based approach lends itself to population-wide approaches, varying from biological and lifestyle interventions to the social justice agenda of the social determinants of health.

The paucity of evidence to suggest that informing people about their lifestyle risks improves health, coupled with the failure of lifestyle campaigns which actually serve to increase health inequalities due to their lower effectiveness in the least advantaged groups (Baum, 2007), indicates that there are very real limits to

what health professionals achieve by using only deficit approaches in addressing dietary change.

On the other hand, mobilisation of individuals and communities, according to their strengths and priorities, has potential to increase engagement with health-protective action (Kretzmann, 2000). Achieving a balance between deficit- and strengths-based approaches can inform interventions to focus on factors which sustain health (Fenton, Brooks, Spencer, & Morgan, 2010), especially benefiting groups who have the most to gain from improved nutrition.

Deficit-based research has been fundamental in identifying and clarifying issues of PHN importance including harmful dietary components and unfavourable dietary patterns, and in providing a better understanding of the social patterning of diet-related problems, including food insecurity, failure-to-thrive and stunting, micronutrient deficiencies, obesity and non-communicable diseases. Deficit approaches have been fundamental to decades of research demonstrating that lower social class, social deprivation and lack of social support are among the most important determinants of health (Marmot, 2005; Marmot & Wilkinson, 2006; Syme & Berkman, 1976; Wilkinson, 1996). When these approaches dominate PHN practice, however, we suggest that this can be harmful rather than helpful. They may lead to services which aim to fill gaps and fix problems, resulting in disempowering community and creating dependency, rather than enabling people to be active agents in their health (Foot & Hopkins, 2010). Strengths-based approaches identify and illuminate health-enhancing assets in a community, valuing what works well (Foot & Hopkins, 2010). Strengths may include networks and connections, individual skills, local organisations' capacities and resources, physical and economic resources and the stories, history and culture of the community (Marois, Sterba, Kretzmann, & Pan, 2008).

Examples of the SBA are found in a variety of health and nutrition projects and although not widely adopted, this approach provides useful tools for complementing other approaches to nutrition research and interventions.

Table 1: Dominant characteristics of strengths- and deficit-based approaches in PHN

	Strengths-based approach	Deficit-based approach
General focus	Community strengths and attributes that can be used as building blocks; Fundamentally informed by the socio-political context of health.	Health-risking behaviours; Indigenous people are an "at risk" population. Can be informed by the socio-political context of health.
Way of thinking about diet	Food and eating as social practices; Dietary practices are seen as solutions to a problem.	Dietary patterns that diverge from ideal constructed as deviant and disease-promoting; Individualised diets; Biomedical and factorial model of disease supports a reductive approach to thinking about food and diets.
Epistemology	Affirmative and constructivist epistemologies; qualitatively driven and multidimensional approaches to social explanation.	Positivist and causal epistemology.
Methodologies and methods consistent with the epistemological position	Predominantly qualitative studies based in critical medical anthropology, critical geography, and feminist research, appreciative inquiry, focused ethnographies, reflexive deep descriptive case studies, participatory research and other arts based health interventions such as photo-voice and digital storytelling.	Quantitative dietary assessment, measurement of clinical and anthropometric variables, and dietary behaviours (risks and barriers) as used in epidemiological studies; Some qualitative nutrition behaviour research also fits here, when it retains a focus on describing problems.
Explanation of health differentials	Salutogenic theory (as extended in the public health literature) see (Bengel, Strittmatter, & Willmann, 1999; Lindstrom & Eriksson, 2006)	Deprivation theory (see Charlton & White, 1995)

Genealogy of a strengths-based approach

A range of fields, including education, psychology, social work, community development and public health draw on a SBA. Rather than focus on 'what's wrong,' a SBA guides thinking about positive resources and capabilities. This has led to high levels of community engagement and empowerment as required for creating improved well-being and coping. A range of nutrition interventions have also engaged with strengths (eg. Aambo, 1997; Aubel, Touré, & Diagne, 2004; Chung, Burke, & Goodman, 2010; Lugo, 1996).

As shown in Table 1, a salutogenic theory is key to a SBA. The salutogenic orientation, primarily explores the conditions of health and the factors that protect and contribute to health (Bengel, et al., 1999). This represents a paradigm shift from disease-centred to a health-centred, resource-oriented model of salutogenesis aimed at prevention, which promotes the population as a co-producer of health, rather than simply a consumer of health services (Morgan & Ziglio, 2007).

The original salutogenic theory of Aaron Antonovsky (Antonovsky, 1996) has been further developed to apply its principles in a more sophisticated fashion to the field of public health (Bengel, et al., 1999; Lindstrom & Eriksson, 2006). This theoretical development has necessitated the introduction of concepts to assist in the understanding of factors that maintain population health, specifically, the concepts of social clustering of behaviours and ways of living, and 'salutogenic settings' (Charlton & White, 1995; Cockerham, Rutten, & Abel, 1997; Frohlich & Potvin, 1999; Lindstrom & Eriksson, 2006; Williams, 1995). Inherent to this approach is a move away from an individualistic 'lifestyle' approach (which is prevalent in clinical dietetics), to understanding about the social clustering of ways of living and the need to consider the interactions with cultural, social and psychological factors rather than merely individual risk factors. 'Salutogenic settings' are environments that actively contribute to, and promote healthy populations. Salutogenic approaches in health promotion identify and work with individual, community or organisational strengths that contribute to health and resilience. A benefit of this approach is that it leads to implications for action towards better health, rather than simply describing poor health (Morgan & Ziglio, 2007).

We propose here an increased emphasis on strengths in nutrition intervention and research. Looking at salutogenic (health promoting) environments and practices is not new to nutrition, as discussed below.

Strengths-based approaches in nutrition

Positive Deviance (PD) is a SBA that emerged in the 1970s. It involves identifying positive behaviours, which facilitate good nutrition in the face of adversity, and community development to promote the health-enhancing behaviours in the community more broadly. PD may use both quantitative and qualitative research methodologies to identify the positive nutrition behaviours (Zeitlin, Ghassemi, & Mansour, 1990) and has been applied widely to identify families where children thrive despite living in difficult circumstances similar to those of their peers where children fail to thrive (Zeitlin, et al., 1990). A supplement of the Food and Nutrition Bulletin features articles that presented in-depth descriptive accounts of the use of PD methods in relation to infant and child care and feeding practices (Marsh & Schroeder, 2002). This volume demonstrates effective PD approaches in facilitating sustained nutrition improvements across a range of infant and child nutrition contexts (Marsh & Schroeder, 2002).

Critics argue that PD has the potential to divert policy attention to limited local interventions when broader economic and food security circumstances need to be improved before good nutrition can be achieved for all (Schuftan, 1993). We argue that working at these two levels of action is complementary, even necessary when working to improve nutrition for disadvantaged populations in society. Interventions downstream need to be supported by upstream interventions to address inequality while working to improve nutrition.

Livelihoods approaches to improving food security are another SBA used to build resilience in communities through working from existing salutogenic factors, including human, social, natural, physical and financial capitals in communities (FAO, n.d.; Law, Ward, & Coveney, 2011; Serrat, 2008). Implementation has demonstrated improvements in peoples' lives and resilience, and enhanced household food security and nutrition (Neely, Sutherland, & Johnson, 2004).

A group of international nutrition projects conducted in Indigenous communities (although not including Australian Indigenous communities) to address the growing burden of non-communicable disease drew on community strengths, including traditional knowledge about nutrient-rich and neglected, traditional foods

(eg. Englberger et al., 2006; Englberger et al., 2010; Kuhnlein et al., 2006). In this work quantitative methods are used to examine the chronic disease burden and nutrient analysis of traditional foods, while ethnographic research explores strengths of communities and traditional food systems that are resources for nutrition improvement initiatives. Community development and social marketing, using the information generated about the local food systems, empowers communities to make decisions and take action to improve nutrition in their own communities (Kaufer et al., 2010). This approach takes the time to work with strengths in local communities to maximise sustainability, instead of using the usual 'lifestyle' formula to address the increasing and serious chronic disease impacts experienced in many Indigenous populations. In the Pacific case study of this international project, achievements included making survey results available to the communities to raise awareness of the high incidence of diabetes, and engaging with local leaders including the President and Governor of Pohnpei, high school students, whole communities and farmers to advocate for nutritious food in ways related to their situations. The approach is not about helping people do something, but about doing it together (Borelli, 2011). It built on existing strengths at many levels in the community to develop appropriate, local and sustainable activities to address complex nutrition issues.

SBA have also been used in community-based Aboriginal and Torres Strait Islander nutrition projects (eg. see Bear-Wingfield, 1996; Groos, 1998), however many of these projects have not been reported in the academic literature. In a recent study intervention, participatory research with a Victorian Aboriginal community demonstrated working with strengths to identify empowering responses to food insecurity that were supported by the local community (Adams et al., 2012). This use of a SBA, is a counter to the type of health promotion that effectively blames Aboriginal people for food and nutrition problems whose origins are historic rather than individual.

Living and working in a deficit-defined world

The common practice within public health of viewing food and eating behaviours as risk factors fits with a biomedical model that supports a reductive approach to thinking about food and diets (Scrinis, 2008). However, approaches that assess culture, age, and socio-economic status as merely 'risk factors' for poor dietary habits fail to appreciate the social embeddedness of these characteristics. Delormier et al. (2009) advance the theoretical argument regarding eating as a social practice rather than simply a behaviour. Notably, these authors highlight the misleading tendency of behaviour-orientated methodologies used in food choice studies to 'exaggerate the extent to which rational choice drives what people choose to eat, and underestimates the extent to which eating is embedded in the flow of day-to-day life' (Delormier, et al., 2009 p. 217).

Within a SBA, the social environments in which eating occurs can be framed as potential strengths contributing to the health and resilience of the community. Unfortunately the social environment, especially when located within those populations perceived as 'vulnerable' to nutritional 'problems', such as Aboriginal and Torres Strait Islanders, is frequently constructed as a risk factor (eg. Abbott, Davidson, Moore, & Rubinstein, 2010). This contributes to negative narratives of Indigenous identity, which privilege stories about ill-health and early death as discussed below.

Negative narratives

Aboriginality is commonly presented as a predictor of poor diet and premature death. Aboriginal or Torres Strait Islander ethnicity, for example, is listed as a risk factor for diabetes (Australian Government, 2010) and cardiovascular risk (National Vascular Disease Prevention Alliance, 2009). In contrast to these public health narratives, Aboriginal narratives of identity portray Aboriginality as a resource for living (Bond, 2005; Brough, Bond, & Hunt, 2004). Examples of salutogenic factors identified in an urban Aboriginal and Torres Strait Islander health promotion project include: extended family; commitment to community; neighbourhood networks; community organisations and community events (Brough, et al., 2004).

When PHN equates 'Aboriginality' with nutrition risk, vulnerability, disease and premature death, dysfunction and non-compliance, Aboriginality becomes firmly located within a negative world of meaning (Bond, 2005). However, ethnic variations in health cannot simply be explained by individual choices, cultural traditions or biological inheritance. The broad context of Indigenous group members' lives underpins group differences in nutritional status.

In PHN we need to avoid negative stereotypes, which act as powerful social tools in constructing damaged identities, which become self-fulfilling prophesies. Health professionals may see Indigenous people in a negative way, leading Indigenous people to also see themselves in a negative light (Roy, 2006). This may result in a belief that they cannot do anything about their health, as a young Aboriginal woman describes below:

> *But I always thought about the health stuff that it wasn't ... a big deal to me. ... it's just like you knew you were going to die by 45 or 40 or something. You knew that your life was going to end because of diabetes or smoking or something like that or a heart attack. You knew that you were going to go early (Bond, Brough, Spurling, & Hayman, 2012, p. 570).*

Working with a more contextualised understanding of Indigenous identity, which recognises positive 'Indigenous realities' of identity and health (e.g. community strength, wellness), reframes health promotion from a focus on deficits to strengths (Bond, 2005). When Aboriginal and Torres Strait Islander community strengths are recognised, it can be seen that people are not all passively waiting for top-down health interventions. A news report of a government intervention for nutrition and food security in a remote Aboriginal community demonstrates this:

> *The $800,000 plan aims to educate people in the APY Lands[1] about nutrition and start growing fruit and vegetables. But the Government has had to defend it amid claims it does little to tackle malnutrition and obesity. Liza Balmer from the NPY[2] Women's Council says it has been running nutrition classes on the lands for 15 years but the Government failed to consult council members.*
>
> *'As far as I'm aware the people that should have been involved and that have the expertise were not consulted in the development of this plan and I think that's fairly clear in the report,' she said. (ABC, December 10, 2010)*

The particular community context is of great importance when developing sustainable nutrition projects and while specific local solutions established through a strengths-based approach may not be transferrable without change, the principles of working with assets are transferrable (Foot & Hopkins, 2010).

1 Anangu, Pitjantjatjara & Yankunytjatjara Lands (commonly referred to as APY) are Aboriginal lands in the far northwest of South Australia

2 Ngaanyatjarra Pitjantjatjara Yankunytjatjara

Problem describing

When a deficit-based approach to nutrition research is taken, nutrition problems are often described without being addressed. Such research does not clearly articulate how to achieve healthy changes, even though further nutrition promotion is recommended, as in much research in Indigenous communities (eg. see D'Onise, McDermott, Leonard, & Campbell, 2012; Gwynn et al., 2012; Valery et al., 2012).

Describing nutrition problems provides valuable information, but it is insufficient to resolve nutrition problems (Baum, 2007). By placing the spotlight on the quantification of the 'problem', by labelling Indigenous peoples as 'diseased' or 'deficient' and by relying on this perspective to launch us into 'corrective' solutions, a shadow is inadvertently cast over part of the story that might just be crucial to finding solutions.

An illustrative example from a study about breastfeeding demonstrates the problem-describing approach common to much research in Indigenous nutrition. It concludes:

> *Rates of parent-reported chest infections and hospitalisations due to these infections continue to be high in Aboriginal infants and children. Because breastfeeding for less than three months and low birth weight are risk factors for these infections, interventions to reduce the prevalence of low birth weight and to increase breastfeeding rates should be primary health goals in Aboriginal communities for the benefits of Aboriginal infants and children. (Oddy et al., 2008 p. 207)*

In this study, the authors rigorously use epidemiological approaches to establish information about breastfeeding rates and match this to hospitalisations of Indigenous infants for a variety of infections. While the study recommends that PHN interventions address breastfeeding in Aboriginal communities, it sheds no light on why breastfeeding rates are low, other factors that may also be involved in the infections (housing, SES, employment, and education) and no clear way to address the low breastfeeding issue they have identified. The article, like many others, identifies problems but not solutions. A strengths-based focus is needed to complement the epidemiological work by working with communities to find ways to improve maternal and infant well-being.

Nutrition policy in Australia also has focused primarily on problems. The National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan states clearly that Aboriginal and Torres Strait Islander peoples are the most disadvantaged population group in Australia (Strategic Inter-Governmental Nutrition Alliance (SIGNAL), 2001). Eat Well Queensland (Queensland Public Health Forum, 2002) identifies Aboriginal and Torres Strait Islander peoples as vulnerable groups and enumerates their loss of traditional diets and lifestyles, their much greater burden of ill health attributed to poor nutrition in comparison with other Queenslanders, the higher incidence of low birth weight, failure to thrive and inappropriate growth of Indigenous children, in addition to high prevalence of diabetes, infections and other indicators of poor nutrition. These present a lopsided view of Indigenous communities, where a picture of unhealthiness and helplessness is presented while positive attributes of those communities are not identified. Neither is there recognition that the extended family and neighbourhood networks, commitment to the community, and the existence of community organisations and events may be sources of strength, and be natural launching points when working on nutrition interventions or research (Brough, et al., 2004). We would therefore argue that a greater attention to SBA in nutrition policy, practice and research is warranted. Aboriginal and Torres Strait Islander communities, despite the multiple problems with which they are associated in the media (Brough, 1999) and research (Brough, 2001), have many strengths with which to work in nutrition promotion (Bond, 2009; Brough, et al., 2004).

A strength based approach in Indigenous health and nutrition

Some health programs in Indigenous Australian communities which are deemed successful in terms of community participation and health outcomes, have developed from bottom-up work, fostering and working with strengths in communities (Brady, 2007; Reilly, Doyle, & Rowley, 2007; Rowley et al., 2000). It is important to consider how a PHN perspective could effectively engage with Aboriginality as a source of strength and resilience. This is identified in the 'Closing the Gap – Prime Minister's Report 2011' which states that closing the gap (between Indigenous and mainstream Australians in health and education) will be most successful when driven by Aboriginal and Torres Strait Islander Australians in partnership with others (Commonwealth of Australia, 2011). This may include community capacity building to promote healthy nutrition (Blechynden, 2007). While a SBA challenges some usual nutrition promotion approaches, it offers the promise of more sustainable nutrition improvement as nutrition professionals work in partnership with community members, ensuring that programs are relevant and 'owned' by the community, as demonstrated by Adams, et al., (2012).

In strengths-based approaches to nutrition and empowerment (of individuals, families, communities, and organisations), both the processes and the outcomes are as important. Asset mapping, which involves collecting stories from community members to gain a better understanding of how the community works, is a first step towards this. Bond (2009) identifies that this process must be empowering, as it is far too easy to be drawn back to community weakness and need. With empowerment, aspirations can be voiced and actioned, and nutrition change driven or supported by community members and/or organisations.

Further steps that could be employed in nutrition research or intervention would vary according to the project goals, but could include: organising a core group; building a community vision and plan; mobilising and linking the assets for healthy nutrition changes; and leveraging activities and resources from outside the community (Cunningham, Mathie, & Coady International Institute, 2002).

Building relationships, developing trust and showing respect are integral to both strengths-based approaches and culturally appropriate service provision in Aboriginal and Torres Strait Islander nutrition. Reciprocity is a key feature of Indigenous protocol (National Health & Medical Research Council, 2003). Trust is built upon principles of reciprocity and respect for the community and its members, which helps illuminate community strengths. Problems of Indigenous 'access' and 'compliance' can be addressed through provision of high quality, culturally safe and community 'owned' health services (Bond, 2005). Within this cultural framework, strengths-based approaches in PHN have much to offer.

Recognising the assets of individuals and communities, rather than keeping a narrow focus on needs and problems, has been shown to inspire positive action for change (Bond, 2009; Diacon & Guimarães, 2003; Reilly, et al., 2007). A project promoting nutrition and

physical activity among Aboriginal people from Victoria demonstrated that outcomes depended on the extent of program engagement with the local community strengths, including community knowledge, existing social structures and systems (Reilly, et al., 2007). Attempts at data collection by questionnaire were not supported by the community and therefore largely unsuccessful. Women declined to participate in a focus group that was to concentrate on health problems, although they participated enthusiastically when their suggestions were supported in the research process. The activities that were subsequently developed effectively assisted the women to learn more about nutrition and health while maintaining the social function of the group.

Although a SBA does not hold all the answers to addressing nutritional inequalities of Aboriginal and Torres Strait Islander peoples, acknowledging existing strengths before attempting to build new ones is an important complement to policy and structural changes towards social justice. In nutrition, a greater balance between descriptive studies and solutions-focused studies that identify strengths and potential points to begin interventions that address nutrition problems is needed. Strengths-based approaches can contribute to developing this balance.

The skills and methodologies required to enhance the SBA in PHN are as yet underdeveloped. They are underrepresented within the professional discipline of PHN, despite their emergence decades ago. The limited presence of SBA in the PHN literature and nutrition and dietetics curricula suggests that there is a need within university programs preparing nutrition professionals to foster understanding of research and intervention approaches that work with strengths. There is also a need to develop appropriate tools for the evaluating the effectiveness of complex strengths-based nutrition interventions as the traditional assumptions related to evaluating health interventions are not framed around strengthening assets, but rather curing disease (Hills, Carroll, & Desjardins, 2010).

Conclusions

A SBA can be seen to both challenge and complement a deficit-based approach. While there is little empirical research on the effectiveness of a SBA and related approaches on nutrition outcomes in general, there is a growing promise of benefits from a SBA in PHN. Its application to food and nutrition issues can strengthen sustainability of nutrition improvements through community ownership in populations who are most disadvantaged by nutrition and health inequalities, including Aboriginal and Torres Strait Islander peoples. As Morgan & Ziglio (2010) suggest, redressing the balance between the strengths and deficit approaches may lead to more effective action on health inequalities. The field of food and nutrition would be served well by this rebalance. In the area of Aboriginal and Torres Strait Islander nutrition, where the agenda is shaped by the 'Closing the Gap' priority of the Australian government (Commonwealth of Australia, 2009), it is of utmost importance that we not only look towards the nutrition inequalities experienced by Aboriginal and Torres Strait Islander peoples, but also to strengths within Aboriginal and Torres Strait Islander communities, so that the nutrition inequalities can be addressed sustainably within these communities.

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Lisa Schubert lectures in public health nutrition at the School of Population Health at The University of Queensland, Australia, where she is the Director of the Master of Public Health Program. Her teaching and research interests lie at the intersection of the social and nutritional sciences, and is shaped by her years working as a community nutritionist and dietitian in varied settings. Lisa continues to explore qualitatively driven research methods to understand everyday food practices, and participatory inquiry methods.