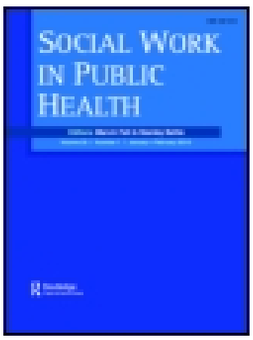

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Community Asset Mapping in Public Health: A Review of Applications and Approaches

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ABSTRACT

Though Community Asset Mapping (CAM) has been widely used in community-development and applied to public health interventions, little has been done to synthesize the current state of this approach. This paper reports the findings from a scoping review of research where CAM was applied to public health practice and research initiatives. We identified and reviewed 28 articles featuring studies that used asset mapping for public health purposes. Overall, we found that the purpose and methods related to asset mapping varied widely across studies. Given the potential benefits of asset mapping and its relevance to social work principles, researchers and public health professionals should approach asset mapping with the same level of attention, rigor, and ethics as other research methodologies or intervention design. There is an obligation to engage in asset mapping in ways that promote our ethical principles of service, dignity, integrity, and competence.

KEYWORDS

Community asset mapping (CAM); public health; social work; scoping review

Introduction

Community asset mapping (CAM) is a community development approach where members of a community are engaged to identify and document available resources that may address particular goals (Kramer, Amos, Lazarus, & Seedat, 2012). CAM may involve identifying tangible or intangible resources in a community and it is designed to facilitate sustainable community-based development (Kretzman & McKnight, 1993; Mathie & Cunningham, 2003). CAM has been used frequently to address community public health goals (Whiting, Kendall, & Wills, 2012) and is particularly relevant to social work, given the discipline's strengths-based perspective. Despite extensive use of CAM in practice and research, little has been done to document how CAM has been applied for public health initiatives across settings, approaches to CAM for public health, and outcomes associated with CAM strategies. This paper addresses this gap in knowledge by presenting a scoping review of research where CAM was applied for public health projects.

Community asset mapping as a community development strategy

CAM has been used for several decades and was initially developed as an alternative approach to traditional community development, which focused more on a community's needs, deficits, and problems (Kretzman & McKnight, 1993). This traditional approach could have negative consequences for communities and therefore, Kretzman and McKnight (1993) recommended asset-building community development, which focused more on capacities, skills and assets of communities. They

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asserted that community development is more effective when community members invest in their own community, especially when outside support may be unavailable.

Viewing a community as a place with assets to be preserved and enhanced instead of deficits to be remedied, CAM was originally built for community-based development (Kretzman & McKnight, 1993; Mathie & Cunningham, 2003). It was also considered as a research technique that provides valid and reliable data on strengths of a community and on the abilities of a community to solve its issues (Lightfoot, McCleary, & Lum, 2014). Furthermore, Lightfoot and colleagues suggested that CAM was a suitable method for social work research because: (1) it shares similar perspectives to a dominant model in social work behavioral intervention – the strengths-based approach; and (2) it fits well with an innovative approach of conducting social work research, particularly community-based participatory research (CBPR), by sharing commonalities with CBPR and allowing for straightforward quantitative analysis for community involvement (Lightfoot et al., 2014). In addition to social work, CAM was also used as a critical community-based participatory research method in other contexts, such as community building for achieving liberatory ideals (Lazarus, Taliep, & Naidoo, 2017), interpersonal violence prevention program development to promote positive forms of masculinity, safety and peace (Taliep et al., 2020), and health promotion (Hodges, Kramer, & Lazarus, 2016; Mosavel, Gough, & Ferrell, 2018).

Approaches to CAM

CAM has been adopted in a broad range of study fields (Kramer et al., 2012), though there has been particular interest in using this strategy for public health (Whiting et al., 2012). Some time ago, a literature review conducted by Kramer and colleagues (2012) identified several asset-based approaches for health that had been implemented. First, they identified the asset-based community development approach utilized in the United States, where CAM was used to identify community assets and then community members invested in mobilizing those assets for their own benefit. A second approach they identified was the toolkit titled, Participatory Inquiry into Religious Health Assets, Networks and Agency (PIRHANA), which was developed in sub-Saharan Africa. This approach encouraged community members to lead inquiries into the religious-based health assets within their communities (e.g., places of worship, beliefs and values) to better understand these assets and how to utilize them. Later, the PIRHANA toolkit was adapted specifically to address HIV/AIDS in South Africa through a program titled, Community Health Assets Mapping for Partnerships (CHAMP), which also focused on supporting community members in developing knowledge that would support health initiatives. The Sustainable Livelihoods Approach (SLA) was developed as an anti-poverty tool that focused on teaching households to mobilize individual and community-level assets to reduce families' vulnerabilities to poverty. Planning for Real® was developed in the United Kingdom and was designed so that external community builders and community members would collaborate to identify and prioritize community needs and assets. Finally, their literature review identified Geographic Information Systems (GIS) as an approach to CAM.

While Kramer and colleagues' (2012) literature review identified specific CAM approaches, very little has been done to identify, classify, or assess the activities that are involved with CAM approaches. Their literature review only described the philosophical assumptions, previous utility in community engagement, and challenges identified in these approaches (Kramer et al., 2012). Further, it is not clear how other asset-based community development models, such as the public health assets framework (Whiting et al., 2012), may incorporate mapping to meet community needs. Since their review, little has been done to evaluate CAM approaches or outcomes associated with CAM models.

Defining health assets

In addition to the activities and approaches involved with CAM, what can be identified as an asset in CAM varies widely. CAM includes procedures for documenting tangible and intangible resources of

a community (Kerka, 2003). A thorough map of community assets may include: (1) gifts, skills, and capacities of the individuals; (2) associations with religious, cultural, athletic, recreational and other purposes; (3) local institutions including private business, public institutions, and nonprofit institutions in communities; (4) physical assets and natural resources; and (5) local economy (Cunningham & Mathie, 2002; Kretzman & McKnight, 1993).

Whiting and colleagues (2012) highlight that there is not a standard definition of a health asset, but they draw upon multiple definitions provided in the literature to give guidance on what they may include (Whiting et al., 2012). In general, health assets may include individual or community resources, factors, or qualities that promote positive health and well-being and/or reduce poor health and health inequalities (Whiting et al., 2012).

Need for current review

Though CAM has been widely used in community-development and applied to public health interventions, little has been done to synthesize the current state of this approach. For instance, little is known about trends in how this strategy is being applied, the approaches and activities associated with CAM, or the outcomes associated with CAM interventions. To address such gaps, this paper reports the findings from a scoping review of research where CAM was applied to public health practice and research initiatives. A scoping review is more appropriate than a systematic review in this case, because the goal is to identify gaps in knowledge, identify how CAM is defined and applied, and to examine key characteristics of CAM (Munn et al., 2018).

Methods

This scoping review was conducted under the guideline of Preferred Reporting Items for Systematic reviews and Meta-Analyses Extension for Scoping Review (PRISM-ScR) and Joanna Briggs Institute (JBI) methodological guidance (Peters et al., 2017; Tricco et al., 2018). The methodology of this review included the following key phases: (1) search strategy identification (i.e., eligibility criteria, information source, citation management), (2) selection of source of evidence, (3) data extraction, and (4) synthesis of results.

Search strategy identifying

Eligibility criteria

Studies were eligible for inclusion if they broadly described the use of asset mapping during 2000 to 2020. Due to limited resources for translation, only studies published in English were included. Papers that described the asset mapping process without conducting one were excluded. Review papers of asset mapping were also excluded from the analysis, but their reference list was reviewed to identify additional studies using asset mapping.

Information source

The initial search was implemented on October 4, 2020. To be comprehensive and to cover a broad range of disciplines, five electronic databases were used: MEDLINE/ PubMed (biomedical and life sciences; 1946 – present), EBSCOhost (multidisciplinary; 1984 – present), Scopus (multidisciplinary; 1788–present), Social Services Abstracts (social work, human services, and related areas, including social welfare, socialpolicy, and community development; 1980–present), and Social Science Citation Index (social science; 1988–present). There were no limits on date, language, subject or type placed on the database search. A search of Google with no date restrictions was also conducted at this time; only the first 100 hits (as sorted by relevance by Google) were screened. The search query consisted of terms considered by the authors to describe the asset mapping and its methodology: *asset mapping, asset-based research*, and *community asset mapping*.

Selection of source of evidence

All citations were imported into the bibliographic manager EndNote X9.3.3, and duplicate citations were removed manually with further duplicates removed when found later in the process. For the first level of screening, only the title and abstract of citations were reviewed to preclude waste of resources in procuring articles that did not meet the minimum inclusion criteria. The full-text of the remaining articles were screened by the first two authors, with ineligible articles removed.

Appraisal of articles

Currently, there are no established guidelines for evaluating the process of asset mapping, particularly when used as a research methodology. Therefore, the following aspects of included studies were identified and evaluated: (a) the article citation; (b) the health issue of focus and location of the project; (c) the stated purpose of the asset map in the project and research methodologies that informed the asset mapping process, as well as whether any mapping software was used (e.g., ArcGIS); (d) evidence of rigor in the methodologies used to inform the asset map (e.g., whether a theoretical framework was used, methods to assess validity of data) and whether any research questions or hypotheses guided the project; and (e) any outcomes identified as a result of the asset mapping methods.

Results

Study contexts

The search strategy initially resulted in 870 cases. Of these, 256 were excluded due to duplicate and 586 were excluded because they were not related to public health. One article by Pfaff and colleagues (Pfaff et al., 2019) focused on the topic of "clinical asset mapping" through informatics, but it focused more on a patient's clinical attributes being mapped, rather than community assets related to public health (Pfaff et al., 2019). Thus, it was also excluded.

Ultimately, a total of 28 articles met the eligibility criteria and were retained for assessment, each representing a unique project. Through this section, individual articles will be identified by their listing in supplemental Table 1 in brackets. In terms of geographic locales, the majority of projects (n = 14) took place within the United States, representing at least 8 states (Andrews et al., 2012; Baker et al., 2007; Brown et al., 2016; Brown & Stalker, 2020; Cutts et al., 2016; Estrada, Ramirez, Gamboa, & Amezola de Herrera, 2018; Finlayson et al., 2017; Florian et al., 2016; Gwede et al., 2010; Makelarski et al., 2013; Millery, Ramos, Lien, Aguirre, & Kukafka, 2015; Ryerson Espino, Aguado, Puente, & Vergara-Rodriguez, 2020; Smith et al., 2017; Villanueva et al., 2016). Another 13 projects were identified in other countries across Europe (n = 5) (Anrooij et al., 2020; Miranda, Garcia-Ramirez, & Albar-Marin, 2020; Soraghan, Boyle, Dominguez-Villoria, Feighan, & Robinson, 2016; South, Giuntoli, & Kinsella, 2015; Whiting, Kendall, & Wills, 2013), Asia (n = 3) (Dewi, Barclay, Wilson, & Passey, 2018; Syarifuddin & Nildawati, 2017; Xu & Maitland, 2017), Africa (n = 1) (Fekadu et al., 2016), South Africa (n = 1) (Taliep et al., 2020), North America (n = 1) (Pivik, 2012), Oceania (n = 1) (O'Connor, Alfrey, Hall, & Burke, 2019), and South America (n = 1) (Toro-Hernandez, Villa-Torres, Mondragon-Barrera, & Camelo-Castillo, 2020). One additional project did not identify a specific location (Caron-Parker & Nichols, 2014).

The health-related topics that the projects focused on varied widely and included: general health disparities (Brown et al., 2016; Brown & Stalker, 2020; Cutts et al., 2016; Estrada et al., 2018; Makelarski et al., 2013; Miranda et al., 2020; O'Connor et al., 2019; Villanueva et al., 2016); general health and well-being (Pivik, 2012; South et al., 2015; Whiting et al., 2013); gerontological issues (Caron-Parker & Nichols, 2014; Smith et al., 2017; Soraghan et al., 2016); nutrition and weight-related health (Anrooij et al., 2020; Baker et al., 2007); mental/behavioral health (Fekadu et al., 2016; Syarifuddin & Nildawati, 2017); tobacco use (Andrews et al., 2012); Tuberculosis (Dewi et al., 2018); oral health (Finlayson et al., 2017); diabetes (Florian et al., 2016); cancer (Gwede et al., 2010); health

informatics (Millery et al., 2015); HIV (Ryerson Espino et al., 2020); interpersonal violence (Taliep et al., 2020); disability (Toro-Hernandez et al., 2020); and refugee health (Xu & Maitland, 2017).

Asset mapping in context

Conceptualization of asset mapping

The definition of asset mapping was fairly consistent across studies as a process for identifying and documenting valuable resources related to a health issue within a community. However, whether asset mapping was used as a research tool or a community development process was not consistent across studies, with some articles blurring the lines between the two purposes. For one study (Xu & Maitland, 2017), the authors specifically identified their initiative as an action research project, which would suggest a combination of both purposes. Another study by Brown and Stalker (2020) combined a CBPR framework with consensus organizing (Brown & Stalker, 2020). It should also be noted that while some projects involved the process of identifying assets and mapping their physical location on a map, other projects described asset mapping as generating a list or inventory of assets without regard for their physical location.

Role of asset maps

The role that asset mapping played in each study also varied, with three related categories emerging for the role of asset maps (see Table 1, categories I, II, III). The first category (I) included projects where asset mapping played a minor role of a larger project, and mapping details were minimal or not provided (n = 5). One example of this was the article by Brown and Stalker (2020), which aimed to conduct a community needs assessment related to health disparities among community members in Baton Rouge, Louisiana (Brown & Stalker, 2020). Here, the researchers integrated data from a number of sources to inform the assessment, including data from asset mapping, crime data, focus groups, interviews, and surveys. Details on how the asset map was developed or how it informed the larger community assessment was not discussed. For most of the articles in this category, asset mapping was used as part of a larger needs assessment.

The second category (II) included projects where asset mapping was a primary product of the project activities that was used as an initial step to inform a separate intervention or health-related initiative (n = 10). For these studies, asset mapping was described as playing a larger role than those in the first category, but the asset mapping was used to inform an intervention or initiative that was the main focus of the project. For example, in the studies by Villanueva and colleagues (2016) and Dewi and colleagues (2018), the asset mapping was used to identify ways to improve the outreach and effectiveness of future public health initiatives (Dewi et al., 2018; Villanueva et al., 2016). The article by Caron-Parker and Nichols (2014), was a methodology-focused paper that provided detail on how they developed a template for asset mapping for aging in place that can be used by researchers and providers in the future (Caron-Parker & Nichols, 2014).

The third category (III, n = 14) included projects where asset mapping was used as a methodological tool to address larger research aims and/or questions (none of the studies appraised tested specific hypotheses). Several of these studies aimed to address disparities and/or access to services. For example, in the study by Gwede and colleagues (Gwede et al., 2010), data collected for asset mapping was integrated with demographic data to map local disparities in access to colorectal screening (Gwede et al., 2010). In the study by Smith and colleagues (Smith et al., 2017), a similar approach was used to identify gaps in falls-prevention services for older adults (Smith et al., 2017). Another example of a study in this category was the one by Makelarski and colleagues (Makelarski et al., 2013), which utilized field observation data to determine the accuracy of local health-related resources that were collected through secondary data analysis sources (e.g., existing databases and resource lists) (Makelarski et al., 2013). Their study found that there were many inaccuracies of data collected through secondary sources.

It should be noted that two studies fit multiple categories. The studies conducted by Estrada and colleagues (Estrada et al., 2018) and Taliep and colleagures (2020) were classified as categories II and

III. For those projects, asset mapping was first used to inform an intervention and the study also described the use of the asset mapping as a methodology (Estrada et al., 2018; Taliep et al., 2020).

Methods used for asset mapping

For a number of studies, asset mapping was listed as a methodology in and of itself, as opposed to a process that was informed by other methodologies. In such cases, little detail on the process of developing the asset map were provided. Of those that did describe methods used to inform asset mapping, qualitative research methods (e.g., interviews, focus groups, field observations) were the most common approaches. Some studies also utilized survey and/or Census data, though these were typically used in addition to qualitative research strategies. Two studies, one by Florian and colleagues (Florian et al., 2016) and another by Whiting and colleagues (Whiting et al., 2013) integrated photovoice methodologies with other data collection methods to learn about community member's perceptions of the asset maps that were created (Florian et al., 2016; Whiting et al., 2013). For example, in the study by Florian and colleagues (Florian et al., 2016) the researchers identified local resources for diabetes management through asset mapping and participants involved in the Photovoice methodology demonstrated that many community members with diabetes did not find these resources to be feasible or helpful (Florian et al., 2016).

Of all of the studies, eight of them reported using some form of digital mapping software to create maps based on the collected data. Four of these studies used ArcGIS (Florian et al., 2016; Gwede et al., 2010; Smith et al., 2017; Soraghan et al., 2016), one used Google Maps (Ryerson Espino et al., 2020), and the other two studies reported using a software that was specifically designed for their study (Makelarski et al., 2013; Villanueva et al., 2016; Xu & Maitland, 2017).

The role of community members in the asset mapping process varied across studies. In seven studies (Brown et al., 2016; Caron-Parker & Nichols, 2014; Florian et al., 2016; Gwede et al., 2010; Smith et al., 2017; Soraghan et al., 2016; Syarifuddin & Nildawati, 2017) the authors did not report community involvement in the process. For the remainder of studies, community members were involved in the design of the project, provided data for the asset maps, or both. For a few studies that reported using a CBPR framework, it was not clear whether community members were involved in asset mapping in roles other than contributing as research participants (Andrews et al., 2012; Anrooij et al., 2020; Baker et al., 2007; Cutts et al., 2016; Millery et al., 2015; O'Connor et al., 2019; Pivik, 2012; Toro-Hernandez et al., 2020; Whiting et al., 2013). For 13 projects, the authors indicated that approval was obtained by an institutional review board (IRB) or other ethics regulating body (Anrooij et al., 2020; Baker et al., 2007; Brown et al., 2016; Dewi et al., 2018; Fekadu et al., 2016; Finlayson et al., 2017; Florian et al., 2016; Gwede et al., 2010; Ryerson Espino et al., 2020; South et al., 2015; Taliep et al., 2020; Toro-Hernandez et al., 2020; Whiting et al., 2013). An additional four described human subjects' protections procedures (e.g., consent forms) (Andrews et al., 2012; Cutts et al., 2016; O'Connor et al., 2019; Pivik, 2012). For the remaining eleven, it was less clear whether procedures were in place to protect community members as research participants or if the researchers viewed them as having roles other than participants.

Approaches to rigor

The most common approach to rigor in the studies was the use of theoretical and/or conceptual frameworks to guide project activities. Of these studies, 12 of them reported that the methods were informed by CBPR, either alone or in combination with another theoretical framework (Brown & Stalker, 2020). For five studies that utilized community members as research partners, the community members received training by the research team (Brown et al., 2016; Dewi et al., 2018; N. Taliep et al., 2020; Xu & Maitland, 2017). A few studies (e.g., Caron-Parker & Nichols, 2014) cited the article by Kretzman and McKnight (1993) as informing their approach to asset mapping. Only one study by Taliep and colleagues (2020) reported developing a manual for their asset mapping process to promote

fidelity across the multiple workshops that were offered to the community for asset mapping activities (N. Taliep et al., 2020).

For qualitative methods that informed asset mapping, the most common indicator of rigor was that the authors provided quotes from their data to demonstrate the trustworthiness of the thematic findings that were generated by the data. Only two studies reported using member checking in order to evaluate the trustworthiness of data that informed the asset map (Brown & Stalker, 2020; Taliep et al., 2020).

Outcomes

None of the studies included in the analysis reported health or clinical-related outcomes (e.g., physical health assessments, mental health assessments). For the majority of studies in categories II and III, the main outcome of the project was the asset map. Some studies that were designed to address specific research questions reported how the maps generated through the project supported their findings. For instance, the studies by Smith and colleagues (Smith et al., 2017) and Gwede and colleagues (Gwede et al., 2010) aimed to identify gaps in service delivery and health disparities (Gwede et al., 2010; Smith et al., 2017). Layering maps can be used to demonstrate where the need for services exist with data about where services are located. Studies that combined asset mapping with other methods, such as the two that use Photovoice, were able to generate findings about community members' perceptions of the maps in addition to generating the maps themselves. In eight of the included studies, the authors provided graphics of their finalized maps or of maps created by community members that were included as part of the process (Estrada et al., 2018; Gwede et al., 2010; O'Connor et al., 2019; Pivik, 2012; Smith et al., 2017; Soraghan et al., 2016; Taliep et al., 2020; Villanueva et al., 2016).

Discussion

Asset mapping is commonly seen as an approach to public health in the literature, though little has been done to systematically evaluate how it is being used for public health research and how it is done. This scoping review identified and categorized 28 articles featuring studies that used asset mapping for public health purposes. Overall, we found that the purpose and methods related to asset mapping varied widely across studies. Given the potential benefits of asset mapping and its relevant to social work principles (Lazarus et al., 2017), researchers and public health professionals should approach asset mapping with the same level of attention, rigor, and ethics as other research methodologies or intervention design. Based on the assessment of articles included in this scoping review, there are some steps that can be taken to improve the quality of asset mapping.

Clarifying the purpose of asset mapping in public health initiatives

This review found that there are two main approaches to using asset mapping in public health research intiatives: mapping as an intervention and mapping as a research methodology. When reporting findings from projects that used asset mapping, researchers should be clear what the role of the asset map is in the project. First, this information is important so that peer reviewers and readers can adequately assess the project presented. For instance, when asset mapping is used as an intervention being studied, the steps taken to design the mapping process should be clear and detailed as any other intervention being studied. In such cases, researchers should be clear about what outcomes were expected from the mapping process and whether those outcomes were achieved. For instance, in many studies, the outcome of the mapping process was the map itself. However, it was not always clear if developing the map helped achieve the public health goals that the study was designed to address. In cases where asset mapping is utilized as a methodology, such as data collection, researchers should be clear about this so that reviewers and readers can evaluate the quality of the approach used to collect the data.

Improving rigor in mapping

Without strong guidelines for asset mapping, researchers took different approaches of gathering the information used for the mapping process, including direct and participant observation, qualitative interviewing, surveys, and document analysis. While it is common practice to provide details on how researchers maximized rigor in such methodologies in other research contexts, this information was often lacking in the studies assessed. Several studies reported that they used Kretzmann and McKnight's (1993) work to guide the development of asset maps. Although Kretzmann and McKnight provided tools for developing an asset map, such as information to help identify assets and sample surveys, their seminal work does not provide as much detail on the process of asset mapping. Additionally, their work was intended to be used for community development and did not discuss the implications or practices for applying their approach to research studies. Nonetheless, findings from the current analysis reveal some potential and practical guidelines for improving rigor in asset mapping for public health studies.

Clear definitions of health assets

While some studies were very clear about what constituted a health asset for their study, others were very vague or broad in their descriptions. Researchers should be very clear on how *health assets* were operationalized. Providing inclusion and exclusion criteria, for instance, would give readers a clearer picture of what may have been labeled as an asset for the project. For studies where multiple people gathered asset data (especially when they were community members), having a clear definition of health assets would help readers evaluate the likelihood that data collection was approached with consistency and fidelity. There may be some studies where researchers may purposefully want to use a broad and nonspecific definition of assets due to the scope and purpose of the study. In such cases, they should provide justification for such decisions.

Participant training

Several studies reported that community members were tasked with gathering health asset data for mapping. Five of these studies reported that these participants received training. In addition to clear definitions of health assets to guide community members, understanding the processes related to participant observation, survey methodologies, interviewing, and other data collection strategies would also insure that the data collected for asset mapping is of high quality. Indeed, over the past decade, the concept of *citizen scientists* has gained popularity in research, especially health research (Naci & Ioannidis, 2015). Research has shown that well-designed training and supportive tools for such community members who participate in data collection can increase the accuracy of the data they collect. Information about the types of trainings that community members receive to participate in asset mapping would be helpful in evaluating a study's quality.

Assessments of data accuracy

For some studies, it was not clear how many individuals were involved in the data collection process. For instance, it was not always obvious if a sole member of the research team culled data from a publically-available list of potential assets or how many participants entered data through crowd-sourced efforts. In either case, very few studies reported using methodology to check the accuracy of the data collected for mapping. Such accuracy assurances could include inter-rater reliability assessments, member checking, and triangulation of data from multiple sources (Padgett, 2016).

Ethical considerations

Although community members were involved in many of the intitiatives highlighted in the reviewed studies, information about institutional review board approval or human subjects protections were not described in the studies. This further blurred the lines between research and non-research public health

interventions. As highlighted by Resnik (2019), traditionally community members either participated in research as either co-researchers or subjects. In the case of citizen scientists, community members may be assuming the role of both, given that they are gathering information related to their own lives and experiences. This raises a number of ethical concerns, including informed consent, confidentiality and privacy, equitable selection of participants, and protection of vulnerable populations (Resnik, 2019).

In cases where researchers are engaged in public health initiatives that partner with community members as collaborators in data collection, they should be forthcoming with community members that information from the initiative may later be published in research journals. This is particularly true because for all of these studies, the communities were not de-identified. Community members have the right to know the potential risks of participating in these initiatives that will result in research, as well as their right to withdraw from the project at any time. In addition, community members should also be trained in human subjects protection principles, given their role as data collectors. For instance, it is not clear on the extent to which community partners in these studies were educated by confidentiality, privacy protection, or even exploitation and coercion.

Limitations

There are limitations to this scoping review. First, there may be additional existing studies that were not identified in the literature due to the search terms. It is also possible that some studies engaged in asset mapping activities, but did not label it as such. Another limitation is that we did not include theses and dissertations in the review, though we recognize from a search on Proquest that asset mapping is a popular approach for student research. Finally, it is a limitation that there are no standard procedures for evaluating asset mapping research or intervention approaches. While we targeted the most relevant qualities of the studies in our review, there may be additional qualities of studies that we did not capture, but nonetheless are important for evaluating their quality.

Conclusion

Community asset mapping offers great opportunity for social workers and social work researchers in public health. While the approach has demonstrated promise in promoting and achieving public health goals, there is an obligation to engage in asset mapping in ways that promote our ethical principles of service, dignity, integrity, and competence.

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