Northumbria Research Link

Citation: Cassetti, Viola, Powell, Katie, Barnes, Amy and Sanders, Tom (2020) A systematic scoping review of asset-based approaches to promote health in communities: development of a framework. Global Health Promotion, 27 (3). pp. 15-23. ISSN 1757-9759

Published by: SAGE

URL: https://doi.org/10.1177/1757975919848925 <https://doi.org/10.1177/1757975919848925>

This version was downloaded from Northumbria Research Link: http://nrl.northumbria.ac.uk/id/eprint/38629/

Northumbria University has developed Northumbria Research Link (NRL) to enable users to access the University's research output. Copyright © and moral rights for items on NRL are retained by the individual author(s) and/or other copyright owners. Single copies of full items can be reproduced, displayed or performed, and given to third parties in any format or medium for personal research or study, educational, or not-for-profit purposes without prior permission or charge, provided the authors, title and full bibliographic details are given, as well as a hyperlink and/or URL to the original metadata page. The content must not be changed in any way. Full items must not be sold commercially in any format or medium without formal permission of the copyright holder. The full policy is available online: http://nrl.northumbria.ac.uk/policies.html

This document may differ from the final, published version of the research and has been made available online in accordance with publisher policies. To read and/or cite from the published version of the research, please visit the publisher's website (a subscription may be required.)

Northumbria University NEWCASTLE

University Library

A systematic scoping review of asset-based approaches to promote health in communities: development of a framework

Viola Cassetti[a], Katie Powell[a], Amy Barnes[a] and Tom Sanders[a+b]

[a] School of Health and Related Research (ScHARR), University of Sheffield, Sheffield, United Kingdom.

[b] Health and Life Sciences, Northumbria University, Newcastle Upon Tyne, UK

Correspondence to: Viola Cassetti, University of Sheffield School of Health and Related Research, 30 regent's street sheffield, Sheffield S1 4DA, United Kingdom. Email: viola.cassetti@gmail.com vcassetti1@sheffield.ac.uk

(This manuscript was submitted on 31 August 2018. Following blind peer review, it was accepted for publication on 22 March 2019)

Abstract

Asset-based approaches (ABAs) to health promotion have become increasingly popular as a way to tackle health inequalities, by empowering people in more disadvantaged communities to use local resources and increase control over health and its determinants. However, questions remain about how they work in practice. This article presents the findings from a systematic scoping review of the empirical literature on ABAs in communities, which aimed to identify the key elements of ABAs, and how they are operationalised in interventions aimed at promoting health and reducing inequalities in local communities. Four databases were searched (Medline, PsycINFO, CINAHL, ASSIA), and papers were included if they described interventions explicitly adopting an ABA but excluded if limited to assets' identification. Thirty articles were included in the review. Data were extracted on: the type of assets that the intervention built upon, how assets were mobilised, the expected outcomes, and evaluation methods. A framework synthesizing the key characteristics of asset-based interventions to promote health in communities is presented. Three main approaches to mobilising assets were identified in the literature: (A) connecting assets, (B) raising awareness of

assets and (C) enabling assets to thrive. It is argued that ABAs to health promotion take a wide variety of forms, making it difficult to anticipate outcomes and to evaluate interventions. The framework presented here can be used to better understand the processes through which ABAs work in practice to promote health and reduce inequalities.

Key words: systematic review, communities, health promotion, asset-based approaches

INTRODUCTION

Health inequalities between people living in relatively more and less disadvantaged areas have been at the core of public health discourse in high income countries over the past two decades (1). In Europe, although various policies and practices have been adopted (2), health inequalities remain wide: recent evidence suggests that the percentage of people reporting good health can vary by up to 17% between those in highest (78%) and the lowest (61%) income quintile (3). In response to the rising concern among researchers and policy-makers regarding how to respond to inequalities, over the past decade an increasing interest has emerged in “asset-based approaches” to health promotion (referred to as ABAs in this paper) (4,5). For the purposes of this paper, we define ABAs as interventions that focus on identifying and mobilising community assets to support health and wellbeing (5-8), and on strengthening people’s capacity to make the best use of these resources with an aim to increase control over their health and that of their community (5,8–10). According to Morgan and Ziglio (6) a health asset can be “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" (p.18). Assets can be individuals and their skills and relations, or local organisations, or elements of the local environment that contribute to health and wellbeing (11). As evidence on the importance for health of social connections and individual and community empowerment has increased (12), researchers supporting the adoption of ABAs suggest that they could help reduce inequalities through strengthening social networks, empowering people to access and mobilise resources, and increasing their control over their own health and its wider determinants (7,9,13).

Three frameworks underpin asset-based approaches to health promotion globally. First is Antonovsky's theory of salutogenesis (14), which argues for a shift from a pathogenic model of health towards exploring what makes people healthy, thus what are the protective factors for health. Second, is the Asset Based Community Development (ABCD) framework (15), which provides a step-by-step guide on how to identify the "assets" already present in communities, to mobilise them in support of community development. Third, is, the Asset Model proposed by Morgan and Ziglio (6), which called for three related actions to develop an evidence base for assets in public health: (a) the development of interventions based on a salutogenic perspective; (b) the use of assets mapping as proposed by Kretzmann and Mcknight (15) as a starting point to develop a trustworthy relationship between local people and professionals, to facilitate the planning of interventions effectively; and (c) the development of new evaluation frameworks and novel indicators to explain how salutogenic interventions work. However, ABAs still lack a robust evidence base (16,17), despite repeated calls for a systematic review of the evidence on ABAs in public health (18,19).

As the existing literature on ABAs centres predominantly on their theoretical basis and less on their implementation, there is uncertainty around what kind of outcomes can be achieved through ABAs (17,19), and it is unclear how interventions adopting ABAs are put into practice (20). Questions remain about what types of interventions are informed by ABAs, their key characteristics, and how they work (or not) in practice to reduce health inequalities. To this end, this systematic scoping review aimed to explore the published literature on interventions in local communities that *explicitly* adopted an ABA, to identify their key characteristics and to understand how assets are mobilised. More specifically, it aimed to answer the following question: How are ABAs operationalised when adopted in interventions aiming to promote health and reduce inequalities in local communities?

METHODS

Drawing on Arksey and O'Malley's (21) recommendations, this scoping review followed four steps: identifying relevant studies through searching databases; selecting studies; extracting and charting the data; and synthesising the evidence. The lack of an agreed definition of ABAs in public health posed a challenge to the development of a search strategy for this review. For instance, not all asset-based programmes name themselves as such, and as other researchers have pointed out (22,23), some authors have tended to adopt the asset-based label retrospectively. On the other hand, sometimes community-based programmes, such as arts-based projects, might not specifically seek to adopt a salutogenic approach to public health, yet, they build upon a positive view of health and well-being, such as promoting skills associated with good mental

health rather than preventing risky behaviours (24,25); a facet that is shared with the assets movement. Given that this project was a scoping review, a decision was made to explore the characteristics of those interventions implemented in local communities making explicit reference to ABAs.

As suggested by Baxter et al (26) initial iterative searches and in-depth reading of reports analysing ABAs (4–7,15–17) helped identify the terms for the final search strategy. The final strategy was based on the “population” and “intervention” components of the PICO (Population, Intervention, Comparator and Outcome) framework (27); with population referring to people living in local communities and intervention referring to any intervention which explicitly adopted an asset-based approach, combining the terms “asset model”, “asset*map*” “asset*-based”, “people or neighbourhood or communit*” and “asset*”, or “salutogenesis” combined with terms associated with local communities and inequalities. Papers were included if they referred to a specific asset-based programme implemented in local communities. At least one of the programme components needed to have built upon, or engaged with, local assets and a description provided of the relevant intervention and expected outcomes. Papers only describing asset mapping were excluded, since this process is not considered an intervention on its own: assets must be mobilised for an intervention to be considered asset-based (5). Papers were included when the described intervention had a health promotion goal, using the WHO definition of health promotion as: a process to increase people’s control over their own health through developing personal skills, strengthening community action, creating supportive environments for health, reorienting health services or building healthy

policies (28). The publication of Antonovsky's text on salutogenesis and health promotion in 1996 (14) was chosen as the starting date for the selection and papers were included if published in English, Spanish, Italian or Catalan (see inclusion/exclusion criteria in supplementary material online). Although it is recommended to search and include grey literature in scoping reviews, due to the breadth of the topic, this review focussed on published literature only.

Four databases (Medline, PsycINFO, CINAHL, ASSIA) were searched between January and September 2017. Other databases were explored during the initial searches (Sociology abstracts and Social Service Index and Social Science Citation Index) but results did not meet the inclusion criteria, and these databases were therefore excluded from the final search. A forward citation search of four key texts was performed using Web of Science (14,15) and Google Scholar (6,7). The following information was extracted from included studies: a description of the intervention; the type of assets identified, and how these were being mobilised; the expected outcomes; how the intervention was evaluated (Table I). This information was initially organised in a table (see supplementary material online) under three overarching blocks: process, outcomes and evaluation. The aim of this first synthesis was to count extracted data and group commonalities across the studies, to provide an overview of the implementation literature. This information was then synthesised further by adopting a thematic approach, grouping together similar outcomes and evaluation practices under a common overarching label to develop a framework of the key characteristics of ABAs (see Table II). During this step, the findings were integrated with information from existing theoretical literature on ABAs (4–7,15–17) on how to initiate a process adopting ABAs and its underpinning attributes. In addition, further synthesis was

required to identify commonalities in how assets were mobilised or incorporated across the included interventions, as Table II shows.

RESULTS

The final search retrieved 760 papers after removal of duplicates. After sifting these by title and abstract, 50 studies were accessed full-text. Thirty met the inclusion criteria and were included in the final review. The PRISMA flow diagram illustrates the selection process (29).

[Figure 1]

Included studies described 28 different interventions. As Table I shows, there is wide variation in the form that ABAs take in health promotion (Table I).

[Table I]

Extracted data from the included studies were synthesised under the following themes: interventions processes, outcomes, and evaluation methods (see supplementary material online and the framework presented in Table II).

Intervention processes

Eighteen interventions targeted people living in communities as a whole, with fewer interventions directed at specific populations within the communities. Although the majority of the interventions were explicitly underpinned by the

ABCD model (15) or the asset model (6), some papers made reference to other approaches as also informing the intervention design, including: Community Based Participatory Research (30–32) Positive Youth Development (33–35); Community engagement (36,37); participatory research approaches (22,38,39), peer support models (40), socio-ecological model (30,34,37) or social capital theory (41) (Table I). In the majority of the interventions, the assets identified were individuals and their skills, or existing organisations, only three included elements of the physical environment (37,48,58).

We propose three main approaches to understand how assets are mobilised:

(A) connecting existing assets

(B) raising awareness of assets

(C) enabling assets to thrive (see Table II).

(A) refers to programmes in which existing people and organisations recognise each other as assets and connect together to work or share resources. Examples included developing new partnerships (22,32,34,37,38,43–52).

(B) refers to tangible existing resources which may be underused, or which other community members may not be aware of. Examples included signposting to services or other resources (30,36,41,42,48,54–56).

(C) reflects processes where potential assets identified needed further support to develop their potential. It describes activities designed to encourage individuals to “become” assets in their communities or to intervene on physical settings. Examples included training lay people to become peer supporters or to deliver an intervention (31,33–35,39–41,57); or establishing recreational parks (22,37,46)

or green infrastructures (37,46,52).

In our analysis, eight interventions used approach A, seven used approach C, three used B and ten used more than one approach combined.

Outcomes

Following South's framework on community-based outcomes (13) *outcomes* were categorised according to three levels: individual, community and organisational. Nineteen interventions anticipated changes in individual outcomes such as increased skills, healthier behaviours or self-confidence. Twenty interventions anticipated community changes such as engagement or development of partnerships and five interventions anticipated changes at organisational level such as developing new interventions or raising awareness of services (see Table I and supplementary material online). However, eighteen interventions included changes at more than one level.

Evaluation

Sixteen studies reported evaluation methods. Within these studies, ten interventions adopted a mixed methods approach to the evaluation, although two of them (45,55) limited the quantitative part to monitoring attendance or satisfaction. Two studies included self-administered surveys to collect data on health behaviour (35,42) or on engagement patterns (43). Only one study (35) incorporated health data from an available census. Qualitative methods were used primarily to explore changes and impact through interviews. The remaining fifteen studies focussed on describing the intervention. Overall, limited discussion was found as to whether and how the intervention had contributed to the

reduction of health inequalities. For example, Durie and Wyatt (22) argue that traditional linear interventions cannot effectively tackle the complexity of inequalities, while adopting ABAs and enabling equal relationships between communities and services could be an alternative way to tackle such complexity. Other authors discussed inequalities as informing target group or area for the intervention, which may suggest that the interventions could reduce inequalities in those population or areas (56,57). One paper specifies that impact on impact on inequalities will be evaluated separately (50).

The combined evidence from theoretical texts and the synthesis from the scoping review led to the development of a framework (Table II) highlighting the key characteristics of ABAs to promote health in local neighbourhoods into the three main blocks: process, outcomes and evaluation practices.

[Table II]

DISCUSSION

This scoping review represents the first attempt to systematically review published empirical literature on ABAs for promoting health in local communities. It has shown that ABAs are implemented in a variety of forms and assets are being mobilised in different ways to improve health. It has proposed a framework for understanding the key dimensions of ABAs in health promotion.

The proposed framework can serve as a basis for reflection when asset-based interventions are being designed; for example, to underpin dialogues about what

assets to mobilise, how, and for what purposes. It should be considered a work in progress to support discussion of what makes an intervention asset-based and how expected outcomes might be brought about. The framework can be tested and refined through further analysis of ABAs.

It should be noted that most interventions sought to *connect* individuals and or organisational assets. The theoretical literature aligns ABAs with community engagement approaches, which might explain this focus. Fewer interventions mobilised physical settings as assets, mainly through approach (B), for instance by encouraging local residents to walk in green areas (37,48,57). Further research should explore barriers to mobilising physical assets.

On the other hand, 'enabling' people to thrive as assets (approach C) may reflect a more top-down strategy as it implies the public health workforce or other stakeholders recognising a potential in individuals. Approach C could also be used to refer to interventions enabling elements of the physical environment to become assets. However, because those actions (22,46,52) resulted from the *connection* of individuals or existing organisations, 'enabling' physical settings to thrive could also be considered as a secondary outcome of the asset-based process.

In fact, many of those outcomes that interventions aimed to achieve could also be thought of as processes leading to health improvement like changes in social capital or the development of local partnerships. It might be more helpful to define ABAs as processes leading to more salutogenic health promotion practice. A change as such requires a shift in mindset in stakeholders engaged in

implementing ABAs, which can be challenging (19). Further research on the potential causal pathways emerging from interventions adopting ABAs could help shed light on how ABAs can reduce inequalities and what their added value could be in comparison to more traditional deficit-based approaches. It seems that there is an implicit assumption about the relationship between connecting, raising awareness of, or enabling assets to thrive, with improved health and reduction of inequalities.

Finally, the variety of expected outcomes makes it difficult to compare interventions or identify common health indicators, a challenge shared by other academics researching community wellbeing (58). As argued by Baker (20) where evidence on ABAs is available, the variety of indicators adopted to measure outcomes makes it difficult to synthesise results and analyse ABAs' effectiveness. The difficulties of tracing and associating specific processes or intermediate social outcomes to health results resembled one of the assertions of the Chicago conference on community intervention in 2009 (59), where researchers proposed to study community intervention as part of a system, presenting system thinking as a potential paradigm. The proposed perspective considers the influence that both a complex system and an intervention can have on a local community and its members. Communities are indeed complex and open systems themselves, where various factors and people interact with each other in different ways, creating different synergies, not always as predicted (60). Asset-based interventions reflect this complexity, and so does the system within which these are implemented, and the health needs they aim to address. Evaluating an asset-based intervention in communities should therefore take a

more comprehensive approach to account for those outcomes, impacts and changes (61) in the dynamics of the contexts, the synergies of the people, the settings and the relationships (19,62). Moreover, how those changes can help reduce inequalities should be further investigated.

To our knowledge, this is the first review to analyse the implementation literature on ABAs and the first attempt to provide a synthesised framework of the variety of assets mobilised and outcomes related to ABAs. Although this review tried to be as comprehensive as possible, the lack of inclusion of grey literature may have left out other examples of ABAs implementation.

CONCLUSION

This review represents a first attempt to systematically search and synthesise the empirical published literature on ABAs to promote health in local communities. It has provided an overview of the key characteristics of interventions adopting an ABA and it has proposed three different strategies through which assets are mobilised within interventions: (A) connecting assets, (B) raising awareness on available assets and (C) enabling assets to thrive. It has discussed the challenges that evaluating ABAs can generate, given the variety of anticipated health-related outcomes, the blurred boundaries of ABAs as processes or outcomes and the different ways in which assets can be mobilised to bring about changes. A lot has been written on assets in public health from a theoretical perspective on the approach and how it should be implemented. Yet, the empirical literature has shown limited evaluation of ABAs that effectively identifies changes attributed to ABAs. The framework presented here can be used in further research that is

needed to understand how ABAs can support health promotion and reduce inequalities.

Conflict of interest

‘The Author(s) declare(s) that there is no conflict of interest’

Funding

This work is supported by the University Prize Scholarship of the University of Sheffield as part of a doctoral training programme in Public Health.

REFERENCES

1. World Health Organization – Regional Office for Europe. Health 2020: A European Policy Framework and Strategy for the 21st Century [Internet]. Copenhagen: WHO Regional Office for Europe; 2013. [cited 2017 Jan 16]. Available from: http://www.euro.who.int/en/publications/policy-documents/health-2020.-a-european-policy-framework-and-strategy-for-the-21st-century-2013
2. European Commission [Internet]. Solidarity in Health. Reducing health inequalities in the EU. [cited 2018 Feb 15]. Available from: https://ec.europa.eu/health/social_determinants/overview_en
3. OECD. Understanding The Socio-Economic Divide In Europe [Internet]. 2017 [cited 2017 Oct 12]. Available from: https://www.oecd.org/els/soc/cope-divide-europe-2017-background-report.pdf
4. Foot J. What makes us healthy? The asset approach in practice: evidence,

action, evaluation [Internet]. Jane Foot; 2012 [cited 2016 Oct 14]. Available from: http://www.janefoot.co.uk/downloads/files/healthy%20FINAL%20FINAL.pdf

5. Hopkins T, Rippon S. Head, hands and heart: asset-based approaches in health care [Internet]. The Health Foundation; 2015 [cited 2016 Oct 10]. Available from: http://www.health.org.uk/publication/head-hands-and-heart-asset-based-approaches-health-care

6. Morgan A, Ziglio E. Revitalising the evidence base for public health: an assets model. Promot Educ; 2007;14 Suppl 2:17–22.

7. Foot J, Hopkins T. A glass half-full: how an asset approach can improve community health and well-being [Internet]. IDeA – Improvement and Development Agency; 2010 [cited 2016 Nov 15]. Available from: https://www.local.gov.uk/sites/default/files/documents/glass-half-full-how-asset-3db.pdf

8. McLean J. Asset based approaches for health improvement: redressing the balance [Internet]. Glasgow: Glasgow Centre for Population Health, Concept Series 9; 2011 [cited 2016 Dec 16]. Available from: https://www.gcph.co.uk/assets/0000/2627/GCPH_Briefing_Paper_CS9web.pdf

9. McLean J. Putting asset based approaches into practice: identification, mobilisation, measurement of asset. Glasgow: Glasgow Centre for Population Health, Concept Series 10; 2012 [cited 2017 Feb 2]. Available from:

https://www.gcph.co.uk/assets/0000/3433/GCPHCS10forweb_1_.pdf

10. Sigerson D, Gruer L. Asset-based approaches to health improvement [Internet]. NHS Scotland; 2011 [cited 2016 Oct 10] Available from: http://www.healthscotland.com/uploads/documents/17101-assetBasedApproachestoHealthImprovementBriefing.pdf

11. Springer AE, Evans AE. Assessing environmental assets for health promotion program planning: a practical framework for health promotion practitioners. Heal Promot Perspect. 2016;6(3):111–8.

12. Marmot M. Fair Society, Healthy Lives. The Marmot Review. [Internet] Strategic Review of Health Inequalities in England post-2010; 2010 [cited 2016 Oct 12]. Available from: https://www.parliament.uk/documents/fair-society-healthy-lives-full-report.pdf

13. South J. A guide to community-centred approaches for health and wellbeing [Internet]. Public Health England; 2015 [cited 2016 Oct 16]. Available from://www.gov.uk/government/publications/health-and-wellbeing-a-guide-to-community-centred-approaches

14. Antonovsky A. The salutogenic model as a theory to guide health promotion. Health Promot Int. 1996;11(1):11–8.

15. Kretzmann JP, McKnight JL. Building communities from the inside out. Skokie, IL: ACTA Publications; 1993.

16. Morgan A. Revisiting the Asset Model: a clarification of ideas and terms. Glob Health Promot. 2014;21(2):3–6.

17. Wood S, Finnis A, Khan H, Ejbye J. At the heart of health. Realising the value of people and communities [Internet]. The Health Foundation &

NESTA; 2016 [cited 2017 Jan 10]. Available from: https://www.nesta.org.uk/sites/default/files/at_the_heart_of_health_-_realising_the_value_of_people_and_communities.pdf

18. Morgan A, Aleman-diaz A. Measuring what matters for young people's health and well-being: an asset approach. Learning for Well-being magazine. 2016;1:1-9.

19. Rippon S, South J. Promoting Asset Based Approaches for Health and Wellbeing: Exploring a Theory of Change and Challenges in Evaluation [Internet]. Leeds: Leeds Beckett University & Aligned Consultancy; 2017 [cited 2018 March 3]. Available from: http://eprints.leedsbeckett.ac.uk/4497/

20. Baker D. Developing and implementing a robust asset-based approach to public health. Perspect Public Health. 2014;134(3):129–30.

21. Arksey H, O'Malley L. Scoping studies: towards a methodological framework. Int J Soc Res Methodol. 2005;8(1):19–32.

22. Durie R, Wyatt K. Connecting communities and complexity: a case study in creating the conditions for transformational change. Crit Public Health. 2013;23(2):174–87.

23. Friedli L. 'What we've tried, hasn't worked': the politics of assets based public health. Crit Public Health. 2013;23(2):131–45.

24. Fredland NM. Nurturing healthy relationships through a community-based interactive theater program. J Community Health Nurs. 2010;27(2):107–18.

25. Heenan D. Art as therapy: an effective way of promoting positive mental health? Disabil Soc. 2006 Mar;21(2):179–91.

26. Baxter SK, Blank L, Woods HB, Payne N, Rimmer M, Goyder E. Using logic model methods in systematic review synthesis: describing complex pathways in referral management interventions. BMC Med Res Methodol. 2014;14(62).

27. Booth A, Sutton A, Papaioannou D. Systematic approaches to a Successful Literature Review. London, Thousand Oaks, New Delhi: Sage Publications Inc.; 2012

28. World Health Organization. The Ottawa Charter for Health Promotion [Internet]. Ottawa, World Health Organization; 1986 [cited 2016 Dec 10]. Available from: https://www.who.int/healthpromotion/conferences/previous/ottawa/en/

29. Moher D, Liberati A, Tetzlaff J, Altman D, the Prisma Group. Preferred Reporting Items for Systematic Reviews and Meta Analyses: The PRISMA Statement. PLoS Med. 2009;6(7):e1000097

30. Martinez LS, Ndulue U, Perea FC. Nuestro Futuro saludable: connecting public health research and community development in partnership to build a healthy environment. Community Dev. 2011;42(2):255–67.

31. Rhodes SD, Kelley C, Siman F, Cashman R, Alonzo J, McGuire J, et al. Using Community-Based Participatory Research (CBPR) to Develop a Community-Level HIV Prevention Intervention for Latinas: A Local Response to a Global Challenge. Women's Heal Issues. 2012;22(3):e293–301.

32. Sharpe PA, Flint S, Burroughs-Girardi EL, Pekuri L, Wilcox S, Forthofer M. Building capacity in disadvantaged communities: development of the

community advocacy and leadership program. Progress in Community Health Partnerships. 2015;9(1):113–27.

33. Bloomberg L, Ganey A, Alba V, Quintero G, Alcantara LA. Chicano-Latino Youth Leadership Institute: an asset-based program for youth. Am J Health Behav. 2003;27 Suppl1:S45-54.

34. Edberg MC, Cleary SD, Andrade EL, Evans WD, Simmons LK, Cubilla-Batista I. Applying Ecological Positive Youth Development Theory to Address Co-Occurring Health Disparities Among Immigrant Latino Youth. Health Promot Pract. 2016;18(4):488-96

35. Kegler M, Rodine S, Marshall L, Oman R, McLeroy K. An asset-based youth development model for preventing teen pregnancy: Illustrations from the HEART of OKC project. Health Education. 2003;103(3):131–44.

36. Derges J, Clow A, Lynch R, Jain S, Phillips G, Petticrew M, et al. 'Well London' and the benefits of participation: results of a qualitative study nested in a cluster randomised trial. BMJ Open. 2014;4(4):e003596.

37. Miller EK, Scofield JL. Slavic Village: Incorporating Active Living into Community Development Through Partnerships. Am J Prev Med. 2009;37(6 Suppl 2):S377–85.

38. Ortega A, Albert S, Sharif M, Langellier B, Garcia R, Glik D, et al. Proyecto Mercado FRESCO: A Multi-level, Community-Engaged Corner Store Intervention in East Los Angeles and Boyle Heights. J Community Health. 2015;40(2):347–56.

39. Mathias KR, Mathias JMP, Hill PC. An asset-focused health needs assessment in a rural community in North India. Asia-Pacific J public Heal.

2015;27(2):NP2623-34.

40. Robinson M, Raine G, Robertson S, Steen M, Day R. Peer support as a resilience building practice with men. J Public Ment Health. 2015;14(4):196–204.

41. Coll-Planas L, Del Valle Gomez G, Bonilla P, Masat T, Puig T, Monteserin R. Promoting social capital to alleviate loneliness and improve health among older people in Spain. Health Soc Care Community. 2017;25(1):145–57.

42. Phillips G, Bottomley C, Schmidt E, Tobi P, Lais S, Yu G, et al. Well London Phase-1: results among adults of a cluster-randomised trial of a community engagement approach to improving health behaviours and mental well-being in deprived inner-city neighbourhoods. J Epidemiol Community Heal. 2014;68:606–14.

43. Kegler MC, Painter JE, Twiss JM, Aronson R, Norton BL. Evaluation findings on community participation in the California Healthy Cities and Communities program. Health Promot Int. 2009;24(4):300–10.

44. Matthiesen M, Froggatt K, Owen E, Ashton JR. End-of-life conversations and care: an asset-based model for community engagement. BMJ Support Palliat Care. 2014;4(3):306–12.

45. Rütten A, Abu-Omar K, Frahsa A, Morgan A, Rutten A, Abu-Omar K, et al. Assets for policy making in health promotion: overcoming political barriers inhibiting women in difficult life situations to access sport facilities. Soc Sci Med. 2009;69(11):1667–73.

46. Sardu C, Mereu A, Sotgiu A, Contu P. A bottom-up art event gave birth to

a process of community empowerment in an Italian village. Glob Health Promot. 2012;19(1):5–13.

47. Semenza JC, Krishnasamy P V, JC S, PV K. Design of a health-promoting neighborhood intervention. Health Promot Pract. 2007 Jul;8(3):243–56.

48. Stead M, Arnott L, Dempsey E. Healthy heroes, magic meals, and a visiting alien: Community-led assets-based social marketing. Social Marketing Quarterly. 2013;19(1):26–39.

49. Yeneabat M, Butterfield AK. “We Can’t Eat a Road:” Asset-Based Community Development and The Gedam Sefer Community Partnership in Ethiopia. J Community Pract. 2012;20(1-2):134–53.

50. Fuertes C, Pasarín MI, Borrell C, Artazcoz LL, Díez E and the Group of Health in the Neighbourhoods. Feasibility of a community action model oriented to reduce inequalities in health. Health Policy. 2012;107:289–95.

51. Baker IR, Dennison BA, Boyer PS, Sellers KF, Russo TJ, Sherwood NA. An asset-based community initiative to reduce television viewing in New York state. 2007;44(5):437–41.

52. DeGregory ST, Chaudhury N, Kennedy P, Noyes P, Maybank A. Community Vision and Interagency Alignment: A Community Planning Process to Promote Active Transportation. Am J Public Health. 2016;106(4):654–7.

53. Janosky JE, Armoutliev EM, Benipal A, Kingsbury D, Teller JLS, Snyder KL, et al. Coalitions for impacting the health of a community: the Summit County Ohio experience. Popul Health Manag. 2013;16(4):246–54.

54. Dobrof J, Heyman JC, Greenberg RM. Building on community assets to

improve palliative and end-of-life care. J Soc Work End Life Palliat Care. 2011;7(1):5–13.

55. Parker E, Meiklejohn B, Patterson C, Edwards K, Preece C, Shuter P, et al. Our games our health: a cultural asset for promoting health in Indigenous communities. Heal Promot J. 2006;17(2):103–8.

56. Riley R, Coghill N, Montgomery A, Feder G, Horwood J. The provision of NHS health checks in a community setting: an ethnographic account. BMC Health Serv Res. 2015;15:546.

57. Hanson S, Cross J, Jones A. Promoting physical activity interventions in communities with poor health and socio-economic profiles: A process evaluation of the implementation of a new walking group scheme. Soc Sci Med. 2016;169:77–85.

58. Bagnall AM, South J, Mitchell B, Pilkington G, Newton R, Di Martino, S. Systematic scoping review of indicators of community wellbeing in the UK [Internet]. What Works Wellbeing; 2017 [cited 2018 Feb 2]. Available from: http://eprints.leedsbeckett.ac.uk/5238/1/community-wellbeing-indicators-scoping-review-v1-2-aug2017.pdf

59. Trickett E, Beehler S, Deutsch C, Green LW, Hawe P, et al. Advancing the science of community-level interventions. Am J Public Health. 2011;101(8):1410–19.

60. Mittelmark MB, Sagy S, Eriksson M, Bauer GF, Pelikan JM, Lindström B, et al., editors. The Handbook of Salutogenesis. Springer; 2017.

61. Jolley G. Evaluating complex community-based health promotion: Addressing the challenges. Eval Program Plann. 2014;45:71–81.

62. Hawe P, Shiell A, Riley T. Theorising interventions as events in systems. Am J Community Psychol. 2009;43(3–4):267–76.