



The
University
Of
Sheffield.

*Asset-based approaches to promote health and
reduce inequalities in neighbourhoods.*

A qualitative theory-based investigation of two cases

A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy

The University of Sheffield
Faculty of Medicine, Dentistry and Health
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Submission Date: 30th June 2020

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Acknowledgement

First of all, I would like to thank all the participants in this study. Although I cannot name them individually for ethical reasons, I would have not been able to achieve this without their contributions. I feel honoured to have met them and shared parts of this experience with them. I would like to give a special thanks to the key informants from both sites, for their interest and their constant support to the research. I've learnt a lot from them and I hope they've learnt something as well from this experience.

I would like to thank the University of Sheffield, for the excellent quality of research training provided, and also for funding this study. Being awarded the University Prize Scholarship gave me the opportunity to undertake these three years research project and become a researcher in the field of public health and in particular in health promotion in place-based communities. I hope I can now continue growing professionally and contributing to this research field and practice.

I would like to thank my supervisors for their guidance throughout these three years. Our relationship was the building block of this adventure and I am really grateful for having shared this journey with you. Your interest and your confidence in my work, together with all your support, has been an asset for this whole experience, thank you.

I would like to thank my partner, who has been there in the times of joy and madness, supporting me and encouraging me. I would like to thank my dad, who has been encouraging me over these years, and who has also been trying to read some of my work, even though he struggled with the contents and the language.

A special thought goes to my mum, who passed away a few days before receiving the news that I was awarded a PhD scholarship. I like to think that, somehow, she knew it anyway, and I hope she would be proud of me today.

Abstract

In recent years, a resurgence of interest towards asset-based approaches to tackle place-based health inequalities has grown within the public health community, despite their limited evidence. This study aimed to understand how ABAs could promote health and reduce inequalities when implemented in less advantaged neighbourhoods. More specifically, it aimed to identify both ABAs' key characteristics, and the changes and processes through which ABAs affect inequalities.

A qualitative research was conducted in two settings (Valencia and Sheffield) where similar AB initiatives were implemented, aimed at training lay people to become health promoters. Data were collected using theory of change workshops, observations and semi-structured interviews with 44 key stakeholders, including community members, Voluntary and Community Sector organisations' workers, and health professionals. A thematic analysis informed by systems thinking was carried out to understand the potential impact of ABAs.

Three main processes were identified. First, 'enabling AB thinking', defined as adopting a positive view to value resources and people's skills and expertise. Second, 'developing AB capacities', described as developing skills, knowledge, self-confidence, and relationships underpinned by AB thinking, to value each other as potential assets. Finally, 'mobilising AB capacities', referred to achieving wider changes in the neighbourhoods, resulting from stakeholders mobilising the developed AB capacities beyond the initiatives. Significantly, contextual factors were found key in enabling or hindering these changes to happen.

This research adds evidence to the theory of ABAs, as it showed that enabling AB thinking is a key ongoing process throughout. It also provides insights to ABAs' implementation, as developing and mobilising AB capacities can foster individual empowerment and the development of social capital among stakeholders, although impact on places was limited because of contextual factors. Finally,

this study shows that adopting qualitative methods informed by systems thinking can help understand ABAs' potential to impact on place-based health inequalities.

Declaration

I, the author, confirm that the Thesis is my own work. I am aware of the University's Guidance on the Use of Unfair Means (www.sheffield.ac.uk/ssid/unfair-means). This work has not been previously been presented for an award at this, or any other, university.

Publications resulting from this PhD

Cassetti, V., Powell, K., Barnes, A., & Sanders, T. (2019). A systematic scoping review of asset-based approaches to promote health in communities: development of a framework. *Global Health Promotion*. [online] [Viewed 15 May 2020] <https://doi.org/10.1177/1757975919848925>

Published abstracts resulting from this PhD

Cassetti, V., Sanders, T., Barnes, A. (2018) Connecting assets to promote health in local communities. Perceived changes among local stakeholders. *Eur. J. Public Health* [online] **28**(supl.4), 74–75. [Viewed 22 April 2020] Available from: <https://doi.org/10.1093/eurpub/cky218.047>

Cassetti, V., Sanders, T., Barnes, A. (2018) 865. Community Health Beyond The P-value: How Qualitative Methodologies Can Support Evaluation Research [Oral presentation]. Xxxvi Reunión Científica De La Sociedad Española De Epidemiología and Xiii Congresso Da Associação Portuguesa De Epidemiologia. September 2018, Lisbon, Portugal. [Viewed 10 October 2019] Available from: https://www.reunionanualsee.org/2018/documentos/gaceta_Sanitaria_2018.pdf

Cassetti V (2018) Il modello degli “assets” nei programmi di promozione della salute comunitaria: una proposta metodologica per valutare l’impatto. In: Ardis S, Guidi G, Pacitti M, et al. (eds) *Rigenerare Territori, Contesti, Professioni*. Raleigh, US: Aonia Edizioni; Lulu Press, pp. 104–106.

Cassetti V (2019) Understanding change in community health promotion interventions: where qualitative research becomes important. QHRN Committee, Libert S, Llewellyn H, et al. (eds) Taking the Pulse of Qualitative Health Research in a Changing World: Crafting a Critical Approach to Social Change and Health in the 21st Century. UCL London. [Viewed 10 February 2020] Available from: https://www.ucl.ac.uk/qualitative-health-research-network/sites/qualitative-health-research-network/files/qualitative_health_research_in_a_changing_world_crafting_a_critical_approach_to_social_change_and_health_21st_century_qhrn_final.pdf

Conference presentations resulting from this PhD

Cassetti, V., Sanders, T., Barnes, A. (2018) Connecting assets to promote health in local communities. Perceived changes among local stakeholders. EUPHA Conference, Ljubliana, Slovenia.

Cassetti V (2018) Il modello degli “assets” nei programmi di promozione della salute comunitaria: una proposta metodologica per valutare l’impatto. In: Rigenerare territori, contesti, professioni, Milano, 1-2 Ottobre 2018.

Cassetti, V., Sanders, T., Barnes, A. (2018) 865. Community Health Beyond The P-value: How Qualitative Methodologies Can Support Evaluation Research [Oral presentation]. Xxxvi Reunión Científica De La Sociedad Española De Epidemiología and Xiii Congresso Da Associação Portuguesa De Epidemiologia. September 2018, Lisbon, Portugal.

Cassetti, V., Sanders, T., Barnes, A., (2018). Asset-based approaches to promote health in local communities: a participatory research across Spain and the UK. IUHPE Conference, Implementing Health Promotion in the Life Course - User Involvement in Practice and Research. September 2018, Trondheim, Norway.

Cassetti, V (2017) How can asset-based community development reduce health inequalities? Exploring the rationale underpinning the assets model and the salutogenic approach to health. [oral presentation] British Medical Sociologist Annual Conference, 13-15 sept, York, UK.

Cassetti, V (2017). How to evaluate asset-based approaches in community health promotion: a protocol for a realist-based evaluation. [Oral presentation]. Concha Colomer International Symposium – ETC Summer School, Alicante, Spain

Cassetti, V (2017) Cómo se presenta un programa basado en activos y cómo éste puede promover la salud comunitaria? Una propuesta de modelo a partir de una revisión de la literatura. Activos para la Salud Comunitaria. Granada, 25-26th of May 2017. Escuela Andaluza de Salud Pública (EASP). Granada, Spain.

Chapter 1. Introduction

1.1 Background to the study

Over the past two decades, inequalities in health within and between countries have been at the core of public health research in high income countries (WHO Europe 2013). Health inequalities are defined as avoidable differences in health (Kawachi et al. 2002), linked to differences in the conditions in which people are born, live, play, work and age; namely the social determinants of health (Dahlgren & Whitehead 1991). In 2005, the Commission on the Social Determinants of Health (CSDH 2008) was set up by the World Health Organization to study the conditions which affect the health of individuals across the life course, to find solutions to increase equity in health and to reduce the gaps in life expectancy that exist within and across countries. Among these conditions, the Commission on the Social Determinants of Health (CSDH 2008) included, for example, the places where people live and the social relationships in which people are embedded as important in determining health. Following the report of the Commission in 2008 (CSDH 2008), policies and actions to tackle health inequalities have been brought forward by the public health community across Europe, such as the white paper 'Together for Health: A Strategic Approach for the EU 2008-2013' (Commission of the European Communities 2007), the Health in All Policies approach (Puska 2007) or the Health 2020 strategy (WHO Europe 2013). However, there are still gaps in the ways that policy-makers have been trying to effectively develop policies and practices to tackle health inequalities. For example, a recent review by renowned epidemiologist Sir Michael Marmot suggests that inequalities across the UK are still wide and, in some cases, have actually widened during the last decade, with an increase in child poverty and in communities living in poor conditions (Marmot 2020).

Over the past decade, in some countries across Europe and in the European Union, emphasis in policies has been placed on people's engagement as a way to increase their health and control over

health determinants, and on the role of creating healthy place-based communities as central to many public health approaches to tackle inequalities (Commission of the European Communities 2007; WHO Europe 2013). This reflects some of the key lines of actions of the health promotion paradigm, which is an approach to public health that focuses on how people can increase control over their health and its determinants, with an emphasis on developing skills, community actions, creating supporting environments, reorienting services and developing healthy policies (WHO 1986). However, although health inequalities have been at the core of the rhetoric of many national policies, implementing strategies have varied across countries (European Commission 2017): ranging from national strategies adopting some form of ‘proportionate universalism’, to ensure efforts were directed at everyone but with most efforts towards those most excluded (Marmot 2013), to cross-sectoral approaches targeting intermediate determinants of health for the most vulnerable populations (European Commission 2017). Nonetheless, today inequalities are still high, within and across most countries in Europe (WHO Europe 2019; Ricciardi 2015; Mackenbach, et al. 2016) and researchers and policy-makers have both claimed the need for innovative approaches to tackle them (WHO Europe 2011).

Within this scenario, where academics and policy-makers are researching novel strategies to reduce inequalities, a resurgence of interest in the potential of “asset-based approaches” (ABAs) to promote health and reduce health inequalities in and between place-based communities has been observed among some academics and policy-makers in high-income countries (Foot 2012; Hopkins & Rippon 2015). Asset-based approaches as a way to tackle place-based health inequalities will be the focus of this thesis. Although lacking a commonly agreed definition, asset-based approaches centre on identifying local resources (assets) available to people within places, which can support health and wellbeing, and on strengthening people’s capacity to make the best use of these resources. Researchers, practitioners and public health workers who support this approach claim that it could help to reduce health inequalities in and between place-based communities through

strengthening social networks, empowering people to use their local resources and increasing control over their own health and over its determinants (McLean 2012; Foot and Hopkins 2010; PHE 2015). Although there have been an increasing number of publications which have analysed and theorised the assets-approach, ABAs still lack a robust evidence base (Morgan 2014; Wood et al. 2016). There are questions about what the key elements of ABAs are and how they are thought to, and do, work in practice to promote health and reduce health inequalities in place-based communities. Moreover, when implemented, asset-based (AB) initiatives are examples of complex interventions in health promotion which can be challenging to evaluate. A complex intervention is an initiative with multiple components and stakeholders, interacting in a dynamic way, which is generally hard to predict (Jolley 2014). Moreover, place-based communities also reflect this complexity as they can be understood as complex systems where people, relationships and contexts continuously interact, change and shape the system itself (Trickett et al. 2011). In recent years, researchers interested in community-based initiatives in the area of public health and health promotion have started discussing the need to adopt different approaches to studying and evaluating these complex initiatives, as traditional research approaches cannot account for the interactions between people, contexts and interventions. Increasingly, qualitative approaches and systems thinking perspectives have been discussed as potential approaches to study and evaluate complex community-based initiatives (Orton et al. 2017; South et al. 2020), and this study also adopted this combined approach.

This thesis focuses on exploring how asset-based approaches work to promote health and reduce inequalities when implemented in less advantaged neighbourhoods, through a qualitative, theory-based inquiry of two asset-based (AB) initiatives, which share similar underpinning approaches and components, but are implemented in two different contexts, one in Valencia (Spain) and one in Sheffield (UK).

1.2 Research question, aim and objectives

The research question of this study is: how can asset-based approaches promote health and reduce inequalities in less advantaged neighbourhoods?

This research question has been articulated as aim and objectives as follows.

Aim: to understand how asset-based approaches can promote health and reduce inequalities when implemented in less advantaged neighbourhoods.

Objectives:

Obj 1: to identify the key characteristics of interventions which adopt an asset-based approach to promote health and reduce inequalities in and between neighbourhoods through analysing the literature on ABAs and data generated through qualitative research into two AB initiatives.

Obj 2: to identify changes and processes through which interventions using ABAs promote health and affect inequalities through analysing the literature on ABAs and data generated through qualitative research into two AB initiatives.

1.3 Structure of this thesis

This thesis is organised into eight chapters. In this first chapter, a brief introduction to the background of this research has been presented. The next chapter, Chapter 2, builds on this by providing more background information about the current situation around place-based health inequalities in Europe, about the health promotion paradigm, and asset-based approaches in public health. Chapter 2 is divided into three main sections. It starts by describing in more depth what

place-based health inequalities are and how these have been researched, highlighting recent research which included more emphasis on the role of social relationships within places as affecting the health of the people living there. It then provides examples of policies which have been adopted to tackle these, and introduces the asset-based approach as a potential approach to tackle health inequalities, discussing how asset-based approaches have started being adopted in current national policies, taking the case of the UK and Spain as significant examples. Section 2.3 of Chapter 2 then moves on to present the health promotion paradigm as an approach to public health and inequalities in place-based communities, as ABAs have been associated with this paradigm. It provides background information to the origin of the health promotion paradigm and it then illustrates key concepts relating to it, namely capacity development, empowerment and increased control, with an aim to explore how health promotion can support reducing health inequalities. Finally, section 2.4 of Chapter 2 introduces the asset-based approach in public health. It starts by exploring the three main frameworks on which the asset-based approach builds upon, namely salutogenesis, Asset-Based Community Development, and the Asset Model. It then presents how the asset-based approach has been recently theorised as key in tackling place-based inequalities, providing an overview of current research on ABAs.

Chapter 3 presents the methods and results from a scoping review of implementation literature on asset-based approaches to identify their key characteristics and the changes which asset-based initiatives can achieve (to respond to objective 1 and 2 of this study). This chapter is based on a recent publication from this thesis: Cassetti et al. (2019). The scoping review presented here found that ABAs can take a variety of forms when implemented in place-based communities, and identified three processes through which assets can be mobilised: 1) connecting assets, 2) raising awareness on assets and 3) enabling assets to thrive (Cassetti et al. 2019). It also found that ABAs can achieve a variety of changes at individual and collective levels, which are best understood as ongoing changes in health and its determinants that can support health promotion. However, the review

highlighted that the implementation literature still lacked evidence of the processes through which ABAs can reduce inequalities when implemented in place-based communities. Hence, the need to further explore the processes which asset-based approaches can initiate. The findings from the scoping review are also discussed in relation to the background material on asset-based approaches and health promotion presented in Chapter 2.

Chapter 4 details the methodology and methods adopted to carry out fieldwork exploring how two different initiatives adopting ABAs could work to promote health and reduce inequalities, one in Spain and one in the UK. This chapter includes a description of the AB initiatives studied, to guide the reader in understanding the complexity of both settings. The Chapter explains how the methodology and methods were informed by systems thinking, it discusses the rationale for the methodology chosen, and provides details about each data collection method and analysis.

Chapter 5 presents the first part of the findings from the qualitative field work in Sheffield and Valencia. It starts by describing the forms which the observed AB initiatives took. It then presents two important ongoing processes which have been identified. The first, is defined in this study as 'enabling asset-based thinking', and refers to a process of adopting a positive mindset and valuing people for their skills and expertise as a result of being involved in AB initiatives. Then, it presents a second important process, defined here as 'developing asset-based capacities' which refers to a process with three key dimensions: acquiring skills and knowledge, increasing self-confidence and developing asset-based relationships.

Chapter 6 presents the second part of the findings from the qualitative fieldwork. It introduces the variety of ongoing changes which have been associated with the observed AB initiatives, as resulting from what has been defined as 'mobilising asset-based capacities'. It also discusses how the contexts where these AB initiatives were implemented acted as enabling or hindering the processes of

mobilising the acquired asset-based capacities, and thus impacted on the possibility of achieving changes at community level as a result of the implementation of the observed AB initiatives.

Chapter 7 discusses the findings in relation to the literature on health promotion and asset-based approaches presented in Chapter 2 and 3. It highlights the contributions which this study makes to this field of knowledge. First, this study adds evidence to the theoretical literature on asset-based approaches, more specifically in terms of their planning and implementation. As it will be shown, it highlights how identifying and mobilising assets is part of the planning of an AB initiative but can also be an ongoing process throughout the implementation. This is because stakeholders need to adopt an asset-based thinking to be able to identify assets, and training to enable this mindset may be needed, as the two fieldwork from this study found. This is why 'enabling asset-based thinking' should be considered as a key process in asset-based approaches and can also be ongoing throughout. Second, this study adds to the understanding of how asset-based approaches can support reduction of health inequalities as it found that the observed AB initiatives can lead to changes associated with increased individual empowerment and development of social capital. However, it adds to the literature presented in chapter 2 and 3 as it shows that being underpinned by an asset-based thinking can enhance the impact which the initiatives generate. It also highlights that taking a systems thinking approach helps analysing how contextual factors can act as favouring or hindering these processes to happen, hence the importance of taking a systems perspective when studying asset-based approaches in place-based communities. It finally discusses the strengths and limitations of the study and provides recommendations for research and practice.

Chapter 8 summarises the research and emphasises the novel contribution that this thesis has made to researching asset-based approaches as ongoing processes which can support reduction of place-based health inequalities, with an emphasis on taking into account how the wider systems in which these initiatives tend to be embedded can affect the impact which asset-based approaches can achieve. It also highlights the methodological contribution of this study, as it shows that adopting a

qualitative approach informed by systems thinking can be helpful in studying complex initiatives such as ABAs.

Chapter 2. Health promotion in place-based communities. Background and rationale for the study.

2.1 Chapter introduction

This chapter presents background information about the current situation around place-based health inequalities in Europe, and introduces the asset-based approaches in public health to highlight the rationale for this study. Section 2.2 starts by briefly introducing the current situation on place-based health inequalities in the European region, and how the relation between places and health has been researched in public health. As it will be shown, recently, increased emphasis has been placed on the role of people and relationships in places, which is also reflected in some of the recent strategies to tackle place-based inequalities in Europe. It will then introduce how ABAs have been recently proposed as an alternative approach to support reduction of health inequalities, showing how ABAs have been adopted in national and local policies, taking the UK and Spain as examples, as these will be the focus of the study. Following this, section 2.3 presents the health promotion paradigm as an approach to public health which has been associated with ABAs and can provide helpful insights to understanding how ABAs work. This section includes an analysis of underpinning concepts that relate to the health promotion paradigm and which are of particular relevance for this study (section 2.3.2). Section 2.4 presents the asset-based approach (ABA) in more details, to provide more background to this study and to highlight the current gaps in research around ABAs. Section 2.4.1 starts by presenting its theoretical roots and section 2.4.2 will present an overview of the current advances in theorising how ABAs work, to shed light on how ABAs are expected to work in practice to reduce inequalities according to current research.

2.2 Place-based health inequalities in Europe

As introduced in Chapter 1, tackling health inequalities to reduce the gaps in life expectancy between and within countries has been a stated priority for researchers and policy-makers in Europe over the past three decades (Zollner 2002; WHO Europe 2013; Plamondon et al. 2018). Recent data show that differences in life expectancy between European countries can reach up to 8.9 years (EPH, EUPHA, & Society for Social Medicine 2015). Moreover, differences like these occur not only between countries but also within countries, and between neighbourhoods within cities, with individuals from the lowest socioeconomic positions and from less advantaged neighbourhoods showing worse health outcomes compared to those from higher socioeconomic positions and living in more advantaged areas. For example, recent data from both Sheffield (UK) and Valencia (Spain), which are the two settings of this research, show a clear gap in life expectancy between neighbourhoods. In Valencia, there can be up to 6.8 years of difference in life expectancy between the more and less advantaged areas (Conselleria de Sanitat Universal i Salut Pública 2018), while in Sheffield this difference reaches almost a 10 years gap between neighbourhoods (Sheffield City Council 2019b).

Research has shown that differences such as these are determined not only by individuals' behaviour, but also by other factors and conditions, namely the social determinants of health (Marmot 2005; Kickbush et al 2016). These are the conditions in which these individuals "are born, grow, live, work and age" (Marmot 2010, p.12) and influence our health either positively or negatively. However, differences in health between more and less disadvantaged places have often tended to be attributed to people's own health behaviours, such as unhealthy eating choices, lack of physical activity and uptake of unhealthy habits like smoking or alcohol consumption, and have resulted in the implementation of behaviour change interventions to address health inequalities. Some researchers have argued that this emphasis on individuals' behaviour can be associated with the rise of neoliberal paradigms within public health approaches during the 1980s (Macintyre et al.

2002), which framed health within the responsibility of individuals, without recognising the contextual drivers of those health behaviours, namely the wider social determinants of health. In fact, research has shown that only around 40% of health issues can be attributed to individuals' behaviours, while social, environmental and economic factors play a more significant role in health (The King's Fund 2019). Similarly, recent work carried out by the WHO Regional Office for Europe (WHO Europe 2019) has identified five essential conditions beyond individual lifestyle, each contributing to support people to live a healthy life: health services (contributing 10%), income security and social protection (35%), living conditions (29%), social and human capital (19%), decent work and employment (7%).

It is therefore important to move beyond individuals' lifestyle and behaviours and take into account the wider social determinants of health in order to address place-based health inequalities. As shown in the rainbow model developed by Dahlgren and Whitehead (1991), the social determinants of health can be clustered into four main areas of influence: 'lifestyle level factors', 'social and community networks', 'living and working conditions', and ultimately wider 'socio-economic, cultural and environmental factors'. Focusing on how the intermediate determinants - 'social and community networks' and 'living and working conditions' - can impact on people's and communities' health can therefore become key in tackling place-based health inequalities, as it will further discuss throughout this chapter.

During the 1990s, however, research on how places could impact on people's health has tended to focus on how environmental factors, such as quality of air and water, could help explaining differences in population health between places (Diez Roux 2001; Macintyre et al. 2002; Kestens et al. 2017). In recent years, a body of research has started focusing on the role that both social relationships and contexts can have in shaping people health and contributing to place-based inequalities (Diez Roux 2001; Kestens et al. 2017; Forrest and Kearns 2001; Hawe and Shiell 2001; South 2014; Orton et al. 2017). One of the main ideas is that people living in a more supportive

network can take collective decisions aimed at creating better surrounding environments and thus increase their control over resources and health (Whitehead 2007). Moreover, increased participation and engagement in community activities, as well as strong social networks, have been associated with better health (O'Mara et al 2013; NICE 2016; Foot 2012; PHE 2015). Importantly, this central role of people and relationships has also been reflected in some of the policies and strategies to tackle inequalities between places in Europe, as the next section will further discuss.

2.2.1 People and relationships at the centre of strategies to promote health and reduce place-based inequalities in Europe

As introduced above, to effectively tackle place-based inequalities it is key to consider the ways in which people, relationships and contexts interact as influencing health. Putting people and communities at the centre of actions to tackle place-based inequalities was indeed suggested by the WHO Commission on the Social Determinants of Health (CSDH 2008), and was reflected in some of the policies and strategies which have been proposed by the public health community and adopted by governments across Europe since 2008, as the next paragraphs will illustrate.

At a more international level across Europe, for instance, already in 2007, the European Commission published the white paper 'Together for Health: A Strategic Approach for the EU 2008-2013' (Commission of the European Communities 2007) where the commitment to support health for all, reduction of inequalities and citizens' empowerment were set out as a strategic approach for the following seven years. The strategy highlighted the importance of cross-sectoral work and set the basis for the Health in All Policies (HiAP) Approach. The HiAP approach supports actions to promote health from all sectors, thus recognising the influence of the wider and intermediate social determinants on people's health and not only their individual behaviour (Donkin et al. 2017).

Then, in 2012, the WHO European Member States adopted the WHO European policy for health and wellbeing, the Health2020 framework, a strategy to improve health and wellbeing and reduce inequalities. This policy recommended actions to reduce health inequalities through building on local assets, supporting the development of resilient communities and creating supportive environments (WHO Europe 2013). Interestingly, these recommendations embed concepts from the asset-based approach, even though evidence of its effectiveness was still limited, as it will be further discussed later in the chapter. Most recently, other strategies proposed by the EU Commission (such as Europe 2020) and other initiatives proposed by global stakeholders like the WHO Europe Health Equity Status Report Initiative (HESRI) (WHO Europe 2019) have pushed towards focussing on the role of non-health sectors as having an impact on health and its determinants. Indeed, according to the recent WHO analysis on the health equity status of the European region (WHO Europe 2019), to effectively promote health equity, what is needed is a combination of intersectoral actions and policies, as no single intervention can be effective on its own.

However, working intersectorally remains a pending issue across Europe; in fact, emphasis on the importance of working intersectorally to tackle inequalities in health has once again been central in the Finnish presidency of the European Council between July and December 2019 (Council of the European Union, conclusions 11164/19, 15th July 2019). Some authors have discussed the challenges to intersectoral work as associated with the traditional sectoral organisation which characterises many European governments (Pons-Vigués et al. 2014; Koivusalo 2010). In fact, a recent scoping review of European policies and interventions on health inequalities found that many interventions still focus on health behaviours changes rather than on the upstream determinants of health inequalities (Pons-Vigués et al. 2014). This might explain why inequalities within and between places have remained high, and new approaches were needed to tackle these.

It is within this scenario that a resurgence of interest in the potential of asset-based approaches (ABAs) to promote health and reduce health inequalities in and between place-based communities

has been seen within the public health community (Foot, 2012; Hopkins & Rippon, 2015). As introduced in Chapter 1, ABAs focus on identifying local resources (health assets) in place-based communities which can support people's health and wellbeing. A "health asset" has been defined as (Morgan and Ziglio 2007, p.18):

"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."

Researchers, practitioners and public health workers who support the asset-based approach claim that strengthening social relationships and empowering people to make better use of their local resources can help reduce inequalities and increase communities' control over their own health and its determinants (McLean 2012; Foot and Hopkins 2010; PHE 2015). In this sense, ABAs reflect the values of the health promotion paradigm, as section 2.3 will further analyse, and are aligned with recent research on place-based communities centred on how people, social relationships and contexts can affect health inequalities, as introduced earlier in section 2.2. However, there are still questions around what ABAs are and how they work in practice, as this chapter will further illustrate. Before further exploring ABAs, however, it is important to highlight that, within such scenario of finding new approaches to tackle place-based health inequalities, over the past decade ABAs have started entering major policy discourses in some European countries (Cofiño et al. 2016), particularly in the UK and in Spain, where ABAs are now part of the national or regional public health strategies, as the next section will briefly illustrate.

2.2.1.1 Asset-based approaches in the UK policy

In 2010 in Scotland, the Chief Medical Officer Sir Harry Burns called for a change in approaches to tackle health inequalities and advocated for the adoption of the asset-model (Scottish Community

Development Centre 2010). This change in perspective, going from the traditional deficit view of what people and communities lack, towards an asset-based view looking at people's and communities' resources is one of the first examples of the adoption of ABAs in the public health policy area in the UK. Interestingly, even though the evidence base for ABAs was still low (Sigerson and Gruer 2011) and most evidence of implementation was coming from grey literature on community work (see for instance Scottish Community Development Centre 2010), an increased emphasis on ABAs in other policies and strategies across the UK has been seen over the following years. For instance, in 2013 and 2014 the annual reports of the Welsh Public Health Department (NHS Wales 2013, 2014) were centred on identifying ways to improve the health of adults and children respectively, explicitly adopting an asset-based approach. Similarly, the agenda for well-being of Public Health England in 2013 (Public Health England 2013) encouraged the adoption of an asset-based approach and specified the recognition of families as assets for health.

At a more local level, and relevant for this thesis, is the example of how local authorities have embedded ABAs into their policies and practices. In Sheffield, during the 2013 re-organisation of the City Council, a new strategy has been developed, the Community Wellbeing Programme (CWP), which aims to reduce inequalities in the most deprived areas of Sheffield through a place-based approach, working together with local voluntary and community sector organisations. The CWP in Sheffield aims to engage local people and organisations through enhancing social capital and adopting the principles of asset-based community development (SchARR, Sheffield City Council and SCC Public Health Specialists 2016). Hence, the central role of ABAs. Moreover, the CWP includes specific health related support through Health Trainers, Health Champion and Practice Champions and the Introduction to Community Development and Health (ICDH) course, which has been one of the focus of this thesis, as Chapter 4 will further discuss (Sheffield City Council 2019a).

Similarly, in Spain, ABAs have been increasingly adopted in policies and strategies at national, regional and local level, as the next section will show.

2.2.1.2 Asset-based approaches in the Spain policy

In 2013, the Spanish Ministry of Health, Social Services and Equality (MSSSI from its Spanish acronym) included the asset-based approach as the central paradigm within the National Strategy for Health Promotion and Prevention (MSSSI 2013), although interest on ABAs was already present a few years earlier (Álvarez-Dardet and Ruiz Cantero 2011; Rivera de los Santos et al. 2011).

At a more local level, and relevant for this thesis, is the example of the Valencian Region which in 2016 developed a policy to promote health, the Fourth Regional Health Plan (Generalitat Valenciana. Conselleria de Sanitat Universal i Salut Pública 2016), which commits to incorporate ABAs as central values in its strategies. The plan has five lines of actions, where the fifth centres on promoting health in all settings, including a specific action plan to support identifying and enhancing local assets for health (line of action 5.7). Moreover, this policy refers to two local initiatives as examples of best practice to support local empowerment and reduce health inequalities. One of these has been the focus of this thesis, the MIHsalud intervention, which will be further discussed in Chapter 4 when detailing the settings of the fieldwork research.

In sum, reducing place-based health inequalities has been at the core of various strategies across Europe over the past decades, although many interventions still tend to focus on individuals' behaviours and do not account for the intermediate and wider social determinants of health. Recent research has placed emphasis on the interaction of people, relationships and contexts as key in understanding and tackling place-based health inequalities, a view which was also reflected in some of the policies and strategies proposed to tackle place-based health inequalities across Europe. Within this scenario, ABAs have started being proposed as a new approach to tackle these inequalities, and have started permeating public health policies in some European countries, as the cases of Spain and the UK have shown.

However, ABAs still lack a robust evidence base (Morgan 2014; Wood et al 2016), which is why this

study aims to explore how ABAs can promote health and reduce inequalities in place-based communities. To do so, it is important to first analyse what is known on ABAs and their underpinning theories, to further understand how they might be contributing to the reduction of health inequalities. One important point to highlight is that ABAs have been associated with the health promotion paradigm in public health (Brooks and Kendall 2013), which can provide useful insights in order to understand ABAs, as the next section will further illustrate.

2.3 The health promotion paradigm to tackle place-based health inequalities

As the section above has shown, recent research on place-based health inequalities has placed emphasis on the role of people and relationships as factors affecting health in communities. This view of health as centred around places, people and relationships has been central in ABAs and has been at the core of the health promotion paradigm. This section will therefore introduce the health promotion paradigm and provide an analysis of the key concepts relating to it - capacities, empowerment and increased control - to help understanding some of the theories informing ABAs.

2.3.1 An introduction to the health promotion paradigm

The beginning of the health promotion paradigm is linked to 1986, when during the first International Conference on Health Promotion in Ottawa, the World Health Organisation (WHO 1986) presented the Ottawa Charter for Health Promotion. The Charter proposed a definition of health promotion as “the process of enabling people to increase control over, and to improve, their health”. As well, it presented five key action areas in Health Promotion, namely: developing personal skills, reorienting health services, creating supportive environments for health, strengthening community action for health and building healthy public policy (WHO 1986). The Charter also proposed three strategies to achieve health promotion: (1) “mediate” as the need to work collaboratively and across all sectors of societies to promote health, (2) “advocate” to ensure that

the political, social and economic contexts can favourably support health and (3) “enable” every individual to be healthy through “achieving equity in health” (WHO 1986). At the time of its publication, in the public health field, the Ottawa Charter for Health Promotion represented a paradigm shift from the traditional disease and dependency perspective which had focused on people’s needs and on the behavioural explanations for ill-health. According to Ridde et al. (2007), the Ottawa Charter for Health promotion can be considered as the first international call to support actions specifically targeting reduction of health inequalities. Moreover, the health promotion paradigm proposed a view of health as a positive “resource for everyday life” (WHO 1986) and it started promoting values of equity, empowerment and community participation (Potvin et al. 2005), placing emphasis on the importance of working across sectors and from different levels of actions, ranging from policies to local development (Jolley 2014). About a decade later, these values and recommendations were reinforced during the 4th international conference on Health Promotion held in Jakarta, which concluded with a declaration setting out five priorities to enhance health promotion in the twentieth century (WHO 1997): (1) promote social responsibilities for health; (2) increase investment for health development; (3) consolidate and expand partnership of health; (4) increase community capacity and empower the individual; (5) secure and infrastructure of Health Promotion. As highlighted again in this declaration, ideas such as developing capacities and empowering individuals were central to health promotion. The Jakarta declaration also included a call for action to governments across the world to invest in health promotion and in intersectoral work, across different institutional sectors and across community members and private and voluntary and community sectors. As the previous section showed, references to working across sectors and with communities have remained central in recent policies to tackle place-based health inequalities, although their implementation is still limited.

The principles of the health promotion paradigm thus become central in efforts to tackle place-based inequalities given its cross-cutting relevance and the role given to the empowerment of

people and communities, as also highlighted in the last (9th) Global Health Promotion Conference in Shanghai in 2016 (WHO 2017). In this sense, ABAs are aligned with the health promotion paradigm (Brooks and Kendall 2013), as ABAs share this focus on people's skills and on orienting actions towards empowering people and communities to increase control over their health and its determinants, as section 2.4 will further discuss. It is therefore important to explore these key concepts underpinning the health promotion paradigm, as a way to shed light on how promoting health in communities can contribute to reducing place-based health inequalities, as the following sections will show.

2.3.2 Key concepts underpinning the health promotion paradigm

As the previous section suggested, developing capacities and empowering individuals, together with the development of social relationships are central concepts within the health promotion paradigm of public health and are presented as supporting the ultimate goal of health promotion, namely: increased control over health. However, capacities and empowerment are complex concepts which appear in many disciplines beyond health promotion, such as community psychology, and development studies. It is therefore useful to introduce these concepts in more detail, and to consider how they have been defined and associated with health promotion and increased control.

2.3.2.1 Developing capacities as a way to promote health

As introduced in the previous section, capacity building has been at the core of health promotion since its inception in the Ottawa Charter (WHO 1986), and later as a key strategy as recommended in the Jakarta Declaration (WHO 1997). However, the concept of capacity is complex and various researchers have been trying to define it for the past decades. In the late 1990s, Goodman et al. (1998) conducted a workshop with CDC workers to identify what dimensions were included in the concept of capacity. The group identified 10 core dimensions, ranging from developing skills and

resources to the capacity to develop 'social and interorganisational networks' and understanding community history and values. Importantly, capacity building can be seen as a process as well as an outcome (Labonte and Laverack 2001 part 1), and according to Goodman et al. (1998), capacity building is context specific, and it can operate at different levels, from the individual to the organisational. Significantly, other researchers (Hawe's et al. 1997) considered capacity building as having an effect that extends beyond itself, in the sense that it provides people and communities with the ability to solve other problems, and not only the first one identified for which the capacity building was put into place. This can be related to the idea of capacity building as a process, which can continue beyond the time frame of an intervention. This is important when it comes to discussing how community-based initiatives work to promote health. For instance, a recent work by South and other researchers (PHE 2015) suggested that building local skills and cohesion is key to improving health and well-being, and increasing people's capacity and community organising can support enhancing control over their own health and environments through providing people with the skills to act on the major determinants. Similar processes have been argued by Whitehead (2007), who discussed that, when interventions to reduce inequalities are targeted at individuals, their aim is to provide those individuals with the skills and confidence which can support them in facing the adverse conditions in which they live, or to empower them to gain understanding and capacities to make use of services to improve their health. This is why capacity building is an important concept in the area of health promotion practice.

In sum, capacity building is a complex construct which includes different dimensions associated with the development of relationships between different people and sectors, with supporting people and communities to increase their knowledge and skills to tackle health determinants and increase control over decisions affecting their health. A recent review of 17 studies on capacity building by Liberato et al. (2011, p.6) found that the major domains to assess capacity building were: "learning opportunities and skills development", "resource mobilization",

“partnership/linkages/networking”, “leadership”, “participatory decision-making”, “assets-based approach”, “sense of community”, “communication”, and “development pathway”. Of particular relevance for this study is the specific inclusion of ABAs as one of the domains of capacity building, as well as the emphasis on ideas of development of skills and relationships, and resource mobilisation, all of which are also linked to ABAs as section 2.4 will further illustrate.

2.3.2.2 Promoting empowerment as a way to promote health

A second important concept which has underpinned the health promotion paradigm since its inception, and has also been associated with ABAs, is that of empowerment (WHO 1986). As argued about capacities, empowerment is a complex concept, and the ways it has been operationalised in practice has shown to be very wide. The WHO (1998) defined individual empowerment as the capacities of an individual to take control over his/her own health, while empowerment at a community level refers to actions taken collectively to improve the health of the whole community. Other authors provided similar definitions (Wallerstein 1992; Zimmerman 2000; Laverack and Pratley 2018), and what is common across all these is that empowerment is defined as a process whereby people who increasingly engage in decision-making, can increase control over their health and its determinants (Whitehead et al. 2016). For instance, according to Laverack and Wallerstein (2001), empowerment approaches provide individuals with increased capacities and create opportunities for these individuals to engage as a collective, find common issues to tackle and thus take collective actions. However, the distinction between individual and community empowerment is important to take into account. For instance, Wallerstein (1992, p.198) differentiated changes associated with empowerment by categorising these as psychological, organisational and community changes. The first can be seen as changes having an impact at individual level, while the other two at a collective one. Psychological empowerment is related to issues such as ‘self-efficacy to act’, ‘belief in group action’ and trust. Organisational empowerment refers to providing well-functioning services, and promoting effective partnership work. However, this concept is still link to

an individual dimension, as it refers to empowered workers, even though they aim to reorient their organisation's activities to support changes at collective level. Finally, community empowerment includes dimensions such as 'increasing local action', 'stronger social networks', 'community competence', equitable access to services (Wallerstein 1992, p.201). Zimmerman (2000) suggested that if empowerment occurs in one of these levels (individual, organisational or community), it will have an impact on the others. More recently, Tengland (2007) discussed how empowerment in the form of increased control can help understanding how health promotion can be fostered. According to this author (Tengland 2007, p.201) increasing people's knowledge, autonomy, self-esteem and self-confidence can all be supportive of empowerment at individual level. For example, he suggests that increasing knowledge can support people in identifying health needs and strengths, while at the same time can relate to becoming aware of what resources are available to tackle health needs or what actions can be undertaken.

In sum, the concept of empowerment is a complex one, and many of its definitions as presented above suggest that it centres on supporting people and communities to achieve skills and decision-making power to tackle health and its determinants. This view of empowerment shares similar dimensions with the concept of capacities as described in the previous section. As it has been argued, research on capacities and empowerment associated both concepts with forms of increased control over health, which is the ultimate goal of health promotion, as defined by the WHO (1986). The next section will therefore shed light on why increased control is important in health and how it can help reducing inequalities.

2.3.2.3 Increased control to promote health and reduce place-based inequalities

Although health promotion has been defined as efforts oriented to increase control over health, questions remain about how control can reduce inequalities in communities, as it is still an understudied topic (Ponsford et al. 2015). Whitehead et al. (2016) have conducted a thorough

analysis of the theories on this association and provided a useful perspective. The authors have divided their findings in three levels at which increasing control over resources and decisions can influence health: individual, community and society. The first two are of particular interest for this study. Individual's control over resources can support people in making decisions over their own life and is strictly related to the concept of social determinants and to a materialist explanation of health inequalities. People of lower socioeconomic position lack access to resources which can support their health, and thus have reduced control over the determinants of their health. This, in turn, can lead to being more exposed to risk factors and the accumulation of these can then result in chronic stress (Whitehead et al. 2016). At the community level, one of the pathways presented by Whitehead et al. (2016, p.56) referred to "collective control/empowerment", which focused on health promoting factors such as developing trust and reciprocity to increase social support. The emphasis is thus on how social relationships within a community can act as supporting people in increasing collective decision-making power over health determinants. This reflect what has been discussed previously in section 2.2 as to how it is important to take into account communities, people and relationships as all related, in order to understand how places can affect health.

In sum, the health promotion paradigm supports actions oriented towards increasing people's control over health and its determinants, with particular emphasis in supporting people and communities to strengthen their relationships and to develop the capacities to gain such control and feel empowered to take actions to tackle health determinants, and thus reduce health inequalities in and between places. ABAs have been associated with the health promotion paradigm, with which ABAs share the emphasis on people's capacities and empowerment (Foot and Hopkins 2010). However, ABAs have also been influenced by theories from other disciplines, and researchers hold different perspectives as to how ABAs work, as the next section will discuss.

2.4 Asset-based approaches and place-based inequalities

As introduced throughout the chapter, in recent years a resurgence of interest in the potential of asset-based approaches to promote health and reduce place-based inequalities has been seen across Europe. However, ABAs still lack a common definition (van Bortel et al. 2019), and their implementation is still understudied. This might be due to the complexity of ABAs, as ABAs draw upon various paradigms and theories, and understanding these different influences can help shedding light on how ABAs may work to promote health and reduce inequalities. The following sections provide an introduction to the origins of ABAs within the area of public health, followed by an overview of how researchers have been theorising their potential to reduce place-based inequalities.

2.4.1 The roots of asset-based approaches in public health

ABAs can find their roots within three major frameworks which will be explored in the next three sections: Antonovsky's salutogenesis theory (Antonovsky 1996), the Asset-Based Community Development framework (Kretzmann and McKinght 1993), and the Asset Model proposed by Morgan and Ziglio (2007).

2.4.1.1 Salutogenesis

The term salutogenesis was coined by the medical sociologist Aaron Antonovsky in the late 70s, combining the two Greek words for health and origins, thus meaning 'the origins of health'. A salutogenic approach to health implies looking at factors that promote health and wellbeing, as opposed to pathogenesis which looks at the causes of diseases. Antonovsky's salutogenic approach (1987, 1996) claims that life swings between the two ends of a continuum of disease-health, and aims to understand and promote events that can move people towards the 'healthy' side of this continuum. His work focused on understanding what makes people healthy and what keeps them

healthy despite potential risk factors. More specifically, Antonovsky was interested in researching how, within similar contexts, some people stayed healthy and others did not, thus uncovering which mechanisms or factors were underpinning and promoting health and well-being, in other words, to identify the origins of health (Mittelmark and Bauer 2017). In Antonovsky's view (1996), people need to perceive life events as comprehensible, manageable and meaningful to be able to cope with them. To do so, he argues, individuals can turn to a set of internal or external resources, ranging from self-esteem to financial possession, called Generalised Resistance Resources (GRRs). The ability to use these resources to face life events is what he termed Sense Of Coherence, or SOC (Lindstrom and Eriksson 2009). Contrary to the traditional deficit approach centred on reducing risk factors for specific diseases, salutogenesis focuses on increasing those resources which allow people to deal with risks in a positive way, to make risk comprehensible and manageable. Antonovsky's answer to what were the origins of health was indeed the development of the concept of sense of coherence (SOC) and a questionnaire to measure it, which accounts for how people experience and cope with life events. A stronger SOC is associated with increased capacity to tackle life events in a healthy way (Maas et al. 2014). As Antonovsky himself put it (1996, p.13), salutogenesis is not a theory of how to "keep people well", but is a theory about how health can occur in individuals considering them as complex social and biological beings. Antonovsky (1996) argued that the dominant paradigms of curative and preventive medicine limit their focus to a specific disease or risk factors affecting an individual. Conversely, salutogenesis is concerned with the individual as a whole, and aims to support him or her in moving towards the healthy side of the continuum. Indeed, a closer look at the salutogenic theoretical position shows how the concept of health promotion as proposed in the Ottawa Charter is embedded with the theory of salutogenesis. In fact, when Antonovsky (1987, 1996) elaborated the salutogenesis theory, he was hoping not to replace the deficit model in medical science, as he knew this was unrealistic, but for salutogenesis to become the theory underpinning health promotion (Mittelmark and Bauer 2017). However, as argued in section 2.2 and 2.3, most interventions labelled as health promotion following the Ottawa Charter

have focused on reducing risk factors or modifying health behaviour rather than promoting positive protective health factors. Thus, it should be asked why this positive view is still underapplied. A claim brought forward by some authors supportive of a salutogenic health promotion approach centres on the lack of robust evidence base in implementation research. In fact, the literature related to salutogenesis is limited and quite heterogeneous (Mittelmark and Bauer 2017). For instance, a focus on the measurement of sense of coherence (SOC) has resulted mainly in descriptive statistical studies, looking for association of SOC with other variables, or using SOC as a predictor of certain behaviours. Generally, these publications do not analyse interventions. As García-Moya and Morgan (2017) have found, there are still gaps in understanding the underlying relation between SOC and well-being. In other papers, salutogenesis is reported as being used as an approach to analysis, but applied to data of projects that are not built on a salutogenic theoretical perspective (see for example: Borwick et al. 2013, Dilani et al. 2008). Likewise, salutogenesis can be the theoretical approach to the research, but to investigate a health issue or problem and not to implement a salutogenic initiative (Roy et al. 2015). The International Union for Health Promotion and Education, a global society for health promotion researchers and practitioners, has established in 2007 a global working group dedicated to the theme of salutogenesis which recently published a position paper to further the application of salutogenesis in theory development and interventions' implementations (Bauer et al. 2019). What Bauer et al. (2019) propose is a theory for salutogenic interventions, which streams from the idea of Antonovsky that life experiences should be consistent (to make them comprehensible), balanced (in the sense of being manageable, not overwhelming or the opposite), and involve active decision-making (to make them meaningful). Interventions should therefore aim to create spaces for shared decision-making processes (meaningful), be based on a shared vision of the desired outcomes so that it's comprehensible to everyone involved, and support communities in identifying challenges as well as assets to support health and development (making the process to achieve health manageable). Although the main focus of salutogenesis is around the individual rather than the collective, salutogenesis can become important when it comes to

developing interventions in place-based communities aimed at engaging local people to identify positive health resources and mobilise them, as ABAs propose. In fact, Antonovsky himself had argued that collective sense of coherence increased individual abilities to be resilient and cope with stressors (Bauer et al. 2019).

2.4.1.2 Asset-based Community Development (ABCD)

The second major underpinning framework in ABAs is the Asset-Based Community Development movement (ABCD) proposed by Kretzmann and McKnight in 1993. ABCD refers to the process of developing and empowering local communities by identifying and connecting residents' own assets and resources to allow them to make the best use of these and develop together (Kretzmann and McKnight 1993). It has been widely applied within community development in high income countries, such as the United States or the UK, and in international development as a successful approach to foster community resilience and disaster preparedness (Vatsa 2004; Freitag et al. 2014). The ABCD approach could be seen as a practical guide about how to integrate salutogenesis into practice. It provides a step-by-step guide on how to identify positive resources, the "assets", already present in communities and how to mobilise them to support community development. A recent work by McKnight and Russell (2018) has provided an updated perspective on ABCD in practice, centred around four key principles which makes ABCD different: resources (using local assets); methods (which refers to the ways these assets are mobilised, by first working with what you have and ultimately decide collectively what external resources are needed and in which forms); functions (what is the impact and the function of how resources are mobilised); and evaluation (intended as a learning process across the other points). Although ABCD can be traced back to the early 1990s (Kretzmann and McKnight 1993), ABCD has entered the field of public health mostly over the past decade (Morgan and Ziglio 2007; Foot and Hopkins 2010). Blickem et al. (2018) comment that ABCD seems to stand on two main approaches, one more individual-based (drawing on salutogenesis and psychology theories) and another one on more collective approaches, which

place emphasis on social capital theories and the importance of social networks and reciprocity as being good for health and wellbeing. Other authors (Harrison et al. 2019) found that relationships and trust are perceived as key mechanisms for change by stakeholders working in voluntary and community sector organisations and who adopt ABCD in their community work. In fact, what emerged in their study is that according to voluntary and community sector organisations, the ABCD model adopts community development principles by being person-centred and looking at strengths rather than deficits, the same principles shared with ABAs. Interestingly, in the UK, ABCD has seen a recent rising interest, associated with discourses around ABAs in public health and community-based work. According to Harrison et al. (2019), after the financial crisis of 2008 in the UK, ABCD seemed to offer a potential solution to continue working in less advantaged areas despite funding cuts and make use of local resources.

2.4.1.3 The Asset Model

The third framework on which ABAs draw upon is the Asset Model (AM) proposed by Morgan and Ziglio in 2007. The AM is a framework to integrate the salutogenic view of health within the public health practice. Its purpose is to call for the development of an evidence base and to enhance the adoption of the model within future policies. As defined by the authors, the AM calls for three related actions: (1) the development of interventions based on a salutogenic perspective, in the sense of developing novel approaches aimed at promoting health, and strengthening people's and communities' resilience and capacities to act as protective factors. This novel approach should include (2) the use of assets mapping as proposed by Kretzmann and Mcknight (1993) - thus as the collective identification and mobilisation of local assets - as a starting point to develop a trustworthy relationship between local people and professionals and facilitate the planning of the intervention effectively. And finally, (3) new evaluation frameworks and novel indicators need to be developed to explain how salutogenic interventions work in different contexts and to measure their effectiveness. It is in this paper that Morgan and Ziglio (2007) have developed the definition of

“health assets” cited earlier which is currently most used. Nonetheless, other authors have suggested that the concept of ‘health assets’ has been found in earlier decades. For instance, Whiting et al. (2012) have traced back the origins of the concept of ‘health assets’ to the beginning of the XX century, with the Peckham Experiment, whereby the idea of positive health and wellbeing was favoured to contrast the creation of diseases. Rotegard et al. (2010) have dated the first appearance of the concept of health assets between the 70s and 80s, within a nursing model proposed by Schlotfeldt who claimed that nursing practice should focus on people’s strengths rather than diseases. Notwithstanding, the current literature on ABAs tend to use Morgan and Ziglio definition (2007), as introduced earlier at the beginning of section 2.2.1.

As these sections have shown, asset-based approaches in public health draw on different frameworks: theories (salutogenesis), practice (ABCD) and a model for policy and evidence development (Asset Model). These represent the main frameworks most often associated with ABAs. Although these set the basis to understand what ABAs are from a theoretical point of view, their implementation is still understudied (Morgan 2014). There are however some shared perspectives on ABAs, as to how ABAs should work to promote health and reduce inequalities when implemented in place-based communities, as the next section will further explore.

2.4.2 Current perspectives on asset-based approaches and their potential to reduce inequalities

Current research on ABAs places emphasis on the importance of engaging people and communities to map assets collectively as a way to empower people and communities (Foot and Hopkins 2010; Foot 2012; Morgan 2014; van Bortel et al. 2019; Whiting et al. 2012; Morgan and Ziglio 2007) and on strengthening social relationships (Foot and Hopkins 2010, Foot 2012; Morgan 2014, Hopkins and Rippon 2015). Fostering engagement and social relationships are considered as key processes within ABAs which can potentially support reduction of place-based health inequalities, as this

section will further discuss.

In terms of engagement, researchers have highlighted that asset-based initiatives should be designed together with local people (Morgan 2014; Cofiño et al. 2016; Foot 2012; Foot and Hopkins 2010), as research has shown that not only that engagement promote health and wellbeing (NICE 2016) but also that residents most often feel proud of their area, and their views and opinions are key to understand how a neighbourhood works, with its interactions of people, places and relationships (Halliday et al. 2018). In ABAs, mapping the community assets, whereby people come together to map positive resources for health in their area, which can then be mobilised through the asset-based initiative, is considered as one of the key steps in developing asset-based initiatives and one of the key processes to foster engagement (Foot and Hopkins 2010). However, it should be taken into account that asset mapping does not work on its own, but it needs to be followed by an assets' mobilisation (Morgan 2014; Hopkins and Rippon 2015). Research has shown that this is important to ensure that the AB initiative develops. For instance, South et al. (2015) conducted a qualitative evaluation of an assets mapping exercise carried out by Community Health Champions of the Altogether Better project in two less advantaged neighbourhoods in Sheffield. Their findings suggest that the asset mapping exercise was successful not only to identify assets but also to encourage the development of new relationships and network. Nonetheless, it also emerged that there was no clear agreement on the use of the asset map once completed, and despite engaging with the local population in the assets' identification, their use was not followed up nor encouraged. The authors concluded that more efforts are needed to ensure asset mapping is included as part of the health promotion programme cycle, and not considered as an outcome itself but as a starting point to allow networks and best use of local resources to occur. However, the ways in which assets are mobilised can vary, as the next chapter will further illustrate.

In terms of strengthening social relationships, as Foot (2012, p.25) has argued, ABAs should support the development of relationships based on "reciprocity, mutuality and solidarity". However, in

ABAs, this central role of relationships has been related to another theoretical concept which has recently been drawing increased attention also in health promotion, the concept of social capital (Morgan 2014; Hawe and Shiell 2000; Adams 2019). Social capital can be defined as “the resources to which individuals and groups have access through their social networks” (Moore and Kawachi 2017, p.1). These can be informational as well as emotional resources, supporting people to access information and feel cared for, which can positively affect their health (Villalonga-Olives and Kawachi 2017). Moreover, social capital can also be defined in terms of the types of relationships established, most commonly defined as bonding, bridging and linking social capital (Poortinga 2012). ‘Bonding social capital’ defines relationships between people within a similar group or with similar characteristics, who develop trustworthy relations and provide social support to each other. ‘Bridging social capital’ defines relationships across different groups, while ‘linking social capital’ defines relationships across people or groups from different hierarchical backgrounds (Carrillo and Riera 2017). Importantly, although linking social capital is the least researched and theorised (Adams 2019; Poortinga 2012), it can be considered as the most relevant when it comes to tackle health inequalities from a community and empowerment perspective. In fact, linking social capital could be important because it allows community members to develop relationships with people or institutions with more political power; which in turn can support residents to advocate for change. Despite increased interest in the role of social capital and health, however, social capital remains a complex concept (Hawe and Shiell 2000). In fact, within the literature of ABAs, social capital is often considered as a health asset which communities have, as well as something which should be developed thorough an asset-based initiative, as the next chapter will further discuss (McLean 2012; Hopkins and Rippon 2015; Blickem et al 2019).

However, as introduced earlier in this section, evidence is still limited as to how ABAs work to promote health and reduce inequalities when implemented in place-based communities (Morgan 2014), and calls for a systematic review of the evidence on asset-based approaches in public health

have repeatedly been made (Morgan and Ziglio 2007; Wood et al. 2016, Foot 2012). Gaps exist as to how ABAs are implemented in practice (Baker 2014), and which outcomes can be achieved through ABAs (Wood et al. 2016). For instance, a recent work carried out by Rippon and South (2017, p.12), who interviewed stakeholders involved in AB initiatives about their potential impact, found that outcomes associated with ABAs widely varied, ranging from building self-esteem or “seeing people be empowered to make changes,” to “building hope in places”, “improving life chances” or “building a stronger community”. Additionally, Baker (2014) has highlighted that the variety of outcomes which ABAs can aim for makes it difficult to synthesis results across different studies and to determine their effectiveness. Indeed, various authors (Morgan 2014, Foot 2012; Sigerson and Gruer 2011) have argued that novel models for the evaluation of ABAs are needed, as the next chapter will further discuss.

As for how ABAs could work when implemented, in a report on ABAs carried out for The Health Foundation, Hopkins and Rippon (2015) started developing a theory of change, to shed light on the implementation of AB initiatives. This centred around four key steps:

1. *Reframing towards assets* (refers to a needed change in culture and practice, which includes assets approaches)
2. *Recognising assets* (refers to mapping assets collectively)
3. *Mobilising assets*
4. *Co-production of assets and outcomes* (both refers to take shared decisions about how assets will be used)

More recently, Rippon and South (2017) furthered developed this theory of change: through interviewing stakeholders involved in ABAs from both academic and practice, their study resulted in the addition of a pre-step in the theory of change named “orientation of assets activities”, which emphasises the importance of adopting a participatory approach in the planning of assets-oriented

actions, of engaging people in dialogues and relationships, and of having an agreed purposeful action. This, in turn, can lead to reframing relationships towards an ABA (step 1 in Hopkins and Rippon 2015), and the other steps described by Hopkins and Rippon (2015).

Importantly, Rippon and South (2017) found that it is challenging for health services or system more generally to shift their ways of working and organising to an ABA, and that most of the time, if pushed from an external source, this shift doesn't lead to an actual impact, it has limited power for change. In fact, a theme which came out from their analysis relates to the fact that ABAs are not a form of technical expertise but what is needed is to "develop an asset mind set", referring to ABAs as the establishment of relationships based on mutual respect, trust and equitable opportunities to participate. This is in line with previous debate around ABAs. For instance, Foot and Hopkins (2010) have argued that working with the assets' perspective requires a change in attitudes and values. Similarly, Baker (2014) has commented that assets-based strategies require a change in mindset and a longer time to show results, but if embraced could lead to long-term results in the reduction of inequalities. Likewise, Wood et al. (2016) argued that ABAs were found to be challenging for professionals, who may require targeted training to adopt such approaches and incorporate them within their practice.

Finally, it should be noted that ABAs have not been free from critiques (Friedli 2012, MacLeod and Emejulu 2014, Roy 2016; Daly and Westwood 2018). For instance, one of the critiques put forward by Friedli (2012) is the lack of acknowledgement of, and discussion about, the underlying causes of social injustice and inequalities. In the title of her work, Friedli reported a quote from a Scottish government document - What we've tried, hasn't worked - through which the government justified the adoption of assets approaches as an alternative to previously failed actions to reduce inequalities. However, Friedli argues that there may have been other factors such as the increased adoption of neoliberal economic models which have represented a burden on the lower socio-economic groups and could have contributed to the maintenance of the inequalities gap. Her major

critique points to the lack of critical analysis of the unbalanced distribution of power between local communities, public institutions and neoliberal economic interests. This, she argued, together with the emphasis on local strengths as key skills for communities' own development, can risk setting the basis - or the justification - for the further reduction of public health services. However, authors supporting the assets approach in public health have highlighted that it should be taken as a complementary approach to the deficit perspective in the design and provision of healthcare, and by no means it should replace service provision (Foot and Hopkins 2010). On another hand, Roy's work (2016) aimed to analyse how practitioners from local social enterprises in Glasgow worked to improve health and wellbeing among their users, and whether their approach followed the implementation of ABAs in Scottish public health strategies. Using data from semi-structured interviews and a focus group, the author found that practitioners working within social enterprise and community development considered ABAs as being the new label for something they were already doing. They argued that they have always adopted an approach based on enhancing skills and creating resilience rather than identifying problems and providing outsider's solutions.

To conclude, these paragraphs have provided an overview of current research on ABAs. As a summary, it can be argued that, when adopted in place-based initiatives, ABAs:

- Focus on what makes people healthy, i.e. which factors, actions, or activities can act as protective to prevent the uptake or the development of unhealthy behaviour (salutogenesis) (Antonovsky 1996, Morgan and Ziglio 2007);
- Build on existing resources, being these skills, people, relations, or physical resources (Foot and Hopkins 2010) and mobilise them (ABCD movement, McKnight and Kretzmann 1993);
- Engage people and communities so they can increase control over the asset-based initiative and over health and its determinants, with an aim to empower them (Foot and Hopkins 2010; Foot 2012; Morgan 2014; van Bortel et al. 2019; Whiting et al. 2012;

Morgan and Ziglio 2007);

- Aim to increase local social capital (Foot and Hopkins 2010) through fostering social relations and networks (Morgan 2014);
- Require a change of perspective, from a deficit to a positive view based on assets (Foot and Hopkins 2010; Rippon and South 2017).

2.5 Concluding thoughts on this chapter

This chapter has presented the public health issue which this study centres on (place-based health inequalities), and has introduced asset-based approaches as a proposed novel strategy to reduce inequalities which have been attracting a rising interest among researchers and policymakers in Europe. It has shown how ABAs have permeated some key policies in public health and health promotion, in particular in the UK and in Spain, even though their evidence base is still limited. It has then highlighted how ABAs have been associated with the health promotion paradigm, a key approach within the area of public health which centres on building on people's capacities and empowering people and communities to increase control over their health and its determinants. Finally, it has explored underpinning concepts and theories which inform both the health promotion paradigm and the asset-based approach, and it has presented an overview of the current advances in theorising how ABAs work, to further shed light on the topic of this thesis.

However, researchers (Morgan 2014; Wood et al 2016; Rippon and South 2017, Van Bortel et al 2019) have argued that the evidence on ABAs is still very limited. This is why this study aims to explore how ABAs might help in reducing inequalities in less advantaged place-based communities.

The following chapter describes the literature review conducted to explore the current implementation literature on ABAs, to identify their key characteristics of ABAs and the changes and processes which ABAs can generate when implemented in place-based communities.

Chapter 3 Asset-based approaches in neighbourhoods. A review of the literature*

* This chapter is based on the following publication:

Cassetti, V, Powell, K, Barnes, A and Sanders, T. (2019) A systematic scoping review of asset-based approaches to promote health in communities: development of a framework. *Global Health Promotion*
<https://doi.org/10.1177%2F1757975919848925>

Many parts of the chapter are paraphrasing what is in the published article. When direct quotations are used, the appropriate citation with page number is provided.

3.1 Chapter introduction

As introduced in the previous chapter, asset-based approaches have become increasingly popular as a way to promote health and reduce inequalities in place-based communities, and particularly so in the UK and Spain. However, ABAs are still an under-researched area of practice. Questions remain about what ABAs are, and how they work in practice, including the changes and processes through which ABAs can promote health at individual and collective levels and support reduction of inequalities. The aim of this chapter is therefore to review in more detail what is known about the implementation of ABAs in place-based communities, their key characteristics, and the changes and process which they enact. It also aims to understand how AB initiatives to promote health in communities have been researched, and how their impact has been evaluated. To fulfil these aims, a scoping review was carried out. A broad review question and three sub-questions were developed, aligned to the overarching research question, aim and objectives of this thesis:

1. What are the key characteristics of ABAs?
 - a. How are ABAs operationalised when adopted in interventions aiming to promote health and reduce inequalities in local communities?

- b. What changes in health and its determinants can take place at individual and collective level as a result of ABAs implemented in neighbourhoods?
- c. How are these changes evaluated?
- d. How can these changes support reduction of place-based health inequalities?

3.2 A scoping review of the literature on asset-based approaches

This study took a scoping review approach to study the implementation literature on ABAs. This type of review was appropriate because a scoping review is particularly indicated to identify gaps in the current literature and to identify the range of studies which refers to a particular topic (Arksey and O'Malley 2005, p.21). Moreover, reviewing the evidence on ABAs presents two major challenges, which a scoping review approach can help to address.

First, and as indicated in the Chapters 1 and 2, there is no agreed definition of what an asset-based approach public health is. For example, during initial searches to familiarise with the topic, it was apparent that there is no clear definition of the key characteristics of an asset-based approach when put into practice, or of which outcomes are likely to be expected. In many community-based initiatives, changes such as increased social capital or community engagement, may at the same time be the anticipated outcomes of an intervention or the processes through which other changes in health or its determinants can be achieved. It is therefore difficult to distinguish between intended outcomes and change processes. This poses a first challenge if a systematic and comprehensive search strategy is to be developed for a review using the traditional PICO structure.

Second, not all interventions using asset-based approaches are labelled or named as such. As other researchers pointed out (Durie and Wyatt 2013; Friedli 2013), the limited published evidence has tended to adopt the asset-based label retrospectively. Additionally, other community-based initiatives do not specifically state to adopt an asset-based approach, yet they build upon a positive

view of health and well-being, which is shared with ABAs. For example, arts-based projects focus on promoting skills associated with better mental health rather than preventing risky behaviours (Dutton 2001; Fredland 2010, Heenan 2006). It is therefore difficult to identify which key terms should be included in a search strategy.

For these reasons, it is difficult to develop a search strategy for a full systematic review and it was thus considered appropriate to adopt a scoping review approach. As recommended by Arksey and O'Malley (2005, p.22), a scoping review follows five steps: "1) identify the research question; 2) identify relevant studies; 3) study selection; 4) charting the data; and 5) collating, summarizing and reporting the results". The next sections will describe in detail the methods for the 5 steps of the scoping review on ABAs.

3.2.1 Identify the research question

As introduced above, the review questions were aligned to the main research question, aim and objectives of this thesis and defined as:

1. What are the key characteristics of ABAs?
 - a. How are ABAs operationalised when adopted in interventions aiming to promote health and reduce inequalities in local communities?
 - b. What changes in health and its determinants can take place at individual and collective level as a result of ABAs implemented in neighbourhoods?
 - c. How are these changes evaluated?
 - d. How can these changes support reduction of place-based health inequalities?

3.2.2 Identify relevant studies

Initial iterative searches (Baxter 2014) were conducted to familiarise with the types and volume of literature available on asset-based approaches to promote health in communities. Search terms were identified through these initial searches and through in-depth reading of theoretical literature (which were discussed in Chapter 2) and key reports analysing the asset-based approach (Foot and Hopkins 2010; Foot 2012; Hopkins and Rippon 2015). Key reports were identified by being the most commonly cited in published work associated with ABAs, and were also included in most recent papers discussing theories and frameworks relating to ABAs (Rippon and South 2017; Blickem et al. 2018; van Bortel et al. 2019).

After conducting iterative initial searches, a systematic approach to the search strategy was adopted to identify implementation literature. The search strategy was developed based on the 'population' and the 'intervention' parts of the PICO strategy, with 'Population' referring to the people living in place-based communities, while the 'Intervention' referred to any initiative which specifically stated to adopt an asset-based approach. Four databases (Medline, PsycINFO, CINAHL, ASSIA) were searched combining terms related to asset-based approaches, such as "asset model", "community assets", or "salutogenesis", with terms related to communities as places (details on the search strategy are in Appendix I). Other databases were searched during the scoping searches (Sociology abstracts and Social Service Index and Social Science Citation Index) but the results were not deemed relevant to asset-based approaches implemented in place-based communities for health promotion, and were therefore excluded from the final search. Forward citation searches of four key texts were performed using Google Scholar (for Morgan and Ziglio 2007; Foot and Hopkins 2010) and Web of Science (for Antonovsky 1996; Kretzmann & McKnight 1993).

3.2.3 Study selection

Papers were included if they met the following inclusion criteria: made explicit reference to ABAs implemented in place-based communities, and at least one of the described intervention's components needed to have engaged with an identified asset. These reflected two of the key principles defined by Foot (2012, p.25), to ensure that the included papers referred to initiatives which were "asset-based" (appreciating local assets) and "place-based" (centred in neighbourhoods). Included papers also needed to provide a description of the intervention and expected outcomes. Papers describing asset mapping only were excluded, as the identification of assets should not be considered an intervention on its own (Morgan 2014); rather, included papers needed to detail how assets were mobilised in some way for it to be considered for inclusion as 'asset-based' (Hopkins and Rippon 2015). To identify health-related literature or health-promoting interventions, papers were included when the proposed intervention reflected one or more of the five lines of action proposed in the Ottawa Charter for Health Promotion (based on Kania et al. 2013). The publication of Antonovsky's text on salutogenesis and health promotion in 1996 was chosen as the starting date for the selection. Table 1 below summarises the inclusion and exclusion criteria.

Table 1: Inclusion and exclusion criteria for the scoping research

	INCLUSION	EXCLUSION
Population/Settings of the intervention	Place-based communities and people living in these.	Interventions not carried out in place-based communities
Type of intervention	Any intervention adopting an asset-based approach (based on two of the key principles defined by Foot (2012, p.25): “Asset-based” – appreciate local assets “Place-based” – neighbourhoods as the core of actions and relations AND Any intervention using one of the five lines of actions proposed in the Ottawa Charter for Health Promotion: developing personal skills, building healthy policies, strengthening community action, creating supportive environment for health, reorienting health services	Interventions which do not adopt an asset-based approach Asset mapping only Intervention which do not use one of the five lines of actions proposed in the Ottawa Charter for Health Promotion
Outcome	Any ‘health’ outcomes or any outcome related to increased control over, or improving the conditions of, the social determinants of health: individual lifestyle factors; social and community networks; living and working conditions; wider socio-economic environment	-
Study type	Original empirical research Published after 1996 In English, Spanish, Italian, Catalan	Commentaries, book reviews, theoretical papers

In line with the recommendation for scoping studies (Arksey & O’Malley 2005), quality assessment was not performed as the literature retrieved was included based on relevance to the research question and the richness of data and insight; rather than to assess effectiveness.

3.2.4 Charting the data

Data was extracted from included sources, using a data extraction form in order to be able to synthesise it on the basis of the key characteristics of asset-based approaches to promote health in place-based communities. Extracted data referred to:

- Study characteristics: objective, methods, results
- Description of the AB initiative
- What, if any, are the theoretical approaches underpinning the AB initiatives?
- What are the intended outcomes of the initiative and how are these being measured/evaluated (which indicators of social change, health or well-being are being used)?
- What kind of assets are the initiatives building on?
- How are these assets used in terms of implementation?

3.2.5 Collating, summarising and reporting the results

Different approaches were used to synthesise the evidence from this review. The information extracted in the table was analysed using a narrative approach, to explore the range of intervention types which can be considered as ABAs, the variety of changes in terms of expected outcomes which can be achieved through implementing initiatives that embed an ABA and how these have been researched or evaluated. This narrative synthesis provided a basis for the development of a framework of key characteristics of ABAs (Cassetti et al. 2019). To develop the framework, data extracted from the implementation literature were counted and grouped under the following categories: interventions processes, outcomes, and evaluation methods (see also Cassetti et al. 2019, including the supplementary material which is included here as Appendix II). This categorisation was used as a pragmatic way of summarising the key characteristics of ABAs in terms of how these initiatives are developed (process), the range of changes in health and its determinants which can be achieved through implementing ABAs (outcomes) and how AB initiatives have been

studied (evaluation); and contributed to achieving objective 1 of this study and the scoping review questions.

Further interpretative analysis was completed to understand how the findings from the scoping review fit with wider theoretical literature on ABAs and health promotion (as introduced in this thesis in Chapter 2) and how the implementation of AB initiatives might affect health inequalities (thus contributing to shed light on objective 2 of this thesis).

3.3 Results from the scoping review

This section presents the findings of the scoping review of implementation literature on ABAs.

3.3.1 Search and study selection

In total, 760 sources were identified from initial searches after removal of duplicates. Four additional papers were identified from the forward searching of key texts and accessed full text for their relevance, but only one was included. A total of 50 studies were accessed full-text, with 30 articles included in the scoping review. These papers referred to a total of 28 different asset-based initiatives, as the PRISMA flow diagram (Moher et al. 2009) below shows.

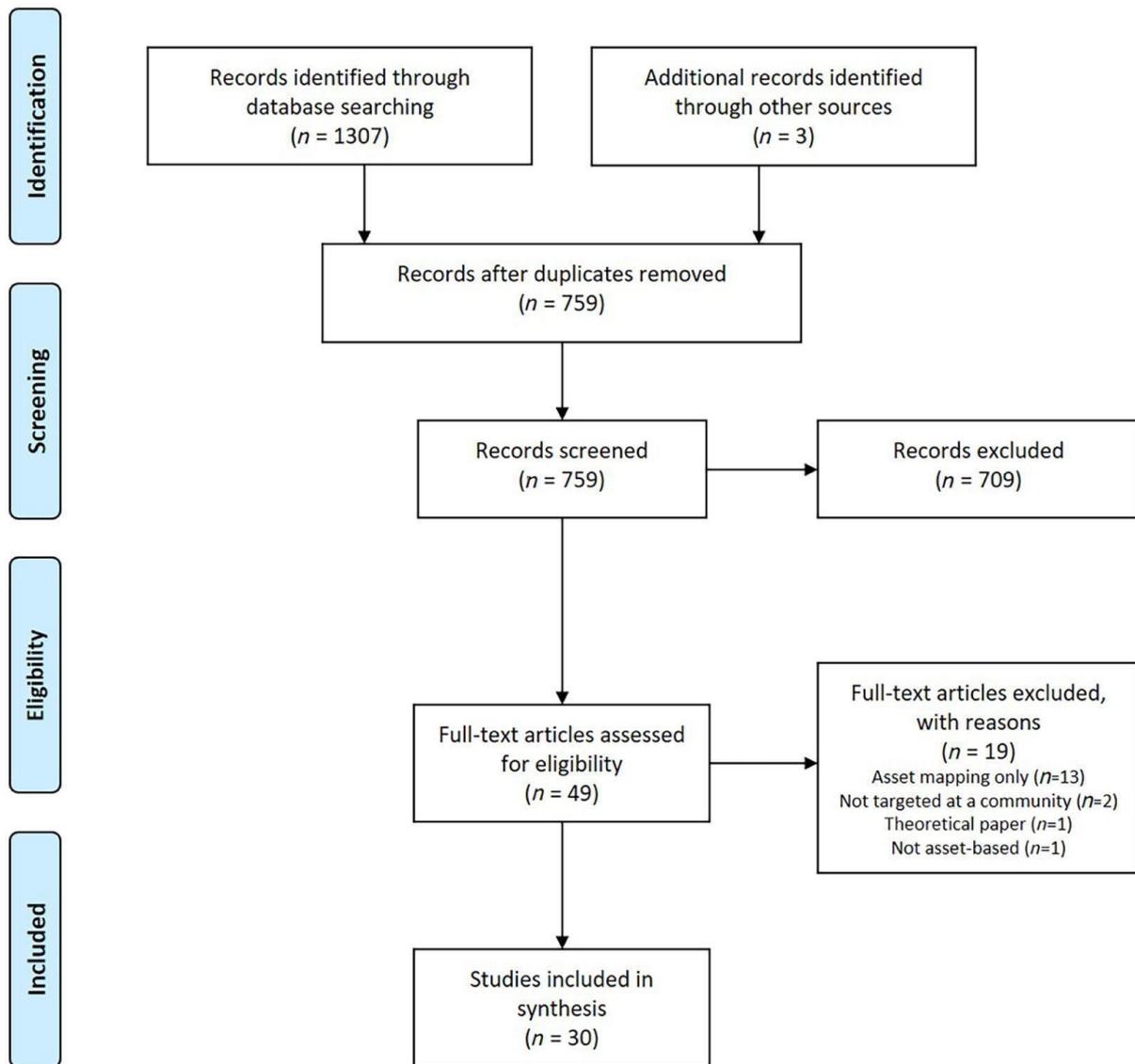


Figure 1: the Prisma flow diagram for the selection of included studies (Original figure is available in Cassetti et al. 2019, p.4). [Permission to re-use this figure is included as Appendix III]

3.3.2 Charting the data: study characteristics

A table with the included studies and their characteristics is available as Table 1 in the published paper (Cassetti et al. 2019) and is included here as Appendix IV. Included papers suggested that ABAs can take a variety of forms in terms of the design of AB initiatives; can lead to a variety of changes at individual and collective level; and a range of different research designs can be used to study AB initiatives or to evaluate impacts.

3.3.2.1 Description of the AB initiatives

A wide variety of AB initiatives emerged from the implementation literature. Most of them showed that AB initiatives are 'multi-component', in the sense that they involved various approaches. Interestingly, all but six papers (Bloomberg et al. 2003; DeGregory et al. 2016; Durie and Wyatt 2013; Martinez et al. 2011; Rhodes et al. 2012; Robertson et al. 2015) included some form of intersectoral work; mostly in the form of the development of intersectoral partnerships between civil society, voluntary and community sector (VCS) organisations and/or primary health care centres. Eleven initiatives included a specific training component, to build capacity or develop the skills of a particular group within the community (Bloomberg et al. 2003; Coll-Planas et al. 2017; Dobrof et al. 2011; Edberg et al. 2016; Martinez et al. 2011; Matthiesen et al. 2014; Ortega et al. 2015; Rhodes et al. 2012; Robertson et al. 2015; Ruth et al. 2015; Sharpe et al. 2015). The activities described varied significantly across all studies. Many were developed in collaboration with local population or local VCS organisations and ranged from developing bike-lanes, to supporting local shops to sell healthier foods near schools, or supporting local volunteers to become walking leaders, or raising funds for further projects among others (see Table 1 in the published paper, Cassetti et al. 2019, included here as Appendix IV). A total of eighteen initiatives were targeted at communities as a whole, while fewer interventions were directed at specific groups such as migrant women, men, young people, elderly people or families.

3.3.2.2 Theoretical approaches underpinning the AB initiatives

Most of the included initiatives made specific reference to the ABCD model of Kretzmann and McKnight (1993) as informing their work. However, some studies referred to other theoretical approaches as underpinning the development of the initiatives described, including: the asset model (Rutten et al. 2009), "Community Based Participatory Research (Martinez et al. 2011; Rhodes et al. 2012; Sharpe et al. 2015) Positive Youth Development (Bloomberg et al. 2003; Edberg et al. 2016;

Kegler et al. 2003); Community engagement (Derges et al. 2014; Miller and Scofield 2009); participatory research approaches (Durie and Wyatt 2013; Ortega et al. 2015; Mathias et al. 2015), peer support models (Robinson et al. 2015), socio-ecological model (Martinez et al. 2011; Edberg et al. 2016; Miller and Scofield 2009) or social capital theory (Coll-Planas et al. 2017)". (Cassetti et al. 2019, p. 3).

3.3.2.3 Mobilising assets: which and how

As introduced in Chapter 2, a health asset can be any resource which can promote health. In the included studies, most of the initiatives described people and their skills as assets, or local VCS organisations, while "only three included elements of the physical environment (Miller and Scofield 2009, Stead et al. 2013; Hanson et al. 2016)." (Cassetti et al. 2019, p. 3). Moreover, only some studies included a description of the asset mapping as part of their initiatives, while most papers provided descriptions of the initiatives' components and achievement but no details about how assets were identified.

Three main approaches "to understand how assets are mobilised" were identified and defined as: "(A) connecting existing assets; (B) raising awareness of assets; (C) enabling assets to thrive." (Cassetti et al. 2019, p. 4).

Connecting existing assets (Approach A) refers to initiatives whereby people and organisations recognise each other as assets and connect together to work or share resources. Examples included sources referred to developing new partnerships (Durie and Wyatt 2013; Sharpe et al. 2015; Edberg et al. 2016; Miller and Scofield 2009; Ortega et al. 2015; Kegler et al. 2003; Matthiesen et al. 2014; Rutten et al. 2009; Sardu et al. 2012; Semenza et al. 2007; Stead et al. 2013; Yeneabat et al. 2012; Fuertes et al. 2012; Baker et al. 2007; DeGregory et al. 2016).

Raising awareness of assets (Approach B) refers to activities which centred on raising awareness on

tangible existing resources that may be underused, or which other community members may not be aware of. Examples in included sources referred to signposting to services or other resources (Martinez et al. 2011; Derges et al. 2016; Coll-Planas et al. 2017; Phillips et al. 2014; Stead et al. 2015; Dobrof et al. 2011; Parker et al. 2006; Riley et al. 2015).

Enabling assets to thrive (Approach C) reflects processes where potential assets identified by public health workers or other community stakeholders needed further support to develop their potential, and describes activities to encourage individuals to “become” assets in their communities or to restore or develop elements of the physical environment. Examples in included sources were: training lay people to become peer supporters or to deliver an intervention (Rhodes et al. 2012; Bloomberg et al. 2003; Edberg et al. 2016; Kegler et al. 2003; Mathias et al. 2015; Robinson et al. 2015; Coll-Planas et al. 2017; Hanson et al. 2016; Sharper et al. 2015); or establishing recreational parks (Durie and Wyatt 2013; Miller and Scofield 2009; Sardu et al. 2012) or green infrastructures (Miller and Scofield 2009; Sardu et al. 2012⁴⁶; DeGregory et al. 2016).

The analysis identified that approach A was used in eight initiatives, approach C in seven, approach B in three, and ten initiatives used more than one approach combined.

3.3.2.4 Outcomes

There was a range of anticipated outcomes or changes mentioned in included sources. The different changes identified reflect three categories: changes at individual, community and organisational levels. These three categories reflect what Morgan and Ziglio (2007) define as the different levels at which health assets can work as protective factors and the work of South (PHE 2015) on community-based outcomes. Nineteen initiatives described changes at individual level which included, for example: the development of new skills and capacities, the take up of healthier habits, and increased self-confidence among others. For instance, some articles aimed to provide people with

capacities to advocate for resources, such as access to funding (Sharpe et al. 2015) or increasing leadership skills (Bloomberg et al. 2003). Twenty initiatives presented changes at community level and included, for instance: the development of new partnerships, increased social capital or engagement, the development of new activities, taking up new volunteer roles, increased social cohesion, relationships and trust. Finally, five initiatives described changes at organisational level, referring to changes in the services provided or strategies to increase awareness on available services (see Table I and supplementary material online, Cassetti et al. 2019, included here as Appendices II and IV). Importantly, more than half of the included studies (eighteen in total) anticipated outcomes in more than one of these categories, which, as will be discussed later in this chapter, reflects the complexity of AB initiatives and their tendency to be multi-components. Most of these outcomes also reflect key concepts underpinning the health promotion paradigm and ABAs (as discussed in Chapter 2), in particular in relation to the development of capacities, relationships and social capital, and the support of empowerment at community level. It is important to highlight this, as this raises questions regarding how different theoretical concepts, changes and processes to support reduction of inequalities combine in ABAs. These insights are discussed further in section 3.4.

3.3.2.5 Research and evaluation methods used to study ABAs

Most of the included studies provided a description of the interventions in a narrative form. However, sixteen studies referred to the evaluation of the described AB initiative, thus providing information as to which evaluation methods have been used to study ABAs. Ten interventions were found to have adopted a mixed methods approach to evaluation, although in two of them (Rutten et al. 2009; Parker et al. 2006) the quantitative part was limited to monitoring attendance or satisfaction. Two studies included self-administered surveys to collect data on health behaviour (Kegler et al. 2003; Phillips et al. 2014) or on engagement patterns (Kegler et al. 2009). One study (Kegler et al. 2003) incorporated health data from an available census. Qualitative studies used

interviews or focus groups to understand how participants perceived changes in themselves or in their relationships or organisations.

Discussions about the impact – actual or potential - on reduction of place-based health inequalities were limited in the included sources. For instance, Durie and Wyatt (2013) discussed the contribution of ABAs in the reduction of inequalities, noting that ABAs enable the development of more equal relationships between people and local services, which according to these authors helps to unpack the complexity of inequalities which more traditional linear approaches to interventions in communities lack. Riley et al. (2015) and Hanson et al. (2016) suggested that the interventions described in their papers could help reduce inequalities because they targeted specific population groups or areas which were the least advantaged, thus providing additional support or resources to those groups or communities.

3.3.3 A framework of the key characteristics of ABAs

A summary framework brings all the above findings together. Drawing on the literature on ABAs presented in Chapter 2, and on the findings from the scoping review presented in this chapter, a framework was developed highlighting the key characteristics of ABAs to promote health in local neighbourhoods (see Figure 2, which was originally published in Cassetti et al. 2019). This framework illustrates AB characteristics in three main blocks: process, outcomes and evaluation practices. Essentially, this framework provides an overview of how asset-based approaches have been implemented and evaluated in the area of health promotion in place-based communities. It includes an overview of how the literature on ABAs suggests that AB initiatives to promote health are planned (first two columns of the Process section) and implemented (third column of the Process section). It offers an overview of the potential outcomes which AB initiatives can achieve, categorised as changes at individual, community and organisational level (Outcome section). Finally, it shows how AB initiatives have been evaluated so far as identified in the implementation literature

presented in this chapter. The framework thus provides a basis about what the key characteristics of ABAs are when implemented in place-based communities. As discussed earlier, these findings help answering objective 1 of this study.

Table 2. A framework of asset-based approaches to promote health in communities.

Process			Outcomes			Evaluation
<i>Identify and prioritise: how?</i>	<i>Planning: which assets?</i>	<i>How are assets being mobilised or applied in practice?</i>	<i>Individual level</i>	<i>Community level</i>	<i>Organisational level</i>	<i>How will the programme evaluate its achievement?</i>
Asset mapping	Individuals' skills, interests	Connect assets among themselves	Health behaviour	Engagement Resilience	Changes in services offered and used	Quantitative approach <i>What has been achieved?</i>
Community engagement approaches	Groups/networks/associations	Raise awareness of available assets	Physical and mental health	Empowerment social capital community well-being	Raise awareness on available services	Counts of the activities or partnerships developed
Joint strategic Needs/Assets assessments	Physical settings	Enable 'assets' to thrive	Capabilities & self-efficacy	Community relations (sense of belonging, new or improved partnerships)		Surveys
Network mapping						Qualitative approaches <i>How is the change or impact perceived at macro/meso/micro level?</i>
Appreciative inquiry				Changes in the built environment		Ethnographies Focus groups Interviews
Photovoice interviews/FGs						Mixed approaches <i>Mixed-methods Conceptual Frameworks Theory-based evaluations</i>

Transversal attributes of asset-based approaches in public health.*

'Asset-based' – appreciate local assets.

'Place-based' – neighbourhoods as the core of actions and relations.

'Relationship-based' – reciprocity and trust.

'Citizen-led, community-driven' – empowerment is central to increase people's control over their own health.

'Social justice and equality' – equal access to assets.

*These attributes should be considered as transversal characteristics. (Based on Foot (4)).

Figure 2: A framework of asset-based approaches to promote health in communities. (originally published as Table 2 in Cassetti et al. 2019, p. 20) [Permission to re-use this figure is included as Appendix III]

3.4 Discussion

This scoping review is the first to systematically review the implementation literature on ABAs to promote health in local communities. The developed framework of the key characteristics of ABAs can be used to support the planning of asset-based initiatives; for instance, to underpin reflections about what assets to mobilise, how, and for what purposes. It is, however, a work in progress which needs to be tested and further refined, which is what the next chapters of this thesis will move on to do. Before doing so, however, it is important to discuss some of the findings presented in section 3.3, and analyse them in relation to some of the literature introduced in Chapter 2, to help shed light on the changes and processes through which ABAs can promote health and reduce place-based health inequalities.

3.4.1 Understanding the theoretical models underpinning ABAs

A first point to discuss in the analysis of the included studies centres on identifying which theoretical models underpinned the described AB initiative, to explore whether the adoption of certain frameworks reflected those discussed by the theoretical literature on ABAs introduced in Chapter 2, section 2.4, and whether it could shed light on the ways the AB initiatives were designed with an aim to impact on place-based health inequalities. Significantly, ideas of community engagement and participatory research approaches were present in many of the studies, in some cases in the form of underpinning approach to the intervention or as part of an action-research process, as some of the studies described adopting Community-Based Participatory Research or Participatory Action Research approaches. As introduced in Chapter 2, people and community engagement has been discussed as central in the theoretical literature on ABAs. However, engagement can vary, ranging from consultation to a more active involvement leading to co-production and coordinated activities. The studies included in this review reflected this variety, ranging from consulting local people about the design of activities, to involving them in running parts of the initiatives, such as the examples

which included the training of lay people to become health advisers (Rhodes et al. 2012; Ruth et al. 2015). Significantly, when community engagement was described as the model underpinning the AB initiatives, most of the actions resulted in the development of partnerships between organisations and the civil society (see for instance Derges et al. 2014; Matthiesen et al. 2014; Miller et al. 2009), thus suggesting that local people took a more active role in planning and implementing the AB initiatives and were not merely consulted about these. This is important, as it also links back to the ABCD model discussed in Chapter 2, and adopted by many of the included studies, which encourages community engagement as part of the planning and implementation of community-based initiatives.

3.4.2 Planning ABAs: the role of assets identification and mobilisation

A second point to highlight relates to assets' identification and mobilisation. The majority of the included studies described assets mobilisations in the form of 'connecting' individuals or organisations as assets (approach A). As introduced in Chapter 2, the theoretical literature on ABAs highlights the importance of community engagement, which might explain this focus. These initiatives were mainly oriented towards increasing the development of new relationships across stakeholders living and working locally, such as in the form of partnerships, to enhance intersectoral work on a specific health issue identified. This is important, as intersectoral work has been highlighted as key in tackling the social determinants of health, as introduced in Chapter 2. On the other hand, fewer papers discussed mobilising more tangible assets, and mainly reflected initiatives aimed at 'raising awareness on' physical assets (approach B), such as green areas where residents could walk (Miller and Scofield 2009; Stead et al. 2013; Hanson et al. 2016). Finally, some of the included studies discussed working with less advantaged people, such as migrants or youth from less advantaged neighbourhoods, to provide them with a range of capacities to feel empowered to take further decisions or actions regarding their health. These studies adopted approach C to the

development of the AB initiative, through 'enabling people to thrive'. Approach C reflects initiatives whereby outside stakeholders, such as public health workers or local voluntary and community sector workers, recognise that community members can be potential assets in their neighbourhoods and develop initiatives to 'enable' them to become assets. This approach to mobilisation draws upon Nutbeam's definition of 'enabling' in his glossary for health promotion (Nutbeam 1998: p.354), defined as:

taking action in partnership with individuals or groups to empower them, through the mobilization of human and material resources, to promote and protect their health.

'Enabling assets to thrive' may therefore appear as a more top-down strategy, where engagement and participatory approaches are less central, as engagement occurred more at the implementation stage rather than during the planning. In fact, some of the included AB initiatives which adopted the 'enabling' people to thrive approach referred mainly to interventions which had a training component, and which included the engagement of lay or peer community members. This is important as research has shown that interventions which have a component on training or improving skills can support people's empowerment. For instance, South et al. (2013, p.11) have argued that the training of lay people can reflect a more "professionally-based knowledge" or take a more personal development approach to empower the individuals. Thus, 'enabling assets to thrive' may also reflect the empowerment approach at the core of the health promotion paradigm introduced in Chapter 2. However, in some of the included studies, 'enabling assets to thrive' was also used to refer to 'enabling' more physical elements to become assets; even though it should also be noted that these actions to enable physical assets can result from the 'connection' of individuals and organisations and can therefore be seen as outcomes of the AB initiative.

In sum, the studies included here were underpinned by a variety of theoretical models which mostly informed the development of the described AB initiative but provided limited explanation as to how

the described AB initiative could have impacted on the health of the communities where it was implemented in terms of reducing place-based inequalities. Moreover, their development and implementation depend on the types of assets identified and how these are mobilised, making each AB initiative very context-specific. Such heterogeneity was found not only with regards to their implementation, but also in terms of the potential outcomes which AB initiatives could achieve, as the following section will further discuss.

3.4.3 Changes in health and its determinants resulting from implementing AB initiatives

A third point to discuss relates to the variety of outcomes associated with ABAs, as the framework in section 3.3.3 shows. Looking at the outcomes section of the proposed framework, it becomes clear that AB initiatives targeted a variety of health and social outcomes, often within the same intervention. Significantly, many of what have been described as AB initiatives' outcomes in this review were also highlighted in Chapter 2 as concepts associated with the health promotion paradigm and ABAs (such as capacity building, empowerment, social capital). However, this review sheds light on an important issue in relations to outcomes associated with ABAs. In fact, most of the changes presented in the outcome section of the framework can also be seen as intermediate steps which have been associated with improving people's health. For instance, many of the included studies discuss providing people with new skills (being this an initial achieved change) as a way to tackle other health determinants (to achieve improved health).

The same can be argued about changes in relationships. Some studies included in the review discussed new relationships as one of the achieved outcomes. In some cases, improved relationships were then associated with the development of new local activities which could support improved health (Durie and Wyatt 2013), with increased resilience (Robinson et al. 2015) or with the reduction of risky health behaviours in young people (Edberg et al. 2016; Kegler et al. 1998, 2003). In other studies, new relationships were associated with increased trust and sense of belonging to a

community (Baker et al. 2007; Bloomberg et al. 2013; Durie and Wyatt 2013; Robinson et al. 2015; Sardu et al. 2012). Thus, changes in relationships acted as initial changes which gave rise to other changes in the communities where the AB initiative was implemented. It should be noted that improving relationships among people living in a community relates back to the concept of bonding and bridging social capital, introduced in Chapter 2. For instance, AB initiatives which involved Lay Health Workers or peers have shown to provide emotional, informational and social support to neighbourhood's residents, which in turn can support the strengthening of bonding (and bridging) social capital (Adams 2019). Thus, social capital can be seen as an outcome per se or as part of a chain of other changes. Moreover, it represents a collective concept, as it refers to relationships between people, but which has an impact at an individual level, as previous research also suggested (Moore and Kawachi 2017).

Finally, many of the studies in this review described the development of community-based partnerships as central to the AB initiative described. As argued above about developing skills or social capital, the development of a partnership can be seen as an initial change (or outcome) to achieve other changes in the communities, such as tackling end of life care (Dobrof et al. 2011), or reducing TV viewing time in young children (Baker et al. 2008). Moreover, developing new partnerships has been discussed as one of the strategies brought forward by the health promotion paradigm as a way to support reduction of place-based inequalities, while at the same time it was discussed as central in ABAs as a way to work intersectorally, and to engage people and communities in the identification and mobilisation of assets, as shown in Chapter 2.

It can thus be argued that rather than understanding changes as a finite achievement, the changes which AB initiatives can achieve are better understood as ongoing processes leading to improved health and reduction of inequalities. However, limited discussion was presented about how these potential processes can impact on health and its determinants. There is a therefore a gap in the

implementation literature reviewed in this study as to how ABAs can impact on health and inequalities when implemented in place-based communities.

Moreover, this view of 'outcomes' as a chain of changes makes AB initiatives complex initiatives to study. This understanding of ABAs as complex initiatives calls for a change of analytical perspective, which could embrace complexity and account for changes as dynamic and evolving processes. This, however, poses a challenge when it comes to studying and evaluating ABAs, as the next section will further discuss.

3.4.4 Approaches to studying ABAs and their complexity

The last point to discuss refers to how AB initiatives have been evaluated. As introduced in section 3.3.2.5, the reviewed studies which included an evaluation of the described AB initiative, reported using a combination of methods, from quantitative, to qualitative to mixed approaches. However, what emerged is that given the variety of outcomes which AB initiatives can achieve, evaluating the potential impact of ABAs can become difficult. In fact, as introduced in Chapter 2, Baker (2014) discussed that synthesising the results of different AB initiatives to determine their effectiveness is difficult because of the variety of indicators adopted in each study. Various authors (Morgan 2014, Foot 2012; Sigerson and Gruer 2011) agree that interventions using an asset-based approach to promote health in communities need novel models for evaluation and appropriate indicators for health and well-being changes that they might influence. However, it could be argued that a completely novel paradigm is not needed, but what is needed is recognition of different designs and methods, coming from the area of social science, which can provide the missing information that experimental methods are not capable to capture (Bambra 2009).

To this end, Trickett et al. (2011) have provided a helpful approach to studying community-based initiatives to reduce inequalities, resulting from a conference held in Chicago in 2009, where

researchers, community members and other stakeholders met to discuss how to carry out research and interventions in place-based communities. The approach proposed by Trickett et al. (2011) suggests that community-based initiatives should be seen as part of processes and events which have an impact on the people engaged in the intervention as well as on the contexts where interventions are implemented. Moreover, the authors suggest adopting a systems thinking approach when studying community-based initiatives, which provides a novel perspective as to how people, relationships and contexts interact with the structure and processes initiated by an intervention.

Significantly, systems thinking and complexity are being increasingly discussed as important in understanding changes in communities from a public health perspective (Foster-Fishman et al. 2007; Gregg et al. 2014; Walton 2014; Jolley 2014; Vaandrager and Kennedy 2017; Hawe et al. 2009; Egan et al. 2019a and 2019b; Orton et al. 2019; South et al. 2020). For instance, as South et al. (2020) have argued, community interventions, especially those with an engagement or empowerment component, do not usually follow a linear pathway of change as designed and intended by professionals (South et al. 2020). Community-based initiatives should therefore be understood through the lens of complexity. In a complex system, different parts interact between each other and generate different behaviours as a result. The system is the result of how these behaviours further interact with the environment. Only one study included in this review (Durie and Wyatt 2013) specifically discussed complexity theory and systems thinking approach as key to unpack the processes initiated through the AB initiative.

As this review has shown, AB initiatives are multi-component and context-specific, thus reflecting most of the key characteristics of complex systems, i.e. non-linear, adaptable, emergent and in continuous evolution (Ricklefs et al. 2007; Quinn-Patton 2011). Therefore, understanding the contexts where initiatives are implemented and how it may influence the development of the processes and changes which are expected to be achieved is key when it comes to evaluating AB

initiatives. Nonetheless, the role of context in evaluating public health intervention has often been neglected (Orton et al. 2017; South et al. 2020). Few attempts to discuss contextual factors have been found in the papers included in this review. For instance, Hanson et al. (2016) discussed potential processes which may have influenced the success of the walking intervention, such as scarce involvement of GPs as having a negative impact on encouraging participants to join the scheme.

To conclude, researching and evaluating the impact of ABAs in place-based communities is challenging and taking a more comprehensive approach is needed to account for how the initiative interact with the contexts, people and relationships, and how these interactions give rise to ongoing processes of change which can support health promotion and reduction of inequalities. To do so, increasing emphasis has been placed on the contribution which adopting a system thinking approach can make to this area of research.

3.5 Concluding thoughts on this chapter

This chapter presented the findings of a scoping review of the implementation literature on ABAs in place-based communities. It proposed a framework of key characteristics of ABAs; helping to respond to objective 1 of this study, and providing a basis that the qualitative research on two specific initiatives builds. Existing implementation literature suggests that AB initiatives can lead to a wide variety of changes, which are best understood as ongoing processes leading to improved health. However, in-depth explanations of the processes through which AB initiatives could impact on health or in reduction of health inequalities are still lacking. Finally, the review highlights the challenges in researching ABAs given that they are complex initiatives implemented in complex settings. This suggests that ABAs are best understood and studied with methods that can take account of such complexity, such as system-thinking and qualitative research. These insights

informed the development of the qualitative fieldwork, as the next Chapter will show, and will be further discussed in Chapter 7.

Chapter 4. Methodology and methods. Exploring ABAs in practice: a qualitative theory-based inquiry

4.1 Chapter introduction

This study aimed to explore how asset-based approaches can promote health and reduce inequalities when implemented in less advantaged neighbourhoods. The previous chapter presented the results of a review of the literature on AB initiatives implemented in neighbourhoods. It presented the key characteristics of initiatives which adopt an asset-based approach and the variety of changes in health and its social determinants which can take place at an individual, community or organisational level as a result of ABAs. The review revealed limited implementation-related evidence about understanding the processes through which ABAs can promote health and reduce inequalities in health. This chapter outlines the empirical fieldwork undertaken to address that gap.

This chapter presents the methodology and methods of the field research conducted over a period of ten months in two settings where two similar AB initiatives were being implemented, with an aim to provide further evidence to answer the objectives of this study:

Obj 1: to identify the key characteristics of interventions which adopt an asset-based approach to promote health and reduce inequalities in and between neighbourhoods through analysing the literature on ABAs and data generated through qualitative research into two AB initiatives.

Obj 2: to identify changes and processes through which interventions using ABAs promote health and affect inequalities through analysing the literature on ABAs and data generated through qualitative research into two AB initiatives.

4.2 Methodology for the study

As discussed in the previous chapters, a call for new models to evaluate community health promotion initiative is not new, but has not been adequately answered. Various authors (Morgan 2014, Foot 2012; Sigerson and Gruer 2011) agree that initiatives using an asset-based approach to promote health in communities need novel models for evaluation and appropriate indicators for health and well-being changes that they might influence. As argued in the previous chapter, recent emphasis has been placed on the role of using qualitative research methods when studying place-based initiatives (Bambra 2009), and on adopting systems thinking approaches (Foster-Fishman et al. 2007; Hawe et al. 2009; South et al. 2020). For these reasons, in this study a combination of methodological approaches has underpinned the data collection and analysis of the fieldwork, as theory-driven evaluation (Weiss 1995; Judge and Bauld 2001; Mackenzie and Blamey 2005), systems thinking and complexity theory (Hawe 2015; Trickett et al. 2011; Jolley 2014; Judge and Bauld 2001). These reflected both current debates on researching AB initiatives as presented earlier in the thesis, and the researcher's ontological position, which will be discussed in section 4.2.2. First, the next section will present these approaches and comment on how they informed this study.

4.2.1 Rationale for conducting a theory-based inquiry informed by systems thinking

As commented earlier in the thesis, since the implementation of asset-based approaches lacked thorough understanding of how these initiatives could support health promotion and reduction of health inequalities, taking a theory-based approach to undertake the fieldwork was deemed appropriate, as the next paragraphs will discuss. Theory-driven approaches to evaluate complex public health initiatives have increasingly been used over the past decades (Breuer et al. 2016), mostly through developing theory of change (TOC) (Weiss 1995) and conducting realist evaluation (Pawson and Tilley 2004). In a nutshell, the main idea of theory-based approaches is to uncover what is the theory underpinning a programme or an initiative, to understand how a programme is

expected to work to achieve its objectives, and then collect data to check how these expectations actually occur in practice. This approach to research was deemed appropriate as a way to explore how ABAs could work to promote health and reduce inequalities, considering the gaps identified in the scoping review presented in Chapter 3. As it will be further discussed in section 4.3.3, in this thesis theory of change tools were used at the beginning of both fieldworks, to discuss with managers and staff what was their understanding of how their AB initiative was supposed to work to promote health and reduce inequalities. In addition to theory-based approaches, this thesis drew on systems thinking perspectives to study both AB initiatives. As introduced at the end of the previous chapter, systems thinking and complexity theory can both provide a more comprehensive view of community initiatives and can help unpacking the complex interactions between initiatives, contexts, people and relations. As with theory-driven approaches, both perspectives are increasingly being incorporated in the evaluation of community initiatives (Walton 2016). This is why combining a theory-based approach with systems thinking provided a helpful framework in this fieldwork. Systems thinking approaches aim to look at initiatives as taking place within systems as a whole rather than distinguishing between isolated elements of a system. Hawe et al. (2009) have argued that a major limit to the evaluation of complex initiatives is the still limited focus on the complexity as being only in the initiative component. The authors argue that complexity is in the settings where the initiative is implemented as well, and any change which may occur needs to be seen as a change in the dynamics of the components of the settings. By following the approach suggested by Hawe et al. (2009), where initiatives should be considered “as events in the system”, the impacts of a programme or initiative can then be understood in terms of changes in the way in which persons, time and place combine (Hawe 2015). In other words, initiatives can be thought of events and activities which change the system because they interact with it, and new capabilities are created from this interaction, leading to changes in the relationships between actors within the system. This view of community-based initiative informed the data analysis of this study, as section 4.3.4 will further illustrate and as the following Chapters will show. This is also in line with what Egan

et al. (2019b) have recently presented in their guidance on using system approaches in evaluation. The authors have commented that embedding system thinking in qualitative research can be helpful to identify how different stakeholders may have changed their relationships or may perceive changes as deriving from an initiative and how these “different parts of the system” can impact on each other (Egan et al. 2019b, p.15). This is why this study conducted a theory-based inquiry through conducting fieldwork in two settings.

Finally, a system perspective should be considered helpful to understand the complexity of initiatives adopting ABAs, as activities, assets mobilisations and potential ‘outcomes’ tend to not be discrete and identifiable but are rather part of a continuous change process, as Chapter 3 has introduced. In an earlier work, Hawe et al. (2004) discussed the importance of studying the impact of complex initiatives in terms of how the different initiative components (which the authors define as ‘forms’) can be combined to achieve specific ‘functions’. For example, rather than standardising the forms of the initiative (ex: the training for GPs), what should be standardised is the function that it is aimed to be achieved, and the steps for the change to occur which can lead to achieve the same results. Thus, if the expected result is to have GPs acquiring a specific skill, there can be different forms to achieve that. This distinction between forms and functions can become helpful when it comes to complex AB initiatives. In fact, as emerged in the scoping review presented in Chapter 3, AB initiatives can take a variety of ‘forms’, such as training, partnerships work, changing urban settings, etc, but the aim is to achieve similar ‘functions’, such as increased social capital, empowerment and control to improve health and wellbeing.

In sum, taking a systems thinking approach to understanding AB initiatives reflects what has been argued in the previous Chapter, in relation to thinking about changes as an ongoing process, a series of loops, whereby an initial input can initiate a change in current capacities or relationships, which in turn can lead to other changes in practices or attitudes. It also reflects the importance of considering the contexts where initiatives are implemented, as contextual factors can enhance or

counter the possibility for these changes and processes to be achieved or initiated. The selected AB initiatives deliver some specific activities, as it will be further illustrated in Chapter 5, and these activities interact in different ways depending on the local context where they are enacted (the neighbourhood and its ongoing activities, the local organisations working in that neighbourhood and the people living there). Therefore, a system approach allowed the researcher to look at context and relationships and how these have changed as a result of, or in association with, the implementation of an AB initiative. Finally, taking a theory-based approach to the research allowed analysing data from both fieldworks with an aim to understand how the observed AB initiatives could give rise to processes through which inequalities could be reduced, and thus respond to the research question and providing evidence on the gaps discussed in relation to the current literature on ABAs.

4.2.2 Ontological position

Considering systems thinking as the overarching approach which informed this study, it is also important to define the researcher's ontological position. Traditionally in research, there have been two major approaches to methodology, quantitative and qualitative, and these are linked to the two ontological positions, namely realism and idealism. However, as argued by Ormstom et al. (2014) there is a spectrum of other intermediate positions. This study can be situated in line with what has been defined as subtle realism: "an external reality exists, but is only known through the human mind and socially constructed meanings" (Ormstom et al. 2014, p.5). Subtle realism is a position brought forward by Hammersley in 1992, which recognises that there is an independent reality, but it also recognises that we cannot know it completely. According to Hammersley (1992), knowledge of reality, as close as researchers can get to it, is still mediated by cultural beliefs and the assumptions researchers may have in relation to knowledge and reality. At the same time, the participants themselves may have their own interpretation of the reality, which is not necessarily the true independent one. In summary, a subtle realism ontological position assumes that there is a reality to be found but that reality is complex and there may be different ways of understanding

it. In this study, this reflects the idea that although the findings cannot represent that independent reality, they can however provide a 'plausible' and 'credible' account of it (Hammersley 1992, p. 51). This approach has underpinned the data collection and analysis since it is assumed that the findings would not simply be the result of a social construction of the reality according to the people living in it, but could be an attempt to represent that reality closer to its underlying essence, i.e. the key processes underpinning ABAs. Considering that the role of the researcher was that of an external person detached from the initiatives under study but familiar with both initiatives and the cultural environment within which they have been implemented, the findings of this research can offer a potential explanation of how ABAs work when implemented in initiatives targeting less advantaged neighbourhoods.

The following sections present the methods which were used in this research. As it will be shown, these methods fit with what Robson (2011) has defined "flexible design" (p.5), therefore adapting to the settings, the events and any emerging findings.

4.3 Methods

As introduced earlier, this study drew on theory-based approaches. To follow this approach, the fieldwork was organised in three main stages: (1) the development of an initial framework to explore the implicit and explicit change processes underpinning the selected initiative using Theory of Change tools (TOC) in consultation with managers and staff of both AB initiatives; (2) five months' fieldwork to collect data on how the initiatives are implemented and perceived by stakeholders involved, and how the wider systems where these initiatives were implemented was structured; (3) the analysis and comparison of the findings within and across the two settings, to identify the core functions, the changes and process which the observed AB initiative enacted and how they interacted with the wider contexts.

In stage one, drawing on the TOC tools to develop the initial framework of how each selected initiative was expected to work has helped uncover some of the assumptions which managers and

staff had regarding the contexts and assets of the communities where each initiative was being implemented, which assets were identified and how they were mobilised. It also supported the researcher to identify the expected changes which the initiatives aimed to achieve, the activities carried out to support these achievements, who the key stakeholders were, and how the relationships between the different stakeholders were expected to develop. This informed the development of the fieldwork, as it highlighted potential participants to interview and events to observe, as sections 4.3.2 and 4.3.3 will further illustrate.

In stage two, following this initial TOC development, the fieldwork enhanced the understanding of the local cultural contexts, but also shed light on how people interacted with their settings, on the processes resulting from these interactions (McNaughton Nicholls et al. 2014), and on how the wider system, including the macro political and economic social structure and the overall public health and health promotion strategies in each settings, related to the community system (Trickett et al. 2011). This fieldwork drew on the ethnographic approach to studying communities. Ethnography is a holistic approach to the understanding of a local context and its social relations (Fetterman 2010). However, researchers have discussed the limits of ethnography to actually provide a holistic picture of a system, because of the continuous changes and dynamic which make up complex systems such as place-based communities (Orton et al. 2019). Nonetheless, Orton et al. (2019) valued ethnography as it entails to spend a long time in the field, and it supports researchers in shedding light on the “full messiness of constantly evolving dynamic system processes” (p. 50). In fact, in initiatives implemented in neighbourhoods, the key ingredient is not the initiative alone but rather its interaction with the local contexts and its inhabitants. As Trickett et al. (2011) have claimed, traditionally initiatives are exported to communities, without knowing how the community is structured. This can become challenging with community initiatives using ABAs, as these depend on the specific characteristics of each local community, and what is valued as promoting health in one context may not be the same in another (Foot 2012). Ethnography allows an in-depth

understanding of social processes, of interactions between individuals within local groups or systems. It uses methods such as observations and interviews, which have been used in this study, as section 4.3.3 will further illustrate.

Finally, in stage 3, the research adopted a more exploratory approach to studying and analysing the interactions of the initiative components with the contexts of implementation and the people from the intervened communities, to develop a more conceptual understanding of how these work, as it will be discussed in Chapter 7.

Finally, it is important to highlight that managers and staff from both AB initiatives have been consulted at the beginning of the fieldwork to identify areas of the initiatives where more research was needed, and at the end of the fieldwork to share and comment on the researcher's findings. This is in line with what Ritchie and Ormston (2014, p.35) have discussed as the rising interest in doing evaluation research "with" rather than "to" participants, so that both parts can learn and benefit from the research process. It is hoped that this research can lead to creating meaningful change in the selected initiative and among its staff because of engaging with the study. However, this is beyond the scope of this work, and would be considered as a secondary outcome.

The following sections details the sampling methods chosen for this research and discuss the methods used to conduct the field research.

4.3.1 Site selection

The early stages of the thesis, as the scoping review on implementation studies was completed, provided an opportunity for the researcher to familiarise with ABAs, to familiarise with national policy stances on ABAs and to consider potential exemplar cases of AB initiatives to study in more detail. Two asset-based initiatives were selected, for being exemplar cases of AB initiatives implemented in the two countries where ABAs have been introduced as part of the national and

regional policies on health promotion (Spain and the UK), as introduced earlier in sections 2.2.1.1 and 2.2.1.2. As indicated in Chapter 2, the MIHsalud programme in Valencia is included as one of the example of good practice in working with ABAs in less advantaged neighbourhoods in the Regional Health Plan 2016-2020 (Generalitat Valenciana. Conselleria de Sanitat Universal i Salut Pública 2016). Similarly, the ICDH course in Sheffield has been discussed as an example of implementing ABAs at local level in the city council strategy for health and wellbeing (SchARR, Sheffield City Council and SCC Public Health Specialists 2016). Moreover, both initiatives are examples of the complexity of ABAs as emerged in the scoping review, being multi-component, involving a variety of different stakeholders and adopting a combination of the three processes to assets mobilisation, as it will be illustrated at the end of this section (Figure 3 and 4). Finally, these were also 'pragmatic' choices given the location of the PhD study in the UK and the researcher's previous competence and connection to Spain. The selection of two similar initiatives, implemented in contrasting settings, thus, allowed the comparison of processes derived from the interaction of a complex multi-component initiative with different contexts, people and relationships. Both initiatives have been selected for being cases rich in information (Emmel 2013), sharing similar initiative components, being community-based and targeting less advantaged areas, and being active for long term, one for ten years and the other for twenty years. The selected cases for this research were two initiatives implemented in less advantaged urban areas, one in Valencia (Spain) and one in Sheffield (UK), where local organisations and local people are being trained to become peer health promoters (Spain) or engaged community members (UK). Both initiatives aim to promote health and wellbeing and to empower local people in less advantaged neighbourhoods, through working in partnerships with local voluntary and community sector organisations (in both settings), which identify volunteers to be trained, so that they can become health promoters in their own communities (in Valencia) or engage in local groups and activities targeting health and the social determinants (in Sheffield). Moreover, in the case of Valencia, the initiative also engages with primary health care services in the neighbourhoods where it is implemented. This means to involve

primary care professionals through regular meetings to discuss activities being carried out in the neighbourhood or potential issues which may have arisen concerning specific people or groups. This is additionally supported by employing Lay Health Workers, a figure resembling that of the health champion in the UK (South 2014), to work in local neighbourhoods, sharing health information with people and supporting Voluntary and Community Sector Organisations to promote health. Drawing on systems thinking approach, it can be argued that the systems where these two initiatives were implemented shared similar components. Both initiatives were implemented in local neighbourhoods, but initiated by a public service located in the city where the initiatives are implemented. In both 'systems', local people and local organisations played a key role in the implementation of the initiative. However, in addition, more macro contextual factors should also be included in the understanding of those 'systems'. As introduced in Chapter 2, section 2.4.3, in Sheffield, it was the city council which was responsible for the initiative and which had specific policies related to working in communities through a network of partnerships between organisations. In Valencia, it was the city-wide public health department who ran the initiative. However, it also involved primary healthcare workers as key stakeholders, thus including both the local health centre team as well as their supporting institutions, the city-wide health department. Both AB initiatives were therefore embedded in a complex network of stakeholders, from the local neighbourhoods and from outside of it, with already different relationships and interactions in place. This is important to highlight, as those complex systems and their components could affect the development of the initiatives and of the changes and process which could be initiated.

To support the readers in understanding the complexity of the selected AB initiatives, Table 2 below describes: the characteristics of the initiatives, their goals and their approaches to assets' mobilisation and their activities. The data presented in Table 2 is a synthesis of a combination of sources. It is based on published articles related to the initiatives (Willis and Mustaphanin 2013a and 2013b; Campbell et al. 2009; MIHsalud 2016; López-Sanchez et al. 2018; López-Sanchez et al.

2013; Sánchez Casado et al. 2018) or on the analysis of other related document which the initiative staff shared with the researcher. Additional information came from the TOC workshops, the presentations which staff members made during an exchange visit, and informal conversations with initiative staff throughout the fieldwork. This descriptive account should allow the readers to understand the activities and the roles of key actors in it, and support the understanding of the networks of relationships existing within that system (Hawe et al. 2009).

Table 2: Description of the aims, target population and activities of the two selected initiatives

<p>MIH Salud (from its acronym in Spanish: women, children and men promoting health) Valencia (Spain)</p>	<p>Introduction to Community Development and Health (ICDH, part of the Community Wellbeing initiative) Sheffield (UK)</p>
<p>AIM: To empower people, promote health and reduce inequalities through training local people to become peer health promoters and to foster working in partnerships with local community organisations, primary healthcare and involve them in delivering health promotion activities.</p> <p>TARGET POPULATION Targeted at VCS organisations and people living in less advantaged areas of Valencia</p> <p>ACTIVITIES 1. Five months training on health promotion topics for people volunteering in the local VCS organisations so they can become lay health volunteers (LHVs) and provide peer support in their communities. The training is called a “learning&action” training, as LHVs attend classes each week and are then required to organise a number of workshops related to the topics learnt. These workshops are carried</p>	<p>AIM: To empower people to take control over their own life and to raise awareness on how to promote the health and wellbeing of their communities through adopting community development principles, thus working on developing local assets.</p> <p>TARGET POPULATION Targeted at people living in the most deprived areas of Sheffield</p> <p>ACTIVITIES 1. The ICDH main activity is to offer training for local members identified by local VCS organisations. The course, Introduction to Community Development and Health (ICDH), is a 15 week course to increase self-confidence, raise awareness on health and its social determinants, promoting</p>

<p>out in their own VCS organisations, for its members and users.</p> <p>2.</p> <p>A once a month session on a health topic, where VCS organisations come along and learn about each other’s activities, services available or other health-related topics. This, together with the training of VCS organisations’ volunteers, is thought to support VCS organisations to become aware of their potential as health-promoting stakeholders</p> <p>3.</p> <p>Community work: three community lay health workers (LHWs) are employed to work in the three less advantaged neighbourhoods as community link/connectors, to share health information through informal chats in the streets or distributing leaflets in local shops which are selected for being ‘health info points’.</p> <p>4.</p> <p>Monthly meetings with primary healthcare professionals in those three less advantaged neighbourhoods to foster a more community-oriented primary healthcare through raising awareness among PHC professionals about the assets available locally and how to work to support local people to access healthcare services appropriately</p>	<p>empowerment and increasing capacities to change and work with others.</p> <p>2.</p> <p>Throughout the course, learners become aware of VCS organisations or project in their area where they can volunteer if interested. In some cases, some of the trained people get engaged in their local groups or in the local partnerships at neighbourhood level, where VCS organisations come together to identify needs and actions to support community health</p>
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As the table shows, the two initiatives shared common characteristics, such as aiming to empower local residents, to work collaboratively with residents and VCS organisations in less advantaged neighbourhoods and training local people to become ‘assets’ in their communities. Drawing on the findings from the scoping review presented in chapter 3, it can be argued that in each setting, there

has been a selection of different assets and that these were mobilised using a combination of the three processes: connecting assets, raising awareness on assets and enabling assets to thrive. First, as for assets' identification, staff recognised local partnerships or community voluntary organisations as potential assets in the local area and aimed to connect these assets together to encourage working in partnership. At the same time, staff members rely on the local organisations representatives as a way to identify local community members as potential leaders and "enabled" them to become assets in their area through encouraging them to attend the training courses. Then, these 'assets' identified by staff members are mobilised as part of the initiative implementation. Course participants engage in training as a way to 'enable' them to become assets for health. During the courses, information is shared as a way to raise awareness on services available and other health related topics. Then, in the case of Sheffield, learners are connected with local VCS organisations. In the case of Valencia, local VCS workers are connected with each other or collaborations with the primary healthcare team is enhanced.

Figure 3 and 4 below represent the activities carried in the two AB initiatives and how these represented different ways to mobilise assets.

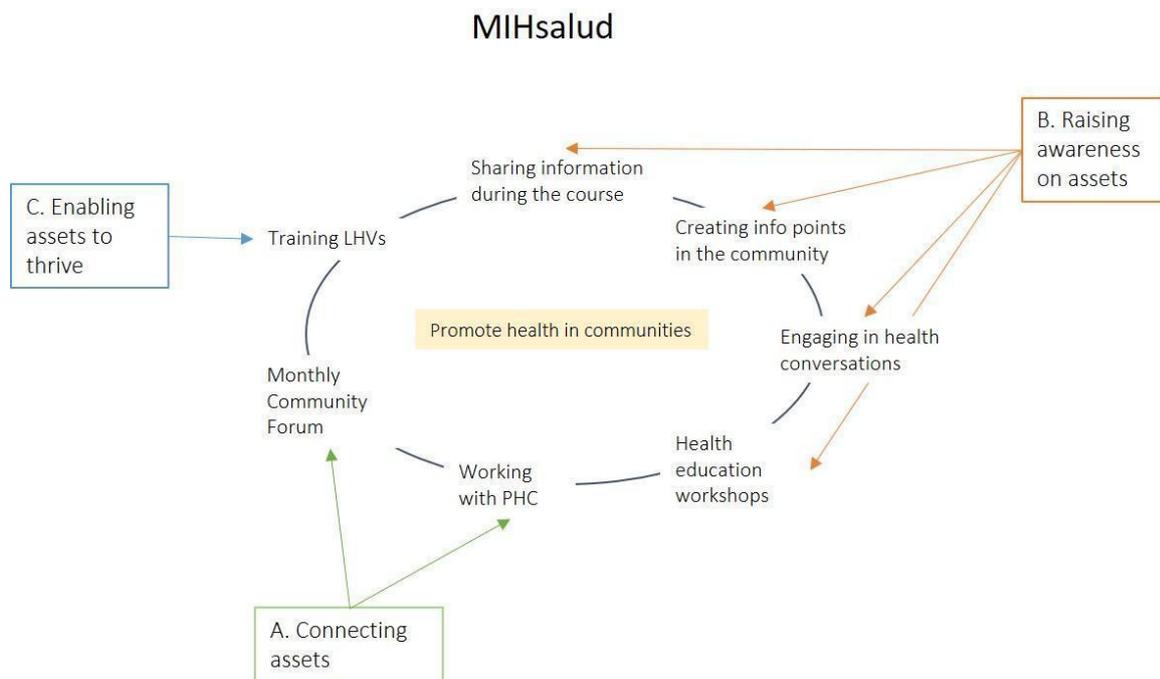


Figure 3: Activities resulting from mobilising assets in MIHsalud

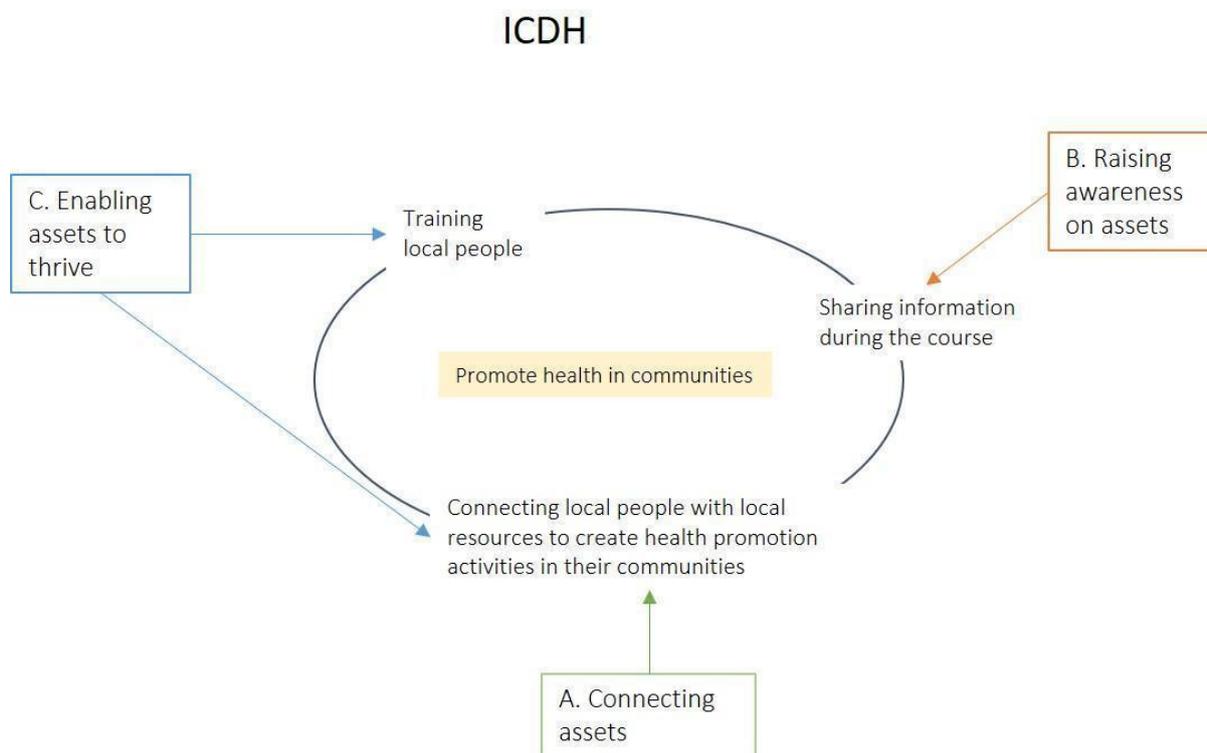


Figure 4: Activities resulting from mobilising assets in the ICDH

Finally, as introduced in Chapter 2, ABAs have permeated both countries' national health policies and local practice. The reason for choosing an international comparative approach is to allow

understanding of whether initiatives with similar components work through similar processes and whether they can or cannot lead to similar results when implemented in contexts which not only differ in their geographical location but also in their current and historical political, social and cultural contexts. If similarities can be found, new hypotheses can be generated as to how ABAs can work when implemented in place-based communities (Vassy and Keller 2012).

This section presented a descriptive account of the initiatives' structures, objectives and activities, which can set the basis to the understanding of the complexity of the settings and initiatives and facilitate the reader in the understanding of the following chapters.

4.3.2 Sampling

In this research, different sampling approaches have been adopted, as the next sections will show.

4.3.2.1 Sampling for the theory of change workshop

As stated earlier in this chapter, the initial TOC workshop was organised in consultation with staff members. To organise the TOC workshop, in each setting a purposive sample of potential stakeholders, who had been directly involved in the design or implementation of the initiative, were identified through discussion with the initiative coordinators. Following this, an introductory email was sent from the initiative coordinator to invite participants to the initial workshop. To avoid pressure in taking part, the researcher then followed up individually with each participant, ensuring that participation to the TOC workshop was voluntary.

In Valencia, a total of ten stakeholders were invited to attend, including: line-managers, front-line staff, lay health workers, voluntary and community sector workers and health professionals who had participated in the development of the initiative and were still engaged in some of its

components. One person did not reply, two participants accepted the invitation but were ultimately unable to attend, and seven participants attended and engaged in the workshop.

In Sheffield, a total of 18 stakeholders, working in six local organisations or institutions were approached and invited to take part in the theory of change workshop. A total of four people attended the theory of change workshop: two initiative staff and two voluntary and community sector workers. Of the remaining 14: three people never replied, four people expressed interest in participating in the study but were unable to attend the event and an interview was arranged at a different time and place with each participant, two people had attended a group interview which was carried out prior to the TOC workshop and were unable to come on the day of the TOC workshop, two people expressed interest in the study but it was not possible to arrange a convenient time for a separate interview, the remaining three people were unable to attend the TOC workshop in the proposed date and did not express interest in arranging a different time to engage in the study.

The theories of change developed in each site set the basis for the researcher to understand how both initiatives were expected to work and through which processes changes were expected to be achieved. At the same time, they became a road map for fieldwork in each site, as theories highlighted who the key stakeholders were, and which activities were being carried out. This information underpinned the selection of participants for the study and the types of events to observe in each setting. The two TOC diagrams are available as Appendix V and VI.

4.3.2.2 Sampling during fieldwork

In each context, a stratified purposive sampling of key stakeholders at institutional and community level was sought for individual or group interviews, to allow variability of perspectives to be shown within each initiative but seeking a degree of homogeneity between the subgroups for cross-

comparison (Ritchie et al. 2014). Sampling was ongoing until data saturation was achieved (Saunders et al. 2018). In this study, saturation is defined as the point in research when data collected from new participants was not adding anything new to the development of an emerging theory about how the two selected initiatives worked in practice to promote health and reduce inequalities, the point of 'informational redundancy' (Saunders et al. 2018).

The institutional level referred to health professionals or managers of the two selected initiatives working at the level of health system, VCS organisations or local council.

In Valencia, practitioners who worked in one of the local areas where the initiative was taking place were approached after participant observations and invited to take part through being interviewed.

In Sheffield, representatives of VCS organisations working in less advantaged neighbourhoods had been approached through the initial theory of change workshop invitation. As stated above, those who could not attend the TOC workshop but expressed an interest in being involved in the study were invited for an interview at a separate time and place.

The community level referred to both frontline staff or local organisations' volunteers delivering or engaging directly with the initiative, like current and former learners.

In Valencia, paid lay health workers who were currently working or have previously worked as frontline staff in the MIHsalud initiative were invited to take part in a group workshop, to explore their perceptions on how the initiative worked, and whether and how it impacted on the health of the people they worked with. As for local organisations' volunteers, a list of former learners (Lay Health Volunteers) was shared with the researcher. An initial selection was made to identify only those organisations working in one of the neighbourhoods where the initiative had been implemented since its beginning. A total of eight organisations had sent volunteers for training over the past ten years. A purposive sample of formerly trained LHVs was invited to be interviewed.

Variability at this level was sought, to explore how and for whom the initiative has had an impact and how that could have led to improved control over health and its social determinants. Two types of lay health 'people' were invited for interviews: Lay Health Workers (LHWs) who were paid employees in their organisation and Lay Health Volunteers (LHVs) who were volunteers in their organisation and were former learners in the MIHsalud course. Additionally, observations during the training course and more in-depth interviews with two LHVs currently being trained allowed exploration and comparison of perceived changes at different stages of the initiative, i.e. during training or after one or more years. Of the LHVs interviewed, all but two were also residents in one of the local neighbourhoods where the initiative is being implemented, and could thus have a particular perspective on the wider impact which the initiative may generate in the area where they live.

In Sheffield, former ICDH learners have taken a variety of different paths and the initiative did not include paid lay health workers, as this role is fulfilled by other types of actors in the UK, such as the health trainers or health champions. Therefore, different strategies were adopted to recruit potential participants. Three former learners and three voluntary and community sector workers were recruited from the original list of potential participants for the TOC workshop. One participant was recruited after the researcher attended a local event in a charity and met a former learner there. A group interview with two tutors and a staff member was conducted before the TOC workshop, during an exchange visit in which initiative representatives from both settings met in person. Finally, because the number of former ICDH learners is significantly higher compared to those who have engaged in the course in Valencia, an additional stratified sampling strategy was carried out. An initial selection was made by identifying three areas of Sheffield where the ICDH course had been ongoing for several years and where contacts had already been made with representatives of local organisations. Then, to comply with local data protection regulation, a selection of previous learners was made by the local coordinator, who acted as the gatekeeper, to

identify learners who had attended the ICDH training in one of these three neighbourhood and lived in the same area where the course was carried out. This narrowed down the number to a total of 45 former ICDH trainees. A letter was sent out by the coordinator which included the invitation to take part in the study and the information sheet with the researcher's contact details. This allowed potential participants to directly contact the researcher, but without having the researcher accessing their personal information without their consent. When discussing the challenges of having such a large number of potential participants, the coordinator felt that based on her previous experience in trying to follow-up with past learners, a very low number of people were going to respond. The coordinator suggested that this may relate to the fact that individuals attend ICDH course when going through a challenging time of their life, and when and if that difficult time comes to an end, they may be less willing to engage with events which relate back to it. Only one participant recruited through this sampling strategy was interviewed. An additional participant showed interest in the research, the interview appointment was arranged twice but due to his/her personal reason, this participant was unable to attend. A third participant expressed interest in being interviewed, but saturation had been already achieved by then and it was decided not to carry out the interview. A fourth participant replied several months later, when the fieldwork was already concluded.

The low number of participants recruited through this approach could be attributed in part to the reasons discussed by the coordinator, as well as potentially to the fact that the information sheet might have been too dense in information. In fact, all the other participants were recruited in-person or through the direct informal contact of a gatekeeper, and a discussion was carried out personally to present them the research verbally, before providing them with the written information sheet and consent form. On one occasion, when the researcher showed the information sheet to a participant, the response was that if she had not known me in person, she would have easily ignored that information sheet.

In summary, this study aimed to engage with a variety of stakeholders whose roles and relations with the initiatives differed, ranging from managers, staff, local groups and volunteers. Each participant was informed orally or via mail and email about the research and its objectives, and received an information sheet with further details and contact numbers for further questions. Negotiating access and ensuring that the role of the researcher and the research is well understood is important in research carried out in communities (Sixsmith et al. 2003). In this study, the role of the researcher as independent from the local service was specified orally to the participants, to avoid pressure in taking part as a form of gratitude towards the initiative and to prevent expectations on immediate changes or benefit beyond the possibility of this study (Webster et al. 2014). Upon acceptance, written consent was obtained prior to the interview or workshop.

The potential harms in engaging in this research were minimal. However, the researcher constantly reflected upon potential risk throughout the fieldwork. In fact, a risk and mitigation plan was developed prior to the beginning of the data collection (available as Appendix VII)

4.3.3 Data collection methods

Data collection and analysis in qualitative research is an iterative rather than linear process. As introduced earlier in this section, this fieldwork drew on ethnographic approaches to studying social groups and communities. Originally developed in the anthropological field, ethnographic research requires the researcher to spend a long period of time in the field, to observe and interact with local people (Atkinson et al. 2011). It can involve the use of three main methods: participant observation, interviews and analysis of related documents (Roper and Saphira 2000; Roulston 2013), which are the same as those proposed by Greene (2000) to conduct a qualitative evaluation. These were the methods used in this fieldwork. In this study, five months of field work were conducted in each of the two selected contexts. This long period of fieldwork allowed the researcher to “immerse” herself in the field and gain a more in-depth understanding of local settings, synergies and relationships

(Atkinson et al. 2011). It has also allowed for community frontline staff and volunteers to familiarise themselves with the researcher. It was hoped that allowing time to develop these relationships with participants set the basis to create a more trustworthy relationship. This in turn should have facilitated them to share their views and perspectives on their surroundings, their relationships with local health volunteers, groups and health professionals.

4.3.3.1 Developing an initial theory of change

According to Fetterman (2010), any ethnography should start with a theoretical model about how the social issue studied works. This model can be based on pre-existing theories or be specifically developed. In this research, the latter approach was adopted, generating a site-specific theory for each setting. The fieldwork began with conducting a workshop with initiative's designers, managers and staff using theory of change (TOC) tools to understand the assumptions on how the initiatives are thought to work and to define which specific issue to explore in each case (see Appendix VIII for further details on the workshop). The Aspen Institute proposed using TOC as a tool to support the planning and evaluation of community initiatives as it aims to uncover the implicit assumptions underlying an initiative and through which change is expected to be achieved (Connell et al. 1995; Anderson 2005). In other words, developing a TOC is a process which aims to make explicit the theories of "how and why a programme will work" (Weiss 1995, p.66). A TOC is therefore a theoretical model which makes explicit the assumptions on the processes through which the change aimed by an initiative can be achieved. To develop a TOC, stakeholders start by identifying the ultimate aim of the initiative and work backwards to make explicit all assumptions which are generally kept uncovered (Breuer et al. 2016). In this study, the proposed workshop included specific questions to encourage participants to identify not only outcomes and assumptions about the processes, but also the key stakeholders and their role within the initiative and the wider system in which this initiative is happening (see TOC questions in Appendix VIII). This reflected what Kania et al. (2013) and Hawe (2015) have pointed out, when they argued that looking at initiatives in

communities through the lens of complexity should implies a focus on the relationships of those social actors involved in the initiative and in the context itself (the wider setting or system), how their interactions may have changed, and what impact this change may have on their well-being and health. As a recent review found (Walton 2014), other authors adopting system approaches to evaluation of community initiatives used participatory approaches to understand the key characteristics of the system, and gain more understanding of “how initiatives are adapted at the local level” (p.124). As well, the boundaries of the system were normally defined by stakeholders involved, thus the importance to involve stakeholders at the beginning of the research. As well, Egan et al. (2019b) have suggested discussing with stakeholders what they may value as important and as influencing the initiative. Thus, involving stakeholders at this initial stage of the fieldwork enabled the researcher to define, together with the stakeholders, the site-specific theory of the initiative (Fetterman 2010) and to identify which areas of the initiative could be further explored and which type of stakeholders to interview throughout the fieldwork. It has also enabled the participants to make explicit some of the assumptions they had about the initiative and discuss these with other professionals with whom they may not work on a daily basis. It is hoped that learning and understanding more about how the initiative can work and the wider impact that it can generate could, in turn, have encouraged what in participatory health research has been defined as transformational learning and support future decisions for further actions (ICPHR 2013).

The TOC session also allowed the researcher to identify who the other key stakeholders involved were, to subsequently gather their perspective on the initiatives, and to identify what the main components of the initiatives were, to explore what to observe and what was expected to be achieved according to stakeholders who designed the initiative. Following the initial theory framework development, methods from ethnographic research have been adopted to collect data during the five months of fieldwork in each site.

4.3.3.2 Observations

One of the main methods in ethnography is participant observation, which has been ongoing throughout the field work. Participant observation is about observing events and relations as they occur in their real-life settings (Robson 2011), and it can provide contextual data beyond what can emerge retrospectively (Mason 2002) through an interview. It is defined as “participant” as the researcher participates as an observer in phenomena taking place in real life settings. It does not imply necessarily to engage directly with the activities or events being observed, but the researcher can interact with the local people as the event takes place (Delamont 2011).

Because of the different ways in which the initiatives observed are implemented, observation across the two settings varied. During the fieldwork in Spain, a variety of events were observed: staff meetings, the training course for LHV, the health workshops delivered by the LHV and shadowing LHV in their daily work. In the Sheffield fieldwork, observations centred mainly in the course, since it was identified as the main activity of the initiative. However, contrary to the Spanish setting, because the course in Sheffield was carried out in a local community, the possibility for informal chats with local voluntary and community sector workers and users and the opportunity to share ideas and experience with participants in the course was higher as compared to Valencia. Therefore, although the type of events observed differed between the two settings, the observations provided rich data on how relationships between stakeholders were taking place, how different people reacted to the contents of the course as applied to their own personal situation and contexts. For example, in Spain, it has been helpful to observe workshops delivered by LHV currently being trained, both at the beginning and at the end of the training, and in different areas of the city, as it has allowed to explore how participants were increasing their confidence in delivering workshops in front of the public, and how they were able to share health promotion messages among their peers. In Sheffield, attending the weekly course sessions and taking notes on the ideas that participants were sharing about how they could engage with others in their communities or what

kind of activities they aimed to develop to promote health in their neighbourhoods provided information about how participants were becoming more aware of themselves, what was needed in their area and which activities they would like to implement.

Nonetheless, it is important to bear in mind that observations require a good degree of reflexivity on the part of the researcher as any observation will be mediated by his/her own selectivity and purpose (Mason 2002). In qualitative research, reflexivity is key to account for how the researcher's own beliefs and knowledge may have impacted on the findings and its interpretation (Ritchie and Ormston 2014). Maxwell (2012) has argued that staying in the field for a longer period allows the researcher to repeatedly observe phenomena in their real settings. This should increase the possibility to understand explanations of certain behaviours or patterns and limit assumptions which may derive from inferring ideas from initial observations only. For example, observing the development of relationships between the different stakeholders in Spain allowed the researcher to understand how there were different factors, personal or work-related, which could impact on the level of engagement of primary health care workers for instance, which from initial observations could come across as limited interest in taking part in the MIHsalud initiative. In Sheffield, observing events carried out in a local neighbourhood has allowed the researcher to gain experience of how people with different backgrounds, experiences and roles (users or voluntary and community sector workers) can engage differently in activities. From initial observations only, other explanations could have emerged, such as lacking interest or commitment.

This is why in this study five months of field work were conducted in each selected site. During the initial period, the researcher observed the daily implementation of the initiative for up to three days per week. Then, observations of specific events were negotiated during the fieldwork and consulted with frontline staff, such as observing part of the training course in both settings, observing the workshops delivered by lay health volunteers in Valencia, and observation of meetings and other community activities in both Valencia and Sheffield. During participant observation, field notes

constituted most of the data. According to Mason (2002) there are different ways to understand field notes. These can be more neutral or incorporate the researcher's own reflections (Mason 2002). Other authors have suggested to record data in a systematic and stratified manner, distinguishing between direct transcription of dialogues, paraphrased dialogues, more conceptual notes derived from initial reflections on an observed event, and ultimately the researcher's own feelings, recorded as separate (Lofland and Lofland, 1995, cited in Padgett 2014). Taking the latter approach, in this study notes have been distinguished between descriptive accounts of the contexts and direct dialogues. For instance, during shadowing of daily LHW activities, notes included the places which we visited, but also how the LHW related to community members, and responses which she may have had to some of my questions. Descriptive accounts enriched the description of the settings in which the initiatives were taking place, thus contributing to provide the "thick-description" as originally proposed by the anthropologist Clifford Geertz in 1973 (Atkinson et al. 2001), which in this case represented the contextual factors which have emerged as important in leveraging the potential impact of the initiatives in both settings. More conceptual reflections and researcher's own perceptions were kept separate, the former as memos (Charmaz 2006), and the latter as explicit perceptions about the phenomenon observed and ideas it may have suggested or how the researcher herself had interpreted it. For example, while shadowing a LHW, a descriptive account would include whom the LHW was talking to and what the main topics discussed were, the researcher's own perception would include ideas around the importance of trusting the LHW in the area but at the same time how the LHW could trust a member of the community and valuing her/his opinion about issues which may have been ongoing in the area. Finally, the reflective memo would centre around a more general idea of trust between different stakeholders, which could have then been linked to other descriptive notes or reflections coming from notes of other observations or from interviews.

In addition to the observations, throughout the fieldwork, an analysis of the internal documents was undertaken, to explore how the initiative was described and its stated goals and objectives and gather available data resulting from previous evaluations where possible. Field observations and document analysis allowed the researcher to gain more understanding of how the initiatives work in practice and to explore how the contextual factors could impact on the expected outcomes.

Access to the settings and to potential participants is another main issue related to engaging in direct observations. Gatekeepers, such as community lay health workers, can be helpful in facilitating this access (Padgett 2012), and it should be continuously negotiated. For example, working closely with the team has facilitated access to the other participants, as initiative staff often acted as gatekeeper providing the researcher the initial contact, but allowing the researcher to follow up on her own. As well, during observations and shadowing of LHWs, walk-along interviews were also carried out (Yeo et al. 2014) to gain more understanding of how the initiative was implemented, familiarising with local contexts, including understanding of the variety of activities which may be happening locally, and to gather perceptions on how the community lay health workers or volunteers perceived the impact of the initiative. This involved shadowing the LHWs in their daily work and discussing with them their tasks, what these mean to them and how they perceive these can make an impact on themselves and on the people they work with. Notes were taken each day during or after the participant observation. These walk-along interviews with LHWs provided more in-depth knowledge about the initiative implementation at neighbourhood level, leading to additional questions to explore which had not been anticipated. These were thus incorporated in the following interviews, to discuss specific issues with respondents and confirm or refute emerging issues. For example, exploring the relationships between local LHWs in the area or among voluntary and community sector workers had not been anticipated. Conversely, questions about participants' perceptions on their neighbourhood turned out to be helpful as background

contextual information but were not eliciting much in-depth information in participants who were residents, but not working in the area.

The following tables describe the phenomenon observed during fieldwork in Valencia (Table 3) and in Sheffield (Table 4) and the duration of the observations or the number of events observed.

Table 3: Observation overview of the fieldwork in Valencia

OBSERVATION TOPIC	Duration in hours or number of events observed
MIHsalud course	26 hours
Workshops delivered by LHV currently being trained	16.5 hours
Meetings of MIHsalud team with health professionals	n=5
Team meeting	n=4
Walking in the neighbourhood with a LHW	19 hours
Extra: public events, walking with a previously trained LHV, visiting two local VCS organisations	n=3

Table 4: Observation overview of the fieldwork in Sheffield

OBSERVATION TOPIC	Duration in hours or number of events observed
ICDH course	36 hours
Extra: public events, walking around a neighbourhood, observing an event led by a former learner.	8.5 hours

4.3.3.3 Interviews

More structured qualitative interviews also accompanied the fieldwork, as a way to gain in-depth understanding of people's perceptions of the changes or impact brought by the initiative in their communities and wider contexts. Qualitative interviews can be relevant when the research aims to

explain how a social phenomenon, such as an initiative, is experienced by the people embedded in its complexity and in the contexts (Mason 2002). According to Legard et al. (2003), in-depth interviews respond to four main characteristics. First, although based on a topic guide, the interview can evolve in a flexible manner, as to allow further explorations of topics as they emerge. Second, interviews develop as a sort of dialogue, to allow respondents to express themselves in their preferred manner. However, as Kvale (2006) has pointed out, interviews also bring with them an asymmetrical power relationship between the interviewers and the respondent which should be taken into account. Conducting participant observation and constant negotiation of access to the field in the two sites helped minimise the asymmetrical relationship, to allow local residents to familiarise with the researchers and to encourage voluntary participation in the research. Third, the interviewer can ask probing and exploratory questions to further gain in-depth details on the issue discussed (Legard et al. 2003). This has also been presented as the tension between allowing respondents to follow their flow of ideas and the need to re-construct the dialogue to what is the main objective of the study and the researcher's interest (Kelly 2010). And fourth, the process of interviewing is considered as producing some sort of knowledge itself (Legard et al. 2003).

Semi-structured in-depth interviews were preferred for this research because they allowed to explore perceptions on the initiative in an open and narrative way, but the researcher could guide the respondent to specific issues which have emerged during the initial workshop with managers and staff. Arthur et al. (2014) have highlighted the importance to have a topic guide developed according to the research question, and which should act as a reminder to the researcher on what needs to be studied or explored. Although the focus of the interview related to understanding the implementation of the initiatives and the perceived changes and processes after being involved in the initiative, the topic guide has been developed including ideas initial findings from the TOC workshops, the participant observations together with information from the walk-along interviews (see topic guide in Appendix IX).

In addition to the seven participants in the TOC workshop, in Valencia, at institutional level, interviews were carried out with a total of eight health professionals working in three local health centres. Six of these were nurses, and two social workers. Additional nurses were invited to take part in the research and had expressed their interest. However, due to a clashing timetable, it was not possible to carry out the interview. It should be nonetheless noted that saturation of information was achieved. One final interview was conducted towards the end of the fieldwork with two members of the initiative staff. It involved a discussion around emerging ideas about how the initiative was working and how it was interacting with contextual factors. Then, at community level, interviews were carried out with former LHV currently working in a local VCS organisation (n=4), currently volunteering in a VCS organisation (n=4), or who were currently neither working nor volunteering for a specific VCS organisation (n=2). One group workshop was carried with current or former LHWs (6 participants).

In Sheffield, participants from the institutional level included voluntary and community sector workers (n=5), three of which had also been learners in the training. Two of these participants had also attended the TOC workshop. One group interview was carried out with two current tutors and one member of the initiative staff, to discuss initial ideas on how the initiative was organised, its aims and objectives and some underlying assumptions. As for community level, three participants were interviewed, one currently volunteering for a local voluntary organisation, and two currently working in other voluntary and community sector organisations, not directly involved with the initiative. Additionally, to share emerging ideas with participants, informal discussion took place during the course, with tutors and learners. As well, a summary of the course observation was prepared and shared with learners on the last day of the course, to check with them whether they agreed on what was presented, and to ensure that no personal information was included. The feedback received from both the tutors and the learners was positive.

Individual interviews could provide a more in-depth discussion on the perceived changes and processes. However, they are also time-consuming. Both at institutional and community level, some interviews have been conducted in pairs or in a small group of three. This has allowed for an enhanced discussion between the researcher and each of the participants as well as allowing participants to discuss between each other and contrast different perspectives on the same issue (Lewis & McNaughton Nicholls 2014), thus enriching the discussion. For instance, in one interview with LHVs, one of the two participants was commenting that she had been unable to use the information gained on the course again, while the other participant challenged this perspective by reminding her that she actually does share information among the members of her community organisations. In other interviews, participants complemented or reinforced what was being said by the other interviewees. This, it could be argued, worked as a probing mechanism (Legard et al. 2003) carried out directly by the interviewees themselves. On the other hand, in interviews with two or more participants, there can be a risk of having a dominant participant whose voice prevails on the other. To avoid this, eliciting direct answers from the rest of the participants (Finch and Lewis 2003) was adopted as a strategy.

Table 5 and Table 6 below presents an overview of the interviews carried out at institutional level and at community level respectively and their duration.

Table 5: Interviews carried out at institutional level

Type of interview	N	Type of participant	Duration	Location
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Individual interview	1	Health professional	1 hour	Valencia
Individual interview	1	Health professional	40 mins	Valencia
Individual interview	1	Health professional	40 mins	Valencia
Individual interview	1	Health professional	30 mins	Valencia
Group interview	2	Health professionals	1.5 hour	Valencia
Group interview	2	Health professionals	1 hour	Valencia
Group interview	2	initiative staff	1 hour	Valencia
Group interview	3	ICDH tutors and staff member	1 hour	Sheffield
Individual interview	1	former ICDH trainee and currently voluntary and community sector worker	50 mins	Sheffield
TOC workshop	4	2 team workers and 2 voluntary and community sector workers	2 hours	Sheffield
Individual interview	1	former ICDH trainee and currently voluntary and community sector worker	40 mins	Sheffield
Individual interview	1	voluntary and community sector worker	1 hour	Sheffield
Individual interview	1	voluntary and community sector worker	1 hour	Sheffield
Individual interview	1	former ICDH trainee and currently voluntary and community sector worker	1 hour	Sheffield

Table 6: Interviews carried out at community level

Type of interview	N	Type of participant	Duration	Location
Individual interview	1	LHV	1.5 hours	Valencia
Individual interview	1	LHV	30 mins	Valencia
Individual interview	1	LHV	1.5 hours	Valencia
Individual interview	1	LHV being trained	1 hour	Valencia
Group interview	3	LHV being trained + 2 voluntary and community sector members	1.5 hour	Valencia
Group interview	2	LHVs	1.5 hour	Valencia
Group interview	3	LHVs	30 mins	Valencia
Group workshop	6	LHW or former LHW	2 hours	Valencia
Individual interview	1	former ICDH trainee, currently working in another organisation	1 hour	Sheffield
Individual interview	1	former ICDH trainee, currently working in another organisation	1 hour	Sheffield
Individual interview	1	former ICDH trainee, currently working in another organisation	1 hour	Sheffield

Additionally, as the research was a cross-country comparison, staff members from both initiatives expressed interested in getting to know each other. An exchange visit was therefore organised in June 2018, towards the end of the fieldwork in the first context and prior to the beginning of the second fieldwork. Three team members from the ICDH initiative travelled to Valencia for two days. The researcher supported the organisation of the exchange and helped with translation during the encounter. An initial formal meeting was organised to present each of the initiatives, which lasted

approximately four hours in total. A representative of the Valencia City Council, four MIHsalud team members and other two public health workers attended the event. Permission was asked to record and transcribe the presentations. A second more informal meeting was organised at a local VCS organisation in Valencia, during which former and current local lay health volunteers and workers engaged in conversations with the visiting ICDH team members about their life stories and the impact that both training had made in their lives. A third meeting was organised at one of the health centres collaborating with the MIHsalud initiative. In this last meeting, the local team of health professionals illustrated how they engaged in the MIHsalud initiative in their neighbourhood and the changes that had been incorporated in their weekly activities as a result.

During this exchange visit, a group interview was conducted with the ICDH team, which set the basis to further understanding of the initiative and its key components. During the session, the researcher drew an initial simplified version of a TOC on a paper while the team was discussing its different components and the activities required.

To summarise, this study used the following methods for data collection:

- Two theory of change workshops in each site were organised at the beginning of the field work period to develop a framework on how the initiative is expected to work together with initiative staff and key stakeholders;
- Participant observation in the communities (including specific events and meetings) where the initiatives were being implemented for a total of around 120 hours;
- Semi-structured interviews (individual, in pairs or in groups) with frontline staff, stakeholders from local VCS organisations and primary health care services, and current and former learners, for a total of 44 participants.

All data collected throughout the research - recorded interviews, theory of change photos and field notes were transcribed verbatim or typed up in the case of written field notes and imported into N-Vivo software v12 in anonymised forms for qualitative analysis. Figure 5 below presents a visual summary of the data collected in the two settings.

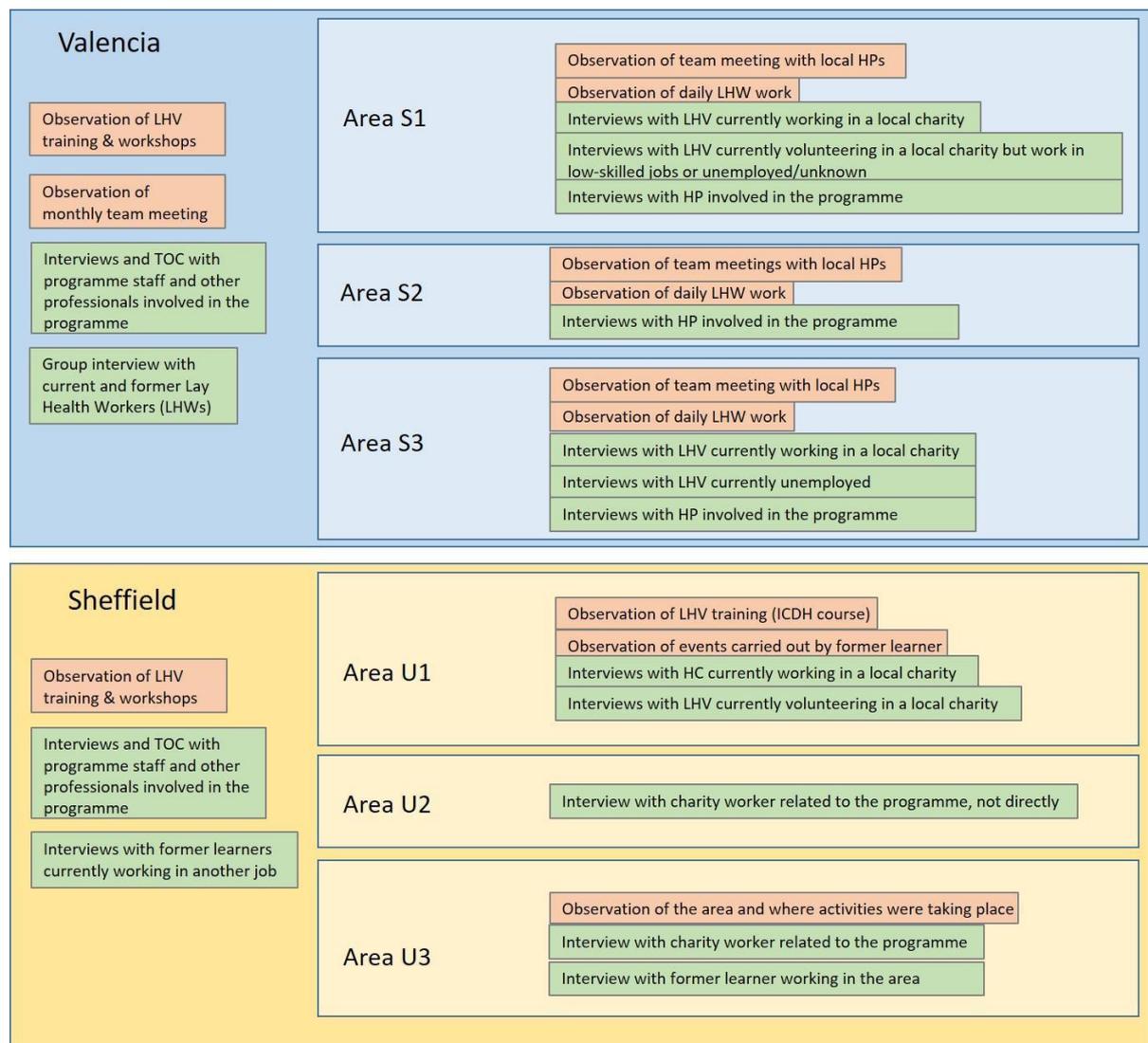


Figure 5: Summary of all data collection approaches in both settings

4.3.4 Data analysis

There can be various approaches to analysing qualitative data (Spencer et al. 2003). In this research a thematic analysis (Braun and Clark 2006) using NVivo v12 has been conducted to explore emerging issues which could shed light on the processes enacted when AB initiatives are implemented. Thematic analysis refers to the process of analysing data taking an inductive approach and identifying recurrent patterns or themes across the material, which could support the development of explanatory theories about certain phenomena (Charmaz 2006). It implies a set of stages: initial reading and familiarising with the data, coding and categorising, interpreting and finding theoretical or explanatory patterns (Lapadat 2012). The process of coding refers to reading line-by-line the texts and labelling specific sentences or paragraphs in such a way that the code can represent that specific data but also others which express a similar concept (Charmaz 2006). According to Charmaz (2006, p. 46), coding can be considered as “the link between collecting data and developing an emergent theory to explain these data”. As coding was carried out using NVivo, it was chosen to code larger paragraphs rather than short sentences, as this facilitated the understanding of the quotes in their context, when reading again through the coded material rather than the original transcripts. During the analysis process, the codes begin to show similar patterns of ideas, to allow the researcher to further synthesise them in more abstract overarching categories or themes (Ritchie et al. 2003).

In this study, an open and inductive approach to the analysis was adopted, to allow for emerging findings from the data to be captured as codes. To keep findings related to the field data, the initial analysis was kept as descriptive as possible, taking an inductive approach with an aim to identify perceived changes as discussed by participants and coding additional comments as part of the context, barriers and facilitators. These were then grouped under three main categories of perceived changes, process to mobilise assets and contextual barriers and facilitators. The analysis has been carried out within and across cases, by comparing emerging codes across the two initiatives or by contrasting codes or themes related to perceived impact across the different

stakeholders in both initiatives. The latter has allowed exploring whether there were cross-case patterns emerging in specific subgroups of participants, either at institutional or at community level (Ritchie et al. 2003).

As a result, when reading the transcripts assigned to each code after this initial descriptive analysis stage, it was found that most codes were supported by data from each setting. These initial codes were also contrasted against the assumptions that emerged from the two initial TOC workshops and used to explore potential change processes. Throughout this first analysis phase, some key topics emerged as important and needed further analysis, for instance the role of capacities, and contextual factors enabling multiple processes to occur. Moreover, some of the codes related to specific activities being carried out as part of the initiatives rather than perceived changes. These codes were then re-organised as part of the analysis of the AB initiatives, and were later grouped under the theme 'ABAs as spaces for encounters and exchanges' (presented in Chapter 5). As analysis is an iterative process, a second phase of the analysis brought the researcher back to the initial codes, with an aim to re-structure those to make sense of the changes and processes which had been observed as recurring within the data, but which were not fully represented through the initial descriptive themes. To do so, transcripts were read for each code, allowing the researcher to check again whether the codes were appropriate for each of the coded sentences, and to ensure that the codes developed were reflecting the data while at the same time representing more abstract concepts. Reading through the codes thus allowed the researcher to identify whether some of the coded fragments could better fit into other codes, and if so, to move these accordingly. Finally, a third phase of the analysis centred on analysing the codes and their description, to identify similarities across more codes and group these into 'higher-order' themes and sub-themes. This third phase was carried out by conducting the analysis using the 'Codebook' from NVivo: a document which includes all the codes assigned in NVivo and their description. This process was supported by continuous reading on the topic of ABAs and its associated literature presented in

Chapter 2, so as to bring conceptual insights from wider literature in to the analysis process. Through this third phase of the analysis, some of the codes were excluded; for example, if it was considered that the information included in the data was not relevant to answer the research objectives. This third phase of the analysis process thus resulted in the development of ‘higher-order’ and more conceptual themes; each with its own set of sub-themes, which were organised around two blocks: (1) the forms which the initiative took (as mentioned above, in relation to the codes referring specifically to the activities carried out as part of the initiatives), and (2) the main processes which the initiatives initiated, including changes in health and its determinants.

Figures 6 to 10 below provide an illustrative example of the final organisation of the themes, sub-themes, and codes. For reasons of space, it has not been possible to include all the codes used in the analysis.

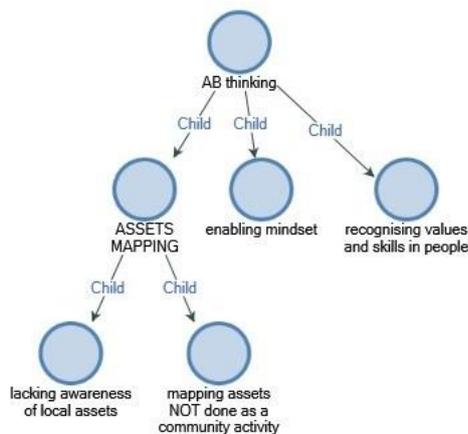


Figure 6: An example of the codes associated with the theme of 'Enabling AB thinking'

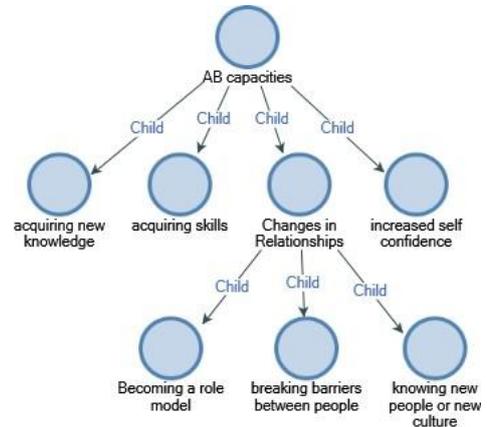


Figure 7: An example of the codes associated with the theme of 'Developing AB capacities'

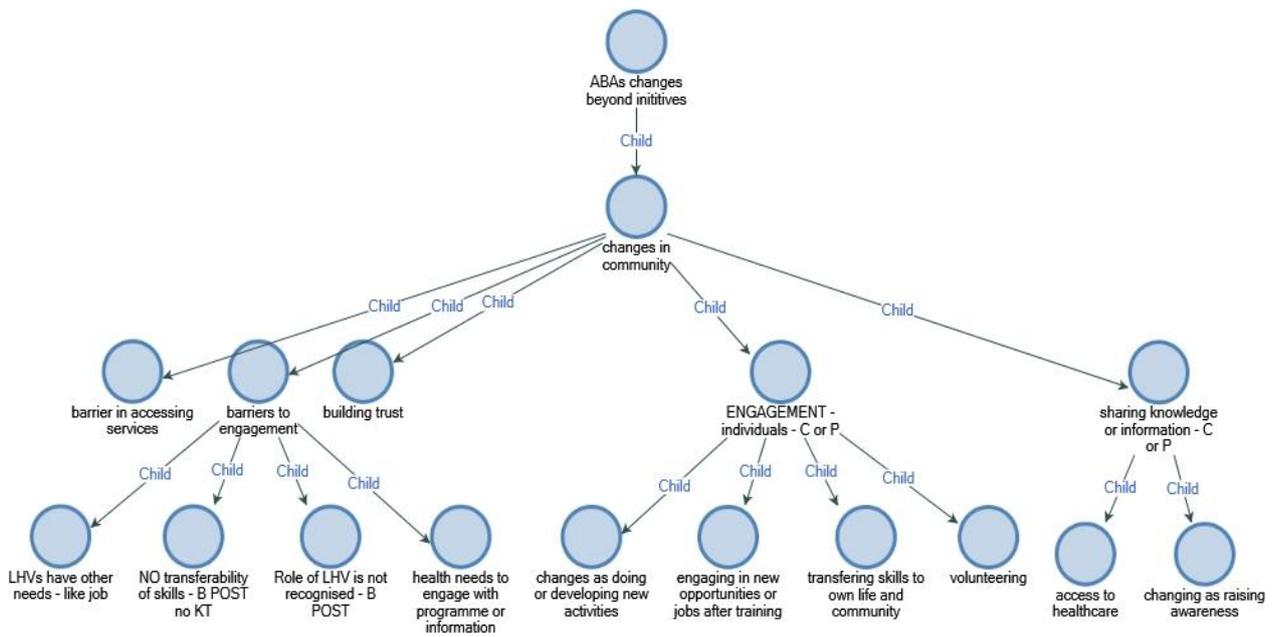


Figure 8: An example of the codes associated with the theme of 'Mobilising AB capacities', sub-theme 'Changes in the community'.

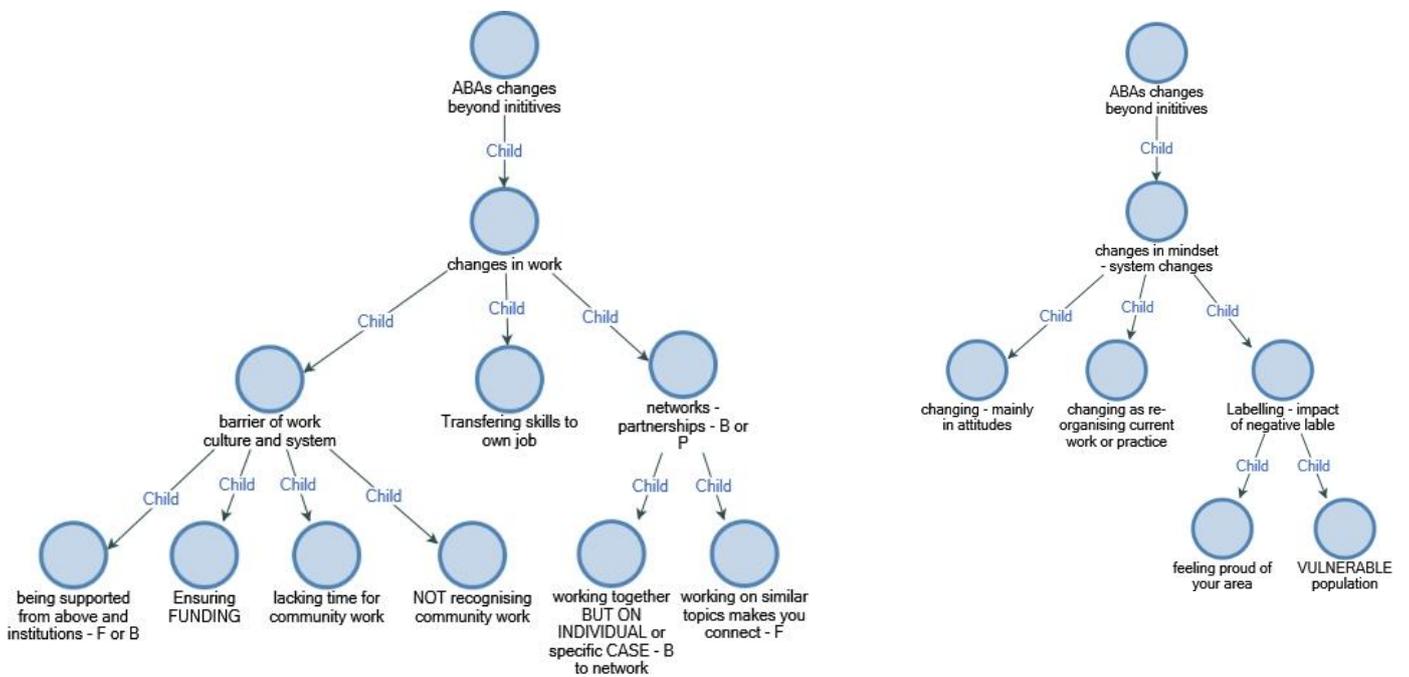


Figure 9: An example of the codes associated with the theme of 'Mobilising AB capacities', sub-theme 'Changes in the work practice'.

Figure 10: An example of the codes associated with the theme of 'Mobilising AB capacities', sub-theme 'Changes in system'.

Finally, this organisation of the themes, sub-themes and codes was contrasted against the research objectives, and organised in a way which provided evidence to meet them. As it will be shown in Chapters 5 and 6, this led to the theme 'ABAs as spaces of encounters and exchanges' indicating the forms which the initiative took, while the themes 'Enabling asset-based thinking' 'Developing asset-based capacities' and 'Mobilising asset-based capacities' refer to the processes and changes which can be achieved throughout the initiatives and beyond them.

Importantly, the ways in which the codes were developed and grouped reflected a systems thinking approach, as introduced earlier in the chapter. As Hawe (2015, p.310) suggested, research in community-based initiatives could focus on: (a) how the initiative interacted with local context and in what ways thinking and practices may have changed as a result of this interaction, what kind of results could be visible as a result of this interaction; (b) how relationships may have changed, in terms of information seeking, decision making, etc;. (c) changes in activities; and (d) changes in the redistribution of resources, being these "material, informational, social, cultural".

The themes resulting from the data analysis were then contrasted with evidence from the literature on ABAs, as it will be shown in Chapter 7. To some extent, this iterative and hybrid approach resembles what Guest et al. (2014) have called Applied Thematic Analysis (ATA) which draws on different approaches, from grounded theory to interpretive phenomenology and centres on transparency in the explanation of the approach chosen.

It is hoped that the themes identified and organised as a way to explain the changes and processes occurred can contribute to the understanding of how ABAs work to promote health and reduce inequalities. Moreover, it is hoped that the findings can support the understanding of which initiative components could be transferred and implemented in other contexts and which factors may reflect endemic characteristics and are not likely to be applicable elsewhere (Shiell et al. 2018).

4.3.5 Feedback to the key stakeholders

A final point is worth discussing, in relation to the final stage of the data collection and analysis. As recommended in qualitative research carried out in communities, reporting the findings to the key stakeholders is important. In Valencia, a feedback session was organised a few months after finishing the fieldwork, when initial analysis had been finalised. The session had a duration of around an hour, and included an overview of the findings in relation to what had emerged in the TOC workshop, together with specific feedback received by former learners and health professionals, as emerged during interviews. Attendees to the sessions included staff from the Public Health Centre, the Lay Health Workers and representatives of a local organisation. In Sheffield, a direct feedback was provided to participants in the course, through a short document developed by the researcher based on observations notes, which showed what had happened during the course in the form of a story. Participants provided their feedback and inputs and were pleased with the summary. This informed the development of a short animated video, available at: <https://www.powtoon.com/online-presentation/fSOwD8m6NFD/intro-to-the-icdh/?mode=movie#/> which was then shared and discussed with staff members, who appreciated it. It is hoped that they can use the video to complement information about what the ICDH course is. It is the intention of the researcher after defending the thesis to develop simple infographic material which can provide a summary of the findings of the whole thesis in lay language, to be shared with the rest of participants.

4.4 Ethics, integrity and informed consent

This research was approved by the Ethics Committee of the University of Sheffield (see Approval Letter in Appendix X). Given the exploratory nature of this research and its being based in communities, potential risks may have occurred and affected the overall process. To minimise these, prior to the beginning of the fieldwork, a risk and mitigation plan was developed, as introduced

above (see Appendix VII). As for participants, the risk in engaging in this research was minimal. However, the researcher has been aware of potential harms and how to minimise these. At the sampling stage, to avoid potential participants to feel pressured in taking part in the research, the gatekeepers were asked to support in approaching local community members or former LHVs, but the final decision on whether to take part in the interview was discussed with the participants themselves, emphasising that participation was voluntary (Webster et al. 2014). In both settings, participants were informed on the nature and purpose of the study orally, and provided with a written information sheet detailing the research project in the local language. Informed consent was obtained in written form from each participant for interviews and TOC workshops. For the analysis and reporting of the findings, participants were anonymised, and any identifying information was removed. As for observations of specific events, since it involved informal conversations with local people or course attendants, the researcher introduced herself and the study, specifying that the purpose of the research was to understand how the initiative was working, and no personal information would be included in the notes. For example, when a participant was saying something interesting, the researcher specifically asked him or her if she could use what he/she just said as an anonymised quote. In other occasions, when participants were working in groups and came up with interesting definitions, for example about what community development was, the researcher asked if she could take a picture and use it in the study, and participants actually helped to take a good one. When observing an event led by a former trainee in Sheffield, he introduced the researcher to the other participants, and it was explained that the researcher was a public health student doing a study on health promotion activities in communities and that she had asked to the former learner if she could come and join the session to learn from all of them. The researcher then asked it was ok for participants, and everyone nodded.

Another potential risk when doing research in communities refers to generating false expectations regarding benefits from taking part. The researcher ensured that each participant understood that

the researcher was not a member of the local NGOs or local government and that her role was purely that of learning through the field research about how the initiatives worked and whether and how it has impacted on the people engaging with it. This was explained in the information sheet and was reiterated during interviews.

Additionally, to ensure no harm resulting from sharing information, the researcher informed potential subjects about the objective of the study, and that confidentiality would have been maintained for the whole process. The findings were thus fed back in anonymised form at the end of the field and discussed with initiative managers and staff, as a way to allow a shared learning to occur.

4.5 Validity, reliability and reflexivity

The concepts of validity and reliability are traditionally associated with quantitative research, and refer to the accuracy, appropriateness and replicability of the methods used and results emerged in the research (Guest et al. 2014). In qualitative research, there has been ongoing debate about whether the terms are relevant for this methodological approach and a variety of alternative suggestions have been made, centred around the idea of credibility of the research methods, data and results (Lub 2015). In this study, the triangulation of field notes, observations of key events and interviews or group workshops was adopted to enhance the validity of the results (Lub 2015; Guest et al. 2014). Since this study has involved comparison of results across and within cases, reliability has been enhanced by following a certain degree of structure in the data collection (Guest et al. 2014), such as using similar topic guides to develop the Theory of Change and for the semi-structured interviews.

A key concept related to issues of validity in qualitative research is the reflexivity of the researcher (Lub 2015). This refers to the process of making explicit the assumptions, values and opinions of the

researcher and which may have an influence on the way findings are analysed and interpreted. In this study, reflexivity has been undertaken through developing trustworthy relationships with participants, but ensuring to maintain a critical view on the initiatives. This was carried out, for instance, by negotiating access to attend meetings or the trainings in both settings, but separating the researcher's own perceptions in the field notes. As suggested by Noble and Smith (2015), this can then support the identification of the descriptive account and the researcher's reflection about what has been observed. As well, being from a different country but able to speak the local languages allowed the researcher to develop a role of a "critical friend" both with those directly working in the initiatives and those who do not. For example, in the former case, by consulting staff at the beginning of the initiative as to whether there were areas where they would welcome information about how the initiative was working, and providing context specific feedback and suggestions at the end of the fieldwork in both settings. As in the relation with stakeholders not directly working in the initiative, reiterating the role of the researcher as external from the initiative organisation contributed to engaging in informal discussions or interview where participants could express their positive opinions as well as constraints or difficulties they may have experienced.

4.6 Concluding thoughts on this chapter

This chapter presented the methodology and methods for the fieldwork in the two settings, to explore the processes through which initiatives using ABAs can potentially reduce inequalities. It has described the methods adopted for the data collection and analysis, providing examples of how the research has been carried out and discussing questions related to ethics and integrity in the research process. The following two chapters present the findings from this fieldwork.

Chapter 5. Findings part I: ABAs as spaces to create and share capacities

5.1 Chapter introduction

This chapter presents the first part of the findings from the fieldworks, which aimed to answer the objectives of this study:

Obj 1: to identify the key characteristics of interventions which adopt an asset-based approach to promote health and reduce inequalities in and between neighbourhoods through analysing the literature on ABAs and data generated through qualitative research into two AB initiatives.

Obj 2: to identify changes and processes through which interventions using ABAs promote health and affect inequalities through analysing the literature on ABAs and data generated through qualitative research into two AB initiatives.

As explained in Chapter 4, this study draws on a systems thinking perspective, conceptualising the two AB initiatives in Sheffield and Valencia as developing through an ongoing process whereby an initial event or series of events create initial changes in relationships or resources, at individual or collective levels, which then lead to other changes which can affect the stakeholders' wider network. The processes observed in both places were: (i) enabling asset-based thinking, (ii) developing asset-based capacities and (iii) mobilising asset-based capacities. As this chapter will show, 'enabling asset-based thinking' emerged as being at the core of the design and development of the AB initiatives. The initiatives were designed to support engaged stakeholders to 'develop asset-based capacities', which they then 'mobilised' beyond the time and spaces created by the intervention, as the next chapter will further illustrate.

This chapter is structured in three sections. Section 5.2 presents the different activities which the AB initiatives developed in an effort to promote changes in health and wider determinants. Section

5.3 presents the first important process that was identified in the research: ‘enabling AB thinking’. ‘Enabling AB thinking’ refers to supporting people to adopt the positive view which was discussed in Chapter 2 as underpinning ABAs, a view which values the strengths and resources of people and communities, rather than focusing on problems and deficits. This process appeared to underpin the development of the AB initiatives in both Sheffield and Valencia, supporting the associated process of ‘developing AB capacities’, but was also promoted as a way of thinking that engaged stakeholders could acquire throughout the AB initiative. Section 5.4 introduces and explains the second identified process ‘developing AB capacities’. Section 5.4 is organised in three subsections which describe the different dimensions which make up asset-based capacities and which interrelate with each other: knowledge and skills, self-confidence and relationships.

When reporting direct quotes, acronyms have been used in some cases to better identify the types of participants but maintaining anonymisation:

LHV: Lay Health Volunteers: people who have been in the courses in Valencia or Sheffield

LHW: people who are currently working or have worked as Lay Health Workers in Valencia

HP: Health Professionals working in primary health care teams in Valencia

VCS worker: Voluntary and Community Sector organisation workers

5.2 The AB initiatives as spaces for encounters and exchanges

As introduced in Chapter 4, section 4.3.1, the observed initiatives in Sheffield and Valencia developed a range of different activities in order to initiate changes to promote health of participants and their wider communities: the training courses for local people in both settings, and in Valencia the monthly meetings for VCS organisations, and the regular meetings with primary health care teams. These activities, which can be seen as the initial events to achieve changes, have been defined here as ‘spaces for encounters and exchanges’, because they represented an

opportunity for an encounter between two or more people, where new relationships were developed and different resources were exchanged, from information to support. They can also be understood as a type of 'event' from which processes were initiated, such as 'enabling asset-based thinking' and 'developing asset-based capacities' as sections 5.3 and 5.4 will further discuss. This section illustrates how the training courses were spaces for encounters and exchanges in both Sheffield and Valencia. It also illustrates how there were additional spaces for encounters enacted by the MIHsalud initiative in Valencia. This section is informed by data from observations, the theory of change workshops, and interviews with current and former learners.

5.2.1 The training courses as spaces for encounters and exchanges

The theory of change workshops, observational data and learners' interviews, revealed that the 'training course' for community members was one of the main activities of the AB initiative in both Sheffield and Valencia, and, as such, was a 'space' that was common to both settings. As introduced in the previous chapter, these community members were selected by staff members and local voluntary and community sector (VCS) organisations because of their identified potential for becoming leaders in their communities, and were often already involved in some forms of volunteering at a local VCS organisation. As this section will illustrate, the ways the courses were designed, in terms of contents and structure created opportunities for those local residents to 'encounter' each other, as a way to meet new people, and for new relationships to develop, exchanging resources such as knowledge and skills, all of which contributed to developing AB capacities, as section 5.3 will further illustrate. In both settings, the training courses adopted an interactive approach to the learning, with practical hands on activities and to favour both professionals-learners interactions and peer interactions, supporting the creation of spaces where each person and her knowledge and expertise was valued, and thus favouring those encounters and exchanges, as the following paragraphs will show.

5.2.1.1 Interactive approach to learning

The courses in both Sheffield and Valencia adopted an interactive approach to learning, whereby learners interacted either with the teacher (in the case of Valencia) or tutor (in the case of Sheffield) and with each other. This interactive approach was an important dimension of the training course as a 'space', as it supported shared learning experiences in which each person brought to the table his or her cultural and experiential knowledge to integrate it with that of others. For example, and as observed in both settings, in each of the course sessions, the teacher or the tutor proposed a topic for discussion to the learners, followed by hands-on group activities. For instance, in Valencia, each theoretical class was jointly run by a health professional and a Lay Health Worker (LHW). Although these theoretical classes were mainly organised around professionally-based knowledge, each class started by asking learners what they already knew about the subject, for example, discussing how they perceive a health need, or how services differed in other countries. This type of interactive approach was important because it contributed to supporting learners to gain confidence about their own knowledge and experiences as important, and therefore enhanced their feeling valued, as it will be further discussed in section 5.4.2. This was followed by a presentation delivered by the health professional. As observed during the fieldwork, sometimes learners integrated what the health professional was discussing, based on their experience as patients or as friends of patients, as this extract from an observation of a class on access to reproductive healthcare during the MIHsalud course shows:

The teacher was saying that any pregnant woman should be granted appropriate care, even without a health card, but a few lay health volunteers in the course started sharing experiences of cases when immigrant pregnant women had been denied prenatal care. Other learners then suggested potential solutions, such as asking to speak with the social worker. The debate made the teacher reflect as to how other health professionals may work when it comes to migrants who are not aware of their

rights, while at the same time it allowed lay health volunteers to share their experiences and receive support from the rest of the group [observation].

In Sheffield, the course also took an interactive approach to learning. For example, classes always started with the tutor asking learners to share something with each other that had happened during the previous week. Then, a presentation of the topic of the week was given by the tutor, together with handouts for the exercises. The tutor then started asking learners questions related to the topic, for instance, what they perceived as health and what could influence their health and that of their neighbourhoods, to encourage own reflection and group-discussion. Similar to what happened in Valencia in the case of MIHsalud, in Sheffield during the ICDH training course, in this interactive approach, learners were valued for the knowledge and expertise that they shared in these ways through the sessions. In fact, the classes usually developed in the form of a dialogue whereby learners shared their knowledge and thoughts about the topic. The tutor facilitated this dialogue and provided feedback when she felt it was needed. For example, as observed in a session dedicated to the topic of 'community resources and skills', the tutor started the debate following questions and instructions from a handout, asking:

"Who is part of the community?". Learners started responding "whoever lives there, like shop owners". One person commented that: "everybody is, but whether they take part or not it depends". The following question from the handout that stated "Who seems not to be part of the community?" generated debate. One learner said "beggars seem outsiders", and another one said "students seem to be a bit on their own and don't fit in as much", but also added that "Sheffield wouldn't be Sheffield without the students". Another participant commented that "they make about 10% of the population in Sheffield". The tutor then replied that it was important also to consider that students bring a lot of resources which can be good for the local economy and the city as well, and to understand why they may appear as outsiders. [observation]

Thus, throughout the training, in the interactive sessions, course participants in both settings were able to learn from professionals and peers through sharing doubts and concerns, and finding solutions by interacting with each other and the teachers.

5.2.2.2 Encouraging peer learning

This interactive approach to learning also allowed learners to share personal experiences in relation to the topic discussed. This also supported peer-education, as knowledge of both professionals and peers were valued, which according to health professionals who participated in the TOC workshop and had contributed to the development of the MIHsalud training, is key in supporting knowledge exchange:

“HPa: because a person who is close to you, you see him or her as equal, [the message] comes to you in a different way from a person who is at a higher level.

HPb: you pay more attention

HPc: the message among peers, comes easier

HPb: yes, it gets easier

Team member 1-Valencia: easier and faster. And with a [real-life] example.”

[TOC workshop Spain]

5.2.2.3 The role of practical ‘hands-on’ activities

To enhance the interactive and shared learning, the types of activities proposed during the courses were important to promote not only knowledge exchange but also practical hands-on experience.

For example, in Valencia, in addition to the theoretical part and to enhance peer-learning further, the second part of each class included practical hands-on activity. A peer LHW delivered the health workshop related to that topic, so that learners could experience the workshop as participants, while at the same time learn the steps needed to deliver it by themselves during the ‘action’ part of the course. Then, when returning to class after the period during which the learners were delivering

the health workshops in the VCS organisations where they volunteered, the session started with a presentation of each lay health volunteer about their experience in delivering the health workshop, discussing what went well and what they could improve. As observed during one of those sessions:

A LHV commented that she had delivered a workshop on women's health in an area of gypsy population, where women did not know what a cytology test was, and she was able to explain it to them. The teacher then asked her how she felt about about delivering the workshop, and she replied: "good!".[observation]

The structuring of these specific types of activities was important as a way to enhance knowledge exchange and the acquisition of practical skills, as section 5.4 will further discuss. In fact, as in Valencia, most classes in Sheffield included an exercise component whereby a role-play task or a group work assignment was given to the learners, to enhance their understanding of the topic discussed with a practical exercise. For example, as observed during a session, learners were asked to *"work in groups as if they were members of a charity committee and were then presented with different scenarios of conflicting situations and had to decide how to solve them"* [observation]. Through this learning approach, learners drew on their own experiences and gained more knowledge and awareness through sharing and discussing these as the next sections will further explore, while the tutor provided feedback or comments when participants were struggling with a topic, to support or encourage critical reflection.

Thus, this interactive approach to the learning, combining theoretical professionally-led sessions with peer education and practical activities, made the training a space to favour exchanges between different people and to support individuals' own development.

5.2.2.4 The training as a health promotion activity

The way the training was organised and run made them an activity which learners found helpful to attend. In fact, learners in both settings discussed the training in positive terms, highlighting that

the ways the courses were delivered, the group and the environment had been helpful to make it a good learning environment and experience. As a former learner from Sheffield commented, the relaxed atmosphere made the ICDH course a very positive life experience:

“LHV1-Sheffield: I think it [the ICDH] has been the best life experience that I’ve had. [...] Coz it’s just the atmosphere, it’s what people need as well, it’s that atmosphere, it’s very relaxed”.

Likewise, as observed during an ICDH session in Sheffield, one learner commented that: *“A learner said ‘coming here (to this charity) and to this course has been really helpful”* [Observation].

Similarly, a current learner in Valencia commented that even though sometimes she did not feel like going to the sessions, she then realised that being in the course was good for her:

LHV8-Valencia [current learner]: “There were days when I didn't want to leave the house, and then because of the commitment to the course and to [name of the person who encouraged her to do it], I told myself ‘Ok, I'm going! I can't fail her’. [I was going] for her, not for me, for her. And then I was there on the course, talking, and relaxing, and I realise “well this is a good, [being here] is good for me too”.

5.2.2.5 Fostering encounters of people from different backgrounds

Finally, the courses were set up as spaces for encounters. Because of the heterogeneity of participants and because of the fostering of peer learning, an important element emphasised by current and former learners in both settings was that the training became spaces of encounters where different cultural and ethnic groups and people from different social status or educational background come to sit all together, breaking down most of those socially constructed barriers, ‘bridging’ these differences, learn from each other and value each other’s expertise. As former learners commented, being together with people from different cultural and ethnic background was perceived as a learning experience itself:

"LHV5-Valencia: And the experience was very good, because you know a lot of people, from many countries

R: during the course you say?

LHV5-Valencia: yes yes, in our course there were like 23 nationalities. That enriches a lot personally and professionally in all aspects. It is unbelievable how it can enrich you culturally speaking.

[...]

LHV4-Valencia: what I liked about it was being able to be with different cultures.

LHV5-Valencia: Yes, you learn a lot in those relations "

To sum up, this approach to the learning supported course participants to share their own knowledge and experience through the courses, and to feel valued for this. This valuing of learners' expertise was found key as enabling the adoption of an asset-based way of thinking, as section 5.3 will discuss. Moreover, being valued for their own expertise also supported learners in increasing their self-confidence, as section 5.4.2 will further examine.

5.2.2 Creating additional spaces for encounters and exchanges in Valencia

Importantly, in the case of Valencia, as emerged through the observations and the theory of change workshop, the MIHsalud initiative created 'other' spaces (beyond the training course) to enhance encounters between different stakeholders locally; namely former learners, Voluntary and Community Sector (VCS) workers and health professionals. These other spaces included the monthly meeting for VCS organisations, and the regular monthly meeting between the MIHsalud team, the local Lay Health Worker (LHW) and the Primary Health care team in the less advantaged neighbourhoods where the AB initiative is implemented. The creation of these spaces in addition to the training course reflects the specificities of the Spanish context, as the MIHsalud initiative aims to enhance the health promoting role of both primary healthcare and local VCS organisations, since health promotion has tended to be seen as a responsibility of public health only. In Sheffield, as

community health and wellbeing is part of the local authority strategy, voluntary and community sector (VCS) organisations seemed to be more aware of their role as health promoters (for example promoting 'health' and 'wellbeing' is often included as part of the VCS organisations' mission or as one of their key activities) and the studied initiative did not focus on creating specific additional spaces to work with voluntary and community sector organisations.

5.2.2.1 Monthly meeting with primary care teams

As introduced at the beginning of this section, the MIHsalud initiative aims not only to train and empower local neighbourhood residents but also to work closely with primary health care services, to foster a more community-oriented approach to health promotion and prevention. To do so, the MIHsalud staff and community lay health workers (LHWs) met monthly with representatives of the primary healthcare team based at the health centres in the areas where the LHWs work.

These meetings appeared to be an informal space for stakeholders from different backgrounds to meet, from professionals working in different areas related to public health and primary care, to community lay health workers. Although in a less structured way than the training course, the meetings still created a space which allowed encounters to occur, and resources (such as information about services or initiatives going on in the neighbourhoods) to be exchanged, as section 5.4.1 will further illustrate. For example, as observed during the fieldwork, these meetings involved MIHsalud staff, local Lay Health Workers (LHWs) and PHC professionals discussing specific neighbourhood issues, as well as MIHsalud staff informing the health professionals of local residents being trained in the course. This appeared to be important because being aware of, for example, who the local Lay Health Volunteer (LHV) was, supported health professionals in understanding how different cultures approach health and wellbeing when the LHV comes from an ethnic minority, as the LHV was able to explain culture issues which health professionals may have, for example different cultural practice related to maternity care [*repeated observations*]. Moreover, during the

monthly meetings, it was observed that the LHW informed the team and the health professionals about the health workshops delivered in local VCS organisations, or other community events where the health professionals could get involved if interested.

5.2.2.2 Monthly community forum for Voluntary and Community Sector organisations

The initiative in Valencia also set up other spaces for encounters for VCS workers working in the city of Valencia. These took the form of a monthly community forum: a space where VCS workers and other interested stakeholders come together to discuss a health topic or learn about what other VCS organisations do to support health and wellbeing. In each meeting, a VCS organisation worker or a representative of a local service presented its work and how it can be related to health promotion, thus raising awareness on services available in different areas of the city. For example, at one meeting that was observed:

two representatives of a local charity which provides support to people in grief presented its activities and provided an overview of how their organisation approached grief, and how grief support groups were carried out. This was followed by group discussions on what other participants to the meeting knew about grief and support provided. The two representatives also left leaflet so that participants can know more about their charity and pass on the information to whom may need it [observation].

These meetings thus became spaces where different local entities get to know each other and share information about available resources.

In summary, this section has focused on how both initiatives created spaces for encounters and exchanges, meaning that the forms that the initiatives adopted create environments where stakeholders involved in the initiatives can come and meet each other, learn about each other and from each other, and discuss and share resources, being these informational or emotional resources. As the next section will illustrate, these spaces were underpinned by, and at the same time promoted, what has been defined in this study as asset-based thinking.

5.3 Enabling AB thinking

'Enabling AB thinking' was identified through analysis as an important process underpinning the AB initiatives examined. It describes the development of that positive view underpinning the assets approach, which enables people to identify assets for health; or, in other words, to value the material resources available locally, as well as the skills and expertise a person can have, including one's own. In fact, as observed during the fieldwork and as emerged during the TOC workshops and in some of the interviews with the different stakeholders, enabling an AB thinking manifested itself mainly in the capacity to value others' skills and expertise, and to value the material resources available. These were what can be described as the 'markers' of enabling AB thinking, the means through which the adoption of the positive view underpinning ABAs was observed. As this section will show, it is both an individual process, as each person will adopt AB thinking in different ways and at different degrees, as well as a collective one, as enabling AB thinking has a relational element when it comes to valuing people and their skills as potential assets and feeling valued. However, this ongoing process emerged in different degrees depending on the types of stakeholders, as the following paragraphs will show.

It is important to mention that enabling an AB thinking was not explicitly included as one of the aims of the initiatives, but has emerged as an underpinning approach, as articulated by staff in both settings during the TOC workshops and as observed during the fieldwork and commented by former learners in interviews. AB thinking underpinned the development of the AB initiatives, as the spaces for encounters and engagement were informed by this positive view which valued people's expertise. At the same time, the AB initiative's activities were designed to support learners and other stakeholders to develop an AB thinking, hence the 'enabling AB thinking' as a core process.

5.3.1 Asset-based thinking as underpinning the development of both initiatives

To begin with, it should be noted that initiatives' staff can be considered as the stakeholders who had already adopted an AB thinking, as they valued local community members for their potential to become health promoters in their neighbourhoods, as well as valuing health professionals and VCS workers as local assets in the case of Valencia, as the next paragraphs will show.

In fact, when discussing ABAs in their initiatives during the TOC workshops, stakeholders identified assets in various ways. Assets were the people they work with [especially Sheffield] as well as the local organisations and services available in a neighbourhood [especially in Valencia]. For example, during the TOC workshop in Sheffield, when discussing why the initiative is centred on training local people, staff talked about neighbourhoods' residents as local people having skills and resources which can potentially support their health and wellbeing and that of their communities. As the quote below illustrates, their discourse centred on looking at the positive factors:

VCS Worker 2-Sheffield: "Mmmm i think our starting point, and I think it is for the four of us sitting here and other colleagues, I think the people we work with are the assets. So, I always start with "what are you good at?", it's never about the problem, it's like "what's your contribution?". [...] It's that positive non-judgemental "what can we do to support you to achieve your personal goals?" because you have got skills, you have got knowledge, and everybody has something to contribute. They might not feel that, because of their experiences. [...] So, for us, it has to be that asset-based approach, that person has something to contribute, and we'll work with that. [TOC workshop, Sheffield]

Similarly, in Valencia, stakeholders in the TOC workshop discussed that the MIHsalud initiative focused on putting people at the centre, as assets, and supported them to mobilise their capacities:

"HPx TOC workshop: [looking at the TOC diagram which had vulnerable people at the centre, the HP commented]: I liked it, maybe it's a coincidence, but 'vulnerable population' is there, in the centre [of the diagram], and that's the main point, it is to put people at the centre, but it is also our goal, our goal is to reach out to those people, and to engage them.

HPx2 TOC workshop: that's what I was going to say, it's our aim but it is also our starting point, through the assets perspective, so that they mobilise their own capacities."

Moreover, the MIHsalud staff commented during the TOC workshop that one of the aims of the initiative was to 'connect assets' among each other, assets being people, local VCS organisations and primary health care services.

5.3.2 Supporting stakeholders to adopt an asset-based thinking

The initiatives adopted different ways to enable the AB thinking. As introduced in the previous section, the different 'spaces for encounters and exchanges' encouraged people to value each other's skills and knowledge and encouraged learning through sharing these.

5.3.2.1 Introducing the assets approach in the courses

In addition, to support course learners to familiarise themselves with the concept of assets, both courses included a part where the assets approach was explicitly introduced. In one of the earlier classes in both settings, learners had to map the assets in their communities, individually (MIHsalud) or in groups (ICDH). As observed, when first presented with the concept of 'assets', current learners in both settings tended to think about assets in a tangible way. For example, when presenting their assets maps produced during the training, course participants described assets as tangible things or structured organisations rather than people or skills, as Figure 11 below shows and as reported by a former learner in Valencia in the quote below:

"LHV1-Valencia: you have a map, your area, and you have to point out the assets. For example, in red the health centers, like the hospital, center of secondary specialised care, the GP health center. In blue, the points that you create, of meeting. For example, when I worked, I knew that if I wanted to meet people or if I wanted to catch that person, I would find them in front of the school door, or in front of the supermarket".

encouraging each other, and they were often commenting and saying powerful words and qualities about each other. [observation]

Thus, in the case of Sheffield, it was through sharing thoughts and experiences in class that learners were encouraged to start valuing what the other participants contributed to the debate and their own capacities. In fact, although not explicitly discussing people's skills and expertise as assets, learners started acquiring this ability to value themselves and others, what has been termed here as AB thinking. As one of the staff members commented during the TOC workshop in Sheffield, the ICDH course was considered as the space to enable this ability to feel 'worth':

ICDH staff: it [the ICDH] nurtures that, that you've got worth. What the group does, it gives you the words to articulate that "I have worth", you can't articulate it elsewhere.

Therefore, in the case of Sheffield, it was the continuous peer-learning and tutor-learners debates and feedback which supported this realisation of feeling valued and encouraged adopting a positive view.

Similarly, in the case of Valencia, learners started feeling valued, both in class and during the delivery of the health workshops. As it happened in Sheffield, the course in Valencia created a space for people to feel 'worth', as this quote from a learner in Valencia shows:

LHV8-Valencia [current learner]: The course was like a therapy, you know? When something hurts, you have a scar and you put on cream and it heals. For me it was a therapy, to achieve this. It means a lot to me. A lot.

R: What do you feel that it has helped you healing the most, or what do you feel that it has given you?

LHV8-Valencia: "you can!" The messages [received] in the training. That really got to me...[...]. "You can", this message was a very strong message for me. [current learner 8, Valencia]

The health workshops which learners in Valencia had to deliver, represented key events which supported learners to feel valued, as they allowed learners to put into practice the skills and

knowledge developed in class, and to receive positive feedback from other people outside of the course, as the following extract from field note shows:

At the workshop also came one of the programme coordinators...the LHV was very excited to have her supervisors coming, but was also very nervous. [...] At the end of the workshop, all women made a round of applause for the LHV. [I could really feel that the LHV felt empowered by delivering this workshop, I could see her feeling proud, and that the participants really look up to her.]. [observation]

In sum, with regards to the courses, although the assets approach was explicitly introduced through the asset mapping exercise, enabling AB thinking was ongoing throughout the whole course, through the interactions between participants and tutors or teachers and through the shared learning approach which the initiatives took, discussed in the previous section.

5.3.2.3 The asset-based thinking can continue beyond the courses

Moreover, the role of time in enabling AB thinking was seen in Sheffield through how former learners discussed the training and the assets approach as related to the capacity of developing a positive thinking. For example, a former learner commented that the course made her think in positive terms, i.e. what has been termed here as enabling AB thinking:

LHV4-Sheffield: "Mmm i enjoyed all of the course, it was like... I suppose fresh air compared to other courses i had attended in the past, like compared to computer classes sitting in a class. So it was a course who would really make you think about how you could make a difference to your own life, but also to that of others in the sense of improving situations, and i suppose about positive thinking, be more positive."

Likewise, another former learner in Sheffield, when asked about the assets approach, replied that it was a new way of thinking and that it helped her seeing potential assets in tangible resources and people's skills around her:

LHV3-Sheffield [current VCS worker]: “It [the assets way of thinking] suits my approach to the world, and seeing the potential and what.... You know, it’s making something, apparently nothing turns out to be something actually, you know, you look around and “oh, there is a church there, there is a mosque there”. Or you know, there are people with all sorts of skills I haven’t thought about. You know, all the hidden treasures in a place.

Other examples of enabling AB thinking were identified in the research, such as that of another former learner who was discussing her current involvement in a neighbourhood group. As the quote below shows, she identified that the agenda of the group meeting was all related to the negative aspects of the area, and her intention was to encourage residents to support the positive aspects of their neighbourhood too:

LHV2-Sheffield: “I’m going to a meeting with this neighbourhood group on Tuesday night, the meeting’s agenda is all the negative things in the area, the antisocial behaviour, the drugs the crime. So I’m gonna go and say, “yes well this is going on, and it needs to be tackled, but how can we increase the positive?”.”

5.3.2.4 Supporting health professionals to adopt an AB thinking

Finally, in the case of Valencia, enabling AB thinking emerged also in health professionals and it came about throughout the regular meetings with the MIHsalud team presented in the previous section. As discussed by health professionals, the first meeting between the MIHsalud team and the primary healthcare centre consisted of a presentation of the MIHsalud initiative, inviting health professionals to collaborate, as the quote below shows:

HP3: It was many years ago, they [the MIHsalud team] asked for nurses and social workers... something like 4 years ago. The public health team of MIHsalud did the workshop, we were introduced to the intervention and to the community LHWs of that time. [Later in the interview, the HP3 added: ‘MIHsalud came and asked for volunteers’ to collaborate in the intervention]

Then, through collaborating with the MIHsalud initiative, primary health care professionals started familiarising themselves with the assets approach. For example, after learning about the assets approach, and as part of the collaboration with the MIHsalud initiative, primary healthcare professionals had to undertake an asset map of the neighbourhoods where their health centre is located, where they mapped tangible resources such as local VCS organisations, schools, supermarkets and the shops where leaflets with health information are distributed, as the quote below shows:

HP2: Then, last year, we made several groups with the young residents and nurses, and we divided the whole neighbourhood. And we went around, and we identified different resources. And we started putting them on a Google Map, but it's not finished yet!

[...]

R: What do you usually record as resources? Schools ...

HP1: associations ...

HP2: the information points, the local leaders. That is what was done here [shows a map]. But then, the one we started doing was wider. Because we begin to identify resources in general. Social resources, sports, even private resources, pharmacies, podiatrists.

Undertaking the asset maps thus set the basis for health professionals working with the MIHsalud team to value the resources available in the neighbourhood. This, combined with developing AB relations with local lay people, supported health professionals to start acquiring that positive AB thinking, to be able to value lay people's skills and expertise, as discussed in the previous section on developing AB relations. Moreover, as commented by another health professionals, working with the assets approach was perceived as enriching their work:

HP3: There was no map here, I had not made any, and we did this [shows the assets map].

R: did you do it with your colleagues or with the community Lay Health Worker (LHW)?

HP3: with the LHW.

R: And what do you think about this 'assets mapping'?

HP3: good. It enriches your work. The problem is that you need a lot of time [to do it well].

In conclusion, the AB thinking is introduced in different ways throughout the courses in both settings and during the meetings with health professionals in the case of Valencia. Moreover, valuing others and having the positive asset-based thinking underpins the variety of changes achieved through these AB initiatives and which are presented in the following section.

5.4 Developing asset-based capacities

As discussed in section 5.2, the observed AB initiatives developed through a set of activities which generated spaces for encounters and exchanges where new relationships were developed, knowledge and skills shared, and where learners start to feel valued, since these spaces were informed by AB thinking, as section 5.3.1 showed. The acquisition of knowledge and skills, the development of new relationships and an increased self-confidence resulting from feeling valued are all dimensions of what in this study has been defined as the development of ‘asset-based (AB) capacities’, which this section will present. Developing AB capacities is defined as the development of different abilities in learners and other stakeholders involved in the initiatives, and includes the development of new skills and knowledge, increased self-confidence and the development of new relations. These capacities have been defined as ‘asset-based’ as they are underpinned by the adoption of an asset-based thinking which values people’s own abilities. These capacities manifested in different degrees, depending on the type of stakeholders, their involvement in the initiative, and on the different forms enacted by the initiatives.

Developing AB capacities came about as a result of the different forms which the initiatives took, such as the training courses in both settings, or the monthly meeting with primary healthcare professionals or with VCS organisations in the case of Spain. These forms represented the initial events which gave rise to the achievement of the different dimensions which characterised AB

capacities in this study: the development of new skills and knowledge, increased self-confidence and the development of new relationships. Developing AB capacities can then lead to further changes which can impact on the wider community where stakeholders live and work. However, those further changes depend on how stakeholders mobilise the acquired AB capacities, as Chapter 6 will discuss.

In the following subsections, the different dimensions which make up AB capacities are presented, using quotes from current and former participants in both courses and observations of key events involving the other stakeholders in Spain.

5.4.1 Developing skills and knowledge

Both initiatives aimed to provide learners and other stakeholders with increased knowledge and skills, which have been considered in this study as dimensions of the development of AB capacities.

Knowledge development is defined here as a form of raised awareness on health, its determinants and health promotion resources, or in other words, raised awareness about local assets. As informed mostly by observations and by some of the interviews with former learners during the fieldwork, there have been different types of knowledge which stakeholders developed, depending on the type of stakeholder and the initiative's form they engaged with, as the next paragraphs will further illustrate. Course participants, as observed during the fieldwork, developed knowledge about health, its determinants and what services are available or what can be done to promote health in their communities. Health professionals and VCS workers, as mostly informed by observations, developed knowledge in the form of raised awareness about local VCS organisations and other health promotion activities carried out in the neighbourhoods where they work.

Skills development is defined here as the skills which learners in both settings and health professionals in Valencia developed throughout the initiative. Learners in the courses, as informed mostly by interviews, developed skills, ranging from skills to share knowledge among their own networks, to skills to set up a health workshop (in Valencia) or a community activity (in Sheffield). Health professionals developed skills related to how to set up health education workshops in lay language.

The next paragraphs will present the different knowledge and skills developed by stakeholders as reported by former learners in interviews and as observed during observations of the courses in both settings and the monthly meetings in Valencia. The knowledge and skills developed varied between the two settings, as the course contents differ, since the contents were developed to reflect the context's perceived needs, as discussed by stakeholders in the TOC workshop.

5.4.1.1 Learning about health and health services and skills to share knowledge among peers in Valencia

In Valencia, as observed throughout the course, participants learned about topics such as health promotion and assets for health, access to healthcare for immigrants, sexual and reproductive healthcare and prevention, and gender equality. For instance, former learners reported learning about health services available which they did not know before. As the following quote shows, a former learner found this knowledge helpful to be more aware of sexual and reproductive health and care:

R: and what about the other topics you discussed in the course?

LHV7-Valencia: the topic on sexual education very helpful.

R: was it helpful?

LHV7-Valencia: yes yes [laughs], on a personal level. Because sometimes these [topics], you hear about them, but then they're gone. But if the GP or nurse comes to explain it to you, you are more aware of them".

Other course participants learnt about how other community members experienced their health. For example, two former learners currently working in VCS organisations reported that the course helped them to understand that some of the health-related information which they assumed as basic and understood by all people was actually unknown to other community members from more marginalised situations such as migrants or ethnic minorities:

“R: just to finish, [how would you define] the impact that participating in this training has been for you.

LHV4-Valencia: mmmmm, i think that, for me, it has been continuing doing what I was doing, but with more information.

LHV5-Valencia: for me... it has impacted me a lot. It made me realise... because you know, because they [her work colleagues] work with more marginalised groups, but I ... yes, it made me realise that there is still lot to do here. That we take many things for granted, which the population does not know. And [realise that there are] people who come from outside and do not know where to go. These are things that are very basic, and that should be known to everyone, and they are not [known].

At the same time, the course provided learners with practical skills. It is designed so that participants not only learn about these topics, but also about how to share related health promotion information through engaging in informal health conversations with their friends and families, and through delivering health workshops with people in the VCS organisations where they volunteer.

Former learners reported learning presentation skills, such as the ability to stand up and present in front of a group, as observed during the fieldwork and as this quote from a former learner illustrate:

LHV1-Valencia: “It [the course] did help me, because you learn how to run workshops, standing up in front of people, I had never done that, quite the contrary.”

5.4.1.2 Learning about health and its determinants and skills to tackle these in Sheffield

In Sheffield, as observed throughout the course, participants learned about what affects their health and that of their communities, discussed topics such as community development principles as a strategy to promote health in communities, learned how to deal with difficult situations or how to plan a community activity. These contents reflect the purpose for which the course was designed for, i.e. to support local people living in less advantaged areas to become community health promoters, as discussed during the TOC workshop:

VCS Worker 2-Sheffield: “What we wanted to do was to engage local people in understanding health in its broader sense, and empowering them so that they could take back some control.”

For example, as this extract from the fieldnotes shows, learners had to think about and discuss how different factors can impact on health and wellbeing:

The week session was related to discussion in pairs and then in group about how social determinants can influence health: money, families and friends, attitudes and behaviours. When discussing money, learners discussed not being able to access healthy food, housing, but also commented that having more money can lead to more stress. The tutor commented on the risks of having young people following youtubers and bloggers who only present one side of the story [like being a rich youtuber] and constantly comparing themselves to that. Another learner commented that money can also be used for the wrong purpose, like buying drugs and alcohol, so having money is not directly linked to being healthier either. One student commented that maybe wealthier people are also better informed and more capable of making healthy choices, more capable of containing excesses. [...]. Learners then discussed ‘access to services’, and discussed the importance of VCS, like allotment or cooking clubs, as they can be very helpful for mental wellbeing but there is always lack of funding for these activities. The co-tutor told an example of an activity which they run in the organisation, and it is now self-funded, because they wanted to continue it, and they “bet” on its success. Another person mentioned that funding can also trap you into pre-set outcomes. Overall, when discussing services, learners discussed how little people knew about

available services sometimes, even though services exist, there is a lack of knowledge of them. [observation of an ICDH session]

As introduced earlier, to enhance interactive learning, most of the weekly sessions were carried out through scenario-based activities, group work and self-reflection, in a relaxed atmosphere where each participant is considered equal. As in Valencia, this allowed learners in Sheffield to not only acquire knowledge about the factors which can affect their health, but also the skills to put in place activities to tackle these factors. For example, learners developed organisational and planning skills, through the scenario-based activities:

The class started with an exercise in pairs, where learners had to develop a project plan to improve their community health [Observation ICDH course].

Or learned about funding opportunities and how to apply for these:

“R: ...so you said something before about funding opportunities, why do you think it was this important, that you got to learn about funding?”

LHV2-Sheffield: yes, I didn't know how to apply for funding, I didn't know what pots were available for community activities

R: and you learned that in the ICDH?

LHV2-Sheffield: yes yes. For my final project in the ICDH I research into community groups how to apply for funding, for an art project. That was my last project.”

Similarly, during the course, information about services available were shared among participants. For example, as observed in the training: *during an exercise aimed at learning about how to plan a health promotion project, a learner proposed the implementation of a low-cost fitness class for the members of the organisation he is involved with. As this was a real-life example of something he aimed to carry out, the tutors and other participants started suggesting where he could apply for funds to run the courses and who to hire as fitness trainer [observation].*

As it happened in Valencia, because participants attending the course had different backgrounds, learners also became more culturally aware:

LHV4-Sheffield: "I think there was a lot of peer... not just peer support but peer learning, I think you learn a lot from other people's experiences and I think it helped everyone who attends the ICDH to become more culturally aware, more open minded, it's interesting"

As these paragraphs have shown, in both settings, developing AB capacities was fostered through developing knowledge throughout the course, because of the actual course contents discussed but also because of the learning from other course participants. The knowledge took the form of a raised awareness on health and its determinants, what can be done to tackle these or what services are available and how to access these. As commented by a former learner in Sheffield, this supported learners in feeling more ownership over their neighbourhood and its resources:

"R: and if you think about changes at neighbourhood level, how do you think something like the ICDH course can make [changes]..."

LHV2-Sheffield: yeah, I think because you find out more about your own neighbourhood, you almost have more ownership over your neighbourhood, and you appreciate it more, because you know what's in your neighbourhood and how it affects people."

This also reflects the expectations of the initiatives' staff, who commented during the TOC workshop that developing new knowledge and skills can be an important driver for change in relation to improving one's health, as this quote from health professionals who participated in the TOC workshop in Valencia shows:

Health professional TOC1: because information broadens your vision and changes your attitude. [...]

Health professional TOC2: and transfers knowledge, tools, that can provide people and local associations with capacities."

As these paragraphs have shown, the acquisition of new knowledge and skills are examples of the changes which these initiatives generated, which at the same time can set the basis for further

processes to occur, such as sharing knowledge among wider network of community members, or developing new activities in the area, as Chapter 6 will further discuss.

5.4.1.3 The additional spaces in Valencia to develop knowledge and skills among health professionals and VCS workers

As for the additional initiative's activities in Valencia, the monthly meetings with the primary healthcare teams became opportunities for health professionals to acquire knowledge about community health. For example, through learning about and discussing community's resources, health professionals started to become aware of the assets approach. As a health professional commented when discussing the assets approach:

“HP6: I had never worked with the assets approach. It was the first time.

R: and how is it going?

HP6: good, good, I really enjoyed it. Actually, in another health centre before this one, they had a community asset map. And there, they used to go to visit local VCS organisations, offered them the services or courses we were doing at the health centres, or go to visit the neighbours association..

R: and this was also because of MIHsalud?

HP6: yes, it was another health centre which collaborated with MIHsalud.”

Moreover, when in one of the health centres, the centre's coordinator allowed time for representatives of the PHC team to work directly in the community with the LHWs, this resulted in health professionals having to deliver health workshops on different topics in local VCS organisations. These health professionals had therefore to learn how to develop health workshops to be delivered outside of the health centre, sometimes on topics they were not familiar with, as commented by one of the health professionals:

“HP1: In an internal PHC team meeting, we explained what workshops were being done, and what the VCS organisations were asking us. And we asked who else wanted to participate. And the truth is, that many colleagues signed up, and it surprised you. So we started designing the workshops. [...] We talked with the sexologist, to run a basic

session to the primary care nurses, to talk about certain sexuality issues. So that if the VCS organisations asked for workshops on sexuality issues, he did not always have to go. And now, we are designing a package of MIHsalud workshops.”

As for the community monthly forums for VCS organisations, as observed during the fieldwork, participants in these forums got to know each other and became aware of some of the services available throughout the city. As this extract from fieldnotes of observations of these forums: “A MIHsalud team member concluded by saying that ‘all the people here today are ‘assets promoters’. What is important is the use we make of these identified assets. Like the forum.’ A forum participant (former LHV) commented: ‘I agree, because I come here and I activate myself, I learn new things, and I feel happy’.” [observations]

Thus, the knowledge developed in these spaces could also be seen as raised awareness of potential assets in their neighbourhoods. For example, in Valencia, a VCS worker reported becoming more aware of the activities of another local organisation:

LHV5-Valencia: many times you have heard of associations or institutions, that you know them, you have heard of them, but you do not know what they are doing. And it has helped us to understand and know. And you have the contact that, at a given moment, if you need... then you already know more about it.

This could support VCS workers to make use of these resources when needed, as it will be further discussed in the next chapter.

To conclude, the initiatives created spaces for encounters and exchanges where the different types of stakeholders engaging with the initiatives were able to develop knowledge and skills, as this section has shown. Moreover, former learners in both settings identified that the training has also supported them in feeling more confident with themselves, as the next section discusses.

5.4.2 Increasing self-confidence

A second dimension of AB capacities was identified in the increased self-confidence. In this study, increased self-confidence was reported mainly by former learners in interviews as an individual change which is initiated through the courses, and it included the feeling of being able to share their views with others, feeling less shy and believing more in themselves. This was related to having been in the training and to the types of activities in which learners had to engage. Moreover, self-confidence also increased as a result of positive interactions with others, who supported learners in feeling valued for their capacities to speak up in front of the public or voice their opinions.

Self-confidence can be considered as another dimension of 'developing AB capacities' which was developed during both training. The next paragraphs will illustrate the different ways in which self-confidence was experienced by former learners.

5.4.2.1 Increased self-confidence can manifest itself in different ways

Learners and former learners discussed self-confidence as manifesting itself in different ways. For example, former learners from both settings reported increasing their self-confidence in the form of being able to voice their opinions in the course group or with their close network of family members:

"LHV2-Valencia: well, as I say, it has changed me ... I [can] talk a little more, or [I can] interact a little more. I learnt how to help others, even my own daughters."

"R: ok.... And if you think about changes in yourself after the ICDH, what would you think is..."

LHV2-Sheffield: mmm I think it's confidence, it's been a really big one.

R: could you tell me a bit more...?

LHV2-Sheffield. Yes, because there was so much group discussion, I learnt that it was ok to voice my opinion. Just to be more outspoken. It did impact my confidence." [former learner 2, Sheffield]

“LHV5-Sheffield: one of the things I really think it helped me on this course was that I was able to be more confident, in speech, and was able to convey my feelings about a certain topic or subject”

Likewise, other former learners described themselves as very shy prior to the course and feeling able to speak up in front of people afterwards:

“LHV3-Valencia: Well, I am very shy about speaking in public, [...] For me, the course helped me with that.”

[observation] Current learner, Valencia: ‘I’ve done two workshops. My charity really helped me a lot. I used to give workshops and feel very nervous and ashamed, but not anymore. I think they went very well’

Another course participant reported that the course gave her the confidence to believe more in herself, to the point of deciding to take up further studies:

LHV4-Sheffield: “I was married very young and probably don’t expect I was able to succeed at education and ICDH, along with other factors, was part of what made me think “I can do this” [the learner is referring to enrol in a University degree after the ICDH course]. It gave me the confidence, by doing a course that allowed me to be reflective, writing a reflective journal, by allowing me to explore what I really wanted to do.” [former learner 4, currently VCS worker Sheffield]

5.4.2.2 Feeling valued enhanced self-confidence

Importantly, having been in the training has represented an opportunity for former learners to feel valued for their capacities within the course, as section 5.3 about enabling AB thinking already discussed, but even outside of the course itself, which contributed to support former learners in feeling more confident about their own capacities. For example, former learners in Valencia who

worked as community Lay Health Workers for the MIHsalud initiative, reported feeling valued for their AB capacities in the communities where they worked, in some cases to the point of becoming role models for other community members. For instance, during a group interview with current and former LHWs, a former LHW described a situation where other community members approached him as a person to seek advice from, and another LHW commented that it was because community members saw the LHW as a role model for them:

"LHW5: the other day, I went out on a Saturday with my friends, and I see a kid from the local school, and we started talking. And the kid tells me, almost crying, and it really shocked me: "how did you get out of this neighbourhood?" He just told me that, with his open heart. "How did you come out of all this? [...]"

LHW1: well, because for him, you are a model."

It is important to note that this idea of becoming role models and supporting their peers reflected one of the key strategies underpinning the programmes, and as a key factor to achieve one of the aims of the initiative, that of empowering people. In fact, staff and managers in Sheffield discussed those ideas during the TOC workshop:

"ICDH staff member: you know, going back to people... I've gone through ICDH and that asset thing. And of all the things really valuable, one of those is that sort of role-modelling type, that put people in the "oh yes, I could do that". Because of that peer... peer sort of self-believe that comes from seeing people like you doing things. And that's such a strong... a bit of a legacy really. [Name of a former learner] has done the course ten years ago, and she still tells people about it." [TOC workshop UK]

In summary, the courses supported learners not only to develop knowledge and skills but also to feel more confident with themselves, as observed during the fieldwork and as reported by former learners. Moreover, the gradual development of the AB thinking further enhanced opportunities for learners to increase their self-confidence, by feeling valued by others during the course or outside of these, as these paragraphs have shown. This suggests that the dimensions of AB capacities

described in these last two subsections, although they can be seen as individual changes, also include a relational dimension, brought about through the spaces for encounters and exchanges and through the feeling valued resulting from the AB thinking. The next section will present the last dimension which makes up the AB capacities, that of developing asset-based relations.

5.4.3 Developing asset-based relations

The third dimension of AB capacities is the development of asset-based (AB) relations. AB relations are defined here as relationships between two or more people, informed by an asset-based thinking, i.e. the view of valuing the other person or persons for their potential to promote health. Those changes in relationships were initiated by the initiatives through the spaces for encounters, whereby stakeholders engaging in AB initiatives start to relate to each other valuing the other person(s) as potential assets. This section is informed by data from observations and interviews with current and former learners from both settings, and with health professionals in Valencia, and describes the different types and ways AB relations were developed.

5.4.3.1 Developing AB relationships among learners

As argued earlier in section 5.2, the initiatives created spaces for people's encounters in the form of the training or in the additional events set up in the case of MIHsalud. As reported by current and former learners, the courses became spaces to meet new people from a variety of cultural and social backgrounds, which not only allowed for new relationships to be developed across those boundaries, but also for relationships where the other person was valued for her/his expertise and social and cultural background.

LHV11-Valencia: "The truth is that it was very interesting, because of the group... that we were so diverse. And I imagine that this year there will be many nationalities too..."

LHV9-Valencia [Current learner]: Mmm... just to say that the people from Spain are the minority in the group. [So] It's great!"

LHV3-Sheffield: "I just always remember back as a participant, and what I really liked about the course was that real mixed about people. Some people were quite well educated, and had different kinds of problems, and there were people who fit your description ['marginalised people'], but I think that was the strength of the course, that it was a real mixture, even though the outcome would be enriching the community and nourishing every individual in there."

5.4.3.2 Developing AB relationships with other stakeholders working locally

Moreover, during the course in Sheffield, AB relationships were also developed between people in the course and professionals working in the neighbourhoods where the initiatives are being implemented. For example, former learners reported that towards the end of the course, a session was dedicated to getting to know representatives of local VCS organisations. In some cases, these meetings allowed direct relationships to be established between learners and VCS workers, allowing learners to be aware of opportunities where the skills and knowledge developed could be helpful, while at the same time allowing VCS workers to meet potential future volunteers or employees which could support the health and wellbeing of the communities where they work. As a former learner commented, it was during the ICDH course that she had an opportunity to meet professionals working in the area, which then allowed her to find a job with the VCS organisation where that professional was working:

"R: and after the ICDH you got the job at the [VCS organisation]?"

LHV2-Sheffield: yes, the guy from the [name of VCS organisation], he came to the ICDH course, to tell us about the community activities they were doing, so that's how I met him."

Conversely, in Valencia, additional AB relationships were developed outside of the courses, between MIHsalud community workers, health professionals and local community members. In fact, as part

of the MIHsalud daily work in less advantaged neighbourhoods, LHWs, together with the health professionals when possible, identified shop owners who can take up the role of 'community leader' in sharing health-related information among their clients. According to the health professionals, the relationships between the LHW and the shop owners is more of a peer-to-peer, while it takes more time and multiple visits to develop a closer relation with the health professionals. As observed when shadowing a LHW and nurses walking in a neighbourhood: *"shop owners were familiar with her, making jokes and having conversations, but they appeared less familiar with the nurses"* [observation].

The relationships established between health professionals and LHWs with those local shop owners were still informed by an AB thinking, although only from the side of LHWs and health professionals, as this extract from fieldnotes shows:

I asked the LHW about community leaders, how she identifies them and whether she tells them that they are "community leaders". LHW explained to me that for her, these local shop owners or employees are community leaders, as they act as such in their daily life, and they have been welcoming LHWs and helping them by sharing health information with their customers. I asked her whether she tells them that they are community leaders, but she said: "no no, that would scare them off, they act like a local leader, but I don't tell them this, I just use the label for us [meaning for staff], to recognise them"

In addition, health professionals involved in the MIHsalud initiative in Valencia also established new AB relationships with VCS organisations working in their local area, as reported by a nurse working in one of the health centre:

"R: One last thing, apart from the institutional support, in terms of change, have you seen any other type of change? As in relations with your co-workers, or ...?"

Nurse: I have seen an improvement. First with the local associations, we have a relation, which we did not have before."

5.4.3.3 Time and continuity as key in the development of AB relationships in neighbourhoods

In Valencia, time played an important role in the development of AB relationships in the local neighbourhoods. For example, health professionals reported that dedicating time to develop those relations was key to break down existing barriers between them, as these quotes from an interview illustrates:

"HP1: Because with the professionals from the health centre, the local shop owners are a bit like that...[distant], but if you go several times ... they see you more like a peer..., yes more like a peer. At first they see you more as a nurse "oh! The nurses are coming here. " But if you go several times ... [she laughs], it's true!

HP2: do you know what I think is the other issue? because we go with the LHW, and since LHW is a lay person, they see her more like a peer than us.

HP1: of course! But then when you go, if you go several times, it's already breaking that invisible barrier ... which is from here (health centre), and ...

HP2: it's like a hierarchy. It's a very big step. "

Likewise, consistency and continuity in pursuing the development of these AB relations was perceived as needed. For example, when asked about relationships with local shop owners, another health professional explained that it was about:

HP3: "going, and going and going, so they get to know you".

Moreover, health professionals believed that potential changes in staff could risk losing the relationships established, as the next extract shows:

[From observation]: [the nurses] both said "it took us about a year to familiarise with the intervention, going out, meeting the people at the info points, but if we leave, there would need to be someone who is motivated, who believes in community activities, to

be able to continue this work". But for how the system is currently made, this is quite precarious.

A similar concern related to LHWs, as when relationships were established by community LHWs with local shop owners, if the latter changed their working place, the development of an AB relationship with the local people had to start again from zero, as the following extract from observation field notes show:

[From shadowing a LHW]: Then, we started walking around and going to some info points. There was one person working in a local pharmacy who she really liked because he seemed interested in the MIHsalud work. But as we arrived there, that person no longer works at that pharmacy, and the current employee had no idea of what MIHsalud was, nor who the LHWs were.

In summary, during the courses and in additional spaces for encounters created by the initiatives, AB relationships were being developed between stakeholders from different backgrounds. AB relationships can be considered as a change at collective level, and are not only developed within the time and space of the initiatives, but can be considered as an ongoing process. In fact, these relations underpinned changes in practice, as the next chapter will show, which can have an impact in the wider communities, being brought forward by former learners or, in the case of Spain, also by other stakeholders involved in the initiatives such as health professionals.

5.5 Summary of the chapter

This chapter has argued that the initiatives in Sheffield and Valencia were both designed to create spaces where local stakeholders with different backgrounds and experiences come together, learn together and share their own experiences. These spaces took the form of the courses and the monthly meetings, and were underpinned by an important process named here as 'enabling AB

thinking' which reflected the development of a positive view, the ability to value others and feeling valued, and the ability to identify assets as people and resources. AB thinking underpinned the AB initiatives themselves, while at the same time it was enabled through the initiatives.

The spaces for encounters and exchanges set up by the observed AB initiatives also give rise to another process, defined here as 'developing AB capacities', which included the development of capacities such as new knowledge and skills, increasing self-confidence and developing AB relations.

The chapter provides evidence of how learners in both settings developed new knowledge during the training, for example through learning about what determines their health, or services available in their areas and how to access these, and acquired new skills like group working or speaking in public. This supported learners in gaining self-confidence. Finally, the initiatives created spaces for developing AB relationships, or in other words developing relations where both parts can be valued for their skills and expertise and for their being potential assets.

To conclude, the initiatives created different spaces which gave rise to similar changes at individual and collective level, as well as to similar processes in both settings, as this chapter has shown.

The next chapter will illustrate how being able to mobilise the developed AB capacities beyond the time and space created by the initiative can support other changes in the stakeholders' wider network. This is because the initiatives generated an input of new resources into the communities where they are implemented, initially in the form of the training and later in the form of former learners who go back to their communities and may engage in a variety of activities bringing with them the newly developed AB capacities.

Chapter 6. Findings part II: Mobilising asset-based capacities: how to increase the impact of ABAs in the wider community

6.1 Chapter introduction

This chapter presents the second part of the findings from the fieldworks and it discusses how the changes introduced and discussed in the last chapter as ‘developing AB capacities’ can give rise to further processes in the neighbourhoods where AB initiatives are being implemented and which can lead to improved health and reduced inequalities. The processes described in this chapter result from how learners and the other stakeholders engaged in the initiatives were able to mobilise the acquired AB capacities. Such mobilisation depended on how the initiative, the stakeholders and the context interacted. In fact, the context became important as a way to enable or hinder the possibility for stakeholders to mobilise AB capacities beyond the time and space of the initiatives.

The chapter presents the variety of ways in which stakeholders mobilised the AB capacities developed and the changes which such mobilisation generated. It is organised in three main sections. Section 6.2 presents processes which can have an impact at a community level, and which resulted from current and former learners being able to mobilise one or more of the acquired AB capacities in their neighbourhoods. Increased self-confidence and the development of AB relationships enhanced opportunities for former learners to engage in their local community; similarly, AB relationships supported knowledge sharing within communities. It shows how these processes can give rise to further changes in the neighbourhoods in terms of former learners taking up volunteering positions, developing new activities or supporting other local members in becoming aware of available services, as well as favouring sharing knowledge between more institutional stakeholders such as health professionals and VCS workers in Valencia. This section includes a discussion on the contextual factors which can influence increased use of services in these neighbourhoods, as these can be important determinants in identifying the potential impact of AB

initiatives. Section 6.3 presents processes which can have an impact on work practices. These processes resulted from how former learners currently working in VCS organisations in both settings, and health professionals in Valencia, have been able to mobilise the developed skills to their own job, or mobilise the developed AB relationships with other institutional stakeholders to enhance working in partnerships. This section also discusses the contextual factors, such as the availability of jobs where AB capacities are needed, the training recognition or the lack of dedicated time and funding for partnership work, which were found to counter the potential for a wider impact in workplaces. Finally, section 6.4 discusses the role that adopting AB thinking can have in generating impacts on the wider system. As the previous chapter showed, AB thinking informed the development of both AB initiatives, and at the same time it was fostered throughout the initiatives. This section will show how adopting AB thinking can generate changes in attitudes which can have impacts in the work culture, thus the importance in terms of potential impacts at system level. However, it also highlights how contextual factors such as institutional support may be key to favour or hinder this process to occur. In addition, it discusses a broader contextual factor, that of negative labelling, which becomes important when considering the potential impact of ABAs in less advantaged neighbourhoods. To conclude, section 6.5 provides a summary of this chapter, while section 6.6 provides a conclusion of both findings' chapters.

6.2 Mobilising asset-based capacities to achieve changes in the local community

As introduced above, the different stakeholders involved in the studied AB initiatives mobilised one or more of the acquired AB capacities in different ways, in their own areas of influence, being these their own social network of families and friends, or their workplace. This section presents the different processes through which current and former learners mobilised AB capacities within their neighbourhoods. It starts by discussing how current and former learners started engaging in their local communities and developing new activities in their areas. It then describes how sharing

knowledge and information among the different stakeholders lead to increased awareness of services and other changes.

6.2.1 Increased self-confidence and AB relationships to enhance engaging in the local community

Engaging in the local community was identified as the process that occurred when course participants decided to take a more active role in their local area, as a result of their increased self-confidence and the newly developed AB relationships. As this section will illustrate, current and former learners engaged in their neighbourhoods in different ways, ranging from volunteering in a local VCS organisation, to taking up more leadership roles and developing new activities in the area. This process of engaging was brought forward by current and former learners individually. Yet, the impact of engaging and generating new activities by volunteering in local VCS organisations could potentially be extended to the wider community of people attending these activities or engaging with these VCS organisations.

Former learners reported that engaging in local activities came about as a result of having increased their self-confidence and/or their relationship network in their local area. For example, a former learner in Sheffield reported that by building up her confidence, she was able to create a new volunteer group in her area and also find a job at a local VCS organisation:

LHV3-Sheffield: "My impression is that a significant proportion, or probably a minority, come from the [ICDH] course with quite amused and inspired and built up confidence to go and volunteer elsewhere, or at [name of VCS organisation] or sometimes to apply to jobs as health trainers, for example. I mean, I did. I definitely built up my confidence, and then I got a job at [name of VCS organisation] the year after. And I also started a community [performing art] group."

Other former learners discussed relationships as being at the core of their involvement in local areas and as being the key to further job opportunities or to developing new activities. For example, a

former learner in Sheffield reported that volunteering in local activities enhanced her opportunities to develop new relations, which in turn resulted in finding new job opportunities:

LHV2-Sheffield: "For example, I was doing the [name] project here last year, and I met people. And one of the person, she runs a community centre in [another area of the city]. And she said "oh, can I take your number?" and I said "yes, sure". Few months later, she called me and says "oh, we are doing a festival, would you like to come along and do a project [...] with the children?". So that led to that event. And from that event, it led to another event, and that's the way it's been.

R: it sounds like there is a lot of network going on.

LHV2-Sheffield: very much networking, yeah."

R: can you still drawn on the network from before, or is it more like chain, like a growing thing?

LHV2-Sheffield: mmm... yeah, I think it is a chain, I think, yes.

R: like going from one to one... and looping back?

Likewise, a former learner in Sheffield discussed organising a local event to foster community cohesion or starting a new community group as resulting from having acquired AB capacities and having established relationships within the community:

"R: and have you been able to do anything in your community?

LHV1-Sheffield: yes, from being a health trainer and having the contacts of the ICDH we worked alongside the [name of a VCS organisation] and the church which is there, we did a community street event. [...] It was a voluntary community event, where we got all the community and different cultures together and get to meet together, and so they can talk to each other. It was more like get to know your neighbours. [...] So the 4-5 members of us got in contact with the [VCS organisation] and asked "could you support us to do this voluntary event?". It was like "bring a dish", so everybody who came, brought a dish, brought their own culture food and you know...that's how it happened..."

Increased engagement in local activities was also reported by a current learner in Valencia, who reported organising day trips with the mothers and fathers' group of a local school as a result of

being involved in the AB initiative. The parents' group at the local school used to be a weekly meeting where someone from a local VCS organisation would come and discuss a topic. However, it was because the learner started delivering the health education workshops in this group that the group itself started to change. Relationships within the group started to become closer, to the point of organising social activities beyond the weekly meeting:

LHV8-Valencia [current learner]: "Yes, we started with the workshops, we have already come closer to each other, okay? Because, of course, we share many things during those workshops: what has happened to us, what we have lived, our experiences. [...]. Before it was a group. A group of mums and dads that come every Friday to talk. Today, for example, we are going to talk about violence. Today we talk about how we can communicate with our children at home to give them advice, or nonviolence. Well, those things, and then everyone would leave. Now [after she started her workshops] we are more united, we are like a team. [...] We also had day trips. We went out on a Friday in the city centre, to visit the town hall square. Another day we went to visit the lagoon. We have relationships now. We know each other better. And we respect each other more".

As well, as this quote showed, through the current learner's activity of having to deliver health workshops in her community, she contributed to the development of new relationships based on mutual respect.

To sum up, increased self-confidence and the development of new (AB) relationships with other stakeholders in the neighbourhoods set the basis for learners and former learners to engage more in their communities. Although it can be challenging to attribute these kinds of changes only to the implementation of the AB initiative in an area, former learners nevertheless discussed them as related to the AB capacities acquired in the training, although not explicitly mentioning 'AB capacities' but through discussing increased self-confidence or new relationships made through the training courses. Local actions such as those described in this section could then result in creating

opportunities for other people in the community, thus increasing the potential impact that AB initiatives can have when moving beyond the programme itself, as the next chapter will further discuss. However, it should be noted that opportunities to engage more in local communities not only depended on the willingness and capacities' mobilisation of learners, but also on the current availability for volunteering opportunities or for spaces where new activities could be proposed and carried out.

6.2.2 AB relationships to enhance sharing knowledge about health and services

Sharing knowledge among community networks is defined as the process occurred when former learners and the other stakeholders in the case of Valencia were able to mobilise the knowledge acquired as part of their acquired AB capacities within their own networks of families, friends and colleagues, as informed by interviews and observations with current and former learners in both settings, and health professionals and VCS workers in Valencia.

Sharing knowledge emerged as an ongoing change process, initiated by the initiatives themselves through the spaces for encounters and exchanges as the previous chapter discussed, and then brought forward by all stakeholders beyond the time and space created by the initiatives. As a process, it gave rise to changes at individual and collective level such as increased awareness and/or use of health and wellbeing services available locally, as the following paragraphs will show.

6.2.2.1 Former learners mobilising knowledge

As introduced in the previous chapter, learners in Valencia engaged in health-related conversations with their friends and families as part of the training, and shared the information acquired about available health services and how to access these continued after the courses. For example, learners in Valencia who were migrants or from ethnic minority backgrounds found the information on the

right to access to health services acquired during the course helpful for their own health and wellbeing, and reported passing it on to their peers and families, as this quote shows:

LHV8-Valencia: in this Gypsy Romanian community, there's a lot of lack of information, they do not know. A lot of things happen because there is a lack of information, and for them [the Gypsy community], [having that information] is enriching. [...] Before I knew that we all have the right to health. But it was something like ... there [away]. Now I have this information here, with me. And this is what I share [with others]. Also, everything I learned in the course, about health... this information and everything I learned is resulting very helpful.

Other former learners in both settings described situations where community members would see them as persons to approach when in need of information related to available services in the area. For instance, as commented by a former learner in Valencia, women from her neighbourhood knew she had knowledge about health and sexual reproductive services, and approached her when in need:

"R: and has it happened to you, after your training, that people come and ask you? I mean, because they know that you are a LHV.. for example among your neighbours, friends...?"

LHV1-Valencia: let's see ... it depends. For example, when I was working, as people already knew that I worked there [refers to a local VCS organisation that supports migrants], especially women... women would talk to each other and then come to me and say "look, it's that girl" and they would approach me. "I have this" or "this happens to me", "what can I do?" "Can you give me an appointment?"

As the quote above also shows, informal networks were key to facilitate knowledge sharing. In fact, as most current and former learners commented, it is typical in communities to share information through 'word of mouth'. As a former learner in Sheffield said:

LHV1-Sheffield: I would say... it's quite a big community, it's a lot of word of mouth, so if I know about this in my community, I'll probably tell other friends, that's how they get to know each other. In the community, there's word of mouth. Getting to know and actually sharing what you know really. And that's how people know as well.

Similarly, a VCS worker in Sheffield commented that:

VCS Worker 1-Sheffield: "So as a community, the people who come to the activities, then go out and talk about the things and we get that. As a community, how it is affected is that they know. Even people who don't come here, they know someone who actually is engaged in some groups. And we have 6 different groups a week. So they know, even if they don't come in, but at least they know. And if someone say "i need this", they can say "oh, go into that building and ask".

Sharing knowledge and information can thus be an informal ongoing process. Although the AB initiatives set up those spaces for encounters and exchange to enhance sharing knowledge, it can be quite an informal and hidden ongoing process within communities, and it can be hard to measure the extent to which information reaches out, as the next quote shows:

LHV3-Valencia: Well, we do not do it [share information with others] on a regular basis, but I think that ... I do not know if it's a daily thing, but I think we do it very often, although you do not realise it. Because if they had not made us make that asset map, I think that we would not know about the many associations or health centres... for example, I thought that our health centre had no emergency service. So [when I knew there was emergency service] I did spread the word, that there was that service there. Maybe without knowing it, I share the information, just like that, naturally.

Nonetheless, providing learners with new knowledge was perceived by staff members in Valencia as key to reach out to those people who are considered most 'vulnerable', as emerged during the TOC workshop. In fact, current community LHWs described situations whereby through delivering workshops, they were able to share information with those community members who are generally less likely to access services or attend events. As observed during a team meeting: *"LHW1 tells the team that she was able to deliver a workshop in the shacks area in which also men came and*

engaged. The whole team was happily surprised, as it is always very hard to have men engaging in these kinds of activities.” [observation team meeting]

To further reach out to community residents, in Valencia, the MIHsalud initiative developed additional spaces, beyond the training itself, to enhance the information sharing process. As introduced in the previous chapter, the initiative included the identification of shop owners who could take up the role of ‘community leaders’ in sharing health-related information among their clients. For example, as observed during the fieldwork: *[observation] when shadowing a LHW in one of the neighbourhoods in Valencia, a shop owner approached her to ask about access to healthcare for undocumented people, because he knew someone who needed to seek medical attention but did not have a health card. The LHW thus explained to the shop owner about what the procedure was, so he could pass on the information to the person in need.*

6.2.2.2 VCS workers and health professionals mobilising knowledge

Sharing knowledge about local activities and services was also discussed by former learners currently working in VCS organisations and by health professionals in Valencia. As described in the previous chapter, the MIHsalud initiative enhanced the knowledge sharing opportunities through the monthly community forums for VCS organisations where participants got to know each other, and became aware of potential assets across the city, to which they could direct friends or families in need. For example, as observed during one of those forum: *“[Observation] A staff member concluded [the session] by saying that ‘[...] the idea is that what we learn here, we can share it, pass it on’, to which a participant replied ‘yes yes, I tell it to my fellows’.*

Likewise, as one health professional reported when talking about a monthly community forum she attended:

HP7: it's very good, if I had more time!, It is interesting because you get to know associations ... there are many, but you do not know what they do. You find out what they do, they spend some time explaining their programmes...and then ... well in this case when [I went], I found out about this resource, it's good because you find out, and then I passed on the information to a colleague of mine who works in that sector.

Therefore, providing current and former learners and other stakeholders working in the neighbourhoods with knowledge about health, health services and how to access these, or what can be done to promote health became a way to reach out to a wider network of people living and working in the local neighbourhoods where the initiatives are implemented, and raise awareness about the services available.

In Sheffield, however, as a response to the local context, the initiative does not take specific forms to support information sharing within VCS organisations or health professionals working in local neighbourhoods. In fact, there are other events already in place which support these information sharing processes among organisations. For instance, in one of the neighbourhoods where the ICDH course is delivered, it is the local library which is responsible for centralising the information regarding what is happening in a specific neighbourhood. A former learner, currently working in a local VCS organisation commented that she was trying to do it alone from one small organisation, but it resulted as being too time-consuming:

LHV3-Sheffield: "I used to try and produce... well i did produce and information leaflet, well... booklet, every quarter, trying to pin down all the activities in our area. It was such a job to do it, and it will get out of date within a month. And it was a really big job, because sometimes it's on the website, sometimes you had to phone people up, sometimes it was on their leaflet. I've given up now, because they have tried to do it centrally, from the library."

6.2.2.3 Asset-based relationships as key to foster knowledge sharing

The importance of having established more formal and direct relationships such as those discussed in the previous chapter, the AB relations, was reported by community workers in both settings and by health professionals in Valencia as fostering the sharing of information about services or events, and its use or attendance. In fact, as emerged in interviews, having developed personal and direct relationships with other stakeholders in the neighbourhood resulting in increased trust among the two parties involved. For example, health professionals in Valencia reported that when invitations to events were made directly, the response was perceived as better compared to more formal invitations coming from statutory bodies:

HP1: Yes, and what works best, is what we did with the promotion of the LHV course. Go to the VCS organisations we know, and give them the information [and tell them:] "Look, this is very interesting, see if someone from your group can go." [...] it is not the same if someone comes

HP2: and they invite you ...!

HP1: of course, they know you, we already have a relationship, we go there. They can call me on the phone, and I can tell them "look at this, it is interesting, so see if someone from the association can go". And probably they go. But if they send [the invitation] from public health, they probably will not go.

Likewise, in Sheffield, participants working in the voluntary and community sector believed that having established trustworthy AB relationships with VCS organisation users supported them when promoting the ICDH course or other events, as reported by one of the tutors:

"Team Member 3-Sheffield: So if you want them to engage, if you want them to come to your course, you have to spend time talking to people about it. You know... 1 out of 10 of my learners will turn up because they have seen the flyer. But nine of them...

R: it's because you talked...

Team Member 3-Sheffield: it's because you've told them, it's word of mouth.

Team Member 4-Sheffield: sometimes it's not just... sometimes at the beginning... you gotta know that person, you may invite them to hear, invite them to that, you

encourage them. And then when there is a course and you say “there is this course”, it’s because they trust you and they go on. I don’t think I ever had a learner who didn’t.”

As these paragraphs have shown, sharing knowledge among community networks can be seen as a process to increase awareness on health and wellbeing services among a wider network of community members. Nonetheless, it should also be noted that the increased awareness of services did not necessarily translate into their increased use.

6.2.2.4 Contextual factors favouring or hindering increased use of services

The context played a role in enabling or countering the translation from increased knowledge of services to its increased use. In fact, two possible explanations regarding lack of access to services emerged through interviews and observations during the fieldwork.

First, a more active engagement with the information or resource shared may depend on potential users having a need or an interest in the information discussed or the services presented. For example, in Valencia, LHWs reported that local people’s main interest related to seek information on how to get a health card to access GP services or how to access sexual and reproductive health services to get contraceptives:

“LHW1: Contraceptive and the health card is what I chat about the most. People take those topics more seriously. There are many interesting topics, but I think these two topics are what people are most ... they are most impacted with. Well, that’s what happens to me.”

Similarly, a VCS worker in Sheffield commented that signposting people to resources was an initial step, but a follow up was needed for people to actually take action and benefit from that resource:

VCS worker 1-Sheffield: “So again, signpost... but signpost doesn’t work if you don’t follow up. Most people who come is coz most of the time they can’t do the things, because of language problem, disability, time whatever it is. So you signpost and you

tick your box. But with us no, we take a lead. If I signpost, I'll ask for feedback. So I'm in between the person and the service."

Second, the ways that the health services are organised and run can make it difficult for some people to access them. In both settings, current and former learners reported episodes where they felt treated poorly by healthcare professionals.

For example, learners in Sheffield discussed receiving poor support when in need, resulting in the worsening of their situation: *there was also a discussion regarding the fact that some learners had mental health issues, they asked for help, to organisations meant to support them, but did not receive it or were poorly treated. This made it worse for them. [course observation in the UK]*

Similarly, in Valencia, a former LHW reported having difficulties when sharing information about local health services and seeing how neighbourhood residents were poorly treated when accessing these:

"LHWb: yes. Because if I tell [a community member], 'go and ask for an appointment with the social workers, that they will do the health card for you, they will solve it for you'. If this community member goes, and no one gives him/her any appointment, well... this person does not go back anymore. He/she would just feel shattered. [...] Sometimes words hurt more than a slap. Because if in front of 20 people, you are trying to make an appointment, and they tell you 'no, that's not how it works', 'I am very busy' How does this make you feel? You don't know how to speak the language properly, you are in a neighbourhood that isn't yours, in an economic condition that is super bad, working collecting scrap metal... how do you feel? Shattered."

At the same time, some health professionals believed that patients feared accessing health services when they are undocumented or with any similar legal issue. For example, a nurse reported that:

"HPb: for me, an important thing when I started participating in this programme was the difficulty that professionals had with a migrant population, on how to communicate,

because it is true that we lacked a lot of culture to understand, but they also addressed us with a little fears and such".

In fact, in Valencia, access to healthcare for some population is difficult. For example, a former learner discussed how undocumented migrants were receiving very high bills for accessing reproductive care services, which then affected this person's chance to access other services until the bill was paid, excluding them even more:

"LHV1-Valencia: I cannot promote health if they do not have access to it. I have to go, begging, well, begging, not that I am begging, but I am looking for the tricks to see how that person who is feeling unwell, and there are people with serious illnesses, it is not that they have a cold ... [pause], [how these persons] can receive medical care, can have access to care. [...] They [the "government"] do not want people to go to the A&E, because it collapses. [But] Girls have been receiving invoices, for delivering their babies, they went [for the delivery] to the A&E, and they received an invoice of 2600-3000 Euros. And from there, there was an embargo; people who do not have anything, they do not have anything, [and then it's like] "here, take it, the bill, 3000 euros", and when that bill is there, they do not have access to scholarships for their kids, and other things..."

This could partly explain why the MIHsalud initiative includes collaboration with primary healthcare services as part of the initiative, to enhance the adoption of an AB thinking in health professionals and create "a more inclusive health system", an aim of the MIHsalud initiative as articulated by participants during the TOC workshop. In fact, to leverage the impact of these barriers in accessing healthcare in Valencia, the development of trustworthy AB relationships between health professionals and lay people was reported as important. As observed in a meeting: *a LHW suggested to the nurse to bring up names of people working in the area when talking to some patients, like 'do you know [name] from that local charity?'. This, according to the LHW could show to the patients that the nurses knew the neighbourhood too, that they knew their difficult situations, and patients could trust them better. The nurse agreed with this, but also placed emphasis on the importance for*

patients to see the nurses as working closely with LHWs too, as a way to increase patients' trust in accessing health services and follow up [observation].

To sum up, the initiatives input knowledge in local neighbourhoods through current and former learners in the courses in both settings, and through engaging health professionals and VCS workers in the other spaces for encounters in the case of Valencia. Sharing the acquired knowledge among wider networks within the communities is another example of how mobilising AB capacities can occur and could result in increased health-related knowledge and use of services for other community members. As this section showed, having established AB relations with other parties within the community could favour the sharing of information about the services available and its increased use. Nonetheless, using these services depends on the contexts where the initiatives are implemented, and more specifically on both the needs and interests of the members of the community, being these learners' own families and friends, or local organisations' workers and users, and on the ways the services are run and organised.

6.3 Mobilising asset-based capacities to achieve changes in work practices

This section centres on how mobilising AB capacities can have an impact on work practices. It starts by describing how former learners currently working in VCS organisations have been able to transfer some of the developed skills and knowledge in their own job, which resulted in changing some of the activities which they delivered or the support provided to the people accessing their VCS organisation. It then discusses how former learners currently working in VCS organisations in both settings, and health professionals in Valencia, mobilised the newly developed AB relationships as a way to enhance working in partnerships across institutional stakeholders. Both sections also introduce the contextual factors which can favour or hinder these changes to happen.

6.3.1 Transferring skills to one's own job

Transferring skills to one's own job is described here as the process occurred when former learners were able to mobilise one or more of the acquired skills into their own workplace. It came about when at the end of the formal period of training former learners went back to their communities with an increased range of knowledge and skills, acquired as part of the 'AB capacities'.

6.3.1.1 Using the skills and knowledge acquired in their work

Former learners currently working in VCS organisations in both settings reported transferring some of the acquired skills into their own job. For example, former learners in Valencia reported using the skills and knowledge from the MIHsalud course when delivering health education workshops in their own work using a lay language:

"LHV4-Valencia: [the course has been a] good experience, at least in my case, and it has been positive for my work, because it helps us, because in the area where I work, for example, that we work on health, it obviously helps us, [like with] even the workshops we did during the course, and those you do later.

R: Are you still doing the workshops?

LHV4-Valencia: Yes, I continue to run workshops, in all areas where we work, we continue doing workshops, it is part of our intervention."

Likewise, a former learner from Sheffield reported reproducing the learning and teaching methods when working as a health trainer in her community:

"R: so, you were saying before that you could use the skills from the [course] in your job as a health trainer...

LHV1-Sheffield: yes, I think the learning methods. The learning and teaching methods, they were fantastic skills I learnt. Using different methods to actually develop that person as well.

6.3.1.2 The skills and knowledge acquired may not be needed in their work

However, contextual factors played an important role in this process, as they influenced the possibility for former learners to mobilise the acquired AB capacities. When the jobs available do not require nor value the skills acquired in the training, it became difficult for former learners to mobilise those skills elsewhere. For example, as former learners in Valencia discussed:

“LHV6-Valencia: [in the work area where I am] I have not delivered the workshops because the work we have is not to give workshops.

LHV5-Valencia: it is another type of work, we do an individual interview and individual follow-up. We have done the workshops during the practical parts of the course.

R: so you no longer ...

LHV5-Valencia: not anymore.”

Similarly, a former learner in Sheffield commented that because of his work tasks, he was unable to apply the group work skills learnt at the ICDH:

R: and have you been able to sort of replicate some of those dynamics, like group work, in other settings, after the ICDH?

LHV5-Sheffield: ehm... I think, not so much in the group work because of the way I'm working here. I work in [name of workplace], and I'm able to work with the students [individually] and I can work with the teachers as well.

6.3.1.3 Lacking formal recognition of the training can hinder opportunities to transfer AB capacities

Another issue discussed in both settings related to the recognition of the course and the new role it may assign to learners in their communities. In Valencia, some former course participants reported the lack of recognition of their role as community Lay Health Volunteers. In fact, the figure of the LHV is currently recognised only by people within the initiative, but the certificate achieved at the

end of the course is not valid for job applications or for recognition in other environments outside of those related with the initiative, as the next quote shows:

“LHV3-Valencia: We received that piece of paper, but that's it. We use it personally, we use it. I use it on a personal level, a lot, but I realise that I could use it more. It should also be updated, because what we were given [refers to course contents] must be updated continuously. Because everything here is going at an impressive speed, and what was worth yesterday, today is not worth it, or has been transformed into something else.

R: And when you say to use it more, what do you mean?

LHV3-Valencia: as a LHV, to feel more useful.”

To counter this, the MIHsalud staff reported that they are currently in the process of applying for it to be recognised from the local employment services.

In Sheffield, however, the ICDH training used to be - but it no longer is - an accredited adult training course. Although current learners have not commented on this, former learners have shown appreciation of the fact that they received an official title at the end of their course. This may suggest that being a certified training was positively valued by former learners. However, as emerged during observations and interviews with former tutors and staff members, the requirements to be followed for the accredited course were too demanding and time-consuming, both for the course tutors and for the learners, as the quote below shows:

LHV4-Sheffield: “When I was first tutor, it was still accredited, so we needed to still do marking, we had an internal moderator, we still had an external moderator coming and assess them. But I think that due to funding... it's the last couple of years that it became non-credited, I think it was just a matter of funding.

R. and how do you think it has impacted the learners in your perspective?

LHV4-Sheffield; mmm I think in some ways, it had positive and negative impacts. Because when it was accredited, you wanted the learners to achieve or hope they can take something back like “yes, you completed your task” or did your journal successfully”. When it was non accredited, it allowed ICDH to start exploring more creative ways of working, and taking it back to basics even more, and working with even

more vulnerable adults because it took away the pressure for accreditation. So to me it felt like it needed to be both, an accredited and non-accredited, so that depending on people's starting point they could progress to the accredited version."

As reported also by tutors during observations, although being an accredited course was a positive element, tutors and former tutors discussed that it may have prevented potential learners to join because of the amount of additional work required to be completed as part of the accreditation.

To sum up, few former learners were able to transfer the acquired skills in different ways to their own jobs. Being able to transfer the AB capacities in their jobs could support changes in practices which can benefit their workplace or have an impact on the people who attend the activities which the former learners developed, such as the health workshops described above. However, there have also been factors which limited the potential impact of such mobilisation, for instance the lack of jobs where the acquired AB capacities are valued, and the lack of official recognition of the training provided.

6.3.2 Mobilising asset-based relationships to enhance partnership work

Enhancing partnership work was identified as a process which occurred when former learners currently working in a VCS organisation and/or health professionals working in primary healthcare centres developed activities in a formal relationship with other organisational stakeholders. Partnership work came about when former learners working in local organisations or health professionals were able to develop asset-based relations across organisations, valuing what the other organisation does, and resulting in collaborations to develop new activities which could impact on the wider network of community members.

Enhancing partnership work, as argued by staff members in the TOC workshops, centred around the idea that, by developing direct relationships between different stakeholders working in the same area, collaborations can emerge and generate new ways to work together, share resources and do not replicate similar actions in the area. This idea underpinned the development of some of the additional spaces which the MIHsalud initiative created, as the following quotes emerged during the TOC workshop in Valencia show:

“R: Why working in partnerships?”

Participant 1: To make better use of resources

Participant 2: to share experiences

Participant 3: to reach the target faster and further. If you go alone you can't ...

Participant 4: do not duplicate efforts

Participant 5: also for efficiency

R: why do you think it is more efficient?

Participant 5: because if you have different sectors working alone and join them, you create continuity in time

Participant 3: because you get a result in less time and with less resources

Participant 1: and also, because you learn from the experience of many people

Participant 6: and that gives you the enthusiasm, from one who has more experience, and transmits it to a new one. To enhance enthusiasm.

Participant 1: yes, to take advantage of the experience of others, the resources”

In fact, working in partnership was identified by staff in both settings as key in their programme's structure and implementation, as the TOC diagram showed (see TOC diagram in Appendices V and VI).

6.3.2.1 Working in partnerships as part of the local strategy or as part of the AB initiative: differences between Sheffield and Valencia

Importantly, as introduced previously in Chapter 2, supporting partnerships work among local VCS organisations and other sectors differed between Sheffield and Valencia because of the current policies to promote community health and wellbeing.

In Sheffield, working in partnerships is part of the current local health promotion strategy for community health and wellbeing and is therefore being implemented in local neighbourhoods through the development of local partnerships between VCS organisations. Community workers from the organisations which lead local partnerships in the neighbourhood where the ICDH courses are run discussed working in partnerships as being beneficial, although lacking dedicated resources to coordinate it and develop it:

LHV6-Sheffield: "In terms of partnerships, this whole approach within... through the team in terms of recognising the importance of partnership even though it's not resourced, it's the importance of understanding the benefits and the wider picture of partnership working."

Conversely, in Spain, working in partnership is one of the pillars which the initiative aims to enhance, as a form to connect 'assets' (being these community members, local VCS organisations and health professionals) to make a better use of resources, as argued by participants in the TOC workshop. For this reason, the initiative in Spain creates additional spaces outside the course to develop these AB relations: the community monthly forum and the regular meetings with primary health care professionals.

Working collaboratively across different organisations thus resulted in the development of different activities within the neighbourhoods in both settings. However, understanding the context is key to understanding how enhancing partnership work occurred. Working in partnership was most often

limited to specific events or activities, as lack of time, resources and funding emerged as main factors hindering these collaborations, as the following sections will illustrate.

6.3.2.2 Partnerships developed for ad hoc collaborations

In some cases, connecting VCS organisations through the spaces for encounters and exchanges resulted in developing coordinated actions. For instance, a participant from Spain, reported that being aware of other organisations working in the same neighbourhood resulted in coordinating actions to support families in most excluded areas.

“R: and participating in a programme like MIHsalud, that has given you contact with people of other nationalities as you said before ... somehow do you think it has helped or not the issue of working with other entities?”

LHV4-Valencia: in my case yes, because you know other people in the area where you work.

R: and have you been able to develop new projects after the programme, or has something else emerged?

LHV4-Valencia: Well, yes, because in the most excluded area of the neighbourhood, [...] we had to get in touch with each other, to see what actions were being carried out, with which families we were working, and that ... ”.

Nonetheless, most participants described working in partnership more as specific ad hoc collaborations, to respond to specific needs within their areas of work. For example, a VCS worker in Sheffield reported that when seeing a primary care patient, if he/she cannot solve all the issues brought forward, he/she can signpost the patient to other organisations which can provide the required support, and work closely with them:

VCS worker 1-Sheffield: “If he says “I'm struggling with money”, so I'll say “ok that's fine, I will ask someone to help you with that”. So, this would be signposted. Or I can say, “come on Monday here, and Citizen Advice Service can help”. I will be then working with

Citizen Advice Service more than normal. And Citizen Advice Service will say, "ok we need more GP support letters for this person", and I'll say "ok, I'll look into it"."

Similarly, a representative of a local organisation in Sheffield reported organising cancer support in her neighbourhood in collaboration with another VCS organisation:

VCS worker 2-Sheffield: "So for example, we've been working with [VCS organisation], who is a hospital who treat people with cancer. And we've got a disproportionate number of people who get cancer in our area, because their health is not good. And I want them to come and work in our area. We can't deliver that, what they deliver. So we've been working with them, to put a bid in, to come and do some outreach in our area. But they've come to us first and said "will you work with us?". So when we understood what they were trying to do, we said yes. So we have been actively involved in shaping their bid, and telling them what would work and what wouldn't work. So that they'll get some resources, to come and work in our area."

Similarly, health professionals in Valencia reported developing ad hoc collaborations with local VCS organisations. As argued earlier, in one neighbourhood in Valencia, the relationship established between the nurses, the local LHW and some of the local VCS organisations resulted in the development of health education workshops, tailored to the needs expressed by the VCS organisations, as this extract from the field notes shows: *[Observation of a meeting between nurses, LHW and a local VCS worker]: it was the second meeting with the organisation and it was aimed at presenting the possible health workshops which the health centre can offer. First, the nurses give their list. The organisation was interested specifically in those workshops related to STIs and gender equality, and the organisation coordinators commented that those [workshops] from last year went very well.*

Similarly, in another neighbourhood in Valencia, a nurse reported that she went out in the community together with the local LHW, to meet with a representative of an elderly centre, and from that meeting, new courses were organised at the elderly centre:

“HP3: And she [the representative of the elderly centre] was happy that the LHW could do workshops there, for example about sexuality, to the elderly people in the neighbourhood [...]. so one way to do all this, is just to go out there and ask [what is needed].”

6.3.2.3 Partnerships work needs time and coordination

However, working in partnership has also been presented as challenging by many stakeholders. As argued with the previous change processes, contextual factors also play a part in enabling working in partnerships to occur or not. As expressed by VCS workers in both settings, developing relationships between organisations requires time, resources and coordination. As a former learner from Sheffield argued:

“R: so, just for me to understand more about this working together, is it more like different organisations offer different services which people can use or you see that there is some sort of collaboration across the charities?”

LHV3-Sheffield: it’s ad hoc collaboration. So sometimes we might do an event and we collaborate on that one-off event, we recruit together and we publicise together. But there is no central coordinating body, here. The council, and other funders, but the council specifically often says “oh, we want you to work together”, and to that end, there are various partnerships, and we lead one. To that will come lots of organisations, but we are all doing our own things. And it’s really difficult to coordinate.”

Similarly, in Valencia, a former learner current working in a VCS organisation discussed that working in partnership takes time and resources, becoming an additional job to do:

“LHWh: if you do your thing, it’s easier and you do it in your hours. If you want to work in a real network, you have to work overtime. Because [you need time] to meet, because the schedules are not the same, because ... it takes time and resources, working in network costs a lot. In this programme, I am seeing it happening, maybe, but in the long term. For example, [VCS organisationX] does very little in network, they are starting. Or [VCS organisationY], for me, they do not work in partnership. They work like “you do this, I do that”. [Really working in partnership] is getting together. But it’s an extra job.”

6.3.2.4 Current funding schemes as hindering partnership work

Another contextual factor which was often discussed by former learners working in voluntary and community sector organisations related to the ways in which health and wellbeing activities are funded, which emerged as being more oriented towards organisations competing against each other rather than favouring working in partnerships. For example, former learners from Valencia commented that although it would be better to collaborate with other entities at local level and not to replicate similar actions, local organisations need to compete against each other in order to survive:

“LHV10-Valencia: yes, I was in two or three forums, where the associations were, and yes, that is very convenient. What happens is... The MIHsalud programme does facilitate that union, but ... we sit all together, exchange experience, but then everyone has their own "shopping" [in terms of funding bids to do or interests].”

Similarly, in Sheffield, a former learner discussed the funding of the partnerships as oriented towards competitions sometimes:

“LHV6-Sheffield: So... ehm... and... yeah, I think it's also in terms of the structure of the partnership, it sets people up to challenge, not challenge sorry, compete with each other. Not because it's what we all people want to, it's just the nature of what has been set up. So, if partnerships are set up, tenders come out, and there are people in a partnership who are part of an organisation who may also go for a tender, or who might also do similar services. People are gonna compete with each other and go for the same tender. So that's the worst part of the partnership, it got people to compete with themselves.”

Moreover, applying for funds was reported by other VCS workers as being a time-consuming activity, to the point that VCS organisations may prefer not to apply at all:

“Sometimes we don’t even apply for council funding because the paperwork to do, we worked it out, it’s almost less than minimum wage what we get paid. Is it worth it? No, it’s not. So we think, let’s just not do it. But what happens is that people miss out. People miss out because we are not able to offer a service, because the council made it that hard. [VCS worker]”.

As this quote also showed, when the context made it challenging for VCS organisations to apply for funding to develop activities locally, whether individually or in partnership, the consequences may negatively impact on the wider community. For example, in Sheffield, learners discussed lack of funding as resulting in fewer activities being proposed for local residents or with higher prices to attend them, as this extract from observation shows: *“The class then started with an exercise in small groups, with scenarios as if the participants were a managing committee and had to deal with some issues. It was interesting to hear the discussion of the participants, and their reflections on the constraint on funding, which was embedded in every discussion. They commented that lack of funding makes local NGOs having to increase their own prices for activities, and that if NGOs are unable to raise funds, they’ll need to stop running that activity.” [ICDH course observation]*

To sum up, in both settings, partnership work has emerged as central to ABAs, with the difference that in Valencia it is the initiative itself which creates the spaces for VCS organisations to get to know each other as a way to encourage working in partnership, while in Sheffield it is part of the current local authority's policy to promote health in communities and it is a strategy already in place, within which the ICDH is situated. As the above sections showed, working in partnerships could lead to the development of activities carried out collaboratively, although it has been described in both settings as challenging. Former learners currently working in VCS organisations reported that challenges arise mainly because of lack of time to develop formal relations and collaboration, and because of the ways the funding schemes are set up to foster competition rather than collaboration.

6.4 Changing attitudes to change the system: the role of AB thinking

This last section presents important changes which can have an impact at a wider level, namely at a systems level. As introduced in the previous chapter, AB thinking informed the development of both AB initiatives, while at the same time, through the spaces for encounters and exchange, the AB initiatives enabled participating stakeholders to adopt the AB thinking. The developed AB capacities which stakeholders mobilise are, in fact, all informed by AB thinking. However, the impact which this change in mindset can generate beyond the time and space of the observed AB initiatives is important, as in some cases the adoption of AB thinking led to changing attitudes and work culture, a process which could help explain how ABAs can impact on the reduction of place-based health inequalities, as the next chapter will further discuss.

This section will start by discussing how transferring AB thinking to the workplace supported changes in attitudes of stakeholders directly engaged in the AB initiatives but also of work colleagues in some cases, as reported by former learners and health professionals. It then discusses the importance of receiving institutional support when working in place-based communities, an issue which has been reported as challenging by most former learners and health professionals. Finally, it will discuss how the use of labels which negatively define people and places can counter the impact of ABAs, thus the importance of enabling the AB thinking as a process to shift from looking at the negative to valuing the positive of people and places.

6.4.1 Transferring AB thinking to the workplace to change attitudes

Transferring the AB thinking to the workplace is defined here as the process occurred when former learners in both settings and health professionals in the case of Valencia were able to incorporate the AB thinking in their work practice, resulting in changing the ways their work was organised or delivered, as well as in their own attitudes and that of their colleagues.

Transferring the AB thinking to the workplace resulted in changes at individual level (attitudes) that at the same time could have an impact at collective level through the ways work was reorganised or delivered. For instance, a former learner currently working in a local VCS organisations in Sheffield commented that adopting AB thinking and thus valuing others as people with skills and potentials has led her to change her attitudes at work as to how she related to neighbourhoods' residents, starting to value them as potential assets who could contribute to the health and wellbeing of their neighbourhood.

"LHV3-Sheffield: Whenever a person comes in, that person has the potential... you know that person has all sorts of potential assets, and you go "oooh, could you possibly help with this? Or could you point me in the direction for that". So, yes, it [the AB thinking] absolutely does inform the way we work, definitely."

Moreover, the same participant commented that the whole organisation adopted the AB thinking as every staff member had been in the course:

R: ...And you said that anyone here at [name of VCS organisation] has been on the course. Could you think about anything that might have changed after that everybody has been on the course? Like in the organisation, or in the relationships with each other or in the community...?

LHV3-Sheffield. well, it certainly makes us a good place, a host for it [the ICDH], because we know exactly what we are talking about when we recommend the course to people. And.... well in my own experience it clarifies my thinking of community.... Asset-based community development. And..... mmmmm.... Thinking about health in a holistic way. So I think what we do here at [name of VCS organisation] is very informed by that, and we are all familiar with those approached to health, you know, we have a very community-based approach to health and holistic approach to health.

Similarly, another former learner currently working in a local VCS organisation in Sheffield commented that the ICDH contributed to changing attitudes within the organisation:

LHV6-Sheffield: [the ICDH course] changed my way of thinking and doing, you know, [from] “this user can’t do it” to “actually yes they can do it, who says they can't.” [...] because the icdh course it kind of just [make] people to think differently, when they are planning. It’s more of ‘community approach’ rather than ‘do something for the sake of it’. And I think that’s what has probably been our [as a VCS organisation] biggest strength.

As for health professionals working in primary health care centres in Valencia, transferring the AB thinking in their workplace resulted for some of them in changing their attitudes towards the communities they work in, and adopted changes in their work practices to enhance community work:

HP6: In fact, thanks to the MIHsalud intervention, we are now paying attention to the community. Because the health professionals are used to people coming to the health centre, and in primary care it is not like that. I am the one who has to go out [referring to meeting people in their communities]. So, through the programme, we have managed to go out in the community [she refers to dedicating two days of the working schedule of two nurses to go out to talk with charities and local shop owners as part of the programme].

This was an important change observed in work practice, as in this health centre there are now two nurses who had re-organised their work schedule to have dedicated time once or twice a week for community activities. Not having time to work in communities was in fact reported by the rest of interviewed health professionals as one of the main limits to changing their work practice.

Moreover, re-organising the work schedule of the nurses was perceived as beneficial by other work colleagues as a way to change the attitudes of the rest of the primary health care team:

“HP8: In other words, in the few years that I've been here, I'm noticing changes, and that this MIHsalud programme “activates” people. [...]

R: “activate” in what sense?

HP8: at work, like monotony ... but if you organise workshops, or meeting. Within the work schedule, the health professional has only appointments, but if you add a workshop there, a meeting there, it is an effort, because [it gives] the adrenaline of giving workshops, right? It is something complementary, of course nobody is going to force you, but people [the rest of the PHC team] are... [kind of starting to engage]

In fact, according to the interviewed health professionals, some of their colleagues started showing interest in community work. This resulted in the nurses collaborating with MIHsalud having to develop guidelines on how to deliver health workshops in lay language, so that any member of the primary health care team could deliver them, as this extract from field note shows: *[the nurses] were telling me that other professionals from the PHC team were initially afraid to deliver the workshops alone, so now the nurses have created a guide of the workshops, which includes time and what to do in details, so that any health professional can use it to go out in the charities and deliver these activities on their own [observation].*

To sum up, when former learners in both settings, and health professionals in Valencia, were able to adopt AB thinking and mobilised it to inform their own work, changes occurred in terms of changes in their own attitudes and in some cases changes in work practices. These changes in attitudes and practices could then be considered as having an impact on neighbourhood residents who engage as users or volunteers in the VCS organisations where former learners were working, or as users attending the health workshop organised by the health professionals' team. Moreover, these changes can lead to further changes in attitudes, such as those reported by health professionals in relation to some of their own work colleagues becoming more interested in community work.

6.4.2 Institutional support to enhance changes in work culture

Nonetheless, the context where these AB initiatives are implemented and where stakeholders work, played an important part in enabling former learner or health professionals to adopt these changes in attitudes and practices. In fact, being supported by one's own institution and line managers, and having community work recognised have both emerged as key factors in the possibility for stakeholders directly engaged with the initiatives to mobilise the acquired AB capacities within their workplace. This was also discussed by staff during the TOC workshops in both settings, who argued that ensuring "institutional support" [TOC workshop Spain] and "political will" [TOC workshop UK] were fundamental for the interventions to exist and for their continuity:

"Team member 3-Sheffield: your question was how do assets work together...? Because what [VCS workers 2] just said, about the people, which we all agree with, without the people we cannot do [anything], and [...] I was just thinking that you need the two together. If you just have the people without the political will, you'll still get somewhere, but you won't see that magic, the scaling up. So we need to work... [on that]." [Sheffield TOC workshop]

6.4.2.1 Institutions' coordinators need to adopt AB thinking to enable wider changes

An important element to support these AB initiatives and enabling changes in attitudes and potentially in the wider systems resides in coordinators being aware of the assets approach. For instance, according to a team member in Sheffield, those individuals who can ensure that the AB initiatives are supported by the institutions need to be aware of the AB thinking, which is why there needed to be a lot of what she termed 'meaningful conversations' with representatives of institutions:

"Team Member 1: to do this political will you have to do those tangible things too, which is to talk to councillors, to convince them, to talk to senior managers, head of services, to pitch them the concept, you have to physically pitch them the concept." [Sheffield TOC workshop]

Moreover, according to staff in both settings, these initiatives themselves started and are still ongoing because of the personal commitment of a few individuals, as a participant in the TOC workshop in Valencia argued:

“Team member 4-Valencia: this programme was born because the people who did it, they believe in it. But if these people leave, this programme stops, and nothing would happen. We continue with the vaccines and that's it. Therefore, if from here [the system], which is where we can create structures, we do not create them, then...[like saying: how can we expect things to happen?]”. [Spain TOC workshop]

Similarly, a team member in Sheffield commented that the initiative was still funded because of the influence of some specific stakeholders in a high position:

“Team member 2-Sheffield: I mean, the programme would have shut down ages ago if the [funding body] hadn't taken it on. But i actually believe that the [funding body] took it on by the grace of some of the players as opposed to the big organisations' desires. It's because some key players, people like XXXXXX...

R: so is it for specific actors?

Team member 1-Sheffield: yes, and they are super seniors, it's not the body of the organisation, it's individual.” [UK TOC workshop]

The same however can be argued in relation to those representatives of local institutions which could support changes to occur in their organisations working locally. For example, health professionals in Valencia argued that being able to get more involved in community work was directly dependent on the interests of the primary healthcare managers. As a health professional commented, about when she used to work in a health centre where the director was committed to actively work in the community:

HP6: “There I learned a lot ... because in other centres when you do more health prevention and promotion, which is the philosophy of primary care, unfortunately everybody looks at you like a weirdo. [...] But when you get to the centre where the coordinator has a clear philosophy, you enjoy it there.”

6.4.2.2 Time, recognition and support are needed to foster systems changes

However, as emerged in the interviews and observations throughout the fieldwork, the current working culture and system within which the initiatives are embedded was perceived by former learners and health professionals as controversial when it came to support the initiative or changes resulting from it.

For example, in Valencia, health professionals lacked time to dedicate to community work. This resulted in some health professionals in Valencia not being able to engage in activities outside of the health centre thus limiting their capacity for engaging in the development of AB relations or incorporate changes in their work practices:

“R: as for the neighbourhood...Have you been given time to go out?”

HP3: no

HP4: no. The programme is carried out within your working time. There is no support.

HP3: I have my job, and that's extra.

R: That is, you get the approval from the managers, but they do not give you time.

HP3: No, I always mention it when [Public Health workers] come here. I would love to.

I've only gone once with LHWs, to walk around the neighbourhood a bit. But I would like to go with LHW, I know she gives health workshops, and do other things. Maybe [I could go] just as an observer, or if I can help with something. To learn a bit, but because of how everything is organised, it is a little more difficult.”

Moreover, both professionals working in primary healthcare in Valencia and those working in the voluntary and community sector in Sheffield have discussed lacking recognition for community work. In both cases, participants felt that their colleagues or managers perceived community work as if they were going out shopping, as the following quotes show:

[Valencia]: “HP1: but then what happened? [the colleagues] started talking.

HP2: yes, "they are going out in the streets" "they are there all day".

HP1: as if we were shopping. So we did a session to explain what we were doing.”

[Sheffield]: Community worker from Sheffield: “our hands are tied so much... if I send someone around, they’ll think we are gonna go and shop, doing our own shopping. There is so much mis-trust. Coz they don’t understand it, they’ve not come from these jobs, they’ve come from like business or corporate jobs.”

To sum up, some former learners currently working in VCS organisations and health professionals were able to transfer the AB thinking to their workplace, which resulted in changes in practices and attitudes. However, the contexts where their work is implemented, and the work culture underpinning these, could act as favouring or hindering those changes to occur.

6.4.3 The AB thinking as a way to counter the impact of negative labelling

This final section sheds light on a final contextual factor, which can be considered as potentially affecting all processes presented in this chapter. As it has been argued throughout these two chapters, an important process at the core of the observed AB initiatives centred on enabling stakeholders to adopt a positive view and valuing themselves and others - the AB thinking. However, it is important to highlight that although the courses supported learners to acquire AB capacities and most former learners have found ways to mobilise these in their communities or workplaces, there are also external factors which may result in limiting the potential for expanding the impact of the initiatives to achieve changes in the neighbourhood. An example of these factors was found in the negative labels of places and people. In fact, the neighbourhoods where these initiatives are being implemented are often those in less advantaged situations or with higher deprivation. However, course participants and professionals working in those neighbourhoods have commented that labelling areas or people using a negative discourse can generate negative feelings, in local people as much as among professionals working in that area, and it made it harder to share the positive aspects of the area with others and to maintain or adopt the AB thinking.

For example, in Sheffield, a former learner described her experience when she was saying where she was living, and people's reactions were even making her afraid:

LHV2-Sheffield: "I just heard the negative things. 'Oh you are not moving there', 'make sure you sleep with a knife underneath your pillow', so I'm thinking 'uuuhh', and got really frightened. But it's just a stereotyped area. Any place is a nice place, you know, if you have just one bad egg, it upsets the rest of it. You can't just sweep all the negative from society. All you can do, trying to promote the area, make it a nice place for people."

Nonetheless, the same former learner was still able to value the neighbourhood and its resources, which may suggest that having adopted an AB thinking supported her in changing her attitude towards the neighbourhood:

LHV2-Sheffield: "emmm, the bad thing was the reputation of that area, because people from the outside had this really bad misconception about the area, and people would say 'you are not from [name of the neighbourhood] are you? You are not the type that lives in [name of the neighbourhood]' and I just think... there's so much community activity there that you don't know about. It's only when you are in that area that you hear about all these good community activities. If there was some way of externalising the good things of certain areas, people would not think so negatively about it."

Similarly, in Valencia, one health professional commented that before coming to work in one of the neighbourhoods where the initiative was implemented, all she had heard were negative opinions. However, once she started working, she was positively surprised:

"HP7: But the concept of [name of neighbourhood] is that of a very conflicting neighbourhood, very marginalised. When I said that I had been assigned here, people put their hands on their heads. But I tell you the truth, I love it. I'm very happy. The team is amazing."

Taking into account negative labelling is important, as labels can impact on people and their health. For example, a former learner currently VCS worker from Sheffield commented that negative labelling of a neighbourhood can negatively impact on the health of the people living there:

VCS worker4-Sheffield: "You know, they don't want to be labelled with 'deprived area' because that's all they have been labelled with. It might be deprived of funds, but we are very rich in culture, we are very rich in experience, in everything else we do. Why are we just labelled as areas of high deprivation? You know... and it's ridiculous, and it impacts on everything else. [...] And it's not just their physical health, it's everything else, it's a bigger picture."

Likewise, LHWs in Valencia discussed how labelling neighbourhoods or people as 'vulnerable' does not favour people's potential to change themselves or the environment around them:

"LHW2: [what we want to achieve is...] equality between equals, and stop being vulnerable, right? Because everyone has that perspective that the people you work with are vulnerable, but what you really work on is to strengthen these people, so that actually you should no longer label them as vulnerable. That is a very big prejudice, and the distance with those people ... is tremendous.

LHW3: Saying 'vulnerable' [...] is to put a label, and it's like saying 'you're not going to get rid of it'"

To conclude, it can be argued that although the studied initiatives supported people from less advantaged areas to adopt the positive AB thinking, to develop new capacities and mobilise these, being labelled as 'vulnerable' people or as coming from a 'deprived' neighbourhood reflects a deficit approach which ABAs are trying to move away from. This becomes important when considering the role that the core process described in the previous chapter, enabling AB thinking, can have, not only among local residents but also among professionals working in the so-called less advantaged areas, as the next chapter will further discuss.

6.5 Summary of the chapter

Mobilising AB capacities thus refers to the variety of processes which occurred as a result of stakeholders being able to mobilise the acquired AB capacities in other settings beyond the activities implemented during the initiatives. As this section has shown, the different ways through which AB

capacities have been mobilised, gave rise to changes which could have an impact on the communities where the initiatives were implemented, or changes in work practice and work culture, the latter potentially having an impact at a more system level. However, the described changes depended on which AB capacities were mobilised, who mobilised them, and the contexts where they are being mobilised.

6.6 Concluding thoughts on the findings: combining them all together

Chapter 5 and 6 presented the variety of processes observed in both AB initiatives and the changes which these processes generated.

The first important process of 'enabling AB thinking' underpinned the development of the activities which the initiatives brought forward while at the same time was enhanced through the initiative itself. It reflected the capacity to adopt the positive view underpinning the assets approach and to value people for their expertise.

The second process presented in Chapter 5, developing AB capacities, is composed of different dimensions which interrelate with each other: developing skills and knowledge, increasing self-confidence, and developing AB relations. This process was initiated in different ways for different people. For example, the courses in both settings created spaces for learners to acquire and share skills and knowledge, and to value each other's capacities. Moreover, in Valencia, the initiative created additional spaces for encounters for other stakeholders, to enhance shared learning and raise awareness on people and organisations as potential assets in the area.

From an individual perspective, developing AB capacities included supporting course participants to develop new skills and knowledge through the shared learning and hands on activities proposed in the courses. From a collective perspective, the initiatives were set up as spaces for encounters, where stakeholders from different backgrounds came together and developed relationships based

on valuing each other for their skills and expertise, what has been termed 'AB thinking'. The courses in both settings were structured so that the learning process was a shared one, meaning that course participants learn from teachers and tutors as well as from interacting with the other participants, learning to value each other's expertise. It is through the capacity of valuing others as potential 'assets' that the AB thinking started to be developed. Moreover, the initiative in Valencia created additional spaces where other stakeholders, namely health professionals and VCS workers, acquired new knowledge in the form of becoming aware of people and resources which can support the health and wellbeing of the communities where they live and work.

Following this, as AB initiatives can be thought of as a series of intermediate changes, which can be enacted depending on how the initiative couples with the context, developing AB capacities gave rise to other processes, as chapter 6 has shown. These were identified as resulting from mobilising AB capacities. For example, when former learners have acquired AB capacities and felt confident to develop new activities as volunteers, or when health professionals or VCS workers embed the AB thinking in their workplace, generating changes in work practices and attitudes. Thus, as former learners and the other stakeholders mobilise their AB capacities, wider changes can be enacted, which can have a collective dimension in the sense that they can impact beyond the former learners' themselves. For example, sharing information among community networks can support families and friends to have better knowledge of services available, or setting up new activities in partnerships can have a positive impact on those attending these activities. However, it is important to take into account the role of the contexts where these stakeholders live and work, which can support or contrast their opportunities to mobilise their AB capacities, as shown in this chapter.

In summary, because of the interaction with the specific context of implementation, the initiatives took multiple forms to enable stakeholders to adopt an AB thinking, to develop the AB capacities and later mobilise these to enhance the impact which the observed AB initiatives can have in the wider community. Because of the different contexts where the two initiatives were implemented, a

variety of processes have been observed, which shared similarities across the two settings but also differed in terms of the type of changes and impacts which the initiatives generated in the neighbourhoods where implemented. As the next chapter will discuss, the processes discussed in these chapters can be considered as changes contributing to promoting health and reducing inequalities.

Chapter 7. Discussion

7.1 Chapter introduction

This chapter discusses the findings in relation to the aim and objectives of the study, and in relation to the literature on place-based health promotion and their underpinning theoretical approaches presented in Chapter 2 and the implementation literature on ABAs presented in Chapter 3. As introduced earlier in the thesis, the objectives of this study were:

Obj 1: to identify the key characteristics of interventions which adopt an asset-based approach to promote health and reduce inequalities in and between neighbourhoods through analysing the literature on ABAs and data generated through qualitative research into two AB initiatives.

Obj 2: to identify changes and processes through which interventions using ABAs promote health and affect inequalities through analysing the literature on ABAs and data generated through qualitative research into two AB initiatives.

The chapter is organised into two main sections, to answer these objectives and highlight the contributions which this study makes. The first section (Section 7.2) discusses the key characteristics of ABAs that have been identified in the research and reflects upon how the insights from the field research relate to the wider literature in Chapter 2 and the scoping review in Chapter 3. The discussion highlights how the process presented in Chapter 5, 'enabling AB thinking' is a key characteristic in the implementation of AB initiatives and can be seen as a prerequisite, but can also be part of an intervention itself, as AB thinking is needed to support any type of stakeholders to shift their mindset towards looking at the positive rather than the traditional deficit view. Moreover, this section highlights that assets identification and mobilisation are also key characteristics of ABAs especially during initial stages of an AB initiative, but can also occur at different stages throughout, depending on who identifies assets and when and how these are mobilised.

Section 7.3 discusses the other two key processes that have been identified in the fieldwork, developing and mobilising AB capacities, and reflect upon the implications of the findings in terms of how these processes and the resulting changes can support health promotion and reduction of place-based health inequalities, to respond to objective 2. It is argued that developing AB capacities can support the development of individual empowerment among learners and the development of social capital among the different stakeholders involved in the AB initiative. However, to increase the impact of ABAs and enable changes and processes which can have an impact in the wider communities and reduce place-based health inequalities, this study highlights that it becomes fundamental to take into account the influence of contextual factors. For this reason, this section will also discuss how taking a systems thinking approach to the research has helped to unpack the complexity of the observed AB initiatives and to understand the processes which resulted from their implementation.

To conclude, sections 7.4, 7.5, 7.6 will discuss the strengths and limitations of this study, and provide recommendations for further research and practice.

7.2 Identifying the key characteristics of ABAs: bringing new evidence to the implementation process

This section will discuss what this study adds to the understanding of the key characteristics of ABAs, more specifically in relation to their implementation process. The research carried out in Sheffield and Valencia supported the findings from the scoping review presented in Chapter 3, that ABAs are complex and can take a variety of forms in their implementation. However, the fieldwork identified more common characteristics across both cases. These were the processes of enabling AB thinking, and identifying and mobilising assets. This study provides evidence on these key characteristics as it

shows that these are processes which can be ongoing throughout the AB initiative and not only be part of the initial stages of their implementation. This study also identified as key characteristics, similar to both settings, the processes of developing and mobilising AB capacities, as shown in Chapter 5 and 6. However, these are better understood as examples of the changes and processes which ABAs can achieve and are discussed in this chapter in relation to their potential to promote health and reduce place-based inequalities in section 7.3.

7.2.1 Enabling AB thinking as the core characteristic and process

The field research in Sheffield and Valencia highlighted that enabling AB thinking is a core characteristic and key process within the observed AB initiatives, and that stakeholders may need time and support to adopt the AB thinking. As set out in Chapter 5, 'enabling AB thinking' can be understood as the development of that positive view underpinning the assets approach, which enables people to identify assets for health; or, in other words, to value the material resources available locally, as well as the skills and expertise a person can have, including one's own. This reflects previous work on ABAs which discusses the need for a change of mindset from a deficit-based to an asset-based view, as introduced in Chapter 2 (Foot and Hopkins 2010; Hopkins and Rippon 2015; Rippon and South 2017). It also reflects the core messages of salutogenesis and ABCD, as introduced in Chapter 2, about looking at positive factors rather than problems and deficits. However, this study adds to the understanding of when and how this change in mindset can come about.

7.2.1.1 Enabling AB thinking can be part of an AB initiative

In terms of the first point about enabling the AB thinking as being a key process within the AB initiative, this study found that both AB initiatives were discussed by staff members as being underpinned by AB thinking, but it also found that the initiatives enabled the development of the

AB thinking among learners, VCS workers and health professionals. As shown in Chapter 5, staff members in both settings had already adopted the AB thinking and developed the AB initiatives building on local assets. In fact, staff identified potential assets in place-based communities and sought to mobilise these through creating spaces to enable 'assets' to be connected and to thrive. It is important to highlight this because it was through those 'spaces for encounters and exchanges' discussed in Chapter 5 that learners, VCS workers and health professionals engaging in the initiative have been able to learn about ABAs and to adopt the AB thinking. However, in the wider literature on ABAs, training community members and/or local professionals on ABAs and on the assets approach, is rarely included as part of an AB initiative, and this change of mindset is seen more like a prerequisite (Rippon and South 2017). This study adds to such understanding as it found that AB thinking was indeed a prerequisite which supported the development of the observed AB initiatives, but at the same time enabling AB thinking emerged as the core process initiated through the AB initiatives, and can be considered as an ongoing process within. Creating 'spaces for encounters and exchanges' can thus be seen as a way to enable the development of AB thinking, which then supported other changes in the targeted communities, as shown in Chapter 6.

7.2.1.2 Adopting an AB thinking may be challenging

In terms of the second point about stakeholders needing time and support to adopt the AB thinking, although enabling AB thinking was identified as a key characteristic and process within the ABAs, and it informed the development of the observed AB initiatives, it is important to note that learners in both settings and also health professionals in Valencia found it challenging to adopt a positive view. These stakeholders engaged in the AB initiatives needed to become familiar with the assets approach through a change in mindset, going from a deficit view to a positive view, in order to understand the language of ABAs and its underpinning principle of valuing assets. However, as discussed in Chapter 5, health professionals commented that ABAs constituted a new approach for them: it was new to shift to a positive view, as well as the idea of valuing local resources and

engaging with these to develop health promotion activities in the neighbourhoods. Similar challenges have been highlighted in previous research on ABAs , which has shown how it can be challenging for local services working on health and wellbeing to shift their ways of working and organising to an ABA (Rippon and South, 2017; Wood et al 2016); and that most of the time, if ABAs are introduced from an external source, there can be limited changes as to how organisations plan and work in and with communities.

Challenges to enabling AB thinking might explain why the MIHsalud staff placed emphasis on working together with the primary healthcare sector, as a way to support health professionals to adopt an AB thinking through the monthly meetings and raising their awareness on the potential that former learners, local LHWs, and local VCS organisations may have to promote health in the neighbourhood where the health professionals work. Interestingly, the latest Spanish strategy on Primary Health Care explicitly highlights that training on ABAs should be provided to health professionals (Ministerio de Sanidad, Consumo y Bienestar Social 2019, BOE 109). This also reflects one of the recommendations proposed by Hopkins and Rippon (2015, p.5), about the need to increase skills and knowledge on ABAs among people working in place-based communities. This is why this thesis highlights the importance of ‘enabling AB thinking’ as being an ongoing process and not just a prerequisite, limited to planning the initial AB initiative.

7.2.1.3 Enabling AB thinking can lead to changes in practices and attitudes

A final key point about ‘enabling AB thinking’ as a key process underpinning the ABAs in this study, is that enabling AB thinking can lead to further changes in practices and attitudes which in turn can impact on health. In fact, enabling AB thinking not only supported learners to adopt the positive view underpinning the assets approach, but as shown in Chapter 6, some of the interviewees in this study reported being able to transfer this change of mindset into their own workplace, supporting changes in attitudes and practices. For instance, some of the health professionals were able to

embed the AB thinking in their practice at the health centre and managed to initiate a change in the work culture, through being recognised for spending more time in their neighbourhoods. This suggests that transferring the AB thinking to the workplace can have further implication in terms of impacting on the ways health promotion services are organised and delivered. In fact, as Foster-Fishman and Behrens (2007) discussed, mindsets and mental models underpin people's attitudes and behaviours and their reactions to proposed changes. Interestingly, other research from the area of Sheffield (Southby and Gamsu 2018) recently analysed partnerships between health professionals and VCS organisations in Sheffield, to identify facilitators and barriers to work intersectorally in communities. One of the key facilitators was found in the capacity for both parties to recognise and value the expertise of the other, which resembles the adoption of an AB thinking. This is why enabling an AB thinking is important, as it can also lead to changes which can impact on place-based inequalities such as those presented in Chapter 6, as section 7.3.3 will further discuss.

To sum up, this study contributes additional evidence to the understanding of the role that the adoption of the AB thinking has in terms of planning and implementing ABAs in neighbourhoods, showing that enabling AB thinking is a key characteristic and process within AB initiatives, it is a prerequisite but can also be part of an initiative itself.

7.2.2 Identifying and mobilising assets: key characteristics and ongoing processes

The above section highlighted that enabling AB thinking is a key characteristic and also a process within ABAs. This finding has important implications in relation to the other two key characteristics of the planning and implementation of ABAs introduced in Chapter 3: identifying and mobilising assets. The field research in Sheffield and Valencia highlighted that both identifying and mobilising assets can also be ongoing processes, occurring at different stages during the initiative, and can vary according to the type of stakeholders engaged in the activity, as the next paragraphs will discuss. This contrasts with the literature discussed in Chapter 2 and 3, which places emphasis on assets'

identification and mobilisation as an activity to be carried out usually at the beginning of an initiative.

7.2.1.1 Identifying assets: who, which, how and when?

The fieldwork in Sheffield and Valencia found that assets identification can be an ongoing process and it varies according to who identifies them, and which, how and when assets are identified. In terms of who identifies assets, as discussed above, the assets identification was presented as part of the initial planning process, carried out by staff in both settings, thus reflecting the evidence discussed in Chapter 3. However, this initial assets' identification did not take a participatory approach involving community members. This contrasts with previous research on ABAs which suggests that it is important to take a participatory approach to the design and development of AB initiatives (van Bortel et al. 2019), so that assets are defined collectively. Nonetheless, this study highlights that not engaging local stakeholders in the assets' identification as part of the planning of the initiative should not be considered as preventing the full adoption of ABAs. In fact, the findings from this study suggest that for an asset mapping to be carried out as a collective action, stakeholders need to have adopted the 'AB thinking', as section 7.2.1 has discussed, to be able to identify assets to map. This relates to the second point from above, as to which assets are identified. Significantly, staff in both sites understood assets broadly as anything with the potential to contribute to health and wellbeing when they defined assets as the people in the communities where the initiatives are implemented, or as resources available in those communities, such as local services, groups, organisations and shops. This reflects the definition of health assets provided by Morgan and Ziglio (2007) and it is in line with the findings from a review on health assets (van Bortel et al. 2019), which found that a broad variety of assets have been defined in the literature. However, as shown in Chapter 5 and as discussed above in section 7.2.1.2, learners and other stakeholders engaged in the initiatives did not always find it easy to think in terms of assets and to define people and skills as potential assets for health. These stakeholders tended to initially think about tangible

resources rather than people and skills. This may be related to the final points of this section, as to how and when assets are identified. Interestingly, the asset approach was first introduced in the courses through the mapping exercise which required learners to map out resources in their neighbourhoods. The asset mapping exercise could suggest focusing on tangible resources such as local shops, organisations and the like. Moreover, in Valencia, the mapping exercise was carried out mainly as an individual activity. It is important to highlight this, as carrying out the asset mapping individually contrasts with what the theoretical literature on asset mapping suggests, that asset mapping is a collective activity, as originally proposed by Kretzmann and McKnight (1996) in their ABCD practice and as suggested by current research on ABAs introduced in Chapter 2 (Foot and Hopkins 2010; Morgan and Ziglio 2007 to name a few). However, this study showed that the individual asset mapping exercise in Valencia and the group asset mapping carried out in class in Sheffield still set the basis to the idea of exploring, and being aware of (tangible) resources in an area. Yet, in both settings, it took the whole duration of the course for learners to start valuing not only material resources but also people and skills as potential health assets. Similarly, the health professionals in Valencia undertook assets maps as part of the collaboration with MIHsalud, focusing mainly on mapping tangible resources available locally and started valuing people and their skills as assets only when they started developing direct relationships with local VCS workers and LHV's. The asset mapping proposed as part of the training was therefore one of the activities within the initiatives intended to familiarise stakeholders with the assets approach. However, it was through being involved in the 'spaces for encounters and exchanges' that learners in both settings, and health professionals and VCS workers in Valencia gradually adopted what has been termed here as 'AB thinking', as discussed earlier in section 7.2.1.

7.2.1.2 Mobilising assets: how and when?

As it has been argued about assets' identification, the fieldwork research in Valencia and Sheffield found that mobilising assets can be seen as an ongoing process throughout and beyond the

initiatives, and not only as an initial part of an AB initiative. In fact, as the following paragraphs will discuss, assets were mobilised in different ways, using one or more of the processes identified in the literature in Chapter 3: connecting assets, raising awareness on assets and enabling assets to thrive (Cassetti et al. 2019), and this process occurred at the beginning of the planning of the observed AB initiatives but has also been ongoing throughout.

As introduced in section 4.3.1, staff members in both settings identified assets to be mobilised in the neighbourhood where the initiatives were implemented. Learners were invited to the course for being potential assets for their communities and the training acted as a form of 'enabling assets to thrive', one of the three ways to mobilise assets discussed in Chapter 3 and in Cassetti et al. (2019). VCS workers and health professionals in the case of Valencia were also considered as potential assets by staff members, and through the 'spaces for encounters and exchanges' created by the initiative they were invited to get to know each other, as a way to be 'connected' with each other, reflecting another way to mobilise assets. These 'assets' identified by staff members were thus mobilised as part of the initiative implementation.

In addition to those initial forms of assets mobilisation, as discussed in Chapter 5 and 6, assets mobilisation was found to be an ongoing process throughout the observed AB initiatives and beyond these. For example, some of the capacities that learners and other stakeholders developed during the courses were then mobilised beyond the time and spaces of the initiatives, as Chapter 6 showed. Learners shared the knowledge acquired on health and services with other community members, which can be seen as a form of 'raising awareness on assets' (Cassetti et al. 2019). Similarly, some of the health professionals involved in the MIHsalud initiative in Valencia and some of the local VCS organisations, after being 'connected' through the initiatives, were able to formally collaborate together and develop further activities. It is important to highlight these, as these are examples of different ways through which assets were mobilised not only as part of the planning and implementation of the AB initiatives, but as ongoing processes during and beyond the initiatives.

However, it should also be noted that stakeholders did not articulate these processes as forms of assets mobilisation. This may be related to how staff and stakeholders hold different perspectives and understanding of ABAs, as other studies found. For instance, a recent research on ethnic minorities involved in asset-based smoking cessation programmes in a Scotland community found that there was a disconnect between how asset-based approaches were perceived and applied by policy-makers or front line staff and how that differed from the perspectives of health professionals and local residents from ethnic communities (De Andrade 2016). Similarly, Roy's research (2016) in Glasgow found that workers engaged in social enterprise and community development discussed their work as always being oriented towards creating skills and resilience, and discussed the assets approach as being just a new label for it.

7.2.3 Summary of this section

This section discussed the contribution of this study to the key characteristics and the theory on ABA implementation, to answer objective 1 of this study. It has shed light on how enabling AB thinking is a prerequisite as well as an ongoing process within the observed AB initiatives. Additionally, it has discussed how the processes of identifying and mobilising assets can be ongoing throughout an initiative, and not just the initial steps required to begin an AB initiative. It has shown that for assets to be identified and mobilised, there first needs to be an understanding of what assets are, and stakeholders engaged in an AB initiative need to learn to value each other and their resources as potential assets - or to adopt an AB thinking-, which is why enabling AB thinking is a key process needed for any AB initiative. Figure 12 below visually represents the implementation of ABAs as ongoing processes of enabling AB thinking, identifying assets and mobilising assets.

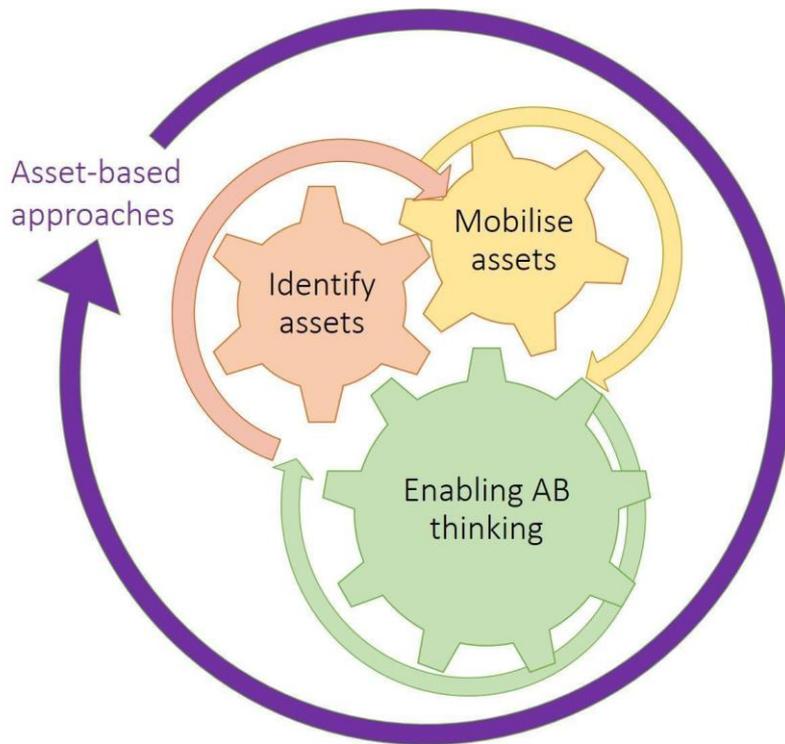


Figure 12: Ongoing processes in the ABAs

The following section will discuss how the identified changes and processes presented in Chapter 5 and 6 can shed light on how ABAs impact on place-based inequalities, thus responding to objective 2 of this research.

7.3 Understanding the changes and processes through which ABAs promote health and reduce inequalities

This section will discuss the changes and processes through which ABAs can promote health and reduce place-based inequalities by shedding light on how the development and mobilisation of AB capacities can be linked to enhancing individual empowerment and social capital in the neighbourhoods where the AB initiatives were implemented. It will then highlight the value of adopting a systems thinking approach to understanding ABAs, which has allowed unpacking of the

complexity of ABAs, and shed light on the importance of wider contextual factors, which can enable or indeed undermine processes through which AB initiatives can promote health and impact on place-based health inequalities.

7.3.1 Developing AB capacities to enhance learners' empowerment

As introduced in Chapter 3, ABAs can lead to a variety of changes. This was also found in the field research in Sheffield and Valencia. The different dimensions presented in Chapter 5 as part of 'developing AB capacities' (increased skills and knowledge, self-confidence and relationships), as well as the wider changes achieved through 'mobilising AB capacities' presented in Chapter 6, are examples of changes which ABAs can generate. As introduced in Chapter 2, the development of capacities has been associated with increased control over health and as a means to support the empowerment of people and communities. This study adds to the understanding of the role of capacities in ABAs as it sheds light on how developing capacities informed by an AB thinking can foster learners' individual empowerment and the impact which this can generate in the wider community.

7.3.1.1 Designing training to support individuals' empowerment

This study found that to support the development of AB capacities, one of the main activities in the studied AB initiatives was to support lay people to learn in ways that developed their sense of confidence and control, and thus support their individual empowerment. The ways the training courses were set up played an important role in this. An important aspect of both training was that the courses were underpinned by AB thinking, since lay knowledge was valued and considered as a resource to be shared and mobilised, as this study found. It is important to highlight this as valuing people for their skills and expertise can further enhance the potential which the training can have on fostering learners' individual empowerment, through increasing their self-confidence, which

according to Tengland (2007) is key to empower people. Therefore, the creation of ‘spaces for encounters and exchanges’ such as the training, informed by an AB thinking which values people and their skills and expertise, can be seen as ways through which individual empowerment is fostered. However, this happened in slightly different ways between the two settings. As shown in Chapter 5, the two training courses differed in terms of the content and the ways the courses were structured, as these reflected the specificities of each context where they were implemented. As the training in the observed AB initiatives targeted lay people living in less advantaged neighbourhoods, South et al. (2013) discussion on the approaches to the training of lay people can become helpful to understand the courses’ role and importance in supporting individual empowerment. As introduced in Chapter 3, according to South et al. (2013, p.11), the training of lay people can reflect a more “professionally-based knowledge” or take a more “personal development” approach to empower the individuals. It can thus be argued that the MIHsalud in-class training had a stronger element of “professionally-based knowledge” than lay people personal development, because health professionals and LHWs delivered the classes. At the same time, however, the MIHsalud training supported the “personal development and empowerment” of the learner (South et al. 2013, p.11) through the practical part of the training where LHWs had to deliver health workshops in their communities. In contrast, the ICDH training centred mainly on the “personal development and empowerment” of the learner (South et al. 2013, p.11), through a more flexible curriculum in class and constant peer learning as part of the course.

7.3.1.2 Individual empowerment in the forms of increased knowledge and self-confidence

Through the training, the observed AB initiatives thus enhanced learners’ individual empowerment, which in this study took the forms of increased knowledge and increased self-confidence. In terms of increased knowledge, as Chapter 5 showed, learners in both settings developed new knowledge about health and health services. As introduced in Chapter 2, according to Tengland (2007) and Whitehead (2007), increased knowledge is a form of empowerment which can promote health, for

example through supporting users to better access services (Whitehead 2007). Tengland (2006, p.202) discussed that knowledge may be empowering when it allows individuals to understand what are the “means available” to change one’s situation, and how to use these means. Indeed, the increased knowledge that learners acquired supported them, for instance, in accessing services when needed, as shown in Chapter 6. However, the fieldwork research also found that it is important to ensure that there is a health needs to access services in order to make that increased knowledge useful.

In addition, in terms of increased self-confidence, some of the learners reported taking up new roles in their communities, for instance as role models for other community members, as presented in Chapter 5, or when engaging as volunteers in local activities or when sharing the acquired knowledge among their networks, as indicated in Chapter 6. Taking up new roles is a way to change one’s own self-image, which according to Tengland (2006) is also a form of empowerment. Moreover, these roles reflect what South et al. (2013, p.10) would define “peer educators” when learners shared information among their own networks, or “bridging roles” when learners supported others in accessing services or when they volunteered in their local communities to develop new activities. Some of these changes in roles can then have an impact within neighbourhoods. For instance, other neighbourhood residents not directly engaged with the AB initiative may benefit from the information received, or from the new activities which former learners develop. However, contrary to what Zimmerman (2000) has suggested, that empowerment at one level can influence empowerment in other levels, this study found that individual empowerment alone, although it contributes to supporting individual people's health and their own development, had limited power over changing the wider social determinants of health within neighbourhoods in Sheffield and Valencia, as section 7.3.3 will further discuss. Before discussing this, however, it is important to highlight that most of the changes which the observed AB initiatives generated through the processes of developing and mobilising AB capacities came about through

the AB relationships developed in the spaces for encounters and exchanges created by the AB initiatives. This relates to the concept of social capital, and can further explain how ABAs can promote health and support reduction of health inequalities, as the next section will discuss.

7.3.2 Developing asset-based relationships to build social capital

This study found that developing AB relationships supported the development of different forms of social capital, and that being underpinned by AB thinking enhanced the impact which these relationships can have in terms of changes and processes which can affect place-based health inequalities, as the next sections will further discuss.

7.3.2.1 Asset-based relationships as forms of bridging and linking social capital

In terms of ‘developing AB relationships’ as supporting the development of forms of social capital, as shown in Chapter 5, the courses provided a space for people from different backgrounds to develop relationships which ‘bridged’ the differences between them, and allowed them to value each other, share knowledge and support each other when in need (Poortinga 2012; Adams 2019). Moreover, learners were able to develop relationships with VCS workers working locally, and in Valencia, in some cases participants also established relationships with healthcare professionals in their local area. The relationships established between course members, and those with the other stakeholders are examples of what has been discussed in Chapter 2 as bridging and linking social capital (Carrillo and Riera 2017). This is important when it comes to understanding the changes at collective level which can support stakeholders engaged in the AB initiatives to increase control over health and its determinants. For example, this study showed that having a direct relationship with members from the primary healthcare team or from local organisations supported most excluded people in better accessing services, or in engaging in the local community and developing new activities which could benefit themselves and other local residents. In fact, Goodman et al. (1998),

when discussing one of the dimensions of community capacity, have argued that community members who have both relations within the community and with others from outside of the community can better address community's issues. This view on the role of bridging and linking social capital can help explain the role of developing AB relationships in promoting health and reducing place-based health inequalities. Moreover, it builds on what has been argued in the previous section about individual empowerment, as having developed the AB relations enhanced the impact which individual empowerment can have at collective level.

7.3.2.2 Asset-based relationships as means to share resources

This study also found that establishing AB relationships between different stakeholders in the neighbourhoods where the initiatives were implemented became a means through which social capital as a resource flew (Moore and Kawachi 2017). For instance, in Chapter 5 it was highlighted that the training courses in both settings allowed participants to gain more knowledge on how to promote health in their communities as part of the course, but additional learning occurred peer-led, between learners who developed AB relationships, through sharing their own knowledge or helpful information with the rest of the groups. This is important, as research has shown that receiving information from a peer enhances the impact which the information provided can have (Adams 2019). In addition, this study found that social capital in the form of emotional resource was also developed among course participants, for example when a person was feeling low and other participants provided support by highlighting that person's quality. This can be an example of how changing relationships can increase learners' support networks, which reflects what Villalonga-Olives and Kawachi (2017) have discussed as the potential process through which social capital can improve health, that is supporting people so that they feel cared for.

Finally, the development of AB relationships between organisational stakeholders such as VCS workers and health professionals as shown in Chapter 6, also became a means through which

informational resources were shared, and awareness of available local services increased among those professionals working in the targeted neighbourhoods. It is important to highlight this as these forms of social capital as informational resources, being shared between organisational stakeholders, could be seen as a way to enhance partnership working, one of the aims of the observed AB initiatives. In fact, previous research has shown that when relationships are established between two or more organisations and result in increasing communication and sharing of information, these can be considered as a form of what has been defined as “cross-sector collaboration” (Southby and Gamsu 2018, p.e361) or “interorganisational network” (Goodman et al. 1998, p.268).

In sum, understanding AB relationships as forms of social capital in terms of relationships across people from different backgrounds, which become the means through which resources (informational and emotional) are shared, provide additional evidence as to how ABAs can promote health and support the reduction of inequalities in local neighbourhoods. Importantly, being informed by AB thinking was found key in enhancing the impact of ABAs, as the next section discusses.

7.3.2.3 Asset-based thinking as enhancing the impact which developing relationships can generate

In terms of understanding changes resulting from ABAs, this study found that being underpinned by AB thinking has important implications as to how AB relationships, understood as forms of social capital, can impact on health and inequalities in neighbourhoods.

First, by being underpinned by AB thinking, the development of AB relationships was based on trust and mutual respect, as introduced in Chapter 6. This is important, as increased trust can enhance the impact which social capital in the form of relationships can have in communities. For instance, as shown in Chapter 6, section 6.2.2.4 in Valencia, learners from ethnic minority backgrounds

reported accessing health services through the direct contact with the lay health worker (LHW) or the health professionals, because they trusted that LHW or health professional independently from the health centre where they were seeking care. This reflects the findings from a study on Community Based Participatory Research between universities and communities (Belone et al. 2016). In Belone et al. (2016) study, trust was believed by community members to develop over time, but also to be mainly related to trust in specific individuals within the university, for their interpersonal skills, whereas mistrust towards the university as an institution remained (Belone et al. 2009). Significantly, in the study presented here, each person felt valued and respected within the AB relationship, which in turn favoured trust towards the other person, independently from the service or organisation she or he may represent.

Second, developing organisational AB relationships underpinned by AB thinking, as described in Chapter 5, section 5.4.3, can support each participant in a partnership to feel that he or she can contribute a knowledge which can complement that of other participants, even when partnerships were developed for more *ad hoc* purposes. For example, in Valencia local VCS organisations were interested in the workshops which both the health professionals and the lay health workers could offer because of the topics covered, which the VCS organisations did not know how to deal with. Similarly, in Sheffield, a local VCS organisation worker discussed organising activities with a health service in their neighbourhood, as the VCS organisation was unable to offer that particular aspect of healthcare. It is important to highlight this, as Aveling & Jovchelovitch (2014) argued that the representation of the self and others is key in understanding the dynamics of a partnership. The authors give the example of when the “other” is seen as vulnerable and in need, and the self is seen as the expert capable of providing what the other is lacking, this creates an imbalanced power relationship between the subjects. Conversely, developing AB relationships underpinned by AB thinking can foster more equal relationships across organisational partners. Moreover, being able to contribute one’s own knowledge and expertise in a partnership can enhance its effectiveness and

impact, as also previous research suggested. For instance, this idea of providing complementary knowledge and skills to a partnership was found fundamental in the effective functioning of a health literacy partnership in Stoke-on-Trent (Estacio et al. 2017). This is important, as partnership work emerged as central in ABAs, as discussed in Chapters 2 and 3, and as discussed by staff members in both settings in this fieldwork. However, contextual factors affected opportunities for partnership work, as the section will further highlight.

Figure 13 below visually summarise the findings from this study, in terms of how the three core processes interact, and how these can the impact on places through the development of individual empowerment and social capital.

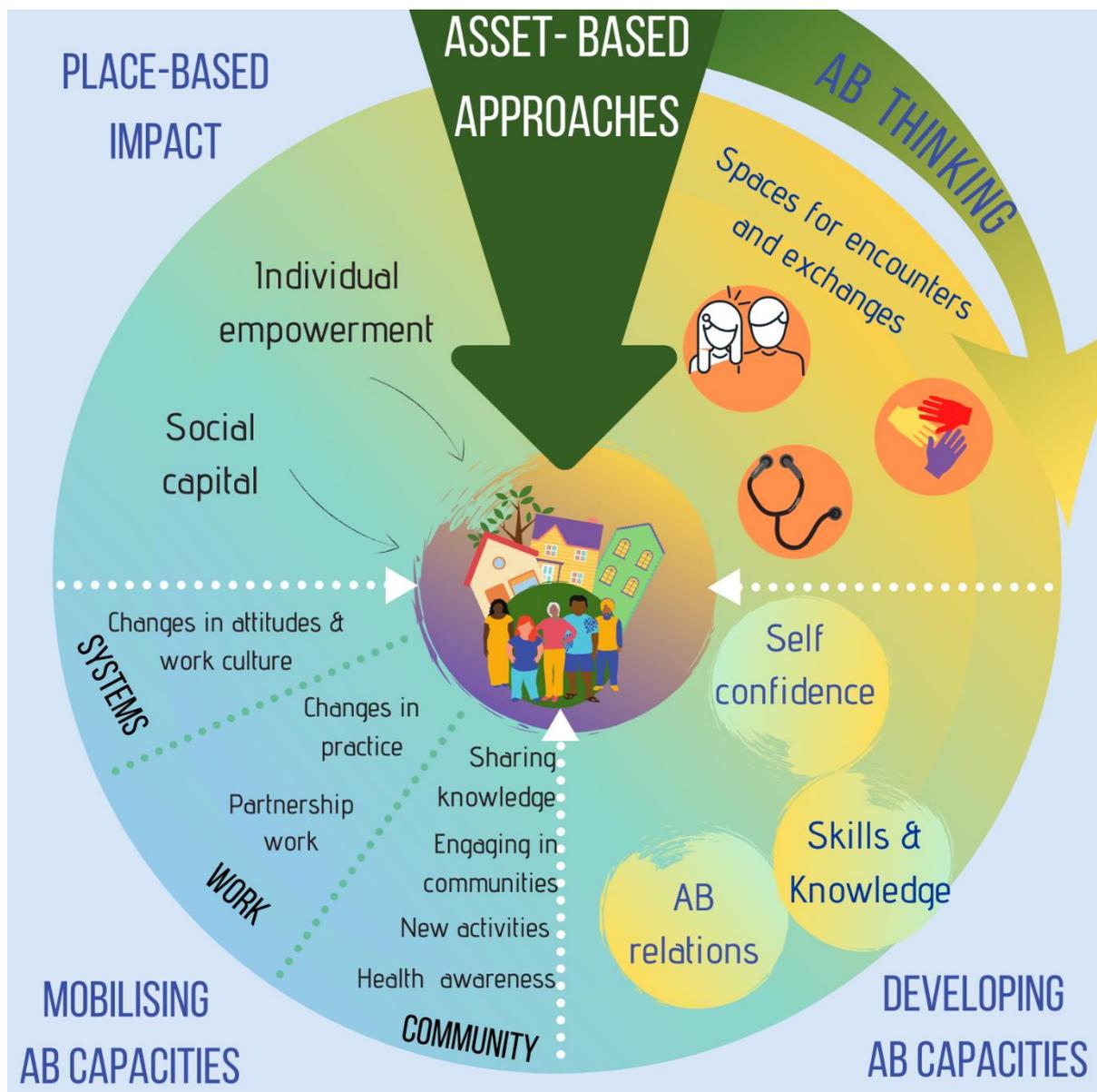


Figure 13: a model of ABAs implemented in neighbourhoods

The next section will discuss how individual empowerment and social capital can be related to wider processes and changes within the communities where the AB initiatives were implemented, provided that contextual factors are taken into account as these influence the potential impact which AB initiatives can have on place-based inequalities.

7.3.3 Unpacking the complexity of ABAs implemented in place-based communities: the role of context as key to enabling processes

As the last sections discussed, developing AB capacities among learners in the courses led to fostering their individual empowerment and can be thought of as a step towards supporting residents from less advantaged communities to increase control over health and its determinants. Moreover, the development of AB relationships fostered more equals relationships between people from different backgrounds, living and working in less advantaged communities, and became a means through which resources were shared, thus becoming forms of social capital. These can therefore be examples of how ABAs can potentially contribute to reduction of health inequalities. However, as presented in Chapter 6, the context played an important role in enhancing or hindering the achievement of wider processes and changes which could reduce place-based health inequalities, as this section will further highlight.

This section will start by discussing how adopting a systems thinking approach supported the understanding of the AB initiatives as ‘events’ in a system, which gave rise to a variety of changes during and beyond the initiative, and which are better understood as ongoing processes. It will then discuss how this approach to understanding ABAs helped shedding light on the role of contextual factors as enablers or barriers to the achievement of changes in health and its determinants, using two examples from this study to illustrate how the AB initiative and the context interact and influence each other.

7.3.3.1 The AB initiatives as ‘events’ in the systems

Through adopting a systems thinking approach to the research, the initiatives were conceptualised as ‘events’ in (complex) systems. As presented in Chapter 5, the observed AB initiatives took a variety of forms - the courses, the monthly meetings - to achieve what Hawe et al.’s (2004) would

define the core functions of the initiative. In fact, 'enabling AB thinking' and 'developing AB capacities' can be understood as the core functions which the AB initiatives achieved. These functions were initiated through different 'events', defined here as the 'spaces for encounters and exchanges', targeted at different stakeholders. Discussing these events as the creation of 'spaces for encounters and exchanges' reflects the systems thinking approach, which, as introduced in Chapter 4, section 4.2.1 does not analyse interventions as a set of defined activities, leading to pre-defined expected outcomes, but it allows to analyse the observed AB initiatives as combinations of forms (the 'activities' of the initiatives) which interact with, and adapt to, different local contexts. This approach to understanding place-based interventions brings back the central role of the contexts of implementation, which has been so often neglected when evaluating public health interventions (Orton et al. 2017; South et al. 2020), and which has shown to be central in this study.

7.3.3.2 Conceptualising changes as ongoing processes

Adopting a systems thinking perspective in this study also supported the understanding of changes as ongoing processes, as also introduced in Chapter 3. In fact, considering the AB initiatives as 'events' happening in a system (like a neighbourhood) suggests that the events initiate a variety of changes, such as those described as the dimensions of 'developing AB capacities' in Chapter 5, which in turn can lead to wider changes in the neighbourhoods where initiatives are implemented, such as those described in Chapter 6, resulting from mobilising AB capacities. It is important to highlight this as this view on ABAs is helpful to shed light on the characteristics of ABAs, to answer objective 1 of this study, as well as to understand the changes and processes which ABAs can generate, to answer to objective 2 of this study. In fact, rather than looking at ABAs as a linear sequence of activities and outcomes, taking a systems thinking approach suggests that ABAs could be understood as ongoing processes, from which different changes can be achieved. The development of AB capacities underpinned by AB thinking can thus be seen as an ongoing process, which has been

shown to enhance learners' individual empowerment and the development of forms of social capital, as the previous sections illustrated.

7.3.3.3 Taking into account the contexts to understand changes and processes

Considering the development of AB capacities as an ongoing process thus calls for an understanding of how 'developing AB capacities' interacts with the wider contexts of the neighbourhoods where initiatives are implemented as a means to achieve other changes in the wider community. For instance, Howe et al. (1997) suggested that capacity building has an effect that extends beyond itself, in the sense that it makes communities capable of solving other problems, not only the first one identified for which the capacity building was put into place. However, as shown in Chapter 6, the potential for changes at collective level depended on the capacities of individuals to mobilise the skills, knowledge, self-confidence and relationships in ways which could impact on the wider systems and its structure, but also depended on how the contexts favoured or hindered such mobilisation.

Two examples from this study are particularly relevant to illustrate the importance of contextual factors. First, health professionals in Valencia were able to develop new activities with local VCS organisations when supported by their coordinator. This reflects a key point in the theory of change developed by Hopkins and Rippon (2015) discussed in Chapter 2, section 2.4.2, which highlighted that for assets to be mobilised there needs to be a support by "system leaders" which can create the conditions for a shift towards ABAs. Thus, in this study, when the 'system leaders', such as a health centre coordinator, supported community work, stakeholders reported being able to mobilise AB capacities and change their own attitudes and practices. These changes can therefore impact on the wider community and can be considered examples of changes in the wider health determinants which can have an impact on place-based communities. This also relates back to what has been argued at the beginning of Chapter 2, and throughout the previous section, about the

importance of considering the role that people and relationships can have in shaping places and how this can affect health, such as the role of 'system leaders' highlighted in this study.

A second example can be found in the lack of funding to work intersectorally, which was often reported as hindering the possibility to work in partnerships. This is in line with recent debates on the need to support intersectoral work through dedicated human and financial resources (McDaid 2018). As introduced in Chapter 2 and 3, working in partnerships has been repeatedly advocated for within the health promotion paradigm, and within some public health strategies across Europe, as a way to support organisations and communities to work together to identify and tackle health determinants in neighbourhoods, to advocate for changes in local services and the like. However, some VCS workers in this study commented that even though they valued getting to know other VCS organisations and being aware of other services available in the neighbourhoods where they work, the development of collaboration was mainly ad-hoc, targeting specific individuals or for specific issues rather than a continuous collaboration. According to these participants, the lack of funding for collaborative work and the overall limited funding opportunities for VCS organisations influenced their willingness and capacity to work together. This reflects evidence from previous research which discussed how lack of funding negatively impacted on the development of an initiative. Van Belle et al. (2010) carried out a theory-driven evaluation of a partnership of different organisations in three African countries. The underlying assumption of the initiative was that by meeting and getting to know each other's work, those organisations will develop synergies, creating partnerships and in turn improving the provision of sexual and reproductive health services for adolescents (Van Belle et al. 2010). These underlying assumptions seem similar to that of the initiatives studied in this research. However, Van Belle et al. (2010) researched a few case studies to analyse how the actual initiative was implemented, and which contextual factors may have influenced its implementation, and found that in all three countries, because of the limited funding and competing interests, organisations did not collaborate, and networking and sharing information

was actually perceived as negative. Conversely, there are examples where ensuring appropriate funding for place-based initiatives has proven effective. For example, van de Venter, E. & Redwood (2016) evaluated a community asset-based intervention in South West England, where dedicated funding was made available to support existing community programmes (arts, skills, craft making, etc) and to encourage their expansion or the creation of new ones. The authors interviewed 12 local people and 18 professionals, focusing mostly on the impact of the funding received, how it translated into their ability to improve their projects. Results found that projects' sustainability was made possible, and this influenced community members' skills, confidence and social network. Similar findings were also reported in two of the studies included in the scoping review in Chapter 3 (Kegler et al. 2009; Sharpe et al. 2015), which described AB initiatives where funding was provided to develop local partnerships.

These two examples shed light on the importance of contextual factors in understanding the potential of ABAs to support reduction of place-based health inequalities. Adopting a systems thinking approach supported such understanding, as systems are made of parts, and therefore concentrating changes only in one part may not result in significant and sustainable changes in the other parts, and therefore in the (desired) change in the whole system (Foster-Fishman and Behrens 2007). This is because it is the interaction between the parts which makes a system work. As chapter 6 showed, although there have been changes occurring within some parts of the systems studied, other changes were not achievable due to contextual factors such as community members' needs and interests, the current work culture and the availability of funding for partnership work. Thus, to achieve systems changes which can support reduction of place-based health inequalities, the contexts of implementation and its own dynamics need to be taken into account as a part of the system, as more authors have been arguing (South et al. 2020; Orton et al. 2019; Hawe et al. 2009; Trickett et al. 2011).

7.3.4 Concluding thoughts on the discussion

In sum, section 7.2 and section 7.3 presented several points for discussion, organised in two main areas to which this study contributes: the theory on ABAs and their implementation, and the processes through which ABAs can promote health and reduce place-based health inequalities. It first shed light on the fact that any stakeholders working with ABAs need to become familiar with the assets approach and with the positive view underpinning it. This has been termed here as AB thinking and it has emerged as a core and ongoing process initiated through the initiatives themselves and which underpinned the resulting changes. It also shed light on how assets' identification and mobilisation can be seen as ongoing processes occurring at the beginning of an AB initiative, but also at different stages throughout. It then discussed how adopting a systems thinking approach to this research has proven helpful to unpack the complexity of ABAs, as a way to conceptualise changes as ongoing processes which AB initiatives can initiate when implemented in place-based communities and how these changes can be associated with potentially supporting reduction of place-based health inequalities. It showed that developing AB capacities can be a step towards individual empowerment and towards developing different forms of social capital as resources and relationships. However, it also discussed that understanding how these processes interact with contextual factors is key to shed light on the impact which ABAs can generate in terms of promoting health and reducing inequalities in place-based communities.

To conclude, the next sections will discuss the strengths and limitations of the study and provide recommendations for research and practice.

7.4 Strengths and limitations of the study

As it has been shown, this study adds evidence to what is known on ABAs implemented in less advantaged neighbourhoods. However, it is important to identify its strengths and limitations, as the next paragraphs will discuss.

An important strength of this study is that it is the first to compare two AB initiatives implemented in contrasting settings, which has proven to enhance the understanding of the processes through which ABAs work by considering its different implementation. It also contributed to this understanding through the scoping review presented in Chapter 3.

This study adopted qualitative methods informed by theory-based and systems thinking approaches, which have proven to be helpful in unpacking the complexity of ABAs and the challenges which AB initiatives can have to achieve changes in a wider system such as a place-based community. Through this approach to the research, it has shed light on the overlapping between changes and processes which can be thought of as part of the complexity of those programmes. Selecting two contrasting settings helped to research how initiatives sharing similar forms can generate similar functions and be exposed to similar challenges in relation to their context of implementation, although each reflected its own characteristics. Moreover, the long period of fieldwork, the adoption of different methods for data collection, and the recruitment of participants from different backgrounds and with different roles within the initiative supported the development of a comprehensive picture of the studied AB initiative. At the same time, it has allowed exploration of similarities and differences even though the two settings differed in many aspects.

It is also important to consider the transferability of the findings. Although this study does not aim to be representative of all ABAs given their variety (in terms of types of initiatives and expected outcomes), it still provides insight which are potentially transferable to other AB initiatives in other

contexts; particularly those that involve similar components and are being implemented in contexts sharing similar social features (Lewis and Ritchie, 2003). The empirical findings of ‘developing and mobilising AB capacities’ as key processes of change may be transferable, as these may be processes that arise from other AB initiatives; even though the capacities developed might be different to those identified in this study. Similarly, the framework of key characteristics of ABAs presented in the scoping review in Chapter 3 represents a synthesis of findings across a variety of primary research studies. This synthesis could be transferred and applied to other settings where an AB initiative is to be planned, as a way to identify potential forms which the AB initiative can take, and potential changes which could be anticipated. Furthermore, the key characteristics identified in this thesis of ‘enabling AB thinking’ and ‘assets’ identification and mobilisation’, which were discussed in section 7.2, can be seen as a contribution to the theory of ABAs rather than an example of its implementation, and it can be argued that these findings represent a form of theoretical generalisability - even though they should be further tested and their validity explored in relation to other AB initiatives (Lewis and Ritchie, 2003). As such, ‘enabling AB thinking’ and ‘assets’ identification and mobilisation’ could be operationalised in different ways but can be transferred and applied to other AB initiatives implemented in communities, independently from the specificity of context and stakeholders involved.

On the other hand, although this study has tried to be as comprehensive as possible, there are still some limitations worth mentioning. First, to have a wider perspective on the impact of the initiatives in the neighbourhoods where they are implemented, the sampling could have benefited from including people not directly engaged with the initiative. For reasons of time and difficulties in accessing those potential participants, perspectives from these people have not been included. Nonetheless, spending time in the field has allowed the researcher to familiarise with the contexts and gain a better understanding of local social and cultural issues, beyond the scope of the studied initiatives. Second, this study shares some characteristics with implementation research. However,

because of the breadth and complexity of the asset-based approach topic itself, this study did not specifically engage with the implementation science literature. This may have provided a complementary approach to the understanding of ABAs and their implementation, and is something for further research on ABAs to consider. Third, it is important to note that this study has only partially been able to capture the impact of ABAs on place-based communities, in terms of health-related outcomes and evidence of reduction of health inequalities (which was one of the objectives of the research). This reflects current challenges in studying community-based initiatives: it is challenging to fully identify and attribute the changes which initiatives can generate in neighbourhood systems, and this is related to the complexity of studying community-based initiatives and ABAs in particular (see Chapter 2 for further arguments on this topic). Moreover, health inequalities are the result of complex socio-economic and political processes. As introduced in Chapter 2, place-based health inequalities can be affected by various intermediate determinants of health. Addressing only a few of these health determinants may support a reduction in individual-level health inequalities, but may not achieve significant reductions in place-based health inequalities. To illustrate this point, an example can be found from this study in former learners sharing information on health and health services among their own networks. Although improved access to this information may support specific individuals to access health services and thus reduce the (individual) impact of inequalities in access, inequalities in access to service may not have reduced at community-level. Significantly, by taking a systems approach in this study it has been possible to understand and show how various contextual factors may favour or hinder the achievement of wider changes at community-level, which may take occur over a long period of time (i.e. years not months). Although this study was unable to collect enough data over an extended time period to analyse place-based reductions of health inequalities, the study has contributed to the evidence base on ABAs by providing evidence of the potential processes - relating to the development of social capital and individual empowerment, as section 7.3 has discussed - through which place-based health inequalities can be affected.

7.5 Recommendations for research

This research represented a novel approach to studying ABAs. These findings contribute to the understanding of how certain types of AB initiatives can work when implemented in less advantaged neighbourhoods in high-income countries. Nonetheless, ABAs remain an understudied topic, and there are a few areas where further research would be needed.

First, because of the complexity of ABAs in terms of their implementation, further research should focus on shedding lights on the different forms ABAs can take, and on the functions which can be achieved through these forms, as a way to enhance transferability to other contexts.

Second, further research should also compare studies on ABAs in place-based communities with evidence from other research on health promotion initiatives, and identify what ABAs can contribute to health promotion compared to more traditional approaches.

Third, more research on how ABAs are understood by practitioners and VCS workers could be supportive to shed light on what is needed to enhance ABAs implementation, and achieve changes at a more organisational level. These changes, according to the finding from this study, can support changes in practice and attitudes through the mobilisation of AB thinking and could enhance the sustainability of changes which have an impact at a wider level in reducing place-based inequalities. For instance, it could be worth researching whether people working in a local VCS organisation or in the local health centre, using an asset approach in their work and in the way their service is organised, can lead to changes at organisational level which could make that organisation or health centre become a potential health asset in the neighbourhood.

Fourth, including participants not directly involved in the initiatives under study would be beneficial as a way to explore the impacts which can be generated beyond the time and space of the initiatives.

7.6 Recommendations for practice

As for recommendations for practice, this study shed light on the complexity of AB initiatives in terms of their planning and implementation.

It found that AB initiatives are not only complex interventions, but also require some prerequisite for their implementation. As discussed at the beginning of this chapter, it is important to bear in mind that for ABAs to be implemented, there needs to be an understanding and an adoption of the positive view underpinning ABAs, the AB thinking. It is therefore key to support local people and other stakeholders working in a place-based community to adopt the AB thinking. The forms through which this can occur can vary depending on the contexts and the stakeholders involved.

It is important to ensure that once the AB thinking has been enabled, further planning or actions should be carried out. In fact, there have been examples of assets' mapping initiatives which did not continue into the assets' mobilisation as part of a wider planning of community interventions, making the asset mapping process only a one-off event and limiting its potential for impact (South et al. 2015).

Moreover, as for the planning and implementation, taking a participatory approach is recommended, as a way to enhance the sustainability of the intervention in the long term. It is also suggested to adopt a systems thinking to the planning phase, as it can help understanding the context of implementation, and how it can favour or hinder the intervention implementation and the resulting processes.

In terms of outcomes associated with AB initiative, it is recommended to be mindful of the potential changes which ABAs can generate. As the scoping review presented in Chapter 3 and in Cassetti et al. (2019) and the fieldwork have shown, there can be a variety of outcomes associated with ABAs,

and they may not always be a discrete finite health outcome but rather a series of ongoing changes and processes.

Finally, it is important to ensure that policy-makers and system leaders are engaged to support the AB initiative: without this, the impact of the AB initiative risks being limited to the good will of interested individuals, and its sustainability is not guaranteed.

Chapter 8. Conclusions

This study aimed to explore how ABAs could promote health and reduce inequalities when implemented in less advantaged neighbourhoods through reviewing the literature on ABAs and through conducting qualitative research in two AB initiatives implemented in two different contexts, one in Valencia (Spain) and one in Sheffield (UK). The next two sections will provide a summary of the findings from this study and highlight its key contributions.

8.1 Summary of key findings

The scoping review presented in Chapter 3 analysed the current literature on the implementation of ABAs in place-based communities, with an aim to identify the key characteristics of ABAs as implemented in neighbourhoods and their expected outcomes. The scoping review found that ABAs can take a variety of forms when implemented in place-based communities. It found that assets can be mobilised in different ways, through three processes: connecting assets, raising awareness on assets and enabling assets to thrive (Cassetti et al. 2019). It also found that ABAs can achieve a variety of changes at individual and collective levels. However, the review highlighted that the implementation literature still lacked evidence of the processes through which ABAs can promote health and reduce inequalities. Moreover, it discussed the need for different approaches to studying ABAs because of their complexity and analysed the contribution which systems thinking can bring to this area of research.

To respond to these gaps, this study conducted fieldwork in two sites where two similar AB initiatives were implemented: Valencia and Sheffield. This study took a theory-based approach informed by the systems thinking perspective to study ABAs, which has provided a novel perspective to the understanding of the complexity of ABAs. Five months of fieldwork were conducted in each site. Data were collected through theory of change workshops with intervention staff and stakeholders, observations of intervention activities and interviews with current and former

learners and VCS workers in both settings. In Valencia, additional interviews were carried out with health professionals who collaborated with the observed AB initiative. Those two AB initiatives represented examples of AB processes.

The initiatives developed as 'spaces for encounters and exchanges', which took the form of training courses in both settings, and the additional forms of the monthly meetings for health professionals and for VCS organisations in Valencia. Three main processes common to the two observed AB initiatives were found: the first two, 'enabling AB thinking' and 'developing AB capacities', presented in Chapter 5, can be considered as the main functions of the observed AB initiatives. 'Enabling AB thinking', referred to supporting the development of the capacity to adopt the positive view underpinning the assets approach and being able to value resources and people for their skills and expertise. 'Developing AB capacities' included the acquisition of skills, knowledge, self-confidence and the development of new relationships, informed by an AB thinking, to value each other as potential assets, hence the term asset-based capacities. The third process, 'mobilising AB capacities' referred to when stakeholders were able to mobilise the developed AB capacities beyond the time and spaces created by the observed AB initiatives, leading to the achievement of other changes in the communities where the initiatives were implemented, as presented in Chapter 6. However, contextual factors were found key as enabling or hindering these processes to happen. Adopting a systems thinking approach to this study helped shedding light on the changes and process in relation to the contexts where these initiatives were implemented, and provided important insights as to how ABAs can impact at a community level to promote health and reduce inequalities, as the next paragraphs will further summarise.

As it has been discussed in Chapter 7, data from the fieldwork helped shedding light on how ABAs work in practice. Significantly, this study added evidence to the implementation process from a theoretical perspective, more specifically on how the processes of identifying and mobilising assets can be ongoing throughout an initiative, and the importance of enabling AB thinking as a way to

engage people with the assets approach. Moreover, adopting AB thinking can also be ongoing throughout the initiative itself, as a way to support different types of stakeholders to learn to value each other and their resources. This is why enabling AB thinking should be considered as a key process needed for any AB initiative.

In addition, in terms of the implementation of ABAs, this study showed that the observed AB initiatives supported the empowerment of involved stakeholders and enhanced the development of social capital, which is in line with the literature on ABAs presented in Chapter 2 and 3. However, this study added to the understanding of how ABAs can promote health and reduce inequalities as it discussed that being underpinned by an AB thinking and enabling involved stakeholders to adopt an AB thinking can enhance the impact which empowerment and social capital can have. Significantly, increasing individual empowerment and building social capital can support processes associated with reduction of inequalities but can also have limited power to achieve changes at community level when initiatives lack a more systems-like approach to the understanding of how contextual factors can enable or hinder wider changes to happen. Finally, this study contributed to the understanding of ABAs from a methodological perspective, as it discussed how the systems thinking approach was helpful to unpack the complexity of these kinds of initiatives.

8.2 Key contributions of this study

To conclude, this study has contributed to the understanding of ABAs in three different areas. First, from the theoretical perspective, it provided new understanding of the key characteristics of ABAs and showed that ABAs are better understood as ongoing processes. Second, from the implementation perspective, it provided new insights as to how AB initiatives work to promote health and reduce inequalities when implemented in less advantaged neighbourhoods. This study also highlighted the importance of taking into account the contexts where initiatives are implemented. Each context shapes the way processes can be initiated, and because of the

interaction with the specific context of implementation, the initiative takes multiple forms to achieve its functions, which in turn can favour or hinder impact on place-based health inequalities, as this study showed in relation to the development and mobilisation of AB capacities. Third, it provided a methodological contribution as to how qualitative approaches informed by systems thinking can help studying complex initiatives, such as ABAs, implemented in complex settings, such as place-based communities.

It is hoped that this study can make a contribution to the understanding of ABAs and to inform the development of further research and practices in relation to the implementation of ABAs in less advantaged place-based communities.

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Appendices

Appendix I: search strategy for the scoping review

(asset* adj1 (model* or based or health or communit* or map*)).ti,ab.

OR

(asset-based or assets-based).ti,ab.

OR

(people or neighborhood or local or communit*) N1 asset*

OR

[(Salutogen* or Antonovsky).ti,ab. AND ((inequalit* or inequit* or disparit*) OR (Communit* or village* or neighbour* or neighborhood* or municipalit* or town* or urban or rural or local*)).ti,ab.]

An example of the search strategy in MEDLINE via OVID is provided below:

Database: Ovid MEDLINE(R) Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R) <1946 to Present>

Search Strategy:

- 1 (asset* adj1 (model* or based or health or communit* or map*)).ti,ab. (393)
- 2 (asset-based or assets-based).ti,ab. (137)
- 3 (Salutogen* or Antonovsky).ti,ab. (611)
- 4 ((people or neighborhood or local or communit*) adj1 asset*).ti,ab. (143)
- 5 (Communit* or village* or neighbour* or neighborhood* or municipalit* or town* or urban or rural or local*).ti,ab. (1712008)
- 6 (inequalit* or inequit* or disparit*).ti,ab. (72107)
- 7 5 or 6 (1766092)
- 8 3 and 7 (91)
- 9 1 or 2 or 4 or 8 (501)
- 10 limit 9 to (abstracts and (catalan or english or italian or spanish)) (458)
- 11 limit 10 to yr="1996 -Current" (450)

Appendix II: First synthesis of the extracted data from the scoping review on ABAs

This source was originally published as SUPPLEMENTARY MATERIAL ONLINE: First synthesis of the extracted data from the scoping review on ABAs (Cassetti et al 2019)

PROCESS			OUTCOMES			EVALUATION
<i>Target population</i>	<i>Theoretical models</i>	<i>Type of assets identified</i>	<i>Individual level</i>	<i>Community level</i>	<i>Organisational level</i>	<i>Methodological approaches</i>
Residents in a community (17) Women (2) Young people (4) Elderly (1) BME (2) Parents and kids (2) Men (1)	Asset-based/ ABCD/ (17) Asset Model (1) social ecological model (3) participatory approaches/ CBPR/ engagement (9) PYD (3) complexity theory (1) social capital theory (1) Peer support (1)	Individuals' skills, interests (23) Groups/ networks (16) Physical settings (3)	Increase healthy eating (5) Increase physical activity (8) Reduce obesity (2) reproductive and sexual health (1) self-confidence (2) reduced stress (1) mental health (3) new skills/capacity building (7) reduced social isolation (2) reduce alcohol & drug abuse (1) reduce teen pregnancy (1) increase resilience (1) increase peer support (1)	Participation/engagement (4) empowerment (3) sense of belonging/community (1) New jobs/internships/ new volunteer roles (3) New activities proposed (3) New partnerships (4) Social networks (2) Social cohesion (1) Trust (1) Social capital (2) Changes in the built environment (safe road to school, green areas, cleaner streets, reformed buildings, etc) (5) better social environment (1) more equal social relations (1)	re-designed or develop intervention (2) Raised awareness on a service (3)	Mixed methods (10) Only Qualitative (2) Only quantitative (2) Qualitative methods used in evaluations: ethnography (1) Focus Groups (6) Interviews (10) Quantitative methods used in evaluations: Surveys/monitoring data collection (13)

Appendix III: Permission to re-use published material from Casetti et al 2019

Please, see email below



Viola Cassetti <vcassetti1@sheffield.ac.uk>

question regarding using of tables in a PhD thesis

PermissionsUK <PermissionsUK@sagepub.com>
To: Viola Cassetti <vcassetti1@sheffield.ac.uk>

17 March 2020 at 22:15

Dear Viola,

Thank you for your email. I'm happy to confirm that as you are a co-author of the article, you are permitted to re-use all portions of the work – in whole or in part – in your thesis, free-of-charge, under the same terms as provided in my previous email.

Best wishes,

Craig Myles
Senior Rights Coordinator
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From: Viola Cassetti <vcassetti1@sheffield.ac.uk>
Sent: Monday, March 9, 2020 2:04 AM
To: PermissionsUK <PermissionsUK@sagepub.com>
Subject: Re: question regarding using of tables in a PhD thesis

Dear Dr. Myles,

Thank you for your response and for the permission to use the tables mentioned in my thesis. Apologies for writing back again, but I forgot to ask permission to also use the Figure 1 with the Prisma Flow Diagram on page 4 of the same article.

Could you please let me know if it is possible to include this as well?

Thank you for all your help and support.

<https://mail.google.com/mail/u/1?ik=29088da977&view=pt&search=all&permmsgid=msg-f%3A1661447435602165601&dsqt=1&simpl=msg-f%3A...> 1/4

24/3/2020

University of Sheffield Mail - question regarding using of tables in a PhD thesis

Kind regards,

Viola Cassetti

On Wed, 4 Mar 2020 at 21:12, PermissionsUK <PermissionsUK@sagepub.com> wrote:

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To: Author Production Queries <authorproductionqueries@sagepub.com>
Subject: question regarding using of tables in a PhD thesis

<https://mail.google.com/mail/u/1?ik=29088da977&view=pt&search=all&permmsgid=msg-f%3A1661447435602165601&dsqt=1&simpl=msg-f%3A...> 2/4

[EXTERNAL]

Dear sir/madame,

I am writing to you in relation to the article published in the Global Health Promotion Journal titled:

Cassetti, V., Powell, K., Barnes, A., & Sanders, T. (2019). A systematic scoping review of asset-based approaches to promote health in communities: development of a framework. *Global Health Promotion*. <https://doi.org/10.1177/1757975919848925>

As this study was part of my PhD thesis, I would need to use and reference the two tables included in the paper. Table 1 will be used as an annex and Table 2 as part of the text.

They will be of course fully referenced, but I just would like to know if there is any specific forms I should fill in, to ask permission to use the tables published in this paper within my PhD thesis.

Thank you in advance for your support.

I look forward to hearing from you.

Kind regards,

Viola Cassetti

--

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Appendix IV: Study characteristics

This was originally published as Table 1 in Casetti et al 2019. For reasons of space, the published source has been adapted to fit in this Word document version.

	Authors, Year, Title, Journal	SUMMARY Of the intervention	Theoretical approach or model	Intended outcomes	Indicators and methods to measure outputs or outcome	OTHER outcomes?	What assets is building on?	How are assets used?
1	Baker et al 2007. <i>An asset-based community initiative to reduce television viewing in New York state.</i> Preventive medicine 44(5)	Part of a wider 3-years project to reduce childhood obesity among preschool-aged children in rural, upstate New York. This part of the intervention aimed to identify available community assets to develop alternative free time activities to reduce TV time in children	asset-based community intervention, asset mapping	create a partnership to provide alternative to TV viewing for children	originally wanted to count obese children from the cohort study but activities were open to all and couldn't count only obese children's participation	sense of belonging to the community. More people and organisations got engaged and enhanced the potential for improving health in their own areas.	local activities and groups	Engaged to deliver new activities during the two designated weeks of "TV off", but continued delivering these beyond the intervention
2	Bloomberg et al (2003) <i>Chicano-Latino Youth Leadership Institute: an asset-based program for youth.</i> American journal of health behavior 27(suppl 1)	In 1993, the health region commission conducted FGs with local chicanos, to explore why low rate of graduate school enrolment. From those results, the Chicano-Latino Youth Leadership Institute was developed (ChYLI). The intervention aims to increase protective factors by building on local and individual assets in young Chicanos and Latino population in Regional Areas of Minnesota. The programme has various aims: build leadership skills, build a network of young leaders, involve chicano and latino youth in community decision making, increase understanding of latino culture, prevent alcohol and drug abuse	Positive Youth Development (PYD)	Short-term outcomes: self-confidence, sense of community and ownership, social and leadership skills, peer and adult role models Ex of results: in 4 years, 43 community activities, organised by those involved in the programme, who are now taking leadership in organising dance classes, or soccer, or cultural celebration like 5 de mayo, etc...	Mixed. An annual FG, conducted 2 months after the institute is finished to explore perceptions. Pre-post survey, exploring questions like: "I know what is a problem in my community" or "I know how to create a solution for it" or "I know how to be a leader" or "I can work with other people"	Long term: increased rates of high school graduates, increased secondary education; reduced drug consumption, and more role models in adults and peers Because the model is focused on PYD, rates of drug use are not checked to avoid pressuring young people with questions regarding drug consumptions. The evaluation team will use school reputation and involvement in voluntary activities as predictors of less drug use	individual skills of youth	build on these skills, to encourage young people to get more involved in their communities

3	<p>Coll-Planas et al (2017) <i>Promoting social capital to alleviate loneliness and improve health among older people in Spain.</i> Health & social care in the community, 25(1)</p>	<p>The intervention involved developing a partnership between primary healthcare centre, local organisations and elderly people. Conducted between 2011 and 2012 in one rural-urban area and two urban areas. Older people were trained to become peer health supporters, to other elderly from their own area and engage them in using local resources. The intervention is run in 15 sessions, where they talk about loneliness, then the volunteers present local community assets and participants decide which 5 they want to visit. They then visit those assets and then use the remaining two sessions to discuss how they would like to continue. The idea is also to raise awareness among professionals about opportunities where they could send older people who may come to the GP because they are lonely.</p>	<p>Social capital theory applying a behaviour change model and care co-ordination.</p>	<p>reduce loneliness, increase social capital at all 3 levels</p>	<p>pre-post test on quality of life, loneliness, engagement in the activities proposed, etc..</p>	<p>participation, social support, self-perceived health, quality of life, depressive symptoms and use of health resources</p>	<p>individual and local resources</p>	<p>local senior men were trained to become volunteers and engage older and more lonely men form their centres. Health professionals were involved to create a network with senior centres (connect) and raise awareness on the problem of loneliness and the availability of assets in their areas.</p>
4	<p>DeGregory et al (2016) <i>Community Vision and Interagency Alignment: A Community Planning Process to Promote Active Transportation.</i> American journal of public health 106(4)</p>	<p>The intervention aimed to engage residents in Brooklyn to increase active transportation and improve community health. By engaging local governments, community NGOs and local residents, it emerged that there were no safe roads for biking. A series of initiative were developed: new bike lanes, local events to raise awareness and free distribution of helmets, a bike clinic, etc...</p>	<p>ABCD</p>	<p>increase active transportation (more physical activity time in transport)</p>	<p>Nº of people engaged and of new activities proposed</p>	<p>changes in the built environment (new bike lanes). New activities emerged because some residents expressed concern that they needed more help in educating kids on safe roads practice so two NGOs organised after school trainings locally.</p>	<p>local individuals and resources</p>	<p>connected to develop new ideas and implement them</p>
5	<p>Derges et al (2014) <i>'Well London' and the benefits of participation: results of a qualitative study nested in a cluster randomised trial.</i> BMJ Open 4</p> <p>Phillips et al (2014) <i>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</i></p>	<p>In these two papers the programme is defined as a community engagement and co-production initiative to promote health. Run between 2007 and 2011, the programme centred on delivering health promotion messages and developing localised activities to change people's behaviours and elements of the local environment when possible.</p>	<p>community engagement model</p> <p>empowerment</p>	<p>improve PA, healthy eating and mental wellbeing</p>	<p>participants' experiences of the Well London interventions and any reported changes to eating, exercise and mental health practices. And views on the neighbourhood environment. Survey, interviews and few observations.</p>	<p>Social cohesion was felt to be facilitated and increased in some cases by the programme itself. Community empowerment is presented in a theory of change diagram provided. Community engagement was hoped, but not always achieved</p>	<p>Local resources</p>	<p>Raise awareness on activities and groups</p>

	<i>inner-city neighbourhoods</i> J Epidemiol Community Health 68							
6	Dobrof et al (2011) <i>Building on community assets to improve palliative and end-of-life care.</i> Journal of social work in end-of-life & palliative care 7(1)	The core idea is to strengthen palliative and end-of-life care in Westchester County, a suburb just north of New York City, and improve educations on the topic among professionals and families. It started from a conference in 2003, where citizens were worried about the ageing population and the need of more services for end of life when terminally ill. The partnerships was formed, it started with 10 doctors, and now it's a coalition of 40 community NGOs, citizens, health centres, senior centres, hospices, etc.. It aims to educate, advocate, share knowledge and build capacity	ABCD	educate and raise awareness on palliative care, build capacity, share knowledge	Survey to describe how participants perceived the partnership, what they learnt and what activities they were carrying out.	advocacy and research for policy	Local Resources (individuals and groups)	Connected and raised awareness on available resources
7	Durie and Wyatt (2013) <i>Connecting communities and complexity: a case study in creating the conditions for transformational change</i> Critical Public Health 23(2)	The aim of the C2 interventions is to adopt ABCD practice to build upon and enhance communities' capacities and promote co-produced solutions between local residents and health professionals	complexity theory, using an ABCD approach. Co-production and participatory research	better relationships	Mixed. N° of actions deriving from the local initiatives and n° of participants attending. Interviews and observations were used in the pilot C2 with planners, staff and participants.	Actions derived from the intervention, such as skateboarding place, dance groups, fruits delivered by the local supermarket, more sense of community and feeling proud of the neighbourhood, etc..., more PA	local people and available resources	mobilise assets and encourage them to work together
8	Edberg et al (2016) <i>Applying Ecological Positive Youth Development Theory to Address Co-Occurring Health Disparities Among Immigrant Latino Youth.</i> Health Promotion Practice	Adelante, a community-university partnership to foster positive youth development and community social networks. It works on three levels, building individual confidence and skills, create community activities to engage youth and improve the environment (clean-up events), and recruit some of the young people in local internships with local business	socioecological model applied to positive youth development	increase youth skills and self-confidence, improve community environment and youth relationships with the surrounding environment, to ultimately reduce risk behaviour	Mixed-method: pre-post surveys, cohort study, qualitative interviews with participants and data on employment through the project	not available	individual skills	promote skills development and foster relationships

9	Fuertes et al (2012) <i>Feasibility of a community action model oriented to reduce inequalities in health.</i> Health Policy 107 (2-3)	The intervention follows three main stages: create partnerships at local level, do a Health needs and assets assessment, and develop a collaborative action plan to improve health. In these 2 neighbourhoods, the actions were varied. It is supported by a Regional policy to improve health in the neighbourhoods.		Varied in each neighbourhood. Examples include: mental health, healthy diet and PA; autonomy of the elders, prevention of child obesity and drug use in adolescents through promoting thai chi in the park, use of local gym, puppet shows, alternative football league, walking groups, etc..	Eighteen pre-selected indicators on various topics. Examples include: n° of meetings held by the partnerships, n° of participants in the activities, n° of activities proposed, satisfaction, etc	the overarching idea is to reduce inequalities, but this current study did not aim to assess whether and how this was achieved	local resources	connected or raise awareness on the available activities
10	Hanson et al 2016 <i>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.</i> Social Science & Medicine 169	Group walking scheme implemented in deprived areas of Norwich, to train local volunteers to deliver one-mile healthy walks. The assets are recognised as being the community volunteers. It mentions that a previous study looked at barriers to walking, this study looked at process. It found that more grass-root approaches to engage walking leaders can work better, and the role of primary healthcare professionals is key in referral when engaging those most vulnerable.	Not included	increase walking time and participation to walking groups	Examples include: n° of people attending the walks Process evaluation was carried out through qualitative interviews.	Not stated	local people	people are trained to deliver the intervention
11	Janosky et al (2013) <i>Coalitions for impacting the health of a community: the Summit County, Ohio, experience.</i> Population health management 16(4)	The Wellness Council is a multisector partnership aiming to develop and enhance existing local resources or ongoing programmes to develop novel solutions to chronic diseases in the communities. Examples of activities developed include: after conducting an asset-mapping and finding that many charities were providing counselling, the Council started connecting organisations within the coalition to develop better services with the available assets and resources.	Not included	Improve community health, intended as physical, social, emotional and spiritual	Not completely specified: the authors mapped the current initiatives using an available framework, the Health Impact Pyramid. It is not an evaluation of the interventions being carried out.	new intervention, re-designed by re-organising available resources in a more efficient way	local resources	connect them to create new proposal of services or interventions

12	Kegler et al (2009) <i>Evaluation findings on community participation in the California Healthy Cities and Communities program.</i> Health Promotion International, 24 (4)	Three years funding in 20 communities, to develop local partnerships, a shared vision and an action plan to be implemented	participatory programme, including an asset-based community assessment	engagement, create new networks	Self-administered survey to engaged participants at end of year 1 and 3. Qualitative interviews and FGs to explore barriers and facilitators to engagement.	Increased decision-power in local activities and in local governments.	existing organisations and people	assets are being connected to expand their membership
13	Kegler et al (2003) <i>An asset-based youth development model for preventing teen pregnancy: Illustrations from the HEART of OKC project.</i> Health Education 103(3)	Two years of needs/ assets assessment in neighbourhood, involving young people in defining assets and developing actions plan collectively, building on available resources to tackle teen pregnancy. The interventions were piloted during the following 5 years.	asset-based: positive youth development and community development	reduce teens pregnancy and other sexual risk behaviour by creating social environment that promote assets development	Mixed. Interviews and FGs. Surveys exploring mobilisation at neighbourhood level, n° of action planned and risk behaviours	Not stated	individual personal assets of the participants and relationships, local physical resources of the neighbourhood (although no example provided on the latter)	the base on which to build the intervention
	Kegler et al (1998) <i>Combining quantitative and qualitative techniques in planning and evaluating a community-wide project to prevent adolescent pregnancy.</i> International Electronic Journal of Health Education 1							
14	Martinez et al (2011) <i>Nuestro Futuro saludable: connecting public health research and community development in partnership to build a healthy environment.</i> Community development) 42(2)	CBPR to develop a tailored intervention for young latino immigrants. it's a 10 weeks after-school programme, to make youth aware of the community assets and how to take advantage of them to improve their health	CBPR, community empowerment and socioecological model	Promote health behaviour, reduce stress, and be aware of the social determinants. Examples include: raise awareness on how environment can influence health, empower young people to take control over health	Not available. The article describes the research-action model	Youth engagement	local people	the environment is used as a setting to raise awareness and allow changes by identifying local assets. Local people are involved to design the intervention in a participatory way

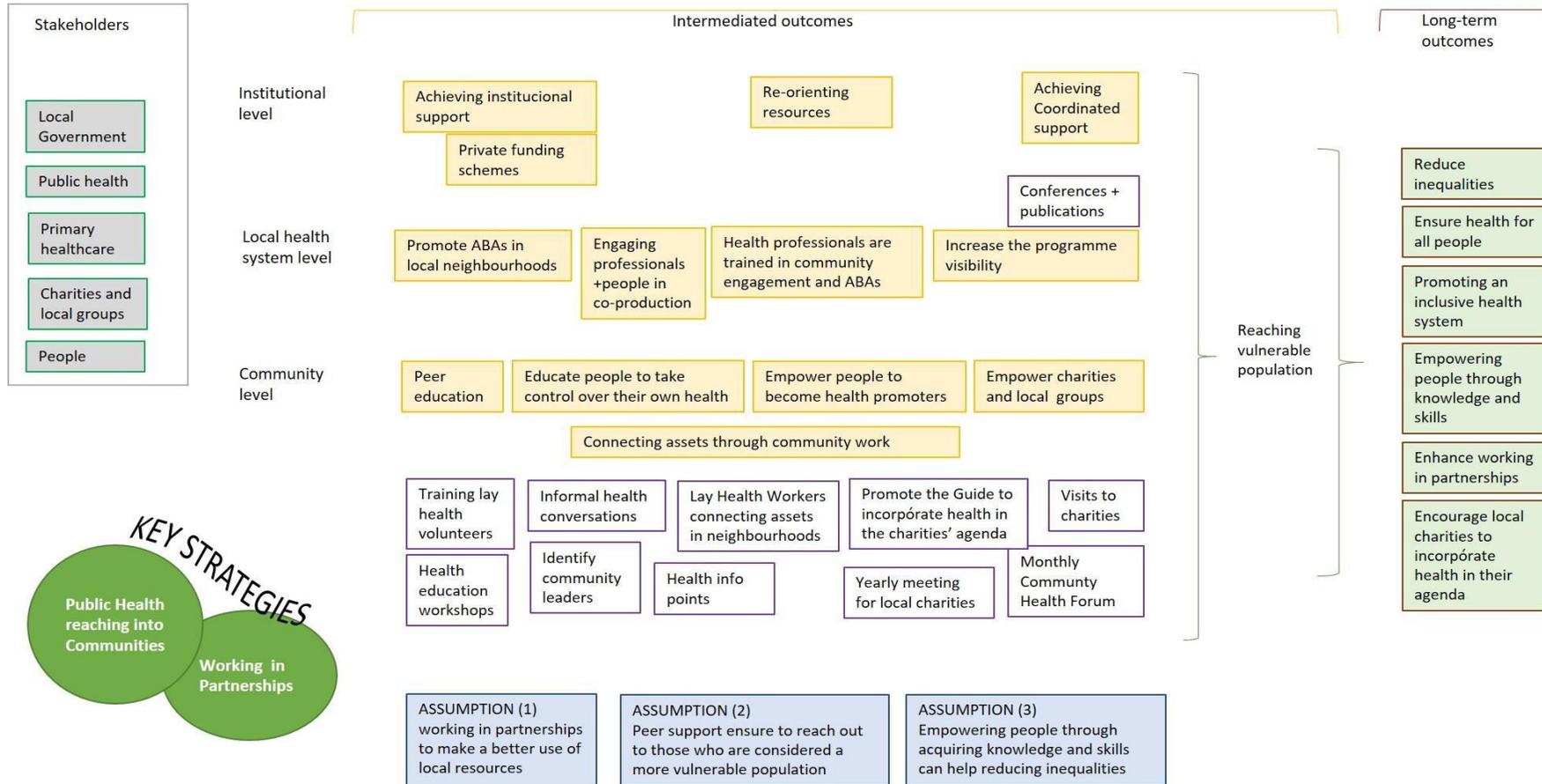
15	Matthiesen et al (2014) <i>End-of-life conversations and care: an asset-based model for community engagement.</i> BMJ supportive & palliative care 4(3)	Asset-based approach to engage community organisations and members to tackle end of life conversations. A new community-wide partnership is formed and an action plan agreed, through which local organisations are engaged in additional activities related to end of life care alongside their own work	asset-based	raise awareness on services available to people for end of life care	Varied according to location. Examples include: attendance to workshops and coverage of radio and newspaper with the campaign; development of new partnerships.	new partnerships of local organisations	local organisations	mobilise assets to work together, or create new networks
16	Miller et al 2009 <i>Slavic Village: Incorporating Active Living into Community Development Through Partnerships</i> American Journal of Preventive Medicine 37 (6, suppl. 2)	it's a neighbourhood project, aimed at creating partnerships to improve the physical and social environment in the area of Slavic Village, in Cleveland. Examples include: safe route to school, workplace wellbeing, asset mapping, social marketing for health promotion.	socioecological model (McLeroy et al 1988), and community engagement approach	changes in physical environment and increasing physical activity of residents through for example safe routes to school, health walks, green spaces.	Varied. Examples include: policy change, availability of the new route, number of neighbourhood maps printed and delivered.	Use funding to support local physical activities programmes, influence new policies, etc... Strengthen partnerships: (ex: youth mapped the neighbourhood to highlight safe walking and biking routes. A local bike co-op funded the printing)	People, relationships and resources	strengthened partnerships to provide new group-based activities, create parks for activities
17	Ortega et al (2015) <i>Proyecto MercadoFRESCO: A Multi-level, Community-Engaged Corner Store Intervention in East Los Angeles and Boyle Heights.</i> Journal of Community Health 40(2)	the intervention aimed to convert some food stores in two latino neighbourhood into healthy food store to increase healthy eating among latinos. it was an action research, where community was engaged since the beginning. To develop the business plan, a former store owner expert was consulted, and for the social marketing at local level the youth were involved in the spread of the message. This involved partnering with other local NGOs who worked with youth, other art-based charities, and creating a school curriculum where students learnt how to create videos, learnt about food justice and health disparities and about social marketing, so they could develop their own healthy education message	PAR	Change the food settings, by increasing the availability of healthy food store	Surveys about food availability, purchase, and fresh food consumption, prior to store conversion, and then again 1-2 years afterwards, with 125 households around the food stores in each neighbourhood. Also random interviews at the stores, to see pattern of consumption changes, pre and post store conversion And four interviews with store owners	increase healthy eating behaviour; new skills in the students who took part in the local school curriculum on food disparities, etc	local resources, including existing NGOs and local food stores	transformed to be healthy settings; connecting resources to offer the new curriculum at school to develop the healthy videos and social marketing

18	Parker et al (2006) <i>Our games our health: a cultural asset for promoting health in Indigenous communities.</i> Health Promotion Journal of Australia 17(2)	The aim was originally to develop a community health promotion intervention targeting men and elderly in the Cherbourg and Stradbroke Island communities. But it then changed to focus on school children. Three phases: community engagement, community mobilisation, capacity building. A community forum was formed, with 10 members from both communities, who met 6 times in total and learnt about traditional games and PA. During the mobilisation, asset mapping was conducted, and cultural assets were "discovered"	asset based	improve physical activities in children through traditional games	process evaluation through FGs and questionnaires on satisfaction and quality of the information	Increased social capital, as new connections emerged, and new awareness of community members about their own cultural and historical traditions	local cultural assets	Improve "use of" and raise awareness on the traditional cultural values and games
19	Rhodes et al (2012) <i>Using Community-Based Participatory Research (CBPR) to Develop a Community-Level HIV Prevention Intervention for Latinas: A Local Response to a Global Challenge</i> Women's Health Issues 22(3)	Train latina women to become lay health advisors (LHAs) and peer supporters. The MUJERES intervention follows eleven steps, ranging from health and needs assessment, reviewing literature on sexual health and developing a targeted training module for local Latina women, and implement the training.	CBPR	improved sexual health, improving KAP of Latina women related to HIV	Different indicators for each activity described: n° of activities. Focus groups were used to identify priorities while developing the intervention	empowerment, as a result of participating in the CBPR	Local social networks: pre-existing social networks of Latinas and the pre-existing, culturally congruent roles of LHAs.	build upon local assets to develop a tailored intervention
20	Riley et al (2015) <i>The provision of NHS health checks in a community setting: an ethnographic account.</i> BMC health services research 15	A health partnership with GPs, lay health trainers, local public health council employees and community engagement workers to plan and deliver outreach NHS health checks. It also involved local people from afro-Caribbean community to help in publicity for the event, and pay them for it.	Not stated	participate in health check, engagement with the activities	Ethnography. Observation and semi-structured interviews with participants and staff, analysed thematically	raise awareness on health issues	local community resources, in terms of local people and local venues	engage local people to promote the event, and use local venues as the settings for the event
21	Robinson et al (2015) <i>Peer support as a resilience building practice with men</i> Journal of Public Mental Health	Five projects to increase resilience among men, spread out across the UK. Eight weeks interventions, with aim to increase coping strategies and involve men in activities like gardening etc.	Peers support models, Mind's own resilience model	resilience and peer support (developed through developing trust, but without talking about emotions at the beginning), and increase social capital and coping skills.	Pre-post surveys and qualitative interviews exploring changes in men's perceived resilience	the long-term idea is that developing trusted social network could provide these men access to other resources in their communities	individual skills	enable them to establish further relations

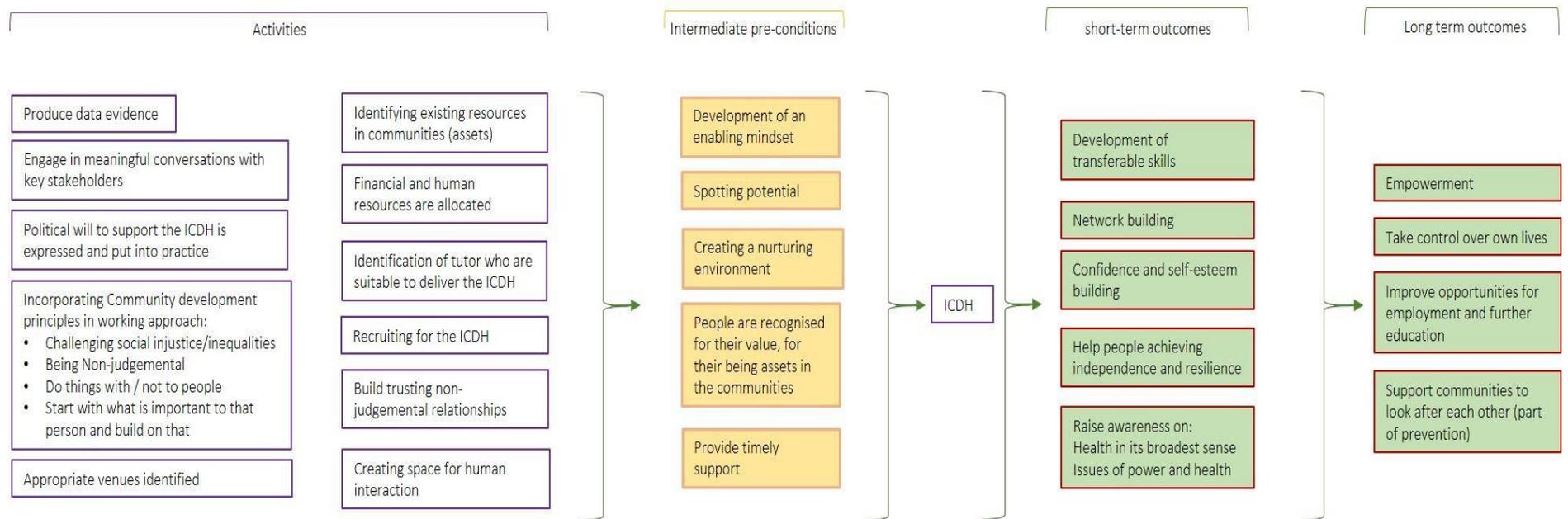
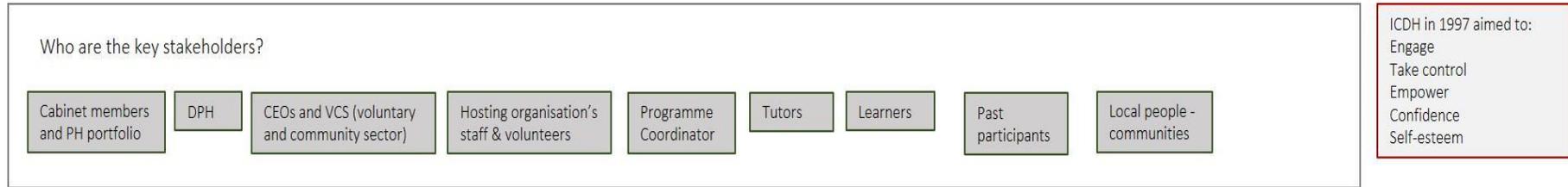
22	Ruth et al (2015) <i>An asset-focused health needs assessment in a rural community in North India.</i> Asia-Pacific journal of public health 27(2)	Training of unmarried women to become LHA and deliver health promotion message with help from doctors; trained other doctors in the use of specific equipment, and created a street theatre on topics of health promotion	RPA, participatory approaches	design a new intervention in a more participatory way	mixed: thematic analysis of interviews and community meetings, medical checks, surveys for the HNA.	new volunteer roles for the women as LHA	local community resources (people)	build upon local assets to develop a tailored intervention, women trained as LHA, doctors gained other new skills, etc..
23	Rutten et al (2009) <i>Assets for policy making in health promotion: overcoming political barriers inhibiting women in difficult life situations to access sport facilities.</i> Social Science and Medicine 69(11)	Asset mapping to identify local assets with the women and involve them in designing an intervention within their neighbourhood to increase PA	Asset model (Morgan and Ziglio 2007; and WHO 2003 "Assets for health and development programme". Framework based on environmental and policy approach to physical activity)	increased physical activity in the women	Mixed. Policy analysis, interviews, observations	low-fee exercise classes were developed, including child care support, women-only indoor pool hours, swimming classes for women-only, offices to organise exercise classes run by the women themselves, and different marketing activities. And new jobs dedicated to fitness at the local council	local community resources	mobilisation of assets to develop a tailored intervention
24	Sardu et al (2012) <i>A bottom-up art event gave birth to a process of community empowerment in an Italian village.</i> Global Health Promotion 19(1)	The process is traced back to 1979 with an art performance that was the entry point for community participation. This experience has been the foundation for the community empowerment.		Advocacy, mediation and communication skills, sense of community and fostered participation and empowerment	Laverak's domain of community empowerment for analysis. Field observation, semi-structured questionnaires, document analysis	Enhanced sense of community was encouraged by the use of arts and have resulted in various things such as: new jobs, development of a park, etc.	individuals and local resources	Work together to develop the play and the following activities
25	Semenza et al (2007) <i>Design of a health-promoting neighborhood intervention.</i> Health Promotion Practice 8(3)	City Repair Projects, in different neighbourhoods, where residents were called together to re-design their own urban space. Minimum 80 % of the residents had to approve the final plan, the ways in which the plan was developed was by creating a core neighbourhood group and organising sessions for people to come along and share ideas and opinions. Fundraising for 1 year prior to re-building could start. Funds needed were not too high as people used recycled material and their own resources	Not specific. It draws on the literature on social capital	strengthen social networks and social capital create a healthy environment	Nº of how many neighbourhoods completed the whole process. In one site, analysis of pre-post reported offences.	Not specified	individuals and local resources	connected to create a new urban environment

26	Sharpe et al (2015) <i>Building capacity in disadvantaged communities: development of the community advocacy and leadership program.</i> Progress in community health partnerships: research, education, and action 9(1)	The Community Advocacy and Leadership Program (CALP) involves eight months training and financial and technical support to create local partnerships.	CBPR	capacity building, increase skills to attract funding in their communities	mean knowledge score, self-assessment on skills, and number of funding application submitted and granted	-	individual personal assets of the participants	Skills are developed through the educational intervention
27	Stead et al (2013) <i>Healthy heroes, magic meals, and a visiting alien: Community-led assets-based social marketing.</i> Social Marketing Quarterly 19(1)	18 months intervention aimed at mobilising local resources to encourage behaviour change through social marketing and community development approaches.	social marketing and community development approaches	engagement in healthy eating and physical activity-based activities.	Mixed: a published book for children, a cook-book, the number of steps taken by different walkers, etc.. results from interviews on how participants felt, etc...	Various. Examples described include: new local relationships, mutual support, collective identity	Local people and volunteers, and local resources which people and business could contribute	base on which the intervention was built. it mobilises local assets to share skills and resources for the common objective.
28	Yeneabat and batterfield (2012) <i>"We Can't Eat a Road:" Asset-Based Community Development and The Gedam Sefer Community Partnership in Ethiopia.</i> Journal of Community Practice 20(1-2)	The Gedam Sefer Community Partnership (GSCP) is a partnership formed between university, local organisations, local people and volunteers from local government. It aimed to develop bottom-up interventions	ABCD	not stated upfront, built together with the community	Not specified, descriptive paper. It used the five building blocks of ABCD to report on the evaluation of the intervention.	new books for the children's library, a summer learn and play school for children, etc...	local resources and people	connected to develop new ideas and implement them

Appendix V: the TOC diagram for the MIHsalud intervention in Valencia



Appendix VI: The TOC diagram for the ICDH intervention in Sheffield



Appendix VII: Risk and mitigation plan

The table below presents the risk and mitigation plan developed before the fieldwork. The overall risk is calculated based on the risk matrix developed by QHSE (2017).

Risk	Likelihood (1=low; 5=high)	Impact (1=low; 5=high)	Overall risk	Mitigation plan
Difficult in access to the field	1	3	low	Familiarisation with the field and negotiation of access has been ongoing in both settings prior to the beginning of the fieldwork. Intervention managers and local NGOs had agreed to support the researcher
Difficulties in recruitment of participants in the communities	3	3	Low-medium	Initial fieldwork will include shadowing of local workers and participants observations of key events. This should allow the community members to familiarise with the researcher and develop a trustworthy relation which should increase the likelihood of them taking part in the research. Additionally, the role of the researcher would be to learn about how they are working, and should prevent participants from feeling under examination and more willing to share their learning
Lack of time or availability to take part in the research	3	1	low	Other participants can be contacted and asked to participate. If the subject is unavailable but not uninterested snowballing technique may be used to ask the subject suggestions of other potential participants
Participants safety in taking part in the research	1	2	low	This is a low risk research and there should be no harm for participants in taking part. However, personal perspectives may be disclosed during group workshops and may contain personal information. The researcher will ensure that issues of confidentiality and anonymity will be discussed at the beginning, during and reiterated at the end of any conversation or group.
Personal safety	1	2	low	Ensure to be in constant contact with local organisations or communicate to local organisations when and where I will be undertaking interviews if not in their premises
Research benefits can be misunderstood and lead to unclear expectations	1	3	low	It will be repeatedly stated that the researcher is interested in learning about how the intervention works and her role is of pure research so that no higher expectations will be generated. This will also be reiterated when inviting participants for interviews or groups.

Appendix VIII: Guideline for the TOC workshop

1. Greetings & introduction [5 mins]

2. OUTCOME MAPPING: [20-25 mins in total]

- [5-10 mins]
- LONG-TERM OUTCOME: What's the main outcome the intervention is aiming to achieve (as for today!)? Has this vision changed since the beginning of the intervention 10 years ago?

Discuss together and agree on what the outcome is - write it on the right side of the blackboard [10 mins]. If outcome has changed, write the old one on top and the second one below

- [10-15 mins]
- MAPPING INTERMEDIATE OUTCOMES: Focusing on the goal today...What changes would you like to see/ what changes need to happen in order to achieve this goal? What are the results the intervention is aiming to achieve? (intermediate outcomes) [like changes in knowledge, behaviour, relationships, etc..]

Ask participants what they think need to be achieved in order to get to that long-term goal. - write these on the blackboard or on post-it

- Ask participants: "are all these intermediate outcomes?" "can some of these be pre-conditions to other?" "Like, if this happens, XX can be achieved..." OR "What needs to happen so that XX can be achieved?"

Map collaboratively what needs to be done to achieve that scenario, in terms of "what needs to happen first to achieve...XX?" .

Map it on the blackboard as a logic diagram

3. intervention ACTIVITIES [5-10 mins]

- List all intervention activities

Write activities in small papers or post-it, so then you can map it on top of the previous diagram

- Has the intervention changed over time in terms of activities?

4. PUTTING IT ALL TOGETHER

Drafting the TOC [10 mins]

- How do the activities contribute to the expected changes/outcomes?

Ask participants to link how each activity is connected to the expected outcomes, and at which level the activity is aiming to make an impact (can be more than one) [*example can be that the training can influence people in their own communities but also transform them in agents of change who can act at health system level, etc..*]

5. DISCUSSION

5a. Discuss the assumptions [15 mins]

- Why and how do you think this activity can lead to this outcome?
- Are there alternative pathways to achieve the expected outcomes?
- What do you think can facilitate or prevent this outcome to happen?

Encourage participants to discuss how they expected the activity-outcome chain to occur and write these assumptions on the draft theory of change

5b. Context and people [10 mins]

- Who are the key actors/stakeholders in your scenario?

List all actors on post-its and then encourage discussion on:

- Of the list of key actors/stakeholders, at which point in the map do they engage with the intervention? How (beneficiaries, delivering the intervention, or else..?)
- Is there any other interaction between these actors beyond the intervention? If so, how do they interact and for which purpose? (through individual actors' initiative, through the intervention, because of policies or recommendations...? Working together, networking, sharing resources or information?)? How were they interacting before and after the

intervention? Would you envision a change in the ways they interact because of the intervention?

5c. Finalise the draft Theory of Change: [5 mins]

- Look at the final TOC diagram
- Does it make sense? Is it coherent?
- Is there anything missing?

6. ASSETS [10-15 MINS]

How would you say that this intervention is adopting an asset-based approach?

What are the assets the intervention is connecting with, or building upon? What kind of relation has the intervention developed with these assets?

Draw a symbol in the draft TOC of what are assets if possible, to make assets recognisable

7. EVALUATION [10 mins]

- What has been achieved so far in relation to the objectives of the intervention?
- What is going well and what is going not so well?
- What were the barriers and facilitators?
- Were there unanticipated outcomes – either positive or negative?
- What are the gaps in the story where more information is needed?

8. CONCLUSIONS [5 mins]

- Summarise the draft TOC
- Thank all participants
- Establish /agree way forward for my research with intervention managers

Appendix IX: Topic guides for the interviews

1.

Draft topic guide for the interview/workshops with current or former learners, or VCS workers

The intervention:

- Could you tell me about your experience with the [name of the intervention]?
- How did you engage with the intervention?
- What is your experience of it? / what do you know about the intervention?
- Whether and how they have continued using things they learnt from the intervention (either information on health services, or skills like delivering workshops)
- Do you know other LHVs in this area
- What do you think would be the role of a LHV?

Perceived changes:

- Could you tell me what, if anything, has changed in your life/in your organisation because of engaging with the [name of the intervention]?
- How has it changed? (examples may include, but are not limited to: workload, type of work, relationship with other organisations or with local administration or with local health professionals?)
- Have you seen any changes also in other people around you?
- And in the neighbourhood?

The neighbourhood:

- Could you tell me a bit more about how the neighbourhood has changed, if it has, over the past few years?

Working in partnership:

- Do you feel you have been able to work in partnerships or networks with other local charities?
- What would you think are the main barrier to that? [if answers is NO, any ideas of why?]

Asset-based approaches

- How did you engage in the process of recognising assets in your neighbourhood?
- How did you engage in making use of those assets?

Perceived impact of the intervention:

- How/What has been the impact of engaging with this intervention?

2.

Draft topic guide for the interview/focus group with health professionals

The neighbourhood:

- could you tell me something about this neighbourhood, like what kind of area it is, what do you know of this neighbourhood and the people that live here.

The intervention:

- Are you familiar with the [name of the intervention]?
- What is your experience of it?
- Whether they knew other LHVs in their area
- What do you think would be the role of a LHV?

Perceived changes:

- Could you tell me what, if anything, has changed in your work/ neighbourhood because of the [name of the intervention]?

Asset-based approaches

- Are you familiar with asset-based approaches to promote health in communities?
- What do you mean/ understand when talking about ABAs to promote health?
- How are asset-based approaches put into practice (in your work or in the health centre)?
- What do you think an asset-based approach can contribute to your work? And to the health and wellbeing of your patients/users?
- How do you feel about ABAs as compared to working more from the traditional deficit perspective?
- How have you incorporated this perspective in your work? What facilitated this incorporation? And what do you feel it was a barrier to it?

Appendix X: Approval Letter Ethics Committee



Downloaded: 29/11/2017
Approved: 29/11/2017

Viola Cassetti
Registration number: 160103955
School of Health and Related Research
Programme: PHD in Public Health

Dear Viola

PROJECT TITLE: Asset-based approaches to promote health and reduce inequalities in neighbourhoods: A qualitative theory-based investigation of two case studies
APPLICATION: Reference Number 016567

On behalf of the University ethics reviewers who reviewed your project, I am pleased to inform you that on 29/11/2017 the above-named project was **approved** on ethics grounds, on the basis that you will adhere to the following documentation that you submitted for ethics review:

- University research ethics application form 016567 (dated 23/11/2017).
- Participant information sheet 1036513 version 3 (23/11/2017).
- Participant consent form 1036366 version 2 (03/11/2017).

If during the course of the project you need to [deviate significantly from the above-approved documentation](#) please inform me since written approval will be required.

Yours sincerely

Jennifer Burr
Ethics Administrator
School of Health and Related Research