

Revitalising the evidence base for public health: an assets model

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Abstract: Historically approaches to the promotion of population health have been based on a deficit model. That is they tend to focus on identifying the problems and needs of populations that require professional resources and high levels of dependence on hospital and welfare services. These deficit models are important and necessary to identify levels of needs and priorities. But they need to be complemented by some other perspectives as they have some drawbacks. Deficit models tend to define communities and individuals in negative terms, disregarding what is positive and works well in particular populations. In contrast 'assets' models tend to accentuate positive capability to identify problems and activate solutions. They focus on promoting salutogenic resources that promote the self esteem and coping abilities of individuals and communities, eventually leading to less dependency on professional services.

Much of the evidence available to policy makers to inform decisions about the most effective approaches to promoting health and to tackling health inequities is based on a deficit model and this may disproportionately lead to policies and practices which disempower the populations and communities who are supposed to benefit from them. An assets approach to health and development embraces a 'salutogenic' notion of health creation and in doing so encourages the full participation of local communities in the health development process.

The asset model presented here aims to revitalise how policy makers, researchers and practitioners think and act to promote a more resourceful approach to tackling health inequities. The model outlines a systematic approach to asset based public health which can provide scientific evidence and best practice on how to maximise the stock of key assets necessary for promoting health. Redressing the balance between the assets and deficit models for evidence based public health could help us to unlock some of the existing barriers to effective action on health inequities. This re-balancing would help in better understanding the factors that influence health and what can be done about them. It would promote a positive and inclusive approach to action. (*Promotion & Education, 2007, Supplement (2): pp.*)

Key words: health assets, salutogenesis, asset mapping, evaluation

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KEY POINTS

- **Redressing the balance between the assets and deficit models for evidence based public health could help unlock some of the existing barriers to effective action on health inequities.**
- **The asset model draws on the theory of salutogenesis to investigate key 'health assets' that support the creation of health rather than the prevention of disease.**
- **Asset mapping supports health professionals build an inventory of the strengths and gifts of the people who make up the community prior to intervening.**
- **The asset model promotes a multi method approach to evaluation using a set of 'salutogenic' indicators to measure the effectiveness of programmes and initiatives aiming to contribute to the reduction in health inequities.**

In an increasing number of countries, politicians, policy makers and practitioners are now convinced at the need to tackle health inequities both between and within countries to ensure that these health inequities are increasingly recognised as a global problem. In 2000, the 189 states of the United Nations reaffirmed their commitment to work toward a world in which eliminating poverty and sustaining development would have the highest priority (WHO, 2003). Nonetheless, whilst there are many examples of National governments developing comprehensive strategies, programmes and initiatives to tackle inequities (DH, 2003; MHSA, 2003; King, 2000), different countries vary in their awareness and commitment to take action (Judge et al., 2006).

Despite the growing number of policy commitments to tackle inequities, overall improvements in health since the 1950s are coupled with persistent differences in health between different social groups. Evidence demonstrates that even in Europe today, there are many examples of systematic differences in health between different social groups and in all European countries most disadvantaged groups have worse health and higher mortality (Whitehead & Dahlgren, 2006). This suggests that some of

the policies and interventions put in place to alleviate these differences are failing some sections of our societies. Moreover in some instances, some of these well intentioned policies may in fact be having some negative unintended consequences. Despite calls for all health policies to be 'equity proofed' (Acheson, 1998; Stahl et al., 2006) many cross government policies are implemented without adequate attention to their impact on health inequities.

Why should this be? Firstly, it is well recognised that the multifaceted causes and solutions required to address the underlying determinants of inequities pose particular problems for policy makers, in that policies need to be long term, require intersectoral collaboration (Exworthy et al., 2003) and continued resources if goals of sustainability are to be reached.

Secondly, whilst there is a wealth of data (Marmot et al., 1991; Wilkinson 1996,) documenting the amount and type of inequities that exist in populations, there is little empirical evidence about the effectiveness of strategies for reducing them (Mackenbach & Bakker, 2002, Whitehead & Dahlgren, 2006). Moreover the evidence that does exist tends to be of a higher general order, describing the types of actions that are required but stopping short of how

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these actions might work for different population groups in different contexts. In addition, the mechanisms giving rise to inequities are still imperfectly understood and evidence remains to be gathered on the effectiveness of interventions to reduce such inequities (Woodward & Kawachi, 2000; WHO, 2005)

Thirdly a lack of attention to follow through well intentioned policies and programmes with sophisticated action plans for implementation, often leads expectations by Governments, professionals and the general public to be undermined. Action plans which don't pay attention to the need for adequate performance management, insufficient integration between policy sectors, and contradictions between health inequities and other policy imperatives may fail (Exworthy et al., 2002).

Fourthly, in the context of this paper we argue that in its quest to improve health and combat disease, public health has focused on gathering evidence about 'what works' from a deficit point of view. That is, there is a tendency to focus on identifying problems and needs of populations that require professional resources and high levels of dependence on hospital and welfare services (Morgan & Ziglio, 2006; Ziglio et al., 2000). This leads to policy development which focuses on the failure of individuals and local communities to avoid disease rather than their potential to create and sustain health and continued development.

Whilst deficit models are important and necessary to identify levels of needs and priorities, they have some drawbacks and need to be complemented by asset perspectives. The asset model presented here aims to redress the balance between evidence derived from the identification of problems to one which accentuates positive capability to jointly identify problems and activate solutions, which promotes the self esteem of individuals and communities leading to less dependency on professional services. The can lead to an increase in the amount and distribution of protective / promoting factors that are assets for individual and community level health. Redressing the balance however does not mean that one approach is better than the other. But in evidence terms at least the asset model may help to further explain the persistence of inequities despite the increased efforts by Government internationally to do something about them.

The asset model described here draws on a number of perspectives to help us more systematically understand the causes and mechanisms of inequities in health and what to do about them by:

- drawing on the theory of salutogenesis to investigate the key factors of 'health

assets', which support the creation of health rather than the prevention of disease.

- applying the concept of asset mapping to help create more effective solutions to implementation working with the existing capabilities and capacities of individuals and communities and building on them.
- employing the use of a new set of asset indicators with multi-method evaluations to assess the effectiveness of community based approaches to tackling health inequities.

What are health assets

The WHO European Office for Investment for Health Development based in Venice, Italy, is using the term "health assets" to mean the resources that individuals and communities have at their disposal, which protect against negative health outcomes and/or promote health status. These assets can be social, financial, physical, environmental or human resources (e.g. education, employment skills, supportive social networks, natural resources, etc.) (Harrison et al., 2004).

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

It is possible to identify health promoting / protecting assets from across all the domains of health determinants including our genetic endowments, social circumstances, environmental conditions, behavioural choices and health services. An inventory of health and development assets would, as a minimum, include:

- At the *individual level*: social competence, resistance skills, commitment to learning, positive values, self esteem and a sense of purpose. For example, with respect to young people an asset approach to health and development could involve prevention activities which focus on protective factors which build resilience to inhibit high-risk behaviours such as substance abuse, violence, and dropping out of school.
- At the *community level*: family and friendship (supportive) networks, intergenerational solidarity, community cohesion, affinity groups (e.g. mutual aid), religious tolerance and harmony. For example, the cohesiveness of a community measured by a set of strong and positive interlocking networks may be seen as a health

asset. In this instance, the asset has the potential to be health promoting irrespective of the levels of disadvantage in that community.

- At the *organisational or institutional level*: environmental resources necessary for promoting physical, mental and social health, employment security and opportunities for voluntary service, safe and pleasant housing, political democracy and participation opportunities, social justice and enhancing equity. For example, health systems across Europe are under utilised instruments for social and economic development. Planners would ask how health services can make best use of their resources (and maximise their assets) to help reduce health inequities by impacting on the wider determinants of health, to build stronger local economies, safeguard the environment and to develop more cohesive communities.

Developing the assets model

Working together, assets based approaches add value to the deficit model by:

- Identifying the range of protective and health promoting factors that act together to support health and well being and the policy options required to build and sustain these factors.
- Promoting the population as a co-producer of health rather than simply a consumer of health care services, thus reducing the demand on scarce resources.
- Strengthening the capacity of individuals and communities to realise their potential for contributing to health development.
- Contributing to more equitable and sustainable social and economic development and hence the goals of other sectors.

In reality, both models are important, however more work needs to be done to redress the balance between the more dominant deficit model and the less well-known (and understood) assets model. The asset model presented here promotes a more systematic approach to understanding the science and practice of an asset approach to health and development. In doing so, it has the potential to create a more robust evidence base that demonstrates why investing in the assets of individuals, communities and organisations can help to reduce the health gap between those most disadvantaged in society and those who achieve best health.

The asset model draws on a number of current and resurgent ideas found in the literature. The first of these is the concept of salutogenesis, coined by Aaron Antonovsky

(1987, 1996) to focus attention on the generation of health as compared to the pathogenesis focus on disease generation. Salutogenesis asks, 'what causes some people to prosper and others to fail or become ill in similar situations?' It emphasizes the success and not the failure of the individual and it searches for the foundations of positive patterns of health rather than the foundation of negative outcomes.

The asset model also incorporates the idea of asset mapping as a way of promoting effective implementation of equity focused policies by taking a positive approach to measuring and diagnosing community capacity to engage in health development activities. Kretzmann & McKnight (1993) describe asset mapping as a process of building an inventory of the strengths and gifts of the people who make up a community prior to intervening. Asset mapping reveals the assets of the entire community and highlights the interconnections among them, which in turn reveals how to access those assets. McKnight (1995) claims that asset mapping is necessary if local people are to find the way toward empowerment and renewal.

The asset model also promotes a multi-disciplinary approach to the evaluation of complex interventions, deriving a new set of 'salutogenic' indicators useful for measuring the effectiveness of these interventions in different contexts.

Figure 1 highlights how the asset model can be utilised to:

- generate a 'salutogenic' evidence base that identifies the most important health promoting and /or protective factors for health and the actions that need to be taken that creates the necessary conditions for health;
- assess how most effectively to implement the actions required to create these conditions for health.
- Develop the most appropriate measures and evaluation frameworks to assess the effectiveness of these actions.

Using salutogenesis to build an evidence base for health

Evidence based public health is now well established and forms an integral part of the decision making process for health development. Much work has already been done to create the scientific base for action (IUHPE, 2000), and a range of methodologies developed to evaluate these actions. The asset model seeks to complement these achievements by building a more systematic approach to collecting and synthesising evidence based on the theory of salutogenesis.

The 'salutogenic' perspective on 'the origin of health' allows us to identify those fac-

tors which keep individuals from moving toward the disease end of the health and illness spectrum (Lindstrom, 2006). It can help us to identify the combination of 'health assets' that are most likely to lead to higher levels of overall health, well being and achievement. Specifically, the concept embraces the need to focus on people's resources and capacity to create health. It argues that the more that individuals understand the world they live in, which is manageable and has meaning, the more they can utilise the resources they have themselves and around them to maintain their own health. Lindstrom (2005) argues that the concept can be applied at an individual, group and societal level.

A 'salutogenic' approach to building an evidence base for public health would include the need to identify those health promoting or protective factors (assets) that are most important in creating health and to understand the implications for action. At its core, salutogenesis asks:

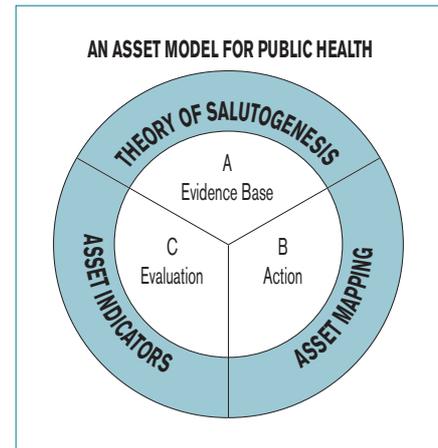
- What external factors contribute to health and development?
- What factors make us more resilient (more able to cope in times of stress)?
- What opens us to more fully experience life?
- What produces overall levels of well being?

Applying this concept to the search for evidence on the determinants of health and the evidence of the most effective actions has the potential to explain further what is required to tackle inequities in health. It also encourages the discipline of modern epidemiology to move towards finding answers to what creates health, rather than its traditional focus of generating evidence about the causes and distribution of disease and early death. The asset model therefore calls for a rethinking of the theoretical basis on which the public health evidence base is built. The key questions for an epidemiology of health would include:

- What are key assets for health and development at each of the key life stages?
- What are the links between these assets and a range of health outcomes?
- How do these assets work in combination to bring about the best health and well being outcomes?
- How may these factors be used to contribute to health inequities?

Of course, there are many examples where this approach to research is already being taken. The assets model aims to encourage a more systematic way of collecting and synthesising this research to ensure that it features in the ongoing practice of evidence based public health which

Figure 1. The asset model.



is still dominated by a positivist biomedical approach to understanding 'what works.'

Notable examples include the work of the ESRC Priority Network (www.ucl.ac.uk/capabilityandresilience) and the Search Institute (<http://www.search-institute.org/>). The ESRC Priority Network (Bartley, 2006) has compiled the most recent evidence on the best ways to promote 'capability and resilience' two concepts used to refer to the ability to react and adapt positively when things go wrong. This research recognizes resilience as an asset because it allows individuals to rise above poor circumstances and succeed either to avoid high risk taking behaviour or to thrive in the face of these circumstances.

The concept of resilience has been identified as an example of an important health asset to support the healthy development of young people particularly those who are growing up in difficult circumstances. Resilient young people possess problem solving skills, social competence and a sense of purpose, which can be utilised as an asset that can help them rebound from setbacks, thrive in the face of poor circumstances, avoid risk-taking behaviour and generally continue on to a productive life.

The Search Institute has developed 40 essential developmental assets for young people, particularly during adolescent years, which foster resilience capabilities and support growing up as healthy, caring and responsible people. Many of the factors associated with resilience in young people relate to the social context within which they live.

Assets in action

The Acheson Report on Inequalities in Health (Acheson 1998) recognized that the solutions to major public health problems such as heart disease, cancers, mental health and accidents are complex. These problems require interventions, which cut across sectors to take account the broader

social, cultural, economic, political and physical environments which shape people's experiences of health and well-being.

Some evidence exists to demonstrate that communities which are more cohesive, characterized by strong social bonds and ties are more likely to maintain and sustain health even in the face of disadvantage (Putnam, 1993; Kawachi, 1997).

The cohesiveness of a community measured by a set of strong and positive interlocking networks and their positive impact on wellbeing may be seen as a health asset. In this instance, the asset has the potential to be health promoting irrespective of the levels of disadvantage in that community.

Supporting the development of strong cohesive communities is now commonplace in many government strategies to tackle health inequities and most people working with local populations realise that good community capacity is a necessary condition for the development, implementation and maintenance of effective interventions (Morgan & Popay, 2007). However, Jordan (1998) argues that whilst the nature and extent of public involvement in determining the most appropriate ways of developing health has increased, the quality of consultation remains questionable. One reason for this is that policy makers under heavy pressure to achieve very specific national policy targets may feel that the involvement of the community is time consuming and that they can suffer a loss of control. This can lead to community involvement activities becoming tokenistic and separated from the main decision making processes of professionals.

Another problem associated with poor community involvement is that professionals tend to define communities by their deficiencies and needs. These needs are often translated into deficiency-orientated policies and programmes which rightly identify the problems and try to address them. A possible downside to this approach is highlighted by Kretzmann and McKnight (1993), who claim from their work with communities that many low-income urban neighbourhoods have become environments of service where behaviours are affected because residents come to believe that their well-being depends upon being a client. They therefore suggest that rather than focus on deficits an alternative approach would be to develop policies and activities based on the assets, capabilities and the skills of people and their neighbourhoods.

Learning how to ask what communities have to offer begins a process of building and developing local capacities for creating health. It brings knowledge, skills, and capacities out into the open, where they

can work together to everyone's benefit. As the web of assets grows, so does the potential for the community to work with professionals as co-producers of health which can also contribute to a sense of belonging and more cohesive communities.

Community asset mapping processes as outlined by Kretzmann and McKnight help to initiate a process that fully mobilizes communities to use their assets around a vision and a plan to solve their own problems. They illustrate the differences between the traditional approach to assessing need and the assets approach, which identifies the following distinct categorisations for asset identification:

- *Primary building blocks*: assets and capacities located inside the neighbourhood and largely under neighbourhood control (e.g. skills, talents and experience of residents, citizen associations etc).
- *Secondary building blocks*: assets located within the community but largely controlled by outsiders (physical resources such as vacant land, energy and waste resources; public institutions and services).
- *Potential building blocks*: resources originating outside the neighbourhood outside the neighbourhood controlled by outsiders (e.g. public capital improvement expenditures).

Guy et al. (2002) promote asset mapping as a positive, realistic (starting with what the community has), and inclusive approach to building the strengths of local communities towards health improvements for all. Assets maps provide a starting point for taking action in a way which builds trust between professionals and local communities.

Asset mapping is therefore a key step in the process of implementing well intentioned policies aiming to tackle health inequities. Good health needs assessment should provide a means of identifying the health assets and needs of a given population to inform decisions about service delivery. Combined with more traditional ways of measuring need, asset mapping can provide health promoters with an understanding of how best to create the conditions required to maximise the potential for health.

Asset mapping also helps us to conceptualise what is 'salutogenic', health enhancing in the contexts of people's physical, emotional, economic and cultural environments. In doing so, it begins the process of identifying the most appropriate 'asset indicators' to be used in the evaluation of strategies aiming to create the conditions for health.

Assets and evaluation

The assets model encourages the use of a new set of indicators to evaluate those programmes and initiatives that are developed to promote health and the reduction of health inequities, as defined in this article. Work is already under way to classify a set of 'salutogenic' indicators that can be used for this purpose (Bauer et al., 2006). The development of these indicators is the first step in producing a revitalised evidence base developed through an assets approach to health and development.

The next perhaps more challenging step is to find appropriate methods and means of evaluating these programmes to help demonstrate the value in investing in the assets based approach. Some of this evidence already exists however as Hunter and Killoran (2004) note, much of the relevant evidence base available to provide answers on the best way of tackling inequities does not match the traditional requirements in evidence based medicine. Evidence arising from a 'salutogenic' approach to health and development probably lies in this domain.

Savedoff et al. (2006) argue that this evaluation gap has arisen because governments and official donors do not demand or produce enough impact evaluations, which aim to tell us the types of social interventions that succeed, and those which are commissioned, are often methodologically flawed.

In addition, whilst there is much rhetoric in policy and research about the need to employ a multidisciplinary approach to finding evidence about the social determinants of health, the positivist model of synthesising evidence in the main part remains in the biomedical tradition.

The assets model uses an evaluation framework that follows the general shifts in policy thinking over the last few years which have refocused interventions:

- From a disease prevention model targeting morbidity and mortality to a more positive approach targeting general health and wellbeing.
- From a model of single disease causality to a multiple dynamic model of health and its determinants.
- From individual style interventions to more community based and system level interventions.
- From the notion of passive recipients of health programmes to a more active public participation movement in health.

The asset model approach to evaluation endorses the framework put forward by Wimbrush and Watson (2000) which demonstrates that there are many stages and forms of evaluation which contribute to the devel-

opment of effective interventions. They call for a more explicit expression of the types of questions that need answering, for whom and for what purpose. Focusing evaluations on outcomes and effectiveness may meet the information needs of strategic planners but often fall short of answering questions for stakeholders involved in other parts of the implementation chain. In addition, as Koelen et al. (2001) argue, 'methods of research have to be determined, among others by the purpose of the study the context and the setting, the theoretical perspectives, the applicability of the measurement tools and the input of community participants.'

More emphasis on evaluation that helps us to understand the mechanisms of change and the underpinning theories upon which programmes are based may help us to overcome the evaluation gap on how best to tackle health inequities. Pawson and Tilley's (1997) notion of realistic evaluation is helpful as it promotes theory driven evaluations which help to capture the linkages between the context (the necessary conditions for an intervention to trigger mechanisms), mechanisms (what is it about a particular intervention that leads to a particular outcome in a given context) and outcomes (the practical effects produced by causal mechanisms being triggered in a given context).

The values of the asset model fit comfortably with these approaches to evaluation. Its framework for evaluation incorporates an analysis of different stakeholder perspectives, in particular, the voices of local communities in the evaluation process, and addresses the need to ask questions not only about what works, but for whom and in what circumstances. In doing so, it draws on a range of approaches and methods to produce a single coherent model for assessing the effectiveness of 'salutogenic' approaches to health and development.

The asset model evaluation framework also answers the call by Hunter and Killoren (2004) for interventions to reflect theoretical approaches to understanding social and environmental sources of structural inequities. As many of the important assets for health and development lie within these domains, it promotes the need to answer questions of how these factors interrelate, how they are mediated and how they are constructed over an individual life history.

The asset model encourages the art of systematic reviewing to pay more attention to how different kinds of evidence can be brought together to help with the task of piecing together and evidence jigsaw (Whitehead et al., 2004). Such a "jigsaw" would encompass different types of evi-

dence – for example, evidence about the potential effectiveness of policies (from experimental, quasi-experimental, and observational studies); evidence on the diagnosis and/or causes of problems that could contribute to the development of appropriate interventions/programmes; evidence on costs and cost-effectiveness.

Essentially, it may therefore not be a lack of evidence that is necessarily the problem, but the ways in which we conceptualise issues and where we look to find the evidence. Judd et al. (2001) advocate a shift away from a pathogenic risk factor and outcomes-orientated perspective of evaluation towards a more balanced menu of possible targets for change and accompanying standards for defining success. They argue that this is not at odds with standards that are systematic and supportive of accountability. A more 'salutogenic' approach to evaluation will allow the process and outcomes of community based evaluations to be relevant to community stakeholders, policy makers and funders.

The asset model has the possibility to help to reconstruct better evaluation frameworks because:

- It seeks to understand the combination of factors required to effect population health.
- It majors on the need to employ community based approaches to health development and in so doing recognises that evaluations should articulate process, impact and experience.

Conclusions

The values and principles of the assets model reflect those originally articulated in the Ottawa Charter (WHO, 1986). In particular, it emphasises the need to strengthen local communities – the model through asset mapping promotes the process of community empowerment to encourage 'their ownership and control of their own endeavours and destinies' (McKnight, 1995). It also supports the development of personal skills through its 'salutogenic' approach to health development. It creates supportive environments by helping to identify the key assets which generate living and working conditions that are safe, stimulating, satisfying and enjoyable.

Many of the key assets required for creating the conditions for health lie within the social context of people's lives and therefore it has the potential to contribute to reducing health inequities.

It has the potential to revitalise the evidence-base for public health by helping politicians, policy makers, researchers and practitioners rethink how to conceptualise the concept of health to:

- Raise the self esteem and resourcefulness of individuals to improve and sustain their own health.
- Provide mechanisms to ensure that all policies and programmes aimed at tackling health inequities take account of the positive attributes already existing in individuals and communities.
- Improve the efficiency of organisations to contribute to the overall wellbeing of the communities they serve.

The asset model presented here aims to revitalise how policy makers, researchers and practitioners think and act to promote a more resourceful approach to tackling health inequities. The model outlines a systematic approach to asset-based public health which can provide scientific evidence and best practice on how to maximise the stock of key assets necessary for promoting health.

In research terms, this evidence-base needs to articulate what the most important assets are for health and development and how policy and practice can support individuals, communities and organisations to utilise them for health and development. Research is also required to convince policy makers of the economic benefits of investing in the positive-centred asset approach. The evidence-base also needs to be drawn from the practical experiences of the people working most closely with communities to understand how these assets can be released in real life settings. If it does this, it has the potential to strengthen the evidence-base for public health, which, to date, has been dominated by deficit models of health.

Redressing the balance between the assets and deficit models for evidence-based public health could help us to unlock some of the existing barriers to effective action on health inequities. This re-balancing would help in better understanding the factors that influence health and what can be done about them. It hence promotes a positive and inclusive approach to action.

Given the increasing global context for health, the model also provides an opportunity for innovation and collaboration at an international level so that we can galvanise efforts to revisit existing evidence with an assets frame of reference, and to collect new data that tells how to maximise the stock of health and development assets, both within and across countries, to help to sustain health for all now and in the future.

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