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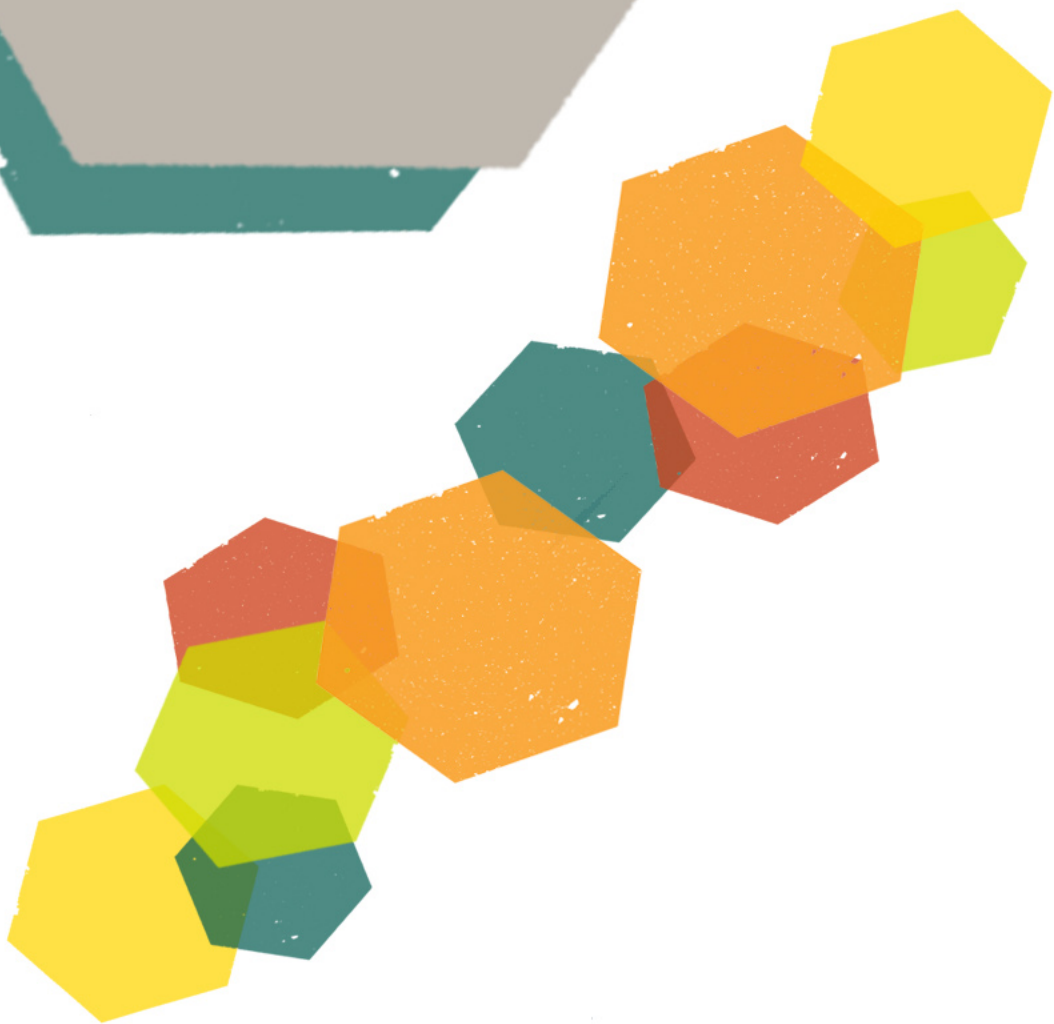
Control and health inequalities:

A review of theory and evidence for practitioners



Control and health inequalities

A review of theory and evidence for practitioners

This report, developed by one of People's Health Trust's learning partners, the New Economics Foundation (NEF), is a literature review of the evidence base around the relationship between collective control and health inequalities.

Summary

Control is an issue that features increasingly in the work of local activists, community-based organisations and professionals in health and local government. It is thought that when people have more control over decisions and actions that affect their lives, they have a better chance of improving and maintaining their health. There is a growing body of evidence to support the view that collective control, exercised by people in groups, has similar potential. This suggests that enabling people in disadvantaged areas to come together to gain more control could help to reduce inequalities in health.

But what does control mean and what does it consist of? How is it linked with health and health inequalities? What can be done to enhance control and what evidence supports links between greater control and better health?

This paper draws together theory and evidence to begin to address these questions. It was initially developed to underpin an evaluation of People's Health Trust's grant funding programmes, and is intended as a resource for communities, community organisations, local authorities, health authorities and others working to build control to improve health at a local level. It cannot answer every question thoroughly, because there is insufficient evidence, but it offers a starting point on which further research can be built.

The main focus of the paper is collective control.

What does control mean?

Without power, you cannot exercise control. 'Power' describes the ability to carry out a desired goal despite resistance, while 'control' means exercising or constraining power over someone or something. Control is complex and operates at multiple levels and in different ways: individual and collective, direct and indirect, actual and perceived. These interact with each other and can be mutually reinforcing, in either positive or negative directions.

The idea of collective control is closely associated with (although not the same as) engaging and empowering people at neighbourhood level.

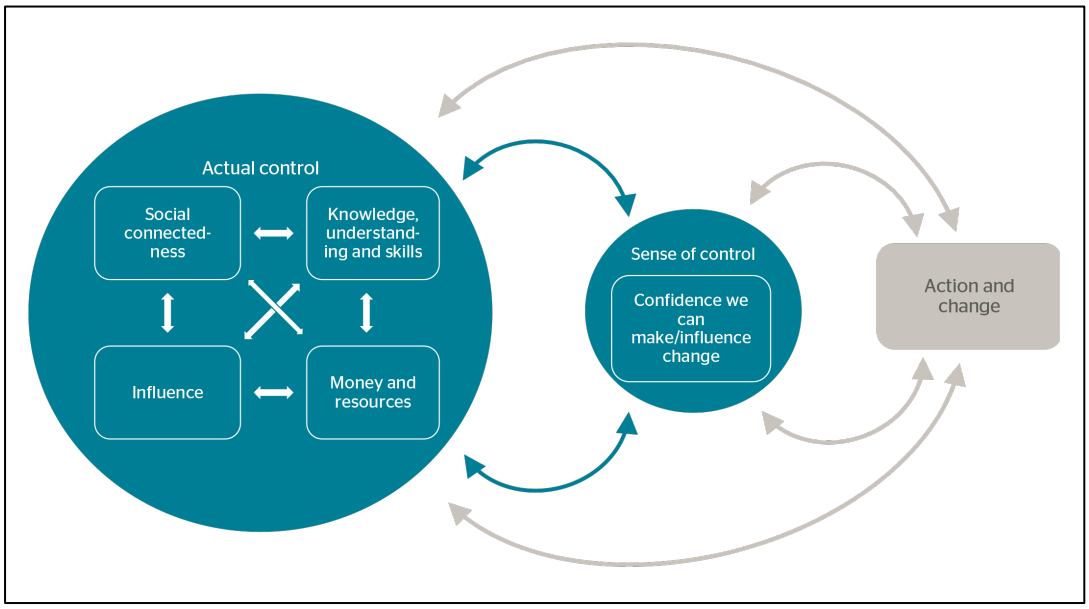
What does control consist of?

Control can be understood in terms of *capabilities, critical awareness* and *agency,* or a blend of all these. It is generated when people have the resources and capacity that enable them to lead the kind of life they value, and to do this at a communal level by acting together. It depends on people sharing knowledge about barriers and opportunities, consciously deciding to address them and then taking action to change things. Social structures influence – and are influenced by – the extent to which people are able to act.

Certain factors can help to generate control, as the diagram below suggests. This represents a theoretical model, based on available evidence, which is being tested through NEF's current research. It suggests that people must be *socially connected* with others who live in their locality, with whom they can build a sense of belonging and trust, mutual support and solidarity. They need *knowledge, understanding and skills,* so that they become aware of local conditions, power structures and possible routes to change. They must have *resources*, such as access to money and other assets including places to meet and time to get involved in action and influencing activities. Local organisations must be able to exert *influence*, by engaging, co-producing and co-operating with local residents to create a platform for local residents' views to be heeded as well as heard, and respected by those in power. And they must have *confidence* that together they can make or influence changes they want.

All these factors interact dynamically. The *experiences* of actual control interact with *feelings* of being in control and the two can strengthen each other. Likewise, collective and individual control overlap and can be mutually reinforcing. Conversely, where positive changes do not happen, any sense of control can drain away.

Figure 1: Dynamic model of control



Source: People's Health Trust ©

How is control linked with health and health inequalities?

There is a growing body of evidence linking control with health and health inequalities. The *Whitehall studies* (1967 and 1988) found that people who experienced low levels of control at work had higher rates of physical and mental illness. The World Health Organization's Commission on the Social Determinants of Health (2006) found that 'the unequal distribution of power, income, goods, and services determine health inequalities' (p.1) and emphasised the importance of inclusion, agency and control for social development, health and wellbeing.

Fair Society, Healthy Lives (2010), known as 'the Marmot Review', confirms these findings. It maintains that inequalities in health reflect the conditions in which people are 'born, grow, live, work and age', and if these are 'favourable, and more equitably distributed, then they will have more control over their lives in ways that will influence their own health and health behaviours, and those of their families' (p.18).

Control can be understood as both a *mechanism of change* and a *determinant of health*. When people have more control over decisions and actions that affect their lives, they can not only influence a range of social and economic factors that affect their health but also reduce risks to their health arising from a lack of control. Together, they can create a 'virtuous cycle' of increasing control and improving health.

However, the picture is not a simple one. Increased control can challenge powerlessness and exclusion, which can otherwise exacerbate structural inequalities. But this will only happen if control as a mechanism of change is adequately supported by health systems, resources and policies at all levels. Similarly, the 'virtuous cycle' is influenced by the structures and systems that shape the conditions in which people live.

What can be done to enhance control?

Collective control can be developed where people who share their neighbourhood and/or interests are able to get together to shape decisions and actions that affect their wellbeing and future prospects. It may be built up through efforts to engage and empower people locally, but it does not necessarily follow.

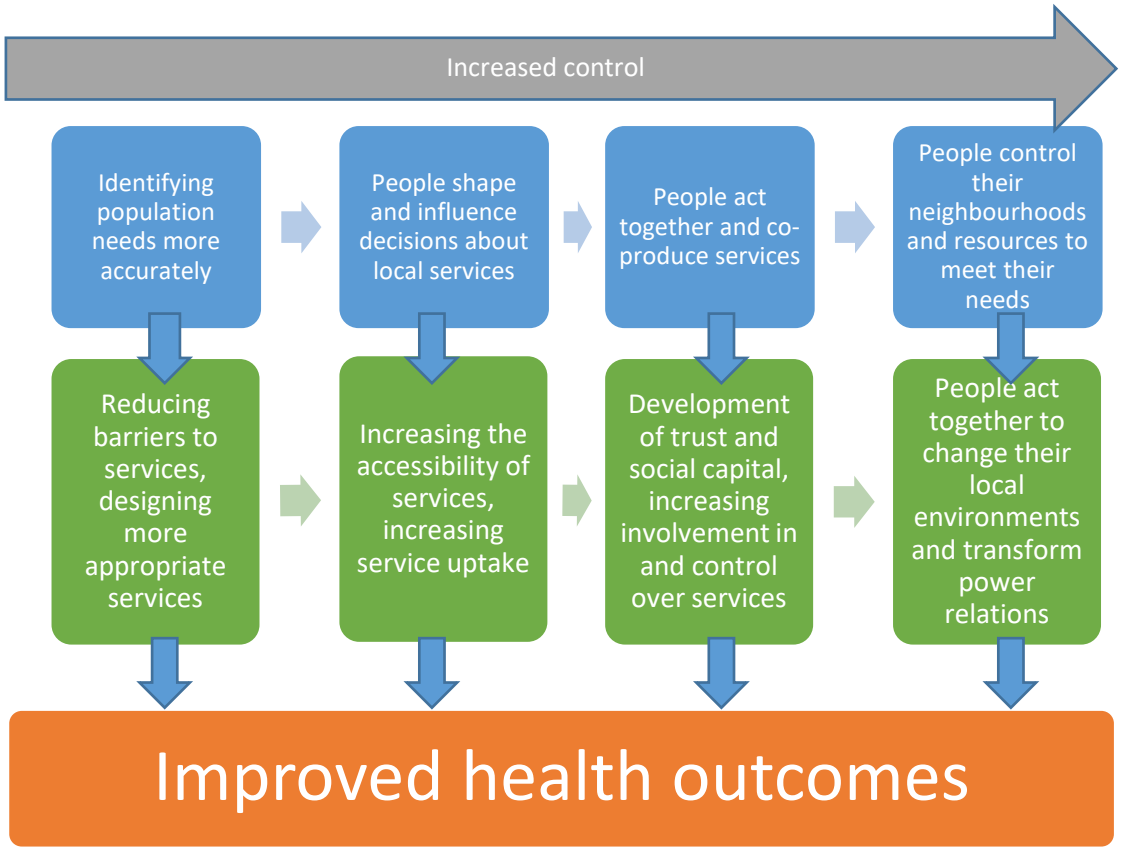
Much depends on how people are engaged in decisions and actions that matter to them, and on the surrounding context. Methods of engagement are more likely to be effective if they value and build on local assets, enable neighbourhoods to act on their own behalf and reach out to those who are otherwise marginalised and excluded. They are more likely to help generate control where there are supportive local organisations, relationships and resources.

There is no single, ideal method for effectively engaging groups of people and enabling them to take control. Instead, it should be possible to choose from a basket of interventions and to combine and blend them according to the needs of a neighbourhood. This would include different ways of strengthening networks, promoting individual activities, building partnerships and making the most of all available resources.

Pathways between greater collective control and improved health can be direct and indirect, for example, by reducing exposure to environmental health threats or by building social networks that combat social isolation and distress. At the neighbourhood level, this could involve a local group taking control by actively engaging in services and shaping them in a way that improves their accessibility or efficacy. This pathway can lead to both improved health outcomes and greater levels of trust and social capital. These pathways are non-linear, as can be seen in Figure 2 below. Another way that increased collective control could lead to social change is by advocating and organising to challenge or transform power relationships. The pathways between such an action and improved health may be bidirectional. An example of this is where the transformation of power relationships leads to changes in the neighbourhood that shape a variety of health determinants with improved health outcomes for the local population as a whole. It is worth noting however, that this will depend on systems of support well beyond the

neighbourhood, ranging, for example, from nationally supportive welfare systems to public policies to provide adequate resources for community organisations.

Figure 2: Collective pathways to improved health outcomes



What evidence supports these pathways?

There is strong evidence linking enhanced individual control to better health at the individual level, but less that links control at a collective or community level to health. There has been far less research in this area. High-ranking methods in the traditional 'hierarchy of evidence' do not lend themselves easily to evaluating neighbourhood-level interventions: these take place in complex, non-linear systems where interactive relationships play a pivotal role, where outcomes are often experienced indirectly and over long periods of time, and where links between cause and effect are hard to trace.

Nevertheless, there is some evidence linking collective control to outcomes for individuals, for groups and for services.

For individuals. Active engagement in local initiatives can bolster self-confidence and self-esteem, which can help people to exert some influence over things that matter to them; this can be a step towards gaining a sense of control. However, where people experience successive waves of engagement without positive results, a more likely outcome is exhaustion and frustration. This calls for interventions that are highly responsive to participating individuals and that enable them to develop a sense of control over the long term.

For groups. The process of building social networks and enhancing 'bonding' and 'bridging' social capital can improve health outcomes by increasing mutual trust and understanding between different population groups, allowing groups to take control to shape their neighbourhoods and develop their communities. This can also build individual-level outcomes, by buffering stress, encouraging healthy behaviours and contributing to a sense of meaning and purpose in life.

For services. Initiatives to increase collective control can improve access to services, enable communities to shape services according to their needs, and improve how people perceive their neighbourhood (which in turn impacts on services). Community participation can improve information flows and build knowledge about health and health services. However, the shortage of research findings means there is not yet any conclusive evidence of direct impacts of collective control on service delivery.

How can the impacts of enhanced control on health be measured?

The main problem with trying to trace causal links between collective control and health is the paucity of research in this area and methodological challenges presented by complex, community-based programmes and systems. We present some of the methodological challenges we have identified in measuring control here, to help create a common base for health workers, individuals and academics working in this area to develop a body of evidence linking control to health.

Potentially useful approaches drawn from relevant evaluations include:

- indicators for community cohesion, which measure the proportion of respondents who believe that people from different backgrounds get on well together in their local area, who feel that they belong to their neighbourhood, and who have meaningful interactions;
- a conceptual framework of empowerment, which considers capability, deciding, and achieving;
- measures of whether residents feel that they can create change or participate locally;
- measures of wellbeing in terms of a sense of self, support, and structure and systems;
- measures of social integration, including perceptions of trust, experiences of discrimination and fear of crime to represent social outcomes;
- shared definitions of 'control', 'neighbourhood' and 'community'.

There are opportunities to build on indicators such as these. Equally important is to develop a shared understanding of the complex meanings and dimensions of community, and of neighbourhood-level interventions and actions among those participating in, designing and evaluating community interventions.

Conclusion

Collective control is a complex concept. Pathways linking control to health and health inequalities are non-linear. There is a shortage of longitudinal data; measuring change at neighbourhood level presents multiple methodological challenges. The challenge now is to bring greater depth, clarity and cohesion to the following areas: measuring control; evaluating complex pathways; establishing causality; collecting longitudinal data on neighbourhood-level change; and tracing outcomes in non-linear systems.

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Introduction

When people have more control over decisions and actions that affect their lives, they have a better chance of improving and maintaining their health. Enabling people in disadvantaged communities to come together and to gain more control could help to reduce inequalities in health that currently exist between lower and higher income groups. These assumptions are based on a growing body of theory and evidence. Increasingly, they influence practical work by the New Economics Foundation (NEF) and other organisations committed to improving wellbeing and social justice.

This paper is intended as a resource for people working in local communities. It draws on findings from academic research and practical experience to address the following questions. What does control mean? What does it consist of? How is control linked with health and health inequalities? What can be done to enhance control? Through what pathways is enhanced collective control thought to lead to better health? What evidence supports this? And how can efforts to increase control be measured? The main focus of this paper is on collective control and community-level health.

Methods

The academic literature in this paper is drawn from a scoping review on health and collective control conducted by NEF in 2017. The methodological approach of the review included: forwards and backwards citation searches based on an earlier NEF review in 2015, forwards and backwards citation searching for papers identified in keyword searches, hand searches of prominent journals in the field and citation searches of key authors in the field. A detailed summary of search terms used and papers identified through key authors can be found in the appendix.

1. What does 'control' mean?

The terms 'power' and 'control' are sometimes used interchangeably, and both have multiple definitions. For the purpose of this review, we take 'power' to mean the ability to carry out a desired goal despite resistance and 'control' to mean exercising or constraining power over someone or something. Unsurprisingly, control is complex. It operates at multiple levels and in different ways: individual and collective, direct and indirect.

Terms that are used to describe individual control include: autonomy; control over one's destiny; ontological security; a sense of coherence; and power to exert one's influence to affect change. Collective control has been described in terms of community empowerment, cultural continuity, collective efficacy, power with (rather than over) others, and a range of interacting factors including community capacity and competence, social cohesion, social capital, and collective efficacy (Whitehead *et al*. 2016, p.53).

More specifically, individual 'empowerment' (a term often used interchangeably with 'control') has been defined as 'an individual's ability to make decisions and have control over his or her personal life' and is seen to be 'similar to other constructs such as self-efficacy and self-esteem... in its emphasis on the development of a positive self-concept or personal competence' (Israel *et al*. 1994, p.152). Community 'empowerment' has been defined as individuals and organizations applying 'their skills and resources in collective efforts to meet their respective needs' (Ibid, p.153).

Beyond this, control can be understood, broadly, in terms of a) personal control, b) social control and c) collective control. Accordingly, personal control is drawn from an individual's social position and the extent to which they have resources available to control their destiny. Social control focuses on macro level socio-political transitions and the extent to which cultural orientations towards particular groups influence the level of control they hold within society (Whitehead et al., 2016, p.54). In contrast, collective control can operate within different power relations, which in turn require different types of support. For example, people need supportive organisational structures and arrangements in order to come together; they need skills, confidence and critical awareness at group level in order to take action together; and they need links and alliances with other groups and organisations who share their goals and interests (IBID). The different levels and settings of control, interact with each other and can be mutually reinforcing, in either positive or negative directions.

Concepts such as control, empowerment and engagement are contested – as are the concepts of community, neighbourhood and place. The range of terms used within public health literature speaks to their theoretical complexity as well how they can sometimes overlap and complement each other. In this review, we focus on collective control and health inequalities, with a view to understanding community or meso level outcomes of control. Due to the current paucity of evidence linking control and health we often draw on examples – with discussions and clarifications – that link community engagement or empowerment to health.

Collective control and communities

This paper is focused mainly on collective control, to reflect a major component of NEF's work, which is to help create conditions that enable people in disadvantaged neighbourhoods to get together and gain more control over their lives and circumstances. In order to understand what constitutes collective control and how it is generated, it is necessary to consider conceptions of community, as well as debates about community-level engagement and empowerment.

The concept of 'community' encompasses many different aspects of life and is often 'understood as an entity that is more than the sum of its parts' (Atkinson et al., 2017, p.14). Community life can take place in a broad range of settings and any one person can be a member of a wide range of communities of which all, none, or some may intersect (Ibid, p.27).

It has been broadly defined as '"being together" (or a more or less convivial association) – a state of being or practices in which people are linked together in some way' (Somerville, 2016, p.4). However, critics point out that simply "being together" may be insufficient to constitute a community: attention should be paid to the quality of relationships between those who are together and to their collective wellbeing. Community wellbeing is said to be 'about strong networks of relationships and support between people in a community, both in close relationships and friendships, and between neighbours and acquaintances' (Community Wellbeing Evidence Programme, 2015).

Communities and community-level empowerment

There is an increasing focus in the health literature on fostering collective control at the community level. There are 'many different ways of describing activities that broadly speaking are focused on enabling communities (defined in terms of place of residence or shared interest) to have greater control over decisions that affect their lives' (Popay, in

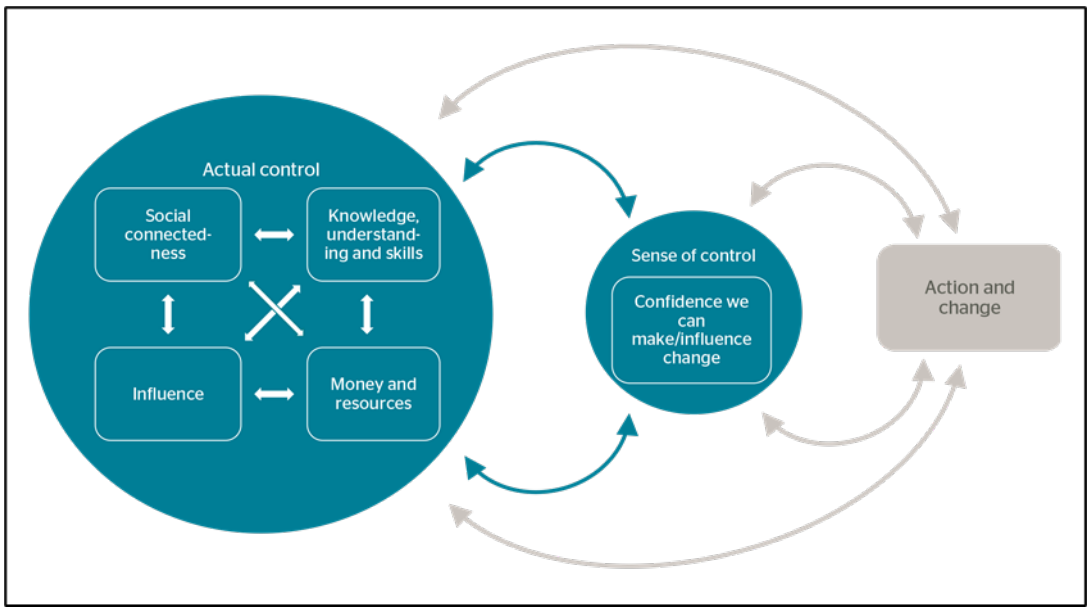
Morgan et al., 2010, p.184). Terms commonly used include development, participation, empowerment, involvement and engagement, the latter often a catchall for the rest (O'Mara-Eves, 2013). In the health promotion literature, these terms convey a proliferation of meanings and forms of intervention, many with widely divergent political ends (Morgan, 2001, p.222). None of these terms can be taken as a proxy for control, although they may contribute to the process of people in communities exercising control.

2. What does control consist of?

A number of theoretical models have been developed to describe the components of control. Drawing on a range of overlapping theoretical perspectives, control can be understood in terms of *capabilities, critical awareness and agency*. Control is generated when people have the resources and capacity that enable them to lead the kind of life they have reason to value, and to do this at a communal level by acting together (Sen, 1999 in Papaioannou, 2016, p.306). At the same time, it is important that people build and share critical awareness about the barriers and opportunities they face, and consciously determine to address them in a way that empowers and emancipates (Friere, 1993; Woodall, 2012, p. 743). When people have the necessary capabilities, consciousness and intent, they must be able to 'enact a process that drives change', whether directly or indirectly (Ling and Dale, 2016, p.4). Such agency both influences and is influenced by social structures (Bhaksar in Harvey, 2002).

The New Economics Foundation has developed a dynamic model of control, building on the definitions and theories outlined above. The model is primarily concerned with collective control, although it is recognised that individual and collective control are not discrete but overlapping and in some cases, mutually reinforcing.

Figure 1: Dynamic model of control



Source: People's Health Trust ©, Evaluating Local Conversations 2016 (2016).

In this model, collective control comprises a range of interacting components. In order to exert control, people must be *socially connected* with others who live in their locality, with whom they can build a sense of belonging and trust, mutual support and solidarity.

They need *knowledge, understanding* and *skills,* so that they become aware of local conditions and their underlying causes, of local power structures, possible routes to change and how to take effective action. They must have *resources*, such as access to money and other assets including places to meet. They must be able to exert *influence*, to have their views heeded as well as heard, and respected by those in positions of power. And they must have *confidence* that together they can make or influence changes that they consider desirable.

These components of control interact dynamically, as Figure 1 indicates. The *experiences* of actual control interact with *feelings* of being in control and the two can reinforce each other. Where a group achieves positive changes, this can not only improve local conditions, but also strengthen the components of control and increase the sense of being able to effect change. Conversely, where positive change doesn't happen, any sense of control can drain way as disappointment and cynicism set in.

3. How is control linked with health and health inequalities?

Over the past 30-40 years, a strong and clear evidence base linking individual control with health and health inequalities has emerged.

Notably, the Whitehall studies, conducted between 1967 and 1988, investigated the social determinants of health among civil servants in the UK. A key finding was that people who experienced low levels of control at work 'had higher rates of sickness absence, of mental illness, of heart disease and pain in the lower back' (Marmot in Bell et al., 2004, p. 8). The second study, Whitehall II, found that levels of control in the home helped to predict coronary heart disease among women but not among men (Chandola et al., 2004), as well as depression and anxiety among both men and women (Griffin et al., 2002). Another study found that increased control can improve well-being, specifically in relation to understanding one's own life and responding to the social conditions that one experiences (Elzer and Jayawickreme, 2015 p.655).

The concept of control was acknowledged as a factor that influenced health by the 1986 Ottawa Charter on Public Health, which was an early expression of the social (as opposed to the medical) model of health. The Charter described health promotion as 'enabling people to increase control over, and to improve, their health' and argued that individuals and groups must be able 'to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment' (Ottawa Charter, 1986). A 2002 WHO report on community participation in local health then acknowledged that there is no consistent use of the terms engagement, control, involvement and empowerment. The report notes 'the quantity of terms and the lack of precision with which they are employed can cause confusion' (WHO, 2002, p.10). This remains a confounding factor for conceptualising control and health, because terms are often blended or conflated in the literature.

The Commission on the Social Determinants of Health (CSDH), sponsored by the World Health Organisation, built on the concepts of enablement and control set out in both the Ottawa Charter and the 2002 report. It argued that the unequal distribution of power, income, goods, and services determine health inequalities (CSDH, 2008, p.1). The

Commission's report, which was based on an exhaustive review of international evidence, called for improvements in built environments, working conditions and social protections in order to achieve better health for all and reduce health inequalities within and between countries across the world. The report argued that built environments are key to fostering community spirit and improved health (Ibid, p.68). This drew on an Urban Settings Knowledge Network report that argued: participatory urban governance is necessary to 'enable communities and local government to partner in building healthier and safer cities' (KNUS, 2007). Based on this the CSDH noted that despite the evidence supporting the importance of community participation in improving built environments, 'the resources and control over decision making processers often remain beyond the reach of people normally excluded at the local and community level' (CSDH, p.63). Underlying this, then, is the idea that although control is linked to health, it cannot be achieved unless supported by local and national governments who ought to contribute to and support the development of local infrastructures and urban environments (IBID). If people are to take control in order to improve their health, being empowered is not enough: they also require adequate social protections and resources. The CSDH argued that 'while it is critical that community members share control over processes that affect their lives, without political commitment and leadership and allocation of resources such initiatives can be short lived'.

Based on this, the report emphasised that greater control was to be achieved not just through state intervention, but also through political empowerment, inclusion and voice. Following Sen's capability approach, the Commission emphasised the importance of inclusion, agency and control for social development, health and wellbeing (CSDH, 2008).

Similarly, Wilkinson and Marmot argue: 'continuing anxiety, insecurity, low self-esteem, social isolation and lack of control over work and home life, have powerful effects on health. Such psychosocial risks accumulate during life and increase the chances of poor mental health and premature death. Long periods of anxiety and insecurity and the lack of supportive friendships are damaging in whatever area of life they arise. The lower people are in the social hierarchy of industrialized countries, the more common these problems become' (Wilkinson and Marmot, 2003, p.12).

In 2008, the UK Secretary of State for Health asked Michael Marmot, who had chaired the CSDH, to conduct an independent review into strategies for reducing health inequalities in England. This culminated in a report called *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post-2010* ('the Marmot Review'), which is frequently the starting point for discussions of health determinants and inequalities in the UK. It confirms and strengthens many of the points raised in the CSDH Report.

A key finding of the Marmot Review is that the social determinants impact on health across the social gradient. People in the middle bear greater health risks than those at the top, while those at the bottom bear greater risks than those in the middle and much greater risks than those at the top - and so forth. To reduce health inequalities it is therefore necessary not simply to tackle poverty, but to level out the social gradient and build a more equal society (Marmot, 2010, p.37).

The Marmot Review confirms findings from earlier research that inequalities in health reflect the conditions in which people are 'born, grow, live, work and age', and if these are 'favourable, and more equitably distributed, then they will have more control over their lives in ways that will influence their own health and health behaviours, and those of their families' (Ibid, p.18). Participation and community engagement play a key role in enabling this to happen: unless they are 'fostered by public service organisations, it will be difficult to provide the penetration of interventions needed to impact on health inequalities'. Accordingly, it is argued, 'political, civic and public service leadership' will need to create conditions that 'enable individuals and communities to take control of their own lives' (Ibid, p. 151).

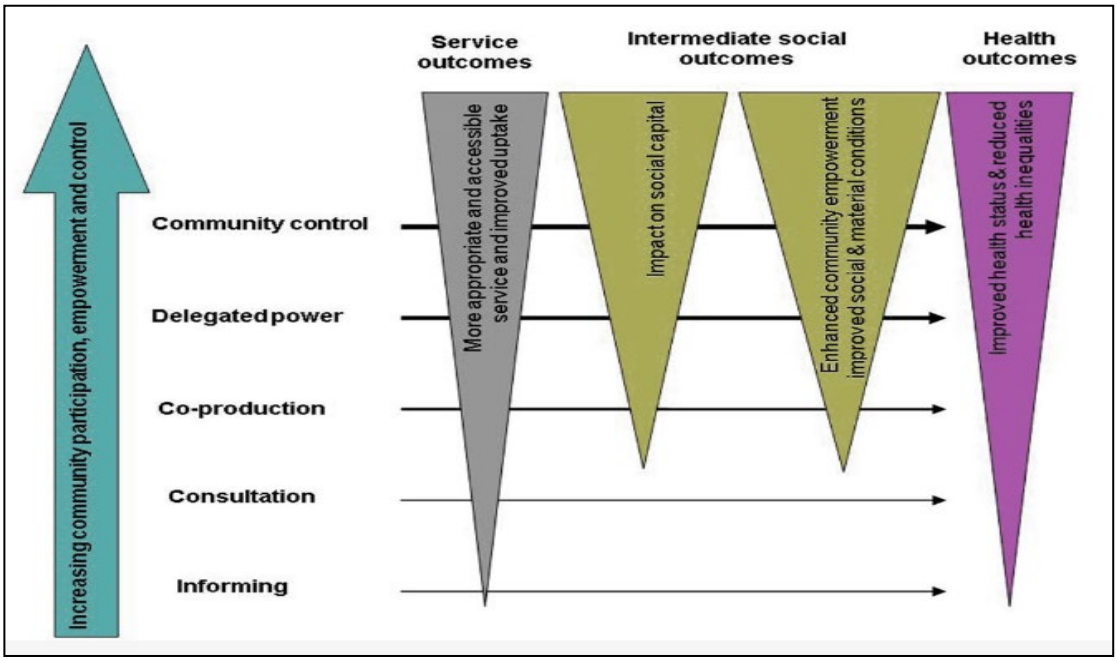
Understood in this way control is both a *mechanism of change* and a *determinant of health*. When people have more control over decisions and actions that affect their lives, they can not only influence a range of social and economic factors that affect their health but also reduce risks to their health arising directly from lack of control. These benefits can be mutually reinforcing, helping to create a 'virtuous cycle' of increasing control and improving health. However, this is predicated on appropriate levels of support, in terms of institutions, politics and resources (NIHR, 2016). There will be very significant limits to what 'empowered' disadvantaged communities can do in a society driven by policies that promote social and economic inequalities. In this way, as argued above, calling for increased collective control must not become a justification for diminishing the welfare state. Instead, it should be a call for greater partnership working where local people, with the support of local and national governments, take control to improve their health. This also involves fostering the kind of leadership capacity within neighbourhoods that creates a 'ripple' effect where everyone is enabled to exercise their capacity to take control and affect change.

4. What can be done to enhance control?

If control can make a significant contribution to improving health and reducing health inequalities, what can be done to enhance control, especially at the collective level? As Marmot and others have pointed out, much depends on how people are engaged in decisions and actions that matter to them. What methods are deployed? How inclusive and meaningful are they? What effects do they have? And what is likely to confound efforts to enhance control?

One widely-used typology of methods developed by Arnstein presents a hierarchy ranging from manipulative and therapeutic approaches, described as 'non-participation', through methods that inform, consult and placate, described as 'tokenism', to partnership, delegated power and citizen control, where 'citizen power' is deemed to take shape. The relationships between levels of engagement and health outcomes that Popay proposes, shown in Figure 3, suggest that increasing levels of participation, empowerment and control can be linked to stronger outcomes in services, social and material conditions, improved health status and reduced health inequalities (NICE, 2008, p. 8; O'Mara-eves et al., 2013; Brunton et al., 2015, p. 1).

Figure 3. Control and Outcome Maximisation



Source: Popay, 2010, p.187

However, the quality of engagement and its effects on control and health cannot be understood simply in terms of levels or degrees of intensity. It is no less important to take account of the type and quality of methods: how far they build on local assets, how communities are perceived and treated by public authorities and how far interventions seeking to engage communities are genuinely inclusive (NICE, 2008, p.9). In addition to this is the argument that a linear model of participation does not take into account the dynamism of communities and of policy problems (Kenny et al., 2014, p. 1910) and that there is no clear model of community engagement that works across all contexts, populations and health issues (O'Mara-Eves et al., 2013).

Building on assets

Traditionally, health improvement initiatives have focused on a deficit approach that takes the needs, problems and deficiencies of an individual or community - such as illness, unhealthy behaviours or deprivation - as its focus. In contrast, an assets model of health improvement focuses on the 'capacity, skills, knowledge, connections and potential' of an individual or a community, which are valued and put to use (Foot and Hopkins, 2010).

The idea is that, rather than treating people and communities as passive recipients of services, they are treated as active agents with various assets that can be drawn upon and built up to maintain and improve health and wellbeing. Asset based approaches to health improvement focus on what contributes to positive health and wellbeing (salutogenic factors) rather than what brings ill health and disease (pathogenic factors) (Morgan, 2007).

Potential health assets include resilience, self-esteem and a sense of purpose; friendship, supportive networks and social cohesion; and environmental resources and safe and pleasant housing (Morgan, 2007, p.17). Engagement initiatives that recognise, value and build on assets within communities are thought more likely (than those that take a deficit

approach) to give communities control and thereby improve health. The Social Care Institute for Excellence describes asset-based approaches as growing 'out of communities' and giving them 'space and support to develop and succeed' (SCIE, 2017). Such approaches can enhance health, wellbeing and resilience by increasing social connectedness, mobilising community capacity, devolving power to communities and co-producing plans and services with local people (IBID). Similarly, based on a review conducted by Bagnall et al. (2015), the National Institute for Health and Clinical Excellence (NICE) recommends 'building on the strengths and capabilities of communities, helping them to identify their needs and working with them to design and deliver initiatives and improve equity' (NICE, 2017).

This is closely aligned with the World Health Organisation's definition of community development: 'A way of working underpinned by a commitment to equality, social justice and participation that enables people to strengthen networks and identify common concerns and supports them in taking action related to them. It respects community-defined priorities, recognises community assets as well as problems, prioritises capacity-building and is a key mechanism for enabling effective community participation and empowerment' (WHO, 2002, p.11).

An important caveat here is that an asset based approach should not value and promote assets *within* communities without taking full account of the ways in which assets *beyond* communities – in the public and private sectors – can underpin or undermine them (Buck and Wenzel, 2018). For example, certain government policies on housing, migration or income support could make it difficult or impossible for people at neighbourhood level to realise their own assets to meet their own needs.

Perceiving and interacting with communities in different ways

Communities may be shaped and influenced by – and may also shape and influence - different types of intervention. Much depends on how communities are perceived and what role they are expected to play in health related interventions. These vary widely and can be more or less likely to enhance collective control and health, as the following table indicates.

Table 1: Typology of community-based intervention

Type of intervention	**Description**
Community as setting forms	Communities are seen as "geographical entities… residents are generally passive recipients of interventions by external agents. They may be asked for advice on adapting interventions to local settings, but adaptation is conducted by external agents. These aim to change individual behaviours as a way of reducing the population's risk of disease".
Community as target forms	Interventions "aim to create healthy community environments rather than change individual behaviours. They do this by selecting population health status indicators and targeting them with behaviour change strategies".

Community as resource forms	These support communities' "participation in and ownership of interventions. They seek to marshal the internal resources and assets within communities and strategically bring them to focus as strategies to address selected priority health problems. These problems can be identified either by the external agent or by the communities themselves".
Community as agent forms	Interventions "respect and reinforce the adaptive, supportive and developmental capacities of communities – 'the resources they need to meet the basic needs of most community members' (Steckler *et al.*, 1993). The external agent's role is to strengthen these 'units of solution' so that communities, defined by common needs, are more able to address them. Interventions 'start where people are' and address issues of common concern, which may not always be health issues".

Adapted from McLeroy et al. in Rosato, 2015, p. 248.

In a similar vein, Morgan makes the distinction between empowerment and utilitarian models of community participation: empowerment models enable communities to take responsibility and control of their own development, while utilitarian models are pragmatic means to reduce or offset the cost of services or to contribute to or collaborate with an externally defined development project (Morgan, 2001, p.221-2). Utilitarian approaches to participation are unlikely to enhance collective control. They broadly align with approaches that aim to change behaviours in order to reduce pressure on public services, and tend to detract from efforts to build empowerment based on critical awareness within communities (Wallerstein, 2017, p.489). This perspective does not see control as both a *mechanism of change* and a *determinant of health.*

Inclusive engagement

Where the aim is to reduce health inequalities, Marmot emphasises not just more control for people generally, but more equal control across the 'social gradient' (Marmot, 2006, p. 18). The underlying causes of ill health (such as poverty, stress and social isolation) can act as barriers to people coming together and engaging in positive health-related decisions and actions. So it is important to tackle the distribution of the social determinants identified by Marmot. It is also important to design interventions to be inclusive, to reach out to those who are excluded and marginalised, and to build the capacity of such groups, to enable them to participate and take control (Coote, 2011, p.288). This is also emphasised by Tritter and McCallum who argue that user involvement in healthcare systems must connect with 'diverse individuals and groups at local, organisational and national levels' (Tritter and McCallum, 2005, p. 165). There is a wealth of experience of how this may be achieved, built over decades of community development, where public participation and community control are strongly featured (Green and Haines, 2014). Some useful insights are captured in Figure 4 below. The underlying assumption is that all groups should be able to take control, especially those who are currently marginalised and disempowered.

Figure 4. Guidance for public authorities seeking to engage marginalised groups

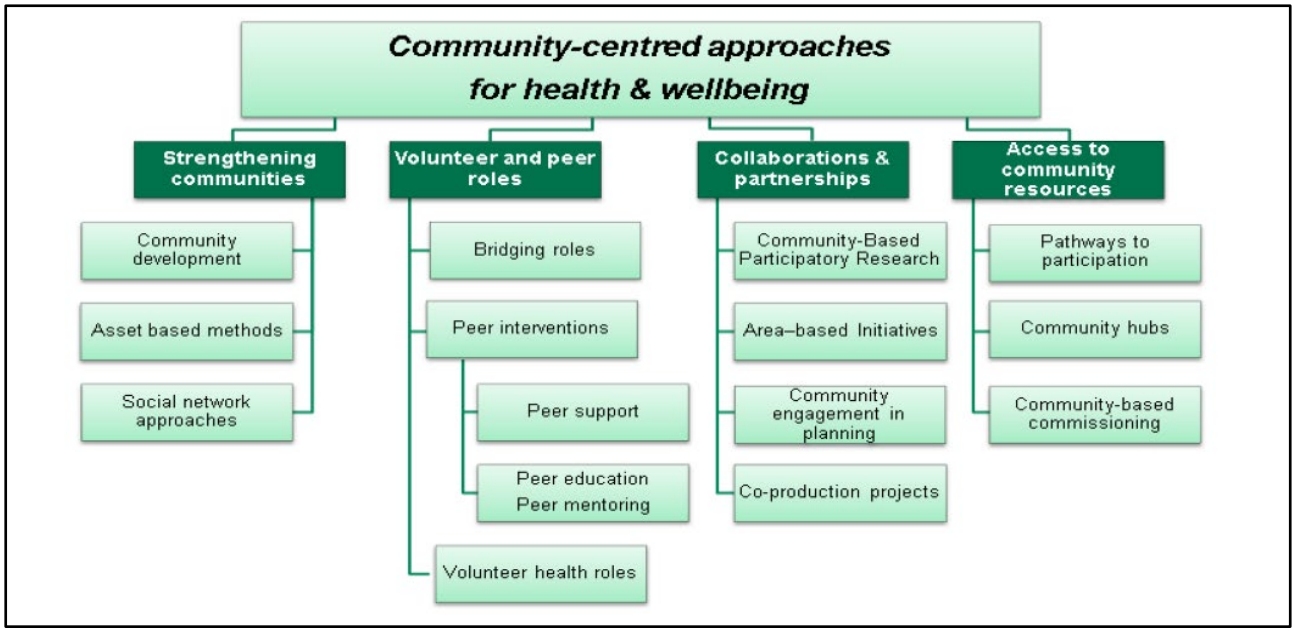
- Identify those whose voices are seldom heard and locate them, using outreach and other community development techniques.
- Meet marginalised groups on their own territory and on their own terms, rather than trying to include token representatives in other participative exercises.
- Let marginalised groups define their own agendas and ways of working – respect their wisdom and experience and treat them as equals.
- Share their language – literally and metaphorically.
- Consider more creative methods for communicating and working together – for example, using artwork, theatre and song instead of the normal stuff of meetings.
- Invest in co-ordination and facilitation and in building and sustaining networks.
- Keep on reaching out – one-off gestures won't help.
- Feed back, reflect, learn and continue to improve ways of sharing responsibility.

Source: Council of Europe, Trends in Social Cohesion no.23, 2001, p. 288.

Combining different approaches

There is no single, ideal method for effectively engaging and empowering groups of people, although there are plenty of competing opinions about which ways are best. Public Health England proposes a "family" of approaches to improving health and wellbeing at local level, which combines different community interventions, models and methods used in the UK. This can be seen in the figure below.

Figure 5. Community-centred approaches for health and wellbeing



Source: South, 2014 in PHE, 2015, p. 17.

This approach recognises that there are distinct groups of methods that serve different purposes: strengthening communities by building capacity within them; volunteer and peer roles to enhance individuals' capabilities; collaborations and partnerships to design and/or deliver services and programmes; and access to community resources to connect people to local assets, information and social activities (PHE, 2015, p.15). Crucially, these categories are not mutually exclusive and many community-level interventions include a

range of them. For example, a Healthy Living Centre as a community hub may offer peer support services such as breast-feeding groups as well as co-produced social action projects that aim to develop local political participation or improve community cohesion.

It follows that interventions should not be narrowly conceptualised. Instead, local people as well as community and health workers should have access to a basket of interventions that can be combined and blended according to the needs of their community (South and Phillips, 2014, p.693).

Confounding Factors

The approaches outlined above can all contribute to enhancing control. It is important to note however, that there are a number of confounding factors that may prevent or inhibit the development of collective control.

In particular, there is the critical view that the discourses of community empowerment, engagement and control can reinforce neoliberal approaches to welfare. Craig argues that some approaches to collective control are 'better known for fiscal conservatism' (Craig, 2007). As a result, for any intervention seeking to enhance control, it is important to ground efforts within a framework that acknowledges broader social and political contexts – combining a view of the local and the national. This could involve an awareness that, unless approaches seeking to enhance control acknowledge and address the fact that health needs and levels of capacity are unevenly distributed within and between neighbourhoods and communities, they are unlikely to succeed in improving health outcomes and reducing health inequalities (Wistow et al., 2015, p. 132). In this way, approaches to enhancing control should seek to build *capacities, critical awareness* and *agency*.

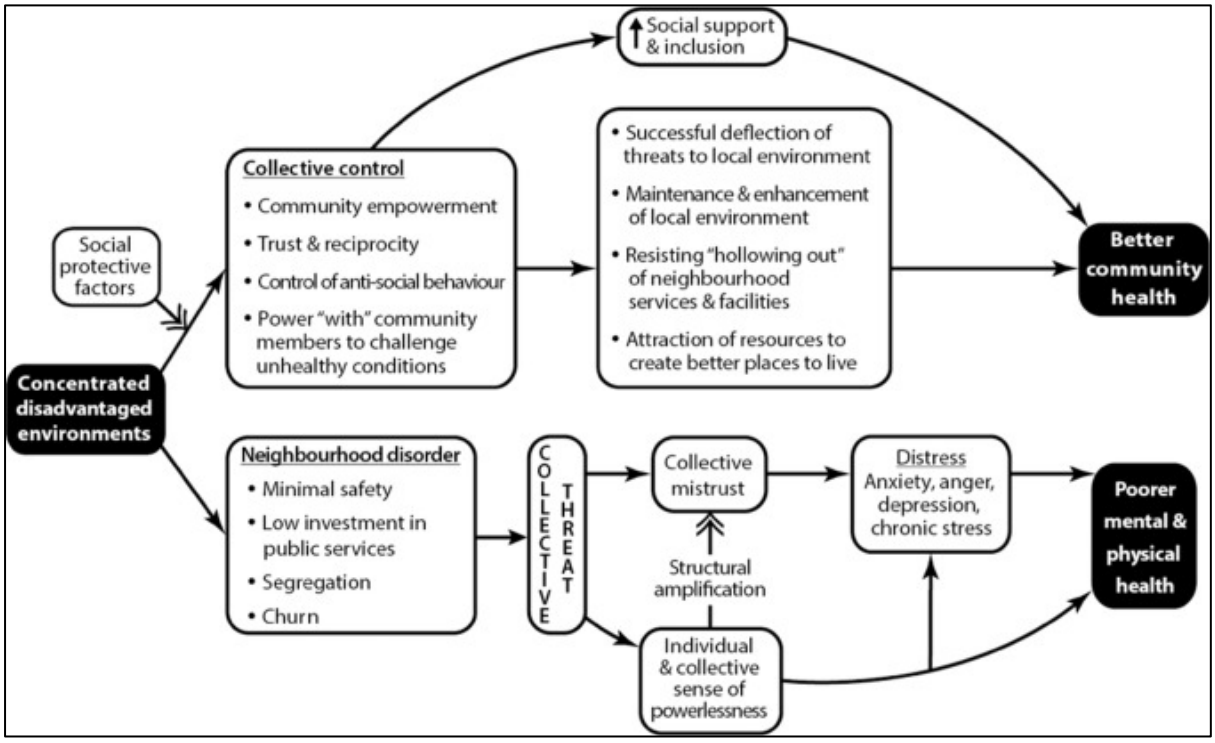
This could take the form of recognising the need to adequately resource and foster skills for leadership within neighbourhoods to enhance collective control. Without adequate financial and structural resources, such as places to meet or investment in skills, people are unlikely to be able to come together to build their *capacities* or *agency*.

Similarly, without a critical understanding of broader systemic concerns relating to the social determinants of health, local people and health workers may not develop the *critical awareness* to influence decisions and transform neighbourhoods. For collective control to create long lasting change, interventions should take into account the quality of local leadership as well as broader concerns about social welfare and adequate resourcing.

5. Pathways towards more collective control and better health

Theories linking community level control to health tend to focus on the processes by which people interact with the places where they live. Interactions between disadvantaged people and disadvantaged living environments may in some circumstances produce a sense of collective threat and powerlessness, which over time is damaging to health. Conversely, interaction between people and place may lead to community empowerment, when community members act together for mutual benefit and challenge unhealthy material conditions, or attract resources to their neighbourhood, to make it a better place to live (Whitehead et al., p.55).

Figure 6: Pathways to collective control and community-level health



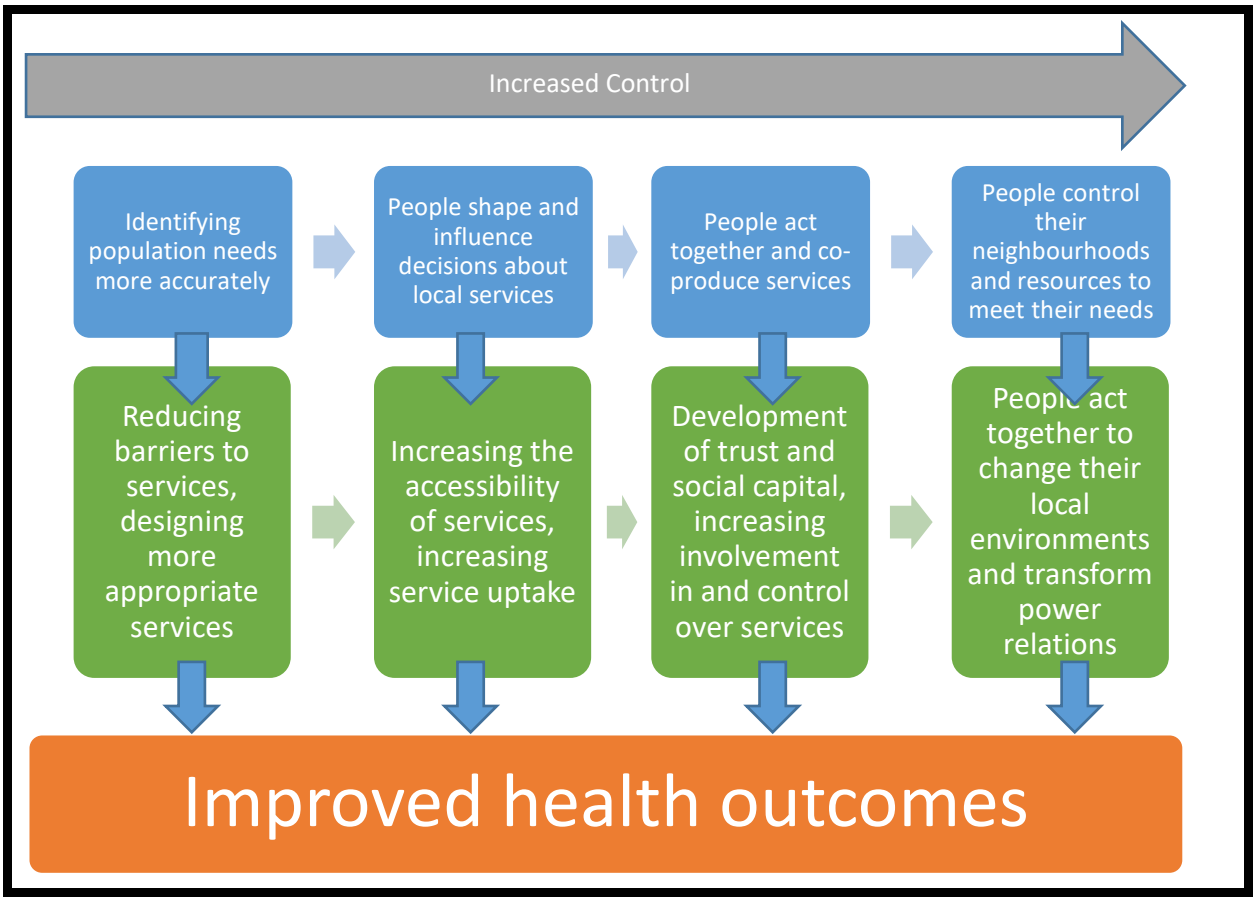
Source: Whitehead et al., 2016.

As the diagram indicates, there is a negative pathway where powerlessness is a chronic stressor, growing out of the day-to-day experience of hard-pressed communities, living in hardship over a long period of time (Whitehead et al., 2016, p.55). This is because 'lack of control over destiny produces a susceptibility to ill-health for people who live in high demand or chronically marginalised situations and who lack adequate resources, supports, or abilities to exert control over their lives' (Wallerstein, 1992, p.202).

At the same time, there are pathways leading from collective control to better health: these can be direct and indirect. The former may include, for example, reduced exposure to environmental toxins as a result of collective control over the source of emissions. Indirect pathways may occur, for example, through improving social supports and supportive networks which combat social isolation and foster a sense of connectedness and community competence. These in turn may help foster trust in the neighbourhood and neighbours, reducing alienation and distress. (Popay *et al.*, 2007; Bernard et al., 2007; De Vos *et al.*, 2009; Whitehead et al., p.57).

Another way of seeing these relationships and pathways is set out in Figure 2, which visualises the pathways from collective control to health and presents a range of potentially positive health outcomes that can come about as a result of increased collective control.

Figure 2: Collective pathways to improved health outcomes



NEF have been asked by People's Health Trust to evaluate two of its grant-giving programmes, Local Conversations and Local People. This review was initially developed to underpin these. NEF's evaluation of the Trust's Local People programme identifies a pathway towards reducing health inequalities where components of control are intermediate outcomes and part of the process of change. The Local People programme works in collaboration with five national charities, supporting 29 community initiatives across the UK. NEF's Theory of Change for this programme sees the combined input of a) grant money and resources from People's Health Trust, b) local people's knowledge, skills and time and, c) the co-productive input of locally based national charities as enabling people to come together to create change. Dialogue as a result of people coming together is then seen as leading to increased social connectedness, understanding and skills as well as increased confidence and influence. These shorter term changes are then seen to contribute to longer term changes in the community including a) improved health and wellbeing, b) improvements in the social determinants of health, c) better local services and, d) increased control in life. NEF's evaluation of both the Local People and Local Conversations programmes will seek to contribute to the evidence base for the pathways from collective control to health.

6. Evidencing pathways from collective control to health

While there is strong evidence linking enhanced individual control to better health at the individual level, there is less evidence linking collective control to health. This review does not equate collective control with engagement or empowerment and acknowledges

that all three terms carry their own conceptual baggage. However, in the absence of evidence linking collective control to health, some of the evidence linking engagement and empowerment to improved health outcomes can provide insights into ways in which pathways between collective control and health may be traced. Here, we examine the evidence linking empowerment and engagement to improved health outcomes and consider them as components of collective control.

Wallerstein in her Health Evidence Synthesis report conducted for the WHO shows that 'empowering initiatives can lead to health outcomes and that empowerment is a viable public health strategy' (Wallerstein, 2006, p.2). However, the report notes that empowerment-based initiatives are complex and depend 'as much on the agency and leadership of the people involved, as the overall context in which they take place' (IBID).

A subsequent meta-analysis of available studies found it was impossible 'to test the hypothesis that community engagement can reduce health inequalities through their impact on social inequalities because of insufficient data' (O'Mara-Eves, 2013, p. 76)[1]. This is largely because there has been far less research in this area and because traditional methods of measuring impacts of health-related measures do not lend themselves to effective evaluation of community-level interventions. These take place in complex, non-linear systems where interactive relationships play a pivotal role and develop organically (Smith and Petticrew in South and Phillips, 2014, p.692-693). Wyatt and Durie build on this by arguing that it is therefore necessary to explore 'the nature of the relations between the agents in the system and their interactions with the social environment which determine the system's behaviour' (Wyatt and Durie, 2013, p.174). Adding to the complexity, it is argued that 'systemic change cannot be externally directed, but occurs as a result of the self-organising interactions and relationships within the system' (O'Mara-Eves et al., 2015, p.17).

Further reasons offered for the lack of a strong evidence base include: 'the complexity and timing of evaluations to understand how complex changes in community relationships affect health and wellbeing outcomes over time, lack of commitment or resource to evaluate interventions of this kind and the point that some forms of community organising are a response to particular situations and research opportunities have been missed' (Eliot et al., p.10). It has also been pointed out that there are no standard definitions of 'community' or 'participation', which makes it difficult to measure the impact of empowerment initiatives using traditional methods (Rifkin, 2014, p.98; Cross et al., 2017, p.1).

Although, as we have noted, community engagement is not a proxy for collective control, there is an emerging body of evidence showing causal links between community engagement activities and improved health, which offer some insights. A systematic review by Cyril et al. (2015), which conducted methodological assessments, found that of the 24 articles that met the review's inclusion criteria, 21 demonstrated a positive impact on health. It concluded that community engagement models could lead to improved health and health behaviours, if 'designed properly and implemented through effective community consultation and participation' (Cyril et al., 2015).

[1] Databases searched for this meta-analysis included: Cochrane Database of Systematic Reviews (CDSR), The Campbell Library, the Database of Abstracts of Reviews of Effects (DARE), the Health Technology Assessment (HTA) database, the NHS Economic Evaluation Database (NHS EED), EPPI-Centre's Trials Register of Promoting Health Interventions

Another review compared the overall effectiveness of public health interventions that incorporated community engagement with controlled conditions where there was little or no such engagement. Overall, interventions using community engagement strategies for disadvantaged groups were found to be effective 'in terms of health behaviours, health consequences, self-efficacy, and perceived social support' (O'Mara-Eves et al., 2015, p.17). Although the authors of this review expressed confidence that these findings were robust and 'not due to systematic methodological biases', they nonetheless note that improved outcomes are likely to be confounded by factors such as intervention intensity and exposure 'lay delivered [interventions] tend to be more intense, one-on-one or small group interventions, than other intervention types' (IBID). Brunton et al., who build on this review, similarly argue that 'higher levels of community engagement are linked to greater beneficial effects than lower community engagement for interventions that target health outcomes amongst disadvantaged groups' (Brunton, 2015, p.9). Although this points to a growing evidence base for the causal link between community engagement and health outcomes, Brunton for example, notes that the evidence linking community engagement to improved health is 'necessarily tentative' (IBID). It is also worth noting that the emphasis on behaviour change in these reviews does not fully map onto the concept of collective control and must therefore not be equated with it. Initiatives reviewed by O'Mara-Eves et al. for example, can be seen as being fairly low on the ladder of participation (see figure 3). Despite this, they can provide insight when working towards building an evidence base linking control to health.

Broadly, there is some evidence linking community engagement and empowerment to outcomes for individuals, for groups and for services. These findings offer insights into the potential effects of collective control.

Outcomes for individuals

Where there is evidence for increased collective control, engagement or empowerment leading to improved health at the individual level, this tends to arise from increased self-confidence and awareness of relevant issues. One review of community engagement and its relationship to health found that 'active engagement in community initiatives may have valuable psychosocial benefits for participants, in terms of bolstering self-confidence and self-esteem' and by making a 'positive impact on individuals' perceptions of personal empowerment'. These perceptions were variously described as 'feeling useful to others, feeling in control of events, being able to express ideas and having an awareness of individual rights' (Attree et al., 2011, p.256).

A qualitative study of a community engagement intervention that sought to address the mental health needs of African and African Caribbean groups found that all participants 'spoke of a sense of empowerment resulting from their participation. Not only could they now take control over their own health and mental health but also with the knowledge and techniques acquired, they could help others' (Mantovani et al., 2017, p167).

Findings from the GoWell urban regeneration programme in Glasgow identified links between empowerment and improved self-efficacy, self-esteem, increased knowledge and awareness, behavior change, a greater sense of community and broadened social networks and social support. There were strong associations between empowerment and mental health, with residents who reported feeling more empowered also reporting more positive attitudes to their surroundings and housing providers (Baba et al., 2017).

However, community engagement has also been found to result in negative outcomes including 'exhaustion and stress, as engagement drained participants' energy levels as well as time and financial resources'. The physical demands of engagement may be particularly onerous for people with disabilities, while 'consultation fatigue and disappointment' may beset participants who have 'experienced successive waves of engagement initiatives' (Attree, 2011, p.250).

Collective Outcomes

The evidence for pathways to improved health at the collective level focuses on building social networks and enhancing social capital. There is a developing body of evidence showing that engagement and empowerment initiatives have the potential to improve health outcomes.

A systematic review focused on community engagement found that 'initiatives that aimed to promote community involvement were attributed with gains in social capital, social cohesion and fostering partnership working' (Milton et al., 2012, p.330). In another review, which draws on a wider review of evidence carried out for the National Institute for Health and Clinical Excellence (NICE) (2006), 'the positive effect of community engagement on participants' social relationships' was a recurring theme and suggested that 'engagement may benefit a community more widely, in terms of increasing mutual trust and understanding between different population group' (Attree et al., 2011, p.256-257).

These collective level outcomes - social capital, cohesion, support and relationships - have been shown to play a vital role in health and wellbeing, by buffering stress, encouraging healthy behaviours and contributing to a sense of meaning and purpose in life (Holt-Lunstad et al., 2010). There is evidence that increased social capital can improve survival rates, reduce mortality, and increase resilience (Cohen and Janicki-Deverts, 2009; Kawachi et al., 1997; Marmot, 2010). These positive outcomes as a result of community engagement identified here are likely to be evident in the outcomes of increased collective control.

Service Level Outcomes

There is some evidence that initiatives to increase community-level engagement and empowerment have the potential to improve access to services, to enable communities to shape services according to their needs, and to improve how people perceive their neighbourhood (which in turn impacts on services).

Evidence suggests that 'community engagement may have a positive impact on residents' perceptions of crime' (Milton et al., 2011, p.332). Another study found that perceived empowerment was 'a robust predictor of feeling safe indoors and outside' (Allik and Kearns, 2016, p. 543).

A number of studies have looked at the relationship between engagement, information flows and improved services. 'Health system literacy' (or knowing how to navigate health-related services) is seen to be a beneficial outcome and it is suggested that 'community participation might affect individuals' and communities' health and services knowledge' (Nimigeer et al., 2015, p. 182). Other reviews note that 'community engagement initiatives have the potential to increase the quality of local services by improving information flows' (Milton et al., 2011, p.330).

However, while some evaluations have tried to assess whether good performance in service delivery is associated with community engagement, it hasn't been possible 'to assess whether community engagement was the mechanism in achieving service outcomes' (Milton et al., 2011, p. 330). There is evidence that it may improve information flows and community involvement in service delivery, but there is 'no conclusive evidence of direct impacts of community engagement on service delivery' (Popay et al., 2007, p.3).

As noted earlier, the main problem with trying to trace causal links between collective control and health is the paucity of research in this area. This is at least partly due to the methodological challenges presented by complex, community-based programmes and systems.

7. Measuring Control

What, then, are the most promising ways of studying the links between control and health? A feasibility study of methods by the New Economics Foundation found that there were no entirely satisfactory examples of quantitative methods to trace effects of community empowerment, but that social network mapping and qualitative comparative analysis (QCA) could strengthen findings from quantitative research.

Two recent reviews have identified quantitative measures that include some domains of collective control: one is of indicators of community wellbeing in use in the UK (Bagnall et al. 2017), the other reviews measures for asset-based approaches (South et al. 2017). Five examples are briefly summarised here.

The Department for Communities & Local Government proposes three national indicators for community cohesion: the percentage of people who believe people from different backgrounds get on well together in their local area; the percentage who feel that they belong to their neighbourhood; and the percentage who have meaningful interactions with people from different backgrounds. The first two are measured locally by the Place Survey. All three are measured nationally by the Citizenship Survey (DCLG 2010).

A conceptual framework of empowerment, proposed for young people involved in housing regeneration, has three dimensions and echoes the components of control identified earlier in this report (p. 4). The first is *capability*, which refers to a community's knowledge and understanding. The second is *deciding*, where communities have opportunities to exercise choice about their future and get to decide things themselves or to influence decisions made by others. The third is *achieving*, where communities may have the ability to attain desired outcomes by instituting actions directly or engendering appropriate actions by others (Lawson & Kearns, 2016).

The Young Foundation's framework for wellbeing and resilience measurement (WARM) considers three domains of wellbeing: *self* (the way people feel about their own lives); *support* (the quality of social supports and networks within the community), and *structure and systems* (the strength of the infrastructure and environment to support people to achieve their aspirations and live a good life). The second domain (support) measures community resilience, by creating a map of assets and vulnerabilities in a community, with a view to estimating its capacity to withstand shock and pinpointing where support should be targeted. (Mguni & Bacon 2010).

An evaluation of the Well London programme measured social integration, collective efficacy and fear of crime to represent social outcomes. Social integration was measured

by how far: some or most people in the neighbourhood can be trusted; people from different backgrounds in the neighbourhood get on; and racial harassment is a problem. Collective efficacy was measured by: how far people in the neighbourhood pull together to improve it; how far they help each other and do things together; whether any actions have been taken to solve problems in the local area in past 12 months; any volunteering activity in last 12 months; and residents' perceptions of antisocial behaviour. Fear of crime was measured by whether people feel safe in the neighbourhood in the daytime and during the night. (Phillips et al. 2014)

A multi-level model has been developed to explore links between social capital and mental health in the wake of disaster. It includes a collective efficacy scale, comprising informal social control, and social cohesion and trust. Informal social control is measured by the likelihood that neighbours could be counted on to intervene if: children were skipping school and hanging out on a street corner; children were spray-painting graffiti on a local building; children were showing disrespect to an adult; a fight broke out in front of their house; and the fire station closest to their home was threatened with budget cuts. Social cohesion and trust is measured by responses to the following statements: people around here are willing to help their neighbours; this is a close-knit neighbourhood; people in this neighbourhood can be trusted; people in this neighbourhood generally do not get along with each other; and people in this neighbourhood do not share the same values (Wind and Komproe, 2012).

Taken together, all these include many of the domains in NEF's dynamic model of control, although none includes all of them. The Local People evaluation NEF is conducting for People's Health Trust includes peer research, case studies, self-appraisal, action learning and process appraisal, as well as surveys to assess individual and collective outcomes. This approach has the potential to address gaps in the evidence presented here. There are opportunities to build on and further develop the existing range of indicators. Equally important, is the need to build a shared understanding of the complex meanings and dimensions of community, and of community-level interventions and actions. A multi-level, mixed-methods approach, which draws on complexity theory and systems theory, emerges from this review as the most appropriate for evaluating Local People.

8. Conclusion

Collective control is a complex concept and is informed by a diverse range of theoretical perspectives. As there is no consistent definition in the literature, it will be important for academic researchers, workers in the health system and local people to work to establish a shared understanding of collective control. Crucial to this is to select or synthesise appropriate theoretical frameworks.

The pathways linking control to health and health inequalities are complex and non-linear. The literature presented here has shown that there is a lack of longitudinal data on the links between control and health, and that measuring change within communities presents multiple methodological challenges.

While there is only limited evidence directly linking collective control and health, there are findings on collective engagement and empowerment that support the view that factors contributing to collective control can have positive health impacts at the individual, collective and service levels. Community engagement initiatives that seek to foster local control have become widely accepted in both health promotion and public

policy circles. However, pathways between control and health are still not sufficiently understood or demonstrated, especially in relation to improved health at the collective and services levels. In particular, there appears to be a shortage of studies that focus on place, community and collective control grounded in salutogenic, asset-based approaches and the social determinants of health.

The challenge now is to bring greater depth, clarity and cohesion to the following areas: measuring control; evaluating complex pathways; establishing causality; collecting longitudinal data on community change; and tracing outcomes in non-linear systems.

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Appendix

Searches for key authors in the field and papers citing key authors published after 2015 generated 60 manuscripts. A further 10 manuscripts published after 2015 were generated by a hand search of the journal *Community Development*. The inclusion methodology was a) papers cited by NEF's 2015 review and b) manuscripts published after 2015.

Hand search Community Development journal with a focus on (50:2), a special issue on health.

Key word searches using Scopus:

"disadvantage" OR "disparities" OR "disparity" OR "equality" OR "equity" OR "gap" OR "gaps" OR "gradient" OR "gradients" OR "health determinants" OR "health education" OR "health inequalities" OR "health promotion" OR "healthy people programs" OR "inequalities" OR "inequality" OR "inequities" OR "inequity" OR "preventive health service" OR "preventive medicine" OR "primary prevention" OR "public health" OR "social medicine" OR "unequal" OR "variation"

AND

"change agent" OR "citizen" OR "community" OR "champion" OR "collaborator" OR "disadvantaged" OR "lay community" OR "lay people" OR "lay person" OR "member" OR "minority" OR "participant" OR "patient" OR "peer" OR "public" OR "representative" OR "resident" OR "service user" OR "stakeholder" OR "user" OR "volunteer" OR "vulnerable"

AND

"capacity building" OR "coalition" OR "collaboration" OR "committee" OR "compact" OR "control" OR "co-production" OR "councils" OR "delegated power" OR "democratic renewal" OR "development" OR "empowerment" OR "engagement" OR "forum" OR "governance" OR "health promotion" OR "initiative" OR "integrated local development programme" OR "intervention guidance" OR "involvement" OR "juries" OR "local area agreement" OR "local governance" OR "local involvement networks" OR "local strategic partnership" OR "mobilisation" OR "mobilization " OR "neighbourhood committee" OR "neighbourhood managers" OR "neighbourhood renewal" OR "neighbourhood wardens" OR "networks" OR "organisation" OR "panels" OR "participation" OR "participation compact" OR "participatory action" OR "partnerships" OR "pathways " OR "priority setting" OR "public engagement" OR "public health" OR "rapid participatory assessment" OR "regeneration" OR "relations" OR "support"

"empowerment" OR "engagement" OR "control" OR "effectance" OR "participation" OR "intervention" OR "autonomy" OR "sense of coherence" OR "power" OR "ontological security" OR "collective efficacy" OR cultural continuity" OR "involvement"

AND

"Community" OR "neighbourhood" OR "co-production" OR "intervention" OR "public" OR "local area" OR "service user" OR "member" OR "participant" OR "user" OR "member" OR "peer" OR "lay member"

AND

“health determinants” OR “health education” OR “health inequalities” OR “health promotion” OR “healthy people programs” OR “inequalities” OR “inequality” OR “inequities” OR “inequity” OR “preventive health service” OR “preventive medicine” OR “primary prevention” OR “public health” OR “social medicine” OR “unequal” OR “variation”

Key author searches identified the following:

- Papers by Whitehead, M: 173
    - Papers by Whitehead, M. with either keywords or title including community, neighbourhood, control, autonomy, self-determination, determinants, engagement AND limited to articles published in or after 2015: 3
    - Papers citing the above: 6
    - Identified as relevant: 1

- Papers by Pennington, A.: 3
    - Papers by Pennington, A. with either keywords or title including community, neighbourhood, control, autonomy, self-determination, determinants, engagement AND limited to articles published in or after 2015: 1
    - Articles exported: 0

- Papers by Orton, L.: 25
    - Papers by Orton, L. with either keywords or title including community, neighbourhood, control, autonomy, self-determination, determinants, engagement: 3
    - Papers citing the above: 5
    - Articles exported: 3

- Papers by Petticrew, M: 183
    - Papers by Petticrew, M. with either keywords or title including community, neighbourhood, control, autonomy, self-determination, determinants, engagement AND limited to articles published after 2015: 15
    - Papers citing the above: 182
    - Identified as relevant (with above inclusion methodology): 1

- All papers by Sowden, A.: 93
    - Papers by Sowden, A.: with either keywords or title including community, neighbourhood, control, autonomy, self-determination, determinants, engagement AND limited to articles published after 2015: 1
    - Articles citing identified papers: 5
    - Articles exported: 0

- All papers by White, M: 29
    - Papers by White, M.: with either keywords or title including community, neighbourhood, control, autonomy, self-determination, determinants, engagement AND limited to articles published after 2015: 1
    - Articles citing identified paper: 5
    - Articles exported: 0

- Papers by Ponsford, R.

    - Papers by Ponsford, R.: with either keywords or title including community, neighbourhood, control, autonomy, self-determination, determinants, engagement AND limited to articles published after 2015: 2
    - Articles citing identified papers: 9
    - Articles exported: 2

- Papers by Collins, M.
    - Papers by Collins, M.: with either keywords or title including community, neighbourhood, control, autonomy, self-determination, determinants, engagement AND limited to articles published after 2015: 2
    - Articles citing identified papers: 13
    - Articles exported: 9

- Papers by Popay, J.: 76
    - Papers by Popay, J.: with either keywords or title including community, neighbourhood, control, autonomy, self-determination, determinants, engagement AND limited to articles published after 2015: 6
    - Articles citing above papers: 28
    - Articles exported: 10

- Papers by Egan, M.: 40
    - Papers by Egan, M. with either keywords or title including community, neighbourhood, control, autonomy, self-determination, determinants, engagement: 4
    - Articles citing above papers: 6
    - Articles exported: 2

- Papers by Lewis, S.: 9
    - Papers by Lewis, S., with either keywords or title including community, neighbourhood, control, autonomy, self-determination, determinants, engagement AND limited to articles published after 2015: 1
    - Articles citing above paper: 0

- Papers by Salway, S.: 57
    - Papers by Salway, S. with either keywords or title including community, neighbourhood, control, autonomy, self-determination, determinants, engagement AND limited to articles published after 2015: 3
    - Articles citing the above: 3
    - Articles exported: 3

- Papers by Halliday, E.
    - Papers by Halliday, E. with either keywords or title including community, neighbourhood, control, autonomy, self-determination, determinants, engagement AND limited to articles published after 2015:
    - Articles citing the above: 9
    - Articles exported: 8

People's Health Trust

www.peopleshealthtrust.org.uk

New Economics Foundation

www.neweconomics.org