Chapter 10
Community Empowerment and Health Improvement: The English Experience

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10.1 Introduction

Involving communities of place and/or interest in all aspects of the development, implementation and evaluation of health development and social regeneration programmes has become common place and is now an explicit requirement of many government strategies promoting social models for action to tackle health inequalities (DH 1999; CSDH 2008). The primary purpose of engaging communities from a policy perspective is to promote more responsive public services, to help improve quality and to support civic renewal (Hamer 2005). However, despite the commitment to community level action in policy terms – at least at the rhetorical level–the practice of how to do it effectively has proved highly complex. Morgan and Ziglio (2007) also highlight that asset based approaches can only be effective if we avoid "community involvement activities becoming tokenistic and separated from the main decision making processes of professionals". One way that this can be achieved is to have a clear definition of community involvement and its associated vocabulary and to make explicit how its different forms can help achieve different objectives. This chapter starts that process by unravelling the multitude of terms and definitions used to encapsulate the involvement of communities in the health development process. It also offers a framework for clarifying how we might build an evidence base that identifies the most effective approaches to community involvement for different purposes and in different contexts.

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10.2 Community Empowerment, Development and Involvement

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. These activities are elements of policies and actions aiming to improve population health and/or reduce health inequalities in many countries. A number of different terms are used to describe these activities notably: *community engagement, community empowerment, community participation and community involvement*. Although there is considerable overlap between the meanings attached to these phrases there are also important distinctions to be drawn between them.

Community development refers to a form of *professional practice* whose practitioners typically have formal qualifications and there are extensive international networks of community development workers. The World Health Organization (WHO) has defined community development as:

> …a way of working underpinned by a commitment to equity, 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, recognizes community assets as well as problems, prioritises capacity-building and is a key mechanism for enabling effective community participation and empowerment (WHO 2002).

As the WHO definition highlights, *community empowerment* is both central to the process of community development and an outcome of this process. According to WHO, empowerment at both individual and community level is a pre-requisite for health improvements and the reduction of health inequalities (WHO 1997).

The World Bank also highlights both process and outcomes when it argues that empowerment in the context of poverty reduction is concerned with:

> …the expansion of assets and capabilities of poor people to participate in, negotiate with, influence, control and hold accountable institutions that affect their lives (Narayan 2002).

The practice of community development and community empowerment is extremely diverse but it is possible to identity common characteristics of these participative strategies including: group dialogue; collective action; advocacy and leadership training; organisational development; and activities aimed at giving more power to community members (Wallerstein 2006). The literature points to three key indicators of successful community development and empowerment: the enhanced agency of communities; the transformation of power relationships between communities, institutions and government; and the removal of formal and informal barriers to effective community action.

Community development activities aimed at increasing individual and community empowerment may be implemented as interventions in their own right – as is the case with many community development and health projects. Alternatively, community development methods may be used as a way of delivering interventions focusing on a specific health issue (e.g. interventions aimed at reducing coronary

heart diseases or injury prevention interventions) or interventions aiming to address the wider social determinants of population health and health inequalities (e.g. neighbourhood regeneration initiatives).

Community engagement or *involvement* is more commonly used in the UK than community empowerment. This is a more eclectic arena of activity that lacks the defining value base underpinning community development and community empowerment. There are no specific formal qualifications for practitioners of "engagement" or "involvement" and many different types of professionals are involved. As Rogers and Robinson (2004) have argued, community engagement involves community members being engaged in different ways and to differing degrees. They may:

- Be given and/or take different degrees of power and responsibility from one off consultations, which have no impact on power relationships, to initiatives involving power being fully devolved to communities.
- Have more or less formal roles in shaping, governing and/or running services taking elected posts for example or attending public meetings.
- Govern and scrutinise public services, operate as "co-producers" in the running of a service or own and deliver the service themselves.
- Be enabled to lead activities from the bottom up or be expected to react to top down initiatives from public sector organisations.

Goodlad (2002) taking a different approach to Rogers and Robinson (2004) distinguishes between three broad types of community engagement: (1) the engagement of community members or voluntary organisations in partnership with formal organisations in deciding what is to be done and then implementing it; (2) membership of voluntary and community organisations getting things done, fostering community links and building skills, self-esteem and networks; and (3) informal community engagement involving social support mechanisms based on kinship, friendship and neighbourhood networks.

Given this diversity it is clear that community engagement activities do not rest on a readily identifiable body of knowledge. They may adopt a community development approach and explicitly encompass the aim of community empowerment or their objectives may be more modest than this. A wide array of specific methods are used including, for example: citizens panels and juries; rapid appraisal techniques; neighbourhood committees; community forums; participatory evaluation and research and community champions. The latter are people chosen in some way from a local community (of place or interest) to provide leadership in support of action in a particular area such as health improvement. Unlike community development, community engagement activities are not undertaken in their own right but rather are mechanisms for delivering specific policies/actions/interventions or may be linked to audit or research such as health equity audits and/or health impact assessment.

The aims of community empowerment, community development and/or community engagement initiative are diverse and can be more or less explicit. They may include:

- Increasing the appropriateness, responsiveness and ultimately the effectiveness of services.
- Promoting community governance and delivery of services.
- Fostering the development of stronger community "social capital" (networks of mutual support and reciprocity based on trust and common interest).
- Empowering communities to define their own needs and solutions and supporting them to meet these needs across a wide policy landscape (e.g. housing, employment, leisure, transport, health and social care etc.).
- Contributing to democratic renewal.

10.3 Community Empowerment and Health Improvements

In theory there are a number of possible interlinked pathways between activities aimed at increasing community engagement and/or empowerment and health outcomes including both improved population health and reduced health inequalities. Most of these pathways suggest that the relationship is indirect mediated by: (1) changes in the effectiveness of services/interventions; (2) improvements in social and material circumstances (including social relationships/capital); and (3) greater control and self efficacy (at individual and community levels). A theoretical framework for thinking about the relationship between different levels of community engagement and/or empowerment and different types of outcomes are shown in Fig. 10.1. Four possible pathways are highlighted.

Pathway 1. Health outcomes resulting from improved *Information flows*: Identifying population needs more accurately and obtaining better quality information from communities on factors operating as barriers to service uptake will contribute to the design of more appropriate and accessible services/interventions. In theory this can lead to health improvements and reduce health inequalities through an increased uptake of more effective services and/or more effective interventions.

Pathway 2. Governance and guardianship: Promoting and supporting community engagement in or control of a service and/or interventions can increase the appropriateness and accessibility of services/interventions, increase uptake and effectiveness and hence have positive health outcomes.

Pathway 3. *Social capital development*: Enhanced community empowerment and/or engagement may also contribute to the development of relationships of trust, reciprocity and exchange within communities, strengthening social capital, which has been shown to be linked to improved health.

Pathway 4. *Control and empowerment*: Community empowerment and/or engagement can also result in communities acting to change their social, material and political environments. This pathway requires the transformation of power relationships between communities, institutions and government increasing the capacity and competence of individuals and their communities to exercise choice and to act

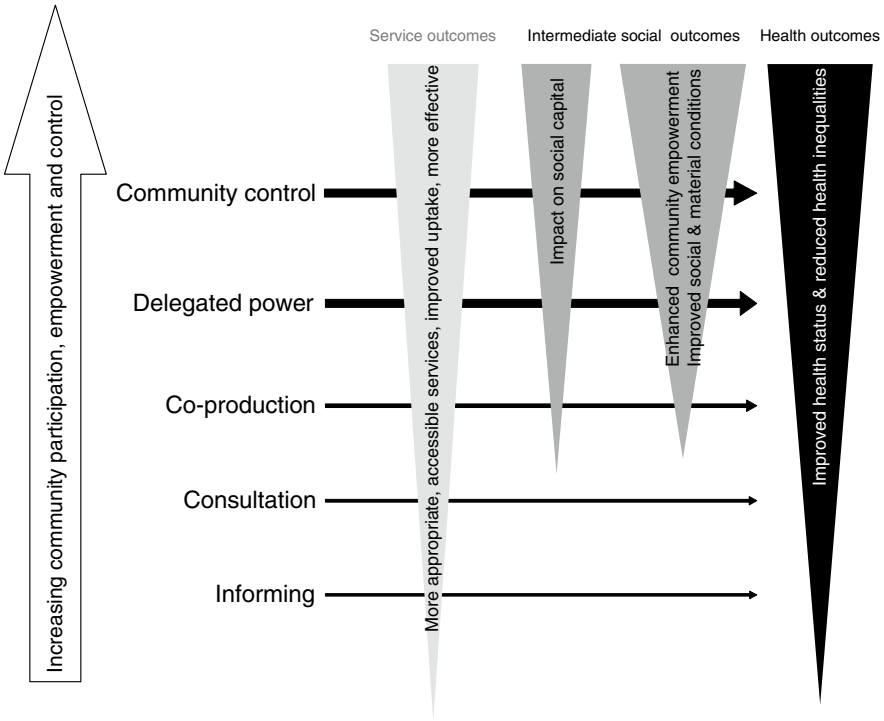

Fig. 10.1 Pathways from community empowerment and engagement to health improvement

on these choices. Health improvement and inequality reduction may therefore result from improvements in individual self-efficacy and control; from collective community action resulting in improved community relationships and material conditions (e.g. increased employment opportunities or improved housing); and from improved effectiveness of services/interventions.

In theory, different pathways to health outcomes will be operating at different "levels" of empowerment and/or engagement. The diagram suggests that at one end of an empowerment/engagement spectrum approach that involves the more or less passive transfer of information from communities to professionals and/or organisations may impact on the appropriateness, accessibility, uptake and ultimately the effectiveness of services but will not impact on dimensions of social capital or result in significant empowerment of a community. Hence the impact on health at population or individual level will be modest. In contrast, the greater the emphasis on giving communities more power and control over decisions that affect their lives, the more likely there are to be positive impacts on service quality, social capital, socioeconomic circumstances, community empowerment and ultimately on population health and health inequalities.

Conversely, it is also important to recognise that whilst the diagram highlights the possible contribution of community engagement/development to health

improvement it is also theoretically possible that community engagement and/or community development initiatives may have negative impacts on service use, social capital and individual and population health. This may result, for example, if "engaged" individuals are not appropriately supported and at the population level if, for example, community expectations of involvement, influence and/or control are not met (Popay and Finegan 2005).

10.4 Community Engagement in Public Health Policy and Practice

Whilst the language of policy is always changing, attempts to promote and support the empowerment or engagement of communities through the development and implementation of public policy have a long history in the United Kingdom and internationally. One of oldest initiatives in the UK was the Community Development Project (CDP) that ran from 1969 to 1978. This was a Home Office initiative that aimed to tackle poverty and deprivation in 12 of the most disadvantaged neighbourhoods at a cost of £5 million which Loney (1983) argued was Britain's largest ever government funded social-action experiment.

Internationally the concept of empowerment is now enshrined in the Ottawa Charter (WHO 1986) and the Jakarta health promotion declaration (WHO 1997) extending the focus on community participation in the 1978 WHO's Alma Ata Declaration (WHO 1978). It is a central plank of international development efforts embedded in the United Nation's Millennium Development Goals (UN 2000), the World Bank's Strategic Framework (Narayan 2002) and the work of the WHO (Sachs 2004).

In the UK, whilst policies focusing on democratic and neighbourhood renewal tend to use the phrase community empowerment, it is community engagement and involvement that are central to national strategies for health promotion and the reduction of health inequalities. An increasing number of public health interventions utilise community engagement as a mechanism for delivering change to achieve population health improvements. The English Public Health White Paper "Choosing Health" (DH 2004) placed great emphasis on the role of communities of place and interest working in partnership with health agencies and local government to address the wider determinants of population health and health inequalities. Key elements of this strategy include:

- An increased role for voluntary and community organisations in the provision of services seeking to engage with the most disadvantaged groups and/or to increase opportunities for people to make healthy lifestyle choices. Specific proposals in the White Paper included funding for community food initiatives in deprived communities, and the Safer and Stronger Communities Fund which was intended to support improvement in parks and public spaces. There was also to be a roll-out of initiatives arising from Local Exercise Action Pilots

including, for example, a Physical Activity Promotion Fund and the appointment of regional physical activity coordinators.

- The development of new forms of community leadership with:
  - "Communities for health" pilots being established in 12 localities, with the aim of promoting action across organisations on a locally chosen health priority.
  - A network of health champions being developed drawn from communities as well as from public, private and voluntary sector organisations to help share good practice.
- Wide consultation with and involvement of communities in health related decision making at a local level.

Similar initiatives are evident across the wider UK policy landscape and the political spectrum including local government reform, urban regeneration, policing, education, housing and devolution where the engagement and/or empowerment of communities in identifying needs, and developing and implementing solutions is now seen to be a pre-requisite for success and sustainability.

10.5 The Challenge of Community Empowerment and Engagement for Health Development

Successful community empowerment and engagement requires communities that are willing and able to engage and public organisations and workers willing and able to share power and influence with communities. Whilst recent reviews of research evidence have identified examples of good practice in community empowerment and engagement they have also identified many significant barriers to more effective practice (see for example, Popay et al. 2007). For example, research on barriers to community involvement in the health sector funded by the Department of Health (Pickin et al. 2002) identified five types of barriers to more effective practice:

- The capacity and willingness of communities to "engage".
- The skills and competencies of health professionals staff.
- The dominance of professional cultures and ideologies.
- The organisational ethos and culture; and
- The dynamics of the local and national political system.

Formal evaluations in England of a number of recent high profile health related initiatives with a commitment to engage with communities at all levels have also pointed to difficulties in the implementation of this policy aspiration (Popay and Finegan 2006; Bridge Consortium 2005; Barnes et al. 2003; Woods et al. 2003; Sullivan et al. 2004; Lloyd 2003; Crawshaw et al. 2003; CRESR 2004; Ball 2002; Myers et al. 2004; Cropper and Ong 2003). There is little evidence, for example, that the strategic directions of Health Action Zones, New Deal for Communities

(urban renewal) initiatives or Sure Start schemes focusing on child health were shaped by local communities although these initiatives did appear to succeed in fostering active community participation in specific health improvement initiatives and in the delivery of services. Attempts to share power and influence with communities in all these initiatives were severely constrained. In particular, the later neglect of the principles of common purpose espoused during the opening stages of these national initiatives. Community participants experienced this as a lack of respect, undermining their motivation to maintain relationships and in so doing undermining any social capital built in the early stages. National evaluations of these initiatives point to deficits in the skills and competencies required for effective working with active communities within public sector organisations at a local, regional and national level including government departments. Whilst those Healthy Living Centres with a stronger community development orientation may have avoided some of these difficulties, the evaluation suggests that they have become marginalised from mainstream policy developments and that learning from their experiences has been limited.

If activities aimed at community empowerment and engagement are to be effective they require both community and organisational capacity. Capacity as used here refers to the values, knowledge, skills, competencies and motivation required by community members, community and public sector organisations and individual professionals to engage effectively in joint discussions, decision making, governance and intervention/programme delivery and evaluation. Whilst methods for engaging and/or empowering communities have received significant critical attention there has been far less attention given to ways of building the capacity for community engagement within public sector organisations. This will require structural and cultural changes at the organisational level as well as improvements in appropriate knowledge, skills and competencies amongst public sector employees.

As always, there is a need for more research into the methods needed to develop appropriate capacities in communities and organisations (whether public or private) to support more collaborative action to promote health and reduce health inequalities. However, there is also a great deal of existing research evidence that can inform the development of good practice in community empowerment and engagement.

10.6 Reviewing Evidence on Good Practice in Community Empowerment, Community Engagement and Community Development and the Impact on Health and Health Inequalities

Community engagement, empowerment and development are not separate, clearly defined, consistently applied activities or interventions. As already noted, the objectives of initiatives can range from relatively passive information provision

and/or exchange to community empowerment and control. Practice is typically characterised by an eclectic assortment of techniques although more formalised methods such as the "community collaborative approach" and "community development approaches" are used. Community development initiatives will always aim to promote and support community empowerment although in practice empowerment is defined in more or less radical ways. The constituent elements of community development practice are also diverse.

Evidence based recommendations to improve practice need to span this diverse field in a meaningful and manageable way. In theory, an evidence review would aim to provide:

- Clear and succinct descriptions of:
- The values and theories of change (Weiss 1998)[1] underpinning different approaches to community empowerment and engagement.
- The key characteristics of these different approaches and the specific methods they use
- An assessment of the impact of different approaches to, and specific methods for, community empowerment and engagement in different communities of interest and/or place on a range of outcomes including:
  - Type, levels and sustainability of empowerment and engagement and the characteristics of people engaged
  - Service appropriateness, accessibility and uptake
  - Social capital/social relationships
  - Community empowerment
  - Individual and community health status including where available impact on health gradients
- Detailed descriptions of the factors and/or processes (operating within the public sector and/or private sector and/or communities) that have been shown to inhibit the effectiveness of approaches to community empowerment and engagement
- An assessment of the effectiveness of approaches that aim to reduce these barriers
- An assessment of the cost-effectiveness of community empowerment and engagement initiatives and if feasible an assessment of cost-effectiveness

In practice, however, the available evidence is still very limited and few of these issues can be addressed in any detail.

[1] The notion of a "theory of change" was developed by Weiss, and refers to "the chain of causal assumption that link programme resources, activities, intermediate outcomes and ultimate goals". It is concerned with how an intervention is expected to work, why, and for whom. A clear understanding of the theory that is intended to underpin a particular approach to or method for community engagement/development can help in the design of the approach/methods and help implementers to ensure that the initiative remains on course as it is implemented.

10.7 Evaluative Evidence on Community Engagement/Development

Evaluating the impact of community engagement and/or development initiatives as interventions with the potential to improve population health and/or reduce health inequalities is challenging. Key documents (Wallerstein 2006; Connell 2004; PAHO 2005; Rootman 2001; Alsop and Heinsohn, 2005; Narayan 2005) in this field suggest that the following factors are crucial in considering the evaluation of community engagement/development and empowerment initiatives.

- The simpler the engagement initiative (focusing for example on the provision and/or exchange of information or on community engagement in the (re) design of services) the more easily it can be evaluated but the less likely it is to have discernable impacts on intermediate social capital and/or community empowerment outcomes or on population health or health inequalities.
- The stronger the focus on community empowerment then the more action will be needed at local, regional and even national levels to support the changes required and the more difficult it will be to clearly delineate a project or programme for evaluation.
- The greater the emphasis on community empowerment then the more dynamic the intervention processes can be expected to be. Genuine community empowerment requires a continual cycle of evaluation and reformulation of the objectives sought and the methods employed. Because the goals and methods can change over time to meet the priorities of those involved, in particular the community, it is difficult to evaluate these initiatives using traditional research designs.
- Community involvement in participative evaluative research is becoming increasing common as a method for engagement and empowerment. This may have implication for the type of methods to be adopted in the evaluation and for the outcomes to be measured.
- With any community empowerment and/or engagement initiative the local context will be a powerful force shaping implementation and impact. The scope for generalising from evaluative research is therefore dependent on the quality of the implementation evaluation undertaken and must depend in part on theoretical reasoning rather than statistical probability.
- Where community engagement is used as one aspect of the delivery mechanisms of a project or programme it will be difficult to link specific outcomes to engagement per se.
- Initiatives aiming to promote community empowerment and/or engagement can be expected to generate positive and/or negative outcomes in different domains (individual, organisational and community), at different levels in a system (local, regional and national), and beyond the specific system, or service area itself. Community representatives may wish to measure different outcomes than those required by the public or private sector participants. The outcomes to be measured may therefore need to be negotiated between all stakeholders and compromises may be needed. Additionally, the inclusion of the communities "voice" in

the assessment of the success of any initiative is now widely recognised to be vital. This will require more qualitative methods aimed at describing experiences of evaluation alongside methods concerned to provide quantitative estimates of effects and "thick" descriptions of context and implementation processes.

- Impacts on health outcomes are unlikely to be seen in the short and perhaps medium terms so long term evaluation is required but this is often beyond the funding available.
- Outcomes on a community's capacity to act for change will not be static. Impacts on intermediate and end health outcomes may be identified for a particular initiative. However, it cannot be assumed that the conditions that enabled these impacts to be achieved will remain in place, or that the capacity acquired by a particular community will be readily transferred to another situation or another time.

Limitations in the evidence base relevant to community empowerment and engagement can be addressed by future research. There is a need for more comparative research and for more research addressing questions of cost and cost-effectiveness. Methodological research is also needed on whether, and how, traditional experimental methods can be adapted for the evaluation of these initiatives, including, for example, new approaches to the construction of controls or place based approaches to allocation (Popay et al. 2005). However, as the WHO has argued the use of randomised controlled trials for the evaluation of complex social intervention is *"in most cases inappropriate, misleading and unnecessarily expensive"* (WHO 1999).

It is inevitable therefore that the evidence to inform recommendations to improve practice in community empowerment and engagement will, of necessity, be very diverse. There is an extensive evidence base available, as recent reviews demonstrate, but this includes a wide range of different evaluative methods including: case study research utilising both qualitative and quantitative methods; ethnographic research; survey research; participative research; the analysis of routine data sources and other approaches including a limited body of experimental research. Many studies are focused exclusively on the process of empowerment and engagement with fewer providing empirical data on outcomes, however defined.

Given this diversity in the evidence base there is a strong case for synthesising it in such a way that the process is able to both populate and test theoretical models of the pathways between different approaches to, and specific methods for, community empowerment and engagement and the various types and levels of outcomes that have been identified some of which have been discussed in this paper. There are a number of such models available in the literature (Wallerstein 2006; Rifkin 2003), in addition to the one developed in Fig. 10.1.

References

Alsop, R., Heinsohn, N. (2005). Measuring empowerment in practice: structuring analysis and framing indicators. In *Policy Research Working Paper Series, 3510.* Washington DC: World Bank

Ball, M. (2002). *Sure Start national evaluation. Getting Sure Start Started.* Nottingham: Department for Education and Science Publications

Barnes, M., Sullivan, H., Matka, E. (2003) *National Evaluation of HAZs. The Development of Collaborative Capacity in Health Action Zones. A final report from the national evaluation*. Birmingham: University of Birmingham

Bridge Consortium. (2005). *The evaluation of the Big Lottery Fund Healthy Living Centres. Third Annual Report of the Bridge Consortium.* London: Big Lottery Fund

Commission on the Social Determinants of Health (CSDH). (2008). *Closing the gap in a generation – health equity through action on the social determinants of health. Final report of the Commission on the Social Determinants of Health*. Geneva: World Health Organisation

Connell, J.P. (2004). Eds. *New Approaches to evaluating community initiatives: concepts, methods and contexts.* New York: Aspen Institute

Crawshaw, P., Bunton R., Gillen K. (2003). Health Action Zones and the problem of community. *Health and Social Care in the Community*, 11(1), 36–44

CRESR. (2004). *New Deal for Communities: The National Evaluation. The Programme Wide Annual Report 2003/04.* Sheffield: Centre for Regional Economic and Social Research, Sheffield Hallam University

Cropper, S., Ong, P. (2003). Salford SARP: Final Year Report of the Process Evaluation – lessons and evidence

DH (1999). *Saving lives: our healthier nation*. London: The Stationery Office

DH. (2004). *Choosing health: making healthy choices easier.* London: Department of Health

Goodlad, R. (2002) "Neighbourhood regeneration policy: rebuilding community?" in: Reclaiming Community, editor V. Nash, London: Institute for Public Policy Research, pp. 65–84 Lloyd, N., O'Brien, M., Lewis, C. (2003). *Sure Start national evaluation summary. Fathers in Sure Start local programmes*

Hamer, R.B. (2005). *Community engagement for health: a preliminary review of training and development needs and existing provision for public sector organisations and their workers.* London: NICE

Lloyd, N., O'Brien, M., Lewis, C. (2003) *Fathers in Sure Start local programmes*. *Sure Start national evaluation summary*. The National Evaluation of Sure Start (NESS) Institute for the Study of Children, Families and Social Issues, Birkbeck, University of London, UK

Loney, M. (1983). *Community against government: the British community development programme, 1968–78: a study of government incompetence*. London: Heinemann

Morgan, A., Ziglio, E. (2007). *Revitalising the evidence base for public health: an assets model.* IUHPE – Promotion and Education Supplement 2. pp. 17–22

Myers, P., Barnes, J., Brodie, I. (2004). *Sure Start national evaluation. Partnership working in Sure Start Local Programmes. A synthesis of early findings from local programme evaluations*

Narayan, D. (2002). *Empowerment and poverty reduction: a sourcebook.* Washington DC: World Bank

Narayan, D. (Ed.) (2005). *Measuring empowerment: cross disciplinary perspectives.* Washington DC: World Bank

PAHO. (2005). *Participatory evaluation of healthy municipalities.* Washington DC: Pan American Health Organisation

Pickin, C., Popay, J., Staley, K., Bruce, N., Jones, C., Gowman, N. (2002). Promoting organisational capacity to engage with active lay communities: developing a model to support organizational change for health, *Health Service Research and Policy*, 7 (1), 34–46

Popay, J., Finegan, H. (2006). *Learning about effective community engagement from selected national initiatives. National Collaborating Centre for Community Engagement Working Paper 5.* Lancaster: Lancaster University

Popay, J., Finegan, H. (2005). *Learning about effective community engagement from selected national initiatives: NCCCE working paper 5.* Report prepared for National Institute for Health and Clinical Excellence

Popay, J., Attree, P., Hornby, D., Milton, B., Whitehead, M., French, B., et al. (2007). *Community engagement to address the wider social determinants of health: A review of evidence on impact, experience & process,* National Institute for Health & Clinical Excellence, London. Available http://www.nice.org.uk/guidance/index.jsp?action=folder&o=34709. cited November 2009

Popay, J., McLeod, A., Kearns, A., Nazroo, J., Whitehead, M. (2005). *New Deal for Communities and health inequalities: A report on work exploring the feasibility of undertaking secondary analysis of the relationship between health inequalities and the NDC policy initiative. Final Report.* Submitted to the Department of Health, May 2005

Rifkin, S.B. (2003). A framework for linking community empowerment and health equity: it is a matter of choice. *Journal of Health, Population and Nutrition*, 21 (3), 168–180

Rogers, B., Robinson, E. (2004). *Active Citizenship Centre Report – The benefits of community engagement. A review of the evidence*. London: Home Office

Rootman, E. (2001). *Evaluation in health promotion: principles and perspectives.* Geneva: World Health Organisation, European Regional Publications

Sachs, J.D. (2004). Health in the developing world: achieving the millennium development goals. *Bulletin of the World Health Organization*, 82 (12), 947–949

Sullivan, H., Judge, K., Sewel, K. (2004). In the eye of the beholder: perceptions of local impact in English Health Action Zones. *Social Science and Medicine*, 59, 1603–1612

UN. (2000). *United Nations Millennium Declaration.* New York: United Nations General Assembly. http://www.un.org/millennium/declaration/ares552e.htm cited May 2009

Wallerstein, N. (2006). *What is the evidence on effectiveness of empowerment to improve health? Copenhagen, WHO Regional Office for Europe (Health Evidence Network report);* http://www.euro.who.int/Document/E88086.pdf cited May 2009

Weiss, C.H. (1998). *Evaluation: methods for studying programs and policies.* New Jersey: Prentice-Hall

Woods, S., Lake, J., Springett, J. (2003). Tackling health inequalities and the HAZ smoking cessation programme: the perfect match? *Critical Public Health*, 13 (1), pp. 61–76

WHO. (1978). Declaration of Alma-Ata. *International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978.* World Health Organization

WHO. (1986). Ottawa Charter for Health Promotion. *The Move Toward A New Public Health, Ottawa 17-21 November 1986.* World Health Organization

WHO. (1997). The Jakarta Declaration on Leading Health Promotion into the 21st Century. *Fourth International Conference on Health Promotion. Jakarta, 1997* http://www.who.int/hpr/NPH/docs/jakara_declaration_en.pdf cited May 2009

WHO. (1999). *Report on recommendations for health promotion effectiveness.* Geneva: World Health Organization

WHO. (2002). *Community participation in local health and sustainable development: approaches and techniques*. World Health Organization Regional Office for Europe, Copenhagen. Available http://www.euro.who.int/healthy-cities/UHT/20050201_11 cited November 2009