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Introduction

Communities and neighborhoods have reemerged as important settings for health promotion; they are particularly effective for encouraging social processes which may shape our life-chances and lead to improved health and well-being (Biddle & Seymour, 2012); consequently, as Scriven and Hodgins (2012) note, of all the settings (cities, schools, workplaces, universities, etc.), communities are the least well defined. Indeed, within the health literature, they are frequently referred to in terms of place, identity, social entity, or collective action.

(a) *Community as a place —the natural, physical, and built environment*
Territorial or place community can be seen as where people have something in common, and this shared element is understood geographically. Another term for this is "locality." As such, community refers to physical characteristics in the green and built local environment *where* people live.

(b) *Community as individual and collective identity (sense of community)*
A second way of defining communities is as individual or collective identities. Communities are groups who share an interest or a common set of circumstances. It is based on notions of a common perception of collective needs and priorities, and an ability to assume collective responsibility for community decisions (Scriven & Hodgins, 2012). A concept is also referred to as "sense of community," a community psychology concept, referring to the *experience* rather than its structure or the physical attributes (Chavis & Wandersman, 1990). Mc Knight and Block (2010) argue that the most significant factors determining one's health are the extent to which people are positively connected to each other, the environment they inhabit, and the local economic opportunities. Or as Rutherford said, "Tend to the social and the individual will flourish" (Rutherford, 2008).

(c) *Community as social entity (cohesion, social capital)*
Neighborhood cohesion and social capital are central constructs when communities are defined as social entities. Neighborhood cohesion has been referred to in the literature as a measure of cognitive and structural capability, community attachment, and the effect of residential stability on individual and contextual effects on local friendship ties, collective attachment, and rates of local social participation (Buckner, 1988).

A socially cohesive neighborhood "hangs together" in such a way that component parts fit in and contribute toward a community's collective well-being, with minimal conflict between groups (Robinson, 2005). The British Government outlined its definition of community cohesion as follows: "Community Cohesion is what must happen in all communities to enable different groups of people to get on well together. A key contributor to community cohesion is integration which is what must happen to enable new residents and existing residents to adjust to one another" (Commission-on-Integration-and-Cohesion, 2007). This is particularly relevant in terms of ethnic, religious, social, and cultural affinity.

The second aspect of community as social entity, community social capital, is a salutary factor on a collective level and can be defined as "features of social organization such as networks, norms, and trust that facilitate coordination and

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cooperation for mutual benefit" (Frohlich & Potvin, 1999). This salutary factor is not the individual him/herself, but the structure surrounding individuals; social capital is a community level or ecological factor. The central premise of social capital is that social ties and networks, although rarely visible, are an incredibly powerful and valuable resource (Elliot et al., 2012).

(d) *Community as collective action (reactive-resilience; proactive community action)*

As collective action, there is a reactive form referred to as resilience and a proactive form referred to as community action. Community resilience refers to the ability of individuals, families, communities, and neighborhoods to cope with adversity and challenges (Morton & Lurie, 2013). The idea of resilience is central to a strength-based or assets approach to health.

It must be taken into account that residents have various ways of "participating," being active in community life that look beyond participation in formalized activities. Participation takes place in spaces, private and public, and in activities they find meaningful as ways of being engaged in and practicing community life (Larsen & Stock, 2011).

A more proactive view refers to community action. Community action means bringing people together to increase their voice in decisions that affect their lives, such as the way their living environment is planned or built. This collective action also changes the way people see themselves: not as individuals, struggling to be heard or acknowledged in some powerful relationship or another, whether this is "individual and the state," or "individual/group to individual/group," but part of a collective of shared interest and vision. Levels of social capital are shaped by the ability of specific communities to have a voice in the decision-making processes affecting them. Communities with less social capital are also perceived to have lower levels of mutual trust and reciprocity (Attwood et al., 2003), bringing with it its own set of issues or problems such as increased isolation, segregation, exclusion, or marginalization of particular groups living in the same community.

Community Intervention Approaches

Community intervention approaches hold widespread appeal in health promotion and as such many have originated in response to the guiding principles of the Ottawa Charter (WHO, 1986). As mentioned, empirical evidence of a salutogenic approach in practice is relatively scarce and thus reviews of the literature yield limited results; alternative examples of community intervention approaches, relevant to salutogenic approach, are likely to emerge in the future. For the purpose of this chapter, we have chosen locality development, an assets orientation, and community organizing as current examples of promising application in the field.

Locality Development

Locality development serves as a base for other organizing, and, in itself, is often aimed at community-wide issues that affect everyone: economic development, education, employment, etc. Its goal is the building of community capacity to deal with whatever needs or issues arise. It also shows itself in smaller community projects—neighborhood cleanups, the building of a community playground, etc.—that help to define and build a sense of community among diverse residents of a locality (http://ctb.ku.edu/en/table-of-contents/assessment/promotion-strategies/community-development/main).

Assets Orientation

An assets-based model of health fits well with salutogenesis since it emphasizes the positive capacity of communities to promote the health of their members (Kawachi, 2010). A health asset has been described as "…any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain health and well-being and to help to reduce health inequalities (see Box 33.1 for examples of assets). These assets can be social, financial, physical, environmental, or human resources, for example employment, education, and supportive social networks (Harrison et al., 2004). These assets can operate as protective and promoting factors to buffer against life's stresses" (Morgan & Ziglio, 2007, p. 18).

> **Box 33.1 Examples of Individual, Community and Organizational Health Assets. (Adapted from Morgan & Ziglio, 2007)**
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> 1. *At the individual level*: social competence, resilience, commitment to learning, positive values, self-esteem, and a sense of purpose
> 2. *At the community level*: family and friendship or supportive networks, intergenerational solidarity, community cohesion, religious tolerance, and harmony
> 3. *At the organizational or institutional level*: environmental resources necessary for promoting physical, mental, and social health, employment security, and opportunities for voluntary service, safe and pleasant housing, political democracy and participation opportunities, social justice, and enhancing equity

In an assets model, planners would ask how a particular community or setting can make best use of their resources (and maximize their assets) to help reduce health inequalities by impacting on the wider determinants of health, to build stronger local economies, to safeguard the environment, and to develop more cohesive communities.

Community Organizing

Many definitions exist but in essence community organizing is a process where people are motivated to come together, as a collective, to address something of mutual importance; it is a dynamic process, which in itself is transformative, with the goal of action, change, and empowerment. It is regarded as a way of strengthening communities, through the transfer of power from the state to local people through community action (Bunyan, 2013). Of particular interest to community organizing is social power. Those with the greatest resources have the greatest power, those with the most knowledge have more force to influence the public debate (Speer & Hughey, 1995). Community organizing is not about mobilizing people toward the interests or objectives of professionals in order, for example, to adopt normative behaviors, such as healthy lifestyle.

Communities as Complex Social Systems

In this chapter, communities and neighborhoods are considered as open complex adaptive systems. The system (community) is perceived as the entity above the individuals in it, with its own characteristics and dynamics. What happens in systems is unpredictable, system components interact and synergies can occur; thus, a linear approach does not apply. System components are systems themselves, and systems are part of other systems—for example, a family is a system itself, which forms part of a community, and the community forms part of the city—otherwise referred to as "nested system" or multilayered. The overall functioning of the system influences the health of individuals who are part of the components of the system (Wilson, 2009). The way that systems vary in the quality of living conditions, including the built, natural, and social environments, has clear implications for community health (Wilson, 2009).

Communities and neighborhoods are embedded in cities as larger social systems. The notion of individuals and of their health, as a complex system, is compatible with the more contemporary socioecological model of health, preferred by health promotion and public health professionals today. Individuals, families, communities, regions, and sociocultural and economic determinants of health are somewhat nested and *interact* with each other at each of these different levels as a complex and synergistic system, requiring a comprehensive system-wide response.

Link Between Healthy Communities and Salutogenesis Communities and Neighborhoods

The salutogenic model remains at the heart of this chapter and will now be explored in relation to community and neighborhood. This model is based on two fundamental concepts: generalized resistance resources (GRRs) and the sense of coherence (SOC). GRRs are resources found within an individual or in their environment that can be used to counter the stressors of everyday life and construct coherent lives experiences. The SOC is the ability to identify and use resources in a health-promoting manner. The approach of the salutogenic theory is to focus on the interaction between the individual, the community, and the environment. Relating the earlier described conceptualizations of community to the salutogenic model means that the locality, sense of community, cohesion, and social capital can be considered as GRRs and that collective action can be considered as the salutogenic mechanism of moving toward the health end of the continuum and building up GRRs. In everyday life, communities are continuously affected by daily hassles and stress which one has to deal with. Whether the outcome will be salutary depends on how communities are able to manage tension by using the resources at their disposal. In this chapter, we are specifically interested in the resources (and/or assets) inherent within the community and the associated processes enabling these resources to be accessed for the benefit of the community and its well-being. Community members share communal aspects that influence how they may interact with their surrounding context and stressors. These shared influences (sometimes referred to as collective SOC since it concerns a group rather than an individual) can enable populations to move toward the ease-end of the continuum (Antonovsky, 1996).

From a pathogenic perspective, urban neighborhoods with many disadvantages are called "*riskscapes*" (Wilson et al., 2008). We suggest the term "*resourcescapes*" with healthy and equitable planning and zoning in communities and access to resources (GRRs) such as homes with gardens, local employment opportunities, easy commuting distances, accessible and affordable grocery stores, recreational and cultural facilities, parks, open space, healthy schools, and medical facilities fit with the salutogenic framework. One way to facilitate stronger SOC is to help raise awareness of available and "untapped" resources, which may enable people to take greater control of their own situation or health and well-being. Several tools now exist to help people and communities themselves to explore the inherent assets.

Possible social assets/resources in the community include, for example, the presence of adult role models who are employed in meaningful and rewarding jobs (Kawachi, 2010) and the presence of informal social control (Sampson et al., 1997). This concept refers to the capacity of a community to regulate behaviors of its members according to collectively desired roles.

The above examples of resources can also help communities to be more resilient against social and environmental transitions such air pollution, urban decay, man-made and natural disasters, and climate change. As the next section illustrates, healthy communities have healthy physical characteristics, a strong sense of community, and a strong social capital. Through a shared interest and vision and profiting from assets available, community members actively organize themselves for better health and well-being.

The link between how people feel and circumstances of their own lives better equips them to survive adverse situations or circumstances (Foot & Hopkins, 2010). Little research however has been devoted to the variety of *mechanisms* that promote the development of a strong collective SOC (García-Moya et al., 2012). As Fone et al. (2006) demonstrate, the ability to conceptualize, define, operationalize, and measure the specific resources and pathways within the social environment that link the neighborhood of residence to health outcome is complex and reliant upon sophisticated multilevel analysis (Lee & Maheswaran, 2011). Not foregoing this type of approach, examining the role of community and neighborhood from a salutogenic and strength perspective requires us to unravel what is meant by a salutogenic pathway. But, as illustrated below, the difficulty in isolating key components within this pathway is in itself a challenge for researchers in this field and may well explain the paucity of research of an empirical nature into salutogenesis involving communities and neighborhood. Some may also ask if it is appropriate or possible, because to do so is to ignore the very complexity that characterizes such systems.

Current Literature on Salutogenesis, Community, and Neighborhood

In this part of the chapter, we explore the relevant literature on how communities influence the health of their members. We primarily consider etiological research that is explicitly related to the salutogenic orientation and/or to key concepts of salutogenesis. Secondarily, we consider research relevant to salutogenesis and show how this research is related to this concept. The literature is brought together under the organizing structure used throughout this chapter of neighborhood or community as: (a) a place, (b) connectedness (we combine sense of community, cohesion, and social capital), and (c) social action.

Community as a Place to Live

Many physical characteristics of communities play a role as a resource or asset. They include features like infrastructure and transportation (see Chap. 34 on cities), enough "space" for everyone, and contact to nature. Related to salutogenesis and the starting point that people and places are being produced in relation to each other, especially making sense of the everyday living environment, plays an important role. Without attempting to oversimplify the complexity, we will describe some of the examples we found.

Research from social work practice (Jack, 2010) concurs that children's mental well-being is associated with sense of place or place attachment which grows out of person–environment interaction. Our use of space has changed over time, we spend significantly more time watching TV or traveling in vehicles and the average child now spends up to 16 h a day in the home compared with recent decades when children played outside and walked, sometimes a fair distance, to school (Ziviani et al., 2004); children however favor a mix of the home and garden, nearby streets, local open spaces, parks, playgrounds, and sports fields (Jack, 2010). Opportunities for increased time outdoors and in safe or enjoyable neighborhoods are now recognized (Thompson et al., 2008) and encouraged, particularly in terms of the built environment and the planning process (Cleland et al., 2010).

Research from cultural geographers (Lager et al., 2013) showed that sense of belonging and well-being of elderly—despite the many changes in the neighborhood—is negotiated and practiced in everyday places and interactions. This shows that, in line with salutogenic theory, people and place do not develop independently. Rather than specific assets or resources, it seems more important that the elderly can age within a familiar and predictable environment.

Maass et al. (2014) analyzed data from a population study including the measurement of SOC and a number of neighborhood variables in a city in Norway and found that the overall satisfaction with the living area and social capital are related. SOC was the strongest correlate for health outcomes. However, they found differences between groups. Satisfaction with quality of neighborhood resources was significantly related to SOC in nonworkers and low-earners and health outcomes in women. The authors recommended that deprived groups might benefit most from health promotion in the neighborhood.

Green Spaces and Contact to Nature

Access to natural environments is associated with a positive assessment of neighborhood satisfaction and time spent on physical activity (Bjork et al., 2008). On the other hand, these types of health effects have only been found for larger

green spaces and not for smaller green spaces (Mitchell & Popham, 2008) and benefits that green space might offer seem easily eclipsed by other conditions such as car dependency (Richardson et al., 2012). Residents might also be more positive about green in their living surroundings if they are in general satisfied about where they live (Nielsen & Hansen, 2007), which suggests how important it is to acknowledge the interplay of different factors within the wider system. That is why van Dillen et al. (2011) and also Thompson and colleagues (2011) stress that it is worthwhile to further investigate the relationship between the quality of streetscape greenery, attractiveness of the neighborhood (or residential satisfaction) health, and well-being.

Compelling evidence exists for links between contact with green space and better mental health (Depledge et al., 2011), however as the literature suggests, access to green space is variable according to where you live. A survey from the Netherlands, involving 25,000 people, reported that those living within 1 km of green space were more likely to have a stronger perception of good health (Maas et al., 2006). The most deprived groups are seven times less likely to live in green areas, whereas adults in this poorest quintile, living near green space, benefit most (Mitchell & Popham, 2008). This is what Marmot refers to in his report as to "environmental injustice"—which he argues "the more deprived the community is, the worse the environments in which people live" (Marmot et al., 2010).

Connectedness

Communities that are more cohesive, characterized by strong social bonds and ties, have been shown to be more likely to maintain and sustain health even in the face of disadvantage (Harrison et al., 2004; Magis, 2010; Morgan & Ziglio, 2007). A meta-analysis of 148 studies investigating the association between social relationships and mortality indicated that individuals with adequate social relationships have a 50% greater likelihood of survival compared with those with poor or insufficient relationships (Holt-Lunstad et al., 2010). The authors hypothesized that this may function through a stress-buffering mechanism or behavioral modeling, within social networks. Although this study was not specifically related to communities, it still supports the importance of social ties for people.

As mentioned in the beginning of this chapter, social capital is central to salutogenic communities. Social capital is an asset of communities, *not* of individuals (Kawachi, 2010), and it is important to make a distinction between the bonding and bridging dimension of social capital (Szreter & Woolcock, 2004). Bonding social capital refers to trusting and cooperative relations between members of a group who are similar in terms of social identity (e.g., race and ethnic-

ity), whereas bridging social capital refers to connections between individuals who are dissimilar with respect to their social identity (e.g., race, ethnicity, social class). Interestingly, bridging social capital is related to better well-being, whereas bonding ties often turn out to be detrimental to the health of residents (Almedom, 2005; Kawachi, 2010) due to the tendency to favor the formation of groups formed on exclusivity rather than inclusivity.

Nevertheless, there is evidence to suggest that people with stronger social networks tend to be stronger, healthier, and happier (Marmot et al., 2010). Critical to this is the social contact and social support that fosters greater self-confidence and reduces isolation in communities: "individuals need communities and communities need engaged citizens to survive" (Friedli & Parsonage, 2009, p. 15).

Indeed, Professor Marmot's review (Marmot et al., 2010) highlights the importance of strong social networks to people's health, by helping people to be more resilient and "bounce back" from adversity; his report presents strong evidence that social networks can help buffer against stressors of everyday life. In this, he also refers to the value of communities in terms of the social relationships as a resource for health and well-being: "it is not so much that social networks stop you getting ill, but they help you to recover when you do get ill" (Marmot et al., 2010).

Community as Social Action

Kawachi (2010) describes three principles to build collective action from an asset-based model of health: (1) invest in a number of activities rather than one, (2) pay attention to the type of social capital and especially invest in bridging social capital, and (3) make sure there is budget available. The benefits reach beyond the individual members and can therefore be seen as a government responsibility. This is critical if we are to avoid what some refer to as the misuse, or abuse, of adopting an assets-based approach, to shift culpability away from central or local government onto individuals and communities. Obviously, balance between the two is more realistic and as this section illustrates, helpful in empowering communities for better health and well-being.

According to Larsen and Stock (2011), constructing a collective identity (collective SOC?) in a neighborhood, based on hegemonic narratives of the neighborhood, of its history and development, can be particularly useful in strengthening community attachment. These authors (ibid., p. 20) stress that "residents have various ways of 'participating' in community life that look beyond participation in formalized activities. Participation takes place in spaces, private and public, and in activities they find meaningful as ways of being engaged in and practicing community life."

Current Research: Interventions

In this section, we outline examples of typical (programmatic) action areas: based on descriptive evidence presented above, including, where available, literature on the effectiveness of interventions, from research that explicitly relates to the salutogenic orientation.

Salutogenic interventions are not only about making sure resources are *available* to people and communities but also about creating opportunities to help people to *recognize* these resources exist in the first place so they can utilize them better. These types of interventions aim to improve the person–environment fit in the microsystem of communities. Fundamentally, resources therefore should be meaningful to the people concerned; as already suggested above, access to resources is variable. Moreover, meaningfulness associated with different resources is also highly subjective, varying between people and places. Thus, efforts to address inequalities in health, associated with place, must start from and be initiated by the people, members of the place, themselves.

Community as a Place

The number of initiatives of promoting health and well-being in natural environments is growing. We have selected a number of case studies/examples to illustrate this: (a) access to green space, (b) community gardens, (c) natural green playgrounds for children, and finally (d) day care on farms, for example, for young people who have difficulties to function effectively in mainstream society.

Supporting communities and environmental improvements to the natural or green spaces, built environment, and public spaces have been shown to positively influence mental health. For example, outdoor physical activity has been found to be particularly beneficial for people's well-being, with evidence that outdoor walking groups have a greater impact on participants' self-esteem and mood than the equivalent activity indoors (Bragg et al., 2013; Burls, 2007); access to green spaces has been associated with reduced inequalities in health (Friedli & Parsonage, 2009). On the other hand, landscape design will not affect a move toward the positive side of the health continuum if the green interventions are "too simplistic" since the relationship between green space and health is complex (Lee & Maheswaran, 2011). Moreover, the positive effects of place result from the interplay of salutogenic mechanisms. According to MIND, a mental health charity in the UK, the natural outdoors is a key factor in promoting mental health and well-being as part of building resilient communities (mind.org.uk). Their research identified benefits of being outdoors as a very strong theme, with people citing garden allotment (homegrown food) groups as particularly helpful because they combine a range of different elements that have a positive impact on their well-being, including physical activity, being in a social group and being outdoors.

Not only are green environments healthy in the sense of being outside, also the collaborative active involvement in the maintenance of natural areas can contribute to better health and well-being. For example, gardening promotes an active lifestyle (Van den Berg & Custers, 2011) and contributes to healthful eating, and children show more active and social type of play in a green outdoor environment than in a traditional playground. Besides the positive results of these initiatives, being involved in the development or maintenance of these types of initiatives can also be as rewarding, promote self-efficacy and esteem, thus promoting health.

An example of a salutary factor in a neighborhood is a community garden which encourages outdoor activities, physical activity, and meaningful engagement, socialization with neighbors as well as aesthetic enhancement. In a Swedish study, three perceived qualities of the green neighborhood environment with salutogenic potential were identified: historical remains (culture), silence such that sounds of nature can be heard (serene), and richness in animal and plant species (lush) (de Jong et al., 2012).

A recent study in Wales pointed out that community gardening provides community gardeners with various social, mental, and physical resources, which can make it easier for people to perceive their lives as meaningful, structured, and understandable. Social initiatives in natural environments can support learning experiences to move toward the ease-end of the health continuum (Esdonk, 2012). The Liverpool City Council (2012) is also one of the best-performing local authorities securing parks and green spaces. Besides many other economic, environmental, and health rationales, they also recognize advantages for communities and people. In their green infrastructure strategy, they write: "Parks are places to meet and celebrate with family and friends. They are inclusive and accessible. They are venues for community festivals, events and sporting activities. Parks are the scene of excitement, refreshment, relaxation, and solitude." In Liverpool, 35,512 people were brought together in parks in 2009/10. More than 30 parks have direct links to community and friend groups. Their voluntary involvement and decision-making directly improve community empowerment and well-being (Liverpool-City-Council, 2012).

Outdoor nature contact is also important for children. Research suggests they prefer and rank highly vegetation in neighborhood parks, playgrounds, and backyard gardens compared with other places (Lee & Maheswaran, 2011). In many cities in the Netherlands, municipalities have started to develop green playing fields in inner city areas as an alternative for schoolyards constructed of stone. Green playing grounds contain a greater diversity for playing and nurture the health and development of children (Dyment & Bell, 2008; Van den Berg & Van den Berg, 2011).

Some interventions are characterised by, and successful specifically because, of the focus on time spent outdoors in green or natural community settings, rich in natural resources, such as the care farm. One study, based on qualitative interviews with young socially excluded males, participating in 6-month intervention on "care farms" in The Netherlands, whereby farmers host young people in need of specific, typically social work intervention, revealed that a range of resources—at the individual, "household" (albeit temporary), organizational, or environmental level—could be linked to the personal development and an increased SOC of the young men. A diversity and richness of resources (and stressors!) created various opportunities for learning: making sense, interpreting, and giving meaning to resources and stressors (Schreuder et al., 2014). Interestingly, young people found, or rediscovered, a sense of meaningfulness, purpose, and structure through small, taken for granted, or everyday aspects such as connection with nature, animals, and people; employment, rules, reciprocity, and respect. This work offers insight into the benefits for some people with complex needs of reconnecting with nature, the environment, and basic social networks.

Place-Related Design Principles

Healthy communities are compact and well connected. Environmental health planners recommend what they call "mixed-use design" (Lee & Maheswaran, 2011). Mixed-use design refers to using the land for varied reasons such as residential, retail, and employment combined with "connectivity" characterized by short distances between places of interest. Based on a review of current evidence (Brown & Grant, 2007) recommend five possible salutogenic interventions central to a "healthy community" design:

1. Paying attention to the green design of roads and transport routes as they reduce stress in the people traveling along them. They describe the Dutch "woonerfs" (home zones) as examples which include lots of street trees, verge planting, and soft surfaces.
2. Providing a range of open spaces for people to use and to observe: parks, gardens, terraces, squares, verges, and river banks, not only in residential spaces but also in the surroundings of businesses.
3. Balancing soft surfaces and vegetative cover for local air hygiene and temperature control.
4. Providing trees for shade and shelter, visual interest, and nearby nature.
5. Build in health using nature as an integrated element of planning: "Nature is not merely an amenity, luxury, frill or decoration. The availability of nearby nature meets and essential human need."

Connected Communities

In terms of the evidence that healthy (strong) communities or neighborhoods contribute to health and well-being, Elliot et al. (2012) concluded that little or no evidence existed for interventions that transformed neighborhood relationships in ways that enhanced collective resources per se, but fairly strong evidence for interventions focused on affirmation of social identity, rather than transformative interventions focused on power, succeeds in forging strong social relationships between a group of people and is good for health (e.g., community gardens); particularly interventions bringing previously isolated individuals in contact with others who share a common experience (such as healthy aging) (Lezwijn et al., 2011).

Nash (2002) promotes a comprehensive approach with essential elements of social work functions such as linking, consensus-building, and community organizing. They also recommend this approach is informed by values of cultural competence and empowerment. Sharing neighborhood history evokes emotions of belonging (Larsen & Stock, 2011), while community gardening can help promote social identity through increased sense of belonging and reciprocity and mutuality (Hale et al., 2011; Saldivar-tanaka & Krasny, 2004; Teig et al., 2009; Wakefield et al., 2007).

An early childhood intervention program, KidsFirst in Canada, which aimed to enhance social capital and social cohesion at community level, managed to bring the community together through conducting broad and targeted community consultations, and developing partnerships. The program enabled vulnerable families to enhance connectedness among themselves, to link them to services, and to integrate them in the larger community (Shan et al., 2012). Investing in social connectedness is, however, not a panacea for health and sometimes can facilitate negative or perverse consequences (Kawachi, 2010) such as exclusion of outsiders, intolerance of diversity, and restrictions on individual freedoms.

Social Community Action

The ability of residents to organize and engage in collective action enables residents of communities to lobby for safety in the neighborhood (Baum et al., 2009), to rally against closure of (health) services (Mooney & Fyfe, 2006), or to manage informal care (Kawachi, 2010). Often this is facilitated by the presence of local organizations.

In the development of social or community action, "trust" plays a central role. The extent to which people are able to participate in the social, economic, and cultural life of their communities clearly depends on the level of trust between

community members. In situations where individuals are both empowered and experience a certain level of "trust," they are more likely to participate in action leading to changes in situations for the better (Ward & Meyer, 2009). This also helps explain the reported success of various autonomously organized urban initiatives (Kremer & Tonkens, 2006).

In the area of disaster management and based on salutogenic principles that communities can develop adaptive capacities to respond and recover from adverse events, O'Sullivan and colleagues (2015) developed a structured interview matrix which was an effective technique to enhance connectedness, common ground, collaborative action, and awareness of existing services and supports in each community.

Synergies Between Improving Place, Connectedness, and Community Action and the Wider Determinants of Health

Improving place, connectedness, and community action have been described as separate matters, but in fact there is strong synergy between the three and therefore it is questionable whether some of the studies reported here are categorized under the best heading.

An example of a wider community-based salutogenic approach is the Mersey Forest project in Liverpool, UK. The aim of this project is to get people involved in the design of their Greenspace, encouraging them to step outside and take ownership of the space. They help to maintain it, benefitting their health through the physical work, developing social skills (Maas et al., 2009) and improving mental health, and for some breaking the cycle of fear and isolation from living alone in a large city. This project has helped to grow food on community allotments and create new community gardens and orchards, sport facilities, and wildlife areas. A critical success factor of this project is not only the green environment but also the utilization of the opportunities (assets) different community groups bring together (Forestry-Commission-England, 2012) and the empowerment gained through the process of collective engagement or social action.

This interrelation of various determinants of health within communities also relates back to the point we made in the beginning of this chapter where we stressed that communities are complex social systems. In addition, health advancement is clearly also not only connected to the community level. An example of this interrelatedness and the role of more distal determinants is the fact that in egalitarian societies with strong safety nets and adequate provision of public goods, neighborhood contexts may be less salient for the health of residents in contrast to segregated and unequal societies as the USA (Kawachi, 2010).

Implications for Salutogenic Practice

In this section, it is important to clearly show what we can learn from this broad literature for advancing the field of salutogenesis—and how the field of community health could benefit from being more explicitly linked to salutogenesis.

Reducing traditional risk factors in neighborhoods remains a relevant and important objective for health promotion. It is equally, some argue, important to redress the balance between the traditional focus on risk and deficit and an assets model. This being the case, underpinning assets approach with salutogenic theory, so a better understanding of how the salutogenic model translates into community and neighborhood level health promotion policy and practice, is therefore required. Unraveling the complex relationship between SOC and GRRs—in the context of community and neighborhood—is an important first step.

Antonovosky originally articulated the need to appreciate the reciprocal or mutual requirement of his salutogenic model: both a strong sense of SOC and interaction with GRRs. Salutogenic research has illustrated this time after time, not least in research conducted in the community and neighborhood, where social connectivity is a clear example of a GRR.

In practical terms, we can conclude that from a salutogenic perspective, rich environments for learning and meaningful contexts seem to play an important role at the community level. As many salutogenic community interventions might be influenced by other broader structural factors, that is, poverty, unemployment, and economic crisis, investing in communities should be complemented by wider structural interventions (Szreter & Woolcock, 2004).

Implications for Salutogenic Research

We found that the available evidence explicitly based on salutogenic theory is limited. However, there are a number of disciplines which apply a similar frame of mind but do not link this to the theory of salutogenesis. We recommend people interested in this area to look into other disciplines than health promotion such as urban sociology, cultural geography, and social work. We found that there is a lot of thinking in the same direction (interaction between environment and how people think, perceive their environment).

Opportunities exist for a greater emphasis on salutogenic theory in all areas of social policy including housing, regeneration, youth and community work, young people and play,

community safety and policing, education, and employment.

There is an abundance of evidence of a relationship between strong social connection or connectivity and enhanced sense of health and well-being. How this plays out at the community level is more difficult to articulate. Research into communities where social capital and cultural capital are seen as GRRs is largely lacking (Lindström, 2012). More research is required that adopts a salutogenic lens for interpreting health and well-being within this context. Recent examples (Dunleavy et al., 2014; Schreuder et al., 2014) have attempted to use the theoretical framework of salutogenesis to identify potential GRRs and the underlying mechanisms of health development; although useful and, seemingly logical, one of the challenges of this approach is to stay critical about what we label as GRRs and SOC. A more inductive type of research is also needed to further examine when a resource becomes a GRR.

A salutogenic community approach/asset approach of creating rich, social, and physical environments for learning and meaningful contexts leads to improved outcomes in a range of domains, and it is difficult to capture them (and certainly only measuring SOC makes little sense). More work is needed to help develop appropriate indicators for both the assets approach and salutogenic theory and other strength-based approaches.

Effects of a salutogenic community approach might not be visible immediately but might take a long time. Health promotion is however used to meet this challenge. For decades now, we have had to educate researchers and policy-makers from other fields or familiar with more traditional paradigms to recognize the relativist and distal nature of so many of the outcomes from health promotion practice. As already mentioned, the complexity of community systems confounds this further. We must therefore seek to develop a range of indicators to measure health and well-being at the community level; if we can break this down further into key concepts to be associated with salutogenic processes, then there will be progress. New research designs are also needed to capture effectiveness questions.

Challenges for the Future

To date, the majority of research into salutogenesis has been done from a quantitative perspective. This is understandable, given that Antonovsky's work focused around the SOC and subsequently the use of SOC scale in attempting to explain causal explanations between individual and particular health outcomes. This approach has some merit for researchers interested in enabling the promotion of health through communities, social networks, and social action. It is, however,

most likely to result in the characterization of certain community types or behavior in terms of strong or weak SOC. Although extrapolations can be made, based on the evidence base for a relationship between SOC and health and well-being, this approach seems limited, largely due to our limited understanding of the precise mechanisms of "what creates SOC and salutogenic setting or place," such as a community (e.g., workplace, neighborhood). More research, particularly involving qualitative inquiry, is needed to explore the closeness of fit between existing theory and experience.

Cross-cultural comparisons of subjective experience are also warranted to test out existing ideas linking salutogenesis with community and neighborhood health in different settings. We need to be confident that the key terms and concepts we develop are relevant in any context. Finally, more evidence is needed, especially from other societal contexts, for example, in less developed countries.

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