Journal of Prevention
https://doi.org/10.1007/s10935-026-00931-9

DEBATE

Prevention Science, Community Empowerment and Social Justice in Achieving Stronger, Healthier Communities

Giovanni Aresi[1,2] · **Glenn Laverack**[3]

Received: 27 July 2025 / Accepted: 15 June 2026

Abstract

Sustainable improvements in health and well-being depend not only on the dissemination of effective interventions, but also on communities having the capacity and power to shape the conditions that influence their lives. In this article, we discuss how a systematic "domains" approach can be used to operationalize empowerment-oriented interventions that view communities as active agents of change. This approach strengthens communities' capacity to take ownership of their health and to co-produce changes based on their needs. We also explain how prevention researchers and practitioners can benefit from key dimensions of capacity building, participation, and social justice. These dimensions can help address the social determinants of health and enable disadvantaged and vulnerable communities to resist dominant, top-down structures through collective organization and action, thereby fostering stronger and healthier communities. Prevention scientists who incorporate empowerment-oriented processes into the communities with which they work are well positioned to support collaborative efforts that promote empowerment, equity, and healthier communities. This approach can enhance the relevance, sustainability, and equity of prevention initiatives.

Keywords Prevention · Health promotion · Community · Empowerment

✉ Giovanni Aresi
giovanni.aresi@unicatt.it

[1] Psychology Department, Università Cattolica del Sacro Cuore, Largo Gemelli 1, 20123 Milano, Italy

[2] CERISVICO Research Centre on Community Development and Organizational Quality of Life, via Garzetta 48, 25121 Brescia, Italy

[3] United Arab Emirates University. Institute of Public Health, Al Ain, United Arab Emirates

Published online: 26 June 2026

Introduction

Communities are critical settings for promoting health and well-being. The community concept has evolved from a particular place or territory, such as a town or neighborhood, to include relationships among people, organizations, and institutions at various socioecological levels (Kloos et al., 2021). This includes non-place-based communities of identity, and virtual communities lacking any territorial proximity (Capece & Costa, 2013). In this paper we focus on place-based communities, localities, and geographic settings, such as towns, rural communities and urban neighborhoods. Localities are distinguished by a tangible environment and intangible organizational, institutional, social and economic dimensions, all of which play a vital role in the health and well-being of the population (Baciu et al., 2017).

We argue that, in working with communities, prevention science has advanced in developing evidence-based practices (EBPs) delivery systems to address the research-practice gap. Yet prevention scientists can benefit from adopting a community empowerment approach as an essential dimension for achieving stronger, healthier communities.

Prevention Science Approaches in Community Settings

Prevention science focuses on developing evidence-based practices (EBPs) that reduce risk factors and enhance protective factors to improve the health and well-being of individuals, families, and communities. Inspired by the principles of evidence-based medicine, the prevention science model provides a framework for producing high-quality evidence that demonstrates the efficacy of an intervention. Among its many merits, prevention science has successfully identified strategies for addressing health problems, as well as strategies that are ineffective or iatrogenic (Fishbein, 2021; Sloboda & David, 2021).

Arguably, prevention science favors a research-to-practice (RTP) approach, which emphasizes transferring evidence-based knowledge and best practices into real-world settings. Strong research and theoretical foundations in preventive intervention development are, of course, critically important and contribute to improving the quality of interventions and assessing their effectiveness. However, in light of recent frameworks advocating greater methodological flexibility and stakeholder engagement in evaluations (Gottfredson et al., 2015; Skivington et al., 2021), the RTP approach has been criticized for favoring fidelity to standardized, single interventions and highly controlled evaluations, often at the expense of contextual responsiveness and local adaptation before large-scale implementation (Archibald, 2015; Flaspohler et al., 2008). There is currently increasing recognition of the limitations of this approach in achieving change within complex social systems such as communities (Moore et al., 2019). The RTP approach views the adoption of innovation from the researcher's perspective, whereas communities and practitioners are represented, either explicitly or implicitly, as passive recipients of the benefits of science (Flaspohler et al., 2008). The community-as-recipient approach is reflected in key constructs used by prevention scientists, including community readiness. This concept refers to a community's

capacity or ability to take action to address an issue of interest. Among prevention scientists, however, it is more often narrowly conceptualized as a community's readiness to adopt evidence-based interventions or systems (Parker et al., 2018; Spoth et al., 2015).

In its more extreme form, the conceptualization of communities as recipients is problematic because it implies the imposition of top-down decisions. It entails adopting a mechanistic and overly simplistic notion of health promotion while ignoring the "many cultural and contextual complexities that are fundamentally important considerations in their praxis" (Archibald, 2015, p. 145). Some authors have suggested that a community-as-recipient approach may have inadvertently contributed to the research–practice gap and the underuse of EBPs (Bumbarger & Perkins, 2008; Joyce & Cartwright, 2020).

Community Partnership Models

In recent decades, several community partnership models have emerged, marking a significant advancement in addressing the research–practice gap in community-based prevention efforts. One such model is *Communities That Care (CTC)* (Hawkins et al., 2002), which has demonstrated favorable youth outcomes related to risk behaviors, as well as important community-level outcomes that support prevention efforts (Kuklinski et al., 2021). CTC promotes a structured, coalition-based prevention system that uses local epidemiological data to identify and prioritize specific risk factors over an extended period. Coalitions receive training and technical and financial assistance, as well as guidance in choosing evidence-based programs to address the identified risk factors.

Another example of a community-centered prevention model is *Getting to Outcomes* (GTO), which uses a 10-step process that includes needs assessment, strategic planning, implementation of EBPs tailored to community needs, process and outcome evaluation, continuous quality improvement, and sustainability planning. GTO has demonstrated effectiveness across a variety of community settings and health issues, including in large-scale trials (Wandersman et al., 2016), by placing control in the hands of community stakeholders and promoting capacity building for effective health promotion.

Although the CTC and GTO models differ, both recognize that translating research evidence into community action requires an intersectoral approach tailored to local priorities, strengths, and needs. They also acknowledge that implementation challenges in community settings arise from multiple community-level factors, including inadequate training, limited organizational buy-in, insufficient stakeholder support, and financial and resource constraints (Kumpfer et al., 2020).

Community partnership models essentially reflect the concept of health infrastructure development, or delivery systems, designed to address barriers to translating research into practice and to facilitate the implementation of EBPs in community settings (Labonte & Laverack, 2001). However, these approaches may be further strengthened by incorporating community empowerment as a more central objective. Expanding attention beyond the prevention of behavioral problems to include participatory approaches and the broader structural determinants of health may enhance

the scope and sustainability of health promotion efforts (Peters et al., 2022; Tengland, 2016).

Next, we discuss how prevention scientists can reorient their work towards social change achieved through community empowerment.

Community Empowerment

Empowerment can be defined as "an intentional, ongoing process centered in the local community, involving mutual respect, critical reflection, caring, and group participation, through which people lacking an equal share of resources gain greater access to and control over those resources" (Cornell Empowerment Group, 1989, p. 2). Empowerment is a dynamic, multilevel construct concerned with unequal power relations, control of resources, and the capacity to determine priorities and actions that build upon local strengths to improve health and well-being while promoting equity and social justice (Prilleltensky, 2012).

Within this approach, communities are viewed as active agents rather than passive recipients, and the aim of health promotion is to help people to empower themselves by strengthening the capacity of local groups, organizations, and communities to take ownership of their health and to co-produce change in their favour (Craig, 2007). Nine 'domains' (the domains approach) have been used to operationalize empowerment-oriented community interventions (Laverack, 2014) as follows:

- Improve participation of community members and groups;
- Develop local formal and informal leadership as part of community capacity building efforts;
- Increase problem assessment capacities by involving community members and groups into the identification of community problems from their perspective;
- Enhance critical awareness of the structural, social, economical and political determinants of (poor) health;
- Build organizational structures, such as committees, informal groups of youths, families, etc. that represent key intermediaries between individuals and the community;
- Improve the capacity of the community to mobilize or gain access to resources to address issues;
- Strengthen community partnerships, for example in the form of coalitions;
- Create an equitable relationship with outside agents, such as researchers and health practitioners;
- Give more control over intervention management in key areas such as planning, implementation, evaluation, finance, administration and reporting.

These domains enable communities to strengthen collective organization and action toward specific, locally identified goals that uses a pragmatic perspective to conceptualize empowerment as a process and a system of relationships rather than as a single intervention. The complexity of the community context requires an iterative,

community-driven, and long-term strategies aimed at producing changes at the level of community practices, programs, and systems (Suarez-Balcazar et al., 2020).

Rather than emphasizing the achievement of specific health and behavioral outcomes alone, success is interpreted in terms of capacity building to help empower individuals and communities, improve functioning and participation in health services, and strengthen the resources and assets that support health across settings. These processes mediate health improvements over time and are important for achieving broader goals (Tengland, 2016; Wilson et al., 2014) such as health inequalities and greater control as through more effective empowerment-oriented health promotion programs (Laverack, 2006; Steinert et al., 2021; Trisnowati et al., 2021).

Shifting the focus toward community empowerment may help prevention scientists work more effectively with stakeholders to foster healthier and more resilient communities. The following sections describe key dimensions of the empowerment-oriented approach and outline important considerations for health promotion program development.

Strengths-Based, Capacity Building Approach

A community's existing strengths and resources should serve as the focal point of collaborative efforts aimed at building capacity, defined as "a more generic increase in community groups' abilities to define, assess, analyze, and act on health (or any other) concerns important to their members" (Labonte & Laverack, 2001, p. 114). This process includes sustaining local leadership; creating or strengthening informal networks and relationships among community groups; promoting autonomy and self-determination at the group and community levels; and increasing awareness of health determinants and power relations that support community engagement and capacity development (Tengland, 2016). From this perspective, capacity building is viewed not only as a means of achieving healthier communities but also as an important outcome. Thus, researchers, local institutions, health organizations, and practitioners can contribute to capacity building both as a process and as an outcome. A recent review of interventions aimed at strengthening community resources reported evidence of effectiveness across a range of individual (e.g., adoption of healthier behaviors) and organizational (e.g., development of new partnerships and adaptation of interventions) outcomes (Cassetti et al., 2020).

Fostering Authentic Participation

Empowerment-oriented efforts require the authentic engagement of community partners as equal collaborators. However, even when such intentions are present, meaningful participation is not always achieved, as demonstrated by a recent review of substance use prevention programs (Aresi et al., 2023). For participation to be empowering, communities must be granted a degree of control and decision-making power (Ozer et al., 2018) as well as opportunities for meaningful involvement that foster a sense of agency and leadership, strengthen social and interpersonal skills, promote critical thinking, and enhance a sense of community (Anyon et al., 2018).

Participatory processes should also support long-term efforts aimed at addressing issues that communities themselves identify as important (Lai, 2008).

The literature on community-engaged research (CER) provides prevention scientists with methodological guidance for developing and sustaining effective and equitable community–academic partnerships to address complex health issues (Goodman et al., 2017). CER is an umbrella term encompassing multiple forms of collaborative research, including Community-Based Participatory Research (Wallerstein, 2021), which represents a community-driven approach rather than a traditional research-to-practice model. CBPR prioritizes community needs and strengths, establishes long-term and equitable community–academic partnerships, particularly with marginalized communities, and applies research findings to community action in ways that promote individual and community empowerment. CBPR frameworks have demonstrated effectiveness in improving policies, practices, and health outcomes across diverse populations (Collins et al., 2018). They have also been identified as a strategy for increasing the cultural and contextual relevance of interventions (Fleischhacker et al., 2016) and fostering community ownership in the implementation of EBPs within disadvantaged communities (Alvidrez et al., 2019).

A Social Justice Framework

Social injustice negatively affects health and well-being and undermines the social fabric of communities (Wilkinson & Pickett, 2018). Preventive interventions that fail to address underlying structural inequalities may inadvertently contribute to widening health disparities by disproportionately benefiting socioeconomically advantaged groups, while disadvantaged and vulnerable populations continue to experience poorer outcomes (Prilleltensky, 2012; Tengland, 2016).

A social justice framework may benefit prevention researchers and practitioners by supporting efforts to address the social determinants of health, including unequal distributions of power and limited access to social, educational, and economic resources, which disproportionately affect disadvantaged communities and contribute to avoidable health inequities (Baciu et al., 2017). Accordingly, both the social and psychological theories commonly used in prevention science and equity-oriented theories and models that emphasize structural determinants of health—such as poverty, discrimination, and limited access to high-quality educational and employment opportunities—are essential for prevention research and practice (Boyd et al., 2023).

Conclusions

Communities are essential settings for promoting health and well-being. Community partnership models such as *Communities That Care* and *Getting to Outcomes* represent important advances in prevention science by strengthening the capacity of community settings to implement evidence-based practices through long-term collaboration and coalition-building. These models have contributed significantly to bridging the research–practice gap and improving prevention efforts in community settings.

At the same time, prevention science could benefit from a broader framework that places community empowerment at the center of prevention efforts. Although the dominant research-to-practice approach has advanced the development and dissemination of effective interventions, its emphasis on standardized implementation may limit responsiveness to the social, cultural, and structural realities of communities. Incorporating empowerment-oriented processes may therefore enhance the relevance, sustainability, and equity of prevention initiatives.

A community empowerment perspective views communities as active agents rather than passive recipients of interventions. From this standpoint, prevention efforts should strengthen local capacities, foster authentic participation, support collective agency, and address broader social determinants of health. In particular, the systematic "domains" approach can be used to reliably operationalize empowerment-oriented interventions and to strengthen community capacity. Importantly, adopting an empowerment-oriented approach does not require abandoning evidence-based prevention; rather, it involves complementing existing models with participatory and context-sensitive strategies that recognize the complexity of community systems and the value of local knowledge.

Ultimately, sustainable improvements in health and well-being depend not only on the dissemination of effective interventions but also on communities having the capacity and power to shape the conditions that influence their lives. Prevention scientists are therefore well positioned to support collaborative processes that promote empowerment, equity, and healthier communities.

Acknowledgements We would like to thank Professor Elena Marta of the Università Cattolica del Sacro Cuore for her comments on an early version of this manuscript.

Funding Open access funding provided by Università Cattolica del Sacro Cuore within the CRUI-CARE Agreement. This research did not receive funding from any public, commercial, or nonprofit sector agency.

Declarations

Conflict of Interest The authors declare that they have no potential conflict of interest with respect to the research, authorship, and/or publication of this article. Dr. Aresi is a member of the Editorial Board of the Journal of Prevention. However, the whole review process was independent, neutral and supervised by the Editor-in-Chief.

References

Alvidrez, J., Nápoles, A. M., Bernal, G., Lloyd, J., Cargill, V., Godette, D., Cooper, L., Brave Heart, H., Das, M. Y., R., & Farhat, T. (2019). Building the evidence base to inform planned intervention adaptations by practitioners serving health disparity populations. *American Journal of Public Health*, *109*(S1), S94–S101. https://doi.org/10.2105/ajph.2018.304915

Anyon, Y., Bender, K., Kennedy, H., & Dechants, J. (2018). A systematic review of youth participatory action research (ypar) in the united states: Methodologies, youth outcomes, and future directions. *Health Education & Behavior*, *45*(6), 865–878. https://doi.org/10.1177/1090198118769357

Archibald, T. (2015). They Just Know: The epistemological politics of evidence-based non-formal education. *Evaluation and Program Planning*, *48*, 137–148. https://doi.org/10.1016/j.evalprogplan.2014.08.001

Aresi, G., Ferrari, V., Marta, E., & Simões, F. (2023). Youth involvement in alcohol and drug prevention: A systematic review. *Journal of Community & Applied Social Psychology*, *33*(5), 1256–1279. https://doi.org/10.1002/casp.2704

Baciu, A., Negussie, Y., Geller, A., & Weinstein, J. N. (2017). *Communities in action: Pathways to health equity*. National Academies. https://doi.org/10.17226/24624

Boyd, R. C., Castro, F. G., Finigan-Carr, N., Okamoto, S. K., Barlow, A., Kim, B. K. E., Lambert, S., Lloyd, J., Zhang, X., Barksdale, C. L., Crowley, D. M., Maldonado-Molina, M., Obasi, E. M., & Kenney, A. (2023). Strategic directions in preventive intervention research to advance health equity. *Prevention Science*, *24*(4), 577–596. https://doi.org/10.1007/s11121-022-01462-5

Bumbarger, B., & Perkins, D. (2008). After randomised trials: Issues related to dissemination of evidence-based interventions. *Journal of Children's Services*, *3*(2), 55–64. https://doi.org/10.1108/17466660200800012

Capece, G.,and, & Costa, R. (2013). The new neighbourhood in the internet era: Network communities serving local communities. *Behaviour & Information Technology*, *32*(5), 438–448. https://doi.org/10.1080/0144929X.2011.610825

Cassetti, V., Powell, K., Barnes, A., & Sanders, T. (2020). A systematic scoping review of asset-based approaches to promote health in communities: Development of a framework. *Global Health Promotion*, *27*(3), 15–23. https://doi.org/10.1177/1757975919848925

Collins, S. E., Clifasefi, S. L., Stanton, J., The, L. A. B., Straits, K. J. E., Gil-Kashiwabara, E., Espinosa, R., Nicasio, P., Andrasik, A. V., Hawes, M. P., Miller, S. M., Nelson, K. A., Orfaly, L. A., Duran, V. E., B. M., & Wallerstein, N. (2018). Community-based participatory research (CBPR): Towards equitable involvement of community in psychology research. *American Psychologist*, *73*(7), 884–898. https://doi.org/10.1037/amp0000167

Cornell Empowerment Group. (1989). Empowerment and family support. *Networking Bulletin*, *1*(2), 1–23.

Craig, G. (2007). Community capacity-building: Something old, something new. *? Critical Social Policy*, *27*(3), 335–359. https://doi.org/10.1177/0261018307078846

Fishbein, D. (2021). The Pivotal Role of Prevention Science in This Syndemic. *Prevention Science*, *22*(1), 94–99. https://doi.org/10.1007/s11121-020-01180-w

Flaspohler, P., Duffy, J., Wandersman, A., Stillman, L., & Maras, M. A. (2008). Unpacking prevention capacity: An intersection of research-to-practice models and community-centered models. *American Journal of Community Psychology*, *41*(3–4), 182–196. https://doi.org/10.1007/s10464-008-9162-3

Fleischhacker, S., Roberts, E., Camplain, R., Evenson, K. R., & Gittelsohn, J. (2016). Promoting physical activity among native american youth: A systematic review of the methodology and current evidence of physical activity interventions and community-wide initiatives. *Journal of Racial and Ethnic Health Disparities*, *3*(4), 608–624. https://doi.org/10.1007/s40615-015-0180-1

Goodman, M. S., Thompson, V. L. S., Johnson, A., Gennarelli, C., Drake, R., Bajwa, B. F., Witherspoon, P., M., & Bowen, D. (2017). Evaluating community engagement in research: Quantitative measure development. *Journal of Community Psychology*, *45*(1), 17–32. https://doi.org/10.1002/jcop.21828

Gottfredson, D. C., Cook, T. D., Gardner, F. E. M., Gorman-Smith, D., Howe, G. W., Sandler, I. N., & Zafft, K. M. (2015). Standards of Evidence for Efficacy, Effectiveness, and Scale-up Research in Prevention Science: Next Generation. *Prevention Science*, *16*(7), 893–926. https://doi.org/10.1007/s11121-015-0555-x

Hawkins, J. D., Catalano, R. F., & Arthur, M. W. (2002). Promoting science-based prevention in communities. *Addictive Behaviors*, *27*(6), 951–976. https://doi.org/10.1016/S0306-4603(02)00298-8

Joyce, K. E., & Cartwright, N. (2020). Bridging the gap between research and practice: Predicting what will work locally. *American Educational Research Journal*, *57*(3), 1045–1082. https://doi.org/10.3102/0002831219866687

Kloos, B., Hill, J., Thomas, E., Case, A. D., Scott, V. C., & Wandersman, A. (2021). *Community psychology: Linking individuals and communities*. American Psychological Association. https://doi.org/10.1037/0000207-000

Kuklinski, M. R., Oesterle, S., Briney, J. S., & Hawkins, J. D. (2021). Long-term impacts and benefit–cost analysis of the communities that care prevention system at age 23, 12 years after baseline. *Prevention Science*, *22*(4), 452–463. https://doi.org/10.1007/s11121-021-01218-7

Kumpfer, K. L., Scheier, L. M., & Brown, J. (2020). Strategies to Avoid Replication Failure With Evidence-Based Prevention Interventions: Case Examples From the Strengthening Families Program. *Evaluation & the Health Professions*, *43*(2), 75–89. https://doi.org/10.1177/0163278718772886

Labonte, R., & Laverack, G. (2001). Capacity building in health promotion, Part 1: For whom? And for what purpose? *Critical Public Health*, *11*(2), 111–127. https://doi.org/10.1080/09581590110039838

Lai, F. C. (2008). Health promotion and participatory action research: The significance of participatory praxis in developing participatory health intervention. In P. Reason & H. Bradbury (Eds.), *The SAGE handbook of action research* (2nd ed., pp. 534–549). Sage. https://doi.org/10.4135/9781848607934

Laverack, G. (2006). Improving health outcomes through community empowerment: A review of the literature. *Journal Of Health, Population, And Nutrition*, *24*(1), 113–120.

Laverack, G. (2014). *The pocket guide to health promotion*. McGraw-Hill.

Moore, G. F., Evans, R. E., Hawkins, J., Littlecott, H., Melendez-Torres, G. J., Bonell, C., & Murphy, S. (2019). From complex social interventions to interventions in complex social systems: Future directions and unresolved questions for intervention development and evaluation. *Evaluation*, *25*(1), 23–45. https://doi.org/10.1177/1356389018803219

Ozer, E. J., Afifi, R., Gibbs, L., & Mathur, R. T. (2018). Youth engagement and participation: Field-building across research and practice. *Journal of Adolescent Health*, *63*(6), 671–672. https://doi.org/10.1016/j.jadohealth.2018.09.011

Parker, C. J., Winston, W., III., Simpson, T., & Brady, S. S. (2018). Community readiness to adopt the communities that care prevention system in an urban setting. *American Journal of Preventive Medicine, 55*(5), S59–S69. https://doi.org/10.1016/j.amepre.2018.05.022

Peters, L. E. R., Kelman, I., Shannon, G., & Tan, D. (2022). Synthesising the shifting terminology of community health: A critiquing review of agent-based approaches. *Global Public Health*, *17*(8), 1492–1506. https://doi.org/10.1080/17441692.2021.1938169

Prilleltensky, I. (2012). Wellness as fairness. *American Journal of Community Psychology, 49*(1), 1–21. https://doi.org/10.1007/s10464-011-9448-8

Skivington, K., Matthews, L., Simpson, S. A., Craig, P., Baird, J., Blazeby, J. M., Boyd, K. A., Craig, N., French, D. P., McIntosh, E., Petticrew, M., Rycroft-Malone, J., White, M., & Moore, L. (2021). A new framework for developing and evaluating complex interventions: Update of Medical Research Council guidance. *BMJ, 374*, Article n2061. https://doi.org/10.1136/bmj.n2061

Sloboda, Z., & David, S. B. (2021). Commentary on the culture of prevention. *Prevention Science, 22*(1), 84–90. https://doi.org/10.1007/s11121-020-01158-8

Spoth, R., Schainker, L. M., Redmond, C., Ralston, E., Yeh, H.-C., & Perkins, D. F. (2015). Mixed picture of readiness for adoption of evidence-based prevention programs in communities: Exploratory surveys of state program delivery systems. *American Journal of Community Psychology, 55*(3), 253–265. https://doi.org/10.1007/s10464-015-9707-1

Steinert, J. I., Alacevich, C., Steele, B., Hennegan, J., & Yakubovich, A. R. (2021). Response strategies for promoting gender equality in public health emergencies: A rapid scoping review. *BMJ Open, 11*(8), Article e048292. https://doi.org/10.1136/bmjopen-2020-048292

Suarez-Balcazar, Y., Francisco, V. T., & Rubén Chávez, N. (2020). Applying community-based participatory approaches to addressing health disparities and promoting health equity. *American Journal of Community Psychology, 66*(3–4), 217–221. https://doi.org/10.1002/ajcp.12487

Tengland, P.-A. (2016). Behavior change or empowerment: On the ethics of health-promotion goals. *Health Care Analysis, 24*(1), 24–46. https://doi.org/10.1007/s10728-013-0265-0

Trisnowati, H., Ismail, D., & Padmawati, R. S. (2021). Health promotion through youth empowerment to prevent and control smoking behavior: A conceptual paper. *Health Education, 121*(3), 275–294. https://doi.org/10.1108/HE-09-2020-0092

Wallerstein, N. (2021). Engage for equity: Advancing the fields of community-based participatory research and community-engaged research in community psychology and the social sciences. *American Journal of Community Psychology*, *67*(3–4), 251–255. https://doi.org/10.1002/ajcp.12530

Wandersman, A., Alia, K., Cook, B. S., Hsu, L. L., & Ramaswamy, R. (2016). Evidence-based interventions are necessary but not sufficient for achieving outcomes in each setting in a complex world: Empowerment evaluation, getting to outcomes, and demonstrating accountability. *American Journal of Evaluation*, *37*(4), 544–561. https://doi.org/10.1177/1098214016660613

Wilkinson, R. D., & Pickett, K. E. (2018). *The inner level: How more equal societies reduce stress, restore sanity and improve everyone's well-being*. Penguin Books Ltd.

Wilson, S., Campbell, D., Dalemarre, L., Fraser-Rahim, H., & Williams, E. (2014). A critical review of an authentic and transformative environmental justice and health community — university partnership. *International Journal of Environmental Research and Public Health*, *11*(12), 12817–12834. https://doi.org/10.3390/ijerph111212817