Improving health and well-being through community health champions: a thematic evaluation of a programme in Yorkshire and Humber

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Abstract

Aims: The contribution that lay people can make to the public health agenda is being increasingly recognised in research and policy literature. This paper examines the role of lay workers (referred to as 'community health champions') involved in community projects delivered by Altogether Better across Yorkshire and Humber. The aim of the paper is to describe key features of the community health champion approach and to examine the evidence that this type of intervention can have an impact on health.

Methods: A qualitative approach was taken to the evaluation, with two strands to gathering evidence: interviews conducted with different stakeholder groups including project leads, key partners from community and statutory sectors and community workers, plus two participatory workshops to gather the views of community health champions. Seven projects (from a possible 12) were identified to be involved in the evaluation. Those projects that allowed the evaluation team to explore fully the champion role (training, infrastructure, etc.) and how that works in practice as a mechanism for empowerment were selected. In total, 29 semi-structured interviews were conducted with project staff and partners, and 30 champions, varying in terms of age, gender, ethnicity and disability, took part in the workshops.

Results: Becoming a community health champion has health benefits such as increased self-esteem and confidence and improved well-being. For some champions, this was the start of a journey to other opportunities such as education or paid employment. There were many examples of the influence of champions extending to the wider community of family, friends and neighbours, including helping to support people to take part in community life. Champions recognised the value of connecting people through social networks, group activities, and linking people into services and the impact that that had on health and well-being. Project staff and partners also recognised that champions were promoting social cohesiveness and helping to integrate people into their community.

Conclusions: The recent public health White Paper suggested that the Altogether Better programme is improving individual and community health as well as increasing social capital, voluntary activity and wider civic participation. This evaluation supports this statement and suggests that the community health champion role can be a catalyst for change for both individuals and communities.

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INTRODUCTION

The Coalition Government's strategy for public health in England highlighted the benefits of the community health champion role and signified the benefits that lay public health workers can make in their local communities.[1] There is growing evidence relating to the benefits of engaging community members in promoting health[2] as positive impacts have been identified across a range of health and social outcomes.[3–10] Involving members of the public in supporting other people to make positive changes in their lives is based on a sound understanding of the value of life experience and the support systems that can exist within neighbourhoods.[11,12]

This paper presents findings of a thematic evaluation of the community health champion role, based on data collected from community projects being delivered as part of Altogether Better in Yorkshire and Humber. Altogether Better is a five-year programme funded by Big Lottery and hosted by Yorkshire and Humber Strategic Health Authority. The overarching aim of the thematic evaluation was to understand how the Altogether Better projects were contributing to health improvement in disadvantaged communities and to provide robust evidence to inform the development of practice. Our evaluation was interested in similarities and differences across the projects, as well as thematic commonalities. This paper specifically examines the role of a community health champion, how the community champion approach is being delivered and what impacts results. It also describes the influence that champions have made in their wider community.

While the term 'community health champion' is a relatively new addition to the already burgeoning array of terminology in this area, the concept has distinct similarities to other types of community and volunteer health roles.[2] The National Institute for Health and Clinical Effectiveness (NICE)[13] defines health champions as:

> *…individuals who possess the experience, enthusiasm and skills to encourage and support other individuals and communities to engage in health promotion activities. They also ensure that the health issues facing communities remain high on the agenda of organisations that can effect change. Health champions offer local authorities and community partnerships short-term support as consultants, encourage them to share good practice and help them develop activities to improve the health of local people.*

Community health champions in Yorkshire and Humber are involved in a huge range of activities including, among others, leading organised health walks, working in allotment and food-growing initiatives, setting up social clubs, delivering health-awareness presentations on chronic conditions, and signposting. The extent to which champions become involved and the intensity of the role depends on individual motivations and on the way that individual projects choose to operate. There are 16 Altogether Better projects (12 of which are located in disadvantaged communities and four of which are based in workplaces) that are working to increase physical activity, improve healthy eating and promote better mental health and well-being. Each project differs in scale, size and approach and details of each individual project can be found on the Altogether Better website (http://www.altogetherbetter.org.uk/home.aspx).

As highlighted in the recent government White Paper on public health,[1] Altogether Better is based on an empowerment model that consists of three key elements: building confidence; building capacity; and system challenge. The model acknowledges that empowerment is a complex process that can occur at an individual, organisational or community level.[14] At the heart of this model are the community health champions who are equipped with the knowledge, confidence and skills to make a difference in their communities. The premise is that community health champions will gain personal benefits from involvement, which will ultimately lead to them inspiring others.[15]

METHODS

Qualitative approaches are becoming increasingly used in evaluation research as they are particularly adept at examining the dynamics of how mechanisms operate and how outcomes are achieved.[16] The use of qualitative methods is particularly suited to evaluating community initiatives, such as Altogether Better.[17] This is because these programmes have multiple and diverse processes and outcomes and therefore demand flexible and sensitive approaches to capture the impact. An important consideration when designing the evaluation was listening to the views of those working directly within projects and in partnerships and also to provide the champions with an opportunity to share their experiences. Seven projects (from a possible 12) were identified to be involved in the evaluation. Those projects that were more 'established' in terms of recruiting and training champions and implementing the empowerment model were selected so that an in-depth understanding of the various community health champion approaches could be captured. A brief overview of the projects selected is presented in Table 1. This thematic evaluation served to complement the programme-level evaluation, which provided a cumulative overview of all the Altogether Better projects.[18]

Data collection was conducted over a three-month period, during which there were two key strands to gathering evidence for the evaluation:

- Interviews with project staff and partners.
- Participatory workshops to gather the views of champions.

The data collection with project staff and partners consisted of 29 interviews. Initially, project leads in each of the six projects were contacted by the evaluation team and invited to participate in the evaluation. In the majority of cases, interviews were conducted face to face, using a semi-structured interview schedule designed to address the aims and objectives of the evaluation. A form of snowball sampling (or chain sampling)

Table 1

Community projects involved in the thematic evaluation

Project name and description	Target groups	Core training provision
One Barnsley Builds capacity within target communities in Barnsley to support local people to improve their health and to become community health educators. Employs two community development and health workers.	Deprived communities living in the two target areas of Barnsley.	14-week accredited course with intensive training and support.
Bradford Seniors Show the Way The project works with older people across the Bradford district in order to improve their health and to encourage them to 'pass on' these health messages to their friends and family.	Older people (50+) living in the Bradford district.	A range of short 'low-level' courses developed by the project team. Less-intensive training and support.
Calderdale Community Health Educators The project recruits, trains and supports individuals within targeted communities to become community health champions and to influence the lifestyle and health of others.	Deprived communities within four target wards in Calderdale.	A range of short courses developed by the project team and partner agencies. Intensive training and support provided.
East Riding of Yorkshire Coastal Health Improvement Programme The project provides advice, activity and support for isolated communities living on the East Riding coast in order that they improve their health.	Deprived communities on the East Riding coastal strip.	Fit4Life five-week programme developed by the project team.
Healthwise Hull Builds capacity within the city's priority communities to support people to improve their health and encourage them to influence others.	Young unemployed people, families on low income, black and minority ethnic (BME) communities, looked-after children, people with poor health, people with learning disabilities and their carers.	14-week accredited course with intensive training and support.
Sheffield Community Health Champions Network The project aims to build capacity within the city's priority communities to support people to improve their health and the health of their friends, family and community.	Deprived communities in Sheffield.	14-week accredited course with intensive training and support.
Older and Active in Leeds This project aims to empower members of the city's older generation to live healthier, more active lives.	Communities in Leeds.	Training delivered by in-house team. Support provided.

was also used, whereby project leads were invited to suggest other key individuals who would be able to contribute to the evaluation.[19] Individuals were then sampled from this list based on how their background and role could contribute to meeting the evaluation's objectives.

The majority of interviews were conducted by a research assistant (the authors were also involved in interviewing) and covered a number of areas including the recruitment, training and development of champions, factors affecting delivery and implementation of the programmes, outcomes and impact and how empowerment approaches work in practice. The length of interviews varied, lasting between 20 and 90 minutes.

In terms of gaining the views of champions, two workshops were facilitated by the authors. Recruitment for the workshops focused on five Altogether Better projects and project leads in these projects were invited to publicise the workshops to their champions. These projects were selected because their models for delivering empowerment approaches varied and the differing experiences of the champions would illuminate the role further. The workshops were designed to be interactive and engaging as well as offering the champions some training in active listening and a chance to network with each other. The workshops also allowed the

Table 2

Sample of projects and number of interviewees

Project	Project staff	Other partners	Champions
One Barnsley	1	1	–
Calderdale Community Health Educator Project	2	4	–
Sheffield Community Health Champions Network	1	6	4
Bradford Seniors Show the Way	5	–	8
East Riding Coastal Health Improvement Programme	1	3	6
Healthwise Hull	2	3	7
Older and Active in Leeds	–	–	5
Total in each category	**12**	**17**	**30**

opportunity for data to be collected, as sections of the workshop (mainly focus group discussions) were digitally recorded after consent had been gained. In total, 30 champions, varying in terms of age, gender, ethnicity and disability, took part. Each champion received a high street shopping voucher in recognition of the time and effort they had invested in the workshops.

Ethical considerations

Community health champions, project staff and partners received an information sheet to explain the purpose of the evaluation in advance of data collection. Participants were free to withdraw from the evaluation at any time. Individuals involved in the evaluation were also assured that they would not be directly identifiable during the reporting of the findings. Given that this was a service evaluation, it did not require formal ethical approval through the National Research Ethics Service (NRES), however documentation was reviewed internally in the university prior to data collection taking place. The evaluation team also adhered to ethical principles of informed consent, confidentiality and so on.

Data analysis

Data analysis was conducted over a number of stages. After all data (interview and workshop recordings) had been transcribed verbatim, members of the evaluation team (including the authors) read and familiarised themselves with the content of the transcripts. Based on this, a coding framework was developed after the entire data set had been worked through systematically. This framework was derived from thematic areas of interest within the data itself often based on repeated patterns across the data set.[20] The coding framework was refined and agreed among the evaluation team and applied to the original transcripts to extract major themes.

RESULTS

The results are presented according to the thematic areas that were identified during data analysis. Where appropriate, direct quotations have been used for illustrative purposes and selected to support the interpretation and findings.

Table 2 shows the projects included within the thematic evaluation and the numbers of individuals that took part in data collection.

The community health champion role

The champions described the range of activities in which they were involved. Organising health walks, delivering presentations to raise awareness of chronic conditions and signposting individuals to services are a small selection of the activities mentioned (see Box 1 for an example of a champion organising a health event). Individuals were involved in these to different degrees; for some their champion role had become central to their lives and occupied much of their time, for others it was a relatively small part. Broadly, their roles could be divided into three main areas:

1. Talking to people informally as part of their daily lives.
2. Providing more intensive support to individuals.
3. Partaking in or managing/leading activities, groups or events.

Sometimes champions were involved as part of a National Health Service (NHS) programme like cardiovascular disease screening, but more often they were based within a community organisation and either engaged with activities they were running, or worked on their own initiative using their informal networks. There were several aspects to the community health champion role that participants felt made them different from most professionals:

- Champions have time, and for many they are never ‘off duty’ – they live where they work and have a lot of informal contact with ‘target’ communities, and this contact is more personal.
- They act as a ‘bridge’ between marginalised individuals and communities and the services and activities that are available.
- They have the time to really get to the bottom of problems and to support people to come up with their own solutions.
- They can go with people who lack the confidence to attend a group or service for the first time.
- They can look to each other for support and expertise.
- They can work at the pace that suits them and the people they are working with and do not have to worry about targets.

Box 1

An example of collaboration on a range of health activities in the community

'We did a health day and we had 100 people in two hours and we put on events with smoking people there and there was games, everything to do with health but it was done as games. Hook-a-Duck was exercise – you hooked a duck and you had to do what it said. It was called family passport day to health and you had to be a family – whether it was one adult and a child or whatever but it was about families doing things together. We had obstacle courses, we had food games, we had taste testing, smoking, laugh out loud corner – everything you can think of we did. Everybody enjoyed it and they got a certificate and a goodie bag with leaflets and freebies and we got funding for fruit and veg and for smoothies and that was all free once you'd paid you £1 as a family – even if there was 10 of you it was still only a pound and everything was free inside and they just really enjoyed it and they said learning about healthy things in a fun way was really good. We had Hook-a-Bag and the questions were all on smoking, so the kids thought it was great hooking a bag and it was something about health inside.'

Community health champion

Qualities required to be a champion

The evaluation investigated the key qualities that people needed if they were to be a successful champion and a consensus emerged from all participants (health champions, project leads and partners) in terms of the attributes required. Empathy, enthusiasm, communication skills and knowing where people could go for further support were all critical qualities mentioned. There were a variety of views on whether it was important for champions to come from the communities with which they worked. In general, project staff and partners talked about champions needing to have a 'sense of community', whereas champions talked more about being 'part of the community' and of having shared experiences, such as having struggled with obesity or mental health issues.

The enthusiasm of champions for their work came across strongly and many individuals were clearly passionate about the role. What motivated them varied somewhat, but there was generally agreement that helping people and doing something to address the issues within their community were central. One community health champion said: *'I've developed a passion for my community and I engage more with my community in a very positive way.'*

The processes needed to support champions

All participants saw training and support as critical to translating the Altogether Better approach into practice. Project leads reported that one of the primary differences between projects was the intensity and duration of the training offered. For example, some projects adopted a less demanding training programme that was designed to cover only a few key topic areas (e.g. keeping active, healthy eating, etc.) and prepare champions for disseminating simple health advice. In contrast, some projects provided a more intensive training package (in some cases this was also accredited), usually delivered over a period of many weeks. A more thorough training package was required as it was envisaged that these champions would have a more 'active' community development role.

Similar to the provision of training for champions, there were differences in the amount of support champions received. Some projects provided regular one-to-one supervision; others had a more 'light-touch' approach and just organised occasional champion meetings. Some champions felt strongly that an adequate level of supervision should be provided:

I think supervision is an important part of volunteering and I don't think all organisations offer what I consider to be an adequate level of support to volunteers. Things like that you're not out of pocket for anything that you do financially is important. There are opportunities there to develop personally within a volunteering role. I think there is a movement away from that traditional view of what being a volunteer is about. I think I've had to negotiate that within my host organisation, I went in there and I wasn't particularly satisfied with the level of supervision but things are moving in a good direction which I consider to be positive and I think they do as well.

As well as personal support, champions appreciated help with setting up activities, and the regular updates, newsletters and mailings that some received were considered useful.

Health and social benefits for community health champions

There was a strong emphasis on the difference the projects had made to the lives of champions. There was, for instance, a firm consensus that by engaging in training and becoming champions, many participants had increased their self-esteem, self-awareness, confidence and in some cases had 'completely transformed'. This, according to the project leads and partners, had been particularly noticeable in individuals who had been out of work for some time or for individuals who had been socially isolated and had lacked self-confidence. One project lead said:

…it does give people a lot of confidence, because some of the people that are health champions and are maybe out of work; the nature of what we're trying to do is empower people and encourage them and motivate them and increase their self-esteem

and things like that. And I think becoming a health champion is a massive boost for people's confidence and self-esteem.

In terms of physical health, some champions talked about the changes they had made, such as losing weight and being more physically active. More frequently, however, they discussed the improvements to their mental health, quality of life and general well-being. Working and learning alongside other people within the champion role, for instance, presented a chance for new friendships to develop and this was a motivating factor for several individuals. This was reported to be particularly important for older people living in rural communities, where poor and sporadic transport links could cause social isolation and disengagement from the community. Being a champion had also given an added sense of purpose to many participants. For example, one course trainer, a project partner, summarised the importance that people place on being identified as a champion: *'They've got a role and they're proud of what they're doing.'*

Many project leads spoke about the 'journey' that many people had made since starting the project and commented on the personal progression of many champions. It did, however, seem that these journeys were more common in the projects with a more intensive style of training. Some champions, for example, had progressed into higher or further education, paid employment or had moved on to volunteer in other voluntary sector projects.

The impact of champions on communities

The champions talked confidently about the changes resulting from people engaging in activities. In some cases these changes were to do with physical health, such as weight loss or smoking cessation, but there was much more emphasis on the difference that group activities were making to people's mental health and well-being.

Champions recognised the value of connecting people through social networks, group activities and linking people into services, and the impact that had on health and well-being. Project staff and partners also recognised that champions were promoting social cohesiveness and helping to integrate people into their community, but were more tentative when articulating the benefits champions were making in the wider community. Several project leads thought that as their projects were still in their infancy (and might only have got as far as training champions), it was too early to expect to see behaviour changes in indirect beneficiaries or to properly assess the wider impact of the work. One project lead said: 'I'm not sure they've been around long enough to say that there's an outcome that they have impacted on behaviour change, I think it's too early for that.'

Despite this, many project leads speculated that the champions would make an impact and would be able to influence communities if they were given time to do so. For example, one said:

I think it's a little bit too early for me to say, but again I'm quite confident that things will change in communities, and I think it will take a long time, I think it will be a long process to fully change communities, but I think they are making a difference.

Altogether Better's empowerment model in practice

Project leads recognised the value of Altogether Better's empowerment model in tackling health inequalities and equipping people with the knowledge, confidence and skills to make a difference in their communities. As one project leader put it: *'To me that empowerment model is something that the project is all about and is crucial to reducing health inequalities and getting people influenced to make those changes.'*

The majority of project leads and partners recognised and understood that empowerment was not only a concept concerning individuals, but it is also about community influence and system challenge. For example, most were able to comment on how individual champions had become 'empowered' and had gained confidence, skills and increased levels of self-esteem. In addition, interviewees also explained how individuals had been able to take more control over their lives and the issues affecting their local area. One project partner said: 'I think it's about people feeling more confident and more skilled and more able to take control over their own lives and have more of a saying in what's going on around them really.'

One key theme to emerge was the heightened awareness that champions had developed in relation to their local environment and their confidence to challenge community infrastructures. One project partner suggested that by improving the confidence and skills of champions, through training and support, they were enabled to influence the wider community. She likened this to ripples in a pond:

So it's about, I suppose it's like the stone in the pond, isn't it for me? I think it's like you drop the stone and you get the ripple effect, and that's how I see the empowerment for those coming on our courses.

A number of barriers were highlighted in relation to Altogether Better's empowerment model and its delivery in practice. Most notably, and as mentioned previously, the time needed to engage communities and build trust was envisaged to be a lengthy process, especially in communities seen as 'hard to reach'. As one project lead described it: *'So that's a big barrier, getting into these communities that are quite insulated sometimes. It's difficult to break that door down.'*

DISCUSSION

This paper set out to illustrate findings from a thematic evaluation of the community health champion role. It intended to examine the key features of the community health champion approach and to examine the evidence that this type of intervention can have an impact on health. The evaluation aimed to understand how the Altogether Better projects in Yorkshire and Humber involve community health champions to improve health and to provide robust evidence to

inform the development of practice. While not all of the Altogether Better projects were included in the evaluation, one strength of the design was that an in-depth and diverse range of perspectives from within projects could be heard, including a range of community health champions, project leads and other key partners. This allowed a comprehensive view of the community health champion role and the mechanisms underlying the empowerment model to be uncovered.

There is agreement within the data that the outcomes for champions as individuals were positive. Project staff and partners observed increases in self-esteem, confidence, self-belief and an improvement in lifestyle, and champions themselves emphasised how they had gained from the role in terms of their mental and social health and general sense of well-being. This finding reiterates wider literature on lay involvement and the impact this has for participants.[21] Indeed, participation as a community health champion not only improved the mental and social health of individuals, but also acted as a catalyst for personal development, resulting in individuals going on to pursue other opportunities and gain subsequent employment. Similar findings were also seen in Attree's [22] study where community support workers reported acquiring skills that could be transferable to other contexts, such as further education or career enhancement.

The differing perspectives between champions and project staff were noted when discussing the outcomes of the Altogether Better projects. For example, the champions themselves were confident that they were making a real difference to people's physical and mental health. However, project staff and partners were more cautious in their assertions. Many projects were still at an early stage of their development and project leads talked about the difficulties of collecting outcome data and were aware that much of their 'evidence' was anecdotal. However, there is a reasonable volume of evidence from systematic reviews indicating that community/lay health workers are effective in supporting positive behaviour changes[2] and the evidence obtained so far from the Altogether Better projects would support this. Champions in the present study also talked confidently about the changes they saw being made to people's lives, specifically in relation to people's mental health and well-being. This impact was seen to be greater for those who experienced mental illness, social isolation or social exclusion. Champions did not use the term but they were recognising the value of social capital (i.e. social networks, group activities, linking people into services) to people's health. Project staff and partners also recognised that champions were promoting social cohesiveness and helping to integrate people into their community. This particular issue is relatively under-explored in the literature. The impact of champions and lay workers on communities and social networks, for example, was identified as a research gap in an evidence review by South *et al.*[2]. Our findings would suggest that champions are making a significant contribution to form and strengthen social networks within communities and that this is arguably one of the most important aspects of their role.

Champions recognised the importance of developing an understanding of the people they were working with and saw themselves as being able to relate and gain trust in a way that was not usually possible for professionals. They also reported that, in contrast to professionals, they were able to move beyond brief advice, to offer time, an informal approach and empathy based on shared experience. The benefits of local knowledge and shared experiences that lay workers have with the communities they are working alongside was a strong theme to emerge from a study that gathered the views of 'experts' who were deemed to have theoretical and practical knowledge in the arena of lay involvement in public health.[23] In this present evaluation, project leads and partners did not allude to this as much as champions, possibly because as professionals themselves this difference in the two roles was less apparent, or they felt they needed to be more circumspect.

In terms of whether the Altogether Better projects were able to deliver their empowerment model, the findings indicate that parts of this are being addressed by the work of champions. For example, in an evidence review on empowerment approaches for health and well-being,[14] moving towards feelings of individual empowerment is described in terms of increase in self-confidence, self-esteem and people feeling more in control of their lives. Most champions suggested that both their self-confidence and that of the people they worked with had improved, and reported how friends and family were beginning to take control of and improve their health as a result of their intervention. There was less evidence in respect to 'system challenge', the final element of Altogether Better's empowerment model.[15] It seems reasonable to argue that Altogether Better projects are still in their infancy and, as participants recognised, it takes time for people to move to challenge existing systems.

Finally, all participants saw training and support as critical to effectiveness in translating the Altogether Better approach into practice. An evidence review analysing the community health champion role[2] pointed to the importance of a supportive infrastructure if programmes to engage the community in promoting health are going to be effective. This would include organising effective recruitment, training, supervision and practical support to undertake activities. The review also identified that there has been little process evaluation about the best ways to recruit, train and provide support. It may be that projects could benefit from comparing both the training and support they offer to ensure that what they provide is fit for purpose, particularly in projects where the champion role has developed beyond that envisaged in the original model. This could also help build the evidence around this aspect of the champion role.

CONCLUSION

The recent Public Health White Paper suggested that Altogether Better is improving individual and community

health as well as increasing social capital, voluntary activities and wider civic participation.[1] It is important to recognise, as highlighted in the Marmot Review,[24] that health in the most disadvantaged communities will only improve if socio-economic determinants are addressed. However, community health champions have the potential to be instrumental in creating a cultural shift in communities towards healthier and more integrated living. These findings chime with current discussion around the need to build a society where people take a more active part and engage more with service development and delivery. There is more work to be done to deepen the understanding of what processes need to be in place to maximise the potential of community health champions and to capture the full impact of their activities, but it is the clear conclusion of this evaluation that engaging lay people in health needs to be an important strand of practice in the challenging times ahead.

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References

1 Secretary of State for Health. *Healthy Lives, Healthy People: Our Strategy for Public Health in England*. London: The Stationery Office, 2010
2 South J, Raine G, White J. *Community Health Champions: Evidence Review*. Leeds: Centre for Health Promotion Research, Leeds Metropolitan University, 2010
3 Fleury J, Keller C, Perez A, Lee SM. The role of lay health advisors in cardiovascular risk reduction: A review. *American Journal of Community Psychology* 2009; 44: 1–2
4 Swider SM. Outcome effectiveness of community health workers: An integrative literature review. *Public Health Nursing* 2002; 19(1): 11–20
5 Medley A, Kennedy C, O'Reilly K, Sweat M. Effectiveness of peer education interventions for HIV prevention in developing countries: A systematic review and meta-analysis. *AIDS Education and Prevention* 2009; 21: 181–206
6 Norris SL, Chowdhury FM, Van Le K, Horsley T, Brownstein JN, Zhang X, et al. Effectiveness of community health workers in the care of persons with diabetes. *Diabetic Medicine: A Journal of the British Diabetic Association* 2006; 23: 544–56
7 Rhodes SD, Foley KL, Zometa CS, Bloom FR. Lay health advisor interventions among Hispanics/Latinos: A qualitative systematic review. *American Journal of Preventive Medicine* 2007; 33: 418–27
8 Bailey TM, Delva J, Gretebeck K, Siefert K, Ismail A. A systematic review of mammography educational interventions for low-income women. *American Journal of Health Promotion* 2005; 20: 96–107
9 Visram S, Drinkwater C. *Health Trainers: A Review of the Evidence*. Newcastle: Northumbria University, 2005
10 Nemcek M, Sabatier R. State of evaluation: Community health workers. *Public Health Nursing* 2003; 20: 260–70
11 Eng E, Parker E, Harlan C. Lay health advisor intervention strategies: A continuum from natural helping to paraprofessional helping. *Health Education and Behavior* 1997; 24: 413–17
12 Cooper C, Arber, Fee L, Ginn J. *The Influence of Social Support*. London: Health Education Authority, 1999
13 National Institute for Health and Clinical Effectiveness (NICE). *Community Engagement to Improve Health*. London: NICE, 2008, p.40
14 Woodall J, Raine G, South J, Warwick-Booth L. *Empowerment & Health and Well-Being: Evidence Review*. Leeds: Centre for Health Promotion Research, Leeds Metropolitan University, 2010
15 Altogether Better. *Altogether Better Programme: Phase 1 Development: Altogether Better*. London: BIG Lottery Fund, 2010
16 Ritchie J, Spencer L, O'Connor W. Carrying out qualitative analysis. In J Ritchie, J Lewis (eds) *Qualitative Research Practice*. London: SAGE, 2003
17 Green J, South J. *Evaluation*. Maidenhead: Open University Press, 2006
18 Turner C. *Altogether Better Programme Evaluation Report 2009*. Whitchurch: DMSS Research and Consultancy, 2010
19 Hennink M, Hutter I, Bailey A. *Qualitative Research Methods*. London: SAGE, 2011
20 Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative Research in Psychology* 2006; 3: 77–101
21 Casiday R, Kinsman E, Fisher C, Bambra C. *Volunteering and Health: What Impact Does It Really Have?* London: Volunteering England, 2008
22 Attree P. 'It was like my little acorn, and it's going to grow into a big tree': A qualitative study of a community support project. *Health and Social Care in the Community* 2004; 12: 155–61
23 South J, Meah A, Bagnall A-M, Kinsella K, Branney P, White J, et al. *People in Public Health: A Study of Approaches to Develop and Support People in Public Health Roles. Final Report*. London: NIHR Service Delivery and Organisation Programme, 2010
24 Marmot M. *Fair Society, Healthy Lives: The Marmot Review. Strategic Review of Health Inequalities in England Post-2010*. London: The Marmot Review, 2010