‘Think differently and be prepared to demonstrate trust’: findings from public hearings, England, on supporting lay people in public health roles

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SUMMARY

Professional support processes are critical for the establishment and maintenance of community health worker programmes. This paper reports on three public hearings held in England, UK, that were conducted as part of a national study into approaches to develop and support lay people in public health roles. Individuals with relevant theoretical or practical expertise, including lay activists, presented evidence in public as expert witnesses. Formal presentations, questions and plenary discussions were recorded and later analysed as qualitative data. This paper presents the results and critically examines emergent issues relating to the sustainability of lay health worker programmes. Consideration is given to the diversity of contemporary practice in England. Barriers seen to affect sustainability included organizational culture and onerous bureaucratic processes. Major themes emerging from the expert evidence included recruitment and training strategies, financial support and the need for a robust infrastructure. The expert hearings, in creating a public space for deliberation, opened up discussion on the levels and type of programme support required to foster lay health worker programmes. The paper concludes that professional support needs to be accompanied by a reorientation of public services to support lay engagement in programme delivery.

Key words: community health workers; community involvement; professional support; expert evidence

INTRODUCTION

Health promotion programmes utilizing the experiential knowledge, skills and support of lay health workers are a feature of many health systems, both in economically developed and in developing countries. Such programmes are predicated on the ability of lay workers to broker and improve connections between health services and communities, particularly where those communities are underserved or disadvantaged in some way (American Association of Diabetes Educators, 2003; Nemceck and Sabatier, 2003). This is not solely a question of increased capacity as it is argued that approaches involving lay health workers can enhance existing social support systems and improve information flows between services and individuals (Dennis, 2003; Rhodes et al., 2007). Health promotion planners and practitioners evidently have an important role in the establishment, implementation and maintenance of these programmes. Indeed research literature points to the importance of professional support processes and calls attention to issues such as recruitment and training (Jackson and Parks, 1997;
Love et al. (2004). A World Health Organization review of community health workers identifies features of successful programmes (World Health Organization, 2007). These include good programme management, the provision of training and continuing education, regular supervision and community mobilization. There is scope for more research on support processes, including effective recruitment strategies and professional roles within lay health worker programmes. Rhodes et al. (Rhodes et al., 2007) in their systematic review of lay health advisor interventions, for example, note the need for greater detail on selection and training. Andrews et al. (Andrews et al., 2004) also conclude that there is a case for more process evaluation and greater understanding of community health worker roles. This paper presents findings from a series of public hearings held in England that deliberated on lay roles and support processes. The aim of the paper is to critically examine emergent themes from those hearings relating to the development and sustainability of lay health worker programmes.

LAY HEALTH WORKERS IN UK PRACTICE

In UK, notwithstanding a long tradition of peer education and peer support interventions (see Parkin and McKeagany, 2000; Farrant and Levenson, 2002; Britten et al., 2006), the adoption of service models involving lay health workers has tended to be fragmented and small scale. More often, community involvement has been a feature of health promotion projects rather than part of mainstream primary health care services (Brown, 2000; Fawcett and South, 2005). Established models, such as lay health advisors (Earp et al., 1997; Eng et al., 1997), have not by and large been adopted within UK practice. Indeed, Popular Opinion Leader interventions, originally developed in the USA to work with the gay community around HIV prevention (Kelly et al., 1992), were not successfully transferred to UK contexts (Elford et al., 2002, 2004; Hart et al., 2004).

The New Labour government (1997–2010) signalled support for greater community involvement in health and stimulated a renewed interest in civic participation (Secretary of State for Health, 2000; Campbell et al., 2008; Secretary of State for Communities and Local Government, 2008). ‘Tackling Health Inequalities, A Programme for Action’ (Department of Health, 2003), for example, identified the opportunity to build practical links with communities and local services through use of lay health workers. In 2008, the National Institute for Health and Clinical Excellence recommended recruiting what were termed ‘agents of change’ in communities who would take on roles such as peer educators or health champions (National Institute for Health and Clinical Excellence, 2008).

Currently there is a growing community of practice around involving lay health workers in programme delivery. In 2008, a competency framework was introduced with nine levels of public health practice [The term ‘public health’ is used in the UK to describe activities undertaken to prevent disease, prolong life and promote health (Wanless, 2004). Public health is considered to involve intersectoral action (Hunter, 2007) and is supported by a multi-disciplinary workforce, which includes health promotion specialists (Royal Society for Public Health, 2009).]; levels 1 and 2 include examples of volunteer and lay health worker roles (Public Health Resource Unit and Skills for Health, 2008). Notwithstanding the introduction of this framework, the context is one of considerable diversity in terms of interventions, service models and patterns of professional support. It is within this context that a national study was instigated in England, UK, to determine how health services can best develop and support lay people involved in delivering public health programmes. A major component of the ‘People in Public Health’ study involved gathering evidence about practice. In 2008, three public hearings were held, where individuals with relevant theoretical or practical experience were invited to give evidence.

METHODS

Design

The public hearings were part of a multi-component study design that sought to include evidence from the scientific, lay and practice-based domains of knowledge. Debates within health promotion about the nature of evidence support the incorporation of experiential
knowledge derived from health promotion practice (Raphael, 2000; McQueen, 2001). This is linked to acceptance of the utility and rigour of participatory research approaches and arguments for greater democratization of research to ensure that it meets the needs of research consumers as well as producers (Entwistle et al., 1998; Macaulay et al., 1999). The design of the public hearings aimed to draw on evidence derived from the practice of lay involvement and to create a public space to allow participation in the construction of knowledge.

The public hearings, also known as expert hearings or deliberative workshops (Strategic Action Programme for Healthy Communities, 2000), were designed to provide a structured forum through which the research team could enter into dialogue with those who were deemed to have theoretical and practical knowledge on lay involvement in programme delivery. Deliberative methods, such as citizens juries and expert panels, have been gaining prominence within the policy sphere as a credible alternative to the use of representative structures because the process of deliberation enables solutions to be generated or decisions formulated between different policy actors, including members of the public (see Coote and Lenaghan, 1997; Abelson et al., 2003; Davies et al., 2006). Examples of deliberation in research are less common, but Potts et al. (2007) describe the use of deliberative methods in a study investigating lay epidemiology of breast cancer.

Participants

Academics, national programme leads, health promotion practitioners, service managers and lay people involved in public health activity, drawn from around the country, were invited to give evidence (as ‘expert witnesses’) before an enquiry panel and public audience. A strategic approach to sampling was taken to ensure that major programmes were represented and evidence was heard from the national health service (NHS), local government, non-governmental and voluntary sectors.

Members of the research team and representatives from the academic–practice collaboration formed an enquiry panel. In order to extend public participation in the hearings, the events were open to the public and advertised through community and practice networks. A prior community event was held as part of the academic–practice collaboration to ensure that lay views informed the hearings. Community activists and practitioners participated in a workshop to discuss their experiences with members of the research team. A series of questions generated at the workshops were used in the public hearings. Two participants subsequently took part in the public hearings: one as an expert witness and one as a member of the enquiry panel.

Process

In June 2008, three public hearings were held in Leeds, an urban area in the north of England. Eighteen expert witnesses gave oral evidence (Table 1), with accompanying presentation slides as appropriate, reflecting on their own experiences and insights in response to four questions. These questions were designed to stimulate debate on (a) the rationale for lay involvement in programme delivery, (b) effective approaches, (c) challenges and (d) wider organizational and support needs. All experts consented to their evidence being placed in the public domain. One individual, who was unable to attend, submitted written evidence. The role of the enquiry panel was to explore the expert evidence through questioning and public debate. Following each presentation, members of the enquiry panel questioned the experts on different aspects. The public audience listened to all the evidence and were able to ask questions and express their views in the plenary and group discussions held in the latter part of each hearing. The formal contributions, panel questions and plenary discussions were audio-recorded and transcribed verbatim with participants’ permission, and also written or electronic evidence, such as PowerPoint presentations, were collated. Notes were taken at the small group discussion but these were not included in the data analysis because it was not possible to obtain consent.

Analysis

Framework analysis was chosen as an appropriate qualitative analysis method, given the applied nature of the study (Pope et al., 2000; Ritchie et al., 2003). The framework of questions was used to create a series of charts, with an additional one for contextual information.
Two researchers (A.M., J.S.) independently indexed all the data, identifying emerging themes. In line with framework analysis methods, themes were summarized and then charted onto a matrix using the framework. Using an iterative process, both researchers subsequently agreed the major thematic categories by returning to the data to identify patterns across the types of experts (lay, practitioner, strategic and academic) and between the three hearings. Due to the nature of the evidence and its production in a public space, it was important to obtain respondent validation; Mays and Pope (Mays and Pope, 2000) suggest that this is a means to improve rigour. A narrative summary of themes was produced and sent around the expert witnesses and panel members for confirmation. It was agreed that quotations would not be attributed to the individual participants. In presenting the results, verbatim quotations drawn from the data are used to illustrate themes.

RESULTS

Divergent perspectives on lay involvement were offered at the hearings and expert witnesses presented issues they deemed significant, either from the perspective of specific health programmes or by drawing more general observations about service organization and delivery. Table 1 illustrates the range of evidence and the programmes represented. The diversity within health promotion practice in England was reflected in the evidence, with different types of lay involvement, ways to define lay roles, philosophical underpinnings and delivery methods represented. Notwithstanding divergent approaches in practice, common themes emerged, particularly in relation to support processes and barriers to engagement. The major thematic categories are displayed in Tables 2 and 3. In presenting the results, it is useful to consider types of support. Some themes concern the actions of professionals working directly with lay workers, which we have termed ‘professional support’. Other themes relate to the indirect support provided by government and public agencies; in other words, how the public health system works to facilitate or constrain the activities of lay health workers, which we have termed ‘organizational support’. As the paper will argue, both professional and organizational support is required to sustain lay involvement in programme delivery.

### Professional support

Professional support issues identified through expert evidence covered recruitment, training,
incentives and ongoing support, thereby reflecting similar themes to earlier reviews of lay workers (Jackson and Parks, 1997; Love et al., 2004; World Health Organization, 2007). In relation to recruitment, there was a strong consensus that recruitment strategies needed to allow individuals with relevant experiential knowledge or sharing a mutual understanding of health issues within specific cultural and social contexts to become engaged in community health activity. These qualities made lay people good health educators because ‘they know how life is for people’ (Hearing 1). One expert witness, in describing recruitment criteria for a breastfeeding peer support programme, contrasted technical knowledge with what can be seen as natural helping qualities (Eng et al., 1997):

We don’t ask for qualifications. I think you need to have a passion… You can teach people breastfeeding techniques, I can teach you to position and attach a baby but I can’t teach you the passion for it or the skills that you need to support people. (Hearing 1)

Recruitment strategies utilizing the embodied and experiential knowledge of lay people did not fit well with systems of professional regulation and control. The following quotations illustrate the difficulties created by the mismatch of expectations:

For a lot of people they were deeply shocked at the amount of responsibility they were expected to take

### Table 2: Summary of themes on effective approaches

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<thead>
<tr>
<th>Summary of approaches that work</th>
<th>Summary of approaches that do not work</th>
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<tr>
<td><strong>Professional support</strong></td>
<td><strong>Professional support</strong></td>
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<tr>
<td>1. Adopting an inclusive approach to recruitment and recruiting from the local community</td>
<td>1. Recruiting community members via poster campaigns</td>
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<td>2. Designing flexible training packages which enable the participation of people traditionally excluded from the education system</td>
<td>2. Regimented recruitment processes which emphasize contractual obligations for volunteers</td>
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<td>3. Establishing a learning culture in which participants are committed and interested</td>
<td>3. Poor management and support of lay people following training</td>
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<td>4. Making connections to adult education opportunities both for self-development and as a route to employment</td>
<td>4. Prescriptive interventions which limit opportunities for lay people to engage with intended beneficiaries</td>
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<td>5. Providing opportunities for people to have fun</td>
<td>5. Rushing implementation with inadequate time to prepare lay people for programme delivery</td>
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<td>6. Paying expenses</td>
<td>6. Trying to deliver interventions on an inadequate budget</td>
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<td>7. Establishing clear demarcation lines in relation to professional roles but valuing the equal worth of volunteers and paid workers</td>
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<th><strong>Organizational support</strong></th>
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<tr>
<td>8. Providing an adequate infrastructure to support people beyond training</td>
<td>4. Organizational culture, including how health services engage with communities and the voluntary sector</td>
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<tr>
<td>9. Involving local people in planning, design and delivery</td>
<td>5. Absence of an infrastructure to support lay people in public sector</td>
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<td>10. Adequate programme funding</td>
<td>6. Bureaucracy and restrictive policies and practice within health services</td>
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<td>11. Awarding grants to small community organizations</td>
<td>7. Providing incentives and expenses, without impacting on welfare benefits</td>
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<tr>
<td>12. Establishing effective partnerships between the health service and other sectors</td>
<td>8. Nature of programme funding, which is more often short-term and oriented to a medical model</td>
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<td>13. Passionate leadership at the highest level</td>
<td>9. Shifts in policy focus with rapid turnover of initiatives</td>
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### Table 3: Summary of themes on challenges

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<th>Challenges identified</th>
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<tr>
<td><strong>Professional support issues</strong></td>
<td><strong>Professional support issues</strong></td>
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<tr>
<td>1. Engaging communities effectively</td>
<td>1. Engaging communities effectively</td>
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<td>2. Recruitment and retention of lay people</td>
<td>2. Recruitment and retention of lay people</td>
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<td>3. Difficulty in engaging and retaining health professionals</td>
<td>3. Difficulty in engaging and retaining health professionals</td>
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<td>10. The challenge of mainstreaming with the fragility of some projects being reliant on key individuals</td>
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Tensions between valuing the qualities lay people brought to health promotion work and the role of professional support were reflected in discussions. Training was seen as essential to develop the necessary knowledge and skills to prepare people adequately for public roles. Support was also needed to overcome barriers to accessing training for those individuals who had little formal education or whose first language was not English. There was a broad consensus that training was most effective when it was enabling rather than didactic, developing knowledge and skills through participatory methods:

Again if you’re going to train people from the communities you’ve got to make [courses] inspirational. You’ve got to make them what I call catchy and that to me is about inspiring but it’s about getting the lay people involved, getting them to go out. (Hearing 3)

The role of ongoing professional support was seen as critical and there were examples given where large scale programmes had underestimated the support needs of lay workers. At the same time, over-professionalization could be counterproductive when seeking to engage underserved or marginalized populations:

It’s that thing you can’t grasp that you lose when things become professionalized and it almost scares away the most vulnerable groups you were always after in the first place… And within the rigorous, robust nature of professionals you lose this empathy and intelligence and it’s really hard to define it but it’s lost in that process. (Hearing 2)

Discussion took place about remuneration and rewards. Evidence at the hearings mostly concerned programmes that involved lay people on a voluntary basis, although alternative service models were presented where lay workers received payment. A major point of discussion in the third hearing, given emphasis by lay participants and those with experience of directly supporting lay health workers, was the need to provide some financial compensation to volunteers, such as travel expenses, in the context of confusing welfare regulations. Given that lay worker roles were being developed with the aim of reaching underserved communities, addressing the economic aspects of support was identified as a critical factor for sustainability; however, employment models were not necessarily seen as the solution. One expert witness cautioned that payment altered the relationship between the lay worker and their community:

Once people are in a paid job you are changing that dynamic. We learned some difficult lessons as a result of employing someone from the Gypsy and Traveller community without giving enough thought to the tensions she would experience. It put her in a completely different situation with the people that she lived with. We must look at those implications. (Hearing 3)

Organizational support
Support and development can be viewed within the parameters of professional practice, but there is also a need to understand the wider health system and how relationships between community and state are constituted in relation to lay worker programmes. Expert witnesses, from community activists through to those working in a strategic capacity, spoke of the existence of a dominant, professionally led organizational culture within the state health service. This resulted in organizational actors at different levels—macro, meso and micro, either unwilling to share power or unable to respond with sufficient flexibility to support and sustain lay involvement. Professional resistance was reported as an important barrier. For example one expert described how a new programme was received:

These very same factors that made them (lay health workers) more accessible to the community were felt to make them almost less accessible to other health professionals and there was a lot of mistrust and suspicion often because there’s a bit of overlap with similar roles. (Hearing 2)

In contrast, a balance between professional and community control was achievable and examples of good practice were reported, where partnerships developed between professionals and lay workers, each valuing the others’ expertise.
Sustainability of lay health worker programmes will rest, in part, on the allocation of resources but also on the existence of a supportive infrastructure (World Health Organization, 2007). Some of the evidence presented was from programmes that had achieved a measure of sustainability. Notwithstanding these successes, frustrations were voiced in relation to funding and the policy environment by community activists and those engaged in directly supporting health promotion programmes. A number of witnesses, both lay and professional, stressed the benefits of small scale funding to stimulate and support lay activity within specific communities, but also drew attention to their experiences of the termination of financial support. One community activist described the onerous bureaucratic procedures associated with administration: ‘as a small group we’ve got more hoops to jump through than any organization’ (Hearing 1).

There was reported to be an absence of strategic support for the development of lay worker programmes, which was seen as a major threat to programme sustainability:

It has traditionally been reliant on the drive and perseverance of committed individuals. (Hearing 3)

Very often it requires the individual initiative of some champions. Very often it’s funny money that comes and goes, and very often these projects don’t feel, even now, quite as mainstreamed as they ought to be. (Hearing 2)

Expert witnesses described the tendency for health organizations to be driven by a medical model with a focus on clinical outcomes, which was often at odds with the priorities and concerns of lay people. There was a strong theme throughout the hearings that system level change was required in relation to allocation of resources, working practices and decision-making processes in order to re-orientate services and increase community control. The title of the paper is drawn from a quotation that encapsulates much of that discussion, signalling the essential shift in power that needs to occur if services are to develop more equal relationships with communities:

Lay involvement is possible at all levels, planning, design, delivery and governance of public health activities...but requires people to think differently and be prepared to demonstrate trust. (Hearing 3)

DISCUSSION

The results from the public hearings provide some contemporary insights with regard to the establishment and maintenance of lay health worker programmes. The results lack the comprehensiveness of a national survey; nonetheless they illuminate significant issues within the different contexts of health promotion practice in England. The construction of evidence involved deliberation within a public space; this served to test and refine emergent themes, thereby improving the rigour of the results. The expert views cannot be seen as representative of current public health practice; indeed many individuals could be described as public health leaders or early adopters (Rogers and Shoemaker, 1971), and this limits generalizability. Alternatively, the scrutiny of expert evidence in a public space ensured that salient issues were identified and this increases the validity of results.

The sampling strategy enabled divergent perspectives to be presented, drawing on both lay and professional expertise. Interestingly this did not, by and large, result in conflicting views being expressed, the exception being the discussions on remuneration. Indeed there was a marked convergence on identifying matters of significance to practice across all groups of experts. The emerging themes, particularly in relation to professional support, relate to process issues highlighted in North American literature (Jackson and Parks, 1997; Leaman et al., 1997). Notwithstanding the diversity of English practice, the rationales advanced for the development of a lay workforce were similar to those proposed elsewhere. One prominent theme being the value of community (lay) members with appropriate cultural and social knowledge, improving the connections between health services and the wider community, particularly where those communities are marginalized or underserved (Altpeter et al., 1998; American Association of Diabetes Educators, 2003; Nemcek and Sabatier, 2003; Rhodes et al., 2007).

It is perhaps unsurprising that issues around training, recruitment and incentives were to the fore in the evidence from the hearings, given that these aspects of programme delivery move a lay person on the continuum suggested by Eng et al. (Eng et al., 1997), from a natural helper within their own community to an actor...
with a health promotion role. The tensions between providing effective training in preparation for roles, while at the same time valuing the natural qualities that lay people bring are reflected in other literature (McQuiston and Uribe, 2001; Love et al., 2004; Springett et al., 2007). Jackson and Parks’ (Jackson and Parks’, 1997) retrospective of lay health advisor programmes for the African-American community found that even within a common model, the patterns of training differed between programmes. Their cautionary note of the dangers of ‘professional imperialism’ was echoed in the themes at the hearings around risks from overly bureaucratic processes, rigid structures and formal training. The most effective type of professional support espoused at the hearings reflected some of the core values of community health promotion in terms of addressing equity issues, support for participatory approaches and enabling people to extend their knowledge, skills and experience (Baum, 1998).

The question of appropriate financial rewards was a major point of discussion in the public hearings and mechanisms for payment of expenses to volunteers were seen to impact negatively on the most economically vulnerable groups. This is similar to findings from Canada, where Leaman et al. (Leaman et al., 1997) in interviews with Community Nutrition Workers, found that financial need is a barrier to retention. Within a UK context, there is a sharp distinction between employment models and volunteering, which is defined as time freely given (The Commission for the Compact, 2005). This distinction may be unhelpful in programmes drawing in lay workers from communities experiencing social inequalities.

Professional support can be critical to the outcomes for lay workers (Leaman et al., 1997; Casiday et al., 2008). The evidence from the hearings suggests that partnerships between lay and professional workers are attainable, allow for mutual learning, and are preferable to a functionalist approach to support and development. Conversely the organizational support provided through the wider health system, and ultimately the state, is more problematic as organizational culture was reported to be antithetical to lay involvement. At this point, we need to consider the nature of the welfare system in England. The NHS, which is at the heart of the public health system, is one of the pillars of the welfare state in the UK. While access to free health care at the point of delivery can be seen as a public good, the relationship between state and service user has been characterized by the dominance of structural interests, paternalism and professional control (Beresford, 2001; North and Peckham, 2001; Milewa et al., 2002). State failure to prevent and address major health disparities has led to policy support for greater community involvement in health (Department of Health, 2003). So paradoxically while public policy has supported lay engagement in order to address health inequalities, evidence from the hearings indicates that structures, systems and organizational culture inhibit the development and sustainability of a lay workforce, and furthermore present additional challenges to the very population groups where such approaches offer most.

In order to deal with the challenges of organizational support, expert witnesses described the necessity of facilitating lay involvement, working both in and outside of the health system. Overall the findings suggest that lay and professional activists may need to take on advocacy roles in order to sustain programmes in the face of resistance and ultimately to secure a more supportive infrastructure. Indeed as our title suggests, programme sustainability requires a paradigm shift resulting in the reorientation of services towards community needs and assets. This touches on issues of participation and power, which are a central concern in health promotion practice (World Health Organization, 2002; Laverack, 2004). While contextual factors limit the transferability of this research, it offers an interesting case study for further international comparisons. An international review also identifies political stewardship and adequate resources as key factors in successful community health worker programmes (World Health Organization, 2007). More comparative research is required to explore the impact of organizational support and welfare infrastructure on the sustainability of lay health worker programmes. In low-income countries where there is more limited capacity in health systems (Hongoro and McPake, 2004), or alternatively where there is more deeply embedded tradition of self-help compared with that of the UK (Bhuyan, 2004), these particular issues may be less prominent.
CONCLUDING REMARKS

Where service models use community members’ knowledge, skills and networks as the basis for the intervention, it is apposite that consideration needs to be given to supportive processes that help individuals fulfil their potential role. This paper points to the importance of recruitment strategies and training methods that enable lay people to build on their experiential and embodied knowledge. Flexible approaches that overcome social, educational and economic barriers to participation are required. There is a risk of over-professionalization highlighted here, and our findings indicate that a balance needs to be struck between provision of professional support, which is deemed necessary to help development of people and delivery of programmes, and relinquishing professional control. Health promotion practitioners, as part of their reflective practice, need to consider how power is distributed within specific programmes and whether professional support is enabling in nature. Given some of the barriers identified, there is scope for greater attention to process issues in programme evaluation.

By using an innovative method, this study was able to deepen the understanding of factors underpinning effective practice and to identify the levels and type of programme support required. Notwithstanding the differences in welfare systems, many of the themes presented have wider resonance with other research that helps develop a common understanding of how successful lay health worker programmes can be built (Jackson and Parks, 1997; Love et al., 2004; Abbott, 2005; World Health Organization, 2007). The public hearings offered some original insights into what type of infrastructure is needed to allow lay health worker programmes to flourish. These aspects have received little attention in the literature but can be seen as critical to ensuring sustainability. The implications are that health promotion planners and practitioners will need to adopt advocacy roles to develop healthy public policy, draw down funding and challenge oppressive practices. Overall, our findings resonate with arguments for greater community participation in health planning and a reorientation of health services.

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