The effectiveness of community engagement approaches and methods for health promotion interventions.

Rapid Review
Phase 3

NICE National Collaborating Centre
University of Teesside

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Executive Summary

This report examines the evidence for the effectiveness of community engagement approaches and methods for health promotion interventions.

Following the February PDG meeting it was agreed that Phase 3 of the Health Promotion Review would involve continuing to review primary study level data (1990 onwards) that arrived following completion of the phase 2 report. A further aim of the phase 3 review was to answer (data permitting) the secondary research questions and where necessary contact the authors of the included papers to obtain additional information required to facilitate this process. Overall, 519 full papers were screened equating to 79% coverage of the available literature identified via the search process.

Specific research questions for this health promotion rapid review were:

- What community development and engagement approaches and methods are effective for the planning (including priority setting and resource allocation), design, delivery or governance of health promotion interventions?

- What are the barriers to using community engagement and development approaches and methods for health promotion interventions and what interventions have successfully overcome these barriers?

Primary research studies were included in this rapid review if they were:

- Focused on community engagement and development approaches or methods used by (health and non health) public, private and voluntary sector professionals and community members where the primary purpose was either:
  - planning (including resource allocation and priority setting), design, delivery or governance of primary health promotion or
  - barriers to using community engagement and development approaches or methods for primary health promotion interventions which have successfully overcome these barriers.

Primary studies were excluded if they did not cover any of the above and/or covered the following exclusion criteria:

- interventions, initiatives or services which target individuals, (rather than a specified community)
- interventions, initiatives or services which include screening programmes
- interventions, initiatives or services which include the planning, design, delivery and/or governance of treatment in healthcare settings (including pharmacological interventions)
- health promotion interventions focusing on secondary prevention or prevention of relapse
- articles assessing the effectiveness of tools such as health impact assessment, healthy equity audit
Studies were also excluded if they were:
- Set in developing countries
- In language other than English
- Published pre 1990

21 primary research studies met the inclusion criteria that covered the following community engagement methods/approaches:

- Community coalitions
- Neighbourhood/community committees
- Peer educators/community volunteers
- School Health Promotion Council
- Peer leadership groups
- Community champions
- Community workshop

The community engagement methods/approaches focused on the planning, design and delivery of an intervention.

Behaviours/areas targeted by the studies were:

- Cardiovascular health
- Childhood immunisation
- Injury prevention
- Sexual health
- Smoking
- Alcohol
- Nutrition
- Physical activity

Four studies were from the UK, 1 study was from a European country (Finland) and 16 studies were non European studies (USA, Canada and Australia).

Findings were presented in relation to the two primary research questions, the first of which (stated below) was categorised into the relevant community engagement methods/approaches.

**What community development and engagement approaches and methods are effective for the planning (including priority setting and resource allocation), design, delivery or governance of health promotion interventions?**

- **Community coalitions**

The effectiveness of community coalitions in changing behaviour appears to depend on the behaviours targeted for change. The lack of a control group in all but 2 of the studies and the minimal specific outcome and impact data presented on community coalitions limits the inferences that can be drawn about effectiveness.
The evidence from 6 studies (one 2+, two 2-, three 3-) suggests that community coalitions used in the planning and design of an intervention may contribute to reducing the number of alcohol related crashes, and contribute to improving a number of alcohol related behaviours as well as improving the prevention of injuries to children, and in promoting a healthy diet in children. In terms of changing bicycle helmet use in children, community coalitions contribute to effective use; although girls are twice as likely as boys to wear helmets. Community coalitions also appear to contribute to effective promotion of physical activity through walking (Davidson et al., 1994; Arbeit et al., 1991; Morris et al., 1994; Holder et al., 1997; Pargee et al., 1999; Williams & Olano, 1999).

The evidence from one study (3-) further suggests that community coalitions may result in increasing feeling within coalition members of being included in the planning and implementation of health education programmes, and thus enabling them to contribute their knowledge to others, particularly the younger generations (Pargee et al., 1999).

The evidence from one study (3-) indicates that community coalitions appear to be associated with the integration of a healthy lifestyle into a community norm (Williams & Olano, 1999).

- **Peer educators/community volunteers**

The effectiveness of peer educators in changing behaviour appears to depend on the behaviour targeted for change.

The evidence from 2 studies (two 1+) suggests that peer educators may be effective in delivering health promotion related education/support in improving vaccination uptake, and decreasing unsafe sex and increasing safe sex practices (Barnes et al., 1999; Tudiver et al., 1992).

The evidence from one study (2-) suggests that in relation to increasing bicycle helmet use, peer educators may be effective for high-income groups but not low-income groups (Parkin et al., 1993).

The evidence from one study (2-) suggests that peer educators would seem to be ineffective in changing injury prevention behaviours in high-risk adolescents, although those receiving the intervention report having increased knowledge, realisation of consequences and awareness of a need for caution (Tenn & Dewis, 1996).

The evidence from one study (3+) tends to suggest that in projects that aim to improve access to healthcare through access and training in ICT, peer educators/community volunteers perceive ICT as a potentially useful tool to combat problems of social exclusion and social isolation (Bolam et al., 2006).

The evidence from one study (3-) also suggests that engaging peer educators in projects that specifically bring together people from different parts of a deprived city can help to dispel some of the prejudices against an area which is deemed a rough and unpopular place to live (EB4U NDC, 2005).
• Neighbourhood/community committees

The evidence from 3 studies (one 1-, two 2-) suggests that the effectiveness of neighbourhood and community committees in changing smoking behaviour is inconsistent (Hancock et al., 2001; Fisher et al., 1998; Kumpusalo et al., 1996).

The evidence from three studies (one 1+, two 2-) indicates that neighbourhood/community committees used in the planning/design of an intervention may be effective in contributing to improving diet (Hunt et al., 1993; Kumpusalo et al., 1996), and reducing alcohol impaired driving, related driving risk, traffic deaths, and injuries (Hingson et al., 1996).

• School Health Promotion Council

The evidence from one study (1+) suggests that a Health Promotion Council used to plan and design activities may enable young people to make safer sex choices (Kirby et al., 2004).

The evidence from one study (1+) further indicates that a Health Promotion Council may be more effective with some population groups e.g. higher risk youth, and for particular approaches e.g. condom promotion (Kirby et al., 2004).

• Peer leadership groups

The evidence from one study (3-) suggests that peer leadership groups used in planning/design may have benefits for the peer leaders in terms of enjoyment and increased confidence in undertaking planning activities (Komro et al 1994).

• Community champions

The evidence from one study (3-) suggests that community champions used in planning/design or delivery can increase their level of knowledge, skills and confidence following training and feel that they make the greatest impact in areas in which they have ownership and a stronger voice within their communities (Elden et al).

• Community workshop

The evidence from one study (3-) suggests that community workshops used in design and delivery of an intervention can maintain a high level of participation. In doing so they can contribute to the development of a sustainable healthy community (by improving awareness and the adoption of healthy lifestyles), to improve the image of an area, strengthen community relations and promote social inclusion (White et al 2003).
What are the barriers to using community engagement and development approaches and methods for primary health promotion interventions and interventions that have successfully overcome these barriers?

Six primary studies (2 UK case studies; 3 USA-based case studies and 1 USA-based process evaluation) provide the evidence for determining the barriers to using community engagement methods and approaches.

The evidence from one study (3+) suggests that the devolvement of power during a project where control over the project becomes more centralised and dominated by the interests of the statutory sector, was a barrier to the community engagement method employed (Bolam et al 2006).

The evidence from 5 studies (one 3+, four 3-) suggests that short term funding, with the risk of not being able to secure further funding to guarantee the long term survival of a project, was perceived to be a major barrier to the use of community engagement methods/approaches (Bolam et al 2006; Holder et al 1997; Pargee et al 1999; White et al 2003; Williams & Olano 1999).

The evidence from one study (3-) further indicates that finding suitable facilities in which to hold coalition meetings and securing access to appropriate meeting places were barriers to the use of community coalitions and the delivery of interventions (Holder et al 1997).

One study (3-) tends to suggest that a major barrier to the acceptance of program design was from those community treatment and service organisations that felt threatened by the policy-based strategies (Holder et al 1997).

The evidence from two studies (one 2-, one 3-) suggests that pre-existing groups coming to the table with their own agendas (and opposing implementation and prevention efforts) and the tendency for some individuals (related to personality and educational status) to monopolise coalition groups is a barrier to this community engagement method (Arbeit et al 1991; Holder et al 1997).

One study (3-) also described how overwhelming coalition members with community related responsibilities could result in a loss of such members (Pargee et al 1999).

The evidence from one study (3-) suggests that a lack of trust by the community in service organisations was a barrier to implementing community engagement methods/approaches (Pargee et al 1999).

Summary and discussion
Twenty one primary studies covering a range of community engagement methods/approaches were identified which focused on the planning, design and/or delivery of primary health promotion interventions. No studies relating to community collaboratives or citizens juries were identified and no data regarding priority setting, resource allocation or governance was found. Six of the 21 primary studies provided the evidence for determining the barriers to using community engagement methods/approaches. However, no data describing
interventions to overcome barriers or information pertaining to what doesn’t work was provided.

**Information gaps**
The majority of the 21 included studies did not contain any outcome or impact data specific to the community engagement method/approach component of the intervention. The primary purpose of the studies was to assess the effectiveness of the health promotion intervention and consequently little or no data was presented on specific community engagement outcomes and/or impact of the community engagement methods/approaches. The lack of a control group in the majority of the studies and the minimal specific outcome and impact data presented on each on the community engagement methods/approaches limits the inferences that can be drawn about effectiveness. However, this is not the same as saying the identified community engagement approaches/methods are ineffective – rather there is limited data available which addresses the primary research questions.

It is also important to note that 139 primary (21%) studies have not arrived within the time frame available to conduct this review and thus we have not been able to interrogate all of the potentially available pool of data. In order to help prioritise the quantity of data to be assessed within the time frame for this review a number of primary studies were also parked (10 other European, 311 non European and 281 country not specified).

While undertaking this review it became evident that some categories of literature were more relevant than others. Most notably the reviews from Cochrane and DARE and the primary studies highlighted via the website screening were of greater relevance as compared to the generic literature search.

Throughout this review we have uncovered a small body of literature that used community champions to deliver primary health promotion interventions. However, these intervention(s) were delivered on a one-to-one basis and thus in accordance with the exclusion criteria for this rapid review they have not been included.

An additional group of 24 UK based primary studies (namely evaluation studies such as HAZ, Sure Start) which made reference to the involvement and/or consultation of community members in various case studies were also identified. Some of these projects are health promotion interventions which may meet the stated inclusion criteria. However, because these evaluation studies do not sufficiently disaggregate the data by specific health promotion intervention and/or do not present outcomes or impact data which can be attributed to specific interventions these studies have been rejected. Two of the primary studies in this group included the use of contraceptive pills as part of the intervention strategy. It was not possible to disaggregate this pharmacological data from the remaining public health data. It should, nevertheless, be noted that these studies may contain reference to what may be relevant data.

**Terminology**
The terminology used by each study to describe a specific named method of community engagement varied considerably. This had implications for this review
in terms of the categorisation of data by community engagement method/approach. Arguably, different terms are being used to describe what may be considered to be the same method/approach and it is often not clear what the differences are between methods e.g. peer educators and community champions. As such this report has categorised community engagement methods/approaches using the terminology of the authors of the included primary studies. It is, however, acknowledged that some categories could be merged.

**Applicability to the UK**
Eleven of the included studies were USA based. The cultural differences between US and UK communities were most pronounced in the interventions used by these projects. This limits the applicability of findings to UK settings where legislative, educational and healthcare systems vary considerably.

**Included studies**

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Title</th>
<th>Journal</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arbeit ML, Serpas DC, Johnson CC, Forcier JE, Berenson GS</td>
<td>The implementation of a cardiovascular school health promotion program: utilization and impact of a school health advisory committee: the Heart Smart program</td>
<td>Health Education Research</td>
<td>1991</td>
</tr>
<tr>
<td>Barnes K, Friedman SM, Brickner NP, Honig J</td>
<td>Impact of community volunteers on immunization rates of children younger than 2 years</td>
<td>Archives of Pediatrics &amp; Adolescent Medicine</td>
<td>1999</td>
</tr>
<tr>
<td>Bolam, B., McLean, C., Pennington, A. &amp; Gillies, P</td>
<td>Using new media to build social capital for Health. A qualitative process evaluation study of participation in the CityNet Project</td>
<td>Journal of Health Psychology</td>
<td>2006</td>
</tr>
<tr>
<td>EB4U NDC</td>
<td>Sexual health and alcohol film in young people</td>
<td><a href="http://www.renewal.net">http://www.renewal.net</a></td>
<td>2005</td>
</tr>
<tr>
<td>Elden, S</td>
<td>North Tees Primary Care Trust. Champions for Community Health</td>
<td><a href="http://www.renewal.net">http://www.renewal.net</a></td>
<td></td>
</tr>
</tbody>
</table>


Section 1. Introduction

1.1 Background to this review
The National Institute for Health and Clinical Excellence (‘NICE’ or ‘The Institute’) has been asked by the Department of Health (DH) to produce programme guidance on community engagement and community development approaches to health improvement, including the use of collaborative methodology and community champions.

For the purposes of this guidance, community has been defined as lay communities (i.e. not professionals) and includes communities of place (e.g. people living in particular geographical areas) and/or communities of shared interest or identify (e.g. males or females, people with disabilities, low income groups).

1.2 The need for guidance
Involving communities in decision-making and in the planning, design, governance and delivery of services can improve health and well-being and make policy initiatives more sustainable. Involving communities, particularly socially and economically disadvantaged groups, is central to national strategies for promoting health and well-being and reducing health inequalities.

Community engagement and community development are two broad overlapping approaches that are commonly used to support the involvement of communities in a range of activities which can improve health and/or reduce health inequalities.

It is suggested that different levels and types of community engagement have different impacts on a range of outcomes, including health status. As the following diagram suggests approaches which involve informing or consulting communities are likely to have a marginal impact on people’s health (or no or marginal impact on any other outcome at the individual or population level).

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6 Community engagement is an umbrella term encompassing a continuum of approaches to engaging communities to improving health and/or reducing health inequalities. Popay, J (2006) Community engagement and community development and health improvement: a background paper for NICE.
7 Community development aims to help communities identify and then tackle common concerns. The approach is underpinned by a commitment to equity and social justice and aims for community empowerment. Popay, J (2006) Community engagement and community development and health improvement: a background paper for NICE.
level). In contrast, the more a community is supported to take control, by being involved in the design, development and implementation of activities to improve their lives (i.e. co-production, delegated power or community control), the more likely their health (and a range of other outcomes) will improve.

Diagram 1: Pathways from community participation, empowerment and control to health improvement

Source: J. Popay, 2006, Community Engagement, community development and health improvement. A Background Paper prepared for NICE.

A variety of methods are being used to involve communities, including (but not limited to) citizens’ panels, citizens’ juries, neighbourhood committees, community forums, community champions and the collaborative methodology. Initiatives such as the Healthy Communities Collaborative incorporate some community development principles to achieve a range of health-related outcomes, such as a reduction in accidental injuries and nutritional improvements among the target population.

8 www.npdt.org/scripts/default.asp?site_id=4&ld=9748
There are many barriers and challenges to community engagement and development, including 'constraints to strategic level community statutory sector partnerships'\(^9\) (see below):

- the culture of statutory sector organisations
- the capacity and willingness of service users and the public to get involved
- the dominance of professional cultures and ideologies in imposing their own structures and solutions on communities
- the overcrowded 'policy implementation' agenda
- the skills and competencies of staff working in public services.

Formal evaluations of initiatives such as Health Action Zones, New Deal for Communities and Sure Start schemes have also pointed to implementation difficulties\(^10\)\(^11\)\(^12\).

1.3 Scope of the reviews

1.3.1 Aspects of community engagement and development methods and approaches that will be covered

NICE guidance will be based on the findings from five components of specific aspects of community engagement and development approaches and methods:

- Health promotion effectiveness review
- Health promotion economics review
- Social determinants effectiveness review
- Social determinants economics review
- Economic analysis

The development of the health promotion review was undertaken in three phases:

- Phase one - assessed the review level literature (a review of reviews).
- Phase two – assessed the primary studies identified within the review-level material.. Additional primary studies (limited to UK studies) identified by the literature searching were also assessed.
- Phase three – assessment of primary studies which did not arrive in time to be included in phase 2 report.

This report presents an overview of the full paper screening and appraisal methods and findings for phase 3 of the health promotion effectiveness review (a

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\(^12\) Popay J, Finegan H et al. (Unpublished) Learning about effective community engagement from selected national initiatives: NCCCE Working Paper 5. Report prepared for NICE.
review of primary studies). This report supersedes the previous rapid review reports - ‘The effectiveness of community engagement approaches and methods for health promotion interventions – Rapid review phase 1 report’ (Summerbell et al, December 2006) and ‘The effectiveness of community engagement approaches and methods for health promotion interventions – Rapid review phase 2 report’ (Summerbell et al, February 2007)

1.3.2 Research Questions
The overarching research question to be addressed by the series of effectiveness and cost effectiveness rapid reviews was:

• What community engagement and community development approaches and methods are effective and cost effective in improving health and reducing health inequalities?

The primary research questions specific to the health promotion rapid review were:

• What community development and engagement approaches and methods are effective for the planning (including priority setting and resource allocation), design, delivery or governance of primary (non-pharmacological) health promotion interventions?

• What are the barriers to using community engagement and development approaches and methods for primary health promotion interventions and what interventions have successfully overcome these barriers?

The effectiveness of each approach or method identified were examined, where relevant data was available, by asking a series of further secondary – research questions (as outlined in section 4.5 of the NICE scope\textsuperscript{13}). The sub-research questions relevant to this review were:

• What is the aim/objective of the approach or method?
• What theoretical framework or value system underpins the design, content and/or delivery of the approach and/or method?
• How does the content of the approach or method influence effectiveness?
• How does delivery of the approach or method influence effectiveness?
• Does effectiveness depend on the intervener?
• What are the significant features of an effective intervener? (Does effectiveness depend on whether they are a community member, volunteer and/or a public sector professional and, if the latter, on their job title or status? Or does it depend on their age, gender, sexuality, ethnicity or knowledge/skill base?)
• Does the site/setting of the approach or method influence effectiveness and, if so, how?
• Does the intensity (or length) of the approach or method influence the effectiveness or duration of the effect?

\textsuperscript{13} http://www.nice.org.uk/page.aspx?o=322729
• Does the impact of the approach or method vary according to the target community (for example, in terms of their age, gender, ethnicity or social circumstances)?
• To what extent is the effectiveness of the approach or method influenced by the level of participation and control in the approach or method (informing, consultative, co-production, delegated power and community control)?
• Is there any differential impact on inequalities in health within and between communities?
• How acceptable is the approach or method to the target community?

The following sub-research question outlined in the NICE scope was considered under the primary research question of this review regarding the effectiveness of community engagement approaches or methods.

• What approaches or methods don’t work?

Three additional sub-research questions outlined in the NICE scope were considered under the primary research question pertaining to barriers.

• What are the barriers and facilitators to implementation (for example, resistance from professionals, members of the public, policy drivers, funding or staff)?
• What methods have been developed to address these barriers and are they effective?
• What are the unintended (positive and negative) outcomes of the approach or method (negative unintended outcomes might include disruption of community cohesion, damage to the self-esteem and/or the subjective health state of individuals engaged)?

The following sub-research question was not addressed as part of this review as a separate review of the economic literature had been commissioned.

• How much does the approach or method cost (in terms of money, people and time)? What evidence is there on cost effectiveness?

1.3.3 Population groups that will be covered
All population groups, including people living in particular geographical areas and ‘communities of interest or shared identity’, for example children, young people and adults and low-income groups, were included.

1.3.4 Outcomes of interest
The following primary outcome measures were of interest:

• improved individual and/or population level health status (morbidity and mortality)
• reduced health-related risk factors (e.g. fewer people smoking)
• improved environmental and socio-economic indicators (e.g. housing)
• reduced health inequalities within and between communities

The following intermediate outcome measures were also identified as of interest:

• the level of involvement and diversity of community members engaged
• the views and experiences of people who have been engaged and of the people/professionals implementing the intervention
• improved information flows/communication between the community and service provider (and vice versa)
• improved service uptake or new service reflecting community perceived needs and/or solutions
• community needs identified more accurately
• improved community engagement (for example, people’s expectations of involvement, influence and/or control are met)
• increased community involvement in the planning (including priority setting, resource allocation), design, delivery and governance of a service
• enhanced social inclusion/exclusion, social cohesion and/or social capital including social relationships within and across communities and public sector agencies
• enhanced community well-being including increased sense of empowerment among target communities to enable them to change the social, material, cultural, environmental and political factors that affect their lives
• improved partnership working between communities, institutions and governments

1.3.5 Review team
The Management Team for the health promotion review based at the NICE collaborating Centre at The University of Teesside, comprises:

| Carolyn Summerbell |
| Katherine Swainston |
| Tamara Brown |

The management team is responsible for ensuring that the milestones are met, risks identified and appropriate steps taken to resolve them.

The Project Team for the health promotion rapid review based at the NICE Collaborating Centre at the University of Teesside, comprises:

| Carolyn Summerbell |
| Katherine Swainston |
| Sarah Smith |
Section 2. Methodology

2.1 Literature search

The literature searches, undertaken by the Lancaster Collaborating Centre, for the mapping review forms the basis of the search strategy for the effectiveness reviews. Literature searches, using terms related to the concept of community engagement in the title and descriptor fields were conducted on the following databases and websites:

- Medline
- CDSR (Cochrane Database of Systematic Reviews)
- DARE (Database of Abstracts of Reviews of Effectiveness)
- ASSIA (Applied Social Science Index and Abstracts)
- ISI Proceedings
- SSCI (Social Science Citation Index)
- EMBASE (Excerpta Medica)
- Sociological Abstracts*
- SIGLE* (System for Index of Grey Literature in Europe)
- CINAHL* (Cumulative Index of Nursing and Allied Health Literature)
- Social Policy and Practice*
- PsychInfo (Psychological Information)
- JRF Findings (Joseph Rowntree Findings)
- EPPI Centre databases: Bibliomap, DoPHER and TRoPHI
- Engaging Communities Learning Network
- Active Citizenship
- Campbell c2 databases: C2-spectr1 and C2-ripe
- Social Care online
- National Research Register (NRR)
- Research Findings Electronic Register (ReFER)
- New Deal for Communities, Sure Start, Single regeneration budgets and Healthy Living Centres websites
- PAIS* (Public Affairs Information System)
- HMIC* (Health Management Information Consortium)
- Renewal

(NB: databases marked * were searched by NHS CRD, York.)

Tailored search terms appropriate for particular databases and websites were used. All searches were from January 1990 onwards and limited to English language records. In order to further restrict the large number of references originally retrieved records from ‘less economically developed countries’ (ledc) were then identified and excluded at this stage. The search terms and the full Medline search strategy are presented in Appendix A. The above search strategy resulted in 42,179 titles.

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2.2 Sources submitted to NICE and to the Lancaster team

Stakeholders submitted 41 references or copies of papers as part of their responses to the NICE scope consultation. These references were entered into a bibliographic database ready for screening.

A further 32 references have been directly sent, by those working in the field, to the Lancaster team.

2.3 Screening of titles and abstracts for relevance

All the titles/abstracts from the literature search results, 41 suggestions from stakeholders and the references sent directly to the Lancaster team were screened for relevance. Screening was generally undertaken by 2 people with the second reviewer only screening a percentage of the records. If the two reviewers disagreed the title/abstract was automatically included.

In some instances the search results only provided a title (i.e. an accompany abstract was not available) – it was agreed not to pursue obtaining these in order to screen this material.

The first 11,351 of the total 42,252 references were screened by the Lancaster Collaborating centre for the mapping review and the inclusion criteria and results of this screening exercise are presented in the mapping review report (CE2-3).

The remaining titles/abstracts were screened by both the Lancaster Collaborating Centre and the NICE team. Titles/abstracts were included if it was based on primary evaluative research or review-level evaluative research and made reference to lay community engagement/development in the following areas:

- Health promotion – the planning (including resource allocation and priority setting), design, delivery or governance of primary health promotion interventions

- Health promotion – the barriers to using community engagement and development approaches and methods for primary health promotion interventions and interventions which have successfully overcome these barriers

- Social determinants - the planning (including resource allocation and priority setting), design, delivery or governance of initiatives aiming to address the following determinants of health:
  - Neighbourhood/community regeneration/renewal/development
  - Housing/built environment
  - Transport
  - Employment/work/job creation
  - Social inclusion/exclusion/capital/empowerment/capacity building

Primary health promotion is defined as any non pharmacological activity which seeks to prevent disease or ill-health or improve health at individual or population level
Social determinants – the barriers to using community engagement and development approaches and methods for the social determinants of health interventions listed above and interventions which have successfully overcome these barriers.

Titles/abstracts were excluded if they did not cover any of the above and/or covered the following exclusion criteria:

- Interventions, initiatives or services which target individuals, (rather than a specified community)
- Interventions, initiatives or services which include screening programmes
- Interventions, initiatives or services which include the planning, design, delivery and/or governance of treatment in healthcare settings (including pharmacological interventions)
- Health promotion interventions focusing on secondary prevention or prevention of relapse\textsuperscript{16}.
- Articles assessing the effectiveness of tools such as health impact assessment, healthy equity audit\textsuperscript{17}
- Articles set in developing countries
- Articles in language other than English
- Publication date before 1990

As suggested by the PDG the 4410 titles/abstracts in the Cochrane database and 5574 titles/abstracts in the Dare database were also screened. Titles and abstract information does not always make reference to community engagement and development methods/approaches if used in planning, design, delivery or governance of an intervention (rather this information may only be present in other sections of the full paper). Consequently, relying on title/abstract screening to identify potentially relevant community engagement/development material may result in potentially relevant references for the health promotion effectiveness rapid review being rejected. In order to avoid this all the Cochrane and Dare titles/abstracts were screened to identify primary health promotion related activity (as defined above). Further screening to identify primary health promotion activity which involved a community engagement/development method/approach was

\textsuperscript{16} Secondary prevention seeks to arrest or retard existing disease and its effects through early detection and appropriate treatment; or to reduce the occurrence of relapses and the establishment of chronic conditions through, for example, effective rehabilitation (www.cdpac.ca/content/faqs/alliance_definitions.asp).

\textsuperscript{17} Reviews which community engagement/development approaches or methods used as part of HIA, HEA etc would however, be accepted.
undertaken at the full paper screening stage (please see below for further details on full paper screening).

All the titles/abstracts were also screened for reference for any economic and/or cost data and if such data was identified these references were sent to the economics team for further consideration. Appendix B provides a table of the results for the various screening components undertaken for titles/abstracts.

The following sections of text will only describe the categories of data included in this phase 3 review and an overview of the methods used for full paper screening and appraisal.

2.4 Identifying primary studies
At the 18th December PDG meeting it was agreed that the Phase 2 and Phase 3 reports for the health promotion review would involve reviewing primary study level data (1990 onwards), with priority consideration to be given to UK data. The following sequence and sources for identifying potentially relevant primary studies were also agreed at this PDG meeting.

Stage one
- The primary studies contained in the 7 accepted review-level papers from the phase 1 report
- The primary studies contained in the 25 reviews tagged as potentially relevant from the phase 1 report
- Potentially relevant primary studies from the 213 pending reviews identified in the phase 1 report (these are the reviews which did not arrive in time to be included in phase 1 report).

Stage two
- The 2361 primary studies identified from the following sources:
  - The 67 primary studies from the website screening results
  - The additional 19 primary studies sent to the Lancaster team during the course of the project
  - 2275 primary studies identified from the database and stakeholder screening results

The following text and table 1 details the sequencing for identifying primary studies for retrieval for all the categories of data. At each stage of the sequence only none duplicated primary studies were ordered for full paper retrieval.

In order help prioritise the quantity of data for retrieval within the time scales available for this review (19th December 2006 to 23rd April 2007) it was agreed that any books, book chapter and dissertations identified in all the various categories of primary studies would not be requested for retrieval. Appendix C lists the 112 references that fell into this category from all of the above categories.
Process for stage one primary studies

2.5 Identifying stage one primary studies
The phase 1 report (Summerbell et al., 2006) outlined that 340 reviews were retrieved of which 333 were excluded and 7 were included in the phase 1 report. Twenty-five reviews that did not meet the inclusion criteria for phase 1 though did contain a small number of potentially relevant primary studies and these reviews were tagged. Two hundred and thirteen reviews did not arrive within the timeframe for phase 1.

The 124 primary studies identified in the 7 accepted review-level papers were ordered for full paper retrieval. The 90 primary studies, which had been identified and tagged as potentially relevant from the 25 tagged review-level papers, were also ordered for full paper retrieval.

The 213 pending reviews were re-ordered. Seventy-nine of these 213 pending reviews were retrieved within the time scales available and screened for relevance using the form on page 47 of the phase 1 report (Summerbell et al 2006). Forty of the retrieved reviews were considered relevant and contained 179 potentially relevant primary studies, which were ordered for full paper retrieval. Thirty-nine reviews were rejected – please see appendix D for all rejected reviews. Appendix E also identifies the 134 reviews which were not retrieved within the timescales available for this report.

One additional review, which had not been identified by the database or website search strategy, was identified by the NICE team. This was screened and identified 37 potentially relevant primary studies for full paper retrieval.

A further two reviews of evaluative studies not identified previously, one by NICE, the other by the Lancaster team, were also screened. These presented an overview of a large number of varying projects. The level of detail presented was such that for many projects it was not possible to identify specific community engagement methods/approaches and the studies did not sufficiently disaggregate the data by specific health promotion intervention. Furthermore, outcome or impact data that could be attributed to specific interventions was not provided in the paper. Consequently, these reviews were excluded. A third review identified by a PDG member was also screened however was excluded primarily as no evaluative data was present.

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18 The main reasons for exclusion were that reviews did not focus on lay community involvement or the barriers to community engagement methods or approaches.
2.6 Identifying stage two primary studies
The 60 references from the website screening results and the additional 19 references sent to the Lancaster team were ordered for full paper retrieval. The Lancaster team also identified one additional primary study following screening of full papers for the social determinants review. This was ordered for full paper retrieval.

The titles and abstracts for the 2275 based primary studies identified from the database and stakeholder screening results were re-screened\(^{23}\). Articles were included if they were primary evaluative research and made reference to community engagement/development approaches and methods used by (health and non-health) public, private and voluntary sectors professionals and community members in interventions where the primary purpose is either the:

- lay involvement of communities in the planning (including resource allocation and priority setting), design, delivery or governance of primary health promotion interventions\(^{24}\)
- barriers to using community engagement and development approaches and methods for primary health promotion interventions and interventions which have successfully overcome these barriers

Articles were excluded if they did not cover any of the above and/or covered the exclusion criteria outlined previously (page 18).

Nine hundred and seventy of these articles were considered potentially relevant to the health promotion review and were categorised as follows (1253 were rejected):

- UK (368 primary studies)
- Other European (10 primary studies)
- Non European (311 primary studies)
- Country not specified (281 primary studies)

The main reasons for rejecting the 1253 titles and abstracts at re-screening was because they were not primary evaluative studies and/or were interventions, initiatives or services which were associated with the planning, design, delivery and/or governance of treatment in healthcare settings.

In order to prioritise the quantity of data for retrieval within the time scales available for this review it was agreed only the 153 (following removal of duplicates, books, book chapters and dissertations) UK primary studies from the re-screened references would be ordered for full paper retrieval (10 other European county articles; 311 non-European country articles and 281 country not specified articles were parked).

\(^{23}\) Fifty duplicates were identified and removed from the 2275 references prior to re-screening commencing; a further two references were identified as potentially relevant to the social determinants review and were forwarded to the Lancaster team.

\(^{24}\) Primary health promotion is defined as any non pharmacological activity which seeks to prevent disease or ill-health or improve health at individual or population level.
### 2.7 Screening primary studies for relevance

As table one indicates 519 (79%) of the 658 full papers ordered for retrieval from the various categories of data arrived in time for consideration in this review. All retrieved full papers were screened for relevance by two people (the second reviewer screening 10% of the full papers) using the full paper screening checklist presented in appendix F. Appendix G presents the references for the 139 primary studies which were not retrieved in time to be included in this review.

Full papers were screened for reference to any economic and/or cost data and if such data was identified these papers were sent to the economics team. Similarly, if papers were identified as potentially relevant to the social determinants review they were forwarded to the review team for consideration.

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25 This includes the 19 additional primary studies sent to Lancaster team, the 37 primary studies from the 1 review study identified by NICE team and 1 primary study identified by the Lancaster team following screening of papers for the social determinants review.
Full paper screening for relevance resulted in the following 21 primary studies being accepted (498 papers were rejected):


EB4U NDC. Sexual health and alcohol film in young people, Brighton; [http://www.renewal.net](http://www.renewal.net); 2005

Elden, S. North Tees Primary Care Trust. Champions for Community Health. [http://www.renewal.net](http://www.renewal.net)


As table 2, below, illustrates, the main reason for exclusion was no lay community involvement in the planning, design, delivery or governance of a primary health promotion intervention or no information regarding the barriers to community engagement.

Table 2. Reasons for primary study paper exclusion

<table>
<thead>
<tr>
<th>Main reason for exclusion</th>
<th>Number of primary studies excluded</th>
</tr>
</thead>
<tbody>
<tr>
<td>No focus on CE/CD methods or approaches and no lay community involvement OR barriers to community engagement</td>
<td>362</td>
</tr>
<tr>
<td>Targeted at individuals</td>
<td>45</td>
</tr>
<tr>
<td>(9 solely excluded on basis of 1-1 delivery of an intervention)</td>
<td></td>
</tr>
</tbody>
</table>
The majority of studies were excluded on numerous counts, for example, they included screening programmes and involved the delivery of an intervention in a healthcare setting.

Appendix H provides a list of the 498 excluded primary studies.

2.8. Data extraction
A pilot study was undertaken on two primary studies identified as accepted for data extraction. This was done to adapt the NICE data extraction tool (NICE, 2006) to ensure that it was relevant for this work (see appendix I for a copy of the data extraction tool). Data extracted included the study type; community engagement/development method/approach; focus of the lay community involvement; intervention characteristics; behaviours/areas targeted by the study; outcome data; findings; conclusions; and policy and practice implications.

Data extraction for each paper was completed by one reviewer with weekly consultations with other team members to discuss areas for clarification.

In order to address the secondary research questions the authors of the included studies in this review were contacted for additional study details.

2.9. Study type and quality appraisal
Each paper was categorised by type and graded for quality by two reviewers in accordance with NICE quality criteria (NICE, 2006).

- Type 1: Systematic reviews, meta-analyses of randomised controlled trials (RCT) or RCTs (including cluster RCTs).
• Type 2: Systematic reviews of/or individual, non-randomised controlled trials, controlled before-and-after studies, cohort studies, interrupted time series studies, case-control studies and correlation studies.

• Type 3: Non-analytic studies (e.g. case reports, case series studies, after only studies)

• Type 4: Expert opinion, formal consensus

Each paper was graded for quality using the NICE quality form appropriate for the particular study methodology. Quality was assessed based on the following criteria (see Appendix J for an example of a quality appraisal checklist):

- Did the study address an appropriate and clearly focused question?
- Was a description of the methodology included?
- Did the study provide details of the measures used?
- Did the study take into account potential confounders?

A code of ‘++’, ‘+’ or ‘-’ was applied to reflect the extent to which bias had been minimised (NICE, 2006):

++ All or most of the criteria have been fulfilled or where they have not been fulfilled the conclusions of the review are thought very unlikely to alter.

+ Some of the criteria have been fulfilled. Those criteria that have not been fulfilled or adequately described are thought unlikely to alter the conclusions.

- Few or no criteria have been fulfilled. The conclusions of the study are thought likely or very likely to alter.

Table 3 below provides a summary of the study type and quality assessment for each of the 21 accepted papers.

Table 3: Quality assessment of included reviews

<table>
<thead>
<tr>
<th>Study type and quality</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1++</td>
<td>Barnes et al (1999); Hunt et al (1993); Kirby et al (2004); Tudiver et al. (1992)</td>
</tr>
<tr>
<td>1+</td>
<td>Hancock et al. (2001)</td>
</tr>
<tr>
<td>1-</td>
<td></td>
</tr>
<tr>
<td>2++</td>
<td>Davidson et al (1994)</td>
</tr>
<tr>
<td>3++</td>
<td></td>
</tr>
</tbody>
</table>
2.10 Study Categorisation

The 21 accepted studies were categorised as follows:

- UK (4 studies)
- Other European (1 study)
- Non European data (16 studies)

<table>
<thead>
<tr>
<th>Country of origin</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finland</td>
<td>Kumpusalo et al (1996)</td>
</tr>
<tr>
<td>Australia</td>
<td>Hancock et al (2001)</td>
</tr>
</tbody>
</table>

The 21 primary studies assessed are described in section 3 and presented in the evidence table located at the end of the results section.

The studies covered various community engagement methods/approaches that were categorised under the following headings (which were identified from the terms used by the authors of the primary studies):

- Community coalitions
- Neighbourhood/community committees
- Peer educators/community volunteers
- School Health Promotion Council
- Peer leadership groups
- Community champions
- Community workshop

The community engagement methods/approaches focused upon lay community involvement in the planning, design, delivery and governance of interventions(s).

Numerous interventions were described by the 21 included studies:

- Educational packages/programmes
- Exercise classes
• Renovation of playgrounds/community areas
• Provision of safety equipment
• Poster/mural painting for children
• Film making
• Mass media campaigns
• Smoking cessation classes
• Promotion of smoke free environments
• Health fairs
• Food demonstrations
• Lantern making
• Internet Web design
• Curriculum development
• Small media item distribution e.g. T-shirts
• Dramatic productions
• Beach parties
• Activity nights e.g. rollerskating, bowling

The health behaviours/areas targeted by the studies were:
• Cardiovascular health
• Childhood immunisation
• Injury prevention
• Sexual health
• Smoking
• Alcohol
• Nutrition
• Physical activity

The outcome measures included in the primary studies were dependent upon the intervention, although they generally could be classified as:
• Behaviour change
• Level of knowledge/awareness
• Injury rates
• Mortality rates
• Impact of community engagement method/approach
• Food intake
• Clinical measures (e.g. blood pressure; cholesterol levels)
• Bicycle helmet use
• Reduction of sedentary lifestyles
• Attitudes
• Sexual risk taking

2.11 Assessing applicability to UK
The external validity of each study was assessed i.e. the study’s generalisability to the target population(s) and setting(s). The barriers to implementing the community engagement approach/method and specific intervention(s) were considered by the reviewer.
Rapid review - health promotion effectiveness phase 3

The majority of included studies were conducted in the Non European countries (USA, Canada and Australia). Variables such as culture, policy context and service/health systems as well as whether the intervention(s) could be employed in the UK by utilising the stated outcome measures, were taken into account when assessing applicability to a UK setting.

2.12 Synthesis
As this work covered differing methodologies, several community engagement methods/approaches, numerous intervention strategies, health behaviours and outcome measures it was considered inappropriate to synthesise the data using meta-analysis. This rapid review is therefore restricted to a narrative overview of all studies that met the inclusion criteria. Where statistical data and details regarding the specific nature of the community engagement method/approach was available in the included studies, this has been extracted and presented in the evidence tables.

The findings have been presented in relation to the two primary research questions and a number of sub-questions identified as of potential interest (outlined in 1.3.2).

The evidence statements were developed using NICE criteria (NICE, 2006, p37) outlined below:

- The best available evidence of the effect of an intervention.
- The strength (quality and quantity) of supporting evidence and its applicability to the populations and settings in question
- The consistency and direction of the evidence base

For four community engagement methods contained within this review (school health promotion council, peer leadership groups, community champions and community workshop), only one study met the inclusion criteria. Evidence statements were drafted for these sections but due caution should be taken in generalising the related findings. This review did not provide any evidence statements related to cost-effectiveness data, as studies found to contain economic data were highlighted for consideration in the economic review.
Section 3. Summary of Findings

The categorisation of community engagement methods/approaches has been done so in relation to the terms used by the authors of the 21 included primary studies.

3.1 Community Coalitions

Six non-European (5 USA; 1 Canada) studies provide evidence for the effectiveness of community coalitions primarily in the planning and design of primary health promotion interventions.

<table>
<thead>
<tr>
<th>Study type and quality</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>2+</td>
<td>Davidson et al (1994)</td>
</tr>
<tr>
<td>3-</td>
<td>Holder et al (1997); Pargee et al (1999); Williams &amp; Olano (1999)</td>
</tr>
</tbody>
</table>

3.1.1 Is the approach or methods effective for the planning (including priority setting and resource allocation), design, delivery or governance of health promotion interventions? What methods/approaches don’t work?

The first USA based pre and post test study (Davidson et al 1994) aimed to evaluate the effectiveness of a community (Safe Kids/Healthy Neighbourhoods) coalition to prevent severe injuries to school-aged children in Central Harlem, New York. The coalition consisted of representatives from city agencies, voluntary organisations, citizen groups, and health professionals, whose purpose was to design appropriate interventions activities. The coalition worked to renovate playgrounds; involve children and adolescents in safe, supervised activities; provide injury and violence prevention education; and provide safety equipment at a reasonable cost. Intervention activities included repairing playgrounds which included over 100 children painting murals, pedestrian safety programmes for schools, a dance program, an art studio, a Little League program, a winter baseball clinic and a soccer league that involved over 1000 children, as well as bicycle safety programs.

Surveillance of injuries that result in hospitalisation or death had been underway for 5 years. This survey data was used to test whether the incidence of severe injury declined during the intervention period. The incidence of injury among school-aged children in central Harlem was reported to have declined during the intervention period. The decline was specific to the targeted group and targeted causes. The results presented indicate that there was approximately 44% reduction in injury risk for targeted injuries in school-aged children in central Harlem during the intervention period. A decline also occurred in the control community where no intervention was undertaken.
No specific outcome or impact data related to the coalition component of the intervention were reported. Duration of effectiveness was not stated though the program lasted for three years indicating a potential long-term effect. The study authors acknowledge limitation due to the relatively brief period of observation (3 years) following the start of the program. They also state that the multiple comparison tests used were difficult to interpret and that the decline in motor vehicle injuries could be due to a general decline. This possibility was supported by a general national decline in motor vehicle injuries. A lack of detail regarding the methods used particularly relating to the control community was apparent in this article. However, some possible confounders were controlled via Poisson regression. This (2+) study was considered to be potentially applicable to the UK as the culturally specific nature of some of the interventions could be overcome by tailoring, for example, sporting activities to UK preferences.

A Canadian based pre and post-test study (Morris, Trimble & Fendley 1994) also focused on injury prevention. This study aimed to determine whether a wide-scale, long-term community promotional effort (coalition) would increase the use of bicycle helmets among local school/college aged children. The Coalition for Head Injury Prevention consisted of representatives of the public health unit, school boards, police, service clubs, retailers, the local Head Injury Association, cycling enthusiasts, the media, and family doctors. Over two years the coalition designed and coordinated a range of activities including print, radio and television advertising, posters, pamphlets, bicycle rodeos, police officers taught a bicycle safety module at local schools and a secondary school drama troupe production. All activities used peer models wherever possible. Bicycle helmet discount coupons were widely distributed and signs promoting bicycle helmet use were erected by the local Council on roads and bicycle paths.

Observers surveyed students riding bicycles at ten observation sites around the city including outside schools and colleges. Observations were undertaken on one date (May 1990) before the intervention began and on three dates during the intervention (October 1990, May 1991, and October 1991). The primary outcome measures were the number of cyclists and whether they wore helmets. Combining the two observation dates for each year, helmet use was reported to have increased from 5.4% in 1990 to 15.4% in 1991. The greatest increase was observed among elementary school students and overall girls were twice as likely to wear helmets as boys.

No specific outcome or impact data related to the Coalition for Head Injury Prevention was reported and duration of effectiveness was not stated. The study (2-) authors did not acknowledge potential confounders such as the lack of a control group and observer bias. The study would seem to be applicable to the UK where the wearing of bicycle helmets is not mandatory and the interventions used could be easily implemented.

A second USA based controlled before and after study (Arbeit et al., 1991) aimed to evaluate the utilisation and impact of a school health advisory committee (coalition) in supporting a cardiovascular school health promotion program (Heart Smart). The school advisory committee consisted of parents from the local community, teachers, food service workers, a physical education teacher, school administrator and Heart Smart Program representative. The majority of interested
parents, teachers and other coalition members resided in the local community. The Health Advisory Committee was established to promote cardiovascular health principles within the school setting, promote cardiovascular health education within the home, and promote 'ownership' of Heart Smart by the school. The committee met monthly to design specific projects to promote the adoption of cardiovascular healthy behaviours. The article focused on the evaluation of one intervention designed by the committee – 'Heart Smart Week'. Features of this intervention week included: on day 1 class discussions on the role of nutrition and exercise and children designing posters promoting cardiovascular health; on day 2 children, parents and teachers participating in aerobic activity with a local sports celebrity; on day 3 children brought heart healthy snacks to school and the cafeteria menu featured only healthy foods; on day 4 children composed an essay promoting a positive self-image and a poem developed by a committee parent was provided for students; day 5 consisted of assertiveness training with an appearance by a local celebrity. Throughout the week parents were provided with a newsletter detailing the activities of the week and students sang the Heart Smart theme song to their peers.

A control school was used to monitor nutrition related outcomes such as school lunch purchases. Students additionally provided self-report information on the amount of food consumed and its palatability and teachers evaluated participation and activity enjoyment. The patterns of school lunch purchases for day 3 (eat hearty) were found to be consistent with previous records at the school. There was a slightly lower number of healthy food purchases at a control school. Self-reports by students indicated a higher consumption of healthy foods at the intervention school compared with the control school and slightly higher palatability ratings were attributed by students at the intervention school. Twenty-three teachers completed the evaluation, documenting that school-wide 94% of children participated in all of the week’s activities. The aerobic warm-up exercise activity was indicated to be most preferred by most students and teachers. Some of the barriers faced during this study are described in section 3.8.

No specific outcome or impact data related to the Health Advisory Committee (Coalition) was reported and duration of effectiveness was not stated. The study authors did not consider any possible confounders such as the reliance on self-report. The study (2-) lacked statistical data to support the findings presented and the method was poorly described, particularly regarding the control school. However, the notion of a school based coalition and a ‘Heart Smart Week’ are potentially transferable to the UK.

The development and effects of coalitions for promoting physical activity among American Indian communities was described by one USA based case study (Pargee et al 1999). The coalition consisted of community members who were all indigenous to one of the seven geographical areas targeted and had demonstrated previous community involvement via tribal affiliation or other local community involvement. The 3-year intervention program was targeted at members of the local rural and urban communities from 7 distinct geographical areas. The community coalitions invited residents to attend forums to discuss the health problems and concerns facing each community and ways in which these might be addressed. The coalitions used the information gathered from the forums to plan, design and organise activities for the seven communities. The
coalition met monthly and members were invited to speak about the events designed and organised by the coalition on local television and radio programmes. Representatives from the seven coalitions combined to form a core coalition that met quarterly, acting as an advisory group for policy guidance.

Local events were chosen as a means whereby the health education messages and tribal traditions could be presented together so that participants experienced how physical activity was a vital part of a healthy lifestyle. Intervention activities included surf fish, stick game (competitors were coached by local elders), fitness walk, intergenerational walk, family fun day, community garden, beach walk and presentations by elders on traditional foods and dance. The case study reports that participants perceived that working with the coalitions helped them to feel included in the planning and implementation of health education programs and be able to contribute their knowledge to others, especially the younger generations. Some of the events organised by the coalitions have become institutionalised in the community calendar. However, not all coalition efforts were successful as is discussed in the subsequent barriers section (3.8) of this review.

No physical activity related impact data was provided and the authors of this case study do not acknowledge any potential confounders including the lack of a control community. Given the cultural differences and nature of the interventions, this study was not deemed to be applicable to UK communities.

Physical activity was, however, the focus of another USA based case study (Williams and Olano 1999), which aimed to determine the effectiveness of using a coalition to promote physical activity among African Americans. Coalition members included community members, representatives from a neighbourhood based community services agency (indigenous community residents), chairperson of a drugs action group, a nurse and two local ministers. The interventions were targeted at African Americans residing in Southeast Stockton, California. The coalition was set up to support a program aiming to increase physical activity and began by determining community needs and intervention strategies. A community meeting was subsequently held to discuss the workings of the coalition. Intervention strategies were considered including walking clubs and the coalition began to identify walking club captains from the lay community and walking routes. Walking captains were trained in exercise techniques and CPR. The coalition liaised with other organisations to help promote physical activity. A Walkathon was sponsored and incentives to join walking clubs were provided e.g. T-shirts, water bottles and caps.

A reduction of sedentary lifestyles was reported but no specific outcome data related to the coalition was reported. The results presented indicate that through the use of the coalition, walking clubs were integrated into community lifestyle, including neighbourhood crime prevention activities (via walking crime patrols) and youth projects. Participation of the coalition in numerous community, cultural, and church events promoted physical activity through walking as a community norm. No statistical data was provided and the duration of effectiveness was not stated though the authors report that coalition activities were undertaken over a two-year period. The study authors did not consider potential confounders. The lack of a control community and insufficient description of outcome measurement resulted in a poor quality score (3-). Cultural differences limit the applicability of the study findings to UK communities.
One final (3-) paper (Holder et al., 1997) aimed to sum up the lessons learned from a 5-year Community Trials Project and make recommendations for others who are with local alcohol prevention services. The community trials project, involved three experimental communities, and focused on the training of community coalitions and task forces in intervention design and media advocacy. Alcohol involved trauma in terms of motor vehicle crashes involving alcohol; sales of alcohol to minors; responsible alcohol serving policies; and media coverage of alcohol issues were measured. The article reports that the interventions implemented by the coalitions significantly reduced the number of alcohol-related crashes (overall reduction was 78 over the 28 month intervention period – representing an approximate annual reduction of 10%); sales of alcohol to minors; responsible alcohol serving policies and increased media coverage of alcohol issues. No statistical data or outcome data specific to the community coalitions were reported, as the barriers to this community engagement method were the focus of the paper. Assessments of quality and applicability to the UK could not be conducted due to the limited information presented. Further discussion regarding the barriers described in this study can be found in section 3.8 of this review.

### Evidence statements

The effectiveness of community coalitions in changing behaviour appears to depend on the behaviours targeted for change. The lack of a control group in all but 2 of the studies and the minimal specific outcome and impact data presented on community coalitions limits the inferences that can be drawn about effectiveness.

The evidence from 6 studies (one 2+, two 2-, three 3-) suggests that community coalitions used in the planning and design of an intervention may contribute to reducing the number of alcohol related crashes, and contribute to improving a number of alcohol related behaviours as well as improving the prevention of injuries to children, and in promoting a healthy diet in children. In terms of changing bicycle helmet use in children, community coalitions contribute to effective use; although girls are twice as likely as boys to wear helmets. Community coalitions also appear to contribute to effective promotion of physical activity through walking (Davidson et al., 1994; Arbeit et al., 1991; Morris et al., 1994; Holder et al., 1997; Pargee et al., 1999; Williams & Olano, 1999).

The evidence from one study (3-) further suggests that community coalitions may result in increasing feeling within coalition members of being included in the planning and implementation of health education programmes, and thus enabling them to contribute their knowledge to others, particularly the younger generations (Pargee et al., 1999).

The evidence from one study (3-) indicates that community coalitions appear to be associated with the integration of a healthy lifestyle into a community norm (Williams & Olano, 1999).
3.1.2 What is the aim/objective of the approach or method?

All six studies aimed to assess the effectiveness of community coalitions in the planning and design of primary health promotion interventions; however, the majority (4 out of the 6) did not report any specific impact or outcome data related to the community coalition. Only impact and outcome data related to the overall effectiveness of the intervention was presented.

3.1.3 What theoretical framework or value system underpins the design, content and/or delivery of the approach and/or method?

The papers included in this review did not contain sufficient detail to address this question.

3.1.4 How does the content and/or delivery of the approach or method influence effectiveness?

A variety of behaviours/areas were targeted by the studies including injury prevention (Davidson et al., 1994 and Morris et al., 1994), nutrition (Arbeit et al., 1991), physical activity (Pargee et al., 1999 and Williams & Olano, 1999) and alcohol-related injuries (Holder et al., 1997). The evidence presented in the six studies suggests that coalitions may be most effective when targeting injury prevention with positive results being found by one (2+) study (Davidson et al., 1994) and one (2-) study (Morris et al., 1994). Coalitions were also found to be effective by one (3-) study at reducing alcohol-related accidents. However, the evidence from one (2-) study (Arbeit et al., 1991) regarding the effectiveness of coalitions in increasing the consumption of healthy foods and from two (3-) studies (Pargee et al., 1999 and Williams & Olano, 1999) aiming to increase physical activity were not conclusive due to the lack of data contained within the relevant studies.

One strategy employed by each coalition was to plan/design numerous interventions to tackle the issues under consideration. It was therefore not possible to assess the effectiveness of specific interventions.

In the majority of studies within this category no outcome/impact data specific to the coalition aspect of the intervention was provided.

Evidence statement
Due to the heterogeneity among the studies and the limited data specific to the nature of the coalitions there is insufficient evidence available to make conclusions about how the content and/or delivery of coalitions influences effectiveness.

3.1.5 Does effectiveness depend on the intervener? What are the significant features of an effective intervener? (Does effectiveness
depend on whether they are a community member, volunteer and/or a public sector professional and, if the latter, on their job title or status? Or does it depend on their age, gender, sexuality, ethnicity or knowledge/skill base?)

The coalitions described in four studies (Davidson et al., 1994; Arbeit et al., 1991; Morris et al., 1994; Williams & Olano, 1999) consisted of representatives from a variety of backgrounds including lay community members and healthcare professionals. Only one coalition (Pargee et al., 1999) was described as solely comprising indigenous members of the community. No further details were provided in any of the remaining studies regarding coalition members (and the effectiveness of particular coalition members in the planning/design process).

Evidence statement
There is insufficient evidence available to make any conclusions about the features of an effective coalition member.

3.1.6 Does the site/setting of the approach or method influence effectiveness and, if so, how?

None of the studies in this review described the meeting arrangements of the coalitions. However, two studies (2-) focused on the use of coalitions in school-settings. No significant increase was found in healthy food consumption (Arbeit et al., 1991) following the intervention activities designed by the coalition. However, an increase in bicycle helmet use was observed among school students (Morris et al., 1994).

Evidence statement
The evidence pertaining to the influence of site/setting is contradictory. While the evidence from one study (2-) indicates that coalitions may be useful in the planning and design of injury prevention interventions in school settings (Morris et al., 1994), another school-based study (2-) found no significant increase in healthy food consumption (Arbeit et al., 1991).

3.1.7 Does the intensity (or length) of the approach or method influence the effectiveness or duration of the effect?

Details regarding the intensity and duration of the planning/design process by each coalition were not provided in any of the included studies. Interventions lasted from one week to several years and follow-up measures also varied accordingly.

Evidence statement
There is insufficient evidence to draw conclusions about the intensity (or length) of the impact of community coalitions.
3.1.8 Does impact of the approach or method vary according to the target community (for example, in terms of their age, gender, ethnicity or social circumstances)?

Coalition efforts targeted children in three of the six studies (Davidson et al., 1994; Arbeit et al., 1991 and Morris et al., 1994). The incidence of injury in school-aged children was reported to decline during the intervention period described by one study (Davidson et al., 1994). A second study (Morris et al., 1994) found that bicycle helmet use increased among school students during a two-year intervention phase, though girls were twice as likely to wear helmets as boys. While school students reported eating more healthy foods (Arbeit et al., 1991) this finding was not supported by an increase in school lunch purchases and no statistical data was provided by the study authors. Two of the remaining three studies (Pargee et al., 1999 and Williams and Olano, 1999) targeted a community as a whole, the former targeting a Native American Indian community. No specific details were provided by either study to enable a conclusive assessment of the effectiveness of the coalitions in reducing sedentary lifestyles in indigenous populations. The final study (Holder et al., 1997) did not provide details as to the target community.

**Evidence statement**

There is some indication from 3 studies (one 2+, two 2-) that the impact of coalitions may be related to specific population groups however there is insufficient evidence to make firm conclusions (Davidson et al., 1994; Arbeit et al., 1991 and Morris et al., 1994).

3.1.9 To what extent is effectiveness of the approach or method influenced by the level of participation and control in the approach or method?

Lay community members were recruited to community coalitions to plan and design a variety of primary health promotion interventions. However, there is insufficient data to determine the exact level at which this operated.

**Evidence statement**

There is insufficient evidence to determine the extent to which the level of participation and control influenced the effectiveness of the community coalitions.

3.1.10 Is there any differential impact on inequalities in health within and between communities?

None of the papers provided any details addressing this question.

**Evidence statement**

There is insufficient evidence to assess the impact of coalitions with regards to health inequalities.
3.1.11 How acceptable is the approach or method to the target community?

None of the papers provided any data specifically considering the acceptability of a coalition to the community members who were recipients of the intervention or to those community members involved in implementing the approach.

**Evidence statement**

There is insufficient evidence to assess the acceptability of a coalition to the target communities.

### 3.2 Peer educators/community volunteers

Six studies (2 UK; 4 non-European - 3 Canada; 1 USA) provide evidence for the effectiveness of peer educators primarily in the delivery of primary health promotion interventions.

<table>
<thead>
<tr>
<th>Study type and quality</th>
<th>Authors</th>
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<tbody>
<tr>
<td>1+</td>
<td>Barnes et al (1999); Tudiver et al., (1992)</td>
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<tr>
<td>2-</td>
<td>Parkin et al. (1993); Tenn &amp; Dewis (1996)</td>
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<tr>
<td>3-</td>
<td>EB4U NDC (2005)</td>
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#### 3.2.1 Is the approach or methods effective for the planning (including priority setting and resource allocation), design, delivery or governance of health promotion interventions? What methods or approaches don't work?

One USA based Randomised Controlled Trial (Barnes et al., 1999) aimed to assess the effectiveness of a volunteer driven outreach programme on immunisation rates in children younger than 2 years. Interventions were targeted at a large, highly mobile, immigrant community originating from the Dominican Republic. Volunteer peer educators were recruited from the local community and provided intervention group families with basic immunisation education and made referrals to the appropriate vaccination services. Immunisation outreach, tracking and follow-up were provided with all intervention families. Control families received no intervention though were notified of the child’s immunisation status at enrolment. The child’s immunisation status was measured 6 months after the family’s enrolment on the program. Significantly more intervention children were found to be up-to-date with their vaccination series than controls (75% vs. 54%; p=0.03). Children in the control families were 2.8 times more likely to be late for a vaccine than intervention children (odds ratio=2.8; p=0.02). An immunisation delay of longer than 30 days at enrolment was found to be a significant predictor of final immunisation delay (odds ratio= 2.6; p=0.02). No outcome or impact data specific to the community volunteer component of the intervention was reported.

Duration of effectiveness was not stated however outcome measurement at 6 months post intervention would seem to indicate a medium term effect. This (1+) study assessed demographics between the intervention and control groups and found no significant differences, though the study authors do acknowledge
limitations in terms of generalisability and selection bias. Given the differences between healthcare systems these USA based study findings are not considered to be applicable to the UK.

A second RCT (Tudiver et al., 1992) conducted in Canada focused on sexual health, aiming to assess the effectiveness of two different kinds of AIDS risk reduction programs for gay and bisexual men practicing sexual behaviour at all ranges of risk for transmission of HIV. Six hundred and twelve men who identified themselves as gay or bisexual were randomly assigned to either single-session groups led by trained volunteer peer educators or four-session groups led by paid counsellors or waiting list control groups. This latter group were offered their choice of either intervention after they completed the follow-up measures.

Twenty volunteers from the gay community were recruited to lead intervention (single-session) groups in which participants met in a highly structured three-hour session for 8-12 participants. Each group met in a group member's home and was led by two of the unpaid trained volunteer peer educators. Intervention activities included introduction and goal-setting, establishing a group rapport, the impact of AIDS on individuals and the community, condom demonstrations, difficulties with safer-sex practices, safe-sex guidelines and safer-sex practices, sexual scenario role play and safer sex fantasies and scenarios. The serial session intervention participants met in small groups of 8-12 for four weekly two-hour sessions with two paid experienced leaders. The sessions included introduction, goal-setting, establishing a group rapport, tasks and discussions about safer-sex, sharing of personal experiences and coping strategies, and skills, role-plays for negotiating for safer sex and closure.

Self-administered questionnaires measured knowledge of AIDS risk, attitudes towards AIDS and sexual practices, and sexual behaviour prior to randomisation and three months post intervention. The number of partners and the practice of unsafe sex were the primary outcome variables. Participants in the single-sessional groups reported significant decreases in unsafe sex and significant increases in safe sex practices at post-intervention (p<0.006). This was not found for the serial-session and control groups (no further statistical data was reported). The rate of decline of practicing unsafe sex was greater for the single-session groups (40%) than for the serial session (14%) or the control (14%) groups. No differences in number of partners were reported between baseline and follow-up for any of the three groups. Gains in knowledge of AIDS risk as well as Attitudes towards AIDS and sexual practices did not vary significantly across the three groups though were significantly higher for the intervention groups combined (single and serial sessions) than the control group (no statistical data was provided). The project was successful in recruiting gay and bisexual men to participate and complete the required tasks. The single-sessional intervention led by peer volunteers was found to be easier to implement and more practical than the serial-sessional led by paid professionals. However, the project was less successful in recruiting and retaining young, less educated, bisexual men.

No specific outcome or impact data associated with the peer leaders was provided. As post intervention measures were undertaken after three months duration of effectiveness would seem to be medium term though whether effects are maintained in the long-term are unknown. The study authors acknowledged
that in this (1+) study the dropout rate was greater than had been expected (21% overall compared to the projected 15%). Furthermore, only 63% of men assigned to the serial sessions received the full four sessions, whereas all of the single-session participants attended all meetings. There was a lack of statistical data to support the majority of reported findings, however power analysis was undertaken to determine sample size and the reliability and validity of measurement instruments was assessed. The findings were considered to be applicable to the UK as the use of volunteer peer educators is a potentially transferable intervention.

A Canadian based controlled non-randomised trial (Parkin et al 1993) aimed to evaluate the effectiveness of a school-based bicycle helmet promotion program in increasing helmet use by children while controlling for secular trends. An educational week “Be Bike Smart” was held at four intervention schools (2 high income and 2 low income). Eighteen schools receiving no intervention acted as a control community. Health nurses facilitated the undertaking of intervention activities, which focused on community involvement, and specifically the use of peer educators. Students performed to their peers at school assemblies to deliver the helmet message and produced posters to promote bicycle helmet use. Parent information nights, discounted helmets and a bicycle rally incorporating the helmet message were additional strategies used to support the peer-led intervention. Approximately 1800 observations of bicycling children were made at randomly selected observation sites 2 to 5 months after the intervention. Observation sites included schools, parks and other recreational areas. Helmet use at all observation sites tripled from 3.4% (pre intervention) to 16% (post intervention). In the high income intervention area, observed helmet use rose from 4% to 36% (p<0.001) in contrast to the high income control area of 4% to 15% (p<0.005). In the low income intervention area there was an increase from 1% to 7%, but it did not differ from the increase in the low-income control area from 3% to 13%. The study found that children were more likely to wear helmets when riding with adults than when riding alone or with other children in both income areas (p<0.001). However, in the low income areas the influence of peers appeared to be stronger, since fewer children wore helmets when riding with other children than in high-income areas (p<0.001). Overall, the program was found to be successful in children of high-income families but not in children of low-income families.

No outcome or impact data associated with peer leaders was provided and duration of effectiveness was not stated though effects would seem to be maintained at 5 months post intervention. The study (2-) authors considered some threats to internal validity e.g. the influence of other campaigns in high-income areas during the study period, but did not account for other confounders such as observer bias. The use of peer leaders in the delivery of a bicycle helmet intervention package in a school environment was felt to be transferable to the UK.

A third Canadian study (Tenn & Dewis, 1996) adopted a controlled non-randomised design to assess the effectiveness of an injury prevention programme developed and presented by an adolescent peer group. The target population receiving the peer-led intervention were high-risk adolescents enrolled in alternative education programs (students with a combination of social and
academic problems). An intervention group received delivery of a peer-led programme, which was compared to the delivery of a prevention presentation to a similar group by a health care professional, both of which were compared to a control group receiving no intervention. Nine peer leaders aged 17-19 years (mean 3 years older than adolescents in the alternative education program) were recruited to a peer group to tailor an educational intervention to lifestyle patterns; risk-taking behaviours and developmental characteristics of young adolescents, and provide social reinforcement orientation. Initially, the peer group met to design and organise the intervention programme though once developed the peer group presented the program to the high-risk adolescents. Intervention activities included an introductory lecture, an obstacle course, sports and risks (involving a visit by a famous sports star), watching a video montage (created by the peer group) considering sport related injuries and working with scenarios linking emotions and risks.

Questionnaires were used incorporating knowledge of injuries, Risk-Taking inventory, Multidimensional Health Locus of Control, Self-efficacy, Behavioural Intent and for the intervention groups qualitative open-ended questions referring to the prevention program delivered. No significant overall differences between groups were reported over time (post-test or 4 month follow-up) on any of the outcome measures. Qualitative data revealed a positive impact of the peer intervention over the health professional led intervention. Individuals in the intervention group described themselves as having increased knowledge, realisation of consequences and awareness of a need for caution.

The study (2-) authors acknowledged that the scales developed for this study (e.g., behavioural intent and self-efficacy) were not pilot tested for content and face validity. They reported delays in follow-up evaluation and variation in teacher’s administration of the evaluation questionnaire. Furthermore, the target population was high risk based on social and educational problems, which may have transferred to the context of the intervention. Power analysis was also not conducted to determine the required sample size. As described previously, the use of peer educators would seem to be transferable to the UK and the interventions described could be implemented in schools or youth groups.

One UK based qualitative process evaluation (Bolam et al., 2006) documented the effects of ‘Ambassador’/peer-educator participation in the Nottingham CityNet project. The project aimed to build aspects of social capital and improve access to health and welfare information and services among disadvantaged groups. The Initial target population was 4 key disadvantaged groups: young African-Caribbean men with mental health difficulties, long-term unemployed men, socially isolated carers and older people. Target groups were subsequently widened to include other individuals (e.g. unemployed females) living in deprived wards of Nottingham. There were three key elements of the project process: to work with local people to design web interface and content; to recruit and train local Ambassadors (as peer educators) to train others in Information Communication Technology (ICT); and to embed the project in local community-based organisations through partnership working. The Ambassadors, recruited from the targeted groups, were trained by project workers to enable users to access a range of services such as email, chat rooms and service information.
Two waves of semi-structured interviews were conducted with the Ambassadors/peer educators between May 2002 and December 2003. A third wave of telephone interviews was conducted with a self-selecting sub-sample of 10 Ambassadors between May and June 2003. Data analysis identified two themes: the psychosocial benefits of participation and problems in devolving power. Initial engagement was described as the result of the peer educators seeking psychological stimulation and having an interest in ICT. For some peer educators, working in the project was a means of keeping engaged despite physical infirmity. Working as an Ambassador had helped participants build feelings of self-efficacy and self-esteem. Such psychological benefits were reported as being complemented by the extension of social networks among the sample. Participants had made new face-to-face contact via Ambassador training and, particularly carers, reported perceiving ICT's as a potentially useful tool to combat problems of social exclusion and reducing social isolation. The second theme was felt to be more applicable to the address the research question pertaining to the barriers to community engagement methods and is therefore discussed in section 3.8 of this review.

The duration of effectiveness was not stated and the case study (3-) authors acknowledge that peer educators were starting from a disempowered position and low levels of confidence. They further recognise that the lack of a control group limits assessment of impact. The sub-sample of Ambassadors who completed follow-up telephone interviews were self-selecting and the authors again acknowledge the potential bias. The project was UK based and therefore is likely to be applicable to other similar communities and populations in the UK.

A second UK based case study (EB4U NDC, 2005) aimed to describe the process and effects of the NDC’s Health4All team who made a short film with local people to raise awareness of sexual health and alcohol abuse issues. With the help of a local film making group, eb4u set out to engage young people aged 14-16 years to make a short film and resource pack to address an identified gap in sex education resources. Young people from six school and youth club settings in the local communities and wider areas participated in the design and delivery of the health promotion intervention.

A day’s workshop on alcohol and substance misuse issues was initially delivered for the young actors and crew. The young people were given considerable input into the films dialogue and storyline and two versions of the film were made, one for entry into competitions and another to show in schools and other youth settings. The case study reports that involvement in the film making process had benefited many of the young people involved via the acquisition of generic (e.g. time management) and specific skills (to film making). The project helped young people to meet others from different parts of the city and from different backgrounds and have a greater insight into career options. The mixture of cast and crew from different parts of the city also helped to dispel some of the prejudices against the area, which is often deemed a rough and unpopular place to live. The paper reported that there was encouraging feedback from those involved in the project and initial audience feedback reports suggested that some young viewers felt it had changed their attitudes to sexual health issues. The resource pack has been piloted successfully with school and youth groups.
No further details were provided regarding the evaluation of the project though the authors state that it is too early to consider the impact of viewing the film on behaviour as the project is ongoing. The duration of effectiveness is therefore unknown at this stage. The authors did not consider any possible confounders relating to this (3-) case study and the evidence presented indicates a lack of objective outcome measures. The project is UK based and is therefore likely to be applicable to other similar communities within the UK.

**Evidence statements**

The effectiveness of peer educators in changing behaviour appears to depend on the behaviour targeted for change.

The evidence from 2 studies (two 1+) suggests that peer educators may be effective in delivering health promotion related education/support in improving vaccination uptake, and decreasing unsafe sex and increasing safe sex practices (Barnes et al., 1999; Tudiver et al., 1992).

The evidence from one study (2-) suggests that in relation to increasing bicycle helmet use, peer educators may be effective for high income groups but not low income groups (Parkin et al., 1993).

The evidence from one study (2-) suggests that peer educators would seem to be ineffective in changing injury prevention behaviours in high-risk adolescents, although those receiving the intervention report having increased knowledge, realisation of consequences and awareness of a need for caution (Tenn & Dewis, 1996).

The evidence from one study (3+) tends to suggest that in projects that aim to improve access to healthcare through access and training in ICT, peer educators/community volunteers perceive ICT as a potentially useful tool to combat problems of social exclusion and social isolation (Bolam et al., 2006).

The evidence from one study (3-) also suggests that engaging peer educators in projects that specifically bring together people from different parts of a deprived city can help to dispel some of the prejudices against an area which is deemed a rough and unpopular place to live (EB4U NDC, 2005).

### 3.2.2 What is the aim/objective of the approach or method?

Four studies assessed the effectiveness of peer educators/community volunteers in the delivery of primary health promotion interventions (Barnes et al., 1999; Tudiver et al., 1992; Parkin et al., 1993; Tenn & Dewis, 1996. One UK study (Bolam et al., 1996) aimed, via the use of peer educators, to build aspects of social capital and improve access to health and welfare information and services among disadvantaged groups. A second UK based case study described the process and effects of engaging young people to make a film designed to raise awareness of sexual health issues (EB4U NDC, 2005).
3.2.3 What theoretical framework or value system underpins the design, content and/or delivery of the approach and/or method?

The papers included in this review did not contain any details that would enable this question to be addressed.

3.2.4 How does the content and or delivery of the approach or method influence effectiveness?

Several behaviours/areas were targeted by the peer educators/community volunteers including immunisation (Barnes et al., 1999), sexual health (Tudiver et al., 1992 and EB4U NDC, 2005) and injury prevention (Parkin et al., 1993 and Tenn & Dewis, 1996). The study described by Bolam and colleagues (2006) had a more general approach, promoting health and social care related information and services. A significant increase in the number of children up-to-date with immunisations was found (Barnes et al., 1999) following education and referrals from community volunteers in one (1+) study. A (2-) study (Parkin et al., 1993) reported an increase in bicycle helmet use in children following a series of activities involving peer educators. However, no significant differences were found a second (2-) study between a peer led intervention and a health professional led intervention aiming to reduce injuries in high-risk adolescents (Tenn & Dewis, 1996). Significant decreases in unsafe sex practices were found in one (1+) study when peer educators led sessions (Tudiver et al., 1992). These effects were not found for sessions led by paid counselors or a control group receiving no intervention. However, no differences were found between interventions in relation to the number of partners. No evaluative data considering the effectiveness of viewing a film promoting safe sex practices created by peer educators was described by one (3-) study (EB4U NDC, 2005). Similarly, no evaluative data relating to the effectiveness of peer educators in improving a disadvantaged communities access to health and social care information and services was provided in a (3+) study (Bolam et al., 2006).

These latter two papers provided qualitative accounts focusing on the experience, perceptions and attitudes of the peer leaders. The acquisition of new skills, developing social networks and psychological benefits of participation were all reported.

In the majority of papers the peer educators/lay community volunteers are described as the intervention. However, the means of delivering the educational messages varied considerably including performing at school assemblies, producing and presenting posters, group discussions, film production and using ICT as a facilitator.

Peer educators delivered the various interventions described in four studies on a group basis. The film produced by EB4U NDC was conducted on a group basis and designed to be delivered to a group of students. Lay community volunteers delivered immunisation education and support to families.
### Evidence statements

Given the lack of available data and the heterogeneity of the behaviours/areas targeted by the peer educators it was not possible to make conclusions about the impact of content.

Given the variety of modes of delivery it was not possible to evaluate the effectiveness of one specific mode of delivery.

#### 3.2.5 Does effectiveness depend on the intervener?

What are the significant features of an effective intervener? (Does effectiveness depend on whether they are a community member, volunteer and/or a public sector professional and, if the latter, on their job title or status? Or does it depend on their age, gender, sexuality, ethnicity or knowledge/skill base?)

Two of the six studies in this category compared the effectiveness of a lay peer educator to the delivery of an intervention by a healthcare professional. While significant differences were found on some measures in relation to sexual health (Tudiver et al., 1992), a significant difference was not found when the target behaviour was injury prevention (Tenn & Dewis, 1996).

One study reported that using female community volunteers (Barnes et al., 1999) to deliver an educational message regarding childhood vaccinations was effective in increasing the number of children with up-to-date vaccination cards. A second study (Tudiver et al., 1992) found that recruiting gay and bisexual men to lead the intervention group was effective at reducing some unsafe sex practices. However, the evidence for the effectiveness of using young people as intervener's was varied. While Parkin (1993) reported an increase in bicycle helmet use, Tenn and Dewis (1996) found no effect of using adolescent peer leaders in relation to injury prevention and a lack of data limited an assessment of effectiveness of the EB4U NDC (2005) project. Finally, an assessment of the effectiveness of peer educators from disadvantaged groups in improving access to health information and services was not possible given the lack of data in the Bolam (2006) paper relating to this impact and outcome.

### Evidence statement

The features that result in an effective intervener may vary depending on the behaviour/area being targeted. However, there is insufficient evidence to make conclusions about the significant features of an effective peer educator/community volunteer.

#### 3.2.6 Does the site/setting of the approach or method influence effectiveness and, if so, how?

Two studies describe the effects of peer educators in school settings (Parkin et al., 1993 and Tenn & Dewis, 1996), with only the former finding any significant
effects in favour of the use of peer leaders. The lay community volunteers described by Barnes and colleagues (1999) visited the homes of families within the target community, a program that did report some success. The film making led by EB4U NDC (2005) took place in a youth setting though insufficient details were provided in this paper or the remaining studies in this category (Tudiver et al., 1992 and Bolam et al., 2006) to determine the exact site/setting of the peer educator interventions.

**Evidence statement**
Evidence relating to whether the site/setting influences the effectiveness of peer educators/community volunteers is insufficient and what evidence is available indicates contradictory findings.

### 3.2.7 Does the intensity (or length) of the approach or method influence the effectiveness or duration of the effect?

Information regarding the intensity and duration of the peer educator/community volunteer interventions was insufficient to fully address this question. Outcome measures varied from immediately following interventions to six months post intervention.

**Evidence statement**
There is insufficient evidence to draw conclusions about the intensity (or length) of the impact of peer educators/community volunteers.

### 3.2.8 Does impact of the approach or method vary according to the target community (for example, in terms of their age, gender, ethnicity or social circumstances)?

The communities targeted by the peer educators/community volunteers varied from immigrant communities (Barnes et al., 1999), disadvantaged communities (Bolam et al., 2006) to school-aged children (Parkin et al., 1993; Tenn & Dewis, 1996; EB4U NDC, 2005) and gay or bisexual men (Tudiver et al., 1992). As described previously the effectiveness of the studies in this category were contradictory.

**Evidence statement**
There is insufficient evidence available to address the impact on the target community.

### 3.2.9 To what extent is effectiveness of the approach or method influenced by the level of participation and control in the approach or method
Volunteer peer educators/community volunteers were recruited from local communities primarily to deliver primary health promotion interventions, most notably education and support. However, there is insufficient data to determine the exact level at which this operated.

**Evidence statement**
There is insufficient evidence to determine the extent to which the level of participation and control influenced the effectiveness of the peer educators/community volunteers.

### 3.2.10 Is there any differential impact on inequalities in health within and between communities?

None of the papers provided any details addressing this question.

**Evidence statement**
There is insufficient evidence to assess the impact of peer educators with regards to health inequalities.

### 3.2.11 How acceptable is the approach or method to the target community?

None of the papers provided any data considering the acceptability of the use of peer educators to either the recipients of the intervention or the community members involved in implementing the approach. Any details pertaining to the barriers experienced in relation to peer educators can be found in section 3.8 of this review.

**Evidence statement**
There is insufficient evidence to assess the acceptability of peer educators to the target communities.
3.3 Neighbourhood/community committees

One European (Finland) and four non-European studies (3 USA; 1 Australia) provide the evidence for the effectiveness of neighbourhood/community committees in the planning of primary health promotion interventions.

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<tr>
<th>Study type and quality</th>
<th>Authors</th>
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<tbody>
<tr>
<td>1+</td>
<td>Hunt et al (1993)</td>
</tr>
<tr>
<td>1-</td>
<td>Hancock et al. (2001)</td>
</tr>
<tr>
<td>2-</td>
<td>Fisher et al (1998); Hingson et al. (1996); Kumpusalo et al (1996);</td>
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</table>

3.3.1 Is the approach or methods effective for the planning (including priority setting and resource allocation), design, delivery or governance of health promotion interventions? What methods or approaches don’t work?

A USA based, randomised controlled trial (Hunt et al 1993) aimed to determine the impact of a worksite cancer prevention program (Treatwell), based on seven food focused messages, on eating patterns of workers. The target population was employees of 16 worksites though three did not complete the program resulting in 5 intervention sites and 8 control sites.

Employees were organised into advisory boards to assist Treatwell staff in tailoring programs to the “culture” of the worksite. Interventions included a weight management program, nutrition program, group discussions, health fairs, summer barbeque and food demonstrations. Members of the worksite advisory board were trained to teach key nutritional messages to other employees. Control worksites received no intervention. Food intake was measured using a Food Frequency Questionnaire (FFQ). Workers in companies receiving the intervention program decreased their use of margarine and butter as spreads (p<0.01) and increased their intake of vegetables (p<0.02) significantly more than workers in control companies. Although not statistically significant there were trends towards an increase in fish, lean meats, fruit, low fat dairy products and whole grain foods, among the intervention companies compared with the control companies.

No specific outcome or impact data related to the Employee Advisory Boards component of the intervention was reported and duration of effectiveness was not stated. The study (1+) authors acknowledged that while they controlled for demographic variables, a lack of reliability was encountered when using the FFQ. Given that the nature of the intervention involved advisory boards designing a tailored intervention program to a specific worksite the trial is potentially applicable to the UK.

A second study (Hancock et al., 2001) adopted a randomised controlled trial design to assess the effectiveness of a community action program (community committee) in decreasing adult smoking rates in rural towns of Australia. Members of 20 local towns were invited to form a Cancer Action in Rural Towns (CART) neighbourhood committee with the purpose of initiating and maintaining
intervention strategies within each of the 20 towns. These neighbourhood/community committees decided to direct intervention activities toward workplaces, sporting organisations, clubs and community organisations and toward the community itself. Intervention activities included promoting smoke free environments in workplaces, restaurants, hotels, motels, and sporting and community clubs. Non-smoking signage was provided, QUIT smoking classes were held and the local media were invited to cover community events including activities for World No Tobacco Day. In workplaces, employers were encouraged to provide employees with QUIT kits, posters were distributed and information was provided that was designed to increase awareness of passive smoking and related health and legal implications. No specific outcome or impact data related to the community committees was reported.

The findings indicated that compared to control towns in which no community committees were formed and interventions undertaken there were no significant differences in adult quit (95% CI: -0.3, +7.2) or uptake rates (95% CI: -2.2, +1.6). There was a reliance on self-reported smoking status via postal questionnaires and overall response rates were poor. There was substantial loss at the three-year follow-up and the study was found to have inadequate power. These potential confounders and high risk of bias resulted in a poor quality rating (1-). The findings were considered to be applicable to the UK in as much as many of the program activities are being implemented at present throughout the UK.

A USA based controlled non-randomised trial (Fisher et al., 1998) also focused on the promotion of non-smoking. The study aimed to evaluate a community organisation approach that emphasised involvement of audiences in programme planning and implementation in promoting non-smoking among African American residents of low-income neighbourhoods. Wellness councils (community/neighbourhood committees) were developed in 3 low-income neighbourhoods, which consisted of local neighbourhood volunteers and a staff member from Neighbourhood Services. A city-wide advisory council composed of predominantly African Americans representing major corporate, medical, religious and community groups was also created to provide linkages to key individuals in the community and gave advice about implementation. Wellness councils in each programme neighbourhood organised and directed activities including smoking cessation classes, billboards and a “gospelfest”. A control community was chosen for equivalent ethnicity, income, and education and received no intervention.

A shortened version of the Behavioural Risk Factor Surveillance System with the addition of items relating to smoking was conducted via random telephone surveys and changes in smoking prevalence were reported. The results indicate that the program was successful in engaging audience members in the planning of neighbourhood activities to promote non-smoking. The prevalence of smoking declined from 34% to 27% in program neighbourhoods (p=0.028) but only from 34% to 33% in comparison neighbourhoods (p=0.641). This difference was apparent within all demographically defined sub-samples.
No specific outcome or impact data related to the Wellness or advisory councils were reported. Duration of effectiveness was not discussed though the intervention and associated evaluation took place over two years. The study authors acknowledged that the design (2-) leaves doubt as to whether the observed differences may have been due to uncontrolled differences between the program and comparison communities. They also state that there were demographic differences between the intervention and comparison communities. However, no other programs assessed smoking in the target population during the study period. The study also relied heavily on self-report and the reliability of measurement instrument was not considered. Given community differences between the USA and the UK this study is not considered to be applicable to the UK.

A USA based, controlled non-randomised evaluation of the Saving Lives Program (Hingson et al 1996) aimed to assess whether a community program that organised multiple city departments and private citizens could reduce alcohol impaired driving, related driving risk, traffic deaths, and injuries. Community task forces consisting of between 20 and 100 concerned private citizens and representatives from various city departments (including schools, law enforcement, healthcare and Government) initiated and designed interventions to reduce drunk driving and speeding in 6 cities in Massachusetts. Five cities in Massachusetts acted as control communities, receiving no intervention, and crash/injury rates in the rest of Massachusetts were monitored throughout the 5 intervention years.

Community task forces initiated and designed interventions including media campaigns, business information programs, drunk driving and speeding awareness days, speed watch telephone hotlines and police training. High school peer led education, Students Against Drunk Drivers chapters, college prevention programs, alcohol free prom nights, beer keg registration and increased liquor outlet surveillance were initiated. To increase pedestrian safety and seat belt use in program communities, additional interventions included media campaigns, police checkpoints, posted cross-walk signs warning motorists of fines failing to stop for pedestrians, added crosswalk guards, including preschool education programs and training for hospital and prenatal clinical staff.

The study outcomes included rate of fatal car accidents (involving and not involving alcohol); rate of injuries resulting from car accidents, including pedestrians; direct observation of safety belt use and rate of speeding (> 10 MPH over speed limit); program awareness, perceptions of enforcement and police traffic citations. Intervention cities relative to the rest of Massachusetts during the 5 intervention years (in comparison to the 5 pre-program years) experienced the following significant changes: A 25% fatal crash reduction (27% on local roadways); a 42% decline in fatal crashes involving alcohol; a 47% decline in number of fatally injured drivers with positive blood alcohol levels; a 39% reduction in fatal crashes involving drivers aged 15-25; 5% reduction in visible injuries per 100 crashes (total injuries it was 3%); a 17% increase in seat belt use; a 43% decline in number of vehicles observed travelling at > 10 MPH over the speed limit; a 49% decline in proportion of 16-19 olds drink driving. Changes in number of fatal crashes involving speeding
drivers were not significantly different between the intervention cities and rest of Massachusetts. By the end of the 5th year, 54% of 16-19 year olds and 40% of adults were aware of the Saving Lives Program (compared to 8% and 10% respectively in rest of Massachusetts). Perception of enforcement did not increase significantly in intervention cites compared to the rest of Massachusetts for adults, but did for teenagers. Overall rates of police traffic citations decreased in the intervention cities compared to the rest of Massachusetts, including speeding tickets and drunk driving citations.

Intervention cities relative to the control cities during the 5 intervention years (in comparison to the 5 pre-program years) experienced the following significant changes: A 33% fatal crash reduction; a 42% decline in fatal crashes involving alcohol. However, no differences in rates of visible, pedestrian and total injuries per 100 crashes were found between intervention and control cities.

No specific outcome or impact data related to the community task force component of the intervention was reported. Given the duration of the intervention and outcome measurements, duration of effectiveness would seem to be long-term. The study authors acknowledged that during the study period the comparison cities initiated police enforcement and school based programs concerning traffic safety and drunk driving and secured funding from the Centre for Substance Abuse prevention to develop community coalitions. The (2-) study is potentially applicable to the UK given that some of the interventions are already in use in the UK.

A Finnish based controlled non-randomised trial (Kumpusalo et al 1996) aimed to assess the impact and outcomes of a low-cost local health promotion programme. Each action group of lay community members consisted of three key men and women of prestige in their villages with the interventions targeted at working-aged people in 6 rural villages. Twice a year each action group planned, together with an adult education institute, a health promotion programme for its own village. The action group enquired about local needs and made recommendations for health promotion interventions. There were three main types of activities: village seminars were held once a month, study groups, courses and sports groups were instituted covering topics such as health cooking and physical exercise and walking campaigns took place twice a year. Local newspapers and radio informed local people of the activities. While control villages did not receive the full intervention package, some extra activities including health seminars and walking tests were offered to community members.

Clinical measures, questionnaires and health examinations were used to determine health profiles and members of the action groups were interviewed to determine the feasibility and impacts of the programme. 60% of the people in the 4 intervention villages and 50% in the two control villages reported changes in health habits during the programme period. The most marked changes in health behaviour took place in dietary habits but the programme had no other impacts on smoking, drinking or exercise habits. There were significant decreases in cholesterol and systolic blood pressure levels in the intervention villages compared to the control villages (p<0.05 and p=0.000 respectively). No decreases in diastolic blood pressure and body mass index were achieved.
There was also a significant decrease in vitamin C levels in the intervention villages compared to the control villages (p=0.002).

Women community members participated more actively than men in the courses and seminars. There were also differences between villages in participation in all activities. No further impact data regarding the action groups were provided and the duration of effectiveness was not stated. The study authors have not considered potential confounders and the article (2-) contained insufficient methodological detail. Given the differences between UK communities and rural fishing villages in Finland the study was not deemed to be applicable to the UK.

**Evidence statements**

The evidence from 3 studies (one 1-, two 2-) suggests that the effectiveness of neighbourhood and community committees in changing smoking behaviour is inconsistent (Hancock et al., 2001; Fisher et al., 1998; Kumpusalo et al., 1996).

The evidence from three studies (one 1+, two 2-) indicates that neighbourhood/community committees used in the planning/design of an intervention may be effective in contributing to improving diet (Hunt et al., 1993; Kumpusalo et al., 1996), and reducing alcohol impaired driving, related driving risk, traffic deaths, and injuries (Hingson et al., 1996).

**3.3.2 What is the aim/objective of the approach or method?**

All five studies aimed to assess the effectiveness of neighbourhood/community committees in the planning of primary health promotion interventions. However, none of the five studies reported any specific impact or outcome data related to the neighbourhood/community committees. Only impact and outcome data related to the overall effectiveness of the intervention was presented.

**3.3.3 What theoretical framework or value system underpins the design, content and/or delivery of the approach and/or method?**

There was insufficient detail regarding the theoretical framework or value systems underpinning the use of neighbourhood/community committees to address this question.

**3.3.4 How does the content and/or delivery of the approach or method influence effectiveness?**

Several behaviours/areas were targeted by the studies including nutrition (Hunt et al., 1993), smoking (Hancock et al., 2001 and Fisher et al., 1998), alcohol related injuries (Hingson et al., 1996) and general health incorporating nutrition and physical activity (Kumpusalo et al., 1996). The two studies (1+ and 2-...
respectively) aiming to improve nutrition (Hunt et al., 1993 and Kumpusalo et al., 1996) reported mixed results with few significant differences. Similarly, while the prevalence of smoking was found to decline in one (2-) study (Fisher et al., 1998), no significant differences in adult quit or uptake rates were found by in a second (1-) study focusing on smoking (Hancock and colleagues, 2001). Hingson and colleagues (1996) reported (2-) a decline the number of fatal and non-fatal car crashes, an increase in seat belt use and a decline in observed speeding following interventions planned by a neighbourhood/community committee.

All of the neighbourhood/community committees described by the papers included in this review planned and initiated a variety of intervention strategies to address the behaviour/area under consideration. Interventions included health fairs, educational classes, media campaigns and the promotion of smoke free environments. It was therefore not possible to assess the effectiveness of specific interventions.

None of studies within this category reported any outcome/impact data specific to the neighbourhood/community committee aspect of the intervention.

Evidence statement

Given the heterogeneity among the studies and the limited data specific to the nature of the neighbourhood/community committees and the content/delivery mechanisms used there is insufficient evidence available to make conclusions about how the content and/or delivery of these committees influences effectiveness.

3.3.5 Does effectiveness depend on the intervener? What are the significant features of an effective intervener? (Does effectiveness depend on whether they are a community member, volunteer and/or a public sector professional and, if the latter, on their job title or status? Or does it depend on their age, gender, sexuality, ethnicity or knowledge/skill base?)

Few details were provided in the five studies regarding the members of the neighbourhood/community committees. One committee was comprised solely of employees of the intervention worksite (Hunt et al., 1993) and another of key men and women of prestige in the intervention villages (Kumpusalo et al., 1996). Volunteers from the local neighbourhood/community and representatives from local services formed the committees in the remaining three studies (Hancock et al., 2001; Fisher et al., 1998 and Hingson et al., 1996). No details regarding age, gender or sexuality were provided in any of the studies though one study demonstrating positive results focused on the recruitment of African American community residents to the committee (Fisher et al., 1998). No details relating to the effectiveness of particular neighbourhood/community committee members in the planning/implementation process were provided by the study authors.
3.3.6 Does the site/setting of the approach or method influence effectiveness and, if so, how?

None of the studies included in this category of the review described the meeting arrangements of the neighbourhood/community committees. One worksite based committee (Hunt et al., 1993) reported significant decreases in the use of margarine and butter and an increased intake in vegetables among employees. However, no other nutrition related benefits were found.

Evidence statement
There is insufficient evidence to make conclusions regarding the influence of site/setting on the effectiveness of a neighbourhood/community committee.

3.3.7 Does the intensity (or length) of the approach or method influence the effectiveness or duration of the effect?

Information regarding the intensity (or length) of the neighbourhood/community committees was not provided in any of the included studies. The timing of outcome measures following interventions planned and implemented by the committees ranged from one to five years, however, details were not provided in all studies. The evidence therefore suggests that where a neighbourhood/community committee has resulted in benefits to the community the effect may be long-term.

Evidence statement
The evidence from 5 studies (one 1+, one 1-, three 2-) suggests that where a neighbourhood/community committee has resulted in benefits to the community the effect may be long-term (Hunt et al., 1993; Hancock et al., 2001; Fisher et al., 1998; Hingson et al., 1996; Kumpusalo et al., 1996).

3.3.8 Does impact of the approach or method vary according to the target community (for example, in terms of their age, gender, ethnicity or social circumstances)?

The target communities described by the five studies varied considerably from working-aged adults, rural and urban settings, low-income African-American communities and predominantly white communities. The two studies
demonstrating positive effects of a neighbourhood/community committee were targeted at two very different communities, one of predominantly low-income African Americans (Fisher et al., 1998) and the other cities with predominantly white residents (Hingson et al., 1996).

**Evidence statement**

Given the heterogeneity of the target communities there is insufficient evidence to make conclusions about the impact of neighbourhood/community committees on specific target communities.

### 3.3.9 To what extent is effectiveness of the approach or method influenced by the level of participation and control in the approach or method?

Lay community members were recruited to neighbourhood/community committees to plan a variety of health promotion interventions. However, there is insufficient data available to determine the exact level at which this operated.

**Evidence statement**

There is insufficient evidence to determine the extent to which the level of participation and control influenced the effectiveness of neighbourhood/community committees.

### 3.3.10 Is there any differential impact on inequalities in health within and between communities?

None of the papers provided any details addressing this question. Thus, there is insufficient evidence to assess the impact of a neighbourhood/community committee with regards to health inequalities.

**Evidence statement**

There is insufficient evidence to assess the impact of neighbourhood/community committees with regards to health inequalities.

### 3.3.11 How acceptable is the approach or method to the target community?

None of the papers provided any data considering the acceptability of the neighbourhood/community committees to the various target communities. Any details pertaining to the barriers experienced in relation to this method/approach can be found in section 3.8 of this review.

**Evidence statement**

There is insufficient evidence to assess the acceptability of neighbourhood/community committees to the target communities.
3.4 School Health Promotion Council

One USA based RCT provides the evidence for the effectiveness of School Health Promotion Councils in the planning/design of primary health promotion interventions.

<table>
<thead>
<tr>
<th>Study type and quality</th>
<th>Authors</th>
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</thead>
<tbody>
<tr>
<td>1+</td>
<td>Kirby et al. (2004)</td>
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</table>

3.4.1 Is the approach or methods effective for the planning (including priority setting and resource allocation), design, delivery or governance of health promotion interventions? What methods or approaches don't work?

One USA based RCT (Kirby et al., 2004) aimed to assess the impact of a school-based HIV, STD and pregnancy prevention intervention on sexual risk-taking behaviours of different sub-groups of students. Twenty schools, ranging in size from 961 to 2733 students, were randomly assigned to receive “Safer Choices” (n=10) or a standard knowledge-based HIV education program (n=10). The Safer Choices intervention consisted of five primary components, the first involving each school forming a Health Promotion Council to plan and design project activities. Health Promotion Councils comprised teachers, students, parents, administrators and community members. The second component focused around curriculum and staff development. The curriculum included ten lessons in the 9th grade and 10 lessons in the 10th grade providing functional knowledge related to HIV, STD’s and pregnancy. In-class peer leaders facilitated selected curriculum activities. The third component involved a student peer resource team implementing activities such as publishing articles in the school newspaper, conducting school opinion polls, distributing small media items (e.g. posters and t-shirts), conducting small group discussion sessions and organising dramatic productions. Parental education was the focus of component four with newsletters being sent to parents three times a year and students being asked to discuss sexuality topics with their parents as part of homework assignments. Schools also conducted additional parent education activities. The final component aimed to facilitate school-community linkages via setting homework assignments that required students to gather information about local resources. HIV positive speakers from the community also gave presentations in schools. No further details regarding the intervention were provided.

Surveys assessing program exposure, demographic characteristics, sexuality related psychosocial factors, and sexual behaviours were conducted at baseline, 7-months, 19 months and 31 months post intervention commencement. The study authors report on five sexual behaviours: initiation of sex, and 4 measures involving condom use: frequency of unprotected sex; number of partners with whom students had unprotected sex; condom use during the last intercourse; and the use of effective contraception. Results were presented in terms of the overall effectiveness of Safer Choices and separately by gender, race/ethnicity, prior sexual experience, and prior sexual risk-taking.

Overall, Safer Choices did not significantly delay the onset of sexual intercourse (p=0.99) and did not increase contraceptive use among those who had sex in the
last three months (p=0.07). Safer Choices did reduce the frequency of sex without a condom (p=0.02), reduced the number of sexual partners in the last three with whom a condom was not used (p=0.04) and increased condom use during last sex among those who had sex in the last three months (p=0.02). No significant gender interaction effect on the initiation of sex was detected (p=0.70). On all four measures involving condom use interaction effects were detected indicting Safer Choices had a greater impact on males than on females. Safer Choices did not delay the initiation of sex among Blacks, Asians, or Whites, but did delay the initiation of sex among Hispanic students (0=0.02). Safer Choices increased condom use at last sex more among Hispanics and Whites than among Blacks (p=0.04). No other significant interaction effects were found. Safer Choices had a significantly greater impact on youth who initiated sex after baseline than on youth who were sexually experienced at baseline (p=0.02). In terms of condom use at last sex, Safer Choices had a greater impact on youth who were sexually experienced at baseline than on youth who initiated sex afterward (no further statistics were provided). Safer Choices had a significant positive effect on higher-risk youth who had unprotected sex before the baseline survey in relation to condom use at last sex (p=0.01) and contraceptive use at last sex (p=0.02).

The study authors concluded that Safer Choices could therefore have a long-term impact, may have positive effects on males and females, all major ethnic groups, sexually inexperienced and experienced youth, and both lower and higher-risk youth. However, it may be especially effective with Hispanic and higher risk youth.

No specific outcome or impact data related to the school health promotion council or the peer educator components of the intervention were provided. Duration of effectiveness was deemed to be long-term given that the study results were based on survey completion at 31 months post intervention commencement.

The study authors acknowledge several limitations including that the study randomly assigned entire schools rather than individual youth. Randomly assigning individual youth may have divided the subgroups more evenly and made the statistical analyses more powerful. Attrition caused by a lack of parental consent and loss at follow-up reduces the generalisability of the findings. The study relied on self-reports of behaviour and the analyses were exploratory not confirmatory and thus more research is needed to confirm the findings. The tests of significance were not corrected for multiple testing and therefore could have been caused by chance. Finally, the study measured the impact of Safer Choices on in-school youth only. This USA based (1+) study may be applicable to UK settings however the differences in school systems would need to be taken into account.

**Evidence statements**
The evidence from one study (1+) suggests that a Health Promotion Council used to plan and design activities may enable young people to make safer sex choices (Kirby et al., 2004).
The evidence from one study (1+) further indicates that a Health Promotion Council may be more effective with some population groups e.g. higher risk youth, and for particular approaches e.g. condom promotion (Kirby et al., 2004).

3.4.2 What is the aim/objective of the approach or method?

The School Health Promotion Council aimed to plan and design interventions that would encourage young people to make safer sex choices and reduce sexual risk-taking behaviours. No specific impact or outcome data related to the School Health Promotion Council or peer educator component of the intervention were reported. Only impact and outcome data related to the overall effectiveness of the intervention was reported.

3.4.3 What theoretical framework or value system underpins the design, content and/or delivery of the approach and/or method?

The paper did not contain sufficient detail to address this question.

3.4.4 How does the content and/or delivery of the approach or method influence effectiveness?

The School Health Promotion Council planned and initiated a variety of interventions including curriculum and staff development, implementing a student peer resource team, using peer leaders to facilitate curriculum activities and parental education. The evidence from this (1+) study suggests that some positive outcomes were achieved in relation to condom use though did not delay the onset of sexual intercourse. No data specific to the impact/outcome of the peer educator component of the intervention was provided.

Evidence statement
Given the variety of interventions employed and the lack of specific impact data it was not possible to assess how content/delivery influences the effectiveness of a School Health Promotion Council.

3.4.5 Does effectiveness depend on the intervener? What are the significant features of an effective intervener? (Does effectiveness depend on whether they are a community member, volunteer and/or a public sector professional and, if the latter, on their job title or status? Or does it depend on their age, gender, sexuality, ethnicity or knowledge/skill base?)

The School Health Promotion Council comprised teachers, students, parents, administrators and interested community members. No further details were provided regarding the council members and the effectiveness of specific council members in the planning/design process.
**Evidence statement**
There is insufficient evidence available to make any conclusions about the features of an effective School Health Promotion Council member.

3.4.6 Does the site/setting of the approach or method influence effectiveness and, if so, how?

The Council was school-based and thus all interventions were targeted at school aged children. The evidence from one study provides an insufficient foundation on which to base a conclusive statement of effectiveness.

**Evidence statement**
There is insufficient evidence available to make any conclusions about how the school setting of a Health Promotion Council influences effectiveness.

3.4.7 Does the intensity (or length) of the approach or method influence the effectiveness or duration of the effect?

As outcome measures were taken 31 months post intervention commencement any effectiveness of a School Health Promotion Council in enabling students to make safer sex choices may be long-term.

**Evidence statement**
The evidence from one study (1+) suggests that a School Health Promotion Council in the planning/design of the promotion of sexual health may have long-term benefits (Kirby et al. 2004).

3.4.8 Does impact of the approach or method vary according to the target community (for example, in terms of their age, gender, ethnicity or social circumstances)?

The target community were 9th grade school students. No further details were provided that enable an assessment of the impact of the School Health Promotion Council on this sub-group of students. As there are no other studies in this category an assessment of the impact of the approach on other communities is not possible.

**Evidence statement**
There is insufficient evidence to determine whether the impact of a School Health Promotion Council varies according to the target community.
3.4.9 To what extent is effectiveness of the approach or method influenced by the level of participation and control in the approach or method?

Schools in the intervention condition formed School Health Promotion Councils to plan and design project activities promoting safer sex choices. Peer leaders facilitated educational sessions and a peer resource team implemented planned activities by promoting safer sex choices (e.g. condom use) throughout the school. Parental education activities were conducted in intervention schools and school-community linkages were facilitated via homework assignments. However, there is insufficient data to determine the exact level at which this operated.

Evidence statement
There is insufficient evidence to determine the extent to which the level of participation and control influenced the effectiveness of the School Health Promotion Councils.

3.4.10 Is there any differential impact on inequalities in health within and between communities?

No details addressing this question were provided in this paper. There is insufficient evidence to assess the impact of a School Health Promotion Council with regards to health inequalities.

Evidence statement
There is insufficient evidence to assess the impact of a School Health Promotion Council with regards to health inequalities.

3.4.11 How acceptable is the approach or method to the target community?

This paper did not provide any data considering the acceptability of the School Health Promotion Council to the target community. Furthermore, no details pertaining to any barriers/facilitators experienced or perceived by the Council were provided.

Evidence statement
There is insufficient evidence to assess the acceptability of a School Health Promotion Council to the target community.

3.5 Peer leadership groups

One USA based case study provides the evidence for the effectiveness of peer leadership groups in the planning/design of primary health promotion interventions.
3.5.1 Is the approach or methods effective for the planning (including priority setting and resource allocation), design, delivery or governance of health promotion interventions? What methods or approaches don't work?

One USA based primary study paper (Komro et al., 1994) aimed to describe the components of a peer participation program for the prevention of alcohol use among young adolescents. The peer participation program was one component of Project Northland, a community wide program that seeks to prevent or delay onset of alcohol use among a cohort of young adolescents. Several papers describing and evaluating Project Northland have been assessed as part of this review however they were excluded on numerous counts. This paper, however, focuses solely on the one component meeting the inclusion criteria, that of peer educators. While Project Northland is a randomised trial, the information presented in the included paper was in case study format.

This (3-) paper notes that 175 students from the 7th grade from 20 schools (no further details provided) became peer leaders, with 66 adult volunteers from the local community also being recruited to facilitate the peer groups. Program goals included providing peer leadership and social support for non-use of alcohol, creating opportunities for alternative behaviours to alcohol use and creating a norm of non-use among young adolescents.

Students were initially informed about the peer leadership groups with a brochure mailed to their home. This brochure described the program and invited the student and their parents to a family event during which games containing an educational message were played. A multi-media recruitment booth also promoted the peer leadership groups. Interested students signed up for a later meeting. Each peer leadership group selected two to five representatives to attend leadership training sessions. Sessions involved training the peer leaders to brainstorm around ideas, conduct surveys, plan budgets, obtain donations and publicise events. These students were encouraged to pass on these skills to other group members.

Most peer leadership groups met during the school day and 166 students participated in planning at least one activity. Peer leaders were perceived to need more guidance in planning the first few events, but this need decreased as their experience and comfort level increased. The planning process was said to provide positive contact with school administrators. Peer leaders organised 62 alcohol-free activities for themselves and their class-mates during the first year of the program. Program activities were supervised by the adult volunteers. Intervention activities planned by the students included dances, parades, golfing, roller skating, bowling, ski trips, movies, beach parties and activity nights.

One hundred and forty three of the one hundred and seventy five peer leaders completed a survey after the first year of the program. 81% of the 143 peer leaders who responded reported that they enjoyed planning activities, 71% reported it was fun and 82% felt confident in their ability to plan activities their peers would enjoy. Most peer leaders (91%) thought it was important for youth to
plan their own alcohol-free activities. The training sessions were seen by most as being helpful (91%). Peer leaders believed activities were popular with their classmates (71%), and 86% felt their classmates had fun at the activities. More than 43% of the Class of 1998 attended at least one peer-planned activity, with a range across the schools of 17% to 87%. Peer leaders felt that some of their classmates did not attend due to classmates not liking the planned activity, classmates having other plans and classmates parents not allowing them to attend.

No further impact data relating solely to the peer leaders or the effectiveness of the peer leader component of the intervention were reported in this or any other paper related to Project Northland that has been screened for this review. As the above results were acquired following the first year of the three years of intervention programs the stated effect may be long-term. The study authors do not acknowledge any limitations in this paper though a reliance on self-reported attitudes was evident. This study was considered to be applicable to the UK given the transferable nature of the interventions implemented.

**Evidence statement**
The evidence from one study (3-) suggests that peer leadership groups used in planning/design may have benefits for the peer leaders in terms of enjoyment and increased confidence in undertaking planning activities (Komro et al 1994).

### 3.5.2 What is the aim/objective of the approach or method?

Peer leadership groups were composed to plan/design activities as part of an alcohol prevention program aiming to promote the non-use of alcohol among adolescents.

### 3.5.3 What theoretical framework or value system underpins the design, content and/or delivery of the approach and/or method?

The paper did not contain sufficient detail to address this question.

### 3.5.4 How does the content and/or delivery of the approach or method influence effectiveness?

Peer leadership groups planned and designed a variety of interventions to promote a norm of non-alcohol use among peers. A variety of activities were implemented to support this process. No impact data pertaining to the effectiveness of the peer leadership groups in meeting its aims were reported. However, members of the peer leadership groups reported enjoying the planning activities, felt it was of benefit to their peers and experienced additional psychosocial benefits as a result of their involvement.
Evidence statement
Given the variety of activities employed and the lack of specific impact data it was not possible to assess how content/delivery influences the effectiveness of peer leadership groups.

3.5.5 Does effectiveness depend on the intervener? What are the significant features of an effective intervener? (Does effectiveness depend on whether they are a community member, volunteer and/or a public sector professional and, if the latter, on their job title or status? Or does it depend on their age, gender, sexuality, ethnicity or knowledge/skill base?)

Members of the peer leadership groups were students in the 7th grade. No further details were provided with regards to gender, ethnicity or any other demographic variable.

Evidence statement
There is insufficient evidence available to make any conclusions about the features of an effective peer leadership group member.

3.5.6 Does the site/setting of the approach or method influence effectiveness and, if so, how?

The peer leadership group was school-based, meeting during the school day to plan activities. The activities implemented took place in a wide range of locations including bowling alleys, the beach and ski resorts.

Evidence statement
There is insufficient evidence available to make any conclusions about how the school setting of peer leadership groups influences effectiveness.

3.5.7 Does the intensity (or length) of the approach or method influence the effectiveness or duration of the effect?

No information regarding the intensity of the approach was provided. Outcome measures were taken following the first year of programme activities however the paper provided no detail regarding how effective the peer leadership groups were in promoting non-alcohol use.

Evidence statement
There is insufficient evidence to draw conclusions about the intensity (or length) of the impact of a peer leadership group.
3.5.8 Does impact of the approach or method vary according to the target community (for example, in terms of their age, gender, ethnicity or social circumstances)?

The target community were 7th grade school students. No further details were provided that enable an assessment of the impact of the peer leadership groups on this target community. As there are no other studies in this category an assessment of the impact of the approach on other communities is not possible.

**Evidence statement**
There is insufficient evidence to determine whether the impact of peer leadership groups varies according to the target community.

3.5.9 To what extent is effectiveness of the approach or method influenced by the level of participation and control in the approach or method?

Students formed peer leadership groups, which were facilitated by adult community volunteers, to plan/design activities promoting non-alcohol use among adolescents. However, there is insufficient data to determine the exact level at which this operated.

**Evidence statement**
There is insufficient evidence to determine the extent to which the level of participation and control influenced the effectiveness of the peer leadership groups.

3.5.10 Is there any differential impact on inequalities in health within and between communities?

No details addressing this question were provided in this paper.

**Evidence statement**
There is insufficient evidence to assess the impact of peer leadership groups with regards to health inequalities.

3.5.11 How acceptable is the approach or method to the target community?

More than 43% of the class of 1998 attended at least one peer-planned activity. This paper did not provide any additional data considering the acceptability of the peer leadership groups to the target community. Furthermore, no details pertaining to any barriers/facilitators experienced or perceived by the peer leaders were provided.
Evidence statement
There is insufficient evidence to assess the acceptability of peer leadership groups to the target community.

3.6 Community champions

One UK case study (3-) provides the evidence for the effectiveness of community champions in the delivery of primary health promotion interventions.

<table>
<thead>
<tr>
<th>Study type and quality</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-</td>
<td>Elden et al.</td>
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3.6.1 Is the approach or methods effective for the planning (including priority setting and resource allocation), design, delivery or governance of health promotion interventions? What methods or approaches don't work?

The case study aimed to describe and report on the effects of a project using local community champions to create a positive health impact and support greater access to preventative health services in one of the most deprived wards in England. Five local BME (black minority and ethnic) women who were active in their communities were recruited to train as community champions. The project had three phases beginning with a 10-week foundation course on definitions of health, methods of promoting health, health resources and local agencies. Phase 2 involved a six-week course on health and lifestyle topics. In phase 3 the community champions delivered a minimum of three “Look After Your Health” sessions on a health topic of their choice. These sessions were delivered to an audience of their peers and social group in settings including community centres, churches and homes. A total of 15 sessions were delivered covering topics from Asian healthy cooking and physical activity to child health and local health services.

Questionnaires were used pre-course, mid-term and post-course to evaluate the community champions’ level of knowledge, skills and confidence. Verbal feedback, written assessments and community evaluations were collected after delivery of the 15 “Look After Your Health” sessions. The results were presented in two themes, the first being participant empowerment. All five community champions demonstrated increased knowledge throughout the project, acquired new skills and developed greater confidence. The community champions were recognised for their achievements at a local awards day and three participants have since gone on to work placements and volunteer opportunities within the community. Community positive health impact was the second theme identified. The community champions felt that they made the strongest impact in areas in which they have ownership and a stronger voice within their communities. Participants stated they felt “better informed” on health topics such as smoking and mental health but did not feel as comfortable in supporting others and signposting individuals to healthcare services. No details were provided regarding the community evaluation of the health promotion sessions.
This case study (3-) relied heavily on self-report and there was no indication of validation of the questionnaires used to assess knowledge, skills and confidence. Other possible confounders were not accounted for though this is not unusual in the reporting of a case study. The project is UK-based and therefore applicability to other similar UK communities would seem to be likely.

**Evidence statement**
The evidence from one study (3-) suggests that community champions used in planning/design or delivery can increase their level of knowledge, skills and confidence following training and feel that they make the greatest impact in areas in which they have ownership and a stronger voice within their communities (Elden et al).

### 3.6.2 What is the aim/objective of the approach or method?

Community champions were trained to deliver health promotion messages to an audience of their peers with the aim of creating a positive health impact and supporting greater access to preventative health services.

### 3.6.3 What theoretical framework or value system underpins the design, content and/or delivery of the approach and/or method?

The paper did not contain sufficient detail to address this question.

### 3.6.4 How does the content and/or delivery of the approach or method influence effectiveness?

Community champions were initially trained on definitions of health, methods of promoting health, health resources and local agencies. This was followed by a course on health and lifestyle topics. Community champions delivered a minimum of three health promoting sessions on a health topic of their choice to an audience of their peers. The community champions reported feeling empowered by the training they had received and perceived their role to have had a positive impact in their community. No evaluative data relating to the effectiveness of the community champions at creating a positive health impact was reported in the paper.

**Evidence statement**
Given the lack of impact data it was not possible to assess how content/delivery influences the effectiveness of community champions.

### 3.6.5 Does effectiveness depend on the intervener? What are the significant features of an effective intervener? (Does effectiveness
depend on whether they are a community member, volunteer and/or a public sector professional and, if the latter, on their job title or status? Or does it depend on their age, gender, sexuality, ethnicity or knowledge/skill base?)

Community champions were 5 local black and ethnic minority women who were active in their communities. No evaluative data pertaining to the effectiveness of the community champions in creating a positive health impact was provided in this paper.

**Evidence statement**
There is insufficient evidence available to make any conclusions about the features of an effective community champion.

### 3.6.6 Does the site/setting of the approach or method influence effectiveness and, if so, how?

Community champions delivered the health promotion sessions in a variety of settings including community centers, homes and churches. No data was provided in the paper that enabled an assessment of the influence of each setting on the effectiveness of the intervention.

**Evidence statement**
There is insufficient evidence available to make any conclusions about how site/setting of community champion delivered health promotion can influence effectiveness.

### 3.6.7 Does the intensity (or length) of the approach or method influence the effectiveness or duration of the effect?

Evaluation data was collected following the final intervention session however no details regarding this data were provided. No information pertaining to the intensity or length of the approach was provided.

**Evidence statement**
There is insufficient evidence to draw conclusions about the intensity (or length) of the impact of community champions.

### 3.6.8 Does impact of the approach or method vary according to the target community (for example, in terms of their age, gender, ethnicity or social circumstances)?

A diverse deprived community with a 30% black minority and ethnic population as well as a number of refugees and people seeking asylum constituted the
target population. No further details were provided regarding the target population or the effectiveness of the community champions in promoting health within this community. As there are no other studies in this category an assessment of the impact of the approach on other communities is not possible.

**Evidence statement**
There is insufficient evidence to determine whether the impact of community champions varies according to the target community.

3.6.9 To what extent is effectiveness of the approach or method influenced by the level of participation and control in the approach or method?

Community champions delivered a minimum of three “Look After Your Health” sessions to an audience of their peers. However, there is insufficient data to determine the exact level at which this operated.

**Evidence statement**
There is insufficient evidence to determine the extent to which the level of participation and control influenced the effectiveness of community champions.

3.6.10 Is there any differential impact on inequalities in health within and between communities?

No details addressing this question were provided in this paper and the effectiveness of the community champions at promoting health was not stated.

**Evidence statement**
There is insufficient evidence to assess the impact of community champions with regards to health inequalities.

3.6.11 How acceptable is the approach or method to the target community?

No information was provided in this paper as to the acceptability of the community champions to the target community.

**Evidence statement**
There is insufficient evidence to assess the acceptability of community champions to the target community.
3.7 Community workshop

One UK case study (3-) provides the evidence for the effectiveness of a community workshop in the design and delivery of primary health promotion interventions.

<table>
<thead>
<tr>
<th>Study type and quality</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-</td>
<td>White et al. (2003)</td>
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</table>

3.7.1 Is the approach or methods effective for the planning (including priority setting and resource allocation), design, delivery or governance of health promotion interventions? What methods or approaches don’t work?

The case study aimed to describe and report on the Wrekenton Lanterns Project, also known as “Happy Hearts”. The neighbourhood project is co-managed by artists and regular volunteers from the community (predominantly local women and young people or ‘apprentices’). The project involves the organisation of workshops in a local school for two weeks of the year in which local residents design and construct their own lanterns in collaboration with professional artists. Health promotion messages are incorporated into the artwork and the project work culminates in a community lantern procession. Workshop lessons about various health issues, specifically about risks to the heart, run simultaneously with the lantern making activity.

The paper presents a narrative account of the project achievements, as viewed by both recipients and deliverers of the intervention, and makes brief reference to an evaluation conducted in 2003 by the University of Durham. The findings indicate that the whole community has developed a sense of ownership of the project by managing and participating in the project. The formal evaluation found that the project had been successful in meeting its aims of contributing to the development of a sustainable healthy community through creating a unique neighbourhood. The project is reported to have helped improve the image of Wrekenton, strengthen community relations, promote social inclusion and maintains a high level of participation each year. The artists involved in the project were reported to feel that community members had expressed ‘emotional literacy’ through their work and that this was facilitated through the workshops. The project is further reported to have provided a forum for local people in which to discuss the needs of the local community and has been effective in educating local people about healthy lifestyles. Before and after studies found that children and adults who were involved in the project are more aware of the risks to their heart and before and after dietary profiles indicate that participants go on to adopt healthier diets.

No further details relating to the before and after studies were provided in the case study, which relied heavily on self-report. The case study authors did not consider possible confounders and the lack of a control community resulted in a type and quality rating of 3-. The project is UK-based and has been running for several years and therefore applicability to other similar UK communities would seem to be likely.
The barriers to this community engagement method/approach were also described by this case study and are presented in the following section (3.2).

**Evidence statement**
The evidence from one study (3-) suggests that community workshops used in design and delivery of an intervention can maintain a high level of participation. In doing so they can contribute to the development of a sustainable healthy community (by improving awareness and the adoption of healthy lifestyles), to improve the image of an area, strengthen community relations and promote social inclusion (White et al. 2003).

3.7.2 What is the aim/objective of the approach or method?
The community workshop aims to engage lay community members to design and deliver health promotion messages to the wider community via artwork.

3.7.3 What theoretical framework or value system underpins the design, content and/or delivery of the approach and/or method?
The paper did not contain sufficient detail to address this question.

3.7.4 How does the content and/or delivery of the approach or method influence effectiveness?
Professional artists and lay community members work together to design and construct candle-fired lanterns, each containing a health promotion message. Workshop lessons informing the community members engaged in the workshop about various health issues, specifically risks to the heart, run alongside the lantern making activities. Evaluation data indicates that the project meets its aims by contributing to the development of a sustainable healthy community. The project has helped improve the image of the local area, strengthened community relations and facilitates discussion about the needs of the community. The project is reported to have been effective in educating people about healthy lifestyles including dietary habits.

**Evidence statement**
The evidence from one (3-) study suggests that peer design/delivery of health promotion messages via a community based arts workshop may encourage the adoption of healthy lifestyles (White et al., 2003).

3.7.5 Does effectiveness depend on the intervener? What are the significant features of an effective intervener? (Does effectiveness depend on whether they are a community member, volunteer and/or
a public sector professional and, if the latter, on their job title or status? Or does it depend on their age, gender, sexuality, ethnicity or knowledge/skill base?)

While the project is managed by community volunteers and artists no data is provided in the paper to identify the specific impacts of these differing individuals. Regular community volunteers were predominantly local women and young people.

**Evidence statement**

There is evidence from one study (3-) to suggest that local women and young people may be more likely to be engaged in the use of a community workshop for design/delivery of a health promotion intervention (White et al. 2003).

---

### 3.7.6 Does the site/setting of the approach or method influence effectiveness and, if so, how?

Finding suitable premises to hold the community workshops was identified as a barrier to this community engagement approach – please see section 3.8.

**Evidence statement**

There is insufficient evidence available to make any conclusions about how site/setting of a community workshop can influence effectiveness.

---

### 3.7.7 Does the intensity (or length) of the approach or method influence the effectiveness or duration of the effect?

The community workshop takes place over a two-week period each year and has been running for over ten years.

**Evidence statement**

There is evidence from one study (3-) to suggest that short-term intense engagement of a community on an annual basis via a community workshop may have long-term benefits, encouraging community members to adopt healthy lifestyles (White et al. 2003).

---

### 3.7.8 Does impact of the approach or method vary according to the target community (for example, in terms of their age, gender, ethnicity or social circumstances)?

The target population was a disadvantaged community however no specific details regarding this population were provided. As there are no other studies in this category an assessment of the impact of the approach on other communities is not possible.
Evidence statement
There is insufficient evidence to determine whether the impact of a community workshop varies according to the target community.

3.7.9 To what extent is effectiveness of the approach or method influenced by the level of participation and control in the approach or method?

Community members worked together to design and construct lanterns containing a health promotion message. Health related educational workshops were ran simultaneously and a lantern parade facilitated a display of the art work to the local community. However, there is insufficient data to determine the exact level at which this operated.

Evidence statement
There is insufficient evidence to determine the extent to which the level of participation and control influenced the effectiveness of a community workshop.

3.7.10 Is there any differential impact on inequalities in health within and between communities?

No details addressing this question were provided in this paper.

Evidence statement
There is insufficient evidence to assess the impact of a community workshop with regards to health inequalities.

3.7.11 How acceptable is the approach or method to the target community?

The paper did not provide evaluative data pertaining to the acceptability of the community workshop to the target community. However, the authors did state that the community had developed a sense of ownership of the project, which maintained a high level of participation each year.

Evidence statement
There is some evidence from one study (3-) to suggest that a community workshop used for planning/design of an intervention may engage a wide range of individuals and thus be acceptable to a disadvantaged community (White et al. 2003).

No studies covered collaborative methodology – one of the community engagement methods explicitly mentioned in the guidance referral from the Department of Health.
3.8 What are the barriers to using community engagement and development approaches and methods for primary health promotion interventions and interventions that have successfully overcome these barriers?

The following sub-research questions are also addressed in this section:

- What are the barriers and facilitators to implementation (for example, resistance from professionals, members of the public, policy drivers, funding or staff)?
- What methods have been developed to address these barriers and are they effective?
- What are the unintended (positive and negative) outcomes of the approach or method (negative unintended outcomes might include disruption of community cohesion, damage to the self-esteem and/or the subjective health state of individuals engaged.)?

Six primary studies (2 UK case studies; 3 USA-based case studies and 1 USA-based process evaluation) provide the evidence for determining the barriers to using community engagement methods and approaches.

<table>
<thead>
<tr>
<th>Study type and quality</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-</td>
<td>Arbeit et al. (1991)</td>
</tr>
<tr>
<td>3+</td>
<td>Bolam et al. (2006)</td>
</tr>
<tr>
<td>3-</td>
<td>Holder et al. (1997); Pargee et al. (1999); White et al. (2003); Williams &amp; Olano (1999)</td>
</tr>
</tbody>
</table>

One process evaluation (Bolam et al., 2006) of a project was designed to engage disadvantaged groups in the design and delivery (via Ambassadors) of Information Communication Technology (ICT) related interventions. The project additionally aimed to build aspects of social capital and improve access to health and welfare information and services. The project was a public/private partnership funded by the EU Social Fund and the Treasury. There were three key elements of the project process, the first being to work with local people to design web interface and content. The second element was to recruit and train local Ambassadors to train others in information-communication technology and finally to embed the project in local community-based organisations through partnership working.

Semi-structured interviews with the Ambassadors (peer educators) uncovered two themes, the psychosocial benefits of participation (described in section 3.2) and problems in devolving power. This second finding, a barrier to the community engagement method employed, indicates that during the evolution of the project, control over the project became more centralised and dominated by the interests of the statutory sector. An unforeseen withdrawal of funding created a crisis in the project and anger and disappointment among Ambassadors and local community partners. The enjoyment and psychosocial benefits became reduced for participants once the future of the project was in doubt. The worst impact, in terms of losing the benefits of project participation including psychosocial factors, was on those Ambassadors who had become heavily involved in the project.
These difficulties did, however, increase support for the embedding of the project in local community organisations.

Similarly, a second UK case study (White et al., 2003) also reported experiencing difficulties each year in securing funding for an art project in a deprived community. The neighbourhood project was predominantly funded via the Arts and Libraries Department of the local council, as well as additional supplements from the Health Authority, Charitable Trusts and sponsors. Co-managed by professional artists and regular volunteers from the community (predominantly local women and young people) the project involves local residents designing and constructing their own lanterns incorporating a health promotion message. This project faced the additional barrier of finding suitable workshop facilities in which community members could construct their lanterns.

A lack of funding and appropriate meeting places for community coalitions were barriers described by the USA-based case studies. One study (Holder et al., 1997) focused specifically on the barriers to using community engagement methods and the lessons learned from researcher-community collaboration. In this example, coalitions involving lay community members worked with researchers to design interventions to reduce alcohol-involved trauma. Researchers often expected faster results than were practically possible. This was overcome by employing a community prevention manager who coordinated implementation strategies by working with local staff in the communities and who served as a liaison to researchers. The local coordinator was indigenous to the community and the connectedness with local interest groups and their priorities facilitated program implementation of the local policy plans. It was not necessary for local staff to be directly involved in delivery of activities, rather effectiveness was related to their presence in the community. A major barrier to acceptance of program design was from those community treatment or service organisations that felt threatened by the policy-based strategies. The local coordinator was responsible for generating funds by applying for grants from Government sources.

Lessons learned by the research team included the acknowledgment that communities are the experts and that while initially coalitions may appear to have little impact they may contribute to ultimate goals. The effectiveness of such coalitions can also not be fully determined until they are working independently. This may, however, be influenced by the specific members of the coalition. One further barrier identified by this study was that of pre-existing groups coming to the table with their own agendas and consequently opposing implementation and prevention efforts.

Overwhelming coalition members with community related responsibilities often resulted in the loss of such members (and their friends/family) from the coalition case study described by Pargee and colleagues (1999). This coalition of American Indians was formed to promote physical activity in the community. However, in areas where the community had a sense of distrust of service organisations, coalition efforts were less successful. Prolonged engagement between the research/programme team and the targeted community helped to build the trusting relationship necessary for programme implementation.
Williams and Olano (1999) case study reports on a community coalition designed to promote physical activity among African Americans via walking clubs. They describe how the coalition implementation of interventions often differed from that discussed with programme staff. Walking routes were altered and walking club captains did not follow basic physical activity guidelines. Enabling the coalition to make these decisions and take ownership of the project was perceived to be the most appropriate strategy.

One final study (Arbeit et al, 1991) aimed to evaluate the utilisation and impact of a school health advisory committee in supporting a cardiovascular school health promotion program (Heart Smart). While the focus of this article was the health impact as opposed to the impact of the coalition the authors did briefly describe some of the difficulties experienced by the coalition. These included personality and educational status related issues persisting in group meetings and the tendency for individuals to monopolise groups. Outside commitments created time limitations for coalition meetings and members of the committee maintained different interests. Participation of school lunch personnel was lacking in the coalition however it was reported that they participated enthusiastically during lunchroom events.

No studies were identified in this review that specifically focused on interventions to overcome barriers to community engagement.

**Evidence statements**

The evidence from one study (3+) suggests that the devolvement of power during a project where control over the project becomes more centralised and dominated by the interests of the statutory sector, was a barrier to the community engagement method employed (Bolam et al., 2006).

The evidence from 5 studies (one 3+, four 3-) suggests that short term funding, with the risk of not been able to secure further funding to guarantee the long term survival of a project, was perceived to be a major barrier to the use of community engagement methods/approaches (Bolam et al 2006; Holder et al 1997; Pargee et al 1999; White et al 2003; Williams & Olano 1999).

The evidence from one study (3-) further indicates that finding suitable facilities in which to hold coalition meetings and securing access to appropriate meeting places were barriers to the use of community coalitions and the delivery of interventions (Holder et al 1997).

One study (3-) tends to suggest that a major barrier to the acceptance of program design was from those community treatment and service organisations that felt threatened by the policy-based strategies (Holder et al 1997).

The evidence from two studies (one 2-, one 3-) suggests that pre-existing groups coming to the table with their own agendas (and opposing implementation and prevention efforts) and the tendency for some individuals (related to personality and educational status) to monopolise
coalition groups is a barrier to this community engagement method (Arbeit et al 1991; Holder et al 1997).

One study (3-) also described how overwhelming coalition members with community related responsibilities could result in a loss of such members (Pargee et al 1999).

The evidence from one study (3-) suggests that a lack of trust by the community in service organisations was a barrier to implementing community engagement methods/approaches (Pargee et al 1999).
Section 4. Summary and Discussion

Twenty one primary studies covering a range of community engagement methods/approaches were identified which focused on the planning, design and/or delivery of primary health promotion interventions. No studies relating to community collaboratives or other methods such as citizens juries were identified and no data regarding priority setting, resource allocation or governance was found. Six of the 21 primary studies provided the evidence for determining the barriers to using community engagement methods/approaches. However, no data describing interventions to overcome barriers or information pertaining to what doesn’t work was provided.

- Information gaps

The majority of the 21 included studies do not contain any outcome or impact data specific to the community engagement method/approach component of the intervention. The primary purpose of the included studies were to assess the effectiveness of the health promotion intervention and consequently little or no data is presented on specific community engagement outcomes and/or impact of using the community engagement methods/approaches as part of the intervention. The lack of a control group in the majority of these studies and the minimal specific outcome and impact data presented on each of the community engagement methods/approaches limits the inferences that can be drawn about effectiveness. However, this is not the same as saying the identified community engagement methods/approaches are ineffective – rather there is limited data available which addresses the primary research questions.

It is also important to note that 139 (21%) primary studies have not arrived within the time frame available to conduct this review and thus we have not been able to interrogate all of the potentially available pool of data. In order to help prioritise the quantity of data to be assessed within the time frame for this review a number of primary studies were also parked (10 other European, 311 non European and 281 country not specified).

While undertaking this review it became evident that some categories of literature were more relevant than others. Most notably the reviews from Cochrane and DARE and the primary studies highlighted via the website screening were of greater relevance as compared to the generic literature search.

Throughout this review we have uncovered a small body of literature (17 primary studies) that used community champions to deliver primary health promotion interventions. However, these intervention(s) were delivered on a one-to-one basis and thus in accordance with the exclusion criteria for this rapid review they have not been included; though may reflect a potentially important area of community activity.

An additional group of 24 UK based primary studies (namely evaluation studies such as HAZ, Sure Start) which made reference to the involvement and/or consultation of community members in various case studies were also identified. Some of these projects are health promotion interventions which may meet the
stated inclusion criteria. However, because these evaluation studies do not sufficiently disaggregate the data by specific health promotion intervention and/or do not present outcomes or impact data which can be attributed to specific interventions these studies have been rejected. Two of the primary studies in this group included the use of contraceptive pills as part of the intervention strategy. It was not possible to disaggregate this pharmacological data from the remaining public health data. It should, nevertheless, be noted that these studies may contain reference to what may be relevant data.

- Terminology

The terminology used by each study to describe a specific named method of community engagement varied considerably. This had implications for this review in terms of the categorisation of data by community engagement method/approach. Arguably, different terms are being used to describe what may be considered to be the same method/approach and it is often not clear what the differences are between methods e.g. peer educators and community champions. As such this report has categorised community engagement methods/approaches using the terminology of the authors of the included primary studies. It is, however, acknowledged that some categories could be merged.

- Applicability to the UK

Eleven of the included studies were USA based. The cultural differences between US and UK communities were most pronounced in the interventions used by these projects. This limits the applicability of findings to UK settings where legislative, educational and healthcare systems vary considerably.
### Evidence Tables – Community Engagement Health Promotion Rapid Review

<table>
<thead>
<tr>
<th>Author &amp; Date</th>
<th>Research Question</th>
<th>Study type &amp; quality</th>
<th>Study population; setting; and country</th>
<th>CE method/ approach</th>
<th>Intervention description and focus of the lay community involvement</th>
<th>Outcomes</th>
<th>Main results</th>
<th>Appli cabl e to UK</th>
<th>Confounder s</th>
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<tbody>
<tr>
<td>Arbeit et al (1991)</td>
<td>To evaluate the utilisation and impact of a school health advisory committee in supporting a cardiovascul ar school health promotion program (Heart Smart). The article focuses on the evaluation of one intervention designed by the committee – ‘Heart Smart’</td>
<td>Study type: Controlled before and after study; Evaluation of ‘Heart Smart Week’</td>
<td>Population: School advisory committee consisted of parents from the local community, teachers, food service workers, physical education teacher; school administrator and Heart Smart Program representative (n = not stated). The majority of interested parents and teachers resided in the local area.</td>
<td>Health Advisory Committee (Coalition)</td>
<td>The Health Advisory Committee was established to: promote cardiovascular health principles within the school setting; promote cardiovascular health education within the home; promote ‘ownership’ of Heart Smart by the school. The committee identified specific projects to promote the adoption of cardiovascular healthy behaviours, one of which was ‘Heart Smart Week’. Features of this intervention week included: on day 1 class discussions on the role of nutrition and exercise; children designing posters promoting cardiovascular health; on day 2 children, parents</td>
<td>School lunch purchases; student self-report on the amount of food consumed and its palatability; teacher evaluation of participation and activity enjoyment</td>
<td>1) Patterns of school lunch purchases for day 3 (eat hearty) were found to be consistent with previous records at the school. There was a slightly lower number of healthy food purchases at a control school (no further details or statistical information provided).</td>
<td>Yes</td>
<td>No consideration of possible confounders by the study authors. The study methods were poorly described particularly regarding the control school. Lack of statistical data to support results. Reliance on self-report.</td>
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<td></td>
<td>26</td>
<td>Focus of lay community involvement may include planning (including resource allocation and priority setting), design, delivery or governance of an intervention.</td>
<td>80</td>
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<td>Week’.</td>
<td>community.</td>
<td></td>
<td></td>
<td></td>
<td>and teachers participating in aerobic activity with a local sports celebrity; on day 3 children brought heart healthy snacks to school and the cafeteria menu featured only healthy foods; on day 4 children composed an essay promoting a positive self-image and a poem developed by a committee parent was provided for students; day 5 consisted of assertiveness training with an appearance by a local celebrity. Throughout the week parents were provided with a newsletter detailing the activities of the week and students singing the Heart Smart theme song. Focus of lay community involvement: Design of an intervention. The committee met monthly.</td>
<td>most students and teachers (no further details provided). No specific impact data related to the Advisory Committee (Coalition) component of the intervention was reported. The authors described some of the difficulties experienced by the School Health Advisory Committee. These included: personality and educational status related issues persisting in group meetings; tendency for individuals to monopolise groups; outside commitments created time limitations; members of the committee maintained different interests. Participation of school lunch personnel was lacking in the coalition however they participated enthusiastically during lunchroom events. Duration of effectiveness was not stated.</td>
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<tr>
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<tr>
<td>Barnes et al (1999)</td>
<td>To assess the effectiveness of a volunteer driven outreach programme on immunisation rates in children younger than 2 years.</td>
<td>Study type: RCT (intervention group n = 71; control group n = 84)</td>
<td>Population: Community volunteers (n = not stated)</td>
<td>Lay community volunteers</td>
<td>Intervention group families received basic immunisation education and referral from the community volunteers. Immunisation outreach, tracking and follow-up were provided with all intervention families. Control families received no intervention though were notified of the child’s immunisation status at enrolment. Focus of lay community involvement: Delivery of an intervention.</td>
<td>Children immunisation status 6 months after enrolment</td>
<td>Significantly more intervention children were up-to-date with their vaccination series than controls (75% vs. 54%; p = 0.03). Children in the control families were 2.8 times more likely to be late for a vaccine than intervention children (odds ratio = 2.8; p = 0.02). An immunisation delay of longer than 30 days at enrolment was a significant predictor of final immunisation delay (odds ratio = 2.6; p = 0.02).</td>
<td>No given differences in health care systems</td>
<td>The study authors acknowledge limitations in generalisability and selection bias. The study assessed demographics between the intervention and control groups and found no significant differences.</td>
</tr>
<tr>
<td>Bolam et al (2006)</td>
<td>To document a process evaluation of the effects of ‘Ambassado’</td>
<td>Study type: Qualitative process evaluation</td>
<td>Population: Initial target population was 4 key disadvantaged groups: young</td>
<td>CityNet An Information Communication Technology-based (ICT)</td>
<td>There were three key elements of the project process: 1) to work with local people to design web interface and content</td>
<td>Two waves of semi-structured interviews were conducted</td>
<td>Findings were presented in two themes:</td>
<td>Initial engagement was</td>
<td>Yes</td>
</tr>
<tr>
<td>Author &amp; Date</td>
<td>Research Question</td>
<td>Study type &amp; quality</td>
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<td>Outcomes</td>
<td>Main results</td>
<td>Application to UK</td>
<td>Confounder(s)</td>
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<td>r participation in the Nottingham CityNet project that aims to build aspects of social capital and improve access to health and welfare information and services among disadvantaged groups.</td>
<td>Quality: 3+</td>
<td>African-Caribbean men with mental health difficulties; long-term unemployed men; socially isolated carers; and older people. The project also targeted those living in deprived wards of Nottingham. Target groups were subsequently widened.</td>
<td>Peers education (via Ambassadors)</td>
<td>2) to recruit and train local Ambassadors to train others in information-communication technology</td>
<td>with the peer educators (Ambassadors) between May 2002 and December 2003. A third wave of telephone interviews was conducted with a self-selecting sample of 10 Ambassadors between May and June 2003.</td>
<td>described as the result of the peer educators seeking psychological stimulation and having an interest in ICT.</td>
<td>Short term (6-12 weeks)</td>
<td>Long term (1 year and beyond)</td>
<td>disempowered position and low levels of confidence. They also recognise that the lack of a control group limits assessment of impact.</td>
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<td>3) to embed the project in local community-based organisations through partnership working. Ambassadors from targeted groups were trained by project workers to enable users to access arrange of services such as email, chat rooms and service information. Focus of lay community involvement: Design and delivery of and intervention.</td>
<td></td>
<td></td>
<td></td>
<td>Medium term (12 weeks to 1 year)</td>
<td></td>
</tr>
<tr>
<td>Author &amp; Date</td>
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<tr>
<td>Davidson et al (1994)</td>
<td>To evaluate the effectiveness of a community coalition to prevent severe injuries to children in the USA</td>
<td>Survey</td>
<td>Coalition consisted of representatives from city agencies, voluntary organisations, citizen groups, health</td>
<td>The coalition worked to 1) renovate playgrounds; 2) involve children and adolescents in safe, supervised activities; 3) provide injury and violence prevention education; 4) provide safety equipment at a reasonable cost.</td>
<td>Surveillance of motor vehicle injuries that result in hospitalisation or death had been underway for 5 years. Data from this</td>
<td>The incidence of injury among school-aged children in central Harlem declined during the intervention. The decline was specific to the targeted group and targeted causes. The intervention period was therefore associated with approximately 44% reduction in injury risk for targeted injuries in school-aged children.</td>
<td></td>
<td>Yes</td>
<td>The study authors acknowledge limitation due to the multiple comparison tests used which they describe as difficult to</td>
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</tbody>
</table>
### Rapid review - health promotion effectiveness phase 3

<table>
<thead>
<tr>
<th>Author &amp; Date</th>
<th>Research Question</th>
<th>Study type &amp; quality</th>
<th>Study population; setting; and country</th>
<th>CE method/ approach</th>
<th>Intervention description and focus of the lay community involvement²⁸</th>
<th>Outcomes</th>
<th>Main results</th>
<th>Applicable to UK</th>
<th>Confounder(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Harlem, New York.</td>
<td>To describe the process and effects of the NDC’s Health4All team who</td>
<td>Study type: Case study</td>
<td>Population: Young actors recruited from the local communities and wider area</td>
<td>With the help of a local film making group eb4u set out to engage local young people to make a short film and resource pack to address an</td>
<td>Perceived benefit of involvement in the film making process/</td>
<td>Involvement in the film making process had benefited many of the young people involved via the acquisition of generic (e.g. time management) and specific skills (to film making). Working</td>
<td></td>
<td>No possible confounders have been described by the study authors.</td>
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<td>Author &amp; Date</td>
<td>Research Question</td>
<td>Study type &amp; quality</td>
<td>Study population; setting; and country</td>
<td>CE method/ approach</td>
<td>Intervention description and focus of the lay community involvement</td>
<td>Outcomes</td>
<td>Main results</td>
<td>Applicable to UK</td>
<td>Confounder(s)</td>
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<td>Elden et</td>
<td>To describe</td>
<td>Study type: Community</td>
<td>The project had three</td>
<td>Pre-course,</td>
<td>Results were presented in</td>
<td>Yes</td>
<td>No</td>
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<thead>
<tr>
<th>26</th>
<th>Outcomes</th>
<th>Main results</th>
<th>Applicable to UK</th>
<th>Confounder(s)</th>
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</thead>
<tbody>
<tr>
<td>26</td>
<td>Short term (6-12 weeks)</td>
<td>Medium term (12 weeks to 1 year)</td>
<td>Long term (1 year and beyond)</td>
<td>Lack of objective outcome measures.</td>
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</table>

- **Outcomes:**
  - Long term (1 year and beyond)
  - Short term (6-12 weeks)
  - Medium term (12 weeks to 1 year)

- **Main results:**
  - on the project helped young people to meet others from different parts of the city and from different backgrounds and have a greater insight into career options. The mixture of cast and crew from different parts of the city helped to dispel some of the prejudices against the area, which is often deemed a rough and unpopular place to live.
  - There was encouraging feedback from those involved in the project (further details not provided). Initial audience feedback is also positive, with some young viewers saying it had changed their attitudes to sexual health.
  - The resource pack has been piloted successfully with school and youth groups (no further details provided).
  - The authors state that it is too early to consider the impact of viewing the film on behaviour as the project is ongoing. Duration of effectiveness is therefore unknown at this stage.
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<tr>
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<tr>
<td>al. “Look After Your Health”</td>
<td>and report the effects of a project using local community champions to create a positive health impact and support greater access to preventative health services.</td>
<td>Case study</td>
<td>Community champions were 5 local BME women who were active in their communities. The project had a specific focus on recruiting BME (black minority and ethnic) community members. Target population: Approximately 6170 residents; diverse community with a 30% BME population as well as a number of refugees and people seeking asylum. Setting: Urban</td>
<td>phases: 1) A 10-week foundation course on definitions of health, methods of promoting health, health resources and local agencies 2) 6-week course on health and lifestyle topics 3) Community champions deliver a minimum of 3 “Look After Your Health” sessions in the community on a health topic of their choice to an audience of their peers. A total of 15 sessions were delivered in community centres, homes, churches, and other settings. Topics included Asian healthy cooking, physical activity, local health services and child health. Focus of lay community involvement: Delivery of an intervention.</td>
<td>midterm and post course questionnaires evaluated participants level of knowledge, skills and confidence Verbal feedback, written assessments and community evaluations were collected after delivery of the 15 “Look After Your Health” sessions.</td>
<td>relation to two themes: Participant empowerment All five participants reported increased knowledge throughout the project, acquired new skills and developed greater confidence. The community champions were recognised for their achievements at a local awards day. Three participants have since gone on to work placements and volunteer opportunities within the community. Community positive health impact Participants felt they made the strongest impact in areas in which they have ownership and a stronger voice within their families/community. Participants stated they felt “better informed” on health topics such as smoking and mental health but did not feel as comfortable in supporting others or in signposting individuals to healthcare services. No details were provided regarding the community evaluation of the health.</td>
<td>consideration of possible confounders by the case study authors Reliance on self-report No validation of questionnaires</td>
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<td>Author &amp; Date</td>
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<td>CE method/ approach</td>
<td>Intervention description and focus of the lay community involvement26</td>
<td>Outcomes</td>
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<td>Fisher et al (1998)</td>
<td>To evaluate a community organisation approach that emphasised involvement of audiences in programme planning and implementation in promoting non-smoking among African American residents of low-income neighbourhoods.</td>
<td>Controlled non-randomised trial involving a 24-month intervention. Control community was chosen for equivalent ethnicity, income, and education and received no intervention. Type &amp; Quality: 2-</td>
<td>Neighbourhood; ranks amongst the 10% most deprived wards in England Country: UK</td>
<td>Wellness councils in each programme neighbourhood organised and directed activities. The city-wide advisory council provided linkages to key individuals in the community and gave advice about implementation. Intervention activities included: smoking cessation classes, billboards and a “gospelfest”. Focus of lay community involvement: Planning and design of an intervention.</td>
<td>Changes in smoking prevalence. A shortened version of the Behavioural Risk Factor Surveillance System with the addition of items relating to smoking was conducted via random telephone surveys. No specific outcome data related to the Wellness or advisory councils were reported.</td>
<td>The programme was successful in engaging audience members in the planning of neighbourhood activities to promote non-smoking. The prevalence of smoking declined from 34% to 27% in programme neighbourhoods (p = 0.028) but only from 34% to 33% in comparison neighbourhoods (p = 0.641). This difference was apparent within all demographically defined sub-samples. Duration of effectiveness was not discussed though the intervention and associated evaluation took place over two years.</td>
<td>No given community differences between the USA and the UK.</td>
<td>The study authors acknowledge that the design leaves doubt as to whether the observed differences may have been due to uncontrolled differences between the program and comparison communities. They also state that there were demographic differences between the intervention and comparison communities.</td>
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<td>Hancock et al. (2001)</td>
<td>Explore the effectiveness of a community action program in decreasing community adult smoking rates in rural towns of Australia</td>
<td>Study type: Randomised controlled trial (using matched pairs design)</td>
<td>Population: 20 towns ranging in population from 5,001-15,000</td>
<td>Community committees</td>
<td>Members of the community were invited to form a CART committee to initiate and maintain intervention strategies within each town. Intervention activities were directed toward workplaces, sporting organisations, clubs and community organisations and the community itself. Intervention activities included: Promoting</td>
<td>Proportions of quitters and uptakers from a cohort of self-described smokers and non- or ex-smokers respectively at 3 years follow-up. No specific outcome data related to the community</td>
<td>No significant differences in quit or uptake rates were reported between adults in the intervention and control towns either overall or as a function of age or gender. The difference in the proportion quitting was 3.5% (intervention-control; 95% CI: -0.3, 7.2). The difference in the proportion taking up smoking was –0.3% (95% CI: -2.2, +1.6). No specific impact data related to the community committee component of the intervention was reported.</td>
<td>No given differences between UK and US communities</td>
<td>The authors acknowledge that the study did not conduct external validation of smoking self-report. They also state that the length of intervention varied between 3 and 3.5 years between the towns</td>
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### Rapid review - health promotion effectiveness phase 3

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<tr>
<td>Hingson et al.</td>
<td>To assess whether a</td>
<td>Study type: Controlled</td>
<td>Population: Task Force</td>
<td>Community Task Forces</td>
<td>To reduce drunk driving and speeding,</td>
<td>Rate of fatal car accidents</td>
<td>Intervention cities relative to the rest of Massachusetts during the</td>
<td>Possibly</td>
<td>The study authors</td>
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</table>

#### Study type & quality:
- Controlled
- Task Force

#### Study population; setting; and country:
- Rural Towns project
- Type & Quality: 1-
- Setting: rural
- Country: Australia

#### CE method/ approach:
- smoke free environments in workplaces, restaurants, hotels, motels, sporting and community clubs and eating places; the provision of non-smoking signage; stalls/activities for World No Tobacco Day; QUIT smoking classes; media coverage of community events and activities. In workplaces, employers were encouraged to provide QUIT kits to employees; posters/brochures were distributed on request; and information was provided that was designed to increase awareness of passive smoking on health and legal repercussions

#### Intervention description and focus of the lay community involvement:
- Planning an intervention committees were reported.

#### Outcomes:
- Duration of effectiveness: not stated though given that the evaluation was conducted after 3 years, this may indicate a long-term effect.

#### Main results:
- Short term (6-12 weeks)
- Medium term (12 weeks to 1 year)
- Long term (1 year and beyond)

#### Applicable to UK:
- under investigation.

#### Confounder(s):
- They describe that the study had inadequate power due to using only 10 towns per condition – 40 towns were needed to detect a 3.5% difference in quit rates over 4 years
- Substantial loss to follow-up that was greater for non-smokers than smokers (and re-contact rate of only 48% for younger adults)
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<tr>
<td>(1996)</td>
<td>community program that organised multiple city departments and private citizens could reduce alcohol impaired driving, related driving risk, traffic deaths, and injuries.</td>
<td>non-randomised evaluation of the Saving Lives Program</td>
<td>Compared 6 intervention cities with 5 comparison cities and the rest of Massachusetts</td>
<td>Type &amp; Quality: 2-</td>
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<td>given that some of the interventions are already in use in the UK</td>
<td>acknowledge that during the study period the comparison cities initiated police enforcement and school based programs concerning traffic safety and drunk driving and secured funding from the Centre for Substance Abuse prevention to develop community coalitions</td>
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<td>membership ranged from 20 to more than 100 persons including concerned private citizens and organisations and officials representing various city departments (e.g. schools, police, recreation, health)</td>
<td>Interventions targeted at (based on 1990 data): 6 cities in Massachusetts with 318,974 predominately white residents (intervention); 5 cities with 378,666 predominately white residents</td>
<td></td>
<td>community task forces initiated and were involved in the design of the following interventions: Media campaigns, business information programs, drunk driving and speeding awareness days, speed watch telephone hotlines, police training, high school peer led education, Students Against Drunk Drivers chapters, college prevention programs, alcohol free prom nights, beer keg registration and increased liquor outlet surveillance. To increase pedestrian safety and seat belt use program communities undertook: Media campaigns, police checkpoints, posted cross-walk signs warning motorists of fines failing to stop for pedestrians, added crosswalk guards, including preschool education programs and</td>
<td></td>
<td>5 intervention years (in comparison to the 5 pre-program years) experienced the following significant changes: 1) A 25% fatal crash reduction (27% on local roadways) 2) A 42% decline in fatal crashes involving alcohol 3) A 47% decline in number of fatally injured drivers with positive blood alcohol levels 4) A 39% reduction in fatal crashes involving drivers aged 15-25 5) 5% reduction in visible injuries per 100 crashes (total injuries it was 3%) 6) A 17% increase in seat belt use 7) A 43% decline in number of vehicles observed travelling at &gt; 10 MPH over the speed limit 8) A 49% decline in proportion of 16-19 olds drink driving</td>
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<td></td>
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<td></td>
<td>(control cities)</td>
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<td>training for hospital and prenatal clinical staff.</td>
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<td>intervention cities and rest of Massachusetts</td>
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<td></td>
<td>Rest of Massachusetts – 5, 318, 785 predominately white residents</td>
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<td>Focus of lay community involvement: Design of intervention.</td>
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<td>By the end of the 5th year, 54% of 16-19 year olds and 40% of adults were aware of the Saving Lives Program (compared to 8% and 10% respectively in rest of Massachusetts).</td>
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<td>Setting: Urban</td>
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<td>Perception of enforcement did not increase significantly in intervention cites compared to the rest of Massachusetts for adults, but did for teenagers.</td>
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<td>Country: USA</td>
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<td>Overall rates of police traffic citations decreased in the intervention cites compared to the rest of Massachusetts, including speeding tickets and drunk driving citations.</td>
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<td>Intervention cities relative to the control cities during the 5 intervention years (in comparison to the 5 pre-program years) experienced the following significant changes:</td>
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<td>1) A 33% fatal crash reduction</td>
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<td>2) A 42% decline in fatal crashes involving alcohol</td>
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### Rapid review - health promotion effectiveness phase 3

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<th>Intervention description and focus of the lay community involvement (^{26})</th>
<th>Outcomes</th>
<th>Main results</th>
<th>Applicable to UK</th>
<th>Confounder(s)</th>
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<tbody>
<tr>
<td>Holder et al (1997)</td>
<td>To sum up the lessons learned from the Community Trials Project and make recommendations for others who are with local alcohol prevention services</td>
<td>Study type: Community Trials Project involved three experimental communities over a 5-year period (no further details in this article) Article</td>
<td>Population: Three communities Setting: Details not reported in this article Country: USA</td>
<td>Community Coalitions and Task Forces</td>
<td>Community Coalitions and Task Forces were involved trained in project design and media advocacy – specifics not reported in this article Focus of lay community involvement: Planning of an intervention.</td>
<td>Alcohol involved trauma in terms of motor vehicle crashes involving alcohol; sales of alcohol to minors; responsible alcohol serving policies; and media</td>
<td>Intervention significantly reduced the number of alcohol-related crashes (overall reduction was 78 over the 28 month intervention period – representing an approximate annual reduction of 10%); sales of alcohol to minors; responsible alcohol serving policies and increased media coverage of alcohol issues (no statistical information provided). The following lessons and recommendations were</td>
<td>Unknown without full details</td>
<td>Unable to determine without further study details</td>
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### Results

However, no differences in rates of visible, pedestrian and total injuries per 100 crashes were found between intervention and control cities.

No specific impact data related to the community task force component of the intervention was reported.

Given the duration of the intervention and outcome measurements, duration of effectiveness would seem to be long-term.
### Rapid review - health promotion effectiveness phase 3

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<th>Confounders</th>
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<tr>
<td></td>
<td>Focus of the paper is barriers to community engagement and development methods and approaches</td>
<td>presented as a case study</td>
<td>Type &amp; Quality: 3-</td>
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<td>coverage of alcohol issues (no further details provided)</td>
<td>discussed by the authors in terms of the following themes:</td>
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<td>No specific outcome data related to the community coalitions were reported as barriers were the focus of the paper.</td>
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<td></td>
<td><strong>Differential Roles of Community Activists and Scientists</strong></td>
<td>Researchers often expected faster results than were practically possible. This was overcome by employing a community prevention manager who coordinated implementation strategies by working with local staff in the communities and who served as a liaison to researchers.</td>
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<td>A major barrier to acceptance of program design was from those community treatment or service organisations that felt threatened by the policy-based strategies.</td>
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<td><strong>Relationship between Researchers and Communities</strong></td>
<td>Scientists must acknowledge their limitations in knowledge and experience and appreciated the wisdom and natural processes of the communities they study (i.e., communities are the experts on themselves)</td>
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<td>Community-initiated interventions at first may appear to have little impact on specified outcomes/goals; however, they may contribute in the end to these goals (i.e., by generating awareness of the goals such as alcohol involved birth defects lead to contacts being initiated for responsible drinking services).</td>
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<td>Short term (6-12 weeks)</td>
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<td>Management Information and Evaluation</td>
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<td>Medium term (12 weeks to 1 year)</td>
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<td>Evaluation data was used as a type of intervention (management information for local staff, generate local news coverage and a basis for project meetings).</td>
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<td>Long term (1 year and beyond)</td>
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<td>Required Staff Effort</td>
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<td>Large amounts of funds were not available to communities (typically only for full-time coordinator and secretary). The local coordinator was indigenous to the community and the connectedness with local interest groups and their priorities facilitated program implementation of the local policy plans. It was not necessary for local staff to be directly involved</td>
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| Hunt et al (1993) | To determine the impact of a worksite cancer prevention program based on seven food | Study type: RCT including baseline and follow-up surveys (overall response rate 74%) | Population: Employees (n = 1762) Setting: 16 worksites were initially recruited, though three | Employee advisory boards | Employees were organised into advisory boards to assist Treatwell staff in tailoring programs to the “culture” of the worksite. Interventions included a weight management program, nutrition | Food intake was measured using a food frequency questionnaire | Workers in companies receiving the intervention programme decreased their use of margarine and butter as spreads (p<0.01) and increased their intake of vegetables (p<0.02) significantly more than workers in control companies. Although not statistically significant there were | Yes | The study authors acknowledge that while they controlled for demographic variables, a lack of reliability was
Rapid review - health promotion effectiveness phase 3

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<th>Research Question</th>
<th>Study type &amp; quality</th>
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<th>CE method/ approach</th>
<th>Intervention description and focus of the lay community involvement</th>
<th>Outcomes</th>
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<tr>
<td>Kirby et al (2004)</td>
<td>To assess the impact of a school-based HIV, STD and pregnancy prevention intervention on sexual risk-taking behaviours of different sub-groups of students</td>
<td>Study type: RCT</td>
<td>Population: Schools ranged in size from 961 to 2733 students (mean = 1767). The cohort included all 9th grade students who completed the baseline survey and were officially enrolled at first follow-up. A total of 3869 students.</td>
<td>School health promotion council Peer educators</td>
<td>The Safer Choices intervention consisted of five primary components: 1) School organisation: Schools formed a health promotion council to coordinate project activities. It included teachers, students, parents, administrators, and community members. 2) Curriculum and staff development: The curriculum included ten lessons in the 9th grade and 10 lessons in the</td>
<td>The evaluation questionnaire included items assessing program exposure, demographic characteristics, sexuality related psychosocial factors, and sexual behaviours. The article reports on five sexual</td>
<td>Overall</td>
<td>Safer Choices did not significantly delay the onset of sexual intercourse (p=0.99) and did not increase contraceptive use among those who had sex in the last three months (p=0.07). Safer Choices did reduce the frequency of sex without a condom (p=0.02), reduced the number of sexual partners in the last three with whom a condom was not used (p=0.04), increased condom use during last sex among those who had sex in the last three months (p=0.02).</td>
<td>Yes providing consideration is given to the differing school systems</td>
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<td>(n=10). Surveys were conducted at baseline, 7-months, 19 months and 31 months post intervention commencement.</td>
<td>Gender, No significant gender interaction effect on the initiation of sex was detected (p=0.70). On all four measures involving condom use interaction effects were detected indicating Safer Choices had a greater impact on males than on females.</td>
<td>Students were tracked for 31 months. Setting: Schools Country: USA</td>
<td>10th grade providing functional knowledge related to HIV, STD's and pregnancy. In-class peer leaders facilitated selected curriculum activities. 3) Peer resources and school environment: A student peer resource team implemented activities such as publishing articles in the school newspaper, conducting school opinion polls, distributing small media items (e.g. posters and t-shirts), conducting small group discussion sessions and organising dramatic productions. 4) Parent education: Newsletters were sent to parents three times a year and students were asked to discuss sexuality topics with their parents as part of homework assignments. Schools also conducted additional parent education activities. 5) School-community behaviours: initiation of sex, and 4 measures involving condom use - frequency of unprotected sex; number of partners with whom students had unprotected sex; condom use during the last intercourse; and the use of effective contraception. The article presents the results overall and separately by gender, race/ethnicity, prior sexual experience, and prior sexual risk-taking.</td>
<td>Gender, No significant gender interaction effect on the initiation of sex was detected (p=0.70). On all four measures involving condom use interaction effects were detected indicating Safer Choices had a greater impact on males than on females.</td>
<td>Race/ethnicity, Safer Choices did not delay the initiation of sex among Blacks, Asians, or Whites, but did delay the initiation of sex among Hispanic students (p=0.02). Safer Choices increased condom use at last sex more among Hispanics and Whites than among Blacks (p=0.04). No other significant interaction effects were found.</td>
<td>Prior sexual experience, Safer Choices had a significantly greater impact on youth who initiated sex after baseline than on youth who were sexually experienced at baseline (p=0.02). In terms of condom use at last sex, Safer Choices had a greater impact on youth who were sexually experienced at baseline (p=0.02).</td>
<td>Attrition caused by a lack of parental consent and loss at follow-up reduces the generalisability of the findings. The study relied on self-reports of behaviour. The analyses were exploratory not confirmatory and thus more research is needed to confirm the findings. The tests of significance were not corrected for multiple testing and therefore could have been caused.</td>
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<td>Linkages: Homework assignments required students to gather information about local resources; HIV positive speakers from the community gave presentations in schools. No further details regarding the intervention were provided. Focus of lay community involvement: Design and delivery of the intervention.</td>
<td>Baseline than on youth who initiated sex afterward (no further statistics were provided). <strong>Prior sexual risk taking</strong> Safer Choices had a significant positive effect on higher-risk youth who had unprotected sex before the baseline survey in relation to condom use at last sex (p=0.01) and contraceptive use at last sex (p=0.02). Safer Choices can therefore have a long-term impact, can have positive effects on males and females, all major ethnic groups, sexually inexperienced and experienced youth, and both lower and higher-risk youth. However, it may be especially effective with Hispanic and higher risk youth. No specific impact data related to the school health promotion council or the peer educator components of the intervention were provided. Duration of effectiveness was long-term. Results were based on survey completion at 31 months post intervention.</td>
<td>Short term (6-12 weeks)</td>
<td>Medium term (12 weeks to 1 year)</td>
<td>Long term (1 year and beyond)</td>
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<td>Komro et al (1994)</td>
<td>To describe the components of a peer participation program for prevention of alcohol use among young adolescents.</td>
<td>Study type: Project Northland is a randomised trial, however the information presented is in case study format.</td>
<td>Population: Peers were students in 7th grade (n=175) Setting: 20 Schools Country: USA</td>
<td>Peer leader groups/peer leaders Adult volunteers were recruited to facilitate the peer groups (n=66)</td>
<td>Student peer leaders planned supervised, alcohol-free activities for themselves and their class-mates. Program goals included: 1) providing peer leadership and social support for non-use of alcohol; 2) creating opportunities for alternative behaviours to alcohol use; 3) creating a norm of non-use among young adolescents. Intervention activities planned by the students included: dances, parades, golfing, roller skating, bowling, ski trips, movies, beach parties and activity nights. Focus of the lay community involvement: Planning/design of an intervention</td>
<td>Survey assessing the attitudes of the peer leaders following the first year of programme activities</td>
<td>Recruitment of peer leaders Students were initially informed about the peer leadership groups with a brochure mailed to their home. This brochure described the program and invited the student and their parents to a family event during which games containing an educational message were played. A multi-media recruitment booth also promoted the peer leadership groups. Interested students signed up for a later meeting. Peer leadership training and planning groups Each peer leadership group selected two to five representatives to attend leadership training sessions. Sessions involved training the peer leaders to brainstorm around ideas, conduct surveys, plan budgets, obtain donations and publicise events. Peer leaders organised 62 supervised, alcohol-free activities during the first year of the program. Most peer leadership</td>
<td>Yes</td>
<td>The study authors do not acknowledge any limitations in this paper. Reliance on self-report</td>
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<td>papers describing and evaluating Project Northland have been assessed as part of this review, however, they were excluded on numerous counts. This paper, however, focuses solely on the one component meeting the inclusion criteria.</td>
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**Rapid review - health promotion effectiveness phase 3**

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<th>Author &amp; Date</th>
<th>Research Question</th>
<th>Study type &amp; quality</th>
<th>Study population; setting; and country</th>
<th>CE method/ approach</th>
<th>Intervention description and focus of the lay community involvement</th>
<th>Outcomes</th>
<th>Main results</th>
<th>Applicable to UK</th>
<th>Confounder</th>
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<tbody>
<tr>
<td>Kumpusalo et al (1996)</td>
<td>To assess the impact and outcomes of a low-cost local health promotion programme</td>
<td>Study type: Controlled non-randomised trial (intervention group n = 4 villages); Population: Each action group consisted of three key men and women of prestige in their villages</td>
<td>‘Action groups’ of lay community members</td>
<td>Twice a year each action group planned, together with an adult education institute, a health promotion programme for its own village. The action group enquired about local needs and health examination to determine health profile.</td>
<td>Clinical measures; questionnaire and health examination to determine health profile.</td>
<td>60% of the people in the 4 intervention villages and 50% in the two control villages reported changes in health habits during the programme period.</td>
<td>The most marked changes in health behaviour took place in</td>
<td>No given the differences between UK comm</td>
<td>The study authors have not considered confounders. Insufficient methodological detail in study</td>
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<tr>
<td>Study type &amp; quality</td>
<td>Study population; setting; and country</td>
<td>CE method/ approach</td>
<td>Intervention description and focus of the lay community involvement26</td>
<td>Outcomes</td>
<td>Main results</td>
<td>Applicability to UK</td>
<td>Confounder(s)</td>
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<td>Control group n = 2 villages</td>
<td>Interventions targeted at working-aged people (20-64 years; n = 793)</td>
<td>Setting: 6 rural villages</td>
<td>Interventions targeted at working-aged people (20-64 years; n = 793)</td>
<td>made recommendations for health promotion interventions.</td>
<td>Members of the action groups were interviewed to determine the feasibility and impacts of the programme</td>
<td>There were significant decreases in cholesterol and systolic blood pressure levels in the intervention villages compared to the control villages (p&lt;0.05 and p=0.000 respectively). No decreases in diastolic blood pressure and body mass index were achieved. There was also a significant decrease in vitamin C levels in the intervention villages compared to the control villages (p=0.002).</td>
<td>No further impact data regarding the action groups were provided. Duration of effectiveness was not stated.</td>
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<td>Setting: 6 rural villages</td>
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Morris, Trimble | To determine | Study type: Pre and post | Population: Coalition for Head Injury | Over two years the coalition designed and | Number of cyclists and | Combining the two observation dates for each year, helmet use | Yes | Study authors do not |

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<td>Morris, Trimble</td>
<td>To determine</td>
<td>Study type: Pre and post</td>
<td>Population: Coalition for Head Injury</td>
<td>Over two years the coalition designed and</td>
<td>Number of cyclists and</td>
<td>Combining the two observation dates for each year, helmet use</td>
<td>Yes</td>
<td>Study authors do not</td>
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<th>Intervention description and focus of the lay community involvement26</th>
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### Author & Date

Fendley (1994)

### Research Question

Whether a wide-scale, long-term community promotional effort would increase the use of bicycle helmets among children.

### Study type & quality

Test design. Survey of students riding bicycles prior to the implementation of intervention activities and following the implementation of activities designed by the community coalition over a 2 year period.

### Study population; setting; and country

Consisted of representatives of the public health unit, school boards, police, service clubs, retailers, the local Head Injury Association, cycling enthusiasts, the media, and family doctors (n = not stated).

Interventions targeted at local school/college children (n = not stated).

Setting: Suburban, schools, colleges,

Country: Canada

### CE method/approach

Prevention

Coordinated a range of activities including: print, radio and television advertising; posters; pamphlets; bicycle rodeos; police officers taught a bicycle safety module at local schools; a secondary school drama troupe production. All activities used peer models wherever possible. Bicycle helmet discount coupons were widely distributed and signs promoting bicycle helmet use were erected by the local Council on roads and bicycle paths.

Focus of lay community involvement: Design of an intervention.

### Intervention description and focus of the lay community involvement

Whether they wore helmets

10 observation sites were chosen around the city including outside schools and colleges.

On one date before the intervention began (May 1990) and three dates during the intervention (October 1990, May 1991, and October 1991) observer’s surveyed students riding bicycles.

No specific outcome data related to the Coalition component of the intervention was reported.

### Outcomes

Increased from 5.4% in 1990 to 15.4% in 1991. The greatest increase was observed among elementary school students. Overall, girls were twice as likely to wear helmets as boys.

No specific impact data related to the Coalition component of the intervention was reported.

### Duration of effectiveness

No specific outcome data related to the Coalition component of the intervention was reported.

### Main results

**Short term (6-12 weeks)**

Medium term (12 weeks to 1 year)

Long term (1 year and beyond)

### Applicable to UK

Acknowledgement potential confounders.

Lack of a control group.

Observer bias unaccounted for.

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<td>Fendley (1994)</td>
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<td>Interventions targeted at local school/college children (n = not stated).</td>
<td>Prevention</td>
<td>Coordinated a range of activities including: print, radio and television advertising; posters; pamphlets; bicycle rodeos; police officers taught a bicycle safety module at local schools; a secondary school drama troupe production. All activities used peer models wherever possible. Bicycle helmet discount coupons were widely distributed and signs promoting bicycle helmet use were erected by the local Council on roads and bicycle paths.</td>
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</table>
### Author & Date

Pargee et al (1999)

### Research Question

To describe the development and effects of coalitions for promoting physical activity among American Indian communities

### Study type & quality

Study type: Case study 3 year intervention program  
Type & Quality: 3-

### Study population; setting; and country

Population: Community coalition members were all indigenous to one of the seven geographical areas targeted and had demonstrated previous community involvement via tribal affiliation or other local community involvement (n = not reported)  
Interventions targeted at: members of the local community from 7 distinct geographical areas (n = not reported)

### CE method/approach

Community forums and community coalitions

### Intervention description and focus of the lay community involvement

The community coalitions invited residents to attend forums to discuss the health problems and concerns facing each community and ways in which these might be addressed.  
The coalitions used the information gathered from the forums to plan, design and organise activities for the seven communities.  
The coalition met monthly and members were invited to speak about their coalitions events on local television and radio programmes.  
The most support was achieved in areas where previous community efforts had been successful. The strategy of identifying key people within each location to join the coalition tended to be ineffective when those individuals became

### Outcomes

**Main results**  
Short term (6-12 weeks)  
Medium term (12 weeks to 1 year)  
Long term (1 year and beyond)  

**Applicable to UK**

No given cultural differences

**Confounders**

The study authors do not acknowledge any potential confounders. No control communities

**Qualitative evaluation of perceptions of the coalitions**  
Numbers of community members engaged

Participants stated that through working with the coalitions they feel included in the planning and implementation of health education programs and are able to contribute their knowledge to others, especially the younger generations.  
Some of the events organised by the coalitions have become institutionalised in the community calendar.  
However, not all coalition efforts were successful particularly in areas where the community had a sense of distrust of service organisations. A lack of appropriate meeting facilities and transportation difficulties were additional barriers.

**Prevention was reported.**
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<tr>
<td>Parkin et al. (1993)</td>
<td>To evaluate the effectiveness of a</td>
<td>Study type: Controlled non-randomised</td>
<td>Population: Four elementary schools;</td>
<td>Peer leaders</td>
<td>An educational week identified as &quot;Be Bike Smart&quot; was held at each intervention school.</td>
<td>Bicycle helmet use</td>
<td>Helmet use at all observation sites tripled from 3.4% (pre intervention) to 16% (post intervention). In the high-income</td>
<td>Yes</td>
<td>Study authors consider some threats to internal validity</td>
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Local events were chosen as a means whereby the health education messages and tribal traditions could be presented together so that participants experienced how physical activity was a vital part of a healthy lifestyle.

Intervention activities included: surf fish; stick game (competitors were coached by local elders); fitness walk; intergenerational walk; family fun day; community garden; beach walk; presentations by elders on traditional foods and dance.

Focus of lay community involvement: Planning, design and delivery of interventions.

overwhelmed with responsibilities and had to drop out of the coalition. When this occurred the family and friends of these key people also stopped attending.

It also became apparent that a clear vision was needed and lay community members must be encouraged to take on leadership roles.

No physical activity related impact data was provided.
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<td>trial (pre and post observation data collected)</td>
<td>children aged 5 to 14; parents (n = not stated)</td>
<td>Health nurses facilitated the undertaking of intervention activities. Interventions focused on community involvement, specifically the use of peer leaders, including: students performing at school assemblies to deliver the helmet message to their peers; students producing posters to promote helmet use; parent information nights, discounted helmets; bicycle rally incorporating the helmet message. Focus of lay community involvement: Delivery of an intervention.</td>
<td>1800 observations of bicycling children were made at randomly selected observation sites 2 to 5 months after the intervention. Observation sites included school, parks and other recreational areas. No outcome data related to peer leaders was provided.</td>
<td>intervention area, observed helmet use rose from 4% to 36% (p&lt;0.001) in contrast to the high-income control area of 4% to 15% (p&lt;0.005). In the low-income intervention area there was an increase from 1% to 7%, but it did not differ from the increase in the low-income control area from 3% to 13%. Children were more likely to wear helmets when riding with adults than when riding alone or with other children in both income areas (p&lt;0.001). However, in the low-income areas the influence of peers appeared to be stronger, since fewer children wore helmets when riding with other children than in high-income areas (p&lt;0.001). Overall, the programme was found to be successful in children of high-income families but not in children of low-income families. No impact data associated with peer leaders was provided. Duration of effectiveness was not</td>
<td>e.g. the influence of other campaigns in high-income areas during the study period. Observer bias</td>
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<td>Tenn &amp; Dewis (1996)</td>
<td>To assess the effectiveness of an injury prevention programme developed and presented by an adolescent peer group for high-risk adolescents.</td>
<td>Study type: Controlled non-randomised trial</td>
<td>The intervention group received delivery of a peer-led programme; this was compared to the delivery of a prevention presentation to a similar group by a health care professional and compared to a control group who received no intervention.</td>
<td>Population: 106 adolescents enrolled in alternative education programmes (students with a combination of social and academic problems) 9 peer leaders aged 17-19 years (mean 3 years older than adolescents in alternative education program</td>
<td>Peer leaders were recruited to a peer group to tailor an educational intervention to lifestyle patterns; risk-taking behaviours and developmental characteristics of young adolescents, and provide social reinforcement orientation. Initially, the peer group met to design and organise the intervention programme. Once the programme was developed the peer group presented this to the high-risk adolescents. Intervention activities included: an introductory lecture; an obstacle course; sports and risks (involving a visit by a famous sports star); watching a video montage (created by the peer group) considering sport related injuries;</td>
<td>Questionnaire incorporating: knowledge of injuries, Risk-Taking inventory; Multidimensional Health Locus of Control; Self-efficacy; Behavioural Intent; and for the intervention groups qualitative open-ended questions referring to the prevention programme delivered.</td>
<td>No significant overall differences between groups were reported over time (post-test or 4 month follow-up) on any of the outcome measures (no statistical data was provided). Qualitative data revealed a positive impact of the peer intervention over the health professional led intervention. Individuals in the intervention group described themselves as having increased knowledge, realisation of consequences and awareness of a need for caution.</td>
<td>Yes</td>
<td>The study authors acknowledged that the scales developed for this study (e.g., behavioural intent and self-efficacy) were not pilot tested for content and face validity. They also state that there were delays in follow-up evaluation and variation in teacher’s administration of the evaluation questionnaire. The target population was high risk based on social and educational...</td>
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<td>Tudiver et al. (1992)</td>
<td>To assess the effectiveness of two different kinds of AIDS risk reduction programs for gay and bisexual men practicing sexual behaviour at all ranges of risk for transmission of HIV.</td>
<td>Study type: RCT</td>
<td>Men were randomly assigned to either a) single-session groups led by trained volunteer peers; b) four-session groups led by paid counsellors; or c) waiting list control groups. This</td>
<td>Working with scenarios linking emotions and risks. Focus of lay community involvement: Planning, design and delivery of an intervention</td>
<td>Participants in the single-session groups reported significant decreases in unsafe sex and significant increases in safe sex practices at post-intervention (p&lt;0.006). This was not found for the serial-session and control groups (no further statistical data was reported). The rate of decline of practicing unsafe sex was greater for the single-session groups (40%) than for the serial session (14%) or the control (14%) groups. No differences in number of partners were reported between baseline and follow-up for any of the three groups (no statistical data was provided).</td>
<td>Yes</td>
<td>The study authors acknowledge that the dropout rate was greater than had been expected (21% overall compared to the projected 15%). Only 63% of men assigned to the serial sessions received the full four sessions.</td>
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<td>Paper reports evaluation of the Talking Sex Project</td>
<td>latter group were offered their choice of either intervention after they completed the follow-up measures. Completion rates: a) Single session – 201, 80% b) Serial session – 88, 79% c) Controls – 212, 85% Type &amp; Quality 1+</td>
<td>last 5 years) Setting: Urban Country: Canada</td>
<td>(5) difficulties with safer-sex practices (6) safe-sex guidelines and safer-sex practices, (7) sexual scenario role play and (8) safer sex fantasies and scenarios 2) Serial session intervention The serial session intervention participants met in small groups of 8-12 for four weekly two-hour sessions with two paid experienced leaders. The sessions included: (1) introduction, goal-setting, establishing a group rapport, (2) tasks and discussions about safer-sex, (3) sharing of personal experiences and coping strategies, and (4) skills, role-plays for negotiating for safer sex, closure. Focus of lay community involvement: Delivery of an intervention</td>
<td>unsafe sex were the primary outcome variables. No outcome data related to the peer leaders was provided. Gains in knowledge of AIDS risk as well as Attitudes towards AIDS and sexual practices did not vary significantly across the three groups though were significantly higher for the intervention groups combined (single and serial sessions) than the control group (no statistical data was provided). The project was successful in recruiting gay and bisexual men to participate and complete the required tasks. The single-session intervention led by peer volunteers was found to be easier to implement and more practical than the serial-sessions led by paid professionals. However, the project was less successful in recruiting and retaining young, less educated, bisexual men (this group were most likely to dropout). No specific impact data associated with the peer leaders was provided. As post intervention measures were undertaken after three months duration of effectiveness would seem to be medium term whereas all of the single-session participants attended all meetings. Power analysis was undertaken to determine sample size Reliability and validity of measurement instruments was assessed</td>
<td>Short term (6-12 weeks) Medium term (12 weeks to 1 year) Long term (1 year and beyond)</td>
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### Author & Date

**White et al. (2003)**

### Research Question

To describe and evaluate the Wrekenton Lanterns Project, also known as "Happy Hearts".

### Study type & quality

**Type & Quality:** Case study

**Population:** Wrekenton has a population of 26,000, which constitutes over 13% of the Gateshead district population.

**Setting:** Gateshead, Tyne & Wear; Disadvantaged community

**Country:** UK

### Study population; setting; and country

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<td>White et al. (2003) The Wrekenton Lanterns Project</td>
<td>To describe and evaluate the Wrekenton Lanterns Project, also known as &quot;Happy Hearts&quot;.</td>
<td>Study type: Case study Type &amp; Quality: 3-</td>
<td>Population: Wrekenton has a population of 26,000, which constitutes over 13% of the Gateshead district population. Setting: Gateshead, Tyne &amp; Wear; Disadvantaged community Country: UK</td>
<td>Wrekenton Lanterns Project The neighbourhood project is co-managed by the artists and regular volunteers from the community (predominantly local women and young people). The young volunteers have been involved in the project for many years and are known as 'apprentices'. The project involves the organisation of workshops in a local school for two weeks of the year, in which local residents design and construct their own lanterns in collaboration with professional artists. Health promotion messages are incorporated into the artwork. The project work culminates in a community lantern procession. The professional artists, volunteer artist and all lay community members work closely to design and assemble the candle-fired lanterns. Workshop lessons about various health issues, specifically about risks to the heart, run simultaneously with the lantern making activity.</td>
<td>Qualitative account of project achievements with the recipients and deliverers of the intervention Project evaluation in 2003 by the University of Durham</td>
<td>Long term (1 year and beyond) though whether effects are maintained in the long-term are unknown.</td>
<td>Yes</td>
<td>No confounders considered by the case study authors. No control community Reliance on self-report No further details provided regarding the before and after studies.</td>
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### Outcomes

The whole community has developed a sense of ownership of the project by managing and participating in the project.

The 2003 evaluation found that the project had been successful in meeting its stated aims – contributing to the development of a sustainable healthy community, through creating a unique neighbourhood.

The project has helped improve the image of Wrekenton and strengthen community relations. The project promotes social inclusion and maintains a high level of participation each year.

The project provides a forum for local people to meet and has facilitated discussion about the needs of the local community.

The project has been effective in educating local people about healthy lifestyles. Before and after studies are said to show that children and adults who get...
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| Williams & Olano (1999) | To determine the effectiveness    | Study type: Case study Type & Population: Coalition members included | Coalition was set up to support a program | The coalition began by determining community needs and intervention strategies. A community | Reduction of sedentary lifestyles | Through the use of the coalition, walking clubs were integrated into community lifestyle, including neighbourhood crime | No given cultural | Confounders not considered by the study authors.

Focus of lay community involvement: Design and delivery of an intervention.

- Evaluation indicated that participants have reflected on their health state, well-being and lifestyle. Before and after dietary profiles are said to indicate that participants go on to adopt healthier diets (no further details provided).
- Community members have expressed ‘emotional literacy’ through their work (expression of feelings) and this is facilitated by the workshops.
- Barriers encountered each year included securing funding for the project and finding suitable workshop premises.
- Duration of effectiveness: Long-term given that the project has been running for ten years.
### Author & Date
- Author & Date: Quality: 3-

### Research Question
- Research Question: s of using a coalition to promote physical activity among African Americans

### Study type & quality
- Study type & quality: Community members, representative s from a neighbourhood based community services agency (indigenous community residents), chairperson of a drugs action group, a nurse and two local ministers (n = not stated).

### Study population; setting; and country
- Study population; setting; and country: Interventions targeted at African Americans residing in Southeast Stockton, California.
- Setting: Urban
- Country: USA

### CE method/ approach
- CE method/ approach: meeting was subsequently held to discuss the workings of the coalition. Intervention strategies were considered including walking clubs and the coalition began to identify walking club captains from the lay community and walking routes. Walking captains were trained in exercise techniques and CPR.

### Intervention description and focus of the lay community involvement
- Intervention description and focus of the lay community involvement: The coalition liaised with other organisations to help promote physical activity. A Walkathon was sponsored and incentives to join walking clubs were provided e.g. T-shirts, water bottles and caps.

### Outcomes
- Outcomes: No specific outcome data related to the Coalition was reported.

### Main results
- Main results:
  - Short term (6-12 weeks)
  - Medium term (12 weeks to 1 year)
  - Long term (1 year and beyond)

### Applicable to UK
- Applicable to UK: differe nces betwe en UK and US comm unitie s

### Confounder
- Confounder: Potential confounders include a lack of a control community, lack of a description of outcome measurement.

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<td>No specific outcome data related to the Coalition was reported.</td>
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<td>coalition to</td>
<td>representative s</td>
<td>Americans residing in Southeast</td>
<td>subsequently held</td>
<td>prevention activities (via walking crime patrols) and youth projects.</td>
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<td>promote physical</td>
<td>from a neighbourhood</td>
<td>Stockton, California.</td>
<td>to discuss the</td>
<td>Participation of the coalition in numerous community, cultural, and church events promoted physical activity through walking as a community norm.</td>
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<td>activity among</td>
<td>based community</td>
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<td>workings of the</td>
<td>However, the coalition implementation of interventions often differed from that discussed with programme staff. Walking routes were altered and walking club captains did not follow basic physical activity guidelines. Coalition members felt that the wider goal of increasing physical activity was of greater importance. Involving church leaders in promoting walking was also found to be difficult and as a result the coalition later identified members in each church who could organise activities in their particular churches.</td>
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<td>(12 weeks to 1 year)</td>
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<td>African Americans</td>
<td>services agency</td>
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<td>coalition.</td>
<td>No statistical data was provided.</td>
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<td>Long term</td>
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<td>(indigenous</td>
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<td>intervention</td>
<td>Duration of effectiveness was not stated. The study considers the coalition activities over a two-year period.</td>
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<td>(1 year and beyond)</td>
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<td>community residents),</td>
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<td>a drugs action group,</td>
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Potential confounders include a lack of a control community, lack of a description of outcome measurement.
Appendix A: MEDLINE Search Strategy

#S1 Search for terms relating to community engagement in the Descriptor field (mesh heading and subject descriptor field) or Title field (in Medline accessed through OCLC FirstSearch)

(mh: communit* n4 engag*) or (su: communit* n4 engag*) or
((mh: communit* n4 develop*) or (su: communit* n4 develop*)) or
((mh: communit* n4 empower*) or (su: communit* n4 empower*)) or
((mh: communit* n4 involv*) or (su: communit* n4 involv*)) or
((mh: communit* n4 participat*) or (su: communit* n4 participat*)) or
((mh: communit* n4 collaborati*) or (su: communit* n4 collaborati*)) or
((mh: communit* n4 consult*) or (su: communit* n4 consult*)) or
((mh: communit* n4 partners*) or (su: communit* n4 partners*)) or

((mh: citizen* n4 engag*) or (su: citizen* n4 engag*) or
((mh: citizen* n4 develop*) or (su: citizen* n4 develop*)) or
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((mh: citizen* n4 partners*) or (su: citizen* n4 partners*))) or

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((mh: ethnic* n4 empowering*) or (su: ethnic* n4 empowering*)) or
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((mh: ethnic* n4 collaborati*) or (su: ethnic* n4 collaborati*)) or
((mh: ethnic* n4 consult*) or (su: ethnic* n4 consult*)) or
((mh: ethnic* n4 partners*) or (su: ethnic* n4 partners*))) or

((mh: stakeholder* n4 engag*) or (su: stakeholder* n4 engag*) or
((mh: stakeholder* n4 develop*) or (su: stakeholder* n4 develop*)) or
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Rapid review - health promotion effectiveness phase 3

(((mh: stakeholder* n4 involv*) or (su: stakeholder* n4 involv*)) or 
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(ti: population n4 involv*) or
(ti: population n4 participat*) or
(ti: population n4 collaborati*) or
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(ti: population n4 partners*)) or

(kw: citizens w jur* or kw: citizens w panel+ or kw: community w forum or kw: community w panel or kw: community w champion+ or kw: collaborative w approach* or kw: rapid w appraisal or kw: health w trainer+ or kw: health w champion+ or kw: neighbo?rhood w committee+ or kw: neighbo?rhood w forum+) and

yr: 1990-2006 and ln= "english"
and yr: 1990-2006 and ln= "english"

#S2 ‘Less Developed countries’ filter (for Medline accessed through OCLC FirstSearch)

((kw: Mexico or kw: Tanzania or kw: Zambia or kw: Uganda or (kw: Eastern w Europe) or kw: Sudan or kw: Mali or kw: Kyrgyzstan or kw: Ethiopia or kw: Ghana or kw: Bangladesh or kw: Senegal or kw: Nigeria or kw: Vietnam or kw: Peru or kw: Amazon or (kw: Far w east) or (kw: North w Pacific) or kw: Ecuador or (kw: Southern w asia) or (kw: SE w Asia) or kw: Brazil or kw: Russia or (kw: Papua w N.G.) or (kw: papua w new w guinea) or kw: Philippines or kw: Grenada or kw: Jamaica or kw: Benin or kw: India or kw: Pakistan or kw: China or kw: Zimbabwe or (kw: Latin w America) or kw: Angola or kw: Cambodia or kw: Tibet or kw: Nepal or kw: Indonesia or kw: Thailand or kw: Afghanistan or (mh: developing w countries) or (su: developing w countries) or ((mh: South w America) or (su: South w America)) or (mh: Africa or su: Africa) or (mh: India or su: India) or ((kw: developing w countr*) or (kw: underdeveloped w countr*) or (kw: under w developed w countr*) or (kw: third w world) or kw: Africa* or kw: India*))

#S3 = #S1 AND #S2
#S3 Total number of refs containing filter (i.e. unwanted) terms

#S4 = #S1 NOT #S3
#S4 Total number of refs NOT containing ‘less developed countries’ filter terms
### Appendix B: Table of results for screening components

<table>
<thead>
<tr>
<th>Databases/websites</th>
<th>No of records</th>
<th>Screening team</th>
<th>Method/approach</th>
<th>Results</th>
</tr>
</thead>
</table>
| Database screening                 | 31526²⁷       | NICE Manchester team      | 2 reviewers – with 2nd reviewer screening 10% of records. If discrepancy between the two reviewers (discrepancy limit in excess of 60%) then a further 10% sample selected for screening. | Health promotion rapid review:  
- Review level material - 245  
- Primary study material - 2275  
Social determinants rapid review: 5764  
Rejected: 18,129  
Tagged for economics team:  
- Health promotion - 49  
- Social determinants - 130 |
| Additional Cochrane database screening | 4410         | NICE London team          | 2 reviewers – with 2nd reviewer screening 10% of records. If discrepancy between the two reviewers (discrepancy limit in excess of 60%) then a further 10% sample selected for screening. | Health promotion rapid review:  
- Review level material - 82  
Social determinants rapid review: 25 of the 82  
Rejected: 4328  
Tagged for economics: 0 |
| Additional Dare database screening  | 5574          | NICE London team          | 2 reviewers – with 2nd reviewer screening 10% of records. If discrepancy between the two reviewers (discrepancy limit in excess of 60%) then a further 10% sample selected for screening. | Health promotion rapid review:  
- Full titles/abstracts review level - 120  
- Provisional titles review level - 45  
Social determinants rapid review: 25 of the full 120 titles/abstracts and 10 of the 45 provisional titles.  
Rejected: 5409 |

²⁷ This represents the number of database references following the screening work undertaken for the ‘Draft discussion paper 1: Community Engagement Mapping Review’ and prior to further removal of any further duplicates and the removal of titles only (no abstract) which were not screened.
<table>
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<tr>
<th>Web based hits</th>
<th>Tagged for economics: 13 of the 120</th>
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</table>
| Bibliomap, DoPHER, TRoPHI, Joseph Rowntree Foundation, ReFeR, C-RIPE, **[967]** Lancaster team | 2 reviewers – with 2nd reviewer screening 10% of records. If discrepancy between the two reviewers (discrepancy limit in excess of 60%) then a further 10% sample selected for screening. Health promotion rapid review:  
  - Review-level material - 23  
  - Primary study material - 38  
Social determinants rapid review: 84  
Rejected: 822  
Tagged for economics: 2 |
| Healthy Living Centres, New Deal for Communities, Sure Start, Dept for Communities and Local Govt, Active Citizenship, Engaging Communities and Renewal.net. **[-]** Lancaster team | One reviewer to search the site and keeps an audit trail of actions i.e. sections of site searched, keywords (where appropriate), links followed and whether record accepted. Health promotion rapid review:  
  - Review level material - 6  
  - Primary study material - 29  
Social determinants rapid review: 309  
Tagged for economics: 6 |
| Information periodically sent from various sources to Lancaster team during course of work eg. new issues of journals, book publications **[-]** Lancaster team | Health promotion rapid review:  
  - Review level material - 1  
  - Primary study material - 19  
Social determinants rapid review: 12  
Tagged for economics: 0 |

28 Provisional records refers to titles which have been evaluated by CRD reviewer as potentially meeting the CRD quality criteria and structured abstract is in the process of being written. Copies of the abstracts for these provisional titles were requested and also screened for relevance.
Appendix C: Books, book chapters and dissertations not requested for retrieval


Alexander M. *Primary care groups and participation: towards power-sharing.* London: [author]; 1999.

Alloway MK. Access to Bristol Alcohol Services by Black and Minority Ethnic Groups Complete. 1111.


Anderson DL. Community orientated primary care: Health needs assessment for Sileby. Primary care relevant to its community Complete. 1111.

Anderson W. The challenge of public involvement. 1111:82-96.

Aspinal MF. Evaluating the Impact and Effectiveness of User and Public Participatory Strategies in the National Health Service: A Grounded Theory Approach Ongoing. 1111.

Bird MS. Healthy Villages: A Community Development Approach to creating sustainable programmes in rural areas Complete. 1 A.D..


Burton P. *Person-to-person consultation exercise: an evaluation.* [Bristol] - School for Advanced Urban Studies, University of Bristol, Rodney Lodge, Grange Road, Clifton, Bristol BS8 4EA: Saus; 1994.

Burton P, Harrison L. *Identifying local health needs.* Policy Press University of Bristol Rodney Lodge Grange Road Bristol BS8 4EA; 1996.


Carroll DR. Promoting physical activity in south Asian Muslim women through 'exercise on prescription' Complete. 1 A.D..
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Centre FPS. *Rethinking public services seminar programme: urban regeneration and zonal policies; education, health, employment*. Sheffield:- Centre for public services; 1999.


Chorn MR. A quantitative study of Multi-disciplinary Collaboration in Community Learning Disabilities Services Complete. 1 A.D..


Cummings C. *Evaluation of the full service extended schools project: end of first year report (Research report RR680)*. Department for Education and Skills Publications PO Box 5050 Sherwood Park Annesley Nottingham NG15 0DJ; 2005.

Dabbs C. Taking the risk to blossom: the Salford Social Entrepreneurs Programme. 1111:49-60.


Diskett DPM. Health Needs Assessment in the Westgate Ward of Gloucester City using rapid appraisal methodology Complete. 1111.


Elsey MH. Community participation in New Deal for Communities scheme in Thornhill, Southampton Complete. 11 A.D..


Fraser J. *Taking part: a project on the involvement of users and carers in community care*. Tyne and Wear (Tyne Bridge Tower, Church Street, Gateshead NE8 2DU): Social Services Inspectorate; 1992.


Harris MJ. User oriented strategies for preventing unwanted pregnancy in adolescents Complete. 11 A.D..

Hays RB. Community level HIV promotion for young gay men. 1994;Abstract.

Henderson P. *Drugs prevention and community development: principles of good practice.* Home Office Central Drugs Prevention Unit Room 354 Horseferry House Dean Ryle Street London SW1P 2AW; 1995.

Horrocks DC. *Community Development and Tackling Health Inequalities Ongoing.* 1111.

Houston MA. *Evaluation of the Sure Start Community Development Initiative: Harold Hill & Marks Gate Complete.* 1111.


Lawton M. *From Startrac to Leisure Choice: The first slow steps towards change.* Swain, John (Ed); Finkelstein, Vic (Ed); French, Sally (Ed); Oliver, Mike (Ed); 1993.


Local GA. *Drugs and community safety: the development of strategies.* Local Government Management Board Layden House 76 86 Turnmill Street London EC1M 5QU; 1997.

Luck M, Jesson J. *Evaluation of community health development.* Community Health UK 6 Terrace Walk Bath BA1 1LN; 1996.


McDonald D, Tungatt M. *Community development and sport (Community Development Briefing Paper No 3).* Community Development Foundation 60 Highbury Grove London N5 2AG; 1992.

Mycroft MH. Community Development & Health Project Action Plan Complete. 1111.


Ross PF. Participation of older people in community based fall prevention exercise programmes in Southwark: exploring barriers to access and acceptability Ongoing. 1111.


Sharpe MH. Community Health Promotion for Young People Complete. 1 A.D..

Shiner M. North Sheffield Drug & Alcohol Project (NSDAP) Complete. 1 A.D..

South N, Teeman D. Young people, drugs and community life: the messages from the research. 1 A.D.:69-80.

Spurgeon PP. Community-led health promotion project - A proposal for development and dissemination Complete. 1 A.D..

Standing CFCD. *Strategic framework for community development; standing conference for community development; supporting people who support communities*. Sheffield-: Standing Conference for Community Development; 2001.


Taylor P. *The lay contribution to public health*. 1111.


Wales DA. Development of a Glasgow community network "Glasgow Health On-line": proposal for a demonstration project Complete. 1 A.D.

Wandersman A. *Community mobilization for prevention and health promotion can work*. Schneiderman, Neil (Ed); Speers, Marjorie A (Ed); Silva, Julia M (Ed); Tomes, Henry (Ed); Gentry, Jacquelyn H (Ed); 2001.

**LAMBETH Community Care Centre.** Contact: Dgm; 1111.


Local voices: the views of local people in purchasing for health. 1111.

Supporting families and community participation. 1111:72-84.


Black health partnership project: draft final report. Sheffield: Sheffield Health Authority; 1996.


A voice in planning and provision of services: bid No. 423. [Leicester]: Leicester Royal Infirmary NHS Trust; 1996.


Putting partnership into practice: involving the public in primary care. Glasgow - Royal Exchange House, 100 Queen Street, Glasgow G1 3DN: Scottish Consumer Council; 1999.


Ground up: Community Links ideas annual; featuring good ideas for tackling poverty, from the ground up. London: Community Links; 2001.


Guidance for developing contraception and sexual health advice services to reach boys and young men. [London]: Department of Health; 2001.


Stories that can change your life: communities challenging health inequalities. Leeds: NaTPaCT; 2005.
Appendix D: Rejected review level material


Ref Type: Abstract


Bergsma LJ. Empowerment education - The link between media literacy and health promotion. American Behavioral Scientist 2004;48(2):152-64.


Ref Type: Abstract

Bull SS, Gillette C, Glasgow RE, Estabrooks P. Work site health promotion research: to what extent can we generalize the results and what is needed to translate research to practice? Health Education & Behavior 2003;30(5):537-49.


Ciliska D, Miles E, O'Brien MA et al. The effectiveness of community interventions to increase fruit and vegetable consumption in people four years of age and older. *Database of abstracts of reviews of effects* 2006;(4).


Ref Type: Abstract


Ref Type: Abstract


DH/Health Inequalities Unit. (2007) Communities for Health: Learning from the Pilots.


Dugdill L, Graham RC, McNair F. Exercise referral: the public health panacea for physical activity promotion? A critical perspective of exercise referral


Finley PR, Crismon ML, Rush AJ. Evaluating the impact of pharmacists in mental health: a systematic review. [Review] [46 refs]. Pharmacotherapy 2003 December;23(12):1634-44.


Gillies P. Effectiveness of alliances and partnerships for health promotion. *Health Promotion International* 2006;13(2).


Herbert RD, Gabriel M. Effects of stretching before and after exercising on muscle soreness and risk of injury: systematic review. [see comment]. [Review] [30 refs]. *BMJ* 2002 August 31;325(7362):468.
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Hey K, Perera R. Competitions and incentives for smoking cessation. *The Cochrane Database of systematic reviews* 2005;(2).


Howard LA. *Nursing and mental health consultation: A public health-community perspective*. Mannino, Fortune V (Ed); Trickett, Edison J (Ed); Shore, Milton F (Ed); Kidder, Margaret Grady (Ed); Levin, Gloria (Ed); 1986.


Jackson NW, Howes FS, Gupta S, Doyle JL, Waters E. Interventions implemented through sporting organisations for increasing participation in sport. *Cochrane Database of Systematic Reviews* (1) 2006.


Ref Type: Abstract


Kwan I, Mapstone J, Roberts I. Interventions for increasing pedestrian and cyclist visibility for the prevention of death and injuries. [Review] [67 refs]. 
Cochrane Database of Systematic Reviews. 2002;CD003438.


Ref Type: Abstract


Lovato C, Linn G, Stead LF, Best A. Impact of tobacco advertising and promotion on increasing adolescent smoking behaviours. [Review] [75 refs]. Cochrane Database of Systematic Reviews. 2003;CD003439.


Meher S, Duley L. Exercise or other physical activity for preventing pre-eclampsia and its complications. [Review] [44 refs]. *Cochrane Database of Systematic Reviews*. 2006;CD005942.

Meher S, Duley L. Rest during pregnancy for preventing pre-eclampsia and its complications in women with normal blood pressure. [Review] [34 refs]. *Cochrane Database of Systematic Reviews*. 2006;CD005939.

Merry S, McDowell H, Hetrick S, Bir J, Muller N. Psychological and/or educational interventions for the prevention of depression in children and adolescents. [Review] [93 refs]. *Cochrane Database of Systematic Reviews*. 2004;CD003380.


Morgan O. Approaches to increase physical activity: reviewing the evidence for exercise-referral schemes. [Review] [25 refs]. *Public Health* 2005 May;119(5):361-70.


Ref Type: Abstract


Ref Type: Abstract

Mullen PD. Maternal smoking during pregnancy and evidence-based intervention to promote cessation. *Primary Care; Clinics in Office Practice* 1999 September;26(3):577-89.


Ogilvie D, Egan M, Hamilton V, Petticrew M. Promoting walking and cycling as an alternative to using cars: systematic review.[see comment]. [Review] [29 refs]. *BMJ* 2004 October 2;329(7469):763.


Ref Type: Abstract

Ref Type: Abstract


Ref Type: Abstract


148


Rathwell T. Realities of Health For All by the year 2000. [Review] [30 refs]. *Social Science & Medicine* 35(4):541-7, 1992 August.


Ref Type: Abstract


Roberts I, Kwan I, Cochrane injuries group driver education reviewers. School-based driver education for the prevention of traffic crashes. *Cochrane Database of Systematic Reviews*. 2001.


Royal ST, Kendrick D, Coleman T. Non-legislative interventions for the promotion of cycle helmet wearing by children. [Review] [36 refs]. *Cochrane Database of Systematic Reviews*. 2005;CD003985.


Sanderson I. Participation and democratic renewal: from 'instrumental' to 'communicative rationality'? *Policy and Politics* 1999;27(3):325-41.


Schensul JJ. Organizing community research partnerships in the struggle against AIDS. *Health Education & Behavior* 1999;26(2):266-83.


Sloboda Z. What we have learned from research about the prevention of HIV transmission among drug abusers. *Public Health Reports* 1998;113 Suppl 1:194-204.


Spoth R, Greenberg M, Bierman K, Redmond C. PROSPER community-university partnership model for public education systems: capacity-building


Thompson DC, Rivara FP. Pool fencing for preventing drowning in children. [Review] [3 refs]. *Cochrane Database of Systematic Reviews*. 2000;CD001047.


Ref Type: Abstract


Wiehe SE, Garrison MM, Christakis DA, Ebel BE, Rivara FP. A systematic review of school-based smoking prevention trials with long-term follow-up. [see


Appendix E - review level material not retrieved


Ref Type: Generic


Ref Type: Report

Ref Type: Report

Ref Type: Generic

Ref Type: Report


Balarajan PR. Ethnic health complete. 2006.

Barker, R. Judging the juries. 2006.
Ref Type: Generic


Bidduph, M. At home in our streets. Landscape . 2002. Ref Type: Abstract


Burns PT. A meta-regression study to explain the heterogeneity in assertive outreach study outcomes. 2006.


Centre FPS. Local authority health overview and scrutiny committees and patient and public involvement forums: working together- a practical guide. 2006. Ref Type: Report


Ref Type: Report


Heslop, M. Participatory research with older people: a sourcebook. 2006.

Ref Type: Generic


Jacobson JW. Administrative and policy dimensions of developmental disabilities services. Matson, Johnny L (Ed); Mulick, James A (Ed); 1991.

Jacobson JW, Burchard SN. Overview of clinical services, social adjustment, and work life in community living. Jacobson, John W (Ed); Burchard, Sara N (Ed); Carling, Paul J (Ed); 1992.


Jones, W. Patient participation. 2006.
Ref Type: Generic

Kelly JA. Sexually transmitted disease prevention approaches that work. Interventions to reduce risk behavior among individuals, groups, and communities. [Review] [5 refs]. Sexually Transmitted Diseases. 1994;21:Suppl-5.

Ref Type: Generic


Low DN. A systematic review of interventions to reduce the incidence of sexually transmitted infections in minority ethnic populations in developed countries. 2006.


Meyrick J. Review of good practice in community participation projects and initiatives which impact on health and well-being Complete. 11 A.D..

Milewa, T. Managerialism and active citizenship in Britain's reformed health service: power and community in an era of decentralisation. 2006.


Mullen PM. Public involvement in health care priority setting: are the methods appropriate and valid? 11 A.D.:163-74.
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Peter E. Review: involvement of former or current users of mental health services may improve outcomes in patients with severe mental illness. *Evidence Based Nursing*. 2003;6:90.


Pickin DC. Locality health needs assessment research project Complete. 11 A.D..


164

Ref Type: Report


Roden MD. Developing a public health approach in Primary Care Complete. 11 A.D..

Rowe, R and Shepherd, M. Public participation in the new NHS: no closer to citizen control. 2006.
Ref Type: Generic

Ref Type: Generic

Rutter DD. Optimising user involvement in the planning and delivery of health care: evaluation of models used by mental health services in London Complete. 11 A.D..

Ryan PM. What is the value of public participation (public preference exercises) in priority setting? Complete. 11 A.D..


Scherer CW, Juanillo NK, Jr. *The continuing challenge of community health risk management and communication*. Thompson, Teresa L (Ed); Dorsey, Alicia M (Ed); Miller, Katherine I (Ed); Parrott, Roxanne (Ed); 2003.


Sitzia MJ. Patient and public involvement in nursing and midwifery research: a systematic review of the literature. 2006.


Stewart-Brown, S. What is the evidence on school health promotion in improving health or preventing disease and, specifically, what is the effectiveness of the health promoting schools approach. 2006. WHO Health Evidence Network.


Szczepura PA. Systematic review of differences in access and uptake of health services by minority ethnic groups in London. 2006.

Szczepura PA. A systematic review of research evidence on ethnicity and communication to inform policy and practice in 4 areas. 2006.


Vincent DJ. Study of the potential contribution of the co-operative movement and community wellbeing centres to health of the nation activities. 2006.

Walsh DM. Patient and public involvement standards. 2006.


Williams PG. A review of social capital and community development projects on the health and wellbeing of children and young people. 2006.
## Appendix F: Full paper in/out screening checklist

<table>
<thead>
<tr>
<th>Author and date</th>
<th>Checked by</th>
<th>YES</th>
<th>NO</th>
<th>UNCLEAR WITH DETAILS</th>
</tr>
</thead>
</table>

1. Is the article focused on community engagement and development approaches or methods used by (health and non-health) public, private and voluntary sector professionals and community members in interventions where the primary purpose is either the:

   - lay involvement of communities in the planning (including resource allocation and priority setting), design, delivery or governance of primary health promotion (e.g. the delivery of accidental injury, physical activity, sexual health intervention)?

   - barriers to using community engagement and development approaches and methods for primary health promotion interventions and interventions which have successfully overcome these barriers?

2. Is the interventions, initiatives or services

   A. targeted at individuals, (rather than a specified community)?

   B. include screening programmes?

   C. include the planning, design, delivery and/or governance of treatment in healthcare settings?

   D. focused on secondary prevention or prevention of relapse?

   E. assessing the effectiveness of tools such as health impact assessment, healthy equity audit?

   F. set in developing countries?

   G. in language other than English?

   H. focused on pharmacological interventions?

**TO BE INCLUDED?**

**IF YES TO 1 AND NO TO ALL OF 2 THEN INCLUDE.**

- Does the article meet the criteria for the social determinants rapid review?

- Is there any cost/economic material contained within the article?
Appendix G: Primary studies rejected

Abelson J. Bringing the public into health technology assessment and coverage policy decisions: From principles to practice. Health Policy. 2006.


Alexander JA, Weiner BJ, Metzger M, Shortell S, Bazzoli GJ. Sustainability of collaborative capacity in community health partnerships. Medical Care Research and Review. 1111;60:130S-166S.


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Rapid review - health promotion effectiveness phase 3


Cresswell J. News focus. Twilight zones... health action zones are to tackle the root. Community Nurse. 1998;4:11.


DH/Health Inequalities Unit. Communities for Health: Learning from the Pilots; 2007.


Devlin AA, Rusling L. What's your problem? *Streetwise*. 1999;No 37


Flocks, J., Clarke, L., Albrecht, S., Bryant, C., Monaghan, P., Baker, H. Implementing a Community-Based Social Marketing Project to Improve Agricultural Worker Health. *Environmental Health Perspectives,* 2001; 109, Supplement 3: 461-468


Gillies P. Students leading the way to smoking cessation: a pilot project. 2004.


Gowman N, Coote A. Health is where the home is. *Community Care*. 1999;No 1261 25 Feb-3 Mar 1999


Rapid review - health promotion effectiveness phase 3


Kuhn L, Davidson LL, Durkin MS. Use of Poisson regression and time series analysis for detecting changes over time in rates of child injury following a prevention program.[see comment]. *American Journal of Epidemiology.* 1994;140:943-955.


Lew R; Chau J; Woo J.M; Nguyen K.D; Okahara L; Min K.J; et al. Annual walkathons as a community education strategy for the Asian American/Pacific Islander populations in Alameda, County, California – *Journal of Health Education*, 1999; 30; 2: 25-30


Loewenson R. Public Participation in health: making people matter. :45.

Long VA, Martin T, Janson-Sand C. The great beginnings program: impact of a nutrition curriculum on nutrition knowledge, diet quality and birth outcomes

Lounsbury KC. The role of power, process, and relationships in participatory research for statewide HIV/AIDS programming. *Social Science & Medicine.* 2006;63:2129-2140.


Minkler M, Fadem P, Perry M, Blum K, Moore L, Rogers J. Ethical dilemmas in participatory action research: a case study from the disability community. *Health Educ Behav.* 2002;29:14-29.


National Primary and Care Trust Development. Engaging now: PCTs working with their communities to improve services and cut health inequalities.:20.


O'Neil, J. Methods to increase booster seat use in 4 to 6 year old children. The 49th AAAM Annual Conference. 2005. Ref Type: Conference Proceeding


Parish C. Poor relation... a co-ordinated attempt to put resources into the poorest communities in an 'intensive and co-ordinated way'. *Nursing Standard*. 2002;16:18-19.


194


Shepherd J, Weare K, Turner G. Peer-led sexual health promotion with young gay and bisexual men- results of the HAPEER project. *Health Education.* 1997;204-212.


Rapid review - health promotion effectiveness phase 3


Stevens SL. *Effects of intervention on booster seat purchase: a field study* [Virginia Polytechnic Institute and State University, 2000.


Tamburro, R F., Shorr, R I., Bush, A J., Kritchevsky, S B., Stidham: G L & Helms, S A. Association between the inception of a SAFE KIDS Coalition and


Tillgren P; Haglund BJA; Kanstrom L; Holm LE. Community analysis in the planning and implementation of the Stockholm cancer prevention program. *Health Prom Int; 1992; 7; 2: 89-97*.


Weinstein LC, Plumb JD, Brawer R. Community engagement of men. *Primary Care; Clinics in Office Practice.* 2006;33:247-259.


Whitehorse LE, Manzano R, Baezconde-Garbanati LA, Hanh G. Culturally tailoring a physical activity program for Hispanic women: recruitment


Worden JK, Solomon LJ, Flynn BS, et al. A community-wide program in


Appendix H: Primary studies not retrieved


Ref Type: Generic


Allen CF. Community development for health and identity politics. 111111


Ref Type: Generic


Ref Type: Generic


Buller DB, Morrill C, Taren D et al. Randomized trial testing the effect of peer education at increasing fruit and vegetable intake. *Journal of the National Cancer Institute*. 1999;91:1491-1500.


Cogdon, A and Belzer, E. G. Dartmouth Health Promotion Study: A longitudinal investigation of the efficacy of coordinating the components of a comprehensive school health promotion program. 1992. Ref Type: Generic


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Lindsay, E, Cameron, R, Walder, R. Ferster D - Planning and implementing the COMMIT protocol in Brantford. *Health and Canadian Society*, 2; 2: 237-267


Ref Type: Report


Ref Type: Report

Ref Type: Report


Perry, CL; Bishop DB; Taylor G; Murray DM; Mays RW; Dudovitz BS; Smyth M; Story M. Changing fruit and vegetable consumption among children: The 5-A-Day Power Plus program in St. Paul, Minnesota. American Journal of Public Health, 88 Iss. 4: 603-609


Reger B, Wootan MG, Booth-Butterfield S, Smith H. 1% or less: a community-based nutrition campaign.[see comment]. Public Health Reports. 1998;113:410-419.


Ref Type: Generic


Van, Assema P.; Steenbakkers,M.; Kok,G.; Eriksen,M.; de,Vries H. - Results of the Dutch community project "Healthy Bergeyk" *Preventive Medicine*, 23 Iss. 3: 394-401


Ref Type: Generic


Appendix I: Data extraction tool

<table>
<thead>
<tr>
<th>Data Extraction Tool: Health promotion rapid review community engagement (CE) programme Phase 2 – Primary study assessment</th>
<th>Ref ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author(s):</td>
<td></td>
</tr>
<tr>
<td>Year:</td>
<td></td>
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<tr>
<td>Title of paper:</td>
<td></td>
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<tr>
<td>Data extracted by:</td>
<td></td>
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<tr>
<td>Date of extraction:</td>
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</table>

1. STUDY DESCRIPTION

1a. Describe the study:

<table>
<thead>
<tr>
<th>Study Type</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>RCT</td>
<td></td>
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<tr>
<td>Controlled non-randomised trial</td>
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<tr>
<td>Controlled before-and-after</td>
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<tr>
<td>Cohort</td>
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<tr>
<td>Interrupted time series</td>
<td></td>
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<tr>
<td>Before and after study</td>
<td></td>
<td></td>
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<tr>
<td>Cross sectional (survey)</td>
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<tr>
<td>Structured interview</td>
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<tr>
<td>Audit/Evaluation</td>
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<tr>
<td>Economic analysis</td>
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<tr>
<td>Case study</td>
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<tr>
<td>Local practice report</td>
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<tr>
<td>Qualitative study</td>
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<td></td>
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<tr>
<td>Focus group(s) interviews</td>
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<tr>
<td>Unstructured interview</td>
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<td></td>
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<tr>
<td>Semi-structured interview</td>
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<tr>
<td>Observation</td>
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<tr>
<td>Other (please state)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1b. Did the study state a clearly focussed research question?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Describe:
## 2. Study Parameters

### 2a. Country:
- UK
- Other Europe
- Non European

### 2b. Setting:
- Urban
- Suburban
- Semi-rural
- Rural
- Combination
- School
- Workplace
- Other (please state)

### 2c. Participants (please describe):

### 2d. Method of recruitment and response rate:

### 2e. Method of allocation to intervention:
- Was allocation concealed? Yes □ No □ Unclear □

### Selection criteria:
- Inclusion:
- Exclusion:

### Description of the Intervention:

### 3a. Theoretical underpinning of the intervention:

### 3b. Method/approach of community engagement/involvement:
- Citizens’ panels □
- Citizens’ juries □
- Neighbourhood committees □
- Community forums □
- Community champions □
- Collaborative methodology □
- Public meetings □
- Other □ (please describe)
3c. What is the focus of the intervention(s) (please describe the content):
- Planning of an intervention
- Resource allocation
- Priority setting
- Design of an intervention
- Delivery of an intervention
- Governance of an intervention
- Barriers to using CE
- Interventions to overcome barriers
- Facilitators for using CE
- Experience of involvement

3d. Level of participation:
- Informing
- Consultation
- Co-production
- Delegated power
- Community control
- Other (please describe)

3e. Role of lay community member in the intervention:

3f. Behaviour(s)/areas targeted by the study:
- Smoking
- Diet
- Physical activity
- Substance misuse
- Sexual health
- Alcohol
- Injury
- Violence
- Other (please state)

3g. Intervention activities (please describe):
3j. Length, duration and intensity of the intervention:

3k. Time to follow-up:

3l. How many participants completed the intervention (n, %):

For non-completers, were the reasons for non-completion described?

3m. If provided, please describe any information regarding organisational/professional preparedness:

4. OUTCOMES

4a. Outcomes:
Health promotion outcomes:
   Health literacy
   Social action and influence
   Health policy changes
   Other
   Describe:
   Were baseline measurements of outcomes assessed? Yes ☐ No ☐

Intermediate outcomes:
   Lifestyle changes
   Social action and influence
   Health policy changes
   Improved information flows between community and service provider
   Identified community needs
   Other
   Describe:
   Were baseline measurements of outcomes assessed? Yes ☐ No ☐

Health and social outcome measures:
   Mortality
   Morbidity
   Quality of life
   Reduce health inequalities
   Other
   Describe:
   Were baseline measurements of outcomes assessed? Yes ☐ No ☐

   Were the outcome measures validated? Yes ☐ No ☐
   If yes, how?
4b. Duration of effectiveness/outcome measurement:
- Short term (6 – 12 weeks) □
- Medium term (12 weeks to 1 year) □
- Long term (1 year and beyond) □

4c. Analyses:
Data collection methods used:

Describe methods used:

4d. Power:
- Was a power calculation presented? Yes □ No □
  If yes, describe:
- Was the study powered to detect an effect if one exists? Yes □ No □

4e. Did the study assess the use of fidelity measures for interventions (please tick)?
- Yes □
- No □
- Not clear □

4f. Any other process details:

5. Results:
Briefly describe the results for each of the main outcomes, paying particular attention to issues relating to health inequalities and cost effectiveness:

6. Conclusions:
Describe

Are there any key criticisms of the conclusions drawn by the authors?
7. Does the paper demonstrate any evidence of harms or adverse effects associated with the intervention and/or use of CE/CD approach or method?

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>☐ (please describe)</td>
</tr>
<tr>
<td>No</td>
<td>☐</td>
</tr>
<tr>
<td>Not clear</td>
<td>☐ (please describe)</td>
</tr>
</tbody>
</table>

8. In your opinion, are the results generalisable to the UK?

<table>
<thead>
<tr>
<th>Option</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>☐</td>
</tr>
<tr>
<td>No</td>
<td>☐</td>
</tr>
<tr>
<td>Not clear</td>
<td>☐</td>
</tr>
</tbody>
</table>

Why (e.g. similar context for behaviour):

9. Do the authors identify any evidence gaps or make any recommendations for further research?

10. Are there policy implications of the work?

11. Are there any practice implications of the work?

Pass to other reviewer for second opinion?

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Yes</td>
<td>☐</td>
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<tr>
<td>No</td>
<td>☐</td>
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<tr>
<td>Accept</td>
<td>☐</td>
</tr>
<tr>
<td>Reject</td>
<td>☐ (describe reason for referral)</td>
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</tbody>
</table>
Appendix J: Example of quality appraisal checklist

Methodology checklist: Case studies (adapted from STROBE checklist, Version 3[^29])

<table>
<thead>
<tr>
<th>Study Identification</th>
<th>Study Identification details (if published-full reference details, if not published-contact details of source).</th>
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<tr>
<th>Guideline topic:</th>
<th>Key question no:</th>
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<tr>
<td>Checklist completed by:</td>
<td></td>
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</tbody>
</table>

**INTRODUCTION**

**Background / Rationale**

Explain background and rationale for the investigation/approach being reported.

**Objectives**

State specific objectives including any pre-specified hypotheses.

**METHODS**

<table>
<thead>
<tr>
<th>Study design</th>
<th>Present key elements of study design. State purpose of original study, if article is one of several from an ongoing study.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting</td>
<td>Describe setting, locations and dates defining periods of data collection.</td>
</tr>
<tr>
<td>Participants</td>
<td>Give inclusion and exclusion criteria (for cases and controls separately where appropriate), sources and methods of selection of participants. Selection bias present?</td>
</tr>
<tr>
<td></td>
<td>Give period and methods of follow-up.</td>
</tr>
<tr>
<td></td>
<td>Give precise defining criteria for cases (eg socioeconomic data, geographical location etc), and rationale for choice of controls.</td>
</tr>
<tr>
<td>Variables of interest</td>
<td>List and clearly define all variables of interest indicating which are seen as outcomes, exposures, potential predictors, potential confounders or effect modifiers.</td>
</tr>
<tr>
<td>Measurement</td>
<td>For each variable of interest give details of methods of assessment (measurement). Were validated outcome measures used? Give results separately for cases and controls where appropriate. Measurement bias present?</td>
</tr>
<tr>
<td></td>
<td>Describe who and when collected the outcome data. For example, were the outcomes assessed retrospectively? Were they collected for the purposes of this study? Recall bias present?</td>
</tr>
<tr>
<td></td>
<td>If applicable, describe comparability of assessment methods across groups.</td>
</tr>
</tbody>
</table>

### Bias
Are identified sources of bias random or are they in one direction? Describe any measures taken to address potential sources of bias.

### Sample size
Describe rationale for study size, including practical and statistical considerations.

### Statistical methods
(a) Describe all statistical methods including those to control for confounding.

- Describe how loss to follow-up and missing data were addressed.
- Describe how any matching of cases and controls and missing data were addressed.
- If applicable, describe methods for subgroup analyses and sensitivity analyses.

### Quantitative variables
Explain how quantitative variables are analyzed e.g. which groupings are chosen, and why.

- Present results from continuous analyses as well as from grouped analyses, if appropriate.

### Funding
Give source of funding and role of funder(s) for the study and, if applicable, the original study on which the present article is based.

### Participants
Report the numbers of individuals at each stage of the study (separately for cases and controls) (e.g. numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow up, and analysed).

- Give reasons for non-participation at each stage.

### Descriptive data
Give characteristics of study participants (separately for cases and controls) (e.g. demographic, clinical, social) and information on exposures and potential confounders.

- Indicate for each variable of interest the completeness of the data.
- Summarize average and total amount of follow up and dates defining follow up.

### Outcome data
Report numbers of outcome events or summary measures over time.

### OVERALL ASSESSMENT
++ Where all or most of the data is adequately described and where the conclusions of the study are thought very unlikely to alter (low risk of bias).
+ Where some of the data is adequately described and where the conclusions of the study are thought unlikely to alter (risk of bias)
- Where few or no of the data is adequately described and where the conclusions of the study are thought likely or very likely to alter (high risk of bias).
References


Pickin C, Popay J, Staely K et al. (2002) Developing a model to enhance the capacity of statutory organisations to engage with lay communities. *Journal of Health Services Research and Policy* 7:(1).


Details of research questions outlined in section 4.5 of NICE scope - [http://www.nice.org.uk/page.aspx?o=322729](http://www.nice.org.uk/page.aspx?o=322729)
Rapid review - health promotion effectiveness phase 3

Definition of secondary prevention
www.cdpac.ca/content/faqs/alliance_definitions.asp

Details of the initiative the Healthy Communities Collaborative
www.npdt.org/scipts/default.asp?site_id=4/7Id=9748