



Public Health
England

Protecting and improving the nation's health

Community champions

A rapid scoping review of community
champion approaches for the pandemic
response and recovery

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Key messages

Community champions (also known as health champions) are community members who volunteer to promote health and wellbeing or improve conditions in their local community. Champions use their social networks and life experience to address barriers to engagement and improve connections between services and disadvantaged communities.

Findings from this rapid review show that community champion approaches have high relevance to reducing health inequalities, whether the context is one of an emergency, or of longer term prevention. Community champions can be key connectors in communities but these roles do not operate in isolation and need to be embedded in effective community engagement strategies.

As public health interventions, community champion approaches can be applied flexibly dependent on local needs and community assets. This review identifies different models and ways of building champion programmes.

Summary of evidence

International evidence on champion-type roles in communicable disease control shows two intervention models. Popular Opinion Leader interventions work by recruiting people who are well placed within social networks and who promote health and risk reduction as part of their daily lives. Secondly, community mobilizers work by contributing to comprehensive, multi-level approaches to prevention and were used successfully in the Ebola response and in vaccination programmes. There is consistent quantitative evidence that both of these intervention models achieve reach into target communities, but the evidence on behavioural impacts is more mixed, and research on champion roles in the coronavirus (COVID-19) pandemic is currently very limited.

UK evidence on community champions in health improvement shows that champions can strengthen social connections in disadvantaged communities and be a link between those communities and services. Five different approaches exist in public health practice: empowerment, capacity building, strengthening participation, integrated and health education. There is consistent qualitative evidence on positive outcomes for community champions and some positive impacts reported for target communities.

UK evidence on implementation indicates that building a supportive infrastructure, offering training that builds skills as well as knowledge, and long term community engagement are important enabling factors.

Application to the coronavirus (COVID-19) pandemic response and recovery

Community champion approaches can be used flexibly to support community engagement in the pandemic response. Evidence highlights the value of volunteers with credibility in the community who can tap into existing social networks. This helps bridge gaps between services and communities.

Recruiting champions from communities who are disproportionately affected by COVID-19 could help to reduce barriers to engagement and support uptake of services, including vaccination. Champions can also tackle stigma.

Longer term, champions could support local approaches to the pandemic recovery, with a focus on health improvement and strengthening community cohesion. Developing champion programmes also helps build emergency preparedness.

There are different evidence-based options for local decision makers who want to use champion approaches in the pandemic response and recovery. Empowerment and capacity building approaches have high relevance in strengthening communities but require time and investment to nurture community action and co-production.

Provision of ongoing support to champions, local coordination, effective community engagement, investment and wider partnerships are enabling factors that have relevance for the legacy of COVID-19 champion schemes.

Background

Community champions or health champions are active community members who draw on their local knowledge, skills and life experience to promote health and wellbeing or improve conditions in their local community (1, 2). The COVID-19 pandemic has demonstrated how important communities and community action are to public health and to the broader response (3, 4). International evidence, including learning from the 2014 to 2016 Ebola outbreak, suggests that comprehensive community engagement strategies should be integral to the pandemic response (5 to 7).

In England, it has been recognised that tailored local approaches built on effective community engagement are now needed to address the health inequalities exposed through the pandemic (8, 9). This has led to renewed interest in the mobilisation of community champions as an approach to improve the pandemic response and to build healthier, more resilient communities as part of recovery.

In October 2020, the Equalities minister announced a 'Community Champions' scheme to support groups at most risk of COVID-19, including ethnic minority communities and other groups who have been disproportionately affected by the COVID-19 pandemic (10). The Ministry of Housing, Communities and Local Government scheme started in January 2021, with funding of over £23 million going to 60 councils and voluntary groups across England to develop champions programmes, with a focus on supporting those most at risk and promoting vaccine uptake (11). Many local authorities are already developing, or repurposing, champion programmes to tackle the barriers faced by communities, including those who are seldom heard.

Public Health England (PHE) commissioned Leeds Beckett University to undertake a rapid review to support this programme by scoping the best available evidence on community health champions as a public health intervention. This builds on a recent report prepared by the Independent Scientific Pandemic Insights Group on Behaviours (SPI-B) for SAGE (Scientific Advisory Group for Emergencies), which examined the evidence for community champion roles in supporting the pandemic response, particularly to improve engagement with the NHS Test and Trace service (12).

The National Institute for Health and Care Excellence (NICE) define community health champions as 'volunteers who, with training and support, help improve the health and wellbeing of their families, communities or workplaces' (13). Community health champion roles are part of the PHE 'family of community-centred approaches' (14). Champion programmes fit within a broad group of community-centred approaches based on volunteer and peer roles (14), which are recommended by NICE Community Engagement guidance (13). The focus of these interventions is usually on reducing health inequalities, with volunteers in bridging roles, connecting with disadvantaged communities (14). Recognition that community members bring knowledge, skills and

connections as well as a commitment to help others is central to champion approaches (15).

Community champions are part of the public health workforce (1). They are usually volunteers but can also be community leaders or front-line workers in community-based organisations. According to the Royal Society for Public Health (RSPH), the wider public health workforce includes people with the opportunities to have healthy conversations as well as lay health workers, like health trainers, and people who contribute to public health through their work (1). In a guide to preventing pandemic fatigue, the World Health Organization (WHO) Europe recommends that members of the public are considered part of the solution to maintaining prevention efforts (7). Informal volunteering is an important feature of emergency responses in disasters and other crises (16).

This review scopes the potential for community champion programmes to contribute to the pandemic response and recovery. The term 'community champion' is used to cover similar terms such as health champions, community health champions or community connectors. The focus is on public health roles where volunteers promote health in their communities and through their social networks. The review does not cover other types of volunteering seen in the UK pandemic response (17) nor mutual aid approaches (18).

Study aims

The aims of the study are:

- to undertake a rapid scoping review on the application, implementation, evaluation and sustainability of community champion programmes as part of the pandemic response and recovery
- to support effective knowledge translation, by gathering and disseminating learning on transferable models and processes that underpin effective community mobilisation and empowerment

The timing of the review at the end of the first year of the pandemic limited what research was available on COVID-19 community champions, therefore the review has scoped existing evidence on champion and 'champion-type' approaches and models that could have applicability. The review draws on 2 main sources. First, international literature on community volunteering roles in health protection, including health emergencies. Second, existing research on UK public health practice about how to develop and implement community champion programmes. The application to the pandemic response is included in the Discussion. The review will be used to inform PHE's cross-government work and any guidance to local systems.

Review methods

A rapid scoping review was undertaken, using systematic processes for searching, selection, and analysis of studies (19) but with some limitations due to timescales. The design applied the eight stages of Rapid Evidence Assessment (20) to ensure the review met the knowledge needs of policy makers and practitioners. Acceleration strategies were used to produce relevant results in a timely fashion (20) These included identifying an initial list of key literature, refining the scope and review questions (RQs) with stakeholders (see Box 1), and forming an expert advisory group. RQs 1 and 2 related to international and UK literature, whereas RQs 3 and 4 related to community champion programmes in UK public health practice. A full protocol is available on request. Methods and results are reported according to the PRISMA Extension for Scoping Reviews (PRISMA-ScR) (21)

Box 1: Review questions

RQ1: What roles do community champions undertake that contribute to the pandemic response and recovery or to similar health emergencies, for example, communicable disease outbreaks or environmental disasters?

RQ2: What outcomes are reported in relation to these roles and with which communities? To what extent are community champions successful in connecting with people from disadvantaged groups or areas?

RQ3: What types of community champion interventions are used in the UK and what are the key features of programmes in terms of supporting effective community mobilisation and outcomes?

RQ4: What implementation processes are needed to recruit, empower and support community champions in their roles in the pandemic response and recovery?

Search strategy

The search strategy was developed and piloted by PHE Knowledge and Library services (Appendix A); this drew on the search strategy used in an earlier review (22) Evidence sources included academic articles and grey literature from 2008. This exclusion date was chosen because of the availability of earlier reviews on community engagement (22 to 27) which were mined for evidence. A list of search terms and synonyms for champions was generated, such as ambassador, health champion, community activator,

community agent, youth champion and COVID-19 messenger. Broad search terms relating to general volunteering roles or community engagement approaches were not included to limit the search. Champion terms were then combined with PHE COVID-19 and health and wellbeing teams.

Academic databases searched were: Medline (Ovid); Embase (Ovid); APA PsycInfo (Ovid); Social Policy and Practice (Ovid); CINAHL Complete (EBSCO); Cochrane Database of Systematic Reviews; SocINDEX (EBSCO); HMIIC (Health Management Information Consortium) (Ovid); Social Care Online. Further publications were identified through searching and mining of reference lists from key literature, including relevant reviews (6, 12, 22 to 24). This helped generate further relevant literature, without widening the scope of searches.

Study selection

Search results were downloaded and de-duplicated using reference management software (Endnote) and titles and abstracts screened for relevance against inclusion and exclusion criteria. The first 20% were double screened and the remaining 80% were screened by a single reviewer, with decisions checked by other team members where there was ambiguity. Full text screening was undertaken by a single reviewer, with referral to the review team where second opinions were required. For RQs 1 and 2, only public health topics related to outbreaks, disasters, emergencies and communicable diseases (based on WHO categories (28)) were included.

Inclusion criteria

1. Intervention: Publications about champion roles, interventions or programmes in public health – promoting health and wellbeing or prevention of disease or reducing health inequalities or improving community conditions by action on the wider determinants of health.
2. Population: All population groups.
3. Setting: All community settings, including neighbourhoods, education settings, community faith settings, community-based organisations eg sports clubs.
4. Study type: Any study type.
5. Country: RQs 1 and 2 – all countries. RQs 3 and 4 – UK only.

Exclusion criteria

1. Studies published before 2008.
2. Intervention: Community engagement approaches that do not involve identifying and mobilising community champions or similar roles. Champion roles in health or care services, where the primary focus was treatment or care.
3. Settings: Workplace interventions without a community or outreach element.

Data extraction

Data were extracted into tables against a range of fields relating to study and intervention characteristics, roles, outcomes and implementation of community champion programmes. The TiDIER checklist was used to improve intervention description and replication (29).

Analysis and synthesis

A textual narrative synthesis (30) was produced to summarise the data, using the RQs to report on (i) champion-type approaches in health emergencies and communicable disease control and (ii) UK community champion approaches. The principles of qualitative framework analysis (31) were applied to summarise themes within fields. Quality appraisal beyond recording study design was not undertaken, in line with scoping review methods (32).

The RE-AIM framework (33) was used to support analysis on different aspects of champion programmes. It was modified to reflect the multiple levels of engagement that typically occur in champion-type programmes: reach (target population), adoption (recruitment of champions as intervention agents), effectiveness (reported outcomes) and implementation (delivery of champion programmes) (33). RQ4 on implementation related to UK studies only; however, following discussions with the expert advisory group, a summary description of evidence on implementation in relation to RQs 1 and 2 was also included. The final narrative synthesis is structured to report on roles and programme features, outcomes (including evidence on reach to target population), and implementation, which covers recruitment, adoption, training, delivery support and infrastructure.

Evidence from practice

To supplement expected gaps in research literature on current public health practice, a small sample of examples of champions schemes was collected from websites and from the results of a COVID-19 schemes mapping exercise conducted by the PHE Healthy Communities team in December 2020. A thematic analysis was undertaken where information was in the public domain. Data were extracted on process issues using similar categories to the review and then themes summarised.

Application of findings

The final stage, in line with Rapid Evidence Assessment methods (20), considered the application of the review results. Discussions in the Expert Advisory Group, whose

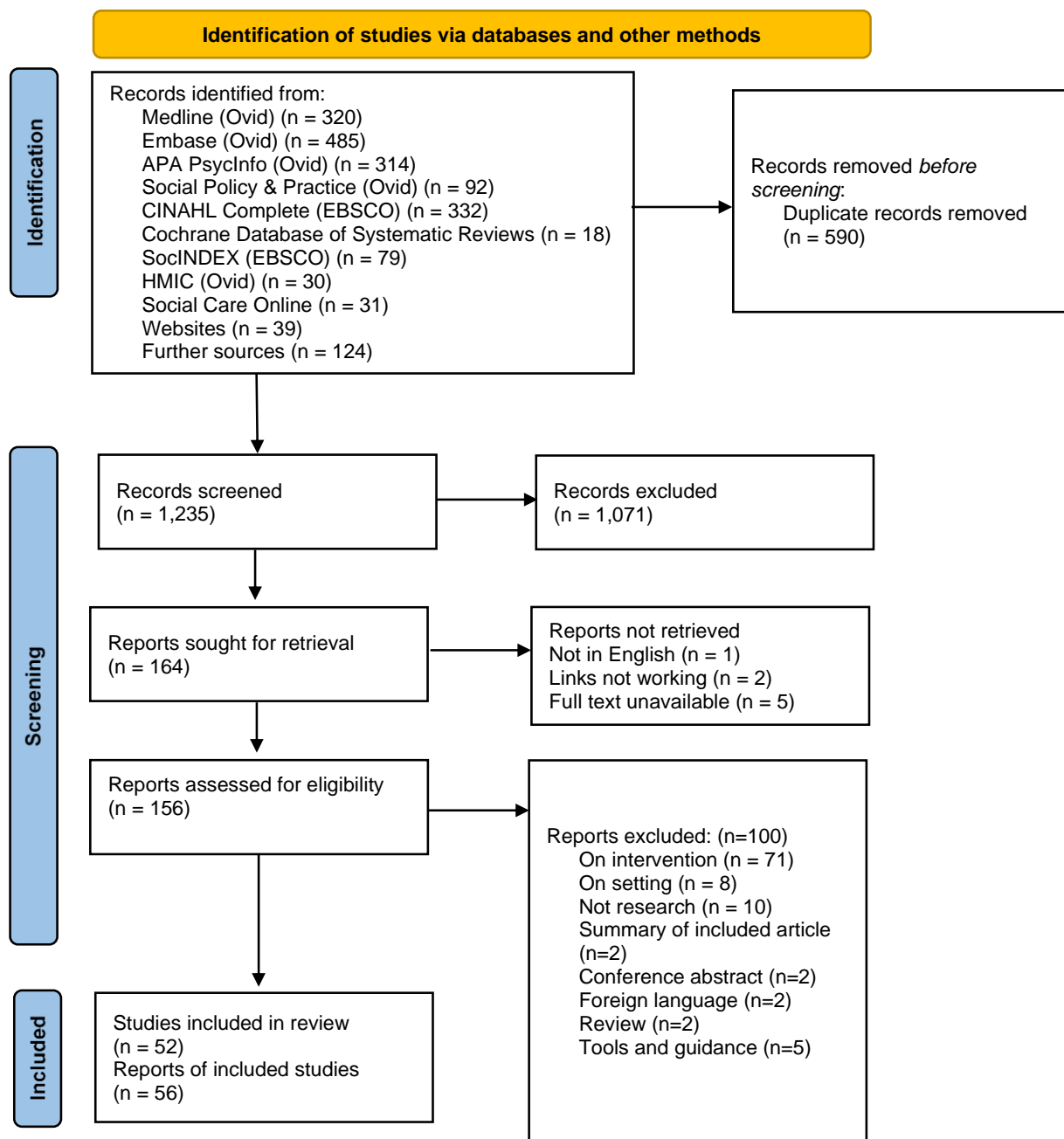
membership included researchers, policy makers and individuals with expertise in public health practice, helped identify the most relevant messages and further implications for the development of champion programmes for the pandemic response and recovery.

Results

Map of evidence

The review aimed to scope the role of community champions and champion-type programmes. Following electronic database and other searches, 1,235 citations were identified. After title and abstract screening, 156 went forward for full text screening. In total, 56 publications (representing 52 studies) were included in the review ([Figure 1](#)). The included studies represented 2 groups of literature relating to the original RQs. Supplementary summary tables of included studies are available from the [Leeds Beckett Repository website](#).

Figure 1: PRISMA flow chart (34)



Further information about this flow chart can be found in the section [Review methods](#).

For RQs 1 and 2, 24 studies (25 publications) were included on champion-type roles in health emergencies and communicable disease control, including the COVID-19 pandemic. There was a mix of study designs: RCTs [n=6], quasi-experimental studies [n=2], other quantitative designs [4], mixed methods evaluations [n=2], qualitative [n=1], secondary analysis [n=4] and case study and reports of programmes [n=5]. Two studies were specific sub-studies (35, 36) within a multi-country trial (37) and a paper on an Ebola programme (5) was linked to a sub-analysis (38). In terms of country, there were 5

US studies. Other studies were from Sierra Leone [n=4], Nigeria [n=3], China [n=2] and Tanzania [n=2]. One study reported on a multi-country trial (37). The rest were from other African countries [n=4], plus India, Peru and Taiwan. All studies described interventions in community settings. Half reported on interventions aimed at HIV and Sexually Transmitted Infections (STI) prevention [n=12] and 6 were on Ebola prevention. Two were on vaccination programmes and 3 on volunteer roles in the COVID-19 pandemic. One paper was on increasing use of malaria nets.

RQs 3 and 4 drew only on UK literature, where 28 studies (31 publications) on community champion or health champion programmes were included. All of these were from England where this broad approach to building the lay workforce has been a feature of public health (1). There was a mix of academic articles [n=10] and grey literature [n=21]. In terms of study design, most studies were mixed method [n=14] or qualitative [n=5] evaluations of champion programmes. Three mixed method studies included an economic analysis. There were 8 studies based on case study designs, and one review. Three studies had secondary publications (2, 39 to 43), which were included in the review as these had relevant information in scoping models. All included studies for RQs 3 and 4 reported on champion roles in health improvement. Most described general health improvement goals; for example, promoting mental health and wellbeing, reducing social isolation or promoting healthy behaviours. Some champion programmes had a single focus, including alcohol reduction (44) preventing female genital mutilation (45), domestic abuse (46), oral health (47), and cancer awareness (48, 49). There were no UK publications that reported on the use of champion-type roles in health emergencies or communicable disease control, including for prevention of COVID-19.

Community champions in communicable disease control

This section reviews champion-type roles in health emergencies and communicable disease control (RQs 1 and 2). All included studies [n=24] reported on community-based interventions outside of the UK that involved the recruitment and training of community volunteers to carry out a health protection role, including communication of health messages through community networks (Appendix B). Two main models were identified (Table 1): 'community mobilizers' (n=12) and Popular Opinion Leaders (POLs) (n=12). These were distinct intervention approaches, distinguished by purpose, roles and delivery modes. Studies on lay health workers or peer educators delivering a specific intervention or service were not in scope. All studies were from outside the UK and issues of transferability are can be found in the Discussion section.

Table 1. Champion-type models for communicable disease control

Model	Focus	Examples
<p>Community mobilizers</p> <ul style="list-style-type: none"> Community mobilizers support prevention and outreach 	<ul style="list-style-type: none"> Multi-level community engagement Mass mobilisation of volunteers Range of roles to support risk reduction Two-way information flow from and to communities 	<p>Community-led Ebola Action, Sierra Leone (5, 38)</p> <p>Health Communication Capacity Collaborative Ebola response, Liberia (50)</p> <p>Contact tracing – COVID-19, Nigeria (51)</p> <p>Social mobilisation network in polio eradication, India (52)</p>
<p>Popular Opinion Leaders (POLs)</p> <ul style="list-style-type: none"> POLs promote risk reduction in social networks 	<ul style="list-style-type: none"> Recruitment and training of volunteers with social influence. POLs use natural conversations and social networks to spread messages Can help reduce stigma Model used primarily for HIV and STI prevention 	<p>National Institute of Mental Health (NIMH) HIV and STD prevention trial (35 to 37)</p> <p>Atlas HIV Prevention Program, US (53)</p> <p>Internet Popular Opinion Leaders, Taiwan (54)</p> <p>1000 Hometown Heroes – COVID-19 prevention, US (55)</p>

Community mobilizers

Community mobilizer interventions are aimed at risk-reduction at a community-level using a social mobilisation approach and training a cadre of volunteers who engage the wider community (50, 52). Of the 12 studies on community mobilizers (5, 38, 50 to 52, 56 to 62), 6 papers related to the Ebola response (5, 38, 50, 57 to 59). Other interventions aimed to increase uptake of polio vaccination (52, 60), use of bed nets for malaria (56) and HIV prevention and gender norms (61, 63). Two publications reported on COVID-19 prevention initiatives (51, 62).

The review found that community mobilizer interventions form a component of comprehensive, multi-level approaches to community-based prevention, including in outbreaks. Social mobilisation was deemed a critical element of the Ebola response where extensive community engagement was undertaken (5, 38, 50, 59). The community mobilizer model involves mass mobilisation of volunteers, who following training then communicate health messages and engage communities in adopting risk reduction behaviours and strategies. Community mobilizers work with individuals, families or households and at a community-level (5, 39, 50, 56, 58, 59).

Roles included:

- communicating health messages, including essential health protection information (5, 38, 52, 56 to 58, 62)
- collecting data and maintaining health records (5, 38, 52, 59, 60)
- contact tracing (51, 59)
- organising community events and workshops (5, 38, 50, 52, 61)
- supporting implementation at community-level (5, 38, 56, 59, 61)

Most interventions were focused on outreach and one-way communication of health information to communities either door-to door (51, 52, 58, 60) or through community events (5, 38, 50, 52, 61). An alternative approach based on 2-way dialogue was reported in 3 studies of community mobilizers during Ebola (5, 38, 59) and in an HIV prevention study (61). In the Community Led Ebola Action (CLEA) programme in Sierra Leone (5, 38), which was delivered through the Social Mobilization Action Consortium (SMAC), community mobilizers were described as leading CLEA and facilitating a flow of information from communities to SMAC. Community mobilizers supported communities to develop and implement local action plans to reduce risk of transmission. They also identified religious leaders and others with influence in a community, who were termed 'community champions' (5, 38).

The role of community mobilizers in outreach to underserved communities was emphasised in 2 studies on increasing vaccine uptake (52, 60). The Polio Eradication Initiative in Northern Nigeria (60) engaged a network of over 9,000 Polio volunteer community mobilizers working with mobile teams. In India, the Social Mobilization Network used community mobilizers to address immunization inequalities by reaching out to 'left out' families (52). A further network of influencers, including women, religious leaders and shopkeepers, supported the campaign (52).

Two papers reported on volunteer mobilisation in relation to the COVID-19 pandemic. Mueller, and others. discussed lessons learnt from COVID-19 contact tracing in Lagos, Nigeria (51). Community mobilizers and volunteers worked in small teams to carry out active case searching through house-to-house enquiries and providing community members with advice to reduce transmission (51). The Libyan 'Volunteer in every street' initiative involved volunteers delivering COVID-19 information in neighbourhoods in Benghazi (62). Over 500 volunteers were recruited through a social media campaign, supported by the Libyan Red Crescent Society and a community health volunteer network. Volunteers received training, plus supporting materials and a volunteer guidebook. Learning points were the value of volunteers talking to people using easy to understand information and communicating in the local dialect (62).

Implementation of community mobilizer programmes

The community mobilizer approach is based on mass mobilisation of volunteers. Most studies reported that community mobilizers were purposively drawn from target communities and had a mix of backgrounds and prior experience (5, 51, 52, 57, 59 to 61). Some studies described significant numbers recruited (40, 52, 57, 64, 65). For example, community mobilizers were central to the Social Mobilization Network, and Siddique, and others, report that this involved 7,300 individuals (98% of whom were women) and 31,000 community influencers in 2 Indian states (52).

Training methods and duration varied between the programmes, from a single day training (58) to an intensive month-long training (61). Several studies discussed how training was delivered through collaborations, with different programme levels to support front line volunteer activity (5, 38, 50, 51, 57, 61). For example, Li and others describe a cascade training model for community education, with public health teams training local trainers who in turn trained community mobilizers (57). In the Nigerian COVID-19 contact tracing initiative, groups of 8 to 10 community mobilizers and volunteers were trained by a health educator and training covered inter-personal communication, community case definition and digital data collection (51).

Most studies described support and coordination of community mobilizers as integral to prevention programmes. As well as the links to local health systems, international government and non-governmental agencies often supported implementation (5, 50, 52, 56, 57, 60, 61). Several studies described interventions with a multi-level infrastructure that supported community mobilizers (52, 56, 58, 59, 61). A common approach was having field supervisors working closely with teams of community mobilizers to support wider community engagement (5, 52, 58, 61). Two studies discussed the integration of community mobilizers within primary health care services (59, 60).

Outcomes and reach

Overall, there was consistent evidence of community mobilizer interventions achieving reach and successful community engagement with the target population (5, 38, 50, 56 to 58, 60, 61). This was a strong finding for community-based approaches in the Ebola crisis (5, 38, 50, 57, 58). A process evaluation of a community mobilisation strategy in Sierra Leone, where over 6,000 community educators were trained, estimated that over 600,000 residents were reached (57). In Nigeria (60) and India (52), community mobilisers were part of community-based vaccination programmes that engaged large numbers of individuals and families, including at risk groups; however, it is not clear what the success criteria were in terms of coverage.

Two papers reported on outcomes for community mobilizers. Li and others reported positive changes in knowledge and understanding following training (57). Qualitative research with community leaders and community mobilizers in Sierra Leone found

positive experiences related to their role, but also difficulties and frustrations around relationships with communities and health services (59).

Six papers reported positive effects in target populations including increased community knowledge (50, 52), and positive changes in attitudes (50, 52) and behaviour (5, 50, 52, 56, 57, 60). It is difficult to attribute these effects to community mobilizers, as these were multi-level community-based programmes; nonetheless the contribution of community mobilization was evidenced from different sources. A cluster RCT of a community mobilization intervention to change gender norms and reduce HIV risk in rural South Africa (63) found no significant difference in behaviours between intervention and control for men, but women reported a significantly lower number of sexual partners.

Based on secondary analyses of routine data, 2 studies showed increases in vaccination uptake and in registration with other health services (52, 60). For example, the Social Mobilization Network reported a greater proportion of children vaccinated in mobile booths in community mobilizer coordinator (CMC) areas compared to non-CMC areas and an overall decline in vaccine resistance between 2007 to 2015 (52).

Changes in community capacity and empowerment were reported in 3 papers (5, 38, 50). Bedson and others, report that 100% of communities engaged through CLEA were able to develop community action plans to reduce risk from Ebola and over 63,000 action points were followed up by mobilizers (5). Community feedback from the action planning process was deemed critical to developing the Ebola response (5). The HC3 collaborative in Liberia also reported positive changes on community action and capacity (50). The empowerment of women and children was reported as a social impact of the Social Mobilization Network (52).

Popular Opinion Leaders

Popular Opinion Leader (POL) interventions are based on the notion of individuals with social standing, or who are well placed within social networks, acting as a source of knowledge and positive influence within their community or social group (35).

Underpinned by Diffusion of Innovation theory (66), POL interventions have been used primarily as an approach to HIV prevention, often working with higher risk populations, including men who have sex with men (MSM), and other groups who experience stigma (35, 55). Of the 12 studies on POLs, 11 were focused on the primary prevention of HIV and STI (35 to 37, 53, 54, 64, 67 to 71) and one discussed the application of the POL model in the COVID-19 response (55). Four studies stated an additional aim of reducing stigma associated with HIV (35, 36, 53, 55). One study was focused on alcohol-using networks as part of HIV prevention (71) and one had a dual focus on HIV prevention and reduction of intimate partner violence (69, 70).

POL (also referred to as C-POL or Community Popular Opinion Leader) interventions involve recruiting key individuals in social settings who are regarded as influential or who are at the heart of social networks. In some interventions, POLs were nominated by their peers (54, 67, 69, 71). The primary role of POLs was to communicate health messages and support risk reduction and behaviour change in community settings where people were socialising or working. Two studies reported that POLs undertook formal outreach activities (53, 67). For example, in the Atlas HIV Prevention Program, which worked with MSM, POLs attended community events to spread messages (53).

Three POL interventions focused on social media as a means of communication within social networks (54, 55, 68). HOPE (Harnessing Online Peer Education) was designed to combine the POL model with use of social media to support training and later, communication of HIV prevention messages (68). The iPOL (internet Popular Opinion Leaders) study used an iPOL platform on Facebook with iPOLs posting HIV related information, for example, film clips, news, personal accounts, and engaging in online conversations on risky behaviour (54).

Quinn discussed the application of the POL model to COVID-19 drawing on prior learning in relation to HIV prevention (55). 'Hometown Heroes' focused on COVID-19 prevention, reduction of health disparities and stigma (55). The new programme aimed to recruit 1,000 social influencers and community leaders from African American and Latinx communities in Milwaukee, who then commit to communicate 'accurate, culturally relevant, tailored information about COVID-19' through their social networks using social media. The role also included communicating messages about mental health, coping strategies and available support services.

Implementation of POL programmes

Findings indicated that the recruitment of POLs as natural leaders and key contacts in a community is critical. In some studies, this was a distinct stage of intervention development requiring ethnographic research or other field work to understand existing social networks (35, 37, 69, 70) or to allow nominations by peers (54, 67, 69, 71). Two papers described recruitment through community-based organisations (64, 68).

Most studies reported successful recruitment of volunteers from the target population. Some programmes aimed at getting significant coverage. Both the multi-country NIMH intervention trial (37) and the Health Leader intervention were aiming to recruit 15 to 20% of the target population as POLs (69).

Following recruitment, POLs received training for the role, typically around 4 to 5 short sessions. Training content covered a mix of health information, including HIV and risk reduction strategies, and skills-based training, including role play (35, 36, 53, 54, 64, 67 to 69, 71). One US study described the development of an online training programme

delivered via Facebook. Content covered stigma and the ethical issues of using social media for health communications as well as information on prevention (68). The Atlas HIV prevention programme successfully developed a 'service learning' approach that combined volunteer service with an educational component to enhance the personal development of POLs (53).

Provision of ongoing support for POLs was reported in several studies (53, 64, 67, 71). This could include regular check in calls or texts (71) and monthly reunions to gather feedback, reflect on conversations and endorse successes (52, 64, 67, 71). Two studies discussed sustainability and retention of POLs. The Health Leaders study used several retention strategies: booster training sessions every 6 months, small grants to support health-related activities initiated by the Health Leaders, and having a community advisory board (69). The Atlas programme aimed to build long term volunteer commitment and empowerment (53). As well as monthly meetings, POLs had a one-on-one 6-month evaluation and reflection meeting with a coordinator.

Outcomes and reach

Overall evidence on POL interventions was generally of good quality, with positive effects on individuals becoming a POL, effective dissemination, and reduction of stigma; however, there was more mixed evidence of changes in behaviours in target communities.

In terms of reach, 5 papers reported evidence of POLs engaging with the wider community and the successful dissemination of information (36, 53, 54, 64, 67). A survey of 200 MSM in Sichuan, China found 47% had direct interaction with a POL (67). A study of the iPOL community-level online intervention reported evidence of effective dissemination of HIV-prevention information; 369 iPOLs posted 432 articles and 503 responses on Facebook with over 900,000 viewers (54).

Five papers reported positive outcomes for POLs following training (35, 53, 64, 9, 70). POLs are themselves members of at-risk communities and the evidence showed benefits in terms of increased knowledge about HIV and prevention (35, 53, 64, 69), increased self-efficacy and confidence (35, 53, 64, 69, 70), and attitude change (35). There was limited evidence from process evaluations. An exception was the Atlas HIV prevention programme which reported positive outcomes, from quantitative and qualitative data, regarding the successful retention of POLs and the benefits of volunteering and service learning (53).

In total, 7 studies reported effects in the target population (35 to 37, 54, 64, 67, 71), and these included 3 RCTs (35 to 37). Outcomes included increased knowledge (35, 54, 67, 71) and changes in attitudes (36, 54, 64, 71). One study reported an increase in self-efficacy around sexual risk behaviours in the target communities (67). Two RCTs of POL

interventions, one focused on marginalised groups in neighbourhoods in Peru (36) and one in Chinese markets (35), reported a reduction in stigmatising attitudes. Rice and others (35) discuss evidence of a ripple effect as the largest changes in reduction of stigma and increase in prevention messages were in POLs, then community members in the intervention markets, with little change in control markets.

The evidence was more mixed on the effects of the POL interventions on behaviour. Three before-after studies reported reductions in sexual risk behaviours in MSM (64, 67, 71). The iPOL intervention showed only partial effects on risk reduction behaviours related to HIV, although there was a significant increase in the frequency of HIV testing in the intervention group (54). In the large multi-country NIMH prevention trial, while there was an overall marked reduction in risk behaviour and incidence, there was no difference between intervention and comparison sites (37). A greater proportion of individuals in the intervention communities reported conversations about STIs and prevention at 2 years (37).

UK community champion approaches

This section reviews UK champion approaches (RQs 3 and 4). Based on 28 included studies, community champion or health champion programmes share common features. These include a recognition of community members as assets who are able to reach out to others in their community and engage them in community-based activities and services (1, 2, 15). Core to the champion role is the promotion of health messages through existing social networks, encouraging adoption of healthy behaviours and strengthening social connections. In comparison with more formalised lay health worker roles, such as health trainers, there is a greater focus on informal volunteering, with variable levels of engagement (1, 15, 72). While the community champion approach is broadly about active citizenship, some programmes worked across community and workplace settings, recruiting people employed in local businesses, public services and voluntary and community and social enterprise (VCSE) organisations as well as volunteers (15, 41, 42, 45, 72 to 74).

Reducing health inequalities was a major focus. Twelve studies described programmes working in socioeconomically disadvantaged areas (2, 15, 41 to 43, 47, 48, 65, 73, 75 to 79). Seven studies reported on champion interventions working with ethnic minority communities (39, 40, 48, 49, 80 to 83), 2 with older people (80, 84), one with young people (48), and 2 with families with children (47, 85).

Most programmes explicitly recruited champions from at-risk communities, recognising their ability to connect to community members. This bridging role was critical and champions from marginalised or seldom-heard groups often brought empathy and shared life experiences (1, 2, 39, 41, 49, 76, 82, 83). Nine studies described champions being involved in signposting to local services and support (39 to 42, 46, 49, 72, 79, 81

to 83, 85, 86). Individual and community empowerment was also reported as a programme aim in many studies.

The included publications represented a broad range of community champion programmes. There is no single intervention model in the UK; however, it was possible to distinguish 5 broad approaches based on how programmes worked with champions and communities (Table 2). Overall, the results suggest that these are linked approaches that give emphasis to different aspects of training and support, rather than mutually exclusive models.

Table 2: Community champions – UK intervention approaches

Approach	Focus on	Examples
<p>Empowerment</p> <ul style="list-style-type: none"> Champions build active communities 	<ul style="list-style-type: none"> Champions strengthening community action on health Citizen-led and asset-based Co-design and delivery of activities Individual and community empowerment 	<p>Altogether Better (2, 15, 43, 87)</p> <p>Sheffield Health Champions (76, 77, 86)</p> <p>Life is Precious (48, 49)</p> <p>Youth.com (48)</p> <p>Tri-borough programme (83)</p> <p>Wigan citizen-led public health (72, 73)</p>
<p>Strengthening participation</p> <ul style="list-style-type: none"> Champions widen participation 	<ul style="list-style-type: none"> Supporting engagement in healthy activities and community events Champions as connectors Less co-design – focus on widening participation Links with community organisations 	<p>Fit as a fiddle (80)</p> <p>Thamesmead (75)</p> <p>Lincolnshire (65)</p> <p>Durham Wellbeing for Life (78)</p>
<p>Capacity building</p> <ul style="list-style-type: none"> Champions as change agents 	<ul style="list-style-type: none"> Development of cadre of champions Using circles of influence within own networks Workplaces and community settings Community leadership 	<p>Sunderland (41, 42)</p> <p>Wandsworth community wellbeing champions (39, 40)</p> <p>Active at 60 (community agents) (84)</p> <p>MiFriendly cities (81, 82)</p> <p>Public health champion university course (74)</p>
<p>Integrated</p> <ul style="list-style-type: none"> Champions link services and communities 	<ul style="list-style-type: none"> Supporting service delivery and uptake Champions work alongside professionals 	<p>Alcohol champions (44)</p> <p>Keep Smiling (47)</p> <p>Change that Lasts (domestic abuse) (46)</p> <p>Tackling FGM initiative (45)</p>

Community champions: A rapid scoping review of community champion approaches for the pandemic response and recovery

	<ul style="list-style-type: none"> • Emphasis on outreach and signposting • Multi-sectoral 	
<p>Health education</p> <ul style="list-style-type: none"> • Champions as messengers 	<ul style="list-style-type: none"> • Professionally designed • Community campaign 	Headstart (85)

Empowerment approaches

In total, 13 studies (14 publications) described empowerment approaches where champions were enabled to play a role in building healthier, more engaged communities (2, 15, 43, 48, 49, 73, 76, 77, 79, 83, 86, 87). Individual and community empowerment was facilitated through training and community-based activities. Generally, the level of engagement was not prescribed and hence ranged from simply participating in a community course through to leading community activities. All champion programmes illustrating an empowerment approach incorporated some element of co-production.

Six studies reported on Altogether Better, an empowerment programme focused on healthy eating, mental health and physical activity; 3 studies on the regional programme (2, 15, 43, 87) and 3 on Sheffield health champions (76, 77, 86). A NICE case study of the Sheffield programme emphasised the importance of working with communities on issues that matter to them rather than professionally determined topics (76). Community ownership, empowerment and 2-way dialogue with services were also central to the Hammersmith and Fulham, Kensington and Chelsea and Westminster community champions programme (referred to as the Tri-Borough scheme) (83) and an earlier project (79).

Other champion programmes based on empowerment principles included:

- ‘Life is Precious’ which used a creative arts approach to engage ethnic minority communities in cancer awareness and uptake of screening (48, 49)
- youth.com which recruited young ambassadors to take on a community leadership role (48) – funding was available for them to develop small community projects independently (48)
- mobilisation of community champions in the Wigan Deal, based on a ‘social movement’ of empowered individuals who could influence friends, families and colleagues (73)

Strengthening participation approaches

Four publications described approaches based on strengthening community engagement in healthy activities (65, 75, 78, 80). Champions or volunteers were involved in communicating health messages and supporting people to participate. Links with community-based organisations were key. There was overlap with empowerment approaches in terms of strengthening community-level activities, but the emphasis was towards widening participation rather than co-production.

Examples included:

- Lincolnshire community health champions scheme where volunteers were attached to VCSE organisations in the area. Champion roles depended on the host organisation;

examples included walk leaders and supporters, befrienders and helping with cookery courses (65)

- Durham 'Wellbeing for Life' where the champions volunteering programme sat within an integrated health and wellbeing service, which included health trainers, health improvement groups and a community health development programme (78)

Capacity building approaches – champions as change agents

Six studies (8 publications) reported on programmes where emphasis was on the development of a cadre of community champions to act as change agents in the community (39 to 42, 74, 81, 82, 84). Community leadership and capacity building were themes. Sunderland Health Champions programme, for example, built individual and community capacity by training volunteers and front-line workers to communicate health improvement messages and undertake brief interventions in disadvantaged communities (41, 42). Health champions were encouraged to use their 'circles of influence' to promote health with their friends, family and the wider community (41, 42).

Other examples included:

- MiFriendly Cities aimed to improve the health of migrant and refugee communities and improve access to services (81, 82). Migrants were viewed as community assets, bringing skills, knowledge and connections (81). Training prepared champions to be change agents in their communities (82)
- Wandsworth community wellbeing champions (39, 40) aimed to reduce health inequalities around mental health experienced by ethnic minority communities. Training developed community leadership capacity with the aim that champions would 'spearhead' awareness raising in their community' (39)

While most champion programmes focused on the lay workforce, Robinson and Brownnett (74) reported on a university course aimed at increasing the skills and knowledge of the wider public health workforce, including people working in the VCSE sector and community businesses.

Integrated approaches – champions linking services and communities

Four publications reported on integrated approaches to prevention where community champions were an important element, working alongside other community workers and professionals (44 to 47). The emphasis was on champions in bridging and outreach roles, providing a link to support uptake of local services.

Examples included:

- an Alcohol Health Champion approach in Greater Manchester trained champions to take on a range of roles, including having informal conversations about alcohol with

- community members, training other champions, carrying out alcohol harm assessment and signposting to specialist services (44)
- health champions supported a school-based oral hygiene programme 'Keep Smiling' in a disadvantaged area of London. The multi-sectoral programme engaged schools, dental teams and also health champions, who promoted the programme with parents and supported a pilot study (47)

Another example emphasised the advocacy role of champions. The 'Tackling FGM Initiative' took a rights-based approach to strengthen community voice (45). The multi-level initiative embedded community champion approaches within wider projects (45).

Health education approaches – champions as messengers

One study described a professionally-led health education campaign 'HeadSmart: Be Brain Tumour Aware' (85). Volunteers raised public awareness by distributing symptom checklists in communities, schools and other settings, and shared their experiences through TV, radio and social media (85).

Outcomes and reach

In total, 21 studies reported that community health champion programmes had achieved reach into communities of interest (1, 39, 42, 44 to 49, 74 to 81, 83 to 85, 87). Several studies provided detailed accounts of successful community engagement with disadvantaged groups (39, 45, 48, 49, 79, 84).

A minority of papers were able to quantify reach, but there were no success criteria in terms of population coverage (44, 79, 80, 85). For example, HeadStart reported their website had nearly 12,000 visits a month and mobile symptom cards had been accessed 2,767 times (85). In Sunderland, a survey of champions (n= 58) found that just under half (46%) reported that they had been able to raise health awareness in the wider community over the previous 2 weeks (42).

There was consistent qualitative evidence across different programmes on the positive impacts for those recruited as champions and some mixed method studies also provided quantitative evidence (41, 42, 80, 84). Empowerment and capacity building approaches demonstrated individual outcomes over time, although it was less clear what proportion of champions gained these benefits (2, 48, 49, 76, 83, 84, 87). For some individuals, becoming a champion was the start of a personal journey that could be transformative, for example, gaining employment (2, 76, 87).

Reported outcomes for champions included:

- psychosocial outcomes: increased confidence (1, 2, 40 to 48, 74, 80, 83, 87); increased self esteem (2, 4, 42, 43); empowerment (2, 40, 45, 48); sense of purpose

- and/or achievement (42, 44, 65, 84) enjoyment and/or social benefits (77, 84, 86); reduced social isolation or increased social connectedness (1, 44, 65, 87)
- knowledge and skills: increased knowledge and understanding (1, 39, 40, 42, 43, 47, 48, 65, 74, 76, 77, 82); awareness of health or social issues (1, 39, 46 to 49, 83); skills development (46, 48, 65, 74, 80, 82, 83, 87)
- health improvement: health and wellbeing impacts (1, 2, 80, 83); behaviour change (2, 41 to 44, 87)
- employment and volunteering: employment, volunteering, education opportunities (2, 40, 43, 80); employability or employment (2, 39, 43, 44, 76, 79, 83, 87)

In general, there was much weaker evidence of the effects on individuals with whom champions were working. Data on recipients were mostly reported indirectly by champions or staff, or through secondary analysis of monitoring data. The most comprehensive mapping of impacts was provided by a social return on investment (SROI) evaluation of the Tri-Borough community champion programme (83). In some studies, it was difficult to disentangle impacts as champions were themselves recruited from target communities (75). Attribution of outcomes was difficult, particularly in comprehensive multi-level programmes (45, 46, 80, 84).

Reported outcomes for recipients who champions connected with included:

- psychosocial outcomes: Increased confidence (83, 86); empowerment (83, 86); attitude change or motivation (45, 48, 80); reduction in social isolation or increased sense of belonging (83, 84, 86)
- knowledge and skills: increased knowledge (45, 48, 83); raised awareness of health or social issues (45, 48, 49, 79, 83)
- health improvement: behaviour change (1, 2, 43, 47, 48, 78 to 80, 83); improvements in physical health (78 to 80, 83, 84); improvements in mental health and wellbeing (2, 78 to 80, 84)

There was some qualitative evidence that community health champion programmes have an impact at a community-level. In total, 9 studies reported community outcomes (2, 44, 45, 48, 49, 77, 79, 83, 86), including community ownership or empowerment (45, 48, 83), community capacity (45, 76, 77), community cohesion (2, 83, 84), increased social capital (2, 83, 84). A study of the Tri-borough community champions programme reported evidence of community empowerment with examples of residents advocating for more culturally appropriate services (83).

In total, 12 studies reported increased uptake of services (44, 47, 48, 76, 79, 81, 83) or improved awareness of services (40, 42, 46, 72, 81, 84, 85). These outcomes, which have effects at an individual-level and in health systems, were primarily linked to the signposting role of champions (42, 46). An evaluation of White City health champions reported that over 400 referrals to Smoking Cessation Services were made and, working

with health trainers, over 200 residents had health checks (79). In terms of access to services, the 'Keep Smiling' project led to increased registrations with dentists (47) whereas an interim evaluation of MiFriendly Cities reported that champions had helped migrants register with GPs (81).

Three papers reported the results of economic evaluations (76, 80, 82). An evaluation of Tri-Borough Community Champions programme found a social return on investment of £5 to £6 of social and economic value generated for each £1 invested (83). The Sheffield champions case study reported a social return on investment of £2.07 for each £1 invested (76). Figures on costs per champion were around £2,700 with champions working with an average of 30 community members (76). The Fit as a Fiddle programme also reported economic value through cost savings to service providers and input of volunteers (80).

Implementation of UK community champion programmes

The review sought to identify relevant approaches to recruit, empower and support community champions in their roles in the pandemic response and recovery (RQ4). The included studies on UK community health champion approaches provided a wealth of information as most studies reported on programmes in public health practice. This section reports review findings on recruitment methods, training, support and infrastructure.

Recruitment

In total 19 papers reported on aspects of recruitment. A range of methods were used to recruit individuals as champions.

Common methods reported included:

- word of mouth (39, 40, 43, 65, 87)
- websites, social media and local advertising (43, 65, 80)
- community-based organisations and existing groups (39, 40, 43, 47, 49, 72, 82, 84)
- champions recruiting other community members (43, 75, 80, 84)

Typically, champions programmes used fairly open recruitment processes, recognising the assets, skills and connections people brought. Some studies discussed the qualities needed, tending to emphasise social skills, life experience and empathy (40, 42, 43, 65, 76, 84). For example, participants in the Lincolnshire health champions evaluation identified essential qualities required to be an effective champion including 'sense of community, empathy, enthusiasm and an ability to communicate' (page 3) (65).

Numbers recruited were often reported in relation to a study rather than a programme and were therefore indicative. There was some evidence of mass mobilisation (1, 73, 83). For example, Altogether Better, with 18,000 champions across the Yorkshire and Humber region (1) and Wigan, with 1,300 community health champions (plus 900 cancer, 500 heart and 200 young health champions) (73). However, it was not clear how many people took up champion roles beyond training and how many were based in workplaces rather than community settings. Other examples of successful recruitment included Sheffield, where over 400 people became champions from 2009 to 2013, exceeding the original target of 180 (76), and 'Change that Lasts', which recruited 141 local residents as community ambassadors around prevention of domestic abuse (46).

Numbers were not the only measure of success as some programmes focused on overcoming barriers to participation for specific groups (39, 48, 49, 82). For example, Life is Precious took a phased approach to engaging with ethnic minority communities, starting with consultative community meetings leading to training and then 52 people being awarded community health champion badges (49).

Barriers to recruitment were not generally discussed. An asset mapping project encountered difficulties in recruiting and retaining existing community health champions as some could not see the relevance to their champion role (77). The evaluation of Fit as a Fiddle reported that some potential volunteers were deterred by bureaucracy or the level of responsibilities and training expected (80).

Training and development

The review findings confirmed that participation in training was integral to developing a cadre of champions, some of whom would take up active roles in their communities. Two studies reported on educational curricula for champions that were designed and evaluated in collaboration with universities (74, 82). However, these were exceptions as most training was community-based and delivered through a public health programme or by community-based organisations.

Training approaches, duration, intensity and content varied considerably between programmes and also within programmes. For example, Altogether Better had no common approach to training across the region. Instead, projects developed training according to local needs and whether champions were being prepared for active community development roles (2, 15). Four other studies also reported programmes using bespoke approaches to training depending on project and volunteer needs (49, 65, 80, 84). Two studies described cascade training models where champions were involved in recruiting and training other champions (43, 44). Overall, there was a stronger focus on training in the empowerment and development champion approaches, where community organising and leadership skills were fostered.

Some programmes adopted more standardised approaches, including offering formal or certificated short courses. Nine studies reported that RSPH Level 2 Award in Understanding Health Improvement was used in training champions (1, 42, 65, 72, 73, 75, 79, 83, 87). The RSPH review stated that by 2013 over 29,000 people had completed this course (1). Three studies reported other accredited courses being used (44, 82, 83). The offer of a range of short health promotion courses was a feature of 2 local authority schemes, in Sunderland and Wigan, which both took system-wide approaches to building champions networks (41, 42, 72, 73).

In terms of content, most champion programmes used a mix of topic information, increasing participants' knowledge and awareness, and skills development to prepare them for their roles. Health and wellbeing topics covered typically included healthy eating, physical activity, mental health and information about local services. Some training dealt with health inequalities and the wider determinants of health (41, 42, 73, 82). Specialist topics were also covered where the programme had a specific focus (44, 46, 47, 83).

In terms of skills development, areas covered included:

- communication skills (39, 48, 82)
- first aid and mental first aid (65, 83)
- gathering community insights (77, 82)
- leadership skills (40, 74)
- risk assessment and safeguarding (65, 83)
- using brief interventions (41, 42)

Five studies included some evaluation of training, reporting outcomes around knowledge, skills acquisition and preparedness (39 to 42, 72, 74, 82). An evaluation of a collaborative public health curriculum developed to train migrant health champions concluded that a structured curriculum with opportunities to practice skills was beneficial in preparing champions for their role (82). Four studies discussed the use of participatory methods, action learning or peer learning methods in training (39, 48, 74, 82) which were used successfully to build confidence and capacity (39, 82). In Wandsworth, the participatory action learning approach initially evaluated well, but follow-up found that some champions felt insufficiently prepared for the role (39, 40).

Six studies reported on training linked to career development or progression to other volunteer roles (2, 44, 65, 76, 79, 87). Some champion programmes offered additional training, for example walk leader training or peer mentoring (65, 87). There was some evidence that access to training, with the potential to gain a qualification, could be an incentive for some volunteers, but the intensity of training could also deter others (65, 80).

Support and coordination

Most studies described provision of ongoing support to champions in their roles. Many programmes had a layered approach where community champions were directly supported through volunteer or project coordinators, who in turn were supported by local organisations (48, 49, 79, 80). In 3 programmes, health improvement and public health teams were directly involved with a role in developing a network of champions (44, 72, 81, 82).

Support was not solely about the individual champion but was also a means to foster community action. Eight studies described local VCSE organisations or community hubs providing a base for champions (48, 65, 76, 77, 79, 81 to 83). Coordinators working from those organisations would support champions and work with them to develop local activities. Having a skilled champion coordinator with good local knowledge who could facilitate participation was identified as an enabler (79, 83).

Support varied even within programmes (15, 83, 84, 87). Turner and McNeish (87) described types of support including support to develop an idea into activity, finding a volunteering opportunity, help to access funding or childcare, administrative support and also 'moral support'. The Active at 60 evaluation found that support for community agents came from different sources including the community group, local funders and other community agents. Only a minority (11%) reported receiving little or no support from the programme (84). Three studies reported use of written guidance to support the champion role (47, 84, 85).

There was consistent qualitative evidence that ongoing support for champions was valued and needed (2, 42, 48, 49, 65, 72, 80). Being unable to provide enough support was raised as a concern of managers in the host organisations in the Lincolnshire evaluation (65). Tailored support was found to be critical to implementation of an empowerment approach (2, 48, 65, 87). For example, a case study of Youth.com identified availability of support as a key facilitating factor that both supported the young ambassadors to achieve their goals and supported wider engagement with young people in the design and delivery of community activities (48).

Four studies reported champions gaining support through peer networks (40, 74, 84, 87). Case study evidence showed that champions benefited from peer support from other community health champions as well as gaining fun and friendship (87). Lack of opportunities for champions to share experiences was identified as a gap in support in the Sunderland programme (42).

Infrastructure

The review identified diverse approaches to programme funding, delivery mechanisms and infrastructure. Almost all champion programmes had partnership arrangements, working across different sectors and often with multiple delivery organisations. Lead organisations included NHS, local authorities, national charities, regional consortium, and local VCSE organisations. There were 4 national champion programmes (45, 80, 84, 85) and 3 regional programmes (15, 48, 81), all with multiple levels supporting delivery.

There was limited evidence around the best models for organisational support although a number of evaluations pointed to the value of having a supportive infrastructure that coordinated the recruitment, training and support of champions (15, 49, 65, 78, 79, 84). Developing good local partnerships, often between statutory services and VCSE organisations, was identified as a major facilitating factor (49, 72, 78, 79, 84). The need for long term investment was also highlighted (48, 65). The relative strength and maturity of community infrastructure was also an issue (48, 83). The evaluation of Active at 60 found that having local funders supporting community-based groups proved to be a useful model that provided a mechanism for national organisations to effectively support local action (84). Learning from the Sheffield health champions programme highlighted the value of a central coordinating organisation that worked with community-based organisations hosting champions as this allowed a flexible response to need (76).

There was consistent qualitative evidence that meaningful community engagement was a factor in sustainability (2, 39, 48, 49, 73, 79, 83). Adequate time to build trust with communities, particularly with marginalised groups, was needed if community empowerment was to be realised (2, 39, 49). The evaluation of Wandsworth community wellbeing champions highlighted the significance of underpinning community engagement (39). Some of the larger programmes took a strategic approach to empowerment (15, 48, 73). For example, the citizen-led public health approach in Wigan involved funding for prevention, more collaborative commissioning, as well as link workers and community champions (73).

UK COVID-19 community champion examples

To supplement the review evidence, a small sample of UK practice examples was collated to consider the application of community health champions to the COVID-19 response. All information was on publicly available websites accessed in February 2021. Five cases were identified from the Local Government Association (LGA) website (Coventry; Cambridgeshire and Peterborough; Cheshire West and Chester; Newham; Tameside), one (Luton) from the SPI-B report (12), and 4 from a mapping undertaken by PHE's Healthy Communities team (Birmingham; Dudley; Southampton; Wirral). All were

council-led initiatives. A brief qualitative analysis charted the main features of the schemes.

The overall picture was one in which champions delivered public health messages on COVID-19 to local communities, mostly via newly-created council-led schemes which had been launched in response to the pandemic. One existing champion scheme had been repurposed for the pandemic and involved a 'network of trusted community leaders' developed over many years.

The main champion role, in the first year of the pandemic, was to relay public health information through their own networks. Some councils suggested potential communication routes such as social media and word of mouth. Sharing of information could be a 2-way process. Five examples indicated that champions fed back information and local intelligence to councils. One council encouraged champions to post about their community champion work on social media using specific hashtags, while another network met regularly to review how messages were received and discuss possible responses.

Recruitment of champions was typically via a council website, where people were encouraged to register. Four councils used similar text to describe the attributes: 'champions can be anyone in the community. You might be the person that everyone knows and trusts. You might be someone who wants to help in whatever way you can – even if this is your first time'. One example presented a more layered approach to recruitment, including a call out via faith, voluntary and community networks, targeting young people through a charity, and encouraging champions to recruit others from their networks.

Information on training was limited, but there did appear to be development opportunities for champions. For example, one website referenced a series of webinars to provide initial advice and training. Ongoing support and resources were available to champions once they had signed up. Typically, champions were informed about the latest COVID-19 information and guidance using a range of communication methods, including online sessions and webinars, emails and newsletters. Council websites had links to resources such as newsletters. One council held a fortnightly information session to update champions and discuss topics raised by them. Another reported bringing champions together in a virtual meeting to give recognition for their contribution.

Overall, this mapping exercise provided a snapshot of champion schemes initiated as part of the pandemic response in England. Information was limited; however, findings indicate how champion approaches can be used to support community engagement through social networks.

Summary of evidence

The review looked at 2 sources of evidence:

- international literature on champion type roles in health emergencies and communicable disease control (RQs 1 and 2)
- UK literature on community champion approaches (RQs 3 and 4)

The review found that community volunteers can play an important role in health emergencies and prevention of communicable disease. Based on evidence from international studies, 2 intervention models share similarities with community champions – Popular Opinion Leaders and community mobilizers. Both models have been adapted in the COVID-19 pandemic. No UK research was found on this topic.

Community mobilizers – key features

Community mobilizers is a social mobilisation approach, recruiting community volunteers who engage communities in risk reduction strategies.

Community mobilizer interventions are usually part of comprehensive, multi-level approaches to prevention. Information can flow both ways – from and to communities.

Mass mobilisation to train and deploy teams of community mobilizers has been used successfully in the Ebola response and to support polio vaccination. Some interventions use a combination of formal roles (mobilizers) and informal roles (champions or influencers); volunteers work together to support risk reduction.

Research indicates that community mobilizers can support successful community outreach and engagement with some evidence of changes in community knowledge, attitudes and behaviours.

Popular Opinion Leaders – key features

Popular Opinion Leader (POL) interventions recruit and train people with influence in a community. POLs communicate risk reduction messages through natural conversations and through existing social networks.

There is a long history of POL interventions for HIV prevention. The model has been adapted to use social media and internet platforms for communication.

There is potential to apply the POL model to spread messages about COVID-19. POL interventions can help reduce stigma by involving people from marginalised populations

Overall research shows positive effects for individuals becoming a POL, and effective dissemination into target communities. Evidence is more mixed for changes in health behaviours.

In the UK, champions (or health champions) are community members who volunteer to promote health in their community. The review found that this approach has been widely used to engage communities and improve health in community. Useful learning on the implementation of community champion programmes could be applied to COVID-19 champion schemes.

UK Community champions – key features

The focus of community (or health) champion programmes is usually on recruiting and nurturing a network of volunteers who communicate informally with others and take part in local activities, rather than delivering structured interventions.

Reducing health inequalities is an important goal, as programmes often work with disadvantaged communities. Evidence suggests champions can successfully connect with other community members and support uptake of services and healthy activities.

There are different approaches to building champion programmes. Some focus on the training and development of champions as change agents, some on building social action or on strengthening participation in community activities and some integrate champions into community-based services.

There is consistent qualitative evidence on the range of benefits for community champions and some impacts for other individuals and communities.

Often training was needs led, but commonly included both information about health and wellbeing and skills development to prepare champions for their role. Ongoing support for champions was valued.

Evidence suggests that a supportive infrastructure and in-depth community engagement underpinned successful champion programmes, especially for empowerment and for capacity building approaches. Enablers included long term investment, time to build trust, having coordination roles to provide support to champions, a mature community infrastructure, and developing local partnerships.

Some local authorities have developed COVID-19 community champion schemes. Although these are lighter touch than many former health champion programmes, they build on the knowledge and connections that volunteers bring.

Discussion

Application to COVID-19

The aim of this review was to scope different models and approaches for developing community champion programmes as part of the pandemic response and recovery. Community champion approaches build community-centred volunteering in disadvantaged communities, tapping into existing social networks and recruiting individuals (champions) who promote health as part of their daily lives (1, 2). The findings show that these approaches, as public health interventions, address barriers to engagement and improve connections between services and communities, and improve health and wellbeing. Overall, community champion approaches contribute to community engagement strategies aiming to reduce health inequalities, whether the context is one of an emergency or in longer term prevention. This confirms findings from other evidence reviews (6, 26, 88) and is supported by UK guidance (13, 14).

At the time of the searches (December 2020), there was very limited evidence on champion or champion type interventions in the context of COVID-19. The review therefore looked at 2 sources of existing evidence: (i) international evidence on community volunteering interventions that were used in other emergencies and for communicable disease control, and (ii) UK evidence on community health champion approaches and implementation. Findings from both parts of the review provide useful information on options for UK public health and for national and local decision makers, particularly in developing champion programmes on from the immediate pandemic response.

Potential models

The mobilisation of community champions is one potential approach within wider efforts to strengthen community resilience and to engage and support communities, particularly those disproportionately affected by the pandemic (8, 11, 89). Evidence indicates that these champion approaches work in different settings and can be applied flexibly, depending on local needs and community assets.

From the international evidence, 2 potential models were identified – community mobilizers and Popular Opinion Leaders (POLs). The review found that recruiting volunteers from target communities improves reach into communities and supports community action to reduce risk, including with marginalised groups. It is difficult to assess transferability of specific interventions to the UK COVID-19 context without further research. The community mobilizer studies were mainly implemented in the global South where health systems are very different. The UK pandemic response to date has not used large scale social mobilisation approaches, as was seen during the

Ebola outbreak (5, 50), although there has been significant volunteer mobilisation through schemes such as the NHS Volunteer Responder scheme (90).

The POL model has potentially more transferability given the focus on dissemination of messages in marginalised communities. One study discussed the application of the POL model to COVID-19 prevention and mental health promotion (55). Some POL interventions had successfully used social media and online communication; however, digital exclusion needs to be considered in a UK context. POL interventions share some features with UK champion approaches, particularly the capacity building approach with the focus on building community leadership and champions and POLs using their circles of influence to disseminate messages (40, 41, 53, 54). In summary, international models have relevance to the UK pandemic response and to reducing health inequalities, but transferability would need to be assessed further.

A strong finding from international evidence was the importance of effective community engagement supported by volunteers drawn from target communities. This finding was also supported by UK evidence. A key finding was the role of community mobilizers in providing social mediation between health systems and communities during Ebola (5, 38, 59), allowing 2-way flow of information. This has high relevance to the UK COVID-19 response, where marginalisation and lack of trust has been linked to inequalities (8). A further cross-cutting finding of relevance to COVID-19 prevention (91) is the potential for champion-type programmes to reduce stigma (35, 36, 44, 45, 50).

The review found 5 approaches in UK public health practice which give emphasis to different aspects of the champion role and programme design. These approaches cannot be viewed as mutually exclusive intervention models, as there were many shared features including engagement through natural conversations and strengthening social networks. Although the UK evidence relates to health improvement and not emergency responses, the findings provide options for local decision makers in utilising champion programmes. Empowerment and capacity building approaches have high relevance in strengthening community resilience and recovery, but evidence suggests that these approaches need time and a supportive infrastructure to nurture community action.

Both international and UK evidence point to the potential to link COVID-19 champions to existing services, whether those are focused on contact tracing, vaccination, prevention or mental health. Signposting and supporting uptake of services or healthy activities is an important champion role and can have benefits for health systems. Two UK studies reported positive return on investments associated with champion programmes (76, 83). Moving from stand-alone champion programmes, as part of the immediate response, to more integrated models could improve access to services for communities most impacted by COVID-19; however, the core principles should remain based on community-led action.

The review findings highlight the value of volunteers with credibility in the community and UK evidence also emphasised champions as community assets. This supports the rationale for local community champions schemes in the pandemic response (10, 11). In developing UK COVID-19 champion schemes, there needs to be recognition that champion roles may vary from talking to family members, through to taking up very active volunteer roles in a community.

There was consistent evidence from the UK studies that becoming a champion can have a range of benefits in relation to knowledge, skills, social connections and personal development. This adds to the evidence base on the benefits of volunteering (92, 93). Champion programmes typically recruit from disadvantaged communities and groups and therefore these approaches have the potential to contribute to reducing health inequalities at an individual and community level.

Lessons for implementation

This review has drawn together previous research about the implementation of champions programmes in UK public health practice and also mapped available international evidence. Overall, findings show that it is possible to mobilise large numbers of champions, although this may not be as important as working in partnership with marginalised groups. Inclusive approaches to recruitment and training based on recognising people as community assets can support wide engagement. Although open recruitment is important, evidence from POL interventions suggests that there may be added value in identifying people who are in leadership roles or with influence in their community. This is also supported by UK evidence indicating that training and supporting a cadre of champions as change agents and community leaders is a valid approach (40, 74, 82).

In terms of training, the review found a range of approaches used in public health practice. RSPH accredited training is one option that has been widely used (1, 94) and the RSPH are currently launching a COVID-19 champions Level 2 training. Notwithstanding the diversity of approaches to training, most champion programmes combined topic information with skills development, often supported through participatory, interactive training methods. Findings on training have relevance where local areas are planning to develop their networks of champions.

Ongoing support to champions, including enabling peer support, local coordination, effective community engagement, investment and wider partnerships, were all identified as enabling factors which have relevance for the legacy of COVID-19 champions schemes. These themes relating to a supportive infrastructure also emerged in some of the international evidence (5, 53). The importance of long term community engagement, supported through training, support systems, funding and partnerships is also confirmed by other evidence reviews (23, 24, 48). Overall, the findings have high relevance to

developing champion programmes as the pandemic response evolves. The review has identified significant aspects of programme development that can be adapted for local contexts. Building and maintaining the infrastructure to engage and support community champions will strengthen emergency preparedness as well as strategic action to reduce health inequalities.

Limitations

This was a rapid scoping review conducted using systematic review methods, but some processes were limited to achieve results in the timescales (19, 20). It was not possible to review broader literature on lay health workers and peer roles, which may have relevance to the research questions. Studies on other volunteer roles that align to current champion role but use different descriptors may have been missed. To ensure high study relevance, the scope and definitions were discussed with different policy stakeholders and PHE colleagues.

At study selection, 20% of the abstracts were double screened to ensure reliability; but selection thereafter was mostly undertaken by a single researcher. Whilst this is a limitation, all decisions on borderline cases were agreed in the team and reasons for exclusion recorded. The analysis was developed by the team and refined through discussions with stakeholders. Further synthesis of cross cutting themes was not undertaken, which is a limitation. Overall, there is confidence that this review covers the best available public health evidence on community health champions, but a more comprehensive review could have identified further relevant evidence.

The involvement of an experienced team with good knowledge of the literature is an accepted strategy for rapid reviews (20). There is a risk of bias as some team members had been involved in UK studies included in the review and had topic expertise. Various techniques were used to ensure objectivity in the review, including a detailed protocol adhering to rapid review guidelines (19). Two researchers who had not been involved in those previous studies undertook initial study selection, and all data extraction was checked by these researchers.

This was a heterogenous body of evidence with diverse study designs and interventions. The international evidence presented the strongest evidence in terms of study design, particularly from the POL interventions, where there were several RCTs. The potential transferability of findings from other countries to the UK context is a limitation. A formal quality appraisal was not undertaken in line with scoping review methods (32). This meant that the strength of findings could not be assessed against risk of bias, which limits the conclusions that can be drawn. The evidence on community mobilizer interventions was generally weaker in study design, nonetheless it provided useful retrospective analysis concerning social mobilisation in outbreaks. In making the review manageable within the timescales, the international literature was limited to champion-

type interventions in health emergencies and prevention of communicable diseases. Inclusion of international studies on champions in health improvement could yield further relevant evidence.

Overall, the UK evidence was weaker, predominately qualitative or mixed methods studies undertaken to evaluate a champion programme in public health practice. Despite these limitations, it was possible to identify different approaches and consistent evidence on implementation. There was no research on champions in the COVID-19 response.

Supplementary evidence from brief COVID-19 champion case studies was useful, but this was a limited mapping. The searches did not identify any research on champions in health emergencies in the UK, such as flooding. This is surprising and there may be relevant research on informal volunteers in health protection that has been missed (16). As a scoping review, effectiveness of models was not assessed (32). In both UK health champion and community mobilizer studies, attribution of outcomes was difficult as these were not 'stand alone' interventions. Often the volunteer element was linked to other community-based activities and broader community engagement strategies. Many UK studies were not designed to evaluate programme impacts; for example, several focused solely on evaluations of training courses and did not include any follow up. There was scant UK evidence from individuals with whom champions engaged, although some community-level outcomes such as increased community cohesion were reported. This is a challenge for capturing the impacts of informal volunteering.

Priorities for further research

Primary research using robust research designs to evaluate the application of community health champion interventions to the COVID-19 response and recovery. Study designs should recognise the diversity of potential approaches and incorporate comparative elements to assess what works, for whom, and in which contexts. There is potential to compare areas with new, existing and no champion programmes against key indicators such as vaccine uptake

The RE-AIM framework (33) can be used to understand programme components and how they work as a whole to reduce health inequalities: adoption (recruitment of champions); reach into target communities; impacts at individual and at community-level; implementation (delivery of champion programmes); and maintenance. Evaluating impact and acceptability from the perspectives of end users, including seldom heard communities, will be important.

Research to identify the best indicators and community-centred research methods that can be used at local authority level and in local organisations to monitor and evaluate champion programmes.

More research on approaches that facilitate informal volunteering in health emergencies. This might include further mapping of UK practice, reviews or secondary analysis.

Conclusions

This rapid scoping review set out to scope the application and implementation of community champion programmes, drawing on the most relevant international and UK literature. Findings confirmed that there is a diverse body of evidence that supports the use of champions and similar roles to reach and engage communities, including disadvantaged communities who are at higher risk.

Two models were identified from international literature on champion-type roles in relation to health emergencies and other health protection roles. POL interventions have been used mainly for HIV prevention, and focus on spreading messages through trusted sources, either through social settings or online. Community mobilizer studies showed evidence of mass mobilisation of volunteers and impactful community engagement.

Review findings on UK community health champion programmes highlight diverse approaches to community engagement and capacity building. There was evidence of reach and improved connections and also consistent evidence on the benefits for those individuals who become champions. There was no UK research on champion roles in health protection, but examples from current public health practice show that local authorities are developing community champion schemes to support the pandemic response.

There is no 'off the shelf' model for developing champion programmes. Instead, the review has highlighted a range of different options. Key findings on UK training approaches and the importance of a supportive infrastructure have direct relevance to those considering the future development and sustainability of local champion programmes. Transferability will need to be considered in the context of local and national challenges around COVID-19.

Overall, the review findings have high relevance to reducing health inequalities, not only in relation to the pandemic response, but also in recovery. A key message is that community champions can be key connectors in communities and between communities and services. These roles do not operate in isolation and need to be embedded in effective community engagement strategies.

Appendix A: Search strategy – Ovid Medline

- 1 community champion*.ti,ab,kw.
- 2 (community adj2 champion*).ti,ab,kw.
- 3 health champion*.ti,ab,kw.
- 4 community health champion*".ti,ab,kw.
- 5 community ambassador*.ti,ab,kw.
- 6 youth champion*.ti,ab,kw.
- 7 (young adj2 champion*).ti,ab,kw.
- 8 young ambassador*.ti,ab,kw.
- 9 community navigator*.ti,ab,kw.
- 10 peer navigator*".ti,ab,kw.
- 11 community connector*".ti,ab,kw.
- 12 community activator*".ti,ab,kw.
- 13 community agent*".ti,ab,kw.
- 14 COVID* messenger".ti,ab,kw.
- 15 COVID* champion*".ti,ab,kw.
- 16 community mobili?er".ti,ab,kw.
- 17 community influencer*".ti,ab,kw.
- 18 lay influencer*".ti,ab,kw.
- 19 (neighbo?rhood adj2 champion*).ti,ab,kw.
- 20 neighbo?rhood manager*".ti,ab,kw.
- 21 neighbo?rhood warden*".ti,ab,kw.
- 22 neighbo?rhood health work*".ti,ab,kw.
- 23 (health* adj2 "neighbourhood work").ti,ab,kw.
- 24 popular opinion leader*.ti,ab,kw.
- 25 or/1 to 24
- 26 limit 25 to yr="2008 - 2021"

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