

The role of Community Champion networks to increase engagement in the context of COVID-19: Evidence and best practice

Background

- This paper seeks to inform work within the NHS Test and Trace programme around the use of Community Champions Networks to support community engagement in mass testing. The paper aims to provide key evidence and learnings which can be applied to building an effective Community Champions scheme for the programme.
- Community Champions are volunteers who, with training and support, help improve the health and wellbeing of their families, communities or workplaces. They motivate and empower people to get involved in health-promoting activities, create groups to meet local needs, and direct people to relevant support and services. Community Champions reflect their local communities and vary by socio-demographic factors including age, ethnicity, gender, health status and education, etc.
- Community Champions contribute in different ways that range from relatively passive involvement, such as sharing information, to more active involvement which includes consultation to provide insight into community needs, and collaboration which includes working in partnership and having shared decision-making power in the planning, design, implementation and evaluation of services.

Key findings

Community Champions programmes are likely to be effective:

- **In contexts where trust in government is low:** For communities where trust is low, community champions can be a key pillar to support prevention and control measures. Substantive community engagement is required to build trust with local communities, dispel myths and disinformation and ensure that interventions are appropriate to local contexts (socioeconomic realities, intra-community divisions, etc.). (high confidence)
- **To promote risk communication and support health facilities:** Evidence from the UK, and internationally during the Ebola pandemic where volunteers helped build community trust and support for Ebola prevention and treatment, suggests community champions can enable health workers to better understand and address people's fears and needs. (high confidence)
- **To identify and facilitate context-specific solutions:** Community Champions can create local and context specific solutions to prevention and control responses, represent local views and needs, offer local authorities and community partnerships short-term support as consultants, and as collaborators help them develop activities to improve the health of local people. (high confidence)
- **To reach vulnerable groups:** Community Champions are more likely to reach individuals that are isolated or marginalised to communicate important health messages and offer support to groups and individuals in their localities. (medium confidence)
- **When Community Champions are trusted and given autonomy** to secure participation from community members and identify activities that will meet the needs of the community, and when there is sincere buy-in from national and local government. (high confidence)

How do the approaches of Community Champions vary by community and setting?

- **There is no 'one-size-fits-all' model for Community Champions.** Different communities and contexts require different approaches and the social and cultural capital of the Community Champion will inform strategies required to promote engagement with health services.
- Community Champions provide support in different ways and **will vary based on the needs of the community and resources available.** For example, development of culturally tailored resources.
- **Settings will vary depending on the needs of the community.** Settings that have been used by community champions include local community centres, cafés in GP surgeries, schools, village halls, local libraries, melas (Asian fairs), places of worship and individuals' homes.

Key challenges for Community Champion schemes include:

- Unintended negative consequences for some Community Champions include **exhaustion and stress**, as on-going involvement can reduce energy levels as well as time and financial resources.
- **Avoid excluding disadvantaged and marginalised groups** which may occur if only traditional community leaders are used to engage communities.
- **Lack of resources** will limit opportunities for community engagement. Proper resourcing is required to achieve the aims of a Community Champions scheme.

Evidence on peer support for mass testing and NHS TT:

- Evidence suggests that the peer education model has been used effectively in HIV programmes and other infectious diseases (which have included testing). This model focuses on peer education (someone that shares similar characteristics or behaviours) rather than Community Champions which relies on community leaders and may exclude marginalised individuals within communities.
- More generally, there is scope for building in Community Champions for the wider NHS TT process (more details on pages 9-10 in the paper).

Recommendations specifically in relation to mass testing and NHS Test and Trace:

1. **Ensure buy-in from key strategic figures within national and local government:** It must be prioritised and funded as part of the CONTAIN framework, which currently predominantly focuses on implementing social restrictions and punitive measures.
2. **Provide appropriate resourcing:** Funding should be provided to cover wages for community champions which will reflect time and investment of their local expertise. This investment is likely to result in positive economic, psychological and social returns on investment. Development of a training programme for champions to use behaviour change techniques is required to maximise impact of this scheme.
3. **Use local networks to ensure Community Champions reflect their local communities** which go beyond traditional 'community leaders' and include more marginalised community members or those that belong to multiple communities at the same time.
4. **Ensure that relationships between local officials and volunteers is collaborative and not hierarchical.** Emphasis should be on co-production at every stage in which local and public health officials and

volunteers are learning from each other; co-production builds relationships and trust. Community Champions should be actively involved in decision-making to avoid exacerbating inequalities in vulnerable groups.

5. **Provide stakeholders within the NHS Test and Trace team with training to support community champions to maximise their social and cultural capital.** They should also recognise potential for fatigue in champions and factor this into resourcing and planning activities at the start of the programme.
6. **Ensure standardisation of core national messages with a degree of autonomy and trust at a local level to facilitate community engagement with NHS Test and Trace services.** This could include a nationally endorsed package that contains all the relevant information and guidelines (e.g. volunteer narratives or scripts for explaining the test process) to ensure best practice is uniformly delivered. Allow for localisation based on use of language and delivery of messages, settings and local barriers.
7. **Create a virtual noticeboard and group chat online between community champions about their current projects.** To make community champions programmes work there needs to be sustained sharing of knowledge between community champions and regular opportunities to meet. Where IT literacy or access may prevent this, use traditional means of two-way communication and dissemination (e.g. phone conferencing, mailing lists and newsletters).
8. **Ensure that process and impact evaluation is built in to any programmes to measure the effectiveness of the scheme.** An on-going feedback cycle is required between stakeholders and champions to monitor the effectiveness of strategies and to provide on-going support throughout the scheme. Evaluation should not be an afterthought, rather it should be included within the programme from conception.

[Main Paper](#)

I. Introduction

Community engagement includes a range of approaches to maximise the involvement of local communities in initiatives to improve their health and wellbeing. Community champions can contribute in different ways that range from sharing information with other community members (peer education) to providing insight into community needs and working in partnership with organisations to plan, refine and evaluate services (community development). Working with local communities, particularly disadvantaged groups, can lead to services that are more appropriate to the needs of marginalised groups such as minority ethnic groups and vulnerable individuals and can be more effective than services provided solely via the NHS and local government services to improve health and wellbeing and reduce health inequalities [1].

Community Champions are volunteers who, with training and support, help improve the health and wellbeing of their families, communities or workplaces. They motivate and empower people to get involved in health-promoting activities, create groups to meet local needs, and direct people to relevant support and services [1].

Barriers to engaging with the NHS Test and Trace programme include its being untrusted and perceived as distant from local people. Community Champions involving local people with local knowledge could help bridge this gulf and increase trust in the NHS Test and Trace programme or mass testing [3].

This report provides an overview of the components of successful community champions networks and includes a more detailed analysis of the evidence in the Annex.

II. What makes a successful Community Champions network, including who the community champions are, how they contribute most effectively, role of settings, impact of social capital?

Community champions reflect their local communities. As a result, community champions are varied by socio-demographic factors such as age, gender, ethnicity, health status, education, etc. [4], but all are closely connected with their communities either in a formally recognised leadership role or as members of their community who are motivated to support others to engage in health promotion activities.

Communities can share a common geographical space or a common identity [5]. Most people belong to more than one community at the same time. Communities will, to varying extents, include some but exclude others. To ensure community champions reflect their communities, it is important to carry out participatory mapping including disadvantaged and marginalised groups [29]. Particular attention must be paid to potential exclusions within and between communities and how to reach the most marginalised members of a community through a range of strategies of engagement. Community champions within a specific area should not be dominated by one group or set of leaders such as faith leaders. Groups such as young adults and women may not recognise or may feel disempowered by single community/faith leaders. As a result, it is important to have a diversity of community champions to reach a diversity of communities within a single place.

Community champions are likely to have most impact when they work not merely as peer educators in their communities but are empowered to contribute to planning, refining and evaluating local services. This will maximise the effectiveness of community champions who can co-create solutions to barriers experienced by the community. Community champions will be able to contribute more effectively if treated by health authorities as integral health system actors rather than passive recipients of the health system that only share 'top-down' communications [6, 7].

When community champions are treated as collaborative partners, they can create local and context specific solutions to prevention and control responses during an infectious disease outbreak [8]. They play the role of knowledge brokers between organisations and communities and can be experts on their own social situations [9]. In communities where trust is low towards government officials, community champions can increase trust when empowered to develop locally feasible and locally owned action-plans that address the needs of the community. Community-based efforts result in increased social acceptance as behaviour changes are made collectively, and increase understanding and awareness of an unfamiliar situation. Community champions can challenge scaremongering, address conspiracy theories and myths, increase legitimate trust in the system, facilitate access to government services, and ease the burden on health systems by developing expanded services in resource-poor contexts. Activities of community champions include designing and planning interventions with health services, enabling access and increasing reach into communities, developing and sharing behaviour change and risk communication, surveillance and tracing, and supporting with logistics and administrative tasks [6, 7, 10, 11].

Community champions have delivered health promotion sessions in a variety of settings including community centres, homes and places of worship [12]. Community participation in health programmes can increase knowledge and skills, increase confidence to deal with issues around social stigma, and access better practical, emotional and personal support [11]. It is estimated that one community hub can meaningfully reach 200-300 households per year [4]. Drawing on their local knowledge, champions understand why local people struggle with specific health and wellbeing issues and as a result, they can also contribute to new ways of delivering local services [4, 13]. These include promoting community activities,

translating and sharing resources for minority ethnic groups, sharing expertise with others, mentoring, leading organised health walks, setting up social clubs, delivering health awareness presentations on health conditions, signposting etc. [1, 10, 14].

At the core of a community champions programme is the autonomy that champions are given to identify activities and settings that will meet the needs of the community. There is no 'one-size-fits-all' model for community champions or community engagement in general. Different communities and contexts require different approaches, and the social and cultural capital of the community champion will inform strategies required to promote engagement with health services. As a result, activities and settings that community champions adopt are varied as these will address local barriers such as distance, availability of resources, affordability of transport, etc. but the function of each activity and setting remains the same, that is, to create a sense of local community ownership and responsibility for health, recognition of local individual and group-based skills that contribute to these efforts and create a sense of local solidarity around collective efforts to optimise health in adverse conditions [4, 14].

The role of settings can determine whether or not an individual engages with the NHS Test and Trace service. Community champions can facilitate an understanding of accessible settings as evidence shows different barriers exist between and within communities. For example, some minority ethnic communities would prefer to be tested in the community by a health professional but other minority ethnic communities may perceive this as discriminatory and lead to disengagement. Community champions have a key role in identifying appropriate settings in consultation with communities to maximise engagement [3].

Evaluations of community champion programmes indicate positive social returns on investment including cost-effective financial returns and increased physical and psychological benefits for community champions and community members. Community champions and other forms of engagement will be more successful if there is full buy-in from national and local government, alongside financial and other support for them. This means a more supportive emphasis needs to be built into the CONTAIN framework. Without this support, a community champions scheme is likely to be perceived as tokenistic and unsuccessful in achieving its aims [4, 6, 10, 14, 15].

III. How should we take account of the social settings and what works best in different circumstances? E.g. Olympics, UK Floods/disaster management, public health settings etc.)

The evidence on good practice in implementing community champion networks is limited and requires further research [19]. While champions have been widely deployed, evaluation of their impact in the UK indicates health volunteer projects can have a short-term impact but at the cost of longer-term fatigue and over-work among volunteers if they are not supported with resources from central and local government [20, 21]. Other evaluations of participatory health work indicate that, unless projects have key, influential supporters within local health services, such as GPs, or government, they will not have much effect [22].

Learning from the disaster management field, participatory health work and evaluations of community champions programmes has informed the following recommendations to combat potentially negative elements of community champion schemes. We suggest the following key elements need to be in place for them to be successful:

- 1. Resources are required particularly in the most deprived areas because volunteering will be most challenging for already hard-pressed groups trying to make a living and manage child and elder-care.** Flexibility in funding will build trust and prevent inefficiencies in the health system by allowing for the

implementation of projects and resources that are needed. Schemes that are funded have been essential to get projects off the ground and enabled new activities that would not have otherwise been possible [4]. When considering costs, in addition to funding and training, costs should include management time, equipment, insurance, feedback and evaluation.

There are variations in the training provided for community champions ranging from one or two-day workshops, to completing a content-specific or a specified number of modules/units (which also varies), to completing an accredited programme. Community champion educators will need to be trained to use evidence-based behaviour change techniques to inform strategies and interventions to co-design with communities. Developing a training programme to enhance or develop communication skills and intervention techniques will require financial investment and resourcing to maximise the impact of community champions.

2. A community champions programme is more powerful when working with local partners such as health services, schools, housing, etc. in a collaborative way. Partnership working between sectors creates an opportunity for more joined-up messages and awareness [4]. This includes complete buy-in from key strategic figures within the national and local government.

3. Recruitment strategies of community champions vary but primarily use extended networks of local contacts via an intermediary with links to the target community. Word of mouth is a powerful medium to promote calls for volunteers from a range of communities particularly for community champions from minority ethnic backgrounds although agencies are also effective to promote volunteers from minority ethnic and White groups [4].

Prior or parallel to calls for volunteers, **communities must be mapped in collaboration with community members.** This is so that the recruiters and organisers of the networks gain the social knowledge to make sure that the profile of volunteers reflect diversity within the community and include central as well as more marginalised segments of this [23, 24, 29]. GPs could play a key role in this mapping and could be asked for advice on local organisations, sports groups, NGOs and other parts of the community to involve in the mapping. There should not be an assumption that ‘well-known leaders’ of faith or other easily identifiable community groups are the best route for connection to communities. It may be, for example, that sports club coordinators, networks of mothers, local shopkeepers or publicans could be a route towards recruitment of volunteers with broader connections and more credibility. Research has shown that creation of relationships between community groups and with public health organisations is a key outcome of participatory mapping [30]. These new connections could be a vital resource which could cut across existing networks and boundaries and draw in traditionally marginalised groups.

4. Relationships between local officials and volunteers should be collaborative and not hierarchical, moving away from the model of ‘teaching’ people to be health educators and then sending them out into the community. Instead the emphasis should be on co-production at every stage in which local and public health officials and volunteers are learning from each other. Fact-finding interviews could be carried out with individuals or groups when they first join, in which they are presented with the issues facing PHE in the area and asked to propose solutions. Volunteers should be enabled to contribute their own insights throughout their involvement, for example by volunteers being regularly brought together to reflect on problems and solutions. These insights can be treated as a rich resource to inform the nature and direction of interventions, especially if there is systematic analysis across all of their insights in light of the background of the volunteer. Evidence of community champions from refugee and migrant backgrounds developing and informing training content highlights the importance of having consensus on content otherwise it could be detrimental to training efforts [31].

Evidence indicates monitoring processes are varied and can be fairly light touch which reflects the resources available within a scheme, i.e. funding levels are adequate for management and administration but are insufficient to support a more proactive approach to monitoring. Community champions, as they attempt to persuade their networks, can be a rich resource of information about what is working and what is not, and why it is not working. They can educate the organisations they are working for by feeding back to them on this. This can include a brief report or completion of a pro forma describing the progress made against the original plan or providing verbal updates during network meetings [4, 27].

Community champion and other community projects supported by PHE should be formatively evaluated to examine whether and how they align with these principles. A feedback system which enables champions and stakeholders to monitor and review initiatives is required. As there is no 'one size fits all' approach there are likely to be differences in the initiatives and activities that community champions develop and promote. A feedback and monitoring system that allows for these differences is required and careful consideration of what is being measured and monitored, e.g. number of community members participating in each stage of the NHS Test and Trace programme, increased reach, awareness, etc.

6. Enable a community of practice for champions to learn from each other as a resource. It is likely that in order to make community champions programmes work there needs to be sustained sharing of knowledge between community champions and regular opportunities to meet. This makes the volunteers an active community for change as they cross usual social boundaries and work together breaking down intra and inter group stigma and fear. It would be useful to create a virtual noticeboard and group chat online between community champions about their current projects. There are a large number of live projects underway that are improvising new forms of community outreach and are actively building new social contracts of collaboration. It is an important time to discuss what is, and what is not, working. A network or forum for community champions will aid dissemination of good practice for volunteers to learn from each other and also provide peer support.

Table 1: Potential roles for Community Champions to facilitate engagement with the NHS Test and Trace service. The importance of funding, training, peer support, feedback and evaluation is key to achieving these roles.

No	Test and Trace Step	Role of Community Champion
1	Being aware of the service	<ul style="list-style-type: none"> Promote awareness of the NHS Test and Trace service. Clarify changes in guidance to the service particularly when information differs at a national and local level. Identify knowledge gaps and information needs.
2	Finding information and identifying symptoms	<ul style="list-style-type: none"> Promote awareness of the symptoms of COVID-19 and when a test will be required based on symptom presentation. Dispel myths or disinformation circulating in the community.
3	Booking a test	<ul style="list-style-type: none"> Work with the community to identify barriers and co-create solutions to booking a test. Work with authorities to ensure methods of booking a test that are acceptable to the community are available. Provide or signpost to information on how to book a test and the different options available to do this.
4	Taking a test	<ul style="list-style-type: none"> With the community, identify barriers and co-create solutions to testing sites and testing procedures that are acceptable. Work with authorities to provide testing sites and testing procedures that are acceptable to the community. Provide or signpost to information on testing sites information on what will happen, how long it will take, etc.

5	Receiving test results	<ul style="list-style-type: none"> Facilitate process of services sharing results in accessible way based on needs of community. Act as a point of contact for community members that are unsure about how to access results.
6	Providing contact history details	<ul style="list-style-type: none"> Provide information on the rationale for providing contact history details and exactly what this process will involve. Co-create solutions to barriers of sharing contact history.
7	Being contacted by the NHS Test and Trace service	<ul style="list-style-type: none"> Liaise with the community to identify barriers and co-create solutions to answering calls from unknown numbers. Work with health organisations to facilitate contact between call centres and community members that address barriers. Develop or share information on the process of being contacted by someone within the Test and Trace service.
8	Managing isolation	<ul style="list-style-type: none"> Ensure community members are supported through isolation and know what to do. Work with health organisations to provide resources required to facilitate self-isolation.
9	Returning to normal	<ul style="list-style-type: none"> Provide and signpost to information about what is and is not permissible under different conditions.
10	Negotiating a local outbreak	<ul style="list-style-type: none"> Provide information on risks specific to the local community and support available and actions required in the event of a local outbreak. Work with community to develop a plan of agreed actions that are locally feasible and locally owned in the event of an outbreak. Work with health organisations to provide resources required to implement locally developed action plan.

IV. Are there any different models for implementing these schemes? Do some work better in particular circumstances?

There are a number of different models of community-centred approaches that aim to mobilise the assets within communities to increase people's control over their health and reduce health inequalities. In volunteer and peer roles, community members use their life experience and social connections to reach out to others to provide advice, information and support or organise activities in their communities [8].

Community champions is based on a leader model and is focussed on individuals making interventions into social networks. Peer educators is based on a much more egalitarian model that can draw in more members of a community especially marginalised members, although it is not always successful at that. Community champions is one narrow model of how to develop public health interventions, that relies on a top-down model within communities (i.e. the identification of 'leaders') therefore it may have some disadvantages as it may exclude marginalised individuals within communities.

Other models of collaboration such as peer-support and participatory mapping are essential to engage communities in mass testing. A peer-educator model includes individuals who share demographic characteristics (e.g. age or gender) or risk behaviours with a target group and trains them to increase awareness, share knowledge and encourage behaviour change among members of that same group. Peers are more likely than individuals that do not have shared characteristics or behaviours to influence the behaviour of group members as they are assumed to be able to gain a level of trust, which allows for more open discussions on sensitive topics. They have better access to hidden populations who may have limited interaction with community leaders and services [32, 33, 34, 35, 36, 37, 38].

Case study: Community Champions in Hackney, London

The LSE Anthropology ethnographic study [74] of the successful response in Hackney to the COVID-19 pandemic is an example of good practice of implementing a Community Champions network.

Initially tensions in the area were increased during the COVID-19 pandemic as minority ethnic communities had high levels of illness and mortality from COVID-19 due to their key worker roles in addition to other factors. In addition, minority ethnic communities were policed more intensively in the area during national social restrictions. However, because of the active work of mutual aid groups and the local authority these tensions were overcome in ways that other places could learn from. Mutual aid groups sprung up in every ward in Hackney at the start of national restrictions and they currently have a community champions scheme. The success of this scheme was sustained by this spontaneous community activity, but was also crucially due to the supportive framework for it created by the local authority and their responsive mapping of deprivation and need in the area.

The local champions introduced in this area are part of broader work of mapping need, creating responsive webs of connection between the local authority and constant informational feedback and problem solving from the bottom up. Community champions are expected not just to be purveyors of correct information, but to be problem solvers and conduits of knowledge from the streets to service providers. This case study illustrates the power of participatory mapping of need, weekly co-production in discussion groups, creation of supportive referral and aid as means to build trust in public health and other policy measures. It is likely that community champions will be more successful in building trust and providing effective results in testing and social isolation practices if they are part of a supportive and responsive local social infrastructure. This needs to be supported by national and ministry level practices across the country perhaps by an explicit repurposing of the elements of the CONTAIN framework.

V. How might technology play a role in successful schemes?

There has been a move to deliver peer support using digital platforms, particularly using the mobile phone. Telephone calling, text messaging, digital support groups and virtual communities are increasingly being used in interventions to successfully address public health concerns, such as to encourage uptake of services and to address concerns such as depression, substance use, poor social support, care engagement, and ART adherence [39, 40, 41, 42, 43, 44, 45, 46].

There are a number of important implications for the use of technology in peer education models:

- Technology is an enabler, not a solution by itself. It is important to work out what a population need, and if these needs can be met through a technology platform. Technology shouldn't replace face-to-face services, but can complement them.
- Engage the participants in the design process to design spaces that fit the digital habits of the population. Different groups have different needs and capabilities with technology, allowing them to be part of the design process will ensure that the model you build meets these needs.
- Strike a balance between peer support, information provision and facilitation. It's important that people engage with one another, but keeping the conversation going and engaging all participants requires good facilitation.
- Referral systems are crucial. Technology platforms can work to triage the kinds of problems people are facing, but they should be built into a referral network, so people with more serious problems can get the support they need.

- Ensure adequate technology support systems in downloading and troubleshooting, and check in services to understand why participants don't engage.

VI. What have we learned so far from COVID-19 volunteering both at the national level and the more local community level?

During the COVID-19 pandemic, two conflicting models of volunteer organisation during the pandemic emerged: a decentralised model where there is an absence of formal command and information and decision-making is dispersed among members, such as mutual aid groups; and a centralised method of command-and-control similar to the NHS volunteer scheme. A decentralised approach facilitated a prompt response that was not delayed by formal checks and processes. Its success was evident in the high level of participation resulting in a new volunteering workforce of working age adults and taking people away from traditional charities, and its flexibility and provision of support which enabled people to stay at home (during the earlier stage of the pandemic). Challenges to this approach included lack of leadership in some cases, where people were keen to offer services but were not willing to take the initiative or support being limited to those already known. The formal centralised model recruited volunteers at speed but delays caused by processes resulted in some volunteers leaving the scheme before it was implemented [55, 56, 57].

Volunteer demographics during the pandemic reflected a largely new volunteer workforce, with the average age of 48 years and composed of more women than men. More affluent community groups had access to more resources which could reproduce and reinforce existing health inequalities. This needs to be explored further to address potential underlying socioeconomic disadvantages which hinder effective voluntary action [54, 62, 63].

New and existing voluntary organisations and projects adapted their services by transferring to digital infrastructure, often at rapid pace. WhatsApp was one of the most popular organising platforms, some groups adopted services such as Slack; Zoom and Skype were used for calls; Google Docs for meeting minutes, and Google Sheets for compiling databases of volunteers and requests. Many groups also sought to tackle the possibility of digital exclusion through physical methods such as mass leafleting and providing digital training sessions, as well as providing tablets and phones to those on their programmes [53, 57].

The pandemic has demonstrated the adaptability and resourcefulness of volunteers and community organisations, who have effectively adjusted to changing conditions as the UK continues to pass through different phases of the pandemic. However, these volunteers are serving to meet needs which are otherwise unmet by public services, their activities serve as a “map of insufficiency” which authorities must pay close attention to [54].

VII. What have we learned from engagement with local communities and community champions during the COVID-19 period?

Factors identified as being important to successful retention of volunteers include: not asking volunteers to engage in activities they are uncomfortable with; allowing volunteers to say no; providing social rewards; nurturing relationships with volunteers; recognising the contribution of volunteers. On a more strategic level, effective and rich responses are underpinned by “community-led infrastructure”, understood as community leadership, trust, relationships with agencies, and access to money. In particular, many community organisations have been able to play a coordinating role by providing smaller mutual aid groups with the infrastructure, systems, and resources required, as well as acting as a communication bridge between groups and local authorities.

Councils that have made concerted efforts in community engagement are the ones that have best facilitated their local mutual aid groups. The Covid-19 “Community Champion” scheme is one example of community engagement: it aims to recruit volunteers in local councils across the country. These volunteers are given the latest information about Covid-19, and are asked to share this information in their community, while feeding back which communications are effective and which are not. However, no systematic report or review has been published regarding the findings from this scheme which means the effectiveness of this approach is not known at this time [54].

The COVID-19 period has seen only two completed consultations of local communities thus far. While such practice is important, these forms of engagement do not tend to involve handing over power in any meaningful sense, and are often merely concerned with getting feedback before a predetermined project. Instead, such approaches need to be combined with a meaningful project of community mobilisation, which builds strong coalitions, leadership, and engenders local communities with the belief that they can enact real change. It is precisely this mass mobilisation which has proved so invaluable in a time of crisis, and if properly tended to may lead to even greater things.

VIII. Recommendations

1. Community champions work must have complete buy-in from key strategic figures within national and local government. It must be prioritised and funded as part of the CONTAIN framework, which currently has a greater focus on implementing social restrictions and punitive measures. Councils should give community organisations the freedom to operate while providing practical support and advice when needed. For example, supplying mobile phones, proactively connecting volunteers with existing networks and other groups, providing spaces and infrastructure to help groups organise, and helping groups to keep track of people with longer-term service needs.
2. Funding should be provided to cover wages for community champions which will reimburse their time and investment of their local expertise. This investment is likely to lead to positive economic, psychological and social returns on investment. More resources will need to be provided in the most deprived areas because volunteering will be most challenging for already hard-pressed groups trying to make a living and manage care responsibilities. Funding should also include costs for training stakeholders and champions, management time, equipment, insurance, and feedback and evaluation processes.
3. Use local networks to identify potential community champions. Ensure champions reflect their local communities and go beyond traditional ‘community leaders’ to include more marginalised community members or those that belong to multiple communities at the same time. When recruiting volunteers, a mapping exercise with recruiters and community members to identify key problems will provide the social knowledge required to ensure the profile of volunteers reflects the diversity and needs within the community and include central as well as more marginalised segments of this. Interviews should also map motivations of volunteers so that activities can be matched with levels of motivation.
4. Relationships between local officials and volunteers should be collaborative and not hierarchical. The model of ‘teaching’ people to be health educators and then sending them out into the community should be avoided. Instead the emphasis should be on co-production at every stage in which local and public health officials and volunteers are learning from each other. Impact of community champions may

be limited if given a passive role of sharing information. Instead they should be actively involved in decision-making and empowered to work with local communities to develop locally feasible and locally owned action plans. This will provide communities with a sense of control and more acceptance of testing programmes if they have been involved in co-creating solutions to barriers of engaging with this service with a trusted member of the community.

5. As there is no 'one size fits all' model for community champions and to account for individual motivations and the way that individual projects choose to operate, standardisation of core national messages with a degree of autonomy and trust at a local level is required to facilitate community engagement with NHS Test and Trace services. This could include a nationally endorsed package that contains all the relevant information and guidelines (e.g. volunteer narratives or scripts for explaining the test process) to ensure best practice is uniformly delivered but allowing for localisation based on use of language, settings, norms, etc. which may vary for each community.
6. Stakeholders within the NHS Test and Trace team should receive training to support community champions to maximise their social and cultural capital. They should also recognise potential for fatigue in champions and factor this into planning activities at the start of the programme.
7. Enable a community of practice for champions to learn from each other as a resource. Create a virtual noticeboard and group chat online between community champions about their current projects. A peer network of champions can provide a support network and forum for sharing different activities for champions to consider which can be proposed when co-creating action plans with community members.
8. There are a large number of live projects underway that are improvising new forms of community outreach and are actively building new social contracts of collaboration. It is an important time to discuss what is, and what is not, working. Process and impact evaluation is required to measure the effectiveness of this scheme. An on-going feedback cycle is required between stakeholders and champions to monitor the effectiveness of strategies and to provide on-going support throughout the scheme.

[Annex I: Detailed evidence review](#)

Community engagement includes a range of approaches to maximise the involvement of local communities in initiatives to improve their health and wellbeing. Working with local communities, particularly disadvantaged groups, can lead to services that are more appropriate to the needs of marginalised groups and vulnerable individuals and can be more effective than services provided solely via the NHS and local government services to improve health and wellbeing and reduce health inequalities [1].

Community champions are volunteers who, with training and support, help improve the health and wellbeing of their families, communities or workplaces. They motivate and empower people to get involved in health-promoting activities, create groups to meet local needs, and direct people to relevant support and services [1].

The NHS Test and Trace programme has four objectives: to increase the availability and speed of testing; identify possible close contacts of those who test positive, and asking those close contacts to isolate; rapidly identify and contain outbreaks; and enable government to learn about infection rates and respond appropriately [2]. There are several steps within this programme that require engagement from local community members. These include: being aware of the service, finding information and identifying symptoms, booking a test, taking a test, receiving test results, providing contact history details, being contacted by the NHS Test and Trace service, managing isolation, returning to normal, and negotiating a local outbreak.

Some of the barriers to engaging with the NHS Test and Trace programme include its proximity to national organisations including the government. Community champions could act as a bridge between national and local authorities and community partnerships to promote the Test and Trace programme. Local teams and information from trusted sources within local communities may have a more effective role in cascading information and building trust in the Test and Trace service [3].

What are the components of successful community champions networks including who the community champions are, how they contribute most effectively, role of settings, impact of social capital?

Who are the community champions?

Community champions reflect their local communities. As a result, community champions are varied and include men, women, children, pensioners, and individuals from minority ethnic groups, individuals with disability, differing levels of education ranging from highly qualified to having no formal qualifications, and from a range of socioeconomic backgrounds but with slightly more emphasis on deprived areas [4]. Community champions can include local leaders, individuals within community and faith-based organisations, community groups, community health committees, stakeholders and individuals [5]. While community champions represent a broad range of individuals, a commonality is that they are closely connected with their communities either in a formally recognised leadership role but often as a lay member of the community who is motivated to support others to engage in health promotion activities.

How do community champions contribute effectively?

Community champions contribute in different ways that range from relatively passive involvement, such as sharing information, to more active involvement which includes consultation to provide insight into

community needs, and collaboration which includes working in partnership, and shared decision-making power in the planning and design of services, through to co-governance or co-production of services [6]. Engagement activities can be summarised into the following four categories [7]:

Information provision: this is passive transfer of information from health officials to communities, e.g. community champions pass on information about government guidelines;

Consultation: active exchange of information between health officials and communities, where community members' advice on planned interventions may be sought, e.g. consulting community champions on appropriate testing sites within a community setting;

Participation: health officials and communities co-identify problems and implement solutions by empowering community structures or local institutions to deliver change, e.g. community champions support authorities to liaise with community members and grassroots organisations to identify specific barriers to engaging with NHS Test and Trace and suggest local solutions; and

Community empowerment: health officials consult widely with and involve communities in local health-related decision-making and use community structures for service provision, e.g. community champions liaise with community members and grassroots organisations to identify challenges and formulate their own solutions to these challenges, e.g. develop processes, identify testing sites, equipment, etc. that are locally owned and feasible to make the Test and Trace service more accessible.

Community empowerment occurs when people work together to shape the decisions that influence their lives and health and begin to create a more equitable society [8]. To ensure a balance between power and representation of diverse voices, community champions should be actively involved with decision-making powers to avoid exacerbating inequalities in vulnerable and minority ethnic communities if passive roles are assumed [6]. Community champions will be able to contribute more effectively if treated by health authorities as integral health system actors rather than passive recipients. Co-producing interventions and explaining the rationale underpinning an intervention will enable community champions to provide information about the intervention to community members more clearly, appropriately manage expectations and will increase trust when accomplishing what was promised [7].

A review of the evidence shows community champions have contributed to designing and planning activities, enabling access to communities, building trust, social and behaviour change communication, risk communication, surveillance and tracing, and supporting with logistics and administrative tasks. A recent review indicates leaders are the most engaged community volunteers and behaviour change communication, risk communication, and surveillance and tracing were the most common function of community engagement [6].

Community champions can create local and context specific solutions to prevention and control responses. They can play the role of knowledge brokers between organisations and communities [9] and support organisations that can effect change by ensuring health issues are high on the agenda, represent local views and needs, offer local authorities and community partnerships short-term support as consultants, and help them develop activities to improve the health of local people [10]. Community champions can eliminate scaremongering, address conspiracy theories and myths, increase trust in the system, facilitate access to government services and also ease the burden on health systems by developing expanded services in resource-poor contexts [6, 11].

Community champions support communities in varied ways. They are more likely to reach individuals that are isolated or marginalised to communicate important health messages and offer support to groups and individuals in their localities. Community champions have delivered health promotion sessions in a variety of

settings including community centres, homes and churches [12] which can increase knowledge and skills. Community participation in health programmes can also increase confidence to deal with issues around social stigma and access better practical, emotional and personal support [11]. It is estimated that one community hub can meaningfully reach 200-300 households per year [4]. Drawing on their local knowledge, champions understand why local people struggle with specific health and wellbeing issues and as a result, they can also contribute to new ways of delivering local services [4, 13]. These include promoting community activities, sharing expertise with others, mentoring, leading organised health walks, setting up social clubs, delivering health awareness presentations on health conditions, signposting etc. [1, 10, 14].

Importantly, there is no 'one-size-fits-all' model for community champions. Different communities and contexts require different approaches and the social and cultural capital of the community champion will inform strategies required to promote engagement with health services.

Role of settings

Community champions work within local settings but it is important to first clarify what is meant by the term 'community' as this can have different meanings for different groups. A place-based definition of community refers to a common geographical space. A community can also be defined as people with shared, common identity, e.g. gender, ethnicity, etc. or interests, e.g. sports, crafts, music, etc. [8]. A community champion network must clearly define the target community that is matched to a community champion to maximise their local knowledge and identify appropriate settings. Individuals are not usually members of a single community and can belong to a diversity of communities within a single place. For example, minority ethnic groups are not members of a single community but might be sports players, volunteers in local religious spaces and have multiple affiliations across what might be considered 'their community.' Groups such as young adults and women may not recognise or may feel disempowered by single community/faith leaders. As a result, it is important to have a diversity of community champions to reach a diversity of communities within a single place.

Settings will vary depending on the needs of the community. For example, activities to promote mental health may require different settings based on the target community with a planned walk for one group and a support group in a local library more appropriate for a different group. There are cost implications when identifying settings as community champions with no financial support may not have the resources required to book rooms or provide refreshments for planned activities.

Some settings are more accessible than others based on distance, availability and affordability of transport, safety, etc. Settings that have been used by community champions include local community centres, cafés in GP surgeries, schools, village halls, local libraries, melas (Asian fairs), places of worship and individuals' homes. The function of these settings remains the same, that is, each social space facilitates the development of engaged and health competent communities [11]. They create a sense of *local community ownership* and responsibility for health by promoting the participation of local people in promoting health and tackling illness alongside health services; recognition of *local individual and group based skills* that contribute to these efforts; and local settings can create a sense of *local solidarity* around collective efforts to optimise health in adverse conditions [11].

The role of settings can determine whether or not an individual engages with the NHS Test and Trace service. Community champions can facilitate an understanding of accessible settings as some communities would prefer to be tested in the community by a health professional but other communities may perceive this as discriminatory and lead to disengagement [3]. Community champions have a key role in identifying appropriate settings in consultation with communities to maximise engagement.

Impact of social capital

Evaluations of community champion programmes indicate positive social returns on investment (SROI). Economic evaluations indicate community champion networks are cost-effective with a SROI of £5-6 return on £2 investment of the Community Champions Fund [4] and between £0.79 - £112.42 for every £1 invested in 15 case studies from the Altogether Better Community and Workplace Health Champion scheme which is calculated based on improved health outcomes, reduction in workplace absence due to stress, increased attendance and participation in social groups, reduced number of people accessing health services and reduced unemployment [14].

The biggest improvement for community members is reduced isolation, increased uptake of physical exercise, improved sense of belonging and being accepted in the community, increased attendance at community centre activities, and improved awareness of health guidance and available health support services in the community [14]. Champions have instilled positive thinking, encouraged enthusiasm, belief in others and self-belief amongst members of their groups [15].

Becoming a community champion also has health benefits for the community champion such as increasing self-esteem and confidence and improved physical and psychological well-being [6, 10]. Champions have also built their confidence, experience, and skills such as ICT, coaching, communication, project management, and qualification to progress to paid work in public health or community development as a result of being a community champion [4].

There are, however, some unintended negative consequences for some community champions which include exhaustion and stress, as on-going involvement can reduce energy levels as well as time and financial resources. The physical demands of engagement were reported as particularly onerous by individuals with disabilities. Consultation fatigue and disappointment were negative consequences for some who had experienced several engagement initiatives. The potential for fatigue needs to be acknowledged and factored into planning activities and training for staff when planning to engage communities with the support of community champions [6].

How do the champions and the approaches they adopt vary by community?

At the core of a community champion programme is the autonomy that champions are given to secure participation from local volunteers and residents and to identify activities that will meet the needs of the community. Community champions are varied and include adults, young people and children from a range of different backgrounds. As a result, community champions provide support in different ways and will vary based on the needs of the community and resources available.

Support that champions provide can include providing support with practical tasks such as helping community members to access services required, providing information in plain English and locally spoken languages for non-English speakers including working with members of the community who speak a community language to get involved in translating and pre-testing it, ensuring the timing of events meets people's needs, establishing and meeting the needs of participants with disabilities, using places and venues that are familiar and accessible to community participants and creating an informal atmosphere, and providing support to meet mandatory requirements, for example to get disclosure and barring service checks [1]. Community champions also promote access to services, create peer support groups to connect with people in similar situations (e.g. illness), develop social groups to develop skills (e.g. physical activity, healthy cooking) and connect people with activities in the community and signposting to other groups [14].

A community champions programme is more powerful when working with local partners such as health services, schools, housing providers, etc. in a cohesive way as this will facilitate feedback and create platforms that will encourage participation in this scheme. Partnership working between sectors creates an opportunity for more joined-up messaging and awareness.

Community champions are trusted and respected by local people more often than officials or professionals from positions of authority. Experiences of managing mistrust during the Ebola outbreak can inform learning in the UK context. For communities where trust is low, community champions can be a key pillar to support prevention and control measures. Substantive community engagement is required to build trust with local communities, dispel myths and disinformation and ensure that interventions are appropriate to local contexts (socioeconomic realities, intra-community divisions, etc.) [7]. During the 2014-15 Ebola epidemic effective measures to engage communities included building partnerships with local and religious leaders, working with the community to adjust key behaviour change messages which significantly contributed to the success achieved in controlling the outbreak and ensuring the resilience of the health system [16].

Community champions can increase trust when empowered to develop locally feasible and locally owned action-plans that address the needs of the community and identify additional resources required when managing infectious disease outbreaks. Community-based efforts result in increased social acceptance as behaviour changes are made collectively, and increase understanding and awareness of an unfamiliar situation [17].

Community volunteers promote behaviour change risk communication and support health facilities by conducting screening, contact tracing and administrative duties in relation to Ebola. As community members and as individuals linked to the same health system, volunteers described building community trust and support for Ebola prevention and treatment, while also enabling formal health workers to better understand and address people's fears and needs [18]. Health officials obtained support for programmes by taking time to identify local community leaders—teachers, chiefs, elders, pastors, clerics, imams—and working with them as gatekeepers for entry into a community. In addition to community leaders, efforts to engage marginalised groups within communities into health development/education projects is required to minimise exclusions within communities that arise based on reliance on community leaders. Only after community structures are engaged, using local resources and communication methods familiar to the community, will health officials have confidence of the community.

The extent to which community champions become involved and the intensity of the role depends on individual motivations and on the way that individual projects choose to operate [10]. As a result, every project is different but critical success factors have been identified as the level of personal commitment in terms of time and energy put into the role, passion for the particular issue or community, getting others involved and the interpersonal skills to motivate and support them, access to additional funding and adaptability and flexibility [4].

To account for the variations in motivational drivers (which may decrease over time), standardisation of core national messages with a degree of autonomy and trust at a local level is required to facilitate community engagement with Test and Trace services. A nationally endorsed package that contains all the relevant information and guidelines (e.g. volunteer narratives or scripts for explaining the test process) is required to ensure best practice is uniformly delivered but allowing for localisation based on use of language and delivery of message. Table 1 maps the Test and Trace journey and the role of a community champion including potential activities to facilitate this process.

Table 1. An overview of the potential role of Community Champions at each stage of the Test and Trace journey.

Test and Trace Step	Role of Community Champion	Example of activities
1. Being aware of the service	<p>Promote awareness of the NHS Test and Trace service.</p> <p>Clarify changes in guidance to the service particularly when information differs at a national and local level.</p>	<p>Community champions in a local area to work together to identify appropriate trusted sources of information for community members, e.g. community leader, GP, youth ambassador, radio, etc. to share information about the Test and Trace service.</p> <p>Provide diverse and representative communications using language that is acceptable to the target community. This may involve simplifying materials or translating/identifying appropriate community members to translate guidance.</p> <p>Share communication based on knowledge of availability of resources, e.g. no smartphone, internet access, etc.</p>
2. Finding information and identifying symptoms	<p>Promote awareness of the symptoms of COVID-19 and when a test will be required based on symptom presentation.</p>	<p>Community champions to work with organisations to ensure information about symptoms is reflective of the target community, e.g. reference to physiological changes reflect skin colour of community members.</p> <p>Identify by discussions among the group of community champions in an area if there are myths or disinformation circulating the community, e.g. do not present to health services if symptomatic based on lack of trust.</p> <p>Use credible sources to counter this by distributing health messages within the community.</p>
3. Booking a test	<p>Provide or signpost to information of how to book a test and the different options available to do this.</p>	<p>Liaise with the community to identify potential barriers to booking a test. Work with communities to identify solutions to the barriers presented.</p> <p>Work with health organisations to ensure methods of booking a test that are acceptable to the target community are available to the community.</p> <p>Tailor communications with communities (groups or individuals) and share via channels of communication that are acceptable and accessible to the target community, e.g. WhatsApp.</p>
4. Taking a test	<p>Provide or signpost to information on how to take a test.</p>	<p>Liaise with the community to identify preferred testing sites. Work with communities to identify potential barriers and solutions to testing sites and/or testing procedures.</p>

	Promote testing sites available within communities and provide information on what will happen, how long it will take, etc.	<p>Work with health organisations to provide testing sites and testing procedures that are acceptable to the target community. Share any concerns that community members have about taking a test, e.g. concerns of loss of income if test positive so that health and government organisations can develop strategies to address these concerns.</p> <p>Work with third sector organisations to cascade information more widely so that organisations can signpost community members to this information.</p> <p>Develop, translate and/or share targeted and tailored health messages to provide information about testing sites.</p>
5. Receiving test results	Facilitate process of services sharing results in accessible way based on needs of community.	<p>Act as a point of contact for community members unsure about how to access results.</p> <p>Liaise with community members about barriers and co-create solutions that can facilitate receiving test results, e.g. ways to address language barriers, having no contact number, etc.</p> <p>Liaise with health organisations to advise on the needs of community to ensure results can be shared using a range of accessible formats.</p>
6. Providing contact history details	Provide information on the rationale for providing contact history details and exactly what this process will involve.	<p>Liaise with community members to understand barriers to sharing contact history and co-create acceptable solutions to providing this information, if required.</p> <p>Create health messages that address specific concerns within communities and share via trusted sources.</p> <p>Liaise with health services to provide alternative means for providing contact history information, e.g. verbally over the phone, provide opt-out options for data saving/sharing to increase sense of control.</p>
7. Being contacted by the NHS Test and Trace service	Provide information on the process of being contacted by someone within the Test and Trace service.	<p>Liaise with the community to identify barriers and co-create solutions to answering calls from unknown numbers or accessing resources without additional support.</p> <p>Work with health organisations to facilitate contact between call centres and community members that take into account resourcing issues or routine behaviour of not answering calls from unknown numbers.</p> <p>Develop/tailor communications to explain this process and share this information using trusted community leaders, individuals and third-sector organisations.</p>

8. Managing isolation	Ensure community members are supported through isolation and know what to do.	Work with communities to identify barriers and co-create solutions to isolation. Work with health organisations to provide resources required to facilitate self-isolation. Maintain contact with individuals that are self-isolating to provide social support and identify any difficulties experienced. Work with third sector organisations to maximise support available for community members that are self-isolating.
9. Returning to normal	Provide and signpost to information about what is and is not permissible under different conditions.	Maintain contact with community members that have been self-isolating and share culturally appropriate and easy to understand information on current guidelines. Work with local third sector organisations to reinforce these messages and increase awareness of accurate guidance.
10. Negotiating a local outbreak	Provide information on risks specific to the local community and support available and actions required in the event of a local outbreak.	Provide information in an accessible format to explain risks to the community in the event of a local outbreak. Work with the community to develop a plan of agreed actions that are locally feasible and locally owned in the event of an outbreak. Work with health organisations to provide resources required to implement locally developed action plan. Work with third sector organisations to maximise support available for the community in the event of a local outbreak.

How should we take account of the social settings and what works best in different circumstances? E.g. Olympics, UK Floods/disaster management, public health settings etc.)

The evidence on good practice in implementing Community Champion networks is limited and requires further research [19]. While Champions have been widely deployed in the Altogether Together and Healthy Walking schemes, evaluation of their impact in the UK has not shown large effects [20, 21]. Other work has suggested that health volunteer projects can have a short-term impact but at the cost of longer-term fatigue and over-work among volunteers if they are not supported with resources from central and local government [6]. Other evaluations of participatory health work indicate that, unless projects have key, influential supporters within local health services, such as GPs, or government, they will not have much effect [22].

Another challenge is that assumptions that communities are coherent and have clear ‘leaders’ or ‘representatives’ may not always be true according to the participatory development literature, which identifies intra-community exclusions and inequalities especially of gender and age [23, 24]. Community engagement cannot escape these power dynamics and even peer education at times can become peer pressure [25]. More significantly perhaps what a community is and who is included or excluded from it is not a simple question to answer. People are not necessarily members of a single community as our identities are formed from multiple relationships, and not all participants in a community recognize the same influencers

or leaders. Communities are a cultural ideal rather than a fully lived practice and there are many tensions within them. People may belong to multiple communities at once, or may form their identity by rejecting membership of a community. Community or community champions could thus risk becoming divisive or segregating different communities who might have similar needs. This could potentially increase processes of stigmatisation both within and between communities around COVID-19 testing and social isolation.

Evidence on good practice in the disaster management field can also inform ways to organise and support the role of community champions. Spontaneous volunteers are individuals that are not affiliated with an official organisation but provide unpaid support at the time of unplanned events, often disasters [26]. The experience and training of spontaneous volunteers is unknown to managers and there is a risk that volunteers will not work under the direction of official responders resulting in increased risk to themselves, those they intend to help and create an additional strain on often limited resources. While little is known about spontaneous volunteers backgrounds and intentions, what is known is that they will arrive to support the community and have valuable local knowledge that can support official responders and should be included as part of response preparedness efforts [27].

Learning from the disaster management field, participatory health work and evaluations of community champions programmes has informed the following recommendations to combat potentially negative elements of community champion schemes. We suggest the following key elements need to be in place for them to be successful:

1. Financial and other resources must be provided to volunteers. More resources will need to be provided in the most deprived areas because volunteering will be most challenging for already hard-pressed groups trying to make a living and manage child and elder-care [28]. Learning from current and previous community champion schemes highlights the value of flexible funding streams. Flexibility in funding may build trust and prevent inefficiencies in the health system by allowing for the implementation of projects and resources that are needed. Schemes that are funded have been essential to get projects off the ground and enabled new activities that would not have otherwise been possible [4]. When considering costs, in addition to funding and training, costs should include management time, equipment, insurance and feedback and evaluation.

2. Community champion and participatory work must have complete buy-in from key strategic figures within national and local government. Participatory work must be prioritised and funded as part of the CONTAIN framework, which currently predominantly focuses on implementing social restrictions and measures that can be perceived as punitive.

3. Prior or parallel to calls for volunteers, communities must be mapped in collaboration with community members. This is so that the recruiters and organisers of the networks gain the **social knowledge** to make sure that the profile of volunteers reflect diversity within the community and include central as well as more marginalised segments of this [29]. In addition, this mapping should identify key problems, lack of access to testing, social isolation or pockets of deprivation that may be preventing uptake of these measures. Local PHE officers in collaboration with GPs could play a key role in this mapping and could be asked for advice on local organisations, sports groups, NGOs and other parts of the community to involve in the mapping. There should not be an assumption that ‘well-known leaders’ of faith or other easily identifiable community groups are the best route for connection to communities. It may be, for example, that sports club coordinators, networks of mothers, local shopkeepers or publicans could be a more route towards recruitment of volunteers with broader connections and more credibility.

Recruitment strategies of community champions vary but primarily use extended networks of local contacts. An intermediary with links to the target community liaises with local partners including local authorities and parish and community councils, libraries, charitable organisations, housing associations, community centres,

and minority ethnic organisations and networks. Activities include attending members' meetings, network events, social and print media, and informal one-to-one conversations in local settings which can be effective with local people who are nervous about approaching agencies outside their community. Word of mouth is a powerful medium to promote calls for volunteers from a range of communities particularly for community champions from minority ethnic backgrounds although agencies are also effective to promote volunteers from minority ethnic and White groups [4].

4. New connections between communities with shared goals should be actively forged through the process of participatory mapping. Research has shown that creation of relationships between community groups and with public health organisations is a key outcome of participatory mapping [30]. These new connections could be a vital resource which could cut across existing networks and boundaries and draw in traditionally marginalised groups.

5. Relationships between local officials and volunteers should be collaborative and not hierarchical, moving away from the model of 'teaching' people to be health educators and then sending them out into the community. Instead the emphasis should be on co-production at every stage in which local and public health officials and volunteers are learning from each other. Fact-finding interviews could be carried out with individuals or groups when they first join, in which they are presented with the issues facing PHE in the area and asked to propose solutions. Volunteers should be enabled to contribute their own insights throughout their involvement, for example by volunteers being regularly brought together to reflect on problems and solutions. These insights can be treated as a rich resource to inform the nature and direction of interventions, especially if there is systematic analysis across all of their insights in light of the background of the informant. Evidence of community champions from refugee and migrant backgrounds developing and informing training content highlights the importance of having consensus on content otherwise it could be detrimental to training efforts [31].

Monitoring processes are varied and can be fairly light touch which reflects the resources available within a scheme, i.e. funding levels are adequate for management and administration but are insufficient to support a more proactive approach to monitoring. Community champions, as they attempt to persuade their networks, can be a rich resource of information about what is working and what is not, and why it is not working. They can educate the organisations they are working for by feeding back to them on this. This can include a brief report or completion of a pro forma describing the progress made against the original plan or providing verbal updates during network meetings [4, 27].

As well as informing responses to challenges, such sessions could build trust among volunteers from within and across communities. This could help to challenge barriers to testing such as stigma and fear about which groups are to blame for the spread of COVID-19 and thereby increase uptake of testing. Thus, community champions or volunteers might not merely convey correct information, but could become the generators of community development and social support.

Community champion and other community projects supported by PHE should be formatively evaluated to examine whether and how they align with these principles. A feedback system which enables champions and stakeholders to monitor and review initiatives is required. As there is no 'one size fits all' approach there are likely to be differences in the initiatives and activities that community champions develop and promote. A feedback and monitoring system that allows for these differences is required and careful consideration of what is being measured and monitored, e.g. number of community members participating in each stage of the NHS Test and Trace programme, increased reach, awareness, etc.

We also recommend that it would be useful to create a virtual noticeboard and group chat online between community champions about their current projects. There are a large number of live projects underway that are improvising new forms of community outreach and are actively building new social contracts of collaboration. It is an important time to discuss what is, and what is not, working. A network or forum for community champions will aid dissemination of good practice for volunteers to learn from each other and also provide peer support.

Are there any different models for implementing these schemes? Do some work better in particular circumstances?

There are a number of different models of community-centred approaches that aim to mobilise the assets within communities to increase people's control over their health and reduce health inequalities. In volunteer and peer roles, community members use their life experience and social connections to reach out to others to provide advice, information and support or organise activities in their communities. Models used to guide this approach include peer support, peer education, health trainers, health champions, community navigators, befriending and volunteer schemes such as health walks [8]. While each of these approaches can engage communities, each model is more suited to specific types of activities and there is increasing evidence of the impact of peer educator models which could be considered to support community engagement in mass testing.

Peer education interventions select individuals who share demographic characteristics (e.g. age or gender) or risk behaviours with a target group and train them to increase awareness, share knowledge and encourage behaviour change among members of that same group. Peer educators are ordinary people from the target community. They do not need any prior knowledge, training or experience in the subject matter but they do need to be motivated to support their community. They tend to have a natural empathy with the target groups in terms of culture, religion and language, as these are important factors which impact on health decisions and behaviours. Peer education can be delivered in formal structured settings (such as classrooms) or informally during the course of everyday interactions [32].

The effectiveness of peer educators in changing behaviour appears to depend on the behaviour targeted for change. Peer educators may be effective in delivering health promotion related education or support in improving vaccination uptake, and decreasing unsafe sex and increasing safe sex practices [33, 34], it has been used to share culturally competent health messages and promote health services with minority ethnic groups where peer educators build on their local knowledge and expertise to inform ways to communicate with the target community [35] and can bring together people from different parts of a deprived city and help to dispel some of the prejudices against an area which is considered to be a rough and unpopular place to live [36].

A lot of evidence of community engagement and testing in relation to infectious diseases comes from the wider HIV literature which focuses on peer education rather than community engagement. Peers are more likely to influence the behaviour of group members as they are assumed to be able to gain a level of trust, which allows for more open discussions on sensitive topics [37]. They have better access to hidden populations who may have limited interaction with traditional health programs and are cost effective in comparison with traditional health-care providers [37, 38].

Each model of community engagement varies. Community Champions is based on a leader model and is focussed on individuals making interventions into social networks. Peer educators is based on a much more egalitarian model that can draw in more members of a community especially marginalised members, although it is not always successful at that. Community champions is one narrow model of how to develop

public health interventions, that relies on a top-down model within communities (i.e. the identification of 'leaders') therefore it may have some disadvantages as it may exclude marginalised individuals within communities.

What examples or case studies exist of good practice in implementing communities Champions networks (UK or internationally)? Are there any things to definitely avoid in setting up these schemes?

The SE Anthropology ethnographic study [74] of the successful response in Hackney to the COVID-19 pandemic is an example of good practice of implementing a Community Champions network.

Hackney is a site of gentrification and wide social divides and inequalities. It is a place of mainly white middle class incomers and older, poorer mostly minority ethnic populations that are very diverse (Caribbean, Vietnamese, Orthodox Jewish, Turkish/Kurdish). This split has been exacerbated since 2010 as a result of cuts in funding for social housing and local authority building of private housing stock. Initially tensions in the area were increased during the COVID-19 pandemic as minority ethnic communities had high levels of illness and mortality from COVID-19 due to their key worker roles in addition to other factors. In addition, minority ethnic communities were policed more intensively in the area during national social restrictions. However, because of the active work of mutual aid groups and the local authority these tensions were overcome in ways that other places could learn from. Mutual aid groups sprung up in every ward in Hackney at the start of national restrictions and they currently have a community champions scheme. The success of this scheme is in part due to this spontaneous community activity, but is also a result of the supportive framework for it created by the local authority and their responsive mapping of deprivation and need in the area.

The foundation for this response has been the sensitive map of need that had been developed by Hackney local authority. It already had in place a Community Impact Report on deprivation in its neighbourhoods, which was updated weekly by all council bodies (social work, education boards, youth workers, disability support etc). This was used to propose practical interventions on a weekly basis. Once COVID-19 hit this was repurposed to deal with the new situation—looking at changing needs each week on the basis of a robust map. Alongside Hackney used their already established care networking group called 'Neighbourhoods'—a discussion and problem solving group intended to improve health outcomes—to propose solutions and locate emerging vulnerabilities. They too used networks already forged to build care access routes especially for people who are reluctant to seek state aid. These bring together community care providers with NHS and other statutory providers. This dense web of referral and aid created a responsive network of care. The local champions recently introduced are part of this broader work of mapping need, creating responsive webs of connection between the local authority and constant informational feedback and problem solving from the bottom up. Given this model of local authority action the community champions are expected not just to be purveyors of correct information, but to be problem solvers and conduits of knowledge from the streets to service providers. This case study illustrates the power of participatory mapping of need, weekly co-production in discussion groups, creation of supportive referral and aid as means to build trust in public health and other policy measures. It is likely that community champions will be more successful in building trust and providing effective results in testing and social isolation practices if they are part of a supportive and responsive local social infrastructure. This needs to be supported by national and ministry level practices across the country perhaps by an explicit repurposing of the elements of the CONTAIN framework.

How might technology play a role in successful schemes?

While the social connections that face-to-face support group and peer education provide can be a powerful mechanism for addressing adherence and providing support, there are a number of barriers to in-person program participation, including; logistical challenges such as transportation and child care, human and infrastructure resources (i.e., needing trained professionals onsite, adequate space to conduct the groups, and allocated time), and privacy (i.e., face-to-face contact and lack of anonymity is unappealing for some individuals) [39]. There has been a move to deliver peer support using digital platforms, particularly using the mobile phone. Telephone calling, text messaging, digital support groups and virtual communities are increasingly being used in interventions to successfully address public health concerns, such as to encourage uptake of services and to address concerns such as depression, substance use, poor social support, care engagement, and ART adherence . However, models most frequently use text message protocols that employ elements of reminder messaging and/or coaching to address intervention goals. Many of these spaces lack the level of facilitation, personalisation and intimacy that people need in addressing personal challenges and psychosocial barriers to uptake and adherence [40, 41].

Case Study: The Zumbido Model

The SHM Foundation has proven the effectiveness of leveraging text message support groups to address adherence to ART in isolated populations living with HIV [42, 43, 44]. Their model, called Zumbido Health Model is a time-limited four-month social support intervention in which participants are assigned to groups of 10-15 peers. These support groups operate through a mobile phone application that allows participants to discuss a range of issues pertinent to their condition or needs, peer to peer, and at any time via text message. Support groups are monitored by facilitators (often community healthcare workers) or professionals (who are able to deliver certified medical advice or referral information). Facilitators also run daily discussion sessions on a diverse range of topics identified as important by the target population. The model allows a peer mentor or educator to reach and monitor the needs of their case load in a light-touch way. This model has been implemented in the UK, Zimbabwe, South Africa, Zambia, Mexico and Guatemala both with isolated populations living with HIV and as a mechanisms to ‘support the peer supporters’ [42, 45, 46].

Experience of running the model at present, during the Covid-19 Pandemic, reveals a number of important implications for the use of technology in peer education models (42, 45), including:

- Technology is an enabler, not a solution by itself. It is important to work out what a population need, and if these needs can be met through a technology platform. Technology shouldn’t replace face-to-face services, but can complement them.
- Engage the participants in the design process to design spaces that fit the digital habits of the population. Different groups have different needs and capabilities with technology, allowing them to be part of the design process will ensure that the model you build meets these needs.
- Strike a balance between peer support, information provision and facilitation. It’s important that people engage with one another, but keeping the conversation going and engaging all participants requires good facilitation.
- Referral systems are crucial. Technology platforms can work to triage the kinds of problems people are facing, but they should be built into a referral network, so people with more serious problems can get the support they need.
- Ensure adequate technology support systems in downloading and troubleshooting, and check in services to understand why participants don’t engage.

COVID-19 specific questions

The COVID-19 pandemic has provoked a remarkable surge in volunteering and community action around the world [47, 48]. Prominent manifestations of this outpouring of community spirit within the UK include the rise of so-called “mutual aid” groups, volunteer-led initiatives where individuals from a particular area group together to meet community needs without the help of official bodies [49]. Over 4000 such groups have formed over the course of the pandemic, with as many as three million participants [50]. On a national level, the national NHS volunteer responders scheme was able to recruit over 750,000 people within four days, three times the initial target [51].

However, such broad statistics tend to obscure the immense variety in the nature, context, and outcomes of this volunteering. Even use of the term “volunteering” is controversial, with some participants rejecting this term due to the implication of a hierarchical relationship between “helper” and “helped”, preferring instead to frame their actions as a mutualistic expression of “neighbours looking out for neighbours” [52].

Regardless of the precise definition we assign to such phenomena (here we use “volunteering” as a general term for all unpaid activity aimed at social benefit) it is clear that civic activity on such a mass scale raises a number of urgent questions, notably: who are the volunteers; what does their volunteering activity consist of; to what extent has it been successful; what are the conditions for its success or failure; what are its outcomes both for those receiving and giving aid? Answering these can provide a critical opportunity for learning that may illuminate political, organisational and psychological questions which are not specific to the COVID-19 context.

What have we learned so far from COVID-19 volunteering both at the national level and the more local community level?

Models of Volunteering

The onset of lockdown saw an outpouring of community spirit and voluntarism; however, this spirit was channelled in a huge variety of ways [53]. Whilst in some areas volunteering activity has surfaced spontaneously, in other areas this activity has emerged as an outgrowth of existing networks, community projects, and organisations [54]. In many cases such organisations have shifted their activities rapidly to COVID-19, mobilising volunteers and relationships with other local groups to create local support schemes [55]: for example, Homebaked in Anfield, a community bakery, closed down much of its traditional operations and started baking 50 to 70 loaves a day, which it provided to the local foodbank and community centre [56].

Two conflicting models of volunteer organisation during the pandemic [57, 28]: on one hand, a decentralised model in which there is an absence of formal command, where information and decision-making is dispersed among members; on the other, a centralised method of command-and-control. The former model is argued as superior in terms of its speed, democratic nature, and ability to meet the needs of those excluded from other services. For example, [57] compares the model of mutual aid groups to the NHS volunteer responders service. The formal nature of the NHS scheme meant that the identities of all volunteers had to be carefully checked, leading to delays in assignment; furthermore, the service only served UK inhabitants who registered as vulnerable, excluding those unwilling or unable to register formally. In contrast, mutual aid groups did not engage in verification of volunteers, and covered anyone who was self-isolating, allowing them to meet the needs of their communities more effectively. However, this analysis also obscures the potential weaknesses of the latter model: one common challenge faced by many mutual aid groups was a lack of leadership, where people were keen to offer services but were not willing to take the initiative [54]. Equally, those engaged in more informal forms of neighbour support also frequently reported the same challenge of reaching vulnerable groups, with help either lacking focus or being limited to those already known [53, 59]. Furthermore, categorising volunteer activity as hierarchical or non-hierarchical, centralised

or decentralised, formal or informal seems an oversimplification. In reality, most organisations “blend and braid” elements of both approaches [60]. For example, Tiratelli and Kaye [54] point out that many groups preserve a “private layer” of interaction for “core” members and organisers, whilst Kavada [57] acknowledges that group administrators were able to participate in a closed Facebook group to exchange tactics.

Despite this caveat, however, it is fair to say that the pandemic has prompted a qualitative shift in volunteering around the country, with traditional formal organisations such as charities losing a large bulk of their volunteers [61] whilst informal associational models thrive. This may be linked to the demographic makeup of the volunteers themselves discussed next.

Volunteer Demographics

The conditions of the pandemic should arguably pose a challenge for volunteering efforts given its high risk to the elderly, normally the demographic most likely to volunteer regularly [62]. However, the present circumstances appear to have led to the emergence of a new volunteer workforce: surveys have found that the average age of Covid mutual aid group members was 48 years. More generally, Mutual Aid groups appear to be concentrated in areas with large numbers of working-age people, a clear consequence of the government’s furlough scheme [54].

Age is not the only driver of participation. Volunteers are also composed of more women than men: while this is in line with general trends [62], it may also represent an extra caring responsibility at a time when women are already shouldering the burden of increased domestic labour. There are also early indications that wealth and class play a role in participation. Across the UK, there is a positive relationship between the density of voluntary groups in an area and measures of socioeconomic advantage, as well as well-being [63]. Although this relationship exists, volunteers are not necessarily wealthy with one survey finding that 48% of volunteer households had an income of less than £30,000 and 30% above, compared to the national median £29,600 [63]. However, it is important to remember that the resources and tactics available to these volunteers, and therefore the overall effectiveness of their volunteering, may not be the same: a report by Taylor and Wilson [64] based on the experiences of community organisers found that whilst most affluent communities organise themselves, communities with few resources often need support. Similarly, one participant in a Mutual Aid group from a relatively poor rural area pointed out that the tactics of other groups such as crowd funding “wouldn’t work in a more deprived area like ours” [54].

In summary, the demographic makeup of COVID-19 volunteers partly reflects new realities, but also existing trends and inequalities. Future work should investigate whether the demographic and geographic distribution of volunteering may simply reproduce and even reinforce the existing inequalities exacerbated by COVID-19. If so, any response in line with the government’s “Leveling Up” policy agenda should address the underlying socioeconomic disadvantages which hinder effective voluntary action [65].

Volunteering Activities

Just what did COVID-19 volunteers do, and how did they go about doing it? Research suggests that volunteers went through, and continue to go through, a process of evolution and adaptation. Delivery of essentials such as food and prescriptions dominated early efforts; however, a second service which became increasingly common as lockdown wore on was the combating of social isolation through activities such as provision of arts and crafts packs, telephone support, and online activities [53]. There is now a growing shift

towards addressing the wider impact of the pandemic on other areas such as employment, benefits, mental health, domestic abuse, and homelessness [53, 57]. There is some evidence that COVID-19 volunteers may become involved in wider political campaigns: Wein [63] found that 83% of mutual aid participants intended to take part in some form of political action in the coming year, with 64% likely to sign petitions and 47% expecting to contact a politician. On an organisational level, ACORN, a community union which organised mutual aid networks around the country, has worked to divert many of its volunteers from community support to eviction resistance campaigns [66].

Evolution not only characterised the nature of the work itself; it also characterised how volunteers carried out that work. In many cases voluntary organisations and projects adapted their services by transferring to digital infrastructure, often at rapid pace [55]. A plethora of digital tools were put to use: whilst WhatsApp was one of the most popular organising platforms, some groups adopted more streamlined services such as Slack; Zoom and Skype were used for calls; Google Docs for meeting minutes, and Google Sheets for compiling databases of volunteers and requests [57]. Many groups also sought to tackle the possibility of digital exclusion through physical methods such as mass leafleting [59]. Other projects such as Skills Enterprise in East Ham offered digital training sessions, as well as providing tablets and phones to those on their programmes [55]. The crisis has demonstrated the adaptability and resourcefulness of volunteers and community organisations, who have effectively adjusted to changing conditions as the UK continues to pass through different phases of the pandemic. However, it is important to remember that insofar as these volunteers are serving to meet needs which are otherwise unmet by public services, their activities serve as a “map of insufficiency” [54] which authorities must pay close attention to.

Successes, Challenges, and Determinants of effectiveness

The collective importance of volunteering during COVID-19 is plain to see. By delivering vital services to vulnerable individuals in the early days of lockdown whilst traditional public services struggled to respond effectively, mutual aid groups undoubtedly played a life-saving role in the UK’s COVID-19 response [54]. Such groups have also generated new partnerships, networks and knowledge, which may serve as a long-term resource (albeit as yet untested) in the event of a “second wave” [67]. In terms of community and voluntary organisations generally, 95% of council leaders and chief executives saw community groups as being significant or very significant in their COVID-19 response [68].

However, volunteer groups have also faced challenges: many have found it hard to sustain the morale and enthusiasm of volunteers over time, with the activity of many groups declining sharply once lockdown started to ease [67]. Other schemes found it hard to generate sufficient demand, or became bogged down in red tape [53]. For example, the length of time it took for volunteers to hear back from the NHS Volunteer Responders Scheme caused initial enthusiasm to dissipate: later data revealed that the army of 750,000 volunteers were given fewer than 20,000 tasks between them [69]. On the opposite end of the spectrum, smaller mutual aid groups who attempted to scale up their operations beyond street level often found that they were lacking in organisation, coordination, local relationships, and trust. For example, this was the case with a group formed in Dalston Ward, which quickly attracted hundreds of volunteers but was unable to attract requests from support due to distrust from the local community [56].

What differentiated effective volunteering endeavours from ineffective ones? On a tactical level, factors identified by groups as being important to successful retention of volunteers include: not asking volunteers to engage in activities they are uncomfortable with; allowing volunteers to say no; providing social rewards; nurturing relationships with volunteers; recognising the contribution of volunteers [52]. On a more strategic level, effective and rich responses are underpinned by “community-led infrastructure”, understood as community leadership, trust, relationships with agencies, and access to money [53]. In particular, many

community organisations have been able to play a coordinating role by providing smaller mutual aid groups with the infrastructure, systems, and resources required, as well as acting as a communication bridge between groups and local authorities [55]. For example, Hastings Emergency Action Response Team (HEART) have been able to coordinate over 900 volunteers, using their local knowledge to identify needs [56]. Nor are such organisations limited to a local level: the nationwide union ACORN was able to set up support systems in nine cities by mid-March. As a result of years of organising and campaigning, ACORN already had an engaged existing membership in each city and well-developed organisational structures. As a result of its success, ACORN's members have been invited to give evidence to the Public Services Select Committee [64]. The local knowledge, relationships, and trust built up over years by such community organisations are therefore crucial to enabling effective large-scale responses.

What have we learned from engagement with local communities and community champions during the COVID-19 period?

The evidence review discussed above raises the question of how authorities can best support local community-led infrastructure. Councils that have made concerted efforts in community engagement are the ones that have best facilitated their local Mutual Aid groups [67]. But what does it mean to “engage” with a community and what does this look like in practice? One definition of community engagement is “involving communities in decision-making and in the planning, governance and delivery of services” [12]. This can take many forms, including: consultation, joint decision-making, and acting together. The Covid-19 “Community Champion” scheme is one example: it aims to recruit volunteers in local councils across the country. These volunteers are given the latest information about Covid-19, and are asked to share this information in their community, whilst feeding back which communications are effective and which are not [70]. As of the time of writing, however, no systematic report or review has been published regarding the findings from this scheme.

It is worth noting, however, that the role of the “Community Champion” is not far from what many mutual aid volunteers took it upon themselves to do in the early days of the pandemic: a survey found that 57% of volunteers supported their neighbours by providing information about the virus [59]. Therefore, until any reports are published, the best approximation we have is likely existing engagement with local community organisations and mutual aid groups. Learning from two forms of community engagement: collaboration and consultation are explored next.

Collaboration with Local Communities

Community organisations have had relationships of varying quality with local authorities. There is a distinction between three types of local council approach: micromanaged, indifferent, and facilitative [54]. In the micromanaged approach, councils seek to control the efforts of volunteers and community organisations, issuing orders in a prescriptive language of “should” and “must”: an approach which has caused participants to view local government as an obstruction [54]. In the indifferent approach, councils fail to support such groups and refuse to collaborate with them, an approach which potentially hinders volunteering and damages public trust. Similarly, members have reported a lack of information sharing and joint planning, an approach which has led to duplication and confusion, as well as a lack of support in accessing funding [55]. These two approaches are contrasted with the facilitative approach, in which local authorities find ways to support communities without smothering them. Examples include: providing practical help such as supplying mobile phones and card readers, providing guidance on how to establish GDPR, safeguarding and PPE systems; proactively connecting volunteers with existing networks and other

groups; providing spaces and infrastructure to help groups organise; helping groups to keep track of people with longer-term service needs [54]. In Bristol, community hub Wellspring Settlement were able to develop a system with the local authority to have volunteers DBS-checked in 24 hours [56]. Overall, councils should give community organisations the freedom to operate whilst providing practical support and advice when needed.

Consulting Local Communities

The pandemic has significant implications for how our society and economy will be structured, not just now in terms of the immediate response of volunteers to COVID-19 but going forward. Local communities and groups are beginning to reorient themselves beyond the temporally-bound demands of the pandemic context, and towards more fundamental structural demands. As Involve argue, at this critical juncture it is crucial that the government policy is not simply shaped by politicians, civil servants and scientists, but communities themselves [71].

The COVID-19 period has seen only two completed consultations of local communities thus far (with the emphasis on local community, rather than simply members of the public). These consist of one by The West Midlands Combined Authority to guide its COVID-19 recovery, and one by the Scottish Government on the impact of COVID-19 on community organisations and their priorities for recovery. The panel for the West Midlands Combined authority agreed six priorities for the recovery: getting back to normal safely, ensuring clear guidance as we move out of lockdown; a strong healthcare system, making sure patients can be treated; mental health provision; preparing children to go back to school in a supported environment; creating new jobs with an emphasis on apprenticeships and entry-level jobs, with additional training provided to help people enter the workforce; promoting and supporting businesses, especially smaller and local businesses [72]. Some of the priorities of the Scottish consultation were: supporting mental health; limiting the impact of future cuts and reduced services on communities; employment issues; a low carbon recovery; tackling inequalities; capitalising on the rise in community spirit [73].

Whilst such practice is important, these forms of engagement do not tend to involve handing over power in any meaningful sense, and are often merely concerned with getting feedback before a predetermined project [67]. Instead, such approaches need to be combined with a meaningful project of community mobilisation, which builds strong coalitions, leadership, and engenders local communities with the belief that they can enact real change [67]. It is precisely this mass mobilisation which has proved so invaluable in a time of crisis, and if properly tended to may lead to even greater things.

Summary

Community champions have the potential to act as knowledge brokers and a bridge between government organisations and local communities. Caution should be exercised when identifying potential community champions to ensure they reflect their local communities. This should go beyond traditional 'community leaders' and include more marginalised community members or those that belong to multiple communities at the same time.

Community champions should be empowered to work as active collaborators with local officials. Restricting the role to passively sharing information will limit the impact of community champions and risks exacerbating inequalities in vulnerable groups. Giving communities the opportunity to co-create local solutions will provide an increased sense of control and acceptance of control measures in the event of a local outbreak.

Funding is required to ensure community champions are reimbursed for their time and investment of local expertise and to cover the cost of resources. More resources will need to be provided in the most deprived areas because volunteering will be most challenging for already hard-pressed groups trying to make a living and manage care responsibilities. This can lead to positive economic, social and psychological returns on investment. Funding should also include training for stakeholders to engage with community champions as equal partners and recognise the potential for fatigue in champions, particularly if there are resourcing issues. A regular feedback cycle is required to obtain valuable insights and learning from champions and to identify support needs of champions.

As individual projects will vary in the way they choose to operate, standardisation of core national messages with a level of autonomy and trust at a local level is required to facilitate community engagement with NHS Test and Trace services. This could include a nationally endorsed package that contains all the relevant information and guidelines (e.g. volunteer narratives or scripts for explaining the test process) to ensure best practice is uniformly delivered but allowing for localisation based on use of language and delivery of message.

The community champion project should be formatively evaluated. There are a large number of live projects underway that are improvising new forms of community outreach and are actively building new social contracts of collaboration. It is an important time to discuss what is, and what is not, working.

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