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Can communities be mobilised to build capacity to respond to the COVID-19 pandemic? A qualitative process evaluation

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Can communities be mobilised to build capacity to respond to the COVID-19 pandemic? A qualitative process evaluation

Abstract

Objectives
Government guidance to manage COVID-19 has been challenged by low levels of health and digital literacy and a lack of official information in different languages. Further, people are inclined to consult trusted sources first, which often contain outdated and conflicting information.

Design
We coordinated online "Covid Confidence" sessions via anchor organisations serving three deprived neighbourhoods with a mix of ethnic and faith groups. We conducted a qualitative process evaluation to explore whether a popular opinion leader/local champion model of health promotion could effectively mobilise pandemic responses. Group discussions during implementation were supplemented by final interviews to assess changes in community capacity to mobilise..

Setting
England, September 2020 – November 2021

Participants
Fifteen sessions were attended by 48 local organisations. A group of local public health and medical experts facilitated discussions to help organisations to make sense of government information in their local context.

Results
The discussion forum led to cross-organisational relationships which enabled communities to mobilise a rapid response. The mobilisation, however, was challenging to integrate with statutory sector management in the early days of the pandemic. People who were trusted by local communities successfully adapted information to different groups. Listening, identifying individual concerns and providing practical support enabled people to make informed decisions on managing exposure and getting vaccinated. Social determinants of health, however, diluted effectiveness of mobilisation. Communities drew upon existing resources and networks, supplemented by small government grants, but concerns were expressed about providing longer term support.

Conclusions
Sessions promoted stronger links between community organisations, who were important mitigators, reducing mistrust in government information. In future, government efforts to manage COVID-19 should partner with communities to co-design and implement prevention and control measures.

Strengths and limitations of this study

- Participants set the agenda for each session thereby ensuring that local issues were addressed
- Locally known public health and medical people acted as links to engage pandemic experts in contextualising information
- Facilitation focused on supporting people to apply their local expertise and knowledge to generating appropriate engagement strategies
- Data collected throughout the project on effectiveness was supplemented by a final set of interviews with local workers and leaders
- Quantitative relationships between engagement and vaccine uptake could not be established as it was not possible to link to individual data

Background

While the government has generated a vast amount of information and guidance about the COVID-19 pandemic, people say that they struggle to keep up with it. The World Health Organisation announced in 2020 that the COVID-19 pandemic had triggered an infodemic, e.g. "an overabundance of information – some accurate and some not – that makes it hard for people to find trustworthy sources and reliable guidance when they need it". [1]. Although rumours and misinformation are spread in all disease outbreaks, information "goes faster and further, like the viruses that travel with people and go faster and further. So it is a new challenge, and the challenge is the [timing] because you need to be faster if you want to fill the void…What is at stake during an outbreak is making sure people will do the right thing to control the disease or to mitigate its impact. So it is not only information to make sure people are informed; it is also making sure people are informed to act appropriately". [2]. When creating information strategies, governments are dealing with a wicked and complex problem, because COVID-19 is (a) a new phenomenon, where the virus as well as the science needed to tackle it is rapidly evolving; (b) treatments and policies for treatment are contested. Further, the government strategies for spreading accurate information have met with varying success, because willingness to accept the facts varies according to the beliefs of any particular group and their attitudes and trust toward government information in general. The success of strategies is not only dependent on local attitudes and beliefs, but also on the characteristics of the messenger e.g. the person or group that is delivering the information.

The success of using what are called local champions has been extensively documented since the HIV/AIDS pandemic began in the 1980s [3].
Local champions are people who are willing to promote local awareness and action via: informal conversations with family, friends, neighbours; street outreach working with local organisations; and virtual outreach, using social media channels. They are well placed to explore the barriers to acting on COVID-19 information, and can serve as bridges to community organisations that can help to remove social and economic barriers to following guidance. This approach to making sense of guidance and

promoting action rests upon the identification of local people who are trusted by others in their community. Several key elements are needed to successfully move people from looking at information to taking action to protect health. These include: enlisting locally known popular opinion leaders, using people with knowledge of the area/group to champion the initiative, providing training and ongoing support to ensure that local people have the confidence to spread the word, encouraging locally trained people to use their own local knowledge to ensure that messages are tailored to different concerns and groups, and feedback to help those who are having the conversations see the impact [4]. The relevance of local champions has been recognised in relation to COVID-19 [5]. We used the principles of this model to organise "Covid Confidence" sessions, with the aim of supporting people in economically deprived neighbourhoods to act appropriately in terms of managing risk.

Methods

COVID-19 Confidence sessions were co-hosted by community organisations and the Sheffield Community Contract Tracers (SCCT) a group comprised of retired Public Health specialists, Directors of Public Health and local GPs. The group originally came together to pilot the effectiveness of community-based contact tracing, and subsequently expanded their role to disseminating COVID-19 information with the aim of promoting understanding to community workers and volunteers. Many of these experts/professionals had long-established links with local voluntary and statutory organisations. The COVID-19 Confidence (CC) sessions were provided in conjunction with online SCCT information sessions providing up to date information. Topics were based on community-identified concerns. The sessions provided them with key facts about COVID-19 exposure, transmission, and protective behaviour as well the COVID-19 vaccines. Discussions drew upon local knowledge and expertise to show how champions can support people to deal with issues arising during the pandemic.

The programme theory for COVID-19 Confidence is based on well-known models for using popular opinion leaders and providing peer support to manage health [3, 6]. We began with a set of assumptions (Table 1).

Table 1 Preliminary logic model for COVID-19 Confidence

If	Then
If people are provided with training on how to communicate key COVID-19 facts, and are supported to use their own expertise to effectively communicate with local groups	Then they will become increasingly confident to deal with difficult conversations about complicated information.
If the people providing the information	Then opportunities to discuss

have local credibility,	misinformation will arise. People who are uncertain of what to do about COVID-19 may be more able to consider the correct information, and make informed decisions about what they are able to do to reduce risk, in light of their own circumstances.
If the number of informal champions in each area increases	Then consistent messages from trusted sources will predominate, decreasing the chances that people will be acting on misinformation.
If communities are able to identify the social, economic, and educational barriers to following COVID-19 guidance,	Then they will be able to connect people to local organisations who can work with them to prevent COVID-19 transmission, and remove barriers to self-isolation if infected.
If local people share their issues and work together to generate solutions,	Then community capacity to deal with issues thrown up by the pandemic will increase.

Community concerns dictated the topics for discussion. This put communities in control over the nature and direction of support. Knowledge exchange and mobilisation was promoted using a participatory action learning and research (PALAR) framework. The framework was used to elicit challenges in supporting local people during the pandemic, figure out possible solutions, observe what happened, and then reflect on what had worked and why [7]. The PALAR process facilitates collective learning, collaboration, and networking to promote social change. When complicated information was presented about COVID-19, participants were given time to engage in a process of collective sensemaking, to question implications, to explore how people might struggle to carry out the guidance and what the guidance would mean for people in different circumstances [8].

We identified three different neighbourhoods that wanted to develop COVID-19 champions. Fifteen sessions were facilitated between September 2020 and November 2021 across three Sheffield neighbourhoods. These neighbourhoods have areas of high local deprivation, a mix of ethnic groups, and 18 – 22% of the community do not have English as their main language. Further, 18 – 27% live in overcrowded housing, which is far more than the national average of 8.7%. Forty eight organisations took part, with a total of 198 participants (including repeat

attenders). Participants drew upon their local knowledge to consider how information could be used in their particular setting. They 'road tested' the information during conversations with people in challenging life circumstances, and fed back in subsequent sessions on how information needed to be tailored for local groups and local issues. Participants used concerns raised by the public to structure sessions, and were involved in reflecting on the utility of the sessions throughout. This information was included in the process evaluation.

Session discussions and notes, as well as interviews, were used to assess whether champions were enabled to have conversations with people and modify information for local groups. Over time, we hoped that repeated participation in the sessions might lead to shared learning and networks of support, building community capacity to address the pandemic. Capacity building happens when community groups become more able to define, assess, analyse and act on health (or any other) things that their local members are concerned about (see Table 2).

Table 2: Indicators of community capacity building

Increased stakeholder participation	People come together to define problems, analyse and decide how to act.
Improved capacity to do problem assessment	When **c**ommunities take the lead in identifying problems, solutions to the problems and actions to resolve the problems they can develop an increased sense of self-determination and capacity.
Local leadership	People in formal and informal positions of authority help to mobilise groups and community organisations.
Empowering organisational structures	Faith groups and community organisations that already provide places for people to come together and address problems.
Stronger links between people and organisations	These can be partnerships, coalitions or voluntary alliances between the community and others, that assist the community in addressing its issues.
Improved resource mobilisation	Resources include expertise of local people, environmental, financial or political, that are identified within communities. The ability of the community both to mobilise resources from within and to negotiate resources from beyond itself is an important factor. The capacity of a group is also dependent on opportunities or constraints (ecological, political and environmental), and the conditions in which people and groups live.
Equitable relationships with outside agents	Outside agents are an important link between communities and external resources. Their role is especially important near the beginning of a crisis, when the process of building new community momentum may be triggered and nurtured. The outside agent increasingly transforms power relationships between her/himself, outside agencies, and the community, such that the community assumes increasing authority.
Enhanced stakeholder	The ability of the community to critically assess the social, political, economic and other causes of inequalities is a crucial stage towards

ability to ask why	developing appropriate personal and social change strategies.
Increased stakeholder control over programme management	Communities become more capable when they have people who can take control over decisions on planning, implementation, evaluation, finances, administration, reporting and conflict resolution.

Source: [9-10]

We evaluated the development of community capacity via session notes and interviews. Participants agreed that sessions would be recorded and notes taken, for the purposes of tracking progress with the action learning cycle. Individuals who were contacted for interviews were given a participant information sheet and asked if they had any questions prior to the interview. The evaluation received ethics approval from Sheffield Hallam University (ER30632144).

Findings

Findings are presented in terms of the indicators for community capacity building (Table 2). Participation records showed that over time, a core group representing a diverse range of local organisations came together, attending sessions, hosted by different neighbourhoods, to learn and bring information back to their own area. The group became a forum for doing problem assessment and identified misinformation as a major issue. Potential solutions were identified and actions taken (Table 3).

Table 3: Combating misinformation: possible solutions and actions taken

Possible solution	Actions taken
Increasing access to up-to-date information.	SCCT sponsored information sessions with expert speakers. Using social media to spread correct information.
Supporting people make sense of information: the nature of COVID-19, getting tested, self-isolating, how vaccines worked and about getting vaccinated.	Opportunities during sessions to discuss information and question experts. Invitations to hospital, primary care and Public Health experts to attend.
Up-skilling workers and volunteers to provide information to local people.	Leaders cascading information. Feedback from workers and volunteers sharing what worked.
Translating into the languages of local communities.	Liaison with the City Council Communications Team and co-producing information.

Modifying technical vocabulary and using pictures or videos.	Co-producing resources. Making videos using local workers and leaders.

Existing faith and other community groups worked with local champions to take action. Organisations that had previously received little formal recognition found the process affirming: "The BAME community themselves got organised – realised that they were actually very active within their own communities". (OB02)

Participants exercised leadership, going back to their communities with specific actions developing stronger links between people who had previously little experience of working together. The links were instrumental in helping communities address COVID-19 issues. SCCT sessions "put us in touch with all sorts of people who are a mine of information…and certainly the workshops enabled us to meet people who were really helpful". (OD02) A number of people attended all of them, which meant that "they were able to share information from one group to another" (OD02). They used sessions to share how to run COVID-19 Q&A sessions, how to build COVID-19 Confidence, and how to adapt information and support to specific groups. (OS03)

Communities increased resource mobilisation by recruiting volunteers fluent in Urdu, Punjabi, Arabic, Hindi, and Bulgarian to produce videos. Locals identified social media platforms that were commonly used to promote messages (OS01). Members of SCC Public Health and Communications teams began to attend sessions, working with local people to produce more accessible written information. Over time, sessions became a conduit for disseminating vaccine clinic schedules to volunteers and COVID-19 Champions. When community leads noted that trusted local people were instrumental in promoting use of drop-in clinics, SCC arranged times and locations in tandem with them. People noted that "the partnership approach really helped with getting messages out". (OS01)

The sessions enabled communities to establish an equitable relationship with SCCT, linking communities to information resources. There was a widely shared perception that " SCC (Sheffield City Council) Public Health staff are very good at what they're doing, but they're not necessarily there when you need them". Thus, the information sessions hosted by SCCT were seen as, "Vital for our work – good to know they were there every 2 weeks". (OB01)

SCCT used their previous working relationships to engage current experts in seminars. They provided updated information on government guidance, explained local and national statistics and outlined the development of the vaccine strategy.

"Though we were all community leaders and community activists and community people, we are not medical people. The questions we were taking to SCCT were the

questions we were hearing from the vulnerable people in the community. I was getting really good answers from SCCT so that was a big asset". (OB01)

Several SCCT members also had a long history of working with local organisations. These crosscutting relationships meant that they were able to facilitate dialogues between expert speakers and local people, with the express aim of making sense of information.

> "Most of the written information is not clear – it really helped our community, ourselves as part of the community, as well as professionals. It's good to get explanations, rather than just information." (OD01)

Countering misinformation was a long-term challenge because of the constantly shifting information about COVID-19. Responsive and timely exchange led to what one participant called a "waterfall effect – they got information and were able to pass that back to others more locally in their area". (OS01) SCCT became an "anchor point - it meant that we were able to keep countering the misinformation that they were getting on a regular basis". (OD01; OD02)

Although the strategies to improve access to relevant information were effective, trust was a major issue.

> "As much as we shared the data, the statistics and what the government were saying, we weren't getting anywhere. There was no trust in the communities because we were working with the government. "(OSO1)

Community organisations decided that the only solution was to increase cross-sector stakeholder participation, using their connections to involve local leaders in collaborating.

> "The only way to get the information out to the communities was to work with the local Imams and local GPs. We worked with particular GPs who people from the community really look up to…..One of these GPs was also very active on social media and the community organisations used his videos a lot. Some of these GPs also came to COVID-19 Confidence".

The fact that these leaders were known and trusted was a tipping point in COVID-19 engagement:

> [So we said] 'your GP and your Imams - two people you really look up to - would they be lying? Would they be putting you at risk?' And we explained that they could be putting themselves more at risk by not getting tested or having the vaccine". (OSO1)

Organisations collaborated with SCC to promote test centres, which "really built a trusting relationship with SCC and Public Health – they learnt from us and we learnt from them". (OS01) The process increased local credibility, because it "meant we knew up to date information... people then trust you because you've known what's going on." (OD02)

The collaboration triggered some changes in programme management. Community organisations - such as the BAME Group- were asked to join statutory sector steering groups and committees. As a result, voluntary sector organisations gained greater awareness of "what was happening on the ground". (OS01) They also became partners in the sense of co-managing COVID-19 issues. "SCC didn't just take a top-down approach – felt they were asked how to best achieve things in the communities". (OS02) Community hubs and anchor organisations informed a number of statutory sector initiatives including COVID-19 Community Response Grants, the COVID-19 information bus, the vaccine van, and developing a cadre of COVID-19 Champions. The 'COVID-19 Community Response Grants' have meant "Closer working relationship than there might normally be, especially with some organisations e.g. around comms – continued focus on getting specific comms out to particular communities". (CO2) Being valued for their knowledge meant that organisations – particularly smaller ones that felt previously missed – believed that they were in a "definitely different relationship now", [where] people in the Council have now recognised the importance of the voluntary sector". (OS02; OS01)

Meetings, discussions and interviews identified the underlying elements that contributed to effective community mobilisation. Drawing upon local knowledge was essential, to ensure that any form of health promotion was seen to be relevant and appropriate. Session participants agreed that "trust was such a massive issue" and it was important to start by involving people who were already locally known and trusted. For example, Roma Slovak and Bulgarian groups were all approached by finding people who had existing relationships with them, to act as a bridge for the COVID-19 volunteers. In some neighbourhoods, a cadre of active volunteers already existed, usually coordinated by the local community anchor organisation. COVID-19 volunteers were in most cases community members, working in other capacities, and local volunteers already knew what people were saying/thinking about the vaccines. (OD01). When volunteers were new to an area, community leaders and people known to the various groups acted as gatekeepers, linking volunteers with the areas which needed support. This gave volunteers credibility. They noted that being endorsed by local people was crucial in gaining trust in an area - "Without that, we wouldn't have got anywhere". (OB02)

It was also important that volunteers had some experiences in common with the local people they were reaching out to. This could be a shared language, a common culture, being a member of a vulnerable group, having COVID-19 or caring for a family member who had COVID-19. For example, a bilingual medical student whose

father had gone through COVID-19 was trusted almost immediately even though he wasn't locally known. Being in a respected role counteracted misinformation. For example, a video of an imam and an Islamic pharmacist at the local mosque included the message given from the Quran saying you should save your own life first. "This really gave them confidence to get the jab". (OD01)

Local workers with established relationships were also able to influence people. A worker who was well known in her local community made a video of herself talking in Arabic about having her vaccine. These pre-existing bridges of trust enabled outreach to a range of ethnic groups in different neighbourhoods (OD01; OSO1).

Finally, the importance of repeated contacts was mentioned frequently. One off, written information is not effective on its own. Outreach often involves having more than one conversation with people, leaving them time to consider and come back with concerns and questions [Sharrow COVID-19 Confidence meeting Feb, June 2021]. Conversations need to start by listening to people's concerns before giving information. Further, information giving needs to be embedded and opportunistic. Opportunities to share information need to be found in the course of engaging people on what matters to them first, building a relationship, and introducing COVID-19 information when appropriate. For example, women's wellbeing sessions were used to "find out what is most important issue for them first – build that relationship and then get onto vaccines when they are ready. It can take a lot of conversations, too – not a quick win. (CC Meeting 11.2022)

People reported that the COVID-19 Confidence approach (Box 2) enabled them to communicate information and support to individuals and local groups. The effectiveness of this approach is supported by previous research using locally known and respected people to raise awareness of health risk during epidemics [3].

Box 2: Covid Confidence Communication Model

Providing information
Receiving information by trusted experts; and
Being encouraged to ask questions
helped workers and volunteers understand COVID-19 guidance.

Developing approaches to communication
Promoting discussion that focuses on
Identifying the challenges of explaining COVID-19;
Considering the concerns and needs of people in different groups and situations; and
Sharing approaches to giving information to local people
helped people to develop approaches for successfully communicating the information to different groups.

Establishing trust
Using people who were known in the neighbourhood, or had something in common
Using familiar vocabulary and preferred language
Listening to concerns before 'telling' people what to do
Repeated contact and conversations
Built trust which inclined people to consider following recommendations.

Reflecting on the process
Coordinating sessions where people were encouraged in
Feeding back on successful ways of communicating information
validated champions, recognising that their local knowledge combined with communication skills is effective.

These communication strategies were reported to influence people, in terms of their stated intentions to self-isolate and to get vaccinated. The surrounding context, however, contained a number of challenges that made it difficult for people to actually follow guidance. Workers reported that people were reluctant to get tested because they needed to continue to work. People were unable to comply with self-isolation and distancing guidelines due to overcrowded and poorly ventilated housing. People were challenged to feed themselves and their families if they were self-isolating, because their incomes were affected. The challenges of managing COVID-19, therefore, reflect the challenges of health inequalities.

Discussion

Our findings align with previous research on the elements needed to effectively communicate risk to people during epidemics [3], and recent community engagement research which found that community leaders, volunteers and multilingual approaches targeted to specific groups can effectively disseminate Covid information and expand access to testing [11-12]. Vaccine hesitancy and lack of trust were major determinants in our decision not to try to attempt linkage of individuals who were supported during the intervention with vaccine uptake. Our evaluation indicated that community engagement can support vaccine uptake. Recent research calls for authentic community outreach [13]but as of yet there are few studies confirming effectiveness [14]. There is, however, evidence from a recent systematic review that community engagement can prevent and control disease during an epidemic, when local leaders, community organisations and networks, key stakeholders and local people communicate social and behavioural risk, and get logistical support from health sectors [15]. Both the review and our study found that community mobilisation tended to happen separately from the health system (see Figure 1). Where previous research did find coordination during contact tracing, the SCCT initiative demonstrating effectiveness of community-based contact tracing [16] but this local initiative was not supported by the national public health system in the UK. Community health committees have been used in prior epidemics to communicate risk and promote behaviour change. In our project, local neighbourhoods used Covid Confidence sessions to foster collective relationships among organisations, which in turn developed communication strategies We found that communities had to embark on a process of "re-contextualising" government information by finding locally appropriate ways of explaining risk.[17] Linkages with health systems came late in the process, most notably with the translation of written information and coordination of clinic schedules with outreach initiatives. In both the review and our study, community resources were inadequate, and there was a weak health support infrastructure. Our communities were able to identify issues quickly, and also keep track of emerging needs, using existing voluntary sector knowledge to draw upon local social networks. This ability to rapidly and flexibly mobilise is identified as a crucial in other studies [18] who note that community mobilisation at early stages can compensate for slower restructuring at statutory level. Other studies also note that given the evidence of effectiveness, communities need to be engaged from the beginning in codesign and co-implementation of public health strategies, sustaining a two-way dialogue to consistently provide transparent and accurate information [19-20]

Last but not least, barriers in the broader context, which have been a problem in past epidemics, continue to limit abilities to connect people to local organisations who

can work with them to prevent COVID-19 transmission, and remove barriers to self-isolation if infected.

Conclusions

Training and support can increase community capacity to manage during the COVID-19 pandemic. Linkages with trusted outside agents who were able to enlist topic experts increased confidence of local people in communicating information, counteracting misinformation, and supporting people to make appropriate decisions. Providing a forum where organisations can identify problems and possible solutions, adapt information and share effective approaches was an important element in developing cross-organisational relationships and supportive networks. This early support enabled communities to mobilise a rapid response. The mobilisation, however, was challenging to integrate with statutory sector management in the early days of the pandemic. Despite increased capacity to manage at community level, however, the broader context of social determinants of health diluted effectiveness of mobilisation. individual ability to follow COVID-19 guidance was undermined by the need to continue work, often in front line jobs, and overcrowded housing. Community mobilisation can be an instrumental component in public health pandemic management. However, communities need to be actively involved in codesign and implementation of public health strategies. The strategies need to be underpinned by government recognition of underlying inequalities that make it difficult to follow COVID-19 19 guidance. As the urgency of the pandemic wanes, the resources needed by community organisations to continue to manage the long term effects of COVID-19 19 need to be retrospectively assessed and coherent funding strategies put in place that support them in continuing to address the underlying issues of health inequality that have been highlighted during the pandemic.

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Can communities be mobilised to build capacity to respond to the COVID-19 pandemic? A qualitative process evaluation

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Objectives

Government guidance to manage COVID-19 was challenged by low levels of health and digital literacy and lack of information in different languages. Covid Confidence sessions were evaluated to assess their effectiveness in counteracting misinformation and provide an alternative source of information about the pandemic.

Design

We worked with community anchor organisations to coordinate online "Covid Confidence" sessions serving three economically deprived, ethnically mixed, neighbourhoods. We conducted a qualitative, participatory process evaluation, in tandem with the sessions to explore whether a popular opinion leader/local champion model of health promotion could mobilise pandemic responses. Group discussions were supplemented by final interviews to assess changes in community capacity to mobilise.

Setting

Sheffield, England, September 2020 – November 2021

Participants

314 community leaders, workers and volunteers representing a variety of local organisations attended sessions. A group of local health experts helped organisations make sense of government information.

Results

Covid Confidence sessions fostered cross-organisational relationships, which enabled rapid community responses. Community champions successfully adapted information to different groups. Listening, identifying individual concerns and providing practical support enabled people to make informed decisions on managing exposure and getting vaccinated. Some people were unable to comply with self-isolation due to overcrowded housing and the need to work. Communities drew upon existing resources and networks.

Conclusions

Sessions promoted stronger links between community organisations who reduced mistrust of government information. In future, government efforts to manage pandemics should partner with communities to co-design and implement prevention and control measures.

Strengths and limitations of study

Strengths:

- Session agendas were based on local concerns, thereby ensuring good engagement by stakeholders.
- Data collected during sessions on effective mobilisation was supplemented by interviews with key informants.

Limitations:

- The relationships between engagement and vaccine uptake could not be established as it was not possible to link interactions with individual data.

Background

While the government has generated a vast amount of information and guidance about the COVID-19 pandemic, people say that they struggle to keep up with it. The World Health Organisation announced in 2020 that the COVID-19 pandemic had triggered an infodemic, e.g. “an overabundance of information – some accurate and some not – that makes it hard for people to find trustworthy sources and reliable guidance when they need it”. [1]. Although rumours and misinformation are spread in all disease outbreaks, information “goes faster and further, like the viruses that travel with people and go faster and further. So it is a new challenge, and the challenge is the [timing] because you need to be faster if you want to fill the void…What is at stake during an outbreak is making sure people will do the right thing to control the disease or to mitigate its impact. So it is not only information to make sure people are informed; it is also making sure people are informed to act appropriately”. [2]. When creating information strategies, governments are dealing with a wicked and complex problem, because COVID-19 is (a) a new phenomenon, where the virus, as well as the science needed to tackle it, is rapidly evolving; (b) treatments and policies for treatment are contested. Further, the government strategies for spreading accurate information have met with varying success, because willingness to accept the facts varies according to the beliefs of any particular group, and their attitudes and trust toward government information in general. The success of strategies is not only dependent on local attitudes and beliefs, but also on the characteristics of the messenger e.g. the person or group that is delivering the information.

The success of using what are called local champions has been extensively documented since the HIV/AIDS pandemic began in the 1980s [3].
Local champions are people, who are willing to promote local awareness and action via: informal conversations with family, friends, neighbours, street outreach working with local organisations, and virtual outreach, using social media channels. They are

well placed to explore the barriers to acting on COVID-19 information, and can serve as bridges to community organisations that can help to remove social and economic barriers to following guidance. This approach to making sense of guidance and promoting action rests upon the identification of local people who are trusted by others in their community. Several key elements are needed to successfully move people from looking at information to taking action to protect health. These include: enlisting locally known popular opinion leaders, using people with knowledge of the area/group to champion the initiative, providing training and ongoing support to ensure that local people have the confidence to spread the word, encouraging locally trained people to use their own local knowledge to ensure that messages are tailored to different concerns and groups, and feedback to help those who are having the conversations see the impact [4]. The relevance of local champions has been recognised in relation to COVID-19 [5]. We used these principles to organise "Covid Confidence" sessions, with the aim of supporting people in economically deprived neighbourhoods to act appropriately in terms of managing risk.

Methods

Sessions were co-produced and hosted by community organisations, who expressed interest in working with the Sheffield Community Contract Tracers (SCCT) to mobilise responses to the pandemic. The SCCT is a voluntary group of retired health professionals, comprised of 9 Public Health specialists, Directors of Public Health and local GPs with experience in infection control, communicable disease control, epidemiology, health promotion, primary care, participatory evaluation, and community organisation. The group originally came together to pilot the effectiveness of community-based contact tracing, and subsequently expanded their role to disseminating COVID-19 information, with the aim of promoting understanding to community workers and volunteers. Many of these experts/professionals had long-established links with local voluntary and statutory organisations. The COVID-19 Confidence (CC) sessions dealt directly with issues of misinformation. They were provided in conjunction with online SCCT information sessions, which delivered up to date information. Topics were based on community-identified concerns. The information sessions aimed to provide people with key facts about COVID-19 exposure, transmission, and protective behaviour, as well as the COVID-19 vaccines. The Covid Confidence sessions drew upon local knowledge and expertise, using discussion to show how champions can support people to deal with issues arising during the pandemic. A participatory process evaluation was conducted, where participants observed and reflected on the utility of the sessions. Qualitative key informant interviews were conducted with a subset of participants at the end of the project.

The programme theory for COVID Confidence is based on well-known models for using popular opinion leaders and providing peer support to manage health [3, 6]. We began with a set of assumptions (Table 1).

Table 1 Preliminary logic model for COVID-19 Confidence

If	Then
If people are provided with training on how to communicate key COVID-19 facts, and are supported to use their own expertise to effectively communicate with local groups	Then they will become increasingly confident to deal with difficult conversations about complicated information.
If the people providing the information have local credibility	Then opportunities to discuss misinformation will arise. People who are uncertain of what to do about COVID-19 may be more able to consider the correct information, and make informed decisions about what they are able to do to reduce risk, in light of their own circumstances.
If the number of informal champions in each area increases	Then consistent messages from trusted sources will predominate, decreasing the chances that people will be acting on misinformation.
If communities are able to identify the social, economic, and educational barriers to following COVID-19 guidance	Then they will be able to connect people to local organisations who can work with them to prevent COVID-19 transmission, and remove barriers to self-isolation if infected.
If local people share their issues and work together to generate solutions,	Then community capacity to deal with issues thrown up by the pandemic will increase.

Covid Confidence session agendas were created by eliciting community concerns, via conversations with anchor organisation leads, and allowing these concerns to dictate the topics for discussion. This put communities in control over the nature and direction of support. Knowledge exchange and mobilisation was then promoted, using a participatory action learning and research framework to explore challenges in supporting local people during the pandemic, figure out possible solutions, observe what happened, and then reflect on what had worked and why [7]. This process facilitates collective learning, collaboration, and networking to promote social change. When complicated information was presented about COVID-19, participants

were given time to engage in a process of collective sensemaking, to question implications, to explore how people might struggle to carry out the guidance and what the guidance would mean for people in different circumstances [8].

Three different neighbourhoods expressed interest in developing COVID-19 champions. Fifteen sessions were facilitated between September 2020 and November 2021 across three Sheffield neighbourhoods. These neighbourhoods have areas of high local deprivation, a mix of ethnic groups, and 18 – 22% of the community do not have English as their main language. Further, 18 – 27% live in overcrowded housing, which is far more than the national average of 8.7%. Forty-eight organisations took part, with a total of 198 participants (including repeat attenders). Participants drew upon their local knowledge to consider how information could be used in their particular setting. They 'road tested' the information during conversations with people in challenging life circumstances, and fed back in subsequent sessions on how information needed to be tailored for local groups and local issues. Participants used concerns raised by the public to structure sessions, and were involved in reflecting on the utility of the sessions throughout. This information was included in the process evaluation.

The participatory process evaluation was conducted in tandem with sessions, generating data from participants' reflections on the challenges and outcomes of taking action, and the utility of the discussions. Participants agreed that sessions would be recorded and notes taken during sessions, for the purposes of tracking progress with the action learning cycle. Notes were fed back to participants in subsequent sessions to reflect on whether and how they enabled champions to have conversations with people and modify information for local groups. Over time, we hoped that repeated participation in the sessions might lead to shared learning and networks of support, building community capacity to address the pandemic. Capacity building happens when community groups become more able to define, assess, analyse and act on health (or any other) things that their local members are concerned about (see Table 2). Key indicators of capacity, developed via prior research [9,10] were used to review the session notes and interviews, in order to assess how the process related to capacity building.

Table 2: Indicators of community capacity building and mobilisation

Increased stakeholder participation	People come together to define problems, analyse and decide how to act.
Improved capacity to do problem assessment	When communities take the lead in identifying problems, solutions to the problems and actions to resolve the problems they can develop an increased sense of self-determination and capacity.
Local leadership	People in formal and informal positions of authority help to mobilise groups and community organisations.
Empowering organisational structures	Faith groups and community organisations that already provide places for people to come together and address problems.
Stronger links between people and organisations	These can be partnerships, coalitions or voluntary alliances between the community and others, that assist the community in addressing its issues.
Improved resource mobilisation	Resources include expertise of local people, environmental, financial or political, that are identified within communities. The ability of the community both to mobilise resources from within and to negotiate resources from beyond itself is an important factor. The capacity of a group is also dependent on opportunities or constraints (ecological, political and environmental), and the conditions in which people and groups live.
Equitable relationships with outside agents	Outside agents are an important link between communities and external resources. Their role is especially important near the beginning of a crisis, when the process of building new community momentum may be triggered and nurtured. The outside agent increasingly transforms power relationships between her/himself, outside agencies, and the community, such that the community assumes increasing authority.
Enhanced stakeholder ability to ask why	The ability of the community to critically assess the social, political, economic and other causes of inequalities is a crucial stage towards developing appropriate personal and social change strategies.
Increased stakeholder control over programme management	Communities become more capable when they have people who can take control over decisions on planning, implementation, evaluation, finances, administration, reporting and conflict resolution.

Source: [9-10]

The session notes were organised by three researchers (JH, PR, FA) using the above indicators as themes, and member checked via 9 key informant interviews

with 12 participants. These were conducted at the end of the project, to assess changes in community capacity to mobilise. The topic guide, developed from findings, asked general questions as well as exploring communication issues that arose about Council coordination of the information bus, and the many positive comments that were made about a local co-produced film (Box 1).

Box 1 Interview topic guide

SCCT role
What are your thoughts on the role that SCCT played in sharing information about Covid?
Did it generate trust? Reduce hesitancy? Form new connections and/or networks?
What has changed – for the long term, rather than temporarily?
Have local knowledge and experiences been valued and recognised by Public Health and the City Council?
Has the process enabled communities to have a voice in managing Covid?

Covid Confidence cascade effect
Some people came to the first sessions and went on to run smaller sessions in local areas, feeding back information from the larger sessions. We'd like to understand the differences in your process – what happened? How did your local sessions develop?

How was local knowledge used through Covid Confidence?
Were there any new ways of doing things? Will these approaches last/be taken forward, or were they Covid-specific?
Were you able to provide advice and support to people who were concerned about symptoms?
Were you able to facilitate sessions that met local needs, for example local language support?

Community Bus
What do you think about the Council's Community Bus?
Is it something that you have helped to support in your area?
Are you getting enough notice to mobilise local workers to show up and support theb us?
How do you think the bus helps to communicate?
Does it help your communities? Have you heard any local feedback about it?

Seldom Heard Communities Film
Were you involved with the Seldom Heard Communities Film?
People have mentioned the film as having been key in the process of managing the pandemic. What do you think?
What impacts do you think the film has had?

We selected key informants from the larger group of participants. They were given a participant information sheet and asked if they had any questions prior to the interview. After checking understanding, verbal consent was taken.

Patient and public involvement
None

Findings

Findings are presented in terms of the indicators for community capacity building (see Table 2 above).

Stakeholder participation records showed community leaders, workers and volunteers representing community groups, local people, health services, university and council departments attended one or more of fifteen sessions (Table 3).

Table 3: Overview of Groups Represented

Type of group represented	Number
Community organisations	23
Faith groups	4
Health service areas	6
Local council departments	9
University departments	4
Youth organisations	2
Community members	6

Four sessions were hosted by two of the neighbourhoods. People from these neighbourhoods also attended the 11 sessions hosted by the third neighbourhood, totalling 314 attendances. From this group of repeat attendees, a core group representing a diverse range of local organisations developed over time. The group became a forum for doing **problem assessment**, identifying shared problems, considering solutions and considering whether they had capacity and resources to take action (Table 4).

Table 4: Combating misinformation: possible solutions and actions taken

Possible solution	**Actions taken**
Increasing access to up-to-date information.	SCCT sponsored information sessions with expert speakers. Using social media to spread correct information.

Supporting people make sense of information: the nature of COVID-19, getting tested, self-isolating, how vaccines worked and about getting vaccinated.	Opportunities during sessions to discuss information and question experts. Invitations to hospital, primary care and Public Health experts to attend.
Up-skilling workers and volunteers to provide information to local people.	Leaders cascading information. Feedback from workers and volunteers sharing what worked.
Translating into the languages of local communities.	Liaison with the City Council Communications Team and co-producing information.
Modifying technical vocabulary and using pictures or videos.	Co-producing resources. Making videos using local workers and leaders.

Participants exercised **local leadership**, identifying local organisations and informal groups that were willing to take action. This included health champions working to spread accurate information and supporting people to consider how they could reduce their risks. Organisations that had previously received little formal recognition found the process **empowering** and affirming: "The BAME community themselves got organised – realised that they were actually very active within their own communities". (OB02) These actions fostered **stronger links** between people who had previously little experience of working together. For example, volunteers from a number of organisations promoted city council information about the vaccine programme, subsequently coming together to assist general practices with vaccine uptake. The links became **empowering organisational structures**, which were instrumental in helping communities come together to address COVID-19 issues. SCCT sessions "put us in touch with all sorts of people who are a mine of information…and certainly the workshops enabled us to meet people who were really helpful". (OD02) A number of people attended all of them, which created **stronger links between people and organisations** which "were able to share information from one group to another" (OD02). They used sessions to share how to run COVID-19 Q&A sessions, how to build Covid confidence, and how to adapt information and support to specific groups. (OS03)

Communities **mobilised resources** by recruiting volunteers fluent in Urdu, Punjabi, Arabic, Hindi, and Bulgarian to produce videos. Locals identified social media platforms that were commonly used to promote messages (OS01). Members of Sheffield City Council (SCC) Public Health and Communications teams began to attend sessions, working with local people to co-produce more accessible written information. Over time, sessions became a conduit for disseminating vaccine clinic schedules to volunteers and COVID-19 Champions. When community leads noted

that trusted local people were instrumental in promoting use of drop-in clinics, SCC arranged times and locations in tandem with them. People noted that "the partnership approach really helped with getting messages out". (OS01)

The sessions enabled communities to establish a more **equitable relationship** with academics and public health experts. SCCT used their previous working relationships to engage current experts in seminars. These crosscutting relationships meant that they were able to facilitate dialogues between expert speakers and local people, with the express aim of making sense of information. Experts provided updated information on government guidance, explained local and national statistics and outlined the development of the vaccine strategy.

> "Most of the written information is not clear – it really helped our community, ourselves as part of the community, as well as professionals. It's good to get explanations, rather than just information." (OD01)

There was a widely shared perception that "SCC Public Health staff are very good at what they're doing, but they're not necessarily there when you need them". Thus, the information sessions hosted by SCCT were seen as "vital for our work – good to know they were there every 2 weeks. Though we were all community leaders and community activists and community people, we are not medical people. The questions we were taking to SCCT were the questions we were hearing from the vulnerable people in the community. I was getting really good answers from SCCT so that was a big asset". (OB01)

Countering misinformation was a long-term challenge because of the constantly shifting information about COVID-19. Responsive and timely exchange led to what one participant called a "waterfall effect – they got information and were able to pass that back to others more locally in their area". (OS01) SCCT became an "anchor point - it meant that we were able to keep countering the misinformation that they were getting on a regular basis". (OD01; OD02)

Although the strategies to improve access to relevant information were effective, champions found that trust was a major issue.

> "As much as we shared the data, the statistics and what the government were saying, we weren't getting anywhere. There was no trust in the communities because we were working with the government. "(OSO1)

Community organisations decided that the only solution was to increase **cross-sector stakeholder collaboration**, which included local leaders.

> "The only way to get the information out to the communities was to work with the local Imams and local GPs. We worked with particular GPs who people from the community really look up to…..One of these GPs was also very active on social media and the community organisations used his videos a lot. Some of these GPs also came to COVID-19 Confidence".

Champions said that the fact that these leaders were known and trusted was a tipping point in COVID-19 engagement:

> [So we said] 'your GP and your Imams - two people you really look up to - would they be lying? Would they be putting you at risk?' And we explained that they could be putting themselves more at risk by not getting tested or having the vaccine". (OSO1)

Organisations collaborated with SCC to promote test centres, which "really built a trusting relationship with SCC and Public Health – they learnt from us and we learnt from them". (OS01) The process increased local credibility, because it "meant we knew up to date information... people then trust you because you've known what's going on." (OD02)

Dealing with mistrust and vaccine hesitancy led stakeholders **to ask why** relationships with government agencies were so poor. A docuseries, co-produced by SCCT and BAME leads, engaged seldom heard communities in describing their situations. (https://www.communitycontacttracers.com/shc/)

The collaboration triggered some changes in **programme management**. Community organisations - such as the BAME Group - were asked to join statutory sector steering groups and committees. As a result, voluntary sector organisations gained greater awareness of "what was happening on the ground". (OS01) They also became partners in the sense of co-managing COVID-19 issues. "SCC didn't just take a top-down approach – felt they were asked how to best achieve things in the communities". (OS02) Community hubs and anchor organisations informed a number of statutory sector initiatives including COVID-19 Community Response Grants, the COVID-19 information bus, the vaccine van, and developing a cadre of COVID-19 Champions. The 'COVID-19 Community Response Grants' have meant "Closer working relationship than there might normally be, especially with some organisations e.g. around comms – continued focus on getting specific comms out to particular communities". (CO2) Being valued for their knowledge meant that organisations – particularly smaller ones that felt previously missed – believed that they were in a "definitely different relationship now", [where] people in the Council have now recognised the importance of the voluntary sector". (OS02; OS01)

Alongside description of capacity building, people also identified the underlying elements that contributed to effective community mobilisation. Drawing upon local

knowledge was essential to counteracting misinformation and ensuring that health promotion was seen to be relevant and appropriate. Session participants agreed that "trust was such a massive issue" and it was important to start by involving people who were already locally known and trusted. For example, Roma Slovak and Bulgarian groups were all approached by finding people who had existing relationships with them, to act as a bridge for the COVID-19 volunteers. In some neighbourhoods, a cadre of active volunteers already existed, usually coordinated by the local community anchor organisation. COVID-19 volunteers were in most cases community members, working in other capacities, and local volunteers already knew what people were saying/thinking about the vaccines. (OD01). When volunteers were new to an area, community leaders and people known to the various groups acted as gatekeepers, linking volunteers with the areas which needed support. This gave volunteers credibility. They noted that being endorsed by local people was crucial in gaining trust in an area - "Without that, we wouldn't have got anywhere". (OB02)

It was also important that volunteers had some experiences in common with the local people they were reaching out to. This could be a shared language, a common culture, being a member of a vulnerable group, having COVID-19 or caring for a family member who had COVID-19. For example, a bilingual medical student whose father had gone through COVID-19 was trusted almost immediately even though he wasn't locally known. Being in a respected role counteracted misinformation. For example, a video of an imam and an Islamic pharmacist at the local mosque included the message given from the Quran saying you should save your own life first. "This really gave them confidence to get the jab". (OD01)

Local workers with established relationships were also able to influence people. A worker who was well known in her local community made a video of herself talking in Arabic about having her vaccine. These pre-existing bridges of trust enabled outreach to a range of ethnic groups in different neighbourhoods (OD01; OSO1).

Finally, the importance of repeated contacts was mentioned frequently. One off, written information is not effective on its own. Outreach often involves having more than one conversation with people, leaving them time to consider and come back with concerns and questions [Sharrow COVID-19 Confidence meeting Feb, June 2021]. Conversations need to start by listening to people's concerns before giving information. Further, information giving needs to be embedded and opportunistic. Opportunities to share information need to be found in the course of engaging people on what matters to them first, building a relationship, and introducing COVID-19 information when appropriate. For example, women's wellbeing sessions were used to "find out what is most important issue for them first – build that relationship and then get onto vaccines when they are ready. It can take a lot of conversations, too – not a quick win. (CC Meeting 11.2022)

Findings were compared to our preliminary logic model for developing Covid Confidence (Table1) and used to develop a final model showing how the approach enabled people to communicate information and support to individuals and local groups (Box 2). The effectiveness of this approach is supported by previous research using locally known and respected people to raise awareness of health risk during epidemics [3].

Box 2: The Covid Confidence Approach

Providing information

Receiving information by trusted experts; and
Being encouraged to ask questions
helped workers and volunteers understand COVID-19 guidance.

Developing approaches to communication

Promoting discussion that focuses on
Identifying the challenges of explaining COVID-19;
Considering the concerns and needs of people in different groups and situations; and
Sharing approaches to giving information to local people
helped people to develop approaches for successfully communicating the information to different groups.

Establishing trust

Using people who were known in the neighbourhood, or had something in common
Using familiar vocabulary and preferred language
Listening to concerns before 'telling' people what to do
Repeated contact and conversations
Built trust which inclined people to consider following recommendations.

Reflecting on the process

Coordinating sessions where people were encouraged in
Feeding back on successful ways of communicating information
validated champions, recognising that their local knowledge combined with communication skills is effective.

In summary, the participants reported that the sessions increased their access to up to date, accurate information, and the sense-making process meant that they were able to explain information to other people. They were able to co-produce translated

material which was useful in local discussions, and co-produced videos were found to be useful (Table 3). People who used the Covid Confidence approach (Box 2) reported that they were able to influence people, in terms of their stated intentions to self-isolate and to get vaccinated. The surrounding context, however, contained a number of challenges that made it difficult for people to actually follow guidance. Workers reported that people were reluctant to get tested, because they needed to continue to work. People were unable to comply with self-isolation and distancing guidelines, due to overcrowded and poorly ventilated housing. People were challenged to feed themselves and their families if they were self-isolating, because their incomes were affected. The challenges of managing COVID-19, therefore, reflect the challenges of health inequalities.

Discussion

The process evaluation had several strengths and weaknesses. Participants set the agenda for each session; this increased attendance and ensured that local issues were addressed. Locally known and trusted public health and medical people facilitated discussion between local people and pandemic experts. This provided data on the challenges of contextualising of information and using local expertise and knowledge to generate appropriate engagement strategies. The data collected during sessions was supplemented by a final set of interviews with local workers and leaders who clarified and confirmed the findings. Unfortunately, quantitative relationships between engagement and vaccine uptake could not be established, as it was not possible to link interactions to decisions to get vaccinated.

Our findings align with previous research on the elements needed to effectively communicate risk to people during epidemics [3], and recent community engagement research which found that community leaders, volunteers and multilingual approaches targeted to specific groups can effectively disseminate COVID-19 information and expand access to testing [11-12]. Recent research calls for authentic community outreach [13] but as of yet there are few studies confirming effectiveness [14].There is evidence from a recent systematic review that community engagement can prevent and control disease during an epidemic, when local leaders, community organisations and networks, key stakeholders and local people communicate social and behavioural risk, and get logistical support from health sectors [15]. Stories from our Covid champions indicated that support promoted vaccine uptake, but we decided not to ask individuals to share personal details allowing us to link them with vaccination decisions, because of the widespread lack of trust. Community-based contact tracing can also promote vaccination [16], but in Sheffield this local initiative was not supported by the UK public health system. In our project, local neighbourhoods used Covid Confidence sessions to foster collective relationships among organisations, which in turn co-developed communication strategies We found that communities had to embark on a process of “re-contextualising” government information by finding locally appropriate ways of

explaining risk [17]. Linkages with health systems came late in the process, translation of written information, information sharing about the timing of the community bus, and coordination of clinic schedules finally occurred in months 9-14. Our study echoed review findings regarding inadequate community resources, and weak health support infrastructures [15]. Our communities were able to identify issues quickly, and also keep track of emerging needs, using existing voluntary sector knowledge to draw upon local social networks. This ability to rapidly and flexibly mobilise is identified as crucial in other studies [18] who note that community mobilisation at early stages can compensate for slower restructuring at statutory level. Other studies also note that given the evidence of effectiveness, communities need to be engaged from the beginning in co-developing and co-implementing public health strategies, sustaining a two-way dialogue to consistently provide transparent and accurate information [19-20].

Last, but not least, barriers in the broader context, which have been a problem in past epidemics, continue to limit abilities to connect people to local organisations who can work with them to prevent COVID-19 transmission, and remove barriers to self-isolation if infected.

Conclusions

In participatory research, impact is defined as the changes that occur during the process of collaborative enquiry and reflection, this includes changes in interactions between individuals and organisations as well as across systems. Our evaluation found that Covid Confidence increased interaction across stakeholders, improved ability to assess local problems and generate solutions, and fostered stronger links that increased community capacity. Trusted outside agents – SCCT members - who were able to enlist topic experts increased confidence of local people in communicating information, counteracting misinformation, and supporting people to make appropriate decisions. Local people began to trust champions as a result. Providing a forum where organisations can identify problems and possible solutions, adapt information and share effective approaches was an important element in developing cross-organisational relationships and supportive networks. Early support can enable communication across local groups to take action. The mobilisation can, however, be challenging to integrate with statutory sector management in the early days of a pandemic. Fewer changes were seen at the level of government systems. Mobilisation, was challenging to integrate with statutory sector management in the early days of the pandemic. Despite having ~~increased~~ capacity to manage at community level, however, the broader context of social determinants of health diluted effectiveness of mobilisation. In the case of COVID-19, individual ability to follow guidance was undermined by the need to continue work, often in front line jobs, and overcrowded housing.

In conclusion, community mobilisation can be an instrumental component in public health pandemic management. However, communities need to be actively involved in codesign and implementation of public health strategies. The strategies need to be underpinned by government recognition of underlying inequalities that make it difficult to follow COVID-19 guidance. As the urgency of the pandemic wanes, the resources needed by community organisations to continue to manage the long-term effects of COVID-19 need to be retrospectively assessed, and coherent funding strategies put in place that support them in continuing to address the underlying issues of health inequality that have been highlighted during the pandemic.

Data are available upon reasonable request
There are no competing interest for any author
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SRQR Checklist Item	Manuscript page number
Title	Title page
Abstract	Abstract page
Problem formulation	2
Purpose or research question	Title page
Qualitative approach	Title page and page 3and 4
Researcher characteristics: NB researchers in participatory evaluation are the people participating in and reflecting on the process	Pages 3 - 7
Context	Page 5
Sampling strategy	Page 3
Ethical issues	Page 5, 8
Data collection methods	Pages 5-7
Data collection instruments	Page 6
Units of study	Page 8
Data processing	Page 6
Data analysis	Page 6
Techniques to enhance trustworthiness	Page 5 , 6-7
Synthesis and interpretation	Page 4 (theory), pages 8-14
Links to empirical data	Pages 8-14
Integration with prior work, implications	Page 14-15
Limitations	Page 14
Conflicts of interest	No conflicts of interest
Funding	Not funded

No.	Topic	Item
	Title and abstract	
S1	Title	Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended
S2	Abstract	Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions
	Introduction	
S3	Problem formulation	Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement
S4	Purpose or research question	Purpose of the study and specific objectives or questions
	Methods	
S5	Qualitative approach and research paradigm	Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale[b]
S6	Researcher characteristics and reflexivity	Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability
S7	Context	Setting/site and salient contextual factors; rationale[b]
S8	Sampling strategy	How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale[b]
S9	Ethical issues pertaining to human subjects	Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues
S10	Data collection methods	Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale[b]
S11	Data collection instruments and technologies	Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study
S12	Units of study	Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)
S13	Data processing	Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/deidentification of excerpts
S14	Data analysis	Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale.[b]
S15	Techniques to enhance trustworthiness	Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale[b]
	Results/findings	
S16	Synthesis and interpretation	Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory
S17	Links to empirical data	Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings
	Discussion	
S18	Integration with prior work, implications, transferability, and contribution(s) to the field	Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/ generalizability; identification of unique contribution(s) to scholarship in a discipline or field
S19	Limitations	Trustworthiness and limitations of findings
	Other	
S20	Conflicts of interest	Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed
S21	Funding	Sources of funding and other support; role of funders in data collection, interpretation, and reporting

[a]The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.
[b]The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

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Can communities be mobilised to build capacity to respond to the COVID-19 pandemic? A qualitative process evaluation

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Can communities be mobilised to build capacity to respond to the COVID-19 pandemic? A qualitative process evaluation

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Can communities be mobilised to build capacity to respond to the COVID-19 pandemic? A qualitative process evaluation

Objectives

Government guidance to manage COVID-19 was challenged by low levels of health and digital literacy and lack of information in different languages. Covid Confidence sessions were evaluated to assess their effectiveness in counteracting misinformation and provide an alternative source of information about the pandemic.

Design

We worked with community anchor organisations to coordinate online "Covid Confidence" sessions serving three economically deprived, ethnically mixed, neighbourhoods. We conducted a qualitative, participatory process evaluation, in tandem with the sessions to explore whether a popular opinion leader/local champion model of health promotion could mobilise pandemic responses. Group discussions were supplemented by final interviews to assess changes in community capacity to mobilise.

Setting

Sheffield, England, September 2020 – November 2021

Participants

314 community leaders, workers and volunteers representing a variety of local organisations attended sessions. A group of local health experts helped organisations make sense of government information.

Results

Covid Confidence sessions fostered cross-organisational relationships, which enabled rapid community responses. Community champions successfully adapted information to different groups. Listening, identifying individual concerns and providing practical support enabled people to make informed decisions on managing exposure and getting vaccinated. Some people were unable to comply with self-isolation due to overcrowded housing and the need to work. Communities drew upon existing resources and networks.

Conclusions

Sessions promoted stronger links between community organisations who reduced mistrust of government information. In future, government efforts to manage pandemics should partner with communities to co-design and implement prevention and control measures.

Strengths and limitations of study

Strengths:

- Session agendas were based on local concerns, thereby ensuring good engagement by stakeholders.
- Data collected during sessions on effective mobilisation was supplemented by interviews with key informants.

Limitations:

- The relationships between engagement and vaccine uptake could not be established as it was not possible to link interactions with individual data.

Background

While the government has generated a vast amount of information and guidance about the COVID-19 pandemic, people say that they struggle to keep up with it. The World Health Organisation announced in 2020 that the COVID-19 pandemic had triggered an infodemic, e.g. “an overabundance of information – some accurate and some not – that makes it hard for people to find trustworthy sources and reliable guidance when they need it”. [1]. Although rumours and misinformation are spread in all disease outbreaks, information “goes faster and further, like the viruses that travel with people and go faster and further. So it is a new challenge, and the challenge is the [timing] because you need to be faster if you want to fill the void…What is at stake during an outbreak is making sure people will do the right thing to control the disease or to mitigate its impact. So it is not only information to make sure people are informed; it is also making sure people are informed to act appropriately”. [2]. When creating information strategies, governments are dealing with a wicked and complex problem, because COVID-19 is (a) a new phenomenon, where the virus, as well as the science needed to tackle it, is rapidly evolving; (b) treatments and policies for treatment are contested. Further, the government strategies for spreading accurate information have met with varying success, because willingness to accept the facts varies according to the beliefs of any particular group, and their attitudes and trust toward government information in general. The success of strategies is not only dependent on local attitudes and beliefs, but also on the characteristics of the messenger e.g. the person or group that is delivering the information.

The success of using what are called local champions has been extensively documented since the HIV/AIDS pandemic began in the 1980s [3].
Local champions are people, who are willing to promote local awareness and action via: informal conversations with family, friends, neighbours, street outreach working with local organisations, and virtual outreach, using social media channels. They are

well placed to explore the barriers to acting on COVID-19 information, and can serve as bridges to community organisations that can help to remove social and economic barriers to following guidance. This approach to making sense of guidance and promoting action rests upon the identification of local people who are trusted by others in their community. Several key elements are needed to successfully move people from looking at information to taking action to protect health. These include: enlisting locally known popular opinion leaders, using people with knowledge of the area/group to champion the initiative, providing training and ongoing support to ensure that local people have the confidence to spread the word, encouraging locally trained people to use their own local knowledge to ensure that messages are tailored to different concerns and groups, and feedback to help those who are having the conversations see the impact [4]. The relevance of local champions has been recognised in relation to COVID-19 [5]. We used these principles to organise "Covid Confidence" sessions, with the aim of supporting people in economically deprived neighbourhoods to act appropriately in terms of managing risk.

Methods

Sessions were co-produced and hosted by community organisations, who expressed interest in working with the Sheffield Community Contract Tracers (SCCT) to mobilise responses to the pandemic. The SCCT is a voluntary group of retired health professionals, comprised of 9 Public Health specialists, Directors of Public Health and local GPs with experience in infection control, communicable disease control, epidemiology, health promotion, primary care, participatory evaluation, and community organisation. The group originally came together to pilot the effectiveness of community-based contact tracing, and subsequently expanded their role to disseminating COVID-19 information, with the aim of promoting understanding to community workers and volunteers. Many of these experts/professionals had long-established links with local voluntary and statutory organisations. The COVID-19 Confidence (CC) sessions dealt directly with issues of misinformation. They were provided in conjunction with online SCCT information sessions, which delivered up to date information. Topics were based on community-identified concerns. The information sessions aimed to provide people with key facts about COVID-19 exposure, transmission, and protective behaviour, as well as the COVID-19 vaccines. The Covid Confidence sessions drew upon local knowledge and expertise, using discussion to show how champions can support people to deal with issues arising during the pandemic. A participatory process evaluation was conducted, where participants observed and reflected on the utility of the sessions. Qualitative key informant interviews were conducted with a subset of participants at the end of the project.

The programme theory for COVID Confidence is based on well-known models for using popular opinion leaders and providing peer support to manage health [3, 6]. We began with a set of assumptions (Table 1).

Table 1 Preliminary logic model for COVID-19 Confidence

If	Then
If people are provided with training on how to communicate key COVID-19 facts, and are supported to use their own expertise to effectively communicate with local groups	Then they will become increasingly confident to deal with difficult conversations about complicated information.
If the people providing the information have local credibility	Then opportunities to discuss misinformation will arise. People who are uncertain of what to do about COVID-19 may be more able to consider the correct information, and make informed decisions about what they are able to do to reduce risk, in light of their own circumstances.
If the number of informal champions in each area increases	Then consistent messages from trusted sources will predominate, decreasing the chances that people will be acting on misinformation.
If communities are able to identify the social, economic, and educational barriers to following COVID-19 guidance	Then they will be able to connect people to local organisations who can work with them to prevent COVID-19 transmission, and remove barriers to self-isolation if infected.
If local people share their issues and work together to generate solutions,	Then community capacity to deal with issues thrown up by the pandemic will increase.

Sources: Kelly et al, 1991; Harris et al, 2015

Covid Confidence session agendas were created by eliciting community concerns, via conversations with anchor organisation leads, and allowing these concerns to dictate the topics for discussion. This put communities in control over the nature and direction of support. Knowledge exchange and mobilisation was then promoted, using a participatory action learning and research framework to explore challenges in supporting local people during the pandemic, figure out possible solutions, observe what happened, and then reflect on what had worked and why [7]. This process facilitates collective learning, collaboration, and networking to promote social

change. When complicated information was presented about COVID-19, participants were given time to engage in a process of collective sensemaking, to question implications, to explore how people might struggle to carry out the guidance and what the guidance would mean for people in different circumstances [8].

Three different neighbourhoods expressed interest in developing COVID-19 champions. Fifteen sessions were facilitated between September 2020 and November 2021 across three Sheffield neighbourhoods. These neighbourhoods have areas of high local deprivation, a mix of ethnic groups, and 18 – 22% of the community do not have English as their main language. Further, 18 – 27% live in overcrowded housing, which is far more than the national average of 8.7%. Forty-eight organisations took part, with a total of 198 participants (including repeat attenders). Participants drew upon their local knowledge to consider how information could be used in their particular setting. They 'road tested' the information during conversations with people in challenging life circumstances, and fed back in subsequent sessions on how information needed to be tailored for local groups and local issues. Participants used concerns raised by the public to structure sessions, and were involved in reflecting on the utility of the sessions throughout. This information was included in the process evaluation.

The participatory process evaluation was conducted in tandem with sessions, generating data from participants' reflections on the challenges and outcomes of taking action, and the utility of the discussions. Participants agreed that sessions would be recorded and notes taken during sessions, for the purposes of tracking progress with the action learning cycle. Notes were fed back to participants in subsequent sessions to reflect on whether and how they enabled champions to have conversations with people and modify information for local groups. Over time, we hoped that repeated participation in the sessions might lead to shared learning and networks of support, building community capacity to address the pandemic. Capacity building happens when community groups become more able to define, assess, analyse and act on health (or any other) things that their local members are concerned about (see Table 2). Key indicators of capacity, developed via prior research [9,10] were used to review the session notes and interviews, in order to assess how the process related to capacity building.

Table 2: Indicators of community capacity building and mobilisation

Increased stakeholder participation	People come together to define problems, analyse and decide how to act.
Improved capacity to do problem assessment	When communities take the lead in identifying problems, solutions to the problems and actions to resolve the problems they can develop an increased sense of self-determination and capacity.
Local leadership	People in formal and informal positions of authority help to mobilise groups and community organisations.
Empowering organisational structures	Faith groups and community organisations that already provide places for people to come together and address problems.
Stronger links between people and organisations	These can be partnerships, coalitions or voluntary alliances between the community and others, that assist the community in addressing its issues.
Improved resource mobilisation	Resources include expertise of local people, environmental, financial or political, that are identified within communities. The ability of the community both to mobilise resources from within and to negotiate resources from beyond itself is an important factor. The capacity of a group is also dependent on opportunities or constraints (ecological, political and environmental), and the conditions in which people and groups live.
Equitable relationships with outside agents	Outside agents are an important link between communities and external resources. Their role is especially important near the beginning of a crisis, when the process of building new community momentum may be triggered and nurtured. The outside agent increasingly transforms power relationships between her/himself, outside agencies, and the community, such that the community assumes increasing authority.
Enhanced stakeholder ability to ask why	The ability of the community to critically assess the social, political, economic and other causes of inequalities is a crucial stage towards developing appropriate personal and social change strategies.
Increased stakeholder control over programme management	Communities become more capable when they have people who can take control over decisions on planning, implementation, evaluation, finances, administration, reporting and conflict resolution.

Source: [9-10]

The session notes were organised by three researchers (JH, PR, FA) using the above indicators as themes, and member checked via 9 key informant interviews

with 12 participants. These were conducted at the end of the project, to assess changes in community capacity to mobilise. The topic guide, developed from findings, asked general questions as well as exploring communication issues that arose about Council coordination of the information bus, and the many positive comments that were made about a local co-produced film (Box 1).

Box 1 Interview topic guide

SCCT role
What are your thoughts on the role that SCCT played in sharing information about Covid?
Did it generate trust? Reduce hesitancy? Form new connections and/or networks?
What has changed – for the long term, rather than temporarily?
Have local knowledge and experiences been valued and recognised by Public Health and the City Council?
Has the process enabled communities to have a voice in managing Covid?

Covid Confidence cascade effect
Some people came to the first sessions and went on to run smaller sessions in local areas, feeding back information from the larger sessions. We'd like to understand the differences in your process – what happened? How did your local sessions develop?

How was local knowledge used through Covid Confidence?
Were there any new ways of doing things? Will these approaches last/be taken forward, or were they Covid-specific?
Were you able to provide advice and support to people who were concerned about symptoms?
Were you able to facilitate sessions that met local needs, for example local language support?

Community Bus
What do you think about the Council's Community Bus?
Is it something that you have helped to support in your area?
Are you getting enough notice to mobilise local workers to show up and support theb us?
How do you think the bus helps to communicate?
Does it help your communities? Have you heard any local feedback about it?

Seldom Heard Communities Film
Were you involved with the Seldom Heard Communities Film?
People have mentioned the film as having been key in the process of managing the pandemic. What do you think?
What impacts do you think the film has had?

We selected key informants from the larger group of participants. They were given a participant information sheet and asked if they had any questions prior to the interview. After checking understanding, verbal consent was taken.

Patient and public involvement
None

Findings

Findings are presented in terms of the indicators for community capacity building (see Table 2 above).

Stakeholder participation records showed community leaders, workers and volunteers representing community groups, local people, health services, university and council departments attended one or more of fifteen sessions (Table 3).

Table 3: Overview of Groups Represented

Type of group represented	Number
Community organisations	23
Faith groups	4
Health service areas	6
Local council departments	9
University departments	4
Youth organisations	2
Community members	6

Four sessions were hosted by two of the neighbourhoods. People from these neighbourhoods also attended the 11 sessions hosted by the third neighbourhood, totalling 314 attendances. From this group of repeat attendees, a core group representing a diverse range of local organisations developed over time. The group became a forum for doing **problem assessment**, identifying shared problems, considering solutions and considering whether they had capacity and resources to take action (Table 4).

Table 4: Combating misinformation: possible solutions and actions taken

Possible solution	**Actions taken**
Increasing access to up-to-date information.	SCCT sponsored information sessions with expert speakers. Using social media to spread correct information.

Supporting people make sense of information: the nature of COVID-19, getting tested, self-isolating, how vaccines worked and about getting vaccinated.	Opportunities during sessions to discuss information and question experts. Invitations to hospital, primary care and Public Health experts to attend.
Up-skilling workers and volunteers to provide information to local people.	Leaders cascading information. Feedback from workers and volunteers sharing what worked.
Translating into the languages of local communities.	Liaison with the City Council Communications Team and co-producing information.
Modifying technical vocabulary and using pictures or videos.	Co-producing resources. Making videos using local workers and leaders.

Participants exercised **local leadership**, identifying local organisations and informal groups that were willing to take action. This included health champions working to spread accurate information and supporting people to consider how they could reduce their risks. Organisations that had previously received little formal recognition found the process **empowering** and affirming: "The BAME community themselves got organised – realised that they were actually very active within their own communities". (OB02) These actions fostered **stronger links** between people who had previously little experience of working together. For example, volunteers from a number of organisations promoted city council information about the vaccine programme, subsequently coming together to assist general practices with vaccine uptake. The links became **empowering organisational structures**, which were instrumental in helping communities come together to address COVID-19 issues. SCCT sessions "put us in touch with all sorts of people who are a mine of information…and certainly the workshops enabled us to meet people who were really helpful". (OD02) A number of people attended all of them, which created **stronger links between people and organisations** which "were able to share information from one group to another" (OD02). They used sessions to share how to run COVID-19 Q&A sessions, how to build Covid confidence, and how to adapt information and support to specific groups. (OS03)

Communities **mobilised resources** by recruiting volunteers fluent in Urdu, Punjabi, Arabic, Hindi, and Bulgarian to produce videos. Locals identified social media platforms that were commonly used to promote messages (OS01). Members of Sheffield City Council (SCC) Public Health and Communications teams began to attend sessions, working with local people to co-produce more accessible written information. Over time, sessions became a conduit for disseminating vaccine clinic schedules to volunteers and COVID-19 Champions. When community leads noted

that trusted local people were instrumental in promoting use of drop-in clinics, SCC arranged times and locations in tandem with them. People noted that "the partnership approach really helped with getting messages out". (OS01)

The sessions enabled communities to establish a more **equitable relationship** with academics and public health experts. SCCT used their previous working relationships to engage current experts in seminars. These crosscutting relationships meant that they were able to facilitate dialogues between expert speakers and local people, with the express aim of making sense of information. Experts provided updated information on government guidance, explained local and national statistics and outlined the development of the vaccine strategy.

> "Most of the written information is not clear – it really helped our community, ourselves as part of the community, as well as professionals. It's good to get explanations, rather than just information." (OD01)

There was a widely shared perception that "SCC Public Health staff are very good at what they're doing, but they're not necessarily there when you need them". Thus, the information sessions hosted by SCCT were seen as "vital for our work – good to know they were there every 2 weeks. Though we were all community leaders and community activists and community people, we are not medical people. The questions we were taking to SCCT were the questions we were hearing from the vulnerable people in the community. I was getting really good answers from SCCT so that was a big asset". (OB01)

Countering misinformation was a long-term challenge because of the constantly shifting information about COVID-19. Responsive and timely exchange led to what one participant called a "waterfall effect – they got information and were able to pass that back to others more locally in their area". (OS01) SCCT became an "anchor point - it meant that we were able to keep countering the misinformation that they were getting on a regular basis". (OD01; OD02)

Although the strategies to improve access to relevant information were effective, champions found that trust was a major issue.

> "As much as we shared the data, the statistics and what the government were saying, we weren't getting anywhere. There was no trust in the communities because we were working with the government. "(OSO1)

Community organisations decided that the only solution was to increase **cross-sector stakeholder collaboration**, which included local leaders.

> "The only way to get the information out to the communities was to work with the local Imams and local GPs. We worked with particular GPs who people from the community really look up to…..One of these GPs was also very active on social media and the community organisations used his videos a lot. Some of these GPs also came to COVID-19 Confidence".

Champions said that the fact that these leaders were known and trusted was a tipping point in COVID-19 engagement:

> [So we said] 'your GP and your Imams - two people you really look up to - would they be lying? Would they be putting you at risk?' And we explained that they could be putting themselves more at risk by not getting tested or having the vaccine". (OSO1)

Organisations collaborated with SCC to promote test centres, which "really built a trusting relationship with SCC and Public Health – they learnt from us and we learnt from them". (OS01) The process increased local credibility, because it "meant we knew up to date information... people then trust you because you've known what's going on." (OD02)

Dealing with mistrust and vaccine hesitancy led stakeholders **to ask why** relationships with government agencies were so poor. A docuseries, co-produced by SCCT and BAME leads, engaged seldom heard communities in describing their situations. (https://www.communitycontacttracers.com/shc/)

The collaboration triggered some changes in **programme management**. Community organisations - such as the BAME Group - were asked to join statutory sector steering groups and committees. As a result, voluntary sector organisations gained greater awareness of "what was happening on the ground". (OS01) They also became partners in the sense of co-managing COVID-19 issues. "SCC didn't just take a top-down approach – felt they were asked how to best achieve things in the communities". (OS02) Community hubs and anchor organisations informed a number of statutory sector initiatives including COVID-19 Community Response Grants, the COVID-19 information bus, the vaccine van, and developing a cadre of COVID-19 Champions. The 'COVID-19 Community Response Grants' have meant "Closer working relationship than there might normally be, especially with some organisations e.g. around comms – continued focus on getting specific comms out to particular communities". (CO2) Being valued for their knowledge meant that organisations – particularly smaller ones that felt previously missed – believed that they were in a "definitely different relationship now", [where] people in the Council have now recognised the importance of the voluntary sector". (OS02; OS01)

Alongside description of capacity building, people also identified the underlying elements that contributed to effective community mobilisation. Drawing upon local

knowledge was essential to counteracting misinformation and ensuring that health promotion was seen to be relevant and appropriate. Session participants agreed that "trust was such a massive issue" and it was important to start by involving people who were already locally known and trusted. For example, Roma Slovak and Bulgarian groups were all approached by finding people who had existing relationships with them, to act as a bridge for the COVID-19 volunteers. In some neighbourhoods, a cadre of active volunteers already existed, usually coordinated by the local community anchor organisation. COVID-19 volunteers were in most cases community members, working in other capacities, and local volunteers already knew what people were saying/thinking about the vaccines. (OD01). When volunteers were new to an area, community leaders and people known to the various groups acted as gatekeepers, linking volunteers with the areas which needed support. This gave volunteers credibility. They noted that being endorsed by local people was crucial in gaining trust in an area - "Without that, we wouldn't have got anywhere". (OB02)

It was also important that volunteers had some experiences in common with the local people they were reaching out to. This could be a shared language, a common culture, being a member of a vulnerable group, having COVID-19 or caring for a family member who had COVID-19. For example, a bilingual medical student whose father had gone through COVID-19 was trusted almost immediately even though he wasn't locally known. Being in a respected role counteracted misinformation. For example, a video of an imam and an Islamic pharmacist at the local mosque included the message given from the Quran saying you should save your own life first. "This really gave them confidence to get the jab". (OD01)

Local workers with established relationships were also able to influence people. A worker who was well known in her local community made a video of herself talking in Arabic about having her vaccine. These pre-existing bridges of trust enabled outreach to a range of ethnic groups in different neighbourhoods (OD01; OSO1).

Finally, the importance of repeated contacts was mentioned frequently. One off, written information is not effective on its own. Outreach often involves having more than one conversation with people, leaving them time to consider and come back with concerns and questions [Sharrow COVID-19 Confidence meeting Feb, June 2021]. Conversations need to start by listening to people's concerns before giving information. Further, information giving needs to be embedded and opportunistic. Opportunities to share information need to be found in the course of engaging people on what matters to them first, building a relationship, and introducing COVID-19 information when appropriate. For example, women's wellbeing sessions were used to "find out what is most important issue for them first – build that relationship and then get onto vaccines when they are ready. It can take a lot of conversations, too – not a quick win. (CC Meeting 11.2022)

Findings were compared to our preliminary logic model for developing Covid Confidence (Table1) and used to develop a final model showing how the approach enabled people to communicate information and support to individuals and local groups (Box 2). The effectiveness of this approach is supported by previous research using locally known and respected people to raise awareness of health risk during epidemics [3].

Box 2: The Covid Confidence Approach

Providing information

Receiving information by trusted experts; and
Being encouraged to ask questions
helped workers and volunteers understand COVID-19 guidance.

Developing approaches to communication

Promoting discussion that focuses on
Identifying the challenges of explaining COVID-19;
Considering the concerns and needs of people in different groups and situations; and
Sharing approaches to giving information to local people
helped people to develop approaches for successfully communicating the information to different groups.

Establishing trust

Using people who were known in the neighbourhood, or had something in common
Using familiar vocabulary and preferred language
Listening to concerns before 'telling' people what to do
Repeated contact and conversations
Built trust which inclined people to consider following recommendations.

Reflecting on the process

Coordinating sessions where people were encouraged in
Feeding back on successful ways of communicating information
validated champions, recognising that their local knowledge combined with communication skills is effective.

In summary, the participants reported that the sessions increased their access to up to date, accurate information, and the sense-making process meant that they were able to explain information to other people. They were able to co-produce translated

material which was useful in local discussions, and co-produced videos were found to be useful (Table 3). People who used the Covid Confidence approach (Box 2) reported that they were able to influence people, in terms of their stated intentions to self-isolate and to get vaccinated. The surrounding context, however, contained a number of challenges that made it difficult for people to actually follow guidance. Workers reported that people were reluctant to get tested, because they needed to continue to work. People were unable to comply with self-isolation and distancing guidelines, due to overcrowded and poorly ventilated housing. People were challenged to feed themselves and their families if they were self-isolating, because their incomes were affected. The challenges of managing COVID-19, therefore, reflect the challenges of health inequalities.

Discussion

The process evaluation had several strengths and weaknesses. Participants set the agenda for each session; this increased attendance and ensured that local issues were addressed. Locally known and trusted public health and medical people facilitated discussion between local people and pandemic experts. This provided data on the challenges of contextualising of information and using local expertise and knowledge to generate appropriate engagement strategies. The data collected during sessions was supplemented by a final set of interviews with local workers and leaders who clarified and confirmed the findings. Unfortunately, quantitative relationships between engagement and vaccine uptake could not be established, as it was not possible to link interactions to decisions to get vaccinated.

Our findings align with previous research on the elements needed to effectively communicate risk to people during epidemics [3], and recent community engagement research which found that community leaders, volunteers and multilingual approaches targeted to specific groups can effectively disseminate COVID-19 information and expand access to testing [11-12]. Recent research calls for authentic community outreach [13] but as of yet there are few studies confirming effectiveness [14].There is evidence from a recent systematic review that community engagement can prevent and control disease during an epidemic, when local leaders, community organisations and networks, key stakeholders and local people communicate social and behavioural risk, and get logistical support from health sectors [15]. Stories from our Covid champions indicated that support promoted vaccine uptake, but we decided not to ask individuals to share personal details allowing us to link them with vaccination decisions, because of the widespread lack of trust. Community-based contact tracing can also promote vaccination [16], but in Sheffield this local initiative was not supported by the UK public health system. In our project, local neighbourhoods used Covid Confidence sessions to foster collective relationships among organisations, which in turn co-developed communication strategies We found that communities had to embark on a process of “re-contextualising” government information by finding locally appropriate ways of

explaining risk [17]. Linkages with health systems came late in the process, translation of written information, information sharing about the timing of the community bus, and coordination of clinic schedules finally occurred in months 9-14. Our study echoed review findings regarding inadequate community resources, and weak health support infrastructures [15]. Our communities were able to identify issues quickly, and also keep track of emerging needs, using existing voluntary sector knowledge to draw upon local social networks. This ability to rapidly and flexibly mobilise is identified as crucial in other studies [18] who note that community mobilisation at early stages can compensate for slower restructuring at statutory level. Other studies also note that given the evidence of effectiveness, communities need to be engaged from the beginning in co-developing and co-implementing public health strategies, sustaining a two-way dialogue to consistently provide transparent and accurate information [19-20].

Last, but not least, barriers in the broader context, which have been a problem in past epidemics, continue to limit abilities to connect people to local organisations who can work with them to prevent COVID-19 transmission, and remove barriers to self-isolation if infected.

Conclusions

In participatory research, impact is defined as the changes that occur during the process of collaborative enquiry and reflection, this includes changes in interactions between individuals and organisations as well as across systems. Our evaluation found that Covid Confidence increased interaction across stakeholders, improved ability to assess local problems and generate solutions, and fostered stronger links that increased community capacity. Trusted outside agents – SCCT members - who were able to enlist topic experts increased confidence of local people in communicating information, counteracting misinformation, and supporting people to make appropriate decisions. Local people began to trust champions as a result. Providing a forum where organisations can identify problems and possible solutions, adapt information and share effective approaches was an important element in developing cross-organisational relationships and supportive networks. Early support can enable communication across local groups to take action. The mobilisation can, however, be challenging to integrate with statutory sector management in the early days of a pandemic. Fewer changes were seen at the level of government systems. Mobilisation, was challenging to integrate with statutory sector management in the early days of the pandemic. Despite having ~~increased~~ capacity to manage at community level, however, the broader context of social determinants of health diluted effectiveness of mobilisation. In the case of COVID-19, individual ability to follow guidance was undermined by the need to continue work, often in front line jobs, and overcrowded housing.

In conclusion, community mobilisation can be an instrumental component in public health pandemic management. However, communities need to be actively involved in codesign and implementation of public health strategies. The strategies need to be underpinned by government recognition of underlying inequalities that make it difficult to follow COVID-19 guidance. As the urgency of the pandemic wanes, the resources needed by community organisations to continue to manage the long-term effects of COVID-19 need to be retrospectively assessed, and coherent funding strategies put in place that support them in continuing to address the underlying issues of health inequality that have been highlighted during the pandemic.

Data are available upon reasonable request
There are no competing interest for any author
The evaluation received ethics approval from Sheffield Hallam University (ER30632144).

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SRQR Checklist Item	Manuscript page number
Title	Title page
Abstract	Abstract page
Problem formulation	2
Purpose or research question	Title page
Qualitative approach	Title page and page 3and 4
Researcher characteristics: NB researchers in participatory evaluation are the people participating in and reflecting on the process	Pages 3 - 7
Context	Page 5
Sampling strategy	Page 3
Ethical issues	Page 5, 8
Data collection methods	Pages 5-7
Data collection instruments	Page 6
Units of study	Page 8
Data processing	Page 6
Data analysis	Page 6
Techniques to enhance trustworthiness	Page 5 , 6-7
Synthesis and interpretation	Page 4 (theory), pages 8-14
Links to empirical data	Pages 8-14
Integration with prior work, implications	Page 14-15
Limitations	Page 14
Conflicts of interest	No conflicts of interest
Funding	Not funded

No.	Topic	Item
	Title and abstract	
S1	Title	Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended
S2	Abstract	Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions
	Introduction	
S3	Problem formulation	Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement
S4	Purpose or research question	Purpose of the study and specific objectives or questions
	Methods	
S5	Qualitative approach and research paradigm	Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale[b]
S6	Researcher characteristics and reflexivity	Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability
S7	Context	Setting/site and salient contextual factors; rationale[b]
S8	Sampling strategy	How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale[b]
S9	Ethical issues pertaining to human subjects	Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues
S10	Data collection methods	Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale[b]
S11	Data collection instruments and technologies	Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study
S12	Units of study	Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)
S13	Data processing	Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/deidentification of excerpts
S14	Data analysis	Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale.[b]
S15	Techniques to enhance trustworthiness	Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale[b]
	Results/findings	
S16	Synthesis and interpretation	Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory
S17	Links to empirical data	Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings
	Discussion	
S18	Integration with prior work, implications, transferability, and contribution(s) to the field	Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/ generalizability; identification of unique contribution(s) to scholarship in a discipline or field
S19	Limitations	Trustworthiness and limitations of findings
	Other	
S20	Conflicts of interest	Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed
S21	Funding	Sources of funding and other support; role of funders in data collection, interpretation, and reporting

[a]The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.
[b]The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.