Using Trusted Relationships and Community-Led Approaches to Promote COVID-19 Vaccine Confidence and Uptake across Ontario

Sara Bhatti, Josephine Pham and Jennifer Rayner

Abstract

Data underscore how challenging it can be for populations that experience systemic and historical barriers to access necessary health information and services, including COVID-19 vaccinations and testing. In this paper, we describe the initiatives used by member centres of Alliance for Healthier Communities to promote vaccine confidence and uptake, highlight specific examples that applied a health equity lens, describe some of the challenges that centres faced and explore the key enablers for these initiatives. Lessons learned here can be used to engage in other health promoting activities including population health efforts currently under way across the country.

Introduction

The COVID-19 pandemic continues to shine a light on deep-rooted social and health inequities, especially those faced by marginalized communities and populations. Data worldwide underscore how racialized and lower income communities are among those hardest hit by the COVID-19 pandemic (Black Health Alliance 2020; National Center for Immunization and Respiratory Diseases [U.S.], Division of Viral Diseases 2020; City of Toronto 2021; Mackey et al. 2021; Mude et al. 2021; The King's Fund 2020). In addition, it can be challenging for populations that experience systemic and historical barriers to access necessary health information and services, including COVID-19 vaccinations, testing and other supports (City of Toronto 2017, 2021).

The focus of Canada's vaccine strategy has been to enable access for as many individuals as quickly possible (PHAC 2020). However, a survey conducted in December 2020 showed that not all Canadians were willing to take the vaccine (Statistics Canada 2021). The data revealed rates of vaccine willingness among visible minorities as comparable to the overall Canadian population (74.8% vs 76.9%), yet rates among certain racialized and marginalized communities, such as Black or Latin American, were much lower (Statistics Canada 2021). This trend was also observed in Ontario (Barrett et al. 2021), one of Canada's most diverse provinces, where 3 out of 10 individuals identify as visible minorities (Government of Ontario 2022).

The Alliance for Healthier Communities (Alliance) is made up of over 100 community-governed primary healthcare organizations across Ontario. Our membership includes Aboriginal Health Access Centres, Community Health Centres (CHCs), community-governed Family Health Teams and nurse practitioner–led clinics (Rayner et al. 2018). All member centres are committed to advancing health equity and use a salary-based funding model to offer comprehensive primary healthcare that is focused on addressing determinants of health, health promotion and community development (Rayner et al. 2018). Priority populations served by Alliance

members include people living in poverty, those in rural and remote areas, as well as those facing other barriers to access, such as newcomers and people experiencing homelessness.

Throughout the pandemic, members of the Alliance have provided hyper-local community-level outreach and support to Black and racialized, Francophone, Mennonite, youth, Indigenous, rural and low-income communities. This has included providing access to a full continuum of supports – from testing and isolation supports to essential information about vaccines, from vaccination access through pop-ups and community clinics to wraparound social supports for adults, children, seniors and families – during which centres have continued to deliver the essential comprehensive primary healthcare that their communities depend on them for. Much of this work was done without any additional resources, funds or personnel; however, a subset of 11 centres did receive financial support ranging from $35,000 to $50,000 from the Public Health Agency of Canada's Immunization Partnership Fund.

Survey Findings

To fully capture the efforts of our member centres in supporting vaccine uptake, we administered a short survey in April 2022. In the following sections, we describe the initiatives used by Alliance member centres, highlight specific examples that applied a health equity lens, describe some of the challenges that centres faced and explore the key enablers for these initiatives.

Initiatives used to promote vaccine uptake

In total, 45 centres had completed the survey resulting in a 43% (45/104) response rate. The majority of centres (Table 1) were involved in either running an on-site vaccine clinic or supporting one, and over 75% had used social media and advertising to promote vaccine uptake. Around 40% had hosted online and in-person events, as well as a vaccine phone line, and over 45% reported developing educational resources. Overall, the centres had supported over 225,000 individuals in receiving a COVID-19 vaccine and had reached over 330,000 individuals through vaccine awareness initiatives. Populations vaccinated were those whose access to healthcare is limited by social determinants of health or systemic marginalization, including Afro-Caribbean and Black, South Asian and Indigenous populations and people living in rural communities, as well as people with disabilities, Franco-Ontarians, Mennonites and people living on low income.

TABLE 1.
Summary of initiatives

Activity type		Percentage of centres that engaged in the activities ($n = 45$)	Number of people reached
Activities supporting vaccine administration	Running an on-site vaccine clinic	89	195,121
	Supporting a pop-up clinic	73	11,765
	Supporting a public health–run vaccine clinic	71	15,060
	Supporting vaccination efforts in other areas (long-term care, shelters, etc.)	49	5,032
	Vaccination in homes	35	275
	Total		**227,253**
Activities promoting vaccine awareness	Social media and advertising	78	279,798
	Development of educational resources	47	25,364
	Hosting online events	42	6,411
	Vaccine information phone line	40	15,583
	Hosting in-person events	38	9,059
	Total		**336,215**

The majority of centres had operated an on-site vaccine clinic as they knew that holding clinics within familiar spaces was crucial in promoting vaccination. On-site clinics were typically staffed between 2 and 15 personnel (e.g., nurse practitioners, physicians, nurses and administrative staff), who often reflected the communities served. A few centres implemented drive-through clinics as they proved to be more advantageous than an on-site clinic. One such centre was Gateway CHC, a rural centre located in central eastern Ontario. The centre was able to vaccinate a greater number of people through their drive-through clinic as the clinic was not bound by the space limitations of the centre. Their patients also expressed feeling

safer receiving the vaccine in their vehicles or outside on lawn chairs as opposed to inside the clinic, where it was harder to reduce contact with others.

Among the initiatives aimed at promoting vaccine awareness, conducting social media campaigns and advertisements were the most common and had reached close to 280,000 individuals through their efforts. Centres would primarily share messages that spread awareness and dispelled common myths; however, a few created and shared their own promotional videos. For example, at Chatham-Kent CHC – a large multi-site centre serving diverse communities including migrant farm workers – a physician upon noticing the low vaccination rate produced a promotional video titled *Vax-A-Nation* (no longer available publicly). The widely shared video outlined the benefits of receiving a COVID-19 vaccine and prompted other local primary care providers and specialists to develop promotional videos within the rural community of Chatham-Kent.

Removing structural barriers and improving equitable access of vaccination services

Alliance members specifically prioritized meeting community members wherever they were to support vaccination efforts. Almost half of the centres had worked at shelters (Table 1), close to 75% had hosted pop-up or mobile clinics and 35% offered vaccines at home to those who were homebound. Other supports included arranging transportation for clients and extending clinic hours, which was especially helpful for clients who could not take time off work. Providing support in navigating the provincial booking system for clients with low digital literacy or limited access to devices was also a key concern. To address this, some centres individually called clients to assist with booking appointments, and others offered opportunistic vaccination during in-person scheduled appointments at the centres. As Alliance members collect sociodemographic data on all clients, some had stratified rates of vaccination to identify populations with low vaccine uptake. This allowed centres to determine which populations required targeted outreach to promote vaccine confidence.

Embedding remote, on-demand live interpretation services into vaccination clinics was extremely valuable for overcoming language barriers when serving clients from diverse cultural backgrounds. In rural areas, isolated Francophone communities were supported by ensuring French language accessibility at each point of contact and bilingual services were maintained by staff in vaccine clinics. Another centre had provided linguistic support by implementing a 24-hour Francophone phone line to answer questions about vaccines without fearing judgement, while another held virtual community town halls with simultaneous interpretation in Bengali, Tamil, Urdu and Punjabi to help overcome hesitancy in South Asian communities.

Utilizing community partnerships to address community needs

Given that many clients served by our centres are from racialized, newcomer or other priority populations with strong vaccine hesitancy, centres heavily relied on community leaders and volunteers to act as trusted cultural ambassadors to dispel circulating myths and misinformation. Ambassador candidates were passionate, well-connected and trusted within their communities as leaders. They were diverse in age, gender and cultural backgrounds to reflect the people in their community. Many of the ambassadors were also not working due to the pandemic and were eager to support their community.

Black Creek CHC, which is based in Toronto and serves racialized communities and those living in poverty, implemented a cultural ambassador model by identifying and recruiting potential candidates in the community through pre-existing relationships with staff. The centre partnered with public health to provide training on how to disseminate correct vaccine information, along with media training to ensure that the voice of community was at the forefront during interviews. Ambassadors worked side by side with centre staff to inform which strategies would work or would not work for their communities. The use of ambassadors helped ensure that community members encountered someone trusted and familiar when entering the centre, making them feel safe and answering any questions they had. Similarly, at Somerset West CHC in Ottawa, a cultural ambassador led extensive ethnocultural advocacy in his work with clients from high-priority neighbourhoods with great success. For instance, the ambassador encountered a client and her son who tested positive for COVID-19 twice but were hesitant to get vaccinated. After connecting with this ambassador, getting information in a language accessible to her and being connected with health providers who answered her medical questions, the client decided to not only get vaccinated but also become a vaccine champion for her community. The ambassador program was a community-led and community-driven approach that made community members feel useful, validated and equal members of the staff team. In total, there were over 20 individuals working as cultural ambassadors across Alliance member centres.

Challenges

Despite the many successes of implementing equity-based and tailored approaches to improving vaccine uptake, the main challenges encountered were attributed to the lack of sustainable funding for staffing and long-term commitment of cultural ambassador roles. With staff turnover or roles ending after one-time funding, many community partnerships were not able to continue their wraparound care. Other barriers included lack of infrastructure or tools to run pop-up

vaccination clinics, low capacity of staff due to unsustainable workloads from primary care and COVID-19 vaccinations and too few options available for low-barrier client access to primary care within marginalized communities.

Discussion

We have described how these hyper-local pandemic responses have worked to move the needle on vaccine uptake. Despite the diversity of these innovations, there are common elements that are key to addressing the current pandemic, as well as future challenges. These enablers include establishing and building on trusted relationships, creatively and collaboratively adapting to the needs of the community and, finally, sustaining trust through investments, resources and support.

Establishing and building on trusted relationships

Alliance members leveraged their long-standing relationships with their communities throughout the pandemic. This included relationships between themselves and their clients, their organizations and their community governors and their organizations and community partners. Having this foundation of trust had enabled centres to partner with their local public health units, cultural community organizations and community members to share accredited vaccine information, hold vaccine clinics and provide culturally safe services, as well as effective vaccine promotional messaging.

The implementation of the ambassador program is a great example of how important and impactful using trusted relationships between clients and their community was. People from marginalized communities often experience difficulty connecting with vaccination messages from people outside of the community (Bhanu et al. 2021; Griffith et al. 2021; U of T News 2021). In addition, outreach and messaging targeted at these communities only during times of crisis have been found to diminish trust and decrease vaccine uptake and confidence (Bhanu et al. 2021; Griffith et al. 2021). Alliance member centres were able to address this need by prioritizing a bottom-up approach to hyper-local community engagement: hiring from the community and building on existing partnerships with community leaders. In doing so, valuable knowledge from community insiders was leveraged to better understand and address the needs of community. For Alliance member centres, this model was a natural fit as peer-led community approaches are integral to program planning and delivery at most centres (Rayner et al. 2018).

Creatively and collaboratively adapting to community needs

Confronting vaccine hesitancy required member centres to avoid using a one-size-fits-all approach. They had to listen deeply and respond innovatively with tailored approaches to advance vaccine confidence in communities with long histories of medical distrust and systemic barriers from historical underfunding. This involved removing structural barriers, as well as creating culturally safe spaces. Through holding focus groups and collaborating with community ambassadors, centres were able to uncover the barriers and needs of their communities and address them accordingly. They were able to use their learnings to develop promotional materials that were culturally relevant and provide logistical support (i.e., booking appointments and partnering with local transportation to offer free rides).

To promote feelings of safety, centres had deliberately embedded staff within their clinics who reflected the linguistic and ethnic backgrounds of the populations served. By using live interpretation services during virtual town halls, centres were able to address misinformation and answer questions in a variety of languages. For communities with significant vaccine distrust (e.g., Mennonite), centres provided private spaces and non-publicized opportunities for individuals to receive vaccination that protected their confidentiality in their community. These examples illustrate the necessity of giving special immunization considerations when needed.

Sustaining trust through investments, resources and support

The lessons learned within these communities must endure beyond the pandemic. Robust investments in community-led strategies can help sustain and expand relationships of trust between the health system and marginalized populations and reduce inequities that lead to poor health outcomes. For example, sustained funding to continue this work and keep cultural ambassador positions has ensured that vaccine promotion initiatives are fluid, collaborative and flexible enough to meet the multi-faceted needs of high-priority populations. Health system leadership will play a key role in ensuring that the strides we have made in building trust are sustained. To emerge from the COVID-19 pandemic equitably and address other health needs and future crises, including the expected massive backlogs in cancer screening, chronic diseases and declines in mental health, we must build on the power in the community.

Conclusion

Marginalized communities and vulnerable populations are often the most adversely impacted by social determinants of health. The COVID-19 pandemic further exacerbated these inequities. Alliance member centres responded by removing barriers to accessing community-based healthcare and taking an equity-driven approach to delivering supports to advance vaccine uptake in these areas. Due to the community-led framework of how Alliance members provide care, centres were able to build on long-standing, trusted relationships with

their communities and respond innovatively with tailored initiatives. Cultural ambassadors were a critical resource to launch dedicated, culturally safe outreach when engaging marginalized communities and sharing accessible, multilingual materials with accredited vaccine information. Ensuring that there were members from the community who look as, act as and speak the same language as high-priority populations was found to be the most effective approach for inspiring trust in vaccination information and clinics. Lessons learned here can be used to engage in other health-promoting activities including the population health efforts currently under way across the country. HQ

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About the Authors

Sara Bhatti, MPH, is the research and evaluation project lead at the Alliance for Healthier Communities in Toronto, ON. She can be reached by e-mail at sara.bhatti@allianceon.org.

Josephine Pham, MSc, is a knowledge mobilization and project coordinator at the Alliance for Healthier Communities in Toronto, ON.

Jennifer Rayner, PhD, is the director of research and evaluation at the Alliance for Healthier Communities in Toronto, ON.