Peer-to-Peer (P2P) Speaking Up About Vaccine Safety:

PROGRAM EVALUATION

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Peer-to-Peer (P2P): Speaking Up About Vaccine Safety Program Evaluation

FINAL REPORT

Submitted to:

Public Health Agency of Canada (PHAC) on behalf of NorWest Community Health Centres and the P2P partnership

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Table of Contents

07 Project Background

08 Partnership Description

10 Project Objectives

13 Evaluation Method

19 Findings

32 Putting It All Together: Summary and Ways Forward

34 Conclusion

35 Appendices

89 Tables

120 Figures

Summary

The Peer-to-Peer (P2P): Speaking Up About Vaccine Safety project was funded by the Public Health Agency of Canada (PHAC) in response to a call for proposals in the Spring of 2021. The call for proposals was to support Canadians' vaccine confidence and uptake and address barriers to accessing vaccination. The call for proposals specified that diverse strategies and targeted interventions were required as there was no "one size fits all" approach to COVID-19 vaccinations. Successful proposals would further require a focus on Canadians who historically have been underserved and whose health is negatively impacted by various social determinants of health.

NorWest Community Health Centres, in partnership with co-lead Dilico Anishinabek Family Care and six other community stakeholder organizations, engaged in this multi-agency collaborative project to support vaccine confidence and uptake in marginalized individuals within Thunder Bay, Fort William First Nation and communities throughout the district of Thunder Bay. The aim of P2P was to serve marginalized populations in Northwestern Ontario through targeted communications and peer outreach to increase uptake for COVID-19 (and other) vaccines.

Throughout the project, the partners focused on developing a local model of vaccination confidence and uptake that considered the health disparities and social determinants of health faced by marginalized individuals and their ability to access timely and accurate information and supports. P2P relied heavily on peer outreach as the main way to engage and develop relationships with individuals in marginalized communities who may be vaccine hesitant or questioning. Based on these approaches, the project successfully implemented vaccination campaigns, targeted communication on positive vaccine messaging, created flexible vaccination clinic availability with transportation and incentives, peer and health provider training on vaccine hesitancy, cultural awareness and safety training, and peer outreach.

The project engaged in a low-barrier evaluation which reviewed the strategies implemented by the partnership to reach the target populations and meet the original goal of PHAC to support vaccine confidence and vaccine uptake...

...based on the evaluation methods (documentation review, content analysis of semi-structured interviews and focus groups, and synthesizing quantitative community vaccination data), several project outcomes were met. These included increased access to evidence-based vaccination information, positive messaging and increased vaccination services for marginalized communities, reduced barriers to care, increased knowledge about vaccination among peer outreach workers, and increased collaboration and crisis response among partner organizations.

Project Background

This project has aimed to address an urgent need to better serve the needs of marginalized populations who have been severely impacted by the pandemic. In February 2021, the Thunder Bay District Health Unit (“TBDHU”) declared a COVID-19 outbreak in Thunder Bay’s homeless population and the demand for an isolation shelter was at an all-time high. The District’s incidence rate of 160 COVID-19 cases per 100,000 people was also the highest in Ontario. The COVID-19 crisis has exposed and amplified health inequities faced by the marginalized communities that NWCHC and partners have long worked to address. Issues brought to light as a result of COVID-19 are ones we will continue to face on an ongoing basis, including those related to vaccine safety, confidence, and access.

The P2P project was based in Thunder Bay, Ontario. Thunder Bay is northwestern Ontario’s largest urban centre and is a service hub for rural and remote regional communities. The District serves a population of 146,048 (of which 21,755 identify as Indigenous). According to Ontario, using 2016 Census data, Thunder Bay has the largest proportion of Indigenous residents among major Canadian cities, yet many of the region’s Indigenous peoples are impacted disproportionately by substance use disorders and homelessness as a result of historical and ongoing colonization. Data shows that 66% of persons experiencing homelessness in Thunder Bay’s 2018 Point in Time Count identified as Indigenous. Social inequities, systemic racism, and increased barriers to accessing culturally safe healthcare uniquely influence individuals accessing prevention and treatment services in this region.

The P2P project was conceptualized as a way to mobilize many types of health care delivery organizations within the Thunder Bay district to serve vulnerable populations in Northwestern Ontario through targeted communications and peer outreach aimed at increasing uptake for COVID-19 (and other) vaccines. Although the project was initiated in the city of Thunder Bay, as the project progressed, outreach activities were extended to the Thunder Bay district at various community organization satellite sites. The project aimed to build capacity and knowledge within these communities related to vaccine confidence which could be sustained well past the project duration.

For the purpose of this project, **vulnerable populations** were described as individuals who may be more likely to be marginalized from accessing broader health services, and more specifically to this project, vaccine-based initiatives in the Thunder Bay city and district. These included identified populations that have difficulty accessing relevant heath care in this region, including but not limited to,...

...Indigenous individuals, people who use substances or engage in injection drug use, those living with HIV, sex workers, those living unhoused, individuals without a primary care provider, people living with mental illness, and individuals with lower socio-economic status. These targeted populations were those who are more likely to face systemic health inequities and who have been negatively impacted by a range of intersecting social determinants of health.

Partnership Description

The P2P project partnership was established from an increased need to enhance community knowledge of vaccine awareness and safety, in addition to vaccination within the Thunder Bay community in response to the COVID-19 pandemic. Community partners were those who identified an initial desire and capacity to collaborate on shared goals to increase vaccine confidence within the region and who had previous experience and expertise reaching this project's target population. Each organization committed to participating in the P2P Project Advisory, and met regularly to guide the direction of the project. This partnership was co-led by two organizations, NorWest Community Health Centres ("NWCHC") and Dilico Anishinabek Family Care ("Dilico") who were responsible for ensuring project activities proceeded in accordance with partnership goals.

Table 1. Description of Community Partners

Organization	Description
Anishnawbe Mushkiki ("Mushkiki")	An Indigenous-led, community-based, Aboriginal Health Access Centre—established in 2001, and one of 11 in Ontario. It's holistic centre (with an inter-professional team of physicians, nurses, nurse practitioners, social workers, health promoters, dietitians, diabetes educators) delivers primary care, health promotion, and traditional wellness programs for Indigenous peoples of all ages in Thunder Bay.
Brain Injury Services of Northern Ontario ("BISNO")	This organization provides supportive rehabilitation services (assisted living, personal support, independence training) for clients living with acquired brain injuries.

Organization	Description
Dilico Anishinabek Family Care (“Dilico”)	An Indigenous-led organization which provides a range of responsive individual, family and community programs and services for Anishinabek people in Thunder Bay District. Its primary care includes access to culturally-safe care, comprehensive clinical counselling and traditional healing through an interdisciplinary team of physicians, nurse practitioners, nurses, social workers, and traditional healers.
Elevate NWO (“Elevate”)	A community-based, non-profit organization that empowers people living with, affected by, or at risk of HIV, AIDS, and HCV in Thunder Bay and northwestern Ontario. Elevate has 10+ years experience in recruiting, training, AND mentoring peers regionally, and has contributed to development of national peer guidelines.
NorWest Community Health Centres (“NWCHC”)	NWCHC delivers primary health care along with allied health services and programs, in addition to health promotion and prevention health care that address the social determinants of health in the City and District of Thunder Bay. In addition to the three clinic sites, they operate mobile health services to provide regular access to primary care services to other district communities and individuals seeking care. (Clinic sites: Thunder Bay, Armstrong, Longlac, Kakabeka Falls)
People Advocating for Change through Empowerment (“PACE”)	An organization which has provided peer support for people living with mental health and addictions in Thunder Bay District for over three decades. (sites: Thunder Bay, Geraldton, Marathon, Schreiber-Terrace Bay, Manitouwadge).
The Salvation Army	This organization provides a range of supports: breakfast program; Food Bank/relevant programming weekly; mobile feeding program (2 locations nightly); emergency shelter/ overflow beds for 30 adult males; longer term housing for adult males living with mental illness; contract with Correction Services for post discharge beds; transitional housing; skill building/life skills programs.

Organization	Description
Thunder Bay District Health Unit (“TBDHU”)	One of Ontario’s 34 Public Health Units, committed to improving health and reducing social inequities in health through evidence-informed practice. TBDHU provides public health expertise in infectious diseases (HCV/HIV prevention, diagnosis, treatment) and vaccine preventable diseases with a focus on vulnerable populations. TBDHU is actively rolling-out the COVID-19 vaccination program in the TBDHU area.

Project Objectives

One fundamental goal of the P2P project was to leverage skills and capacity among community members, “peers”, considered to be those with similar lived experiences as those who may require more support to build vaccine confidence in the Thunder Bay district. Their focus within the P2P project was to apply their contextual understanding of vaccine hesitancy within the region and provide ongoing consultation to organizational partners, including participating in various organizational and community-based committees, regional strategy meetings, and inter-agency discussions. Peers were employed to meaningfully engage more vulnerable individuals by sharing relevant evidence-based information in a way that was culturally and contextually relevant for each target individual. They either volunteered (and financially compensated with stipends) or were employed through various partner organizations to support project activities as Harm Reduction Workers.

The three main objectives of the P2P project, described in more detail below, were as follows:

01 Increase access to vaccination services by mobilizing P2P partners and peer influencers.

02 Improve knowledge about vaccination and build confidence in vaccines among marginalized populations.

03 Measure the effectiveness of street-level interventions in improving demand for and access to COVID-19 and other vaccines.

01 Objective

Increase access to vaccination services by mobilizing P2P partners and peer influencers, who will enhance the capacity of street-level outreach with marginalized populations

This project goal was to emphasize the mobilization of community partners in addition to peer influencers in the Thunder Bay city and district. All partners who committed to this project have outreach networks in place and have specific expertise in working with marginalized groups most prevalent in these communities. Although many organizations have prior experience collaborating across groups, there has not been a formal process by which partners could regularly communicate and engage with one another to collaborate for vaccine administration and outreach activities. The P2P team aimed to create spaces for people to connect, and to offer opportunities for peers and community members to learn from and support each other engaging in similar activities across organizations.

02 Objective

Improve knowledge about vaccination and build confidence in vaccines among marginalized populations, by developing and implementing targeted communications

This objective largely focused on the development of public health promotion materials based on the stated needs from peers, community partners, and feedback from street-level interactions with target demographics with the P2P harm reduction workers. This objective aimed to develop materials that can be used to share evidence-based information about vaccination in addition to information about vaccination clinics to improve vaccine confidence within vulnerable populations. These materials included the development of brochures, fact sheets, and various forms of social media messaging to reach individuals in the community that were targeted to address the culturally and contextually relevant needs within various populations.

The second goal within this objective was to engage in broader peer and staff training across organizations. This project aimed to support development of new sets of skills (such as health literacy, targeted communications) among peers and participants who use the P2P services as well to foster connections among peer groups across organizations. Partner organizations had a shared need to train staff in evidence-based vaccine knowledge and ways to discuss hesitancy within the community. Peer and broader staff training initiatives related to vaccine confidence, community-based initiatives (including shared services and vaccination campaigns) was a secondary goal of this project.

The third objective was to design and implement street-level interventions including pop-up vaccine clinics, systems navigation to access clinics and digital vaccine certificates, and to provide wrap-around support to individuals who face more barriers seeking health services, including access and confidence in vaccination. These initiatives aimed to provide timely, accessible, and culturally-relevant community interventions that could facilitate vaccination within more vulnerable populations, implemented through primary care clinics, emergency shelters, and street-level or mobile interventions.

03 Objective

Measure the effectiveness of street-level interventions in improving demand for and access to COVID-19 and other vaccines .

The aim of this objective was to assess the effectiveness of project goals and engagement among vulnerable populations with the street-level interventions delivered through the P2P project and the overall perceived effectiveness of project activities for reaching both a primary and secondary audience. The primary audience of this project was considered to be potentially vulnerable individuals with whom the partner organizations engaged with, while the secondary audience was the frontline health care workers and service providers working within the community to provide evidence-based information of COVID-19 and vaccination benefits with these individuals.

This objective was largely focused on identifying firstly the perceived benefits to the Thunder Bay community, in addition to strengths, barriers, and future directions of vaccination education, training, peer support, and clinic opportunities within the P2P project, partner organizations, and the broader Thunder Bay city and district. This objective specifically aimed to identify strategies to promote the successful implementation of peer outreach to support public health education. Given the commitment and organizational focus among some project partners, this objective also aimed to address Indigenous-specific needs and barriers to vaccine education within the region.

Evaluation Method

A low barrier evaluation approach was selected to identify how the previously outlined project goals were addressed throughout the P2P project implementation. Given that project partners had many competing demands when addressing an increase in community need in the wake of COVID-19, we attempted to complete an evaluation in such a manner that reduced the resources required from project partners to increase accessibility of evaluation participation. Our method involved:

01 **a document review of meeting minutes and created resources,**

02 **obtaining summaries of agency-specific project activities**

03 **completing a content analysis of semi-structured focus groups and interviews with relevant project collaborators, and**

04 **synthesizing community-specific quantitative data provided by the local community health unit about relevant project-related vaccine activities.**

A timeline of the evaluation process is described in Figure 1.

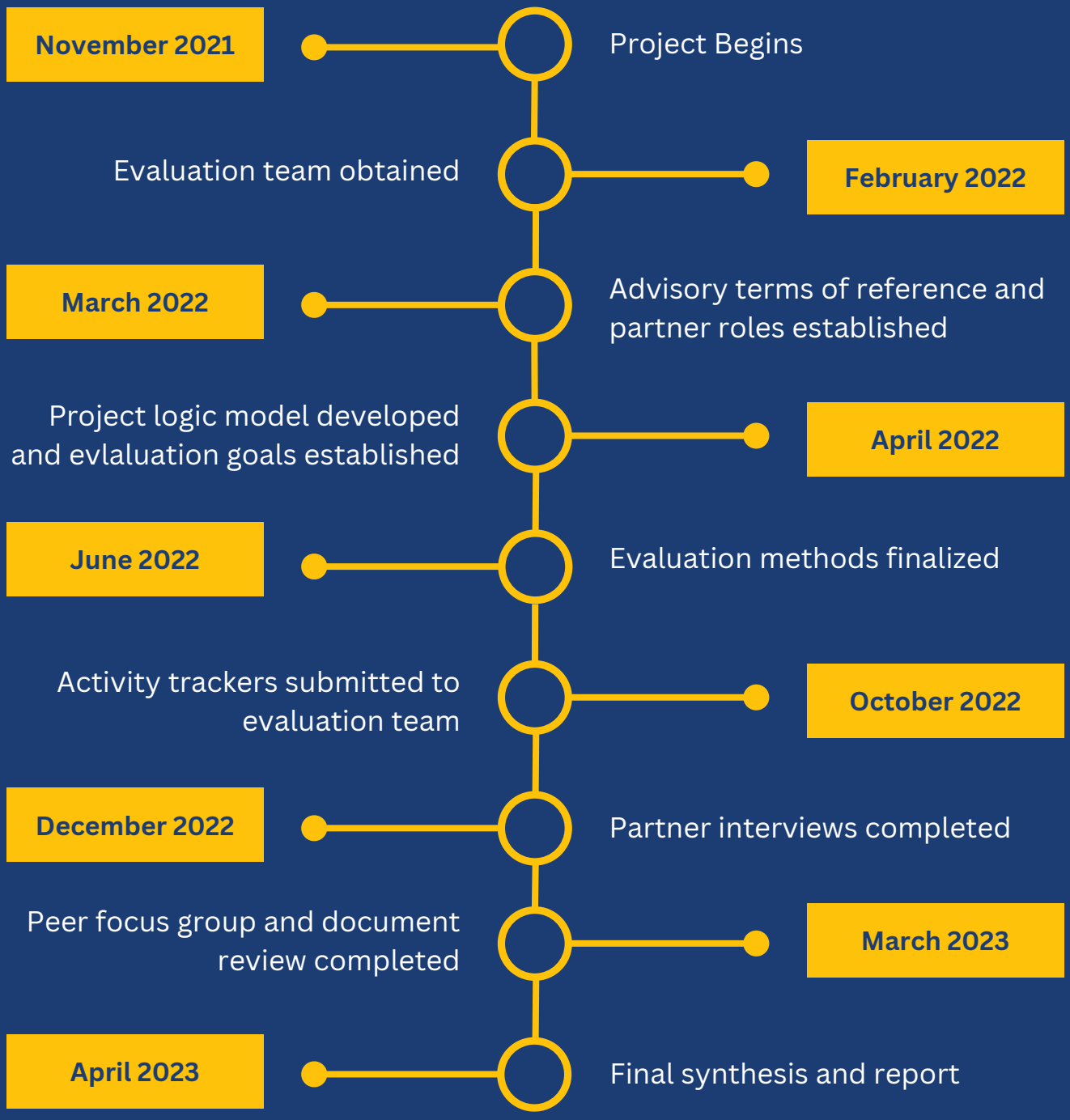


Figure 1. Evaluation timeline

Theory of Change

A logic model was developed following consultation with partners occurring in an advisory meeting on April 22, 2022. This model outlined the tangible and intangible inputs, activities, timelines, and outputs of the project as one way to guide the evaluation process. Figure 2.0 Logic Model illustrates the theory of change via inputs, activities, outputs and outcomes of the project. The full impact of the project will not be fully realized within the project parameters. However, the immediate impact of increasing vaccination uptake resulted in not only in increasing the health outcomes of individuals but health of the community. This project identified solutions to increase awareness of health benefits of vaccinations and addressed tlower vaccination uptake within marginalized populations.

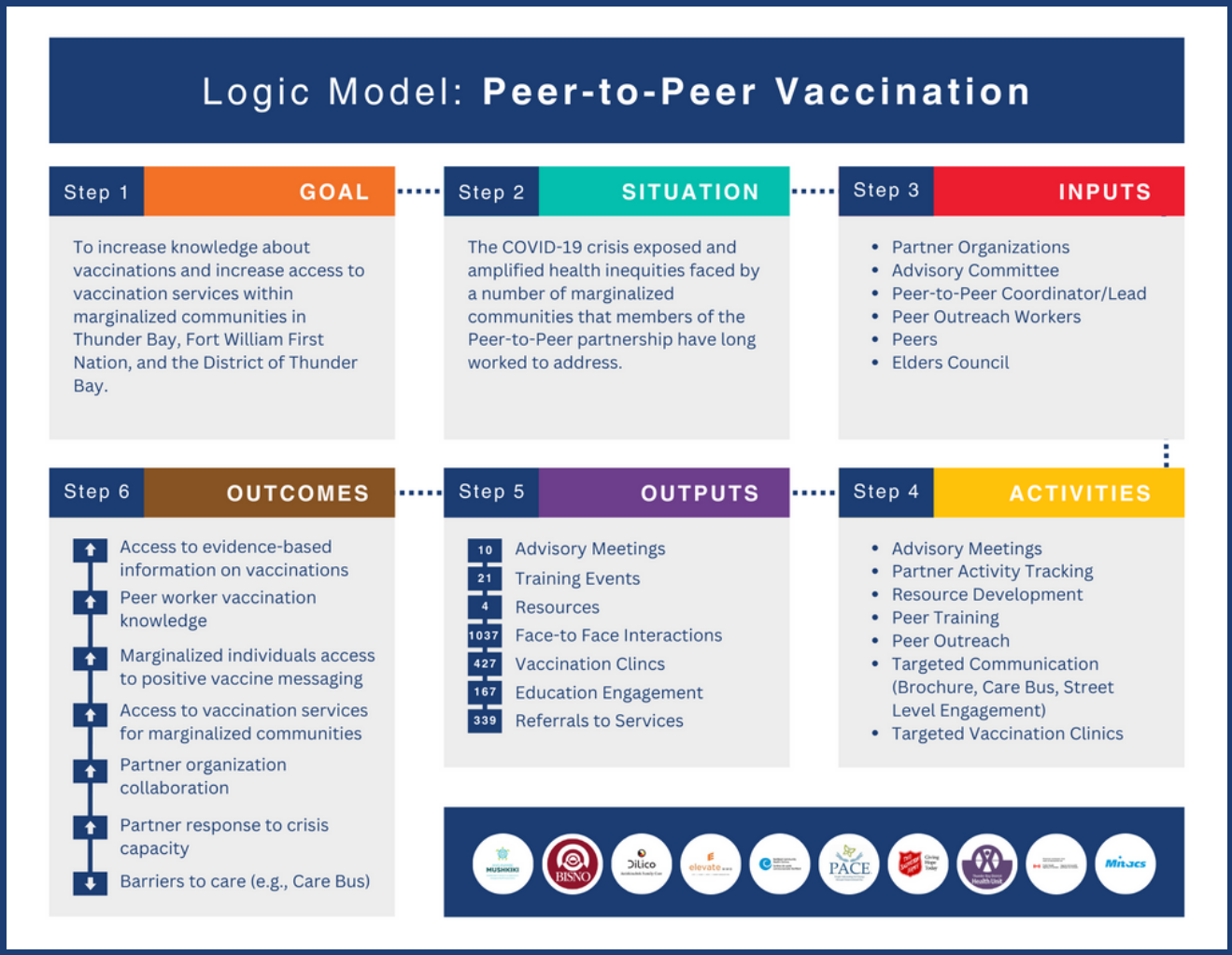


Figure 2. Logic Model

Evaluation Activity 1. Document Reviews

Meeting Minutes. We reviewed minutes of ten project partner meetings from February 7, 2022 until March 16, 2023. We examined project partner attendance, new and old business agenda items (in relation to identifying project activities completed), and any other relevant items discussed in the minutes pertinent to the project evaluation.

Staff Training Resources. Partners were asked to submit documents related to type of staff training and share relevant materials related to how staff obtained information related to the project goals.

Public Health Promotion Resources. Partners were asked to submit any relevant public health promotion resources, including ad campaigns, social media posts, and any developed materials related to the goals of the project. These were reviewed and summarized in the report.

Evaluation Activity 2. Project Activity Tracking

Each organization completed an activity tracking log (Appendix A) every quarter which described the nature and frequency of project activities related to staff or peer training, vaccine clinics, or information sharing. Training was operationalized as any activity related to building knowledge related to vaccine safety in the community, and included informal time with local experts, online training webinars, sharing resources among partners or staff, among other activities. Public information and vaccine health promotion activity sharing was conceptualized to be activities that disseminated evidence-based information with the targeted project population. This included radio, social media, and poster campaigns, in addition to in-person meetings, online webinars, and distribution of public health education resources. Any organized vaccine clinic (either formally organized or a pop-up clinic through other public health access campaigns) led-by or participated in by a community partner that aligned with the project goals was considered a related project activity in the scope of this evaluation.

Evaluation Activity 3. Content Analysis

Community Partner Interviews. Individual interviews were completed with 11 individuals across the eight project partners. The majority of organizations had one individual complete an interview for the evaluation, with the exception of Mushkiki who had 2 individuals complete an interview, and NWCHC, who had three individuals complete interviews. Participants were identified through participating collaborators at project meetings, and then a snowball sampling approach was used to identify any other relevant individuals to interview. Interviews were completed on zoom based on participant preferences and were recorded.

Interviews aimed to assess the efficacy of mobilization among community partners and relevant project stakeholders (Objective 1) in addition to their perspectives of the overall experience and effectiveness of the project (Objective 3). We asked participants about their organizational focus, types of activities implemented within the organization (vaccination clinic, staff training, or information sharing), in addition to how successful these activities were perceived to be. We asked participants to elaborate on future considerations to enhance vaccine uptake in the region, barriers to completing or administering project activities, and to describe any benefit or concern related to partnering with this project in addition to future needs to continue activities related to promoting vaccine safety.

Transcripts were thematically analyzed by one independent rater using NVivo qualitative analysis software. Preliminary themes were reviewed by two additional raters and were initially validated with community partners to assess if results accurately represented the experiences of the project. This was particularly relevant to capture relevant information pertaining to the distinct cultural and contextual experiences within the P2P project, such as the Indigenous-led organization partners or those providing services in the Thunder Bay district.

Peer Outreach Worker Focus Group. A focus group with four peer outreach workers was completed on March 16, 2023. The goal of this focus group was to obtain relevant information from peers involved with this project. For the purpose of this evaluation, as previously defined by the P2P project collaborators, this group was open to any individual with lived experience or was employed with the organizations as a peer outreach worker. This group consisted of two male and two female participants, three of which described themselves as having previous lived experience with substance use and/or homelessness. One individual self-identified as Indigenous. Among the three individuals who disclosed their training history, two indicated they had previously worked as a peer outreach worker prior to this project.

Advisory Focus Group. A focus group with twelve individuals involved with the project, across five partner organizations was completed on March 16, 2023. The purpose of this activity was to gather recommendations from project partners related to next steps and future directions of activities related to the P2P project through a partner based, collaborative discussion, rather than individual interviews.

4. Descriptive Quantitative Analysis of COVID-19 Vaccination Clinics

A data-sharing agreement was established between the TBDHU and Lakehead University, School of Social Work, to share the de-identified data for COVID-19 vaccination clinics in Thunder Bay and District over the P2P project evaluation period. This quantitative data will demonstrate the number of vaccination clinics and vaccinations that occurred within the region during the evaluation time period of July 15, 2021 to March 31, 2023. An addendum to the P2P project evaluation will occur once the data is received.

Findings

Overall, findings from this evaluation suggest that the P2P: Speaking Up About Vaccine Safety project likely contributed to increased COVID-19 vaccination in the Thunder Bay city and district communities. Community partners collaborated to actively implement a series of community-based vaccination campaigns, training for peers and other project staff within the community, and to provide a series of vaccination clinics that were deemed to be more accessible for the targeted populations within this project. These project activities aimed to leverage peer and outreach workers to enhance positive communication about vaccination among vulnerable populations to provide real time evidence-based knowledge about vaccines among Thunder Bay city and district communities.

01 Objective Partner Mobilization and Collaboration

Based on the terms of reference created for the P2P partnership, partners decided that Advisory meetings for the project would occur monthly (with the exception of July and August months). Invited attendees to this Advisory Committee were the eight community partners identified in the P2P project. These meetings were chaired by a member of NWCHC, who was responsible for meeting scheduling, preparing agendas, drafting meeting minutes, and follow up on outstanding agenda action items. Based on the review of ten monthly meeting minutes, these responsibilities were regularly met.

A review of these meeting minutes indicated that among the eight community partners, on average, five organizations attended each meeting. Among organizations, lead partners (NWCHC and Dilico) had the highest attendance rate, with NWCHC chairing and attending all partner meetings. TBDHU also attended all scheduled meetings. With respect to the remaining five project partners, meeting participation rates were variable, and ranged from 30 to 70% meeting attendance, with disclosed regrets for non-attendance largely attributed to staffing shortages, competing demands (including community crises or organizational-related concerns), and limited resources experienced among these largely outreach-focused community organizations.

For example, the two organizations with the lowest participation rates (40% and 30% attendance respectively), both provide a comprehensive range of services within the community to largely vulnerable populations, which may have created increased barriers to project participation. Participation in monthly meetings also dissipated slightly over time, with the first five meetings having 75% partner attendance (six of eight organizations), with the remaining five meetings attended on average by 60% of partners (mean of 4.8 partners per meeting), however this may be slightly influenced by the last meeting being in person (with 5 partners in attendance) rather than in the typical web-based format.

Active Collaboration

With respect to regular collaboration on project related activities, organizations part of partnership advisory communicated regularly and shared information among one another. In total, the organizations collaborated on vaccine clinics with a community organization 182 times. Out of these partnered vaccine clinics, organizations within the partnership collaborated with one another 152 times. Information sharing was another way in which the advisory committee collaborated. In total, partner organizations collaborated on information sharing with additional community organizations 20 times. Out of these collaborative information sharing activities, organizations within the partnership collaborated with one another 19 times. The partner organizations collaborated on activities specified as “other” on the activity tracker. This category represented vaccine supportive activities such as surveillance testing and helping obtain vaccine passports as well as activities such as meetings with other organizations to receive guidance about hand washing and masking. In total, the organizations collaborated with a community organization 25 times and out of these times, collaboration among the organizations within the partnership occurred 4 times. Lastly, the organizations within the partnership collaborated with each other for staff training purposes 3 times and reported zero collaborations with organizations outside of the partnership advisory.

Partner Identified Experiences of Mobilization and Collaboration

Eleven individuals across eight organizations were asked about their experiences being involved in and conducting the Peer-to-Peer Vaccine Hesitancy Project. Among the themes obtained through qualitative interviews, participants described many benefits (Table 2) of the project, including many themes related to the benefits of this community partnership and collaboration.

Among the 11 identified benefits of the overall project, five themes described perceived benefits of mobilization and collaboration among community partners. These were themes of “Working in Partnership,” “Providing Wrap Around Supports,” “Communication Among Organizations,” “Service Breadth”, and “Sharing Resources Among Organizations.”

The “Working in Partnership” theme was endorsed by a total of 10 participants (91% of sample), and across all eight organizations as a benefit to the project. Participants in their individual interviews discussed how working together across organizations benefited each organization’s clients or service users, and the overall communities served in general. They relayed that the increased demands upon community organizations in response to the COVID-19 pandemic were partially diminished by the ability to work together and leverage various service provider resources and strengths within communities, with the shared broader goal of community health and wellbeing. This was related to project activities including resource sharing across organizations (endorsed by five organizations, and 50% of participants), that enabled organizations to leverage other organizations’ health communications, vaccine clinics or community-based activities, and training to improve services for community in a bi-directional and reciprocal relationship maintained through the P2P partnership. Among the six non-Indigenous led community agencies involved in this project, four (67% of sample) described the importance of being able to regularly collaborate with Indigenous-led agencies within the community to better reach individuals in need (Table 3). In relation to the “Communication Among Organizations,” both Indigenous-focused organizations partnered with the project highlighted this as a strength of the project, and contextualized experiences of this project as being beneficial to maintain strong relationships with other organizations in the community as a benefit to Indigenous individuals within the city and district.

Among the barriers or concerns noted with the overall project (Table 4), with respect to mobilization and collaboration activities, no organizations expressed any type of limitation or concern with this project goal related to engaging or maintaining participation at an organizational level. One identified theme among the 12 barriers identified for conducting project activities was identified to be staffing consistency among community organizations, which was identified by two partners (25% of organizations). These partners relayed that staff turnover, experienced across many health care organizations in this region for the duration of this project, impacted the communication across organizations. Partners indicated that changing staff on the project hindered the timely completion of project goals and created confusion at times for who was the primary contact at each organization. A review of meeting minutes indicated that across the eight partners, three had personnel changes regarding who were responsible for regular completion of P2P project activities. When asked about specific challenges that partners faced in regards to working in a partnership, four sub-themes were derived related to the communication breakdowns due to staff turnover, initial project coordination among partners, the timing of organization related to project activities, and dissipated partner engagement over time for the duration of the project. Subthemes were endorsed by a range of one to three project partners.

When asked about specific challenges that partners faced in regards to working in a partnership, four sub-themes were derived related to the communication breakdowns due to staff turnover, initial project coordination among partners, the timing of organization related to project activities, and dissipated partner engagement over time for the duration of the project. Subthemes were endorsed by a range of one to three project partners.

When partners discussed their ideas regarding future directions of this project (Table 5), four organizations (50%) indicated that the community partnership should be continued, and could likely be extended to other shared goals unrelated to vaccine hesitancy. In the final "official" meeting of the P2P project, and the final evaluation focus group, all organizations in attendance (five of eight), indicated that they would like to continue to meet monthly after the project has formally ended. When asked specifically about how partners could overcome barriers associated with challenges related to the partnership, they discussed improving the long-term planning processes of the project to improve communication, ensure adequate staffing to reduce communication breakdowns due to staff turnover, finding more concrete ways to share the knowledge gained from this project within the community, and establishing a clear plan that is communicated to all partners at theonset of the project. Each of these four future directions were discussed by one partner per sub-theme.

Partner Takeaways and Future Directions of Project Collaboration

In the final partner focus group, held during the last advisory meeting, the five organizations present shared a number of key takeaways resulting from the collaborative nature of the project, many of which overlapped with themes previously derived from individual interviews. Two additional themes shared in this focus group were apparent throughout all conversations, that were deemed to facilitate a successful partnership and overall, project implementation. These were considered to be 1) **Relationships** with community members and across organizations, and 2) creating a **community model** of practice. Partners agreed that:

1) The relationships established and/or enhanced was the key factor to the project's development and implementation. The critical components of these relationships with vulnerable community members engaged with the project were:

- taking the time to build relationships
- trust as the foundation for all engagement activities
- non-competitiveness among organizations
- understanding each partners capacity and priorities (leading to equitable partner roles and responsibilities), and
- recognition of the importance of Indigenous and non-Indigenous partners working together to meet community needs

2) The creation of a community model to respond to the immediate needs of the community and in particular marginalized communities was essential. The highlights of this model were

- the local context as key; not relying on bigger city models
- collaboration is transferable and necessary for ongoing/new projects; not just in response to a crisis/pandemic, and
- the inclusion of peers as necessary and required

02 Objective Project Activities to Build Awareness and Confidence

Project partners completed a series of activities that aimed to build awareness of vaccine safety, community-clinics, and increase vaccine confidence in communities, including implementing targeted communications for respective populations commonly interacted with within each organization.

Vaccination Campaigns

Training

Peer Outreach

Indigenous-Specific Activities

1. Vaccination Campaigns

Some of the project partners reported conducting scheduled centre-based vaccine clinics in the community and clinics over the duration of the project. In response to community needs and to reduce barriers of attending scheduled centre-based vaccine clinics, the partnership also held mobile and/or pop-up clinics. Some of these low-barrier clinics were held on a mobile van or bus; others took place at various community organizations. Some examples of pop-up locations include a warming shelter, housing facilities and treatment centres. Additionally, organizations conducted miscellaneous vaccine-clinic related activities which involved vaccine supportive activities such as providing vaccine passports for individuals who received their vaccine at a street outreach clinic and COVID-19 testing clinics.

While it was outside of three organization's mandates, five of the partnering organizations conducted vaccine clinics. In total, the partnering organizations conducted 426 vaccine clinics. Of these, 325 were held in Thunder Bay, 62 were held in First Nation communities in the District of Thunder Bay, 25 were held on Fort William First Nation, and 16 were conducted in towns across the District of Thunder Bay. Two organizations conducted vaccine clinics in both Thunder Bay and the surrounding District of Thunder Bay, including First Nation communities. All other partner organizations were mandated to conduct clinics in Thunder Bay only. For vaccine clinics, the organizations collaborated with other organizations 182 times. Of these times, collaboration among the partnering organizations occurred 152 times.

Seven partnership organizations reported engaging in information sharing activities to bolster vaccine campaigns. This included activities such as distributing brochures, posters, and/or fact sheets, hosting webinars and social media livestreams, providing in-person presentations, and face-to-face individual meetings with community members. Across the partnering organizations, information sharing was reported 36 times. Of the reported instances, face-to-face individual meetings with community members happened most frequently.

During the project NWCHC provided 804 COVID-19 vaccinations and 389 flu vaccinations. Vaccinations were received at 41 vaccination clinics; the clinics included scheduled vaccination clinics (14) and pop-up clinics (27). The clinic statistics show a differentiation between where COVID-19 vaccinations and flu vaccinations were received by individuals. COVID-19 vaccinations were more likely to be received at the pop-up clinics; 79% of COVID-19 vaccinations occured at pop-up clinics whereas only 39% of flu vaccinations occurred at pop-up clinics. Flu vaccinations occured more often at scheduled vaccination clinics.

2. Training

All organizations engaged in COVID-19 vaccination-related staff training. Three organizations reported project-specific staff (health care provider) or peer training. Across all organizations, project-related staff training was reported 21 times. One partner organization provided nine training opportunities for peers. Other partner organizations reported project-specific health care provider training 12 times. Of all project-related staff training, there were 19 training opportunities in Thunder Bay and one organization reported conducting two project-specific training opportunities in Fort William First Nation.

Peers were asked to identify what training strategies they found helpful when obtaining their own information about vaccines and best-practices associated with sharing information (Table 7). They identified that using a team-based approach, having informal opportunities to seek information, and having training that was peer-led were the three specific project related activities that aided in their understanding of vaccines, particularly as some peers in the focus group previously described themselves as vaccine hesitant prior to participating in this project.

2.1 Creating and Distributing Training Resources

Training resources were created and ranged from clinic pamphlets and handouts (Appendix E) to promotional resources (Appendix D). Specific training and education documents that were distributed among partners and across community clinics are described below and included in Appendices B and C.

A. *Talking About Vaccines with Vulnerable Populations in Thunder Bay and District: A Guide for Peers and Outreach Workers- Training Guide (Appendix B1)*

This guide was developed by NWCHC's peer outreach team leader as a framework to regularly share vaccine-specific information with peers and peer outreach workers embedded within their larger community health team. This training guide identifies ten topics related to vaccine safety and access for vulnerable individuals living in the Thunder Bay city and district. Information is shared through short, twenty minute "team huddles" regularly, to provide an informal space for peers and peer workers to have information shared by another team member, ask questions about information, and discuss ways this information could be shared with community members they regularly interact with. Topics included in this guide were:

Vaccines	General Communication about Vaccines
COVID-19 Vaccines	Talking about Vaccine Hesitancy
Seasonal Flu in Thunder Bay	P2P Vaccine Confidence Project
Vaccine Access in Thunder Bay	Vaccines During Pregnancy
Vaccine Hesitancy and Confidence	Indigenous Folks and Vaccines

B. *Wise Practices for Supporting COVID-19 Vaccination (Appendix B2)*

This 1 hour, 45 minute webinar discussed wise practices for health care providers and organizations supporting access to COVID-19 vaccination within Indigenous communities. This was supported by one community partner, NWCHC and another community organization, Indigenous Primary Health Care Council (IPHCC). It reviewed how the history of barriers to access and discrimination in health care affects health care use among Indigenous communities, present day implications for vaccination, and wise practices. Wise practices included in this webinar were 1) scrutinize power dynamics present among health care user and, 2) ways unsettle such privilege, and 3) discussed access to the Indigenous Participation in Ontario's COVID-19 response resource developed by the IPHCC.

C. *Talking About Vaccine Safety with Vulnerable Populations (Appendix C1)*

This resource guide is a user-friendly synthesis of strategies to discuss vaccine safety among vulnerable populations designed for health care users. Information for this pamphlet was derived from interviews and knowledge of peers and peer outreach workers affiliated with the project, who regularly work with individuals who are homeless or who use drugs. Strategies included in this review were: 1) Build trust and relationships first, 2) Use a peer-led approach, and 3) recognize and respect client prioritizes and values. Additional "Dos" and "Don'ts" of discussing vaccines with vulnerable populations are included.

3. Peer Outreach

The inclusion of outreach by peers with lived experience was the main function of the P2P project delivery. The targeted street-level communication built awareness and confidence and addressed vaccine questioning. The project engaged two different models of peer support; peer outreach workers who were employees and peers who were not employees but received honorariums for their time with the project. All peers received training on COVID-19, vaccinations processes available in the region, positive and evidence-based messaging for those questioning vaccinations, and access to local cultural and Indigenous-specific knowledge related to vaccination. Organizations also reported building capacity amongst other peer or outreach staff within their organizations for example, NWCHC trained their peer workers who staffed the Care Bus with COVID-19 training and resources. Internal capacity building extended the reach of positive vaccination messaging as well as building in supports and transportation to get individuals to a vaccination clinic. The Peer Outreach Workers engaged in 937 face-to-face interactions with individuals who were questioning vaccinations and held 167 engagement sessions specific to educating individuals about COVID-19 and COVID-19 vaccinations. The peers (non-employees who received honorariums) working with Elevate provided 2 group discussion opportunities called 'Kitchen Table Talks' which reached 17 individuals and engaged in over 100 conversations via peer street-based outreach or within the waming centre.

The focus group and qualitative interviews consistently reported that the success of peer outreach model was the time peers took on a daily basis to develop relationships and build trust with the individuals they were engaging with. Peer engagement did not typically start with conversations related to vaccinations but with conversations about addressing the basic needs of individuals. Peers were able to build these relationships with ease as they understood from their own lived experience what was the most important to the individuals they were interacting with. Two specific areas that benefitted from peer outreach was having peers that understood or had their own personal experience with 1) systemic oppression and colonization that resulted in a mistrust of government policies and mandates, and/or 2) stigmatization and negative experiences with the healthcare system. This understanding led to peers taking their time to build relationships and earn the trust of individuals before engaging in conversation about vaccines. This approach created space for peers to support individuals in their daily life, for example, transporting clients to medical appointments, distributing harm reduction supplies, completeing housing applications, and referring to withdrawal management services. This tangible support resulted in 339 referrals made to other services and programs to meet individuals needs. The relational approach meant that daily conversations were occurring where vaccines naturally became part of a conversation inversus starting a conversation only to discuss vaccinations or vaccine hesitancies or questioning.

This approach led to an immediate vaccine uptake over the duration of the project as evidenced by the face-to-face interactions, education engagement sessions that lead to over 800 COVID-19 vaccinations.

The peer model also lead to a the immediate exchange of information between health care workers, peers and individuals questioning vaccination(s). The peers acted as a conduit where they gathered information about vaccine hesitancies, barriers and questioning from individuals and then shared these findings with health care providers, who in turn would provided vaccine safety messaging and information to dispel any misinformation. This information was then provided back to the individuals; this approach provided realtime evidence based responses. This information from health care providers also increased the awareness and confidence of the peers to have the required information to increase their capacity and knowledge base.

4. Indigenous-Specific Activities

Overall, the organizations completed 87 vaccine clinics within First Nation communities. These activities were completely largely by the two First Nation organization partners (Dilico and Anishnawbe Mushkiki), who co-facilitated vaccine clinics with many other organization partners who regularly provided health services within Indigenous contexts. Dilico provided a COVID-19 FAQ document (Appendix C2) for First Nation communities and reported two health care provider staff training opportunities on Fort William First Nation related to mask fit testing training. There were no reported training opportunities located in Indigenous communities within the District of Thunder Bay. Activities occurring with these communities were mostly led by Indigenous-centered organizations, and as such, although not formally consulted through project engagement, regularly consulted Elders, community leaders (including chief and council), and additional community remembers as required through organizational derived best-practices.

03 Objective Measured Effectiveness and Overall Experience

This objective was largely measured through the qualitative themes derived from both partner interviews and the peer focus group. Themes related to project goals of specific activities (including vaccination clinics and training opportunities), peer engagement and outreach, and Indigenous-specific activities are discussed below. Relevant sub-themes related to larger project evaluation outcomes (derived from Tables 2 through 11) were used to provide evidence for these identified categories.

1. Completion of Project Activities (Vaccine and Training)
Organizational partners described a series of strategies that they deemed that were used to contribute to successful programming (i.e., reached clients, greater attendance, facilitated acceptability, among other activities described in Table 6. Among the identified activities, many were identified to be successful due to the ongoing collaboration and mobilization of community partners (discussed in Objective 1). In addition to such initiatives, higher endorsed activities facilitated through the P2P project were providing incentives for vaccination (six participants; 55% of sample), providing one-to-one education (five participants; 45% of sample), and simplifying the language of distributed public health information (five participants; 45% of sample). Using a low-barrier approach to clinic or service access, facilitating access to resources, and providing mobile care or outreach services were endorsed by four participants, or 36% of the sample.

With respect to training-specific endeavours independently attributed to project effectiveness, in addition to increased access to vaccine resources, additionally endorsed activities were the use of webinars, in-person education, informal communication (among agencies and peers), flexible staff training (including learning at one's own pace and time) among P2P partner organizations. These sub-themes were endorsed by one or two individual participants (9% to 18% of the total sample).

Barriers related to implementing project specific activities (Table 4) were predominately related to accessibility to clinics and organizations. Among the eleven barriers discussed, three were related to the realities within communities that reduce access to project specific activities, and health services in general. These were identified as: transportation, access to technology, and securing location within communities for activities. To reduce these barriers, the project implemented five specific approaches. These were:

1. **"Pop-Up" Vaccine Clinics** to reduce accessibility issues and engage individuals where they are at. NorWest Community Health Centres hosted pop-up vaccine clinics at local warming centres, social services-administered housing/apartment buildings, and at treatment and recovery homes. These locations were planned in collaboration with project partners and community partners.

2. **Peer workers engaged in daily outreach** and acted as the liaison or connection with the healthcare services. The peer workers focused on building rapport and forming trusting relationships and were able to provide wrap-around care and support the most immediate needs of the individuals they were engaged with. This engagement led to vaccination uptake by individuals they were supporting.

3. **Cultural training** provided the context and content to serve Indigenous Peoples better and enhance project partners' awareness of the implications of government-driven vaccinations and mistrust of these government policies. The Indigenous Primary Health Care Council (IPHCC) provided the training to the partner organizations and their staff.

4. An **inventory of low-barrier vaccine clinics** was maintained with up-to-date information to provide to individuals who were requesting vaccination. This allowed for an immediate response when individuals were ready to be vaccinated.

5. Utilizing the **Care Bus** to engage in positive vaccination messaging and transportation to vaccination clinics, as well as facilitating access for individuals to other community-based supports and services, such as regularly occurring meal, or resource distribution campaigns.

Additional barriers related to changes and consistency in staff members (endorsed by six individuals) and care provider burn out (endorsed by three individuals) as a challenge for implementing project activities. For one organization involved with the project, they identified a lack of connection with the district communities as being a barrier to project implementation, however reflected that it was likely related to the scope of their organization, rather than the project overall given that other community partners were regularly connected and present in district communities.

2. Peer Engagement and Outreach

2.1 Partner-Related Perceptions of Effectiveness and Experiences

Among the 11 listed benefits (conceptualized as positive outcomes) of the P2P project, three individuals explicitly identified that facilitating peer support with the community was a relative benefit of this project. When asked about specific facilitators of project success, using peers to engage vaccine hesitant or more vulnerable community members was identified as one activity among the 17 themes identified (Table 6). When partners were explicitly asked about specific ways in which peers involved in the project were successfully engaged, two organizations who actively embedded peers within their organizational activities (NWCHC and Elevate) provided ways in which this activity was bolstered (Table 8). Both organizations indicated that providing appropriate incentivization contributed to the success of peer work. NWCHC indicated comprehensive training opportunities and engaging local peers who held relevant community-based knowledge within the region also contributed to success.

2.2 Peer-Related Perceptions of Effectiveness and Experiences

Among the approaches that were specifically identified by peers engaged with the P2P partnership (Table 9), many were similar to those identified by partner organizations, however peers emphasized outreach specific activities more regularly than partners. In a focus group with four peers who were either currently or previously engaged with the project, they identified that appropriate incentivization for service users, relationship/trust building, and tailored approaches for each individual client or service user based on their individual needs and lived experiences all contributed to increased vaccination with the Thunder Bay city. There was a particular emphasis on providing financial incentives to particularly vulnerable populations, as all peers suggested that pop-up clinics without compensation were not used as regularly as those which did provide some financial support. Representative quotes of facilitators of vaccination from a peer perspective are found in Table 9.

Through peer outreach engagement with individuals who were yet to be vaccinated, five main barriers were identified 1) general mistrust of health care systems and government, 2) lack of incentives for vaccination, 3) feeling like they did not need to be vaccinated, and 4) reluctance to conform. Additional discussion from peers within this group highlighted that some additional barriers included previous negative experiences with healthcare providers and organizations, and competing daily priorities (e.g., finding shelter, food security, staying safe, avoiding substance withdrawal, and addressing mental and physical health issues), among these populations.

Specific facilitators of peer work in general (Table 11), were described by peers, and included the use of a harm reduction approach, approaching community members from a place of genuine compassion with non-judgemental approach, and having shared lived experiences, while recognizing one's personal privilege, were identified to be useful when discussing vaccine specific strategies with more vulnerable community members.

3. Indigenous-Specific Project Activities

Participants described strategies that successfully engaged Indigenous populations in the region related to COVID-19 vaccination (Table 3). Among the nine sub-themes identified within this topic, many focused on Indigenous partnership, trust or relationship building, incorporation of Elders and knowledge keepers, and incorporating contextual and cultural knowledge regarding historical trauma and hardship faced within communities.

These were attributed to increasing vaccine confidence and trust of organizations delivering vaccine-related services within the district. Some examples included the Wise Practices webinar training, distribution of Indigenous-specific best-practices and handouts within community, and consistent communication and engagement with Indigenous-led organization P2P project partners.

An initial goal proposed within the Advisory was to formally engage Elders, cultural leaders, and knowledge keepers within the P2P project. Although this did not occur in the time frame of the project, one sub-theme illustrated within the broader theme of Indigenous engagement across the P2P project, indicated that these activities were embedded within various organizational activities regardless of formal Elder engagement by the project. Four organizations (2 Indigenous-led and 2 non-Indigenous led) discussed organizational level activities that facilitated cultural engagement with cultural coordinators, Elders, or prioritization of knowledge within vaccine related activities. When asked about future directions of the project, one partner discussed the importance of continuing to use Indigenous ways of knowing in future project directions when continuing project activities.

Putting It All Together: Summary and Ways Forward

The Peer-to-Peer (P2P): Speaking Up About Vaccine Safety engaged in a series of vaccine clinics, public health education and staff training, in addition to peer outreach that was mobilized through the collaboration of eight community partners in the Thunder Bay District.

Community partners remain committed to addressing the health disparities and needs of vulnerable individuals and communities. They will continue to examine ways in which P2P partnerships can be used Thunder Bay and District to improve vaccine safety among individuals with higher health needs (see Appendix F: Lessons Learned). Although this project has ended, all partners have agreed to continue to regularly meet to continue to discuss vaccine related activities and efforts within the community. This will provide regular access for key partners in the Thunder Bay district and city to communicate about the ongoing needs within and across organizations related to shared vaccination goals. Next steps can include:

- Partners will continue to meet on a monthly basis
- New terms of agreement will be explored in relation to changing Advisory goals, and will include broader discussion on leverage peer-based strategies to explore broader vaccination efforts in the community.

- NWCHC will employ a program coordinator who will continue to monitor and evaluate the healthcare programs and services delivered related to vaccination in the community, as well as vaccination hesitancy.
- A number of peers hired for P2P will continue in peer roles elsewhere in the partner organizations, the knowledge built throughout the project will be maintained within the partnerships
- Seek ongoing opportunities to include peers in the delivery of services within partner organizations
- Support of community-based self-sustaining peer networks across organizations, particularly among lead partners. This will establish partners as friendly, welcoming, and safe spaces for peers, but also build longer-term capacity within the peer network.
- Identification of additional Advisory partners
- Development of peer-based networks in district communities to regularly engage in future Advisory activities
- Engagement with existing Elder advisories through the Indigenous-led organization Advisory partners

As the community needs of the COVID-19 pandemic have shifted, it is possible that the needs of various organizations within the communities have also changed. Re-identifying additional community-based partners with similar goals to the Advisory may be beneficial, particularly among organizations by which the Advisory regularly collaborated with to implement project activities, but were not formal partners on this project to date. It is possible that some organizations who initially declined to participate in the Advisory given increased organizational and staffing demands at the height of the pandemic, may now have the ability to participate. Including additional organizations may enhance the network of community organizations within the Advisory and increase success of future activities.

These strategies can support the ongoing sustainability of the project, but also address some of the project limitations. For the purposes of this project, no district-based peers or individuals who were targeted through project strategies were able to be engaged in the evaluation framework. We were also not able to identify if specific project activities contributed to increased vaccination rates among these community members, however we did find that project related activities likely reduced barriers to vaccination among vulnerable populations in the targeted communities. Given the low-barrier method used within the evaluation, retrospective reporting of project activities through the project activity tracker likely meant that the number of project activities were underreported by some organizations.

Conclusion

The P2P Project was initiated in response to an urgent need to serve the needs of marginalized populations severely impacted by the COVID-19 pandemic in Northwestern Ontario. This collaborative and community-based approach mobilized various healthcare delivery organizations within the Thunder Bay district to serve vulnerable populations and provide low-barrier access to vaccine clinics and information. Organizations involved in the P2P Project worked collaboratively to build capacity and knowledge within community organizations and district satellite sites to reduce vaccine questioning among populations disproportionately affected by the pandemic.

Appendices

Appendix A: Activity Tracker Type and Descriptors
Appendix B: Training Resources
- **Appendix B1:** Talking about Vaccines with Vulnerable Populations in Thunder Bay District: A Guide for Peers and Outreach Workers – Training Guide
- **Appendix B2:** Training Resources – Wise Practices Poster

Appendix C: Education Resources for Health Care Providers
- **Appendix C1:** Talking about vaccine safety with vulnerable populations
- **Appendix C2:** COVID-19 Vaccination FAQs (Dilico Anishinabek Family Care)

Appendix D: Promotional Resources
- **Appendix D1:** Video – Peer Voices: Why I Chose to Get Vaccinated
- **Appendix D2:** Why it's important to get vaccinated

Appendix E: Clinic Schedule and Transportation Resources
- **Appendix E1:** Vaccination and Care Bus Schedule
- **Appendix E2:** Where to get your COVID and Flu Vaccine this Winter

Appendix F: P2P Vaccine Safety Project and Care Bus Project Lessons Learned

Appendix A

Activity Tracker Type and Descriptors

P2P Activity Tracker

Activity Type	Activity Type Descriptor
Vaccination Clinic	Vax Clinic- Scheduled centre-based (clinic or community)
	Vax Clinic- Mobile Pop-Up
	Vax Clinic- Other
Staff Training	Training-presentation to staff
	Training-Informal staff Q and A's with expert
	Training- Online learning
	Training- Resource sharing
	Training- Other
Information Sharing	Info Sharing- Distribution of Brochures/Posters/Fact Sheets
	Info Sharing- Webinar
	Info Sharing- In-person presentation
	Info-Sharing- Social media campaigns (i.e.FB live)
	Info Sharing-Telephone campaign
	Info sharing- Radio campaign
	Info sharing- Face-to-face individual meetings
	Info Sharing- Other
Other	N/A

Appendix B1

Talking about Vaccines with Vulnerable Populations in Thunder Bay District: A Guide for Peers and Outreach Workers – Training Guide

Talking About Vaccines with Vulnerable Populations in Thunder Bay and District: A Guide for Peers and Outreach Workers

Training Guide

Training Guide Outline

1. **Vaccines:**
   - What are vaccines and why are they important for vulnerable populations
   - Routine Immunization Schedule
   - Ontario Publically Funded Immunization Schedule: https://www.health.gov.on.ca/en/pro/programs/immunization/docs/Publicly_Funded_ImmunizationSchedule.pdf

2. **COVID Vaccines**
   - Vaccine Doses
   - COVID -19 Vaccine Development and Approval Process in Canada
   - COVID-19 Vaccine Ongoing Safety Monitoring
   - COVID-19 Vaccine Brands
   - Who should get COVID-19 vaccinations
   - COVID-19 in Thunder Bay: https://www.tbdhu.com/datadashboard

3. **Seasonal Flu Vaccines**
   - Seasonal Flu / Influenza
   - Flu Shots:
   - COVID and Flu Season

4. **Where to get vaccines in Thunder Bay (Access) – Updated Fall 2022**
   - General Vaccines
   - Vaccines During Pregnancy
   - COVID Vaccines
   - Flu Vaccines
   - Things to think about when referring someone to a vaccine clinic

5. **Vaccine Hesitancy and Confidence**
   - Vaccine Hesitancy
   - Vaccine Hesitancy Continuum
   - COVID Vaccine Hesitancies: https://www.vhguide.ca/details/advice/affirm

- Three Cs Model

6. **General Communication Tips for Talking About Vaccines**
   - General Communication Strategies
   - Talking About Vaccine Safety
   - Addressing Vaccine Hesitancies

7. **Motivational Interviewing Techniques to Talk About Vaccine Hesitancy**
   - What is Motivational Interviewing
   - Techniques of Motivational Interviewing

8. **P2P Vaccine Confidence Project**
   - Project Overview
   - Project Objectives
   - Project Activities and Outputs

9. **Vaccines during Pregnancy and Breastfeeding**
   - Immunizations During Pregnancy
   - Immunizations While Breastfeeding
   - Recommended Vaccines for Pregnant People:
     - Pertussis (Whooping Cough) / Tdap:
     - Influenza/Seasonal flu vaccine:
     - COVID vaccines
   - Vaccine Hesitancy During Pregnancy

10. **Indigenous People and Vaccines: Reasons for Hesitancy and Culturally Safe Communication Approaches**
    - Wise Practices Webinar

1. Vaccines

- What are vaccines and why are they important for vulnerable populations
    - Vaccines are products that protect people against many diseases that can be very dangerous and even deadly. These are known as vaccine-preventable diseases. Different than most medicines that treat or cure diseases, vaccines prevent you from getting sick with the disease in the first place.

        - ➢ *What are some examples of vaccine-preventable diseases?*

    - Vaccination is a simple, safe, and effective way of protecting yourself against harmful diseases, before you come into contact with them. It uses your body's natural defenses to build resistance to specific infections and makes your immune system stronger.
    - Vaccines train your immune system to create antibodies, just as it does when it's exposed to a disease. However, because vaccines contain only killed or weakened forms of germs like viruses or bacteria, they do not cause the disease or put you at risk of its complications.
    - Vaccination is the act of introducing a vaccine into the body to produce immunity to a specific disease.
    - Immunization is the process by which a person or animal becomes protected against a disease. This term is often used interchangeably with vaccination.
    - Immunity**:** Protection from an infectious disease. If you are immune to a disease, you can be exposed to it without becoming infected.
    - WHO video: https://www.who.int/news-room/questions-and-answers/item/vaccines-and-immunization-what-is-vaccination
- Note: every vaccine ingredient serves a purpose: to provide immunity, to keep the vaccine safe and long lasting, or to make the vaccine more effective.
- Video: How do vaccines work: https://www.youtube.com/watch?v=rb7TVW77ZCs

    - ➢ *Explain how vaccines work in plain and simple language*

- Routine Immunization Schedule:
    - Pregnancy Vaccines: Routine immunizations up to date, seasonal flu vaccine, Tdap (tetanus and diphtheria) during pregnancy (to pass antibodies to fetus so they have protection before they receive their own immunizations starting at 2 months), and COVID vaccines
    - Childhood Vaccines:
        - 2, 4, 6, 12, 15, and 18 months: Diphtheria, tetanus, pertussis, polio, haemophilus influenzae type b (DTaP-IPV-Hib) vaccine, Pneumococcal conjugate (Pneu-C-13) vaccine, Rotavirus (Rot-1) vaccine, Meningococcal conjugate (Men-C-C) vaccine, Measles, mumps and rubella (MMR) vaccine.

        - 4-6 years old: Tetanus, diphtheria, pertussis and polio (Tdap-IPV) vaccine, Measles, mumps, rubella and varicella (MMRV) vaccine
        - Grade 7: Meningococcal conjugate (Men-C-ACYW) vaccine, Hepatitis B (HB) vaccine, Human Papillomavirus (HPV) vaccine.
        - 14-16 years old: Tetanus, diphtheria and pertussis (Tdap) vaccine.
    - Adult Vaccines: Seasonal Flu vaccines, Tetanus and Diphtheria (Td) vaccine (every 10 years) and COVID primary series + booster doses
    - Senior Vaccines: Pneumococcal polysaccharide vaccine (adults 65+ years) and shingles vaccine (65-70 years)
    - Other vaccines depending on risk of exposure: E.g. Rabies, Yellow fever, Typhoid, Monkey Pox, etc. (not part of the routine immunization schedule)

        - *What vaccines do you think are especially important for vulnerable populations? Why?*

- Ontario Publically Funded Immunization Schedule: https://www.health.gov.on.ca/en/pro/programs/immunization/docs/Publicly_Funded_ImmunizationSchedule.pdf

Discussion: Any questions? Future Topics you would like more information on?

2. COVID Vaccines

- *Have you received your primary series and booster doses of COVID vaccines? Why or why not? What were some hesitations that you had around receiving these vaccines and why did you decide to get vaccinated?*

- Vaccine Doses
  - Primary Series: 2 doses (3 doses for people that are immunocompromised), with 8 weeks in between doses.
  - Booster Doses: After primary series is complete, you can start to receive booster doses. All Ontarians aged five years and older are encouraged to get their booster dose, as evidence shows that vaccine protection decreases over time.
    - Bivalent COVID Vaccine: Bivalent vaccines are vaccines that target two different viruses or strains of the same virus. The bivalent COVID vaccine targets the original COVID-19 virus and the Omnicron variant, which is currently the dominant variant in circulation in Ontario. Bivalent vaccine help to create a broader immune response and improves the strength and duration of protection against the most dominant COVID-19 variants in circulation.
    - Bivalent vaccines are now being administered as booster doses only (you must have completed your primary series to receive it) for people 12 years and older.
    - Recommended interval for booster doses is six months; however individuals at a high risk for severe COVID-19 illness are recommended to get bivalent booster doses at a minimum 3 month interval in consultation with a HCP.
    - Note: Infants and children aged six months to under five years are eligible for a primary series only. A booster dose is not approved for this age group.

- *A client got two doses of the COVID-19 vaccine in 2021 and has not received any other COVID-19 vaccines doses since then. What would you say to them to try to convince them to get booster doses?*

- COVID -19 Vaccine Development and Approval Process in Canada
  - All vaccines (including the COVID-19 vaccines) go through an in-depth testing process to show that they are safe and effective before they are approved for use in Canada. Vaccines are among the most strictly regulated medical products in Canada.
  - Standards of safety, efficacy, and quality have not been compromised to expedite the approval of COVID-19 vaccines. The COVID vaccine approval process happened so quickly for several reasons:
    - Reduced time delays in the vaccine approval process (e.g. submit data on rolling basis)
    - Quick adaptation of existing research programs such as those focusing on mRNA- and viral-vector-based technology.
    - International collaboration among scientists, health professionals, researchers, industry and governments.

        - Increased dedicated funding.
        - Quick recruitment of participants for clinical trials.
        - Rapid set-up of clinical trials to demonstrate effectiveness of the vaccine.

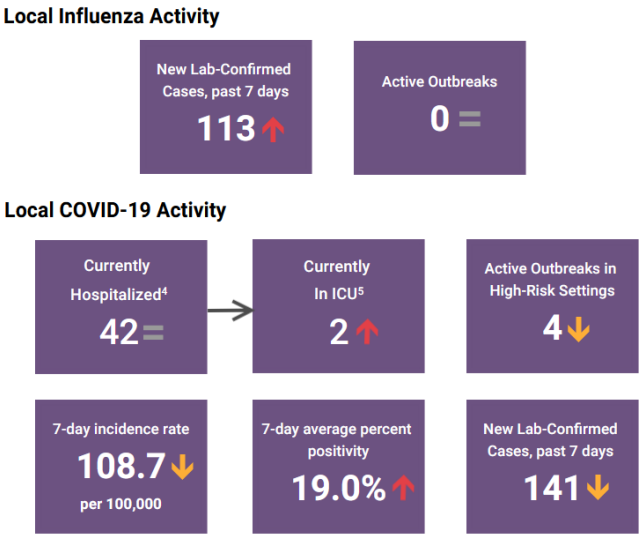
- COVID-19 Vaccine Ongoing Safety Monitoring
    - Monitoring of the vaccine's safety and effectiveness will continue now and into the future. This is done by Health Canada and the Public Health Agency of Canada (PHAC) at the federal level as well as among provincial, territorial and local public health authorities, health care professionals, the vaccine industry, international regulators and the public.
    - Ongoing vaccine safety monitoring is essential for the detection of, and timely response to, vaccine safety concerns.
    - An adverse event following immunization (also known as an AEFI) is a serious or unexpected reaction that happens after someone receives a vaccine. An adverse event may or may not have been caused by the vaccine. In all provinces and territories health care providers report all adverse events to their local public health unit, known as AEFI reports. This information is used and studied by scientists to monitor vaccine safety.
- Video about vaccine approval and safety in Canada: https://www.youtube.com/watch?v=QiiLoc-eztM&t=89s

- COVID-19 Vaccine Brands:
    - Pfizer: Pfizer-BioNTech Comirnaty vaccine, mRNA vaccine
    - Moderna: – Moderna Spikevax vaccine, mRNA vaccine
    - Video about COVID-19 vaccine: https://www.youtube.com/watch?v=uWGTciX795o

- Who should get COVID-19 vaccinations:
    - COVID-19 vaccines are available to everybody aged six months and older in Ontario at no cost, regardless of citizenship or immigration status, even if you do not have an Ontario health card.
    - COVID-19 vaccinations are especially important for individuals at high risk for severe COVID-19 illness. This includes:
        - Individuals aged 65 years and older
        - Residents of long-term care homes, retirement homes, Elder Care Lodges, and individuals living in other congregate settings aged 12 years and older
        - Individuals aged 12 years and older with an underlying medical condition that places them at high risk of severe COVID-19
        - Health care workers
        - Pregnant individuals
        - Adults who identify as First Nations, Inuit or Métis and their adult non-Indigenous household members
        - Adults in racialized communities and/or marginalized communities disproportionately affected by COVID-19

- *Thinking about vulnerable populations, how might getting COVID impact them differently than the regular population? Why would getting a COVID vaccine be especially important for these folks?*

- COVID-19 in Thunder Bay, October 2022:
  - Local data updated weekly: https://www.tbdhu.com/datadashboard



Discussion: Any questions? Future Topics you would like more information on?

3. Seasonal Flu Vaccines

- Seasonal Flu / Influenza
  - Seasonal Influenza is a respiratory infection caused by influenza viruses that circulate in all parts of the world.
  - The symptoms of the flu and the common cold can be very similar but, unlike a case of the common cold, the flu can lead to serious health problems like pneumonia.
  - Seasonal influenza (the flu) is characterized by:
    - Sudden onset of fever
    - Cough (usually dry); can be severe and can last 2 or more weeks
    - Headache
    - Muscle and joint pain
    - Feeling unwell
    - Sore throat
    - Runny nose
  - Flu season typically runs from late fall to early spring.
  - Most people recover from fever and other symptoms within a week without requiring medical attention. But influenza can cause severe illness or death especially in people at high risk.
  - Who is most at risk:
    - Babies under six months old are too young to get the flu shot, but they'll get some protection if their parent got the flu shot while they were pregnant.
    - Children under five years of age, because their immune systems are developing, and their airways are small and more easily blocked
    - People 65 years old and older, because their immune systems are weaker and they are more likely to have an underlying condition that increases their risk
    - Pregnant people, because their immune system, heart and lungs change – especially later in pregnancy – making them more likely to get seriously ill from the flu
    - People with underlying health conditions, such as asthma, heart disease or diabetes

  - Although the burden of influenza can vary from year to year, flu is estimated to cause about 12,200 hospitalizations and 3,500 deaths in Canada each year.

    - *Thinking about vulnerable populations, how might getting the flu impact them differently than the regular population? Why would getting a flu vaccine be especially important for these folks?*

- Flu Shots:
  - The annual flu shot strengthens the body's response against the flu by stimulating the immune system and building antibodies against the virus, making the body stronger and ready to fight off the flu.
  - The flu shot helps to:
    - protect you if you're exposed to the virus
    - prevent you from getting very sick from flu complications
    - protect people close to you because you're less likely to spread the virus to them

        - reduce additional burden on the health care system as it responds to the COVID-19 pandemic
        - reduce your chances of being infected with the flu and COVID-19 at the same time, which could lead to serious complications
    - Flu shots are now available to all Ontarians six months of age and older.
    - Flu shots are free.
    - The flu shot is different each year because the virus changes frequently; that is why you need to get it every fall.
    - You should get a flu shot as soon as possible as it takes two weeks to take effect and build your immunity.
    - All flu vaccines available in Ontario are inactivated vaccines that contain the killed version of the virus that causes the flu. Because of this, you can't get the flu from the vaccine.
    - Only one dose of a vaccine is needed, with the exception of any child from 6 months to under 9 years of age who is receiving a flu vaccine for the first time. These children will require a second dose at least 4 weeks after their first for full protection.
    - Most people in Ontario (6 months to 64 years) will receive a quadrivalent vaccine, meaning the vaccine protects against two influenza A strains of the virus and two influenza B strains.
    - Video Summary about the Flu Vaccine: https://www.youtube.com/watch?v=odbQgx6s6eI

        ➢ *Why are you getting the flu shot this year?*

- COVID and Flu Season:
    - With two different viruses circulating this fall, both influenza and COVID-19, there is a risk that our health care system will become overwhelmed with cases of respiratory infections. For example, currently Ontarios pediatric ICUs are at capacity: (https://www.cbc.ca/news/canada/toronto/ontario-pediatric-beds-overcapacity-1.6647643)
    - Fewer cases of the flu means fewer people in the hospital, freeing up our health care system to respond to serious cases of COVID-19 or other health emergencies.
    - The flu shot does not protect against COVID-19 and the COVID-19 shot does not protect against the flu. That is why people need both. If somebody contracts one of these respiratory infections, it could compromise their body's immune response if they are then exposed to the other virus.
    - The best way that people can protect themselves and our health care system is to get their flu shot this year, as well as a bivalent COVID-19 immunization once they qualify for one.
        - Anyone over the age of 5 can receive both the COVID vaccine (including the bivalent booster) and the influenza vaccine at the same time. There's no concern about increased side effects from both vaccines, nor are there any concerns about them not working as well if you get them at the same time. Overall, the side effects are very minimal with both of these vaccines. They're both very safe.
        - For children 6 months to under 5 years of age, giving both the flu and COVID-19 vaccines at the same time is NOT currently recommended. Children in this age range should wait 14 days in between receiving either vaccine, out of an abundance of caution and so medical professionals can track any potential side effects more easily.

Discussion: Any questions? Future Topics you would like more information on?

4. Vaccine Access in Thunder Bay

- General Vaccines:
  - Health Care Provider (doctor or nurse practitioner)
  - TBDHU Street Outreach: (807) 629-2157
    - Follow high risk immunization schedule (e.g. people that use IV drugs, HIV+ and HepC+) – HepA, HepB, Pneu-C-13, Pneu-C-23, Men-C-ACYW (see schedule below)

- Vaccines During Pregnancy:
  - Health Care Provider (doctor or nurse practitioner)
  - Midwife

- Flu and COVID Vaccines:
  - Health Care Provider (doctor or nurse practitioner)

  - Participating Pharmacies
    - For people 2 years of age and older
    - Call ahead of time to confirm supply

  - TBDHU Street Outreach: (807) 629-2157
    - Have COVID primary doses (Pfizer and Moderna) and Bivalent Boosters as well as flu vaccines on street outreach (see schedule below).
    - Walk-up, no appointment needed

  - Mindimooyen Health Clinic (ONWA): (807) 697-1753
    - Holistic Indigenous-run clinic
    - Monday – Friday 9:00am – 4:30pm. Located at 380 Ray Boulevard. Appointments or drop-in available.
    - Not specific to ONWA clients; To be eligible for this clinic you must be Indigenous, live in an Indigenous household, or work in an Indigenous community (Proof of Indigenous ancestry is required).
    - Have COVID primary doses (Pfizer and Moderna) and Bivalent Boosters. Flu shots available for people six months and older

  - CLE Coliseum Clinic:
    - Walk-in available
    - November and December CLE Clinic Hours:
      - Mondays: 9:00am – 4:00pm
      - Tuesdays: 11:30am – 6:30pm
      - Wednesdays: 9:00am – 4:00pm
    - Holiday Hours:
      - Monday, December 19th 9-4
      - Tuesday, December 20th 11:30-6:30
      - Wednesday, December 21st 9-4

- Wednesday, December 28th 9-4
- Thursday, December 29th 9-4
- Tuesday, January 3rd 11:30-6:30
- Wednesday, January 4th 9-4

- Matawa Health Co-operative: (807) 346-2370
  - Walk-ins welcome depending on vaccine supply.
  - Located in Victoriaville Mall; Pfizer and Moderna COVID vaccines available on Wednesdays, Thursdays and Fridays.
  - Open to Indigenous adults, including non-Indigenous household members
  - Transportation support available.

- Dilico Health Centre (200 Anemki Place): (807) 626-5200
  - Wednesdays: 5:00pm – 8:00pm
  - Fridays 9:30am – 11:30am
  - Walk-in, priority for Dilico clients and FWFN

- Community Clinic Outreach Schedule

- Winter TBDHU Street Outreach Schedule (High Risk, COVID and Flu Vaccines available):
  - Monday AM: Cummings Street Apartments
  - Monday PM: Grace Place
  - Tuesday PM: Dew Drop Inn
  - Wednesday PM: Shelter House back alley
  - Thursday PM: Dew Drop Inn
  - Friday AM: Spence Court (Amelia Street)
  - Friday PM: Shelter House back alley

- Things to think about when referring someone to a vaccine clinic:
  - Are the staff experienced with working with vulnerable populations? Are the health care providers going to treat them well? Stigma
  - Cultural Safety
  - Transportation
  - Do they need someone to go with them and support them?

➢ *Where did you get your first COVID vaccine. Describe the process.*

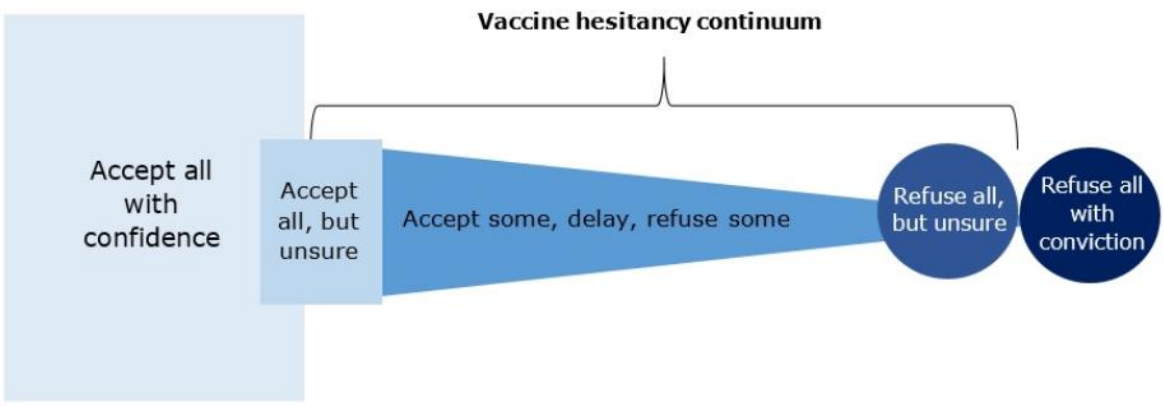
➢ *What are some challenges you might experience for getting a client to a same-day vaccination clinic? How would you address these challenges?*

➢ *Discussion: Any questions? Future Topics you would like more information on?*

5. Vaccine Hesitancy and Confidence

- Vaccine Hesitancy: The delay in acceptance or refusal of vaccines despite availability of vaccination services.
    - Complex and context-specific
    - Varying over time and place
    - Vaccine specific
- Vaccine hesitancy is an attitude or sentiment, whereas vaccination is an action, which is measured to determine vaccine coverage.
- The period of hesitancy and indecision is a time of vulnerability, as well as opportunity. Sentiments concerning whether to undergo vaccination can change, and change again, as evidenced in multiple surveys showing that Covid-19 vaccine sentiments are influenced by factors such as a new report of vaccine risks or perceptions of increasing or decreasing disease threats.

- Vaccine Hesitancy Continuum:



Adapted from MacDonald and the SAGE Working Group on Vaccine Hesitancy (2015).

- Vaccine hesitancy represents a key barrier to vaccination success. In early 2019, prior to the COVID-19 pandemic, the World Health Organization listed vaccine hesitancy among the top ten threats to global health.
- When vaccine uptake is low or decreases, it undermines the strength and public health impact of vaccination programs that exist to keep individuals and communities safe from vaccine-preventable diseases. As a result, communities in which vaccine uptake is low are at a greater risk of localized outbreaks of vaccine-preventable diseases.
- Most Canadians indicate that they intend to get vaccinated against COVID-19 when a vaccine is available to them. However, research also shows that many Canadians express some level of hesitancy in the vaccines. Surveys from the start of the pandemic suggest that while a small portion of Canadians do not intend to get a COVID-19 vaccine, others intend to either wait before getting vaccinated or have not yet made up their minds about vaccination.

- Certain sub-groups in Canada are more likely to report COVID-19 vaccine hesitancy. These include Black Canadians, Indigenous peoples, newcomers, and younger adults, among others. Some of these sub-groups are also more likely to experience other social and structural barriers to accessing vaccinations.

- COVID Vaccine Hesitancies: **https://www.vhguide.ca/details/advice/affirm**
  - Safety and science concerns
    - Concerned about the science
    - Worried that mRNA vaccines could alter their DNA
    - Medically complex
    - Pregnancy, fertility or reproductive concerns
    - Side effects of the vaccine
  - Influenced by rumors, conspiracies or misinformation
  - Conflict with personal or political views
    - Vaccines go against natural lifestyle or alternative medicines
    - Politics and government involvement with vaccines
  - Religious or moral objections to vaccines
  - Traumatized by previous health care experiences
    - Individual or personal negative experience
    - Community, group or historical trauma
  - Afraid of needles
  - General vaccine hesitancies
  - No concerns about the pandemic
  - Pediatric vaccine hesitancies

- Three Cs Model: Three main areas of vaccine hesitancy, with different approaches for how to address each one
  1. CONFIDENCE: The level of trust in the effectiveness and safety of vaccines, the system that delivers vaccines and the motives of those who establish vaccine policies
  2. COMPLACENCY: The perception that the risks of vaccine-preventable diseases are low and vaccines are not necessary.
  3. CONVENIENCE: The extent to which vaccines are available, affordable, accessible, and individual's ability to understand (as a reflection of language and health literacy) the need for vaccinations.

     ➢ *Where would the following people fit in the three Cs model? (Confidence, Complacency or Convenience)*

     -Someone who does not have transportation to get to a vaccine clinic

     -Someone who believes the vaccines inject microchips

-Someone who had COVID before and "it wasn't that bad"

-Someone who has more pressing concerns (food, housing, safety, etc.)

- *What are vaccine hesitancies you are likely to come across in your work that you would like more information about / more practice to have a conversation.*

- *Pick a reason for vaccine hesitancy; In the next session you will role play and the other P2P worker will try to convince you to get a vaccination*

- *Discussion: Any questions? Future Topics you would like more information on?*

6. General Communication Tips for Talking About Vaccines

"You are the experts in what your community needs"

- General Communication Strategies:
  - ✓ Start from a place of empathy and understanding.
  - ✓ Avoid judgement or labels. Perceived attacks on beliefs and decisions can be felt as attacks on themselves as individuals.
  - ✓ Listen to and respond to client questions, and use a tailored approach.
  - ✓ Cultivate a "safe space" for discussion about vaccination.
  - ✓ Engage in active listening and creating opportunities to learn about patients' questions, values and experiences.
  - ✓ Activate the "right" emotions. Be intentional about tapping into positive emotions like hope, love, pride and the concern for others, rather than evoking shame, guilt, fear or sadness.

    - ➢ *Give some examples about how you might invoke the "right" emotions when talking about getting vaccinated?*

- Talking About Vaccine Safety
  - ✓ Assume clients will want to be vaccinated, but be prepared for questions. Use presumptive statements that convey the social norm of vaccination and the expectation that clients will get vaccinated.
  - ✓ Provide assurance of vaccine safety and effectiveness. Explain the vaccine development, government approval, and monitoring and distribution process.
  - ✓ Include information on risks and benefits of vaccination, as most people are looking for balanced information. Frame immunizations in terms of positive individual and collective gains.
  - ✓ Proactively explain side effects
  - ✓ To create emotional safety, provide the individual with clear information on "what to expect" or "what happens next" during the vaccination process.
  - ✓ Support the client to get vaccinated when they are ready. Let them know where they can get vaccinated, support with transportation or accompany them through the vaccination process to ensure they have a good experience.

    - ➢ *Pick two check marks above and give an example about what you might say in conversation with a client.*

- Addressing Vaccine Hesitancies

- ✓ Address vaccine hesitancy and respond to dominant concerns without judgement or overly directive language
- ✓ There are many reasons why people may be hesitant. People's concerns are real and they need thoughtful and specific approaches that speak directly to them. Tailored messaging strives to understand people's questions and motivations and respond to them.
- ✓ Be transparent on the risks and benefits of getting vaccinated and inform patients of the risks of not getting vaccinated.
- ✓ Monitor misinformation and develop counter messages. Address misinformation by sharing key facts. Do not repeat the myth as this may reinforce it.
- ✓ For those who have expressed a deeper general mistrust in vaccines, communications should still be balanced, empathetic, and compassionate. Even if this approach does not immediately lead to vaccine acceptance, it could help build relationships and trust, which may lead to greater willingness to consider vaccination in the future.
- ✓ Give your strong recommendation to get vaccinated.
- ✓ Open up / use storytelling about your own experiences getting vaccinated, vaccinating other patients and/or how you have chosen or encourage vaccination for your loved ones.

    - ➢ *What are the risks of not getting vaccinated?*
    - ➢ *Practice (in one sentence) giving your strong recommendation to a client to get vaccinated.*

- Other notes:
    - ✓ For marginalized community members, messages building trust and confidence should also focus on transparency, supporting autonomy, and validating past and ongoing lived experiences of discrimination. Take an explicitly anti-racist/anti-oppressive stance, recognizing that some communities have justified fears about vaccination.
    - ✓ People are more open to speaking with peers. Creating opportunities for peer discussion can provide "social proof" and experiential knowledge. Social proof of others getting vaccinated and seeing tangible benefits that come with it may play the most significant role in motivating people to put their fears aside. The experiences of those closest to us can be the most powerful when it comes to making a decision.

        - ➢ *Have you ever made a personal decision based on social proof? Explain.*

        - ➢ *Discussion: Any questions? Future Topics you would like more information on?*

7. Motivational Interviewing Techniques to Talk About Vaccine Hesitancy

- **What is Motivational Interviewing**
  - Motivational interviewing (MI) is a client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.
  - The goal of MI is to help people manage mixed feelings and move towards healthy behaviour change that is consistent with their values and needs.
    MI was initially created to be used in psychotherapy and counseling based treatments of alcohol use disorder.
  - MI is used in almost every health discipline. It plays a very key role in helping people with addiction navigate change and the techniques can also be applied to discussions about vaccines.
  - There are many different techniques that can be used during MI. These techniques highlight and help clients talk about specific topics.
  - **Note:** A very key aspect of any interviewing/counseling relationship is to remember that you have no power over your client's decision making and all you can do is provide options. Ultimately we cannot decide things for people or even push them in a certain direction (despite how confident we may be it's the best choice for them) if we want success in our interactions with the client they need to be the one to make the change on their own volition.

- Techniques of Motivational Interviewing:
  - Open ended questions:
    - Any question that can be answered in three words or less is **not** open ended. Questions with direct answers or yes or no questions would be considered "closed" questions and the opposite of what you'd want to use when generating thoughtful conversation with a client.
    - An example of a closed question on addiction would be ***"How many drinks did you have to have today to stop being sick."*** This can be thought provoking and a strong in your face approach but it doesn't create conversation it just makes the client make a statement. If you want to go deeper and explore you need to form your questions so they cannot be easily answered in a few words. For this example I'd encourage you to form a question closer to the wording of this ***"Tell me about how your drinking has changed?"***

    - *What are some examples of open-ended questions you may ask of someone who is vaccine hesitant?*

  - Paraphrasing:

- When you paraphrase the statement it makes the client hear their own ideas and statements out loud in the same context but from a new perspective.
- To paraphrase a client you'll want to take a small chunk of the answer you've been given by the client and repeat it back to them with slightly different wording.
- An example of this would be a client was asked the open ended question example above and responded *"When I first started drinking it was for fun with a bunch of friends we used to drink before class in school so it would be more fun to go. Recently I start to feel sick by the afternoon if I skip drinking in the morning. Now even if I do drink all day I don't even feel it."* There's a few opportunities to paraphrase depending on the direction you'd like to take this conversation one example could be: *"When you first started drinking it was so you could have fun but now if you do drink you don't feel anything but when you don't drink you get sick"* In this example I used a paraphrase to highlight the change in the clients relationship with alcohol.

- *A client says "I do not want to get the flu vaccine because I will get sick if I get it. Also, I get sick every year anyways and I have always been fine." How would you paraphrase this statement back to the client?*

  - Key Word Encourager:
    - Key word encouragers highlight an aspect of the clients answer to a question for further discussion.
    - A key word encourager uses one word and silence to encourage the client to elaborate.
    - Using the above example if a client provided you with this response: *When I first started drinking it was for fun with a bunch of friends we used to drink before class in school so it would be more fun to go. Recently I start to feel sick by the afternoon if I skip drinking in the morning. Now even if I do drink all day I don't even feel it."* The key word encourager is simply picking one word and then providing space and silence for the client to elaborate. It is simply repeating that word back and giving some space for thoughts to form and further explanation to come people like to fill space and silence you'll be surprised how effectively this generates further conversation. In the provided example I'd look at the word "fun" as it is key to the experience described by the client. An example response using key word encouragers to provoke further discussion would simply be *""It was for fun?"*

- *What are some key word encouragers you might use in a conversation about vaccines with a client that is vaccine hesitant?*

- *Discussion: Any questions? Future Topics you would like more information on?*

8. P2P Vaccine Confidence Project

- Project Overview:
    - Title: Peer-to-Peer (P2P): Speaking Out About Vaccine Safety
    - July 2021 – March 2023
    - Funded by the Public Health Agency of Canada: Immunization Partnership Fund (IPF). This fund is supporting hundreds of projects across Canada that all are working to promote vaccine education and uptake (see brochure photo below).
    - Staff: Juanita (Project Supervisor), Travis and Jennifer (Co-Coordinators) and Tasha and Erica (P2P Vaccine Outreach Workers)
        - Also involved: Partner Organizations, Kaitlin (communications), Science North
    - NWCHC + partner organizations (BISNO, Elevate, PACE, TBDHU, Salvation Army, Dilico, Mushkiki) and Lakehead University is supporting project evaluation.

- Project Objectives:
    1. Increase access to vaccination services by mobilizing P2P partners and peer influencers, who will enhance the capacity of street-level outreach with marginalized populations.
    2. Improve knowledge about vaccination and build confidence in vaccines among marginalized populations by developing and implementing targeted communications.
    3. Measure the effectiveness of street-level interventions in improving demand for and access to COVID-19 vaccines and other vaccines.

- Project Activities and Outputs:

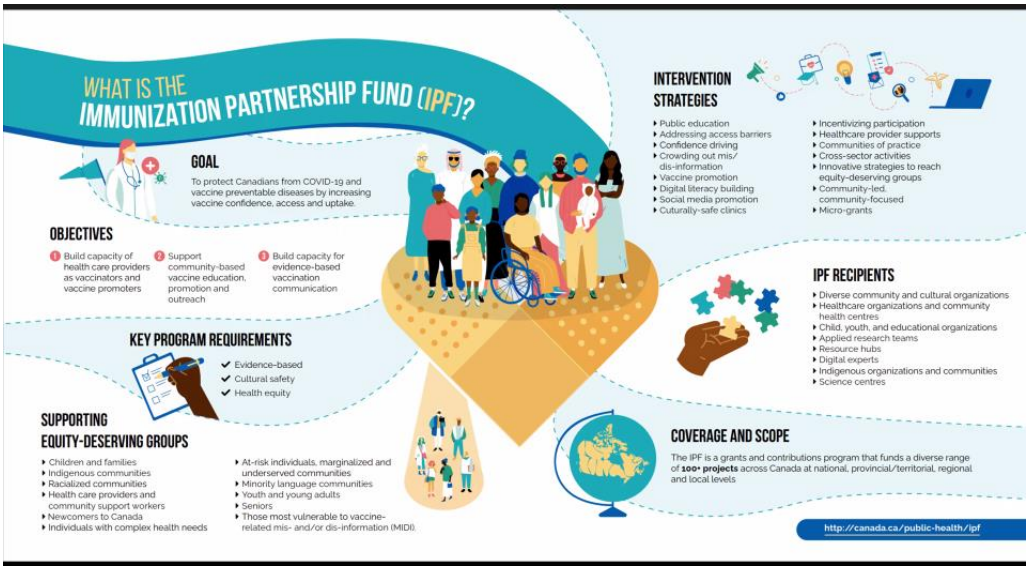
Outcome (Objective) 1: Increase access to vaccination services by mobilizing P2P partners and peer influencers, who will enhance the capacity of street-level outreach with marginalized populations

Activity 1.1: Establish an Advisory Committee, who will meet monthly for guidance, to support resource development and mobilize supports throughout the project.	**Activity 1.2:** Establish and integrate P2P team with existing outreach networks through NWCHC and partners for service delivery	**Activity 1.3:** Deliver community-wide and street level interventions, as per the Mobilization Plan
Number of Members attending monthly meetings	Trained and skilled P2P project team	● Outreach Time and Delivery of Services (wrap around services) ● Relationships and trust with vulnerable populations ● Increased awareness about COVID-19 (and other) vaccines (among peers and vulnerable populations) ● Pop-up and Mobile Clinics

Objective 2: Improve knowledge about vaccination and build confidence in vaccines among marginalized populations, by developing and implementing targeted communications		
Activity 2.1: Develop and implement a P2P Mobilization Plan	**Activity 2.1:** Develop an outreach and communications strategy that aligns with P2P Mobilization Plan and deliver targeted communicaitons throught the project.	**Activity 2.3:** Compile the P2P evaluation findings into a vaccine hesitancy resource for frontline health care providers
Two Engagement sessions with partners, peers and Elders that identify bariers and drivers to vaccination P2P Vaccine Mobilization Plan	Communication Strategy Social Media Campaign and Posts across partner organizations Print Media targeting vulnerable populaitons Training for Peers	Vaccine Hesitancy resource for HCPs

Objective 3: Measure the effectiveness of street-level interventions in improving demand for and access to COVID-19 vaccines and other vaccines		
Activity 3.1: Develop an Evaluation Framework in consultation with community partners and initiate initial sampling.	**Activity 3.2:** Implement evaluation activities and finalize evaluation report	**Activity 3.3:** Complete and submit regular and final reports as required to Public Health Agency of Canada (PHAC)
Hire third-party evaluator Evaluation Framework	Evaluation Report Dissemination of Evaluation Report	Mid-term Reports Final Report

- *Which activities do you directly play a role in implementing? What are your personal goals while working on this project?*
- *Do you have any suggestions for how to implement any of the activities?*
- *How can we make the work we are doing throughout the project timeline (until March 2023) more sustainable so that if funding is not received again, gains made by the project will continue to have an impact in the community?*



Developed by the P2P (Peer-to-Peer) Vaccine Safety Project, 2022 - 2023

9. Vaccines During Pregnancy and Breastfeeding

- Immunizations During Pregnancy
    - Vaccination is an important part of a healthy pregnancy, with health benefits for both the pregnant person and their baby.
    - A persons immune system changes during pregnancy, which puts pregnant people at an increased risk of infection and an increased risk of severe outcomes once infected (e.g. COVID, influenza, etc.).
    - The fetus can also be affected by infections that can result in congenital abnormalities, impaired fetal growth or severe neonatal illness.
    - Vaccinated people can pass antibodies to their baby through the placenta and through breastmilk (gives unvaccinated babies some protection).
    - Vaccines do not affect fertility.
    - The vaccine ingredients are safe to pregnant people and the developing baby.
    - Pregnant people have the same rate of common side-effects as non-pregnant people (sore arm, mild headache, fever, chills).

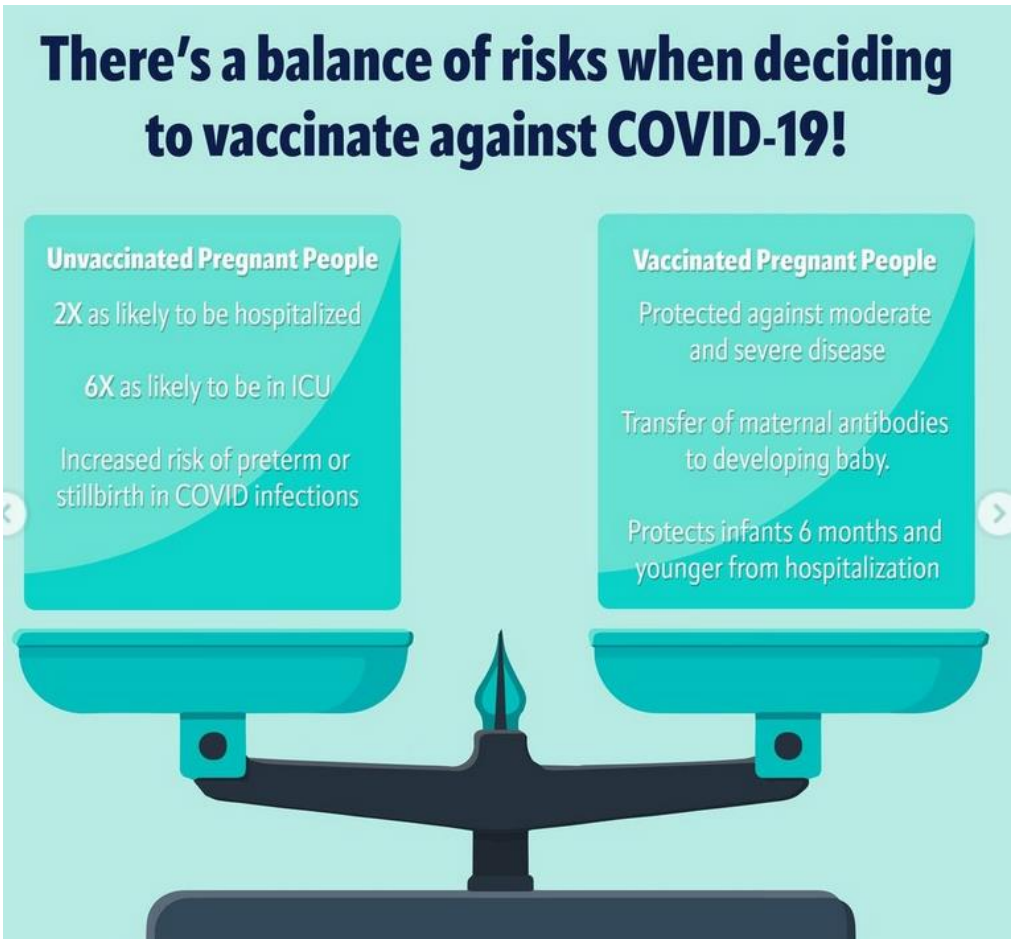
- Immunizations While Breastfeeding
    - In general, routinely recommended vaccines can be safely administered to breastfeeding women.
    - There are limited data available regarding the effects of immunization of breastfeeding women on their infants; however, there have been no reported adverse events related to administration of routine vaccines.

➢ *What are some concerns / questions about vaccines you might expect from pregnant people?*

- <u>Recommended Vaccines for Pregnant People:</u>
    - Most vaccines can be given during pregnancy. Only live vaccines, such as MMR (measles, mumps and rubella) are generally not recommended.
    - Routine immunizations should be up to date.
    - <u>Pertussis (Whooping Cough) / Tdap:</u>
        - Tdap (tetanus and diphtheria) should be given during <u>every</u> pregnancy (immunity wanes in the years following vaccination).
        - Ideally administered between 27 and 32 weeks gestation, however women can receive the vaccine earlier to later.
        - Tdap vaccination during pregnancy is safe for both the mother and the fetus.
        - When Tdap is given in pregnancy, the mother produces antibodies that pass to the fetus so they have protection before they receive their own immunizations starting at 2 months. Whooping Cough (pertussis) is particularly dangerous for infants who are too young to receive their first dose of vaccine.
        - Tdap vaccination in pregnancy is estimated to protect 90% of infants less than 3 months of age against whopping cough.
    - <u>Influenza/Seasonal flu vaccine:</u>

- All pregnant women should receive the inactivated influenza vaccine during each pregnancy.
- Pregnant women are at higher risk of developing complications such as pneumonia if they get influenza. Moreover, influenza during pregnancy increases the risk of preterm delivery and low birth weight.
- Administration of an inactivated influenza vaccine during pregnancy is safe for both the mother and the fetus.
- Although influenza vaccine effectiveness can vary from season to season, vaccination continues to be the best available way to prevent influenza infection and its complications. Vaccination can also reduce symptom severity, and the risk of hospitalization and death.

- <u>COVID vaccines</u>
  - COVID-19 vaccination is urged for people who are pregnant.
  - Pregnancy increases the risk of severe outcomes of COVID-19 for a person who is pregnant, including the need for ICU admission, invasive medical ventilation, and people who are pregnant are at an increased risk of death due to COVID-19.
  - Additionally, infection with COVID during pregnancy has been associated with increases in poor pregnancy outcomes, such as increases in pre-term birth, pre-eclampsia, stillbirth and low birth weight.
  - There are no safety concerns specific to pregnancy that have been noted for COVID-19 vaccines. The COVID-19 vaccine does not increase miscarriage, still birth, preterm birth, complications at birth, congenital abnormalities or babies being born smaller than expected.
  - Additionally, vaccination during pregnancy may provide some additional protection to newborns by passing protective antibodies via the placenta. This gives the newborn some protection until they are able to be vaccinated themselves at 6 months or older.
  - People who are planning a pregnancy, pregnant, or breastfeeding should get a complete series of mRNA COVID-19 vaccines, and a booster dose, when eligible.



- Science North: Give Vaccines A Shot! (IPF Project). Video: COVID vaccines and pregnancy: https://www.youtube.com/watch?v=g-PE7ntrY1s

- Vaccine Hesitancy During Pregnancy
  - Vaccine hesitation is an already known phenomenon in pregnant and lactating women.
  - Many potential reasons for hesitancy:
    - Not wanting to be immunized while pregnant (but okay with being immunized when not pregnant)
    - Not knowing what vaccines are recommended during pregnancy
    - Vaccines not recommended or offered by health care provider
    - Belief that the vaccine is not necessary or effective
    - Fear of adverse events (including potentially long-term adverse events, especially for children of breastfeeding women)
  - A major role in vaccination compliance is played by family members and friends of pregnant or breastfeeding women. Personal stories are often reasons why people, including people who are pregnant, choose to be vaccinated.

- Pregnant people reported that the safety and protection of themselves, and their family members was one of the main reasons for vaccination uptake.

➢ *Role Play: A mother is pregnant with her second baby and has some concerns about getting vaccinated while pregnant. She has received the Tdap vaccine as recommended by her midwife as she did this in her first pregnancy. She has concerns about getting influenza and covid vaccines while pregnant because she did not get them in her first pregnancy and "everything turned out fine". She is not sure that the benefits of vaccination outweigh the harms of vaccination while pregnant.*

10. Indigenous People and Vaccines: Reasons for Hesitancy and Culturally Safe Communication Approaches

- Zoom Recording: WISE Practices for those Supporting COVID Vaccination. Password: ?&?S43M2

Appendix B2

Training Resources – Wise Practices Poster

NorWest Community Health Centres
Centres de santé communautaire NorWest

INDIGENOUS PRIMARY HEALTH CARE COUNCIL

WEBINAR

WISE PRACTICES FOR THOSE SUPPORTING COVID VACCINATION

Foundational knowledge for vaccinators servicing Indigenous populations

9:00 - 10:00 AM

February 8, 2023

For more information contact Jennifer at jpasiciel@norwestchc.org

Appendix C1

Talking about vaccine safety with vulnerable populations

Talking About Vaccine Safety with Vulnerable Populations

Informed and Developed by Peer Outreach Workers that have these conversations everyday on the streets of Thunder Bay

Special Considerations for People Who Use Drugs and People that are Homeless or Under-Housed.

1. Build Trust and a Relationship First

Hesitancy and mistrust of vaccines are often tied to larger mistrust of the medical system and government. It will take time and multiple visits to build trust as a health care provider. First show up for clients and help them in other areas so they believe you have their best interest at heart, then you can bring up vaccines. Always provide wrap-around care.

Wrap-Around Care Includes: *(Ask clients what they need, don't make assumptions)*

CARE is defined as: listening, showing up, advocating, meeting clients where they are at, as well as the following when able:

- Addictions support
- Food and water
- Access to safe shelter
- Mental health needs
- Physical health needs
- Harm reduction
- Referral to services
- Transportation
- Basic needs (clothing, hygiene supplies, PPE)

2. Use a Peer-led Approach

Peers come from their own lived experiences and are relatable for clients. People with lived experience are often the most appropriate and trusted individuals to provide information and resources addressing concerns about vaccines.

> *"From my experience, I still have my own hesitancy, but I'll get vaccinated cause I know it's good for me. I think it's the need to control the situation, control what happens to me. But I know it's the right thing to do for me and my community; it's the best thing to help prevent the spread. I'm okay with some vaccines and not others, it doesn't make sense" (Peer Outreach Worker).*

3. Recognize and Respect Client Priorities and Values

It's about really understanding a client's situation. COVID and vaccine fatigue is real and there are many other crises people are managing. Clients may be dealing with withdrawals, unsafe drugs, getting daily food, shelter and staying safe. Don't assume people are able to prioritize preventative health. Be ready to support a client to get vaccinated when they want it, recognizing that a client's priorities may change each day.

DO

- ✓ **Meet People Where They Are At.** Don't rush conversations about vaccines. Try to keep the door open for future conversations. Take advantage of when clients are willing and able to discuss vaccines and get them to a clinic that day, if possible.
- ✓ **Reduce Barriers.** Make transportation available, make sure clinics are culturally safe, know local low-barrier clinics and pop-up clinics (e.g. no ID needed), send clients to a clinic with a peer or outreach worker, make sure various vaccine brands are available to accommodate preferences.
- ✓ **Show Respect and Empathy.** Don't flinch or make assumptions when you see track marks; actually listen and be attentive. Body language is huge. Drop the medical for a second and just engage as a human.
- ✓ **Give Value to the Vaccine.** Incentivize getting vaccinated based on current life circumstances (cash, food, or services). If incentivizing vaccinations, make sure to get informed consent so that people understand why they are getting vaccinated and don't feel forced.
- ✓ **Have One-on-One, Tailored Conversations.** Let people know that they are at an increased risk if they get sick. They are more likely to be severely ill and hospitalized if they get COVID or the flu. They don't necessarily have time or a place to be sick if they don't have a safe space to rest and recover. They can also easily spread it to others in shelters, encampments, etc. Use Motivational Interviewing techniques.
- ✓ **Share Your Own Experiences.** "I got _____ vaccine because _____", or "I vaccinated my children because _____." Storytelling and social proof are often more effective to explain the reasons for getting vaccinated rather than providing statistics and medical terms.
- ✓ **Use a Trauma-Informed Approach.** Lots of clients have had choice taken away from them in their life so reintroduce choices for them to feel more empowered and to help with trusting relationships.

DON'T

- ✗ **Don't** bring up vaccines before you have a trusting relationship with the client.
- ✗ **Don't** tell people what to do.
- ✗ **Don't** talk about vaccines when people are dope sick, in a crisis, or have other more urgent needs.

Be Ready to Talk About

Common Questions People Are Asking About Vaccines

- Why should I care?
- When or where can I get vaccinated?
- Is it going to make me sick?
- Do I need it or have to get it?
- Did you get the COVID / flu vaccine? Why?

Common Misconceptions We Hear From Clients

- I'll get sick if I get the vaccine.
- It's better for me to get sick and for my immune system to fight it off.
- COVID is over.
- Vaccines alter your DNA.
- Vaccines are a form of government control (e.g. ongoing colonization, microchips).
- It was developed too fast.
- I'm feeling fine so I don't need it.

Special Considerations to be culturally sensitive: *Vaccine strategies cannot follow a 'one size fits all' approach.*

Check out the WISE Practices for COVID Vaccinators Webinar

Visit the webinar here. Password: ?&?S43M2

Developed by the Peer-to-Peer Vaccine Safety Project

NorWest Community Health Centres / Centres de santé communautaire NorWest · Dilico Anishinabek Family Care · PACE People Advocating for Change through Empowerment Inc. · BISNO Brain Injury Services of Northern Ontario · elevate NWO · Thunder Bay District Health Unit · Anishnawbe Mushkiki Community Health & Wellness · The Salvation Army Journey to Life Centre

Appendix C2

COVID-19 Vaccination FAQs (Dilico Anishinabek Family Care)

Dilico
Anishinabek Family Care

200 Anemki Place
Fort William First Nation
Thunder Bay, ON P7J 1L6
Toll-free: 1-800-465-3985
Facsimile: (807) 626-7999
www.dilico.com

COVID-19 Vaccination
Frequently Asked Questions

When do we expect to see a vaccine in our communities?
Health Canada approved Canada's first COVID-19 vaccine on December 9, 2020. Shipments to Canada will begin soon and we anticipate being able to start delivery in early 2021. Priority groups will receive the first few batches of the vaccines, with the rollout taking between six to nine months.

Who will be the first to receive the vaccine?
While details on the delivery and administration are still being worked out, priority groups include:

- Residents, staff, essential caregivers, and other employees of congregate living settings (e.g., long-term care homes and retirement homes) that provide care for seniors because they are at higher risk of infection and serious illness from COVID-19;
- Health care workers, including hospital employees, other staff who work or study in hospitals, and other health care personnel;
- Adults in Indigenous communities, including remote communities where risk of transmission is high; and
- Adult recipients of home health care.

What are the side-effects from the vaccine?
Through vaccine trials, the most prominent side-effects were arm pain, fever and fatigue. In most cases, the side-effects went away within 48 hours. No significant side-effects were observed during the clinical trials.

We hear that there are different types of vaccines. What are they made of and which one will we receive?
While several emerging vaccines for COVID-19 exist, most are based on RNA (Ribonucleic acid). For the COVID-19 vaccine, a specific spike protein was identified and is being used to excite the natural human immune response system. This allows us to fight-off or reject the virus. Because the vaccine is not using an actual virus, it is very safe for humans.
All the vaccines are very similar with minor differences in things like who can receive it, or in different storage temperatures. The vaccine that the communities receive has not yet been identified, but our nurses will be trained on how to administer each one we deliver.

Is there anyone who should not receive the vaccine?
Some vaccines have restrictions on who can receive it. For instance, Pfizer recommends people with severe food allergies should be cautious about receiving that vaccine. All of our nurses have training in giving vaccines and will also have additional training specific to the Covid-19 vaccines. They will work with each patient to ensure the process is safe. We will also

require that those who receive the vaccine to wait for 15 minutes after being administered it to ensure there are no adverse effects.

How did they develop a vaccine so quickly?
While it appears the vaccines were developed quickly, much of the research came from the past 20 years of studying other coronaviruses (SARS and MERS). This allowed researcher to identify and isolate the virus early on. Additionally, since the virus is so prevalent in the population, it allowed for easy recruiting and testing of infected people to see if the vaccine works and is safe. Significant financial support from governments provided vaccine developers the funding to move from one trial to the next, and thus helped speed things up. The clinical trials were not rushed and it the vaccine was determined to be safe and effective. Human participants were monitored the same way as any other vaccine.

How effective is the vaccine? Will I need to receive an annual booster shot?
Most of the emerging vaccines are over 90% effective. While you may still get the Covid-19 virus after receiving the vaccine, because your body will now have built up an immunity, it will fight of the virus much quicker and you will experience a milder form of the illness with fewer if any symptoms.
Current data estimates the length of protection to be at least a couple of years with the possibility of a booster shot after that.

How will the vaccine be administered? What about the logistics of getting it to our community and temperature storage?
Most of the vaccines require two doses, with the second dose being administered three to four weeks later. While some vaccines do require special temperature storages over the long-term, we have the facilities and equipment available to administer any of the vaccines so far.

After I receive the vaccine, will I still need to follow COVID-19 precautions?
For the time being, yes. Most COVID-19 precautions will remain until a certain percentage of the population receive the vaccine (herd immunity). Even though you are vaccinated, there is still a very low risk that you can get COVID-19 or infect someone else with it.

I am young and healthy. Do you still recommend the vaccine?
Yes, it is strongly recommended that you receive the vaccine as soon as you are eligible to. Herd immunity is when enough of the population receives the vaccine to make it very difficult for the virus to live off of human hosts. It is expected that we need approximately 70% of the population to be vaccinated to achieve herd immunity. Some individuals will not be able to receive the vaccine due to personal risk, and this is why it is so important that everyone who can get the vaccine does.

Interest Information and Relevant Websites

Government of Canada - Coronavirus Disease (COVID-19): https://www.canada.ca/en/public-health/services/diseases/coronavirus-disease-covid-19.html

Government of Canada – Vaccines and Treatments for COVID-19: https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/prevention-risks/covid-19-vaccine-treatment.html

Public Health Ontario: https://www.publichealthontario.ca/

Association of Medical Microbiology and Infectious Disease Canada: https://www.ammi.ca/

Thunder Bay District Health Unit – Coronavirus: https://www.tbdhu.com/coronavirus

Algoma Public Health – COVID-19: http://www.algomapublichealth.com/disease-and-illness/infectious-diseases/novel-coronavirus/

COVID19 Vaccine Tracker: https://covid19.trackvaccines.org/

COVID10 Misinformation Watch: https://covid19misinfo.org/

Appendix D1

Video – Peer Voices: Why I Chose to Get Vaccinated

https://www.facebook.com/reel/707415074156349/

Appendix D2

Why it’s important to get vaccinated

WHY IT'S IMPORTANT TO GET VACCINATED

1. Vaccines Are the Best Way to Protect Yourself and Your Loved Ones from Preventable Disease
2. Vaccines Have Saved Lives for Over 100 Years
3. Vaccines Can Prevent Serious Illness
4. The Vaccines You Receive Are Safe
5. Proceed to the observation room post-vaccination.

HAVE ANY QUESTIONS?

ASK AN OUTREACH WORKER TODAY!

NorWest Community Health Centres

Centres de santé communautaire NorWest

Appendix E1

Vaccination and Care Bus Schedule

NorWest Community Health Centres

Centres de santé communautaire NorWest

Care Bus

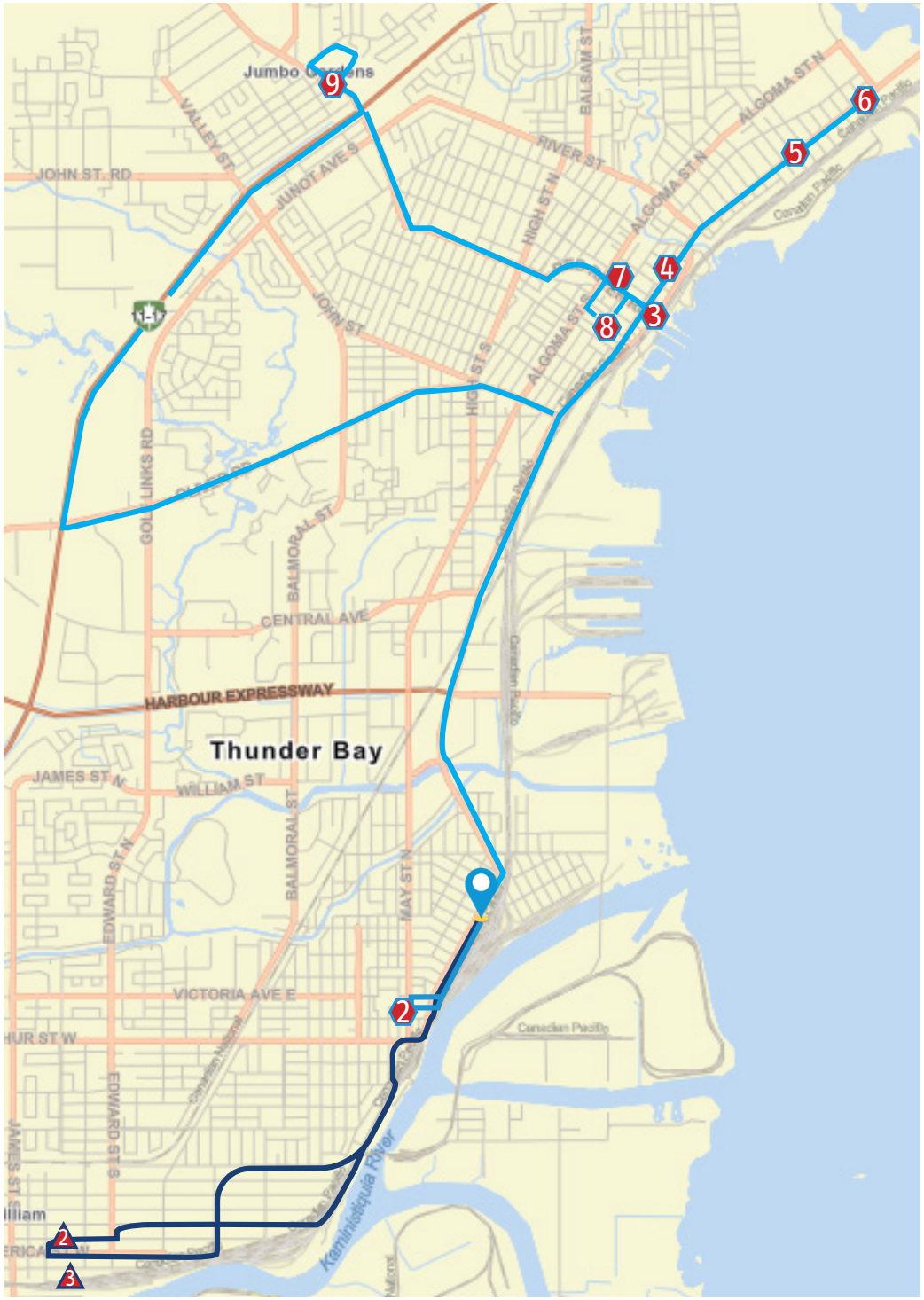
Catch the Care Bus to get to/from a vaccine clinic this winter.

Hours of Operation

7 days a week from 1 – 9pm

(807) 627-8459

As of December 20, 2022



NorWest Community Health Centres
Centres de santé communautaire NorWest
Care Bus

WINTER 2022-2023

Port Arthur Route

- NorWest CHC
- 2 PACE Warming Centre
- 3 Water St. Terminal
- 4 Elevate NWO Warming Centre
- 5 Indigenous Friendship Centre
- 6 Salvation Army
- 7 Court St & Red River Rd.
- 8 Court St & Pearl St.
- 9 County Park (behind Walmart)

Westfort Route

- NorWest CHC
- 2 Spence Court
- 3 OATC Westfort

Bus Contact: (807) 627-8459

****The routes are subject to change, as there may be adjustments in order to best support areas of our community****

lspc lakehead social planning council
The District of Thunder Bay Social Services Administration Board
Dr. Peter Centre
Thunder Bay Drug Strategy

NorWest Community Health Centres

Centres de santé communautaire NorWest

Care Bus

HOURS OF OPERATION

7 DAYS A WEEK: 1pm-9pm *(last call for service at 8:30pm)*

CONTACT

(807) 627-8459

Appendix E2

Where to get your COVID and Flu Vaccine this Winter

WHERE TO GET YOUR COVID & FLU VACCINE THIS WINTER

2023

01 Healthcare Provider

Talk to your healthcare provider

02 Street Outreach Van

Walk-ins welcome, no appointment needed

- **Monday Afternoons:** Grace Place
- **Tuesday Afternoons:** Dew Drop Inn
- **Wednesday Afternoons:** Shelter House (back alley)
- **Thursday Afternoons:** Dew Drop Inn
- **Friday Mornings:** Spence Court
- **Friday Afternoons:** Shelter House (back alley)

03 Mindimooyenh Health Clinic

Walk-ins welcome; appointments also available
Transportation to / from clinic available
Phone: (807) 697-1753
Address: 380 Ray Boulevard

Monday to Friday from 9am-4:30pm

04 CLE Mass Clinic

Walk-ins welcome, no appointment needed
Location: 425 Northern Avenue

- **Mondays:** 9am – 4pm
- **Tuesdays:** 11:30am – 6pm
- **Wednesdays:** 9am – 4pm

05 Matawa Health Cooperative

Appointments preferred, walk-in available

Phone: (807) 346-2370
Address: 101 Syndicate Ave N, Suite 510A

Monday to Friday from 8:30am-4:30pm

NorWest Community Health Centres
Centres de santé communautaire NorWest

Thunder Bay District Health Unit

Appendix F

P2P Vaccine Safety Project and Care Bus Project Lessons Learned

NorWest Community Health Centres
Centres de santé communautaire NorWest

Ontario Health

P2P Vaccine Safety Project and Care Bus Project Lessons Learned

March 2023

P2P Vaccine Safety Project (General)

- It is necessary to build in ongoing training for peers to keep vaccines and other health topics relevant and front of mind for peer workers. Recommend doing training on a bi-weekly basis.
- Incentivization of vaccines (and other health care services and behaviors) for vulnerable populations is a complicated practice that requires more research and community discussion. Addressing the social determinates of health through incentivizing is important, however, this also creates potential discrepancies between and among organizations. Incentivization can also make some clients more hesitant about vaccines or make people feel coerced into being vaccinated without being fully educated to make a personal choice. Health risks may be associated with individuals accepting/receiving additional vaccinations if poor historians, and if there is no centralized documentation system in place.
- We recognize the value and necessity of taking the time to build trust and relationships with clients. Measuring the importance and inherent value of relationship and trust building is difficult which makes it difficult to quantitatively express and capture a significant and important part of the work completed by peer outreach workers.
- For the P2P Vaccine Safety Project, and possibly other one-time funding projects, the documenting and recording of client interactions in an electronic medical record system is not a requirement. This does not allow the organization to capture this data for comprehensive reporting purposes; secondary data tracking systems need to be established. Documenting peer work and client interactions is valuable from an organizational perspective, and could enhance continuity of care.
- Contract fatigue and stress associated with possible unemployment at the end of a contract is difficult for staff. Some staff found it challenging to continue in their roles towards the end of the contract knowing that the relationships developed with clients would be ending. This is also difficult for clients who have come to rely on and trust peer workers that know their story.
- Don't plan to go straight into vaccine hesitancy and vaccine communications work with clients when designing a project targeting vulnerable populations. It is necessary to first focus on building relationships and trust and addressing the social determinants of health before doing any vaccine-related work.

P2P Vaccine Safety Advisory Committee

- Need clarity from the start about organizational capacity and ability to participate throughout the project. It is important to discuss and recognize the organizational limitations that some organizations have. Adapting committee roles and responsibilities as needed will help alleviate frustration.
- Some relevant organizations were not present on the committee that could be included in the future, including Mindimooyenh Health Clinic (ONWA), local shelters and other local health care providers.

Peer-Led Work

- Recognize the values that peers bring to projects, and find ways to provide benefits for peers/contractual workers to ensure access to sick days, bereavement, and mental health days are available. Build this into contracts for casual relief staff and peer workers, while also providing some flexibility and case-by-case review as needed. Create space for conservations with peers about mental health needs and provide support to navigate this in a timely manner (i.e. attending treatment programs). Recognize that some peers are at different places in their life and some may choose and need to access services for themselves.
- Develop strategies to prevent burnout. Peer-led work is emotional work. Plan for regular debriefing, check-ins that focus on connecting, ensure peers take days off as needed, always have a back-up staff scheduled, and build in access to resources (e.g. counselling, treatment, etc.).
- Adapt organizational policies and practices that create barriers for peers. This includes accepting written, drop-off resumes (rather than only through online submission system). Have the option to submit paper time sheets if peers are not comfortable or don't have access to phone or computer. If information needs to be shared with peers, do it via face-to-face communication, rather than through a handout or email. At the same time, make sure to build the capacity and skills of the peers to learn new processes, such as completing online time sheets or using a work email.
- Review organizational practices regarding peer led work. For example, requiring a driver's license if peers are not required to drive a vehicle as this can be an employment barrier for some peers.
- Include ongoing training and discussions around establishing healthy boundaries (e.g. spending own money on supplies people need, working after hours, sharing personal phone number, etc.). Peer outreach workers may choose to spend their own money or supplies for clients (e.g. cigarettes, food, coffee, etc.), may choose to support clients after hours, or share their personal phone number or address. Make sure to constantly debrief with peers about workload, emotional load, spending money on clients, and address any challenges as they arise and develop work policies if needed.
- Be proactive about mitigating workplace stigma of peers from within the organization and other partner organizations. Make sure peer roles, importance and necessity of peer work is shared with all staff (e.g. so they do not get dismissed when they are "not needed").
- Build skills and capacity for peers that will assist them with ongoing employment opportunities within the organization and/or community. Support peer workers to network and build their professional relationships. This includes learning about internal programs as well as other community programs (e.g. encourage peers to attend the monthly Outreach Workers Network meetings).

Flu / Pop-Up Vaccine Clinics

- Peers are providing significant enhancements to address social determinants of health and reduce barriers to care. It is more than ensuring individuals are vaccinated but is about building relationships, having conversations, and meeting other needs for clients.
- Recognize the importance of the peer-led role in pop-up and mobile clinics. Peers are a valued part of the inter-professional care team. Peer outreach workers also provide a safety net for staff and clients during pop-up clinics. Ensure roles are clearly defined for all staff before clinics.
- Offer both COVID vaccines and flu vaccines (as well as other vaccines for vulnerable populations). Clients were often asking if they could get their COVID vaccine at flu clinics and this would be an opportune time to get clients all seasonal vaccines at the same time.

- Provide incentives (cash) to get people to come in and get vaccinated. Ensure consent and information about consent is expressed in clear, plain language. Allow space for asking questions. Make sure that education about importance and reasons for getting vaccinated are communicated to clients and that they are still able to give consent.
- For District Social Services Administrative Board (DSSAB) building clinics, have DSSAB and a peer outreach worker go door-to-door the day before the clinic to talk about vaccines and answer questions and address hesitancies or concerns ahead of time. Also, go door-to-door on the day of the clinic. Ensure clear communication of clinic dates and times to all staff and partner organizations.
- Have a circulating peer outreach worker available for the duration of the vaccine clinic to talk to people in and around the clinic (e.g. at Spence Court clinic, they could have gone across the street when people were lining up for food at the Gathering Place and talked to people about vaccines while they were waiting in line). It might be slow for them at times, but it is important to have a peer available to address hesitancies, and other concerns, as they come up.
- Ensure posters with correct times are posted ahead of time (1 week before the clinic) throughout the building or clinic location.

Care Bus

- Gap in services: Care Bus ends at 8:30pm and local shelters do not start intake until 9pm. SOS used to run until 2am, but with SOS services being terminated there is no support after 8:30pm. The Care Bus was often turning down clients at 8:45pm that were asking to be referred to services (e.g. detox) in order to end on time. It would be ideal if the Care Bus could run later into the evening (e.g. 12 hour shifts: 1pm – 1am).
- Bus drivers (Kasper Transport staff) require Indigenous Cultural Safety training which can be offered by NorWest Community Health Centre. Care Bus drivers are third party external staff but they are *client facing* who engage with NorWest Community Health Centres clients.
- Detox referrals were a big success this year. Care Bus staff really cared about getting people to detox when they were ready and went out of their way to coordinate referral and transport and reduce barriers.
- Hiring issue: People who said they worked for the Care Bus vs. who actually worked on the Care Bus in previous years (clarify internal process to ensure correct information gets to hiring committee).
- Provide ongoing training for peers on relevant health topics (vaccines, overdose response, local services and how to do referrals, Lifeguard App, etc.) to ensure they are able to have conversations on these topics and recognize their importance. Schedule this into the Care Bus staff work time.
- Do a bi-weekly or monthly review with Kasper Transport and NorWest Community Health Centre (Management team/Care Bus coordinator) about days the bus runs and reasons for the bus not running to ensure financial issues are dealt with in a timely manner. Developing a log system to notify finance about variations in Care Bus schedule required.
- Partnerships with some private properties were a challenge. NWCHC approached private properties in the city to get permission for the bus to access their property to pick-up / drop-off clients and were denied access at two important locations (Arthur Street Marketplace and Thunder Centre). Follow-up

letters were sent out to these businesses, however, we were ultimately unable to go on these private properties, which meant we could not meet clients at these locations. Engaging in proactive relationship building and being proactive may assist with this. Sharing the positive feedback received from other private properties (e.g. Intercity Shopping Centre, etc.)

- A lot of people from outside Thunder Bay use the Care Bus (seem to stumble into it). Possibly advertise Care Bus services outside of Thunder Bay as well (e.g. in Northern airports, FN communities).
- Staffing Challenges:
    - See lessons learned about integrating peer workers (above).
    - Scheduling: Care bus runs 7 days/week; need back-up plan for coordinator to support scheduling and staffing when Care Bus Workers are unable to do scheduled shifts. This year the Care Bus Coordinator worked 7 days / week. Possibly have weekend coordinator or manager on call responsible for covering weekend shifts, or have NWCHC scheduling staff do all Care Bus scheduling and always coordinate with manager on call.
    - Care Bus Staff: Coverage when staff were unable to come in for scheduled shifts was an ongoing challenge this season. Often, we were struggling to find staff to run the Care Bus the day of the shift. This stress was caused by multiple factors including:
        - Care Bus staff leaving work for unplanned reasons (going to treatment, death), and staff taking sick days, mental health days, bereavement, etc.
        - Back-up casual relief staff were already working full time and have other commitments so were often unable to support back-up shifts when it was needed.
        - Ensure staffing and scheduling was completed in advance by moving this responsibility to the Logistics coordinator. Scheduling was not always clear to staff about when they were working on the bus (e.g. occasionally staff would show up at 8:30 am and be asked to do a full Care Bus shift until 9pm).
    - Things to do differently:
        - Hire extra staff and schedule everyone for part time work from the start. Possibly always schedule 3 workers for the bus. Always have 1-2 people "scheduled" as back-up staff to cover shifts. Determine pay / compensation for being a back-up staff.
        - Hire peer outreach workers (people with lived experience) as well as community health workers to staff the Care Bus.
        - Have more NWCHC staff as well as potentially staff from partner organizations available for casual relief (e.g. do a larger training of peers / outreach workers) so that we have backup options for people that could work the Care Bus (maybe train all peers at Outreach Workers Network Meeting).
    - Sick days: Need a plan in place if a staff is sick for a week or multiple weeks.
- Bus maintenance and bus break down challenges were ongoing throughout the year. Without a back-up bus available, the Care Bus did not run for several days during the winter due to maintenance. Best option would be to have a back-up bus available to cover when there are bus maintenance issues.
- Ongoing challenges around using a harm reduction approach and ensuring clients are kept safe. For example, having clarity about alcohol consumption on the Care Buss. The enforcement of this rule is challenging for frontline staff as taking a hard stance on this issue may create a barrier for some clients to ride the bus. However, permitting people to drink on the Care Bus increases the risk of unsafe

behavior towards staff and other clients. Taking a proactive approach for this challenge: increase skills of staff, ensure there is a consistent approach that aligns with organizational values, community and ensures client safety, establishing clear expectations.

- 24 hour bans (rather than one-week or one-month bans) seemed to work well for most clients and meant that clients that were banned from most other essential services in town could still access the bus.
- Clients don't always know what services we provide; people go straight to the back of the bus and sit down. Utilize the space within the Care Bus to leverage sharing of signage about services offered on the bus. Have Care Bus staff talk to clients about services offered, especially at the start of the Care Bus season.
- Offering of wifi by T Bay Tel was corporate donation that could be leveraged again in addition to receiving donations from the community.

Prepared by: Jennifer Pasiciel, Travis Franklin (Coordinators)
Approved by: Juanita Lawson, CEO, NorWest Community Health Centres

Tables

01 Community Partners

02 Partner Identified Benefits of the P2P Project

03 Partner Identified Project Strategies for Engaging Indigenous Populations

04 Partner Identified Project Barriers and Challenges

05 Partner Identified Future Directions of the P2P Project

06 Partner Identified Facilitators of Project Success

07 Peer Identified Successful Training Strategies

08 Partner Identified Strategies for Employing Peer Work

09 Peer Identified Ways Improve Vaccine Confidence

10 Peer Identified Barriers to Vaccination in Community

11 Peer Identified Generalized Benefits of Peer Work

Table 1. Community Partners

Description: A description of community partners.

Organization	Description
Anishnawbe Mushkiki ("Mushkiki")	An Indigenous-led, community-based, Aboriginal Health Access Centre—established in 2001, and one of 11 in Ontario. It's holistic centre (with an inter-professional team of physicians, nurses, nurse practitioners, social workers, health promoters, dietitians, diabetes educators) delivers primary care, health promotion, and traditional wellness programs for Indigenous peoples of all ages in Thunder Bay.
Brain Injury Services of Northern Ontario ("BISNO")	This organization provides supportive rehabilitation services (assisted living, personal support, independence training) for clients living with acquired brain injuries.
Dilico Anishinabek Family Care ("Dilico")	An Indigenous-led organization which provides a range of responsive individual, family and community programs and services for Anishinabek people in Thunder Bay District. Its primary care includes access to culturally-safe care, comprehensive clinical counselling and traditional healing through an interdisciplinary team of physicians, nurse practitioners, nurses, social workers, and traditional healers.
Elevate NWO ("Elevate")	A community-based, non-profit organization that empowers people living with, affected by, or at risk of HIV, AIDS, and HCV in Thunder Bay and northwestern Ontario. Elevate has 10+ years' experience in recruiting, training, mentoring peers regionally and has contributed to development of national peer guidelines.

Organization	Description
NorWest Community Health Centres (“NWCHC”)	NWCHC delivers primary health care along with allied health services and programs, in addition to health promotion and prevention health care that address the social determinants of health in the City and District of Thunder Bay. In addition to the three clinic sites, they operate mobile health services to provide regular access to primary care services to other district communities and individuals seeking care (Clinic sites: Thunder Bay, Armstrong, Longlac)
People Advocating for Change through Empowerment (“PACE”)	An organization which has provided peer support for people living with mental health and addictions in Thunder Bay District for over three decades (sites: Thunder Bay, Geraldton, Marathon, Schreiber-Terrace Bay, Manitouwadge).
The Salvation Army	This organization provides a range of supports: breakfast program; Food Bank/relevant programming weekly; mobile feeding program (2 locations nightly); emergency shelter/ overflow beds for 30 adult males; longer term housing for adult males living with mental illness; contract with Correction Services for post discharge beds; transitional housing; skill building/life skills programs.
Thunder Bay District Health Unit (“TBDHU”)	One of Ontario’s 34 Public Health Units, committed to improving health and reducing social inequities in health through evidence-informed practice. TBDHU provides public health expertise in infectious diseases (HCV/HIV prevention, diagnosis, treatment) and vaccine preventable diseases with a focus on vulnerable populations. TBDHU is actively rolling-out the COVID-19 vaccination program in the TBDHU area.

Table 2. Partner Identified Benefits of P2P Project

D**escription:** Subthemes nested in this theme describe the perceived benefits of being involved in/conducting the Peer-to-Peer Vaccine Hesitancy Project. Participants were asked to describe and outline the perceived benefits of the Peer-to-Peer Project overall.

Subthemes	Count	Representative Quote
Training for staff	4	"...What we certainly could do is, like... we could provide some training for NorWest... around things that they might need to consider when they're working with someone with a brain injury, because not everybody with a brain injury is on our case load."
Supporting clients in getting vaccinated	4	"I think it's it's supporting, supporting our clients, you know, to get the vaccine. I think that's that's been a huge, that's sort of been our number one raison d'etre"
Resources & supports for family	3	"Because brain injury doesn't just happen to the person, it happens to the whole family and so many of those families receive the same education and support to access those resources. That's where we spend the bulk of our time."
Working in a partnership	9	"I mean, health human resources are in short supply so when we're able to sort of supplement and have other organizations join us and work with us, that's super helpful."

Subthemes	Count	Representative Quote
Providing wrap-around supports	7	"...that whole notion of wrap around supports for people because we are dealing with vulnerable people that probably need more than one service provider to help meet their needs."
Communication among organizations	2	"It was nice to have that support of everybody, so it was something very unique that came out of this partnership, this proposal, that we wouldn't have seen before, because it really brought everybody together. It was nice to know that if I was in Marathon area or Terrace Bay, they kind of knew what they were doing, what we could provide, or where we could send our First Nation members who live there, where they could send you their First Nations to us"
Sharing resources among organizations (e.g., locations, vaccines)	5	"We shared vaccines, like 'I've got four vaccines left, you can use them'. So, it was kind of nice to have those supports available. But to know actually what was going on because we kind of planned it together. So it was... "can you bring the vaccines, we're heading that way?" kind of thing, "can you store it for us?". So, this back and forth. It was really nice to have that extra resource because before we're always siloed, like all the small First Nations were all very siloed so this is really different to see everybody working together and planning together, and sharing their, you know, what we could do, what we can't do, and then some pitch in where they where they were lacking kind of thing."

Subthemes	Count	Representative Quote
Transferable activities (into District)	6	"...I do feel like the pop-up clinics are very like... our pop-up testing/immunization events are fairly successful. We often partner with other organizations, so, you know, bringing a lot of other services that clients might be looking to connect with, or where it would be helpful for them to connect with. Kind of creating this one stop shopping model, if that makes sense. I think that that certainly could probably be effective in other communities as well."
Service Breadth	6	"So, we have a very large client base in general, so partnering with organizations that can help support and play different pieces of that into disciplinary care team so it's not all on one internal organization is huge."
Greater access to vaccines	2	"...One of the benefits would be just the consideration of perhaps how this population might need to access vaccines. Accessing healthcare is always challenging for individuals who are homeless who may have had that experiences previously with the health care system, so access has been a key consideration" "...Again like this, I think, had heavily focused on COVID, but certainly a lot of other vaccines were also provided throughout the course of the project so far, high risk immunizations and things like that, adhering to the Ontario schedule."
Peer Support	3	"I think the other aspect was bringing in that element of peer support. So, I think those are sort of the key pieces of the project. That, I think will help move that forward."

Table 3. Partner Identified Project Strategies for Engaging Indigenous Populations

D**escription:** Subthemes within this overarching theme describe strategies that were deemed as successful in engaging, educating, and conducting activities specifically with Indigenous populations in the region.

Subthemes	Count	Representative Quote
Harm reduction approach	2	"...For those ones, we respected their decision, they didn't put the vaccine down in any way, but they promoted them, you know. So, we said can you promote social distancing? Hand hygiene, wearing a mask, taking care of a loved one when they have COVID? You know, those kinds of measures we helped educate them with like, how can you keep yourself safe even though you don't have the vaccine, kind of thing. So those ones, they really appreciate us taking the time and not saying, "well, you know, you're going to get sick if you don't take the vaccine" and "look at so-and-so". They appreciate us, you know, respecting their decision, and just saying what can I do to keep myself safe and my loved ones safe, kind of thing." "it's being able to meet multiple needs at the same time. So, when we go to run a COVID clinic this winter, it will be looking at pairing it up on a day when we have a really great meal, or we're having a feast. We'll be looking at having it on a day when we have our food bank running, where we have like other resources, so you know, I can give you 20 minutes of my time to get this vaccination because you've helped me sort out a priority for me"

Subthemes	Count	Representative Quote
Informed consent	3	“ We really tried to make sure they had informed consent before getting that vaccine and then not just saying “you show up here, and you're getting the needle” kind of thing. So, and eventually we knew which ones were still not vaccinated, so we just kind of reached out to them to seem like you know, “you showed up that day… did you change your mind? Do you require some more information? Here is some other places you could go”.
Transparent practices	1	"Especially, you know, in the First Nations a lot of them has to do with like colonization and being forced to take medication without any kind of proper consent. So, we had to make sure that we were culturally sensitive too, and that's why they didn't like the paper, all the paper we were bringing in for the consent forms and it was really distressing for them when the consent form for the vaccine kept changing. “Why is it so long? Now it's shorter, now it's one page” and that mistrust came in there too. So, we had to keep explaining the situation”
Traditional healer/Elder/cultural coordinator access	4	“In the communities, we do have the time so our staff really did take that time, “would you like to talk to a mental health counsellor? Would you like to talk to a traditional healer or a cultural coordinator?”. So, just to help with the mental health aspect because they were feeling, um, how do you explain it, in their community they were feeling like, “oh, so-and-so shouldn’t be helped because they didn’t take the vaccine”, kind of thing, you know. They were feeling like left out or outcast or something like that.”

Subthemes	Count	Representative Quote
Taking history into account (e.g., colonization, IRS, etc.)	5	“I think it's just considering the cultural history and the colonialism and how that fits into our relationship building and rebuilding trust because a lot of Indigenous people do not necessarily trust health care providers and for good reason, historically”
Building trust	5	“...it's maybe even just consideration that you're working within that system of mistrust of, you know, historical trauma and all of those other aspects. So, I think it's trauma informed work. It's trauma informed practice. It's very important, and which all goes towards building that trust and being, you know, becoming a safe place to access care.”
Partnering with Indigenous organization	6	“ I think it's very important to have our Indigenous partners at the table, again, kind of going back to what I spoke to with the historical trauma and colonialism and addressing some of those pieces. I think that is very, it was a strength having those partners at the table.”
Indigenous-identifying clinicians	1	“We have 2 Indigenous, or now 3, physicians at the time. So that was kind of nice to know that they had some Indigenous resources too that they could, you know, come upon. I think it helped validate the information that we were sending too, so they knew that the physician was listening, and we also had our our Indigenous pharmacist as well on those talks, because they, he, would explain the vaccine and, kind of, he did it in a really nice way, especially all the science stuff behind the vaccine”

Subthemes	Count	Representative Quote
Respecting Autonomy	2	“I think, we just had to be patient with people, and understand that people do have the right to choose not to receive the vaccine”

Table 4. Partner Identified Project Barriers and Challenges

D**escription:** Subthemes within this overarching theme describe perceived barriers and challenges service providers encountered while conducting Peer-to-Peer Project activities.

Subthemes	Count	Representative Quote
Transportation	4	“Transportation is challenging and time is money in certain circumstances when you're dealing with really vulnerable folks”
Access to Technology	2	“It was hard to get, because a lot of First Nations didn't have virtual, so we had to actually had to go there with our supplies, and then, you know, provide the education face to face, kind of thing, on how to utilize the PPE and then to mask fit test their staff that were frontline and were working on their COVID teams”
Securing location for activities	1	“I think for the small towns it was trying to find the location. The offices in the smaller towns are smaller, so they were looking for partnerships with everybody in a small town.”
Public perception/stigma	5	“because there just is so much tension in community about COVID mandates and vaccines, and the convoy, and everything else that that like I said, the noise, is just so extreme that it really, really pollutes the conversation.”

Subthemes	Count	Representative Quote
Complex patient presentations	2	“...it does take a lot of time to build trust in relationships with clients and theres just like so many needs for clients like, so many big picture needs and so much wrap around care needed for people that like getting to the vaccine piece is like it can't even happen in a lot of situations, because there's just like so many other like medical needs ahead of that, social needs, just even day to day, like someone living in a tent and it's like winter approaching and what are you doing for this client?”
Group education sessions	1	“I would say it's those larger groups, like trying to hold a larger sort of info session. It's not great with this population with this subject. We've had it work very successfully with other things, but this subject, because there just is so much tension in community about COVID mandates and vaccines, and the convoy, and everything else”
Funding	3	“It comes down to resources, so human resources, funding resources”

Subthemes	Count	Representative Quote
Consistent Staffing	6	“I think sometimes it's mostly logistics, and ensuring that we have enough folks to run a smooth clinic, and if, because again, if clients have to wait, like if we get a bottleneck, for example, and they're waiting around and waiting around and waiting around... That's kind of a disincentive for them to stick around and get their immunization.” “...Some other key things that can be difficult with partnerships is communication, in general. I think right now we see... I’m gonna try the acronym again... Health care human resources crisis... there we go... across the board and I think because of that we see a ton of turnover, and because of the turnover we see a lot of stuttered communication where communication starts and then it stops, and then there's turnover, and there's no communication until either the turnover is someone interested in that project”
Lack of resources	3	“we don't have the resources at the hospital does. There are some realities of what individuals, who or what organizations can do if they're smaller. And if they don't have a lot of that, you know, frontline support, so I think that's some challenge”
Care provider burnout	3	“...And then I would think also, a health care provider kind of burn out, they don’t wanna talk about COVID anymore. That is a challenge and that's just the reality of it, you know, people, you know, this is over 3 years now we're still talking about COVID and lessons learned, and I think, you know, in health care, some of them just want to move on.”

Subthemes	Count	Representative Quote
Lack of community connection	1	"...I think not having necessarily connection to those communities ahead of time or doing education campaigns in those communities ahead of time, from our perspective, may have hindered that"

Table 5. Partner Identified Future Directions of the P2P Project

D**escription:** Subthemes nested within this theme described potential avenues for future services within both Thunder Bay and the District of Thunder Bay.

Subthemes	Count	Representative Quote
Mobile Care	3	“A mobile unit would have been nice for those that struggle with mental health issues for sure."
Community partnerships	1	“I think that this particular partnership just demonstrates the importance of partnership, like I just said in about having that sort of orchestrated process of wrap around services for people, and you know, it should continue for whatever reason. It shouldn't just be around vaccine hesitancy. It should be around meeting people's needs or wherever they're at, at the time. And that we need to continue, you know, we live here in the North, so I like to use Northern analogy. So, you know, we should all be getting the canoe and paddling in the same direction.”
Utilizing Indigenous ways of knowing	1	“...I really like how they just recognize how like peers like our Elders can really make a difference, and utilizing the traditional ways of the Indigenous peoples for delivering that type of information, I think, moving forward, I’d love to see that continue”

Table 6. Partner Identified Facilitators of Project Success

D**escription:** Subthemes nested in this theme describe strategies community partners utilized that resulted in successful programming (i.e., reached clients, greater attendance, facilitated acceptability, etc.)

Subthemes	Count	Representative Quote
One-on-one education	5	"...There's a lot of interaction with my staff and the clients, so a lot of one-to-one conversation. Sometimes, you know, when it comes to medical components, you know, it's an area that some of our clients don't necessarily want to deal with physicians, doctors, needles, anything like that."
Outreach	3	"Perhaps also serving this population, and so just ensuring that you know their understanding of the right products and stuff like that. I think, in terms of success around messaging to clients, I think a lot of that is probably health teaching in the moment by nursing staff at clinics and, or even, outreach staff, sort of, you know, touting the importance of protecting yourself and protecting others."

Subthemes	Count	Representative Quote
Mobile Care	4	“...mobile vaccination is probably the most effective way to do it. I see this right now, even with working consistent outreach with the care bus where we have outreach workers going around 8 hours a day and having either vaccinations accessible on something like that which we haven't done quite yet this year, but plan to do later on, or being able to pick up the phone and call the street nurses and meet in a mutual location. You'll see the success rate or the vaccination rates go way up because a lot of the people it's not a high priority. There's too many other serious or significant health or economical or social concerns that they're facing at the time that it doesn't even make their top 10, not even close.”
Facilitating access to resources	4	“We did a larger clinic where we invited multiple different services, including paramedics to do retina testing and referrals, the Health Unit to do different kinds of screenings, the cancer screening that gets done through the regional hospital, and I can't recall them all, but a large number of different health care providers doing a myriad of different services. I think that was probably our best attended pop-up style clinic”
Providing administrative assistance	1	“giving them the information that they need to access, you know, respective clinics, or if they need assistance with technology to support, to do online booking or whatever I mean. Those are the kinds of things that we help people with, anyway. I mean, not everybody is techno savvy. Not everybody has access to technology. So sometimes we need to facilitate that they have access to sort of those community resources”

Subthemes	Count	Representative Quote
Webinars for staff education	2	"My staff like the zoom stuff. It was good. It was adequate for them. They learned lots"
Providing informed consent	1	"We really tried to make sure they had informed consent before getting that vaccine and then not just saying "you show up here, and you're getting the needle" kind of thing. So, and eventually we knew which ones were still not vaccinated, so we just kind of reached out to them to seem like you know, "you showed up that day... did you change your mind? Do you require some more information? Here is some other places you could go".
Modifying educational documents to simple language	5	"You know, you provide like a presentation that's just very brief and to the point, and put in a language where we understand, simple language, simple words. That's what we did. So I think that's why they were successful, because we filter down exactly with the top dogs were saying" "In terms of information, I think, I think of one of the outreach workers that says "we don't like when you use your big words", so I think probably I'm sure at some point we've run into, you know, have we tailored the health counseling to be, as you know..."
Providing incentives	6	"That's one of the things that we don't have in this, right, is a way to incentivize the vaccinations. But that really works for our people or at least that's what we've seen testing anyways."

Subthemes	Count	Representative Quote
In-person education	1	“So those were probably the most successful, but they had to be face face because our First Nations, their virtual capacity wasn't as great as in the city.”
Informal education	1	“Catching them sort of informally, and that over coffee thing, it seems to be working across the age groups and across the genders and across ethnicities.”
Relationship Building	3	“Obviously, often times with vulnerable populations, relationship building is really important and gaining trust is really important”
Harm Reduction	2	“But if you're, you know, engaging them in other things, maybe providing from harm reduction equipment, maybe just conversation where they're gauging your level of judgment, and all of those other things, right? So I think those are some of the techniques that I think work with our, with our clientele.” “ I see first-hand that a lot of these newer approaches on harm reduction and ways that would have been very resistant in a health care a couple of years ago, are creating positive health outcomes.”
Flexible Staff Training	1	“So I think that flexible, at their own pace is nice, and it could kind of be fit in to the day where it makes the most sense, and they're not feeling like they're, you know, taking away from client work and other duties, it’s a little burdensome.”

Subthemes	Count	Representative Quote
Individually tailored approaches	3	“...there is no universal approach. People are too complex to try and map something out like that, I think taking multi layered and multifaceted approaches is the best solution when doing it. I think it's sometimes trial and error until we have better equipped teams to be able to take large dynamic approaches, which is the best solution.”
Peers	4	“...when it's coming from a doctor to one of our clients, it doesn't work. But when it's coming from someone with lived experience to that population like explaining why they were hesitant before they started this job and then all the education that came through this job and then doing their own research, and like kind of talking about their family in their network, and why they chose to get vaccinated.”
Low barrier clinics/service access	4	“...because it was just a wide open, you know, you don't have to have a health card we can find, you know, we can figure it out for you. I think that's a barrier that a lot of people think is in place is that you would need a health card, or you need identification, or you need something else to access the vaccine, and our ability to just say, “nope, just come on in and we'll get you vaccinated” brought in a, you know, a population we may not have otherwise seen”

Table 7. Peer Identified Successful Training Strategies

D**escription:** Subthemes nested within this theme describe training avenues that the peers deemed successful or had greater acceptability. Peers were asked to describe facets of training that were successful and considered a strength. When describing training activities, peers highlighted specific aspects that were beneficial.

Subthemes	Count	Representative Quote
Team-based approach	3	“There was avenues for that she had a board at one point where she started brainstorming her next training ideas, and we were always welcome to add to that, but they were so thorough that I could never think of anything outside of that. But again, yeah, there were always opportunity. She always said, if anything comes up, or, again, if you have any more questions you get answered. So we're very grateful for that”
Informal training	2	“...just in the mornings, really? Non formal, you know, having a conversation. Yeah. Right. Having a conversation in the morning before you start our day with her"
Peer-led training	1	“And learning from the peers, myself. Right, that has made all the difference.”

Table 8. Partner Identified Strategies for Employing Peer Work

D**escription:** Subthemes nested within this theme describe training avenues that the peers deemed successful or had greater acceptability. Peers were asked to describe facets of training that were successful and considered a strength. When describing training activities, peers highlighted specific aspects that were beneficial.

Subthemes	Count	Representative Quote	Partner Endorsement
Incentivizing Peers	2	“Incentivize and motivate the peers. And you would think that just a paycheck would do it, but it's not, it's more. It actually takes a little bit more. So, it's about creating a healthy, competitive nature, you know. So, we did we created a bingo sheet and it's got questions like talk to somebody about COVID vaccination and there’s like 3 key points that they have to, like, talk about, um, talk to somebody about harm reduction, and talk to somebody about, you know, and so it's got all these different things”	Norwest

Subthemes	Count	Representative Quote	Partner Endorsement
Comprehensive Training	2	“...they do receive many other competencies just around the work and the populations they work with, because despite having a focus on immunization, the work they do to build these relationships is very complex and multi layered.”	Norwest
Local Peers	2	“You obviously need local peers for each like for each project, so it's not like peers from Toronto can come up here and necessarily be as effective because they won't know the services, they won't know the population as well.	Norwest

Table 9. Peer Identified Ways Improve Vaccine Confidence

D**escription:** Subthemes nested under this theme describe successful strategies and approaches to reduce vaccine questioning.

Subthemes	Count	Representative Quote
Relationship building	3	“building relationships. Like, when I started out on the care bus, that's where I started building those relationships. And I worked at detox. And so I've had relationships with the vulnerable. So being able to go out there, and we would do like, the soup truck on Wednesdays, and then we do outreach on Wednesdays, going to different places where they, you know, hang out, and that's like thunder center, county fair. The Arthur Street Market, City Hall, and we've built those relationships, then when it came time to get them to, you know, to bring them to get a vaccine. They'd be more open to that”
Treating people with respect and dignity	2	“treat them with dignity and respect, because they deserve it. They deserve it.”

Subthemes	Count	Representative Quote
Wrap-around care	2	“Yeah, vaccines are the least thing that they they're worried about shelter they're worried about their next fix because their adult sick, right? They're worried about where they're going to sleep at night, what do they have to do for their next BNL and all of these other things. So it's this layer of getting to, to bring them in and wrap them the wraparound care probate, making them feel loved and accepted, and then have those conversations like, Hey, you're more vulnerable. And if you get sick, if you get the flu, and you're dope, sick, and all these other things that are going on for you, why not get the flu shot to try to prevent that, right”
Individualized approaches	2	“I think that you need to know who you're speaking with first. Right? Like I don't want to ever just lump everybody here, everybody here. It's like you go out and do the same approach for everybody because we do We've seen more more good from out of that than anything else and all being timid for this group, or like, you know, like, that's not how it works. We want to treat them all the same. But it's gaining those relationships as individuals, like, I'm going to treat this one different because they know their story and unknown what's actually going on.”

Subthemes	Count	Representative Quote
Providing information/facts/education	1	“Because, you know, the government saying, kind of sent me a free, free choice and all this stuff, but you can't travel, if you don't have this, you can't do this if you don't have this. So again, it is like they are saying these things, right. But it's trying to get away from that with them, I think and bringing them back to the facts and back to the solution of, you know, what this is best, this is going to help you.”
Harm reduction	1	“if they're if they're really against it, I'm not pushing, I'm not going to break down my relationship with them for it. And I'm not gonna have a breakdown in the relationship, because there's more things that are higher need for them than a vaccine. Yeah, so learn food and water and all of these things, right? Safety, vaccines, kind of sorts, getting those things done first, maybe having them house having them, you know, a little bit more food, not such food insecurity, right? It's, their approach is different for every individual.”
Utilizing peers	2	“just to say how vital I think, and this is opinion here, how important peer to peer work is, like, I think there should be peers everywhere. And I think, like for me, I'm so passionate about this because I know what it feels like to be out there. Right. So in my recovery journey, it was somebody that came up to me that had lived extreme realize that I trusted that I believed you. Right? Because I've seen you walk this walk to it's different. lived experience is so vital I believe in today, like in what we need to do for our population and to gain trust.”

Subthemes	Count	Representative Quote
Easier access to vaccines	2	“I think a lot of people are getting have gotten the vaccination after being hesitant, was seen things people on the care bus that have had vaccines in the past, you know, and, and, you know, and quite frankly, you know, I've done a lot worse put a lot worse in my body than a vaccine. So, you know, I think being able to talk to them”

Table 10. Peer Identified Barriers to Vaccination in Community

D**escription:** Subthemes nested within this theme describe reasons why community members are hesitant to getting vaccinated

Subthemes	Count	Representative Quote
Mistrust of medicine “bad medicine”, health systems, and government	5	“So I know that that idea that, like Western world stuff is bad medicine, when they rather use their their medicines themselves. Right. So I've had experience with it. Definitely. And that's what I heard on the street is bad medicine. Okay. So because they'll hear, they'll hear from their community members on the board, or they'll be online on Facebook. And they'll say, you know, ask them, What will you think about it? And then it's bad medicine. Right” “You know, feeling like the government is just trying to control you again. And how can I? Like I am First Nation myself, I'm at how can I just dispute that?” “That it's, that's just a hoax. Like, I don't need it.”
Lack of incentive	1	“I guess some of the clinics some of the pop ups didn't have didn't have any money that they were giving out. That would be a that's it's been a flop every time.”

Subthemes	Count	Representative Quote
Don’t need to be vaccinated	1	“the flu shot keeps you sick, right? They don't have they don't have a lot that, like they, they've never had it in their life where they're going to have it now. They don't need it. And I would explain to them, that they're more vulnerable to get sick. And you say, like, you know, you're, you're, yeah, you don't have a bed to lay into once you have the flu, right. Like it's gonna put everything off everything else off that you need to do get water, get food, get whatever shelter, lots of other Western medicine do government's trying to control us. That's huge.”
Reluctance to Conform	2	“you know, fighting, fighting the fight and being homeless, being addicted to drugs, living on the street and not seen any kind of real help available. You know, and that's where your mindsets at right when you're homeless, on drugs and alcohol, you want things you want, and now you want help you want it today? It just wasn't happening. So conforming to that, you know, being vaccinated like everybody else, and just you know, giving into the system was something that I was fighting as well.”

Table 11. Peer Identified Generalized Benefits of Peer Work

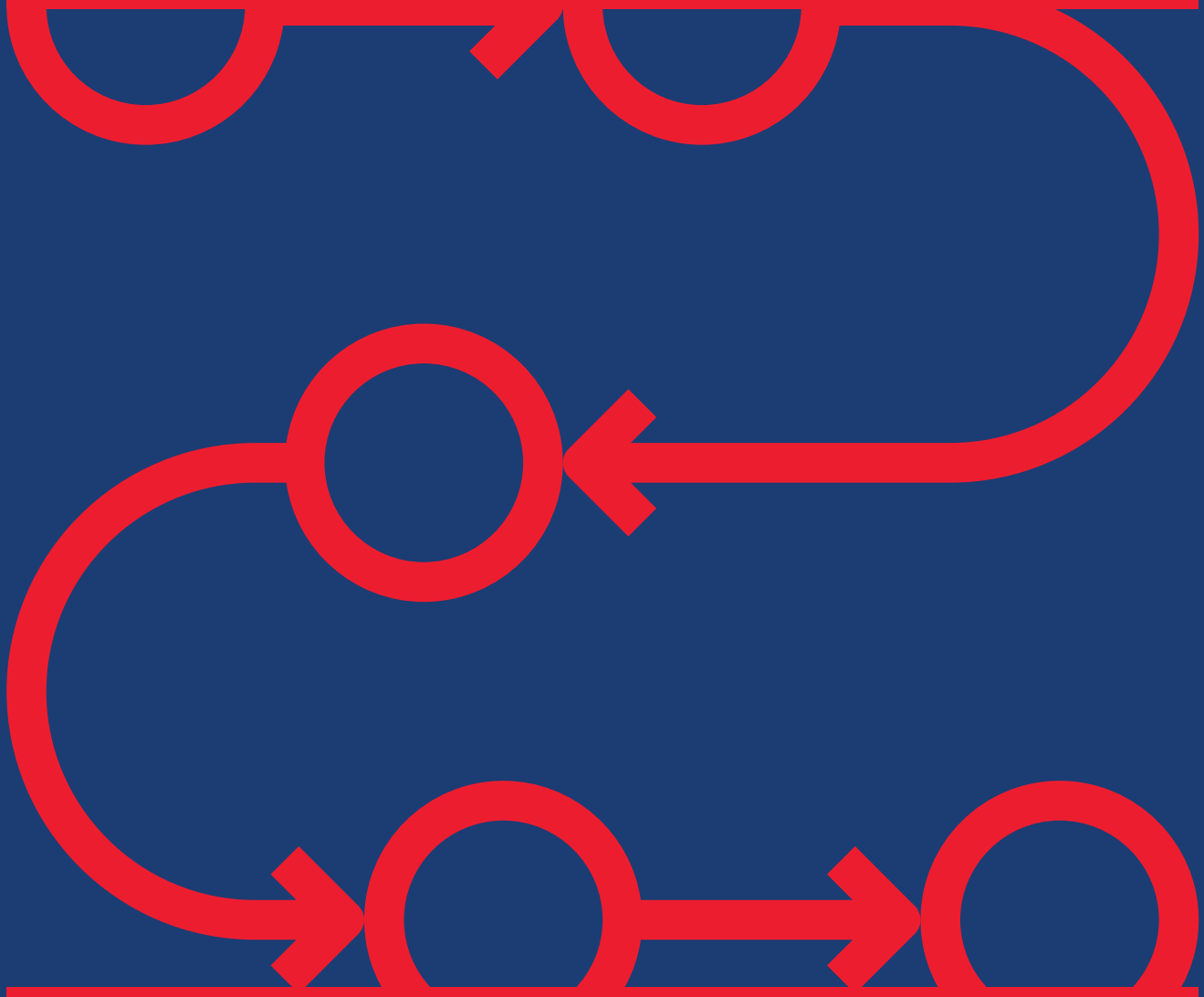
D**escription:** Subthemes nested under this theme describe and define “peer” and “peer work”.

Subthemes	Count	Representative Quote
Lived Experience	5	“I think it depends on the job, right. Like here, we deal with a lot of people in addictions. Right. So maybe people in recovery, like to deny, and that I know, and an Erica has her own lived experience. So she can attest to it. Right. Like, I think that we all have lived experience, let's just be real, you know, have it” “But I think when we lead with our lived experiences is just in my when I lead with my lived experience, and what I know, as opposed to what I know of a book, I get better results. And the I get a better connection with humans.”
Harm Reduction/Taking non-judgemental approach	2	“I've been there, and I am on the other end. Now, whenever you're ready, I'll meet you where you're at, and I'll accept you. You just let me know. Or you know, I'll be there for you. I'll be coming to you. I'll be checking in on you. So it makes a world of difference.” “Harm reduction is also so vital. Absolutely. It's so vital just to meet them where they're at know that that's it's okay that you're it's okay you still deserve to be respected and loved and here's some food and yeah you know cared for everybody deserves that but they're they're not treated very well city.”

Subthemes	Count	Representative Quote
Understanding personal privilege	1	“so I think it is it's the peer to peer but leading with your heart like actually giving a shit about recognizing how privileged we truly are. That I get to go home to a warm bath and I get to go home and have clean water from a tap I don't have to run for water like the summertime”

Figures

01 Evaluation timeline



02 Logic Model

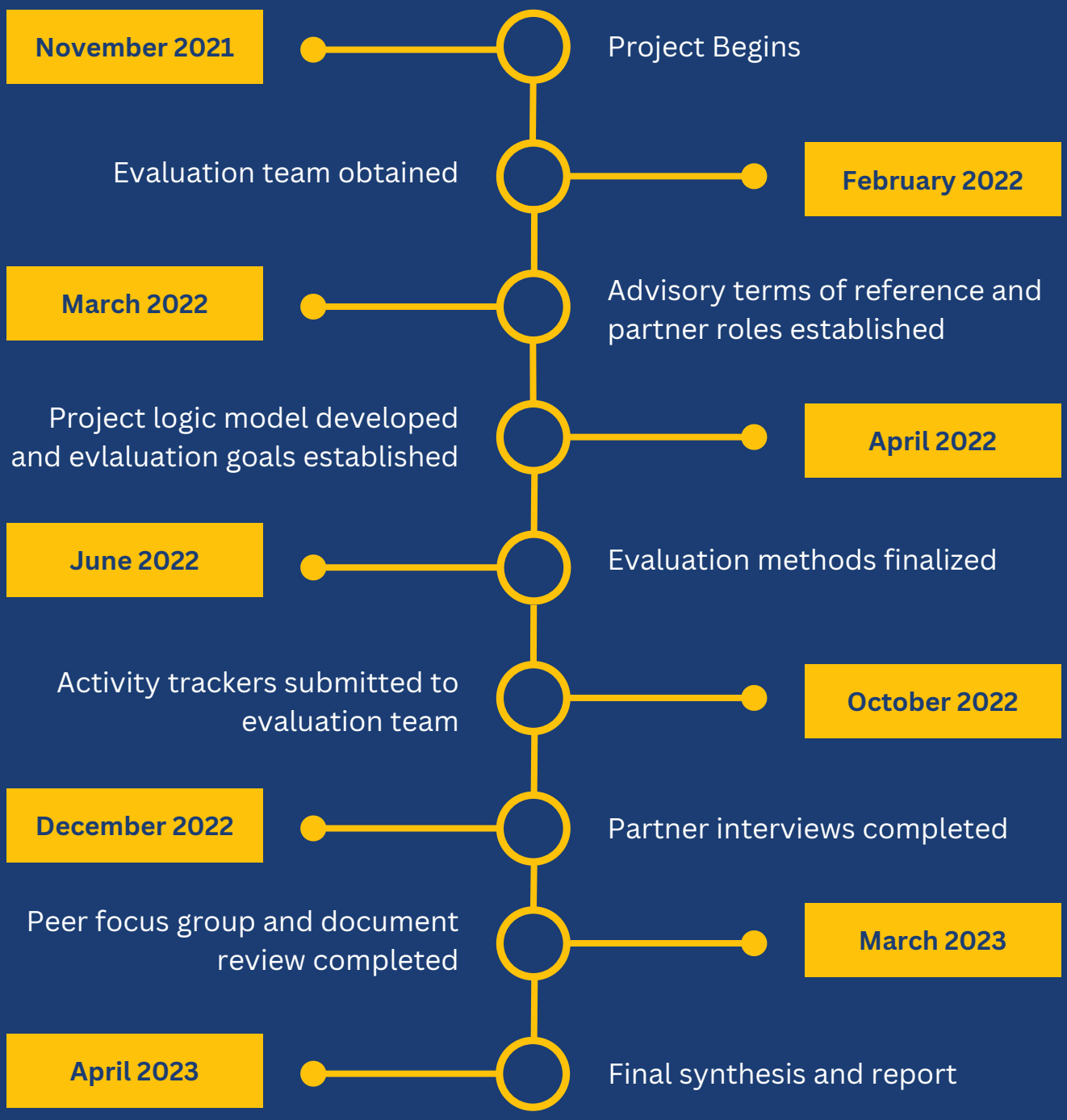


Figure 1. Evaluation timeline

Logic Model: **Peer-to-Peer Vaccination**

Step 1 GOAL

To increase knowledge about vaccinations and increase access to vaccination services within marginalized communities in Thunder Bay, Fort William First Nation, and the District of Thunder Bay.

Step 2 SITUATION

The COVID-19 crisis exposed and amplified health inequities faced by a number of marginalized communities that members of the Peer-to-Peer partnership have long worked to address.

Step 3 INPUTS

- Partner Organizations
- Advisory Committee
- Peer-to-Peer Coordinator/Lead
- Peer Outreach Workers
- Peers
- Elders Council

Step 4 ACTIVITIES

- Advisory Meetings
- Partner Activity Tracking
- Resource Development
- Peer Training
- Peer Outreach
- Targeted Communication (Brochure, Care Bus, Street Level Engagement)
- Targeted Vaccination Clinics

Step 5 OUTPUTS

- 10 Advisory Meetings
- 21 Training Events
- 4 Resources
- 1037 Face-to Face Interactions
- 427 Vaccination Clincs
- 167 Education Engagement
- 339 Referrals to Services

Step 6 OUTCOMES

- Access to evidence-based information on vaccinations
- Peer worker vaccination knowledge
- Marginalized individuals access to positive vaccine messaging
- Access to vaccination services for marginalized communities
- Partner organization collaboration
- Partner response to crisis capacity
- Barriers to care (e.g., Care Bus)