VACCINE CONFIDENCE PROJECT

EVALUATION REPORT

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atira
WOMEN'S RESOURCE SOCIETY

atira.bc.ca

Land Acknowledgement

Atira Women's Resource Society respectfully acknowledges the First Nations, Métis, and Inuk peoples as the first inhabitants and traditional custodians of the lands where we live, learn, and work. Atira is located on the traditional territories of Coast Salish peoples including the xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), Sel̓íl̓witulh (Tsleil-Waututh), Katzie, kʷikʷəƛəm (Kwikwetlem), Semiahmoo, Stó:lō and Tsawwassen Nations. We recognize and remember that this land was stolen and its people forcibly displaced.

We ask that you take a moment to remember where you live, learn, and work and to reflect on the impact of residential schools, the Sixties Scoop, missing and murdered women, anti-Indigenous racism, the treatment of First Nations, Métis and Inuk people in our health care system, and Indigenous poverty on reserves and in our cities and towns. Take a moment to ask yourself what you are prepared to do to create change and what you are prepared to give up to ensure Indigenous people do not remain landless and homeless on their homelands.

This resource can be downloaded from
atira.bc.ca/what-we-do/training-resources/vaccine-confidence

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1. Introduction

The Immunization Partnership Fund (IPF) was created by the Government of Canada in response to the COVID-19 pandemic (1). The IPF aims to support community-based efforts to increase COVID-19 vaccine acceptance and uptake among Canadians, address vaccine misinformation and disinformation, and reduce vaccine preventable disease (1).

The IPF-funded Vaccine Hesitancy Project, run by Atira Women's Resource Society (Atira), aimed to support community-based vaccine education, promotion, and outreach to women who have experienced violence, abuse, or marginalization (3). The project explored reasons for vaccine hesitancy among women who have experienced interpersonal or systemic violence (2). And, it used a peer-led approach in an effort to meaningfully engage with women about their concerns, to help them have confidence in, and receive, available vaccines (2).

This report details the independent evaluation of Atira's vaccine hesitancy project. The evaluation focused on understanding the overall impact and effectiveness of the project, including:

- The experience for peer support workers
- Whether the project was effective at meaningfully engaging with women to increase vaccine comfort and uptake, and
- If the organizational logistics and approach were effective, and replicable.

2. Vaccine Hesitancy Project Summary

The foundation of Atira's vaccine hesitancy project is based on peer expertise and peer relationships. Peer Support Workers were central in both the development of the project approach and the strategies for engaging with women. Like all Atira programs, approaches to promote accessibility and consider diversity and equity were prioritized in this project (3).

Throughout the project, peers used non-judgmental and trauma-informed approaches to build relationships with women accessing Atira's housing and non-residential programs (3). Using a mix of one-on-one and group interactions, peers offered evidence-based information, emotional support, trust, and practical help to support vaccine comfort and uptake (3).

Recognizing that there are many reasons for vaccine hesitancy, Peer Support Workers provided a range of supports to women. Peers did everything from sharing evidence and information, to dispelling misinformation, addressing vaccine fears, scheduling vaccine appointments, finding relevant language-appropriate information, organizing childcare, and providing post-vaccine support with groceries and meals (2). In-house vaccination clinics were also offered through this project, in order to increase comfort, access, and uptake of vaccines. These in-house clinics created a more relaxed environment than typical health care settings – coffee and snacks would be provided for women, while peers were available to discuss vaccine concerns and share stories with women (2).

3. Understanding Vaccine Hesitancy in our Community

Vaccine hesitancy arises for many different reasons (4). Among women who have experienced violence, abuse or marginalization, one of the major reasons for vaccine hesitancy is previous negative experiences with the health care system or general mistrust of government (4). These negative experiences with health care services have been and continue to be affected by sexism, racism, colonialism, transphobia, and other forms of oppression (4). From an Indigenous perspective, Indigenous people may link the vaccine with the colonial legacy of systemic racism, medical experimentation and mistreatment (4). Most women also shared that vaccine hesitancy was related to lack of access to information or misinformation about vaccines (4). Other women who were vaccine hesitant were individuals who were open to vaccination, but had difficulties accessing health care services. This included, for example, not knowing where to get vaccinated, not knowing how to book an appointment, or having limited access to a phone, computer, or the internet to book an appointment (4). In addition, many women were grappling with how to take time off from work or family responsibilities to get vaccinated and take time to recover from possible side effects (4). Other reasons for vaccine hesitancy included lack of transportation to vaccine clinics and language barriers limiting access to comfort and safety information, as well as booking and appointment logistics (4).

By acknowledging concerns around vaccines as a valid response to harmful histories and continuing legacies of adverse interactions with the healthcare system, Atira's vaccine hesitancy project aimed to provide non-judgmental trauma-informed education that guides individuals to making an informed decision around the COVID-19 vaccines. Additionally, through the peer model, the project recognized and worked to address the structural barriers that often make all aspects of vaccination difficult for women, both before, during and after the vaccine itself.

4. Why We Used a Peer Led Approach

Peer-led approaches have a long history of success, ensuring programming and engagement is designed and implemented in ways that make sense for the community experience and context. Practice evolves from the stories and knowledge of people with lived experience and their allies (4). Historically, peer-led movements have been an important part of initiatives to address gender-based violence. Currently, peer networks and community expertise are driving efforts to address many public health initiatives, including the opioid crisis (4). The COVID-19 pandemic led to new networks of mutual aid and community organizing, and an opportunity for peer-led work to support vaccine comfort (4).

Atira has long understood the value of peer-led efforts, and the approach has been embraced as a guiding principle and part of their core work philosophy. As such, peer-led efforts have been widely adopted across all of Atira's programs. For example, there are peers support workers at the overdose prevention sites to guide and support women to safe use practices, and peers at the residential programs to support women with day-to-day needs.

Peer support programs to promote vaccine confidence are well suited to help to build trustworthy and safe relationships for women who have experienced violence and abuse. All of Atira's Peer Support Workers have lived experience of violence and marginalization, including substance use, sex work, incarceration, and discrimination on the basis of race, sexual orientation, or gender identity (4). Because the peers share lived experience with the women they assist, they can meet women "where they are at" and provide empathetic and honest communication and support (4). The Peer Support Workers reflect the diversity of women accessing Atira's programs and services, ranging in age from 19 to 65 (4). Indigenous, Black, and women of colour, cis and trans women, and women who are immigrants or refugees were also represented. Peers also spoke at least eight different languages: English, French, Arabic, Spanish, Hindi, Urdu, Mandarin, and several Indigenous languages (4). If women were looking for support or help in other languages, or from other cultures, peers could draw on the highly diverse staff at Atira. With staff from all over the world, Atira currently has employees speaking 49 different languages and dialects.

5. Vaccine Hesitancy Project Description

The project launched in October 2021 with the parallel work of forming the advisory committee and initiating peer recruitment. These steps were quickly followed with the first round of peer training, and engaging with women. Details on each of these steps follows.

Advisory committee

Atira hired a Project Coordinator and formed an advisory committee on November 2021. The advisory committee guided the project work, and served as a hub for connecting key members of the initiative – health authority representatives, program managers, Atira staff, and peers. The advisory committee met on a regular monthly basis and included the following members:

1. Operational Excellence Director;
2. Project Coordinator, Vaccine and Immunization Peer Training Program;
3. Five Program Managers;
4. Four Peer Support Workers;
5. Seven representatives from local health authorities (VCH, FH, FNHA); and
6. Community stakeholders (PHS, BCACHC)

This committee provided a forum for discussion and problem solving on matters related to building community capacity for COVID-19 vaccine confidence, uptake, and access (5). The advisory committee compiled existing available resources on addressing vaccination concerns, and determined a set of current best practices (5). Working with guidance from the Advisory Committee, the Project Coordinator developed the initial training curriculum that gave peers the tools to address concerns and hesitancies around vaccination (5).

Peer Recruitment

Between October and November 2021, the Advisory Committee sought out current housing residents and community members to become Peer Support Workers (2). Program Managers from specific Atira programs also recommended peers from within each site. The Project Coordinator and Atira's on-staff Nurse conducted preliminary meetings with each peer to assess their interest, commitment, vaccination status, and general knowledge. This process resulted in the initial recruitment of 15 Peer Support Workers. There was a rolling intake of peers throughout the course of the project, with more peers joining, and some peers leaving the position. As of December 2022, 33 total Peer Support Workers had been recruited and trained.

Peer Training

In order to support the peers with their roles, a training curriculum was developed specifically for this project. The training included a presentation and a short module that was designed by the Project Coordinator and reviewed by the Atira Operational Excellence Department and community partners. These materials were designed with techniques and language that aligned with the peer context, and focused on public health benefits to immunization, COVID-19 vaccine information, reasons for vaccine hesitancy, active listening skills, and the importance of trust in addressing women's vaccine concerns. Two initial training sessions were held with peers in November 2021 to orient them to the project (2). These sessions were held in a relaxed environment.

After the initial training, refresher training sessions were held with new Peer Support Workers. These subsequent sessions incorporated feedback from peers on the content and design of the training, and included new information based on the learnings from the project to date. Part way through the project, Peer Support Workers also co-developed an online, open access training module that was created with the aim of supporting Peer and Community Support Workers in other communities, with the same principles and approaches that this project used. Finally, peers also supported in the creation and design of outreach materials such as videos and posters.

Peers in Action

After completion of the training module, the Peer Support Workers applied the skills and information they learned in the communities they live in (5). The peers used all sorts of approaches to connect with women and build trust, including art-making, listening to music together, and cooking or baking together. A number of settings were used to create safe, informal, and welcoming environments where women could come talk to Peer Support Workers and feel heard and understood. These included connecting with women within residences through conversation, while cooking together, or sitting around. As well as through more organized community conversation sessions, pop-up in-house vaccination clinics, art-therapy sessions, and breakfast sessions (2).

Over the course of the project, peers supported women in a wide variety of ways, always with the trauma-informed, non-judgemental approach central to this project. Through their one-on-one or group interactions, Peer Support Workers listened to and empathized with women's concerns, fears and perceptions regarding vaccines. They discussed the facts and myths most relevant to each woman. Peers also provided support that might facilitate the process of getting vaccinated, such as: accompanying women to clinics, helping women with chores after the vaccine, providing or coordinating childcare during or after their appointment, providing emotional support, and even organizing fun activities together while women were experiencing post-vaccine side effects (2).

As the Peer Support Workers interacted with women about vaccines, they checked in about their successes and struggles with the Project Coordinator on a weekly basis, and the advisory committee on a monthly basis (2, 5). The weekly check-ins between the peers and the Project Coordinator helped ensure regular reflections took place, and were an opportunity to address any issues the peers were facing during their work. Through trusting relationships with women accessing supportive housing services, the Peer Support Workers were an essential link between project staff and women served (5).

Continuous Learning

The project used a continuous learning approach, where feedback was welcomed and solicited through multiple channels in ongoing ways. The advisory committee regularly compiled new information regarding the COVID-19 pandemic and vaccine roll out, and supported the project team to incorporate this information into their practices and materials. The initial training module received Peer feedback that was then incorporated into subsequent versions of the training. Peer check-ins allowed project staff to understand how things were going for each Peer Support Worker, and peer focus groups allowed for collective knowledge sharing and project learning. The continuous learning model was integral to developing materials and project approaches that best met women's needs, in a rapidly changing pandemic context.

6. Evaluation Approach & Methods

All evaluation methods and the tools were developed in partnership with the Atira project team, and informed by both peers and staff.

The evaluation of Atira's vaccine hesitancy project was informed by four streams of information:

1. Reviewing available project documents, including training materials, reports, and data.
2. Conversations with five staff members – to hear about project impact, operational and logistic considerations, and to co-develop the data collection approach for peers and women.
3. Connecting with six peers – seeking to understand their thoughts on project impact and about the peer experience in the project.
4. Surveying women directly – to understand the impact and effectiveness of the project on vaccine comfort, hesitancy, and uptake.

Gathering data from these different perspectives helped to offer a clearer picture of how the project went as a whole. This enabled a more fulsome understanding of the project impacts, and dimensions to consider for replicability, be that at Atira, or at other community programs.

Data collection methods for staff and peer perspectives were qualitative, and included individual conversations (interviews), small group settings (focus group), and the option to submit written perspectives. These methods allowed us to adapt to what was most comfortable and feasible for participants. The survey with women was conducted by Peers Support Workers, and both peers and women were paid for their time. Peers helping with the surveys did so at different sites than they live and work, so that they could conduct surveys with women they hadn't yet supported. This was done in an effort to allow women to express their feedback of peers more freely and honestly.

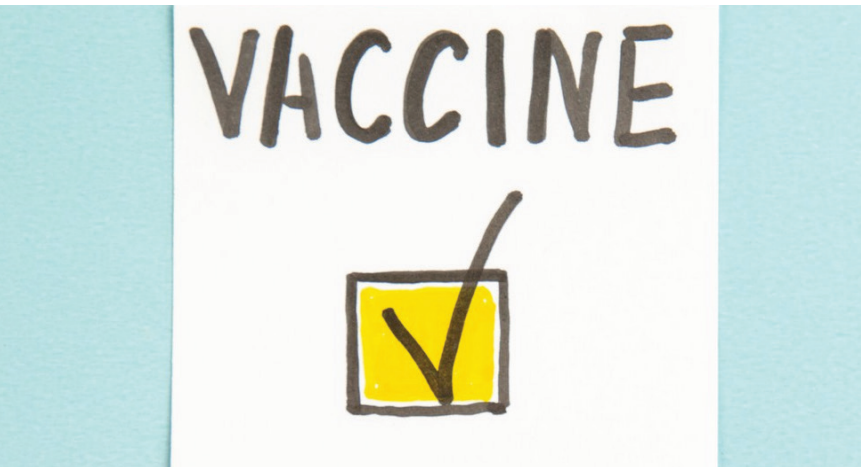
7. What We Learned

Through interviews, focus groups and surveys with staff, peers and women, we learned about the successes, the challenges, and the impact of the program, as well as considerations for future replication. These findings are summarized below.

Key Findings

- The project was an effective, responsive, and pragmatic way to address an important public health issue. Peer Support Workers met women where they were at – providing connection, information, support, and care, as needed and appropriate to facilitate vaccine comfort and uptake. This helped women to feel more comfortable and more able to access vaccines.
- The Peer Support model provided tailored, wrap-around support, in a flexible way. This adaptable support was important for success, as hesitancy and barriers to vaccination differ for everyone.
- Most women who interacted with peers experienced increased comfort with, and access to, COVID vaccines. Many also had increased comfort and access to other seasonal vaccines.
- Peer Support Workers decreased the burden on vaccine clinic staff, who are not positioned to have prolonged, trust-building conversations with women coming through for their vaccine.
- The care and support peer workers provided enabled hundreds of women from Atira housing and non-residential services to get vaccinated.
- The peers themselves learned from the process, and all reported really enjoying the work. They also appreciated having extra avenues for income.

Outcomes By the Numbers



By December 2022, the Vaccine Hesitancy Project had accomplished a lot:

- Peers enabled the delivery of **432** vaccines – **262** COVID-19 vaccines and **170** flu vaccines (2)
- **33** peer workers recruited and trained
- **26** peers worked as Peer Support Workers

- Over **198** hours of peer training provided
- Over **5000** peer hours worked (2)
- On average, **eight** peers engaged with women every week (2)
- Peers engaged with more than **240** women in discussions about vaccines (2)
- **35** vaccination clinics were supported by peer workers (2)

Survey Results

The survey with women was launched in January 2023, with Peer Support Workers conducting the surveys. Peers were assigned to conduct the survey at different sites than where they live and regularly work as peer support workers for the project, so that women could more freely express their feedback of the experience without concern of insulting the peer they had engaged with. A convenience sampling approach was used for pragmatic reasons. Peer Support Workers went to Atira residences and asked women willing to chat if they would like to complete the survey. Participation in the Vaccine Hesitancy Project, or experience connecting with peers about vaccine hesitancy, was not an eligibility requirement for the survey.

Women were paid $15 to complete the survey. Peers were compensated at their standard wage for conducting the surveys. At the time of this report, 32 women had completed the survey. All women approached to complete the survey, agreed to do so.

Of the survey respondents:

- **75% (24)** had received at least one COVID-19 vaccine
- **44% (14)** had received 3 or more shots
- **60% (19)** had spoken to a Peer Support Worker
- Of those **60% (19)** that had spoken to a peer worker
  - **79% (15)** got their COVID-19 vaccine(s)
  - **95% (18)** reported that the peer workers listened to their questions and concerns
  - And **100% (19)** of those women said they had a positive experience, with the peer support worker helping them to feel more comfortable, more supported, and less afraid

- Overall, **50% (16)** of women reported that the peer helped them feel more comfortable getting their COVID-19 vaccine
- What's more, **44% (14)** of women reported peer interactions also helped them feel more comfortable getting their flu shot this year.
- Notably, **97% (31)** of women surveyed felt that a program like this is good to offer.

What Worked Well

Several core aspects of the approach were found to be central to why the project worked so well, in both process and outcomes. Eight key themes tied to project success are detailed here.

1. A relational approach

- The project was rooted in a trust-based approach, with peers engaging with women through conversation, connection, and support. Women were not scared or threatened into vaccines. There was time built-in to the peer engagement approach – in every setting – for conversations, debunking, and trust building. This was the foundation of the program, and critical for its success.
- The relational approach allowed for peers and women to connect, for women's needs and concerns to be addressed, and for the program to grown and adapt to what women most needed in order to address hesitancy and barriers to vaccine comfort.
- Peers, staff, and women themselves spoke about how connections, relationships, trust, and time, were central to its success. Allowing for learning, trust building, and information sharing at a pace that matched the need.

2. Evidence Based

- The relational approach to the project was paired with a commitment to being evidence-based. Being a reliable and trustworthy source of information was central to the project, and to the Peer Worker role.
- The commitment to being evidence-based guided many aspects of the project approach as it played out in an emergent pandemic situation. Peers, staff, and the advisory committee all understood that continuous learning, knowledge sharing, and training would be integral for success. This shared understanding and clear commitment to being evidence-based, in addition to relational and trauma informed, anchored the work. And accessing and sharing high quality information was a clear commitment from peers over the life of the project.

3. Peer led & Peer responsive

- From the outset, peers were seen as experts and key links between women accessing Atira residential and non-residential services and the project team. Accordingly, peers were involved in the design and roll-out of the approach, as well as speaking to how it was going once active. All of this directly informed project strategies, learning materials, and engagement approaches. Understanding the importance of staying attuned to peer experiences and inputs strengthened the project operations and outcomes.
- Peer led work is strong, sound, and ideally suited for the vaccine hesitancy project. Peers were able to connect with women, support their needs, and enable vaccine comfort and uptake extremely effectively. Alternate project models that hinged on staff or outsiders playing these roles would have struggled with making connections as efficiently, and time constraints limiting when, and for how long, women could be supported would have limited the depth and scope of support offered. The ability for peers to be flexible, and meet women's needs as they emerged, would be hard to replicate in other ways.
- Peers reported really enjoying the work. They enjoyed the learning that came from the role, the income, as well as increasing their own social networks through the role.
- Structuring the project to allow peers to have flexibility in their hours, and to join and leave the program in a rolling way, created a positive and realistic context for peers to engage with the work.

4. Adaptive wrap-around programming

- Vaccine hesitancy is not a singular issue or experience that is consistent across people. Hesitancy can mean everything from vaccine fears, to side-effect anxiety, to logistical concerns around who will watch the kids while mom gets the vaccine, or how women will cope with meals, clean up, and child minding if they are sick for hours, or days, following the vaccine. Flexible wrap-around support means that peers are able to show up and support women in a range of ways, in order to best address the differing reasons for vaccine hesitancy and barriers to uptake.

- In this project, adaptive wrap-around support was central to its success. Peers helped with the practical, logistical, and emotional barriers that were leading to vaccine hesitancy, both before and after vaccination. Things like helping to book appointments, schedule times, watch kids while mom gets her shot, or bringing them food if they're feeling unwell afterwards, all lead to greater trust, a sense of safety in the process, and greater uptake in initial vaccination and subsequent boosters.

- Using a variety of ways to connect and engage with women over the course of the project was important. As was a willingness and desire to try new and different approaches to building trusting relationships and meeting women's needs. Complementing peer engagement activities were small group activities. Community conversations, breakfast tables, and art therapy groups were offered as ways to connect, engage, build trust, and address fears. Each site, and each woman may need different approaches for success. Coming prepared with a host of options, and a desire to hear and try new approaches, was central to success in this project.

- The art therapy sessions run by the Vaccine Hesitancy Project in one of Atira's programs for women 55+ is one example of well-received innovative programming. Art therapy, an approach largely influenced by the fields of art and psychology, uses the creative process, pieces of art created in therapy, and third-party artwork to help people in treatment develop self-awareness, explore emotions, address unresolved emotional conflicts, improve social skills, and raise self-esteem.

  Initiated in the fall of 2022, the sessions received steady interest from women. Sessions run every week, with 7–10 women participating in each one. In the sessions, women use art to explore some of the fundamental reasons that people do not get vaccinated, through themes of healing, self-love, health-related decision-making, and self-respect. Each session, the women gather, making art, talking about their everyday challenges around the dining room table while enjoying snacks, coffee, and tea. At the end of each session, the room is filled with joy, laughter, and happiness.

  Work created in this process may be showcased in various ways so that women who participated in the regroup can stay connected to the positive energy from the experience, and to further spread the message of healing and health. For instance, one collective art project has been framed and hung on the dining room wall, where women gather to eat and hang out together most days. There may also be a video developed of the works created in this group, that can be shared more broadly.

5. In-house clinics offered in residences

- In-house, mobile, or pop-up clinics were offered at many Atira sites. At each one, Peers provided support during the clinics, fostering a safe, welcoming environment. With no pressure or obligation to get the vaccine, women were welcome to check out the pop-up clinic, chat with peers to discuss their vaccination concerns and options, have a snack, observe, and hang out (6).
- This in-house no-pressure approach to the clinics worked exceptionally well to increase access and uptake of vaccination. The clinics reduced multiple barriers to uptake, including those related to accessing clinics (booking, transportation, way-finding) and those related to comfort and safety (familiar non-clinical environment, snacks and coffee, art-making, peer presence and support).
- According to project staff and vaccine clinic staff (i.e., staff from health authorities and local pharmacies) Peer Support Workers definitively decreased the burden on vaccine clinic staff, who are simply not positioned to have prolonged, trust-building conversations with women coming through for their vaccine.
- Additionally, vaccine clinic staff do not always have the range of personnel available to align with women's culture, language, history, or identity. This means that women may not find someone they feel safe and able to speak with to address their hesitancy. Peers, however, were quite likely to be aligned in those ways.

6. Incentives

- Staff, peers, and women all reported that incentives were an important part of motivating vaccine uptake.
    - Food increased turn out at all events, including vaccine clinics and conversation gatherings.
    - Cash incentives were a very effective motivator for women to get their vaccine.
    - Taxi vouchers helped simplify access to off-site vaccine clinics.

7. A continuous learning approach (ongoing evaluation)

- A continuous learning approach, with an eye to the process and outcomes, also played a key role in the project's success. Changing project practices – like developing the peer training, and making info and vaccine safety posters – based on peer and staff feedback allowed the team to continuously refine the approach, leading to better experiences and outcomes for all.
- The project team got regular updates from peers on how things were going, and any needed training materials; and the team also exchanged new COVID-19 vaccine information and learned about new vaccine misinformation through these regular check-ins.
- Peer group gatherings provided a regular opportunity for staff to hear more about what was and wasn't working with the approach, and for peers to share strategies, info, and approaches, among each other.
- The peers all reported valuing these regular check-ins, especially the peer group gatherings.

8. Partnerships

- Partnerships were deeply valued by the project team, and project success was amplified through the many community partnerships developed and sustained during the project.
- Strong partnerships with other groups, some IPF funded, working in health, housing, infectious disease, and community outreach were sought out and where possible, formed. These partnerships allowed for valuable shared learning, programming (e.g., regular health clinics), support in the development of educational materials, the delivery of vaccine information, and awareness raising and outreach.
- The team built relationships with a network of pharmacies to offer vaccines. This enabled more in-house vaccine clinics to occur, and simultaneously helped decrease the pressure on health authorities to provide all the vaccine clinics needed to be successful. These pharmacy partnerships also enabled more in-house clinics for recent seasonal vaccines, which made them far more accessible for most women.

Unexpected Benefits of the Project

Participants in the evaluation were all asked to share any unexpected benefits, or negative outcomes, of the project. No negative outcomes were shared, directly or indirectly. There were, however, a few notable unexpected benefits of the project that stood out, and warrant mentioning.

1. Helping with more than just COVID-19 vaccine hesitancy

Though the main focus of the project was vaccine hesitancy, in reality, the project provided education and support around COVID-19 in general. Over the course of the project, collective knowledge about COVID-19 risk, transmission, testing, isolation, and self-protection changed rapidly. Peers were "in the field" as a point of contact, and a source of evidence-based information, throughout. Peers answered questions about COVID-19 risk and spread, different vaccine types and safety concerns, and helped women get access to, and use, at-home COVID-19 tests. Peers support workers helped disseminate sound information in a time of great uncertainty. They increased safety and likely decreased transmission by helping distribute and teach the proper use of home tests, model mask wearing, and support isolation when needed. The positive effects of peer presence reach well beyond the defined scope of decreasing vaccine hesitancy.

2. Beyond COVID-19 – Supporting immunization comfort & uptake more broadly

The project's primary focus was COVID-19 vaccine hesitancy, however, over the life of the project the scope naturally expanded to include seasonal immunizations like influenza and pneumococcal. As with COVID-19 vaccine comfort, the peer model has been successful at supporting women to get their seasonal vaccines. Over 170 influenza vaccinations were administered this year with peer help. Supporting broader vaccine comfort and uptake is a notable positive outcome of this initiative. One that highlights the value of an adaptable peer-led model in its ability to extend beyond its initial scope and further support adjacent public health goals.

3. Peer Learning

Peer Support Workers learned a great deal about COVID-19 vaccines, however, their learning did not end there. They also received training in relational skills such as active listening and non-judgmental discussion. Peers reported value in the range of content they learned, sharing that it was helpful for their roles as peer support workers, and for their lives and work more broadly.

4. Transferrable skills & sustained employment

Through their training and employment as Peer Support Workers, peers gained a variety of transferable skills (e.g., supporting scheduling and logistics, active listening, and clear communication). For at least one peer support worker, this employment experience led to securing ongoing employment in the community.

Project Challenges

No significant issues disrupting project operations or outcomes surfaced in the evaluation, however, a few challenges and frustrations were identified. While many of these challenges were known elements of the project context, they are shared here for collective learning on the real-life factors that influence this sort of project work.

1. The changing landscape of COVID-19 information

This project launched early in a global pandemic. Information was sparse, and changing often. It was hard for everyone to keep up-to-date, and also hard to build trust as a reliable source of information if information was out-of-date. Peers reported feeling that the training offered was really good, but that they also did additional research to feel up to date, or to understand more about current misinformation, which was rapidly changing.

2. Insufficient Indigenous Resources

- The project team worked hard to have Indigenous specific materials, resources, and peers on the project. However, limited available time for both in-house and partner organization Indigenous personnel meant this could not happen as desired. Similarly, print resources designed for Indigenous women were not widely available.
- Ideally, the project team would have had Indigenous partners, staff, and peers involved from the outset – to guide the approach, and to be available for Indigenous women. But, as was the case here, sometimes that isn't feasible. In this case, the team was aware of the gap, and tried to address it as best as possible over the course of the project by continuing to reach out to Indigenous led organizations, work with internal staff as available, and hire and support Indigenous Peer Support Workers.

3. Timing of Funding Disbursement

Funds were disbursed from the funder later than expected, so that meant a late and somewhat rushed start to the work. Ideally the project could have started closer to the initial disbursement date, which would have allowed for more lead time in recruiting peers, and developing training materials, before launch.

4. Understanding the full scope of "hesitancy"

The project set out to address vaccine hesitancy, a somewhat vague term that many associate with an initial concern about vaccination. "Hesitancy" makes many people think of something that you can overcome, and then be done with – perhaps something that doesn't even surface again for booster shots. In reality, hesitancy occurred due to a host of fears, misinformation, and structural barriers. Many of which persist or recur with every subsequent COVID-19 booster or seasonal vaccine. People who got their first shot may still be "hesitant" to get a subsequent one because the same concerns, fears, or structural barriers still exist.

The team focused a good deal of energy in the early stages of the work trying to engage with women who had not yet been vaccinated, focusing less on women who had received at least one vaccine dose. Understanding earlier that hesitancy can be understood broadly, and can recur with every vaccine appointment, could have enabled greater engagement strategies earlier in the process.

5. Insufficient or Slow Knowledge Sharing among IPF Grantees

Many people involved in the project shared a gentle frustration that there wasn't a streamlined or centralized way to share knowledge or pool resources with other IPF grantees. Knowing there were other organizations likely working on projects with similar goals, but not sharing resources, strategically exchanging materials, and avoiding work duplication felt like a missed opportunity for many involved in this work. For those working on this project, and many others in this field, there is a deep desire to optimize scarce resources to yield maximum gain for the communities serviced. Opportunities to collaborate with other organizations developing similar resources or approaches would be both sensible and valued.

Considerations for Replication

As part of the evaluation, we reflected on what people would need to know if replicating this project – at Atira, or elsewhere – including strategies for success, and things they would do differently. The following key considerations emerged.

1. Intentionally design for a peer led program

- Design the project approach from the outset to allow for peers to come in and out of the Peer Support Worker position as it fits with their lives. Peers turn over. A lot. For all sorts of legitimate and sound reasons. Sometimes the role isn't the right fit, often women move out of residence, or more on to other initiatives. It would be unrealistic to run the project expecting one group of peers to stay for the duration. Anticipating the changing nature of the peer team is important to running a peer model effectively.
- Peer-led work can take more time than a typical staff operated program. The reality of peers' lives means that they too are often dealing with personal stresses, triggers, pressures, and needs. Anticipating a variable cadence to the work, in addition to peer turn over, will set the project up for realistic timelines and processes.
- Hire intentionally – For this peer model to be successful, it is very important to have someone who knows the context of the group, and the peers, involved in recruitment and hiring. Peers need to be selected for the roles based on having the right skills and abilities –the ability to connect and engage with their peers, a desire to learn, and a belief in the purpose of the work. In order to know this, you need to know the peers.
- People often confuse peer-led with peer-run. For this model to be successful, the project needed to be managed by Atira, but peer led. This means:

    - Staff support the operations and logistics of the work.
    - Peers guide the approach to engagement.
    - Staff sense-check and ensure the feasibility of proposed activities and approaches.
    - Peers provide feedback to staff and the advisory committee on what's working and what's not.
    - Peer feedback is addressed immediately, as best as possible.

    In this way, peers are key players in the project work, but there is no expectation that project management lands on peers.

2. Employ a continuous learning approach

Continuous learning is critical in order to stay attuned to the pace of new information coming out, shifting social contexts, and new peer support workers. A strategy for on-going, open, learning and information sharing needs to be built into the plan and approach.

3. Think big about barrier and enablers

Understanding that hesitancy can refer to a whole range of limiting factors influencing whether women get vaccinated or not is important in order to effectively design and broadly implement the project strategy. Whether developing another program focused on vaccine hesitancy, or a different public health topic, thinking big about what may be affecting comfort and uptake is a sound approach to help ensure you design the most meaningful strategy possible.

4. Offer incentives

Women appreciated having incentives for getting the vaccine. Cash, food on site, gift cards for food, and taxi vouchers were all reported as helpful and motivating for women in addition to emotional and logistical support.

5. Foster a supportive environment

A supportive environment within the team, and across sites where peers will be working, is important for success. Within team support is important to enable a safe learning environment. While site leadership being supportive of the project goal, it is important for Peer Support Workers to be successful in their roles.

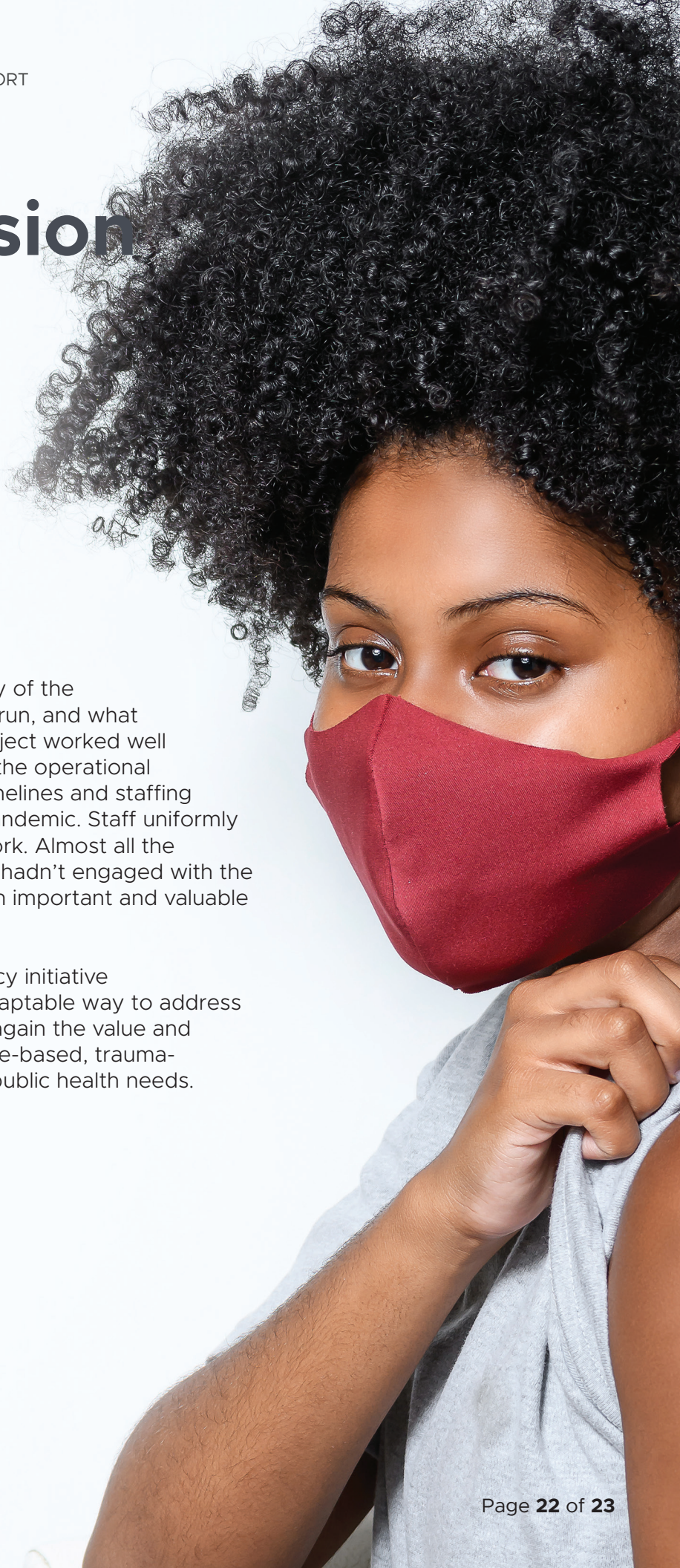
Limited support, or direct opposition to the project from leadership on sites, makes it harder for peers to do the work. To accomplish this, try engaging program managers or site leaders in early project design and training sessions, so they understand the nature of the initiative and the importance of the work, and can be part of designing and informing the process from the outset.

8. Conclusion

Overall, the Vaccine Hesitancy Project was a success. People liked the project approach, and the outcomes. Flexible wrap-around support worked effectively to minimize social, emotional, and structural factors affecting hesitancy. The peer approached helped to decrease the burden of labour on health care and vaccine clinic staff, and the initiative supported over 430 vaccinations.

Peer Support Workers speak highly of the project – their role, the way it was run, and what they got from it. Staff think the project worked well overall, even when accounting for the operational challenges that came from tight timelines and staffing and training during an emerging pandemic. Staff uniformly agreed that the peers did great work. Almost all the women surveyed, even those who hadn't engaged with the project yet, agreed that this was an important and valuable project to run.

Atira's peer based vaccine hesitancy initiative demonstrates a responsive and adaptable way to address vaccine hesitancy. Demonstrating again the value and effectiveness of relational, evidence-based, trauma-informed approaches to complex public health needs.



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