

HEALTH EQUITY RESEARCH

UNDERSERVED GROUPS AND THE
COVID-19 VACCINE EXPERIENCE

EXECUTIVE SUMMARY

BACKGROUND

From June – September 2021, the SCD research team worked with the Ministry of Health, GCPE, and key community partners to understand and improve service & information pathways to healthcare to ensure equitable access to the COVID vaccine and information. The research approach was to focus on engaging with community organizations to build a deeper understanding of key groups and communities that weren't being reached by government content and services.

HEALTH EQUITY FRAMEWORK

The team developed a health equity framework to determine which groups to prioritize in our research. We referenced federal health equity frameworks as well as COVID specific indicators that assessed risk and impact of COVID to determine groups that face amplified barriers to access and experience multiple factors that lead to disproportionate negative impacts. The following groups were prioritized:

- Migrant or undocumented workers
- Youth in or aging out of care
- Sex workers facing precarious housing

WHO WE ENGAGED

We spoke to community organizations across BC, supporting groups who are based in Kamloops, Prince George, Okanagan region, the Lower Mainland, and Vancouver Island

The community partners we engaged with include Migrant Workers Centre, Prince George New Hope Society, MAP BC, Federation of Social Services BC, AMSSA (Affiliation of Multicultural Societies and Service Agencies of BC), Federation of BC Youth in Care Networks, Umbrella Multicultural Health Co-op, BCCDC (Knowledge translation team), Health Authority communications teams.

KEY FINDINGS

Fear & mistrust in a time of COVID

Across all three groups we engaged with, mistrust in government and institutions were prevalent due to:

- Existing systemic barriers and inequities amplified by global pandemic (e.g. colonial violence, racial discrimination,
- Poor and traumatic past experiences with health institutions, government representatives, and authorities

RESEARCH QUESTIONS

1. How can government provide equitable access to health content, information, and services?

2. How are existing health inequities impacting how underserved populations access COVID information and services?

KEY FINDINGS CONTINUED

Support the supporters

Support organizations fill in key service gaps for underserved populations. They are often at capacity, providing direct service, supporting service navigation, and providing emotional support. Supporting community organizations will improve service access and experience for underserved groups.

Move at the speed of trust

Trust building is an important part of collaborating with community members and organizations. Proper service design necessitates proper time and resources allocated to build trust between partners, align on goals and approach, and find ways to work together. Short timelines do not allow teams or partners to let trust guide the process of collaboration.

Past experiences of a system impact access to services

Chronic systemic challenges to access essential services from healthcare to housing in the past have impacted perceptions and expectations of what services can or can't be used. For example:

- Racism and discrimination at hospitals and clinics have made sex workers feel unsafe and unwanted in institutional setting

OPPORTUNITY SPACES

1. Ongoing dialogue and feedback

- Building and maintaining infrastructure (e.g. relationships with community organizations, feedback mechanisms, etc.) to support communication between parts of government, health authorities, various types of community organizations, and B.C. residents themselves.

Possible next steps:

- Identify existing ministry contacts/relationships with community organizations doing direct service delivery
- Establish working groups or roundtables with diverse participation from organizations
- Invite frontline staff person to existing roundtable
- Share stories from frontline organizations across government

2. Targeted or customized messaging

- Creating customized messaging for groups with different lived experiences to make it easier for support organizations.

Possible next steps:

- Work with a community organization to co-develop customized messaging for the people they serve for an upcoming campaign or project
- Understand who the people you serve are, what challenges have/do they face, and how can information be shared with them in a safe way?

3. Community relations coordinator

- Designated roles in government and the broader public sector to facilitate the relationship building and information sharing required to properly reach and support underserved populations.

Possible next steps:

- Assign time and resources to understand and build relationships with community organizations that serve the same people as your program
- Develop networks and pathways between folks doing similar work (e.g. government, health authorities, direct service organizations) so connections can be strong and apparent

4. Enhanced capacity in government to design for equity with communities

- Stronger infrastructure to support proper collaboration with communities to design more equitable access to services

Possible next steps:

- Internal actor mapping to develop multi-disciplinary/cross-functional teams in government
- Mapping to identify internal landscape/point of essential decision

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PART ONE

RESEARCH APPROACH

BACKGROUND

The scope of this project focused on understanding and improving information pathways to ensure equitable access to the COVID vaccine. The team’s research approach was to build a deeper understanding of community organizations and how they were supporting groups that weren’t being reached by government content. We first had to identify priority groups, and then reach out to organizations that supported them.

This project was done in parallel with a project that investigated how the B.C. government’s multi-language COVID content was being received. The Health Equity project team chose to center lived experiences as the key approach to answering our research questions, while the multi-language COVID project began directly with COVID content. This, as a larger team, provided a more holistic understanding of the barriers faced by folks.

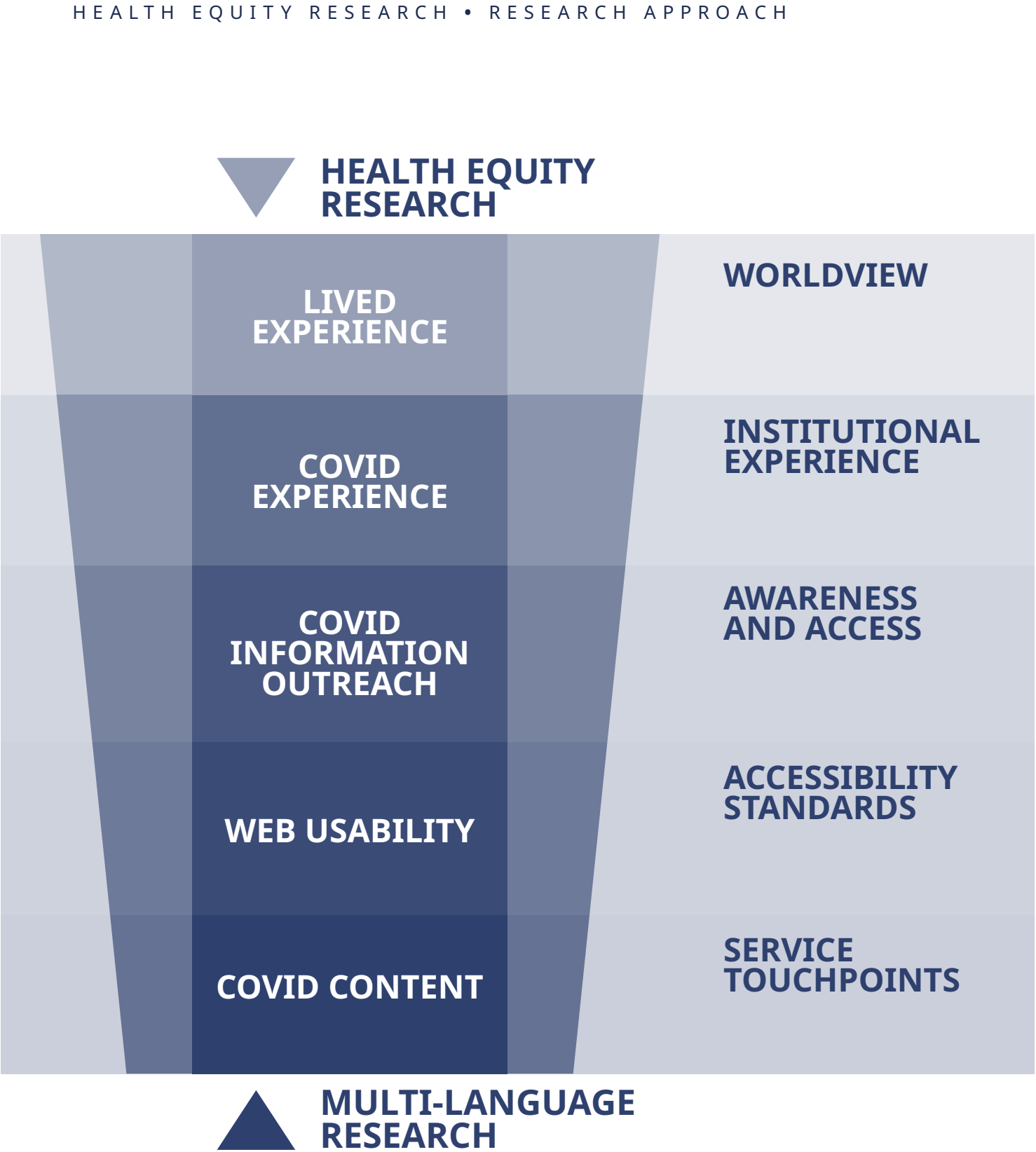


Fig 1. Health Equity Research Approach

HEALTH EQUITY FRAMEWORK

This project sought to increase understanding of behaviour and experience of people facing barriers to accessing the COVID vaccine so government content and services could better meet their needs. To take a health equity lens to understand COVID vaccine access, we developed a health equity framework to determine which groups to prioritize in our research. We referenced federal health equity frameworks as well as COVID specific indicators that assessed risk and impact of COVID to determine groups that face amplified barriers to access and experience multiple factors that lead to disproportionate negative impacts. We created a cross-referenced framework with Identity factors on the x-axis and indicators of health (COVID) inequity on the y-axis.

The process of prioritization was done by using data to fill in each intersection of identity factor and inequity indicator. For example, at the intersection of occupation (identity factor) and risk of acquiring infection (indicator), we identified sex workers, long-term care staff, folks in the service industry, and other folks who can't work from home, had an increased risk. We prioritized groups that emerged at multiple intersections and faced multiple barriers to equitable healthcare (and COVID vaccine) access. These were: migrant or undocumented workers, folks living or working close to the street, and youth in or aging out of care.

IDENTITY FACTORS

Place of Residence	Race / Ethnicity	Occupation	Socio-economic status	Housing
Gender	Age	Education	Religion	Ability

INDICATORS OF INEQUITY

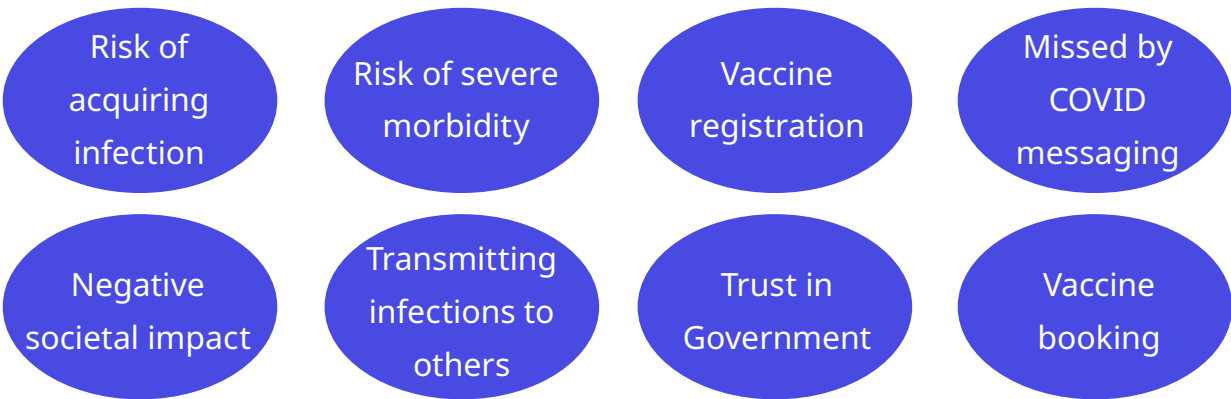


Fig 2. Identity Factors and Indicators of Inequity Used

IDENTITY FACTORS

HOUSING		OCCUPATION	
COVID INEQUITY INDICATORS TRANSMIT INFECTIONS TO OTHERS	Living in Shelter or Communal Housing	Transient Folks	Sex Work
	Prisons, Rehab centres	Unable to Self-isolate	Can't Work From Home
	Large and High Number Households		Factory Workers, Grocery Stores
			Frontline Staff, Essential Workers

Fig 3. Example section of health equity framework

METHODS

This project relied on a mix of quantitative and qualitative primary and secondary research. We began with secondary quantitative research, by collating different data sets, including provincial demographic data, vaccine booking and registration data, etc. Secondary research also included important reports on the COVID experience for various groups, including migrant workers, youth in or aging out of care, and sex workers.

Qualitative research included one-on-one coffee chats or informal interviews with community organizations. A rough interview guide was developed to better understand community partners, how they've been supporting folks (before and) during COVID, and what value this project could offer to each organization.

RESEARCH RECRUITMENT AND KEY PARTNERS

Our research recruitment approach focused on engaging with community support organizations and partners to provide key insights into the populations and communities we focused on. This was important step in trust building and consent-seeking knowing that these groups have

histories of mistrust and over-engagement, while also recognizing our role and positionality as researchers with the government might pose the risk of (re)traumatizing and unsafe spaces.

LIMITATIONS OF OUR RESEARCH

Given our extremely small sample size, our research is not comprehensive or a reflection of every individual's experience. The scope of the project was also a limitation as government largely focused on digital channels of information sharing (e.g. website, social media, etc.) The team faced limitations on what we could build and where we could implement. This limited the project team's ability to respond to the challenges that emerged in our qualitative research, such as the need for low-barrier mobile clinics in the Interior.

Another limitation was the lack of time and structure allowed for trust-building. The project was originally designed to facilitate deep collaboration with community organizations, moving at the speed of trust. However, due to a short timeline and no existing community collaboration structures, the project team had to pivot from a co-design project to a strictly research and opportunity identification project.

RESEARCH QUESTIONS

The two main research question guiding this project were:

- 1. How can government provide equitable access to health content, information, and services?**
- 2. How do existing health inequities impact how underserved populations access COVID information and services?**

PART TWO

FINDINGS

KEY THEMES FOR UNDERSERVED GROUPS

Access to COVID vaccine information and services is directly impacted by the systemic and structural barriers faced by underserved groups. Through our research, we learned about 3 main groups:

- Migrant workers and undocumented folks
- Women living or working close to the street
- Youth in or aging out of care

The key themes that emerged across all groups were:

1. Layers of mistrust exist as these groups have faced systemic discrimination and abuse at the hands of formal institutions. These experiences make folks feel unsafe and/ or uncomfortable in institutional and healthcare spaces
2. Their lived experience impacts how they choose to access services and information. These decisions are driven by who folks trust to support them without harming them
3. There is a shared lack of agency felt by most folks because government and other institutions have dictated many decisions.
4. Folks trust and rely on local supports (drop-

ins, outreach workers, community-based services), who are often also key sources of information.

The following illustrations compile project findings about each group's lived experience before and during COVID. Through this project, the team learned the importance of grounding folks' experience during COVID in the context of their lived experience before COVID, especially the systemic barriers and challenges they faced.

INFORMATION CHANNELS AND PATHWAYS

Key common channels of information for these populations are predominantly in-person channels. The team consistently heard about the importance of information shared through word-of-mouth from multiple sources, including at drop-in centres, through peers, or social workers.

Information found in physical spaces were also favoured, especially when receiving in-person services. For example, bulletin boards, food banks, and pamphlets at Service BC were mentioned as possible points of information sharing.

For migrant workers especially, some information was shared through social media and news from their home countries. This could be shared through their own peer networks, over Whatsapp or WeChat, but focused on communications from the home country.

WHAT ARE CONTEXT PROFILES

Context profiles are qualitative design method of conveying how a set of systemic barriers and specific circumstances might intersectionally impact one's experience of systems, namely, government/institutional services and programs.

WHAT ARE JOURNEY MAPS

Journey maps are a design artefacts used to help map out the steps of someone's experience or service journey.

These maps highlight the key challenges, working wells, and opportunities to improve the vaccination experience.

CONTEXT FOR MIGRANT WORKER BASED IN THE INTERIOR



A migrant or undocumented farm worker based in the Okanagan

“*I’m worried I could lose my job and be deported for missing work because of a vaccine appointment.*”

Fig 4. Context for Migrant Workers in the Interior

SYSTEMIC BARRIERS

Power imbalance

Dependent on employer for all access to services and resources – visa status tied to employer

Surveillance & control

Lack of mobility, often limited to farm

Disconnected from healthcare services

Lack of permanent resident status or MSP

Lack of PR and labour rights

No knowledge of protections and rights as an undocumented worker

How are they experienced and felt?

Fear of deportation

Uncertainty and constant fear of what will affect status or livelihood

Fear of COVID & getting sick

Unable to pay cost of private healthcare, Unaware of Canadian healthcare system, poor access for folks in remote areas

Isolated & disempowered

COVID quarantined in a foreign country, disconnected from family and friends, unable to leave place of work to access healthcare and support

VALUE-BASED NEEDS

Assurance of safety

Ability to make informed decisions without impacting status

Familiarity

Trusts info and support from home country, in their first language

Economic stability

Having work to support family overseas

Language and cultural barriers

Lack of access and awareness of supports (translation, navigating Canadian systems)

What could it look and feel like?

No personal information collected

Formal institutions don’t require names, addresses, or anything that could be used against undocumented folks
Fear of COVID & getting sick

In-language information

Translated information and services available

Access to PR, MSP, etc.

Increasing access to legal status and frameworks of protection

Connection to Canadian services and resources upon arrival

Providing information about healthcare, legal clinics, and others at the airport or Service BC



JOURNEY FOR UNDERSERVED GROUPS

JOURNEY OF A MIGRANT WORKER
BASED IN THE INTERIOR

Legend

💡 Opportunities

(Mis)trust theme

✅ Working Wells

👤 Touchpoint/Channel

⚠️ Challenges

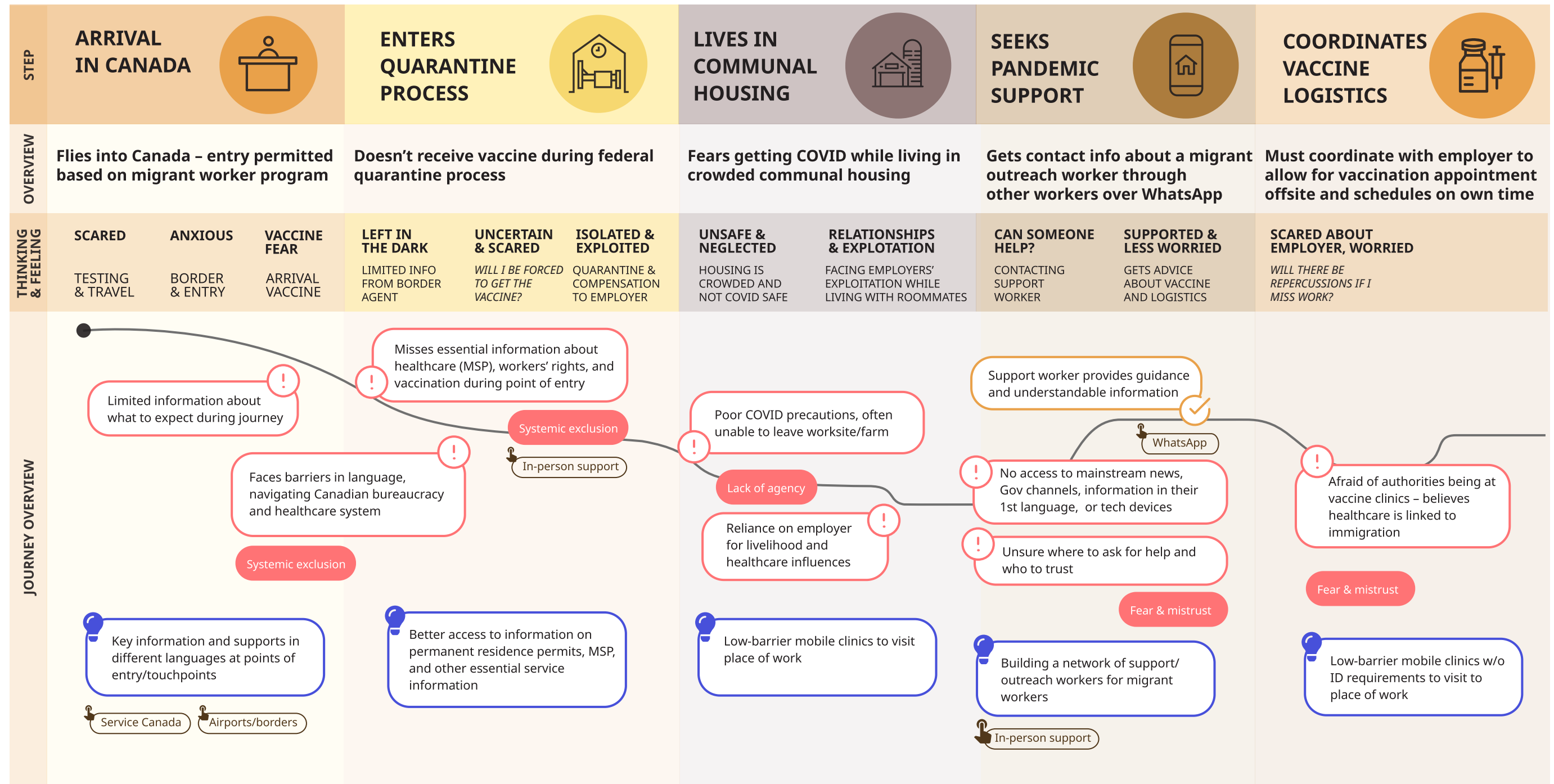


Fig 5. Journey for a Migrant Worker Based in the Interior

CONTEXT FOR YOUTH IN OR AGING OUT OF CARE



A young person based in rural BC transitioning out of the government care system

“ *I haven’t had good care experiences. My interactions with the government reps leave me feeling that I haven’t heard or helped me in the ways I need.* ”

Fig 6. Context for Youth In or Aging out of Care

SYSTEMIC BARRIERS

Systemic discrimination

History of intergenerational trauma, colonial, racialized, and gender-based violence

Lack of agency

Inability to make own decisions about their health and body

Institutional trauma

Poor experience with gov institutions (MCFD, healthcare system, etc.)

Lack of stability

Being left out, feeling transient between care support system

How are they experienced and felt?

Trauma

Exposure to re-triggering/traumatizing events, being in clinical or dehumanizing spaces during transition

Unheard & disempowered

Not being included in decision-making spaces, unable to make own informed decisions

Mistrust

Fear and skepticism of institutions due to poor past experiences

VALUE-BASED NEEDS

Being included and heard

Having a say in decision-making that affects their lives

Agency & Autonomy

Ability to make own informed decisions

Safe, peer-led spaces

Spaces for dialogue and community with youth and trusted support workers

What could it look and feel like?

Youth advisory council

Giving youth voice in information, service, and policy decision-making processes

Spaces to ask questions

Opportunities for open dialogue to discuss fears, hesitations, perceptions, etc.

Youth-led information sessions

Youth leading spaces for dialogue and sharing information with each other; connecting to services and resources available to them



JOURNEY FOR UNDERSERVED GROUPS

JOURNEY FOR YOUTH IN OR AGING OUT OF CARE

Legend

(Mis)trust theme

Touchpoint/Channel

Opportunities

Working Wells

Challenges

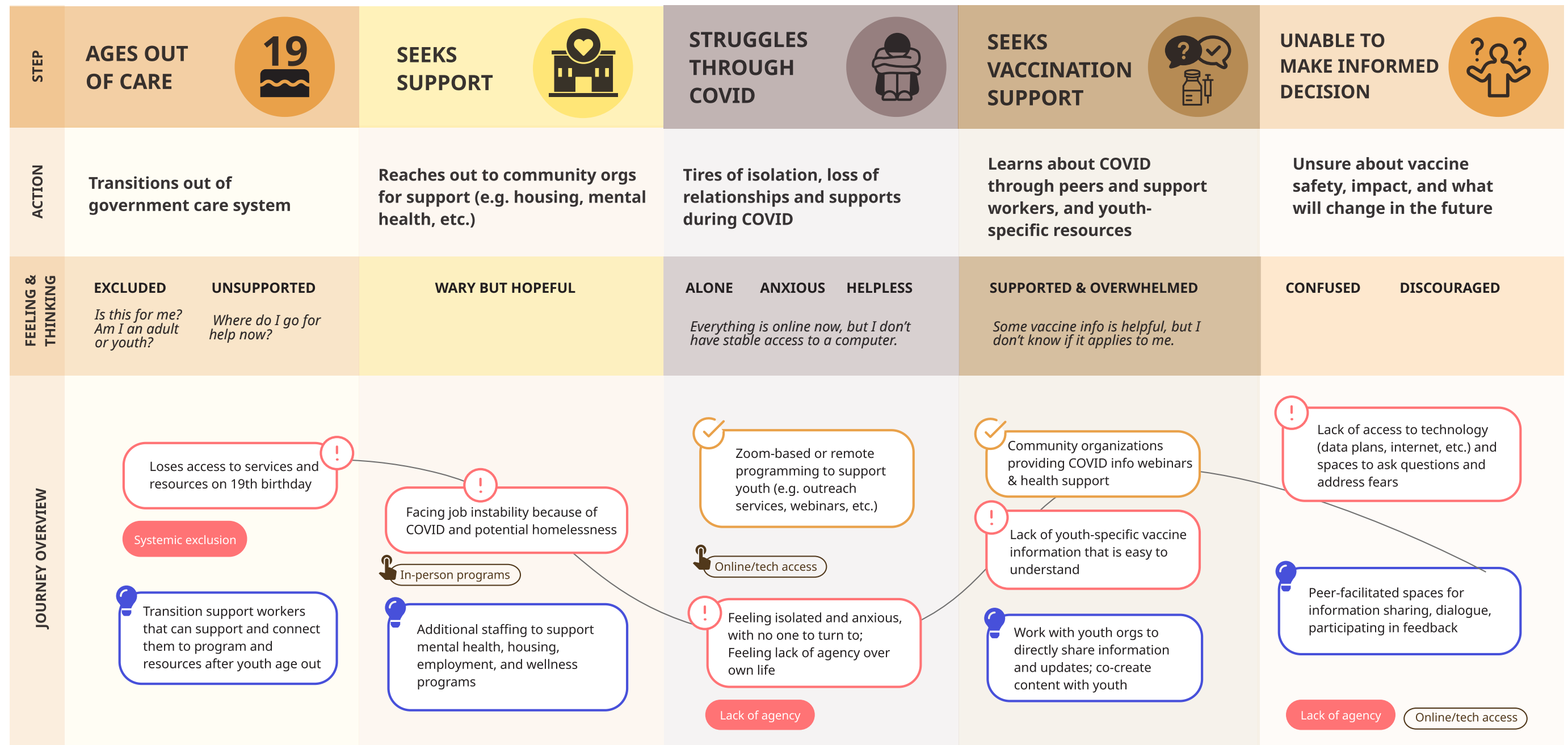


Fig 7. Journey for Youth In or Aging out of Care

CONTEXT FOR WOMEN BASED IN THE NORTH WORKING OR LIVING CLOSE TO THE STREET



Someone who identifies as a sex worker in Prince George facing precarious housing and neglect from healthcare

“We’ve been told what to do our whole lives. The vaccination feels like another thing we don’t have a choice over.”

Fig 8. Context for Women Based in the North Working or Living Close to the Street

SYSTEMIC BARRIERS

Discriminatory institutions

History of being turned away, abused, and dismissed by government healthcare and authorities

Lack of agency

Inability to make own decisions about their health and body – stigmas perpetuated by social biases

Abuse & trauma

Intergenerational trauma, colonial, racialized, and gender-based violence

How are they experienced and felt?

Unsafe & unheard

History of being turned away, abused, and dismissed by government healthcare and authorities

Disempowered

Lack of access to information and support in trusted spaces amplifying inability to make own informed decisions

Fear & mistrust

Poor past experiences with healthcare, government, and authorities leading to reliance on own community & support orgs

VALUE-BASED NEEDS

Feeling heard & understood

Support and comfort from familiar and trusted people, feeling seen from trauma-informed and context-inclusive perspective

Agency & Autonomy

Ability to make own informed decisions about their body and type of healthcare

Safe spaces

Reliable and non-judgemental spaces for care, shelter, and community

What could it look and feel like?

Trauma-informed staff

Frontline government and healthcare staff with trauma-informed training to meet folks where they are

Safe spaces to ask questions

Opportunities to ask questions about risks, perceptions, and impacts of service in trusted spaces

Co-locating services

Co-locating essential healthcare services in already trusted spaces, with opportunities to build trust and relationships



JOURNEY FOR UNDERSERVED GROUPS

JOURNEY FOR WOMEN BASED IN THE NORTH WORKING OR LIVING CLOSE TO THE STREET

Legend

(Mis)trust theme

Touchpoint/Channel

Opportunities

Working Wells

Challenges

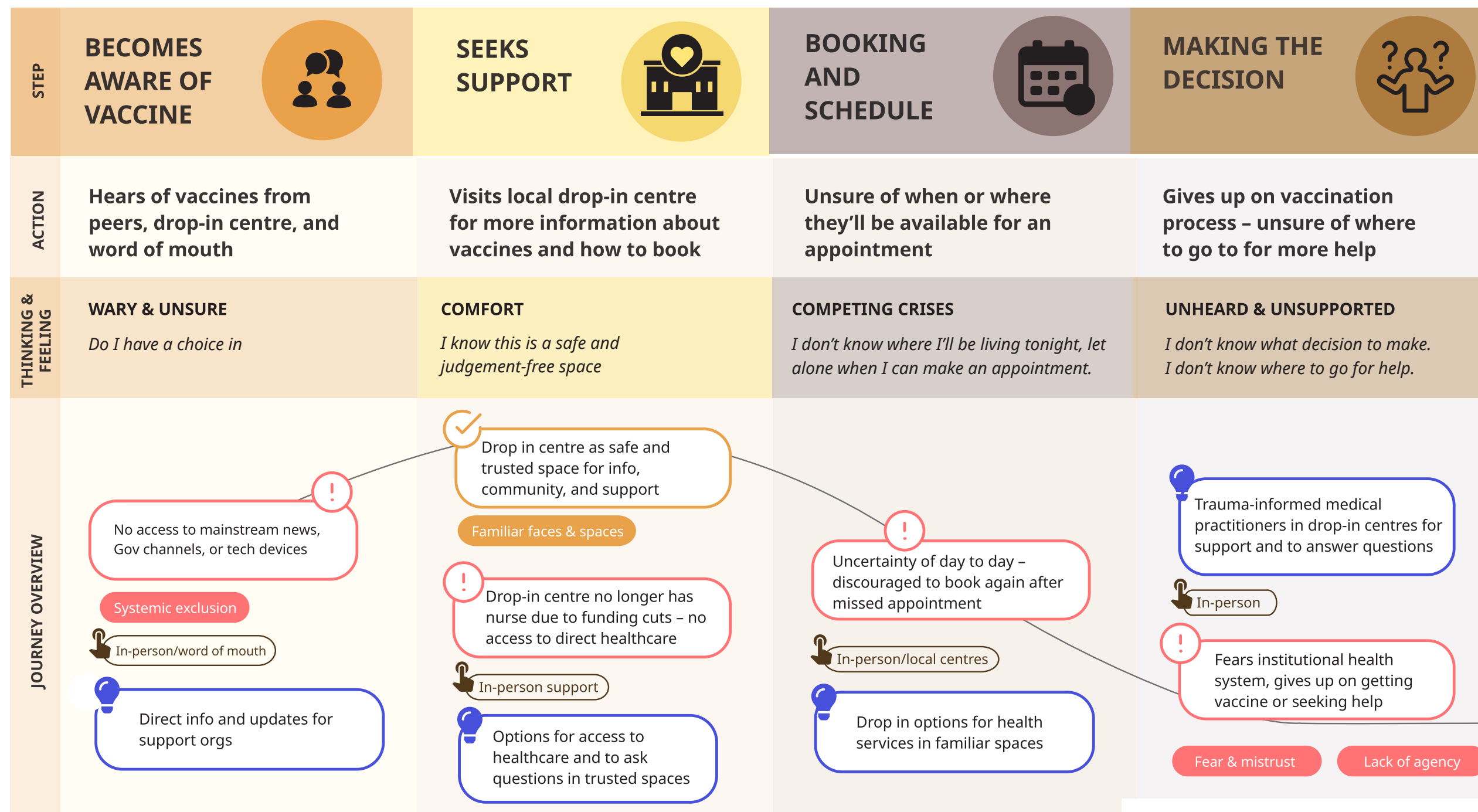


Fig 9. Journey for Women Based in the North Working or Living Close to the Street

KEY THEMES FOR COMMUNITY ORGANIZATIONS

Support organizations are a vital point of connection and support for B.C. residents. Prior to and during COVID, they have done the work of providing key services to folks and helping them navigate complex government services. We spoke to two types of support organizations:

- Direct support organizations, that provide direct service delivery to meet changing needs of the folks they serve (e.g. outreach programs, drop-in programs, counselling, etc.)
- Umbrella support organizations, that consist of and coordinate information-sharing and collaboration across a membership of direct support organizations.

Both types of support organization do vital work in filling gaps left by government services, especially for historically underserved populations. The key themes that emerged from learning from both types of support organizations were:

1. Chronic under-resourcing of organizations that support underserved populations, particularly in the North, have been exacerbated during COVID

2. COVID has helped to establish connections between organizations working at different levels (e.g. local, regional, province-wide)
3. Support organizations are key resources and channels of information-sharing for populations that mistrust government and other formal institutions

INFORMATION CHANNELS AND PATHWAYS

Support organizations are key actors and connectors in information pathways between the provincial government and B.C. residents.

Umbrella support organizations, particularly during COVID, have been connected to government channels through large outreach email blasts, government working groups, cross-sector meetings, etc. They have played a key role in translating and sharing that information with their members, who provide direct support to B.C. residents, through meetings and COVID information roundup emails.

Direct support organizations have been filling key gaps in service, especially for communities

that have been disproportionately affected by COVID.

They've been staying updated on changing news and guidelines through a variety of sources, especially email blasts, participation in cross-sector tables, and select websites. Their methods of sharing information out with the people they serve has shifted during COVID, as much of it was in-person prior to the pandemic. In the past year, support organizations have been sharing information through:

- Whatsapp groups
- Emails and phone calls
- Infographics shared through emails, Whatsapp, social media, and websites
- Fact sheets and guidance documents

These channels are a result of the work done by direct support organizations to understand the most effective ways of sharing information. Identifying these channels is an important step in understand the opportunities available for organizations/ teams inside and outside government.

COMMUNITY SUPPORT PROVIDER



Person from a support organization who works directly with community members (e.g. outreach worker, front-line support staff, etc.)

“Some of our clients have experienced trauma and have other competing crises. COVID isn’t a priority for them and they don’t have the attention to look for info – we try to keep it safe and simple for them.”

Fig 10. Context for Direct Community Support Organizations





JOURNEY FOR SUPPORT ORGANIZATIONS

JOURNEY FOR COMMUNITY SUPPORT PROVIDER

Legend

Opportunities

(Mis)trust theme

Working Wells

Touchpoint/Channel

Challenges

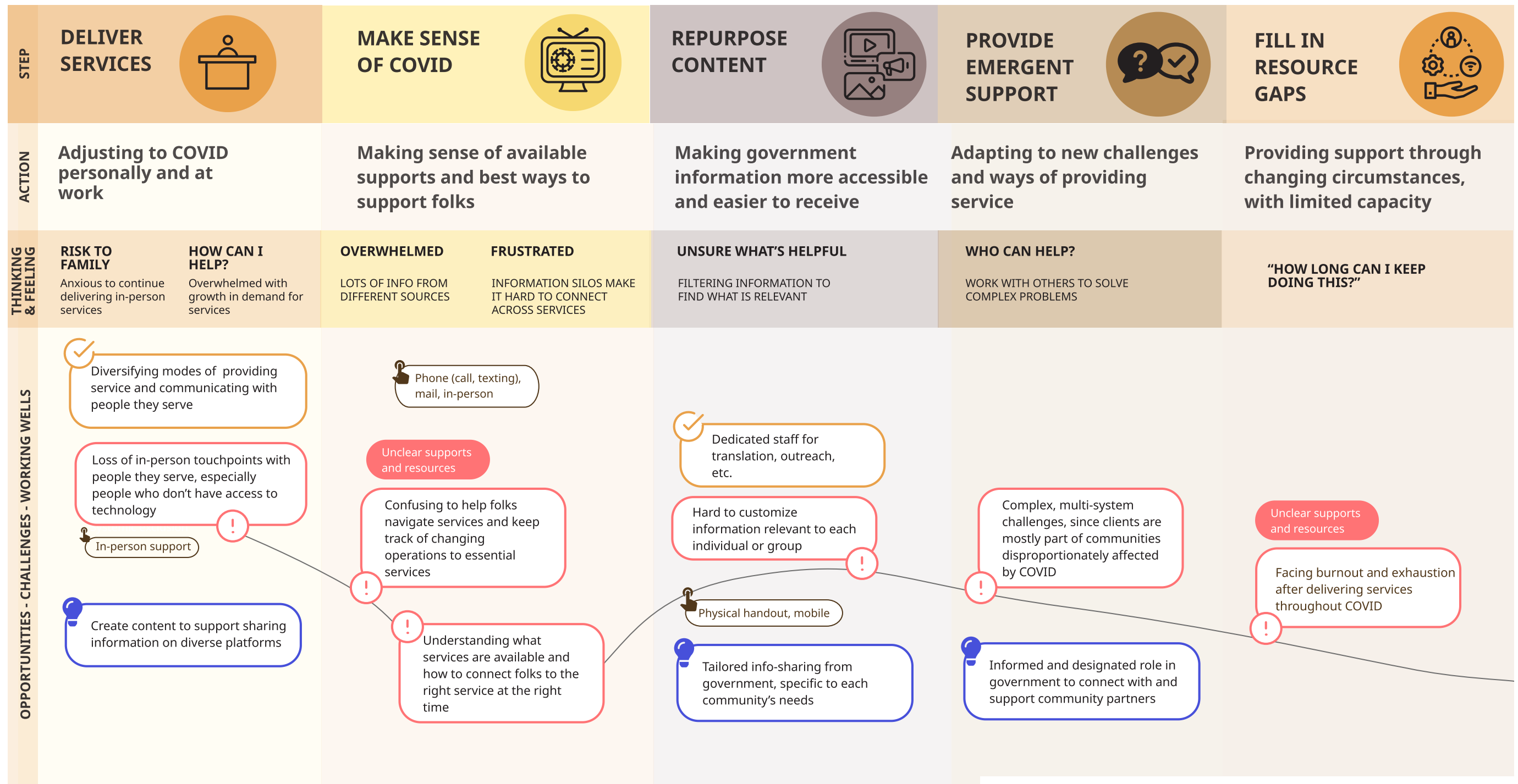


Fig 11. Journey for Direct Community Support Organization



CONTEXT FOR SUPPORT ORGANIZATIONS

JOURNEY FOR UMBRELLA SUPPORT ORGANIZATION

Legend

(Mis)trust theme

Touchpoint/Channel

Opportunities

Working Wells

Challenges

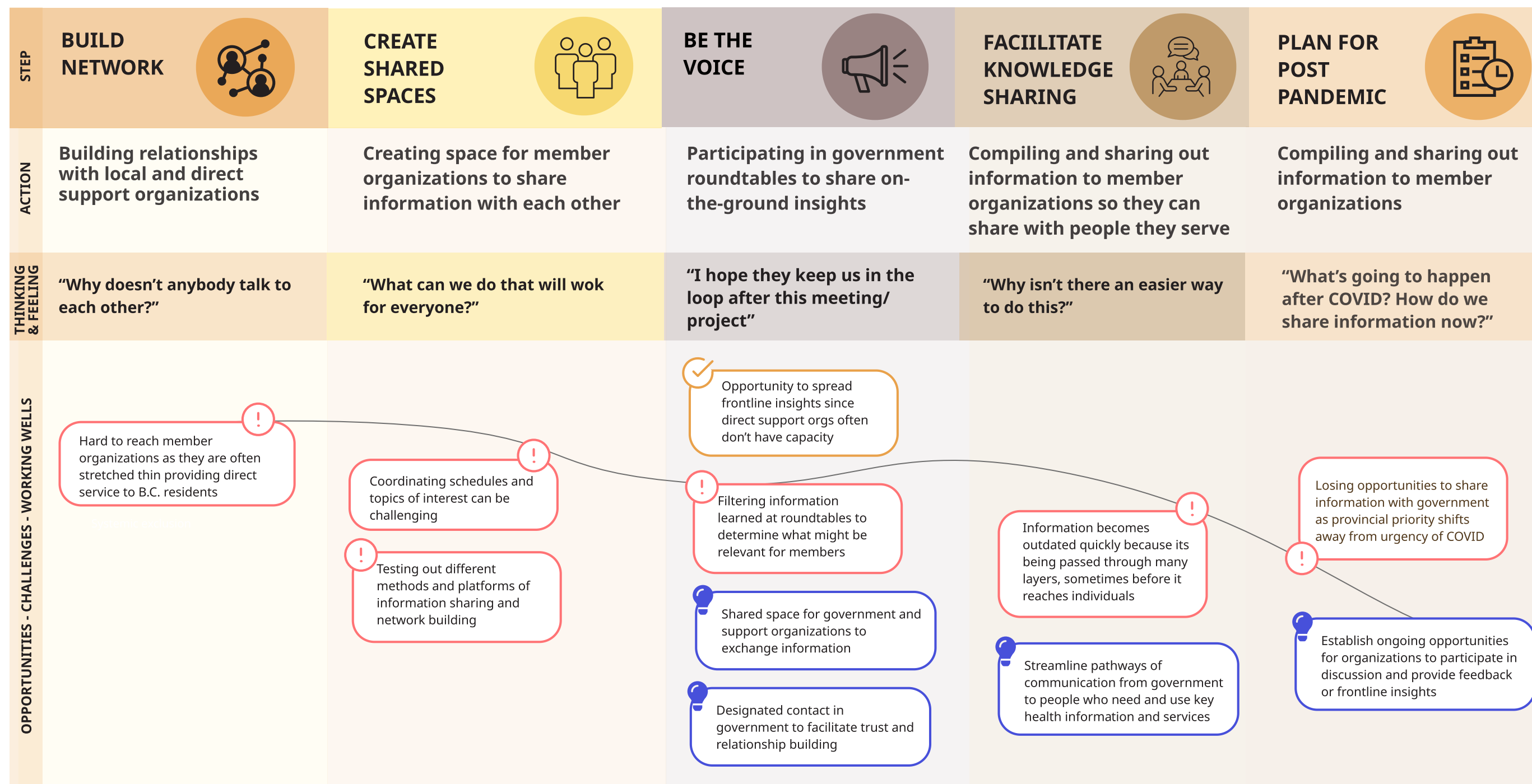


Fig 12. Journey for Umbrella Support Organization

TRUST FRAMEWORK

This trust framework is a result of the past two and a half months of design research. The project team puts forward this framework to propose that access to government/ health information and services is actually dictated and impacted by an individual or group's past experience with the government and what and who they trust to ask for help.

Three layers exist in the framework: experience, access to service (touchpoints), information channels.

- Experience: Experiences heard across groups when trying to learn about or access key healthcare or government services
- Access: Services that can be and are accessed – experience can often create barriers in what folks think they're entitled to access or other perceptions of how and what they can access
- Information channels: Trusted and commonly used channels for information sharing



Fig 13a. Trust Framework Overview

HOW TO USE THE TRUST FRAMEWORK

This framework can be helpful in understanding where barriers to service exist when and where there is (mis)trust.

Working from the inside out, you can see how an experience impacts where people go for support, and where these points of access then impact where information is shared and received.



Fig 13b. Applied Trust Framework

TRUST FRAMEWORK CONTINUED

This project originally asked questions about how the government website was connecting (or not connecting) B.C. residents to important COVID information. However, through the course of the work, the project team learned that the government website was not an effective way of reaching folks facing existing systemic health inequities. Existing access to essential services and trust in government are key elements in determining if and how folks access vaccine information.

The trust framework illustrates the need to first address the systemic, racial abuse and discrimination folks face/ have faced while accessing key government and health services before prioritizing digital channels of information sharing.

OPPORTUNITIES

We've identified opportunities grounded in each of the key populations we've learned about through this project. In this space, we will highlight key themes that have emerged across all groups as opportunities for governments to better support these groups.

1. Ongoing dialogue and feedback
2. Targeted or customized messaging
3. Community relations coordinator
4. Enhanced capacity in government to design for equity with communities

Ongoing dialogue and feedback

COVID has provided precedents and validated a growing need to intensify communication both ways, from residents to government and from government to B.C. residents. This requires building and maintaining infrastructure (e.g. relationships with community organizations, feedback mechanisms, etc.) to support communication between parts of government, health authorities, various types of community organizations, and B.C. residents themselves.

Creating strong pathways of communication will allow government to understand and address the changing needs of B.C. residents.

It will also allow government to provide space for important conversations about systemic barriers and how to improve access to and experience of key services.

Targeted or customized messaging

As support organizations adapt to meet emerging needs of the people they serve, much of their time is spent pulling information from different sources and customizing it for each distinct group. There lies an opportunity for government to create customized messaging for groups with different lived experiences to make it easier for support organizations. This requires the communication infrastructure from Opportunity 1, so government teams are kept up to date on how services are being accessed and experienced and can develop messaging to respond to those.

Customized messaging from government will vastly improve the experience for community organizations and the people they serve. It will allow support organizations to better connect underserved populations with the information and services they need and increase the reach of the information itself.

OPPORTUNITIES CONTINUED

Community relations coordinator

Another impact of COVID has been the building of cross-sector tables, which has validated the importance of relationships across government and civil society. There is a key opportunity around a position in government to facilitate the relationship building and information sharing required to properly reach and support underserved populations. This coordinator position would be vital in making connections with community organizations, helping to customize messaging for different lived experiences and creating platforms to share information both ways.

Embedding positions in government to build and maintain relationships with support organizations allows space to build the infrastructure needed to sustain the information networks created during COVID. This is a vital element in earning the trust of historically underserved populations, who don't often see their needs being prioritized in government decisions.

Enhanced capacity in government to design for health equity with communities

Design research and service design gives government some of the tools to work towards systemic change (e.g. health equity, improved service access and experience, etc.). However, this project has emphasized the need for stronger infrastructure to support that work, especially when collaborating with communities. This includes a multidisciplinary team of design researchers, health practitioners, communication specialists, community relations coordinators, and other staff to confront the layers of systemic inequities and collaborate within and outside of government to design better service / system experiences.

Developing capacity for teams to do this work means starting from and addressing systemic challenges with communities that live with these inequities. This infrastructure would need to give teams appropriate time and resources to do deep community-based work, including compensation options for community partners to be embedded in the team. Support from leadership, in the form of guidance, direction, and clearing obstacles, is necessary for this type of work to be successful. This infrastructure is an important step to support embedding a health equity mandate in B.C.'s post-pandemic services.

Thank you for reading this report.
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