



National
Adult and
Influenza
Immunization
Summit

Advancing Immunization Equity Through Research and Evaluation:

An Inventory of Promising Efforts Now Underway

August 14, 2024



Executive Summary

This document is a collaborative effort of the Equity Working Group of the National Adult and Influenza Immunization Summit (NAIIS). The purpose is to identify recently completed and emerging research and evaluation projects that are assessing vaccine equity interventions. The document provides easy access to intervention designs and evaluation methodologies applied for each project, as well as the measured results. In addition, it offers a discussion of what can be learned from recent vaccine equity efforts and provides considerations for future directions to establish the evidence base needed to implement effective vaccine equity interventions.

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Introduction

ABOUT THIS REPORT

The immediate, devastating and disproportionate impact of the COVID-19 pandemic on people of color, [low-income families](#), and other vulnerable populations has led to rapid investments in vaccine equity programs. Not only were rates of COVID-19 infections, hospitalizations and mortality higher among people of color, those with disabilities and those with lower incomes, but these groups also faced significant hurdles in accessing and building confidence in vaccines.

Without the basic health protections afforded by vaccinations, disadvantaged communities confronted additional risks to their lives and livelihoods.

Families who had household members with jobs in “critical service areas,” such as transportation, health services, grocery or pharmacy activities, for example, had higher rates of morbidity and mortality from COVID-19 which presented a dramatic public health risk to workers’ families.

Legislators, immunization experts and community leaders met the urgency of the pandemic moment, including a recognition of the inequities in COVID-19 illness and vaccination, with creativity and innovation.

They financed, designed and adapted thousands of interventions at the national, state, local and hyperlocal levels aimed at improving access to and confidence in vaccinations, and responding to community-based concerns about development and production of COVID-19 vaccines. Many of these programs specifically focused on improving vaccine equity as a central component of health equity.

Since then, much has been learned about what drives vaccine equity, but the emerging evidence remains scattered and hard to compare, and no playbook for how to design and evaluate vaccine equity programs at scale exists.

In spring 2024, the NAIIS Vaccine Equity Group embarked on an effort to summarize and contextualize the emerging evidence supporting strategies to improve equity, and articulate insights on how to move the field forward. This report captures the group’s conversations, reviews and key take-aways, and includes an inventory of recent vaccine equity research and implementation projects.

*Establishing the evidence-base
for what works best to increase
vaccine equity in racial and
ethnic communities.*

— CDC



WHAT IS VACCINE EQUITY?

Vaccine equity is an element of health equity. Vaccinations against diseases such as measles, polio, and diphtheria have saved millions of lives since their introduction and have led to dramatic improvements in life expectancy.

The benefits of vaccines, however, have historically not been shared equally across the globe or within the United States. Rates of adult vaccinations against some diseases show significant disparities by population.

The COVID-19 pandemic demonstrated how patterns of inequity and clustering of conditions disproportionately affect some populations, resulting in worse health outcomes for these populations. It also demonstrated that concentrated intentional efforts could reduce these inequities.

Equity leaders have advocated for a framework for vaccine distribution and demand generation that bases investment and prioritization decisions on protecting those at highest risk for exposure and those who are experiencing the worst outcomes from a disease. This framework applies both during an outbreak of a novel disease or in the ongoing fight against endemic diseases.

The determination of a higher risk of exposure to infection or of severe illness can be due to many factors—such as age, increased exposure at work, structural disparities or economic status, among others. COVID-19 for example hit people with chronic illness such as diabetes, asthma and obesity especially hard—conditions that disproportionately affect Black and brown Americans. Consequently, vaccination campaigns in communities of color were prioritized once these disease dynamics became known. Equity advocates, however, point out that there is sufficient evidence to show that vulnerable populations are consistently faring worse in disease outbreaks, and should have been prioritized from the beginning.

One common way in which vaccine equity is measured is by collecting data to understand the differences in vaccination rates along racial and ethnic groups. For example, [a recent government report](#) notes that vaccination rates for Black or African American and Hispanic or Latino adults were about 13% below that of White adults for each of four adult vaccines.

It is important to note that differentials in vaccination rates along racial and ethnic parameters is an essential but only one of several ways to conceptualize, measure and understand vaccine inequities.

The work group noted for example that focusing on race and ethnicity alone misses persons such as those who don't fit easily into one racial or ethnic group, LGBTQ+ persons or persons with disabilities, or persons who are facing adversities such as housing insecurity or economic hardship. When exploring vaccine equity, it is essential to measure outcomes for all vulnerable populations affected by the disease.

Paying attention to disproportionate outcomes is another important way to measure vaccine equity. Work group members pointed out that for example comparing vaccination rates of Black people to those of White people is inadequate if Black people are dying from a disease at twice the rate of White people.

To achieve equity, vaccination rates amongst populations that face a higher burden of disease should also be higher.

The focus of meaningful equity, then, centers on achieving high rates of vaccination access and demand for all communities. Once the variance across populations is addressed and all individuals residing in the United States have equal opportunity for vaccination, comparisons to white populations become unnecessary. In this context,

it is important to consider root causes among undervaccinated populations, including lack of trust in institutional vaccination campaigns due to both historic and more recent exploitation and political targeting of specific populations.

In a nutshell, vaccine equity is about providing access to and generating demand in long

established vaccines and new vaccines for all populations, with a priority on those populations who need the protection from a given vaccine the most.

In this report, we focus on vaccine equity in the United States.

ABOUT THE NAIIS

[The NAIIS](#) is dedicated to addressing and resolving adult and influenza immunization issues and improving the use of vaccines recommended by CDC's Advisory Committee on Immunization Practices. The NAIIS consists of over 700 partners, representing more than 130 public and private organizations, its three main sponsors are CDC-National Center for Immunization

and Respiratory Diseases, Immunize.org and HHS Office of Infectious Disease and HIV/AIDS Policy. Over a 20-year period, the NAIIS has supported numerous workgroups, that have coalesced many partners over time to address emerging immunization issues that impact the implementation of ACIP recommendations.

ABOUT THE VACCINE EQUITY WORKING GROUP

This document summarizes conversations and insights of the NAIIS Equity Working Group of the National Adult and Influenza Immunization Summit from March to July 2024.

The Working Group's purpose is:

- To exchange information about best practices to achieve vaccine equity.
- To support community-based organizations and the vaccine conversations their trusted messengers have in their communities.
- To collaborate on an inventory of vaccine equity evaluation efforts.

Past NAIIS Equity Group Activities include:

["Community-based Organizations and Trusted Messengers: An Approach for Reducing Immunization Disparities."](#)

["Spotlight on Adult Immunization Disparities"](#)

Co-Chairs: Susan Farrall at HHS-National Vaccine Program, Office of Infectious Disease and HIV/AIDS Policy, and Synovia Moss of Good Health Wins, National Council of Negro Women.

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DISCLAIMER

Information included in this report represents the observations of the working group members or information that is publicly available. It does not represent the official positions of the organizations or any working group participant and it does not constitute an endorsement of any organization or organization's product.



What have we learned about the drivers of effective vaccine equity interventions?

SUMMING UP SOME TRUTHS

The swift and national response to the United States' COVID-19 vaccine equity challenges provided a proof of concept that it is possible to reduce disparities in vaccination rates and disease outcomes. While the underlying drivers of vaccine inequities are complex, the collective efforts resulted in improved vaccination rates for high-risk populations, as well as improved outcomes for these groups.

When comparing and contrasting their experiences implementing and evaluating vaccine equity interventions, members of the NAIIS Vaccine Equity Working Group identified several key learnings and drivers of success:

Evaluations have to serve the people a program aims to support.

When designing a program evaluation, a key principle is to define an operational definition of the population(s) of focus and establish the core challenges and priorities of each population of focus. **It is essential to ensure that the evaluation is aligned with what is meaningful to measure for each specific population.** This starts with understanding the health impact of the disease and vaccination rates among the population of focus wherever possible and continues with investigating what the unique barriers to vaccination may be for that population. For example, when vaccines are available predominantly through physicians' offices, pharmacies and medical clinics, understanding what proportion of the target population does not have access to, ability to absorb the cost of services from, or trust in the healthcare system is essential. Vaccine equity work is particularly concerned with people who are often not reached by or entirely covered by standard healthcare insurance and delivery systems.

A “vaccine hesitancy” framework can impede our ability to focus on equity and system-level barriers to vaccination.

Throughout the COVID-19 pandemic, a strong focus on “vaccine hesitancy” resulted in significant underinvestment in programs that increase access and vaccine demand. A “vaccine hesitancy” framework places the onus of motivation and of accessing the vaccine on the individual, instead of acknowledging and addressing institutional and structural failures and responsibilities alongside individual-level drivers. For people who work several jobs, have few or no sick days and can't afford childcare, for example, the ‘cost’ of taking time off to get vaccinated differs significantly from those who are less pressured for time and resources. **Being labeled ‘vaccine hesitant’ further alienates individuals confronting these challenges and confirms for them that ‘the system’ does not understand their realities.** Vaccine equity programs are most effective when they understand that people's choices are shaped by complex psychological, social, structural and other interacting factors, and apply tools to listen and respond to the unique experiences and realities within each target population. The term “vaccine demand” is increasingly used to describe and study these complex factors involved in people's vaccination journey.

Collaboration with community-based partners is essential for ensuring vaccine equity.

When it comes to vaccine equity, one size does not fit all. Each community and population is unique. The work group observed that a common feature of successful vaccine equity programs is that the partner is a part of or knows the population well.



Local organizations and leaders who are in relationship with residents and neighbors have a deep knowledge of common concerns, questions, challenges and communication preferences; they know the history of their community and how people have interacted with local systems and institutions, from the local police to local policy makers. They know peoples' aspirations, how they care for each other, and what it looks like to be in solidarity with them, which makes local organizations and community leaders experts in building and sustaining the trust central to vaccination.

Potential partners range from organizations serving specific groups, such as the elderly or people with disabilities, to churches to place-based community organizations and more. Strategies for immunization programs to engage partners consistently include community advisory boards, periodic focus groups with community members, and collaborations with specific organizations.

Engagement should start with and periodically include listening to what these partners and the populations they serve are experiencing, so immunization programs can understand how the vaccines fit into people's lives at baseline and over time. Next to standard listening methodologies such as focus groups and community conversations, additional approaches such as peer research methods have been found to enable more open conversations, decrease the potential for misunderstanding, and provide access to 'less heard' voices.

Funding organizations and researchers can further facilitate impact by applying resources and convening power to enable ways for partners to talk to each other, for example by establishing and supporting communities of practice, and ways for partners to create collaborations amongst each other.

Evaluating vaccination programs and their impact on equity has long been the domain of academics and professional researchers. Unless local community partners are also engaged in the design and review of the evaluation framework and protocols as well, the commitment to vaccine equity is lost.

Local community organizations play an important role in vaccine equity work. In a nation with few safety nets, particularly for the working poor, they provide essential support for people on a number of challenges including affordable housing, food security and access to healthcare and other social determinants of health. Community organizations often do this work on a shoestring budget, and bring in-depth community knowledge that is essential to success, including when and how the vaccine fits into community members' lives alongside other urgent priorities. Equity Group members observed that evaluations of vaccination programs must be responsive to funder needs for accountability and stewardship and also must assess the metrics of success as defined by the community itself. Specifically, group members have had success with the following strategies:

- **Integrating the community knowledge that partners bring when considering which communities to focus on and how. Including partners in decisions about what data will be collected and why.** This includes explaining why the data is collected and how it is being used, and asking: Does the suggested evaluation approach measure what is most important for your community? For example, community organizations are often asked to count how many vaccine events they have held and how many people attended, when these organizations would also like to measure why people came, if the event had an impact on people's knowledge, attitude and beliefs about vaccines, and if a person ended up seeing a provider about vaccination or to get vaccinated. One Vaccine Equity Group member for example gave community partners an option to write their outcomes of interest into the proposal.



- **Support partner organizations to strengthen their capacity for implementation and evaluation.** Recognizing that community partners may not have the resources, infrastructure or prior experience to evaluate vaccination access and confidence programs or to collect and manage the large amounts of data needed for in-depth studies. Organizations shouldn't be expected to meet the design and reporting requirements of funders without also being given the support needed to strengthen their capacity to implement these programs and collect and interpret data needed for evaluation. True cooperation between trained evaluators and community groups will yield more relevant sustainable findings. The Community Engagement Alliance from NIH is one such example.
- **Be cognizant of the burden of data collection and collect the minimum data possible to fit the purpose.** When designing an intervention, a first thought is often to collect new data. Instead, programs should check if there is existing data to use. It may not be exactly what an evaluator had in mind but may be enough to answer the question(s). This can limit the data collection burden to partners or make space for collecting other important data and retain the focus of a community-level organization on the implementation of the work, which often makes up the vast majority of staff time and effort. The CDC for example has pared down some data requirements to let communities collect more real-time data.
- **Incorporate and build on the resources that are already in place.** Many local partner organizations have a long history in their communities and have stepped up in emergencies or to protect their communities for a long time. Trust and consistency are a resource in itself. The same is true for established, successful ways of working with the community.
- **Provide specific technical assistance and templates for necessary data collection.** When the support is indirect, for example when

working with a larger number of organizations across populations and geographies that report into one data collection system, it is helpful to create offline templates that mirror what is in the online data collection system, to help organizations understand what is being asked. In addition, a phone or email helpline provides ways to problem solve and discuss local solutions to collecting appropriate data.

As one member of the group states in all her work:

"I don't want to get engaged, I want to get married. We have to be in it, together, for the long term."

- **Constant, effective communication is key and supports strong, sustainable partnerships.** Communication tools such as regular office hours, email reminders and support calls have proven helpful to build and maintain relationships, identify questions about program elements or data submissions, and support partners with submitting data as intended and within the agreed-upon timeframe.
- **Engage the expertise and insights of partners in interpreting data and observations and creating meaning from the data.** Throughout the program, it is important to share the data back with partners and share opportunities to discuss the data, so partners can contextualize findings and collaborate on the interpretation and framing of results.
- **Technical assistance to these on-the-ground partners cannot be a one-off.** It needs to be sustained and responsive to changing needs throughout the lifetime of the program.
- **Support for partners should also include building capacity for sustained vaccine equity work.** Partner organizations may need support in applying for additional opportunities



to sustain vaccine equity work with your organization and other funders. This can include support with terminology used in proposals, understanding what organizational status is needed to receive federal, state or foundation funding, and building data collection and evaluation plans from the start with partners that showcase the collaborative achievement of outcomes, moving beyond one-dimensional reporting of metrics to providing dimensional understanding of how the achievements were gained. The Workgroup suggested that these kinds of sustainability efforts should be written into funding opportunities. ***As one member of the group states in all her work: “I don’t want to get engaged, I want to get married. We have to be in it, together, for the long term.”***

Vaccine equity work is fluid and needs to be reassessed at various stages of a vaccine rollout.

Equity group members emphasized the changing nature of vaccination work. During the COVID-19 pandemic, organizations had to adapt their interventions and approaches in real-time. There was value in governments sharing information

transparently and acknowledging that vaccine science and recommendations were constantly evolving. This was important to maintain trust.

In any vaccination campaign, people’s perceptions and understanding may be shifting, and so are the outside conditions. Vaccine distribution, billing and payment complexities and newly emerging vaccination recommendations are all factors that can impact a person’s access to needed vaccines. Physicians’ offices may administer flu but not or no longer administer COVID-19 vaccines, for example. Targeted disinformation may make people with historic mistrust in medical systems vulnerable to new misconceptions about vaccines.

As a result, an intervention and evaluation that worked a year ago may not work now. There are no cookie-cutter approaches to vaccine equity work.

This work must be guided by a constant feedback loop from partners at the front lines in communities, to gain insight on where obstacles present themselves and when, and to understand what types of approaches may be needed at different periods of time to achieve desired outcomes.

RESOURCES

- Vaccinate Your Family: [Supporting CBOs to Reignite a Culture of Immunization – Vaccinate Your Family](#)
- National Institute of Health’s [Community Engagement Alliance Project](#)
- Rockefeller Foundation’s [Infrastructures of Trust: The Case for Building Vaccine Demand](#)
- A Community Guide to Advance Health Equity (available at: www.advancinghealthequity.nnphi.org)

Moving the field forward

ADVANCING VACCINE EQUITY RESEARCH

Members of the Vaccine Equity Working Group acknowledged that the investments made during the COVID-19 pandemic accelerated the development of new methods and set new standards for vaccine equity research. The urgent need to reduce disparities for example enabled federal agencies to work in new ways, including increased flexibility in setting up grants, and in designing and adjusting reporting requirements based on listening and incorporating feedback from partners. Recognizing intersectionality and bringing partners together across fields and silos was another research innovation born out of pandemic need.

The working group members stressed the importance of continuing in this direction, and not “going back to normal.” The group articulated concrete next steps that can be taken by the scientific community—and required by funders—to improve measurements, methods and approaches, and close gaps in the evidence base on effective strategies to improve vaccine equity.

Key opportunities to close current gaps include:

- **Develop more robust evidence on what works, for whom, and in what contexts.** This is essential to guiding budgeting, program planning, interventions and evaluations at all levels—national, state, regional and local. While the CDC Community Guide has served as an important resource to increase immunization rates, investing in the generation of a comparable guide focused on effective vaccine equity strategies would provide essential support for practitioners and evaluators alike.
- **Conduct more granular research that can illuminate distinct aspects of the vaccination journey.** Human behavior as well as vaccination-relevant factors that are outside of the

control of the individual (such as distance to a vaccination site) are complex. As a result, hard evidence on the chain-of-causality—in other words, the direct influence of an intervention on behavior—is hard to generate. The urgency of the COVID-19 pandemic made it particularly difficult to create the conditions necessary for this type of research, which includes methods such as combining formative research with a randomized controlled trial (RCT). The working group also discussed examples such as storytelling, which provides important context not captured in more direct information delivery methods and does show impact but is difficult to demonstrate at scale for broad population impact or for identifying useful links between the intervention and behavior change. Large scale efforts to rigorously apply mixed-methods data compilation and analysis could provide new and important insights for action.

- **Identify and measure the reinforcing elements or the moderating variables of vaccine equity efforts.** For example, many interventions count the number of mobile vaccination clinics that were held. Rigorous approaches are needed to measure the human relationships that were needed for the clinics to take place and have people show up and identify the relative weight of factors such as gatekeeper engagement, partnership presence, and trust created or sustained. Advancing this domain of inquiry can provide critical insight into factors that meaningfully address mistrust or a limited ability to overcome obstacles to meet outcome goals.
- **Build infrastructure and capacity for more qualitative information collection,** which provides important insights on hard-to-measure aspects such as interpersonal dynamics and factors that may be invisible in quantitative evaluation tools. For example, most surveys



on barriers to vaccination currently overlook response options and limit their data collection by not providing an open text box where people may write in a barrier which may be different from what is on the list of options. Closed-response options contain an embedded assumption that survey creators knew all potential responses, which is not possible. While larger-scale qualitative approaches (such as story gathering, focus groups, interviews, or photovoice projects) can create high value datasets, open-ended questions on survey research are a relatively inexpensive and easily manageable data collection method that can be applied in most situations.

- **Identify opportunities to braid and blend funding mechanisms.** Braided funding combines two or more sources of funding while maintaining separate reporting structures. Blended funding pools different sources of funding without separate tracking. Braiding and blending funding allows partner organizations to create more sustainable funding sources by not depending on one grant alone for vaccination equity work. It also allows organizations to connect the issues different funders are interested in with what matters to the community. For example, while funding during the pandemic favored COVID-19 vaccination, some low-income communities also needed support with challenges such as violence prevention, rent support, and food insecurity—which can all be precursors of people having the time and capacity to access vaccination. Combining funding for separate challenges while bundling interventions to support people with whatever their needs are allows partners to deliver effective and locally meaningful interventions.
- **Include requesting cost-effectiveness studies in RFPs so that intervention designs** can evaluate specific interventions such as mobile clinics to guide resource allocation. Cost-effectiveness research could assist implementation partners with data to enable cost-benefit analyses in

the future when focusing on hard-to-reach populations, and guide evidence-based policy decisions for future funding approaches.

- **Generate and sustainably archive supportive materials and evaluation toolkits** for community partners, such as a bank of validated survey questions, to standardize data collection and improve the quality of evaluations. An archive of materials collected would need sustained public facing access with minimal cost or membership barriers, in order to achieve the goal of knowledge sharing.

We know evidence-based strategies for increasing immunization rates. But what are the evidence-based strategies that will close the gaps in differential immunization rates and confidence?

- **Align and provide guidance on how to measure sustainability.** There are two aspects to evaluating sustainability:
 - Measuring what is needed for partners to be able to continue to invest in vaccination equity after the project concludes.
 - Longitudinal measures to better understand if, when and how sustained efforts improve outcomes. This includes understanding how improved outcomes are defined by various communities across the country, beyond metrics of morbidity and mortality.
- **Measure personal experiences of racism and other systemic barriers** as part of the evaluation process. As noted in the previous section, engagement with community partners in the creation of implementation and evaluation plans is critical for meaningful program implementation and identification of outcomes. When partners are not included in early



decision making or implementation framing and planning, programs and evaluation plans may be created without the positional benefit from members of the communities of focus. It is important that we improve our understanding of the impact on evaluation of ignoring such events and how long-standing and structurally embedded discrimination and experiences of bias may skew data collection, analysis, and the process of collectively meaning making of the findings.

The scientific community should collaborate to make progress on these research opportunities and close research gaps.

Efforts already underway include [the Mercury Project](#), a consortium of social and behavioral scientists working on illuminating aspects of people's vaccine decision making.

As more adult vaccines enter the market and new adult immunization programs are developed, including research designs that are capable of generating better evidence on vaccine equity are essential to generating better health outcomes for all.

RESOURCES

- ASTHO's new [Championing Change Toolkit](#) is a great starting point for community-based work.



Emerging Practice Examples to Inform Vaccine Evaluators

OVERVIEW

In this chapter, you will find a compilation of evaluations of vaccine equity interventions and programs. Our goal in creating this inventory is to make it easier to assess and review the current state of vaccine equity intervention evaluations. Given the diversity in methodologies, metrics and data collection practices applied in the field, we synthesized all projects into a template. The template classifies programs according to the intervention strategy or research approach applied, making it easier for evaluators to quickly identify previous studies with similar interventions and relevant objectives, and to learn about additional methodologies they may want to apply in future work.

The included evaluation projects are also sorted and tagged according to an intervention's specific strategy or the study's approach. Tags include:

- Communications & social media interventions
- Partnerships
- Community Engaged Research (CEnR) or Community Based Participatory Research (CBPR)
- Quasi-experimental design
- Mixed-method data collection
- storytelling data methods



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Best Practices for COVID-19 Testing and Vaccination Study

US Office of the Assistant Secretary for Planning and Evaluation (ASPE) and Mathematica, in collaboration with US Office of the Assistant Secretary for Health (OASH)

Profile developed from publicly available information: May 2024

OVERVIEW

Vaccine	COVID-19 and routine vaccinations
Duration	2022-2025
Population	This study will identify and examine promising practices for COVID-19 testing and vaccination services in populations who are medically or socially at disproportionate risk for COVID-19 or related adverse outcomes. The study considers the experience of health departments, pharmacies, community-based organizations, tribal groups, and community health centers, as well as the lived experience of community members.
Location	Nation-wide (22 states selected for the national survey; 7 states and 2 tribal organizations in these 22 states for site visits)
Funding/Sponsors	The Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the Office of the Assistant Secretary for Health
Goals	Study goals include identifying and examining promising practices to improve: • COVID-19 testing awareness, access, and uptake • COVID-19 vaccination confidence, access, and uptake • Routine vaccination confidence, access, and uptake during the COVID-19 pandemic.
Intervention Design/ Methodology	This large national study encompasses an environmental scan, a national survey, state and tribal organization site visits, and roundtable-style state convenings. An Expert Panel of federal and non-federal experts meet throughout the study to guide the project. The project completed a preliminary environmental scan synthesizing information from key informant interviews and a targeted review of peer-reviewed and gray literature to understand the range of programs intended to improve COVID-19 testing, COVID-19 vaccination, and routine vaccinations for the populations of focus for the study. Using findings from the environmental scan, a national survey was developed and administered to gather information from local organizations about their efforts to improve COVID-19 testing and vaccination in populations that are medically or socially at disproportionate risk for COVID-19 or related adverse outcomes. As of April, 2024, site visits are underway.

EVALUATION METHODS

The project team developed a framework for assessing best practices and identifying the populations and communities of highest interest to focus this work. We will use the framework to guide an initial environmental scan to identify promising programs and practices, followed by data collection through a national survey, state

site visits, and state convenings. Using these qualitative and quantitative data, and informed by the best practices framework, the project team will identify and assess best practices and develop dissemination tools which key stakeholders can use to implement and adapt best practices in their communities.

KEY FINDINGS (to date)

The environmental scan provided findings on common barriers to COVID-19 vaccination and testing services and routine vaccinations, as well as strategies to help people overcome those barriers. The report also provides a list of 266 examples of COVID-19 vaccination and testing programs.

The national survey collected responses from 164 organizations involved in COVID-19 testing and vaccination across 22 states. The survey provided a list of the frequency and types of strategies local organizations used to deliver or promote COVID-19 testing and vaccination. The site visits are ongoing and main findings will be available upon its completion in 2025.

ADDITIONAL INFORMATION

[Best Practices for COVID-19 Vaccination and Testing | ASPE \(hhs.gov\)](#)

[Best Practices for COVID-19 Vaccination and Testing: Environmental Scan Report](#)



Boston Medical Center COVID Response Program

Boston Medical Center (BMC)

Profile developed from publicly available information: May 2024

OVERVIEW

This program assessed evidence on narrowing disparities.

Vaccine	COVID-19
Duration	December 2020 - November 2021
Population	Communities most vulnerable as indicated by Social Vulnerability Index
Location	Boston, Massachusetts
Funding/Sponsors	BMC used HRSA funds, reimbursement from insurance companies, and grants to cover the operation.
Goals	Leverage established partnerships to build confidence in COVID-19 vaccines and increase access to vaccination in communities most impacted by COVID-19.
Intervention Design/ Methodology	The intervention was based on a conceptual framework for community engagement and included several key strategies: ● Community-Based Vaccination Sites: BMC established vaccination sites in churches and community centers within highly vulnerable urban areas, identified using the Social Vulnerability Index (SVI). These sites were co-branded with local community health centers (CHCs) to leverage their established trust and recognition within the community. ● Mobile Vaccination Events: To reach underserved populations, BMC organized mobile vaccination events at various locations, including schools, grocery stores, and community events. These mobile sites were strategically placed in areas identified as “vaccine deserts” using robust analytics. ● Communication Campaign: A targeted communication campaign featuring trusted messengers from the community was launched to build vaccine confidence. This included dialogues on social media, print, radio, and television, often featuring government officials and community leaders. ● Partnerships and Collaboration: BMC collaborated with state and local health departments, the Commonwealth of Massachusetts, and community leaders to ensure equitable vaccine distribution and to address structural barriers to vaccination

EVALUATION METHODS

Methodology: quantitative

The evaluation of the BMC vaccination program involved analyzing programmatic data and methodology focused on key implementation science domains, particularly adoption and reach:

- **Adoption:** Assessed using the number of community vaccination sites and mobile vaccination events
- **Reach:** Assessed using the number of vaccinations administered, stratified by race and SVI decile.

KEY FINDINGS

Outputs:

- Establishment of seven community-based vaccination clinics
- Conducted 99 individual mobile vaccination events
- 109,938 first doses and 93,178 second doses were administered
- The majority of doses were administered at community vaccination events

Outcomes:

- The percentage of vaccines going to the most vulnerable residents varied across sites. Percent of persons receiving first doses in SVI deciles 8-10:
 - Community vaccination sites: 34%
 - Mobile vaccination events: 68%
 - BMC Outpatient Ambulatory Clinic: 52%

ADDITIONAL INFORMATION

Sabrina A. Assoumou, Alicia Peterson, Ellen Ginman, et al. [Addressing Inequities in SARS-CoV-2 Vaccine Uptake: The Boston Medical Center Health System Experience](#). Ann Intern Med.2022

California’s COVID-19 Vaccine Equity Policy

California Department of Public Health

Profile developed from publicly available information: May 2024

OVERVIEW

This program assessed evidence on narrowing disparities.

Vaccine	COVID-19
Duration	May – June 2021
Population	Communities most impacted by COVID-19 as determined by the State’s “Vaccine Equity Metric”
Location	California
Funding/Sponsors	California Department of Public Health
Goals	Address place based and racial/ethnic disparities in COVID-19 vaccination using the Vaccine Equity Metric to determine allocation.
Intervention Design/ Methodology	The state used a modified version of the Healthy Places Index (an area-based socioeconomic measure that evaluates the relationship between key drivers of health and life expectancy at birth) the Vaccine Equity Metric (VEM), to determine COVID-19 vaccine distribution among the state’s vulnerable communities. The California Department of Public Health assigned a VEM score for every ZIP code in California. These scores were percentile ranked and partitioned into quartiles. VEM quartile 1 was interpreted as the 25 percent of ZIP codes in the state where residents have the least opportunity to live a healthy life. The policy then allocated 40 percent of available vaccines to VEM quartile 1 communities, with the remaining 60 percent of vaccines divided evenly among VEM quartile 2–4 communities. The policy also included equity-oriented technical assistance, contracting support, staffing resources, and mobile vaccination sites for local health jurisdictions to aid their vaccination outreach. Finally, vaccination appointments were reserved for VEM quartile 1 residents to ensure that vaccines allocated to VEM quartile 1 communities were administered to the intended residents.

EVALUATION METHODS

Methodology: quantitative

Comparison of vaccination rates in the VEM quartile 1 to rates in zip codes outside of quartile 1, four weeks before and four weeks after the policy started on March 1, 2021.

KEY FINDINGS

Outputs: n/a

Outcomes:

- The vaccination rate increased the most in VEM quartile 1 after the equity allocation, from 9,998 vaccinations per 100,000 in the four weeks before the equity allocation to 18,146 per 100,000 in the four weeks after.
- The vaccination rate in VEM quartile 1 zip codes in the four weeks after policy implementation increased by an estimated 28.4 % compared with non-VEM quartile 1 zip codes.
- However, over the eight week period, the vaccination rate was lowest in VEM quartile 1 (the target population) and highest in VEM quartile 4. And as of June 2021, vaccination rates for Black and Latinx residents, who are overrepresented in quartile 1 and prioritized for the vaccine, continued to lag behind the state average.

ADDITIONAL FINDINGS, INSIGHTS, LIMITATIONS

The evaluation of the policy found mixed results. Overall the policy was not able to close the racial and ethnic disparities in vaccination rates. However, the policy was able to increase the number of vaccinations delivered in these communities.

Additional evaluations of the policy found that the VEM on its own couldn’t adequately address vaccine disparities. Rather, the state’s policy needed to combine the index with additional efforts such as community engagement. The strengths and weaknesses of the state’s vaccine equity policy are further discussed in the links below.

ADDITIONAL INFORMATION

Evaluation: California’s [COVID-19 Vaccine Equity Policy: Cases, Hospitalizations, And Deaths Averted In Affected Communities](#). Christopher M. Hoover, Emily Estus, Ada Kwan, Kristal Raymond, Tanu Sreedharan, Tomás León, Seema Jain, and Priya B. SheteHealth Affairs 2024 43:5, 632-640

California Pan-Ethnic Health Network.(2021). [Nothing About Us Without Us: Can Area-Based Social Indices Effectively Advance Health Equity.](#)

Community Engagement Alliance (CEAL): Community Engagement Alliance Regional Teams

National Institutes of Health

Profile Submitted July 2024

OVERVIEW

This program assessed evidence on narrowing disparities.

Vaccine	COVID-19
Duration	Ongoing
Population	Underserved communities that are disproportionately impacted by racial, ethnic, and socioeconomic disparities and who are also underrepresented in clinical trials.
Location	Teams across 21 states, Washington D.C. and Puerto Rico
Funding/Sponsors	NIH
Goals	The NIH Community Engagement Alliance (CEAL) was launched in the fall of 2020 as part of the federal government's response to the COVID-19 pandemic. Initially, CEAL Regional Teams consisting of academic and community partnerships within states focused on fostering trust, COVID-19 awareness, education, and research to support communities of color. Since 2020 CEAL has expanded to add programs addressing remaining health disparities including maternal health, climate health, health knowledge, primary care research, and other important public health topics. Strengthening community partnerships through community engaged research is at the center of CEAL's mission to address racial, ethnic and socioeconomic health disparities. Utilizing community-engaged research methods, CEAL works to include local people in the research process, especially people from communities that could benefit from or be affected by the research. Methods include community health workers, partnerships with community-based organizations and collaboration with trusted community leaders. Research teams and communities work together as equal partners to create and carry out studies, analyze data, and share findings.
Intervention Design/ Methodology	Using community-engaged research approaches, CEAL Regional Teams investigated the factors contributing to health inequities at a local level to design and implement strategies to address deficits in accurate health information, encourage preventative behaviors, promote participation in COVID-19 research

- Continued -

Intervention
Design/
Methodology
(continued)

(including vaccine trials), and increase vaccination adoption among communities most vulnerable to COVID. Teams developed and tested educational materials and messages; worked with community trusted sources and influencers to test effective dissemination of health information; host vaccination and COVID-19 testing events; and trained community health workers and health care providers.

As reported in the January 2024 issue of the American Journal of Public Health, twenty-one CEAL teams across states, the District of Columbia, and Puerto Rico reached nearly 91 million people in 101 counties where the predominant populations represented disproportionately affected groups. CEAL research teams have held more than 6,800 local events reaching more than 780,000 participants. This includes vaccination events at which more than 640,000 people received the COVID-19 vaccine. Furthermore, more than 3400 people have signed up to participate in COVID-19-related clinical trials. [Read more about CEAL's Approach and Impact](#)

EVALUATION METHODS

Impact of CEAL efforts on vaccination disparities at a national level has been evaluated using two key metrics:

- COVID-19 vaccination rates in CEAL communities compared to communities without CEAL programming
- Longitudinal assessment of COVID-19 vaccine confidence, attitudes and behavior in CEAL communities

At a local level: The CEAL approach relied on a hypothesized mechanism of change by linking activities (e.g., engagement of partners,

information dissemination) to eventual short-term (e.g., increased knowledge) and intermediate-term (e.g., increased vaccination) outcomes. Community-based CEAL research teams studied vaccination disparities in their communities using a broad range of methodologies including programmatic evaluations and assessments of communication campaign reach. Details on these evaluations were reported in dozens of locally-authored research papers, including several in the Journal of American Public Health Association. (Links are shared on page 24.)

KEY FINDINGS

On a national level

- Vaccination rates in CEAL communities were nearly 6% higher by late 2022.
- Percentage of people in CEAL communities reporting they were likely to get or have

received a COVID-19 vaccine increased significantly over time in most groups, especially American Indian or Alaska Native and Hispanic or Latino groups

- continued -

KEY FINDINGS (continued)

On the state and local level

- In January 2024, the American Journal of Public Health devoted a supplemental issue to this program [Leveraging the Power of Communities During Public Health Emergencies](#) which featured 25 editorials and papers that discuss CEAL's community-engaged research during the COVID-19 pandemic.
- At the 2023 American Public Health Association Annual Meeting, CEAL teams led over 30 presentations and events focused on CEAL's success, lessons learned, and promising practices. You can see those [here](#)

Links to Publications on State and Local CEAL Efforts (non-exhaustive list)

1. [A New Model for Engagement and Action Mitigating COVID-19 Harm in Vulnerable Communities: The Work of Collaborative Community Engagement Alliance \(CEAL\) Initiatives in Three Southern States](#)
2. [Temporal Changes in Vaccine-Specific Willingness Across Race/Ethnicity Following Serious Adverse Event Reports](#)
3. [Participatory Trust-Building Model for Conducting Health Equity Research With Rural and Urban Native American, Black, and Latinx Communities: WEAVE NM \(Wide Engagement for Assessing Vaccine Equity in New Mexico\)](#)
4. [Rapid Community Translation in the Colorado CEAL \(CO-CEAL\) Program: Transcreating Messaging to Promote COVID-19 Vaccination](#)
5. [Grassroots and Digital Outreach Strategies Raise Awareness of COVID-19 Information and Research in Baltimore City](#)
6. [COVID-19 Knowledge, Beliefs, and Intention to Get Vaccinated: A Brief Educational Intervention Among Black and Hispanic Populations](#)
7. [Addressing COVID-19 Vaccine Hesitancy With Community Distribution of Conversation Cards](#)
8. [The Power of Partnership: NYCEAL Collaborations With Health Agencies and Mobile Vaccination](#)
9. [COVID-19 Information, Trust, and Risk Perception Across Diverse Communities in the United States: Initial Findings from a Multistate Community Engagement Alliance \(CEAL\)](#)
10. [Effectiveness of Community-Engaged Research Strategies in Increasing COVID-19 Vaccinations in Targeted Communities: The Community Engagement Alliance \(CEAL\) Regional Teams](#)
11. [Campaign in Puerto Rico Encourages Uptake of Booster Vaccine \(PR CEAL\)](#)
12. [Learning about Vaccine Hesitancy from the Recently Vaccinated \(AR CEAL\)](#)
13. [The Secret to Boosting Vaccine Confidence? It Comes From The Community \(AZ CEAL\)](#)

ADDITIONAL FINDINGS, INSIGHTS, LIMITATIONS

The approaches and strategies utilized by CEAL Regional Teams provide guidance on strategies and approaches to ensure that historically marginalized communities are part of the planning and implementation for effective strategies.

Creating opportunities for research that combine lived experiences with the tools of researchers makes an impact on those communities, and the up-and-coming authors who publish. Taken together, these local-driven research efforts add up to make a large national impact, since the sheer amount of these efforts, taken together, is associated with increased COVID vaccination rates.

This work provides robust evidence for:

- Integrating community members into vaccine equity research and interventions using community engage research methods to strengthen the impact and effectiveness of interventions
- The impact that local, community engaged efforts can have on national issues.

ADDITIONAL INFORMATION

[CEAL Website](#)



DRIVIng Equity in Flu Vaccination

Center for Sustainable Health Care Quality and Equity (SHC) at the National Minority Quality Forum (NMQF)

Profile submitted July 2024

OVERVIEW

This program assessed evidence on narrowing disparities.

Vaccine	Influenza, COVID-19 and all adult vaccinations
Duration	2020-2024
Population	People of color
Location	25 U.S. States
Funding/Sponsors	Centers for Disease Control (CDC) and Sanofi
Goals	The DRIVIng Equity in Flu Vaccination program is a clinician and community-based, multi-year activity aimed at promoting flu vaccination in people of color. The program goals are to sustainably increase flu and adult immunization acceptance and equity.
Intervention Design/ Methodology	Participating clinics are provided education for their clinicians and staff as well as patients along with support in implementing rapid cycle quality improvement (QI) projects to increase vaccination rates in their patients of color. Pharmacists, as part of the Community Pharmacist Ambassadors Program, are provided education on how to effectively engage and educate communities of color about flu and other adult vaccinations. More here: Community Pharmacist Ambassadors - Sustainable Health Care Community organizations, including churches serving people of color in the Faith Health Alliance (Faith health alliance - Sustainable Health Care) and barbers and hair stylists who participate in HAIR Wellness Warriors (Wellness warriors – Sustainable Health Care), are supported in providing education and community-based vaccination. Health Champions (Health Champions - Sustainable Health Care) is an activity providing communication resources to the community to promote vaccination. Recruitment and distribution of activities is accomplished through partnership with national organizations, direct outreach to organizations, and social media and online marketing efforts.

EVALUATION METHODS

The DRIVE programs are evaluated annually using multiple methodologies:

- Reach is determined in terms of number of organizational and individual participants as well as the distribution of and participation in educational/communications resources
- Participating clinics complete a pre-project practice assessment survey to shed light on their practice and patient characteristics, approach to vaccination, and barriers/needs in terms of promoting vaccination; a post-program survey is implemented to assess any changes that occurred
- Participating clinics provide a write-up of their QI activities
- Participating clinics provide ongoing data on flu/adult vaccination rates
- The number of educational and community-based vaccine activities are measured
- Changes in clinician and community member knowledge, attitudes, and behavior vis-à-vis flu/adult vaccines

KEY FINDINGS

In the last flu season the following results were obtained:

- SHC partnered with health systems, clinics, pharmacists, churches, stylists and barbers in 25 states. Including:
 - 43 Churches
 - 15 stylists and barbers
 - 155 clinics
 - 215 pharmacists
- A total of 175,102 flu vaccinations were given in the 2023-24 season as a result of the DRIVE program, a 10% increase in flu vaccination rates
- Communication results:
 - 408 webinar participants
 - 326,221 social media views via 291 posts
 - 10,651 health champion emails sent

Practice assessment survey results: Wide range of practices participated (e.g., FQHC, FCC, residency program, health system, individual practices)

with diverse patient populations; they largely implement evidence-based strategies to promote vaccination, although tracking data by race/ethnicity and community-based engagement and events were uncommon; needs included more vaccine access, culturally appropriate patient education materials, and clinic training on making a strong recommendation.

Clinic post-survey results: Wide-spread use of vaccine champion, however, limited engagement with patients who turn down vaccination; co-vaccination with the COVID vaccine was seen as a plus for flu vaccination.

Community-based survey: Revealed among a largely older and fairly healthy Black population acceptance of flu vaccination to protect their own health and that of their family members; ease of access was a correlated factor; physician's office preferred location for vaccination; among the unvaccinated participants, concerns about need, side-effects, and safety as well as racism/discrimination were significantly increased over the vaccinated group.

ADDITIONAL FINDINGS, INSIGHTS, LIMITATIONS

Selected program highlights:

NYC Health and Hospitals – Elmhurst: Multiple clinic, hospital, and community-based activities

- 6,004 vaccines for patients/community members – 10% increase from previous year; 3,845 for their employees – 60% increase from previous year

Holyoke Health

- 3,324 flu vaccines from the three clinical teams this year – 25% increase from previous year

ARCare

- 12,142 flu vaccines this year – 10% increase from previous year

National Association of Free and Charitable Clinics

- 4,937 vaccines given by 13 clinics

Southeast Medical Group, GA

- 45 participating clinic sites
- 17,476 flu vaccines given
- 3 “winning” locations had 256%, 240%, and 183% increase from previous year

South Carolina Association of Community Actions Partnerships, Inc.

- Partnered with Walgreens
- 6,000 flu vaccines given

NOLA Program

- 89,677 vaccines given – 25% increase over previous year in African American population

Faith Health Alliance

- 2,250 vaccines at 50 events

Equity First Vaccination Initiative

The Rockefeller Foundation, RAND Health Care, and Brown University School of Public Health

Profile submitted July 2024

OVERVIEW

Vaccine	COVID-19
Duration	April 2021 - August 2022
Population	Communities of people who identify as Black, Indigenous, and People of Color (BIPOC) and low-wage communities disproportionately affected by COVID-19
Location	5 demonstration cities in the US (Baltimore, Maryland; Chicago, Illinois; Houston, Texas; Newark, New Jersey; and Oakland, California)
Funding/Sponsors	The Rockefeller Foundation
Goals	The U.S. Equity-First Vaccination Initiative (EVI) aimed to reduce racial and economic inequities in COVID-19 vaccination across five demonstration cities and over the longer term, strengthen the public health system to achieve more equitable outcomes. Over 90 community-based organizations (CBOs) and other local partners led hyper-local, place-based, holistic work to increase vaccination confidence, access and uptake in low-wage and BIPOC communities.
Intervention Design/ Methodology	The EVI employed a place-based, collective impact model to enhance vaccination efforts among BIPOC communities. The initiative’s methodology centered around anchor organizations in five demonstration cities—Baltimore, Chicago, Houston, Newark, and Oakland—each selecting and supporting CBOs through subgrants. This structure enabled the anchor partners to leverage their local knowledge and connections to select diverse and trusted CBOs, fostering trust and ensuring the implementation of tailored vaccination strategies. The initiative prioritized rapid deployment of resources, acknowledging the urgent need for equitable vaccination access. Anchor organizations, supported by a range of learning, communication, and advocacy partners, facilitated continuous capacity building, learning and adaptation through communities of practice and bespoke support, enhancing the CBOs’ capabilities in data collection, vaccine demand generation, communications and technical assistance.

- Continued -

Intervention Design/ Methodology (continued) The intervention design included comprehensive support systems, such as the MegaComms team, which provided training and resources for health communication, including community listening, misinformation resilience and translating new evidence into accurate, tailored messages for hyperlocal audiences quickly. Learning partners like Mathematica, Brown University and the RAND Corporation offered technical assistance and data analysis support, helping CBOs field surveys, track key performance indicators (KPIs), and measure the reach of communications and community engagement activities. The Brown team also led several bespoke assessments with select organizations, such as a survey and focus group assessing changing youth attitudes towards vaccines. This data-driven approach enabled the initiative to identify barriers to vaccination and adapt strategies accordingly. Additionally, the initiative integrated a focus on emotional and mental health, recognizing the pandemic's toll on CBOs and emphasizing flexibility and support for partners' well-being.

EVALUATION METHODS

The EVI project utilized a mixed-methods approach to evaluate its impact, combining both qualitative and quantitative methods to provide a comprehensive analysis. The evaluation framework included:

- Qualitative data from interviews and surveys
- Quantitative data at the city level.
- KPIs: defined to track essential activities such as vaccination events, assistance provided, vaccinations administered, and communication efforts. These indicators were reported monthly by the anchor partners, who compiled and cleaned the data for consistency and comparability across sites.
 - KPI 1: Number of events held that month at which vaccinations were offered
 - KPI 2: Number of times that someone received assistance to get vaccinated, such as transportation help, interpreter services, or help with registration

- KPI 3: Number of vaccination doses given that month
- KPI 4: Number of connections made through online and offline reach

Qualitative methods included virtual semi-structured interviews conducted with organizational leaders, staff from anchor and key partners, and selected CBOs. Monthly reflections were also gathered through online surveys or brief discussions, as well as monthly office hours of the communications group. This approach allowed for detailed exploration of the EVI's implementation, capturing the experiences and insights of the partners involved. Supplementary data, such as screen captures of flyers, photos from social media, and meeting notes, enriched the qualitative analysis. The combined use of qualitative and quantitative data ensured that the evaluation captured both the measurable outputs and the nuanced experiences of the EVI partners, providing a robust understanding of the initiative's impact.

KEY FINDINGS

Output measures:

- CBOs held over 4,500 events where vaccination occurred
- Provided assistance to get vaccinated almost 155,000 times,
- Administered nearly 65,000 vaccinations
- Made almost 15 million connections with people to provide accurate vaccination information.

Outcome measures:

The EVI reached its target population and contributed to improving vaccination equity among BIPOC communities. Key outcome findings include:

- Participating CBOs in cities with longstanding inequities saw a substantial increase in vaccination rates among Latinx residents, but less progress was noted for Black residents. Nationally, the number of first and second COVID-19 vaccine doses administered declined over time, but vaccinations through the EVI continued to trend upward.

ADDITIONAL FINDINGS, INSIGHTS, LIMITATIONS

- The EVI's primary impact on participating CBOs was the capacity these organizations built and continued to strengthen over time, including building health communication infrastructure and skills; establishing relationships, networks, and communities of practice in their cities; and advocating for equitable policies in their communities.
- Building relationships through authentic, ongoing partnerships, bridging sectors, partnering with trusted messengers, and harnessing the power of communities of practice for support and shared problem-solving were effective.
- CBOs that did not traditionally work in public health effectively pivoted to address COVID-19 vaccination barriers, playing a critical role in the pandemic response.
- CBOs adapted their strategies based on changing local contexts and needs, demonstrating flexibility and responsiveness.
- Addressing broader social determinants of health, such as food insecurity and housing, was crucial for vaccination efforts.
- Using trusted community messengers was vital for overcoming vaccine hesitancy and misinformation.
- Collaborations with non-traditional public health partners, including legal services and faith-based organizations, effectively reached diverse populations.
- Continuous engagement and feedback loops between anchor partners and CBOs allowed for real-time adjustments and improvements.
- Long-term, sustained support for CBOs is necessary to maintain public health gains and build resilience against future health emergencies.
- The equity-focused approach elevated the voices of marginalized communities, fostering a more inclusive and equitable health system.

- Continued -

ADDITIONAL FINDINGS, INSIGHTS, LIMITATIONS (continued)

Limitations:

- Although the results of EVI provide important insights that are relevant beyond these five communities, it is important to not

overgeneralize the findings to all BIPOC and low-wage populations in all settings. Rather, the lessons learned need to be tailored to the specific contexts and populations to which they will be applied.

ADDITIONAL INFORMATION

Additional insights and full reports can be found here:

https://www.rand.org/pubs/research_reports/RRA1627-2.html

<https://buildingvaccinedemand.org/wp-content/uploads/2022/09/2022-vaccine-demand.pdf>

<https://equityfirstplaybook.wordpress.com/>

Expanding the Role of Promotores de Salud and Community Health Workers as Vaccination Community Navigators

Vaccinate Your Family, Día de la Mujer Latina

Profile submitted: August 2024

OVERVIEW

Vaccine	All vaccines
Duration	Ongoing
Population	Community Health Workers and Promotores de Salud (CHW/Ps)
Location	United States
Funding/Sponsors	Centers for Disease Control and Prevention (CDC)
Goals	Build the capacity of CHW/Ps to increase vaccination uptake throughout the lifespan.
Intervention Design/Methodology	Vaccinate Your Family (VYF) and Día de la Mujer Latina, Inc. (DML) partnered to create the Vaccination Community Navigator (VCN) Training, a four-part, bilingual (English/Spanish) continuing education curriculum to increase the capacity of CHW/Ps (measured through changes in knowledge and self-reported confidence) to bolster vaccine confidence and navigate people of all ages to vaccination services in their communities. In the spring of 2022, VYF and DML piloted the curriculum in Texas to test the acceptability and effectiveness of the training. Over 200 CHW/Ps and CHW instructors completed the training in English and Spanish through either a self-paced, online course or a hybrid model with part of the training being conducted in person. VYF then used lessons learned from the pilot to enhance and expand the training curriculum for a national audience in 2023. In addition to the self-paced, online training series, VYF added additional programmatic components, including an online community and regular virtual Community of Practice meetings where CHW/Ps can share resources, ask questions, and find timely information related to vaccines. VYF also collaborated with DML to adapt the online curriculum for in-person instruction and provided technical and financial support to select organizations to offer the training in a classroom setting for those experiencing technology barriers.

- Continued -

Intervention
Design/
Methodology
(continued)

Training materials underwent review by CHW/Ps to ensure that they were culturally and linguistically appropriate, and CHW/Ps are actively involved in the selection of topics addressed during Community of Practice meetings.

The curriculum has been approved for certified continuing education credits for CHW/Ps by the Texas Department of State Health Services. Continuing education credits for CHW/Ps are provided for VCN courses and Community of Practice meetings, courtesy of DML.

EVALUATION METHODS

VYF uses a combination of data collection activities to evaluate the program. These include:

- Pre/post-test quizzes at the beginning and end of each course to assess changes in knowledge
- Pre-course surveys to gather demographic and occupational data, baseline self-reported confidence levels, and behaviors related to vaccine outreach
- Post-course surveys to assess perceived changes in knowledge and confidence, intent to use the information covered in the courses, and participant feedback on the courses
- Follow-up surveys to assess knowledge retention, self-reported confidence, and behaviors regarding vaccine outreach

- Post-event surveys to gather feedback on live virtual Community of Practice meetings
- Questionnaire for in-person facilitators to gather their feedback on in-person facilitation of VCN courses
- Regular partner meetings to gather input and feedback from partners

CHW/Ps at DML were involved in the development, review, and testing of data collection methodology and instruments to ensure they were culturally and linguistically appropriate. Gift cards are offered to follow-up survey respondents as compensation for their participation.

KEY FINDINGS

VCN Core Curriculum Online

Since its national launch in early 2023, 850+ additional people have enrolled in VCN online courses, and 550+ have completed 75% or more of at least one course. Among those who fully completed courses, post-course forms showed that participants increased their pre/post quiz

scores by an average of 19-26.9 percentage points. 92-96% reported that the training increased their confidence in their ability to talk about vaccines with others, and 96.1% reported the training increased their confidence in their ability to navigate people to vaccine services.

- Continued -

KEY FINDINGS (continued)

A follow-up survey of participants months after they completed VCN courses found that among survey respondents (n=152):

- The majority have used the information received in the trainings to increase vaccine confidence in their community (86.6%) and navigate people to vaccine services (69.6%).
- The majority said the trainings helped them engage more people in vaccine conversations (89.9%), helped them have stronger, more productive conversations about vaccines (89.2%), and helped them connect more people to vaccine services (70.3%).

VCN Community of Practice Meetings

An average of 93 people (range: 66-129) have attended each of the virtual Community of Practice meetings, and post-event surveys show the meetings have been well received by participants. An average of 93% (range: 73-100%) of post-event survey respondents have said they planned to use the information presented during the meeting.

VCN Online Community

The VCN Online Community now includes more than 600 members. According to a follow-up survey of members, 79.2% of respondents (n=72) reported using information or resources they've found on the VCN Online Community to try to increase vaccine confidence in their community, and 61.4% (n=70) reported using those resources to connect people to vaccine services.

In-Person Facilitation of VCN courses

In early 2024, seven organizations in six states participated in a pilot cohort that received technical and financial support to facilitate VCN courses in in-person classroom settings. Among the various sites, in-person facilitators have so far trained more than 200 additional people using the adapted VCN curriculum. Evaluation of this pilot is still ongoing.

ADDITIONAL FINDINGS, INSIGHTS, LIMITATIONS

Vaccination Community Navigator program participants are well-positioned to increase vaccine equity. According to a follow-up survey of those participating in the VCN program activities in 2023 (n=320):

- Most participants identify as belonging to communities experiencing vaccine disparities, with 58% identifying as Hispanic, Latino, or of Spanish origin; 22% as Black or African American; and 6% as Native American or Alaska Native.

- Most participants report working with groups where vaccine equity is especially crucial: 69% reported working with uninsured adults; 60% reported working with people living with long-term health challenges (e.g. diabetes or heart disease); 58% reported working with immigrants, migrant workers, or refugees; 53% reported working with people experiencing homelessness or housing insecurity; and 48% reported working with pregnant people.

- Continued -

ADDITIONAL FINDINGS, INSIGHTS, LIMITATIONS (continued)

- Most (94%) report trying to increase vaccine confidence by engaging clients, patients, or community members in vaccine conversations (e.g., responding to questions or concerns about vaccines) and/or trying to connect clients, patients, or community members to vaccine services (95%).

There's an urgent need to better integrate CHW/Ps into the vaccine ecosystem. CHW/Ps are key trusted messengers with extensive knowledge and understanding of their communities. Public health departments, medical systems, community-based organizations, and other agencies working to advance vaccine equity should engage CHW/Ps — not only in the implementation of activities, but also in the planning, development, evaluation, and reporting of vaccine-focused initiatives.

Limitations

Evaluation activities provide useful insights into the effectiveness and acceptability of the program's activities, as well as whether and how participants applied what they learned to increase vaccination in their communities. However, much of the data gathered are self-reported, and VYF was unable to measure whether, how, and to what extent programmatic activities directly contributed to improvements in vaccine equity.

Likewise, more funding — and more flexibility in funding — is needed to ensure that CHW/Ps are adequately compensated for their work in increasing vaccine confidence, access, and uptake. While the VCN program was generously supported in large part by the CDC, VYF was unable to use the federal funds to purchase incentives for CHW/Ps participating in the program's activities, including follow-up surveys that were central to program evaluation. VYF was able to find outside funding to provide gift cards for follow-up survey respondents; however, the program team was unable to offer financial incentives for CHW/Ps to compensate them for their time or offset the costs associated with their participation in VCN courses or meetings, beyond continuing education certificates. Being able to use federal funds to provide incentives for participation would likely increase participation among CHW/Ps overall, improve the quality of the program's evaluation, and honor the valuable role CHW/Ps play in protecting their communities from vaccine-preventable diseases and advancing vaccine equity.

ADDITIONAL INFORMATION

[Vaccination Community Navigator Core Curriculum](#)

[VCN Online Community](#)



Extension Collaboration on Immunization Teaching and Engagement (EXCITE)

Extension Foundation, the United States Department of Agriculture – National Institute of Food and Agriculture (USDA-NIFA) and the Center for Disease Control and Prevention (CDC)

Profile submitted May 2024

OVERVIEW

Vaccine	COVID-19 and all adult vaccinations
Duration	2022-2023
Population	Rural and medically underserved communities
Location	47 states, 1 U.S. Territory, 17 Native American Reservations
Funding/Sponsors	Centers for Disease Control
Goals	The EXCITE project represented a high-speed initiative aimed at swiftly providing the public with up-to-date, evidence-based information. Its primary objective was to empower individuals to make informed decisions regarding COVID-19 prevention through the utilization of available vaccines.
Intervention Design/ Methodology	To accomplish above goal, EXCITE developed the “COVID-19 Immunization Education Program (Vaccinate with Confidence)”, a one-year project to quickly roll out and test various messages about the vaccine in prioritized counties around the country by providing funding for outreach and education efforts to 72 land-grant universities across the country.

EVALUATION METHODS

Methodology: mixed methods	• The number of vaccination clinics held
EXCITE characterized impact with:	• The number of immunizations provided
• The number and type of engagement activities completed	• Changes in priority populations’ rates of vaccine hesitancy/confidence, vaccine knowledge and vaccine behavior for both COVID vaccines and other adult vaccines such as the flu vaccine
• The number of engagement/educational assets created or adopted	- Continued -
• The reach of engagement activities by type	

EVALUATION METHODS (continued)

- These were assessed using surveys with questions adapted from the CDC's COVID-19 Vaccine Confidence Survey Question Bank that is a part of their [COVID-19 Rapid Community Assessment Guide](#) and the CDC Confidence Survey Question Bank
- Number and strength of partnerships involved
- The strength of partnerships was determined by the level of involvement between partners based on the [National Network for Collaboration Framework. Relationships](#) between partners were evaluated before and after the EXCITE project. In Year 2 Extension Unique strengths were identified as well as project limitations.

KEY FINDINGS

Outputs:

- 178,228 engagement activities completed which included: direct communication, in-person events, mass media, print materials, social media, vaccination clinics, virtual events, and billboards.
- 630 engagement/educational assets developed including slide decks, infographics, text & images, videos, evaluation resources, social media graphics, and billboards
- 19,586,347 citizens reached
- 1,046 vaccination clinics hosted
- 26,023 COVID vaccines administered; 26,063 adult immunizations administered

Outcomes:

- 19 projects reported “Improved perceived importance of vaccines for preventive health and disease prevention”; 12 projects reported “Improved vaccination rate”; 9 projects reported “Improved trust in vaccinations; 6 projects reported “Improved social norms emphasizing importance of vaccinations”; 9 projects reported “Decreased barriers to vaccinations”
- 644 partnerships involved
 - The development of the majority of the partnerships moved at least one point along the continuum per the scale used in the [National Network Collaboration Framework](#)

ADDITIONAL FINDINGS, INSIGHTS, LIMITATIONS

Cooperative Extension with over 32,000 offices in every county or parish in the United States and its territories serves as a trusted messenger especially to rural populations.

ADDITIONAL INFORMATION

Website: [EXCITE Project Website](#)

Resource Documents

[EXCITE Activity 1 Final Report: June 2021–October 2022](#)

[EXCITE Activity 2 Final Report: 2022–May 2023](#)

[EXCITE Annual Report Year 1 2021–2022](#)

[EXCITE Annual Report Year 2 2022–2023](#)

Good Health Women’s Immunization Networks (Good Health WINs)

National Council of Negro Women, Inc. (NCNW)

Profile submitted: August 2024

OVERVIEW

Vaccine	COVID-19, influenza, and all recommended adult immunizations. Expanded scope of work to include child and adolescent immunizations.
Duration	2020-2024, on going
Population	African American communities, with an emphasis on women and racially and ethnically diverse adult populations facing health disparities.
Location	Nationwide, with a focus on communities with significant African American populations (urban and rural) and college campuses.
Funding/Sponsors	Centers for Disease Control (CDC)’s Partnering for Vaccine Equity with additional support with vaccine industry partners.
Goals	1. Increase vaccine awareness and access within African American communities with a strong CBO infrastructure. 2. Enhance vaccination coverage among racially and ethnically diverse adult populations facing disparities. 3. Foster collaborative discussions with key vaccine ecosystem and industry partners.
Intervention Design/ Methodology	Community of Practice - Bi-Monthly educational and technical assistance to Good Health WINs (GHWs) mini-grant subrecipients. Good Health WINs Trusted Messenger Certificate Program - 6 on-line modules co-developed in partnership with Vaccinate Your Family. Modules include: 1. Building Trust with CBO Trusted Messengers 2. History of Vaccination in the Context of African Americans 3. Trust in Vaccines: How they work, different kinds, and bringing vaccines safely to market 4. Trusted Information: Tips to Combat Mis- and Disinformation 5. Infrastructure of Trust: Vaccine Confidence One Person, Organization, Community at a Time 6. Leveraging Trust to Impact Vaccine Advocacy

EVALUATION METHODS

Methodology: mixed methods

GHWs provides mini-grants to state and national organizations who conduct community-engaged work and provide monthly reports to NCNW.

Evaluation for GHWs includes two-tiers:

1. National bi-annual reporting by NCNW to the CDC
2. Monthly reporting by each funded CBO mini-grant chapter/recipient. Community level data includes: community engagement program information, outreach strategies, demographics, successes and barriers. Evaluation methods include both qualitative and quantitative measures: interviews, Pre-/Post Surveys, Polling and focus groups

KEY FINDINGS

Number of state and national organizational partners: 40

Number of Community of Practice Sessions held: 81

Number of Community of Practice Participants (2020-2024): 81,717

Preliminary Data from January – July 2024 includes:

- Number of individual participant /GHWs Attendees: 575,816

- Zip codes where GHWs programs/events were conducted: 5, 594
- Number of GHWs Trusted Messenger Certificate Attendees (4 Modules as of July 2024): 2,972
- Number of GHWs Community-level partnerships: 6,742
- Number of Smartsheet monthly reports completed: 2,075

ADDITIONAL FINDINGS, INSIGHTS, LIMITATIONS

Recent analysis of the Good Health Women's Immunization Networks (GHWs) program has uncovered several key findings and insights regarding preventive healthcare priorities and knowledge gaps. Notably, emerging trends indicate a growing emphasis on personalized healthcare interventions, patient advocacy and the

need for targeted education to address specific community concerns about vaccine confidence, efficacy and safety. Although challenges related to engaging diverse communities and sustaining long-term vaccination efforts remain significant, the CBO infrastructure may be an effective

- Continued -

ADDITIONAL FINDINGS, INSIGHTS, LIMITATIONS (continued)

approach to building vaccine confidence with trusted messengers. Variability in community engagement, driven by differing cultural contexts and trust levels, alongside inconsistent funding availability, has impeded broader outreach and sustained impact. Currently, GHWs operates at only 10% of its full capability, highlighting

the need for increased resources and strategic partnerships to expand its reach. Despite these limitations, several manuscripts are in preparation, to highlight program successes aiming to disseminate the program's results and share valuable insights to inform future public health initiatives.

ADDITIONAL INFORMATION

ncnw.org

goodhealthwins.org



Immunization Partnership Fund

The Public Health Agency of Canada

Profile submitted August 2024

OVERVIEW

Vaccine	All routine immunizations across the life course (childhood and adult), as well as influenza and COVID-19
Duration	2016-2026
Population	Populations with disproportionately low rates of vaccination coverage and uptake, higher rates of vaccine hesitancy, are at higher risk for serious outcomes from vaccine-preventable diseases and face systemic or structural barriers to accessing vaccination.
Location	Across Canada at the national, provincial/territorial, regional and local community levels.
Funding/Sponsors	The Government of Canada
Goals	The Immunization Partnership Fund (IPF) is a grants and contributions program of the Public Health Agency of Canada. The IPF seeks to increase confidence and uptake of vaccination in Canada, particularly among populations that may face greater barriers to vaccination, higher rates of vaccine hesitancy, and increased susceptibility to serious illness associated with vaccine-preventable diseases.
Intervention Design/ Methodology	Since 2016 the IPF has completed four funding cycles: 2016-2021: \$25 Million CAD (21 recipients) 2021-2023: \$54 Million CAD (106 recipients) 2023-2024: \$9.5 Million CAD (55 recipients) 2024-2026: \$10 Million CAD (39 recipients) Initial funding (2016-2020) supported large and well-established organizations and governments at regional, provincial and national levels in combatting vaccine hesitancy and promoting, piloting, and identifying best vaccine promotion practices. At the onset of the COVID-19 pandemic, IPF expanded funding to address specific equity gaps by focusing on communities and populations experiencing or facing social and/or structural inequities. IPF-funded projects must adhere to the program’s core principles, ensuring that interventions are equity-promoting, culturally safe and evidence-informed. The objective of IPF-funded projects is to support community-centered vaccination, education, promotion and outreach activities among these populations, and build the capacity of healthcare service providers to better meet their needs.

EVALUATION METHODS

The IPF undertakes regular project monitoring activities, which includes annual data collection through completed performance measurement tools (PMTs). PMTs are data collection instruments (both qualitative and quantitative data) that allow recipients to report progress on activities and indicators during the previous fiscal year (April 1 to March 31). The PMT is based on the program logic model which outlines the assumptions and expected short, medium and long-term outcomes related to the IPF's theory

of change for three broad audiences — people in Canada, healthcare providers, and vaccination stakeholders. Additionally, the PMT allows the IPF to evaluate how recipients align with program objectives and core principles, how they are reaching their intended audience(s) and priority population(s) through low-barrier approaches and alignment with Sex and Gender-based Analysis Plus (SGBA+) goals, and analyze key elements of project implementation, such as best practices and innovative approaches.

KEY FINDINGS

2021-2023 investments:

IPF projects successfully reached all intended audiences:

- People in Canada (87 projects): Includes Indigenous communities, parents, children and youth, ethno-cultural minorities, newcomers, marginalized and underserved communities, religious minority communities
- Healthcare providers (52 projects): Includes physicians, nurses, pharmacists, midwives, personal support workers
- Vaccination stakeholders (53 projects): Includes community-based organizations, federal/provincial/territorial/regional/municipal vaccination policy and program planners

Of the 106 IPF funding recipients:

- 12 projects focused on the needs of Black Canadians
- 20 projects focused on the needs of Indigenous communities
- 48 projects reached children, youth and parents

- 48 projects supported the needs of healthcare providers
- 48 projects reached newcomers and refugees
- 13 projects supported the 2SLGBTQIA+ population

Logic Model Outcomes:

- Ultimate outcome: Through the efforts of IPF projects and their partners, more than 351,200 people in Canada received a COVID-19 vaccine.
- Long-term outcomes: Through the efforts of IPF projects and their partners, there were close to 4,500 vaccination opportunities.
- Medium-term outcomes: IPF resources were used 20.8M times, including over 1M instances of direct in-person access.
- Short-term outcomes: IPF resources were made available to 331.5M individuals.
- Outputs: IPF funded projects developed, curated or adapted 26,525 unique COVID-19 vaccine confidence resources, activities or services.

- Continued -

KEY FINDINGS (continued)

All 106 projects upheld IPF's Core Program Principles:

- Equity-promoting: Efforts that address the systemic barriers that impede equitable access to vaccines by improving access to tailored resources and services among communities or populations experiencing or facing social and/or structural inequities
- Cultural safety: An environment free of racism and discrimination, where people feel safe accessing services and healthcare
- Evidence-informed: Using evidence to inform understanding of an issue and/or implementing solutions identified through objective research, best or wise practices

As an equity-promoting program, the IPF strives to apply a SGBA+ perspective in all elements of implementation and analysis. The ability of IPF projects to respect and reflect the intersectionality of the communities they serve is illustrated by identifying the intended audience of IPF projects in combination with the low-barrier or barrier reducing approaches used:

- Culturally appropriate care: 65% of projects
- Meeting people “where they’re at”: 57% of projects
- Linguistically sensitive care: 48% of projects
- Social events: 38% of projects
- Incentives: 37% of projects
- Wellness kits: 37% of projects
- Food baskets/meals: 34% of projects
- Extended hours: 33% of projects
- Transportation and accompaniment: 32% of projects
- Anonymized care (no need to show ID): 29% of projects
- Religiously sensitive care: 26% of projects
- Motivational interviewing: 25% of projects

- 2SLGBTQIA: 21% of projects
- Trauma-informed care: 21% of projects
- Child care: 15% of projects

The most successful projects featured the following themes:

- Be flexible/adaptable to the changing vaccination landscape
- Share information transparently; vaccine science is constantly evolving
- Meet people where they’re at
- Develop and demonstrate an understanding of a community’s historical context and present-day priorities before addressing vaccine confidence
- There is no “one-size-fits-all”
- Tailor initiatives to reflect the unique experiences of the community
- Trust and relationship building
- Build relationships and trust as the foundation for vaccine confidence
- Include community members in planning and implementation to increase engagement and “buy-in”
- Leverage credibility of community leaders
- Recruit trusted leaders in respectful ways to make inroads in tightly knit communities
- Representation matters
- Recruit and train community ambassadors who understand the lived/living experience of your audience
- Engage healthcare professionals and other experts with the same lived experience as your audience
- Establish and maintain partnerships to better reach and serve your audience
- Strategic partnerships can increase access to the intended audience and support knowledge dissemination

ADDITIONAL FINDINGS, INSIGHTS, LIMITATIONS

Challenges observed by the IPF: - While the IPF has seen a great number of successes since its implementation in 2016, IPF has also observed the following challenges: - Burnout and fatigue has been experienced by recent IPF funding recipients, especially due to the length of the pandemic. - Misinformation and disinformation (MIDI) continue to threaten vaccination in Canada. IPF recipients, through the funded projects, addressed MIDI directly through education, community engagement, online tools and local outreach. However, MIDI remains a challenge to	vaccination efforts and contributes to vaccine hesitancy - Related to MIDI, backlash against vaccination programming, as was seen during the pandemic, can impede efforts to ensure equitable and timely access to vaccines - Distrust in vaccination has been observed by IPF recipients, in particular those working with Indigenous and diverse cultural-linguistic communities. This can be fueled by MIDI or may also result from historical trauma - Administrative burden with reporting requirements.
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ADDITIONAL INFORMATION

- [Program Website](#)
- [Current Funding \(2024-2026\) Call for Applications](#)

Mpox Vaccine Equity Program

Fulton County Board of Health, Georgia

Profile developed from publicly available information: May 2024

OVERVIEW

This program assessed evidence on narrowing disparities.

Vaccine	Mpox
Duration	June - September 2022
Population	Black/African American and Hispanic/Latino men who have sex with men
Location	Fulton County, Georgia
Funding/Sponsors	Fulton County Board of Health (FCBOH)
Goals	In the first two weeks of Mpox vaccine roll out, over 70% of the disease burden occurred in non-White persons, whereas over 90% of the vaccines went to White men. The purpose of the intervention was to correct racial/ethnic disparities in vaccine administration and attempt to match vaccine distribution to disease burden.
Intervention Design/Methodology	To correct these disparities, FCBOH implemented two key strategies. • The FCBOH partnered with community-based organizations (CBOs) specifically serving Black and Latino men who have sex with men. These partnerships provided trusted messengers to disseminate reliable and accurate information quickly to those who would benefit most from vaccination. • During the rollout, one day per week of vaccine administration was specifically reserved for partnering CBOs and the clients they identified as eligible for the vaccine.

EVALUATION METHODS

Methodology: quantitative

- To evaluate the intervention’s impact on disparities, the number of first dose Mpox vaccines given to non-White individuals compared to White individuals was assessed.

KEY FINDINGS

Outputs: n/a

Outcomes:

- During the intervention period, a total of 4,794 first dose Mpox vaccines were administered, with 2,851 (59%) given to non-White individuals and 1,865 (39%) given to White individuals.
- In the first two weeks of vaccine administration, over 70% of the disease burden occurred in non-White persons, whereas over 90% of the vaccines went to White men. A reversal of the disparity occurred by July 26, with a greater number (cumulative) of total vaccines going to Black and Latino recipients by August 2, a trend that was sustained through the end of the intervention.

ADDITIONAL INFORMATION

[Reversing Inequity in Mpox Vaccine Distribution, Fulton County, Georgia, June–September 2022](#)

National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities

CDC's National Center for State, Tribal, Local and Territorial Public Health Infrastructure and Workforce (Public Health Infrastructure Center)

Profile developed from publicly available information: May 2024

OVERVIEW

Vaccine	COVID-19
Duration	June 2021 - May 2026
Population	Populations at higher risk and that are underserved, including racial and ethnic minority groups and people living in rural communities
Location	Nationwide
Funding/Sponsors	U.S. Department of Health and Human Services (HHS)
Goals	The intended outcomes are to: • Reduce COVID-19-related health disparities • Improve and increase testing and contact tracing among populations at higher risk and that are underserved, including racial and ethnic minority groups and people living in rural communities • Improve state, local, US territorial and freely associated state health department capacity and services to prevent and control COVID-19 infection (or transmission) among populations at higher risk and that are underserved, including racial and ethnic minority groups and people living in rural communities
Intervention Design/ Methodology	Program Strategies • Expand existing and/or develop new mitigation and prevention resources and services to reduce COVID-19 related disparities among populations at higher risk and that are underserved. • Increase/improve data collection and reporting for populations experiencing a disproportionate burden of COVID-19 infection, severe illness, and death to guide the response to the COVID-19 pandemic. • Build, leverage, and expand infrastructure support for COVID-19 prevention and control among populations that are at higher risk and underserved. • Mobilize partners and collaborators to advance health equity and address social determinants of health as they relate to COVID-19 health disparities among populations at higher risk and that are underserved.

EVALUATION METHODS

Performance Measures corresponded to each of the four strategies listed above. The measures related to vaccines include:

- **Measure 1.1:** Number of COVID-19 mitigation and prevention resources and services delivered in support of populations that are underserved and disproportionately affected by type (e.g. mobile clinic)
- **Measure 1.5:** Delivery and access to vaccination resources and services in support of populations that are underserved and disproportionately affected
 - Number of vaccination resources and services delivered in support of populations that are underserved and disproportionately affected
- Populations of focus that were supported by vaccination resources and services
 - Number of vaccination resources and services delivered to population of focus
 - Settings where vaccination resources and services were delivered to populations of focus
 - How vaccination resources and services were delivered to populations of focus
 - Partners mobilized to delivered vaccination resources and services to populations of focus

KEY FINDING

Forthcoming

ADDITIONAL INFORMATION

[CDC's Initiative to Address COVID-19 Health Disparities: Lesson](#)



NWC5 and VAC5 Grant Awards Analysis

Centers for Disease Control (CDC), National Center for Immunization and Respiratory Diseases, Immunization Services Division, Advancing Research in Immunization Services Network (ARISE) and the Administration for Community Living (ACL)

Profile submitted August 2024

OVERVIEW

Vaccine	COVID-19
Duration	Survey field June to August 2023
Population	The survey included responses from 89 state- and territory-level grantees who had received Aging and Disability Resource Center Vaccine Access (NWC5) and/or Older Americans Act Vaccine Access (VAC5) Grant. These grantees represented government entities such as state and territorial departments of health, economic security, aging, senior services, elder affairs, and human services.
Location	Country wide
Funding/Sponsors	CDC, NCIRD
Goals	The goal of the study was to evaluate the impact of CDC and ACL grants (\$100M) on adults' COVID-19 vaccine uptake among older adults and people with disabilities. It aimed to assess the strategies employed by states and territories to enhance vaccination rates in these populations.
Intervention Design/ Methodology	The grants provided funding for education and outreach activities, dissemination of credible information about COVID-19 vaccines, engagement in outreach activities to the public, media outreach activities, scheduling appointments, providing transportation, and supporting partnerships. NWC5 grantees utilized funding to support a range of partners while VAC5 grantees primarily focused on direct contracts with Area Agencies on Aging.

EVALUATION METHODS

Methodology: mixed methods, retrospective survey

The evaluation was conducted through a retrospective survey that explored approaches to improve adult COVID-19 immunization uptake,

the extent to which these approaches promoted vaccine equity, the impact of grant funding on ACL activities around COVID-19 vaccination, and identification of promising practices and lessons learned from grant-supported efforts.

KEY FINDINGS

- Both NWC5 and VAC5 grantees used funds for education and outreach, including disseminating credible information about COVID-19 vaccines, engaging in outreach activities to the public, and conducting media outreach activities. They also focused on efforts to increase access to vaccination such as scheduling appointments and providing transportation. However, VAC5 grantees primarily utilized direct contracts with Area Agencies on Aging, while NWC5 grantees supported a range of partners to reach older adults and people with disabilities.
- NWC5 funds reached a larger population at a lower cost per individual reached in comparison to VAC5 funds, suggesting cost efficiencies in its utilization.
- Both NWC5 and VAC5 grantees expressed positive perceptions regarding the impact of funding on achieving COVID-19 immunization goals, specifically in increasing vaccine uptake.
- NWC5 grantees expressed more optimism than VAC5 grantees regarding the likelihood of sustaining efforts after funding ends.

ADDITIONAL FINDINGS, INSIGHTS, LIMITATIONS

Additional Insights:

- The findings underscore the importance of collaboration between federal agencies in addressing vaccination challenges among older adults and people with disabilities.
- Partnerships and outreach campaigns played a key role in increasing vaccine equity among older adults and adults with disabilities—populations that are not always reached by mainstream methods.
- NWC5 and VAC5 funding helped state- and territory-level grantees boost organizational capacities during a period when additional capacity was most needed.

Limitations:

- Cross-sectional data were collected during the summer of 2023, which may not fully capture the dynamic nature of COVID-19 vaccination strategies and developments that occurred over the course of the full grant period.

- Variations in the vaccination landscape during different phases of the pandemic could have affected the relevance and effectiveness of interventions funded by the NWC5 and VAC5 grants. The survey may not have captured rapid shifts in vaccine distribution priorities, emerging variants of the virus, and evolving public perceptions.
- There is a possibility of social desirability bias, where grantees may have downplayed challenges or reported fewer obstacles to show gratitude for the funding received. This bias could affect our understanding of the actual challenges faced by grantees.
- The reasons for differences between NWC5 and VAC5 grants in reported challenges were not explored in this survey. Further investigation is needed to understand these differences and how they impact implementation obstacles.

Partnering with Community Action Agencies to Improve Trust in Vaccines

The Association of State and Territorial Health Officials (ASTHO), National Community Action Partnership, Gramercy Research Group

Profile Submitted June 2024

OVERVIEW

Vaccine	Adult vaccines, focusing primarily on COVID-19 and influenza
Duration	2021 to 2024
Population	Adult racial and ethnic minority groups, focusing on: rural populations, low-income communities, people who are uninsured/underinsured, people living with disabilities, people experiencing homelessness, migrant populations, tribal communities
Location	ASTHO provided subawards to five community action agencies (CAAs) covering the following geographic areas, all areas with high rates of disparities of vaccination rates and other disparities as indicated in the Social Vulnerability Index: • Community Action Program for Central Arkansas (CAPCA) – White, Cleburne and Faulkner counties, AR • Pickens Community Action – Pickens County, AL • Enrichment Services Program, Inc. – Russell County, AL; Troup and Stewart Counties, GA • Community Action Partnership of Kern (CAPK) – Kern County, CA • Palmetto Community Action Partnership – Berkeley County, SC
Funding/Sponsors	This is one of the evaluation-focused projects of CDC’s Partnering for Vaccine Equity (P4VE) Program.
Goals	This project works with five community action agencies connected to the National Community Action Partnership (NCAP). ASTHO, NCAP and the five community action agencies are implementing a Community Action Team model that focuses on an integrated set of services provided at deeply trusted agencies embedded in their communities.

- continued -

**Goals
(continued)**

The goals of the project are to:

- Build the evidence base of effective interventions to improve vaccination coverage.
- Identify and implement strategies to reduce racial and/or ethnic disparities in adult vaccination coverage

The project has multiple components including technical assistance, engaging in site visits, enabling opportunities for peer-to-peer learning, developing community and provider-oriented resources such as a Vaccine Equity toolkit, and hosting a culminating meeting to share lessons learned.

In addition, ASTHO and NCAP have been working with our five community action agency partners to identify strategies to sustain vaccine equity and health equity efforts beyond the funding period of this grant.

**Intervention
Design/
Methodology**

ASTHO's Vaccine Equity project used a public health-community action-healthcare partnership approach to increase acceptance and uptake of vaccines. The grant focused on adult COVID-19 and influenza immunizations, but other age groups and additional vaccines were included to increase acceptance and reach.

Community action agencies work to increase stability among the populations they serve by increasing access to housing, childcare, food and nutrition, healthcare, training, and education. CAAs are an ideal complement to public health's mission to address the social determinants of health. CAAs are also experts in using the community action team model to increase outreach by working with other sectors in the community. Over the last several years, ASTHO's five CAA partners worked with their local faith-based organizations, schools and universities, cultural leaders, health departments, healthcare providers and others to increase access to vaccines and to amplify their messaging that vaccines are safe and effective.

NCAP hosted a learning community among the five CAAs to provide opportunities for peer-to-peer learning and to bring in experts on strategies such as: braiding and layering of funding, using a whole family approach, and measuring the impact of messaging. ASTHO partnered with our internal disability inclusion experts to provide a series of trainings on vaccine equity for people living with disabilities.



EVALUATION METHODS

Methodology: mixed methods

ASTHO contracted with Gramercy Research Group to develop an evaluation framework and reporting tools for this project. Gramercy Research Group developed an evaluation strategy stratified at three levels:

- Partnerships – including engagement, collaboration and satisfaction
- Sites – including strategies/implementation, partners/collaboration and alignment with similar activities in the community
- Impact – including changes in outcomes of interest and impact compared to similar initiatives

The evaluation strategy includes a mix of quantitative and qualitative data collection, while keeping reporting burden low for our community partners. Gramercy Research Group developed an online engagement report for community partners to submit monthly quantitative data on their outreach efforts. For sites with limited capacity to complete online submissions, Gramercy contacted the community partners and completed the monthly reports using an interview format. The Gramercy team also conducted qualitative interviews with each site quarterly to obtain more in-depth information. Evaluation data included:

- Types of partners engaged over time to support vaccine coverage, including: community members, organizational staff, partner organizations, stakeholders and government officials

- New partners engaged to support vaccine coverage
- Populations reached (noting the intersectionality between many of these groups): Homeless populations, migrant populations, people who are undocumented, low-income populations, race/ethnicity, migrant/seasonal workers, tribal communities, people with disabilities

Types of strategies used to reach populations of focus: communication strategies (media, social media, PSAs, advertisements), community events, etc.

- # and types of events to support vaccine coverage categorized as: planning, outreach, training and/or clinic events
- # and types of vaccines administered: COVID-19, influenza, Pneumococcal, Shingles, HPV, Tetanus, Whooping Cough, T-dap, or other
- # of community members engaged in vaccine coverage efforts
- Demographics of community members who supported vaccine coverage efforts and who received vaccines including race/ethnicity, sex and age
- Successes, barriers, lessons learned and key messages when implementing vaccine coverage activities
- In addition to periodic reports to funders, the data is being compiled into a series of case studies on each site and a final evaluation report (forthcoming).



KEY FINDINGS

Data as of May 8, 2024:

- # Outreach events: 261
- # Clinic events: 150
- # Planning/training/other events: 109
- # Community members engaged (directly or via media/social media): 1,648,944
- # Adult vaccines (COVID primary, boosters, flu, Shingles and others): 5,808

ADDITIONAL FINDINGS, INSIGHTS, LIMITATIONS

Our evaluation work had a number of limitations, including:

- This project was implemented under an emergency response scenario, so the evaluation was quickly implemented to meet the needs of funder requirements, but not necessarily what would have been most useful to community partners
- More support should have been given on the outset to ensure data collection, including baseline data, was collected uniformly across all sites
- We were unable to directly link county vaccination rates to outreach efforts due to data limitations. (For example, an event held in a certain county could draw people from multiple neighboring counties.)
- We were not able to directly measure the impact of trusted messengers.
- We should have collected data on number of referrals to other services such as housing, food, childcare, etc. as this was a big outcome – we only have anecdotal reports
- Data may not represent unique individuals, as the sites reported data in aggregate
- Most community partners had limited staffing and staff played multiple roles within each organization. Most partners did not have dedicated data collection/evaluation staff so data collection efforts focused on collected as much data as possible to evaluate the most important project-related outcomes without being cumbersome to community partners.

ADDITIONAL INFORMATION

[New ASTHO Program Aims to Increase Equity in Adult Immunization | ASTHO](#)

[Partnering with Community Action Agencies Can Improve Trust in Vaccines | ASTHO](#)

[Advancing Health Equity Through Immunization](#)

[Championing Change: A Toolkit for Addressing Vaccine Equity Through Community Mobilization](#)

[ASTHO Helping Agencies and Providers Advance Vaccine Equity](#)



Promising Practices Project

Urban Institute

Profile developed from publicly available information: May 2024

OVERVIEW

Vaccine	Adult COVID-19 and influenza vaccines
Duration	Ongoing
Population	Underserved communities
Location	Nationwide
Funding/Sponsors	CDC as part of the Partnering for Vaccine Equity Project (P4VE)
Goals	The goal of the CDC’s Partnering for Vaccine Equity (P4VE) program is to address racial and ethnic disparities in adult COVID-19 and influenza vaccination rates.
Intervention Design/ Methodology	The P4VE program funds national, state, local, and community-level partners to improve equitable access to vaccines by promoting vaccine confidence and addressing barriers to vaccination. Alongside funding the program provides technical assistance, guidance and communications to partners’ activities such as researching and addressing vaccine misinformation. The Urban Institute participates in P4VE in two ways: 1. Acting as the group learning manager for the P4VE learning community 2. Providing sub-grants and technical assistance to community-based organizations (CBOs) participating in P4VE. The Urban Institute’s Promising Practices Project, supported 18 CBOs to implement tailored outreach strategies to advance vaccine equity and uptake in their communities. The project provided grants of up to \$25,000 to each of the organizations to develop, implement, and evaluate the effectiveness of a promising practice in one of three areas: 1. media based outreach 2. community based outreach 3. vaccine events and partnerships The 18 organizations provided with Promising Practices grants were able to build their evaluation capacity to measure the effects of their program activities. Overall, the Promising Practices Project sought to build a foundation of evidence-based practices that promote vaccine equity and reduce vaccine disparities among underserved communities.

EVALUATION METHODS

Methodology: Mixed methods

Output Measurements:

Across the three different practice areas (media-based outreach, community-based outreach and vaccine events and partnerships), CBOs measured effectiveness with the following evaluation methods and metrics:

- Online social engagement metrics (e.g. number of likes on a Facebook post or views of a Youtube video, number of resource downloads)
- Traditional media metrics (e.g. number of radio listeners)
- Number of vaccination events held
- Number of event attendees

- Number of vaccine doses administered
- Number of partnerships
- Number of people referred to other social or health services

Outcome Measurements:

- Pre- and post- assessment surveys to measure media literacy skills, vaccine knowledge
- Participant satisfaction and demographic surveys (questions included event participant experience, reasons for attending, barriers to care and preferred outreach, etc)
- Interviews and focus groups with community members to assess information habits, communication preferences and current vaccination myths/misinformation

KEY FINDING

Output Measures:

Details on each CBO's evaluations can be found [here](#).

Additional Measures:

Collectively, evaluation of CBOs' engagement activities revealed the following promising practices:

- holding events within community settings that are familiar to community members
- developing trusted relationships within the community and working closely in and with the communities they wish to reach and serve

- tailoring and targeting culturally and linguistically appropriate messages to reach distinct populations and groups
- using diverse media and strategies to access different audiences and maximize the overall reach of messaging
- promoting COVID-19 vaccine information and education within a broader public health or holistic health context
- countering the constant, rampant misinformation in social and print media that is shared among friends and family about COVID-19 and how to prevent and protect oneself from it

ADDITIONAL INFORMATION

Urban Institute [Building the Evidence Base for Advancing Vaccine Equity](#)



Supporting Community-Based Organizations to Ignite a Culture of Immunization: Report

Vaccinate Your Family & Día de la Mujer Latina

Profile submitted August 2024

OVERVIEW

Vaccine	All vaccines
Duration	Report issued in September 2022.
Population	Policymakers, government agencies, funding organizations
Location	United States
Funding/Sponsors	Vaccinate Your Family
Goals	Examine how federal funding earmarked for community-based vaccination efforts was distributed during the COVID pandemic
Intervention Design/ Methodology	Vaccinate Your Family worked with Avalere Health to conduct an analysis of the federal vaccine confidence funding distributed to organizations and institutions under Sections 2302 and 2501 under the American Rescue Plan Act, as well as other COVID-19 relief awards, including the CARES Act and the Coronavirus Response and Relief Supplemental Appropriations. The report also included call outs from partners at the National Council of Negro Women and Día de la Mujer Latina, who offered extensive lessons learned.

EVALUATION METHODS

The analysis utilized HHS’ Tracking Accountability in Government Grants System (TAGGS) website, Grants.gov, USASpending, SAM.gov and GovTribe for information on any grants authorized.

Grant opportunities for CBOs were evaluated based on three criteria:

- Response time — Did the government’s Requests for Proposals (RFPs) allow organizations sufficient time to submit a response, given the often complex and time-consuming process required to fulfill the requirements for federal grant opportunities?

- Project length — Was the proposed project length sufficient for CBOs and other grantees to build capacity and infrastructure within their communities?
- Conditions — Did the conditions of who could apply for the grant preclude local CBOs from applying in factor of larger organizations and institutions less familiar with the community but more equipped to complete and qualify for federal grant applications?

The list of grantees and their award amounts were also compiled and included in the appendix of the report.

KEY FINDINGS

This report examines when and how COVID-appropriated dollars were spent to support the number one driver of vaccination rates in vulnerable communities: community-based organizations (CBOs).

They considered how the nearly \$500 million identified by Congress specifically for community efforts was allocated and included a comprehensive lists of those efforts.

Barriers to compensation may threaten CBO participation in future programming and pose risks for public health initiatives. The investigation found that the way government agencies developed their grantmaking protocols often made it difficult for CBOs to become recipients/ collaborate. In multiple cases, grant conditions, as well as short application windows and funding

periods, appeared to privilege larger institutions with greater administrative capacity, rather than smaller CBOs with deeper community ties.

Government grants represent the majority of CBO funding; however, these grants are often inconsistent and require administrative resources that are difficult for smaller CBOs to maintain. Even as sub-recipients for larger organizations awarded federal funding, CBOs can face substantial barriers. Reimbursement models favored by some larger organizations, for example, rely on the partner organization to front the costs of implementing activities and be reimbursed only after the work is completed. This can put devastating financial strain on CBOs and limit their ability to work in their communities.

ADDITIONAL FINDINGS, INSIGHTS, LIMITATIONS

Federal funding must be transparent and recalibrated. Federal legislation regarding funds for vaccine infrastructure and confidence could, and should, include language mandating that funds meant for local CBOs be given to those organization.

Private donors can fill gaps the government cannot. Private donors, such as individuals, foundations, and other non-governmental institutions, often have more flexibility in their funding than the federal government.

Public health partners must incorporate CBOs into their work. To truly reignite the culture of immunization, the public health community must aim for equity, not equality. There are many spaces where public health should not just bring another chair to the table but give up their seats and look to CBOs for instruction and next steps. All public health partners should look at their spheres of influence and determine whether there are CBOs missing.

ADDITIONAL INFORMATION

[Supporting CBOs to Reignite a Culture of Immunization - Vaccinate Your Family](#)

The Vaccine Equity Project

National Network of Public Health Institutes (NNPHI)

Profile submitted August 2024

OVERVIEW

Vaccine	COVID-19 (primary focus), also influenza, TDAP, Hep, RSV, shingles, pneumonia, adult routine immunizations were provided.
Duration	July 2021 – December 2024
Population	Communities of color, rural communities, refugee and immigrant, limited English language groups, LGBTQIA+, Tribal communities. N= 45 languages, 45 identity groups.
Location	Nationwide
Funding/Sponsors	Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS); (CDC-RFA-IP21-2113: <i>Immunization Research, Demonstration, Public Information and Education Training and Clinical Skills Improvement Projects</i>)
Goals	This work focused on COVID-19 vaccinations and identified and tested strategies and implementation approaches that exemplify best practices for public health outreach initiatives to under resourced and hard-to-reach populations.
Intervention Design/ Methodology	This project included an evaluation designed to support frontline organizations so they can take the lead in developing and evaluating outreach approaches that address their community’s needs in linguistically and culturally responsive ways. NNPHI worked with eight community-based organizational (CBO) partners and three coordinating organizations over the course of 3 years. Our CBO partners worked with 287 community organizations in 204 counties during this time. This project used a mixed-method phenomenological approach that was grounded in a participatory model of evaluation. Interviews were conducted by a contractor to avoid potential perception of bias. Input from CBO partners shaped the cross-portfolio outcome measures.

EVALUATION METHODS

Methodology: mixed-method phenomenological

Partners worked together to identify evaluation measures meaningful to each community, as well as approaches to gather data that aligned with federal reporting and funding requirements. Community co-creation was key. Evaluation for this project was two-tiered: (1) sites were required to include evaluation in their workplans in year 1; this built capacity across partners and provided the necessary funding to hire high-quality partners; (2) evaluation across the portfolio of partners by NNPHI. Site evaluation (#1) involved TA from NNPHI for coordination/inclusion of required metrics with minimal burden; (#2) included submission of tracking data monthly, check-in meetings to share activity updates monthly, a series of individual in-depth interviews with staff at each site, and three all-hands facilitated group discussions about overall themes, with the purpose of collaborative meaning making.

At the end of year 1, NNPHI was able to identify themes and common metrics across sites. In year 2, the contracted partner conducted in-depth site interviews, and convened three virtual group dialogues to bring observations to the partners and gather direct feedback and reflection. From this, a set of Guiding Principles and implementation strategies that fell into each domain were identified. NNPHI drafted a summary of this information and presented it to the partners in person at an in-person gathering, where language was edited together and concepts were validated.

Data collected in year 3 used a standardized tracking sheet with key variables collected across all sites, as well as tracking data for application of the Guiding Principles each month.

Data collected on monthly tracking sheets submitted by CBOs included:

- Zip codes or counties where outreach was conducted
- Self-identified demographics
- Guiding Principles and Strategies applied each month (from a list)
- Number of events held for training or education about adult vaccination
- Number of events where vaccines for COVID or other adult vaccines were provided
- Number of COVID vaccines provided; Other types of adult vaccines offered
- Types of media used for outreach and number of individuals reached
- Number of new and existing organizational partnerships by month
- Languages used in outreach, education, or training

Project ECHO webinars (n=8) included survey data collected after each session.

KEY FINDINGS

- Outreach for adult vaccination occurred in 204 counties in the geographical United States
- Reached populations that self-identified as 45 different identity groups (e.g. Hmong, Indonesian, KaRen, LGBTQIA+, unhoused, etc) and spoke 45 languages.
- Over the project period, 351 vaccine clinics were conducted
- Approximately 26,845 people (a known undercount) were vaccinated for COVID-19 as well as offering Influenza, TDAP, Hepatitis, and RSV vaccines.
- 873 education or training events were held through 484 organizational partnerships on this project.
- Materials created for outreach both in person and through social media reached 989,222 people, with more than 376 items (e.g. flyers, PSAs, ad copy, media messages, etc.) created.

- This does not include counts from 17 national webinars hosted by NNPHI.

A brief write up on early impact can be read [here](#) and The Guide to Advancing Health Equity will be available [here](#).

[Five Guiding Principles and correlational implementation strategies](#) were identified by the partners. These were validated by tracking implementation at a total of 8 CBO partner sites. All concepts were validated by subsequent data, although several strategies appear to be used only in early stages of projects. Project ECHO series webinars explored these principles in depth and were rated highly by attendees.

By providing explicit evaluation funding, partnerships that had not previously existed were formed, developing infrastructure not only through relationship creation but also through skills and insight development for CBO partners related to evaluation approaches and value.

ADDITIONAL FINDINGS, INSIGHTS, LIMITATIONS

A Community Guide for Advancing Health Equity is being produced from lessons learned with links to toolkits and customizable resources.

- A total of 17 webinars were hosted by NNPHI during this project period:
- A 3-session series in year 1 focused on centering community narratives, for PH professionals, featuring our CBO partners.
- A 3-session series of media training webinars were held in year 2 for CBO partners.

- A 3-session series Data Bootcamp was held in year 3 for CBO partners.
- An 8-session Project ECHO series for an interactive audience consisting of public health professionals, institute staff, university researchers, funding partners, and community based non-profit professionals.

Recorded videos will be hosted on www.advancinghealthequity.nnphi.org when the site goes live.

Unidos De Salud/United in Health

Latino Task Force (LTF), UC San Francisco, UC Berkeley, San Francisco Department of Public Health, Chan Zuckerberg Biohub

Profile developed from publicly available information: May 2024

OVERVIEW

This program assessed evidence on narrowing disparities.

Vaccine	COVID-19
Duration	2020 - Ongoing
Population	Latinx Communities
Location	Mission District neighborhood, San Francisco, CA
Funding/Sponsors	UCSF, Chan Zuckerberg Initiative, Crankstart Foundation, Patrick J. McGovern Foundation, San Francisco Department of Public Health
Goals	Sought to increase uptake of COVID-19 vaccination among Latinx persons in the Mission District of San Francisco and to activate clients to be community vaccine ambassadors within their social networks.
Intervention Design/Methodology	UeS designed and implemented the “Motivate, Vaccinate, and Activate” strategy a community-centered, culturally-tailored, theory-informed and multi-component vaccination strategy aimed at addressing multiple barriers to COVID-19 vaccination faced by Latinx and other community members such as transportation and “institutional mistrust”. The “Motivate, Vaccinate, and Activate” strategy’s design was guided by the PRECEDE Model.

EVALUATION METHODS

UeS used the Reach, Effectiveness, Adoption, Implementation and Maintenance (RE-AIM) framework evaluate the “Motivate, Vaccinate and Activate” strategy as it allowed for individual client-level outcomes (reach and effectiveness), as well as site and community-level outcomes (effectiveness, implementation, and maintenance). Below are details on the indicators used to assess each component of the RE-AIM framework and the data collection/source used.

Reach:

- Number of vaccination appointments scheduled at the UeS site
- Number of vaccine doses delivered at the UeS site
- Vaccination and demographic information collected at the UeS site

Effectiveness: Assessed using indicators of behavior change

- Proportion of clients who said that they were able to get vaccinated more quickly had the neighborhood site not existed
- Proportion of clients who stated that they were more likely to reach out to and recommend vaccination to their unvaccinated friends, family members and coworkers after their experiences at the UeS neighborhood vaccination site.

- Proportion of clients who completed their second vaccine dose at the UeS site
- Collected in a post-vaccination structured survey

Implementation: Measured with assessment of fidelity to each of the implementation strategy components and acceptability of the overall implementation strategy among community members vaccinated through the UeS Neighborhood site.

- (Fidelity) Were the components of the Motivate, Vaccinate, Activate strategy delivered?
- (Fidelity) What, if any, adaptations were made to the components?
- (Acceptability) Percentage of clients who said they would recommend the UeS site to others, collected in post-vaccination structured survey

Maintenance:

- Assessment of temporal trends in the number of individuals receiving their first COVID-19 vaccination—overall and according to both eligibility criteria and ethnicity.

KEY FINDINGS

RE-AIM Framework:

Reach:

- 12,103 unique individuals registered for a COVID-19 vaccine at the UeS site
- Of which 11,098 (91.7%) received at least one vaccine dose at the UeS site
- Among all eligible individuals estimated to be living in the Mission District, 5.7% received at least one vaccine dose at the neighborhood site; this included 11.9% of the estimated number of Latinx residents. Compared to the ethnic makeup of the Mission District, clients receiving at least one vaccine dose at the neighborhood vaccination site were far more likely to be Latinx and far less likely to be white.

Effectiveness:

- 58.4% of clients that said they got vaccinated sooner than they otherwise would have had the neighborhood vaccination site not existed; this included 56.1% of Latinx clients and 63.2% of non-Latinx clients (Table 5).
- 90.1% of clients said they were more likely to recommend getting vaccinated to family members, friends, and co-workers after their experiences at the neighborhood vaccination site
- 91.0% said that after their first vaccination experience, they personally reached out to at least one unvaccinated person they knew to recommend COVID-19 vaccination; Latinx clients were more likely than non-Latinx clients to reach out and recommend vaccination to 3 or more persons

Implementation:

- Fidelity: Overall, each of the components of the “Motivate, Vaccinate, and Activate” strategy were delivered as originally intended with few adaptations.

- Acceptability: The UeS neighborhood site was highly acceptable to clients who were vaccinated there. Of 997 clients completing the survey, 98.6% stated that they would recommend the site to others

Maintenance:

- The large majority of clients reached throughout the entire implementation period were Latinx. While the number of new individuals vaccinated in May 2021 declined (mirroring local and national trends), the proportion of daily vaccinations that were among Latinx individuals increased.

Outputs:

- 12,103 unique individuals registered for a COVID-19 vaccine at the UeS site
- Of which 11,098 (91.7%) received at least one vaccine dose at the UeS site

Outcomes:

- 70% of more than 11,000 vaccine recipients during the evaluation period were Latinx
- 98% of clients completed both vaccine doses, which is higher than early national estimates of 88%
- The vaccination program was highly acceptable, with 99% of clients reporting they would recommend the site to others.
- The program was also highly effective, as 58% of people reported that they were vaccinated sooner because of the program, and among those who received both vaccine doses, over 90% of clients personally reached out to at least one person in their social network to recommend COVID-19 vaccination

ADDITIONAL FINDINGS, INSIGHTS, LIMITATIONS

- Unable to fully disentangle the relative effects of the different components and subcomponents of the overall strategy.
- Though a high proportion of people reported that someone they referred received a vaccine, it cannot be measured directly.

ADDITIONAL INFORMATION

Report: [*Advancing COVID Health Equity: Strategies for developing an equity-first response*](#)

VA Puget Sound Vaccine Equity Project

Puget Sound Veterans Affairs Health Care System

Profile developed from publicly available information: May 2024

OVERVIEW

This program assessed evidence on narrowing disparities.

Vaccine	COVID-19
Duration	2020-2021
Population	Veterans and active-duty service members
Location	VA Puget Sound - Seattle and Tacoma Washington locations
Funding/Sponsors	US Department of Veterans Affairs
Goals	Equitable, coordinated, and data-driven COVID-19 vaccination drive with respect to race, ethnicity, age, and geographic distance in a veteran population
Intervention Design/ Methodology	Began with the design of a vaccination allocation and priority strategy that identified individuals for early targeted outreach based on CDC-defined high-risk comorbidities and high-risk racial or ethnic groups. The allocation strategy then informed their outreach, delivery and monitoring strategies. For example, “facilitate uptake among those suspected to be at risk of barriers to vaccination, our facility worked with trusted frontline personnel, community stakeholders, our Social Work service, and local nonprofit veteran advocacy groups. We specifically disseminated tailored outreach to homeless veterans and rural and minority veterans”

EVALUATION METHODS

Methodology: quantitative	Outcome Measurements: Vaccine equity was monitored at intervals of every 10,000 vaccinations by comparing the cumulative proportion vaccinated by race and ethnicity, sex, and rural status within each agecohort.
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KEY FINDINGS

As of July 28, 2021, the facility had administered a total of 79,643 vaccinations to 41,386 individual veterans, representing 41.6% of the total	population of 99,362 veterans, including 41.5% of Black enrollees, 28.9% of American Indian/Native Alaskan enrollees, and 34.9% of white enrollees.
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ADDITIONAL INFORMATION

The interventions approach and its evaluation is shared in the article: [Best Practices for an Equitable COVID-19 Vaccination Program \(October 2021\)](#)

REACH Lessons Learned Project

Association of Immunization Managers (AIM)

OVERVIEW

[REACH \(Racial and Ethnic Approaches to Community Health\)](#) is a national program sponsored by the Centers for Disease Control and Prevention (CDC) to reduce racial and ethnic health disparities. AIM partnered with CDC to engage and support participating REACH organizations in their efforts to address racial and ethnic disparities related to COVID-19 and flu vaccination coverage

Through this partnership—known as iREACH—recipients plan and carry out local, culturally appropriate programs to address racial and ethnic disparities in immunization coverage among Black/African American, Latino, Asian, American Indian, and Pacific Island/Alaska Native communities. AIM provided opportunities for support, collaboration, coaching, and learning focused on navigating implementation challenges and sharing promising practices.

Vaccine	Primarily COVID-19 vaccines and flu vaccines. A few of the other adult-recommended vaccines were incorporated between October 2023–September 2024.
Duration	October 2020–September 2024
Population	Black/African American, Latino, Asian, American Indian, and Pacific Island/Alaska Native communities across the United States.
Location	REACH organizations were located across 26 states/jurisdictions: Alabama, Alaska, Arizona, Arkansas, California, Connecticut, Florida, Georgia, Hawaii, South Carolina, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, Nevada, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington, District of Columbia.
Funding/Sponsors	AIM's iREACH program and the evaluation was supported by the CDC of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$3,250,000, with 100 percent funded by CDC. The contents of this report reflect the views of the author(s) and do not necessarily represent the official views of, nor are the contents an endorsement by, CDC, or the U.S. Government.
Goals	The goal of iREACH was to assist organizations in their efforts to address racial and ethnic disparities in immunization coverage and promote and sustain vaccine equity.

Intervention Design/Methodology
Through the iREACH partnership, AIM supported organizations in their planning and implementation of local and culturally appropriate programs to address racial and ethnic disparities in immunization coverage and to promote vaccine equity.

As a part of AIM's Lessons Learned Project: COVID-19 and Flu Vaccination Best Practices in REACH communities, Neimand Collaborative was subcontracted by AIM to conduct a national environmental scan, confidential, one-on-one interviews, and online Virtual Roundtable discussions with REACH recipients. This effort documented the successes and challenges of working in communities to increase flu and COVID-19 vaccination rates and explored ways to strengthen and sustain the partnerships and activities developed over the last few years to create meaningful change in the communities that REACH recipients served.

Ten 30-minute, in-depth key informant interviews were conducted via Zoom in September 2023 with REACH recipients supported by AIM. Interviewees represented organizations that spanned a range of geographic and demographic populations.

3 online (Virtual) Roundtable discussions were facilitated on the Advanced Strategy Lab Converge platform

- The Virtual Roundtables were group discussions with a moderator who led the group through both verbal and typed discussion questions/topics.
- 34 total participants across three sessions participated, representing 24 REACH organizations.
- Each session included REACH recipients who primarily served a respective racial/ethnic community.

EVALUATION METHODS

The project’s methodology included:	organizations that spanned a range of geographic and demographic populations in the United States.
• National environmental scan • Ten 30-minute, in-depth key informant interviews conducted with REACH recipients supported by AIM. Interviewees represented	• Three virtual round-table discussions with a total of 34 participants, representing 24 REACH organizations.

KEY FINDINGS

1. Community Conditions: REACH recipient communities and priority populations are racially, ethnically, and immigrant-status diverse—requiring the activation of a range of flu and COVID-19 outreach tactics and strategies that were tailored to the needs of each community.
2. Community Strengths: A communal mindset, on-the-ground networks, and willingness and propensity to help each other through existing community activism, volunteerism, and engagement are community strengths that supported REACH organizations in their outreach efforts. Leaning into community strengths helped elevate the importance of the vaccines, reduced stigma, and established access points within the community.
3. Challenges and Successes/Lessons Learned

A few challenges encountered:

- Recipients shared that challenges evolved over the course of the pandemic between 2020 and 2023 (fear and mistrust, creating clarity and understanding about the vaccine, COVID-19 messaging fatigue) and in many instances became easier to manage.
- Other challenges were tactical and involved how to go about communicating and reaching community members, for example - ensuring native language accessibility, translations, and local dialect were accurate and culturally inclusive was a challenge. Recipients often did not have the resources or capacity to manage this need.
- Recipients also said that measuring effectiveness and understanding if specific strategies and tactics were working proved difficult. Measuring the effectiveness of partnerships based on whether the partnering organization was willing to

collaborate on future events or the length of that partnership was common, rather than measuring vaccine uptake.

A few lessons learned:

- Being clear about expectations, such as event promotion or logistical responsibilities, from the outset strengthened partner relationships.
- Knowing that the messenger was just as important as the message and critical in either combatting or fueling the spread of information. To build trust in messengers, recipients ensured that messengers were representative of the community.
- Combining vaccine outreach with general health promotions was considered a “must do” moving forward and a way to continue the conversation about vaccines beyond the pandemic.
- Engaging trusted messengers, leveraging unified and existing networks/coalitions, utilizing door-to-door and community events, and partnering with faith-based organizations are critical best practices for successful community outreach.
- Using local context, language, and demographic inclusivity in messages and visuals are key.
- Feedback-gathering and including community input in the process to inform messages, dialect, and imagery are important for building trust.
- Emphasizing the importance, safety, and effectiveness of vaccines — as well as clarifying dosing guidance and frequency — in messages is essential.

A full read out of findings from the interviews and round table discussions can be found [here](#).



ADDITIONAL FINDINGS, INSIGHTS, LIMITATIONS

Lessons learned about flu and COVID-19 vaccination communications and outreach were far-reaching. Through these key informant interviews and during Virtual Roundtable discussions consisting of cohorts of organizations serving similar populations, recipients provided a framework for future efforts focused on protecting the public from vaccine-preventable disease and illness.

Limitation - This report cannot be generalized to all communities across the country, but rather this is what was learned in these specific communities.

ADDITIONAL INFORMATION

<https://www.immunizationmanagers.org/resources/ireach-lessons-learned-report/>