Community Evaluator Project COVID-19 Disparities Grant Report: Findings from Participatory Evaluation Projects on Pandemic Related Inequities in Massachusetts

Tufts Interdisciplinary Evaluation Research (TIER)

Emma Posner, Melissa Colón, Michelle Thompson,
Rebecca Fauth, and Jessica Goldberg

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Disclaimer:
The findings and recommendations of this report are those of the authors and do not necessarily represent the official position of or endorsement by the Centers for Disease Control and Prevention or the Massachusetts Department of Public Health.

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Section I. Introduction

With funding from the Centers for Disease Control and Prevention (CDC) National Initiative to Address COVID-19 Health Disparities Award, the Massachusetts Department of Public Health (MDPH) funded Tufts Interdisciplinary Evaluation Research (TIER) to conduct a series of participatory evaluation projects on inequities related to the COVID-19 pandemic. One of the four overarching strategies under the CDC COVID-19 Disparities Award is to increase and improve data collection and reporting; this strategy includes a range of activities focused on strengthening the state's collection, analysis, and dissemination of data. Conducted using TIER's Community Evaluator model, these participatory evaluation projects seek to bring resident voices into—and illuminate their perspectives on—the state's public health response efforts. [i]

TIER's Community Evaluator model brings together program participants, residents, service providers, community leaders, and researchers to collaborate on evaluation projects. Community Evaluators are trained in a community-based participatory research (CBPR) approach, which emphasizes the importance of: (a) placing knowledge production in the hands of those directly affected by the issues being studied; (b) forming academic-community partnerships based on a commitment to co-learning; (c) building capacity in communities by training community members in evaluation; and (d) proposing program and policy solutions that represent communities' goals and aspirations.[1]

Over the course of the project period (fiscal years (FY) 2022–2024), TIER has partnered with Community Evaluators to design and implement a series of participatory evaluation projects and translate findings into program and policy recommendations. These projects are being carried out in two cohorts: the first cohort was conducted from Winter 2022 to Spring 2023 ("Cohort 1"), and the second is underway (Spring 2023 to Spring 2024 ["Cohort 2"]). This staggered approach has allowed us to incorporate improvements to the Community Evaluator model and explore emerging pandemic issues over the course of the project period. This report summarizes Cohort 1 projects, which were as follows:

- Lawrence residents' perceptions of a Telehealth Kiosk located in the Lawrence Public Library
- The experiences of frontline workers during the pandemic
- Pregnant people's decision-making on COVID-19 vaccination during pregnancy
- Parents' perceptions of COVID-19 vaccination among young children (ages 6 months–4 years)

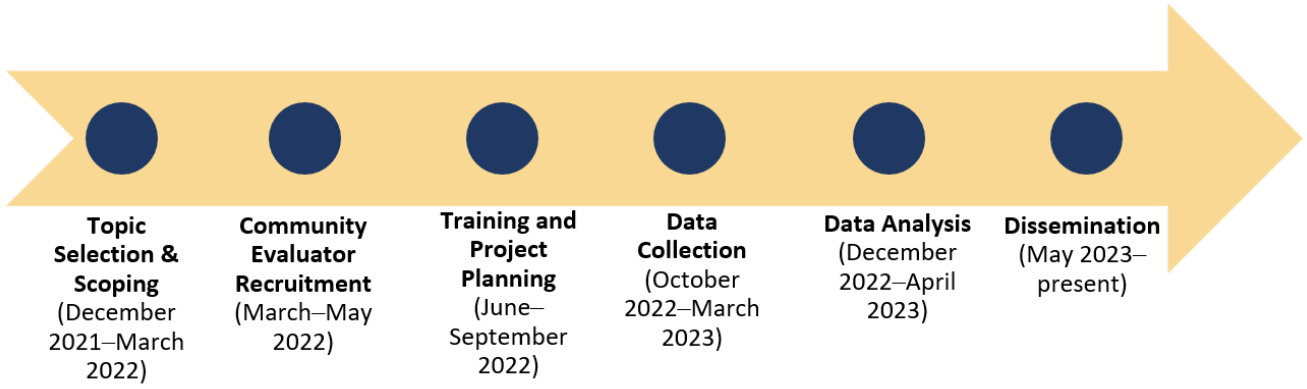
We begin with an overview of the Cohort 1 project planning and implementation process. Then, we describe methods, results and recommendations from each of the four projects. We close with a summary of findings across the four projects and offer a set of overall recommendations to inform MDPH's ongoing public health response and community-based evaluation efforts.

Project Planning and Implementation

In this section, we summarize the project planning process, including: (a) topic selection, (b) Community Evaluator recruitment, and (c) training and project planning. For an overall timeline of the work described in this report, see Figure 1.

[i] Priority populations as outlined in the CDC COVID-19 Disparities Grant include: African American, Latino, and Indigenous and Native American people, Asian Americans and Pacific Islanders, and other people of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) people; people with disabilities; people who live in rural communities; people over the age of 65, and people otherwise adversely affected by persistent poverty or inequality. These projects focused on engaging a subset of these priority populations.

Figure 1: Cohort 1 Timeline



Topic Selection and Scoping

In December 2021, TIER collaborated with MDPH partners to distribute a brief questionnaire to MDPH staff asking them to propose community-based evaluation projects that could inform the ongoing pandemic response. Twenty-two projects were proposed, and a team of MDPH and TIER staff reviewed proposals and rated them against priority and feasibility criteria to identify four projects to carry out under this grant. Priority criteria focused on alignment with the goals of the grant, including a focus on understanding racial and other inequities exacerbated by COVID-19. Feasibility criteria accounted for the potential to carry out the proposed project within the constraints of existing funding, other MDPH initiatives, and timelines.

Each selected project was connected with the MDPH team that proposed their project; this was the team that was leading public health efforts related to the topic area and well-positioned to consider the implications of project findings. During the scoping process, TIER met with MDPH project teams to learn about priority communities and populations, discuss goals for the project, and identify existing partnerships with community-based organizations to help guide Community Evaluator recruitment. Table 1 summarizes the selected projects, MDPH project teams, and overarching goals. The projects were subsequently designed in partnership with Community Evaluators selected to work on these projects.

Table 1: Cohort 1 Projects

Project	MDPH Project Team	Goal
Lawrence Telehealth Kiosk	MDPH Lawrence Telehealth Kiosk Implementation Team, *Lawrence-based Partners in Child Development (PCD), the Lawrence Public Library, and MDPH Bureau of Family Health and Nutrition*	Learn how Lawrence residents are using a new Telehealth Kiosk located inside the Lawrence Public Library
Experiences of Frontline Workers	The COVID-19 Community Impact Survey (CCIS) team and the Occupational Health Surveillance Program (OHSP*), MDPH Bureau of Community Health and Prevention*	Learn how frontline workers in restaurants and childcare settings have been impacted by COVID-19 to inform MDPH programs and resources to better support these populations
COVID-19 Vaccination During Pregnancy	The COVID-19 Pregnancy Surveillance Team, *MDPH Bureau of Family Health and Nutrition*	Learn from people who were pregnant during the pandemic about why they did or did not get the vaccine, and how MDPH can support COVID-19 vaccination among pregnant people

Project	MDPH Project Team	Goal
Pediatric Vaccine Equity Project	Pediatric and Family Workstream—the Vaccine Equity Initiative (VEI), *MDPH Commissioner's Office*	Learn from parents/caregivers about how they are feeling about the vaccine—what might prevent them from vaccinating their child, what would motivate them, and what supports or information they would need

Community Evaluator Recruitment and Selection

The goal of the recruitment process was to identify potential Community Evaluators who bring a connection and lived experience to the project's topic area personally and/or professionally. TIER collaborated with MDPH and other state and community partners to distribute the recruitment call through networks and organizations connected to each project's focal community; these included, for example, childcare centers, family support programs, community-based advisory councils, and parent leadership groups.

Candidates completed an online application on Qualtrics that emphasized understanding applicants' experience with the project topic areas and relationships in their communities. TIER received 147 applications, from which we selected 10 Community Evaluators for the four Cohort 1 projects. When selecting candidates, we considered their applications, interviews, and references, looking for individuals who met the following criteria: (a) personal or professional interest and/or experience specific to the selected projects; (b) lived and/or worked with and had strong connections within the selected projects' focal communities and populations; (c) bilingual fluency in language spoken by focal populations; and (d) time, flexibility, and interests aligned with requirements of the Community Evaluator role. For a demographic summary of the applicant pool and selected Community Evaluators, see Table 2.

Table 2: Demographic Characteristics of the Community Evaluator Applicant Pool

Characteristic	Applicant Pool (*n* = 147)	Selected Community Evaluators (*n* = 10)
Geographic Communities	57 communities representing all Massachusetts regions: • Boston—23.1% • Central—4.1% • Metro West—10.2% • Northeast—24.5% • Southeast—24.5% • Western—9.5% 4.0% of applicants were from out of state & 0.7% were from unspecified or multiple communities	Seven communities in 4 of the 6 Massachusetts regions: • Boston—Boston & Chelsea • Northeast—Lawrence & Malden • Southeast—Brockton & Fall River • Western—Chicopee
Race/Ethnicity (*n* = 146)	• Asian—7.5% • Black, African, or African American—31.5% • Latino/a/x[ii]—24.7% • Middle Eastern—2.1% • More than one race/ethnicity—6.8% • White or European—27.4%	• Asian (*n* = 2) • Black, African, or African American (*n*=3) • Latina (*n* = 4) • Middle Eastern (*n* = 1)
Language	57% spoke at least one language other than English, with 27 unique languages represented overall. Most common languages:	7 spoke least one language other than English, including Cantonese, French, Haitian Creole, Spanish, and Vietnamese

[ii] The terms Hispanic, Latina, Latino, Latine, and Latinx are used to refer to individuals of ethnic, racial, national origin and/or ancestry that stems from Latin America. In this report, we use the term Latino as this is the term that the Community Evaluators most commonly used to describe their communities. We also use the terms that are used by the referenced data.

Characteristic	Applicant Pool (*n* = 147)	Selected Community Evaluators (*n* = 10)
	• Spanish—29.3% • Haitian Creole—12.2% • French—10.2% • Cape Verdean Creole—4.1% • Portuguese—4.1%	

The 10 Community Evaluators selected ranged from ages 19 to 51 years. All ten brought personal relationships within the communities and/or topics that the projects focused on. All but one had work experience in health and human services fields, including family support services and home visiting, social work, economic case management, maternal health, and vocational programs. Half of the Community Evaluators were also completing Associate's and Bachelor's degree programs while working. The majority had no evaluation or research training or experience prior to participating in this project. Bios of the Community Evaluators are available on the TIER website: TIER Community Evaluators.

Community Evaluator Training

Community Evaluators participated in a series of trainings and ongoing mentorship to design and carry out evaluation projects. These trainings were designed to facilitate hands-on learning and culminated with each Community Evaluator developing and implementing their own evaluation plan with mentorship and support from TIER staff. See Table 3 for a description of TIER's training structure and mentorship approach.

Table 3: TIER Community Evaluator Training Modules and Mentorship Approach

Training	Focus	Mentorship Approach
Orientation Meeting*	Orientation to the project and discussion of onboarding logistics, held in participants' home communities	Throughout the project, Community Evaluators received mentorship and coaching from TIER to carry out their projects using four mechanisms. ***Individual Coaching.*** Meetings with TIER mentors focused on reviewing feedback on project materials (e.g., data collection instrument, analysis). Each Community Evaluator had one or more TIER mentors to guide their project overall, and their work to implement a specific method. ***Peer Learning.*** Group meetings to collaborate on strategies or the technicalities of their selected methods (e.g., recruitment strategies, facilitation strategies), as well as collaborate on content-specific components of their project (e.g., brainstorm recommendations). ***Cohort Support.*** Cohort meetings at key project junctures, such as during participant recruitment or when preparing for final presentations, to facilitate idea sharing and community building across projects. ***MDPH Touchpoints.*** Meetings with MDPH project teams at key stages of the process, such as data collection and analysis, to discuss questions,
Kickoff*	Introduction to CBPR, the Community Evaluator model, and project goals. The Kickoff included Community Evaluators, TIER, and MDPH representatives	
Designing Your Project	Overview of the evaluation process, including different types of data and methods	
Research Ethics[iii]	Introduction to research ethics, including principles of research ethics, informed consent, and confidentiality, and how these operate in an evaluation context	
Choosing a Method	Developing evaluation questions and choosing a method, including information on several different methods. Participants received a Methods Guide that detailed different evaluation methods	
Selected Methods (Focus Groups, Interviews, or Surveys)	Introduction to the method Community Evaluators selected for their projects (interviews, surveys, or focus groups), including question development and data collection processes. Each Community Evaluator received training in their selected method	

[iii] This training module focused on research ethics to fulfill the requirements for the Tufts Social, Behavioral, and Educational Research (SBER) Institutional Review Board (IRB).

Training	Focus	Mentorship Approach
Analysis Workshops	Hands-on training on thematic analysis (interviews, focus groups) and interpreting and visualizing quantitative data (surveys). Each Community Evaluator learned analytic approaches using data collected for their projects.	context, or updates as Community Evaluators carried out their projects.

**Denotes in-person training.*

Project Design

Each Community Evaluator team reviewed a range of information sources when designing their evaluation approach (i.e., method selection, sampling, data collection instrument design), including (a) summaries project goals, scope, and intended use of findings; and (b) background information pertinent to their topic, such as previous evaluation or research on the topic and existing data (e.g., CCIS data, vaccination data). In addition, Community Evaluators met with MDPH project teams to discuss project goals and existing initiatives in their topic area. Throughout the project design process, Community Evaluators drew on their own experiences and observations as members of the communities that their projects sought to engage.

Once Community Evaluators drafted their data collection instruments, they worked with other Community Evaluators, Community Evaluator alumni, TIER mentors, and/or others in their personal networks to refine and pilot them. Community Evaluators working on the same project (e.g., COVID-19 pediatric vaccination) looked at one another's questions to identify questions that would be relevant to ask across their projects' subpopulations. During this phase, Community Evaluators tested survey logic and usability, and practiced leading interviews and focus groups using their topic guides.

The details of each project design are outlined in Section III: Results, and topic guides are available in Appendix A: Data Collection Instruments.

Implementation

The implementation of the evaluation plans – including data collection, analysis, and reporting—was led by TIER. During this phase, TIER staff mentored Community Evaluators to carry out their projects within the context of their communities and project goals.

Data collection occurred between October 2022 and March 2023. Overall, the four projects reached 293 Massachusetts residents through 14 focus groups (n = 51 participants), 18 one-on-one interviews, and two surveys (n = 224 respondents in total). Methods and samples specific to each project are described in Section III: Results.

The work summarized in this report represents a collaboration between Community Evaluators, other TIER staff, and community partners. Each partner has brought their expertise to different phases of the project, as described below:

- **Community Evaluators** drew on their own expertise and experiences, training provided by TIER, and the broad project goals to design and carry out evaluation projects in their communities. They analyzed the data they collected and collaborated with other Community Evaluators and TIER mentors to develop within- and cross-project recommendations.
- **Community Evaluator Alumni**, who had worked on previous participatory evaluation projects with TIER, assisted with focus group training and participant recruitment, and conducted additional focus groups for one project.

- **Community Partners**, such as family support programs and local organizations, supported outreach efforts virtually and/or hosted outreach or data collection at their organization.
- **TIER Mentors**, including staff and consultants, supported Community Evaluators on the design, implementation, and analysis of the four projects, and conducted the synthesis of findings within and across projects that is reflected in this report. They developed and conducted trainings, provided ongoing mentorship, and liaised with project partners.

This report ties together the work and contributions of these partners, highlighting key findings from each project, similarities and differences across the different communities and subpopulations, and implications for public health response efforts.

Analysis

The analysis phase occurred between December and April 2023. TIER developed quantitative and qualitative analysis plans to guide the overall analysis training and approach, and each Community Evaluator analyzed findings from their own data collection. For quantitative findings, Community Evaluators identified the key evaluation questions they hoped to answer and mapped these to specific survey questions and variables, and TIER then ran analyses in SPSS 28. With support from TIER, Community Evaluators reviewed outputs for each of their evaluation questions and identified key findings and takeaways. For qualitative findings, Community Evaluators conducted holistic coding of their transcripts, and identified emerging themes both within and across their interviews and focus groups. TIER mentors also independently reviewed each transcript and generated themes as a reliability check and supported Community Evaluators to refine their themes throughout the analysis phase. The analysis processes are described in more detail in Appendix B: Analysis Plan Summary.

The next section includes chapters describing each of the four projects. Each chapter includes brief background on the topic, a description of the project design, results organized by evaluation aims and key findings, and recommendations.

Section II. Project Results

Evaluation of the Lawrence Telehealth Kiosk

Community Evaluator Team: Olien Lu and Hypatia Ortega
Community Partners: Partners in Child Development (PCD) and the Lawrence Public Library
TIER Mentors: Jessica Goldberg, Emma Posner, and Michelle Thompson

Background

Because in-person access to medical services was limited during the COVID-19 pandemic, and often contributed to increased risk of exposure to the virus, many providers pivoted to delivering services via telehealth.[2] Telehealth refers to the provision of health, mental health, or other services via a cell phone, tablet, or other device, rather than in a provider's office or clinic in-person. Both state and federal policies—such as policies related to reimbursement, prescribing, and privacy as they apply to virtual service delivery platforms—became more flexible to make it easier for providers to offer telehealth service during the pandemic.[3,4]

In 2020–2021, MDPH's Bureau for Family Health and Nutrition (BFHN) received funding to address the need for telehealth services due to COVID-19,[iv] focusing its efforts within the community of Lawrence. Located in the northeast region of the state, Lawrence is a city of just under 80,000 residents. As of 2019, 81% of Lawrence residents identify as Latino, most of whom are of Dominican heritage.[5] Over the past few years, the community of Lawrence has been uniquely affected by more than one crisis. In 2018, Lawrence experienced a series of gas explosions and related fires that led to the evacuation of over 8,000 homes.[6] During the height of the pandemic, Lawrence experienced one of the highest COVID-19 positivity rates in the state,[7] and was identified by MDPH as one of 20 priority communities based on high COVID-19 case rates and other socioeconomic factors.[v]

BFHN partnered with the Federation for Children with Special Health Needs, Partners in Child Development (PCD) in Lawrence, local providers, community members, and other partners to identify how to use these telehealth funds to increase access to services within the city. This initiative led to the implementation of a Telehealth Kiosk in the Lawrence Public Library that opened in March 2022. The Telehealth Kiosk is a private modular pod (i.e., an enclosed space) designed to create a safe, accessible, and confidential space that Lawrence residents can use for a wide range of purposes, such as to access health and social services, or for other educational or personal needs.

Because most in-person services had resumed by the time the Telehealth Kiosk opened in spring of 2022, the evaluation focused on understanding how the Telehealth Kiosk could best meet the needs of the Lawrence community after pandemic emergency measures regarding in-person services were lifted. The goal of this evaluation project was to understand if the Kiosk is a useful resource for community members, and how the Telehealth Kiosk could be improved to better support the community. Evaluation aims were to learn:

[iv] Funding to support the Telehealth Kiosk was provided to MDPH from the Association for Maternal and Child Health Program (AMCHP)'s Coronavirus Aid, Relief, and Economic Security (CARES) Act: Maternal and Child Health Telehealth Capacity in Public Health Systems Direct Award.
[v] MDPH initially identified 20 priority communities to focus its COVID-19 response efforts, and later expanded to 30 communities. For more on how communities were prioritized by the Vaccine Equity Initiative, please see: https://www.mass.gov/info-details/covid-19-vaccine-equity-initiative.

- Whether Lawrence residents are aware of the Telehealth Kiosk, how they heard about it, and whether they used it
- What residents are using the Telehealth Kiosk for and/or what they are interested in using the Telehealth Kiosk for
- Whether the Telehealth Kiosk is a useful service for the Lawrence community, particularly as in-person services had resumed

Project Design

The Community Evaluators leading this project –Olien Lu and Hypatia Ortega—are long-time members of the Lawrence community, bringing to the project their own personal and familial experiences, as well as their experiences working in direct service family support and vocational training programs (for more on the evaluation team, see Community Evaluator Bios). They decided to administer an online survey to gather as many responses as possible, given that the Telehealth Kiosk is open to all members of the Lawrence community.

Data Collection

The Community Evaluators worked with TIER mentors to design a 25-item survey that asked questions related to awareness of the Telehealth Kiosk, reasons for use or potential use, how respondents could see using it, and overall perceptions of the Telehealth Kiosk as a resource. The survey was programmed into Qualtrics in both English and Spanish. Recruitment materials were also available in both languages and Community Evaluators distributed them using a multifaceted outreach strategy that included distribution to local organizations and networks via email and text, posting flyers in high-traffic locations (e.g., local cafes, community-based organizations, library), and partnering with adult education classes to share information with students in real time. The online survey included a built-in set of screener questions to ensure that participants met eligibility criteria (i.e., Lawrence residents 18 and older) before completing the survey. Participants received a $10 gift card for completing the survey, which was open from October 2022 through January 2023.

Data Analysis

Survey data were cleaned and analyzed descriptively in SPSS 28 using frequencies and other bivariate descriptive analyses (e.g., crosstabs). In collaboration with the TIER mentors, Community Evaluators reviewed analysis outputs for each evaluation aim and identified key findings and emerging themes. For more on the quantitative analysis process, see Appendix B: Analysis Plan Summary.

Sample

The final survey sample included 205 respondents. Table 4 provides an overview of project methods, participant eligibility, sample size, and selected participant demographics.

Table 4: Lawrence Telehealth Kiosk—Project Design

Focal Community (Eligibility)	Method (Sample Size)	Selected Participant Demographics
Lawrence residents (Individuals 18+ who live in Lawrence)	Survey (n = 205)	• Most (94.1%) survey respondents identified as Latino[vi] • 85.9% reported that they spoke Spanish in their homes • 70.6% worked in Lawrence

[vi] The percent of respondents who identified as Latino is higher than the proportion of Latino residents in Lawrence (81%, according to the census).[8]

Focal Community (Eligibility)	Method (Sample Size)	Selected Participant Demographics
		• 54.6% reported that their households received at least one ongoing support including chronic disease management, mental health, special education, developmental, family support, vocational, legal, child welfare, and/or benefit programs • 42.3% participated in benefit programs like the Supplemental Nutrition Program for Women, Infants, and Children (WIC), Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or MassHealth

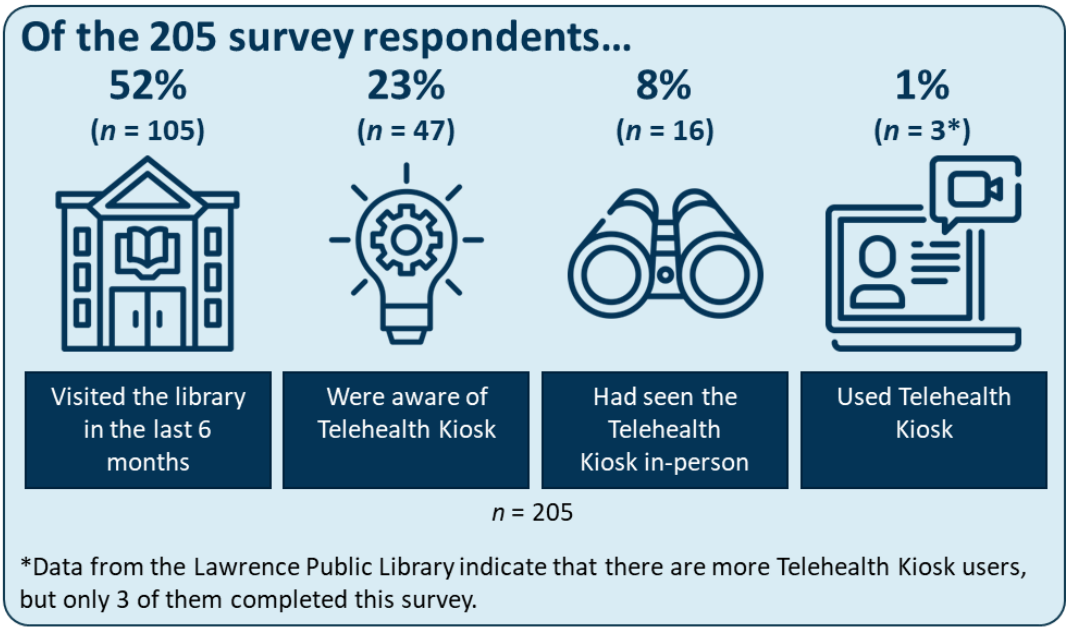
Results

In this section, we highlight selected findings from the survey. For additional findings, refer to Appendix C: Evaluation of the Lawrence Telehealth Kiosk – Final Presentation.

Awareness and Usage of the Telehealth Kiosk

Over half of the 205 respondents (51.5%) had visited the Lawrence Public Library in the last 6 months, but fewer than a quarter of them (22.9%) were aware of the Telehealth Kiosk. Even fewer had seen the Telehealth Kiosk in-person (8.0%) and only three respondents used the Telehealth Kiosk themselves.[vii] Figure 2 summarizes survey respondents' awareness and usage of the Telehealth Kiosk.

Figure 2. Survey Respondents' Awareness and Usage of the Telehealth Kiosk

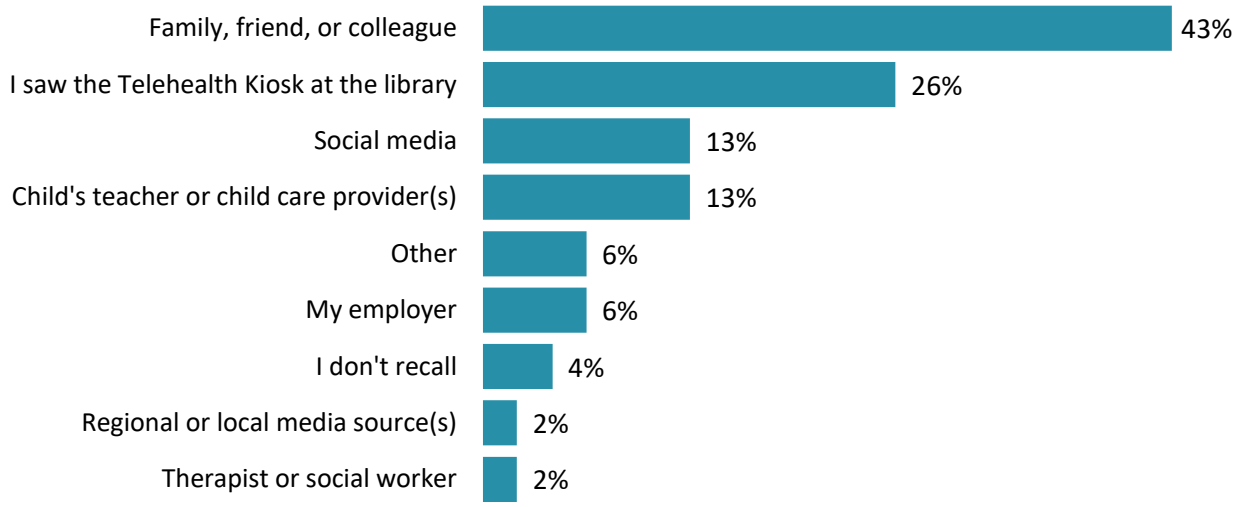


Of the 47 respondents who were aware of the Telehealth Kiosk, almost half (42.6%) learned about it through word-of-mouth from family, friends, or colleagues, and just over a quarter (25.5%) learned about it from seeing it at the library. On the other hand, only 2% of respondents learned about the Telehealth Kiosk through

[vii] The Lawrence Public Library has data indicating that there are more Kiosk users, but only 3 of them completed this survey.

regional or local media sources, or from their therapist or social worker. Figure 3 shows how respondents learned about the Telehealth Kiosk.

Figure 3. How Survey Respondents Learned about the Telehealth Kiosk (n = 47)



Potential Use of the Telehealth Kiosk

Most respondents had not used the Telehealth Kiosk prior to completing the survey. Among those respondents (*n* = 200), when asked if they could see themselves using the Telehealth Kiosk, 49.5% said "yes" and 41.5% said "maybe." When asked *how* they could see themselves using the Telehealth Kiosk, respondents would be most likely to use the Telehealth Kiosk for educational needs or adult medical visits, as shown in Figure 4. For many of these potential users, the Telehealth Kiosk would address a need for a quiet place to study or a private place for an appointment, as shown in Figure 5.

Figure 4. Potential Activities that Survey Respondents Would Use the Telehealth Kiosk For (n = 171)

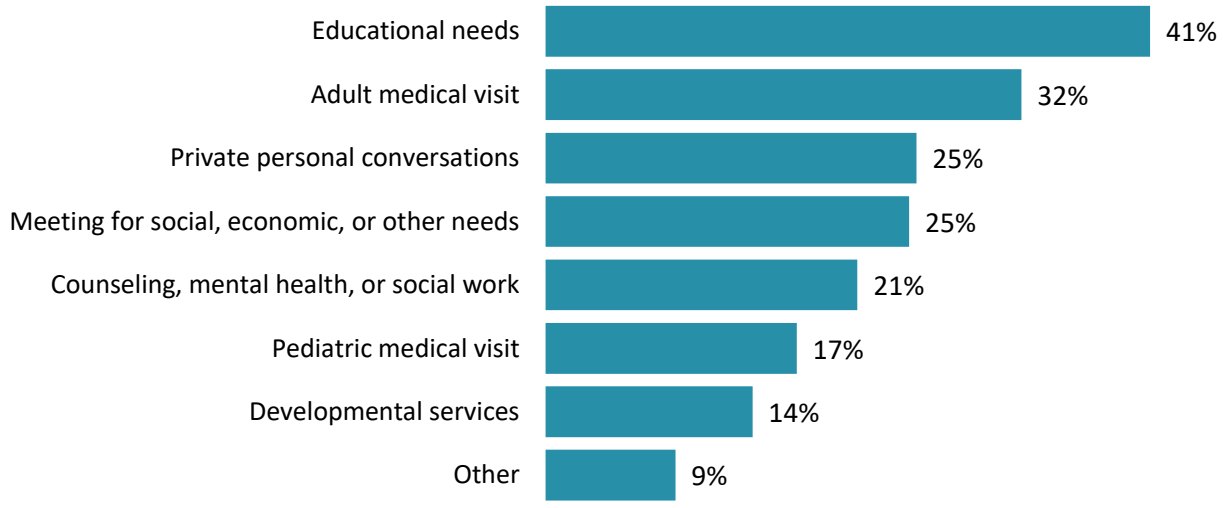
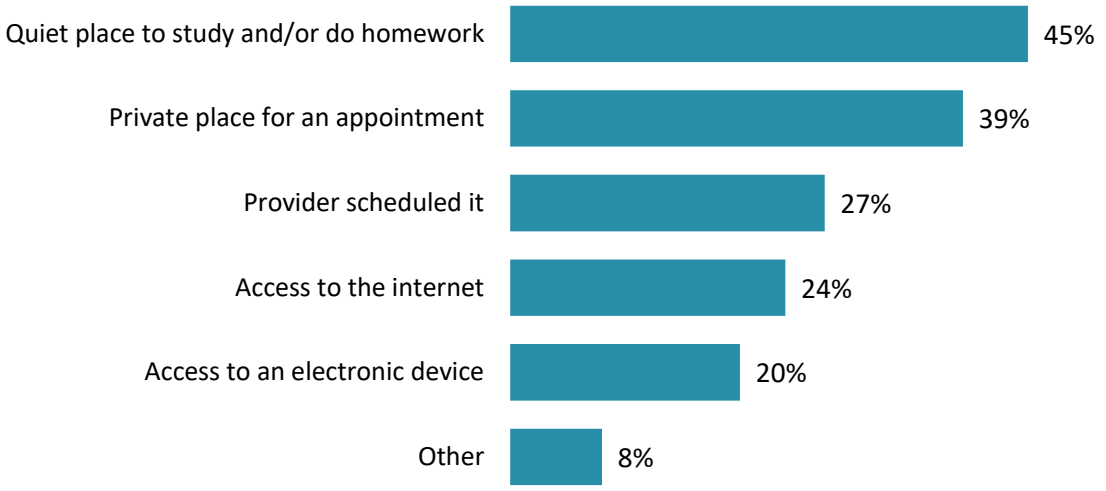


Figure 5. Potential Reasons Why Survey Respondents Would Use the Kiosk (n = 177)



Importance of the Telehealth Kiosk to the Community

Recognizing that in-person services had reopened since the Telehealth Kiosk was first funded, the survey asked respondents whether they thought the Telehealth Kiosk was still an important service for the Lawrence community. Although most respondents had not used the Telehealth Kiosk themselves, the majority (94.9%) thought the Telehealth Kiosk was an important service for the community. Additionally, over three-quarters (77.8%) of respondents said that they would recommend the Telehealth Kiosk to another person.

Issue Spotlight:
Evolving Telehealth Contexts

When MDPH initially received funding to support a telehealth initiative in 2020–21, residents did not have access to many in-person health and social services due to the pandemic. In response, the Telehealth Kiosk was designed to support access to telehealth, and to ensure that Lawrence residents had the privacy, equipment, and resources needed to access health and social services. When the Lawrence Telehealth Kiosk opened in March of 2022, many in-person health and social services had reopened. Despite this shift, this survey suggests that Lawrence residents remain interested in the Telehealth Kiosk as a resource within the Lawrence community for potential uses beyond telehealth, the most common being educational needs (41%).

Recommendations and Implications

Community Evaluators interpreted survey findings through the lens of their own deep understanding of the Lawrence community and generated the following recommendations.

Branding. Given that many survey respondents could see themselves using the Telehealth Kiosk for non-medical visit reasons (such as educational needs), the current name ("Telehealth Kiosk") may not reflect the ways that people want to interact with this service. The Telehealth Kiosk should be renamed to represent the various ways that people can use it. Community members could be included in the naming process, for instance at a community fair or library social event.

Marketing. The Telehealth Kiosk should continue to advertise in Spanish and English throughout the Lawrence community, both formally and through word-of-mouth. Despite a local media campaign to build awareness about the Telehealth Kiosk, only 2% of respondents heard about the Telehealth Kiosk through local media. Instead, many survey respondents reported learning about the Telehealth Kiosk from their personal networks,

which supports how important word-of-mouth information sharing is within the Lawrence community. Reaching people through social media, community fairs, and other in-person events will be key.

Expansion. Although respondents recognized the importance of the Telehealth Kiosk and many could picture themselves using it, more information is needed to determine whether and how to scale the Telehealth Kiosk. Implementing partners should consider monitoring usage of the Telehealth Kiosk over the next several months to inform next steps. Based on the information received from this project, multiple smaller spaces or cubicles – whether located in the library or another community setting—could also be an appropriate way to address respondents' interests in using the Telehealth Kiosk for educational needs.

Further Evaluation. This survey provided information that can inform program improvements, but also illuminated new questions. Given that this evaluation reached few people who have used the Telehealth Kiosk, future evaluation efforts should focus on learning about people's experiences using the Telehealth Kiosk, including how people are using the Telehealth Kiosk (e.g., what types of appointments or activities), which equipment in the Telehealth Kiosk they are using (if any), and any challenges faced using the Telehealth Kiosk (e.g., with the online reservation system, using the technology). Future evaluation could also engage providers to learn if they are still offering telehealth or virtual services, and how a Telehealth Kiosk could support their service delivery. To support evaluation and quality improvement efforts, the Telehealth Kiosk reservation system could be updated to track many of these elements, including reasons for use, activities taking place in the Telehealth Kiosk, and equipment or technology needs.

Experiences of Frontline Workers in Restaurants and Childcare Settings

Community Evaluator Team: Angel Chen Ma, Diannette Marrero, and Joy Umeh
TIER Mentors: Rebecca Fauth and Emma Posner

Background

Frontline workers refers to workers in various roles across industries that worked in person during the pandemic—such as childcare workers, food service workers, healthcare workers, bus drivers, and others—whose work made them especially vulnerable to SARS-Co-V-2 (i.e., COVID-19)[viii] infection.[9] In the fall of 2020, MDPH administered the COVID-19 Community Impact Survey (CCIS) to understand how the pandemic was affecting residents across the state. More than 33,000 people responded to the survey, and about 1 in 2 employed respondents worked in person outside of the home during the pandemic.[10] The survey found that those attending in-person work at the height of the pandemic were more likely to identify as Hispanic/Latinx, speak languages other than English, and have low household incomes. Frontline workers were twice as likely to test positive for COVID-19 compared to respondents working from home, and many experienced changes to their work hours or jobs during the pandemic. The pandemic also affected frontline workers' mental health, with nearly half of the workers in the accommodations and food services industry, and nearly a third of childcare workers, experiencing 15 or more days of poor mental health in the month prior to completing the survey.[10] Although the survey pointed to some broad challenges, further context on frontline workers' specific experiences during the pandemic can help inform the state's ongoing pandemic response and public health preparedness planning.

Our team partnered with MDPH to identify two groups of frontline workers that were uniquely affected by the COVID-19 pandemic: 1) restaurant workers, who are understood to have experienced changes to their work, such as job loss or changes to their hours;[11] and 2) childcare workers, who are known to receive low wages, experience high turnover, and experience chronic health concerns.[12]

A team of Community Evaluators based in the Boston, Northeast, and Western regions of Massachusetts designed a qualitative evaluation to understand:

- How the pandemic affected workers personally and professionally
- Supports, benefits, and/or information received during the pandemic
- Experiences with workplace health and safety protocols and policies
- Changes unique to industries and/or fields since fall of 2020
- How MDPH can tailor its response to specific groups and industries

Project Design

The three Community Evaluators working on this project – Angel Chen Ma, Joy Umeh, and Diannette Marrero—each worked within the professional fields and/or geographic communities that their projects focused on, as a restaurant worker in the Boston area, childcare teacher in a Boston-based early childhood center, and economic assistance case manager in Springfield, respectively (for more on the evaluation team, see Community Evaluator Bios).

[viii] Note that the SARS-Co-V-2 infection is referred to as COVID-19 in this report.

Frontline worker projects designed by each of the Community Evaluators were as follows:

- Angel Chen Ma chose to conduct one-on-one interviews with **restaurant workers** who are Chinese immigrants or children of Chinese immigrants to understand how people's experiences with racism and as immigrants affected their experiences as frontline restaurant workers during the pandemic.
- Joy Umeh chose to conduct one-on-one interviews with **childcare teachers and center directors** to understand the different experiences of workers in distinct roles and across centers.
- Diannette Marrero chose to conduct virtual focus groups with **childcare teachers** to bring together teachers from a range of centers in western MA, and to explore experiences across centers.

Data Collection

Each Community Evaluator developed a data collection protocol (i.e., interview and focus group questions), with some shared questions across samples and some questions unique to their samples (See Appendix A: Data Collection Instruments). Community Evaluators also asked brief demographic questions to describe the participant population; these questions were asked at the beginning of interviews or in the form of a brief demographic survey on Qualtrics at the beginning of focus groups. Recruitment materials were in English and distributed via email, text, and in-person to local organizations and personal and professional networks (e.g., restaurant owners, childcare centers, community colleges). Community Evaluators conducted focus groups and interviews virtually (with the exception of one in-person interview), between October 2022 and March 2023. Participants received a $50 gift card to a store of choice for their time and participation. A TIER mentor was present at each focus group to provide logistical support (e.g., with demographic survey, the distribution of the gift cards), and interviews consisted of only the Community Evaluator and participant.

Data Analysis

All interviews and focus groups were audio recorded and transcribed. Data were analyzed thematically relative to the overall evaluation aims and Community Evaluators' own experiences.[13,14] Community Evaluators reviewed transcripts for each interview or focus group they conducted to (a) identify significant quotes that embodied the evaluation aims, (b) generate thematic codes to describe these statements, (c) describe three to four themes from each interview or focus group, and (d) describe themes that emerged across their data. TIER mentors independently reviewed each transcript and generated themes as a reliability check. Mentors then met with Community Evaluators to discuss any differences that may have been found in their independent analyses, and to collaboratively refine emerging themes. At the end of the analysis phase, Community Evaluators shared key findings with one another to identify similarities, differences, and recommendations across the subpopulations. For more on the qualitative analysis process, see Appendix B: Analysis Plan Summary.

Samples

For the project overall, there were 18 participants. Table 5 provides an overview of project methods, participant eligibility, sample size, and selected participant demographics.

Table 5: Experiences of Frontline Workers – Project Design

Subpopulation (MA region)	Method (Sample Size)	Eligibility	Selected Demographics
Restaurant workers (Boston and Northeast)	Interviews (*n* = 4)	• Ages 18–25 • Worked in restaurants during pandemic (customer-facing roles) • Identify as Chinese immigrants or children of Chinese immigrants	• All identified as Chinese • Represented 4 Asian restaurants (3 of them Chinese restaurants)

Subpopulation (MA region)	Method (Sample Size)	Eligibility	Selected Demographics
Childcare teachers and directors (Boston)	Interviews (*n* = 6)	• 18+ • Directors or teachers in early childcare (0–5) centers in Boston	• 3 directors • 3 teachers • Range of centers
Childcare teachers (Western)	3 Focus groups (*n* = 8)	• 18+ • Classroom teachers in early childcare centers (0–5) in • Springfield, Chicopee, Holyoke, or the surrounding area	• All classroom teachers • Worked at centers in Northampton, Holyoke, and Springfield

Results

In this section, we highlight common themes across the frontline workers groups, as well as themes unique to each subpopulation and/or industry. For additional findings by subpopulation, refer to Appendix C: The Experiences of Frontline Workers – Final Presentation.

Cross-cutting Themes: Restaurant and Childcare Workers

Pandemic experiences: Personal and professional uncertainty

Participants described concerns about being infected by COVID-19 at work and efforts to reduce their exposure. Childcare workers, in particular, described navigating their own fears about personal and family safety while caring for other people's children. One Boston-based teacher reflected on this tension in the context of the early days of the pandemic: *"…the people that you love the most…they need you, these families, these children need you. But you need your family, your family needs you, so it's, like, very hard. You want to continue to get paid because we're talking back when like no state was saying, stay home, we'll pay you to stay home…If I stay home, no one's going to forgive my electric bill or rent…So again, dealing with…so many stressors."* While childcare workers reported limited ability to work from home or to minimize their exposure due to the realities of working with young children (further described below), they also reflected on a deep commitment to their colleagues and the children they serve.

Participants also described uncertainties related to their employment and income. Other than personal stimulus checks from the federal government, restaurant workers did not describe receiving work-related financial benefits unique to their work. While two of the restaurant workers reported a decrease in wages as the restaurant they worked for lost income, the other two worked in restaurants that saw steady or increased business during the pandemic, and therefore their wages were either stable or increased. Childcare workers described job-related uncertainty including changes to their roles and work schedules, decreasing student enrollment or class sizes, concerns about not having enough COVID-19 sick time, and vaccination mandates. Some participants in western Massachusetts explained that those childcare workers who received pandemic-related furlough benefits when not working or working reduced hours earned more than others in similar roles who worked full-time. One Boston-based director reflected on the responsibility felt by leadership to support workers, "*we have about 50 employees who count on us for income to support their families and support themselves. And you want to make sure that they have a job to come back to as well. So, it was a very pressure filled, stressful time during that time*."

Access to information

Participants shared challenges sifting through available information, but there were differences in participants' information needs—both as workers and as residents. Among restaurant workers, the challenge was finding or accessing information; no restaurant worker mentioned specific guidance on safety protocols provided to their restaurant by government or other agencies, or specifically mentioned information that they referred to

related to workplace safety. One restaurant worker, who worked at a restaurant owned by their parents, described challenges finding information in Chinese: *"I can translate somewhat but it's also kind of stressful for me to like not know how to completely relay all this information to my family members."* Childcare workers, on the other hand, described a plethora of information and guidance from different sources; for many, the challenge was how to sift through what sometimes felt like conflicting pieces of information as the situation – and information—rapidly evolved. Across interviews and focus groups, participants referenced guidance from a range of sources, including the CDC, MDPH, local boards of health, the Department of Early Education and Care (EEC), the Office of Head Start, and their organization—and many described how it could be challenging to wade through and interpret this guidance, and in some cases to determine who to listen to and who to trust. Both restaurant workers and childcare workers suggested the need for more support to ensure safety protocols were being implemented properly; as described by one restaurant worker, "*I think what [MDPH] could have done more of is check in on the restaurants and see how they are doing. Just because we set up everything and followed all the proper protocols, but from what I remember, I didn't remember anybody come in to check on if we're doing everything properly."*

Themes Specific to Restaurant Workers

Restaurant changes: The shifting nature of restaurant business

Restaurant workers described changes to physical spaces to facilitate distancing, such as setting up dividers between tables, moving takeout pickup by entrances, and outdoor seating. Other safety protocols mentioned included cleaning and sanitation, such as disinfecting high touch items, shifting to single-use utensils, or providing hand sanitizer for customers; mask requirements for customers when not at their tables; and masking among staff. One participant described how implementing safety protocols was expensive for restaurants, specifically noting the cost of dividers between tables and an increase in the cost of hand sanitizer during the pandemic.

Pandemic-related changes were largely described in the context of changes to restaurants' business models. Three of the four participants described working in restaurants that had been primarily dine-in, however, during the pandemic, all of them had to quickly change their models to stay open, such as by offering takeout only and partnering with online ordering apps. Participants also referenced changes to the nature of their roles; although all participants were in customer-facing roles (such as servers), during the pandemic there was less customer interaction.

Stereotyping and discrimination against Chinese Americans: Media coverage and community support

Questions specific to this sample explored participants experiences' as Chinese immigrants, or children of immigrants, working in Chinese or Asian restaurants during the pandemic. All participants shared an awareness of hate crimes against Asian Americans through media coverage, and one participant remembers feeling wary of her surroundings because she was afraid of experiencing racism as she had seen through the media. None of the four participants shared that they personally experienced discrimination based on their race during the pandemic, and participants described feeling generally safe in their communities. All reflected on the importance of living within large Asian communities. As one participant shared, *"especially in Malden the community's like very diverse in all types of people, and especially obviously the Asian population here is like pretty high compared to some [other communities]. But definitely, I see during like, in social media, like, other Asian Americans, or just Asians in general getting harassed…during COVID-19."*

Themes Specific to Childcare Workers

Workplace health and safety: Ever-changing safety protocols

Examples of safety protocols described in interviews and focus groups with childcare workers included: physical distancing; providing children with individual toys and supplies and/or more frequent toy washing protocols; enhanced cleaning and sanitation protocols; smaller class sizes, including establishing closed groups, or "pods," of children and teachers; mask requirements for staff and toddlers; and, in some cases, COVID-19 testing. Many participants also described the necessity of their organization's COVID-19 pay or COVID-19 sick time—separate from standard sick hours or personal time—for use when facing COVID-19 infection or exposure. However, this time was often insufficient to cover repeat exposures (a common occurrence in childcare centers) or infection, and participants were unclear how much longer COVID-19 sick time would last. One participant also shared the ripple effect of other sectors' workplace policies on their childcare center, noting that, later in the pandemic, when parents had less flexibility at work, children were more likely to come to school when sick.

Overall, although all participants agreed on the importance of following their center's safety protocols, many emphasized how challenging it was to interpret, implement, and stay up to date with what felt like ever-changing policies. As one teacher from western Massachusetts described, it seemed like guidelines changed practically every week*: "we had to send you [children] home if you had a runny nose. But then, the next week no, you can stay with a runny nose, but you need a note from your doctor saying you have allergies. But then the next week, you're gonna be sent home again…It was a lot to keep up with. We almost kind of came in on Mondays, and were like, okay, what are the rules now?*" Participants also shared how safety protocols varied by centers'—and even teachers'—own interpretation. Another teacher in western Massachusetts observed different interpretations of guidance when switching between centers: *"…what [prior childcare center] thought the regulations were, and what my [current childcare center] thought the regulations were, were two vastly different things…And it was confusing, because it's like, okay, but that's not what the regulation says. This is what we're doing. And it's got to be somewhere in the middle..."* In the absence of consistent guidance, sometimes staff would take matters into their own hands; one participant described referring to the EEC handbook directly to interpret the guidelines for themselves.

From their perspective setting center-level policy, directors reflected on their own set of challenges sifting through available information to develop guidelines that can keep centers open while keeping children and teachers safe. One director in Boston reflected on how the biggest challenge was "*handling all of the unknowns"*: *"…you have to, basically, really stay in tune to all of the information that's being put out there by all of the agencies, all of the health departments, make sure you have as much information as you can do and then try to use your own judgment to make the safest decision possible*." For leadership, determining safety policies required navigating a precarious balance between providing families with childcare, while accounting for varying staff comfort levels and complex safety considerations.

Realities of COVID-19 in an early childhood context

Not only were guidelines constantly changing, but, to participants, they also felt at odds with the realities of working in an early childhood classroom. Participants recounted how protocols were not developmentally appropriate or realistic. One teacher in Boston shared what it was like to implement guidelines: *"they were saying, you can't be in close contact of individuals. You have to avoid fluids, but, if you've ever worked with young children, fluids and closeness are like the top two that happen throughout the whole day. Like even if you're just sitting there reading a book, all of them want to fight for your lap."* Teachers emphasized the challenges of physical distancing when supporting a classroom of young children, discouraging children from sharing toys, masking as they are developing social-emotional and language skills, and a heightened awareness of holding or hugging children when they needed comfort. Some reflected on how technology does not meet children's need for physical contact, practice with motor skills, and socialization. Overall, many teachers and directors were concerned about the effects of the pandemic on child development, and observed delays in language development, motor skills, and self-help skills, as well as behavioral concerns. Some reflected on unique challenges faced by children experiencing developmental delays or social challenges, such as involvement with child welfare, including the inability to receive services (e.g., Early Intervention, mental health services) in the classroom at points during the pandemic or how safety protocols may not accommodate these children's needs.

Issue Spotlight:

COVID-19 Vaccine Mandates: Mixed Experiences

During the height of the pandemic, the vaccine was not approved for children under age 5. For teachers, the vaccine brought on new and complex challenges; some staff expressed relief, and others shared that they themselves – or those they work with – were afraid or did not trust the vaccine. Amidst what was already a staff shortage, some centers lost employees over vaccine mandates. One director shared that:

> *"we felt…we couldn't ask employees to get vaccinated to keep their job. We did put into place that if you chose not to vaccinate that you needed to continue to wear a mask, when we lifted our mask mandate in the building, and people were comfortable with that."*

This example captures the challenges that childcare centers faced balancing vaccine policies and other safety measures with staffing considerations.

Undervalued and unsupported—An industry crisis

Participants reflected on a childcare industry crisis that pre-dated the COVID-19 pandemic, with challenges including low pay, burnout, and staff attrition—all challenges that were exacerbated by the pandemic. Many teachers felt unsupported and undervalued as they fulfilled added responsibilities during the pandemic, such as functioning as classroom cleaner, therapist, and nurse, often without additional compensation or the supports they needed. One director, whose center served as an emergency childcare provider for essential workers during the height of the pandemic, reflected on how childcare workers were undervalued as lynchpins for other emergency services: "*I also think about those health care workers that got all those extra incentives. I know nurses that we're getting $500 just to walk through the door to do a shift. How come we weren't getting $500 to walk through the door to do a shift for those people to be able to go to work? Not that, you know, compensation is needed sometimes, but I think the recognition of you couldn't go to work unless we had been here."*

Teachers described learning to teach remotely without training, being held to the same expectations when the children are entering the classroom in a fundamentally different place, and the need for more support from leadership. Teachers in both Boston and western Massachusetts described changing jobs during the pandemic; in one particular focus group, all three teachers were either thinking about changing, or had recently changed,

jobs due to work-related stressors. One teacher shared: "*We had time to really contemplate. Is this what we want to do for the amount of money that we do it for? And…are we being appreciated as much as we feel like we're giving to everyone else's families?*"

Recommendations and Implications

Both food service and childcare industries provided critical services that allowed the economy to remain open during much of the pandemic.[15] And yet, this project points to the tension between workers – and their families'—physical and economic wellbeing. Participants needed to work, but this work often led to increased COVID-19 exposure risk for themselves and family. Further complicating this tension, many workers also shared a sense of duty—to their businesses, staff and colleagues, and people they serve.

As the state responded to a rapidly evolving situation–fluctuating case rates, the approval of the vaccine, and emerging science—response efforts did not always account for the realities of frontline workers. This evaluation highlights opportunities to improve information and support for frontline workers as COVID-19 persists, and through future public health emergencies. Community Evaluators participated in a series of collaborative meetings to discuss findings and recommendations from both restaurant and childcare workers, and to develop the following recommendations for the project overall.

Make information more accessible. While the childcare workers who participated described an excess of information—and challenges sifting through this guidance—the restaurant workers noted challenges accessing information related to COVID-19 and benefits for workers or businesses. Sharing information in a variety of languages and ways will help ensure that workers know which guidance to refer to, and that they can access benefits and information designed to support them. Specifically, information could be shared through short videos rather than lengthy written documents and outside of government websites.

Coordinate guidance and communication. Both groups of workers noted how challenging it could be to determine which sets of policies and guidance to follow (e.g., city or state), or to understand the role that different state agencies play across industries (e.g., EEC relative to MDPH). Developing a flow chart on how agencies work together and which guidance to follow would better guide workers on frequently changing policies. MDPH could also explore opportunities to develop shared guidance, training modules, or other resources in collaboration with agencies in the childcare or restaurant sectors. These sources could include, for example, templates for policies that organizations or centers might look to when developing their own; best practice guidelines for supporting workers through public health crises; or public health resources available to different types of workers and workplaces in a range of languages.

Support and respect the field. Many of the childcare workers reported that they did not feel valued for the role they played supporting families during the pandemic, and that they did not feel they had the support they needed to do their jobs. They shared that the pandemic intensified already-existing concerns—such as staffing shortages, low wages, and burnout—that make it difficult to attract and retain childcare providers both within individual childcare centers and within the childcare field more broadly. Organizations and agencies (e.g., MDPH, EEC, and the Department of Transitional Assistance) need to collaborate across sectors to deepen investments and support for the early childhood workforce, such as through competitive compensation and benefits (such as sick leave), job training, and professional development.

Recognize the unique needs of different industries. Lastly, this project highlights how the needs of workers are unique to each industry. Frontline workers brought unique and important insights into some of the day-to-day challenges that resulted from COVID-19 policies and guidelines, such as unrealistic expectations about social

distancing from toddlers, and masking in restaurant settings. These findings underscore how important it is to have individuals with first-hand experience at the table when decisions about workplaces, workers, and client or customer well-being are made.

Overall, these recommendations also point to the need to provide ongoing support to workers and businesses implementing these protocols within the day-to-day realities of their workplace, and the role that MDPH could play to support different industries in times of public health crisis. To support public health efforts on issues affecting workers—and tailor its efforts to the nuances of different fields—MDPH could host meetings or listening sessions for workers focused on specific public health issues, meet with frontline workers in their own work environment, or co-host public health professional development or networking meetings in collaboration with other agencies.

Pregnancy COVID-19 Vaccination

Community Evaluator Team: Maudeline Auguste and Sasha Rivera
TIER Mentors: Melissa Colón, Emma Posner, Michelle Thompson
Additional Acknowledgements: Sophie Antoine and Barbara Pierre

Background

Studies show that pregnant and recently pregnant (up to 6 weeks postpartum) people[ix] who test positive for COVID-19 during pregnancy are at higher risk for severe illness, hospitalization, and death when compared to nonpregnant people.[16] Evidence suggests that these risks are reduced when pregnant people are vaccinated against COVID-19.[17]

To inform its COVID-19 response efforts among pregnant people, MDPH estimated rates of COVID-19 vaccination (receipt of at least one dose) during pregnancy by linking vaccination and birth certificate data. Findings suggest that, of the 66,450 people who delivered during the study period of May 2021 through March 2022, only 37.3% had received the COVID-19 vaccination before or during pregnancy (compared to 78% in the general population). When disaggregated by race, data show lower vaccination rates among birthing people who identified by self-report in the birth certificate as Black (16%), Hispanic (17%), and American Indian/Alaska Native (20%) when compared to those who identified as White (42%) and Asian (46%). When further disaggregated by self-reported ethnicity, lowest uptakes of vaccination during pregnancy were reported by people who identified as Haitian (13.2%), Puerto Rican (11.2%), and Cape Verdean (10.8%).[x18]

MDPH's analysis of COVID-19 vaccination rates during pregnancy points to differences in vaccination rates between groups, but it does not elucidate pregnant people's experiences, or decision-making among unique subgroups. To better understand the vaccination data, a team of Community Evaluators based in Fall River and Brockton designed a mixed-method evaluation that focused on understanding:

- Where and how pregnant people[xi] receive information about the vaccine
- How pregnant people make decisions about the COVID-19 vaccine
- Pregnant people's pandemic experiences and perspectives on the COVID-19 vaccine
- Recommendations for how MDPH can improve vaccination efforts

Project Design

The two Community Evaluators working on this project –Sasha Rivera and Maudeline Auguste—each worked as family support workers in the communities of Fall River and Brockton, respectively, during the pandemic, and are both parents and members of the communities that their projects focused on (for more on the evaluation team, see Community Evaluator Bios). They each designed an evaluation project that was informed by findings from the MDPH data and their own experiences with pregnancy during the pandemic personally and/or as family support workers.

- Sasha Rivera chose to administer a survey to reach ***Latina mothers in Fall River*** who had been pregnant during the pandemic. She sought to gather a rounded view of the diverse Fall River Latino community.

[ix] Overall project objectives focused on understanding the experiences of people who were pregnant during the pandemic to be gender inclusive. Because all who participated in the evaluation activities self-identified as women, we use that term when describing results.
[x] On birth certificates, residents write in how they self-identify their race and ethnicity, rather than responding to pre-determined categories. Ethnicity data for the study period were missing for 0.4% of individuals.
[xi] Overall project objectives focused on understanding the experiences of people who were pregnant during the pandemic to be gender inclusive. Because all who participated in the evaluation activities self-identified as women, we use that term when describing results.

Recruitment flyers were distributed to service providers, such as family support programs and health clinics, via email and local newsletters, and during in-person outreach at WIC and other community settings.

- Maudeline Auguste chose to conduct one-on-one interviews with ***Haitian mothers in Brockton*** because she felt face-to-face conversations were important within the Haitian community. Interviews in Haitian Creole allowed her to understand people's perspectives in their preferred language and own words. She conducted recruitment in-person at markets frequented by the Haitian community in the Brockton area, giving participants a flyer with information on how to sign up for an interview.

Data Collection

Survey of Latina Mothers in the Fall River area

Sasha Rivera worked with TIER mentors to design and administer a 36-item survey that asked questions related to prenatal care experiences, information received about the COVID-19 vaccine, and vaccine decision-making. The online survey was programmed into Qualtrics in both English and Spanish. Recruitment materials were available in both languages and distributed via email, text, and in-person to local organizations and networks. Surveys included a built-in set of screener questions to ensure that participants met eligibility criteria before completing the survey. Participants received a $15 gift card for completing the survey, which was open from November 2022 to March 2023.

Interviews with Haitian Mothers in the Brockton area

Maudeline Auguste developed an interview protocol that included questions related to participants' experiences with pregnancy during the pandemic, their beliefs about and perceptions of the COVID-19 vaccine, and how they made decisions about the COVID-19 vaccine. She conducted a total of eight interviews, and participants received a $50 gift card to a local store of choice for their time and participation.

Data Analysis

Survey of Latina Mothers in the Fall River area

Survey data were cleaned and analyzed descriptively in SPSS 28 using frequencies. In collaboration with the TIER mentors, the Community Evaluator reviewed analysis outputs for each evaluation aim and identified key findings and emerging themes.

Interviews with Haitian Mothers in the Brockton area

All interviews were audio recorded and transcribed first in Haitian Creole and then translated into English. Within one day of the interview—to support the interview debrief and in alignment with our safety protocol—another Haitian Creole-speaking member of the TIER evaluation team reviewed the interview audio recordings. Data were analyzed thematically relative to the overall evaluation aims and Community Evaluator's own experiences.[13,14] The Community Evaluator reviewed transcripts for each interview in Haitian Creole to (a) identify significant quotes that embodied the evaluation aims, (b) generate thematic codes to describe these statements, (c) describe three to four themes from each interview, and (d) describe themes that emerged across their data. TIER mentors independently reviewed each translated transcript and generated themes as a reliability check. Mentors then met with the Community Evaluator to discuss any differences that may have been found in their independent analyses, and to collaboratively refine emerging themes.

At the end of the analysis phase, Community Evaluators shared key findings across methods with one another to identify similarities, differences, and recommendations across the subpopulations. For more on the quantitative and qualitative and analysis process, see Appendix B: Analysis Plan Summary.

Samples

Across the two subpopulations, there were 27 participants. Table 6 provides an overview of project methods, participant eligibility, sample size, and selected participant demographics.

Table 6: COVID-19 Vaccination During Pregnancy—Project Design

Subpopulation	Method (Sample Size)	Eligibility Criteria	Selected Participant Demographics
Latina mothers	Survey (*n* = 19)	• Identify as Latina/e/x • Speak English or Spanish • Live in Fall River, Somerset, Swansea, or Westport • Were pregnant during the pandemic	• 2 pregnant at time of survey completion and the remaining 17 had experienced pregnancy at least once since May 2021 • 12 were born outside of the United States • 14 indicated Spanish as a preferred language • All identified as Latina: Puerto Rican (*n* = 6), Honduran (*n* = 3), Ecuadorian (*n* = 2), Brazilian (*n* = 2), Salvadorean (*n* = 1), Mexican (*n* = 1), Guatemalan (*n* = 1), Dominican (*n* = 1), Latina unspecified (*n* = 2)
Haitian mothers	One-on-one Interviews (*n* = 8)	• Identify as Haitian • Speak Haitian Creole • Live in the Brockton area • Were pregnant during the pandemic • Did not receive the COVID-19 vaccine before becoming pregnant	• All were born outside of the United States • 3 arrived in the U.S. in the past 5 years • 4 worked in direct service roles (3 in healthcare and 1 in human services) and 4 were not working during the pandemic

Results

Across both subpopulations, the majority of participants received at least one dose of the COVID-19 vaccine (See Table 9). In this section, we describe findings by subpopulation. Then, we summarize findings and recommendations across subpopulations.

Table 7: Vaccination Status by Subpopulation

Subpopulation	Parents' Vaccination Status	Vaccination Timeframe
Latina mothers in Fall River (*n = 19)*	• 11 of 19 had received at least one dose of the COVID-19 vaccine.	• 6 received the vaccine before pregnancy • 4 received the vaccine during pregnancy • 1 received the vaccine after pregnancy
Haitian mothers in Brockton *(n* = 8)	• 7 of 8 received at least one dose of the COVID-19 vaccine.	• 2 received the vaccine during pregnancy • 5 received the vaccine after giving birth[xii]

[xii] For three of the five participants who received the vaccine after birth, the vaccine was not available during their pregnancy.

Sources of information on the vaccine

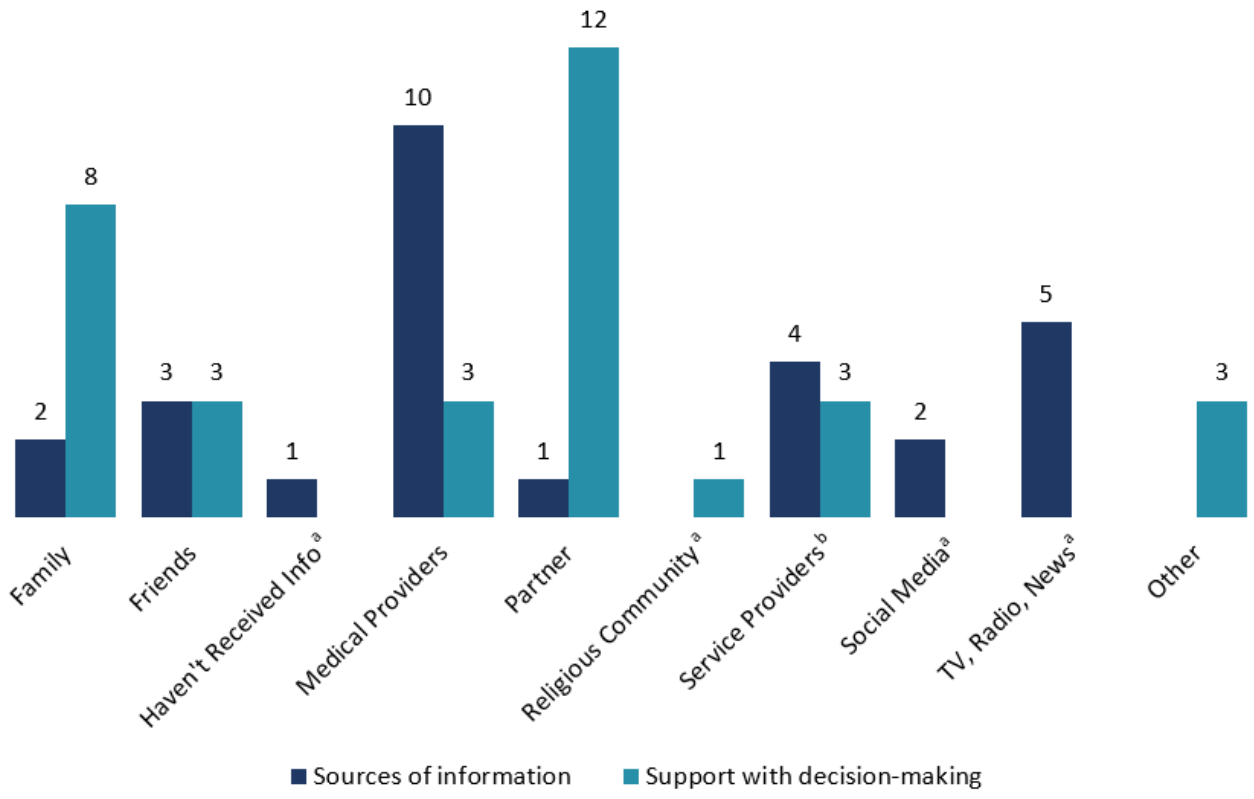
Respondents were asked about their access to medical care and the languages in which they received prenatal care. Thirteen of 19 respondents (68%) indicated that they had a primary care provider (PCP) prior to pregnancy. Most respondents (15 of 18 , or 83%) received their prenatal care from an OB-GYN. Eighteen of 18 respondents (100%) reported that they received their prenatal care in a language that they felt comfortable in.

Respondents were asked a series of questions about information they received on the COVID-19 vaccine. More than half (10 of 19 respondents, or 53%) reported receiving information on the vaccine from their medical providers. Most (14 of 18 respondents, or 78%) reported feeling comfortable talking to their prenatal care provider regarding their questions or concerns about the COVID-19 vaccine.

Vaccine decision-making

Most of the respondents born outside of the United States or Puerto Rico received the COVID-19 vaccine (10 out of 12, or 83%), only 1 of the 7 respondents (14%) born in the United States or Puerto Rico received the COVID-19 vaccine. Although respondents reported medical providers as their most common source of information on the vaccine, most respondents reported that their partner and family were among those who helped them make decisions about the vaccine (See Figure 6).

Figure 6: Where people receive information on the vaccine, as compared to who supports their decision making (n = 19)*



Note. a: Some response options were not included in both questions, based upon context. b: Service providers includes community organizations/programs, such as family support workers and programs, home visitors, social workers, parent mentors, and WIC.

Respondents were asked via open response items why they decided to vaccinate or not, and their perspectives on why pregnant Latina women have low vaccination rates. Table 7 summarizes the findings from participants' open-ended responses. Overall, the most salient theme that emerged from these open-ended responses was a concern for protection – of oneself and one's babies. The theme of protection emerged as a reason why people received the vaccine, as well as a reason why people choose *not* to vaccinate.[xiii] Responses were grouped by theme and the main ideas are summarized below.

Table 8: Responses to open-ended question about vaccine decision-making

Reasons for Personal Vaccination Decisions		Perspectives on Why Pregnant Latina Women Have Low Vaccination Rates (*n = 14*)[xiv]
Reasons to vaccinate (*n* = 11)	**Reasons not to vaccinate (*n* = 7)**	
• Health (e.g., afraid of getting COVID-19 during pregnancy, medical advice)* • Protection of others (e.g., families, people they work with)* • Protection of their babies* • Work requirements	• Unnecessary (e.g., fought COVID-19 already) • Not ready or uncomfortable • Protection of their babies • Reactions to other vaccines (i.e., flu shot) • Insufficient research	• Fear or concerns about the vaccine* • Lack of information (e.g., side effects, long term effects)* • People's right to make their own decisions • Protection of themselves • Myths or misconceptions about the vaccine (e.g., what the vaccine will do to their bodies) • Questions about whether the vaccine works

**Indicates 3 or more responses.*

When asked to provide recommendations on how MDPH can improve vaccination efforts, the most common (6 of 19 respondents, or 32%) recommendations were to provide or share more information on the vaccine (such as about the benefits and disadvantages) and to create more spaces for Latina women to talk about the vaccine with other Latina women or Latina doctors (4 of 19 respondents, or 21%). In her response, one participant suggested *"speaking to other Latina women that have been vaccinated while pregnant. Maybe speaking to a Latina doctor about the risks and the benefits to make sure that the baby will not be harmed in the long run."* These recommendations highlight the role that both the medical community and other Latina mothers could play in addressing concerns summarized in Table 8 about risks, benefits, and protection.

Haitian Mothers in the Brockton Area: Interview Findings

Stress, struggles, and isolation: Life during the pandemic

Haitian mothers described their pregnancy and caring for a newborn during the pandemic as a time of deep vulnerability, isolation, and stress. They felt worried about getting sick, getting family members sick, and not being able to care for themselves or others. They also described living in fear of complications with their pregnancy and childbirth and being unable to count on help from outside the house. Their fears were compounded by the unknowns about how the virus affects pregnant people and babies.

Many participants maintained a strong commitment to distancing to keep themselves and their families safe physically, which led to profound feelings of isolation. One participant described what it was like to isolate from other family members when she and her family (including her baby) were sick with COVID-19: "*[Other family members] had to protect themselves, they could not come in to help us. It's kind of humiliating. Corona is humiliating. It's like when reading the Bible and you have leprosy. It's like a long time ago when AIDS first appeared and you have AIDS, people don't approach each other*." Participants described this sense of isolation

[xiii] Note that the responses to these open-ended items were typically extremely brief (a phrase or a few words), limiting the interpretation of responses.
[xiv] Responses of "I don't know" were excluded from this analysis.

in many other aspects of their lives, such as not being able to see family while pregnant or after children were born; caring for children without support; not being able to attend church; not being able to work due to health risks; and, on the occasion that prenatal care visits were in-person, finding empty hospitals and waiting rooms.

Vaccine perspectives: Faith and the vaccine

Participants described the ways that religious beliefs shaped their own and their communities' perspectives on the pandemic and the COVID-19 vaccine. When referring to their own faith, participants reflected on God as a form of protection and strength, describing their babies as "*se Bondye ki fèm kado l*" ("gifts from God"), and that they were able to overcome challenges during the pandemic "*gras a Dye*" (by the "the grace of God"). Although participants did not explicitly focus on their own religious beliefs when describing their vaccine perspectives, several spoke about how people in their community believed that the vaccine was against their faith and could bring them misfortune. One participant—who received the COVID-19 vaccine by choice—described how her mother encouraged her to get vaccinated, despite her mother's own beliefs about the vaccine: *"my mother encouraged us to go and get [the vaccine] ourselves. My mother didn't take it because of her Christian faith. She told me that she must pray. She must ask God before she takes it…She asked God, but God did not answer her. Then she told me [she] went to pray. She asked God, but God told her he already gave her a vaccine and for her not to take it. I don't force her to take it. It's her faith."* Some participants described how some religious communities have contributed to beliefs against the vaccine, for example by suggesting that the vaccine is against the bible.

Decision-making

Despite knowing benefits of the vaccine and receiving information from their doctors, participants worried about the short- and long-term effects of the vaccine. Some described more generalized fears in their community that the vaccine is intended to harm Black people, with one participant noting that "*there are those who say [the vaccine] is something they do to destroy Black people*." Although seven of the eight participants received the COVID-19 vaccine, many felt that they did not have a choice. Participants shared stories of being forced to take the vaccine, often due to their jobs, or to access services. As one participant described: "*I took it by force because I was going to lose my job, I had no choice, but I was still doubtful. I didn't, it's not that I didn't trust it, I didn't understand it. It was more political than humanitarian at some points*." Another mother described being forced by their medical providers: "*…before I gave birth, they told me they wouldn't touch me if I didn't take it. I had to take it.*" Overall, only half of the participants made their own independent decisions about the COVID-19 vaccine; of these, three chose to receive the vaccine after giving birth,[xv] and one refused to get the vaccine when she was asked to by hospital staff. Even as many participants felt they had no choice, some shared they were grateful for the vaccine and its role reducing COVID-19 rates.

Many participants shared how Haitian women believe their own natural remedies would protect them against, or help them fight, COVID-19. They also shared other precautions—apart from the vaccine—that they felt more comfortable taking to minimize their risk of exposure to the virus, such as masking or distancing. The only participant who did not receive the vaccine reflected on her decision-making: *"I'm just going to protect myself with a mask and I will take some tea, but I won't take anything that will have side effects on me."* Instead of receiving the COVID-19 vaccine, this mother took other measures she felt would reduce her risk.

[xv] Of these three, two indicated that the vaccine was not available when they were pregnant.

Information (and misinformation)

Across the interviews, participants referenced the role of word-of-mouth information sharing in their communities. Participants drew on stories they themselves have heard via word-of-mouth about experiences with the COVID-19 virus or COVID-19 vaccine side effects. Several spoke about the challenges of navigating widespread misinformation and distrust, such as theories that the vaccine would lead to infertility, is a form of population control, or is a way to track humans. Participants described feeling unsure of what to believe or who to trust as they worked to balance information from different sources, such as their church, their family, medical providers, politicians, and personal networks, and resulting feelings of vaccine hesitancy; when referring to side effects she had heard about, the one participant who had decided to receive the vaccine noted ,*"I don't know if they were rumors or facts."* Another participant shared, "*they said that it was against the Bible, that it wasn't a good vaccine, that they wanted to kill us all. All of this made us reluctant to take it. When we heard about all that people were saying about the vaccine to scare us out of taking it, it made us think twice*." Although word-of-mouth helped spread misinformation and exacerbate distrust, it was also described as a powerful way to build trust. The participant who described beliefs that the vaccine was against the Bible recommended, "*If the vaccine won't cause any damage to their bodies, let them clearly, let the people know that it is something for us, to learn from Haitians or we make people talk to each other to show people after taking the vaccine, they do not need to be afraid because the vaccine does not cause any damage to their body*." Participants suggested that women may be more likely to trust sources of information that they already have a relationship with—for example, family members, church leaders, or other Haitian women.

Recommendations and Implications

Findings from the survey elucidated how Latina mothers living in Fall River received information about the vaccine and what informed their decisions on COVID-19 vaccination, while the interviews explored perspectives and decision-making in more depth, among Haitian mothers living in the Brockton area. Although most participants (18 of 27 participants overall, or 67%) received at least one dose of the COVID-19 vaccine, this project uncovered vaccine hesitancy and uneasiness among two different communities. It should be noted that all participants were pregnant during the pandemic and most had delivered by the time they participated in this project. Although questions focused on vaccination during pregnancy, the timing of data collection relative to their pregnancies may have influenced responses. That is, it is possible that participants reflected on their vaccine perspectives and decisions more broadly when participating in the survey and interviews, rather than solely in relation to their pregnancy.

From the survey we learned that, despite the fact survey respondents were largely connected to a medical home and receiving information about the vaccine from medical providers in their preferred languages, it was partners and family members who guided their vaccine decision-making. During interviews, many participants shared that despite concerns about the vaccine – and in many cases beliefs against the vaccine – they had no choice but to vaccinate. Taken together, findings from this project underscore the importance of COVID-19 vaccination initiatives that provide pregnant people and their partners and family members with the information they need to make decisions. These results also point to opportunities to strengthen COVID-19 vaccination efforts to support pregnant people's decision-making processes and address their concerns. Community Evaluators participated in a series of collaborative meetings to develop the following recommendations for the project overall.

What: Provide more comprehensive information. Participants expressed the need for more education and information on the vaccine that can guide decision-making. Both the survey and interviews suggest the need for information on the benefits and disadvantages of the vaccine, side effects, and effects on pregnant people and children. Information should be accessible, using plain language that is understandable to people outside of the medical and scientific community, but also comprehensive, enabling people to make decisions for themselves.

How: Focus on how and to whom information is delivered. This project suggests the need to create space for people to ask questions and engage women's broader support systems to support vaccine decision-making. Care should be taken to consider how information is shared, such as by engaging family members and partners and sharing information in people's preferred languages. Further, more can be done to tailor information sharing to local contexts, such as by engaging religious leaders and churches that support the vaccine, and offering community gatherings where women can discuss the vaccine with other community members in their preferred language.

Issue Spotlight:
Accounting for Social Support

The survey pointed to the role of partners and family members in supporting respondents' vaccine decision-making. During interviews, participants reflected on attending appointments during the pandemic, and being unable to draw on their social supports due to COVID-19 guidelines. One Haitian mother described going to her prenatal visits without support:

> *"You don't really have anyone with you who could talk to the doctor. Someone who could tell the doctor what is wrong with you. Why you came...They would not allow two people to enter. Only the sick person. Although I was pregnant and suffering, I was the only one who could go inside. My husband could not go in with me."*

Together, these findings underscore the importance of accounting for pregnant people's support systems in tailored vaccine outreach strategies.

Where: Reach people where their communities gather. Vaccine outreach efforts should focus on trusted locations, and recognize that these locations may vary by community, group, and individual. For example, despite efforts to focus vaccine outreach in community settings, people who are concerned about vaccine side effects may prefer receiving vaccines or vaccine information from a medical provider or clinic. For others, trusted locations may be outside of medical settings, such as churches or public schools, or places where their communities gather.

These findings affirm the importance of tailoring vaccine outreach approaches within communities and highlight opportunities to strengthen these approaches by accounting for differences in perspectives *within* communities, both between and among subpopulations. Vaccine decisions can be deeply personal for any person, and pregnancy presents an added layer; participants across both subpopulations emphasized their concerns about vaccine side effects on their babies. In interviews with Haitian mothers in particular, we also saw how vaccine decisions were grounded within cultural, religious, and historical contexts – with participants referring to the Haitian community's religious beliefs about the vaccine and alluding to a history of racism as some noted beliefs within their community that the vaccine was intended to harm Black people.

To further tailor vaccine response efforts to pregnant people and mothers, an initial step could include hosting community forums for expectant families in partnership with trusted and family-centered organizations, such as religious organizations, family clinics, or family centers, and in a variety of languages. During these forums, families could provide feedback on what information they are seeking and who they see as trusted messengers, as well as where they would feel comfortable learning about and/or receiving the vaccine. These

forums could include opportunities for families to hear from providers and/or from parents in their community who have been vaccinated, ask questions, and voice concerns. Following these forums, it would be important to share with and/or demonstrate to expectant families the ways that voices from their own community have helped shape vaccine outreach efforts locally, monitor the effectiveness of these outreach efforts, and refine them to support ongoing improvements.

Pediatric COVID-19 Vaccination

Community Evaluator Team: Carolyn Boumila-Vega, Keiana Cox, and Bethany Morales
TIER Mentors: Melissa Colón, Emma Posner
Additional Acknowledgements: Sophie Antoine, Nneka Hall, Consuelo Perez

Background

Throughout the pandemic, the MDPH Vaccine Equity Initiative (VEI) has worked to increase access to and acceptance of the COVID-19 vaccine in 20 Massachusetts cities and towns disproportionately affected by COVID-19.[xvi] This project began before the authorization of the COVID-19 vaccine for young children ages 6 months to 4 years. In anticipation of this authorization, MDPH sought to understand parents' perspectives on the COVID-19 vaccine, focusing on: (a) parents in communities with low vaccination rates such as Boston and Fall River, (b) parents in communities that experienced significant health and social challenges related to COVID-19 such as Chelsea, and (c) parents who identify as Black or Latino.

Young children ages 6 months through 4 years old were the last age group to be authorized to receive the COVID-19 vaccine,[xvii] and Massachusetts COVID-19 vaccination data[xviii] indicates that this group continues to have the lowest rates of any age group. As of April 2023, in Massachusetts overall, 25% of children ages 0-4 have received their first dose of the vaccine, compared to 63% of children ages 5-11, 91% of children ages 12-15, and 91% of children 16-19. [xix]

To learn about the context behind these rates, a group of Community Evaluators in Boston, Chelsea, and Fall River designed a qualitative evaluation to understand the perspectives of: (a) Black parents; (b) Latino parents; and (3) first-time young parents. Specifically, this project focused on:

- Parents' perspectives on the COVID-19 vaccine
- What support or information parents would need to make decisions about the vaccine
- How parents are making decisions about the COVID-19 vaccine for themselves and their children
- Recommendations for how MDPH can improve vaccination efforts.

Project Design

The three Community Evaluators working on this project –Keiana Cox, Bethany Morales, and Carolyn Boumila-Vega—all work in health or human services, are parents, and bring personal and/or professional experiences as members of the communities that their projects focused on (for more on the evaluation team, see Community Evaluator Bios). Based on their personal and/or professional experiences, all three identified subpopulations and geographic communities to engage. They each chose to collect data through focus groups as they believed bringing parents together would result in rich conversations among parents about their feelings, beliefs, and experiences with the COVID-19 vaccine for young children.

[xvi] Priority communities for the Vaccine Equity Initiative (VEI) include: Boston, Brockton, Chelsea, Everett, Fall River, Fitchburg, Framingham, Haverhill, Holyoke, Lawrence, Leominster, Lowell, Lynn, Malden, Methuen, New Bedford, Randolph, Revere, Springfield, and Worcester. For more on the VEI, see: https://www.mass.gov/info-details/covid-19-vaccine-equity-initiative.
[xvii] The Centers for Disease Control and Prevention (CDC) authorized the vaccines for children 6 months through 4 years old on June 18, 2022.
[xviii] Updated weekly on the Mass.gov COVID-19 Response Reporting Dashboard, available at: https://www.mass.gov/info-details/covid-19-response-reporting#covid-19-interactive-data-dashboard-
[xix] Reported COVID-19 vaccination data are as of 4/19/23, which was just following the data collection period. Vaccination rates (at least one dose) for children ages 0-4 vary considerably by community. Retrieved from the Massachusetts COVID-19 Response Reporting Dashboard: https://www.mass.gov/info-details/covid-19-response-reporting. COVID-19 vaccination has been available for all children/youth over the age of five since October 29, 2021.

Data Collection

The Community Evaluators developed focus group protocols for their subpopulations, with common questions across samples and questions unique to their sample (See Appendix A: Data Collection Instruments). Community Evaluators also asked brief demographic questions to describe the participant population; these questions were asked in the form of a brief demographic survey on Qualtrics at the beginning of focus groups. Recruitment occurred via email and word of mouth to partners (e.g., community-based organizations, family support programs) that Community Evaluators were connected to personally and/or professionally, and potential participants received a flyer with information on how to sign up. Participants received a $50 gift card to a store of choice for their time and participation.

Originally, all three Community Evaluators planned to host focus groups in-person at community-based organizations that were familiar to potential participants. Due to initial challenges with outreach and recruitment for in-person focus groups—and an interest in gathering insight from additional parents—additional virtual focus groups were organized and facilitated by Community Evaluator alumni Nneka Hall and Consuelo Perez, and TIER mentor Melissa Colón.[xx] Between December 2022 and March 2023, a total of 11 focus groups were organized, comprising 42 participants. Participant demographics are summarized below.

Data Analysis

Focus groups were audio recorded, and transcripts were generated from those recordings. A TIER staff member was present at each focus group; their role was to offer logistical support (e.g., with demographic survey, the distribution of the gift cards). Data were analyzed thematically relative to the overall evaluation aims and the Community Evaluators' own experiences.[13,14] The evaluation team reviewed each transcript to (a) identify significant quotes that embodied the evaluation aims, (b) based on the significant quotes, generate three to four themes from each focus group, and (c) describe themes that emerged across the data. Mentors met with Community Evaluators to collaboratively refine emerging themes. At the end of the analysis phase, Community Evaluators shared key findings with one another to identify similarities, differences, and recommendations across the subpopulations. For more on the qualitative analysis process, see Appendix B: Analysis Plan Summary.

Samples

Overall, there were 42 participants across the three subpopulations. Although we distinguish between subpopulations when reporting on findings, many participants shared characteristics with more than one subpopulation—for example, Black parent and Latino parent focus groups included some young parents, and young parent focus groups included parents who identified as Black and/or Latino. Among first-time young parents, half (*n* = 4) identified as White, and the other half identified as African, Hispanic, and Puerto Rican. In focus groups with Black parents, most participants identified as either Black/African American (*n* = 6) or more than one ethnicity (*n* = 5), and a couple of participants identified as either African or Puerto Rican. Among Latino parents, more than half were from Central American countries (*n* = 8), including Honduras, Guatemala, and El Salvador. The focus group with Latino parents and guardians in Chelsea specifically recruited immigrants; the other two focus groups were open to any parent who identified as Latino, spoke Spanish, and met the eligibility criteria. Most participants in the Latino parents and guardian focus groups were born outside of the United States (*n* = 13). See Table 8 for additional context on each subpopulation, including method, participant eligibility, sample size, and selected participant demographics.

[xx] Nneka facilitated one interview and one focus group, and Consuelo and Melissa facilitated one focus group each.

Table 9: Pediatric COVID-19 Vaccination—Project Design

Subpopulation	Eligibility	Sample Size	Selected Participant Demographics[xxi]
First Time Young Parents	• First-time young parent (18–25) with a child under age 5 • Lives in Fall River	2 focus groups (*n* = 8)	• Education: High school/GED (*n* = 2) & some college (*n* = 6) • Number & ages of children: <18 years (*n* = 12) & <5 years (*n* = 9)
Black Parents	• Self-Identify as Black • Parent of a child under 5 • Lives in the Boston area	6 focus groups (*n* = 19)	• Education: High school/GED (*n* = 6), some college (*n* = 3), Associate's (*n* = 4), Bachelors (*n* = 1), and post-bachelor's (*n* = 5) • 15 mothers & 4 fathers • Number & ages of children: <18 years (*n* = 34) & <5 years (*n* = 27)
Latino Parents and Guardians	• Self-Identify as Latino • Parent or Guardian of a child under 5 • Lives in Chelsea (for one focus group) or the Boston area • Speak Spanish	3 focus groups (*n* = 15)	• Education: Less than high school (*n* = 4), high school/GED (*n* = 3), some college (*n* = 1), bachelors (*n* = 3), post-bachelor's (*n* = 2) • Number & ages of children: <18 (*n* = 35) & <5 years (*n* = 18)

Results

Across the three subpopulations, young parents had the lowest vaccination rates for both themselves and their children, and Latino parents had the highest. Table 9 summarizes status by subpopulation, estimated based on what participants disclosed during focus groups. Important to note is that many parents across the three subpopulations reported that they had been required by employers to get vaccinated themselves—due to mandates—and expressed the importance of making this decision for their children.

Table 10: Parent and Child Vaccination Status by Subpopulation

Subpopulation	Parents' Vaccination Status	Their Children's (0–4) Vaccination Status
Young Parents (*n* = 8)	• Less than half were vaccinated, all due to workplace mandates	• None had vaccinated their young children
Black Parents (*n* = 19)	• More than half were vaccinated themselves, many due to work mandates	• Less than a fifth had vaccinated their young children.
Latino Parents and Guardians (*n* = 15)	• Almost all were vaccinated, most by choice	• About half had vaccinated their young children.

In this section, we describe themes that emerged across subpopulations. Then, we describe themes unique to each subpopulation.

[xxi] Not all participants chose to complete the demographic survey. Selected demographics reflect 8/8 young parents, 16/19 Black parents, and 14/15 Latino parents.

Vaccine perspectives: A sense of caution

Across subpopulations, parents expressed a sense of caution toward the COVID-19 vaccine for young children, and a need for more information and time to make decisions for their children. For many parents, the newness of the COVID-19 vaccine, the speed of vaccine development, and the lack of longitudinal research was a driving force for their concerns. Contributing to their sense of caution, some parents shared their own negative experiences with the COVID-19 vaccine, such as feeling forced by employer mandates and experiencing side effects. Parents also expressed questions about whether the vaccine was necessary—some sharing that their children had mild cases of COVID-19 or had received protection through their vaccinated mothers' antibodies while breastfeeding—and were wary about giving children an unnecessary vaccine as their immune systems develop. Some young parents and Black parents raised questions about how messaging on reasons to get vaccinated shifted from preventing the virus to reducing its severity.

Before making decisions, parents wanted more information, to discuss the vaccine with their pediatricians, and to see how the vaccine has affected other children. Many Latino parents had positive feelings about the vaccine and were quick to vaccinate themselves, yet they also felt they needed time to weigh the pros and cons of the vaccine for their children. As one Latina mother, who experienced side effects when she herself received the vaccine, explained, *"…I'm going to wait for more people to vaccinate children and I'm going to see what the side effects are. Maybe I'm going to vaccinate them next month, so yes, I will vaccinate them, but wait first*." Across all subpopulations, many echoed this interest in waiting, emphasizing the need for more time to gather information before they would feel comfortable vaccinating their young children.

Issue Spotlight:

COVID-19 Vaccines vs. Other Pediatric Vaccines

Most parents reported adhering to the recommended vaccine schedule for young children, but the COVID-19 vaccine felt different. Differences included: the speed of vaccine development, new technology used for the COVID-19 vaccine, how the vaccine is not yet normalized on the pediatric vaccine schedule, not knowing side effects, and the perceived threat of the virus. A Latina mother contrasts the COVID-19 vaccine with the chicken pox, summarizing parents' anxiety:

> "*The chickenpox vaccine or the other vaccines we took, and that we give our children, we neither think nor ask since it has existed for so long. We don't even ask about the reactions or ask about long side effects or anything. But since the COVID thing is so new, this is our era, we are anxious to know how children will react."*

Further, a Black father described how he and his wife considered the severity of COVID-19 compared to other viruses when deciding whether to vaccinate their daughter:

> *"…what we consider the threat level for [my daughter] right now with COVID-19 wasn't very high, but we do feel like, you know, polio is very important to have, the flu shot is very important to have. Things that actually kill kids, you know?"*

Although most parents generally supported pediatric vaccines, the newness of COVID-19 raised some unique considerations.

Seeking trusted information

Parents wanted information on vaccine ingredients, risks, and side effects from doctors, experts and scientists, and members of their community. Although most parents received information from pediatricians, this information did not meet many parents' needs. Parents wanted to know not just the benefits, but also the risks and ingredients. As one young mother in Fall River shared: "*I want to know the scary information…I want*

to know all the real information behind all of it." Some Black parents wanted to know specifically what information sources pediatricians use to inform their guidance, or needed their pediatrician's enthusiastic endorsement before they would consider vaccinating their young children. Latino parents expressed the need for personal conversations with their pediatrician (rather than text messages or written materials), in languages and using terms people can understand. One Latina mother emphasized the importance of these personal conversations in the Latino community and the need for parents to have direct conversations with medical providers. She said, *"…I would say that perhaps something that would help the Latino families, that comes deeply grounded by our culture, would be to talk one-to-one. No papers. Because we are not going to read them. We need more in-person conversations, live. That they see…'I have my mask, you don't have to fear. I'm going to give you guidance…' More guidance from pediatricians. And nurses."*

Many parents drew on a range of information sources when making vaccine decisions, and some struggled to reconcile the information and misinformation they were hearing or reading about with messaging from their medical providers. Some parents described information from many directions as overwhelming; one Black mother shared, "*I don't even watch the news at all. So, I don't live in a bubble, but I kind of live in a bubble to try to protect myself, because I just feel like it's so much being poured at me. I just can't think, it's too overwhelming*." When describing her own experience with the COVID-19 vaccine while pregnant, one young mother in Fall River had read that the vaccine could increase the risk of miscarriage in the first trimester of pregnancy (this is not supported by evidence on the vaccine[19])[xxii] and was frustrated that her doctor had not talked with her about what she believed to be this risk:

> "*Not once did anybody mention to me the risk of a miscarriage in the first trimester. Not a single time. Not my OB [obstetrician]. Not any doctors that I talked to, not anybody at [the pharmacy] or anything like that… and when I did my own research and I came across that and I brought it up to my OB, my OB was like yes, that is actually a factor. So if you feel more comfortable, then we should wait until after your first trimester...You're going to tell me about all the benefits, but I think [doctors] need to be completely transparent with everything, because other than that, I feel like there's always something that they're hiding.*"

This example points to the complex relationship between information and misinformation available publicly and information provided by medical providers.

In addition to their doctors, participants wanted to hear from scientists and vaccine experts and networks within their communities. From scientists and vaccine experts, participants wanted to learn about the process and speed of vaccine development, and ingredients in the vaccine. Some parents had not known other parents who had vaccinated their young children. Black parents and Latino parents discussed the importance of hearing from other parents in their communities – including family and friends—who have vaccinated their young children.

Decision-making in the context of public health strategies: Distrust and pressure

All subpopulations critiqued vaccine outreach initiatives that they saw as including messaging that feels overly simplistic, and strategies that feel "*suspicious*" or almost coercive. Participants had critiques about vaccine messaging, incentives, and mandates, as follows:

[xxii] It is important to note that there is *no* evidence to support that vaccines increase the risk of miscarriage. For further information, see: Rimmer, et al 2023.

- ***Messaging:*** Many participants felt vaccine messaging did not provide the information they needed to make their own decisions. One young mother in Fall River felt that vaccination campaigns could have been more transparent about vaccine evidence. She said, "*…. let the study speak for themselves. Show people what is happening when they are taking it…I feel like they're just like, 'take it, take it, take it, don't ask questions. Just trust us.' When really they should be providing why we should be trusting them.*"
- ***Incentives*:** All subpopulations critiqued vaccine incentives programs—how offering cash incentives for the COVID-19 vaccine but not for other types of vaccines felt "suspicious" and verged on coercive, particularly given the financial stressors many families were facing. Some Latina mothers expressed how vaccine incentives discourage people from making decisions based on their health; as one Latina mother shared, "*that was a very very bad, horrible decision that they made. Do you know why? Because each person should only make a decision to get vaccinated based on their health and well-being*."
- ***Mandates:*** Many parents had no choice but to get the vaccine themselves because of jobs, schools, or other settings that enforced a mandate. Black parents and young parents described how repetitive school and health care messaging made people feel they were being pressured to vaccinate their young children. They expressed concerns that COVID-19 vaccine may eventually be mandated for young children.

Vaccine efforts: The importance of community-driven initiatives

Participants across subpopulations touched on the importance of vaccine outreach that occurs *from within* their communities. Both Black parents and young parents critiqued public health efforts that targeted them and their communities, expressing little reason to trust these initiatives. As one Black father shared, *"…is society really helping me move forward? Do they really care about me and my family, and the resources we need? So then why would they care if I get vaccinated? For my own sake or for others? I feel like that's how the community sees it."* A Black mother described her general mistrust for the government's vaccine outreach campaigns in her community, mentioning, for example, text messages offering free Uber rides and billboards; she said, *"you come to the projects, you put yourself in the projects, but then you go in this radius, different mile radiuses, you have a rich area over here and rich area over there, but you're not going to these other places. You're just coming right here to us. And why are you coming to us?"* These examples point to a heightened awareness of feeling *"targeted"* by vaccination campaigns.

The Latino parent focus group in Chelsea highlighted the value of grassroots public health efforts, mentioning efforts led by a community-based organization and the city. During this focus group, Latina mothers and caregivers spoke enthusiastically about community-driven initiatives that they could turn to for high-quality information, support with vaccine access, and resources to support residents' broader needs. Many parents described first hearing about the vaccine from their pediatricians or a trusted community-based organization, and also spoke about door knocking initiatives in Chelsea to promote conversations about the vaccine and its benefits. One Latina mother described door knocking campaigns, noting that *"this is still the initiative that was the greatest."* She said, *"they're going to knock on doors and explain the benefit. Because it's not as if, when the vaccine comes out, they're going to send people saying, 'look, this has a negative effect.' No. They're going to promote it as something good."* Most parents in the Chelsea focus group were vaccinated themselves and had vaccinated their young children.

Themes Unique to Subpopulations

Black Parents: Systemic racism and distrust

Black parents described an awareness of the long histories of racist and exploitative practices by the health care systems and government against communities of color, and in particular Black people, referencing the Tuskegee Airmen experiment and experiments broadly, for example. Participants discussed how systemic

racism shaped deeply rooted distrust, described by one participant as "*passed on from generation to generation*." As one Black mother shared: "*…there was a lot of like conspiracy theories that the vaccine was put out there to kind of get people infected with COVID…but like generally, history, hasn't been too kind to minorities associated with healthcare."* They discussed ongoing mistreatment and distrust, including concerns about limited testing of the COVID-19 vaccine, and concerns that healthcare providers will not be transparent or do not take the concerns of Black people seriously, including pregnant Black women. Within this context of systemic racism, participants described how vaccination efforts that specifically target their communities—such as by offering free Uber rides to vaccination sites—have been met with skepticism. They shared concerns about they themselves or their children being treated like "*guinea pigs*" and "*lab rats*." This distrust was so profound that even though many participants shared how they have been deeply affected by COVID-19—for example, extended hospitalizations, caregiving in isolation while sick themselves, death of family members—they were hesitant to get themselves and their children vaccinated. One Black mother described these feelings as follows: "*I think it's all around just hard for parents now, because you don't know what exactly to trust and what not to trust, especially when you're coming from the Black and Brown and minority community*."

Young Parents: Lack of transparency

At the time of the focus groups, only one young parent had made a firm decision regarding the pediatric vaccine, having decided not to vaccinate their young children. The remaining participants—some of whom first learned about the approval of the COVID-19 vaccine through the focus group—did not feel that the perceived risks were worth what they saw as unclear benefits and were leaning toward not vaccinating. Factoring into these concerns, several participants felt that medical researchers and government were not transparent about aspects of the vaccine, including the speed of vaccine development. As described by one young mother, "*[COVID-19's] only been out for a few years and they were able to come up for vaccine for that. But there's been diseases that have been around for years that they can't find the cure for. How were they able to find the cure so quickly for this, but not everything else that's in the world that's been here for years?*" Participants also described how misinformation—such as the conspiracy theories that the vaccine is a form of population control or has a chip to track people—contributes to distrust and suggested that many believe these theories. When asked why vaccination rates may be low in her community, one young mother suggested that people *"…think COVID vaccine is a setup and there is something in these shots...Like they feel like the government is lying…that's what I've heard, from like a lot of people that I know…"*

Latino Parents: The vaccine as protection and hope

In two of the three Latino parent and guardian focus groups, nearly all participants, and many of their children, had been vaccinated against COVID-19. Many Latino parents shared how witnessing severe illness and death within their families and community instilled a fear of the virus. Several also described vaccines as a necessity due to the health-related vulnerabilities they experience themselves or within their families; this was particularly the case in a focus group that included Latino parents of children with special health needs. Overall parents were not just worried about getting sick, but also about passing COVID-19 to their families, especially children, and about job loss due to illness. In two focus groups, participants described the vaccine as both a vital tool to protect against the COVID-19 virus and an antidote to a deep sense of fear and anxiety, noting that the vaccine may not prevent infection, but would likely protect against severe illness. Participants also discussed the vaccine as a "*blessing*" and "*privilege*"—particularly as family members outside of the United States did not have easy access to vaccination or health care—and how the vaccine brought feelings of hope. One Latina mother described her feelings about the COVID-19 vaccine: "*I also felt confident, happy, blessed, privileged, because although COVID-19 was new and it caused us a lot of fear and uncertainty, I had the*

knowledge of how vaccines have come throughout history…and how they used in difficult times. So, I had that confidence that the vaccine was a hope."

While most Latino parents saw the vaccine in a positive light, several parents expressed resentment toward workplace mandates. Some also noted that they would not vaccinate their children due largely to the newness of the vaccine or had waited before deciding to vaccinate them.

Recommendations

All participants were deeply concerned with the decision about whether to vaccinate their children. They emphasized the need for time and information to make these decisions, and many expressed concerns that vaccine mandates and incentive programs will impede people's ability to make their own choice. Findings also point to the importance of acknowledging social, historical, cultural, and community contexts when considering vaccination rates among broad sub-groups. Black parents underscored the need to account for the structural racism within the public health and health care systems that foment a sense of distrust. Young parents suggest that further transparency about the COVID-19 vaccine can help mitigate misinformation. Latino parents emphasized the need to consider strategies that allow for community conversations.

The following recommendations were co-developed by Community Evaluators and TIER mentors to respond to concerns shared across subpopulations, as well as to emphasize findings unique to specific groups.

Leverage pediatricians. This project highlighted the critical role that pediatricians play as brokers of public health efforts for young children. Participants want their pediatricians to be up to date on the latest research, to address parents' concerns directly, and to take care not to pressure them. Pediatricians should give parents time to process information and make their own decisions. To carry forward this recommendation, MDPH could partner with provider groups and networks to support trainings for medical providers on having conversations about the vaccine, and/or continue to provide other resources (e.g., talking points, information sheets) that can support open conversations with families about the vaccine.

Provide comprehensive information pertaining to children. Parents were looking for information on the short- and long-term effects of the vaccine, risks and benefits, ingredients, and the speed of vaccine development. Messaging should clearly outline what is and is not known about the vaccine, and why and how guidance may change. Information should also be shared in a variety of languages and formats to meet the diverse literacy and information needs of parents. Some examples could include: an online resource hub for parents with information on adverse vaccine effects or planning parent forums with scientists or vaccine experts.

Re-evaluate outreach strategies. There is a need to realign vaccine outreach strategies to support parents' own decision-making. Messaging should focus not on convincing parents to vaccinate their children, but on ensuring parents have the information they need to decide. Public health initiatives should also consider the role of other mitigation strategies; some parents may not vaccinate their children but want information on treatment and prevention of COVID-19. Further, despite critiques that vaccine incentive programs were perceived as suspicious and coercive, some parents shared that these incentives were helpful in the face of financial stress. Instead of tying incentive programs to vaccine uptake, MDPH could consider initiatives that re-purpose incentives for public health education efforts and/or to support families' basic needs, irrespective of vaccine decisions.

Support strategies that build community. Across subpopulations, parents saw other parents as trusted sources of information; they want to learn from parents who have chosen to vaccinate their children, including about their experience and how they made these decisions. As one Latina mother said: "*other mothers can*

help us become more comfortable in vaccinating our children." Initiatives that encourage parents to talk with one another and that are led by community-based organizations could help build trust in the vaccine. This recommendation is consistent with research on improving the alignment of health care communication and messaging with Latino community values such as *familismo* (family and community orientation towards well-being) and *personalismo* (interpersonal connections).[20] For example, funding could be provided to local organization for family nights focused on public health topics; during these meetings, parents could have the opportunity connect with one another about resources and information that have been helpful to them.

Prioritize building trust. Underpinning these recommendations is the need for public health efforts to build trust with communities. Building trust should happen in a variety of ways—ranging from improving communication between providers and families; partnering with local leaders and community organizations to support local vaccine efforts or engaging local leaders as advisors on vaccine strategies; or hosting listening sessions to hear and respond to parents' concerns.

Section IV. Discussion and Conclusion

Together, these projects offer a multi-faceted view of residents' perspectives on COVID-19 response efforts and highlight opportunities to improve ongoing public health initiatives and build the public's trust with health systems. Collectively, the projects shine light on some common experiences and themes across distinct geographic communities and populations. Drawing on findings from across the four projects, we offer some overall recommendations.

A focus on equity has been at the center of MDPH's pandemic response strategies. Since early in vaccine planning, for example, MDPH's Vaccine Equity Initiative worked to explicitly address structural inequities by prioritizing geographic communities and subpopulations disproportionately impacted by COVID-19.[21] To promote equity in vaccine distribution, the state allocated a percentage of the its vaccines to 30 priority communities[21] and prioritized residents in correctional facilities and shelters in phase one of the vaccine rollout.[22] The state also worked to eliminate barriers to vaccine access through innovative strategies such as mobile vaccination clinics.[23] Overall, Massachusetts has among the highest rates of COVID-19 vaccine uptake in the United States,[24] even among some of the populations, such as Black and Latino residents, that other states were less successful in reaching.[25] [26] Going solely by indicators of uptake, then, Massachusetts' vaccination efforts were largely successful. The projects described here, however, complicate the idea of what constitutes "equity" in the context of a public health response. Our conclusions highlight some of the tensions that can exist between rapid public health response focused on equitable resource allocation, and a legacy of distrust toward medical and government systems.

Cross-cutting Themes and Recommendations

Information and Messaging

The pandemic presented a unique moment for residents to become critical consumers of public health information, and participants described an acute awareness of public health guidance and strategies to mitigate risk for themselves or others, recounting changing science, reading research studies, and following protocols. They emphasized the importance of having the information that they need to make decisions for themselves, their families, and their workplaces.

Provide information that can be widely understood, but that is not simplistic. Participants want to hear the science and research behind public health measures. For frontline workers, this emerged in their efforts to understand the rationale behind guidance that felt unclear or impractical. People making decisions about the vaccine during pregnancy or for their young children described the need for comprehensive information that could help them weigh the risks and benefits. Although grounded in public health communications practices that are designed to be simple and accessible, messaging like "*Trust the Facts, Get the Vax*" presumed trust for public health systems and government within a climate of profound distrust. Further, this messaging did not provide the information—such as on risks or ingredients—that residents felt they needed to make their own informed decisions about their health, reinforcing this distrust.

Be transparent about changing science. Public health emergencies rely on information that is rapidly evolving, and participants are also looking for transparency as guidance changes. Transparency about changing science and shifting guidance—and continuing to promote public health literacy across the state—could help build a common understanding of how and why guidance evolves. To do this, MDPH could continue to integrate a focus on health literacy and numeracy (or understanding of public health data) into its public health messaging, for example by embedding an orientation on how to interpret data on dashboards shared with the public, defining medical and public health terms to build resident knowledge, hosting "office hours" where

residents could speak to public health experts or leaders directly, or developing brief videos that provide a window into the process of developing guidance (e.g., what information is considered, who decides).

Coordinate guidance and information sharing. Frontline workers, as well as parents across the two vaccine projects, reflected on a sense of information overload and were left to discern for themselves which information was reliable and which guidance to follow, within a climate of widespread misinformation. Frontline workers, for example, described receiving information and guidance that was constantly changing from multiple organizations and entities, such as the CDC, MDPH, local boards of health, doctors' offices, EEC, schools, and places of employment. Coordinating information sharing could reduce confusion and support adherence to guidelines. It could also build trust in public health and emergency response efforts by clarifying how entities work together and reduce opportunities for misinformation. Some examples could include creating joint guidance for frontline workers across state or local agencies, such as between MDPH and EEC; or developing a public facing infographic that outlines how agencies work together in public health emergencies and who residents can turn to for information. This information should be available in various languages and culturally relevant.

Support dialogue at the community level. More work needs to be done to ensure that information reaches residents by considering local contexts, including languages spoken, where people access information, and trusted messengers. Findings also underscored the importance of word-of-mouth information sharing in many communities. In Lawrence, most participants had learned about the Telehealth Kiosk from friends and family. As parents and workers described the sheer abundance of COVID-19 vaccine information (and misinformation) available through the news and social media, they elevated the need for personal or community conversations. Community dialogues could include partnering with local organizations to host conversations among parents to share vaccine concerns and experiences with one another; holding listening sessions between parents and scientists or vaccine experts; and convening conversations between workers or parents and policy- or decision-makers to ensure that guidance meet people's needs.

Autonomy and Choice

These projects point to a lack of autonomy and choice that many felt during the pandemic. Despite precautions, many frontline workers – who are disproportionately low-income[27]—had limited control over their exposure given the realities of their work or workplace, and many had to comply with vaccination mandates to keep their jobs. Not having had a choice about the COVID-19 vaccine themselves, many parents were deeply concerned about being able to make COVID-19 vaccine decisions for their children.

Acknowledge issues of agency. Across the frontline worker and both vaccine projects, participants discussed how hard it was to find a balance between their own personal and family safety and their need to work or engage in other activities in person. At the center of this tension were vaccine mandates and economic contexts. Frontline workers described concerns about their own personal safety, but felt they had no choice but to work in-person. They also spoke of colleagues leaving their jobs due to vaccine mandates, and pregnant women and parents described receiving the COVID-19 vaccine—despite profound concerns—to keep their jobs. People's stories and experiences also highlighted the inherent tension that can exist between policies created for the public's health—such as vaccine mandates—people's own priorities and beliefs, and communities' well-founded distrust in government, medical, and public health systems.

Engage providers – while emphasizing choice. Although most parents shared that they would consult pediatricians on their vaccine decision-making, many of these same participants grappled with conflicting information they have heard elsewhere, or felt pediatricians were not addressing their concerns about the

vaccine. Some participants who expressed distrust for the vaccine wondered if pediatricians would endorse the vaccine in the absence of clinic or hospital protocols, expressing distrust for medical and government systems, and other industries (e.g., the media, pharmaceutical industry). Public health initiatives should provide education to pediatricians, OB/GYNs, and other medical providers on how to discuss the COVID-19 vaccine with patients, including how to speak transparently about benefits and risks and support people's rights to make their own decisions. As emphasized by literature on embedding an anti-racist lens within public health and healthcare systems, this provider education should include an explicit focus on the root causes of distrust, and public health and medicine's history of experimentation and exploitation of communities of color, in particular Black communities.[28]

Interrogate vaccine incentive programs. Although there is some evidence to suggest that incentive programs may increase vaccination rates in certain contexts, these programs raise ethical questions.[29] Many participants discussed profound distrust for the vaccine—as well as the government, medical, and public health systems—that is rooted in a legacy of racism, oppression, and medical exploitation. Further, Black, Latino, and young parents participating in this project point to how these incentive programs have exacerbated some communities' skepticism of the vaccine. Should funding for incentive programs continue, MDPH could consider de-coupling incentives from vaccination, instead supporting residents' voices and own decision-making, or immediate concrete needs. To do this, MDPH could provide incentives for residents to attend community meetings or share their opinion on the vaccine. In future public health emergencies, MDPH could also explore reallocating incentive funds to support cash transfers to low-income families in communities disproportionately impacted by these emergencies, drawing from emerging research on such programs.[30,31]

The Legacy of Distrust

Finally, these projects emphasize the need to address the distrust for public health, government, and medical systems, rooted in racism, oppression, and mistreatment of Black, Indigenous, and People of Color (BIPOC). Addressing this distrust will require explicitly accounting for this legacy in the design of public health initiatives and ensuring that people are heard. Public health and government systems at all levels—state and local—cannot wait until there are crises to build trust with residents.

Contend with the legacy of public health and government agencies. For many, concerns about the vaccine stem from the legacy of racism, exploitation, and mistreatment of Black people, particularly among medical and public health systems. Communities who are most likely to experience this distrust—such as BIPOC communities and low-income communities—were also disproportionately impacted by the COVID-19 pandemic.[32] Among the participants we spoke with, this distrust appeared to be at the root of their vaccine decision-making. Massachusetts has been proactive in minimizing barriers among residents seeking the COVID-19 vaccine, for example by setting up mobile vaccination clinics or offering transportation. However, not one participant explicitly focused on logistical barriers as either facilitating or hindering their vaccine access. Instead, for many participants we spoke to, it was not barriers that drove their vaccination decisions or hesitance, but questions of transparency and trust. Many participants, particularly in the parent focus groups, pointed to how some of the very initiatives designed to promote access to the vaccine in their communities—such as free rides and incentive programs—exacerbated concerns, making some people feel targeted and coerced rather than supported. To mitigate their concerns, participants were looking to hear from one another, and from voices they trust in their communities.

These findings highlight some of the ways in which the Vaccine Equity Initiative's strategies have been very much on the right track – and some opportunities to strengthen future response efforts. Participants' interest in hearing from trusted voices within their communities affirms the importance of investing in community-based organizations to lead local vaccine outreach efforts—a key strategy for MDPH during the vaccine rollout process. In fact, the community-driven vaccine response efforts described in the Pediatric COVID-19 Vaccination Chapter, were funded, in part, by the Vaccine Equity Initiative (see box for example). However, in communities that may not have local community- or faith-based organizations with the infrastructure or trust to lead grassroots public health efforts—or where groups of residents are disconnected from these entities—strategies are needed to build partnerships with trusted voices, and to connect residents with one another.

From the vaccine projects in particular, many participants' stories reflect the ways that emergencies can unearth profound distrust—grounded in a long history of systemic oppression. They underscore the need to build authentic partnerships outside crises. Drawing from the work of the Vaccine Equity Initiative and other community engagement efforts, MDPH should continue investing in local partners and leaders to drive public health initiatives in their communities, recognizing the different groups that comprise a city, town, or demographic group, and the need for multiple partnerships and outreach strategies *within* a given community. These partnerships can help build platforms for two-way exchanges between state agencies and residents, both ensuring that residents have venues to voice their perspectives on public health initiatives and allowing MDPH to keep a pulse on resident perspectives—and adjust course—in real time. As funding for the pandemic response fades, new MDPH initiatives, such as the Community Health Equity Initiative and the Root Cause Solutions Exchange, are poised to sustain a commitment to engaging resident voices and build on lessons learned from the state's COVID-19 response.

The Role of Community Driven Initiatives: An Example from Chelsea

During the focus group in Chelsea, participants uplifted the role of La Colaborativa in local COVID-19 vaccination efforts. La Colaborativa, a Chelsea-based non-profit, works to empower Latinx immigrants to through a variety of social, economic, and health programs. During the pandemic, La Colaborativa emerged as a national model for addressing the needs of a predominately Latinx, immigrant, and Spanish-speaking community at the epicenter of the pandemic.[19] La Colaborativa provided a large-scale food pantry, emergency housing stabilization, re-employment initiatives, mental health supports, and mobile COVID-19 testing and vaccine pop-up clinics. Their COVID-19 response efforts were funded, in part, by MDPH. Many participants in the Chelsea focus group described learning about the pediatric vaccine from La Colaborativa. One participant who used La Colaborativa's food pantry and vaccination services described how the staff not only provided immediate support to residents but they "*have also been mindful to ask people if they are vaccinated, and if not vaccinated, they tell them, you can get that here as well*." As seen with La Colaborativa, trusted community-based organizations that have the relationships and infrastructure for grassroots organizing are best positioned to lead local public health response efforts.

Use data for action. This report reflects dialogue with and between Community Evaluators, participants, community-based organizations, and TIER mentors, to tell a story about how community members experienced the state's public health response efforts and opportunities for improvement. Throughout the process, the most common – and often the first – question raised by partners was *"how will findings be used?"* As one Haitian mother asked her interviewer: "*when you have finished collecting the data, what do you plan to do with all the data you are collecting from each person? I don't think I'm the only one that you interviewed, what do you plan to do with all the information that you're collecting from them?*" This question calls on state

officials and public health experts, along with evaluators, to be accountable for acting on findings with guidance from communities, and for communicating both findings and actions to the communities that shared their stories. When identifying action steps, these findings must be considered within the context of antiracism frameworks that argue for the need to look beyond the individual—for example, beyond individual vaccine decisions—and focusing on social, political, and other interrelated systems that produce racial and other inequities.[33] Visibly translating participatory evaluation findings into practice is a crucial step in building trust and accountability in public health and government response efforts.

The Work Continues…

This report describes a collaborative effort to engage residents in MDPH's pandemic response through participatory evaluation projects that include a range of partners. Over the coming year, we are implementing—and working to strengthen—the Community Evaluator model through both ongoing dissemination and new projects.

To date, these findings have been shared with project partners through presentations and dialogue and will be shared with state and local networks and other forums. As these projects underscored the need to reach residents through a range of formats and venues, we are working together with Community Evaluators to identify different forums and formats to reach a wide range of audiences for both these and upcoming projects. Further, these findings emphasize the importance of ensuring that residents are heard through action. As part of the dissemination phase, Community Evaluators met with MDPH project teams to discuss implications for ongoing public health initiatives.

There are always unanticipated complexities that emerge during evaluation projects, and participatory evaluation projects are no different. Co-creating evaluation projects takes time—to support training, dialogue between Community Evaluators, MDPH project teams, and other collaborators, and relationship development with outreach partners—making it particularly challenging to accommodate compressed project timelines. In addition, central to this project, Community Evaluators brought their own experiences and expertise related to project topics and focal communities, and this also meant re-visiting their own pandemic experiences through the stories shared by participants. Further, Community Evaluators were part-time members of our evaluation team balancing full-time roles and commitments outside of these projects. Our evaluation teams needed to think creatively about outreach, recognizing that both community partners and residents have been flooded with information and evaluation requests on topics related to COVID-19, and that these projects focused on experiences, challenges, and topics—such as the COVID-19 vaccine—that were particularly contentious and timely. To address these challenges, we drew on additional support from our evaluation team as needed—including staff, consultants, and Community Evaluator alumni—on outreach, data collection, and analysis.

Over the coming year, we are working with new communities to understand the ways in which structural inequities and injustices have been exacerbated by the pandemic, and how efforts to address them can be strengthened. Upcoming participatory evaluation projects under this grant focus on adolescent mental health, breastfeeding support for parents, and the experiences of cancer survivors in rural communities and people with disabilities. To carry out these projects, we have recruited another cohort of Community Evaluators from across the state. We are also engaging already-trained Community Evaluators in partnership with the MDPH Root Cause Solutions Exchange; for this project, a team of Community Evaluator alumni will work with the Exchange to identify policies that are contributing to health inequities in their communities and develop recommendations for addressing these issues through local policy and practice change. We hope these projects will generate findings to inform improvements to public health programs, and new ways to engage resident voices into public health planning decision-making.

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Appendices

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Appendix A: Data Collection Instruments

Evaluation of the Lawrence Telehealth Kiosk: Survey

Consent

This survey is available in both English and Spanish. To change the language, please use the dropdown menu located at the top right corner of this page.
Esta encuesta está disponible en inglés o español. Para cambiar el idioma, utilice el menú desplegable ubicado en la esquina superior derecha de esta página.

In collaboration with the Massachusetts Department of Public Health (MDPH), Tufts Interdisciplinary Evaluation Research (TIER; a team from Tufts University) is conducting a survey of Lawrence residents about a new Telehealth Kiosk located at the main branch of the Lawrence Public Library.

The Telehealth Kiosk opened in March 2022, as a free, safe, and accessible physical space (i.e., a private room) that contains a computer, Wi-Fi, and headset for residents to use.

Specifically, we're interested in learning:
1. Whether Lawrence residents have heard about and/or used the Telehealth Kiosk
2. What Lawrence residents might be interested in using the Telehealth Kiosk for
3. How the Telehealth Kiosk can be improved

To participate, you need to be 18 years or older and a resident of Lawrence. *You do not need to be familiar with the Telehealth Kiosk to complete the survey.*

The survey will take approximately 5-10 minutes to complete. Please remember that this survey is completely voluntary; there are no consequences to saying "no" to participating and you may choose to skip questions that you prefer not to answer.

All information collected through this survey will be confidential, meaning you will not be identified in any way and we will not share identifiable information with MDPH or any agency that you receive services from. Information used in reports, publications, or presentations will never be tied directly to your name.

We would like to thank you for your time by offering a $10 gift card to El Taller or Target by e-mail or mail for participating in this study. If you have questions or would like more information about the survey, please contact the TIER Team at LawrenceKioskProject@gmail.com. If you have questions about the project overall, please contact the Principal Investigator of the study, Jessica Goldberg, at Jessica.Goldberg@tufts.edu.

We appreciate you taking the time to contribute to this project.

Consent Questions

1. Do you agree to complete this survey?
   - Yes, I would like to complete the survey.
   - No, I would not like to complete this survey. [SKIP TO END OF SURVEY]

Before you begin the survey, please check this box.

The first set of questions ask whether you meet the eligibility criteria to take this survey. As a reminder, people who meet the following criteria are eligible: Over 18 years old and live in Lawrence

2. Do you live in Lawrence?
   - Yes
   - No [SKIP TO END OF SURVEY]

3. Do you work in Lawrence?
   - Yes
   - No

4. Are you over 18 years old?
   - Yes
   - No [SKIP TO END OF SURVEY]

First, we are going to ask you some questions about you and your household.

5. How old are you?

_____

6. Do you have children (under 18) living in your household?
   - Yes
   - No

[DISPLAY 6.1 IF THE ANSWER TO QUESTION 6 WAS YES]

6.1. Children How many children (under 18) live in your household?

_____

7. Are you Latino/a/x and/or Hispanic?
   - Yes
   - No

8. What is your race? (Select all that apply)
   - Asian
   - Black, African, or African American
   - Native American or Alaska Native
   - Native Hawaiian or Pacific Islander
   - White
   - Other (please specify all) _____
   - Prefer not to answer

9. What is your ethnic and/or national background (some examples include but are not limited to: Brazilian, Dominican, Guatemalan, Portuguese, Puerto Rican, Russian, Vietnamese, etc.)?

_____

10. What language(s) are spoken in your home? (Select all that apply)
   - Arabic
   - Chinese
   - English
   - French
   - Greek
   - Haitian Creole
   - Italian
   - Khmer
   - Portuguese
   - Russian
   - Spanish
   - Vietnamese
   - Other (please specify) _____
   - Prefer not to answer

11. Do you, or anyone in your household, receive ongoing support and services related to any of the categories below? (Select all that apply).

- Chronic disease management (for example, diabetes)
- Developmental services (for example, Early Intervention, Occupational Therapy, Physical Therapy, Speech therapy, etc.)
- Mental health services (for example, therapy)
- Family support services (for example, home visiting)
- Special education services (for example, IEP meetings)
- Vocational services (for example, MassRehab)
- Legal services (for example, meeting with a lawyer, supervision)
- Department of Children & Families (DCF) services (for example, case management, foster care)
- Benefit programs (for example, WIC, Mass Health, SNAP, TANF)
- Other (please specify) _____
- None

12. Do you have regular access to internet?

- Yes
- No

13. Which of the following sources do you read, listen to, or watch at least once per week?

- El Mundo
- La Mega
- Power 800
- Radio Católica
- Radio Torrente Programación
- Rumbo
- The Eagle Tribune
- The Valley Patriot
- WCCM
- Other (specify) _____
- I do not listen to and/or read local media sources

14. Have you visited the main branch of the Lawrence Public Library in the last 6 months?

- Yes
- No
- I don't remember

[DISPLAY 14.1 IF THE ANSWER TO QUESTION 14 WAS YES]

14.1. About how many times have you visited the Lawrence Public Library in the last 6 months?

- 1-2 times
- 3-5 times
- 6-10 times
- 11 or more times

Telehealth Kiosk

The Telehealth Kiosk is located at the main branch of the Lawrence Public Library and opened in March 2022. The Telehealth Kiosk was planned in response to the COVID-19 pandemic, which restricted people from receiving services in-person. The Telehealth Kiosk is a free, safe, and accessible physical space (i.e., a private room) that contains a computer, Wi-Fi, and headset that families, participants, or clients would book in advance to use for an appointment, including:

- **Developmental services (for example, Early Intervention (EI), speech therapy)**
- **Counseling/mental health/social work**
- **Pediatric or family medical visit**
- **Meeting for social, economic, or other needs (for example, applying for MassHealth, SSI)**
- **Educational needs (for example, study space)**
- **Other private or personal conversations**

15. Before taking this survey, were you aware of the Telehealth Kiosk located at the Lawrence Public Library?

- Yes
- No

[DISPLAY 15.1 IF THE ANSWER TO QUESTION 15 WAS YES]

15.1. How did you learn about the Telehealth Kiosk? (Select all that apply)

- I saw the Telehealth Kiosk at the library
- Family, friend, or colleague
- My employer
- Child's teacher or child care provider(s)
- Doctor or nurse
- Therapist or social worker
- Regional or local media source(s) (for example, Power 800, Radio Católica, Fortaleciendo Familias, Cambiando El Mundo de Personas Con Discapacidad)
- Social media (for example, Facebook)
- Other (please specify) _____
- I don't recall

[DISPLAY 15.2 IF THE ANSWER TO QUESTION 15 WAS YES]

15.2. Do you know of anyone, including yourself, **who has used** the Telehealth Kiosk located at the main branch of the Lawrence Public Library?

- Yes
- No

[DISPLAY 15.3 IF THE ANSWER TO QUESTION 15.2 WAS YES]

15.3. Tell us who you know who has used the Telehealth Kiosk. (Select all that apply)

- I have used it.
- Someone other than me in my household has used it.
- Someone that I know outside of my household has used it.

[DISPLAY 15.4 IF THE ANSWER TO QUESTION 15.3 WAS "I have used it"]

15.4. Did you use the Telehealth Kiosk to provide a service (for example, seeing a patient, conducting a therapy session, providing tutoring services)?

- Yes
- No

[DISPLAY TEXT IF THE ANSWER TO QUESTION 15 WAS YES and ANSWER TO QUESTION 15.2 WAS NO]

Or

[IF THE ANSWER TO QUESTION 15.2 WAS YES and ANSWER TO QUESTION 15.3 WAS "I have used it"]

The next questions ask about whether you've tried to use the Telehealth Kiosk and whether you think you would use it.

[DISPLAY 16 IF THE ANSWER TO QUESTION 15 WAS YES AND TEXT WAS DISPLAYED]

16. Have you ever seen the Telehealth Kiosk in-person?

- Yes
- No

[DISPLAY 17 IF THE ANSWER TO QUESTION 15 WAS YES AND ANSWER TO QUESTION 15.2 WAS NO]

Or

[DISPLAY I7 IF THE ANSWER TO QUESTION 15.2 WAS YES AND ANSWER TO QUESTION 15.3 WAS "I have used it"]

I7. Have you ever tried to book or use the Telehealth Kiosk?

- Yes
- No

[DISPLAY 18 IF THE ANSWER TO QUESTION 16 WAS YES AND ANSWER TO QUESTION 17 WAS NO]

18. Why haven't you tried to book or use the Telehealth Kiosk?
- I didn't have a need for it.
- The space didn't feel private.
- The location wasn't convenient
- Other (please specify) _____

[DISPLAY 19 IF THE ANSWER TO QUESTION 15 WAS YES AND ANSWER TO QUESTION 15.2 WAS NO]

Or

[DISPLAY 19 IF THE ANSWER TO QUESTION 15.2 WAS YES AND ANSWER TO QUESTION 15.3 WAS "I have used it"]

19. Can you see yourself using the Telehealth Kiosk?
- Yes
- No
- Maybe

[DISPLAY 19.1 IF THE ANSWER TO QUESTION 19 WAS YES OR MAYBE]

19.1. For what reason(s) could you see yourself using the Telehealth Kiosk? (Select all that apply)

- For a private place for an appointment.
- For access to the internet.
- For access to an electronic device such as a tablet, computer, laptop, or smartphone.
- If my provider scheduled my appointment or meeting there.
- For a quiet place to study and/or do homework.
- Other (please specify) _____

19.2 For what types of activities could you see yourself using it? (Select all that apply)
- Developmental services (for example, Early Intervention (EI), speech therapy)
- Counseling/mental health/social work
- Pediatric medical visit
- Adult medical visit
- Meeting for social, economic, or other needs (for example, signing up for benefits such as MassHealth, SSI, etc.)
- Educational needs (for example, study space)
- Private personal conversations (for example, job interviews)
- Other (please specify) _____

[DISPLAY TEXT IF THE ANSWER TO QUESTION 15 WAS NO]

The Telehealth Kiosk, located at the main branch Lawrence Public Library, is a private space that can be used for visits with health or social service providers. You can use the Telehealth Kiosk for services such as Early Intervention, therapy, family support services, counseling, monitoring your health status or of a family member, and follow-up appointments among many others.

[DISPLAY 20 IF THE ANSWER TO QUESTION 15 WAS NO]

20. Now that you know what Telehealth Kiosk could be used for, can you see yourself using it?
- Yes
- No
- Maybe

[DISPLAY 20.1 IF THE ANSWER TO QUESTION 20 WAS YES OR MAYBE]

20.1 For what reason(s) could you see yourself using the Telehealth Kiosk? (Select all that apply)
- For a private place for an appointment.
- For access to the internet.
- For access to an electronic device such as a tablet, computer, laptop, or smartphone.
- If my provider scheduled my appointment or meeting there.
- For a quiet place to study and/or do homework.
- Other (please specify) _____

[DISPLAY 20.2 IF THE ANSWER TO QUESTION 20 WAS YES OR MAYBE]

20.2 For what types of activities could you see yourself using it? (Select all that apply)
- Developmental services (for example, Early Intervention (EI), speech therapy)
- Counseling/mental health/social work
- Pediatric medical visit
- Adult medical visit
- Meeting for social, economic, or other needs (for example, signing up for benefits such as MassHealth, SSI, etc.)
- Educational needs (for example, study space)
- Private personal conversations (for example, job interviews)
- Other (please specify) _____

[DISPLAY 21 IF THE ANSWER TO QUESTION 15.3 WAS "I have used it"]

21. How many times have you used the Telehealth Kiosk located at the Lawrence Public Library?

_____

[DISPLAY 22 IF THE ANSWER TO QUESTION 15.3 WAS "I have used it"]

22. What has been the reason(s) for your visit(s) to the Telehealth Kiosk? (Select all that apply)

- For a private place for an appointment.
- For access to the internet.
- For access to an electronic device such as a tablet, computer, laptop, or smartphone.
- My provider scheduled my appointment or meeting there.
- For a quiet place to study and/or do homework.
- Other (please specify) _____
- Do not recall

[DISPLAY 23 IF THE ANSWER TO QUESTION 15.3 WAS "I have used it"]

23. For what purpose(s) have you used the Telehealth Kiosk at the Lawrence Public Library? (Select all that apply)

- Developmental services (for example, Early Intervention (EI), speech therapy)
- Counseling/mental health/social work
- Pediatric medical visit
- Adult medical visit
- Meeting for social, economic, or other needs (for example, signing up for benefits such as MassHealth, SSI, etc.)
- Educational needs (for example, study space)
- Private personal conversations (for example, job interviews)
- Other (please specify) _____

[DISPLAY 24 IF THE ANSWER TO QUESTION 15.3 WAS "I have used it"]

24. Thinking about the visit where you had the *most* people in the Telehealth Kiosk with you, how many people were there in total, including yourself?

- 1 (I was alone)
- 2 people
- 3-4 people
- More than 4 people

[DISPLAY 25 IF THE ANSWER TO QUESTION 15.3 WAS "I have used it"]

25. How satisfied were you with your experience using the Telehealth Kiosk?

- Very satisfied
- Satisfied
- Dissatisfied
- Very dissatisfied

[DISPLAY 25.1 IF THE ANSWER TO QUESTION 25 WAS "Very satisfied" OR "Satisfied"]

25.1. Would you like to explain your answer? (What made it satisfying?)

_____

[DISPLAY 25.2 IF THE ANSWER TO QUESTION 25 WAS “Very dissatisfied” OR “Dissatisfied”

25.2. Would you like to explain your answer? (What made it dissatisfying?)

_____

[DISPLAY TEXT IF THE ANSWER TO QUESTION 15.4 WAS YES

You told us that you used the Telehealth Kiosk as a provider. For the remainder of the survey, please answer the questions as a potential consumer of the Telehealth Kiosk (who might use the space for receiving services or other personal needs), not as your provider role.

[DISPLAY 26 IF THE ANSWER TO QUESTION 15.3 WAS “I have used it”]

26. We are interested in learning about what would make the Telehealth Kiosk appealing and/or accessible to more people. What recommendations do you have? (Select all that apply)

- Make the space more private (for example, add shades or curtains so people can't see in)
- Make booking confidential (for example, do not require providing your name or the purpose of the visit)
- Make booking easier
- Provide a Kiosk attendant to assist with technology
- Increase providers' awareness about the Telehealth Kiosk
- Move it to a different location
- I can't think of anything
- Other (please specify) _____

[DISPLAY 26.1 IF THE ANSWER TO QUESTION 26 WAS “Move it to a different location”]

26.1 What location would you be more likely to use the Telehealth Kiosk in?

_____

[DISPLAY 26.2 IF THE ANSWER TO QUESTION 26 WAS “Make booking easier”]

26.2. What would make booking easier?

_____

[DISPLAY 26.3 IF THE ANSWER TO QUESTION 26 WAS NOT “I can’t think of anything”]

26.3 If there are any recommendations you'd like to explain, please tell us below.

_____

These last questions are about your overall feelings and opinions about the Telehealth Kiosk.

[DISPLAY 27 IF THE ANSWER TO QUESTION 15.3 WAS “I have used it”]

Or

[DISPLAY 27 IF THE ANSWER TO QUESTION 15.4 WAS "Developmental service (for example, Early Intervention (EI), speech therapy)," "Counseling/mental health/social work," "Pediatric medical visit," "Adult medical visit," "Meeting for social, economic, or other needs (for example, signing up for benefits such as MassHealth, SSI, etc."]

27. How comfortable would you be receiving the following services in the Telehealth Kiosk?

	Very uncomfortable	Uncomfortable	Neutral	Comfortable	Very comfortable	N/A
Developmental services *(e.g., Early Intervention (EI), speech therapy)*	○	○	○	○	○	○
Counseling/mental health/social work	○	○	○	○	○	○
Pediatric medical visit	○	○	○	○	○	○
Adult medical visit	○	○	○	○	○	○
Meeting for social, economic, or other needs *(e.g., signing up for benefits such as MassHealth, SSI, etc.)*	○	○	○	○	○	○
Educational needs *(e.g., study space)*	○	○	○	○	○	○
Private personal conversations *(e.g., job interviews*	○	○	○	○	○	○

28. Based on what you know about the Telehealth Kiosk, would you recommend the Telehealth Kiosk to another person?

- Yes
- No
- Maybe

29. Now that COVID-19 restrictions have been relaxed, do you think a Telehealth Kiosk is an important service for the Lawrence community?

- Yes
- No

30. Is there anything else you think we should know?

- No
- Yes (please explain) _____

Experiences of Frontline Workers Project: Interview and Focus Group Guides

Restaurant Workers in Eastern Massachusetts

Demographic Questions

1. How old are you?
2. Where do you live now?
3. How old were you when you came to the US?
4. Where were you born?
5. Where do you work now?
6. Are you currently attending University or have previously?
7. What languages can you speak?
8. What language do you speak at home?

Opening Questions

1. What brought you to Massachusetts?
2. What job(s) did you have during the pandemic?
3. What made you want to participate in this interview?

In-Depth Questions

4. Tell me about your experiences coming into the US.
    - If not applicable, what have your experiences been like in the US? (Children of immigrants)
5. Let us focus on your time working as a restaurant worker. Starting in March 2020, until the present, what restaurant(s) did you work at?
    - How long have you been working there?
    - How did you get that job?
    - Why did you choose to work there?
    - What were the challenges?
6. Now let's focus on your work during the pandemic. What was it like to work in a restaurant during the pandemic?
    - Did the restaurant do anything differently because of the pandemic?
    - Did your restaurant lay you off or lower your hours because of the pandemic? What happened to your employment?
    - What changed between your time working pre-pandemic and post-pandemic?
    - Did you notice any difference in the amount of money you earned before and after the pandemic?
7. What kind of support did the government or other agencies provide to help you during the pandemic?
    - What is your opinion of them?
8. Did your status as a Chinese immigrant/child of an immigrant affect the way you felt or how you were treated? If so, how?
    - Do you think you were treated unfairly because of the pandemic?
9. What were you worried about at the beginning of the pandemic? What are you worried about now?

10. What support would have been helpful to you during the pandemic? What kind of support would be helpful to you now and in the future?

Closing Questions

11. I will be making recommendations to MDPH to support the needs of restaurant workers. What recommendations do you have?
12. Is there anything that I missed or brushed by too quickly that you want to go more in-depth into?

Director/Leaders at Childcare Centers in Boston

Demographic Questions

1. Where do you live? (Name of Town)
2. Where do you currently work?
3. What is your job title?
4. How long have you been working here?
5. How long have you worked with young children?
6. What is your race and/or ethnicity?
7. What language(s) do you speak? Prefer?

Interview Questions

1. What interested you in working at a daycare?
    a. What interested you in starting and/or leading an early childhood center?
2. How would you describe a typical day in this position?
3. The pandemic started in March 2020. Do you remember how you first found that early education centers were closing? How did you feel about that?
4. This project is interested in learning about the experiences of early childhood workers. What is it like to be an early childhood director/leader during this pandemic?
    a. What are the biggest challenges of this job since the beginning of Covid?
    b. What support services or government aid did your center receive during the pandemic
        i. What did you think of these supports?
    c. What is your primary source for COVID-19 information that you use to inform your work/workers?
    d. How has Covid-19 personally affected your life?
5. How has your facility adjusted to reopening with COVID guidelines?
    a. Did your center create its own COVID-19 guidelines? If yes, how did you create them?
    b. What challenges did you come across relaying the guidelines to staff?
    c. Can you tell me a little bit more about how you relayed information to staff (for example, how often were staff meetings, did you post information for staff to see, communication with other leadership, etc.)?
6. What changes were made to ensure the safety of the children and the workers?
    a. Did your facility lose a lot of kids or employees due to the COVID guidelines that were released?
    b. What happens if a child shows symptoms of COVID-19? How will you isolate them until their parent can pick them up?
    c. Parents are not allowed to come into the classroom at all. At your center, has this always been a policy or has this recently started because of Covid-19?

   d. Did you center have a COVID-19 vaccination requirement?
      i. How did you feel that being vaccinated was [required or nonrequired] as an early childhood worker?
   e. Did your center struggle during this time (for example, financially, low staffing, low enrollment, or in other ways)?
      i. Were parents charged more to have their child in daycare during or after Covid-19?
      ii. Were workers given a raise or incentives to come into work during Covid?
7. How safe did you feel reopening?
8. Do you think some of the guidelines created during the pandemic should have been created long before?
   a. If Yes, why?
9. What benefits were you given or wish you were given?
   a. For your center? For you personally?
10. What do you think you will remember most about you working during the pandemic?
11. What is it that you would like the Department of Public Health to know about what it's like to respond to a pandemic as a leader in a childcare center?
   a. What health information might have benefited your center before COVID-19?
   b. What health information might benefit your center now?
12. What recommendations do you have to improve work experiences of childcare workers?

Teachers at Childcare Centers in Boston

Demographic questions

1. Where do you live? (Name of Town)
2. Where do you currently work?
3. What is your job title?
4. How long have you been working here?
5. How long have you worked with young children?
6. What is your ethnicity?
7. What language(s) do you speak? Prefer?

Interview Questions

8. What interested you in working at a daycare?
9. How would you describe a typical day in this position?

Now I am going to ask questions about your experiences working as Early Childhood essential worker during the pandemic.

10. The pandemic started in March 2020. Do you remember how you first found that early education centers were closing? How did you feel about that?
11. This project is interested in learning about the experiences of early childhood workers. What is it like to be an early childhood worker during this pandemic?
   a. What are the biggest challenges of this job since the beginning of Covid?
   b. What support services or government aid did you receive during the pandemic because you were an early childhood worker? For example, this could be a check from your center while it was closed, or a stimulus check.
      i. What did you think of these supports?

c. What is your primary source for COVID-19 information?
d. How has COVID-19 personally affected your life?

These next questions focus on your policies and practices at your work site during the pandemic.

12. How has your facility adjusted to reopening with COVID guidelines?
13. What changes were made to ensure the safety of the children and the workers?
    a. Did your facility lose a lot of kids or employees due to the COVID guidelines that were released?
    b. What happens if a child shows symptoms of COVID-19? How will you isolate them until their parent can pick them up?
    c. Parents are not allowed to come into the classroom at all. At your center, has this always been a policy or has this recently started because of Covid-19?
    d. Did your center have a COVID-19 vaccination policy?
        i. How did you feel that being vaccinated was [required or nonrequired] as an early childhood worker?
    e. Did your center struggle during this time (for example, financially, low staffing, low enrollment, or in other ways)?
        i. Were workers given a raise or incentives to come into work during Covid?
14. How safe did you feel returning to work?
15. Do you think some of the guidelines created during the pandemic should have been created long before? Why?
16. What benefits were you given or wish you were given?
17. What do you think you will remember most about you working during the pandemic?
18. What is it that you would like the Department of Public Health to know about the experiences of early childhood care workers?
19. What recommendations do you have to improve work experiences of childcare workers?

Early Childhood Teachers at Centers in Western, MA

Opening Questions

1. How long have you been in the early childhood childcare field?
2. Why did you enter the early childhood childcare field? And what type of center do you work in? (no name is needed just what type nonprofit etc.)

In-Depth Focus Group Questions

3. Think back to March 2020 as you learned the news about the pandemic, what were your initial feelings?
4. How has COVID impacted you as a frontline childcare worker:
    a. Financially?
    b. Emotionally?
5. What were some of the changes that your facility put in place during the initial phase of the pandemic?
    a. How did the change in business hours at your facility during COVID make you (the childcare worker) feel as a childcare worker?
    b. How did you adjust going forward with the new changes?

6. What safety protocols were put in place?
    a. Who established the guidelines during the pandemic?
    b. Who enforced the rules/set the guidelines for your facility?
    c. Do you feel those safety precautions were enough?
    d. How did the changes in safety precautions (ex: smaller class size) at your facility during the pandemic make you feel?
    e. Did you feel safe coming to work?
7. To what extent did you feel supported by your employer during the pandemic?
    a. If you or someone in your family feel sick with COVID, to what extent did you feel your employer supported you?
8. Did children not being vaccinated impact your want to work during COVID?
9. What doubts did you have during COVID that made you question your job?
10. How do you feel about childcare now and how it's changed since the pandemic?

Closing Questions

11. Is there anything else that you feel is important that I should know about regarding childcare workers and the impact of COVID-19 that I have not asked yet?
12. I will be making a series of recommendations to the Department of Public Health (DPH) based on what we learn. Are there any recommendations you have that you would like me to communicate back to DPH? What would you recommend?

Pregnancy COVID-19 Vaccination Project: Survey

Consent

This survey is available in both English and Spanish. To change the language, please use the dropdown menu located at the top right corner of this page. *Esta encuesta está disponible en inglés o español. Para cambiar el idioma, utilice el menú desplegable ubicado en la esquina superior derecha de esta página.*

Thank you for your interest in our survey! This study is being conducted by researchers at Tufts Interdisciplinary Evaluation Research (TIER) at Tufts University in Medford, Massachusetts, in collaboration with the Massachusetts Department of Public Health (MDPH) and with support from the Centers for Disease Control and Prevention (CDC).

TIER is conducting a survey of people who were pregnant during the COVID-19 pandemic, to learn about their experiences during the pandemic and their feelings about COVID-19 vaccination. Information we learn through this project will help MDPH better support pregnant people through its COVID-19 response efforts.

The survey will take about 10 minutes to complete. Please remember that this survey is completely voluntary; there are no consequences to saying “no” to participating and you may choose to skip questions that you prefer not to answer.

All information collected through this survey will be confidential, meaning you will not be identified in any way and we will not share identifiable information with MDPH or any agency that you receive services from. Information used in reports, publications, or presentations will never be tied directly to your name.

We would like to thank you for your time by offering a $15 Target or Dunkin Donuts gift card by e-mail or mail for participating in this study. If you have any questions about the survey or project more broadly, please contact the TIER team at tier@tufts.edu.

To begin, click "next."

1. This survey asks about your experience with pregnancy during COVID-19 and your feelings about the COVID-19 vaccine. Do you agree to complete this survey?

- Yes, I would like to complete the survey.
- No, I would not like to complete this survey. [SKIP TO END OF SURVEY]

Eligibility Screener

The next set of questions ask whether you meet the eligibility criteria to take this survey.

2. How old are you?

_____

3. Where do you currently live?

- Fall River
- Swansea
- Somerset
- Westport
- Other city or town (please specify) _____

4. Are you currently pregnant?

- Yes
- No
- I don't know

[DISPLAY 4.1 IF ANSWER TO QUESTION 4 WAS NO OR "I don't know"]

4.1. Were you pregnant at any point between May 2021 and now? For example, if your youngest child is *less than* 22 months old.

- Yes
- No

5. Are you Latina/Latino or Hispanic?

- Yes
- No

[DISPLAY TEXT IF ANSWER TO QUESTION 2 WAS LESS THAN 18]

Or

[DISPLAY TEXT IF ANSWER TO QUESTION 4.1 WAS NO]

Or

[DISPLAY TEXT IF ANSWER TO QUESTION 5 WAS NO]

Thank you for your interest in our survey! Based on your responses, we've determined that you do not meet the eligibility criteria for this study. We appreciate your time!

[SKIP TO END OF SURVEY]

Demographics

The next set of questions ask a little bit about you and your family.

6. What is your ethnic and/or national background? (Some examples include but are not limited to: Dominican, Ecuadorian, Guatemalan, Puerto Rican).

_____

7. Which categories describe you? (Select all that apply)

- Asian
- Black, African, or African American
- Native American or Alaska Native
- Native Hawaiian or Pacific Islander
- White
- Other (please specify all) _____
- Prefer not to answer

8. How many years have you lived in the United States?

- Less than a year
- 1-5 years
- More than 5 years

9. Were you born in the United States?

- Yes
- No

10. Were you born in Puerto Rico?

- Yes
- No

11. Please tell us the year you were born.

_____

12. Please describe your gender.

- Man
- Woman
- Non-Binary
- Transgender Man
- Transgender Woman
- Other (please specify) _____
- Prefer not to answer

13. What is/are your preferred language(s)? (Select all that apply)

- Spanish
- English
- Portuguese
- Other (please specify) _____

14. What is your highest level of education?

- Less than high school
- GED/HiSET
- High School Graduate
- Some College
- Associate's Degree or Technical Degree (i.e. Cosmetology, electrician)
- Bachelor's Degree
- Master's Degree or higher
- Other (please specify) _____

15. What is your marital status?

- Single
- Not Married, but in a Relationship
- Married
- Separated or Divorced
- Widowed
- Other (please specify) _____

16. How many children (under the age of 18) are currently in your care?

_____

[DISPLAY 17 IF ANSWER TO QUESTION 4 WAS YES]

17. Think about your current pregnancy. Is this your first pregnancy?

- Yes
- No
- I don't know

[DISPLAY 18 IF ANSWER TO QUESTION 4 WAS NO OR "I don't know"]

18. Think about your most recent pregnancy. Was this your first pregnancy?

- Yes
- No
- I don't know

19. Did you have a primary care provider BEFORE your pregnancy?

- Yes
- No

Recent Pregnancy

[DISPLAY TEXT IF ANSWER TO QUESTION 4.1 WAS YES]

The following questions are about your experiences while pregnant. If you have had more than one pregnancy since May 2021, answer these questions about your *most recent* pregnancy.

[DISPLAY 20 IF ANSWER TO QUESTION 4.1 WAS YES]

20. What was the delivery date of your most recent pregnancy?

Month (1)	▼ January (1) ... (150)
Day (2)	▼ January (1) ... (150)
Year (3)	▼ January (1) ... (150)

[DISPLAY 21 IF ANSWER TO QUESTION 4.1 WAS YES]

21. From whom did you receive your prenatal care? (Select all that apply)

- Emergency Room Provider
- Primary Care Provider
- OB-GYN
- Doula
- Midwife
- I did not receive prenatal care
- Other (please specify) _____

[DISPLAY 21.1 IF ANSWER TO QUESTION 21 WAS NOT "I did not receive prenatal care"]

21.1. Please tell us the name of the practice where you received prenatal care. For example, Truesdale OB-GYN, Highland OB-GYN, or another practice.

_____

[DISPLAY 21.2 IF ANSWER TO QUESTION 21 WAS NOT "I did not receive prenatal care"]

21.1 During what trimester of your pregnancy did you begin prenatal care?

- First trimester (0-3 months)
- Second trimester (4-6 months)
- Third trimester (7-9+ months)

[DISPLAY 21.3 IF ANSWER TO QUESTION 21 WAS NOT "I did not receive prenatal care"]

21.3. Did you receive your prenatal care in a language you feel comfortable with?

- Yes, I received ***all*** of my prenatal care in a language I'm comfortable with.
- Yes, I received ***some*** of my prenatal care in a language I'm comfortable with.
- No, I received ***none*** of my prenatal care in a language I'm comfortable with.

[DISPLAY 21.4 IF ANSWER TO QUESTION 21 WAS NOT "I did not receive prenatal care"]

21.4. In what language(s) did you receive your prenatal care? (Select all that apply)

- English
- Spanish
- Portuguese
- Other (please specify) _____

[DISPLAY 22 IF ANSWER TO QUESTION 4.1 WAS YES]

22. Did you have any pre-existing health conditions before your most recent pregnancy? For example, hypertension (high blood pressure), overweight, underweight, asthma, other bronchial conditions or other pre-existing health conditions.

- Yes
- No

[DISPLAY 23 IF ANSWER TO QUESTION 4.1 WAS YES]

23. During your most recent pregnancy, who helped you make decisions regarding your pregnancy and baby? (Select all that apply)

- Partner
- Family members
- Friends
- Medical providers (for example, prenatal care provider, doula, visiting nurse, primary care provider, emergency room provider)
- Service providers and community organization or programs (for example, family support workers and programs, home visitors, social workers, parent mentors, WIC)
- My religious community (e.g., pastor)
- People in my Support Groups (for example, Mommy and Me or First Time Mom groups)
- Other (please specify) _____

Current Pregnancy

[DISPLAY TEXT IF ANSWER TO QUESTION 4 WAS YES]

The following questions are about your experiences during your current pregnancy.

[DISPLAY 24 IF ANSWER TO QUESTION 4 WAS YES]

24. What is your current due date?

Month	▼ January... (150)
Day	▼ January... (150)
Year	▼ January... (150)

[DISPLAY 25 IF ANSWER TO QUESTION 4 WAS YES]

25. From whom have you been receiving your prenatal care? (Select all that apply)

- Doula
- Emergency Room Provider
- Midwife
- OB-GYN
- Primary Care Provider
- I have not received prenatal care
- Other (please specify) _____

[DISPLAY 25.1 IF ANSWER TO QUESTION 25 WAS NOT "I have not received prenatal care"]

25.1. Please tell us the name of the practice where you have been receiving prenatal care. For example, Truesdale OB-GYN, Highland OB-GYN, or another practice.

_____

[DISPLAY 25.2 IF ANSWER TO QUESTION 25 WAS NOT "I have not received prenatal care"]

25.2. During what trimester of your pregnancy did you begin prenatal care?

- First trimester (0-3 months)
- Second trimester (4-6 months)
- Third trimester (7-9+ months)

[DISPLAY 25.3 IF ANSWER TO QUESTION 25 WAS NOT "I have not received prenatal care"]

25.3. Have you been receiving your prenatal care in a language you feel comfortable with?

- Yes, I have received ***all*** of my prenatal care in a language I'm comfortable with.
- Yes, I have received ***some*** of my prenatal care in a language I'm comfortable with.
- No, I have received ***none*** of my prenatal care in a language I'm comfortable with.

[DISPLAY 25.4 IF ANSWER TO QUESTION 25 WAS NOT "I have not received prenatal care"]

25.4. In what language(s) have you been receiving your prenatal care? (Select all that apply)

- English
- Spanish
- Portuguese
- Other (please specify) _____

[DISPLAY 26 IF ANSWER TO QUESTION 4 WAS YES]

26. Did you have any pre-existing health conditions before your current pregnancy? For example, hypertension (high blood pressure), overweight, underweight, asthma, other bronchial conditions or other pre-existing health conditions.

- Yes
- No

[DISPLAY 27 IF ANSWER TO QUESTION 4 WAS YES]

27. During your current pregnancy, who has helped you make decisions regarding your pregnancy and baby? (Select all that apply)

- Partner
- Family members
- Friends
- Medical providers (for example, prenatal care provider, doula, visiting nurse, primary care provider, emergency room provider)
- Service providers and community organization or programs (for example, family support workers and programs, home visitors, social workers, parent mentors, WIC)
- My religious community (e.g., pastor)
- People in my support groups (for example, Mommy and Me or First Time Mom groups)
- Other (please specify) _____

Vaccinations

In this section, we want to know more about your experiences related to common vaccinations.

28. As far as you know, were you up to date with the regularly recommended vaccinations before becoming pregnant? For example, tetanus, diphtheria, pertussis (Tdap) vaccine, hepatitis B vaccine, etc.

- Yes
- No
- I don't know

[DISPLAY 29 IF ANSWER TO QUESTION 4 WAS YES]

29. Have you received a flu shot during your current pregnancy?

- Yes
- No
- I don't know

[DISPLAY 30 IF ANSWER TO QUESTION 29 WAS NO]

30. Do you plan to receive a flu shot while you are pregnant?

- Yes
- No
- I'm not sure

[DISPLAY 31 IF ANSWER TO QUESTION 4 WAS YES]

31. Did you receive a flu shot during your most recent pregnancy?

- Yes
- No
- I don't know

These next questions ask about your experiences with the COVID-19 vaccine.

32. Where did you get information regarding the COVID-19 vaccination for people who are pregnant? (Select all that apply)

- Partner
- Family members
- Friends
- Medical providers (for example, prenatal care provider, doula, visiting nurse, primary care provider, emergency room provider)
- Service providers and community organization or programs (for example, family support workers and programs, home visitors, social workers, parent mentors, WIC)
- My religious community (e.g., pastor)
- People in my support groups (for example, Mommy and Me or First Time Mom groups)
- Community resource fair
- Social media or online forums
- Television, radio and newspapers articles
- Other (please specify) _____
- I have not received information on the COVID-19 vaccine for people who are pregnant

[DISPLAY 33 IF ANSWER TO QUESTION 32 WAS NOT "I have not received information on the COVID-19 vaccine for people who are pregnant"]

33. To your knowledge, did any of the information you received come from the following sources? (Select all that apply)

- Centers for Disease Control and Prevention (CDC)
- Massachusetts Department of Public Health (MDPH)
- Local board of health or my city/town's health department
- I don't know

[DISPLAY 35 IF ANSWER TO QUESTION 32 WAS NOT "I have not received information on the COVID-19 vaccine for people who are pregnant"]

35. In which language(s) did you receive information regarding the COVID-19 vaccination for people who are pregnant? (Select all that apply)

- English
- Spanish
- Portuguese
- Other (please specify) _____

[DISPLAY 36 IF ANSWER TO QUESTION 32 WAS “I have not received information on the COVID-19 vaccine for people who are pregnant“ AND ANSWER TO QUESTION 4 WAS NO or “I don’t know”]

36. Did your prenatal care provider discuss the COVID-19 vaccine with you?

- Yes
- No

[DISPLAY 37 IF ANSWER TO QUESTION 32 WAS “I have not received information on the COVID-19 vaccine for people who are pregnant“ AND ANSWER TO QUESTION 4 WAS YES

37. Has your prenatal care provider discussed the COVID-19 vaccine with you?

- Yes
- No

[DISPLAY 38 IF ANSWER TO QUESTION 36 OR 37 WAS YES]

38. Please rate your comfort level when discussing the COVID-19 vaccination with your prenatal provider.

- Very comfortable
- Comfortable
- Neither comfortable nor uncomfortable
- Uncomfortable
- Very uncomfortable

[DISPLAY 39 IF ANSWER TO QUESTION 37 WAS NO]

39. How comfortable would you be discussing the COVID-19 vaccine with your prenatal care provider?

- Very comfortable
- Comfortable
- Neither comfortable nor uncomfortable
- Uncomfortable
- Very uncomfortable

[DISPLAY 40 IF ANSWER TO QUESTION 36 WAS NO]

40. How comfortable would you haven been discussing the COVID-19 vaccine with your prenatal care provider?

- Very comfortable
- Comfortable
- Neither comfortable nor uncomfortable
- Uncomfortable
- Very uncomfortable

[DISPLAY 41 IF ANSWER TO QUESTION 37 WAS YES]

41. Think about your current pregnancy. Do you feel your prenatal provider addressed your questions or concerns about the COVID-19 vaccination?

- All of my questions or concerns were addressed.
- Some of my questions or concerns were addressed.
- None of my questions or concerns were addressed.
- I didn't have any questions or concerns.

[DISPLAY 42 IF ANSWER TO QUESTION 36 WAS YES]

42. Think about your most recent pregnancy. Did you feel your prenatal provider addressed your questions or concerns about the COVID-19 vaccination?

- All of my questions or concerns were addressed.
- Some of my questions or concerns were addressed.
- None of my questions or concerns were addressed.
- I didn't have any questions or concerns.

43. Have any of the following helped you make decisions about the COVID-19 vaccine? (Select all that apply)

- Partner
- Family members
- Friends
- Medical providers (for example, prenatal care provider, doula, visiting nurse, primary care provider, emergency room provider)
- Service providers and community organization or programs (for example, family support workers and programs, home visitors, social workers, parent mentors, WIC)
- My religious community (e.g., pastor)
- People in my support groups (for example, Mommy and Me or First Time Mom groups)
- Community resource fair
- Social media or online forums
- Television, radio and newspapers articles
- Other (please specify) _____
- None – No one helped me make decisions about the vaccine.

[DISPLAY 44 IF ANSWER TO QUESTION 4 WAS YES]

44. Have you received *any* COVID-19 vaccination?

- Yes
- No

[DISPLAY 44.1 IF ANSWER TO QUESTION 44 WAS YES]

44.1. When did you receive your first COVID-19 vaccination dose?

- Before my current pregnancy
- During my ***current*** pregnancy
- During a ***previous*** pregnancy
- Other (please specify) _____

[DISPLAY 44.2 IF ANSWER TO QUESTION 44 WAS NO]

44.2. Do you plan to get vaccinated against COVID-19?

- Yes, during my pregnancy
- Yes, after giving birth
- No
- I haven't decided

[DISPLAY 45 IF ANSWER TO QUESTION 4 WAS YES]

45. Have you received *any* COVID-19 vaccination?

- Yes
- No

[DISPLAY 45.1 IF ANSWER TO QUESTION 45 WAS YES]

45.1. When did you receive your first COVID-19 vaccination dose?

- Before my Pregnancy
- During my Pregnancy
- After Giving Birth
- Other (please specify) _____

[DISPLAY 46 IF ANSWER TO QUESTION 45.1 WAS "Before my current pregnancy" OR "Before my Pregnancy"]

46. In a sentence or two, please explain why you decided to get vaccinated against COVID-19 before pregnancy.

_____

[DISPLAY 47 IF ANSWER TO QUESTION 44.1 WAS "During my current pregnancy" OR "During a previous pregnancy" OR "During my Pregnancy" OR IF ANSWER TO QUESTION 44.2 WAS "Yes, during my pregnancy]

47. In a sentence or two, please explain why you decided to get vaccinated against COVID-19 during pregnancy.

_____

[DISPLAY 48 IF ANSWER TO QUESTION 44.2 WAS "Yes, after giving birth" OR IF ANSWER TO QUESTION 45.1 WAS "After giving birth"]

48. In a sentence or two, please explain why you decided to get vaccinated against COVID-19 after giving birth.

_____

[DISPLAY 49 IF ANSWER TO QUESTION 44.1 WAS "Other (please specify) or IF ANSWER TO QUESTION 45.1 was "Other (please specify)]

49. In a sentence or two, please explain why you decided to get vaccinated against COVID-19.

_____

For Unvaccinated

[DISPLAY 50 IF ANSWER TO QUESTION 44.2 WAS "I haven't decided"]
50. In a sentence or two, please tell us why you haven't decided whether to get vaccinated against COVID-19.

_____

[DISPLAY 51 IF ANSWER TO QUESTION 44 OR 45 WAS NO AND IF ANSWER TO QUESTION 44.2 WAS NO]

51. In a sentence or two, please tell us why you decided not to get vaccinated against COVID-19.

_____

For Vaccinated

[DISPLAY 52 IF ANSWER TO QUESTION 44 OR 45 WAS YES]

52. How would you describe your COVID-19 vaccination status?

- o I am partially vaccinated (for example, I have received one dose of Pfizer or Moderna)
- o I am fully vaccinated but not boosted (for example, I have received two doses of Pfizer or Moderna, or one dose of Johnson & Johnson)
- o I am fully vaccinated and have received at least one booster shot
- o I don't know

[DISPLAY 53 IF ANSWER TO QUESTION 44 OR 45 WAS YES]

53. What season and year was your first COVID-19 vaccination dose?

▼ Spring 2021... I don't remember

[DISPLAY 54 IF ANSWER TO QUESTION 44.1 WAS "During my current pregnancy" OR "During a previous pregnancy" or "During my Pregnancy"]

54. During what trimester did you get the first dose of the COVID-19 vaccine?

- o First trimester (0-3 months)
- o Second trimester (4-6 months)
- o Third trimester (7-9+ months)
- o I don't remember

Closing

55. Did anyone in your close circle (for example, family members, friends) receive a COVID-19 vaccination during their pregnancy?

- o Yes
- o No
- o I don't know

These last two questions ask for your perspective on how the Massachusetts Department of Public Health (MDPH) can address the barriers or concerns regarding the COVID-19 vaccination among pregnant Latina/o or Hispanic people. The Centers for Disease Control and Prevention (CDC) and health care providers recommend that all pregnant people receive the COVID-19 vaccination. Yet, Latina/o or Hispanic people who are pregnant have some of the lowest vaccination rates.

56. In a sentence or two, tell us why you think pregnant Latina/o or Hispanic people have low rates of vaccination against COVID-19.

_____

57. In a sentence or two, tell us what you think can be done to increase comfort with the COVID-19 vaccine among pregnant people in the Latina/o or Hispanic community.

_____

Pregnancy COVID-19 Vaccination Project: Interview Guide

Haitian Mothers in Brockton

Demographic & Opening Questions

1. How are you doing today? (opening)
2. Can you tell me a little about where you live... what town you live in? How long have you been living there?
3. What languages do you speak?
4. Who do you live with?
5. How old are you?
    a. 18-24 years old
    b. 25-29 years old
    c. 30-34 years old
    d. 35-39 years old
    e. 40 + years old
6. Where were you born?
7. If not born in the U.S, when did you come to the United States?

Pandemic

1. In this project, we want to understand the pregnancy experiences of Haitian Women during the pandemic and their thoughts on the vaccine. Let's start by talking about the pandemic. Where were you living in March 2020?
2. How did you first find out about the pandemic?
    a. Were you working/student at that time? What was that like?
3. How did you initially view the COVID-19 virus?
4. How do you view it now?

Pregnancy

5. When was your baby born?
6. Where did you give birth?
7. Is this your first baby?
8. What is it like to be pregnant during the pandemic?
9. When you were pregnant, what concerns did you have for yourself or your baby?
10. Where did you get your prenatal care? How did you choose this place?
    a. *How did you feel when you went to [that hospital/clinic] during that time?*
11. Did they have any special rules or restrictions because of COVID-19?
12. How did it feel to have an infant during the pandemic?
13. What concerns did you have?
14. Overall, how do feel about the care you received while you were pregnant?

COVID-19 Vaccine

15. The COVID-19 Vaccine became widely available for pregnant people in May 2021. How did you first find out that pregnant people could be vaccinated? How did you feel about it?
16. Do you know anyone who received a vaccine while pregnant?
17. Did you receive the vaccine while pregnant? Why or why not?

18. How did you make your decision? (What helped you make that decision)?
19. How did you feel about your decision?
    a. If they did NOT get vaccinated while pregnant, did you receive the vaccine after you were pregnant? Why or why not?
    b. What concerns if any did you have about the vaccine?
20. What did your family or friends think about your decision to get vaccinated or not get vaccinated?

Closing Questions

21. The Massachusetts Department of Public Health is interested in understanding how they can address people's questions and concerns about the COVID-19 vaccine. Haitian women have some of the lowest vaccination rates in Massachusetts. Why do you think that is?

22. What do you think can be done to increase Haitian women's comfort with the vaccine?

23. Now that you know about the project, tell me your thoughts about this project. Do you have any suggestions?
    a. Do you think this topic is important to people to know about? Why/why not?
24. Do you have any questions for me?

Pediatric COVID-19 Vaccination Project: Focus Group Guides

Black Parents in Boston

Opening Questions

1. Why did you decide to join our focus group today?
2. Please tell us how many kids you have and their ages.

Information

3. The pediatric vaccine was approved for young children on June 18. When and how did you first hear that your child was eligible for vaccination?
    a. How did you feel about this news?
4. The purpose of this focus group is to get more information about parents' feelings about the COVID-19 vaccine for their kids. Let's start by talking about the information you have received. What information have you received about the COVID-19 vaccine for children aged 0-4/Where did you receive the information from?
5. Who would you want to hear from to get accurate information about the covid 19 vaccine for children aged 0-4 to feel comfortable vaccinating your child?

Making an Informed Decision

Remember that there is no right or wrong answer – the purpose of this focus group is to hear from parents no matter what decision they've made.

6. *For fathers focus group only:* Do you go to your children's annual doctor's appointments? Do you feel like you have input on what vaccines your children receive?
7. Based on the information you've received, how has that information affected your decision to vaccinate or not vaccinate your child?
8. For those of you who might or have vaccinated your child, what barriers did you face in getting them vaccinated? What helped you make your decision?
9. For those of you who didn't get your children vaccinated, how do you feel about your decision? Do you feel like you made the right decision?

Community Context

10. Did you or anyone you know get COVID? What was this experience like for them/you? How did this experience affect them/you?
11. Black residents in Massachusetts have some of the lowest vaccination rates of Covid-19, why do you think that is?

Conclusion

12. As we prepare to wrap up, can each of you give me your top 2 decision-making factors that you've used in the past when deciding whether or not to vaccinate your children? Think about the vaccines your children have already had, for example Meningitis.
    a. How is your thinking on why you got your child that vaccine similar or different from your thinking about the COVID-19 vaccine?

13. I will be making a series of recommendations to the Massachusetts Department of Public Health (MDPH) regarding the experiences of Black parents and the childhood COVID-19 vaccine. Are there any additional ideas you would like to add/share at this time?

a. What would you want DPH to know about your experiences and how to make them better?

14. Do you think there is anything we should've covered but didn't?

Spanish-speaking Latino Parents

Opening Questions & Introduction to the Topic

1. Please tell us how many kids you have and their ages.
2. *The purpose of this focus group is to understand how parents make or have made decisions about the COVID-19 vaccine for their young children. First, we'll talk about the COVID-19 vaccine in general. This question is focused on the parents. How many here are vaccinated? (raise of hands).* What convinced you to get vaccinated?
    a. Why did you get vaccinated?

Pediatric Vaccine

3. The pediatric vaccine was approved on June 17, 2022. How did you first hear that your child was eligible for vaccination?
4. How did you feel knowing your child was eligible?
5. The purpose of this focus group is to get more information about parents' feelings about the COVID-19 vaccine for their kids. What are your thoughts about the pediatric vaccine?
6. Let's talk about the information you have received. What information have you received about the COVID-19 vaccine for children aged 0-4?
7. Where did you receive the information from?
8. Who would you *want* to hear from to get accurate information about the covid 19 vaccine for children aged 0-4 to feel comfortable vaccinating your child?

Decision-Making

9. What would be a helpful resource to guide your decision process on whether or not to vaccinate your child against COVID-19?
10. How many have had your Pediatric aged child (ages 0-5) vaccinated? How did you decide to vaccinate your child?
    a. *For those who have had their children vaccinated:* What convinced you to vaccinate your child? Why did you do it?
        - What was the experience like?
    b. *For those who have not had their children vaccinated:* Why haven't you? What would change your mind?

11. Whether or not you got your child vaccinated, do you feel you made the right decision?
12. What would you need logistically to bring your 0–5-year-old to be vaccinated?
    a. If already vaccinated: What *did* you need logistically?

Closing

13. What is the most important reason for you to decide to vaccinate or not vaccinate your child? Think about the vaccines your children have already had, for example Meningitis.
    a. How is your thinking on why you got your child that vaccine similar or different from your thinking about the COVID-19 vaccine?

In Chelsea, children ages 0-4 are the group with the lowest vaccination rate. As of March 2023, approximately 19% of children have received at least one dose of the COVID-19 vaccine, compared to 74% of children 5-11 and 95% of children ages 12-18.

14. What do you think parents in Chelsea need to feel comfortable to vaccinate their children?
15. Based on this focus group, I will be providing recommendations to DPH about how to provide information and resources to support COVID-19 vaccination among young children in our community. What would you suggest to DPH?

Young Parents in Fall River

We are going to talk about the Pediatric COVID Childhood Vaccine for ages 0-4. First, I will ask some questions about how you heard about the Pediatric Covid Vaccine. Then I ask questions about your opinions about and resources related to the COVID-19 vaccine for young children.

Opening Questions

1. Why did you decide to join our focus group today?
2. Please tell us how many kids you have and their ages.

Information

3. When and how did you first find out that the Covid 19 vaccine for children between 0-4 was approved?
4. How did you feel about this news?
5. How did/would you access information about the Pediatric Covid vaccine?
6. Consider all the resources and information you have seen about the Pediatric Covid vaccine. What did you find was most helpful?
7. Based on what on the information you have, what are your thoughts on the Pediatric Covid vaccine?
    a. Do you have any concerns about the pediatric COVID-19 Vaccine?
    b. What is a strength you believe can come from having this age group vaccinated?

Beliefs

8. How many here are vaccinated?
9. What convinced you to get vaccinated? Why did you get vaccinated?
10. With the recent CDC/FDA approval of Pediatric Vaccination for ages 6months-5years, who and/or what helped you make a decision about the pediatric COVID vaccine?
11. Have you decided to vaccinate your child?
    c. If yes, what was the driving factor in your decision to vaccinate?
    d. If not, what were your beliefs on why this was the best decision for your child?
12. Fall River has a vaccination rate that is much lower than the state overall.
    a. What are your thoughts on why parents in the Fall River community chose/might choose to vaccinate children ages 6m-5yr?
    b. Why might parents choose NOT to vaccinate their children?

Closing

13. As we prepare to wrap up, can each of you give me 2- driving factors that help makes their parents' decisions on the vaccine for these children 0-5?

14. MDPH is interested in understanding the perspectives of parents as they make decisions regarding vaccinating their children. What kind of information/resources do you believe parents need to make informed decisions about vaccines?
    a. What do you think DPH can do to improve vaccination rates in this community?

Appendix B: Analysis Plan Summary

Below, we briefly describe the overall analysis plan and approach that applied across projects. This plan formed the basis of the analysis workshops and trainings, and the subsequent steps followed by Community Evaluators and TIER mentors.

Quantitative Analysis Plan

To facilitate the survey analysis process, TIER developed an analysis approach that included the following overall steps.

- *Step 1–Analysis Planning:* The TIER analyst, a full-time member of the TIER evaluation team, cleaned the data to prepare for analysis. Community Evaluators developed an analysis plan by identifying the key evaluation questions they hoped to answer, mapping these to specific survey questions and variables. Data cleaning decisions (e.g., creation of variables, re-coding) were made in coordination with the Community Evaluators, to ensure that the dataset was structured in a way that would allow them to see the information they most wanted to know.
- *Step 2 – Running Analyses:* The TIER analyst ran these analyses in SPSS 28. Frequencies were run for all variables; Community Evaluators also selected a small number of other bivariate descriptive analyses (e.g., crosstabs) needed to explore their key evaluation questions.
- *Step 3 – Reviewing Outputs:* With support from TIER, Community Evaluators reviewed summaries of outputs and identified patterns in their data to develop takeaways for each of their evaluation questions.
- *Step 4 – Data Visualization:* Community Evaluators identified key findings to highlight using data graphs and other visuals. Community Evaluators received training and support to develop graphs and charts in Microsoft Excel and PowerPoint.
- *Step 5 – Summarize Findings and Recommendations:* Using their data and visuals, Community Evaluator summarized their sample, key takeaways, and conclusions and recommendations grounded in evidence from their analysis.

Qualitative Analysis Plan

Community Evaluators were trained to conduct *reflexive thematic analysis* of their data, informed by both their evaluation aims and own lived experiences. Reflexive thematic analysis "*puts researcher subjectivity at the core of the approach, reflexivity, or acknowledging the researcher's role in knowledge generation*" (Joy et. al., 2023, p. 1).[1] The qualitative analysis process followed the following steps.[1–3]

- *Step 1 – Initial Review:* Community Evaluators and TIER mentors briefly read the entire interview or focus group transcript to familiarize themselves with the data.
- *Step 2 – Holistic Coding:* Community Evaluators reviewed their transcripts to identify text that felt significant relative to their evaluation aims, and coded these statements using broad categories (e.g., lack of information, pediatrician influence).[4] At the end of this step, Community Evaluators had a list of significant quotes, and an emerging list of codes.
- *Step 3 – Summarizing:* Community Evaluators grouped codes into broader categories, and identified quotes that served as evidence for each emerging theme. At the end of this step, Community Evaluators had identified three to four of the most salient themes for each interview or focus group.

- *Step 4 – Matrix Review:* A matrix approach was used to visualize emerging themes across interviews and focus groups,[4] and identify patterns. Community Evaluators used these matrices to identify three to four cross-cutting themes and began to generate recommendations.
- *Step 5 – Finalize Themes & Recommendations:* Community Evaluators refined each theme by identifying examples across interview and focus group transcripts. Community Evaluators also identified "outliers"—or experiences that emerged infrequently or were surprising—and considered the nuances offered by these perspectives.[5]

Community Evaluators began their analysis after completing one interview or focus group and refined their themes throughout the data collection and analysis phase.

References

1. Joy, E., Braun, V., & Clarke, V. (2023). *Doing reflexive thematic analysis: A reflexive account*. https://uwe-repository.worktribe.com/output/10434562
2. Braun, V., & Clarke, V. (2021). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, *18*(3), 328–352. https://doi.org/10.1080/14780887.2020.1769238
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4. Huberman, A. M., Miles, M., & Saldana, J. (2014). *Qualitative data analysis: A methods sourcebook*. Thousand Oaks, California: Sage Publications, Inc.
5. Erickson, F. (2004). Demystifying data construction and analysis. *Anthropology & Education Quarterly*, *35*(4), 486–493.

Lawrence Telehealth Kiosk Community-Based Evaluation

Olien Lu and Hypatia Ortega

May 3rd, 2023

Welcome!

Olien Lu
Community Evaluator
Prettylu14@hotmail.com

Hypatia Ortega Hilario
Community Evaluator
Hypatiaortega5@gmail.com

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Background

Response to COVID-19

- Massachusetts Department of Public Health's (MDPH)'s Bureau of Family Health and Nutrition (BFHN) received funding in 2020-2021 to address the need for telehealth services due to COVID-19.

- BFHN partnered with the Federation for Children with Special Health Needs, the Professional Center for Child Development (PCCD), local providers, stakeholders, community members, and the City of Lawrence to launch the new Telehealth Kiosk in the Lawrence Public Library in March 2022. The Kiosk is designed to create a safe, accessible, and confidential space for Lawrence residents to access health and social services.

The Lawrence Telehealth Kiosk

- The Lawrence Telehealth Kiosk is located at the main branch of the Lawrence Public Library and opened in March 2022.
- It was planned in response to the COVID-19 pandemic, which restricted people from receiving services in-person.

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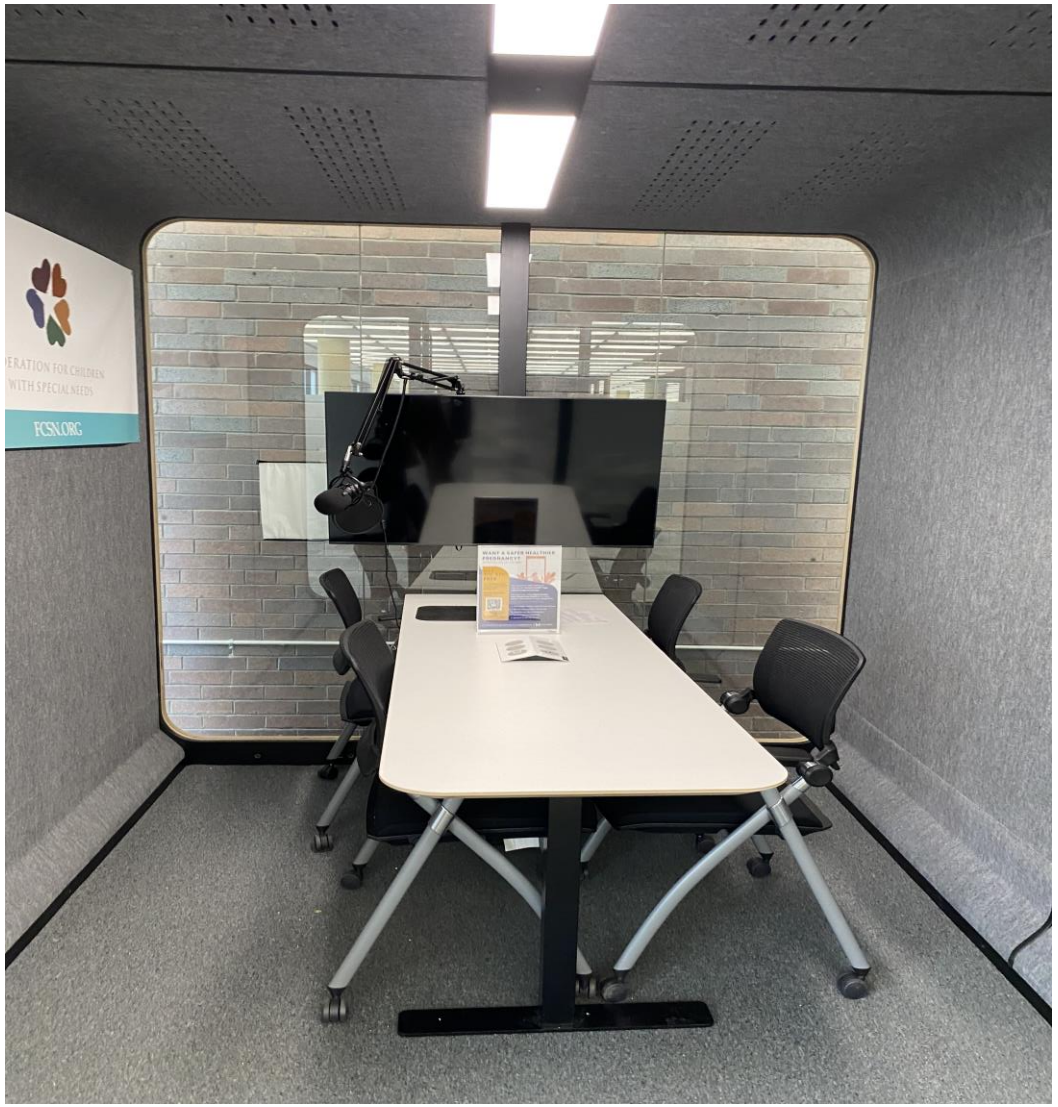
The Lawrence Telehealth Kiosk

- Seating for up to 4 people
- Wi-fi
- Computer
- Headset



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Evaluation

This evaluation helped us answer key questions about the Telehealth Kiosk, including:

Who used and was aware of the Telehealth Kiosk?

How did people learn about the Telehealth Kiosk?

Could people see themselves using the Telehealth Kiosk? For which activities?

Is the Telehealth Kiosk important for the community?

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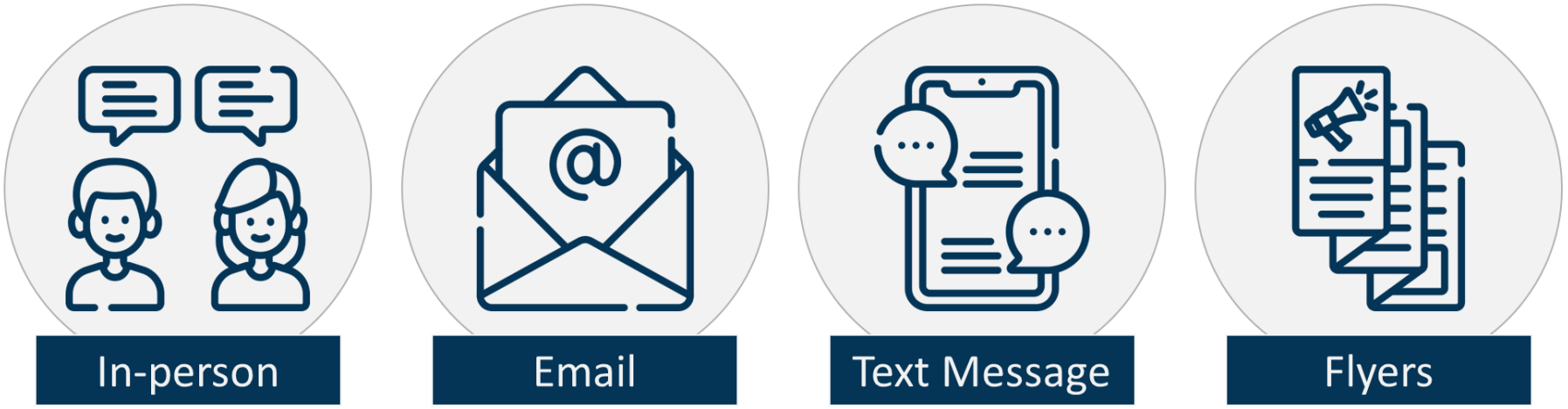
Project Design

The web-based survey was shared through a variety of formats:



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Recruitment Flyer

Sample Demographics

- 94% of respondents identified as **Hispanic/Latino**
- Most respondents' **preferred language was either Spanish or English**
- 70% also **worked in Lawrence**
- Over half of respondents' households received at least one **ongoing support**

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Key Findings

Finding #1: Telehealth Kiosk Awareness and Usage was low.

205	105	47	16	3*
				
responded to the survey	visited library	aware of Telehealth Kiosk	seen Telehealth Kiosk in-person	used Telehealth Kiosk

*We know through data provided by the Lawrence Public Library that there are more Telehealth Kiosk users.

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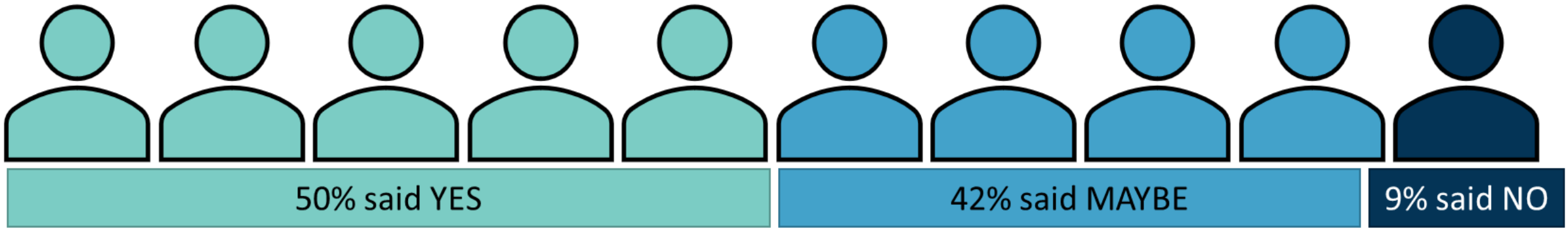
Finding #2: Respondents could see themselves using the Telehealth Kiosk.



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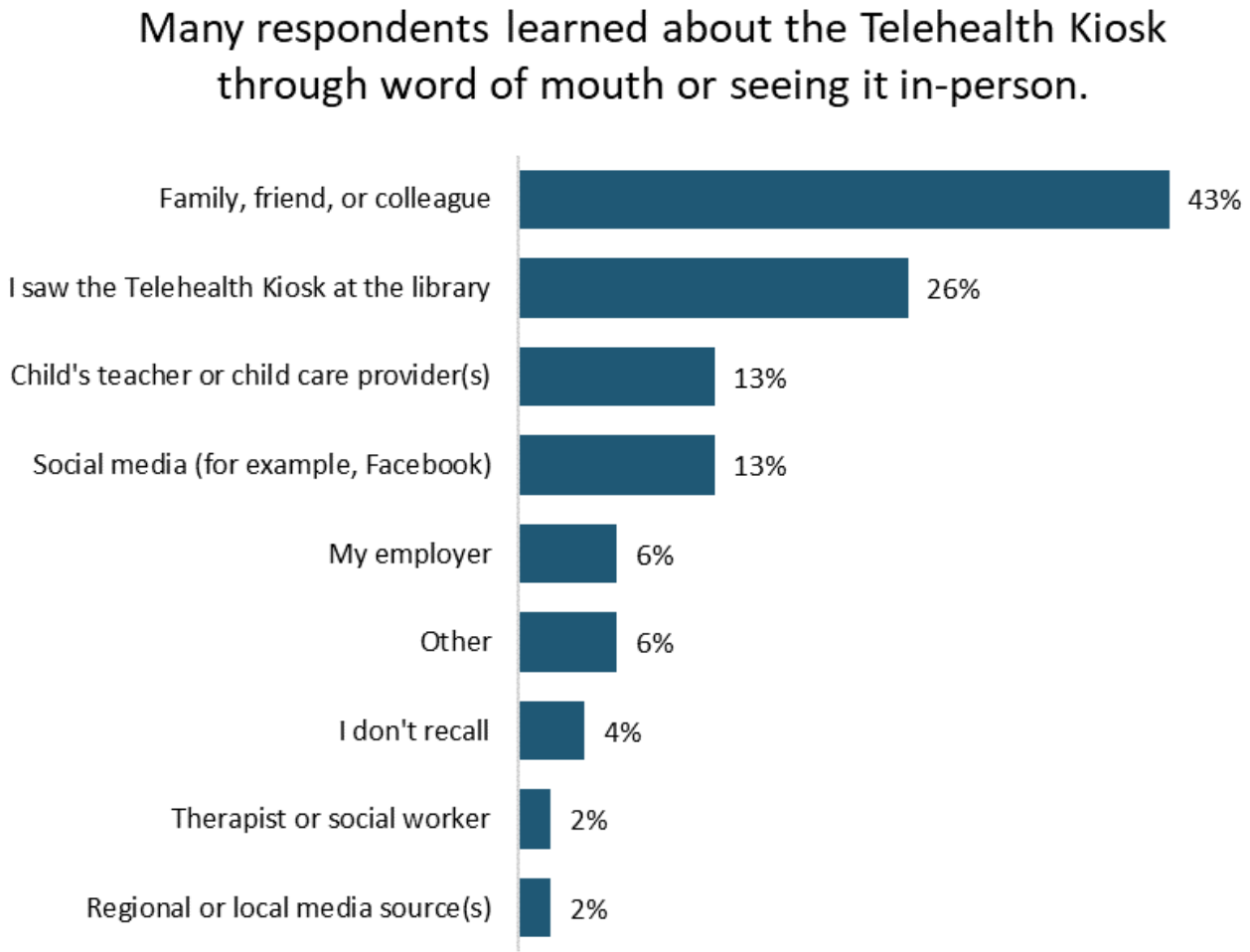
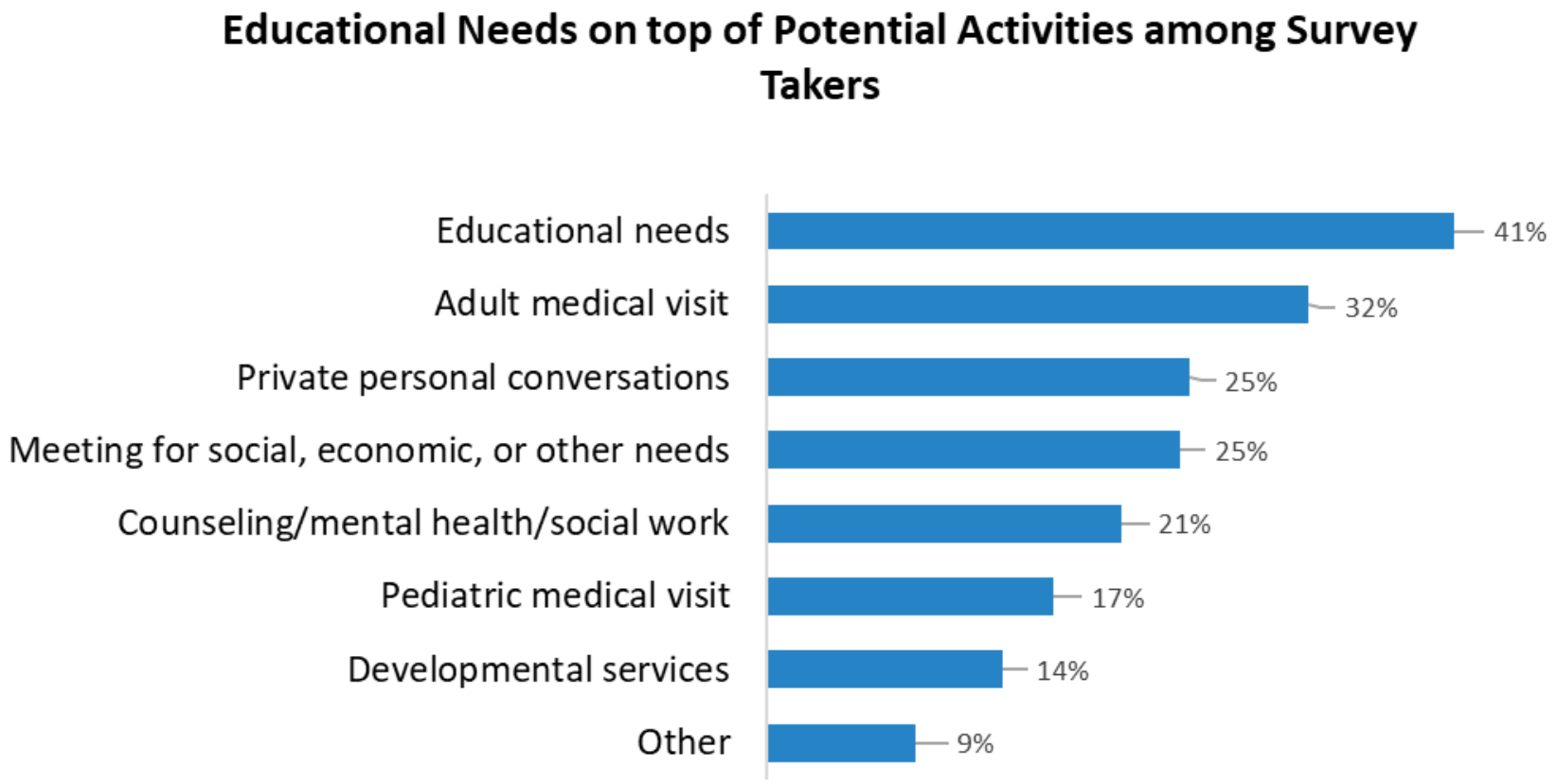
Finding #3: Respondents learned about the Telehealth Kiosk



N= 47

Finding #4: Potential Usage of the Telehealth Kiosk



N=171

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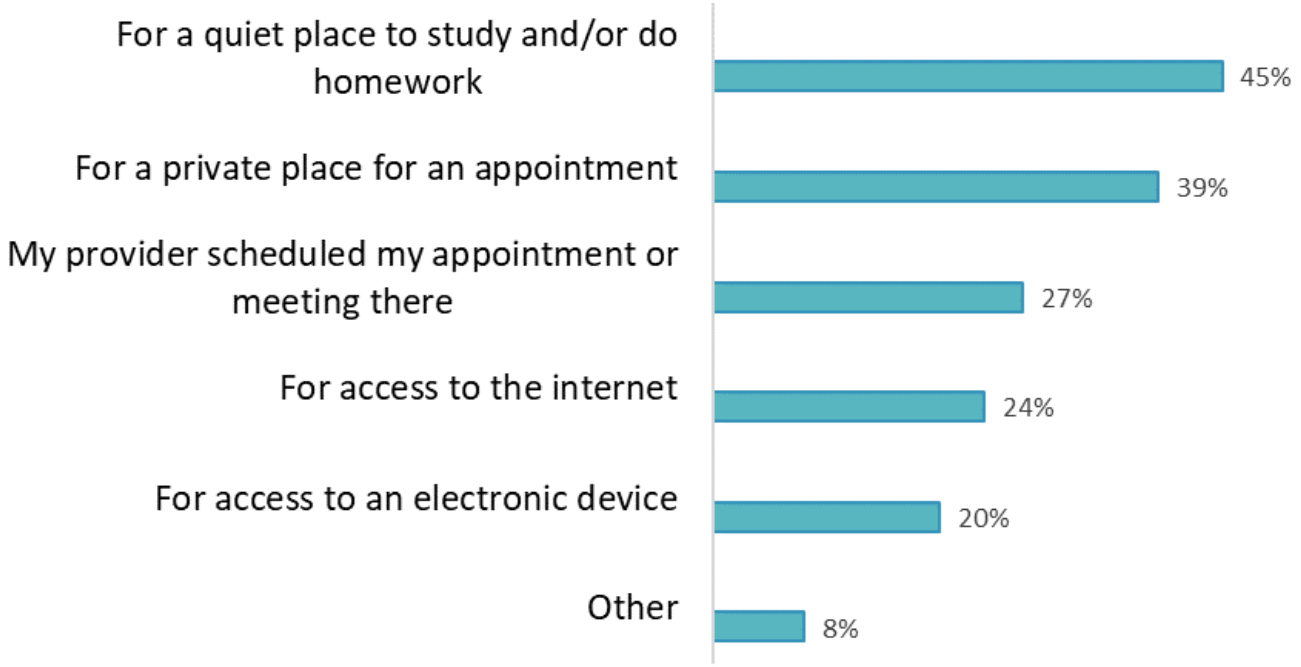
Finding #5: Potential Usage of the Telehealth Kiosk

Private and Personal Reasons on top for Potential Reasons among Survey Takers



N=177

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Finding #6: The Telehealth Kiosk is important to the Lawrence community.

95% *of survey takers agreed the Telehealth Kiosk was an important service for the community* (*n*=197)

78% *of survey takers would recommend the Telehealth Kiosk to another person* (*n*=198)

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Recommendations & Reflections

Our Recommendations

Further Evaluation:

- Consider another study sampling those who have actually used the Lawrence Telehealth Kiosk.
- Consider surveying providers. Would providers use the Lawrence Telehealth Kiosk and in what ways?

Marketing:

- Consider re-branding/re-naming the Lawrence Telehealth Kiosk – broaden it so that the name implies intended uses.
- Whatever the name ends up being, be consistent with the name (Telehealth Kiosk) when referring to it.
- Continue marketing campaigns for current Telehealth Kiosk, in Spanish and English through local radio and social media and at community fairs. The strategy for this will depend on who the target audience will be.
- Think about scaling in response to demand. Is there a cost-efficient alternative to the Telehealth kiosk so that more private space is available?

Logistics:

- Train staff on assisting/trouble shooting with patrons who have reserved the Lawrence Telehealth Kiosk.
- Add cancellation button for Telehealth Kiosk reservation system.

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Acknowledgement

The cross-organizational collaboration was key to this project – Thank you!

MA Department of Public Health

The Professional Center for Child Development

Lawrence Public Library

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Discussion

How would a version of the Lawrence Telehealth Kiosk benefit your community?

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Questions?

Understanding the Experiences of Frontline Workers

Angel Chen Ma, Joy Umeh, Diannette Marrero

May 3, 2023

Background: Frontline Workers in Massachusetts

- In-person during pandemic (often to deliver a service)
  - More likely Hispanic/Latinx, speak languages other than English, and low income
- Pandemic experiences
  - More likely to report testing positive
  - Disruption to work hours or job loss
  - Poor mental health (self-reported)
- Compounding stressors
  - Undervalued and underpaid workforces

*About 5 in 10 (49%) **accommodation and food services workers** experienced 15 or more days of poor mental health in the last 30 days*

*About 3 in 10 (31%) of **childcare workers** experienced 15 or more days of poor mental health in the last 30 days.*

Source: CCIS Chapter – Mental Health and Potential Stressors Among Frontline Workers

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Project Focus

- How the pandemic affected workers (personally, financially, professionally, etc.)
- How experiences and needs have changed since fall 2020
- Experiences with health and safety protocols and policies
- Supports or benefits received during the pandemic
- How MDPH can tailor its response to specific groups and industries

Frontline Worker Communities:

- Restaurant workers of Chinese descent (eastern Massachusetts)
- Childcare workers (ages 0-5):
  - Directors & Teachers (Boston)
  - Teachers (Springfield)

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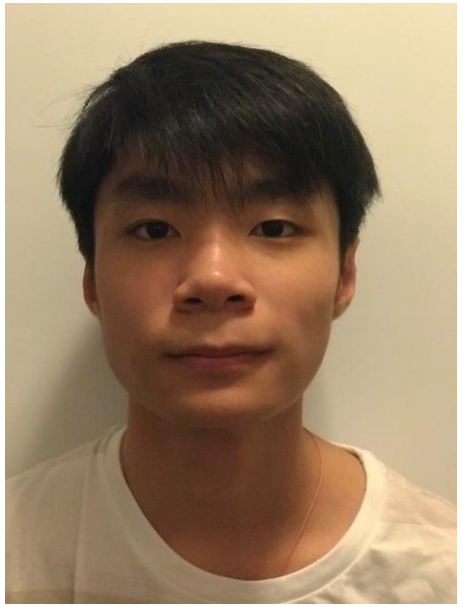
Community Evaluator Team



Angel Chen Ma
Malden, MA
Community Evaluator
Restaurant Worker & Student

Joy Umeh
Milton, MA
Community Evaluator
Childcare Worker & Student

Diannette Marrero
Chicopee, MA
Community Evaluator
DTA Economic Assistance Case Manager & Student

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Restaurant Workers: Project Design

My Sample:

- 4 participants of Chinese descent living in MA
- All restaurant workers in eastern MA
- All young adults

Method: Interviews

- Chosen to gather more qualitative data
- To understand participants' unique experiences more in-depth

Major Themes:

- Restaurant Changes
- Importance of Community
- Uncertainty

Theme: Restaurant Changes

- Safety protocols followed throughout pandemic.
  - Examples:
    - Proper distancing in restaurant seating
    - Masks required anywhere in restaurant
- Change in restaurant profits.
  - Personal income at similar levels for people working.
- Switch from primarily dine-in to takeout and delivery services.

"We had a huge loss of profit, I would say in our restaurant we could only do takeout, and that definitely impacted us."
- Restaurant Worker (Family Owned Restaurant)

"We will provide it to the customers, and if the customers were to get up to go to use the restrooms or anything there is like mask required, and sanitary required."
- Restaurant Worker

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Theme: Importance of Community

- Media coverage
  - Discrimination shown more online
- No participants experienced harm based on their race.
- Positive atmosphere towards servers in restaurants
- Boston compared to NYC
- Large Asian community in Boston.

> *"Not for me, because coming to the restaurant everyday with the same customers that I know we always treated the same way even though there is 2 other co-workers that I work with, and their English was not efficient, as I do. They still treated the same."*
> *- Restaurant Worker*

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Theme: Uncertainty

- No participants received aid as a restaurant worker
- Information overload
  - Not knowing which information to trust
  - Made working hard due to unknown effects
- Trying to keep a distance to be safe
  - Worried about family

"There was so much information coming from all different like sources so it's like it feels chaotic because like every day there's like new information coming out but not from the same sources and sometimes it's saying different things and it's very confusing for anyone in general and you don't really know what's true or not like it was broad but you don't know if it's accurate or not."
- Restaurant Worker (Family Owned)

"So as I came back to work as a server. There was a lot of a concern for us as well, so there is like a really close contact with the customer and then you're pretty really like afraid, if you do get caught with the COVID thing or not. So that was the hard part with working in the front."
- Restaurant Worker

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Project Design

Method: Interviews
- 3 early childhood educators
-3 early childhood directors

Sample: Qualitative data
-To listen and learn from their experiences

Major themes:
- Safety, Effects of Covid, Uncertainty, and Support

Safety

- Worried about their personal safety and others
- Implemented different guidelines and protocols
- Safety guidelines: Mask wearing, dividing classes into smaller groups, and vaccination policies for staff
- Some centers, provided teachers with weekly COVID test and one center offered vaccination clinics in the school gym
- Teachers felt the government just wanted people to go back to work

"I didn't believe in the policy, because the policy just wanted everyone to get back to work as soon as possible" -Teacher

"So what we did was we gave each child their own little bin and in their bin was all of the materials paint, paper, glue, scissors, crayons, markers. And that that really was their tool kit for when they wanted to do any kind of those activities. So it was a sense of their own." -Director

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Effects of COVID-19

- COVID has effected all the participants view on viruses, sickness, and spending quality time with family
- Teachers/ Schools have opened the eyes of the world to the value of educators
- Some centers lost teachers and Teachers lost their job, lost family members
- The use of technology
- Delays are increasing in child development
  - For example: children have increased the use of electronic books instead of page turning

"I think people forget how much people lost during COVID. So it wasn't just about the work, but it was around. As a director, dealing with a lot of personal losses, not only my own, but my whole entire staff, we had a number of staff that lost family members to COVID or other related sort of illnesses and the impact that being in an environment where you couldn't always see your family was pretty difficult." -Director

"Like it's two sides of the same coin. I think there's a lot of great potential and possibility in what we learned we can use technology for. And also we have to remind ourselves that technology cannot replace the in. Close proximity physical contact kind of learning that especially young children need." -Teacher

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Uncertainty

- Each participant stated that they had mixed emotions about what was happening.

"I cried a lot during this pandemic"
-Director

- Schools and businesses were closing
  - Virus caused a lot of anxiety about seeing family, returning to work, and helping children

- Uncertainty about the Vaccination:
  - Some were people were happy and encourage others to get vaccinated
  - Others were afraid and questioned the effects of this unknown solution

"I'm handling all of the unknowns. Make sure you have as much information as you can do and then try to use your own judgment to make the safest decision possible. Early on, there was a lot of misinformation going on. And you have to really find accurate sources of information and use that to the best of your ability to keep everybody safe"
-Director

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Support/ Unsupported

Support

- Teachers received masks, weekly Covid test, Covid pay, and updates on symptoms and ways to protect themselves.
- A director received grants, paycheck protection, PPE masks, dry goods, and Covid pay that support their workers for months.

"We have about 50 employees who count on us for income to support their families and support themselves. And you want to make sure that they have a job to come back to as well. very pressure filled, stressful time during that time." -Director

Unsupported

- Teachers had more roles on top of daily duties such as a school cleaner and nurse
- No incentive or high pay
- The need for additional support

"COVID is the reason why I left that job was like after I saw how unsupported, and how undervalued not only me, but other people were like they just did not care, so I was like no like. I have other options that I can take. I can leave this field, or I can just go to another job. And so that's what I did." -Teacher

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Childcare Teachers : Project Design

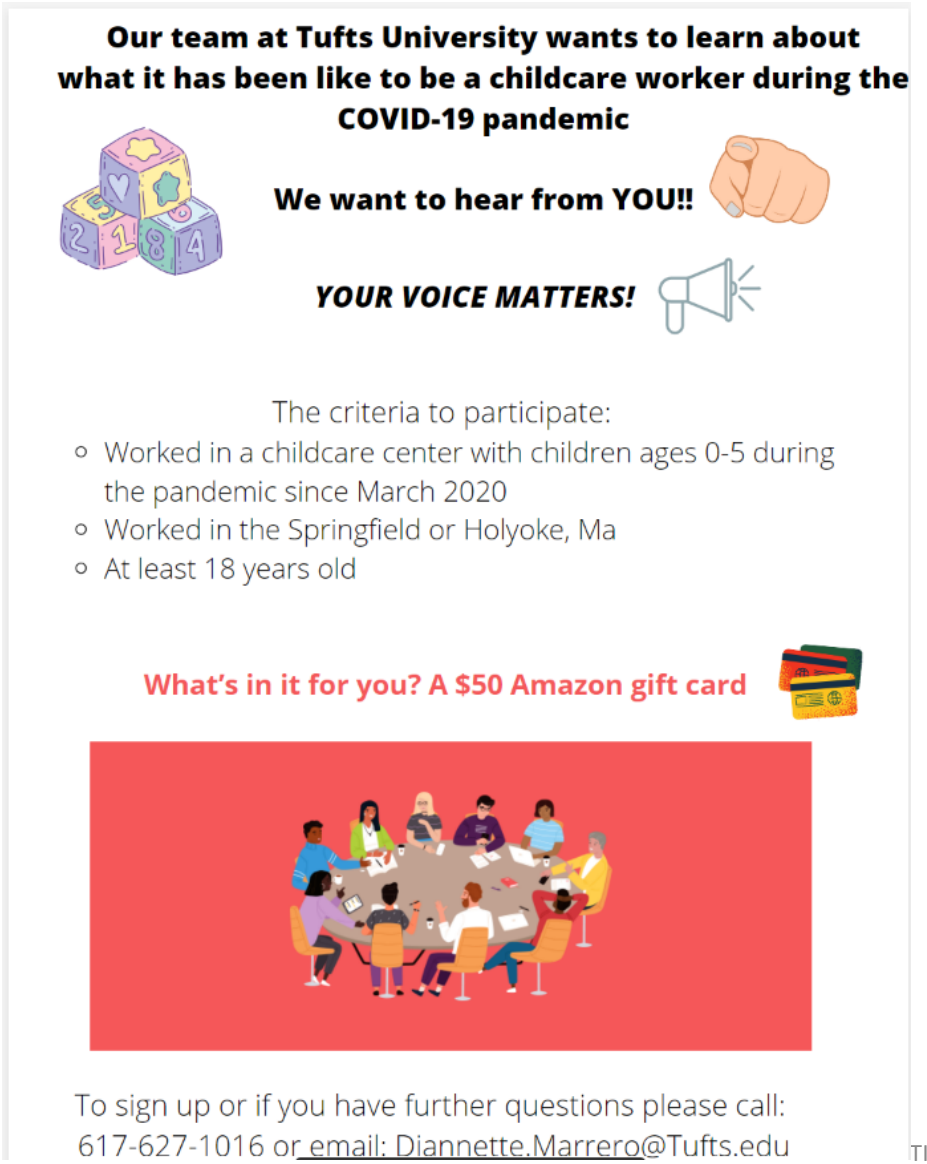
Method: Focus Groups (Qualitative Data)

- 3 Focus Groups
- This allowed me to better collect responses and analyze my findings by speaking with the participants and hear their personal experiences.

My Sample:

- 8 participants (teachers)
- Work in Western MA (Springfield, Holyoke, Northampton)
- Represent 4 centers
- 7 have been in the field for 10+ years

Thematic Analysis



Lack of child developmental and other supports impacted teachers' interaction with their students

"They didn't know how to use these tools. So, we had to show them. Because we have 15 kids. I can't feed 15, 3, 4, 5 year-olds."

"Children were not the same, the kids don't have the same amount of language, children only know about 5 words, lack self-help skills."

"It kind of seemed like the kids didn't know what to do. They're on tablets and computers all day when I'm like, oh, here's some toys there like blocks like, what do I do with these? So, then you have to kind of teach up. You build with blocks."

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Pivoting guidelines impacted teachers, children, and families

"We had to send you home if you had a running nose. But then, the next week no, you can stay with everybody, but you need a note from your doctor, saying you have allergies. But then the next week you're going to be sent home again. It was just a lot to keep up with. We almost kind of came in on Mondays, and we're like, okay, what? What are the rules now?"

"Oh, well, she can't pick him up like that. And I was like. How am I going to explain to this child. No, I can't hold you right now, because you know there's a pandemic going on like that's all that child needed was to be held, and I think those are the unrealistic things, especially in an infant classroom"

Industry Crisis

"I couldn't get unemployment because I'm working full time, but people are getting unemployment, and they're making more money than I am for unemployed."

"I left for more money and a different job."

"We had someone lie about it and then it came out that they weren't vaccinated."

"So, we keep getting sniped by the public schools. We've lost so much staff to the public schools because they're expanding their preschool programming. Our staff is going over to the public school, so they are trying very, very hard for staff retention where we are."

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Key Takeaways from Childcare sub-Projects

- Teachers and directors are prioritizing children above all else in the midst of a pandemic.
- Pandemic had negative impacts on child development, that impacted how teachers interacted with their students in the classroom.
- Teachers faced safety concerns during COVID, and worried for their families and others (including children's families).

Overall Recommendations

1. Support and respect the field

- Support teachers through compensation, recruitment, and training

2. Make supports more accessible to workers

- Make information and resources more accessible (e.g., 211 resource line, other resources)
- Not all workers or businesses (restaurants, centers) could access benefits

3. Share important information, but address misinformation

- Not only on government websites
- Translating official government notices (& making sure people know where to access them)

4. Improve communication for current/future public health emergencies

- Agencies (e.g., city, state) need to be on the same page
- Develop a flow chart to better guide industries on frequently changing protocols/guidelines

5. Recognize that each setting/worker group (e.g., restaurant, childcare) has different needs

- Understand the needs of each restaurant and how they will accommodate staff, customers
- Understand each field's realities: *"Not one rule is always right for the population"*

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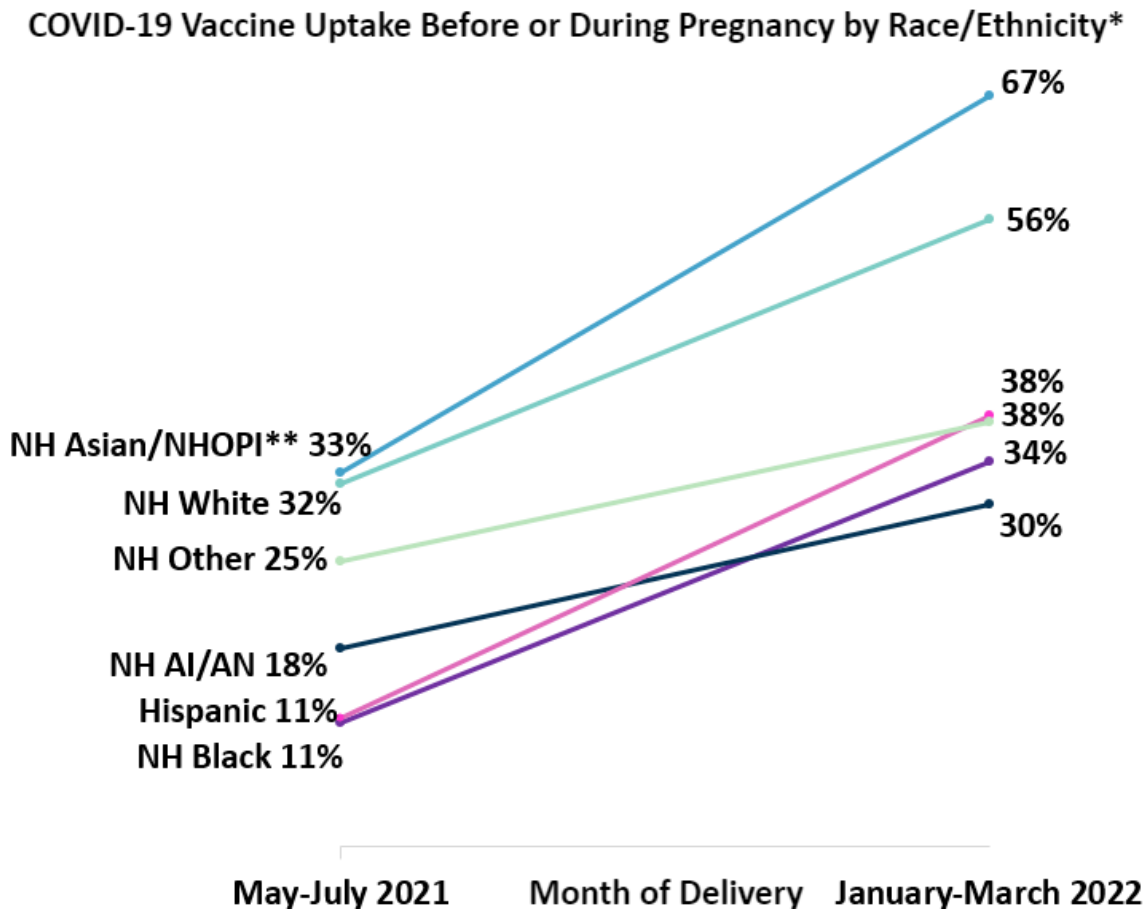
COVID-19 Pregnancy Vaccination Project

Sasha Rivera & Maudeline Auguste

May 3, 2023

Background

- Pregnant people are at higher risk COVID-19 and pregnancy complications
- MDPH estimated percent of pregnant people who received at least 1 COVID-19 vaccine
- 40% of pregnant people were vaccinated, vs. 78% of MA population overall (March 2022)
- Rates lowest among people who identified as:
  - American Indian/Alaska Native, Hispanic, non-Hispanic (NH) Black, and non-Hispanic (NH) other



Data Source: Massachusetts Immunization Information System, Bureau of Infectious Diseases and Laboratory Sciences (current through May 23, 2022) & Registry of Vital Records and Statistics (current through March 31, 2022)
Analyses conducted by Massachusetts Department of Public Health COVID-19 Pregnancy Surveillance Team
*For race/ethnicity, Hispanic was top-coded over all race/ethnicity groups followed by American Indian/Alaska Native, Black, Asian/Native Hawaiian/Pacific Islander, White, then Other/Unknown
**NHOPI: Native Hawaiian or Other Pacific Islander

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COVID-19 vaccination uptake* was lowest among those who self-identified as Dominican, Haitian, Puerto Rican, or Cape Verdean

Self-reported Ethnicity	N	Proportion vaccinated before or during pregnancy
Pregnant people, overall	30711	34.6%
Cambodian	219	25.1%
Colombian	187	25.1%
Portuguese	886	22.7%
Brazilian	1062	21.0%
Salvadoran	500	20.2%
African	734	17.7%
Honduran	197	17.3%
Guatemalan	518	17.2%
African American	1489	16.8%
Caribbean	239	16.7%
Dominican	1441	14.0%
Haitian	638	13.2%
Puerto Rican	2083	11.2%
Cape Verdean	564	10.8%

*__Vaccination uptake__: receipt of ≥1 doses of COVID-19 vaccine before or during pregnancy among deliveries occurring between May 1, 2021 and March 31, 2022.

Source: Shephard, H.

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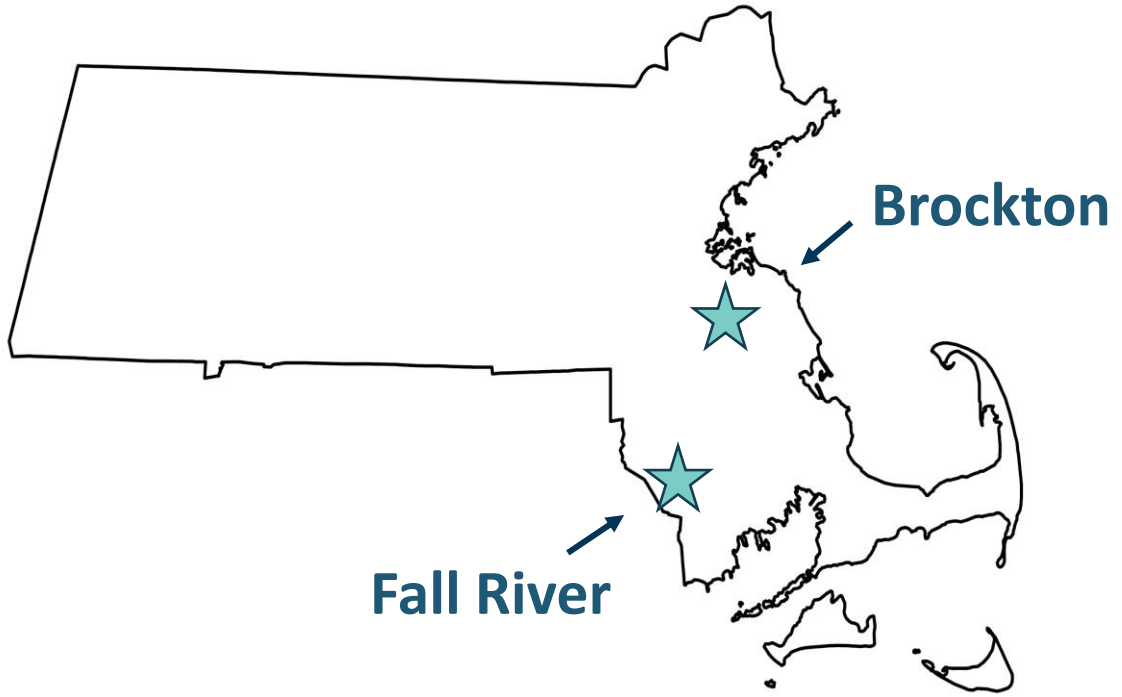
Project Focus

- The experiences of Haitian and Hispanic/Latina pregnant women during the pandemic
- How pregnant women are making decisions about the COVID-19 vaccine
- Where pregnant women are receiving information about the vaccine
- The "why" behind vaccination rates
- Recommendations for MDPH



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Community Evaluator Team

Sasha Rivera
Community Evaluator
Fall River, MA

Maudeline Auguste
Community Evaluator
Brockton, MA

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Understanding the experiences of Hispanic/Latina pregnant women in Fall River

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My Path to this Project

- Family Support Worker with first time parents
- Interest in Community Evaluator role
  - Gaining knowledge, sharing knowledge
- Curiosity about vaccination rates among Hispanic/Latina women in the area
  - Insights from role as Family Support Worker

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My Approach

- Sample selection
  - Decided to broaden eligibility to include more women of Latina/ Hispanic ethnicities
- Method: Survey
  - Anonymous responses in a community who might fear repercussions.
- Eligibility
  - To complete the survey, responders had to: identify as Hispanic/Latina, pregnant since May 2021, and live in the Greater Fall River area
- Recruitment
  - I was able to share information with co-workers and other community agencies
  - Created relationships with local providers (ex: local WIC office)

Survey Outreach at Fall River WIC Diaper Bank

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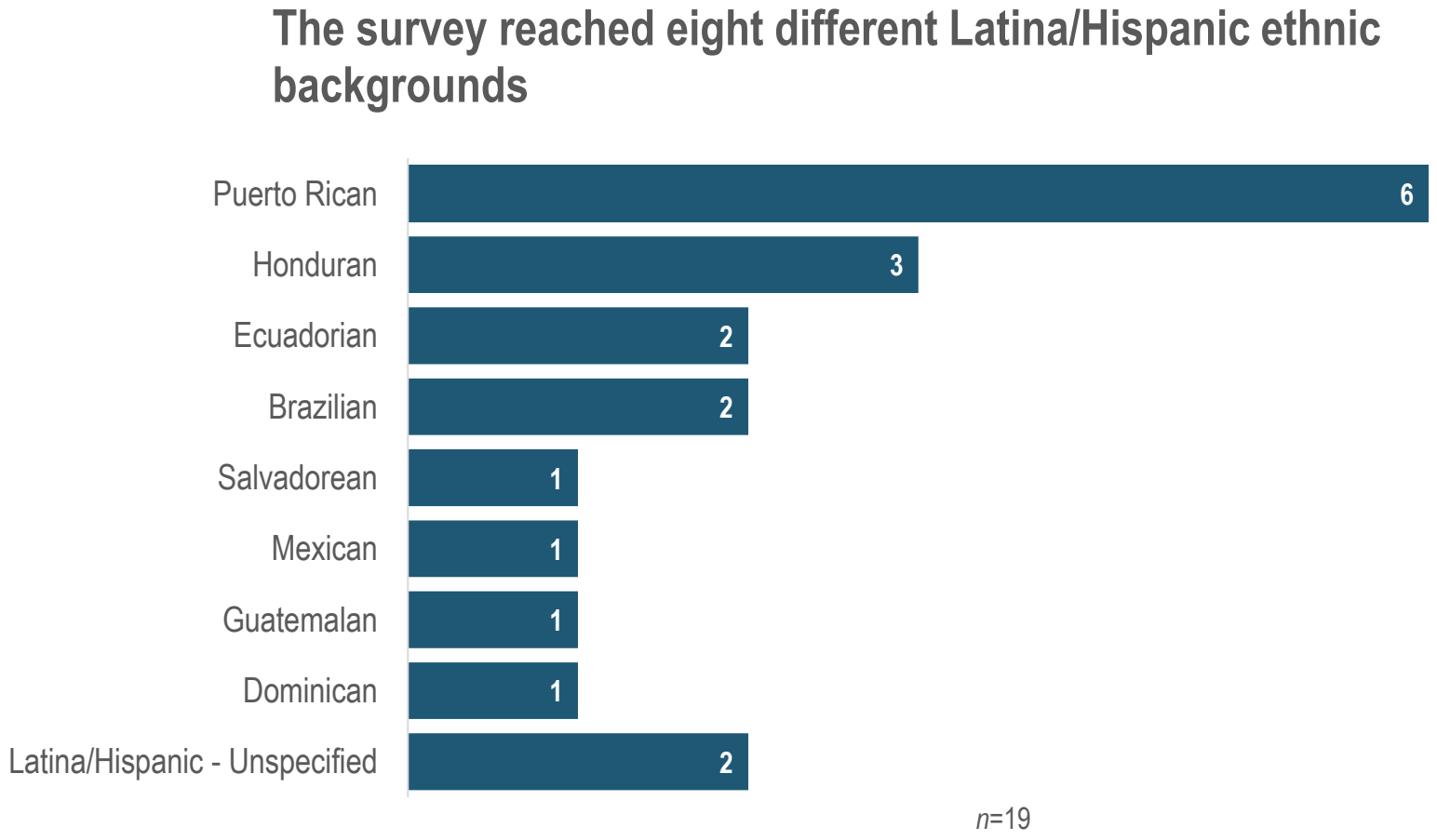
Survey Sample

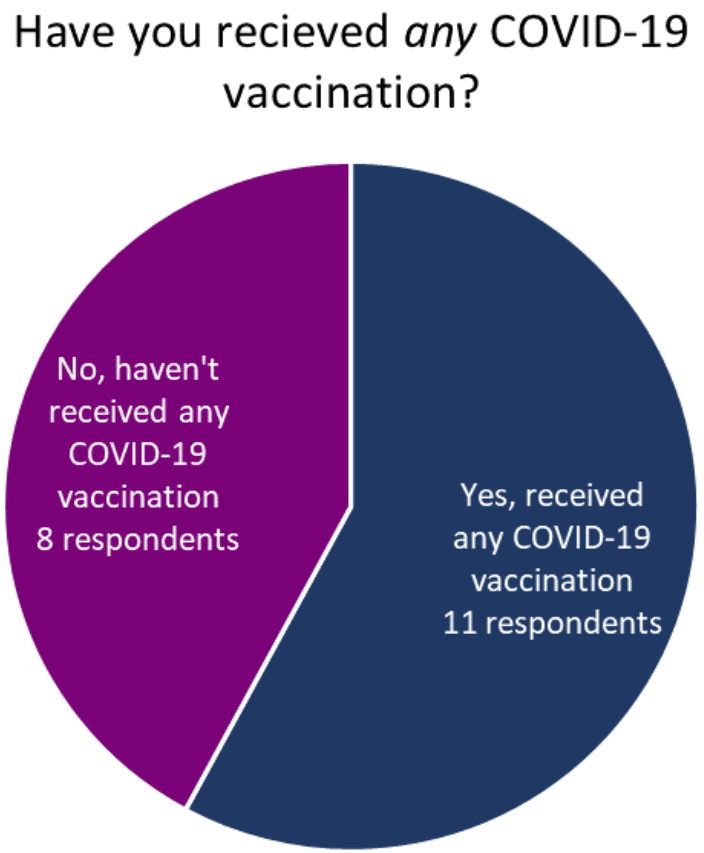
- n=19
- All identified as women
- 13 had a PCP prior to pregnancy
- Language:14 participants indicated Spanish as a preferred language



Sources of Information

- **8 respondents** were able to identify the source of where their information was coming from (MDPH, CDC, local board of health). (8 of 18 respondents)
- **10 respondents** reported they received their information from their doctor. (10 of 19 respondents)
- **Most respondents** reported they felt comfortable talking to their prenatal provider about their questions or concerns. (14 of 18 respondents)
- **All** respondents reported they received their prenatal care in a language they felt comfortable in. (18 of 18 respondents)

Vaccine Numbers: To vaccinate, or not vaccinate?



n=19

- **Reasons to Vaccinate**
  - To protect families and people they worked with
  - To protect their babies during pregnancy
  - Afraid of getting COVID
  - Medical advice they were given
- **Reasons to Not Vaccinate:**
  - Did not feel comfortable
  - Don’t think it's necessary
  - Not prepared

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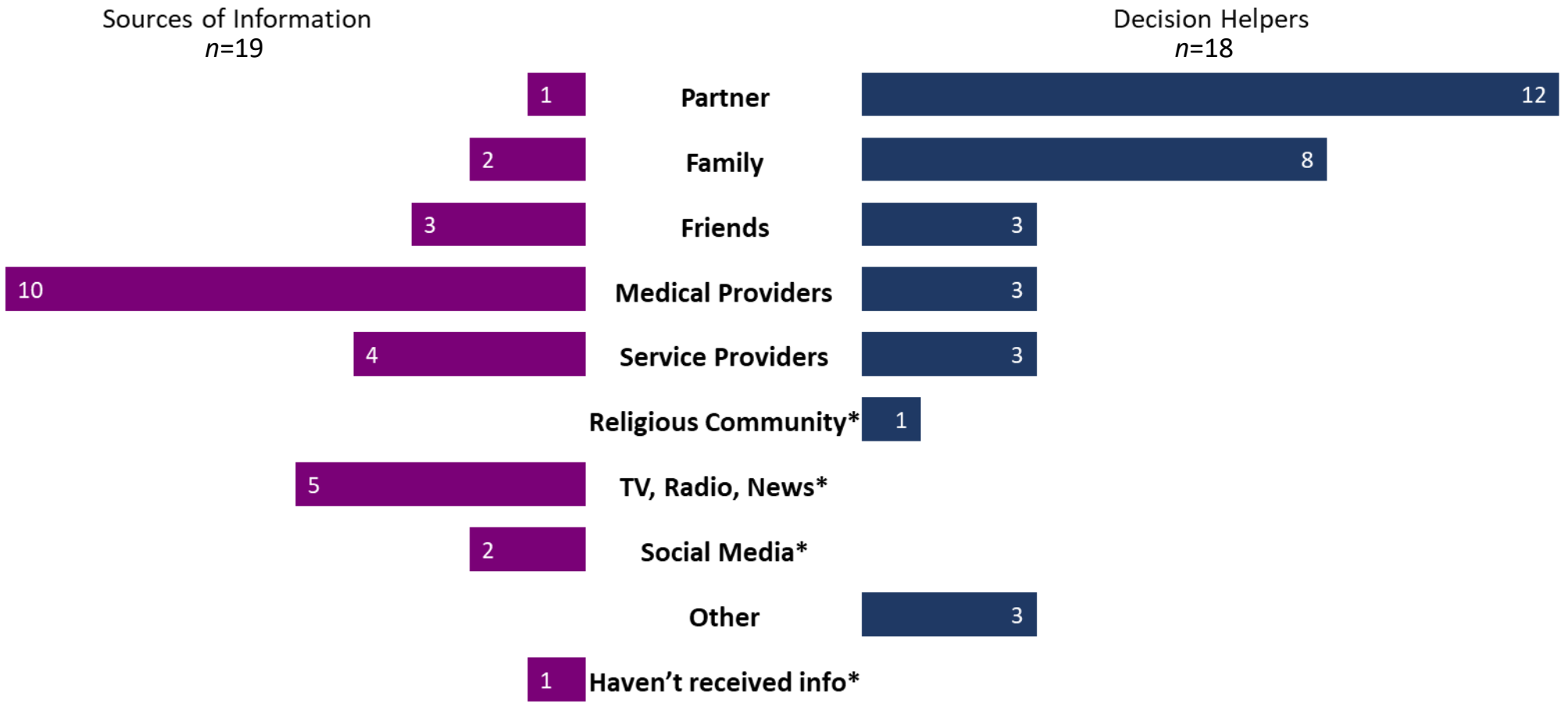
Vaccine Decisions



*Some response options were not included in both questions, based upon context.

What do Hispanic/Latina women think about the community's low vaccination rates?

"They are scared"

"Because of fear, they don't not agree, other people scare them"

"A need to know the side effects"

"There are a lot of myths, beliefs, and misconceptions about the vaccine can do to the body/health which make people not want to get it"

"In need of information"

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What can be done to increase vaccination rates?

"Give them information and tell them the pros and cons regarding the vaccine"

"Talking to other Latina women that have been vaccinated while pregnant. Maybe speaking to a Latina doctor about the risks and the benefits..... "

"Nothing in particular. The CDC recently released the vaccine don't work 100%. So there's really no point to it, especially given there is no long term research. ..... "

"There are a lot of myths, beliefs, misconceptions about what the vaccine can do body/health which make people not want to get it."

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Main Takeaways

- Most responders were connected to a medical home
- Information regarding the COVID-19 vaccine was getting out to responders
  - Some responders were able to identify and name their information sources
  - Information was received in a language responders felt comfortable in.
- But, there is room for improvement
  - More information needed on long term effects (if any).
  - Wanting more information on the pros and cons regarding the vaccine.
- Family members assisting with making decisions regarding pregnancy and care.

Understanding the experiences of Haitian pregnant women in Brockton

My Path to this Project

- Work in Family Resource Center and vaccine clinics
- Interest in Community Evaluator role
  - Passion for community-based work
- Curiosity about the topic
  - Understanding perspectives in Haitian community
  - The “why” behind vaccine decisions

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My Approach

- Community
  - Haitian women in the Brockton area
- Method: Interviews
  - In Haitian Creole (*organic data*)
- Recruitment
  - In-person recruitment at Haitian stores
- New perspectives on community-based work

Participant Demographics

- Interview sample: 8 participants
  - All were pregnant Haitian women during the pandemic
  - All spoke Haitian Creole
  - Current residents in the Brockton area
- Other context
  - 3 of them were health care workers
  - 3 of them were new to the country (transnational experiences)

- **Thematic analysis – three ideas**

Stress and struggles

Life During the pandemic

- Added difficulties for participants: pregnancy, caring for a newborn
- Living in fear for themselves, newborn, family
- Complications with pregnancy and childbirth
- Mentally tired and drained
- Intense isolation
- Lack of Social Support
  - No family to support the new born or mom

"It was kind of stressful, because you know when you're pregnant you become vulnerable."

"Corona is humiliating. It's like when reading the Bible and you have leprosy. It's like a long time ago when AIDS first appeared and you have AIDS, people don't approach each other."

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Reasons why many (pregnant Haitian women) refused the vaccine

Very hesitant to get vaccines while pregnant:

- Religious reasons
- Prefer natural remedies
- Misinformation about the vaccine
- Suspicious of how long it took to develop
- Worried about long term side effects for self and baby
- Fear

"But you know, back then as Haitians, we had our own remedy, and people were telling us what to do"

"They said that it was against the Bible, that it wasn't a good vaccine, that they wanted to kill us all"

"She must ask God before she takes it. She told me went to pray. She asked God, but God did not answer her. Then she told me went to pray. She asked God, but God told her he already gave her a vaccine and for her not to take it."

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Opinions from people who got the vaccine

- 7of 8 received the COVID-19 vaccine
- Many felt they had no choice– mandated by work, and felt powerless
- Despite their feelings, some also felt grateful for the vaccine– saw how it helped reduce rates

"But, when people know some information such as small details about the vaccine, if it is something to take or not, then they will feel safer to take it if they do research about it"

Overall Recommendations

Participant Recommendations

- ***What***: Provide more comprehensive information
  - For example: benefits; side effects (if any); findings specific to pregnant women and children; in simple language

- ***How:*** Focus on *how* the information is delivered
  - For example: In a user friendly and concise way; encouragement to ask questions; opportunities to share information with family members/decision supporters; small community gatherings to ask questions and share concerns (in preferred languages)

- ***Where*****:** Reach people where their communities gather
  - Medical settings vs. community settings (e.g., shopping centers, grocery stores)?
  - Social institutions that are important to Haitian people (e.g., *Church, Public Schools*, *Places of Gathering, places of trust)*

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Additional Reflections

- Stop providing vaccine incentives
  - By giving the incentives, what is the message you are sending?
- Involve family members in the decision-making process
- Ask people what they need
  - How do they want information? Where?
  - People want to feel seen and heard through action

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Parent Perspectives on the Pediatric COVID-19 Vaccine

Carolyn Boumila-Vega, Keiana Cox, Bethany Morales

May 3, 2023

Community Evaluator Team

Bethany Morales
Community Evaluator
Fall River

Keiana Cox
Community Evaluator
Boston

Carolyn Boumila-Vega
Community Evaluator
Chelsea

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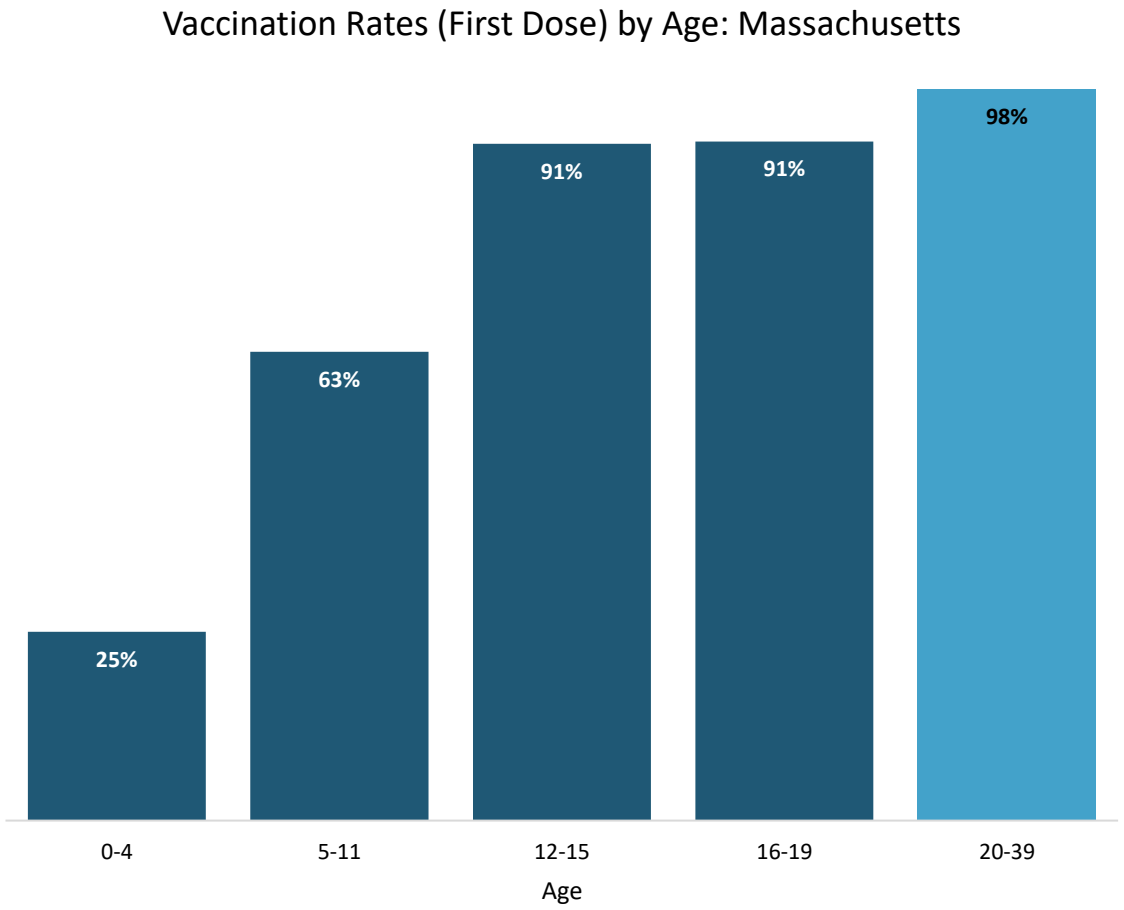
Pediatric COVID-19 Vaccine Background

- COVID-19 vaccine authorized for children over 6 months on 6/18/22
- Last age group to receive authorization
- Age group with the lowest COVID-19 vaccination rates
- Little known from parents at the community level



Data reflects vaccination rates through 3/27/2023: https://www.mass.gov/info-details/covid-19-vaccine-equity-initiative-community-specific-vaccination-data

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Project Focus

- Perspectives and decision-making processes
  - *Parents themselves*
  - *Their children*
- Information received about the vaccine
- Barriers & facilitators to vaccine access
- Recommendations for MDPH

Participant Population:

- Parents/caregivers of children under 5
  - Young parents (Fall River)
  - Latino parents/caregivers (Spanish-speaking) (Chelsea)
  - Black parents (Boston)
- 5 focus groups (+ 2 interviews)
  - n= 26

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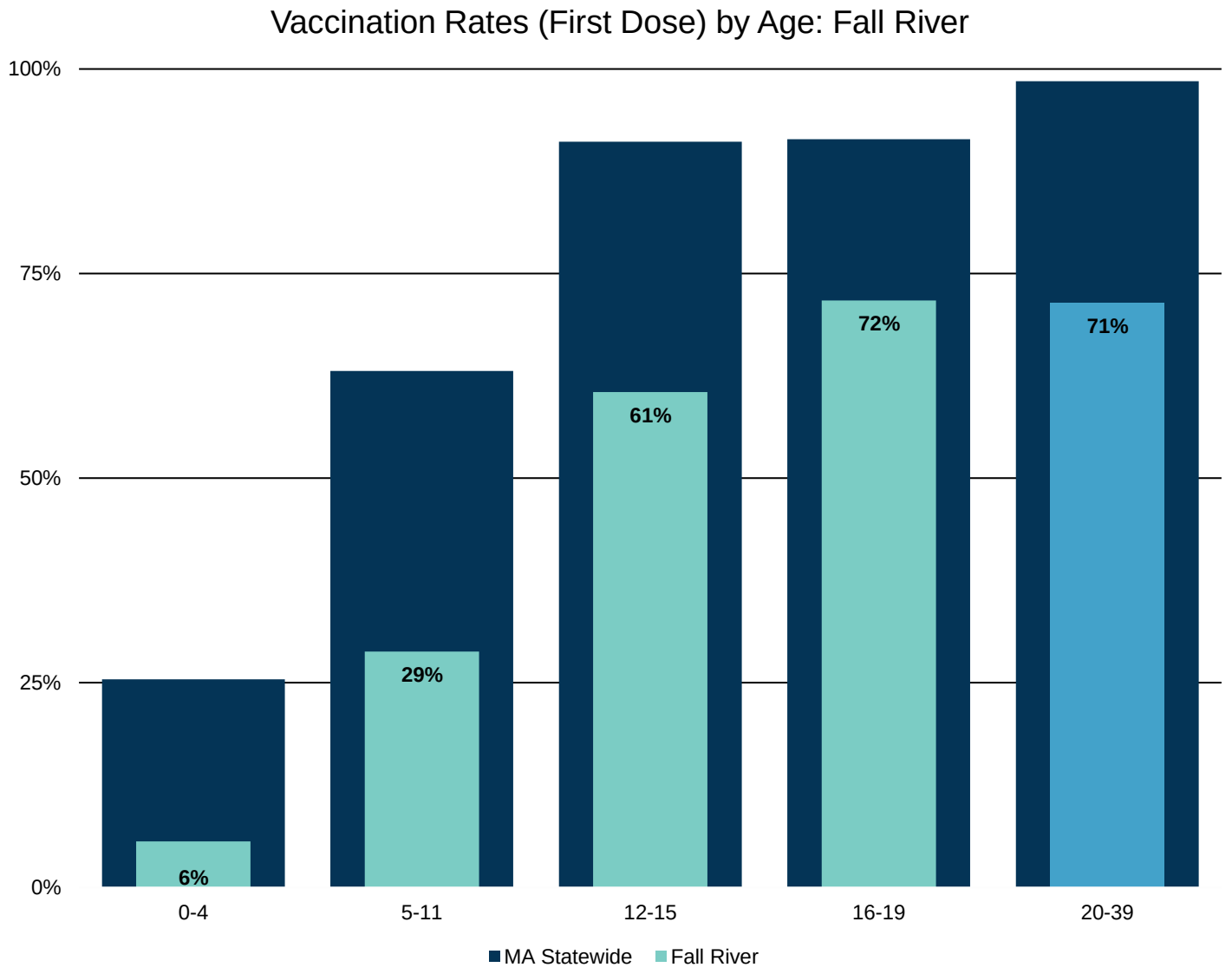
Fall River: COVID-19 Vaccination by Age



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"I'm strongly against putting something in my daughter's body that we don't have enough research about."

-Participant

"The Covid vaccine is a setup, and there is something in the shot"

-Participant

"Someone said it earlier but DPH, the pediatrician, center for disease control and mass.gov, they'll know more about it because they were the ones doing the studies. They'll be able to tell me hard facts, like I don't care. I want to know the scary information, and I want to know all the real information."

-Participant

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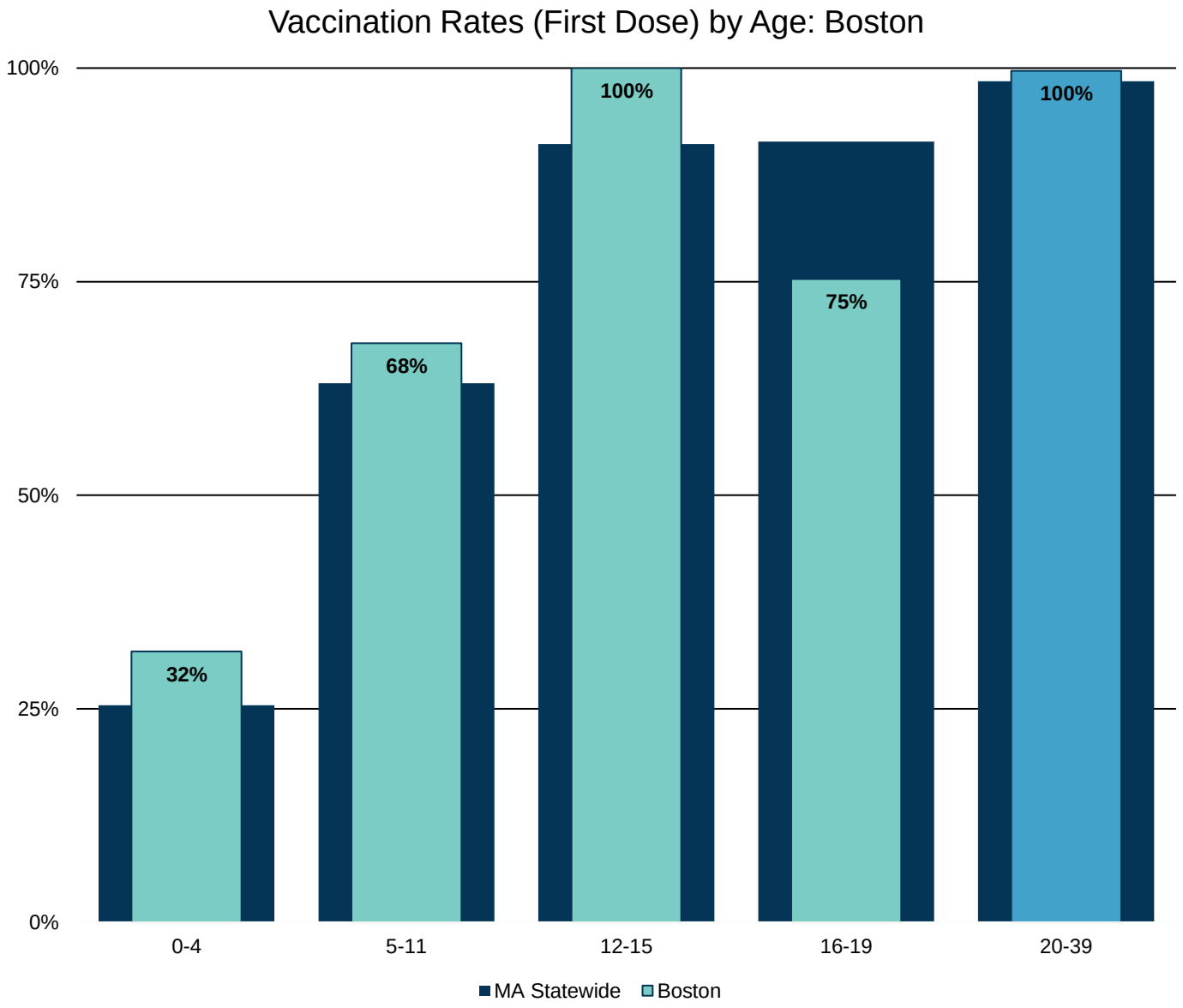
Boston: COVID-19 Vaccination by Age



Data reflects vaccination rates through 3/27/2023: https://www.mass.gov/info-details/covid-19-vaccine-equity-initiative-community-specific-vaccination-data

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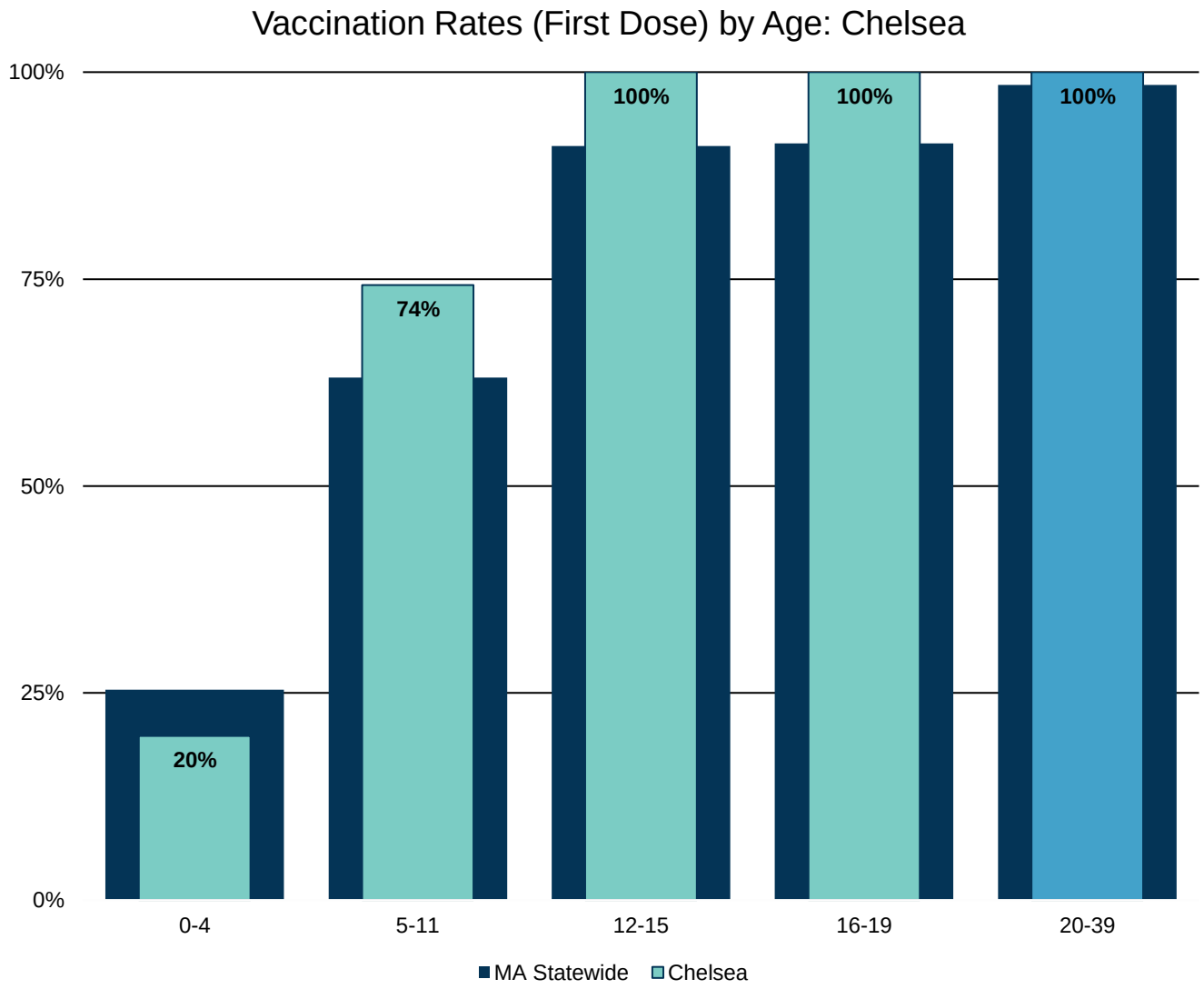
Boston

"I think that was like a big thing with minorities like kinda like there was a lot of like conspiracy theories that the vaccine was put out there to kind of get people infected with Covid…but like generally, history, Hasn't been too kind to minorities associated with healthcare." -Mother

"My daughter's life is a huge factor"
-Father

Chelsea: Vaccination by Age



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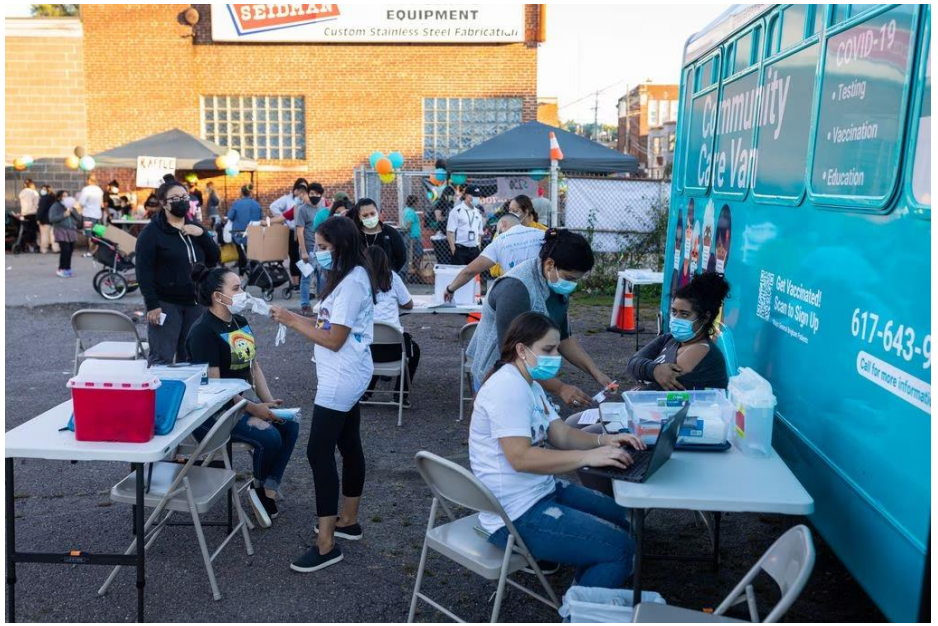
Chelsea context:

- 1.8 square miles
- Sanctuary city
- Large undocumented population
- ~70% Latino



Residents getting vaccinated at La Colaborativa

La Colaborativa hosted food banks during the Pandemic.

Vaccination line

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Recommendations

1. **Leverage pediatricians**

2. **Provide comprehensive information**
   - People can do own cost/benefit analysis

3. **Let people hear from the source**
   - For example: scientists, researchers

4. **Incentives & choice:** Are people vaccinating because they want to?
   - Incentives are complex – how do you roll them back?

5. **People want their voices to be heard**, with follow through.
   - What's being done based on people's voices and perspectives?

6. **Build trust** (community organizations, leaders, healthcare)
   - Parents not taking decisions lightly

7. **Parents don't want vaccine mandates for this age group**
   - Many didn't feel they had a choice themselves

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