

# Vaccine Access and Acceptability Among the Hispanic Population in Rural Southeast Idaho

September 2021



**CommuniVax**

A Coalition to Strengthen the Community's Role  
in an Equitable COVID-19 Vaccination Campaign



Idaho State University

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# CommuniVax: Idaho Local Report



*Figure 1. American Falls, Aberdeen area: southeastern Idaho.*

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## Executive Summary

This report includes a description of research, interventions, and recommendations that helped raise awareness of and access to the COVID-19 vaccine in Hispanic communities that make up 31% of the population in and near the small, rural towns of American Falls and Aberdeen, Idaho.

Many Hispanic individuals are employed in the agricultural sector. Such work is typically not well paid and is replete with occupational dangers. In addition, COVID-19 took a disproportionate toll on the Hispanic population in Idaho. In December 2020, the state's Hispanic population had a 20% higher rate of hospitalization for COVID-19 than should be expected if there were even distribution across demographics.<sup>1</sup>

In response to this disparity, in the spring of 2021, when COVID-19 vaccines began to be distributed more widely, Idaho CommuniVax brought together 24 Idaho State University students and faculty, community members, and Southeastern Idaho Public Health. Our team collaborated on a community-driven research strategy that involved introducing the project by directly speaking with 11 public health and primary care providers, community leaders and educators. We then conducted 41 interviews (32 in English, 9 in Spanish) and 3 focus groups (all in English) with Hispanic community members and other key stakeholders.

Results from analysis of the data suggest that there is little vaccine hesitancy and/or refusal in the Hispanic communities of southeast Idaho. They also suggested that lack of formal education was not a barrier to wanting or receiving a vaccine. Most of the study population wanted the vaccine because they wanted to continue to work and contribute to the security of their families and communities.

Overall COVID-19 vaccination rates are extremely low in both Bingham and Power counties, where American Falls and Aberdeen are located. Bingham maintains rates of 33.5% and Power maintains rates of 37.8% vaccination of total population compared with 51.5% in the United States as a whole.<sup>2,3</sup>

***Based on these findings, we support more efforts to address hesitancy and acceptability of COVID-19 vaccines in non-Hispanic as well as Hispanic communities.***

The following recommendations complement the recommendations set forth by the larger US CommuniVax coalition<sup>4</sup>:

- 1. Make community and public health more visible and viable**
  - a. Critically reflect on and evaluate how community and public health is understood in Idaho
  - b. Promote community and public health and its programs

- c. Support sustainable, long- and short-term funding for community and public health; avoid crisis funding-only opportunities

**2. Ensure sustained community engagement**

- a. Conduct long-term research and evaluation on vaccination topics that is community-driven
- b. Establish pathways to continuing education and higher educational degrees for community health workers, certified nursing assistants, and other basic healthcare workers
- c. Build stronger, multisectoral bridges to address public health

**3. Advocate for child and adult COVID-19 vaccinations for the future of Idaho**

- a. Develop trust between public health and local communities
- b. Plan for the future; do not disband the COVID-19 task forces
- c. Commit to long-term development of community and regional relationships that will not need to be rebuilt in the face of another pandemic

## Introduction

### Project Background

In spring 2021, COVID-19 vaccines were beginning to be distributed more widely. It was at this time that Idaho CommuniVax brought together 24 Idaho State University (ISU) students, faculty, and community members to help raise awareness of and access to the vaccines for the Hispanic population in rural regions of Bingham and Power counties. We conducted safe, Zoom-based interviews and focus groups with community members and other stakeholders to help us better understand expectations and concerns about COVID-19 and the vaccine. This, in turn, helped us support real-time interventions that reduced health inequities and improved the COVID-19 vaccine rollout in southeastern Idaho.

To ensure our research was community-driven, we developed new relationships, relied on long-standing ones, and partnered with local authorities, stakeholders, and community members. Before doing any work, we spoke directly with 11 public health and primary care providers, community leaders, and educators. This helped us understand the unique circumstances faced by the Hispanic population in the area. Our relationship with Southeastern Idaho Public Health (SIPH), with whom we had biweekly meetings, sparked organic development of intervention activities and contributed to the ways in which SIPH went about improving access to and acceptability of vaccines.

### Population Characteristics

Our work focused on the population in and around American Falls and Aberdeen, Idaho, which covers 1,676 square miles<sup>5</sup> and has a population of 16,276, 31% of which is Hispanic.<sup>6</sup> There is no question that the Hispanic population in this area experiences social and health disparities. US Census data suggests that 19% of the Hispanic population in these census tracts had income below the poverty level, compared with 10% of the non-Hispanic White population.<sup>7</sup> Forty-six percent of Hispanic individuals aged 25 and over in these areas have not obtained a high school diploma.<sup>6</sup>

Top industries employing a large number of Hispanic individuals in the area include agriculture, agribusiness, food processing, transportation, and warehousing.<sup>8,9</sup> Although there are no formal numbers, many workers are undocumented. Pay is often low, and jobs often come without health insurance. Forty-one percent of Hispanic individuals in the area, ages 19 to 64, are uninsured compared with 12% of non-Hispanic White individuals.<sup>6</sup>

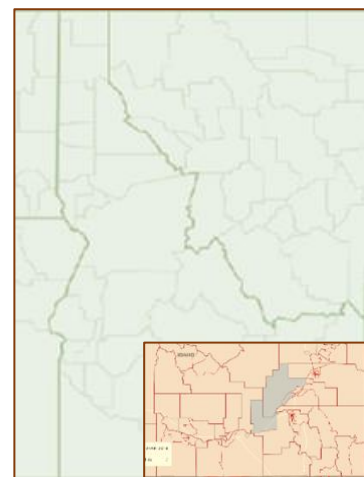


Figure 1. Map of research area.

## Impact of COVID-19

COVID-19 took a disproportionate toll on the Hispanic population in Idaho. In December of 2020, the state’s Hispanic population had a 20% higher rate of hospitalization for COVID-19 than should be expected if there were even distribution across demographics.<sup>1</sup>

According to SIPH, available data does not accurately represent case or vaccination rates among the Hispanic population. SIPH only publicly reports on cases by age, gender, and confirmed healthcare worker status—not by ethnicity. This is because the state of Idaho did not require reporting by ethnicity or race until late February of 2021, and the question of race/ethnicity is often not asked by providers (personal communication, M. Mann, March 2, 2021).

At the statewide level, out of 196,128 cases, only 107,684 (55%) are associated with known ethnicity.<sup>10</sup> What is known, is that the number of Hispanic individuals who died in 2020 was higher than normal. Deaths increased by 27% over the previous year. This made COVID-19 the leading cause of death for Hispanic individuals compared with it being the third leading cause of death for all other racial and ethnic groups in Idaho.<sup>11</sup>

As Table 1 suggests, COVID-19 vaccination rates are extremely low in both Bingham and Power counties. No data is available by ethnicity at the county level. Statewide, of those whose ethnicity was reported, 44,553 Hispanic individuals versus 400,515 non-Hispanic individuals with Idaho addresses completed a full series of vaccinations.<sup>12</sup>

Table 1. Vaccination Percentages of Bingham and Power Counties Compared with Idaho and the United States

Vaccination Percentages	Bingham County	Power County	Idaho	United States
Percent of total population fully vaccinated	33.5% <sup>2</sup>	37.8% <sup>2</sup>	38.52% <sup>13</sup>	51.5% <sup>3</sup>
Percent of population ≥ 12 years of age fully vaccinated	N/A <sup>2</sup>	N/A <sup>2</sup>	47.8% <sup>13</sup>	60.2% <sup>3</sup>
Percent of population ≥ 65 years of age fully vaccinated	74.8 <sup>2</sup>	78.5 <sup>2</sup>	75.3% <sup>13</sup>	81.2% <sup>3</sup>

## Research Design and Approach

In January 2021, we hired a team of 20 ISU students who are in the health professions and social sciences. Half of these students are Hispanic, bilingual, and live in American Falls or Aberdeen. We trained them to gather data to help us understand perceptions about COVID-19 and perceptions about access to and acceptability of the COVID-19 vaccine. Idaho State University opted to accept approval from the Johns Hopkins Bloomberg School of Public Health Institutional Review Board (IRB0015200) for this research project.



By May 24, 2021, our team conducted and analyzed 41 semistructured interviews (Table 2) and 2 focus groups with members of the Hispanic community. We also conducted one focus group with public health officials from the area. Thirty-two of the interviews were conducted in Spanish and 9 were conducted in English. All focus groups were conducted in English.

Table 2. Gender and age of interviewees (N=41)

<b>Gender</b>	<b>Age 18-29</b>	<b>Age 30-45</b>	<b>Age 45-60</b>	<b>Ages 60+</b>
Male (n = 17)	3	5	5	4
Female (n = 24)	6	11	3	4

## Observations



*Figure 3. Power County train.*

## Process Observations

Several of the young adults we interviewed were currently enrolled in postsecondary education, and they were clearly interested and positive about being vaccinated. Some of these individuals were part of our CommuniVax team. They were integral parts of the communities of study and provided entrée into areas we would not otherwise have had access to. These students were hesitant to receive the vaccine because of fears about its effects on their future ability to conceive children.

We addressed this topic with them early in January 2021, and were able to provide the whole team of student researchers with the most up-to-date information that showed no effects from the vaccine on women's fertility. This was the most pressing concern among the young women that we interviewed. Not only did the team learn about this issue, but we also initiated an open forum with the team for questions about COVID-19 and the vaccinations where we could discuss the latest scientific findings on these topics and where we could dispel misinformation.

This type of activity is an example of how our team has helped local healthcare professionals develop just-in-time interventions. In another example, early this spring we determined that undocumented workers were concerned about going to a government-sponsored public health office to get vaccinated. People were afraid that they would have to show proof that they were in the United States legally. Our team worked with SIPH to develop a flyer that expressly stated that no documentation of any kind would be required for a person to receive a vaccination through their office.

At the same time, SIPH removed language from its intake form that stated information would be shared with insurance providers. This was important because insurance providers only insure those who are documented. This language could be a deterrent to those without social security numbers or state identification numbers. An additional flyer was developed in Spanish that explained where and how one could get the COVID-19 vaccine. Members of the research team distributed the flyers to local farms and Hispanic grocery stores, where many undocumented individuals and their families live and work.

***This example demonstrates the efficacy of having researchers from our local university (ISU), being involved with and trusted by officials in the local health departments.***

## Outcome Observations

Based on the interviews and focus groups, we did not find much vaccine hesitancy and/or refusal in the Hispanic communities of southeast Idaho. As indicated in the data above, there is no question that Idaho is lagging in vaccination rates, but these findings beg the questions: (1) is it the Hispanic community that we need to focus on? and (2) if we are not seeing hesitancy in the Hispanic community, and there is strong access to vaccines, what can we do more broadly within the state to improve rates of acceptance?

What we do know is that interviewees from the Hispanic community had some differing reasons for taking the vaccine. Some respondents said yes because they received information about the vaccine that answered their questions, and they easily found somewhere to get vaccinated. Locally, Rockland Pharmacy teamed up with the high school to offer clinics. Bingham Memorial Hospital, the Health West medical clinic, and SIPH all reached out to workplaces and locally trusted establishments.

Fear was also a driving factor for individuals to get vaccinated; fear of the virus, fear of losing work time, fear of losing their jobs, and even fear of huge hospital bills that could result in medical bankruptcies. These fears were exacerbated for undocumented individuals.

There were also some rumors that people were afraid that their employers would fire them if they didn't get vaccinated. These were unfounded fears, but the mistrust was apparent and it was something that needed to be countered with clear information.

## Vaccination and Education Level

The Hispanic communities in southeast Idaho are diverse when it comes to education level and proficiency in spoken and written English.

The Hispanic university students on our team come from rural southeast Idaho and are highly educated by local standards. Their university-level educations have given them the intellectual tools to absorb new information, to seek out high-quality information on their own, and to convey that information to their friends and relatives in their home communities. A bachelor's degree is a huge achievement for these Hispanic youth; many are first generation college students in their families.

In the age groups 30 and above, the role of education in vaccine uptake was less clear. Individual's abilities to speak English was very much tied to where they attended school; those individuals who went to school in Mexico remain mostly Spanish-speakers. The age group of 30 to 45 was more likely to not want vaccines and to not have completed postsecondary education; they went straight into working in agriculture and associated businesses (restaurants in particular).

Those individuals over the age of 45 who we interviewed had limited English capabilities, in general, and they were very pro vaccination. Their information about the vaccines came from friends and family, Spanish television and radio stations, and local and national English television and radio outlets. ***For these groups, lack of formal education did not seem to prevent them from getting vaccinated.***

## Vaccine Experiences

Among the male adults ages 18 to 60, the need to work was a resounding reason for getting vaccinated. Of the men in this category the vast majority were working in agriculture; several men in our pool of interviews had come on temporary work visas from Mexico. All the men working on the large farms spoke about how their employers had gotten the vaccines for them, and they had received the vaccine. The local clinics, pharmacies, and health department have held vaccine clinics at the farms and warehouses. No one spoke about having difficulties in accessing a vaccine if they wanted one.

The *ranchos*, or farms, along the Snake River Plain are seen as physically distanced from the threat of COVID-19. As one migrant farmworker said, "Buying food is when we go out. Since we don't go out here at the ranch, there are very few of us, so there is no problem, right. But when we go out to the stores, that's where the problem is." Agricultural work takes place 6 or 7 days a week for very long hours. The owners of the farms became aware of the devastation that COVID-19 could have on their workforces in the spring of 2020. They were keen to get their workers immunized and through a mix of suggestions, information, and some pressure, they have achieved high vaccination rates.

Workers took the vaccines because they wanted to be vaccinated, they saw vaccines as neutral, but possibly helpful in maintaining their health and working capacity. For a very few, they felt pressure from employers (whether real or imagined) that it was necessary to be vaccinated in order to continue working at their current place of employment.

Coupled with the availability of the vaccine is the lack of health insurance for many of the individuals working in agricultural jobs. The fear of getting sick and losing work was palpable in the interviews and the attendant hospital bills that faced families whose members were very sick with COVID-19 earlier in the pandemic were a strong incentive for vaccination. In most cases, those individuals who knew someone who had been very sick or died of COVID-19 stated that as a reason for wanting the vaccine.

Women in the workforce were more mixed in their reasons for getting vaccinated. While work did play a role for most, and certainly for more of the older women, some of the younger women were not planning on getting vaccinated for reasons such as feeling their immune systems were strong enough to fight it off. As one young Hispanic woman working in a clinic said, “If I got COVID, I think it would just be a bump in the road,” and so she refused the vaccine when it was offered at her place of work. Another young woman cited being allergic to many things and being afraid of the vaccine. The older women (ages 30 years and up), especially those working in agriculture or at restaurants and other businesses, stated that they were vaccinated or planning on getting the vaccine.

### **Vulnerable Health Status**

Among the older interviewees (both men and women over 60 years), almost all of them were vaccinated. This age group, in general, took COVID-19 seriously and did their best to avoid it through masking, distancing, and vaccination. One woman, who was 76 years old at the time of her interview, said she’d never had a vaccine in her life and didn’t think she’d take this one, although, when pressed, said she might consider it if her doctor brought it to her home.

For the other individuals in this age category, healthcare providers gave them information and were quickly ready with “the jab” when they acquiesced, as was this 72 year-old woman with diabetes when she described:

*Yeah, okay, I just, I didn't want to get it because they said that it was, that it hurt too much and that, I said no, I'm not going to get it. And I wasn't going to get it. I was asking a lady at the drugstore and she told me to go to the apothecary ... and he told me, you'd better be vaccinated. If you don't, you'll get COVID[-19] and it's going to give you, and you could die, and there's ... I said I'd better get it. He said I'll give it to you. It won't hurt at all. Right? And he gave it to me and it didn't hurt at all, nothing. (Interview was edited and condensed for clarity)*

In general, individuals in the older age category have lost relatives in both the United States and Mexico and were aware of how serious the illness is for them. Many of these older individuals spend much of their time in contact with family left behind in Mexico. They made constant comparisons between how the pandemic and vaccination were handled in the 2 countries; many of the interviewees for this project came from rural, farming communities in Chihuahua and Guanajuato. The desperate situations in small communities in Mexico where their families still reside has made the pandemic even more difficult for these Idaho families to endure and was a reason that some gave for getting the vaccine.

### **Reasons Not To Get Vaccinated**

The most prominent reason people of any age or gender cited for not getting the vaccine was that they felt that their body would be able to fend off the infection without the help of the vaccine. Younger individuals spoke about this in a couple of cases and in one case an elderly individual also felt their own immune system was strong enough to provide good protection to them. Some individuals were hesitant to get the vaccine, although they said they would, as they were worried about having to lose even 1 or 2 days at work.

Another individual said he rejected the vaccine because it had been developed too quickly and had “come out of nowhere.” He had been infected with COVID-19 twice, according to him, both times he lost his sense of smell and had a terrible fever. He had also lost several relatives both in the United States and Mexico to the virus in the last year. In addition to distrust of a quickly developed vaccine, another reason for not being vaccinated included the idea that COVID-19 was part of a “plandemic”—something manufactured by a malevolent US (or foreign) government.

Interestingly, the physical barriers to vaccination that one might expect did not come up in the interviews; distance and isolation on the ranches were not a problem as the vaccines were brought out to the workers. It should be noted that the majority of the vaccines have been given during the spring and early summer at this point. If the rollout had occurred in November, the logistics would have been much more difficult with road closures due to blizzards and with the high numbers of COVID-19 cases at that time (winter of 2020/2021).

### **Research Takeaways**

One of the major takeaways from these interviews is that Hispanic farmworkers employed on farms in southeast Idaho are getting vaccinated. The workplace vaccination efforts are effective. Interview respondents and their families and coworkers are being vaccinated in a timely fashion.

Despite our team’s findings showing higher than expected vaccination acceptability in the southeast Idaho Hispanic population, Idaho’s overall vaccination rates remain low. What we do know about differences between ethnicities is complicated because

reporting is not consistent. Other parts of the general population are not getting the vaccine because they do not want it and/or they have access issues.

Vaccine and mask resistance are high in the state, with great controversy overshadowing health needs and realities.<sup>14</sup> Misinformation associated with fertility concerns, conservatism, and uncertainty about vaccine safety are just some of the issues thwarting successful vaccine uptake and use of masks.<sup>15</sup>

Addressing these issues in a holistic, empathetic, and clear way can pave a path forward for Idaho, a path that is less vulnerable in the face of new COVID-19 variants, like Delta. The following recommendations address how we understand and treat community and public health for the whole of Idaho, emphasizing that all its citizens deserve equal access to correct information, vaccines, health programs, and those positive aspects of everyday life that determine health status.

## Recommendations



*Figure 4. Power County Courthouse.*

This section introduces 3 localized recommendations and actions that complement CommuniVax’s national recommendations listed in Appendix A. These local recommendations target the interconnectivity of individuals, communities, healthcare providers, and state and federal level institutions; these levels operate in tandem. Addressing issues at all levels will provide better outcomes in relation to vaccination rates plus overall health status of Idahoans. Such an approach allows for more opportunity to address the social determinants of health that exist at all levels.<sup>16</sup>

In southeastern Idaho’s Hispanic population there is a will to get vaccinated and there is access to vaccines. Nevertheless, the state of Idaho has abysmal COVID-19 vaccination rates. To address this issue, and to improve health equity in the future, the recommendations we put forth are holistic. They address how to improve community and public health and how to better integrate community and public health into Idaho’s culture. We also address how to create a stronger focus on the value of vaccines.



## A. Make community and public health more visible and viable

*I think being able to put into place personnel resources that are there consistently to build that trust especially in smaller communities but also those people that we put into place reflect the population. So, they need to have common experiences with the people that they're going to be serving. (Local public health official)*

SIPH works diligently with limited resources. Its operating model considers community needs and attempts to address those needs. Working with SIPH showed how, when provided the time, resources, and opportunity, public health systems operate exceptionally well. SIPH responded quickly when presented with information that would make vaccine distribution to the Hispanic population more effective. They rapidly adjusted how they were getting vaccines into the community by working with local farms and businesses.

SIPH is structured for civic engagement by having county commissioners serve on their board, this can cause friction due to commissioner's different levels of healthcare knowledge. Even with their tireless work and dedication, public health services and employees in all of Idaho are under threat. Effective March 1, 2022, "the state will no longer be required to provide state funded support to the health districts."<sup>17</sup>



Figure 2. Health West medical clinic, Aberdeen, Idaho.

It will be up to individual counties to make up the difference left with the withdrawal of state funds, and the money will come out of reduced indigent services programs. To stem this tide, it will be important to:

1. *Support these efforts with sustainable, long- and short-term funding for community and public health. Avoid crisis funding-only opportunities.*

*In the 25 years I've worked in public health, there have now been 3 instances where a chronically underfunded and under-resourced public health system, all of a sudden, just has money being thrown at it. Like more money than we can reasonably spend in an appropriate way... But the reality is our resources are so stretched in the 'in-between times' that we [...] I would love to have a public health nurse and a community health worker in every office, but we don't have the resources for that. (Idaho public health official)*

2. *Critically reflect on, and evaluate, how community and public health is understood and perceived by individuals (healthcare providers, business owners, educators), communities (including religious groups and age groups), and decision makers (city councils, county commissioners, legislators). Doing so will help public health, as an institution, understand and respond to the current lack of political will and reduced allocation of resources in the midst of what many are calling the largest public health crisis in the past 100 years.*
3. *Promote and invest in community and public health and its programs—emphasizing that to address individual health, we must address its social determinants. In addition to the work already being done through campaigns that name public health issues, like smoking cessation or suicide prevention, engage in a campaign that names what public health is and does, and who it is for.*

## B. Ensure sustained community engagement

*Like with L ... everybody knows her. They trust her. And they bring their kids there for shots, and they come get their flu shot every year—and so, being able to build that model when we're not in a crisis is really critical moving forward. (Focus group, local health official)*

The creation of trust between public health officials, clinicians, and the community members that they serve is at the heart of increasing access to community and public health services of all kinds. Trust comes from interacting over time. Not all encounters are perfect nor is everyone always pleased with the conversation or the outcomes, but the overall intent is to stay at the table and keep working on the issue in a positive manner.

There are many ways to effectively sustain interaction and provide a pipeline that stretches between individuals, communities, and policy and decision makers at all levels:

1. *Conduct long-term research and evaluation on vaccination topics that is participatory and community driven.* Scientific understandings of both COVID-19 and the vaccines that prevent it are evolving. State universities are called upon to commit to conducting local health research with district health departments and communities to create high-quality community level data, better public health messaging, and a more informed citizenry.
  - a. For all Idahoans, it is important to reinforce the message, in some form, “Science is a journey, not a destination.” The public needs to understand that scientific understandings should change over time as we learn more.
  - b. Vaccine disinformation continues to change with every passing day. Myths and disinformation about COVID-19 and its vaccinations are perpetuated on social media and from person to person. This disinformation needs to be understood as a moving target; what matters most to people changes over time. Research regarding the most effective ways to correct misinformation shows that combining retraction with an alternative explanation is reported to be most effective compared with fact-checking and appeals to credibility.<sup>18</sup>
  - c. Provide clearly stated messaging that avoids ambiguity and cannot be widely misinterpreted. For example: Dr. Janet Woodcock, acting commissioner of the US Food and Drug Administration (FDA), has said that the FDA “conducted a rigorous and thorough review” of the vaccines before allowing them to be given to people and that the Pfizer vaccine “meets FDA’s high standards for safety and effectiveness.... Getting more of our population vaccinated is critical to moving forward and past this pandemic.”<sup>19</sup> (Quote was edited and condensed for clarity)
2. *Based on our experience working with 20 ISU student researchers on the CommuniVax project, we strongly encourage Idaho educators to establish pathways for continuing education and higher education degrees for CHWs, certified nursing assistants, and other basic healthcare workers.* It is essential to create strong models that are integrated into paths toward professionalism for young community members who want to become healthcare professionals. This will create future generations of providers who understand that to address individual health, its social determinants must also be addressed.
  - a. Provide clear curricula for CHWs to advance into established university-level medical programs of all levels, make CHWs a stepping stone to an educational pathway that leads from basic community-based health

education providers to individuals becoming professional nurses, doctors, doctors of nursing practice, physician assistants, and public health practitioners who are engaged, well remunerated, and respected decision makers of the future.

- b. Support the educational goals of our area's youth with funded scholarships and internships that will bolster our clinical and community health workforce in the future.
- c. Integrate students, as a curricular requirement, into local research projects, run by faculty of the universities that serve our state. The 20 students who participated in CommuniVax exemplify this. They were taught to formally research and analyze local problems, think critically about their connection with broader contexts, develop messages to foster change, bring those messages to local decision makers, and participate in creating timely, effective change.

### *3. Build stronger, multisectoral bridges to address community and public health*

- a. Expand county public health department offices in rural areas.
- b. SIPH and all public health districts in Idaho should continue to leverage and strengthen partnerships with county commissioners to ensure more employees have time to attend and participate in county meetings.
- c. Provide multisectoral training to employees and create more communication opportunities between primary care and community and public health. This can be done by developing interprofessional learning opportunities for college and university health profession students, supporting interprofessional continuing education for existing health professionals, and building community coalitions that operate consistently across the state (ie, that involve members of not only the primary care and behavioral health sector but also education, transportation, local government). Collaboration with the state's 3 Area Health Education Centers, who are tasked with doing these very things, will be invaluable.
- d. Reestablish the Idaho Healthcare Summit and involve more public health and primary care providers as well as community-based organizations.

## **C. Advocate for child and adult COVID-19 vaccinations for the future of Idaho**

Vaccine hesitancy in Idaho is not solely associated with COVID-19. Idaho citizens have long-standing concerns about vaccines, their side effects, and their intended use. In fact,

“Idaho law allows a parent/guardian to claim exemption from immunization requirements for their child based on religious or personal beliefs.”<sup>20</sup> Personal beliefs is an extremely broad category.

While Idaho CommuniVax revealed little vaccine hesitancy in the Hispanic population, overall, the state of Idaho has low COVID-19 vaccination rates.<sup>2,3</sup> Hesitancy is often associated with those in the majority political party,<sup>14</sup> which tends to be the population more likely to influence policies, to sit on decision-making boards and to contribute to the majority political will in the state.

1. *Gain trust. Addressing hesitancy is a matter of addressing and developing trust between Public Health and local communities.* Consideration of social, cultural, political, and systemic factors will lead to more transparent development of interventions.
  - a. More detailed data needs to be collected and presented to the public that accurately reflects demographic differences based on race and ethnicity for: number of cases, number of deaths, geographic spread, and changes over time. Demonstrate to the public how data is used to create changing mandates.
  - b. Continue to hold weekly public health district video postings on social media explaining trends.
  - c. Provide free, expedient COVID-19 testing.
  - d. Continue to bring vaccines to people—make them accessible, visible, and always free. Workplaces are effective locales for offering vaccinations, this should be a strategy for all employers to consider as they support their workers in getting vaccinated.
  - e. Continue to create a culture of masking for COVID-19 and all airborne diseases.
2. *Plan for the future, not just of COVID-19 and its variants, but for the future of the public health workforce to support more wide-reaching vaccination campaigns* (put public health nurses back in community offices and create opportunities for public health to work more closely with primary care).
  - a. Do not disband the COVID-19 task forces.
  - b. Commit to long-term development of community and regional relationships that will not need to be rebuilt in the face of another pandemic. Leverage them into disaster-planning entities that are already uniquely informed, in part, by local community coalition insights to

facilitate clear, comprehensive understandings of community perceptions, hesitations, and needs.

## Conclusions

At a time when state funding for public health is in jeopardy, we are at a moment when clear thinking about the future is essential. Yes, the immediate task at hand is changing the tide of vaccine hesitancy, not just in the Hispanic population, but in the entire state of Idaho. As the Delta variant looms and other variants threaten shortly behind, we are still in a state of crisis, with intensive care unit bed occupancy higher than it was at the peak of the pandemic in late 2020.<sup>10</sup>

We have to think beyond the COVID-19 crisis, toward the future of community and public health as a hard-fastened component of Idaho's healthcare plans.

Maani and Galea<sup>21</sup> clearly articulate that the public health system in the United States is fragmented, disjointed, and woefully underfunded—so much so that there is a \$4.5 billion “shortfall in funding to provide a minimum standard of foundational public health capabilities.” They go on to emphasize that short-term funding to address COVID-19 will not fix long-standing deficits in resources and capacity. Southeast Idaho is feeling these deficits in a deeply concerning way. Without a complete transformation in how public health is valued and funded in the state, it is likely that disparities that existed before COVID-19 will persist into the future.

With this in mind, we must consider how to move forward at a time when Idaho is one of the fastest growing states in the United States.

*How can the state and its citizens create access to adequate numbers of community and public health services?*

The short answer is that more stable, long- and short-term funding is needed. The more complex answer is that funding must improve health status by working across sectors, and addressing disparities in the contexts within which people live, work, and play. We believe the recommendations herein are a great first step to making this happen.

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## Appendix A. CommuniVax National Recommendations

### Urgent Actions: Take immediately to improve vaccine coverage within underserved communities

#### 1. Humanize delivery and communication strategies for COVID-19 vaccines

To reverse the vaccination campaign’s current slowdown and persistent unevenness in vaccine coverage, the campaign should support more peer-led and neighborhood-based opportunities for community conversation and for convenient vaccine access. Health systems and health departments should develop and/or strengthen their collaborations with community-based organizations (CBOs), FBOs (faith-based organizations), and community health workers (CHWs) and, importantly, commit to maintaining these relationships after the COVID-19 pandemic subsides. CBOs, FBOs, and CHWs should play a key role in identifying reasons for low vaccination coverage and should be involved in developing interventions to address those issues, such as providing vaccines at locations community members perceive as safe, familiar, and convenient. Groups and people communicating about COVID-19 vaccination should target as many social settings as possible—in person, on air, and on screen—to create multiple opportunities that prompt peer-to-peer conversations about vaccination. Individuals do not make their decision alone, even if they make the final decision about getting the vaccine.

#### 2. Anchor COVID-19 vaccination for hard-hit areas in a holistic recovery process

First, public agencies, hospitals and health systems, nonprofit social service providers, CBOs, FBOs, and CHWs should align themselves around a “whole person” model of recovery to meet underserved communities’ self-identified needs (eg, food, housing, jobs, mental health support) and to multiply the benefits of each vaccination encounter. A wraparound service approach provides the sense of safety and security important to informed health decision making. Second, local and state jurisdictions should take immediate steps to plan for long-term recovery and community resilience by: (a) convening a cross-sector council of stakeholders, including Black and Hispanic/Latino leaders, CBOs, FBOs, and CHWs to apply a whole-of-community, whole-of-government approach; and (b) engaging existing data-driven coordinating bodies that already facilitate disaster recovery, economic development, and other long-range planning.

## Essential Actions: Execute steadily to create systems-level changes and advance health equity broadly

### **3. Develop a national immunization program to protect people throughout the life course**

During the COVID-19 vaccination effort, public health authorities and government leaders at federal and state levels should capitalize on an already highly successful national immunization program for children, building out systems to provide broader coverage for COVID-19 vaccines and the 13 other vaccines recommended for some or all adults. Tasks include reconfiguring funding systems to support a life-course (versus childhood-only) approach to immunization, facilitating the integration of adult immunization with other health systems and priorities, and developing systems to monitor program progress and measure social and economic impacts. The funding support must be adequate to ensure health departments have sufficient staffing to oversee progress in enhancing adult immunization uptake and can take corrective actions if progress is judged to be inadequate.

### **4. Rebuild the public health infrastructure, properly staffing it for community engagement**

Political leaders at all levels should allocate steady core funding for the public health infrastructure, sustaining its capacity to respond to future emergencies and address prevalent health challenges (eg, diabetes, heart disease) that affect communities of color in greater numbers. A mandatory national investment of \$4.5 billion per year in a public health infrastructure fund will ensure a predictable minimum capacity at state and local levels. State and local officials should provide steadfast support to agencies that protect the health of their populations. Furthermore, state and local health departments should commit to the strategic goals of promoting equity in their ranks at every level, including their boards of health, and strengthening human-centric competencies through the recruitment of more social and community proficient professionals, such as health educators/promoters, risk communicators, language translators, social media strategists, and sociobehavioral researchers.

### **5. Stabilize the community health system as the backbone for equity and resilience**

Federal, state, and local leaders should take steps to formalize and finance the country's struggling, but promising, community health system. Through community roots and shared experiences, CHWs build trust with clients while navigating health and human services systems, bridge client and provider cultures to adapt service delivery and better meet needs, and advocate for system-level changes that will improve clients' access to care and overall health. In consultation with local, regional, and national CHW networks, federal and state officials should create sustainable financing strategies (including Medicaid reimbursement) for community health work on disease prevention,

health promotion, and social determinants of health. To generate opportunities and a career ladder, state legislators should authorize a CHW workforce development plan; public health officials should work with human resources systems to create positions at varying levels of experience. To acknowledge the deep social assets and community organizing abilities of CBOs, FBOs, and CHW-led organizations, public and private funders should provide grants directly to these entities, adapting funding processes and eligibility criteria to create an environment where communities with the greatest need benefit from funding first.