Understanding Barriers to COVID-19 Testing in Community-Based Organizations and Tribes
Grant Report

October 2022

Oregon Health Authority

Public Health Division

Acute and Communicable Disease Prevention

Funded under the Epidemiology and Laboratory Capacity Emerging Issues (E) Project: Funding for the Enhanced Detection, Response, Surveillance, and Prevention of COVID-19 Supported through the Paycheck Protection Program and Health Care Enhancement Act of 2020

Overview

This grant was created as a smaller grant under the funding of the Epidemiology and Laboratory Capacity Emerging Issues (E) Project: Funding for the Enhanced Detection, Response, Surveillance, and Prevention of COVID-19 Supported through the Paycheck Protection Program and Health Care Enhancement Act of 2020. This grant project was outlined in a larger grant workplan as part of Strategy 5. Activity 3., which was to "Implement prevention strategies in high-risk settings or within vulnerable populations (including tribal nations) including proactive monitoring for asymptomatic case detection." The goal of this grant was to enhance understanding of COVID-19 testing access and barriers in communities disproportionately impacted by COVID-19.

While 75% of Oregonians identified as White, in September 2021, White people accounted for only 45% of COVID-19 cases, highlighting the disproportionate impact COVID-19 had on Oregon communities of color and tribal communities[1]. To learn about experiences related to barriers to COVID-19 testing and to identify possible solutions to overcome those barriers, the Oregon Health Authority[2] (OHA) established a grant opportunity to fund up to 10 community-based organizations (CBOs) who served these communities. In August 2021, a Statement of Work and a Request for Proposals were released. At this time, mixed methods were used to encourage CBOs to apply for the grant. OHAs Community Engagement Team included the grant application in their newsletter which was sent to CBOs across Oregon. The application was also included in private and state-owned distribution lists. In addition, word of mouth was used to further advertise the application. Proposals from CBOs were due by September 30, 2021. Ten proposals were received, all ten were approved for the award, and each was notified of their award on October 10, 2021. Contracts for each awardee were initiated allowing for payments to be invoiced for work starting January 1st, 2022 through October 31, 2022. Invoices were submitted via email and were reimbursed at a rate of $75 for every two hours worked on grant activities, with invoicing totaling up to $7,500 per CBO. For further information on the implementation schedule of this grant, see Appendix A and Appendix B.

This report summarizes information on the participating CBOs, how they collected data, the barriers to COVID-19 testing they identified, recommendations for removing these barriers, feedback on grant participation, barriers and difficulties encountered during this grant project, and acknowledgements. See Appendices C through G for copies of each CBO report which include CBOs methods for gathering data, findings, suggestions, and feedback on grant participation.

[1] In Oregon, Hispanic/Latino community, Hawaiian and Pacific Islander, Black, and American Indian/Alaskan Native communities have been those most disproportionately affected.

[2] This effort was led by the Oregon Public Health Division's (OPHD) Acute and Communicable Disease Prevention (ACDP) section.

Participating Sites & Who They Serve

Ten sites applied for and were accepted as awardees for the Understanding Barriers to COVID-19 Testing in Community-Based Organizations and Tribes grant. Three sites declined to participate before contract execution and another two discontinued participation after contract execution but did not invoice for any work done.

The sites that provided reports served a wide range of people throughout Oregon. One site spoke to people in rural communities along the northwest coast while another focused on rural communities in northeast Oregon. Three of the sites focused on urban and rural areas outside of Portland, the largest city in Oregon; one of these sites also completed outreach in Portland. One site spoke to people in urban and rural areas around the capital city, Salem. Overall, the sites served urban and rural areas throughout much of Oregon.

Bienestar builds housing, hope, and community for the wellbeing of Latinxs, immigrants, and all families in need in Washington and Columbia counties. These counties consist of rural and urban communities west of Portland. Many of the people Bienestar serves are immigrants and farmworkers.

Clatsop Community Action (CCA) serves people in Clatsop County which is small rural county along the northern coast of Oregon. CCA serves all racial and ethnic groups including Latinx, Black, Indigenous, Pacific Islander, Asian, and White communities. CCA is a bilingual organization and provides materials and community outreach in English and Spanish.

Marshallese American Network for Interacting Together (MANIT) serves Marshallese people across Oregon. For the purpose of this grant, MANIT spoke with people at vaccine events in Union, Washington, and Marion counties. Union county is a rural area in eastern Oregon. Washington and Marion counties consist of both rural and urban communities outside of Salem and Portland.

Somali American Council of Oregon (SACOO) serves Black and African communities with an emphasis on East African and specifically Somali people. SACOO serves people in Multnomah, Washington, and Clackamas counties. These counties consist of rural and urban areas, including Portland.

Togo Community Organization of Oregon (TOGO CORE) serves African immigrants, refugees, and descendants with an emphasis on the Togolese community. TOGO CORE serves people in Oregon and Southwest Washington with a main office in Portland.

Site Data Collection Methods

Sites utilized a variety of methods to collect data from members of their communities. Many sites completed data collection at community COVID-19 vaccination events. One site mentioned that community members who did not want a vaccine attended events to be with members of their community. In addition, some sites called, texted, and had Zoom calls with community members. One site held a focus group with community leaders and administered questionnaires to their staff members. Another site posted a survey to their website.

A mixture of pre-made questionnaires and free answer questions were asked in effort to gather both quantitative and qualitative data. Each site was encouraged to create their own questionnaires relevant to the communities they served, and many translated their questions into the primary language(s) spoken in the communities they served. OHA also provided example questions that could be adapted to meet site needs. See Appendix H for the example questions provided.

Identified Barriers to Testing

Sites identified a variety of barriers community members faced to getting tested for COVID-19. Many sites also reported on barriers to COVID-19 vaccinations, an issue that was felt to be related to COVID-19 testing barriers. Results indicated many similarities in the barriers people faced to getting vaccinated and tested for COVID-19. A compilation of site report findings is outlined below.

Language & Literacy Barriers: Four sites indicated lack of languages utilized by testing sites and in informational materials was a barrier for people. While not all sites mentioned the languages spoken by those they interviewed, the sites that reported language as a barrier primarily served those who spoke Spanish, Somali, Nahuatl, Mam, and Marshallese. Not having options for languages other than English was an issue in many steps of the testing process, including when searching for information on tests, scheduling tests, filling out online appointment reservation forms, and completing paperwork at testing sites. In addition, paperwork provided only in English and Spanish was a barrier for people from Central America who had low literacy rates and primarily spoke indigenous languages such as Mam and Nahuatl.

Cost: The expense of tests was reported to be a barrier by three sites. It was too expensive to get a COVID-19 test because of the actual cost of the test, the cost of missing work to get tested, and the potential cost of having to miss work if someone tested positive. One site noted this would be especially true for working class immigrants with many dependents in their households. Even when free at home testing kits were provided, the limited number of tests given to each household proved to be a barrier to some families. Additionally, one site reported there were issues with people accessing as many tests as they needed due to their insurance only covering a certain number of tests in a given timeframe. Similar cost-related barriers were identified in getting vaccinated; many people who were uninsured had not been made aware that vaccines were free. People were also reluctant to get vaccinated in case they needed to take time off work due to side effects.

Technological Requirements & Technology Access: Three site indicated community members had trouble using technology to search for testing sites and/or reliable test-related information. This was especially true for older adults and people who only had access to smartphones and not computers at their home. Not having an email address was also a barrier to scheduling appointments.

No Barriers due to At Home Kits: Three sites reported that many or most of the community members they spoke with were no longer facing barriers to COVID-19 testing due to at-home testing kits sent by the federal government.

Lack of Appointment Availability: Two organizations reported a lack of appointment availability was a barrier for their communities. Both not having any available test appointments and not having test appointments after work hours were barriers for many people.

Misinformation: Fear-inducing misinformation about testing and vaccination was reported by two sites. Misinformation was spread in a variety of ways, including person to person, on the news, and through social media. One specific area of misinformation was around test accuracy; people had been told the tests were not accurate and had high rates of false positives. Another area was around the safety of COVID-19 vaccines; the newness and short development timeline of the vaccine made people hesitant to get vaccinated because they had heard of a variety of potential health risks related to getting vaccinated (including contracting COVID-19) and/or had experienced medical related trauma in their birth country. A third area was that people could not afford COVID-19 tests due to not having insurance, despite tests being offered for free.

Lack of Childcare & Transportation: One site reported a lack of transportation and childcare prevented many of their community members from being able to access testing. A second site noted the same was true for getting vaccinated.

Test Result Reporting: One site reported people did not get tested because they did not want positive test results sent to their county.

Lack of PCR Tests: One site indicated there was an issue with getting a test early in the pandemic because testing sites were running out of tests.

Discomfort with Self-Administered Tests: One site reported people did not want to administer at-home kits themselves due to discomfort.

Time: One site reported the length of time it took to schedule a test appointment was a barrier for people.

Recommendations to Reduce Barriers to Testing

CBOs were asked to provide recommendations from their staff and the community members they spoke with on how to reduce barriers to COVID-19 testing. In addition, OHA staff provided recommendations based on CBO reports and discussions they had with CBOs. Here is a compilation of recommendations:

- Reduce language barriers
    a. Provide testing and vaccination sites with resources, training, and staffing to ensure they can communicate and provide materials in a wide variety of languages, including Spanish, Somali, Marshallese, Mam, and Nahuatl
    b. Ensure testing sites have scheduling options in a variety of languages
    c. Ensure testing sites have translators available to help with paperwork, especially if paperwork is not provided in a variety of languages or if there is a large population of people in their area with low literacy rates
- Reduce cost barriers
    a. Continue to send households free at home testing kits; provide more tests to larger households
    b. Offer free PCR tests
    c. Do not allow insurance companies to put caps on the number of tests someone can receive
- Reduce practical barriers
    a. Provide free transportation to testing sites or ensure there are many testing sites in an area so people can walk to them. Alternatively, offer to deliver tests or perform tests at someone's home
    b. Provide free childcare at testing sites or provide reimbursement for childcare for people who go to testing sites
    c. Ensure testing times are available after typical work hours
- Provide non-technical options for scheduling tests and obtaining information about tests
- Reduce the spread of misinformation around testing and vaccination throughout all communities in multiple areas (news, word of mouth, social media). Educate community leaders on how to battle misinformation and provide culturally appropriate educational materials in a variety of languages.
- Provide culturally appropriate and translated educational materials on
    a. The accuracy of each type of test, rates of false positives, and rates of false negatives
    b. The safety of COVID-19 vaccines and low percentage of potential side effects
    c. How to access free at-home and free PCR tests
    d. How to self-administer at home test kits
- Widely advertise testing options through a variety of means and languages
- Make the entire testing process (including scheduling) as quick and simple as possible

Feedback on Grant Participation

Sites overall provided positive feedback about grant participation. They valued the opportunity to speak with community members and learn about their experiences around COVID-19 vaccination and testing. It was suggested that OHA share this report with community partners, so they are made aware of barriers to COVID-19 testing experienced in different communities around Oregon. Multiple sites indicated they learned a lot of things they were not aware of in their communities, such as widespread misinformation about testing and vaccinations.

Sites also indicated disapproval of some components of grant participation. While not in the official reports, sites indicated frustration at the long wait times for the contracting process and invoice processing. In addition, sites indicated the grant should have offered reimbursement not only for staff time but also to pay community members for sharing their lived experiences; this is best practice for community-based work as people should be compensated for providing time and expertise on the experiences of themselves, their families, and their communities. OHA staff echo this feedback and agree future grants should have options for payments to community members and reduced time in contracting and invoice processing.

Barriers and Challenges to this Grant Project

A number of challenges and barriers came up throughout the timeline of this grant project. Foremost, the duration and intensity of the impact of the COVID-19 pandemic on the innerworkings of OHA posed a great challenge; staffing redirected to COVID-19 efforts took away from administrative resources that would have otherwise been available for managing a grant such as this one. Due to these factors, there were unusually long wait times for contracts and invoices to be processed. The length of the contracting period caused multiple sites to decline the grant and for the grant deliverable timeline to be shortened, leading to sites having to decrease the rigor and complexity of their community outreach efforts. Further, the months it took for invoices to be processed and reimbursed proved a difficulty to sites who were hesitant to continue doing work they had yet to be paid for.

In addition, the staffing structure within OHA related to pandemic funding was also a barrier. With many staff being in limited duration positions funded by temporary pandemic relief grants, OHA had experienced much staff turnover. This reality affected the grant project as the two people who originally managed the grant were in limited duration positions which they transitioned out of in favor of permanent positions. The time it took to identify and onboard two new staff onto the project led to further delays in the grant timeline. While these challenges were not impossible to overcome, they highlight the drawbacks of not having dedicated administrative, fiscal, and project management staff for grant projects such as this one.

Acknowledgements

This grant would not be possible without the contributions of our funder, community-based organizations, community members, and OHA organizers. We are grateful for the funding opportunity for this grant under the larger grant awarded to OHA—the Epidemiology and Laboratory Capacity Emerging Issues (E) Project: Funding for the Enhanced Detection, Response, Surveillance, and Prevention of COVID-19 Supported through the Paycheck Protection Program and Health Care Enhancement Act of 2020. We are grateful to organizers at OHA who started and coordinated the grant, including Melissa Sutton and Kristen Donheffner who conceptualized this project, Helen Kidane and Renee Harger who ran the initial part of the project, Larissa Williams and Molly Norris who ran the second part of the project and wrote this report, and our fiscal and administrative teams who managed contracting and invoices. Moreover, we greatly appreciate the contributions of the community-based organizations who carried out the bulk of the work for this project; many people were involved in the important tasks of designing community outreach, creating questionnaires, gathering data, and writing reports to share community knowledge and experiences about barriers to COVID-19 testing. We also recognize the essential contributions of hundreds of community members throughout Oregon who shared their stories and ideas around barriers to COVID-19 testing in their communities. We are excited to see how the contributions and hard work of so many people will reduce barriers to testing for our communities disproportionately impact by the pandemic and systemic health inequities. We hope this project will contribute to reducing health inequities related to COVID-19 and beyond.

Appendix A. Implementation Schedule and Challenges

Grant activities were scheduled to begin on January 1, 2022, and the project was scheduled to conclude on November 1, 2022. However, due to contracting delays at OHA[3], work for most CBOs did not begin until after July 1, 2022. On January 10, 2022, OHA hosted a kick-off meeting with all awardees to review the contracting process, deliverables, and proposals. Two sites declined the award in March as contracts were still awaiting execution by OHA.

In April 2022, both OHA staff overseeing this project resigned. In May 2022, two new OHA staff were identified to resume work starting June 2022. Sites were contacted to gauge their interest in and ability to continue with the grant and finalize the contracting process. Eight remaining sites indicated they were interested, however, two sites stopped responding to outreach after June 12, 2022 and July 13, 2022. OHA discontinued efforts to contact these sites on July 15, 2022 and August 1, 2022.Grant deliverables and expectations were modified because sites would have less time to engage with their communities to gather data and write reports. The six remaining sites began to collect data from their communities in late June 2022. Data collection ended for most sites by the end of August 2022. In August, OHA checked in with CBOs via Microsoft Teams calls to provide technical assistance around switching from data collection to report writing.

Though drafts of reports were originally due to OHA by May 2, 2022, given the complexity of the pandemic and the delays in contract execution, this due date was extended. One site indicated they had not been able to collect data and did not have the capacity to participate in the grant on September 20, 2022; all other sites submitted their initial reports by September 26, 2022. On September 30, 2022, OHA provided feedback to each CBO on their initial draft reports. Three sites were asked to modify their report and submit a revised report by October 7, 2022. Two of the sites did not respond to requests for report revisions and did not submit a revised report. The third site indicated reluctance to spend more time on the grant because they had not received payment for work completed to date. This site submitted a final report October 21, 2022.

A draft of this report was provided to grantees on October 25, 2022 with a request for feedback. One grantee requested a change to their organization description. No other feedback or requests were received. The report was finalized on November 1, 2022.

[3] Oregon began to see a surge in COVID-19 cases in December 2021 and did not subside until February 2022. OHA was overwhelmed with the response and was unable to respond to non-urgent activities which included this funding opportunity.

Appendix B. Implementation Timeline

Date	Activity
August 2, 2021	Statement of Work and Request for Proposals released
September 30, 2021	Request for Proposals due
October 10, 2021	Identified and notified ten grantees
January 1, 2022	Grant activities began (could invoice for work on/after this date)
January 10, 2022	Kick-off meeting with grantees to discuss contract, deliverables and proposals
March 2022	Two grantees declined the grant due to contracting delays
April 2022	Both staff overseeing grant activities resigned
May 2022	Two new staff identified to oversee grant activities
June 6, 2022	Eight grantees contacted to gauge interest and capacity to continue with grant; all eight grantees indicated interest
June 12, 2022	Final correspondence received from one grantee; grantee was assumed to no longer be interested in participating in the grant after final outreach attempt on July 15, 2022
June—July 2022	Formal check-in with seven grantees to regroup after a long project pause
July 13, 2022	Final correspondence received from one grantee; grantee was assumed to no longer be interested in participating in the grant after final outreach attempt on August 1, 2022
June—July 2022	Grant contracts finalized and executed for six grantees
July 2022	Grantee data collection activities began
August 31, 2022	Grantees completed data collection
August 31, 2022	Data collection wrap-up call with grantees; transition to preparing reports

September 23, 2022	Initial reports of results due from grantees; four grantees submitted reports by this date
September 26, 2022	Fifth grantee submitted an initial report
October 30, 2022	Report feedback provided to all grantees; requests for revisions provided to three grantees
October 7, 2022	Revised report requested by this date for three grantees; did not receive revised reports this date
October 21, 2022	Received revised report from one grantee
October 25, 2022	Draft of this grant report sent to grantees for feedback
October 28, 2022	Deadline for grantees to provide feedback on this report
November 1, 2022	Final grant report submitted; final grant report shared with grantees
November 1, 2022	Contract ended

Barriers to COVID-19 Testing Grant Report

BIENESTAR

ESMERALDA SANCHEZ

SEPTEMBER 2022

Overview

Bienestar organized and held five COVID-19 vaccine clinics in partnership with OHA through the VOTE Program. These clinics served approximately 400 community members and were an opportunity for Bienestar staff to have conversations with approximately 80 community members about barriers to COVID testing and possible beliefs, misconceptions, or lack of information that may exist. Bienestar's Community Health Worker also organized a focus group of 10 community leaders (Promotores) who do outreach and provide support to Bienestar's community of over 2000 residents. The demographics of the Promotores represent the demographics of their community, which is 95% Latinx and majority Spanish-speaking, immigrant-headed households. Finally, the Community Health Worker and team did a survey of Bienestar staff, which is 87% Latinx, with immigrants, farmworkers, and tenants of low-income affordable housing represented. Both the focus group and the survey were done specifically for the purpose of this grant.

Data Collection

Data collected through the vaccine events was primarily qualitative and came from conversations with those receiving the vaccine or their families, as we discovered verbal communication was more likely to engage participants at vaccine events and more likely to be successful. The 80 attendees participating in the community engagement, plus their families who often joined them, had a chance to speak with Bienestar's Community Health Worker about their experiences.

Data collected through the focus group of Promotores was also qualitative and the discussion was prompted by questions curated beforehand. Ten community members participated in the focus group.

Vaccine events and the focus group were conducted in person.

The survey provided to Bienestar staff received 19 responses, and the data was primarily quantitative, measuring predetermined responses to questions. The survey was provided and filled out virtually.

Description of questions:

Bienestar staff did not find that any of our questions were perceived as out of place or difficult for people to answer. We ensured that the questions were easily understandable and provided them bilingually to avoid misinterpretation and difficulty answering.

Summarize the data collected by numbers:

For the survey, 23 participants were asked to fill it out, and we received 19 responses. All responders answered all questions. Please see pie graphs below for a numerical representation of relevant questions and responses.

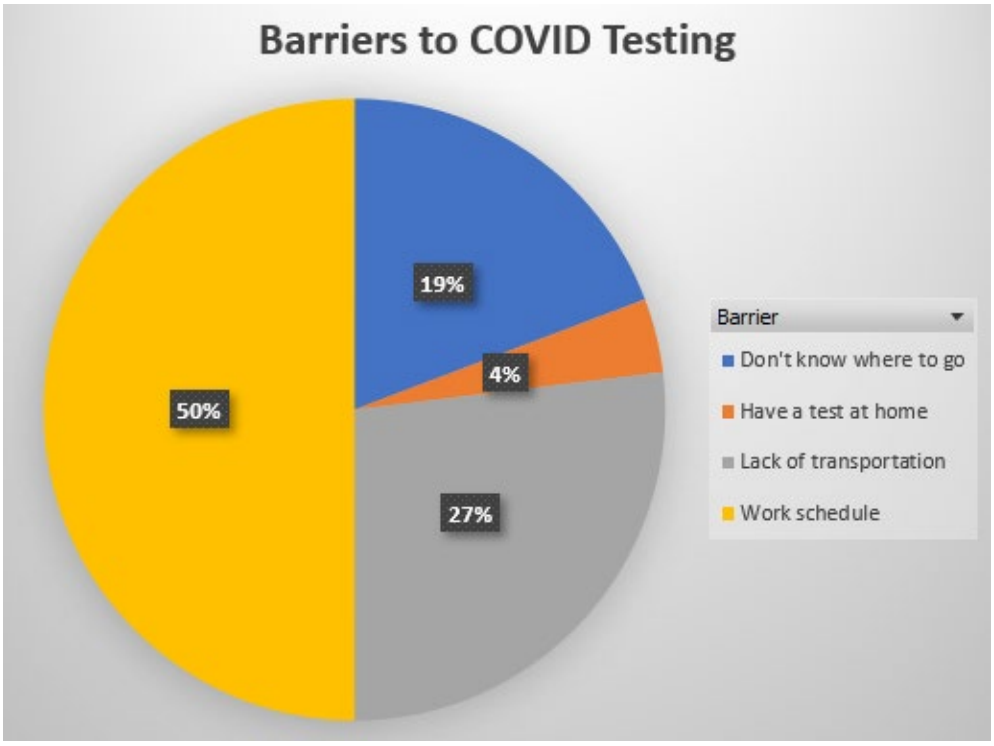
Data Interpretations, Recommendations, and Conclusion

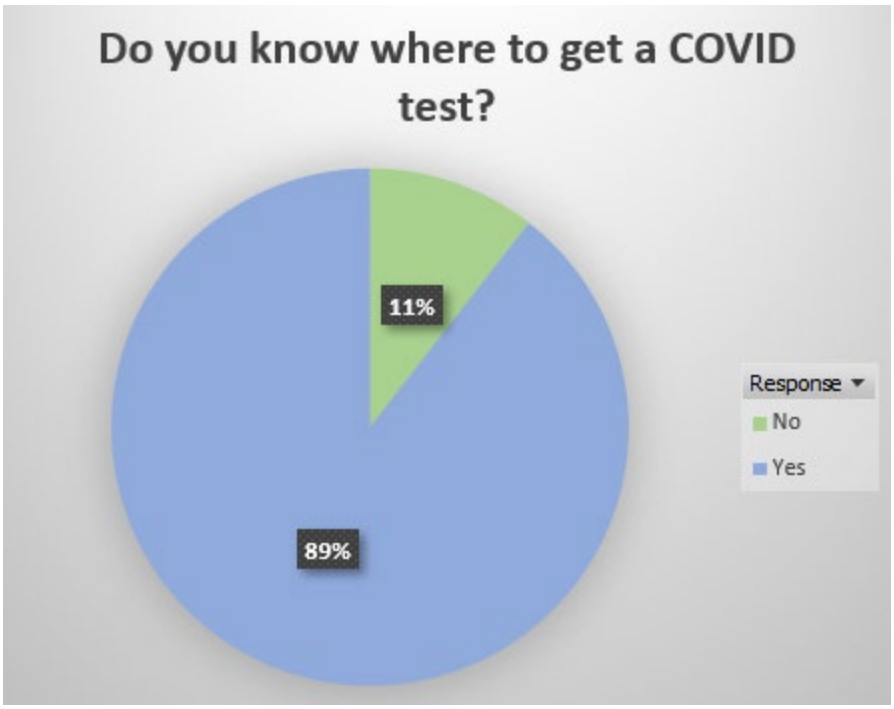
Major Findings:

Participants expressed distrust of the vaccine and COVID tests, particularly due to how quickly the vaccine was developed and distributed. Fear was a significant barrier, with concerns from respondents who had endured medical trauma in their country of origin, as well as those who were afraid the test would be painful or that they would contract COVID-19 from the test.

Insufficient technology skills were a barrier to finding where COVID tests were available and accessing reliable information about these tests. English-language only information and providers were also a barrier.

A lack of transportation and testing services available after work hours as well as a need for childcare also factored in for many respondents. Many respondents were concerned about the financial implications of missing work should their test come back positive.





Recommendations for reducing identified barriers

The Latinx immigrant community is very reliant on word of mouth and printed information that is made accessible. These channels must be utilized to reduce barriers to COVID testing.

Other methods of reducing barriers include establishing a trusted provider in the community and making services and information accessible and bilingual.

Continuing to broaden networks by bringing in different stakeholders (i.e. LPHAs, CBOs, health care providers, etc.) to create a network of culturally specific, bilingual information and services.

Feedback on Grant Participation

Bienestar was grateful for the opportunity to participate in this grant as it gave us an incentive to learn more about barriers our community faces. However, we want to acknowledge that we are not health care providers and ensure that OHA and the community both understand our role as a non-health provider CBO. Although we have a deep and trusting relationship with the community, guidance from OHA on health topics, i.e. support in developing the questions used in community engagement, would be welcome on further collaborations.

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Clatsop Community Action (CCA) worked closely with the Clatsop County Health Department to provide outreach, engagement and interpretation support for County-sponsored vaccination events and testing clinics.

- We used our established contact lists to conduct telephone outreach to many of our vulnerable (and all of our Spanish-speaking) clients, informing them of vaccination and testing opportunities, gathering informal experiential data and scheduling appointments for individuals and families, where applicable.
- We provided translation for distributed informational materials, including flyers and social media posts to inform the community of upcoming vaccination and testing events.
- Our staff delivered in-person support for vaccination events and testing clinics, providing general support and assistance as well as interpretation for Spanish-speaking attendees.
- We provided breakfast and lunch to employees and volunteers participating in vaccination and testing clinics.
- We collaborated with the Health Department to organize events specifically focused on the Latin(x) and Spanish-speaking communities across the county.

We conducted informal interviews during these processes, gathering personal narratives and anecdotes as we directly engaged with the community. We also conducted an anonymous digital survey – distributed to our clients via email to collect feedback and information. Our telephone outreach list consisted of approximately 200 Spanish-speaking individuals. Vaccination events were held several times per week, and testing clinics were held daily through the height of our engagement process.

Barriers to testing and vaccination in the Hispanic Population

- Language barriers: during early vaccination events, there was inconsistent language access.
  - A lack of Spanish-language materials for distribution.
  - A lack of Spanish-speaking staff able to answer telephones and schedule appointments
  - Spanish-speaking clients needed more assistance with English-language paperwork during vaccination events.
- Digital barriers:
  - The Hispanic population often faces technology and language barriers.
  - Limited access to digital tools needed to secure an appointment, especially among those who are older.
  - Most of the Hispanic population does not have access to emails, and don't have computers at home. They have smartphones, but they have difficulty navigating registration system that is not in Spanish.
- A significant portion of the Spanish speaking population of Clatsop County (particularly those from El Salvador and Guatemala) have very low literacy rates, and require assistance with paperwork, even when well-translated into Spanish.

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- Lack of knowledge about vaccine cost or importance.
    - A majority of the Hispanic members of our community are uninsured. They were unaware that vaccine was free for all and were concerned about the cost.
    - A large part of the Hispanic population did not receive regular vaccines in their country-of-origin, and were not familiar with the process. They were afraid of having a shot and often considered them to be unnecessary.
- Limited time to attend vaccination hours events.
    - Many of the Hispanic community are essential workers (working in the seafood industry, or at restaurants and hotels) with limited or no time off. They expressed a belief that they could not afford to miss a day of work if they experienced any side effects from the vaccine.

- Transportation barriers:
    - Many Latino populations work in canneries, restaurants, and hotels.
    - Many Low-income families do not have their own transportation to attend vaccination events.

Barriers to testing and vaccination in the Elderly Population

- Digital barriers:
    - Limited access to emails and digitally distributed information.
    - Lack of tools and skills to navigate digital scheduling platforms.
- Difficulty filling paperwork by themselves at vaccination clinics and testing events.

- Difficulty waiting in line for long periods of time when vaccination events were at the Clatsop County Fairground.

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Community Feedback

During our outreach and survey collection, we asked the community directly for feedback. Some direct quotes from our survey responses follow below.

Community recommendations for improving vaccinations:

- More sites for any transportation issues
- Having options evening for people working full time in office ours.
- Walk in options
- Outdoor pop-up testing sites
- The vaccine events have been really positive and easy to get to with expanded hours. No complaints about the vaccines.
- I think a good job was done giving folks many opportunities to be tested at many different locations and settings
- Have vaccination availability outside of normal office hours, during lunch hours, 5days a week, and on Saturday. There needs to be more accessible hours for varying industries.
- Better communication about times and locations.

Community recommendations for improving testing access:

- Better publicized
- Also, more sites for any transportation issues
- Doing in places more accessible for people who does not have a car and need a ride.
- Having options evening for people working full time in office ours.
- Interpreter full time on testing clinics.
- Outdoor pop-up testing sites
- Have expanded hours so that the testing is available during non-business hours.
- There was a time earlier on where it was hard to find a place (or test), this seems to have vastly improved
- Delivery services for COVID tests so that people remain isolated from the population. Transportation is an issue for people in our rural area, so there needs to be more than one avenue to reach populations.
- Better information about times testing is available, and locations. Don't do testing all the way at the Hazardous Waste Plant or Camp Rilea. That's too far for some people to travel when they think they have Covid symptoms or feel sick.

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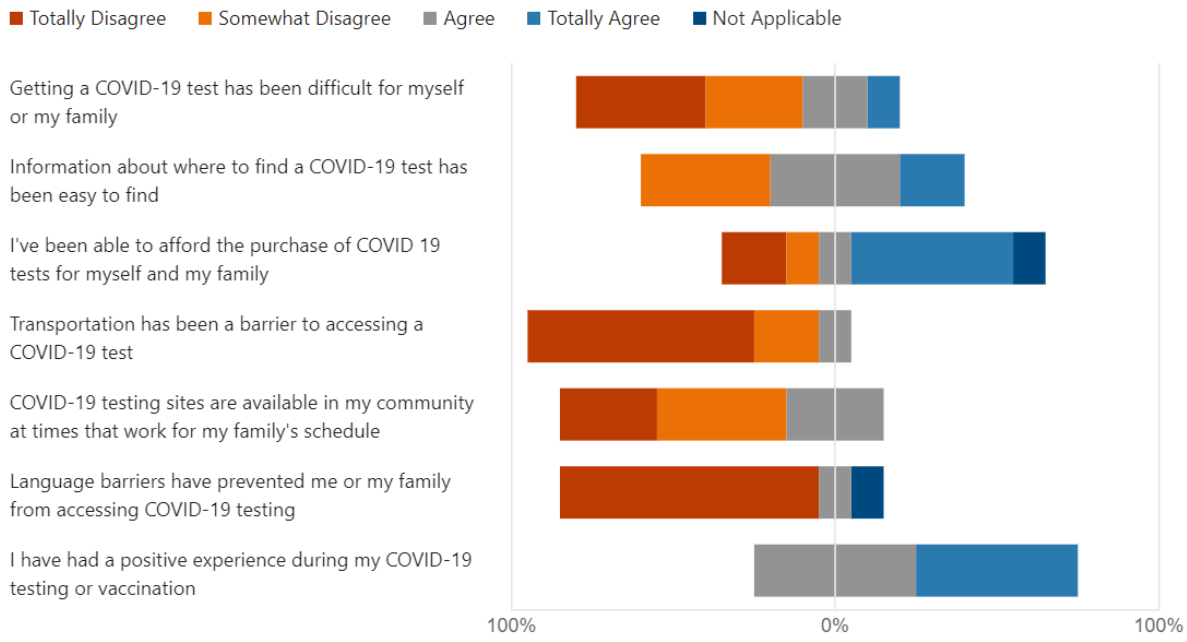
1. Please rate how strongly you agree or disagree with each of the statements related to your experience with COVID-19 testing.



Barriers to COVID-19 Testing in the Marshallese Population

Marshallese American Network for Interacting Together (MANIT)

Oregon, United States of America

September 2022

Overview

MANIT conducted interviews at vaccine events, conducted phone interviews, and designed a survey to determine some of the causes and consequences of COVID-19 testing hesitancy in the Marshallese population in Oregon.

The organization hosted a series of vaccine events in Union, Washington, and Marion Counties; MANIT solicited information from people who attended during these events. In some cases, people participated in the events to be with other community members or to watch well-known Marshallese performers; that is, they did not get vaccinated. This circumstance enabled MANIT to have a broader sampling of individuals who were receptive or unreceptive to getting tested.

MANIT was already committed to providing opportunities for community members to receive vaccinations through another funding source. However, MANIT used the opportunity to collect information about testing hesitancy in the Marshallese population. Phone interviews were conducted to reach individuals who participated in MANIT vaccine outreach programs but chose not to get vaccinated.

The Marshallese people often travel to visit family members in other states. Important social occasions include *kemems* (1st Birthday) and funerals. The Marshallese are concerned that their health status does not adversely impact their ability to honor these commitments.
MANIT has worked with the Oregon Health Authority (OHA) to develop translations of health materials into Marshallese. We posted announcements about our events (including articles and reports in newspapers in local communities in Oregon and the Marshall Islands). Approximately 600 people attended MANIT's in-person events, and about 1500 were reached through social media.

At the 1st Marshallese cultural event (Manit Day) hosted by MANIT in Monmouth, Oregon, on October 1, 2022, thousands of Marshallese from all over Oregon honored their culture. It was the first time since the 1970s that the Marshallese population held a significant event in Monmouth. COVID-19 vaccines were made available through the OHA Field Ops Team but could only get 35 people vaccinated. OHA did not offer COVID-19 testing at the event.

Data Collection

MANIT conducted 112 in-person interviews and 23 phone interviews. Thirty-seven people also went through MANIT's website (https://www.manit.org) and filled out the survey. Some of the MANIT staff were able to talk with some of the community members about testing and vaccination at the Manit Day event.

In general, people were willing to answer the questions. More complete answers were sometimes available by phone. Another thing that seemed to make a difference was whether the interviewers were the same sex as the interviewee or lived in the same community. Some interviewers (perhaps seen as more personable) typically got fuller responses. Women interviewers sometimes had better success getting answers.

Though they answered the questions, many respondents gave a generic response, laughed or shrugged, and changed the subject. Many people didn't want to go into detail; they resisted being asked the same question more than once.

Data Interpretations, Recommendations, and Conclusion

When at-home test kits became widely available, many barriers to testing disappeared. People could see on their terms how the test operated, administer them, and monitor the results. This did not make our findings irrelevant, but it did make asking questions more complex: people apparently felt that tests were now available; what people did with them was their own business. There was also tiredness about being questioned and a hunger for human contact of a more personal kind.

So– Yay! for the federal decision to send COVID tests to everyone. A critical threshold was crossed by putting the choice of testing in the hands of the public and removing the cost obstacle.

The efforts made by OHA to allow community partners to play a meaningful role in addressing the COVID pandemic have also been game-changer. A pathway for change has been established even when barriers are not crossed right away (i.e., hesitancy remains).

Feedback on Grant Participation

MANIT has had trouble understanding why a distinction between testing hesitancy and vaccine hesitancy is being made. Majority of the people surveyed raised concerns about the technology usage and time they had to spend to book an appointment to get tested at a local pharmacy. Sometimes it had to do with communication barriers, they had no one to help them arrange their appointment to get tested at a pharmacy or a clinic.

Conducting the interviews, while often frustrating, also had some significant and encouraging results. Speaking in very general terms, our hope at MANIT is to engage community members in such a way that they feel invited to share their experiences and consider how they, as individuals, can be better served by our nonprofit. Navigating American society is a major challenge for the Marshallese, even those born in this country or who have spent the majority of their life here. It's difficult for people to feel hopeful or openhearted about how their personal and family lives can improve. Yet, this place of discomfort, even shame, also holds a great deal of promise. If community members can see and acknowledge that current situations are unsatisfactory, they can begin to take the initiative to make constructive changes.

On the other hand, MANIT emphasizes culture and the existing strengths of the Marshallese people to enable a broader identification with American society. OHA should share the findings of this grant among community partners. We all need to be encouraged to see outside of our cultural boxes, to make a society that works for everyone.

Barriers to COVID-19 Testing Grant Report

SACOO
KHALID ALI
SEPTEMBER, 2022

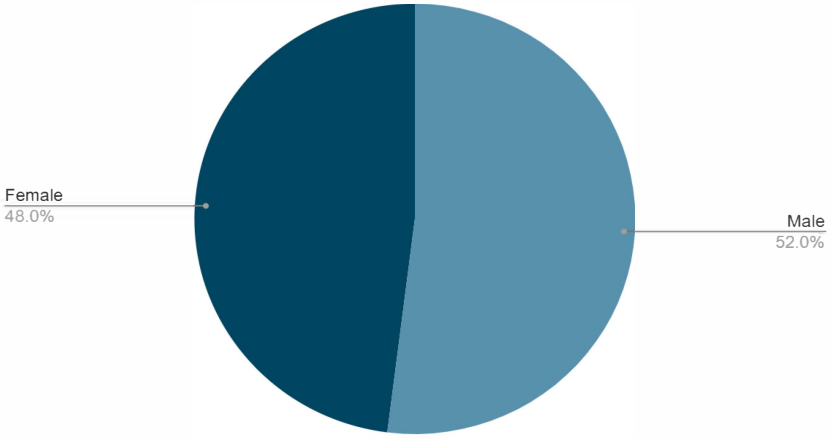
Overview

The COVID-19 pandemic has affected countless lives all around the world. With so many complex variants to a life-threatening virus, the vast population found itself in a standstill, desperate for answers. Here at SACOO, it has been our mission to inform and advocate for our community as best as possible to ensure their safety and spread awareness. A majority of our clients come from the East African region, mainly from Somalia. With the many uncertainties in the world, a lot of miscommunication and misinformation has affected the Somali community greatly. In partnership with OHA, the Testing Barriers grant allowed us to really deep dive and get a sense of what the members of our community have dealt with over the past two years. We invited 100 clients from the community to take a survey, and conversate, in efforts to gain insight and data about the COVID-19 vaccine, COVID-19 test, and any other struggles they have experienced since the pandemic.

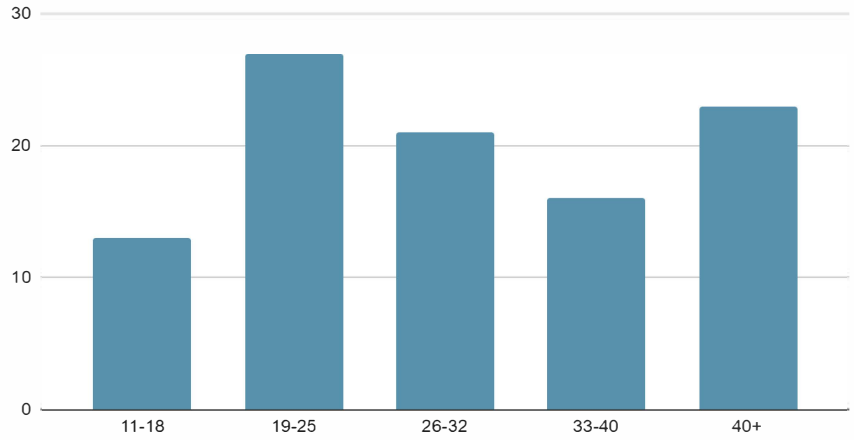
Data Collection

We conducted 60% of our surveys in person, and 40% over the phone. The goal was to diversify and have balanced responses from different genders, age groups, household sizes, vaccinated and non-vaccinated, etc. We received both qualitative & quantitative feedback from the surveys, which gave us different perspectives based on each person's living situation.

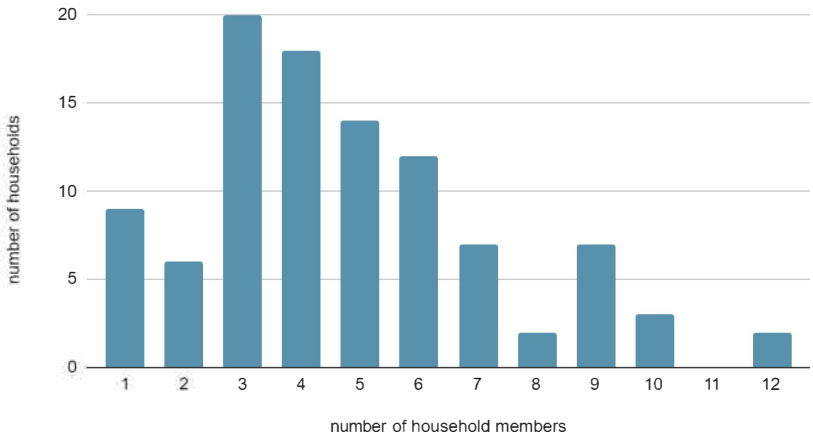
GENDER



AGE GROUPS

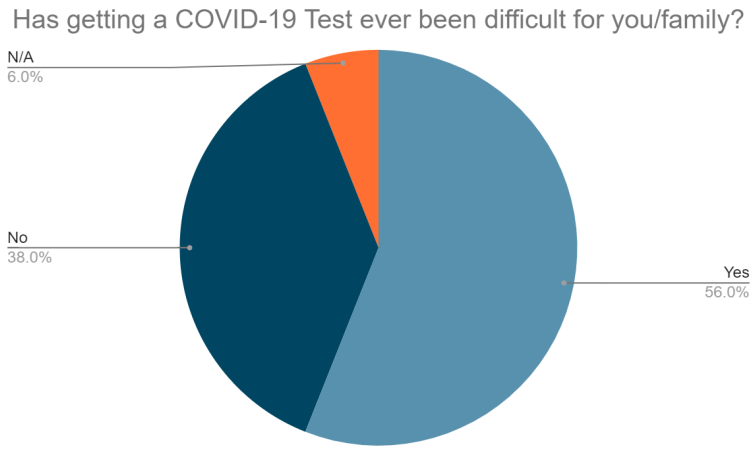


HOUSEHOLD SIZE



(All 100 participants were given the opportunity to answer the same questions and were encouraged to share and expand on any topics needed)

Question 1: Has getting a COVID-19 Test ever been difficult for you or your family?



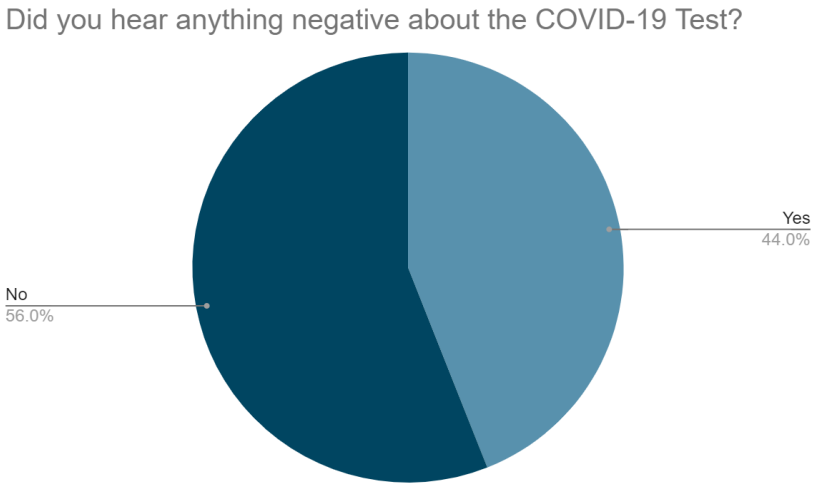
The majority of our clients were able to find a COVID-19 Test without any troubles. The main reason being that the COVID-19 Test has been much more accessible in recent months. At home kits have made it much more convenient for families, large or small, to receive results in the comfort of their own home. It's low of cost and can be accessed from many different local branches and pharmacies.

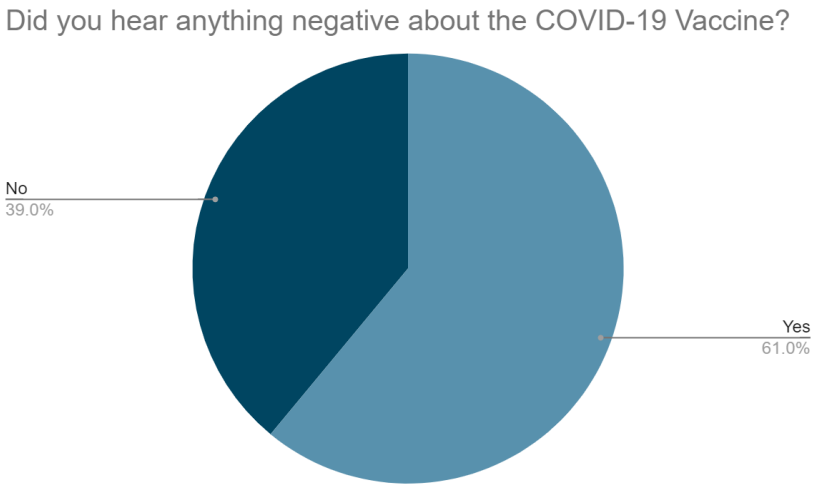
The data collected led us to expand on why 38% of our clients had difficulties finding a COVID-19 Test. An often occurring problem that the Somali community has faced is that there is a language barrier at testing locations (both a figurative and literal barriar). 34% of those clients have experienced troubles at testing locations due a language barrier. Having an application written in Somali or a translator on hand would alleviate the struggles of the testing process.

Another alarming concern is that 37% of all clients also reported that they had difficulties finding accessible testing locations during the pandemic. Wait times for appointments were extensive and testing locations were turning away asymptomatic persons. This caused many families to panic with the fear of the unknown. “I had to quarantine with my wife and 6 kids for 8 days before we were able to get a test for the whole family. Tests were expensive and we didn’t have a choice but to wait. We all tested positive and had to quarantine for an additional 14 days. It would have been nice to have a free test that wasn’t so hard to get.” said one of the clients.

Offering more free testing locations with more testing times would contribute to members of the community to get tested more regularly.
19% of our clients felt the cost for the COVID-19 test was too expensive. During a time where working situations were greatly unstable and uncertain, members of the Somali community experienced hardships with finding affordable tests. With the average household size of our clients being 4.7 people per household, we can infer that this would cause a barrier for most working class immigrants.

Questions 2 & 3: Did you hear anything negative about the COVID-19 Test/Vaccine





We presented these two questions to our clients, not expecting the kind of responses that we did. We found that the biggest barrier for members of the Somali Community not getting either tested or vaccinated was the fear and misconceptions that were spreading throughout the community. The changing of regulations and practices during the pandemic led the Somali Community to raise eyebrows and ask questions that they never had answered to this day. Being immigrants in this country, the members of the community tend to stick together. They share whatever information they have heard from the news, social media, and any other source between their close friends and family. This causes the spread of information and/or misinformation at an expedited rate.

44% of our clients have heard something negative regarding the COVID-19 Test. The major reason being that our clients felt that the test was inaccurate. This caused many families to be discouraged in the system and what ultimately played a part in them not getting tested regularly. Studies show that the rapid antigen test is 73% accurate for those with symptoms during the first week. Along with this statistic, lots of conspiracies have circulated within the community such as why there were so many false positives, as well as conspiracies about the COVID-19 Vaccine.

A staggering 61% of our clients have heard something negative about the COVID-19 Vaccine. This sparked conversation between us and our clients as to what exactly they have heard over this time. With the COVID-19 Vaccine so new to the world, there was an extreme level of uncertainty. A big concern of the members of the Somali Community was that there would be prolonging health complications for those who get vaccinated. Infertility, heart failure, blood clots, and seizures were all concerns mentioned by our

clients. Although the COVID-19 Vaccine has proven to help with COVID-19 symptoms, the small percentage of health complications is what has resonated within the community for the last two years.

Concluding Statement

We are fortunate enough to be in a position where we can give back to our clients and spread awareness on their behalf as well as the rest of the Somali Community. The majority of our Somali clients are those located in the North East Portland Metro Area. With the 100 clients we were able to encounter with, we feel we were able to embody our community and give them a voice through this grant. The concerns and obstacles our community has faced since the beginning of the pandemic is what we are striving to alleviate here at SACOO.

Feedback on Grant Participation

The Testing Barriers Grant has given us an opportunity to shed light on true barriers that the members of our community have been facing since the start of the pandemic. There was an evident disconnect between the Somali Community and the health leaders of the State and this grant allowed us to bridge that gap. Participating in this grant has been very fulfilling and insightful. The overwhelming responses and honesty was not something that we expected. We are honored to do our part to keep the members of the community and everyone else, safe and healthy.

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EIN (501) (c) (3): 46-1947669
Vision: Building a healthy, wealthy, and joyful community

Barriers Against Testing Report

TOGO COMMUNITY ORGANISATION OF OREGON

NOVEMBER 2022

TOGO COMMUNITY ORGANIZATION OF OREGON

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Overview

Our organization Togo Community Organization of Oregon (TOGOCORE) has been dedicating a lot of time to addressing various concerns related to COVID-19 in our community since the beginning of the pandemic. We serve about 90 families across the African diaspora, and the people that we focused most on were adults and young adults in the west African community. We wanted to address the topic with people who were able to actively make decisions for themselves and for their families, so we reached out to immigrants and refugees, adults, young adults, and heads of households in respective families. The outreach was done by employees/community leaders of TogoCore who are better equipped to connect with the targeted population because of our shared background and language.

Data Collection

When thinking about ways to have the conversation about barriers to testing with our community, we utilized zoom meetings, one-on-one calls, text messages, and polls. We previously found that our community responded well to regular online check-ins via zoom, so we kept that method of communication for this project.

Questions Asked/Polled

- What prevents you from getting tested for Covid-19?
- Did you have trouble finding locations to get tested?
- What fear prevented you?
- Out of obstacles, was transportation one of them

Out of the 90 families reached, we got answers from 16% of the families through zoom meetings, one-on-one calls, text messages, and polls.

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Findings

We found that most people in our community do not have barriers to testing. Some people with insurance were limited to testing a few times in a time frame, and others without insurance often didn't know they could get tested for free until much later.

Another problem that came up was that at the peak of COVID-19, testing kits were running out at some testing sites. Additionally, some people didn't want to have their info sent out to the county if they tested positive, so they refrained from getting tested. At the same time, there was a lack of information being shared between testing sites and healthcare providers.

When at-home test kits started coming through, there was a limited amount per household, and some people felt uncomfortable doing the home kit themselves. Cultural and religious background also prevented some people from going to get tested.

Suggestions

At this point most of the barriers identified have been somehow resolved, however there could be better communication between counties about patients updated testing data.

Conclusion

In general, most community members didn't have problems getting tested during the pandemic. However, the few barriers to testing that we discovered within our community were difficult to rectify from our position. They were issues stemming from a lack of order on a local county level, as well as the individual members' lack of confidence in their ability to administer self-tests.

Appendix H. Example Questions

1. Has getting a COVID-19 test been difficult for you and/or your family? Y/N/NA

    a. If yes, what were the things that made getting a COVID-19 test difficult? (open text)

2. Did you/your family experience any of the following issues with getting a COVID-19 test? (Check All That Apply).

- Didn't know where to go to get a test
- Tests not offered for asymptomatic persons
- Tests were too expensive
- Tests required insurance coverage
- Testing site only tested established patients
- Language barrier
- Could not get to the testing site
- Lack of accessible testing locations
- Time barriers/constraints in my schedule made it difficult to get tested
- I could not find any testing times available
- Other (Write in)

3. Did challenges to getting a COVID-19 test cause any problems for you or your family? Y/N/NA

    a. If yes, what problems did you experience due to not being able to get a COVID-19 test? (open text)

4. Did you hear anything negative about COVID-19 testing? Y/N

    a. If yes, what did hear? (open text)

5. Did you hear anything negative about COVID-19 vaccines? Y/N

    a. If yes, what did you hear? (open text)

6. How could COVID-19 testing be improved? (open text)

7. How could COVID-19 vaccination be improved? (open text)