COVID-19 Vaccination Program for Migrant and Refugee Women in Western Australia: Community-Led Approach and Decolonising Practice Reflections

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ABSTRACT:

The COVID-19 pandemic disproportionately impacted culturally and racially marginalised (CARM) migrants in Australia, with communities having varying levels of accurate knowledge about COVID-19 vaccines. At the height of the pandemic, public health programs that prioritised colonial knowledge and practices resulted in negative social, economic, and health outcomes for CARM communities. To support access to COVID-19 vaccinations and equity in delivery, therefore, it is critical that awareness-raising programs are tailored to meet all communities' intersecting needs. In this paper, we share our reflections on a community-led COVID-19 vaccination awareness program designed specifically for CARM migrant women in Perth, Western Australia. The program was led by CARM migrant women who delivered five public information sessions for women in the Pakistani, Iraqi, Chin, and Indonesian communities. This paper offers an overview of the program and critical reflections on the challenges involved in community-led programs that are underpinned by a commitment to decolonisation.

KEYWORDS: community-led interventions; COVID-19 vaccination messaging; culturally and racially marginalised communities; intersectionality; decolonisation

Introduction

Amongst growing calls to decolonise the fields of public and global health, the Coronavirus Disease 2019 (COVID-19) pandemic exposed asymmetries of power (Abimbola et al., 2021), particularly in its disproportionate impact on Black, Indigenous, and People of Colour (e.g., Balakrishan, 2021; Kim & Bostwick, 2020; Lazarus et al., 2020). In Australia, where the current study is based, culturally and racially marginalised (CARM)[1] communities, including refugees and asylum seekers, faced a heightened burden on their physical and emotional well-being, economic stability, and social lives due to the pandemic (Smith & Judd, 2020; Walsh, Due & Ziersch, 2022). Public health programs that centred Euro-Western ways of 'knowing and doing' shaped the language and response to the pandemic which compounded negative outcomes for CARM communities. For example, communication about avoiding community outbreaks was hindered in Australia because of monolingual assumptions about communicating with CARM communities, leading to increased transmission in high-density CARM population areas (Jakubowicz, 2021; Seale, Mahimbo, Harris-Roxas, & Chaves, 2021; Wild et al., 2021). Such outbreaks highlight the complex interplay between social determinants of health and communicable diseases and the need for community-centred engagement. They also highlight how structures of power created by colonisation, including racism and xenophobia, cause inequitable health outcomes for marginalised communities (Narasimhan & Chandanabhumma, 2021).

[1] We intentionally avoid using the term 'culturally and linguistically diverse' (CALD) and opt for 'culturally and racially marginalised' (CARM) to emphasise the impact of race, racism, and discrimination based on religion or culture on marginalised communities within a dominant white culture. Addressing this requires challenging discourses that perpetuate inequality and colonialism in Australia (Abimbola et al., 2021).

In the context of vaccination acceptance and uptake, community-centred engagement with CARM communities is crucial for equitable access as it empowers individuals to make informed decisions. However, lower levels of literacy among CARM communities have been shown to be associated with increased vaccine hesitancy (Dodd, Cvejic, Bonner, Pickles, & McCaffery, 2021; Seale et al., 2021). Further, misconceptions about COVID-19 vaccines have been found to be more common in groups with lower levels of health and English literacy (McCaffery et al., 2020; Miles, Cassidy, & Bennet, 2021). To counter this, some experts recommend decentralising vaccine messages within local cultural and religious networks, using audio-visual formats for illiterate individuals, and relying on trusted community sources for information (Healy et al., 2022; Miles et al., 2021).

While acknowledging the importance of literacy and language in vaccination awareness messaging, the intersecting influence of gender and cultural identity on vaccine acceptance and uptake remains understudied. Some research has found that women in the US are more likely to uptake the COVID vaccination than men (e.g., Lazarus et al., 2020) and within Black and Latinx communities, women have been recorded a lower acceptance rate than men (e.g., Balasuriya et al, 2021). This pattern has also been found in Australia (e.g., Ayre, et al., 2021; Healey et al., 2022).

This emerging literature highlights the importance of COVID-19 vaccination messaging addressing the intersecting needs of communities, including literacy, language, cultural, and gender considerations. This underscores the need to consider intersectionality in public health, a concept coined by Kimberlé Crenshaw (1989), which acknowledges that individuals are influenced by multiple factors beyond just gender or race. In terms of decolonisation, intersectionality is critical in identifying how colonial structures that preserve power,

including racism, sexism and capitalism, intersect to produce poorer health and well-being outcomes for marginalised communities.

This paper presents a critical reflection on a community-led and delivered COVID-19 vaccination awareness program for women from four CARM communities in Boorloo[2], Western Australia and the extent to which practices underpinning the program can be informed by decolonising principles and processes. This paper is thus situated within emerging research on COVID-19's impact on CARM community health, gender perspectives in migration, public health scholarship, and decolonisation.

Community-led approach and decolonial principles and process

During the COVID-19 pandemic, public health programs that centred Euro-Western knowledge and practices led to adverse social, economic, and health consequences for marginalised communities (Jakubowicz, 2021; Seale et al., 2021; Wild et al., 2021). In this regard, vaccine awareness programs that not only address the intersecting needs of CARM communities but that centre the knowledge of CARM communities from design to implementation, are critical (Burgess et al., 2021). One way that this may occur is through programs that are community-based and led by communities which can help challenge the power imbalance between the practitioner/researcher and community.

Community-led public health messaging in marginalised communities has been found to promote equitable outcomes in CARM communities including higher COVID-19 vaccine uptake (Long et al., 2021), reduced tuberculosis transmission (Lee, Kim, & Phillips, 2021), increased mental health awareness (McMorrow, Hancher-Rauch, Ohmit, & Roberson, 2021),

[2] Boorloo is Noongar name for Perth, Western Australia. Noongar means 'a person of the south-west of Western Australia,' or the name for the 'original inhabitants of the south-west of Western Australia'

and improved oral health literacy (Dimitropoulos et al., 2020). This approach recognises, prioritises, and celebrates community members' expertise while encouraging those without lived experience to leverage their privileges, skills, and resources to support this objective.

While community-led programs can disrupt power imbalances, the principles and processes of decolonisation are not widely applied in public health, and there is ongoing debate about their implementation (Narasimhan & Chandanabhumma, 2021). For example, some scholars argue that decolonising global health requires fighting 'against ingrained systems of dominance and power in the work to improve the health of populations' (Khan et al., 2021, p 1). Others argue that decolonisation requires a complete systemic overhaul, including the removal of the coloniser and dismantling of power-preserving colonial structures, including racism, sexism and capitalism (Chaudhuri, Mkumba, Raveendran & Smith, 2021). Through the lens of these diverse decolonial perspectives, we reflect on the possibilities (and limits) of decolonial practice in our community-led COVID-19 vaccine awareness program.

Positionality and Place

Community-led public health interventions informed by a commitment to decolonisation require continuous reflection about questions of place, including how colonisation in Boorloo, Western Australia continues to lead to negative health outcomes for marginalised communities, including First Nations peoples. It also requires questions of positionality. These include, who is undertaking the intervention and by what right? Whose agenda is driving the development of the intervention? How might this shape and impact the intervention, including how it is designed and undertaken, who participates, what is made visible, and what may be rendered absent?

Authors Sobia, Lana and Anam are women seeking asylum who have been living in the Australian community on temporary visas for up to 10 years and are members of the community-led incorporated network Professional Migrant Women's Network (PMWN). They are all professionally trained in their home countries and have faced enormous challenges in accessing professionally relevant employment in Australia (see Hartley, Shah, Barkat, Abdullah, & Lumbus, 2022). Sobia formed the PMWN in 2020 in response to these challenges with the aim of establishing equal work opportunities for CARM migrant women.

Sobia is originally from Pakistan where she worked as a lawyer. She has been in Australia since 2012 and has recently commenced her law degree which will enable her overseas qualifications to be recognised in Australia. With first author Lisa, Sobia led the development of the funding application for the current project. She also cultivated a working relationship with the Australian Islamic Medical Association (AIMA), which offered guidance on program design and mentored the PMWN women delivering the program to their communities.

Lana, an Iraqi general physician and specialist radiologist studying at Curtin University for a Master of Public Health degree, has been in Australia for four years and is currently undergoing the process of gaining recognition for her general practice qualifications. Lana delivered sessions in Arabic for the Iraqi community.

Anam, a trained pharmacist from Pakistan, has been in Australia for 9 years and conducted the sessions with the Pakistani community in Urdu. Her pharmacy qualifications have not been formally recognised in Australia.

All three women were critical gatekeepers of culturally relevant knowledge within a range of CARM communities and co-developed and delivered the program. There were leaders of the

Chin and Malaysian communities who were critical gatekeepers – however, for the purposes of this paper, reflections are only given from Sobia, Lana and Aman.

Lisa is a white Australian woman who holds a permanent academic position at an Australian university. She has worked with Sobia, Lana and Anam as both a researcher and advocate for a number of years. As an academic in the dominant Australian culture, she had access to Euro-Western knowledge systems and institutional information, which informed her work in grant applications, paper writing, and program evaluation tool development. Lisa, therefore, could be described as more of a facilitator and a 'partner in the process of knowledge production, rather than the chief director of the engagement' (Wood, 2017 p 1).

A reflection on ethics

This paper offers a critique and reflection of the program, from the perspectives of the authors. The reflections do not draw on data obtained from the evaluation surveys from the women who participated in the information sessions. This is important to highlight because a university human ethics clearance was not obtained to use the data from these surveys.

This was the case for a number of reasons. There is growing acceptance and recognition that current ethical protocols within universities that are underpinned by colonial systems of knowledge are not appropriate to cater for participatory, community-led initiatives (Wood, 2017). The imposition of ethical protocols, including the use of information and consent forms and an explanation of how data will be used, can often reinforce inequalities and lead to a reluctance of community members to participate (Wood, 2017).

Given the current project involved engaging known 'hard-to-reach' communities (Perrins, Ferdous, Hay, Harreveld, & Reid-Searl, 2021), after consultation with over 10 potential

participants from the four community groups, we made the collective decision to not apply for university ethical approval to use the 'data' from the surveys given to participants. The vast majority of these women thought that a formal ethics process would discourage participation.

Despite not having a formal ethics review, we prioritised ethical practice and reflexivity in the development and delivery of the program. This involved a discussion among the five community facilitators, the AIMA General Practitioner (GP), and Lisa about our assumptions, motivations, identities, and potential influence on the project. We also considered barriers to women's participation in the program. For the Chin community, for example, it was identified many Chin women did not feel comfortable participating without men from their community present. We therefore ran that session with men present. Other ethical practices included briefing participants about the importance of confidentiality, and Lisa's non-attendance at information sessions to promote cultural safety and community.

Overview of the program

There were five COVID-19 vaccination information sessions delivered between December 2021 and January 2022, reaching a total of 107 women from the Iraqi, Pakistani, Indonesian and Chin communities in Perth. Four sessions were delivered in person in community halls located nearby where respective communities predominately reside to ensure ease of access, and one session was delivered online due to a lockdown occurring during that time. As the program manager, Sobia was present at each of the sessions. A female Australian registered GP from AIMA was also present at each of the sessions to answer any questions asked by participants. The program was funded by the Federation of Ethnic Communities Council of

Australia (FECCA), a peak national body that receives funding from the Federal Government.

Prior to the start of the program, team members worked together to develop and pre-and-post session survey. The survey content was relatively prescriptive due to the funder requiring specific questions around knowledge about COVID-19 vaccinations to be included. However, all team members had the opportunity to include any further questions they thought would be relevant and important to include.

Although there were slight differences in the structure of how each session was delivered, each session included the PMWN facilitator delivering a presentation in the community language which included information about COVID-19 as a virus, COVID-19 vaccinations including how they work, the risks and benefits, where to access them, as well as the safety of the vaccine for pregnant and breastfeeding women. Each of the PMWN facilitators was respected and connected with members of their communities. Accompanying the presentation was a translated PowerPoint slide. This part of the session lasted for approximately 30 minutes. The remainder of the session allowed time for questions and answers, although as discussed below, there were differences between community groups in terms of how many engaged women were in asking questions in the formal session.

After the session, a WhatsApp group was created for each session group for them to ask additional questions they might have. These groups were monitored by the respective PMWN member who delivered the session, Sobia, and a representative from AIMA.

Reflections on the challenges and successes of the program

Engaging community members

Lana, Sobia, Aman, and two other facilitators, despite strong community connections, encountered challenges engaging women community members. There was general resistance to attending a COVID-19 vaccination information session, as some women believed they already had sufficient information on the topic.

Lana reached out to long-time Iraqi friends in Australia, asking for referrals to the information session for Iraqi women. She explained the session's goals and sought their support. Flyers promoting free henna tattoos, skin pampering tutorials, and refreshments were distributed at community gathering places. Similar strategies were used in the Indonesian and Pakistani communities. They appeared to be effective, with all sessions being well attended. These engagement strategies were time-consuming, involving multiple individual follow-ups via mobile phone to secure attendance. This aligns with prior research emphasizing the importance of culturally relevant activities as incentives for participation and for creating culturally and gender-safe spaces (Long et al., 2021).

Key hesitancies and misconceptions among women participants

After women participants committed to attending, Lana, Sobia, and Aman observed differences in their confidence regarding the vaccine's safety and efficacy. Challenges emerged in accessing accurate vaccine information, especially on social media like Facebook. This was a recurring topic in the sessions, and participants were given reliable Australian government health websites, including translated versions, as trusted sources.

Lana, Sobia, and Aman identified gender-specific concerns discussed in all sessions, highlighting that these issues might not have been effectively addressed in the presence of men. Concerns included vaccine impacts on fertility, pregnancy, menstrual cycles,

breastfeeding, and children's vaccinations. This is in contrast to the Chin community session where such issues were not openly discussed given men were present.

In-language delivery

Each session was conducted in the community's language, including translated PowerPoint slides. The content was a collaborative effort involving PMWN facilitators, guidance from the AIMA representative, and input from the funder, FECCA. Sobia, Lana, and Aman emphasized that delivering information in the participants' language enhanced comprehension and built trust with the facilitators. It was challenging to determine whether participants engaged more with the PowerPoint content, the presenter, or both. Nevertheless, this underscores prior research indicating that written information in language alone may not suffice, and audio-visual mediums could be beneficial (Healy et al., 2022; Miles et al., 2021).

Creating culturally and gender-safe spaces

As discussed, there was a need to encourage attendance by embedding culturally and gender-relevant incentives in the program, including henna tattooing. Lana felt that because the program was community-led and delivered, it helped establish trust and connection with community members, creating a safe space by which participants could know the deliverer and the project goals. It was also seen as important to engage with the participants regularly in the lead-up to and after the delivery of the program. Lana reflects that this was important not only for building trust with community members but also so that a culturally and gender-safe space for participants could be created. Decolonising public health involves incorporating local cultural knowledge. While the bulk of the program's COVID-19 vaccination information was required to come from Federal Government-endorsed sites, culturally specific examples were provided to clarify common vaccine-related questions.

Lisa, as a white woman, did not attend the sessions with the motive to increase cultural safety.

Post-intervention engagement

After each session, WhatsApp groups were established for participants to ask questions, moderated by the delivering PMWN member, Sobia, and an AIMA representative. Usage varied across communities, with notable participation from the Chin community. However, it's important to note that this method assumes a certain level of literacy, excluding illiterate women. Future programs should consider alternatives, such as follow-up phone calls, to include all participants.

Dissemination of program findings

Funding mandated writing an evaluation report based on the survey findings. The draft report was distributed to participants for feedback and input via the WhatsApp groups. Only two participants offered feedback which was likely due to a range of reasons including time restraints and the report was written in English. We had no funds to translate the report which is a significant limitation, particularly from a decolonial perspective.

In terms of the current paper, the five community facilitators who delivered the program and Lisa deliberated on the merits of producing a journal article reflecting on the program. Lisa, employed at a university with access to Euro-Western knowledge systems, spoke to the colonial underpinnings of academic writing and publishing and promoted a discussion on whether power structures could be disrupted in this process. A clear limitation in doing so was there was no funding to compensate for time spent writing and as a consequence, only Sobia, Lana and Aman ended up co-writing this journal article.

Despite this clear limitation and the requirement to write in English, efforts were made to try and disrupt the power imbalance between Lisa and Sobia, Lana, and Aman through Kaur's (2022) 'reflective pedagogy,' an iterative co-writing process. This involved initial brainstorming sessions, informal training on academic writing, and individual writing by Sobia, Lana, and Aman. Peer feedback sessions helped refine shared themes and differences. Lisa collated and structured these reflections iteratively, seeking input. We also deliberated on the journal outlet, concluding that an open-access journal would be critical so the knowledge could be accessible beyond universities.

Conclusion and Implications for Future Practice

There are a number of key lessons learned from this program that may be useful for practitioners and researchers seeking to engage in projects and/or research that is community-led and underpinned by a commitment to decolonisation.

Building trust and relationships between project team members and the community were crucial for the success of our community-led program. This is especially true when engaging CARM women, who are often positioned as ‘hard to reach’ due to their intersecting disadvantages (Perrins et al., 2021). Sobia, Lana, and Aman stressed the importance of community members leading and delivering the program to build the trust needed for participant engagement. Trust and transparency among team members were established from the project's outset through open dialogue and reflection on how each member's intersecting identities and positions influence their role in the program, including the dissemination of project outcomes.

Our program underscores the need for culturally and gender-safe public health spaces to enable communities facing intersectional marginalisation to participate and engage. Aligned with Khan et al.'s (2021) perspective on decolonising global health which requires dominant colonial structures to be challenged, by increasing COVID-19 vaccination literacy our program worked to disrupt structures that contribute to poorer health outcomes for CARM women in Australia (Caperchione, Kolt, Tennent, & Mummery, 2011; Hughson et al., 2017), including systemic racism in Australia's healthcare systems (Bastos, Harnois, & Paradies, 2018).

Cultural and gender safety was promoted by centring local cultural knowledge in the information session (e.g., using cultural examples), Lisa as a white woman not attending the sessions, delivering information in-language, and offering culturally specific incentives like henna tattoos. While centring local cultural knowledge is crucial in decolonial practice (Pant et al., 2022), our program was constrained by the funder's requirement to use Australian Government sources for COVID-19 vaccination information. The impact of dominant white, attending programs should also be considered seriously.

Our project also underscores the need for project team members to embrace an ethics of care from the project's inception, which includes addressing barriers that may hinder community involvement. This ethics of care should also involve open discussions on disrupting power imbalances through inclusive program delivery and knowledge production. In our case, this discussion was ongoing and notably time-consuming, particularly during this article's writing phase, where power asymmetries between Sobia, Lana, Aman, and Lisa – as a member and benefiter of colonial structures in Australia - became more pronounced.

In writing this article, we learned the importance of respecting all authors as knowledge producers. However, as noted by Seye Abimbola (2019), academic publishing is a colonial project that enforces boundaries on acceptable knowledge, resulting in 'epistemic privilege' (Khan, 2022). This privilege often dictates that the lead author, if not all authors, must have a university affiliation. However, through, iterative co-writing processes like those discussed in this paper, some of these power imbalances can be disrupted. However, because the community facilitator's time for writing this article was uncompensated, it prevented two members from contributing their time to its development. The failure to have funding for this writing process reinforced structures of colonial power, in particular capitalism, which decolonisation aims to dismantle (Chaudhuri et al., 2021).

As the use of community-led and participatory methodologies grows across various disciplines, there is the risk that they are employed without considering the necessary time, budget and other resources to engage with communities meaningfully and ethically. These are critical considerations for researchers and practitioners wanting to engage in work that elevates the expertise of community members in ways that be formally acknowledged, prioritised, and celebrated. Such considerations are even more critical for those committed to decolonising, in its varying forms.

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