POLICY BRIEF

COVID-19 Vaccine Hesitancy and Acceptability in Multiethnic Communities: Implications for Public Health Policy, Messaging, and Community Outreach

February 2021

Savanna L Carson PhD, Juan Barron, Alejandra Casillas MD MSHS, Yelba Castellon-Lopez MD MS, Nanibaa' A Garrison PhD, Lisa Mansfield PhD MSN RN, Keith C Norris MD PhD, Raphael Landovitz MD, D'Ann Morris MPA, Ejiro Ntekume MPH, Stefanie D Vassar MS, Arleen F Brown MD PhD

SUMMARY – Combating Coronavirus Disease 2019 (COVID-19) vaccine hesitancy is critical to reducing health disparities. We conducted an exploratory study on vaccine hesitancy in multiethnic Los Angeles communities to provide insights for public health vaccine policy, messaging, and outreach.

"For people who have been let down by the system in the past, I would hope that there is a little bit of compassion, understanding and patience, and not treating someone as less than because they are impacted by situations in the past."

-AMERICAN INDIAN PARTICIPANT

"What phase are the undocumented in?"

-LATINO PARTICIPANT

GAP – The COVID-19 pandemic has disproportionately affected racial/ethnic minority communities. These impacts are magnified by pre-existing disparities in comorbidities and the persistent inequitable distribution of resources related to the social determinants of health. Understanding the factors influencing vaccine uptake is critical to narrowing COVID-19 related disparities in racial/ethnic minority communities.

RESPONSE – We used qualitative, community-engaged methods to examine barriers and facilitators for vaccine acceptability and factors contributing to vaccine hesitancy in multiethnic groups at high risk for COVID-19 infection and morbidity in Los Angeles County.

RESULTS – From November 2020 to January 2021, we conducted 13 virtual focus groups on COVID-19 vaccine hesitancy and acceptability based on five racial/ethnic categories. These included 70 participants who self-identified as American Indian, African American, Filipino, Latino, or Pacific Islander. Methods and demographics are available on page 3. Thematic topics and concerns raised were:

***Vaccine Knowledge*:** Participants wanted to be informed about vaccine clinical trial outcomes (i.e., safety, efficacy, side effects), racial/ethnic representation in clinical trials, and comparisons of the approved vaccines. Outcomes pertinent to sub-populations (i.e., race/ethnicity, age, chronic disease, disability) were requested to understand if the vaccine is deemed safe for the participants and their communities. Participants asked questions about the vaccine's development process and the influence of politicization, and pharmaceutical companies' interests, motives, and profits.

KEY TAKEAWAYS

- Invest in community-based engagement from trusted partners and entities
- Promote sensitivity and empathy; validate and listen to concerns leading to hesitancy
- Provide timely and accessible information from credible sources
- Increase data transparency for sub-populations
- Reduce structural barriers in vaccine access
- Promote altruistic and culturally congruent concepts in vaccine messaging

***Barriers to Vaccination*:** Socioeconomic, structural, physical, and systematic barriers to vaccination identified include:

- Lack of understanding of eligibility (costs, insurance status, legal status)
- Accessibility concerns (language barriers, disabled persons or individuals with chronic health conditions, technology limitations)
- Accommodations (transportation, restrooms, child/elder care)
- Employment barriers (including time off for vaccination and sick leave for vaccine side effects)
- References to previous historical and contemporary unethical research studies, mistreatment, or discrimination

***Desire for sensitive, respectful, and equitable treatment*:** Participants requested acknowledgment, empathy, and understanding of current and historical events leading to communities' mistrust. Requests were made for additional time and reasonable accommodation for informed decision-making (not rushing vaccination or mandatory

"The U.S. has never been 100% pro-Black, so why are we getting preferential treatment for a vaccine now?"

-BLACK PARTICIPANT

vaccination). Participants also asked for sensitivity to those for whom this pandemic has been devastating, physically, psychologically, and emotionally. Participants expressed fears of differential treatment, inequity, mistreatment, or mismanagement in vaccine allocation or getting "*the short end of the stick*."

***Outreach considerations*:** Participants expressed a need for COVID-19 vaccine information from various trusted and experienced sources and hearing from vaccinated leaders. Participants proposed localized, community-based outreach and vaccination access. Financial or non-financial incentives were seen as a potential motivator for receiving a COVID-19 vaccine.

"The other concern is the long-term effects and not sampling enough Pacific Islanders, women, people of color, those with health disparities ...the timeframe of which a vaccine is normally vetted, this is so quick, it's pretty scary. That's the word on I'm getting on the Coconut Wireless vine."

-PACIFIC ISLANDER PARTICIPANT

PUBLIC HEALTH POLICY & RECOMMENDATIONS

Invest in community-engaged outreach by trusted community leaders and organizations

Known, respected, and trusted community leaders and entities are the preferred source of influence and information around COVID-19 vaccines. Community leaders or trusted entities may include community clinics or primary care providers, community health workers, faith-based organizations, cultural leaders, schools, and more.

Participatory discussions or "*safe spaces*" with medical professionals to ask questions and address concerns and share COVID-19 information (e.g., community workshops, town halls, and hotlines). Varied pathways for trusted communications should be enacted (internet-alternative methods, mailers, phone, etc.), and tell-one-teach-one campaigns should be implemented.

Respondents endorsed the empowerment of micro-engagement within multigenerational families, neighborhoods, or personal networks.

Acknowledge historical and contemporary medical mistrust and promote sensitivity and empathy in outreach

Medical and public health professionals should display heightened awareness, compassion, and understanding for populations portraying vaccine indecision. Current and historical events or personal traumas have led to medical and governmental mistrust. Communication should not trivialize the pandemic or place blame on communities hesitant to receive the vaccine when delivering information. Instead, sources should portray sensitivity towards those who have faced hardships and loss during the pandemic and acknowledge how historical medical mistrust and mistreatment has played in the concerns many communities are voicing. Acknowledge the complicity of the medical profession in systemic racism.

Provide timely and accessible information from credible sources to actively combat misinformation, provide context, and increase trustworthiness in vaccines

Provide accurate, emergent updates to combat misinformation, rumors, and myths, especially as news about the COVID-19 pandemic and vaccine rapidly evolves through social media, news, and current events in local communities. Provide information in a community-friendly and accessible format, including infographics, simplified and appropriate language translations/dialects, and culturally relevant information. Information should be delivered through multiple sources (TV, radio, social media, local community spaces) and should be ongoing to allow for bidirectional communication. Communication should be transparent, emphasizing what is known and unknown, and validating the importance of asking questions and addressing concerns.

SHARE TRUST ORGANIZE PARTNER STOP COVID-19 CA THE COVID-19 CALIFORNIA ALLIANCE
UCLA CTS
NIH CEAL Community Engagement Alliance

"We're doing it for the other people in our family that aren't as healthy as us or who are more at-risk, especially with diabetes and high blood pressure, and kind of the normal stuff that especially older Filipinos have, we just can't be too careful."

-FILIPINO PARTICIPANT

Highlight successes and increase data transparency to increase relatability and build trust

Show research outcomes directly relating to individuals or communities facing particular vulnerabilities who may question vaccine acceptability. Collect and provide data in clinical trial participation, infection, and vaccination rates by race/ethnicity, age, chronic disease status, and disability.[1] Acknowledge what data is unavailable. Data should be accessible and tailored to populations of all educational backgrounds.

Support and finance resources for reducing structural barriers to vaccination

Strategies to increase accessibility and reduce barriers to vaccination:

- Increase accessibility (translation, internet-alternative outreach, transportation support)
- Increase local availability in vaccine allocation: mobile vaccination sites, home visits, community-based vaccination sites (schools, churches, and local trusted organizations)
- Build upon trusted community networks and organizations that may facilitate communication, outreach, and vaccination logistics for vulnerable individuals

Promote altruistic, communal, and culturally congruent reasons in vaccine messaging

Communal communication should be used, including *"for the safety of family, friends, communities and loved ones,"* and tailored to motives relevant to cultural beliefs and practices. Additional motivating communications include reducing anxiety, returning to school, hope for improved employment opportunities or workplace safety, and resuming cultural and social norms.

Participant Demographics

- **24% American Indian** (3 groups, n=17 participants)
- **24% African-American** (3 groups, n=17 participants)
- **16% Filipino** (2 groups, n=11 participants)
- **21% Latino** (3 groups, n=15 participants)
- **14% Pacific Islander** (2 groups, n=10 participants)
- **46% 50+ years of age**
- **45% Essential workers**
- **56% reside within low-income zip codes** (Median household income ≤$40K U.S. Census 2010)
- **34% responded "unlikely" in willingness to obtain the vaccine**

[1]Example of a community-facing vaccine guide with clinical trial participation, effectiveness, and outcomes by race/ethnicity and chronic disease, January 2020, STOP COVID CA, UCLA https://www.stopcovid-19ca.org/resources Direct link: https://drive.google.com/file/d/1GNhlKp9RZUvSx2BAhJZvpxCzdKaTwzpw/view

METHODS: A semi-structured interview guide was developed based on vaccine hesitancy literature. Trained facilitators and community representatives who self-identified with each race or ethnicity led the focus groups. Focus groups were two hours in length and participants were compensated for participation in this study. Participants were recruited through snowball sampling through community partners and community networks. Transcripts and field notes were analyzed to develop prominent themes shared across groups and specific to each community.

LIMITATIONS: The results from this study are preliminary. Generalizability of findings may not be applicable to other vulnerable groups or geographic areas. The timing of this study (before and after initial public release of the COVID-19 vaccines) may have influenced participants' knowledge and awareness about the vaccines, however these finding provide real-time insight into community concerns and distillation of information (or lack thereof) and questions.

FUNDING: This research is supported by CEAL/STOP COVID-19 CA Grant Number 21-312-0217571-66106L, NIH National Center for Advancing Translational Science (NCATS) grant UL1TR001881 (UCLA), and UCLA OCRC 20-51.

SHARE TRUST ORGANIZE PARTNER STOP COVID-19 CA THE COVID-19 CALIFORNIA ALLIANCE

UCLA CTS

NIH CEAL Community Engagement Alliance