Dear Chairman Mendelson, Dear Council members,

Thank you for the opportunity to testify on the important topic of vaccine hesitancy and school reopening. I am an infectious disease epidemiologist at Harvard TH Chan School of Public Health. I will start by reviewing vaccine hesitancy and its roots, then offer three principle approaches to address it, followed by three recommendations considering the specific context of school reopening in the District of Columbia.

Vaccine hesitancy is a multifaceted-phenomenon that is associated with fears and doubts on the risk-benefit of vaccines in terms of effectiveness and safety concerns. This is in particular related to new vaccines. Risk perception of both the disease threats and the vaccine has always been embedded in historical-socio-cultural contexts. Furthermore, vaccine confidence reflects a set of relationships with individuals as part of a community decision. Our research has found that there is wide geographic variation in COVID-19 vaccine acceptance. Key attributes have shaped differential profiles in different subgroups. Among them, public trust plays a central role determining the vaccine acceptance. In general, marginalized subgroups are more vulnerable in terms of COVID-19 vaccine hesitancy. The findings of lower COVID-19 vaccine acceptance among Black Americans are alarming, but not surprising. From the Tuskegee Study to the Mississippi Appendectomies, the U.S. medical establishment has a long history of experimenting on people of color without their consent. Distrust of a new COVID-19 vaccine is not anti-science, but rather based in history and personal experience.

Vaccine hesitancy among people of color therefore requires targeted approaches to rebuild the trust. Here I offer three principle approaches -

First, a trusted alliance needs to be formed to engage with the communities and to reduce safety concerns. Ideally. it should be led by trusted public health professionals, with government officials, media, and other prominent community leaders taking supportive roles. Non-traditional partners with high trust levels need to be integral parts of the team. Listening and empathizing (instead of blaming) communities’ concerns will be a big part of the dialogue, when providing clear and consistent messaging about vaccine safety. Focus group can be a powerful way of hearing communities’ concerns. Accessible languages will be helpful on how COVID-19 vaccines are being developed, what safety measures are in place, and what thresholds of safety need to be met before vaccines are approved. Vaccination should be framed as a tool to bring justice and benefits to communities of color.

Second, peer influence is an important game-changer to build a pro-vaccine social norm in communities of color. Community messengers, including pastors, teachers, community organizers, and local elected officials, can help lead by example by talking about their own plans to get vaccinated, and encouraging the people they encounter to do the same through ongoing dialogues. Collaboration with local social media platforms and influencers for research on online communities and strategies are especially of importance.

Third, combating the distrust with historical roots requires policymakers’ mindsets that are not narrowly focused on the current vaccine hesitancy problem at hand. An effective way of rebuilding the trust, especially among the most heavily-hit communities, is to prioritize expanding health care access and invest in improvements of quality of life, education, jobs and family.

To implement these approaches given the specific school reopening context in District of Columbia, here are some recommendations –

First, vast majority of residents in District of Columbia need to get vaccinated to bring an end to the virus transmission and make school reopening as safe as possible. We learn from infectious disease transmission dynamics that even with an overall high vaccination coverage, pockets of low vaccination will result in spreading of the virus. It is thus urgent to make a targeted effort to increase vaccine coverage among communities of color.

Second, school systems should not, and cannot be the sole player to carry this responsibility. A concerted effort by designated taskforce is needed to coordinate an alliance, and to engage all parties including media, schools, grassroots organizations and non-traditional partners such as churches, social media groups and opinion leaders within the communities. Community efforts that build on relationships with community leaders and equity infrastructure can fill an outreach void. Experiences from other jurisdictions include work by the Michigan Health and Human Services (MHHS) Department, which has made partnerships across the state to understand the needs of all communities—and all diverse Black communities. Another example is the Florida's Statewide COVID-19 Vaccine Community Engagement Task Force, which comprises Black higher education representatives, business owners, media representatives, and politicians.

Third, resource mobilization is required to make a concerted effort feasible, to support the coordination, training, research and community engagement. Funding mechanisms such as timely grant awards can make a quick difference.

In summary, the speediness of school re-opening and academic recovery will be largely determined by the speed of vaccination, especially among the most vulnerable communities. There is an urgent need for a concerted target effort to improve vaccine acceptance among communities with higher vaccine hesitancy. By prioritizing a coordinated effort improving vaccine coverage among these communities, school re-opening and academic recovery process can be made safer, steadier and faster.

Thank you,

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