

The vaccine rush: in this stage of the COVID-19 response, ‘community’ matters more than ever

Rochelle Ann Burgess; Richard H Osborne; Kenneth A. Yongabi; Trisha Greenhalgh; Deepti Gurdasani, Gagandeep Kang, Adegoke. G. Falade; Anna Odone, Reinhard Busse, Jose M. Martin-Moreno, Stephen Reicher & Martin McKee.

The announcement that effective and safe vaccines for Covid-19 are imminent has been greeted with enthusiasm. Discussions around the ethical challenges of ensuring fair access within and across countries, and which groups should be prioritised are underway.^{1,2} Manufacturers expect to provide up to 50 million vaccine doses before the end of 2020, and 1.3 billion doses in 2021, raising concerns about equity in access, as governments representing just 14% of the global population have secured 80% of projected supply.² National governments across Europe have promised rapid access to vaccines, some as early as December.³

While this signals hope for a return to some kind of normality, vaccine-based protection is contingent on sufficient population coverage, requiring effective governance, organisational, and logistical measures, within a wider control strategy that includes continued surveillance and appropriate countermeasures.⁴ In this new phase of the response, successful roll out will only be achieved by addressing a largely overlooked aspect of pandemic management: effective community engagement, and more specifically, building local acceptability, confidence, and overcoming cultural, socio-economic and political barriers to uptake of vaccines among societies.

From the outset it is important to distinguish between those taking an absolute stance against vaccination (anti-vaxxers) and those with limited or inaccurate health information, establishing genuine concerns and questions about any given vaccine, its safety and the extent to which it is being deployed in their interests, before accepting it (vaccine hesitancy). In conflating and problematising the spectrum of those who do not accept vaccination, authorities may further erode trust and confidence, thereby exacerbating rather than resolving the factors underlying hesitancy. COVID-19 vaccines arrive as the social contract between some governments and their populations has been eroded at many levels⁵ where many, especially those in vulnerable groups, have limited confidence that their government will protect them. In the UK for example, a Parliamentary report highlighted that over 60% of Black people do not believe that their health is protected by the NHS to the same extent as white people.⁶

Globally, the pandemic has further marginalised historically oppressed and excluded groups, including people living with disabilities, and growing numbers living in precarity. They have suffered disproportionate economic and health consequences, and have been excluded from social protection and resources needed to minimise their contracting the virus. The widespread impacts of the pandemic have illuminated the structural violence embedded in society. Now these communities are being asked to trust the same structures that have contributed to their experiences of abuse, trauma, and marginalisation in order to access vaccines and to benefit the wider population.

Given such realities, we must reflect on the complex history of mass drug administration (MDA) and vertical immunisation programmes globally, which remind us that there are no magic bullets. For example, Sudan's Blue Nile Health project, an MDA programme designed to control malaria, schistosomiasis and other diseases, had little success. In some cases, transmission rates were higher after the campaign had ended than before.⁸ Uptake of vaccine programmes such as HPV and measles have been influenced by wide-reaching historical socio-economic inequalities within and across geographical and other communities of difference. In Nigeria, polio eradication campaigns were slowed due to valid concerns about the motives of sponsors, inadequate testing and consent procedures, and inadequate engagement with local knowledge about health and illness. Efforts were eventually turned around through widespread community dialogues, which helped to foster social learning and establish equity and generate and restore trust and participation in the programme.⁹ **Examples of successful immunisation campaigns, such as India's polio eradication efforts, are similarly rooted in widescale social mobilisation and systems strengthening.** A recent modelling study reveals how weaknesses in implementation of a COVID-19 vaccination strategy will seriously reduce the efficacy of the vaccine as reported in clinical trials, while also pointing to the need for investment to promote public confidence in vaccines and maintaining other mitigation measures.¹⁰

The 'public' is not a homogenous entity. It is complex, composed of individuals and family groups shaped by contexts, experiences, and desires in a constellation of communities with different patterns of health literacy, values and expectations.¹¹ A top-down, one-size fits all approach has derailed countless well-meaning global health solutions, and in the context of vaccine implementation risks leaving many groups behind, again. We need to understand this diversity using comprehensive local approaches that give communities a voice; that demonstrate they are heard; map local concerns and alliances, and co-design programmes to maximise vaccine uptake from the ground up.

As an initial step, policy makers must accelerate dialogue and support the development of community networks, leveraging and supporting existing local channels that influence decision making, such as community and faith leaders, teachers and sports and youth clubs. In this way, we gain deeper understandings of intersecting challenges and opportunities, while establishing trust, and learn to build effective communication and public health messaging. Such efforts must be paired with investment in structures that enable people to contribute to this process. Participatory community engagement is cost-effective, increases uptake, and substantially reduces health-care resources needed to achieve desired levels of vaccination.¹²

We outline our recommendations to achieve meaningful engagement with diverse communities in preparation for COVID-19 vaccine roll out below (Panel). Our bottom-up approach devolves the power of design and implementation of communication strategies to local actors, supported by evidence syntheses, enabling them to mobilise local expertise that can engage with and shift attitudes on vaccines and wider government handling of the crisis.

We must learn from the past, as the stakes are high. Mistakes now risk cementing mistrust in the ability of science and governments to manage the pandemic. Taking a little time and space to listen to those who have the most at stake will pave the way for much needed change.

Conflict of interest statement:

MM is a member of Independent Sage

SR is a member of Independent Sage, participates in SPI-B – Behavioural Science Advisory Group to SAGE and participates in the advisory Group to the Scottish CMO on COVID-19.

RB is supported by project funding from the Berlin University Alliance (112_PreEP_Corona)

KAY is Coordinator of the African Union-ASRIC Afro Centric Working Group on COVID-19 Response.

All other authors have no conflicts to declare.

Panel 1: A pathway to enabling community engagement in COVID-19 response and vaccine rollout

Level of action	Primary aim	Key actors	Responsibilities	Mechanisms for delivery
Local level (boroughs, towns, villages)	Establish community COVID-19 vaccine task forces	<p>Community leaders across multiple categories: <i>Faith groups</i> <i>ethnic/cultural identities;</i> <i>teachers; healers;</i> <i>family networks;</i> <i>Communities of practice (expert patient groups;)</i></p> <p>Third sector organisations working locally (youth organisations, etc) General Practice/ community clinics</p>	<ul style="list-style-type: none"> · Mapping networks of relationships; trust; social power · Identify at risk groups · map local influencers · Identify trusted communication channels (expand through targeted funding) · Define content for locally meaningful communication campaigns and make available in diverse formats · Work with regional public health and community services to implement and monitor vaccination programmes phased by priority groups, enabling locally driven expertise and processes 	<ul style="list-style-type: none"> - Focus group discussions - Community co-design forums - Online surveys - Direct outreach (phone/face to face) - Peer to peer engagements

Regional level (municipalities, regions, counties)	Coordinate and facilitate actions of local COVID-19 vaccine task forces	Regional Public Health Hospital trusts/consortiums Primary care networks	<ul style="list-style-type: none"> · Work with local community leaders to implement locally defined communication strategies · Develop and strengthen regional networks to access to resources for at risk groups to enable uptake · Sharing of information and experience that is transferable across other regional settings · Provide data monitoring and logistical support, liaising with local trusts and service sectors to ensure easy access to local communities, and resources are targeting the right groups effectively 	<ul style="list-style-type: none"> - Wide ranging large and small public forums (including online delivery) - Production of educational materials - Coordinate delivery of vaccines - Knowledge fairs, where community leaders and local health coordinators can exchange perspectives - establishing new paid posts to maintain community involvement at local level
National level	Coordinate and release funding	Departments and ministries linked to health, local government and community/civil society	Provide funding and infrastructure support to allow joined up working across related systems and structures to provide a systems wide approach to vaccine uptake	Micro grants to community task forces and community groups (including young people) to promote vaccines and vaccination programmes in meaningful ways
	Coordinate and deliver national messaging		Fund and deliver wide scale multiple platform mass media of positive and routine experiences of diverse individual, families and communities receiving the vaccine	

References (max 12)

1. Stiko DER and Leopoldina. Recommendations for fair and regulated access to a COVID-19 vaccine. 2020. <https://www.ethikrat.org/en/press-releases/2020/recommendations-for-fair-and-regulated-access-to-a-covid-19-vaccine/> (accessed 19th November 2020).
2. Ghosh J. Vaccine apartheid. 2020. <https://www.project-syndicate.org/commentary/pfizer-vaccine-doses-claimed-by-rich-countries-weakens-covax-by-jayati-ghosh-2020-11> (accessed 19th November 2020).
3. Cameron-Chileshe J, Neville S, Parker G, Dempsey H. Matt Hancock tells NHS to prepare for Covid vaccine from December. 2020. <https://www.ft.com/content/b5df3eec-ffa4-460c-8ab6-eb60c2ff0d5e> (accessed 16th November 2020).
4. Gurdasani D, Bear L, Bogaert D, et al. The UK needs a sustainable strategy for COVID-19. *Lancet* 2020.
5. The Lancet. COVID-19: remaking the social contract. *The Lancet* 2020; **395**(10234): 1401.
6. Joint Committee on Human Rights. Black people, racism and human rights. Eleventh Report of Session 2019–21. 2020. <https://committees.parliament.uk/publications/3376/documents/32359/default/> (accessed 16th November 2020).
7. Expert Panel on effective ways of investing in health. Vaccination Programmes and Health Systems in the European Union. 2020. https://ec.europa.eu/health/sites/health/files/expert_panel/docs/020_vaccinationpgms_en.pdf (accessed 16th November 2020).
8. Amin M, Abubaker H. Control of schistosomiasis in the Gezira Irrigation Scheme, Sudan. *J Biosoc Sci* 2017; **49**(1): 83-98.
9. Jegede AS. What led to the Nigerian boycott of the polio vaccination campaign? *PLoS Med* 2007; **4**(3): e73-e.
10. Paltiel AD, Schwartz JL, Zheng A, Walensky RP. Clinical Outcomes Of A COVID-19 Vaccine: Implementation Over Efficacy. *Health Aff (Millwood)* 2020: 101377hlthaff202002054.
11. Batterham RW, Hawkins M, Collins PA, Buchbinder R, Osborne RH. Health literacy: applying current concepts to improve health services and reduce health inequalities. *Public Health* 2016; **132**: 3-12.
12. NICE. Community engagement to increase childhood immunisations. 2012. <https://www.nice.org.uk/sharedlearning/community-engagement-to-increase-childhood-immunisations> (accessed 16th November 2020).