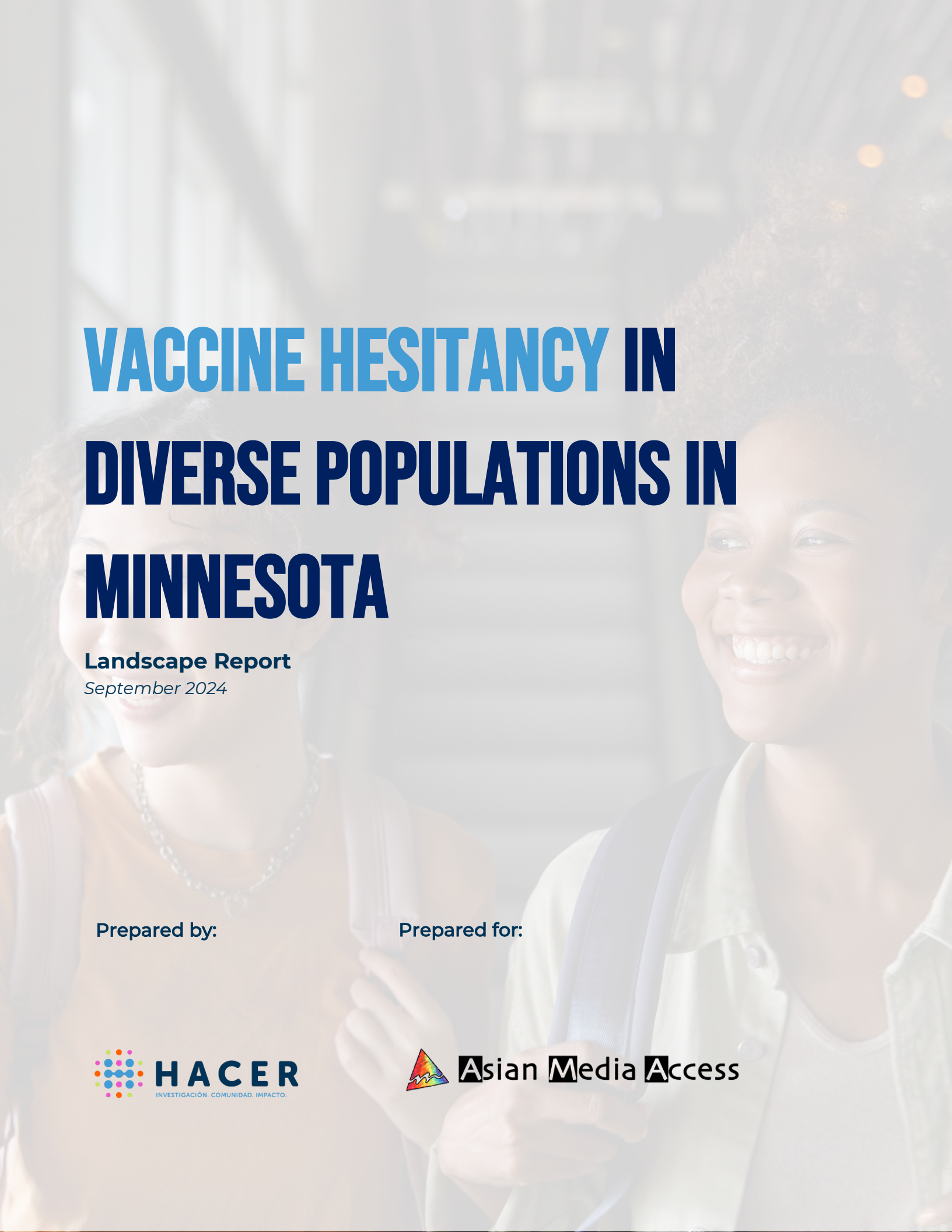
VACCINE HESITANCY IN DIVERSE POPULATIONS IN MINNESOTA

Landscape Report

September 2024



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BACKGROUND

Community Vaccine Hesitancy

There have been multiple studies on vaccine hesitancy since the beginning of the COVID-19 pandemic. A study by Quadri et al. shows that language barriers lead to delayed vaccine uptake and worse COVID – 19 health outcomes (2023). A literature review by Khubchandani & Macias (2021) shares that factors related to vaccine hesitancy among Hispanic and African American populations can include: younger age and female gender (Daly & Robinson, 2021); lower-income and education (Fisher et al., 2020); medical mistrust and lack of information (Latkin., 2021); racial discrimination and past mistreatment (Khubchandani et al., 2021); perceived barriers such as lack of time, costs, and fear of getting sick (Ruiz et al., 2021); and concerns about side effects, efficacy, and safety (Gibson et al., 2021). However, a study by Szilagyi et al. found that healthcare provider recommendations are associated with lower vaccine hesitancy rates (2021).

There have also been studies about the speed of vaccine uptake. Vaccine uptake data at a national level state that Black, Hispanic, and White Americans have an 84-85% two dose vaccination rate, and American Indians and Alaska Natives (AIAN) have a 77% uptake rate (Na et al., 2023). However, uptake of the boosters is much lower; White Americans have the highest rate at 35%, then Asian at 29%, AIAN at 26%, Black at 23% and Hispanic Americans at 17%. This matches current Minnesotan data which states that booster uptake as of Spring 2024 was at the following rates: White at 24.6%, Asian/Pacific Islander at 22.5%, AIAN at 16.1%, Hispanic at 15.2%, Black at 13.2%; Multiracial at 11.1% (MDH, 2024). This shows that there is still a low uptake rate of the boosters even if more people have the initial two shot dose.

In the initial Covid-19 vaccination pushes, rural areas had lower rates of vaccine uptake than the Twin Cities area (Halter 2021). There were also delays in reaching uptake threshold goals between different groups – White and Asian communities in Minnesota reached a threshold of 50% vaccination against COVID-19 in June 2021. However, Latino and Black Communities reached that same threshold in December 2021, and American Indian and Alaska Native communities reached that same threshold in March 2022, indicating a gap in uptake rates of COVID-19 vaccinations (Planlap, 2023).

KEY OBJECTIVES AND METHODOLOGY

Community Assessment Interviews

Asian Media Access (AMA) conducted 25 interviews with public health workers across the country working with a variety of different communities. AMA's objective in conducting this interview was to understand how organizations across the country were reaching BIPOC populations and addressing vaccine hesitancy in a culturally responsive way. They sought to gain information from their own trusted network of public health providers.

The interviewees were selected from a group of contacts that AMA has across the country who are trusted messengers within their own communities and working with vaccine hesitancy. AMA reached out to a larger group of contacts and conducted interviews with those who responded. AMA was seeking to work with Asian, Black, Hispanic/Latino, American Indian, LGBTQ+, and pregnant woman serving organizations. These interviews took place from March 2024 to August 2024. They were conducted in New York, California, Oklahoma and Minnesota. These interviews were video recorded and then transcribed. HACER staff read the interviews and coded them for key themes.

Vaccination Education Session Following-up with Focus Group Discussions

Collaborated with our partner Asian American Business Resilience Network, who hosted the following vaccination education sessions with trusted community leaders. After their training, AMA also conducted focus groups with participants across cultural groups exploring vaccine hesitancy and acceptance. The discussions were aimed to uncover the level of understanding after addressing misconceptions about vaccines. Initial thematic summaries highlight key findings.

Population of Focus	Partner organization	Focus Group dates	Number of community member participants
Hmong	Hmong Senior Center	6/11/2024	32 participants
Vietnamese	Vietnamese Center, MN	6/30/2024	69 participants
African American	Urban Research and Outreach Engagement Center (UROC), MN	7/02/24	32 participants
Chinese	UROC	7/09/24	19 participants
Hmong	UROC	7/16/24	16 participants
BIPOC Homeless and low income	UROC	7/23/24	18 participants
Somali	UROC	7/30/24	7 participants
Laotian	UROC	8/06/24	32 participants
Somali	Skyline Math and Science Academy	8/24/24	14 Participants

FINDINGS

AMA conducted focus group discussions and interviews to learn more about the causes of vaccine hesitancy, the barriers to vaccination, and the community approaches to addressing vaccine hesitancy and improving vaccine uptake.

SECTION I. Focus Group Results

A. Causes of Vaccine Hesitancy

Fear

Fear of adverse reactions was one of the factors mentioned by multiple different communities. Misinformation and a lack of information caused community members to worry about what could happen to them once they received the vaccine. *"Some people have side effects. We're all different at the end of the day and what if someone has an allergic reaction and dies?"* One of the focus populations, pregnant women, had worries about what could happen to their babies. Additionally, immigrant communities reported higher numbers of concerns related to COVID-19 side effects.

Misunderstanding

Lack of general understanding was another cause for hesitancy when the public did not understand the process of vaccination or how vaccines work. *"If I get a COVID-19 vaccination, I will be protected 100% against coronavirus"*, one focus group participant reported, highlighting the lack of awareness of how immunizations affect the immune system.

Access

Lack of access to vaccines and to culturally and linguistically relevant education materials was another factor related to vaccine hesitancy. Some focus group participants reported it was hard to travel to the vaccination locations and some individuals had insurance concerns. Additionally, costs, and lack of cultural knowledge on navigating the healthcare system created structural barriers to vaccinations and increased vaccine hesitancy. Additionally, participants highlighted that linguistic access was also a common barrier, especially for interpretation services and healthcare materials; Many times, information and interpretation services were not available in respondents' primary language.

Autonomy

Other focus group respondents felt there was a lack of autonomy in the vaccination process, increasing vaccine hesitancy. They felt that they had to choose between their job and their bodily autonomy due to workplace vaccination mandates, saying, *"They don't want to lose their job, and it's been forced upon them. You have to take it. They have no choice."*

Cultural and Religious Beliefs

Some groups felt that their health was better addressed through traditional medicine or through religions. Asian, African immigrant, and Indigenous focus group respondents most often stated they relied on natural immunization and traditional medicines as an alternative to vaccination.

> *"I've always struggled to get basic vaccines; just because all my family prefers more traditional methods of protection, prevention, illness and such."*

Mistrust

The historic mistreatment, abuse, and enacted racism against marginalized populations within both the medial and public health fields played a major role in mistrust of vaccination efforts. African American populations brought up past medical experimentation as a reason to not trust the vaccine, such as the Tuskegee Syphilis Experiment. *"When it came to COVID-19, I was wary that they might not give me the best or they might not give me the right one because of the way I look".* Others stated that the vaccine was produced too rapidly for them to trust it.

B. Solutions to Vaccine Hesitancy

These concerns were addressed by community organizations and AMA through outreach and health fairs, education, and community interactions at cultural events. Outreach and health fairs helped provide access to vaccines, while education efforts helped with the fear of adverse reactions and lack of understanding of vaccines. Cultural events helped alleviate vaccine hesitancy caused by cultural and religious beliefs, concern over autonomy, and historic racism and mistrust. Additionally, some community organizations are making vaccines accessible through community events and working with partner organizations to have vaccination available to their members at the time/place members feel comfortable with.

SECTION II. Interview Results

Interviews focused on examining the barriers to vaccination and potential facilitators of vaccine uptake. Looking at the interviews, the main themes that were brought up were communication, having trusted messengers, and culturally relevant care or messages. The second most common themes were the importance of intergenerational connections, trust building, and access to vaccines. Many of these themes tie together and overlap, such as communication being more effective when it comes from trusted messengers and when it is culturally relevant.

A. Communication

There were many methods mentioned by those interviewed who brought up communication as one of the ways that they countered vaccine hesitancy, but some themes stood out – honesty, engaging openly and on a one-to-one level, and family stories.

Key communication methods mentioned included:

- Open and honest communication: Telling the truth of vaccines and vaccination.
- Personal stories: Sharing how the vaccine has helped you or those you love directly.
- Communication to counter misinformation: Ensuring that community members had accurate information even if they'd come in with misconceptions.
- Not acting from a sense of entitlement in communications: Approaching community members with humility.
- Representing the community in communications: Using photos of people who looked like the communities for whom you are engaging.
- Mailings to spread the word: Making the information accessible by text and at a distance.
- Asking those who got vaccines to advertise: Using trusted community members to promote vaccinations using both verbal and non-verbal communications (such as providing vaccination themed t-shirts and having conversations).
- Family-based communications: Reaching out to specific members of the family or specific members of a community was another strategy used by many of the public health workers.

Trusted Messengers

Communication methods are important, but another common theme was who was doing the communicating. Where messages were coming from was a factor that affected how the community saw the messages. Some public health workers indicated that there were trusted members of the community that they could work with to get the message out to other members of that community, tapping into those networks. A similar method was to look at individual members of families and communicating with the member of the family who would reach out to the others.

Similarly, on a structural level, the organization providing the information was important. Was it a message coming from the local Tribal Council or a local organization that community members would know? Or was it coming from further away, from a federal government that may seem disconnected? Spreading information from sources the community knows and trusts changes the power of the messaging for addressing vaccine hesitancy.

As one interviewee working with a Latino community organization stated, *"If you have the funding and you have community-based organizations that want to help, sure, there's accountability. There's paperwork. We'll do all that. But allow us to do what we do because the community has that relationship that trusted. They know our faces."* This highlights the importance of involving community workers who are a part of that

community.

Culturally Relevant Messaging

One public health worker who was working with an Indigenous tribal organization said in an interview, *"When we create flyers for in-house events or media, we try to incorporate traditional designs as much as we can. For me, that's hard to do. My tribe has different designs that are very different in how they're created. And so I've reached out to an elder and I said, could you help me with this?"* This public health worker stated that they were Indigenous themself, but from a different tribe than the organization they were working for. This quote highlights the importance of culturally specific communication and reaching out to those with knowledge within a population.

The public health worker's commentary on culturally relevant work was like the trusted messengers and communications aspects reported by other interviewees. They mentioned tying communications into what communities were familiar with, such as including imagery that might feel natural to them or draw them in. Other public health workers also mentioned using familiar symbols in communication materials.

But beyond the messaging itself, the resources available to community members are important. One interviewee mentioned the importance of having access to traditional medicine at the hospital when patients were hospitalized for COVID-19. This is not specifically related to vaccination, but ensuring patients getting vaccinated have access to cultural objects they may need applies to COVID-19 vaccination as well.

B. Intergenerational Connections

Interviewees unveiled the importance of topics related to intergenerational knowledge and power. Topics related to the intergenerational themes included:

- Asking elders with respect for their help
- Protecting elders through vaccinations
- Incorporating multiple generations into programs and messaging

C. Trust Building

Public health workers stated that they used a variety of methods to build trust with the community including meeting members of the community where they're at, telling stories, and hiring or collaborating with people from the community who would then become trusted messengers.

One interviewee highlights the importance of trust building especially given historical trauma and context within communities. Being thoughtful about the historic injustice and abuse caused by healthcare and public health fields within marginalized communities is essential to rebuilding trust and addressing vaccine hesitancy. As one interviewee shared,

"Considering the history of what we've been through as a community, there had to be a lot of education that had to take place on why the vaccination is taking place, why you're receiving the vaccination, and the challenges that come with it. So for the last couple of years, there's been a lot of education and a lot of building trust. And also giving the black community the autonomy to make the decision if they want to receive it or not has been a big deal."

D. Access

Access was another important topic – if vaccination locations aren't accessible to those you aim to use them, or aren't in locations people are likely to frequent, there will be less uptake in vaccines and less opportunity for those who might not go out of their way to get a vaccine to become vaccinated. One strategy was co-location with other services, partnering with community organizations as well as having access to vaccination and COVID-19 testing at bigger events. Some discussed providing testing access to a much larger range of people than their general activities in order to be of service to the broader community.

"In our tribal communities, in our rural communities, sometimes we don't have access to the services we need and so we take it as our mission to meet the needs of our clients so that they have every health opportunity that they need to have the best outcomes."

SECTION III: Populations of Focus

Looking at the interview and focus group summaries collectively, key findings elucidate barriers to vaccinations, facilitator of vaccinations, and proposed solutions provided by community members and organizations. AMA reached out to organizations working with Asian, Latino, Black, Indigenous, LGBTQ+ populations as well as organizations working with pregnant people. The table below provides an overview of key findings disaggregated by these populations of focus.

Population of Focus	Key Findings Across Activities	Barriers to Vaccinations	Facilitators of Vaccinations	Proposed Solutions from the Community
African American / Black	• Historical trauma[1, 2] • Religious beliefs[2] • Cultural beliefs[2] • Misinformation[1]	• Tuskegee Experiments[1,2] • Trust in God to protect against illness and heal illness[2] • Preference toward natural / holistic medicines[2] • Belief that vaccinations do not work or are contaminated with microchips[1]	• Trust-building[1] • Education[1] • Clear and accurate communication[1] • Culturally relevant communication[1] • Use of personal stories[1]	• Rebuild community trust- acknowledge historical trauma[1] • Empower autonomy in vaccination- choice in type of vaccine[1] • Provide scientifically accurate education on vaccinations and importance[1]

Asian American	• Cultural beliefs[2]
	• Language[1]
		• Preference toward natural / holistic medicine[2]
		• Provide education and information in preferred languages[1]
			• Clear and accurate communication[1]
			• Culturally relevant communication[1]
				• Provide scientifically accurate education on vaccinations and importance[1],[2]
				• Meet the community where they are at:
				  o Health fairs[2]
				  o Cultural events[2]
				  o Vaccine events[2]

Hispanic / Latinx	• Misinformation[1] • Language[1] • Immigration status[1] • Access to vaccines / vaccination sites[1]	• Belief that vaccine was created too quickly[1] • Lack of resources / providers in Spanish, Portuguese, and indigenous languages[1] • Fear of deportation[1] • Timing and locations of vaccination sites inaccessible for working population[1]	• Trusted messengers[1] • Trust-building[1] • Clear and accurate communication[1] • Culturally relevant communication[1]	• Partner with community organizations and build community relationships[1]

Population of Focus	Key Findings Across Activities	Barriers to Vaccinations	Facilitators of Vaccinations	Proposed Solutions from the Community
Native American	• Historical trauma[1,2] • Cultural beliefs[2] • Access to vaccines / vaccination sites[1]	• Historical trauma of Boarding Schools[1,2] • Preference toward natural / holistic medicine[2] • Difficult to obtain vaccines on reservations / rural communities[1]	• Trusted messengers[1] • Trust-building[1] • Clear and accurate communication[1] • Use of personal stories[1] • Intergenerational[1]	• Utilize traditional designs and messaging[1] • Rely on elder expertise for culturally relevant messaging[1]
LGBTQ+	• Misinformation[1] • Competing health priorities[1]	• Belief that vaccine was created too quickly[1] • HIV/AIDS and STD prevention and HPV vaccinations[1]	• Education[1] • Clear and accurate communication[1] • Use of personal stories[1]	• Go to events where the community is already gathering[1] • Utilize community leader voices for messaging[1]
Pregnant Women	• Misinformation[1] • Competing health priorities[1] • Fear of effects on baby[1] • Access to vaccines/ vaccination sites[1]	• Belief that the vaccine is dangerous to fetus[1] • Fear of health effects for the baby[1] • Fear of obtaining illness while in public places hosting vaccinations[1] • Autonomy factor[1]	• Trusted messengers[1] • Intergenerational[1]	• Consistent messaging across toolkits, medical providers, and trusted messengers[1]

**Interview Data[1]

**Focus Group Discussion Summary Data[2]

CONCLUSION

Recommended Solutions

Based on the content of the interviews and focus groups, it is recommended that vaccine providers work closely with partners in the communities. It is important to connect with trusted community members to better build relationships with the whole community. Trusted community members can bring a vaccination method forward and give advice on communication style, format, and imagery. These trusted community members should be compensated for their time and expertise.

Next Steps

AMA will be continuing their work with vaccine access. They plan to redefine vaccine hesitancy as a multifaceted social issue incorporating historic systemic barriers, cultural beliefs in addition to other factors. Moreover, AMA will be supporting underserved populations, those that are uninsured and underinsured, with pop-up vaccine clinics that prioritize the comfort of those they're serving. AMA intends to analyze the Vaccine Awareness Survey in more depth for increased understanding of the general public's perceptions of vaccinations; This information will be shared with community members to mitigate vaccine hesitancy.

AMA will also be expanding multilingual resources by creating vaccination resources in heritage languages. AMA has multiple ongoing communication strategies including social media, a monthly BALL eMagazine and their website; These will be used to communicate vaccination information. AMA will be improving social media practices providing information that is evidence-based in an area that is often full of misinformation.

Finally, AMA will be offering capacity building opportunities such as Vaccine Awareness Education, Cultural Intelligence Framework Training, and AAPI communication style training to enhance understanding of vaccines and improve communication between health agencies and immigrant and refugee communities. In addition to these steps, AMA will be developing a vaccine equity toolkit with videos and community engagement strategies based on their own successful strategies.

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