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RESEARCH ARTICLE:

Understanding and Addressing COVID-19 Vaccine Hesitancy in the United States through Effective Health Communication

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Commentary

Sharma (2022) defines vaccine hesitancy as the tendency of individuals to refuse a vaccine which is in high demand or highly recommended for the sake of health. Vaccine hesitancy is a notable hurdle to public health efforts globally, including in the United States of America. Despite the safety and effectiveness of vaccines, there is still a great resistance to them by citizens. Whilst uptake of vaccinations was initially dependent upon supply issues, globally there have been reports of significant vaccine 'hesitancy' hampering current vaccine uptake (Zhang *et al.*, 2022). According to the World Health Organisation, vaccine hesitancy is the reluctance or refusal to vaccinate despite the availability of vaccines. Kennedy (2020) also opines that vaccine hesitancy is a particularly big problem in high-income countries. In these locations, vaccination policies are generally characterised by active choice: children are permitted to enter school without receiving vaccines if they meet medical, religious, philosophical, or personal belief exemptions. This indicates that vaccine hesitancy is more complex than we think. One of the factors that contributed to vaccine hesitancy in the United States during COVID-19 was former President Trump. Donald Trump, the former US president, erroneously and often referred to the Coronavirus as the "China virus", and this statement aggravated the whole situation. This statement caused the majority of his followers to be hesitant towards masks and the COVID-19 vaccine. The USA and Australia present a good contrasting case. There was a largescale disregard of preventive measures and ultimately a whopping figure of thousands of COVID-deaths in the USA while in Australia, where misinformation and disinformation were adequately managed and experts' findings strictly adhered to, far fewer deaths were recorded.

Ndhlovu, Muleya, and Udoh (2024) state that the intersection of politics and crisis communication in sub-Saharan Africa pre-dates the COVID-19 pandemic. In this case, politicians expediently picked and chose COVID-19-related information and tailored it to achieve narratives that worked in their favour, often compromising the effectiveness of official health messages by health institutions. It is worthy of note that vaccine hesitancy poses a significant challenge to the public and it might also be of interest that vaccine hesitancy is driven by factors such as religious or cultural belief, misinformation amongst people, and sometimes lack of trust in the government. Zhang *et al.* (2022) share the opinion that observers have noted that the internet and social media play a key role in spreading fears about vaccine safety. Understanding the intricacies around vaccine hesitancy is significant for developing strategies to reduce vaccine it. In this editorial, the author explores vaccine hesitancy in the United States of America and proposes interventions to address this pertinent issue. Hesitancy to accept vaccines is not a new phenomenon, what is new is that considerable hesitancy now comes from individuals with higher levels of education. People who refuse to take vaccines should not be seen as problematic people who must be educated. What is problematic, as noted in this article, is that the provision of given information neither addresses individual reasons for hesitancy nor does it help health authorities to mainstream programmes (Cao *et al*., 2022, Troiano and Nardi, 2021). "As of September 13, 2021, 52.8 per cent of people in counties that voted for Biden were fully vaccinated compared to 39.9 per cent of Trump supporting counties, a 12.9 percentage point difference" (Kates, Tolbert and Orgera, 2021).

It is especially important to note that the United State of America's literacy level is high, 79 per cent of American adults nationwide are literate (Mamedova and Pawlowski, 2019). Looking at the high literacy level in the United States of America and its health systems, America has a sophisticated health sector, and one would generally think it should translate to less hesitancy and more informed health choices, however, this is not the case when

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compared to other Organisation for Economic Co-operation and Development (OCED) countries because of the disposition of the ex-president (Turner, Woloszko, Chalaux and Dek, 2022).

Public health organisations and policy leaders have long called for more coordinated strategies and resources to address vaccine hesitancy in the United States. However, to date, no dedicated policy, public health department, or resources have been aimed at vaccine confidence and acceptance of issues. Misinformation is propagated through social media platforms and online communities have contributed to the dissemination of unfounded claims linking vaccines to adverse health outcomes, such as autism (Nuwarda, Ramzan, Weekes and Veysel, 2022). The World Health Organisation (2015) also opines that vaccine hesitancy is influenced by factors such as misinformation, complacency, convenience, and lack of confidence. One can also not rule out the role of historical injustices as system disparities in health care have played on the marginalised communities and have, one way or the other, left a scar on the citizens. One such example is the Tuskegee experiment which began in 1932. The Tuskegee Syphilis Study was conducted in 1930s Alabama on African American men with untreated syphilis. The study focused on poverty-stricken men in Macon County, who lacked education and job opportunities. Local doctors sought to understand the disease's impact by surveying both white and black residents (Gilliard, 2010: Perlstadt, 2024). Hence there is a need for these issues to be addressed so that the trust of the communities can be gained. Cultural and religious beliefs also play an important role in shaping vaccine attitudes, and understanding cultural perspective is crucial for engaging hesitant communities. Previous research has found that vaccine hesitancy often occurs after a systematic assessment of vaccinations and most times, the decision to reject vaccination is not due to lack of access to care.

Addressing vaccine hesitancy requires a multi-pronged approach that addresses the origin of mistrust and misinformation while still advocating for vaccine literacy and accessibility. One such approach is health communication (utilising effective communication tools), access to vaccines, and engaging with communities. Schiavo (2013) defined health communication as:

> *"A multifaceted and multidisciplinary field of research, theory, and practice concerned with reaching different populations and groups to exchange health-related information, ideas, and methods to influence, engage, empower, and support individuals, communities, health-care professionals, patients, policymakers, organizations, special groups, and the public so that they will champion, introduce, adopt, or sustain a health or social behaviour, practice, or policy that will ultimately improve individual, community, and public health outcomes."*

The quotation above has some implications. First is the fact that different populations and groups must be reached. The second implication is that persuasive methods must be designed to disseminate information to the citizens. Effective communication is key to dispelling fears, addressing concerns, and promoting acceptance of the vaccination (WHO, 2015). Hence communication must be a high priority in order to tackle vaccine hesitancy. Goldstein *et al.* (2015) assert that public confidence in vaccines and vaccine delivery systems decreased in 1999 due to poor communication regarding the decision to minimise the use of thimerosal as a preservative in some vaccines and thus led to increased vaccine hesitancy and refusal. Goldstein *et al.* (2015) also define communication as a two-way process, and further state that it is in equal measure a process of listening and telling. Agbede (2023) defines advertising as a form of communication which relies on a social context to develop culturally relevant adverts. Therefore, it is only right to say that vaccine hesitancy can be reduced through adequate and informative advertisements as it speaks to the emotions of humans. Obregón *et al.* (2009) note that there is little information in the literature about communication interventions for the promotion of vaccinations, although community dialogues and mass media have received some attention. As such, public health campaigns should work on evidence-based messaging to debunk myths and misconceptions surrounding vaccines. Goldstein *et al*. (2015) assert that many communication tools are available to address vaccine hesitancy and some of the tools include mass electronic media, digital media, print media, social mobilisation, mobile technology, and service-based communication. The listed tools are great assets for addressing citizens' vaccine hesitancy.

Engaging with communities most affected by vaccine hesitancy is essential for rekindling trust and addressing past concerns. This involves organising sports events, market days, talk shows, health awareness days, and health show drives to sensitise the need to be vaccinated along with the risks associated with not being vaccinated. All of these can lead to greater trust and promote vaccine acceptance. Communication is valuable tool if used properly. Though there is a high rate of vaccine hesitancy, a well-thought-out communication strategy should be integrated

by health comminutors in the Department of Health to address the fears of the recipients and the factors strengthening vaccine hesitancy. Also, vaccine access and affordability are important for increasing uptake amongst disadvantaged communities. This can be achieved by implementing mobile vaccination clinics, providing free transportation, and access to vaccination loyalty cards. This brings one to the big question of how we can go beyond political rhetoric and separate it from health communication?

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