
REDUCING THE IMPACT OF COVID-19 ON BLACK COMMUNITIES IN CANADA: BUILDING CONFIDENCE AND DECREASING VACCINE HESITANCY

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The consequences of infection with SARS-CoV-2, the causative agent of COVID-19, have been profound. COVID-19 has affected virtually all communities to varying degrees, either directly due to disease burden or indirectly due to the tremendous disruption of everyday life. In the UK, USA, and Canada, racialized groups, including Black communities have been disproportionately affected. Canadian neighborhoods with the largest proportions of visible minorities are typically those reporting higher COVID-19-related mortality [1]. In the Greater Toronto Area (GTA) of Ontario, as of December 2020, Black individuals accounted for 9% of the population and more than 14-21% of reported cases of COVID-19 (21% during summer 2020). This is in contrast to the white population that accounted for 48% of the population of the GTA and 17-23% of cases of COVID-19 (17% during summer 2020) [2]. In addition to Black communities, other racialized groups are disproportionately affected. In the Peel regions of Ontario, South Asians account for 32 percent of the population and 59% of cases compared with Whites who account for 37% of the population and 13% of cases [3]. Reasons for these groups being disproportionately affected by COVID-19 might vary, but are rooted in the social determinants of health, while recognizing that other factor might contribute, included some that are yet to be determined.

In the above context, how might these communities be best protected from COVID-19? Despite the higher burden of infection in racialized communities, the prevalence level is expected to be several fold below the threshold required to achieve herd or community immunity. Protection will require a multi-faceted strategy including the use of vaccines against SARS-CoV-2. However, a major obstacle to successful vaccination strategies is vaccine hesitancy, an entity that existed prior to the onset of COVID-19 and which has been characterized and defined by the World Health Organization and recognized as one of the top 10 threats to global health [4-5]. Current evidence suggest high levels of hesitancy among the North American Black population, including those in Canada [6-8]. Major contributors to hesitancy include low levels of trust in the health care system in general and wrong or misleading information relating to COVID-19 vaccines, culminating in lack of confidence in the vaccines. Hesitancy is also influenced by other specific factors, including access to the vaccine and personal and religious beliefs. For example, someone who has to take unpaid time off from work to get vaccinated might be hesitant to be vaccinated. Similarly, access requiring online signing up might be problematic for some individuals for several reasons, including internet access and age group. Individuals with good access and vaccine confidence at a personal level (e.g. health care workers), might be reluctant to be vaccinated due to religious beliefs in an effort to conform to the guidance from their religious leaders [9]. In this regard, one

way of thinking about these relationships is the following, which summarizes the fact that access, beliefs and confidence are all proportionally related to hesitancy:

$$\text{Access} + \text{Beliefs} + \text{Confidence} \propto \text{Hesitancy} \text{ or } \mathbf{A + B + C \propto H}$$

(symbol \propto denotes the expression “proportional to”)

Data are needed to better understand the reasons for vaccine hesitancy in the Black population. It will be necessary to develop strategies to address these and other factors in order to build confidence and reduce hesitancy. While several approaches could be taken, a phased development and implementation of these strategies is one approach that could be considered.

Phase i: Information gathering

The first phase in the approach to addressing hesitancy within the Black community involves information-gathering. This should include the documentation of the extent of hesitancy and the reasons. It cannot be assumed that the reasons for hesitancy will be the same across the various sub-groups within the communities due to differences in lived experiences of individuals and their families. For example, the historical reasons for mistrust of the health care system might be different across various groups based on the particular diaspora communities with which their families are most aligned [10]. It is important to determine the sources of information for members of the community, which might include the internet, religious leaders/congregations and social interactions that might be aligned with age group.

Phase ii: Providing accurate vaccine information

It is important to correct misinformation so that, for individuals who choose not to be vaccinated, their choice is based on reasons other than wrong information. It would seem appropriate for communities that are most affected by COVID-19 to be prioritized for vaccination. However, the communication of the reasons for such prioritization must be clear in order to avoid misinterpretation of intent. In this regard, one misconception is that some groups are being vaccinated first to observe outcomes prior to vaccinating other groups; this is a false statement which can lead to reluctance on the part of some persons to be vaccinated at this time.

There are different stages in the process of correcting wrong information. First, it is essential to educate the educators so that they are better equipped to spread correct information to the community at large. These educators represent a cross-section of persons from all social levels of society and should include community and religious leaders, role models, among others.

Second, it is essential to work with individuals and groups that are trusted and are most well-connected with communities due to a long history of working with the communities. Education is important on issues relating to the vaccines, including but not limited to their development process, who is responsible for their development, how they work, the ingredients in a viral and side effects. Furthermore, the outcomes prevented by the vaccines should be clearly outlined to the public as this relates to what is being prevented. In this regard, a potential vaccine candidate might be very effective in preventing severe illness and death, but less effective in preventing someone from getting mild or asymptomatic illness.

Phase iii: Initiating the process of addressing structural barriers and continued community engagement

Structural barriers will take varying approaches and time to be dismantled. The identification of the resource needs that are required to address various infrastructural issues is an important consideration at this stage. Beyond the process of identifying these resources, there should be evidence, even if only limited data are available, of the efforts that are being made to address some structural issues. In addition, continued and uniquely-tailored community engagement is essential.

Phase iv: Vaccination and post-vaccination information gathering

Vaccination should take into account access to health care and as such should be delivered in a manner that allows easy access within the communities and with the appropriate levels of support to allow for time off from work without penalty. Access should be viewed through an equity lens to enable individuals to be provided with the supports that they need to get vaccinated. For example, an online vaccine sign-up process might be challenging for elderly persons and those with limited internet access and should take into account language considerations. Following vaccination, data gathering is important to ensure that there is equity in the distribution of vaccines. Furthermore, documentation of favorable outcomes through vaccine surveillance might assist in enhancing confidence in the vaccines.

Phase v: Continuation of efforts to address structural barriers

The process of addressing structural barriers should continue and represent a marathon and not a sprint. Once resources have been identified, it is important for these to employ such resources to reduce health disparities in general and including the factors that contribute to over-representation of medical co-morbidities in Black and racialized communities. Factors that contribute to health disparities that need to be addressed relate to affordable housing,

discrimination, healthcare access and utilization, occupation, education, wealth gaps, community safety among others [11].

A series of overlapping phases of strategies are needed to address vaccine hesitancy among Black and other racialized groups. Ultimately, efforts need to be enhanced to ensure that individuals who are making decisions for themselves and their families are equipped with correct information. Strategies that engage prominent religious leaders, community health educators and other members of the communities are essential. The process of building trust and enhancing confidence represents a continuum which should continue well beyond the COVID-19 pandemic.

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