

Center for Strategic and International Studies

Online Event

“Trusting a COVID-19 Vaccine: What’s Next?”

RECORDING DATE:

Friday, April 9, 2021 at 1:00 p.m. EST

FEATURING:

Bruce Gellin, M.D.,

President of Global Immunization, Sabin Vaccine Institute

Margaret “Peggy” Hamburg, M.D.,

Former Commissioner, U.S. Food and Drug Administration; Interim Vice President of Global Biological Policy and Programs, Nuclear Threat Initiative

Juliette Kayyem,

Senior Belfer Lecturer in International Security, Harvard’s Kennedy School of Government

Julia Spencer,

Associate Vice President of Global Vaccines Public Policy, Partnerships, and Government Affairs, Merck & Co., Inc.

CSIS EXPERTS:

Katherine E. Bliss,

Senior Fellow, Global Health Policy Center, CSIS

J. Stephen Morrison,

Senior Vice President and Director, Global Health Policy Center, CSIS

Heidi J. Larson,

Senior Associate (Non-resident), Global Health Policy Center, CSIS

*Transcript By
Superior Transcriptions LLC
www.superiortranscriptions.com*

Katherine E. Bliss: Hello and welcome to this public conversation about vaccine confidence and COVID-19 vaccines in the United States. My name's Katherine Bliss and I'm a senior fellow with the CSIS Global Health Policy Center. I direct the work of the CSIS London School of Hygiene and Tropical Medicine's High-Level Panel on Vaccine Confidence Misinformation, and National Security.

In July of 2020, CSIS joined with the London School to convene a bipartisan and international group of experts from public health, cybersecurity, public opinion research, social media, and communications to assess the implications of misinformation and vaccine confidence for U.S. national security within the COVID context. The High-Level Panel on Vaccine Confidence and Misinformation is co-chaired by Steve Morrison, senior vice president at CSIS and director of the Global Health Policy Center, and Heidi Larson, professor of anthropology, risk and decision science at the London School and the founding director of its Vaccine Confidence Project.

Now, as the High-Level Panel met virtually over the summer and fall the members were very clear about three things: The low levels of public confidence in COVID vaccines being reported over that period represented a clear threat to the potential of the United States to effectively control and recover from the pandemic, that having an ample supply of safe and effective vaccines would be critical but that they must be delivered to the public in a coherent and effective manner to ensure public confidence in them and demand for them, and that addressing the challenges of misinformation and disinformation in particular about vaccines and around COVID vaccines especially requires a multidisciplinary, multipronged approach.

Now, in October the panel issued a call to action, defining the problems of vaccine confidence and misinformation about vaccines as a national security threat. The panel outlined five recommendations, including a call for a national dialogue on vaccines, innovative approaches to reaching diverse and underserved populations, as well as the focus on activity by mainstream and digital media to stop the spread of disinformation and instead accelerate collaboration with health providers to amplify scientific content.

The call to action's fifth recommendation was focused on the need for federal reform, greater interagency coordination and leadership at the National Security Council, as well as increased U.S. support for global immunization partners. As the panel prepares its final report and recommendations, which will be launched at a public event in early May, we've initiated a series of events to discuss the call to action's recommendations and to foster dialogue about these issues. This is the fourth of those meetings.

Today we'll hear from experts in the areas of public health, national security, health and foreign policy, and public-private partnerships, as well

as the panel co-chairs about some potential options for improving federal coordination and response around COVID-19 vaccine demand and distribution, domestically as well as internationally. Now, a great deal has happened in the five months since the call to action was released.

Since December, three COVID-19 vaccines have been granted emergency use authorization in the United States. As of yesterday, more than 112 million people have had at least one dose of vaccine, with 66 million people fully vaccinated. The White House has established a COVID-19 equity taskforce to better understand and remedy the challenges in access to COVID-19 vaccines. And the National Security Council has restored a directorate for global health security and biodefense. At the same time, a number of educational programs have already begun, reaching out to key populations to help people make informed decisions about COVID-19 vaccines.

To set the stage for today's discussion we'll first hear from panel co-chair Heidi Larson. She will share some of the project's recent analysis about global vaccine confidence trends and explain how what's happening in the United States compares with other regions. I'll then turn the conversation over to Steve Morrison, senior vice president of CSIS and co-chair, with Heidi, of the High-Level Panel to introduce our next speakers and to moderate the session. But before we get started, let me remind those of you in the audience that there is a button on the event page that you can click to enter a question or comment that will come to the panel, and we'll be able to incorporate them into the discussion.

So, Heidi, with that the mic is yours.

Heidi J. Larson: Thanks very much. Oh, let's see. I just have two minutes here just to put in context over the last meetings and discussions we've had, we've noticed and looked at data that has shown the ups and downs of public confidence and willingness in vaccines since the start of the pandemic. Last June, these are wave one, two, and three that we've been running in multiple countries. In the U.S., as in a number of European countries we saw that the sentiment – the confidence went down in September-October. And that was after a higher optimism or encouraging for a vaccine. But that was back in June, is the first wave, then September-October.

And then towards the end of the year confidence was going up in most places, but not all. And as you can see in France, and particularly Germany, the boost that we saw around other countries in the face of a second wave, as well as the higher – the high efficacy reported around Pfizer, in the beginning of the year/end of last year France and Germany also started to express concerns about AstraZeneca, which contributed to their flattening – flattened confidence. Let's see. Next one.

This is a global survey done by colleagues at Imperial College. And just the point of showing you this – these figures – this is Australia, Canada, Germany, Denmark, Spain, France, Israel, Italy, Japan, Korea, Netherlands, Norway, Singapore, Sweden, and the U.K., from left to right. Just to give you a scope there. But as you can see, between just one month – between January and February there was extremely – there was extreme volatility in the sentiments in a number of countries.

So I think the main point in this slide, again, is that this is a very volatile space. We can't look at one point in time. This is influenced by external events – not only safety events but political events and new vaccines and emerging variants. It's a very dynamic and changing landscape. And that's just one thing that we – and this is not about to come in the immediate future, and just to bring a – bring that to the fore.

The last slide I have, which is a particularly concerning one, is that we've seen quite an impact of the AstraZeneca reported concerns across Africa. In Nigeria, we had done a big survey in – this was the first wave. This was last fall. And there was 49 percent of the Nigerians strongly agreed they would accept a vaccine. And wave three, which was just last month – around the time that the AstraZeneca issues were coming to a head, so to speak – it dropped 25 percent. Even perceptions of effectiveness dropped almost in half.

As you can see on the right, even from a day-to-day, as we were collecting data, the percentage of people who said they would accept a COVID vaccine dropped by the day. This is – I think the point here is to remember that we are not only living in a connected world in multiple ways, but sentiments are incredible viral and issues and concerns that show up in some countries travel quickly and have impacts. This is particularly concerning in Nigeria and in Africa because the AstraZeneca vaccine has been a core vaccine – one of the main vaccines for COVAX. So this is a concern.

But just again, sentiments and confidence is highly volatile. It spreads. It's rapid. And it has impacts on people's willingness to take a vaccine. So all the more reason for the important work of the commission here. And I really look forward to the discussions. And thanks, everyone. Over to Steve, my co-chair.

J. Stephen
Morrison:

Thanks, Heidi. It's great to see you. Those are pretty sovereign and dramatic facts that you're bringing forward. And thanks to Katherine. I want to also offer thanks to the team that's helped put this all together. Michaela Simoneau, absolutely integral to everything that's happening here today, and the production team – Graham MacGillivray, John Monts and Clifton Jones and Mary Wright – special thanks to all of you.

We have a terrific group of friends and members of the high-level panel who've joined us today. And we're going to have this conversation with them. It'll start momentarily.

Peggy Hamburg's with us, former Commissioner of the Food and Drug administration, currently interim vice president for Global Biological Policy and Programs at the Nuclear Threat Initiative. Welcome, Peggy.

Juliette Kayyem, is with us. She's the senior Belfer lecturer in international security at the Kennedy School of Government at Harvard.

Bruce Gellin's with us, president for Global Immunization at the Sabin Institute here in Washington, D.C.

And our fourth – our fourth guest and member of the High-Level Panel, Julia Spencer with Merck, where she's the associate vice president of global vaccines, public policy and partnerships, and government affairs.

I'm going to start with Peggy. We're going to roll through and hear some quick opening remarks to specific questions from all of these speakers in sequence, and then we'll come back for – to hear a bit more from Heidi, and have some conversation among ourselves. So, Peggy, I'm going to start with you. You know, we just heard from Heidi, there's a lot of turmoil concentrated in Europe, and the U.K., and elsewhere around adverse impacts, around production shortfalls, disruptions. And we're seeing some of that in the United States. Also there's the variants, scientific uncertainty. How might the challenges that we're seeing in the vaccine rollout internationally – how might those, including the EMA concerns over AstraZeneca vaccine, changes in dosing schedules and the like, are they having an impact in the United States on confidence and trust? Or will they?

Margaret "Peggy"
Hamburg:

Well, thank you, Steve. An important question. And thank you for also doing this session focused on the issues of vaccine confidence and hesitancy, which are so fundamentally important to public health and progress against COVID. This is clearly a very, very challenging time. We have the huge opportunity that having safe and effective vaccines gives us to really control the spread of this novel coronavirus and really begin to see a change in the public health landscape. But as the vaccine is rolling out in this country and in others, we're also seeing ongoing spread of worrisome proportions and the emergence of variants that make the task more challenging, as there is enhanced transmission and more serious disease associated with at least one of those variants. And some concern as well about whether variants can evade the efficacy of vaccines or natural immunity, to some significant degree.

So all of this is in the background. We have to move the vaccine out to as many people as we can. The issues of access are huge. We still have to

move the vaccine out to as many people as we can. The issues of access are huge. Still all the people who want it in this country, and certainly around the world, are not getting it. But also, recognize that there are pockets of people everywhere that are hesitant about taking the vaccine, that they don't have confidence. We've heard about that just now from Heidi, and much important work has come from her and others to deepen our understanding of this problem.

Trust in the importance, the safety, and the efficacy of the vaccines is very fundamental. But also whether or not there's a compatibility of a person's religious beliefs of their political ideology with vaccination makes a difference. In the U.S. we're now seeing, you know, more and more people of a certain political stripe not wanting to be vaccinated. And we also know there are people who, for historic reasons, have distrusted the health-care system and are concerned about getting vaccine as well. So all of that is in the background, and an active anti-vaccination movement that's been around for quite a while now and ramped up during COVID.

And then when you layer on top of that uncertainty that's brought in by safety concerns that aren't fully understood or explained, reports about manufacturing problems and contamination of vaccine. When you hear discussions amongst prominent, respected scientists about do we really need two doses, or could we just have one, or could we lower the dose of a vaccine? And there seems to be scientific uncertainty about the appropriate use of vaccines – all of that does matter. And Heidi certainly gave a compelling discussion about how in other countries it's really undermining trust and confidence and uptake of vaccine.

So we need to be very, very attentive to the need for clear messaging. We need to make sure that people understand why certain kinds of issues may emerge, as we learn more about vaccines, to be able to put a safety question into context, to be able to explain a manufacturing problem. It doesn't mean that all vaccine is contaminated, and that it's important that science is iterative. And as we learn more, the recommendations may change. And it's important that the messaging in our country is also aligned with messaging in other countries. And, you know, from the regulators to the scientists, to the public officials, so that we can diffuse as much of this uncertainty and confusion, which is already occurring in an atmosphere of, I think, unprecedented misinformation and intentional disinformation in many cases around vaccines. So the issue you raise with your question, Stephen, is very, very important, and one we have to be actively addressing today, tomorrow, and going forward.

J. Stephen
Morrison:

Thanks very much, Peggy.

I'm going to turn to Bruce to offer some thoughts. The Biden administration is shifting its posture towards vaccine diplomacy. We've had a few statements made both by Secretary Blinken and by President Biden

recently. There's still some uncertainty exactly what that will mean, but there's certainly been a move toward greater engagement internationally in the pandemic response. Bruce, in your view, these issues around building vaccine confidence, how would they fit? If we see a broader engagement by the United States in trying to shape the global response and be supportive, how are these vaccine confidence issues going to be built into that, in your view?

Bruce Gellin:

Well, sorry, let me – let me start by saying, you know, I think that the fact that the U.S. has now put down a marker for vaccine diplomacy is a sign that they're reemerging in a global health leadership position. I think that's really important. But I think your point's an important one, that the vaccine diplomacy is largely about supply, and it's an important one, the degree to which we're going to be able to donate vaccine that we have to support financially the efforts to vaccinate around the world, and encourage other countries to do the same. That's really important on the supply.

But let's not forget that there is this demand element of it as well. And just because you build it, just because you have it doesn't mean they will come. And so I hope that as a part of this is this conversation about trust and the importance of confidence. And that is equally built in as we start to move supplies to the parts of the world where they're needed. I think that we're – you know, we can – we can export the playbook we're now evolving here about engaging communities, making sure that health-care workers are at – the ones who are being the first to receive vaccines are read in on what the science is, are able to communicate what they're learning to their patients as they make recommendations as well.

And I think at the same time, Peggy raised this as well, is that these other structures that we have in place, that confidence in the vaccine is confidence in the system that brings those vaccines about, and the systems to make sure that there is adequate regulation so the vaccines that are delivered are safe, that there is a surveillance system to look for safety issues that might light up. All those are important. And I think those are the kind of things we want to make sure that we build into this, our diplomacy package, so it is not just we're going to get vaccines to places, but we're going to have them in a way that people will want to receive them.

So I think that the CDC playbook of doing that, what we're trying to do here, particularly with engaging individuals and communities, is really going to be important. It's clear that communication's a huge component of this. It's also clear that there's no soundbite that's going to turn all this around. So to be able to have conversations with clear, honest communications, as Peggy was saying, to be able to communicate what we know and what we don't know, what we're learning about it, and to acknowledge that things – we'll continue to learn things. It's a learning agenda. And we're going to learn – as we learn new things, we're going to be able to communicate those because there may be things that we have to shift along the way.

And I think if we're open with – in the same way we're trying to do here – with the populations, they can better understand when there are shifts and things that light up, whether it's a safety issue, or a distribution issue, or some other science issue that comes forward. So we just need to prepare the groundwork on the confidence, communication, and trust side as we've moving supplies around the world.

J. Stephen
Morrison:

Thanks very much, Bruce.

Juliette Kayyem, we've learned a lot, it seems to me, about approaching vaccine hesitancy and our understanding of it and what makes communities more hesitant. And that's evolved over the course of the pandemic. We've heard a lot about – in our own discussions around targeted approaches versus, you know, broad-scale national programs. And we know that as we've moving from scarcity of supply to abundance of supply we're beginning to see doses go unused and we're beginning to see the contours of hesitancy defined much more clearly to us. And that's taken a lot of people by surprise. And it's really revealed the scale of this – of this challenge that we face here. Say a few words about what you've observed, pleased.

Juliette Kayyem:

That was smart. That was like very March 2020. Hi, everyone.

I want to focus on a few things related to homeland security, just the U.S. So vaccine hesitancy has meant a lot of different things. And so I think we have to be clear what vaccine hesitancy is, as compared to anti-vaccination. And the good news on vaccine hesitancy is it is less a fear than we once believed. So remember when the polling starts – and in particular, I want to commend the Kaiser Family Foundation for their very consistent polling – we were at 50-50 percent in this country. There's no way you're getting to herd immunity with that. So those numbers are terrifying to someone like me who's not a doctor. I'm just a supply demand person and think about, you know, what states are building and what localities are building, and advising a lot of governors and mayors in this regard in terms of vaccine distribution.

So vaccine hesitancy, it turns out, eventually – or what we're looking at now is about 40 percent of Americans are, you know, I'll – you know, I'm going to knock you out of the front of the line because I want it that badly. That's probably – that's me. The other 40 percent are not at no. They are at not yet. And I think that's really important for people to know, because I think what it suggests – and you're starting to see it – is that vaccinations beget vaccinations. I mean, in other words, the more that this goes on, it's easier to get, I understand what category I'm in, and in particular delivery is related to hesitancy.

In other words, I like this move that the Biden administration is contemplating. I never liked the idea of federal large vaccination sites. They don't work. They're too big. They may satisfy some immediate need, but people really want to go to CVS, and they want to go to Walgreens, and they want to see their pharmacist. And so the most tactical we can make this the more you're going to have vaccinations beget vaccinations. So that's the good news. So all these numbers that you see – now, we've been pretty consistently between 75 and 80 percent. And so there's a problem of vaccine access for minority communities. But African Americans, despite some of the popular conventional wisdom, African Americans are as gung-ho about vaccinations as non-African American communities. Hispanic men we have a problem with, but that's also related to ideology, which is the second part.

So our vaccination problem, the red light that a lot of us have been seeing for about two – red flashing light for about two months now – I did something I thought I'd never do. I went on Dr. Oz, just because, you know, talking to conservative communities is important. Is we're seeing Evangelicals, conservative men, conservative women, childbearing age women very, very at no. And that is going to be our challenge in the months ahead as we get vaccine saturated.

I'll get into the national security issues, and I just want to say two things that is related to that. It's not an un-moveable no. So that's also good. The first is, I don't matter. In fact, Dr. Fauci doesn't matter. Dr. Oz doesn't matter. That this group moves by peer conversation. So the more that we can get people in these communities to accept vaccination and people feel more comfortable, they're less reluctant. Shaming doesn't work. Beating them over the head with politics doesn't work. It is really community based.

The second good news, at least in trying to move this group of conservatives, is the move I hope which becomes very, very strong in Q2, in this quarter, is, you know, every neighborhood corner pharmacy has it. I mean, in other words we get out of these big sites. They are anonymous. People feel nervous about them. And in some – and make it, you know, where I've been buying paper towels for the last couple years, make that where I get my vaccination. And this – and this is my last point – and this is interesting.

I think we can learn a lot from our tribal communities which, if you look at the data, are doing gangbusters. Not necessarily a community that has a lot of confidence in public health, let alone government public health. That was because it was tactical, it was localized, elders and others were behind it and got behind it early. And maybe that's a lesson for evangelicals and other MAGA conservatives who are – they're my only – you know, if you just look at the numbers, that's the only thing I start to get very, very nervous

about. Everyone else – everyone else will get there because the numbers suggest they are.

J. Stephen
Morrison:

Juliette, just to add a bit more on the whole question around Republican voters. A third of Republican voters we're told will not accept a vaccine. And half of Republican men. And this particular form of refusal is particularly acute when you're looking at younger voters and rural voters. So say a bit about that, because that's become a red flashing light very recently.

Juliette Kayyem:

Right, for us, yeah. And that number is going to be – you know, I don't know what percentage of the population, that could keep us – look, there's not a moment of herd immunity, but that's going to keep us from getting at least 15 percent, 17 percent of the population. So there's a couple things that we're starting to see. So, you know, I work tactically on the ground. That's what I do. I advise these mayors and stuff. So a couple things. So one is, it is not at all clear that polling will remain consistent two or three months from now.

So remember, we're still in – for most states, we're still in the divided allocation phase. In other – like, Massachusetts is still at 55 and older. So as things open up you might start to see more movement. But these are people responding to conspiracy theories, disinformation, and of course a year of an entire – you know, a White House, let's be honest – or a president. Not a White House. A president and others minimizing the threat. So if the threat is minimized, why the heck do I need to get the vaccine for something that really wasn't a problem? And so shame that the Trump family has not been photographed taking vaccines. Good for McConnell. Good for these religious Evangelical leaders for coming out there. We're just going to need more of that. The Dolly Parton's of the world mean something to conservative communities too. And she's been epic in that regard. So we need more of that.

J. Stephen
Morrison:

Thanks very much, Juliette.

Julia Spencer, thank you so much for being with us today. What's it going to take, in your view, to pull these programs together? We're talking about families and communities, we're talking about bringing them into some form of partnership – public-private partnerships with providers, with federal officials, regulators, employers. Tell us more about your thinking on that, because I know you're quite engaged.

Julia Spencer:

So thanks so much, Stephen. It's a pleasure to be joining my fellow panelists to discuss this really important topic. I think your question is the question. How do we take what we know about the attitudes and beliefs towards vaccination that, I think, you know, the other panelists described very well, and apply that knowledge toward strengthening confidence and building trust in the institutions that provide vaccination?

We know that who people trust can look very different, I think as Juliette so well-articulated. And when it comes to vaccination, we also know that hearing a consistent message is important. So that tell us that transforming hesitancy into confidence will take a diverse, multisectoral set of partners and collaborations, working from the hyperlocal conversation in a church, within a parent group, across the fence with your neighbor, or at your local pharmacy, and amplifying that with information that is – that is being conveyed with states as well as places like Washington, London, Geneva, and Johannesburg. Because this is all connected globally, as Heidi pointed out in her introductory remarks.

And so as we've discussed frequently in our panel meetings, vaccine confidence has been a concerning issue for many years. This did not start with COVID. We saw the implications of this playing out in things like the reemergence of measles in the last years even preceding this pandemic. So we weren't in a great place in terms of complacency and trust in vaccination in certain communities going into this pandemic. We've seen troubling declines in the percentage of U.S. adults who believe it's important to have their children vaccinated, and who believe that they have personally benefited from the development of vaccines over the last 50 years.

So that is a worrying picture that tells us that vaccine hesitancy will not end with this pandemic. But the increased awareness and dialogue about vaccination does present us with a tremendous opportunity and a tremendous risk as we navigate what is the most aggressive vaccination campaign certainly in this country, and likely in the world, that we have undertake in a century. So in terms of solutions, there is no one-size-fit-all approach to vaccine confidence. But there are tenets that we can all use in our efforts, whether we are regulators, or manufacturers, or employers, or community leaders.

We know that improving confidence starts at the community level, led by trusted members within that community. And people need to trust the messenger if they are going to trust the message. And they also need to understand how to access credible information. National surveys have shown that community members trust their doctors, their pharmacists, religious leaders, and employers. So we need to engage these leaders, give them the information and training they need to help people make informed decisions. And that sounds easy, but as, you know, Ruth and Peggy were telling us, this information is evolving rapidly and it is not always easy to be able to convey this in a way that people do find trusting and credible.

And so this takes ongoing resources. It takes coordination. And it takes capacity building. And I think we were all really happy to see what has been going on in the U.S. over the last month or so, with the federal government making significant advances in resources, in coordination, and in capacity building. The Biden administration announced that it would

dedicate \$10 billion from the American Rescue Plan to expand access to vaccines and to build confidence in our most vulnerable and underserved communities.

These funds will be distributed to states and localities so that community organizations and leaders are the visible faces of vaccine confidence. And the administration is planning to amplify these efforts by establishing an all-volunteer group called the COVID-19 Community Corps, which is made up of employers, nonprofits, religious leaders, and others so that people are hearing from trusted voices in a way that is culturally sensitive and applies the principles of health literacy, which are so important. And the goal here really is to meet people where they are and to tailor the intervention that will drive uptake in vaccination for those communities.

This focus on equity is so essential, and our ability to reach these communities really depends on our ability to understand the causes behind our hesitancy, whether those are political or those are historical based on institutional racism, unethical medical experimentation, or what they are hearing from their political leaders. And I think, you know, there have been a lot of studies that have been done looking at trust in specific communities. One recent national study showed that just one in three Latinx Americans and only one in seven Black Americans either mostly or completely trust that the COVID vaccine will be safe.

So I think we're all optimistic, but we recognize that there is a lot of work to do to change perceptions and beliefs in these pockets of communities where you do have deep-seated perceptions. And it's important to recognize that these underserved populations may suffer from access barriers. I think you also heard that from Juliette. And it's going to be critically important that once people made a decision to get vaccinated, that vaccines must be accessible to them. So ensuring that vaccination services are available with no out-of-pocket costs, and expanding the places where people can get vaccinated, these are critically important to ensure that the intent to get vaccinated results in vaccination. And we're seeing these solutions being deployed right now for COVID. And we have an opportunity to ensure that they remain place for the long term.

And that's important because while we are all working to address confidence in COVID-19 vaccines, we are also in jeopardy of losing ground on routine immunization. And we have seen, you know, troubling information coming out of the administration on the reduction in orders for vaccines for the Vaccine for Children Program. And these are the providers that are serving those who are most at risk and vulnerable, people on Medicaid, the uninsured, and the underinsured. And so, you know, as we are trying to focus our efforts on building confidence and trust in COVID-19 vaccines, we really should take a long view as we're responding to this crisis, recognizing that the next health emergency is only a plane ride away. But we also have concerns on routine immunization in our own backyard.

We have an opportunity, I think, to provide the lessons that we are learning now and the public-private partnerships that we are standing up for COVID, to be able to have those sustain after the pandemic is over, and to be able to share that technical information, the system strengthening work that is being done, that can help not only the U.S., but can also help our allies and our neighbors around the world.

And so I'll just close by saying that we all have a role to play. Whether we are an employer, a government, a community group, a religious organization, a health-care practitioner, but also the PTA president and the front-office professional in the local health clinic. And the work that we all do now is going to be critical to build confidence in vaccination, but it's also a down payment on preventing vaccine preventable diseases and outbreaks in the future. So my hope is that we really do take the opportunities that we have in learning about what works when it comes to confidence, and we really think about how we apply those to the longer term so that our systems are more able to deal with this kind of thing on a day-to-day basis, in addition to when the next pandemic happens.

J. Stephen
Morrison:

Thank you very much, Julia.

I want to come back to Heidi and ask a question of Heidi. The AstraZeneca drama has been going on for some time. And it's gone in multiple directions. It started with production shortfalls. It got enclosed within confrontation between the U.K. and the EU, with all those tensions associated with Brexit. Its communications and scientific reporting stumbles. It's now reports of the blood clots, and the confusing or shifting policies of many different governments and many different regulatory authorities around what this all means and what it should mean. And this has had an impact in the U.K. and Europe. And I don't think we are insulated from the impact. Our newspapers, our press accounts are full of stories of all of this. So what can you tell us? What can we expect, Heidi?

Heidi J. Larson:

OK. We are very lucky that this came up after 20 million people had been given the vaccine in the U.K. alone, because we all know that when we do mass vaccines – mass vaccination of the scale and scope that this campaign has been globally, that somewhere along the line we would see risks that were not picked up in the trial stage. Rare, presumably, but this could have happened in the first few weeks of rollout, which would have been a much more complicated picture. We have, as we heard before – I think it was Juliette who was talking about what we call the social proof, the more people see other people getting vaccinated, it builds confidence.

So I remind people, when asked about this, that there are 20 million people who did well on this vaccine and are going to be protected. There has been a confirmation of this risk, particularly of the cerebral-related clots. But it's one in a million. For four in a million they've assessed here for the blood

clots, and one in a million in terms of deaths. But it is extremely rare. And the idea is to detect as many symptoms as you can, if indeed this happens. Well, if that had been clear in the beginning, it would have saved a bit of the angst that went on. It's still not good news to ever hear about a risk, but we know that, you know, putting it into perspective, it's small, and rare, and relative to the preventing COVID.

What has happened is because different ages were given the vaccine across Europe – in the beginning Germany said don't give it to over – I believe it was over 65, because there were nobody in trials over 65. And now this has switched. We've got the U.K. saying, don't give it to under 30 because the actual benefit and risk weighing – which is very high and clear for older people – is less – the benefit relative to the risk is less overwhelming, compelling, I should say. So all of this to say that it has been a difficult time. We are lucky that this happened as late as it did.

We're – it's pretty amazing that across the different vaccine that have been rolled out we've really had very good safety experience. And I think we should, you know, champion that. I think we have to be extremely empathetic with anybody who reports symptoms of any kind afterwards, and not just say, you know, go home and a paracetamol without really listening to people. This is a really intense time for post-marketing surveillance. And just to say that, you know, these things do travel, as I said in the opening.

I think we have to – in terms of our framing of hesitancy, I think we have to change the tone of hesitancy. I've actually seen some language where people talked about eliminating hesitancy. I think hesitancy in the context of risk and hesitancy in general actually can be a very responsible thing. First-time mother who is hesitant, she wants to have all the information she can. In this current environment of uncertainty, and a very – and a clearly reported risk it's OK to be hesitant. And I think we should make sure we're not judging people for their questions but try to make sure we get the right information to get that movable middle to a place of confidence. And I agree that access is part of that mix.

J. Stephen
Morrison:

Juliette, did you want to say a bit in response?

Juliette Kayyem:

I can quickly respond. And Heidi's exactly right. Just on the U.S. side, in the focus groups, especially conservative women or women who, you know, want to have kids and they're just not sure, the scope of the trials for the three vaccines, it wasn't 10 people. It wasn't 100 people. It was a couple hundred thousand people. When they get that information it completely changes the way they think about it. So you and I, all of us, we read every piece of paper, every filing to the FDA, you know, for, you know, the emergency use. We know how big these tests were. So that's one piece of information that can go very far.

And then I think the other point that Heidi just made about the social proof, which I think is just a great – that vaccinations beget vaccinations – in crowd studies, because, you know, in security we study crowd control. We call it social cohesion, the phenomenon of the empty parking lot and why are the eight cars all in the same place. And there is an idea of social cohesion, the sense that that first car knew something, right? They had the inside scoop, so the other seven cars all parked near it. And that is actually what you're starting to see with vaccinations. So we have to move that first car to the right parking space, but then you start to see the social cohesion form about that. So, you know, I'm optimistic by nature, so I'm hoping that we can move those very reluctant, you know, beyond hesitant groups.

J. Stephen
Morrison:

Thank you.

One of our questions – one of our audience members raised a question around the weaknesses of the federal, state, and local health systems and what kinds of collaboration/coordination could ensure a better outcome. And that relates to something we had talked about in preparation for this meeting, which is we're seeing very dramatic increases under the American Rescue Plan – the \$1.9 trillion plan – and other appropriations in building national efforts on vaccine and vaccine confidence. In that context – I mean, it's early days. That work is just beginning. But there is a big shift underway. How do we expect federal agencies are going to work differently in this coming phase with state and local officials to make sure that funding's moved and we have the right impact and it goes to these purposes we've heard about of building capacity, but also building confidence and the like?

I want to ask Peggy and Bruce to weigh in quickly on that and then invite the other speakers to jump in. Peggy?

Margaret "Peggy"
Hamburg:

Amazing, you know, we're still having trouble with unmuting. (Laughter.)

I was saying that, you know, early on we had so much fragmentation in our response, and we were seeing states pitted against themselves and disconnects between expertise, capacity, and resources at the federal level and what was needed at state and local. I think that has been recognized as having been very detrimental. And efforts are being made now to have a whole-of-government approach, both across all the components at the federal level but also integrating state and local, and that's crucial. And we're at a critical moment for that now as we're trying to get vaccine out to as many people as possible and also other critical resources.

We need to be having clear communication with guidance and recommendations coming from our great public health agencies like FDA and CDC to help state and local policymakers and public health officials and the public understand about the state of knowledge, what can and should be done. But we have to have two-way communication because we need to

be hearing from states and localities about their experience on the ground and what is needed, and some of the best strategies to make a difference. And certainly as we think about the vaccine rollout, we need to make sure that we are aligning the vaccine with the pockets that remain under-immunized and the capacity to provide the vaccination.

And I hope that we will also, as has been noted, continue to build out the systems that matter in the places where people live, because that ultimately will help us, you know, complete this journey. We need not to be thinking about federally sponsored big stadium vaccination campaigns, but making it available where people know where to go, trust the providers, and have confidence in the system.

And just one last thought on the local-state-federal coordination. It is crucially important that we make sure that there's adequate collection of data about who's getting vaccine, what vaccine they're getting, and enabling the kind of post-market surveillance that Heidi mentioned, the ongoing collection of information about people's experience with the vaccine, so that we can better understand if there are emerging safety issues of concern, and also better understand appropriate use of these vaccines because there are still unanswered questions like the durability of the protection. So it's really important that we have that integrated data collection and monitoring as well.

Thanks.

J. Stephen
Morrison:

Thanks, Peggy.

Bruce?

Bruce Gellin:

Well, maybe the silver lining in the states having been left on their own early on is that these are now 50 laboratories. And I think building on what Peggy and what Julia was saying, there is – there is a lot of learning going on on what works and what doesn't work, and the ability to develop that community of practice to share that information on what works and what doesn't work. That's true in the United States it's true around the world to be able to share – to be able to share those kind of experiences.

I've been privileged to hear a number of the states talking about their experience. I'll just share one which I hadn't heard before, which was the – to shift away from the use of the word “mass” for vaccination programs. They said, well, if you fill in the blank, “mass” blank, there's nothing good that's filled in after “mass.” So let's talk about something else. Let's talk about community-level programs or something else. Again, so this is just one of dozens of – and many more – insights from the ground that I think are going to help to improve the experience everywhere – and again, not just here but around the world.

J. Stephen
Morrison:

Thanks.

Julia, you must have some thoughts on this.

Julia Spencer:

Yeah. I agree with everything that has been said, and maybe I'll just put – I'll put a positive spin on some things that actually I think have helped in the U.S. that we can, you know, help to export to other places.

And that is scope of practice laws. In a lot of places, only physicians are able to provide vaccinations or a very limited number of providers. And in the U.S., because you have pharmacists that can vaccinate in states and then you have vaccination that can happen in pharmacies, is a big step to increasing the surge capacity that we have in the United States. So I think how do we look at both where the gaps are, but also where we do have infrastructure and to make sure that we're sustaining that infrastructure so that it can support day-do-day immunization and can surge when it's needed.

I think on the downside, going into this pandemic, you know, state and local public health has been under-resourced and has really been, you know, crumbling in terms of infrastructure for too many years. And when public health is not able to do its day-to-day job, then – because of the resources and capacity that it has – then it's really difficult for it to continue to do that job and to surge to what is, you know, this unprecedented, you know, once-in-a-century event. And so thinking about going forward, how do we make sure that state and local public health in the U.S. is at a level of capability and capacity so that on a given day it can carry out its mission, but it also is able to then surge to do the kinds of things that are being asked of it right now.

J. Stephen
Morrison:

Thanks.

Juliette, I wanted to ask you a question around security. This high-level panel, in the report that we're issuing in early May, we make a – we make a very strong case that these issues around vaccine confidence, trust, misinformation are matters of national security. They get in the way of us being able to control the pandemic, get out from underneath it, restore our economy, restore the prosperity and good standing of the American people, and contribute to the reopening of the world and stabilization. There's tensions between the public health community and talking in terms of security. There's the cycle of crisis and complacency, where, as things – as we get out of the acute phase, a lot of people are going to want to forgive and forget and move on. What are your thoughts on this, on how to continue to reinforce to people after this profound drama the security consequences of this?

Juliette Kayyem:

So this is a great question. And I think there's probably less of a tension. I think in some ways as we've talked about in the meetings, we really should

see the security benefit of the public health communications and strategy; in other words, that they really do align. And they align in three important ways. I want to end with, I think, the most important.

First of all, we have a real security issue. We have the supply chain issue with the protection of the supply chain. We've seen vaccine trucks get moved over. We saw a mass killing – we don't know the motivation – at a market that was delivering vaccinations. So we've – we just have that pure tactical security issue that we need to address for the long term, especially if there is a third shot necessary. And also, of course, as people come out, the stress, the tension, the unease may show itself in violence.

The second is disinformation is actually a national security issue. We know that the Russians are amplifying a very strong anti-vax movement in this country. They've done it before. They, you know, target the misinformation. So we have to treat this just like misinformation in the voting scheme, that this is a way to undermine American confidence in its own structures and delivery structures, and treat it as such – call it out, bring it down, get – and get the social media platforms to do it.

And then the third is, of course, I think the bigger issue, which is just America's resiliency. How do I want to say this? I love America, but. I mean, hard for us to say that we're a legitimate alternative to, say, China, for example – which, whatever blame we want to put on China – in terms of its capacity to respond. So if you're the rest of the world, you know, our exceptionalism is only in our heads now, right, and it's going to be very hard for a lot of Americans to accept it. You talk to our kids, our teenagers, and they sort of burst out laughing when you talk about American exceptionalism, right, because they're looking at this country and saying we haven't exerted strength for the last four years, let alone five years to the outside world. So we really have to view us getting back to normal as the – you know, President Biden always like to say America is back and I kind of, you know, sort of, not quite yet, right? Because it's not – you can't just say it. We have to be able to help other countries, to be huge trade partners. We have to be able to travel and the social diplomacy of having families go to other countries. None of that's happening.

So those are the three ways I think about it. I think they complement the public health issue, and honestly I hope it can get many in the military to move because we do have vaccine hesitancy way too high in the military. So maybe putting it in the security framework might help.

J. Stephen
Morrison:

Thanks.

Peggy, I think you had some thoughts on this.

Margaret "Peggy"
Hamburg:

Yeah. I just wanted to underscore that we also have to, I think, help the American people and some of our political leaders understand that our

national security really does also depend on our reaching out and helping to ensure that the rest of the world gets access to vaccines as well. You know, we cannot just protect ourselves by looking at what happens within our borders and managing all of that. We really have to make sure that we are controlling disease wherever it's happening because the more the virus is spreading, wherever it's spreading, the more there are opportunities for our country to be at risk, you know, whether it's through variants that continue to emerge and are more concerning, or whether simply because as we open up there will be more travel and trade and more opportunities for disease somewhere else, even a remote part of the world, to be in our backyard tomorrow. So we really need to be thinking about security in a global context, as well.

Juliette Kayyem: Yeah.

J. Stephen Morrison: Thanks so much, Peggy.

Bruce or Julia, would you like to add to this discussion around security? I'm going to turn to Heidi to do sort of the closing benediction for us here today. Bruce?

Bruce Gellin: No, I mean, we talk about this a lot, I mean, that our health security is linked to national security and it's global. And I think the most compelling case is what Peggy just made, that it's – while there is a lot of moral suasion about equity and the like, it's pretty clear that unless we keep variants from proliferating, we're going to constantly be at risk.

J. Stephen Morrison: Thank you.

Julia?

Julia Spencer: Maybe just to punctuate what has been said, strong systems are what is going to keep us all safe in the future, in addition to all of the things that we've talked about today. And so ensuring that you have data infrastructure, you have pharmaco vigilance, you have safety systems in countries that are capable of detecting disease, as well as ensuring that you're able to deploy the medical countermeasures needed and to track those is critically important. It is a role that the U.S. can help to play in building capacity in other countries. And until everyone has it, then we're not safe.

J. Stephen Morrison: Thanks so much.

Heidi, can you share with us your closing thoughts?

Heidi J. Larson: Well, first, thanks to everyone. This has been a really rich conversation and really crucial.

I think that, coming back to what Peggy was saying in the beginning, recognizing that there are multiple levers of the confidence and resistance from historical to belief based to the uncertainty in scientific environment and the uncertainty in the pandemic environment, including variants you just mentioned.

Julia, I think the point you made that this vaccine hesitancy didn't start with COVID and it won't end with COVID, I would add to that that how we handle these – the rest – the moving forward, especially in this more sensitive time when the eager ones have gotten their vaccines and we're going to hit potentially a more – well, we are going to hit a more bumpy road, how we handle that – the engagement, the approaches – actually could – we won't – we won't lose vaccine hesitancy, but we can change that trust relationship.

And I think what Bruce said, there's a lot of learning going on at a state level. I've really been moved with some of the smaller local-level initiatives in the U.S., in the U.K., with Bangladeshi restaurant owners to barbers in Maryland to tribal leaders. I mean, it's fantastic if you look at that level. And we can use that to rebuild relationships that will be only a benefit moving forward and contribute to security.

And just to end on the this is all global and the slide I opened with, I think just we need the U.S. strong in the world. And I look forward to building that confidence and new type of diplomacy. Thank you.

J. Stephen
Morrison:

Thanks so much, Heidi.

And I want to just thank Julia, Juliette, Bruce, and Peggy for your time. And your dedication to this high-level panel over the last 10 months has just been terrifically generous. I want to offer very special thanks to my colleague Katherine Bliss for her leadership in directing this project, which has proven to be so rich and fruitful, and to Michaela Simoneau, who has kept us all online so successfully over the months. So thank you all for joining us.

Thanks to our audience members who've tuned in. Thanks to C-SPAN for broadcasting. We're adjourned.

(END)