

Center for Strategic and International Studies

Online Event

“Trusting a COVID-19 Vaccine: Who’s Left Unheard?”

RECORDING DATE:

Friday, January 8, 2020 at 1:00 p.m. EST

FEATURING:

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Heidi J. Larson,

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Katherine E. Bliss:

Hello. Good morning and welcome to the second in a series of public conversations about vaccine confidence and COVID-19 vaccines the United States. My name is Katherine Bliss and I'm a senior fellow with the CSIS Global Health Policy Center. Back in July of 2020 the CSIS London School of Hygiene and Tropical Medicine High-Level Panel on Vaccine Confidence and Misinformation convened a bipartisan and international group of experts from public health, cybersecurity, public opinion research and communications to assess the implications of misinformation and vaccine confidence for U.S. national security within the COVID context.

And as the High-Level Panel met several times over the summer and fall, the members were very clear about at least three things: First, that the lackluster public confidence in COVID vaccines that was being reported represented a clear threat to national security; second, that it is not enough to have safe and effective vaccines, but that to ensure public confidence in them they must be delivered to the public in a coherent and effective manner; and third, that addressing the challenges of misinformation and disinformation about COVID vaccines requires a multidisciplinary, multipronged approach.

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 call to action outlined five key recommendations. Let me summarize each one. Now, the first call for the rapid launch of an independent panel on vaccines and misinformation to assess the decline in popular trust in science in the United States and to recommend concrete levels to be taken at the national, state, and local levels.

The second noted that innovative approaches are needed to reach diverse and underserved populations with vaccines, and other social services support, and that this could include integrating the delivery of COVID vaccines into a broader platform of assistance, such as access to other kinds of health care, counseling and referrals for housing or unemployment benefits, or other kinds of social services. The third urged pledges and actions by mainstream and digital media to proactively stop the spread of mis- and disinformation to encourage collaboration with health providers to amplify social – excuse me – to amplify scientific content on social media platforms.

The fourth encouraged increased activism by key social and economic sectors to initiate national dialogue about vaccines and empower people

to make informed choices within the COVID context. And finally, the fifth recommendation emphasized federal reform, including interagency leadership at the National Security Council and increased U.S. support for global immunization partners to address vaccine confidence within the larger context of immunization services.

Now that the call to action is out, we've initiated a series of public events to discuss the recommendations and hear input from other groups. This is the second of those meetings. Our first one, in December, focused on the public opinion climate and the potential for establishing an independent review panel to address the root causes of hesitancy around COVID-19 vaccines in the United States, and to develop recommendations to address it in diverse communities where it has manifested. And this is right at the moment when the first ones were being approved for emergency use, back at the beginning of December.

Our next one, on January 27th, will focus on the third recommendation of the panel around media and the steps that mainstream and social media can take to address misinformation and disinformation. Today we'll be focusing on the call to action's second recommendation – that is, reaching underserved communities that have been the hardest hit by the pandemic with vaccines and, importantly, information about them, and meeting those communities' needs for health and social services beyond just COVID vaccines. Really looking at the entire context.

And really one year into the COVID pandemic, and just one week into 2021, this is a timely discussion, as right now we're seeing information about new and highly transmissible COVID variants, the highest rates of COVID hospitalizations in the United States since the spring, and the number of cases and deaths trending upwards. And all this while the nationwide vaccination process has, by many accounts, gotten off to a bit of a bumpy start.

I'm very pleased to turn things over to Heidi Larson, director of the Vaccine Confidence Project and co-chair of the High-Level Panel, to introduce our speakers and lead the discussion. And before I do that, let me just remind those of you in the audience that there is a button you can click on the event website in order to enter a question or a comment that will come to the panel over the course of our discussion. Heidi, let me turn it over to you.

Heidi J. Larson:

Thanks so much. I'm thrilled to be able to moderate the session today. We've got three fantastic speakers, who are remarkable health leaders in different domains. And I'll introduce them one by one and ask for their comments on the challenges we have, actually – the challenges and opportunities ahead around reaching some underserved and sometimes skeptical populations with COVID-19 vaccines, and different views from their different perspectives and roles.

We'll start with Denise Gray-Felder, who I know well from her early work and continuing work, before it became a more popular area of work – (laughs) – as founding president and CEO of Communication for Social Change Consortium. She's launched that after working and leading some relevant initiatives in the Rockefeller Foundation, and in the interim was chief communication officer at the Medicine Center in University of Michigan. I won't go through the long CV, but I just want to turn it over to you, Denise, to kick off the comments this morning. And then I'll come and introduce the other two speakers for their comments. Thanks so much.

Denise A. Gray-Felder: Thanks very much, Heidi. First of all, I guess I'd like to start with stating the obvious, which is communities of color, we're not outliers. Our members do not universally – our members do universally understand the risk of COVID-19 and we do appreciate science and vaccines. But like the majority of the White population in the United States we care about staying healthy, keeping our families healthy, and keeping our neighbors healthy. Among the reasons significant numbers of Black and brown people are underserved by the medical community in this country are, just to name a few, rising doctors and hospital costs, housing patterns, persistent poverty or unemployment, employers who simply do not provide health insurance, and racial discrimination.

More than 27 percent of Hispanics in the United States do not have health insurance, and nearly 14 percent of Black Americans do not have health insurance. We simply cannot continue, and we should not absorb those statistics willingly. We fight hard to keep our families – we being communities of color – fight hard to keep our families healthy and safe from COVID, just like anyone else in this country. But I assume that when significant numbers of people of color refuse to take COVID vaccines, it is not – or, say they will refuse to take COVID vaccines – it is not because he, she, or they do not care. It is not a political statement and it is not a political decision.

People whose families have been historically marginalized and mistreated in the United States are remarkably loyal citizens, in spite of all this country has thrown at us and taken from us. So my first observation is: History matters. Providing equitable access and motivating patients to take the vaccine requires all of us to understand the history, good and bad, of people of color and health in this country and to help us move forward together. History cannot and must not be discounted. It's part of our jobs as health care communications – physicians, nurses, other health care providers, even medical researchers – to listen, to discuss, and to accept an individual's total reality, the whole person. Not to judge, and not to try to make history irrelevant.

I worked, as Heidi said, for years with UNICEF and other U.N. organizations on polio vaccine in parts of the world that had not reached herd immunity. I was continually surprised by the level of rational actions that underlaid a mother's refusal to allow her children to receive a simple oral polio vaccine. We would explain – our health care teams would explain, but it's just a drop. It does not hurt the baby. But even this simple explanation – with even this simple explanation, many mothers refused. In northern Nigeria in particular, we learned quickly that family values and cultural dynamics were critical, for we had to find workarounds.

In the Muslim communities in the north of Nigeria, and particularly in four northern states, wives and mothers were expected to seek advice about managing their family first from their mothers in law, many of whom lived right there with them. We learned to communicate with both of the women of the households. We discovered that when mom in law understood the grandbaby could be crippled from polio, or worse, she became cooperative. She found ways to defy her son's wishes or to have the vaccines occur when the son was not home. And if we got really lucky, one of my favorite stories is when the emir's wife of that state turned out to be a Carnegie-Mellon scholar. And she believed in vaccines. So she told her husband's congregants that Allah expected children to be healthy.

Today we see similar challenges here in the northeast, particularly in New York and New Jersey, among mothers who may claim they're simply anti-vaxxers. So first recommendation: Find the right influencers. For most people, if we respect and trust the person telling the message we will accept and trust the message and respond hopefully positively to vaccines. It was mothers in law in northern Nigeria.

And here right in New Jersey, in Hunterdon County it might likely be Mommy and Me groups. An example of the right influencer, Tom Joyner while a radio DJ launched a campaign called Take a Loved One to the Doctor Tuesdays. He became a reliable influence on Black men who were brothers, fathers, husbands, sons, nephews to get regular prostate checks. Let's figure out for COVID vaccines how to get the next Tom Joyner on board to reach the First Nations, the Black, and the Spanish-speaking communities in this country.

My second recommendation: Use history in truthful and ethical ways. I'm told that some Black and brown patients state that the treatment of Henrietta Lacks is part of their reason not to take or accept the COVID vaccine. So we must point out that Mrs. Lacks' story is misunderstood, if that's the type of decision that's being made. Mrs. Lacks was not harmed physically by a vaccine. She was not informed nor compensated, of course, for the unauthorized use and sale of her cancer

cells. These were clearly abuses of her human rights, patient rights, and her privacy rights. Yet, Mrs. Lacks' cells have contributed to the first polio vaccine research, to cancer research, to in vitro fertilization and, more recently, to studies on the impact of SARS-CoV replication in the human body. While this end does not justify the means, we must continue to tell the complete truthful stories.

Third recommendation: Dialogue. Dialogue with friends, families, colleagues, and patients of color always trumps dictums. Distrust of doctors is real. Fear of seeing a doctor is real. Avoiding doctors is real. And dialogue is essential for changing behaviors. So if you're in a position, please do not brush away vaccine hesitancy as silly or foolish. If patients are willing to accept a COVID vaccine from someone who looks more like him or her, by all means please help that patient find that someone.

Fourth and final recommendation: Professionals, health care professionals, do not discount my truth. My truth is real to me and I may not care what you think about it. A little background from Dr. Roy Wilson, president of Wayne State University in Detroit. He is a physician, and epidemiologist, and a researcher who serves on Michigan Governor Whitmer's Coronavirus Taskforce on Racial Disparities. In a recent newspaper article he said, considering that 58 percent of the Black people state that they will not take a vaccine, this caused him to share a few of his truths.

One, that the Moderna and – both the Moderna and Pfizer vaccines currently available had a good representation of at least 10 percent in their clinical trials. One of the NIH's lead scientists for vaccine development is an African American woman. African Americans serve on FDA panels that recommended the two vaccines for emergency use authorization. Principal investigators in both the Moderna and Johnson & Johnson ongoing vaccine studies are Detroiters – a city which, by the way, has one of the highest populations of Black residents, about 82 percent. The seemingly rapid development of the two vaccines currently in use is really not all that rapid, because they are based on years of foundational research of the mRNA platform. So this is not a situation – to all people of color, please know corners were not cut in vaccine development.

I'd like to close by saying simply: COVID – no one gets COVID from either of the two vaccines. B, vaccines are safe for Black, White, brown, purple, green, and red – as my kids used to say when they were small. We put our neighbors and family – we in the communities of color will continue to put our neighbors and families first and take the risks when we understand and accept them. And finally, your story – like mine, like all of ours – matters greatly. Be heard. Thank you.

Heidi J. Larson: Thanks, Ms. – Denise, and particularly for distilling some of our key points for moving forward. I’m a big advocate for listening and dialogue.

I’m happy to introduce our next panelist, LaQuandra Nesbitt, who is the director of the District of Columbia Department of Health, and a physician leader, and a mobilizer, and promoting and prompting innovation. And we really look forward to your perspectives and comments. Thanks.

LaQuandra S. Nesbitt: Thank you so much, Heidi. And I’m grateful to have the opportunity to be with you all today.

You know, there’s been a lot of opportunities to talk about the reasons why we have disparities in COVID-related outcomes in the United States. And so much of that is rooted in the reasons why we have disparities and inequities in our country overall. I’ll start with talking about just that specific thing, and the need for us to recognize that the reason why we have disparities in COVID-19 related outcomes is because we need to recognize that these disparities are not due to the acute nature of the emerging infectious disease, but that it is rooted in the systemic nature of what causes disparities in health outcomes and health care disparities overall.

We also have to recognize that in order to eliminate these disparities in COVID-19-related outcomes, whether we be talking about the treatment disparities or the vaccine disparities that we have the potential to see, is the need to engage multiple sectors of government beyond governmental public health in the COVID-19 response. And I think you’ll hear a little bit of what I mean by that when we talk about addressing vaccine hesitancy. And the third thing is the need to have efficiently – the need to efficiently mobilize a public/private partnership.

And we – in order to do these things, or how that – a further expansion on that – and Denise spoke about this – is that we must be very intentional in three key areas: Access to health care. So, vaccination, we often think about that as an extension of health care, even if it’s early on in a prevention aspect. We need to address the social and structural determinants of health, so thinking about this a lot about health literacy, thinking about people who live on the margins who are underemployed, often have challenges with accessing health care or health services, as they are traditionally offered.

I was having a conversation with family members who – many of these vaccine clinics that are offered, people want to work in these clinics from 8:00 to 4:00. People who often have underemployment need services to be offered outside of the traditional time and may not want

to come into something that is being described as a health clinic or in a health care setting. So how we think about how these services are even structured is going to be critical to the uptake of them. And then addressing the structural and intentional racism that exists around health care services, and the mistrust in the health care institutions.

And so Denise has already talked about the issues and concerns about Henrietta Lacks. I trained in Baltimore City. And if I had been exposed to a lot of the things that I later learned around Henrietta Lacks it would have sensitized me a lot more to what my patients – who grew up in Baltimore – believed around health care institutions. And when I was referring them to certain services and their resistance to receiving those certain services, I would have been able to help them navigate those things a lot better if I had been less ignorant to some of those historical practices.

So we talk a lot about nine key drivers of health that would help us achieve equity. And medical care, medical service is only one of them. Education, employment, income, housing, transportation, food environment, outdoor environment, community safety round out those other nine key drivers. And all of those are going to be very critical when we talk about these vaccination efforts. Some of them because they compete for people's time and their prioritization when they're making decisions. And then some of them will be critical in terms of how we get people to actually – the way that we have to structure access to these vaccine programs.

So some of – when we talk about vaccination hesitancy – when we surveyed our population here in the District of Columbia we saw that rates for acceptance of the COVID-19 vaccine was as high as 90 percent in some populations and was as low as 60 percent amongst Blacks or African Americans. And what was of other concern was even when we looked at health care workers and essential workers who were Black or African American, the acceptance of the COVID-19 vaccine still did not move above 60 percent.

So when you talk about how you develop effective strategies for being able to address hesitancy or increase confidence for the vaccine, and they're saying it's because they have concern about safety and effectiveness, or they have concern about the speed with which the vaccine was made – being the top two reasons – you have to then start to be, again, to unpack other layers that motivate them or drive their decisions around health when it comes to COVID-19 in particular.

As Denise mentioned, we have to be careful to over-pathologize (sic) the decision-making and behavioral practices of communities of color. They are as interested and as invested in keeping themselves safe and healthy as it relates to COVID-19 as they are with every other health condition

that befalls us in this country. We surveyed our community early on in our COVID-19 response back in the spring when we were thinking about reopening our community, recognizing that access to and uptake of a vaccine would be the only way that we could get back to our pre-COVID state.

And at that time, the top three things that people listed as being the most important to them was how we would take care of and protect our vulnerable communities, how we would achieve equity in a reopening framework, and protecting the health of themselves and their families. So being able to create an approach around vaccination that values those three things was more important to people than jobs, and transportation, and economy. And we still believe that those things hold true in terms of core values, despite the fact that this has gone on much longer than people could have imagined when we were surveying them back in the spring.

So what will appeal to people? We've taken the approach of recognizing that having doctors and nurses going out and talking to people about the importance of vaccination or why we are getting vaccinated isn't going to be the best solution all of them. Talking – even though safety and effectiveness of the vaccine is what people are listing as their greatest concern, or the speed with which it's made, isn't always going to be the best way to move the needle for folks. But having next-door neighbors who have been vaccinated tell people about their experience, or why they chose to be vaccinated, is going to do a lot more to grab people into this vaccine movement, and decrease hesitancy, and build confidence.

So we've done key informant interviews. We've brought in credible messengers. We've had lots of people who are in the community who are working on the front lines be taped and issued those PSAs through a number of modes and modalities – using social media, local newspapers – that appeal to a number of audiences as ways to move that messaging forward in our community. We're not relying on any one sector to be the sole messenger of messaging around why this vaccine is so important. Everyone has the information they need around the science. Everyone has the information they need around the safety and effectiveness of the vaccine. But the human story is what is going to, we believe, move communities of color and give them the confidence that they need in terms of safety.

So I will sort of stop there in terms of what this – these different levels of touchpoints will look like in our community, what our social engagement strategy will look like. We are doing grassroots and grass tops in our community to be able to reach people. And acknowledging the challenges that the health care community historically has created for this movement. And recognizing that this is not going to be an issue of the privilege in terms of the historical things that have happened with

vaccine hesitancy and anti-vaxxers, but one around systemic distrust of the medical community that has been for experimentation with Blacks and African Americans that we will need to address this time around.

And we are prepared to do that by mobilizing community members who recognize that if communities of color don't get vaccinated we will just continue to exacerbate the COVID-related disparities and COVID-related inequities that are already existing. And we will continue to perish at much higher rates. Thank you.

Heidi J. Larson:

Thanks very much. All important. And I think the alignment with core values is key, but that takes listening and understanding what those values are.

The last panelist, and certainly not the least, as they say – (laughs) – is Umair Shah. We are thrilled to have you here today. You're currently secretary of health in Washington State Department of Health, but just moved from being executive director and local health authority for Harris County in Houston, which was quite a significant role in itself. So we're – thank you for taking the time and look forward to your sharing your comments. Thank you.

Umair A. Shah:

Thank you, Heidi. And thank you all for joining us this morning on such an important topic. And I just want to echo the comments that were made by my fellow speakers that vaccines and vaccine hesitancy mistrust and distrust are all significant concerns, regardless of whether I was in Harris County in Houston – which I am leaving after a 24 to 25 years of being in Texas, 16-17 years at Harris County – and now only over the last two weeks being at the state of Washington. So it's – right now, for me, in this transition from Texas to Washington, it's really a tale of two cities, two worlds that I'm – that I'm living in. One, a world that I'm very familiar with, and another a world that is new to me.

And yet what I'm finding is that the themes that were in play in Harris County are very similar to the themes that are in play in the state of Washington. And I think that is underscored by my fellow panelists who just spoke, that this is really a universal issue. And whether it's a domestic concern, or domestic audience, or a domestic population or, as our first panelist spoke about, related to a global experience, there are a number of different factors that we all have to take into account with what's happening. I want to underscore the point that COVID-19 did not begin health inequities. Certainly, if anything, it has unearthed and accentuated those health inequities that have been longstanding.

And the real concerns that we have are really very much that this has been a very difficult time for all of us around the world related to COVID-19. And the concern is that as we have been in what I call this really dark tunnel – this long, dark tunnel, we have a light at the end of

the tunnel, which is to get past this pandemic. The beginning of the end of this pandemic is vaccination. And unfortunately, when we have vaccine hesitancy or reluctance, or just frank disbelief that vaccines work, or vaccines are a solution, or vaccines are some therapeutic that should be taken, we have a real issue because this is really what we need to be solving in order to get past this pandemic. And unfortunately that's the biggest concern, whether it's in Texas, Washington, anywhere across the country, or even across the globe.

I always believe that – the three cornerstone values that I bring to the table during my public health career have been innovation, engagement, and equity. And I believe all three of those values have an incredible amount of resonance when it comes to this topic. Obviously, we have to be creative. We have to be thinking about technologies and ways to really rapidly deploy and do things with vaccine development, as well as vaccine dissemination, as well as vaccine administration. So we all the way from the piece of having a vaccine, for example, a COVID-19 vaccine that's in theory, that's developed, that's produced, eventually that's disseminated to states, and then to – from those states to local communities, and eventually into the arms of people. All of us will agree that if you have vaccines that are not in the arms of people, then it's – the whole process of developing those vaccines really has been of little value.

The second piece of it is engagement. And this has already been brought up, but I do want to make it clear that engagement is not just a one-time process. Engagement is a long-term relationship with community members. This is something that we, in government, have a very challenging time with. It is very difficult to engage when oftentimes the very communities that we are engaging with do not look at government agencies or those who work in government to be trusted. And whether it's from the Tuskegee experience, whether it's our Indigenous communities who have been harmed. And remember, we have 29 tribes – sovereign nations in the state of Washington in addition to local health jurisdictions. We also know during COVID-19 at the very beginning Asian American populations were discriminated against. And we also recognize that Hispanic and African American populations have been disproportionately impacted by this – by this horrific pandemic.

And so engagement is so key. And yet, when persons in communities do not trust government it's very difficult to move forward on that. What I'm learning is that the state of Washington, fortunately, has engaged in a very robust way with nearly 20,000 people during the process of vaccine discussions about COVID-19 over the last several months. And that has included a number of different languages, key informing interviews, community conversations, focus groups, and really trying to get to what are the concerns about safety and efficacy of the vaccine? And the main concerns are really the rapid development, the lack of

transparency about the vaccine development, across all communities, groups, and sectors fearing that a vaccine somehow may be mandated.

And that fear was worse in certain communities, especially African American, Indigenous communities, and communities of color, due to the history of medical experimentation and really concerns about really moving in a direction where these fears were then further accentuated by inaccessibility of vaccines, or feeling there was not an adequate supply, or concerns that peoples would not be prioritized. And there were a lot of additional pieces that drove fear, including fear that if vaccines were delivered that in some way those vaccines would not reach populations that were including older adults, people with disabilities, even pregnant people, children, and people of color. And so there's a real big concern that we have.

And the third piece, in addition to engagement, that I mention was equity. And equity is the cornerstone of what all of us are wanting, and trying, and hoping to achieve. But it's not just a hope and a prayer. It's something we have to really work towards. And so inequities have driven this pandemic in a way that we have not seen in recent memory. And yet, those are the very inequities that are driving many of the challenges. When we were working towards planning – and that means everything, as I mentioned, from development of vaccine to dissemination of vaccine and the logistics that into the development and distribution administration of those vaccines – we have had a real challenge in this nation because our federal government has spent a lot of incredible energies on developing those vaccines.

But in my opinion, the really – the moving towards the final – as they said, the last mile of getting vaccines into the arms of people, were left to states and locals. The very states and locals that were actually taxed by the COVID-19 pandemic with testing, and contact tracing, and all sorts of other public health efforts. And there was little effort that was made as well on communications. And that includes the engagement that I spoke about earlier, where communications is such a key aspect of what we have all recognized is important when you're – when you're working on something such as vaccines with communities.

So I go back, and as I close here, to just a couple of additional comments. We know that there are those sometimes termed as anti-vaxxers who do not perhaps believe that vaccines are the solution or that vaccines should be championed as they are. And whether or not we agree and do not agree – and in fact, we should not agree – that vaccines are an issue, because vaccines are a solution, the problem and the concern is that we also have to engage individuals who are also of disbelief, who do not trust vaccines as a construct, while we also have to address those people who are not believing in vaccines not because of a fundamentally – a

fundamental mistrust or distrust in the construct of vaccines but because they do not have good information.

And so our job is what I always refer to as the ABCs. The A is to raise awareness. But we can't stop there. We have to go the BC, which is behavior change. And behavior change is a science. And it's something that we have not been very good at doing as public health officials, as health officials, as physicians, as nurses. We have not been able to change behavior because oftentimes we have been working from the standpoint of our science and our evidence is enough. We wear our white coats. That's enough. We can use the big words and scary words sometimes. We use the banner of public health, or science, or health or health care. And what we miss is the opportunity to be part of the community.

Ultimately, we have to engage because we're a member of a community. And we should be willing to engage our community because we are part of that community. But when there is mistrust of us, then we have to rely on our leaders and our partners, including faith leaders. People – what I call in the people – health happens where you live, learn, work, worship, and play. And we talked about leaders in all those different sectors.

So finally, I just want to close by saying that we know that there's an incredible diversity in our communities – diversity of populations, people, cultures, religions, national origins. But there's also diversity of thought. And it is our job and our hope – and it can't just be a hope and a prayer but it has to be hard work towards – how do we bring those disparate peoples with different ideas, different thoughts, together so we can vaccinate as many people as we can in our country, because ultimately that's our way out of this pandemic. So with that idea, we'll turn it back over to you.

Heidi J. Larson:

Thanks so much. Yeah, many different perspectives coming together, before I comment on any of them – but thank you so much. It's been a valuable complement and different perspectives. You do come – (laughs) – you have had the opportunity to be in two states that are probably hosting some of the most extreme anti-science. So power to you. (Laughs.)

I'm going to turn over to Steve to bring his thoughts and reflections to the panel and to our audience. Thanks.

J. Stephen Morrison:

Thank you, Heidi.

First, I want to just offer a tribute to LaQuandra Nesbitt. I'm a District of Columbia resident. I've watched her leadership. It's remarkable. It

makes me very proud and very confident in our city. And I want to thank her.

And I want to thank Umair Shah for his role. We've connected with Umair in Harris County, in Houston in the past, during the Ebola era and more recently. And his leadership is quite remarkable, and highly impactful.

And Denise Gray-Felder, who has pushed on these issues both internationally and domestically with such skill and commitment.

I'm going to offer some quick comments on the bigger picture of where this fits. My basic premise is that these issues we're talking about – trust and confidence and inequities – are security matters. And I'll explain what I mean by that. And the second, related, point to that is: There has been a shift in national consciousness, I believe, at the political level in recognition of this. President-elect Biden has made clear that dealing with COVID-19, dealing with trust and confidence, dealing with inequities is a number-one national priority. It is tied to his perception of U.S. national interest. And it is the top line priority.

Today there was the announcement of the structure of the NSC, this morning. And in that announcement global health and public health in the United States are listed as central issues within that national security structure very prominently. We've already had the president declare that Professor Marcella Nunez-Smith is going to play a key role, not only as co-chair of the COVID-19 advisory group but also will be chair of an equity taskforce. This is unprecedented. This is the first recognition that these issues need a national approach, they need someone of the skill and talent and commitment as Professor Nunez-Smith, and the profile and visibility.

Obviously how we operationalize this national commitment, how we tie it closely to U.S. national interest, is still a challenge. And it's one that will be worked out. But I take these measures as very important signals of a change – a fundamental change of consciousness that is tying these matters to U.S. national interest and security. Obviously, the urgency of the moment is clearly in – very much in the forefront. Three hundred and sixty-five thousand Americans dead of COVID-19 – the majority disproportionate – wildly disproportionate impacts on populations of color and poverty. Twenty-one-point-six million cases, the same. Four thousand persons dead one day this week. And 237,000 cases, on average, per day. And hospitalizations running at a breaking point at 133,000 beds occupied at current moment.

We just had the economic forecast delivered this morning showing that in the last month job losses of 50,000. Our economy is in reverse, highly vulnerable. The marketplace may look strong but the impacts on

communities and the communities we're talking about – those that suffer the greatest disparities, inequities, marginalization, and discrimination, are those that are suffering economically in a very acute and aggravated way. We know that we're at – our health systems are at the risk of breaking. We know we've had to turn to the military to help. We've had to turn to National Guard to supplement and backstop vaccination campaigns, the Army Corps of Engineers to help on an emergency crash basis expand facilities, military medics to come into backstop and complement staff during acute shortages.

The last thing I'd say is that we are in a particularly fraught moment, where these issues are playing themselves through. We know that we are in the midst of an economic crisis. We're in the midst of a surge. Our staff are stressed. We have the new variant arriving. And we're attempting to roll our vaccines in the midst of that. But as our events of this week at the Capitol showed us, we're at a moment of national political crisis, where we could have a mob attack the Capitol. Racism is embedded in that attack and has become a first and foremost issue in the discussion of what this all means. And it has exposed to use the reality that a large segment of our population refuses to accept facts.

When we have, in the middle of the night after the assault upon the Capitol, seven members of the Senate and 140 members of House Republicans continue to vote in favor of the lies that the president has put forward, this shows us how disunified we are and how we've broken into different populations with different reference points to reality. This level of disunity and chaos will drive down public confidence and trust in all areas, including the ones we're talking about here with respect to vaccines. I'll just stop there. Thank you so much.

Heidi J. Larson: Thanks very much, Steve. Correct me if I'm wrong, Katherine or Michaela, are there no questions that have come in, or I'm – just to make sure I'm not missing something here.

J. Stephen Morrison: I don't believe so, Heidi. I think you're free to – free to move forward.
Heidi J. Larson: OK, great. Well, you know, one of the things – OK, here's one coming in. Partnerships are going to be critical to reach these vulnerable communities. How are public health officials thinking of engaging organizations like Capital Area Food Bank to make the outreach and awareness efforts and provide food distribution that can be bundled? We stand ready to support. That's the kind of engagement we need. Start with the willing, right? (Laughs.) I guess this is over to LaQuandra, but it does raise that important point that came up a number of times, the importance of moving outside of health sector only.

Over to LaQuandra.

LaQuandra S. Nesbitt: Sure, Heidi. And thanks. I appreciate the question.

We do a lot of expectation management in public health as it relates to the COVID-19 response in terms of what the capabilities and capacity of our community partners, especially in our social services organizations, businesses, and other key partners have the capacity and capability to do. What we're often looking for are message amplifiers. And we have – we often have a lot of key talking points or collateral messages and images that we've created that we're often looking for these partners to distribute.

One of the things that has happened with the development of these particular vaccines that we have now is that we have significant limitations in being able to use community partners, even if they were to secure their own providers, in being able to establish themselves as distribution points of vaccine, right? So there's a lot of logistical limitations in being able to engage community partners as sites for vaccination or being able to be providers of vaccination because of storage requirements. It will lead to a lot of waste of vaccine.

What we can effectively do, and what we really want to do, is to use these providers as amplifiers of messaging, distributors of information, to be able to answer questions that people would have, or to be able to identify credible messengers, people who come to them for services who have already been vaccinated, who can then be used to help get other people on board, to say: This is why I got vaccinated, this is what my experience was like, et cetera, who other people trust in those circles.

It doesn't require for us to always give you something directly, to call you up and say: Hey, would you do X, Y, Z? Those messages are – those information documents are readily available. We ask people to go to our – to come to our website, especially these mature organizations, right? Food banks are mature organizations who can capture materials from us, and to spread them out, to disseminate them, et cetera. And even for those who may say, well, we can't afford to print materials, et cetera, if you notify us of that we can deliver materials to you to disseminate.

So at this point in the juncture we can really engage with you effectively in partnerships to do that. What we cannot do at this point is to set up a clinic in certain food banks, right? We've set up maybe one in a park and recreation facility adjacent to you, or in your neighborhood, or in a senior center in your neighborhood. And we want you to be able to help move people into those particular sites at this point, is the best way to think about what partnership looks like with the government and to have people have confidence in being able to get vaccinated.

And again, a lot of that is because of the limitations in being able to store and to logistically distribute the vaccines, because of their life cycle. That could change as we have more vaccines that get approved.

Heidi J. Larson:

Great. Thanks very much. I have a couple more questions here and then – I have two that came in and I have one myself. What is the best – one is, what is the best good information we can share? And I just – I think I'd like to answer that and say for a start, the best good information is relevant information because a lot of times I find that from health authorities or, as Umair referred to the white-coat assumptions, is information pushed out because we think it's important. And I would answer that question by saying: The best information is making sure it's relevant to the questions and concerns of the community.

The next question, and I'm going to do a tour de table, as they say, so if any of you have an additional comment on that please weigh in when I come back to you. And then the next question is from Brian Byrd at the State Health Foundation in New York. What would be the best role for grantmaking foundations in reducing misinformation and mistrust. I could go on and on about that one – (laughs) – but I'll – actually, I think – yeah. That maybe over to Denise, having your foundation background on that. And personally, I would say funding understanding of it – funding a lot of the points that have come up across all the panelists on what – on understanding what's driving it. I often say that we don't have a misinformation problem as much as a relationship problem. And that's the part we need to understand.

But, Denise, do you have any comments on this last point? And then I'll have a wrap-up question.

Denise A. Gray-Felder: Thanks. I think that, Brian, you and your colleagues – and for full disclosure, Brian also worked for the Rockefeller Foundation.

Heidi J. Larson: Yeah

Denise A. Gray-Felder: I think that you and your colleagues could do a great service in helping identify and mobilize the influencers, the people that can actually make an impact in the communities that we're targeting. Particularly in the state of New York where it is a quite complex set of communities, and getting people to share – to have access to and share the same information, and be able to in a systematic way listen to and respond to the concerns and the questions and the inaccurate information that communities are getting and spreading would be extremely helpful. How do you put that into a grant? You and I will have to talk about that, I think, offline, because it is very, very tricky. But, you know, you know as well as I some major organizations that can do that reasonably well.

Heidi J. Larson:

Thanks, Denise. And I have one last question I'd like to turn to each of the panelists to give just a one-point answer on this. One of the – one of the points that's come across – that's come up in all the panelists is the importance of history and being conscious of personal and communities histories, and how it's influencing people's willingness and acceptance of vaccines. COVID is a historical moment. The world is going to frame history as before and after COVID.

From each of the panelists, can you tell me, what is the one thing that you think is going to be the most important that can start to change the trajectory so that people have a good historical memory and do not further undermine the negative histories that have – we're still struggling to overcome? So if each of you – what is the one thing you think is going to be most important to get right so that we have a positive history to pave the way for higher confidence more broadly?

I'll start with – go backwards here – I'll start with Umair, and then LaQuandra, and then Denise. Thanks.

Umair A. Shah:

Thanks, Heidi. And as I answer that question I did want to just make one comment as you talked about history. You know, I do think that we have to be thinking also about shared history. The issue is that many in our communities are not just people who were born and raised in our communities. They are often coming from other communities across – whether the country or across the globe. And so shared history can be very complicated because it's about the communities that are in a community, but those communities are actually also made up of people from an incredibly rich history from across the world. And we don't always keep that in mind. And I just wanted to make sure to highlight that.

I would say turning the corner. That's what I would really say. We should all be troubled by what we saw over the last few days not just in Washington – the Washington, D.C., but also Washington in Olympia. I mean we also had some real unrest around the Capitol in Olympia. And I – you know, I think all of us should be troubled by the divisive nature by which there has been dialogue, or lack thereof, in this nation. And that has been the story of this pandemic. We have vilified, we have attacked, we have fought, we have shouted, but we have really done very little in terms of discussing and having dialogue with each other.

And so that's been the story of this last year. I call this – if you could, in a sports metaphor, 2020 was the first half. We just hit halftime, which is the holidays and just the beginning. And now we have a new administration coming in, and this 2021 will be the second half. And turning the corner really is, what do we do in the second half? We've already honestly had some ways that I think many of us thought that this nation would never respond to COVID-19 or pandemics such as this,

and that's exactly what we saw play out in this last year. I don't care if it's left or right. I don't care if it's red or blue. I don't care if it's progressive or conservative. It doesn't matter. We should all be united because our enemy shouldn't be each other. It should be this virus.

Very similar to – I refer to “Independence Day” with Will Smith, the movie, where the whole world united against the aliens, and we all fought the aliens. We should all be fighting a virus, not each other. And so turning the corner means that next half that we're beginning here is really an opportunity and a responsibility for all of us to get it right when it comes to engagement, when it comes assuring equity, and when it comes to really making certain that all of our communities have access to precious commodities, such as COVID-19 vaccine, and that they will also be wanting, and willing, and interested in taking those vaccines.

Thanks, Heidi.

Heidi J. Larson:

Thanks. That's a pretty powerful and important sentiment there.

We're really on the edge of time, but if LaQuandra and Denise have, like, a one-word – (laughs) – kind of what they want and a last final comment from Steve. Thanks.

LaQuandra S. Nesbitt:

So I didn't really have a one-word thing, but if you'll indulge because I think it's – what I want to say is kind of, I think, critically important. One of the things that I think we need to get right is the merger of some critical issues around diversity, equity, and inclusion. And we have been working really hard for a long time in this country to diversify the workforce.

And particularly the health care workforce and the public health workforce, and to make sure that people understand how critically important that is to achieve equity in outcomes. And we have been investing a lot in that diversity as well as it comes to medicine, research. And we've done that. And many of those people are now providing health care. They're invested in biomedical research. They're invested in many of the technologies that have led us to this vaccine.

And one of the things that we have an opportunity to get right, in order to reduce some of this hesitancy that exists in communities of color, is to let them know that the people that they have been so proud of, for becoming doctors and nurses and researchers and scientists – have been part of what has led us to this discovery. So I'm not a big social media user, I'm not a big Facebook-er, and I don't tell a lot of personal stories.

But I took the opportunity to tell people that the people who worked in General Motors, who are my parents, who raised a pharmacist who has

a PharmD, who raised a biochemist who does drug design, and who raised me who is a physician, who is the leader of a health department in the nation's capital, realized that dream for the three daughters that they birthed in the late '70s, right? And we are part of the movement that could get us to the place that would create a COVID-19 vaccine and would then deliver it in hospitals and communities across this country.

So if the three of us, who you went to public high schools with in Flint, Michigan, who you went to public colleges and universities and HBCU's with, could encourage you to get this, right, then it's something that you can trust. And that's a turning point for people of color. And it's a turning point for Latinx kids who have friends like us, who are sorority sisters with us, right? So that's a critical moment that we have the opportunity to do.

So that workforce that has been created, that is part of this scientific discovery, that is part of this health care workforce – whether you be pharmacists, physical therapists, whether you – we have the opportunity to turn that corner and humanize us in a way that gets people to understand we're not part of a system that you shouldn't trust. We're part of a system that you should trust because you invested in us early on to get us to a point that turned things around in this nation, that helps to make you better as a person and as a community.

Heidi J. Larson: Thanks. That's a pretty powerful story for someone who's not a storyteller. (Laughs.) Thank you so much.

Denise, and then Steve. Thanks. I hope others will bear with us for the extra few minutes because it's definitely worth your time. (Laughs.)

Denise A. Gray-Felder: Thanks, Heidi.

I would just say very, very quickly that my hope is that what we do today, next week, next month in COVID vaccine communication and development will make a dramatic and lasting impacting in ending discrimination in health care delivery in this country, and that people like LaQuandra and I – go Michigan, state of Michigan and university – will no longer have to worry about what happens to their Black boys and their Black girls when they go into a hospital. That would be my hope for this work.

Heidi J. Larson: Fantastic. And to Steve.

J. Stephen Morrison: Thank you. And thanks to everyone who's participated here. This has been very inspiring. I guess my closing thought is that we cannot – we have to think ahead – that as we get on the other side of this crisis there's going to be a natural and understandable urge to move beyond this – these crises. And there will be a threat of forgetfulness or amnesia

as we move away from these matters. And we need to fight against that. And I think one way to fight against that, and to make sure that the sort of progress that each of you has articulated as essential to take out of this historical experience, to graduate to another spot in our society and overcome our inequities we need to – we need to think about how that could be done to avoid the complacency, the forgetfulness, the amnesia that happens after profound traumas of this kind.

We need some kind of form of reset and reckoning that can help us in this way. And I would suggest that it should be something along the lines of a 9/11 Commission, that can pull on the different voices that we've talked about today, around what we have experienced and how to capitalize on what we have learned and seen as these deep-rooted problems, and how aggravated they have become. Thank you.

(END)