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Commentary

Approaching coronavirus disease 2019 (COVID-19) vaccine hesitancy among healthcare personnel: The importance of cultural competency

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Vaccine hesitancy was listed as one of the 10 greatest threats to global health by the World Health Organization in 2019.[1] The subsequent coronavirus disease 2019 (COVID-19) pandemic has highlighted health disparities in severe acute respiratory coronavirus virus 2 (SARS-CoV-2) acquisition, COVID-19 hospitalization, and COVID-19 deaths among different racial and ethnic groups that has been driven by structural racism and inequities in distribution of social determinants of health.[2,3] Differences in COVID-19 vaccine uptake by race and ethnicity have also been noted among healthcare personnel (HCP). A meta-analysis of 35 studies (76,471 HCP) noted the prevalence of COVID-19 vaccine hesitancy varied worldwide with an average of 22.51%, with a broad range from 4.3% in a study of HCP in China to a high of 72% in HCP in the Congo.[4] In the United States, a large study of >10,871 Philadelphia HCP during the weeks prior to COVID-19 vaccine availability, 50% of those surveyed expressed some degree of vaccine hesitancy, with the highest hesitancy among Black HCP (82%, 732 of 882).[5] COVID-19 vaccine acceptance in the general public also varies by race (Black persons have lowest uptake), age (increased uptake in older persons), location (state and region), social vulnerability (lower uptake among the most vulnerable), and sex (lower uptake in men).[6]

Cultural competency aims to meet the needs of diverse populations to ensure the knowledge and skills to provide effective care.[7] Cultural competency must be taken into consideration as we target COVID-19 vaccination in HCP to reduce the risk of both healthcare-associated and community acquisition of SARS-CoV-2 infection. Many historically marginalized groups have a history of mistrust of healthcare institutions that persists in current times given continued inequities.[3] HCP from marginalized communities are often keenly aware of the legacy of racism in healthcare including, but not limited to, forced sterilization in the American Indian community and the intentional withholding of penicillin from Black men with known syphilis in Tuskegee, Alabama. This justified mistrust exists among HCP as well, and awareness of these cultural differences should inform COVID-19 vaccination outreach methods. Considerations include, but are not limited to, methods of communicating in a culturally competent way, understanding HCP barriers (both historic and existing) to vaccine acceptance, acknowledging the importance of social determinants of health that may limit vaccine access, and ensuring equitable access to vaccines (even within a healthcare system). Requiring COVID-19 vaccination as a condition of employment has proven the most effective means to increase HCP vaccine coverage both for COVID-19 and other vaccines (eg, influenza)[8]; however, cultural competency of HCP themselves is imperative.

A great example of using cultural competency to increase COVID-19 vaccine uptake includes the tremendous efforts of vaccine education, outreach, and uptake in Native American communities.[9] They tailored outreach and messaging strategies to their communities, and much of it was performed by trusted members of the communities. COVID-19 vaccination was portrayed as the ideal way to prevent suffering that the pandemic brought to tribal communities. They emphasized the preservation of culture and language. They also stressed the importance of protecting the elders in the community by prioritizing vaccination. As a result, per US COVID-19 vaccine administration data, where race or ethnicity is known, the percentage of American Indian and Alaska Native persons vaccinated rose from baseline weeks ahead of rates among other racial and ethnic groups and have consistently had vaccination rates higher than non-Hispanic white persons in both the "at least 1 dose" and "completed primary series" groups.[9,10]

Healthcare systems can incorporate cultural competency to aid in decreasing HCP COVID-19 vaccine hesitancy. First, healthcare systems must ensure that COVID-19 vaccine education materials and sessions (virtual and in-person) are in languages that reflect the HCP population. Second, they must ensure that materials are tailored to various education levels (eg, many HCP do not have a high school education). Third, the race and ethnicity of HCP who provide COVID-19 education sessions should ideally reflect the race and ethnicity of the HCP who are receiving education. Racial concordance has been shown to positively affect the establishment of trust in healthcare settings.[3] Fourth, one should ideally meet the HCP at their work location (eg, consider taking the educational sessions and COVID-19 vaccine carts "on the road"). Mobile vaccine visits to environmental services departments, nursing units, and food and nutrition services departments can create opportunities to provide on-the-spot education as well as COVID-19 vaccines. Finally, healthcare systems must ensure that HCP have easy access to COVID-19 vaccines (eg, offer COVID-19 vaccines

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during different shifts {day and night} and, if COVID-19 vaccines are offered off site, they must ensure that HCP with transportation limitations are able to reach these sites. If a healthcare institution suggests that the HCP obtain their COVID-19 vaccines or boosters at grocery stores or retail pharmacies, it is imperative to consider that HCP may reside in food deserts or have limited access to commercial pharmacies. Healthcare systems must provide options that are accessible to these HCPs.

Reducing COVID-19 vaccine hesitancy is an urgent public health issue, and culturally sensitive HCP messaging is essential to inspire confidence and to maximize COVID-19 vaccine uptake in our healthcare institutions. This messaging must be varied, modifiable, and diversified to reach as many HCP as possible.[3] The messaging must consider (though not limited to) the race, ethnicity, native language spoken, and education level of the HCP. Incorporating cultural competency will not only allow us to provide optimal protection of individual patients and our HCP but will also likely result in downstream education, by these same HCP, to the communities in which they reside. To gain the trust of our communities, it is essentially that we gain the trust of our HCP with culturally sensitive tailored messaging and outreach.

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