

# The Road to COVID-19 Immunity:

Building Trust and  
Combating Misinformation



As millions of people within high-income countries anxiously await their turn to receive a COVID-19 vaccine, not only will billions of people in low and lower-middle income countries **not have access this year**, but many that do will opt not to receive the vaccine due to mistrust or misinformation. Defined as a “delay in acceptance or refusal of vaccines despite availability of vaccination services,” **vaccine hesitancy has been reported** in more than 90% of countries around the world and can be caused by a range of factors from safety concerns, myths and misconceptions to mistrust in healthcare professionals or the healthcare system.

A rise in misinformation during COVID-19—such as inaccurate health advice as well as disinformation, including deceptive propaganda—has further compounded already-present vaccine hesitancy. For example, as the pandemic surged in Afghanistan—a country whose health system has already been weakened by decades of instability—misinformation **circulated among IRC beneficiaries** claiming that Muslims were immune to the virus, that closure of madrassas and mosques would further spread COVID-19, and those even suspected of having the virus would be injected with poison in hospital facilities.

This challenge is not unique to COVID-19. During the peak of the **Ebola outbreak**, communities were largely kept in the dark with minimal access to information about the disease, prevention, or treatment. Coupled with **existing mistrust of the government and institutions** including the United Nations—misinformation was rampant and allowed the disease to spread further.

BOTTOM: Anxhela Gradeci, a 25-year-old junior doctor and refugee from Albania, treats patients with COVID-19 in a North London hospital.





A **recent poll** in six African countries suggests 62% of people would choose to receive a COVID-19 vaccine, which would not be enough for population immunity, while a **social media survey** found that 79% of participants in Lebanon have hesitancy toward a COVID-19 vaccine. Distrust in government and health officials is one of the primary reasons for this. In places such as Syria, Yemen, and Somalia, a **lack of trust in officials** has been a particular challenge in disseminating public health information about COVID-19, while within the United States, a **December survey** found that 40% of Black people are unwilling to get vaccinated due to distrust of the medical system.

TOP: In Somalia, additional precautions and adaptations allow children to continue receiving nutrition support at IRC health clinics..

BOTTOM: Two community health volunteers visit with displaced families in Yemen to raise awareness about COVID-19 prevention.



Based on the International Rescue Committee's (IRC) **experience and expertise** working to combat infectious diseases within conflict and crisis-affected countries, we know that if information is scientifically accurate, but not adapted for local contexts, people are less likely to trust it and may look for answers elsewhere. As many people will not have wide-spread access to COVID-19 vaccines this year, these months are crucial to begin building trust, engaging communities, and increasing both knowledge and acceptance of the vaccine so that once doses do arrive, a successful rollout can occur.

### Here are five things the international community can do to assist with these efforts:

**1. Empower All Frontline Staff.** Across conflict and crisis-affected countries, Community Health Workers (CHWs) play a critical role in bringing care closer to hard-to-reach communities; linking people with the formal health system; and helping to share critical and life-saving health messages. During the pandemic, **CHWs have served as trusted sources** for key messages on COVID-19, including how it is spread, how to reduce the risk of infection, and who is most at risk and should stay at home. Each setting, however, requires a tailored approach when engaging health care workers. For example, many people within conflict and crisis-affected contexts **distrust** government-run clinics and official health care services. A soon-to-be-released survey from the IRC finds that in Nigeria, aid recipients trust humanitarian workers more than any other source of information. In preparation for the COVID-19 vaccine, the international community needs to understand and recognize the most influential frontline health staff and ensure they are well-equipped to play a leading role in generating demand.

**2. Proactively Engage Trusted Local Voices.** In contexts where mistrust of government and health officials exists, it is imperative that trusted community leaders—including **religious leaders** and elders—and individuals are proactively engaged as local champions for COVID-19 vaccines. These influencers should be actively involved in planning for and rolling out the vaccine distribution, which will not only help with building vaccine acceptance, but also with mobilization efforts. For example, as part of routine immunization efforts in Ethiopia, the IRC works closely with religious leaders to inform them about the benefits of the vaccines, dispel misinformation, and garner their support in mobilizing community members.

**3. Tailor Local Strategies to Local Realities.** A one-size fits all approach does not work with a worldwide pandemic as people access information in many ways. Within crisis and conflict settings, authorities need to share information using accessible platforms and take local customs, culture, and language into consideration. We also know that perceptions are shaped by people's unique experiences. Community-based information campaigns **must allow for two-way communication**, where individual concerns are listened to, local barriers are understood, and resulting approaches and messaging are adapted accordingly. Efforts must also include specific strategies for engaging refugees, displaced people, and other mobile populations. Open communications channels—that flow both up and down—can not only assist in ensuring no one is left behind in vaccination efforts, but can aid in building lasting trust within communities.

**4. Recognize and Address Gender Inequalities.** In wealthier countries such as the United States, recent polling suggests that **women may be more concerned about COVID-19 vaccine safety than men.** Part of this stems from misinformation around vaccinations potentially causing infertility and missing data on the vaccine's impact on pregnant women. This extends further to Black and Hispanic women who have concerns about historical discrimination by the healthcare system. Women in conflict and crisis-affected countries typically have less access to the Internet and



PHOTO: In Colombia, we have adapted our health programming and continue to provide lifesaving health services to Venezuelans with high vulnerability levels.



information networks than men, which early on **contributed to discrepancies** between male and female confirmed COVID-19 cases, compared to global averages. We also know women's financial and decision-making autonomy correlates with higher vaccination rates. For example, a soon-to-be-released observational study conducted by the IRC in Ethiopia found that every unit increase in a woman's household autonomy was associated with a 36% increase in a child being fully vaccinated.

PHOTO: The IRC team in El Salvador distributes COVID-19 hygiene kits to families.

**5. Utilize Familiar and Trusted Information Channels.** Recent IRC data from Nigeria shows that online and digital platforms are some of the least-trusted sources of information. It is imperative that all information is shared **across a diverse set of platforms** for each specific context. For example, in El Salvador, the IRC's **CuentaNos** platform has been helping to debunk incorrect information related to so-called natural cures to COVID-19, while in Northwestern Syria, our early childhood development program uses WhatsApp to share critical health messages, such as the importance of handwashing. Digital solutions, however, are not always the most useful when trying to get information to the hardest-to-reach people. We know that "last mile" communities are not using these technologies, but rather rely heavily on face-to-face interactions and interpersonal relationships. Leveraging traditional methods, especially given historical vaccine challenges, alongside new, digital methods is vital to reaching each member of a community.

The pandemic and its effects will not end until everyone is accounted for, including refugees and internally displaced persons. As the global community races to increase production of COVID-19 vaccines, efforts must also be strengthened to generate demand. This means, engaging communities, mobilizing credible voices, and investing in the tools and activities to ensure critical, life-saving information reaches the last mile.