

Final Needs Assessment Report

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About the Georgia Rural Health Innovation Center

In 2018, Georgia lawmakers dedicated special funds to establish a new Rural Health Innovation Center tasked with confronting the complex health care challenges and wellness disparities facing rural communities. Mercer University School of Medicine (MUSM) was awarded the grant funds in 2019 and formally established the Georgia Rural Health Innovation Center on its Macon campus. MUSM boasts a longstanding commitment to serving rural Georgia's health needs, with a mission to educate physicians dedicated to tackling the health challenges in rural Georgia. The Georgia Rural Health Innovation Center serves as a critical resource to rural communities to improve access and effectiveness of health care by offering research, collaboration, and training opportunities.



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Introduction

In May of 2021, the North Central Health District (NCHD) engaged the Georgia Rural Health Innovation Center (GRHIC) at Mercer University School of Medicine to assess the drivers of COVID-19 and Influenza (“flu”) vaccine hesitancy in Hancock County, Georgia. This work stemmed from the ongoing Centers for Disease Control and Prevention, Racial and Ethnic Approaches to Community Health (CDC REACH) grant managed by NCHD.

This report covers the needs assessment period of May 5, 2021 to August 31, 2022. The purpose of this assessment is to assess vaccine hesitancy among African-American residents in Hancock County, Georgia.

Data collection included 426 community surveys, 14 focus groups, and eight key informant interviews. This report details findings from each portion of the assessment (e.g., surveys, focus groups, key informant interviews) as well as overall themes and recommendations. Also discussed in this report are findings from the audience-testing phase of the COVID-19 and flu vaccine messages.

Community Survey

Methodology

This report is based on two sets of questionnaire data collected from convenience samples of Hancock County residents from May 2021 to July 2022. The first set of data is based on responses to the COVID-19 questionnaire. The second set of data is based on responses to the flu questionnaire. The questionnaires were similar; each questionnaire was created to directly assess possible differences related to vaccine hesitancy. The results are based on self-reported data.

Questionnaire Development

The questionnaires are based on the CDC's Core Vaccine Confidence Survey Question Bank (54-item questionnaire) and are similar except that one asks about COVID-19 and the other about the flu. The items were then refined to approximately 45 items and discussed with NCHD leadership. NCHD concerns were length and appropriateness of some of the items, response options, and literacy level. Based on NCHD comments, the questionnaires were further refined and modified. Four items, based on recent studies regarding vaccine hesitancy supported by the Health Belief Model (HBM), a widely used behavioral public health model, were also added (Rosenstock, 1974; Trent, Salmon, & MacIntyre, 2021; Wong et al., 2021). These items covered perceived importance, perceived likelihood of acquiring COVID-19/flu, perceived severity of the condition if contracted, and social norms (number of loved ones who've been vaccinated against COVID-19/flu). The final version of the questionnaires consisted of 27 self-report items, 17 covering COVID-19/flu issues and concerns, and 10 regarding demographics and trusted sources. The questionnaires were short in length (e.g., take less than five minutes to complete).

Summary of COVID-19 and Flu Surveys (N=426)

First, a short overview summarizes all participants for both the COVID-19 and flu surveys. The total number of survey participants was 426 (COVID-19 surveys, N=238; flu surveys, N=188 participants). Not all participants completed their demographic data. The available data can be found in Tables 1-4.

Table 1: Demographics, COVID-19 and Flu Survey Participants

Age	52.7 (\pm 16.7)
Sex	
Female	263 (70.5%)
Male	110 (29.5%)
Race	
Black/African American	332 (92.2%)
White	28 (7.8%)
Marital Status	
Single	157 (46.7%)
Engaged/Married	136 (40.5%)
Widowed/divorced/separated	43 (12.8%)
Education	
Less than high school	19 (5.8%)
High school graduate/GED	147 (44.8%)
Some college	52 (15.9%)
College graduate/advanced degree	110 (33.5%)
Employment	
Not in workforce	55 (16.6%)
Employed (full-/part-time/self)	182 (54.8%)
Retired	95 (28.6%)
Number of people in household (including respondent)	2.5 (\pm 1.3)

Additionally, Table 2 displays a comparison between the COVID-19 and flu surveys. A *p*-value of less than 0.05 (in bold) means it is a statistically significant difference. If the *p*-value is higher than 0.05, it means that statistically, there is not enough sufficient evidence to support the data.

Table 2: Comparison between COVID-19 and Flu surveys

	COVID-19	Flu	<i>p</i>-value
Have had the disease	27.6%	49.4%	<.001
Were or are hesitant about its vaccine	28.8%	24.1%	.277
Got vaccinated for it	90.1%	56.7%	<.001
Planned to get vaccinated for it in next 3 months	57.1%	38.4%	.001
Do not trust its vaccine	16.9%	14.2%	.448
Agreed that its vaccine gives you the disease	11.4%	16.9%	.103

COVID-19 Survey (N=238)

The COVID-19 portion of the survey contained 13 questions, 6 opinion statements, and 8 demographical questions. Demographic characteristics are summarized in Table 3.

Table 3: Demographics, COVID-19 Survey Participants (N = 238)

Age	53.3 (\pm 16.7)
Sex	
Female	144 (88.9%)
Male	65 (31.1%)
Race	
Black/African American	184 (92.5%)
White	15 (7.5%)
Marital Status	
Single	84 (46.2%)
Engaged/Married	76 (41.8%)
Widowed/Divorced/Separated	22 (12.1%)
Education	
Less than high school	13 (7.6%)
High School graduate	85 (47.2%)
Some college	22 (12.2%)
College graduate/Advanced degree	60 (33.3%)
Employment	
Not in workforce	26 (14.2%)
Employed	99 (54.1%)
Retired	58 (31.7%)
Number of people in household (including respondent)	2.5 (\pm 1.2)

Demographics

The average age was 53.3 (\pm 16.7) years old with a quarter of participants (e.g., survey respondents) being 66 years of age and over. Ages ranged from 18 through 95 years (Figure 1).

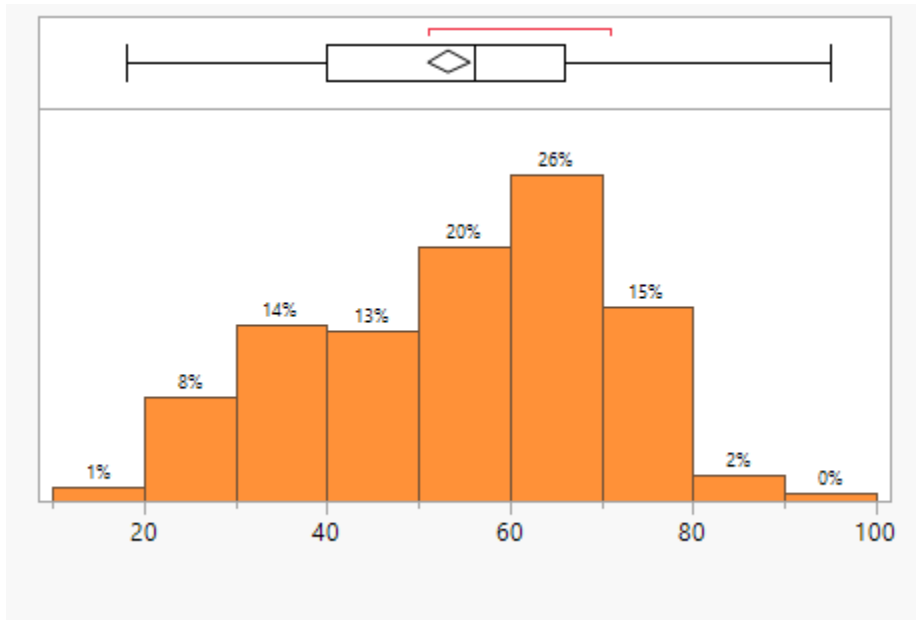


Figure 1: Histogram and boxplot, Age distribution of COVID-19 survey participants

Most participants were female (88.9%) and Black or African American (92.5%). A total of one-third (33.3%) of the participants held an undergraduate or advanced college degree. Nearly half (46.2%) reported their marital status as single (Figure 2).

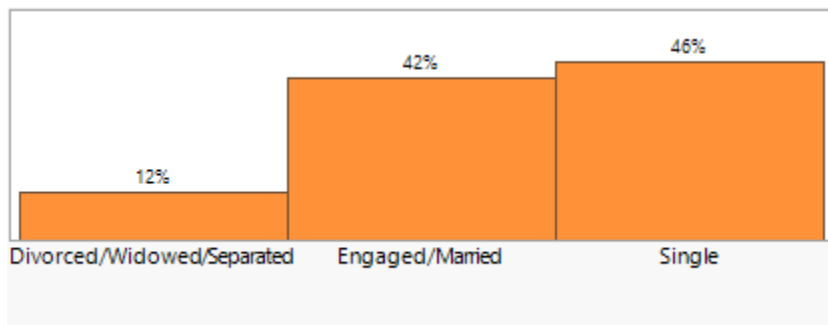


Figure 2: Histogram, Marital status of COVID-19 survey participants

When asked about the number individuals living in their household, participants' answers varied, with an average of 2.5 people (± 1.2) (Figure 3).

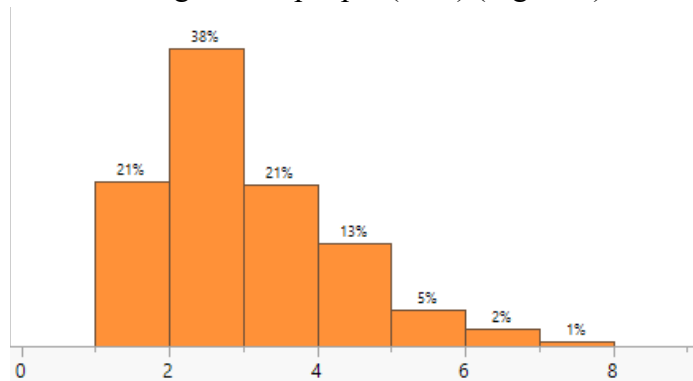


Figure 3: Histogram, Number of individuals in household (including self)

Most participants were working (54.1%) or were retired (31.7%). About 14.2% were unemployed, homemakers, or unable to work. A majority of participants (N=16) were teachers or educators, although various occupations were reported (e.g., health professionals, customer service, retail employee, housekeeper, truck driver, hairdresser, and city or county employee).

Questionnaire Items

A total of 64 participants (27.6%) has had COVID-19. Most reported that they were not at all sick (44.4%), with more than one-third (42.0%) somewhat sick and 13.6% very sick.

When asked about the COVID-19 vaccines, most participants (90.1%) stated they had already received a vaccine. Participants that had received the vaccine were significantly older (average age=54.8) than those who have not received it (average age=40.6). There was no difference within gender and race.

Of those who did not receive the vaccine, 57.1% reported plans on getting it in the next few months. A “word cloud” (i.e., an image generated by linguistic programs of the most commonly used words or phrases in a text or survey appearing larger than other words) found below was created to display the reasons why participants decided to, or not, get vaccinated (Figure 4). Results indicated that most participants wanted to get the vaccine to protect others and prevent themselves or others (e.g., family, elderly) from getting sick.

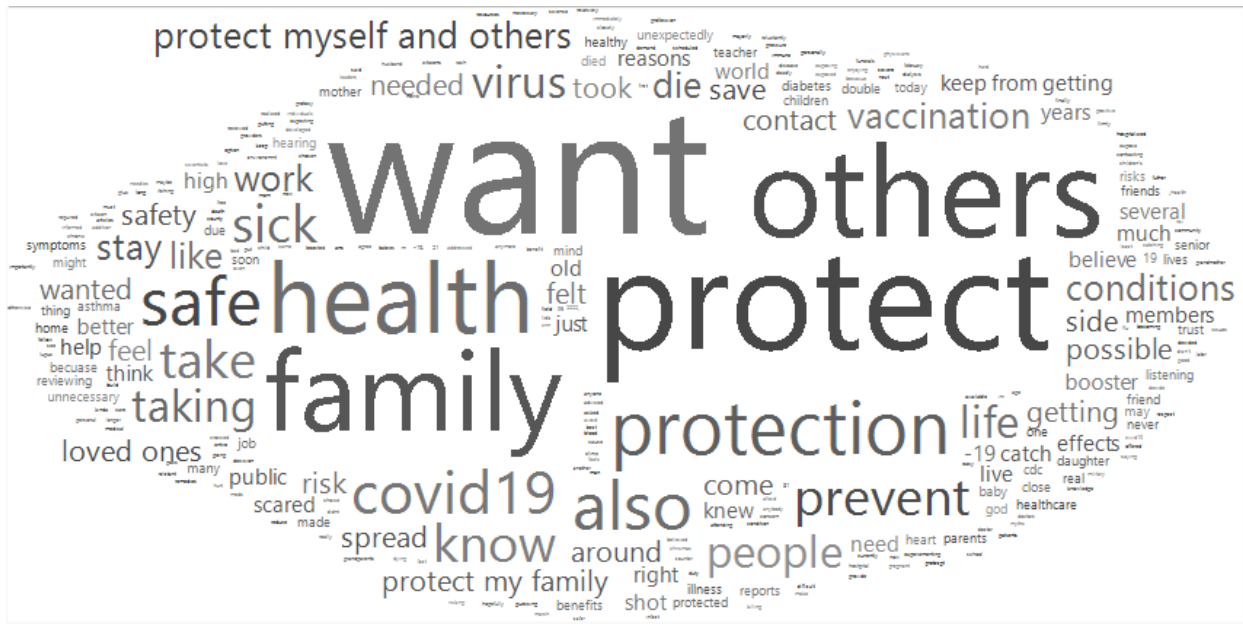


Figure 4: Q2.1 “Please tell us why you DID, or DID NOT get the vaccine?”

A color gradient was added to the word cloud to detect whether or not participants received the COVID-19 vaccine (Figure 5). Red indicates that participants received the vaccine. Blue indicates that participants did not receive the vaccine. For the participants who did not receive the vaccine (blue), the word cloud indicated that these participants expressed that the vaccine was unnecessary, afraid of pain or the side effects, or having a medical condition (chronic or temporary). Participants in this group also mentioned the vaccine not being available, while others “just do not want it”.

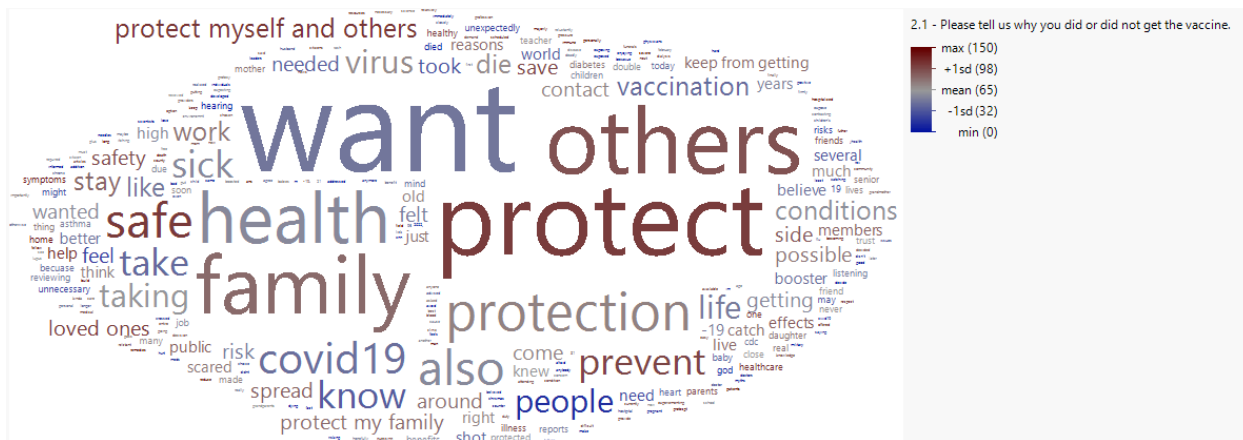


Figure 5: Q2.1 “Please tell us why you DID or DID not get the vaccine”, (colored by having received the vaccine or not)

Most participants (47.1%) reported it would be somewhat serious for them if they would get it, while only 12.6% stated it would not be serious at all. In the preliminary findings, more participants (63.2%) thought it would be somewhat serious, while only 6.1% thought it would not be serious at all. Analyses revealed that there was no relationship with hesitancy, nor with already having had COVID-19.

When asked about how many of their loved ones and close friends have received the COVID-19 vaccine, a majority (73.3%) replied “most” or “almost all of them”.

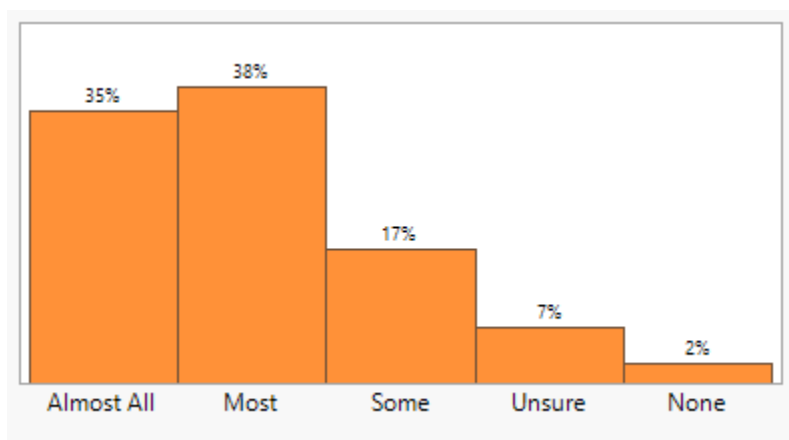


Figure 8: Histogram, Q7 “How many of your loved ones or close friends have received the COVID-19 vaccine?”

The majority (83.8%) of participants also felt that the vaccine is effective at preventing COVID-19 and keeping them well. A total of five participants (2.2%) strongly disagreed. Most participants (86.6%) also agreed that getting the vaccine will protect their loved ones.

When asked whether participants thought the vaccine itself could give them COVID-19, 11.4% (decrease from 12.9% in the preliminary findings) agreed. In addition, 16.9% agreed that they do not trust the COVID-19 vaccine (decrease from 24.5% in the preliminary findings), yet only 16.7% stated they do not trust most vaccines. Less than one-third of participants (21.1%) reported they or someone they know, has had a bad experience with vaccines (decreased from 30.6% in the preliminary findings).

When asked about the information sources participants trust the most when it comes to health, the most common sources mentioned were predominantly healthcare professionals (including doctors, nurses, physicians, specialists (N=93), and the CDC (N=26). The news was ranked third (N=14). God was tied with research as a reliable source on health (N=5).



Figure 9: D10 “What source of information do you MOST trust when it comes to your health?”

When asked about sources participants do not trust, the media (including social media) are most often mentioned (gray) (Figure 10). Those who lean more towards distrust of COVID-19 vaccines (red), are more distrustful of the news, word of mouth, and Facebook. Those who are more trusting of the vaccine (blue), are distrustful media (especially social media) and Internet.



Figure 10: D10 “What source of information do you LEAST trust when it comes to your health?”

Flu Vaccine Survey (N= 188)

The flu vaccine survey used the same questions as the COVID-19 survey.

Table 4: Demographics, Flu Survey Participants

Age	52.0 (\pm 16.7)
Sex	
Female	119 (72.6%)
Male	45 (27.4%)
Race	
Black/African American	149 (92.0%)
White	13 (8.0%)
Marital Status	
Single	74 (47.8%)
Engaged/Married	60 (38.7%)
Widowed/Divorced/Separated	21 (13.5%)
Education	
Less than high school	6 (4.1%)
High School graduate	62 (41.9%)
Some college	30 (20.3%)
College graduate/Advanced degree	50 (33.8%)
Employment	
Not in workforce	29 (19.3%)
Employed	85 (56.7%)
Retired	36 (24.0%)
Number of people in household (including respondent)	2.5 (\pm 1.3)

Demographics

The average age of the participants was 52.0 (\pm 16.7) years old, with ages ranging from 18 to 88 years old (Figure 11).

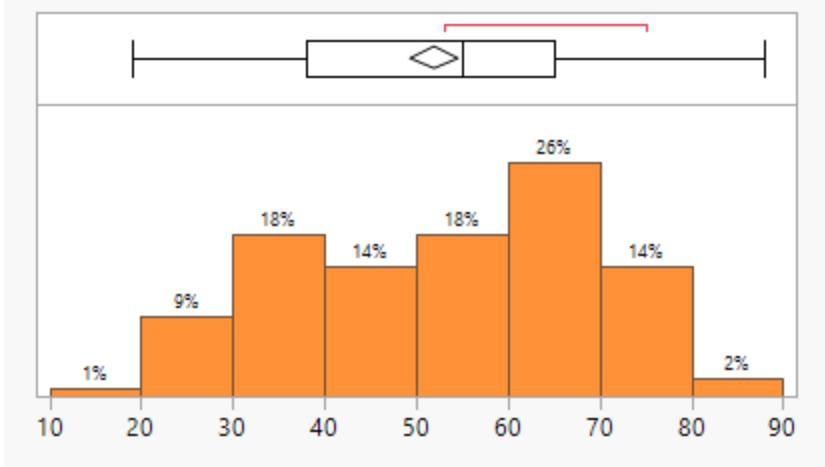


Figure 11: Histogram and boxplot, Age distribution of flu survey participants

Most participants (92.0%) were Black or African American, and female (72.6%). The majority were high school graduates (41.9%) (compared to the preliminary findings where majority of participants were college educated or higher (68.8%)). Participants were generally single (47.4%) or married (39.0%) (Figure 12).

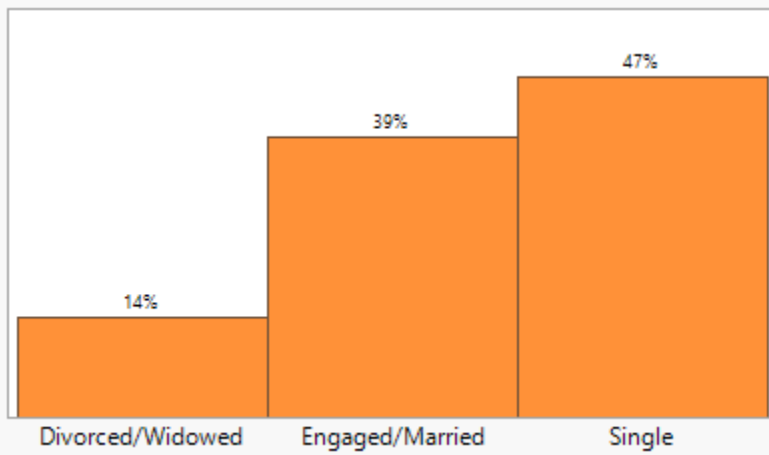


Figure 12: Histogram, Marital status of flu survey participants

On average, there were 2.5 (± 1.3) individuals living in their household, with the most common being two individuals per household (38.0%).

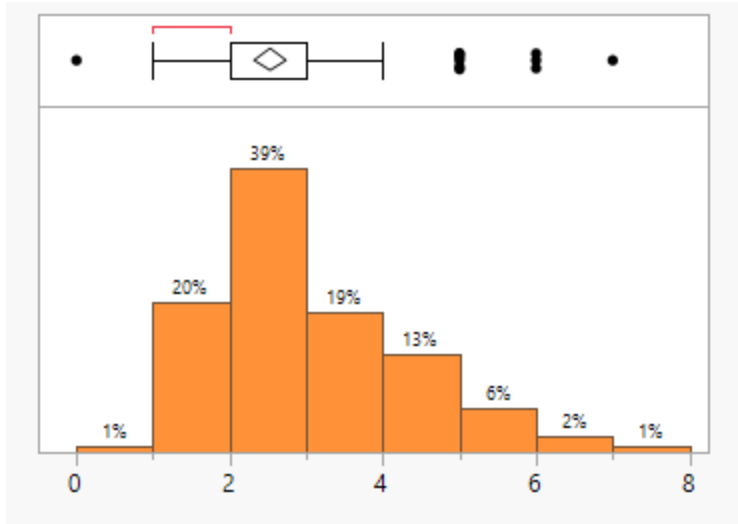


Figure 13: Histogram and boxplot, Number of individuals in household (including self)

Over half of the participants (56.7%) were employed (full-time, or part-time), while 24.0% were retired and 19.3% was unemployed, disabled, or a homemaker.

Questions

Less than half (49.4%) of participants (compared to initial needs assessment [INA] findings, 51.7%) stated they have had the flu at some point in their lives. About one-fifth (22.0%) indicated that they did not feel at all sick with 31.9% stating having felt very sick. Additionally, most participants (56.7%), in comparison to INA findings (61.5%), have received their flu vaccine in the past year. This aligns with preliminary findings in which 58.0% received their flu vaccine in the past year.

When asked why participants did or did not get the flu vaccination, those who did get the vaccine (in red) mainly mentioned: it was safe, preventative, protects others, already take it yearly, take it because they have underlying conditions (e.g., diabetes, lupus), and it is recommended and/or advised by doctors (Figure 14). Those who did not get the vaccine mentioned: being allergic to eggs, being afraid of needles, having underlying conditions, not wanting it, “just never getting it” as a routine, being hesitant to get it, or getting sick from the vaccine.

Most participants (53.4%) (a slight decrease from 54.8% in the INA findings) reported not having had, or not knowing anyone who has had, a bad experience with vaccines with 26.1% knowing someone who has had a bad experience.

When asked which sources of information they trust the MOST when it comes to their health, the following word cloud summarized the data (Figure 16). It appears that doctors (N=55), CDC (N=15), healthcare professionals (N=7), science and research (N=10), health departments (N=4), and God (N=4) are the main trusted sources.



Figure 16: D9 “What source of information do you trust MOST when it comes to your health?”

When asked which source of information participants trusted the LEAST, they replied mostly with social media (N=21), word of mouth (N=17), news (N=12), media (N=11), “people” (N=8), and Internet (N=6) (Figure 17).

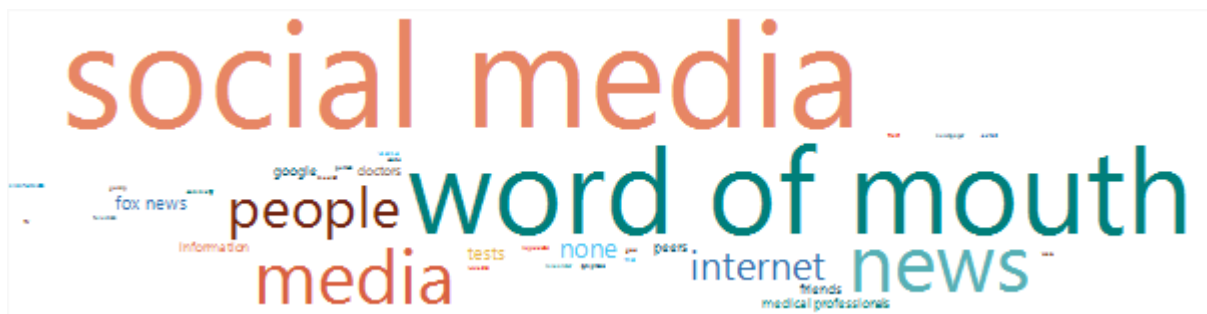


Figure 17: D10 “What source of information do you trust LEAST when it comes to your health?”

Focus Groups

Methodology

Between May 2021 and June 2022, the GRHIC conducted a total of 14 focus groups with a total of 68 participants from Hancock County. Throughout May and August 2021, focus groups were convened with educators, healthcare workers, and faith leaders in efforts to gauge a broad community perspective representative of the common sectors that comprise a community (e.g., education, healthcare, faith organizations). During the audience testing phase of COVID-19 and flu vaccine messaging (August – September 2021), three focus groups were convened for lay community members. Findings from the audience testing focus groups are discussed in the “Audience Testing of COVID-19 and Flu Vaccine Messaging” section of the report. Standard (non- audience testing) focus groups were later convened between October 2021 and June 2022. To note, although majority of focus group participants identified as African American and were female, all-male (African American) focus groups were identified towards the end of the data collection period (February 2022- June 2022). This highlighted a shift to better target and understand vaccine hesitancy among this group. According to the Georgia Department of Public Health Vaccine Distribution Dashboard, this group has remained low in COVID-19 vaccine uptake although there have been slight increases over time. Anecdotally, the same can be stated for flu vaccine uptake among this group.

A semi-structured interview guide was employed to provide flexibility to engage more thoroughly with topics not identified in advance. Topics for discussion included, community impact of COVID-19/Flu, personal thoughts on vaccination, drivers of vaccination, vaccine hesitancy, barriers to vaccination, trusted information, and untrusted information.

Focus group sessions were recorded, transcribed, and analyzed using a thematic analysis (i.e. finding common and diverging themes and concepts). Two independent reviewers analyzed each interview to insure validity of analysis. Findings were then assessed across groups for common and divergent themes.

Topic 1: Community Impact of COVID-19/Flu

Majority of focus group participants described COVID-19 as having a significant physical, psychological, economic, and/or social impact compared to flu. Initially, nursing home facilities were most impacted and there was an influx in business for the local mortuary due to the high number of deaths. Participants mentioned that the elderly’s immune systems were weaker and most vulnerable implying that most of the deaths were from the nursing homes. Participants also felt that COVID-19 may have been present earlier (between October 2019 or November 2019) in the community, but during that time, there was no testing or diagnosis for COVID-19. The death of loved ones (e.g., burden of death) was oft-mentioned and one of the most significant impacts. Disruption of schools impacted parents of school-aged children and students’ ability to not

physically attend class, in turn, affecting their ability to learn according to focus group participants. The impact on the “younger generation” (e.g., adolescent population) further mentioned by participants included: perceived invincibility, the lack of motivation to complete school assignments due to virtual learning (as oppose to face-to-face contact with teachers), decreased social activity with their peers, increased eating behaviors due to being home, and the fear and stigma of being COVID-19 positive (e.g., ostracized by peers).

Relative to COVID-19, participants also lamented on the psychological stress, anxiety, and fear caused by the COVID-19 pandemic. Additional stressors such as uncertainty, social isolation, and stigma, particularly among the adolescent population, also emerged as themes. Focus group participants discussed the widespread economic impact on both the individual (e.g., job loss) and community level (e.g., shutdown of local industry, altered hours of operation) highlighting job layoffs and having to seek employment in neighboring counties. Prevalently, the social impact, relative to the cycling of the closing and re-opening of churches and the loss of physical church gatherings, introduced a shift in how community members worshipped. Hancock County boasts a very large religious population and is home to several churches. Many focus group participants believe that death is inevitable and that God has a plan for everyone.

The impact of flu was less prominent in the discussion and when asked, many suggested that flu concerns had been drowned out by COVID-19. One participant remarked that people are now “getting sick with flu and calling it COVID.”

Representative Quotes:

“The stress of it all. How do I deal with the grief, uh, and the pain of losing my loved ones?”

“Um, some have been terminated their ... have lost their jobs, some people have lost jobs 'cause people out in... a lotta people that are in Hancock commute to the surrounding Baldwin counties, you know? So, people I know have been laid off and haven't been called back. So it affects employment, I know that's one of the impact it is having.”

“And COVID-19 has really take taken um a toll on Hancock county. We have lost a lot of friends and loved ones. And I wish that people would really wear they mask, do better wearing they mask, and beli- believe in what's goin on, that it's for real, you know.”

“...as recently as 3 weeks ago I lost uh first cousin a sister in law and a brother in law um from the virus. Uh this is no joke. Uh I have both of my shots uh and people need to take this real serious.”

“I don't take flu shots and I'm I don't have nothing 'gainst it I just don't take em.”

“Um, I can speak from um, college students as well. Like, doing your classes online, it's like you just don't have the motivation that you used to when you just go in in person. And like, having that one on one contact with even your teacher or your classmate.”

“Big initial impact on nursing home facilities and the elderly.... workers and patients contracted COVID and many died.”

Topic 2: Personal Thoughts on Vaccination

Participants were asked to share their personal perspectives on vaccination for both the flu and COVID-19. Although there was difference in opinions overall, participants felt that their views were representative of the community, diverse in nature like themselves. Initially, almost all expressed support for vaccination efforts and viewed vaccination as generally positively. However, as the needs assessment began to saturate the Hancock community, more self-identified, unvaccinated participants joined the focus groups and shared their perspectives regarding vaccinations and their hesitancy. A major theme among unvaccinated participants was a desire for more information (e.g., about long-term side effects) and misunderstandings of the usefulness of the COVID-19 vaccine. Self-identified, vaccinated participants felt that the COVID-19 vaccine was needed. One participant felt that another “shut-down” would be necessary to minimize disease spread. A few vaccinated participants, who were initially hesitant, expressed that they decided to get the COVID-19 vaccine because they wanted to protect others and loved ones. Protection, of either others or loved ones, was a dominant theme in vaccine uptake. Among vaccinated and unvaccinated participants, both discussed the “booster shot” highlighting confusion and questioning the need for a booster shot; some vaccinated participants shared that they have or will be receiving the booster shot.

Flu and COVID-19 vaccine opinions did not always align. Some expressed strong sentiment associated with not getting the flu vaccine, especially around the idea of getting sick from the vaccine. Participants who decided against the flu vaccine highlighted personal experiences of observing family members having negative reactions (e.g., headaches, feeling like “they were going to die”) from the flu vaccine. Also, participants remarked that some people do not take “the shot” because they feel it is not as detrimental as COVID-19, it is not talked about as much, and it has lower mortality than COVID-19. However, participants who received the flu shot also mentioned receiving vaccines for other illnesses such as whooping cough and shingles.

In consensus, both self-identified, vaccinated and unvaccinated participants connotated Biblical undertones such as “remaining prayerful”, “trusting in God”, and that the COVID-19 pandemic was “God’s work”. Both groups felt that it was an individual’s personal choice in deciding to get vaccinated or not, and that personal experiences with vaccines (e.g., observing family member’s negative reactions) was a deciding factor, in lieu of, expert medical advice. Additionally, at one

point, both groups were skeptical of the government's role in releasing information and administering the vaccine and also having a political agenda.

Representative Quotes:

“COVID a little bit greater than the flu. COVID just I never seen nothin like it. So I just, we have to trust in God baby.”

“Uh, like I was saying, the, uh, the flu shot, it put a little fear in me because though- my two little ones had it and I really thought I was, something else was gonna happen to them. And so, but I've had my pneumonia shot and everything. But I, I refuse to take a flu shot. But I will take the, um, the other vaccine that come out.”

“Well, I'm anti-vaccines. I think it's ... I think it's another alternative, you know, for ... for just, you know, putting medicine in ... in your body. Uh, you got, you know, different herbal stuff, you know, off the land that you can use to keep your immune system and stuff boosted up.”

“I have no qualms with the vaccines, flu vaccine, COVID vaccine. We take all other kind of medicine. We go to doctors we have here, and if they give a shot we don't know what's in those shots. We don't know what's in that medicine, but, uh, we take the medicine.”

“I've always been an advocate for the flu vaccine. However, it was different when it came to the COVID-19 vaccine. I said initially, no I don't want it, there's not enough research, there's not enough information on it, it would be a hazard to me.”

Topic 3: Drivers of Vaccination

Participants expressed many factors that motivated individuals to become vaccinated. Fear of COVID-19, uncertainty, credibility of vaccine information, and severe illness was a common response. One participant described very specific fears of being placed on a ventilator. Many referenced the potential of returning to “normal” as a key factor. Gatherings like church, sports, and other similar events were referenced. The motivation cited here was two-fold, a desire to begin having these events again, and also a desire to feel more comfortable and safer attending these events.

One almost universal theme that arose in all groups was a desire to protect others. Many participants highlighted that they are employed outside of town and convene with others (who also are employed outside of their town); they did not want to spread COVID-19 to others or bring it back to their families. Also, participants mentioned that some of their jobs encouraged them to take the COVID-19 vaccine. In congruence with “protecting others”, participants suggested that vaccinations provided a sense of mental security (i.e. peace of mind) and a better chance of “living a full life without being sick.”

As for financial motivation (i.e. incentives), participants were variable in response regarding financial incentives being a motivating factor to get vaccinated. Some participants felt incentives were necessary. Others felt that some community members may feel that they “could not be bought” or that there was something wrong with the vaccine if they (presumably the government) was paying individuals to receive the vaccine.

Representative Quotes:

“I think it's for the protection of others. Since we're all educators. We don't want to risk the staff members. Especially our students contracting something that we could have prevented, prevented.”

“Because a lot of people, they ready to get back to normal. They, they ready to go and start football season. They say they tired of wearing masks. They wanna go back.”

“You know, a lot of people didn't do it until they started saying, “Hey, we gonna pay you to come get this shot.... You know, even with that out there, that would not be the reason that I would run down there.”

“You know, like say ... [removal of name], you know, offer you money to come take this shot. It, it just seem like it's a motive behind to me.”

Topic 4: Vaccine Hesitancy

Responses to questions about vaccine hesitancy in the community contained a variety of specific examples that generally clustered into a few categories of hesitancy. Some of the common and prominent themes were “fear of the unknown”, misinformation, mistrust (both historic and of the government and healthcare system- United States Public Health Service Syphilis Study at Tuskegee), vaccine development (e.g., “hurriedness” of vaccine process”), and the long-term effects of COVID-19. Other lesser themes include perceived biological immunity (expressed among self-identified, unvaccinated participants), religious reasons, and “COVID-19 associated” stigma among the adolescent population (described by focus group participants).

This “fear of the unknown” was also closely related to and in some cases the result of two other common themes: misinformation and inconsistent messages. Misinformation was noted to be wide spread and pervasive. Initially, conspiracy theories such as belief that microchips were included in the vaccine, that COVID-19 or the vaccine were intended to kill African Americans, and that the vaccines being given to African Americans was not real or was inferior to that given to whites. The aforementioned conspiracy theories were mentioned in the early stages of the assessment but was not oft-mentioned as the needs assessment progressed.

Inconsistent messaging was frequently cited as a driver of hesitancy. Many were confused by the volume of conflicting information available in the media, social media, and by word of mouth.

Some participants specifically cited shifting and evolving public health guidance as inconsistent. Discussions about the COVID-19 vaccine booster (whether to take the vaccine or not) has emerged among community members.

Some participants brought up personal reasons and personal experiences as drivers of hesitancy. Things like, getting sick after the flu shot or bad side effects experienced by friends seemed to factor prominently in some individuals' decision-making process. Throughout the needs assessment, these experiences were consistently discussed revealing an emergent theme: group-think mentality (towards vaccines). This "group-think mentality" towards vaccine uptake was often illustrated among participants. For example, if the individual does not get the vaccine, then their friends and/or family will not get it neither, or if someone they know (e.g., a close relative such as their mother or brother) were not infected with COVID-19, then they too will not get infected. For the ones who received the vaccine they strongly encouraged their friends and/or family to get vaccinated. Additionally, some cited very specific personal reasons such as personal health history. It is important to note that many who were unvaccinated (self-identified) voiced this as a major source of personal hesitancy. Both self-identified, vaccinated and unvaccinated participants supported vaccination in general, but unvaccinated participants emphasized the need for more vaccine alternatives to be presented (e.g., more awareness about herbal and dietary supplements) to make better informed decisions.

Another notable source of hesitancy was a perception of low or no risk to one's personal wellbeing and perceived biological immunity. Typically, participants associated this with young adults and teenagers (perceived invincibility). Some did reference this attitude in older populations but most agreed that it was less common in these groups. Very few individuals noted personally feeling "immune" without the vaccination remarking that their exposure to COVID-19 did not result in illness and that they have never gotten the flu.

Also, other major themes revealed among self-identified, unvaccinated participants was the need for comprehensive vaccine campaigns that also discussed vaccine alternatives such as taking herbal supplements or other natural immune boosters, bring more awareness about making better lifestyles choices (e.g., consuming healthier diets, increased physical activity), and to stop "vaccine bullying" by vaccinated individuals because they decided not to or are hesitant about receiving the COVID-19 vaccine. To note "vaccine bullying" is a descriptive term used by the Project Lead to capture the synthesis of focus group participants' perceptions and beliefs regarding perceived (negatively) racially-targeted vaccine messaging and overall emotional sentiment toward vaccinated individuals.

There was a consensus among the focus group participants that more information and a comprehensive vaccine education awareness campaign (inclusive of vaccine alternatives and associated pros/cons) may be helpful towards increasing residents' likelihood and confidence in vaccine uptake and decreasing vaccine hesitancy to make better informed decisions. These

vaccine campaigns should be implemented by a respected healthcare source(s) with the help of community members. On-going mobile vaccination and vaccine education workshops are ideal.

Representative Quotes:

“Yeah, I think, uh ... Excuse me, I'm sorry. Um, the people that have taken the shot, they get upset with other people that haven't taken the shots”.

“And, that make them more scared of taking the shot. Saying, "Why are you gonna get mad at me because I didn't take the shot? I'm not getting mad at you 'cause you took it." Just saying. So, why, we got to learn how to talk to people. And, they think about ... Like you said, they think about, um, they want to pay you to take the shot”

“Uh, some of the reasons that people are hesitant about taking. Some of them even go back to the Tuskegee incident”.

“I know I've got people my age who think there's a microchip in the vaccine. And it's all on Facebook, where somebody had went and got the vaccine and somebody came up... There was some type of scan and like it showed some number. And people believe that.”

“Like for example, the Johnson & Johnson vaccine. Initially it was great. Then it wasn't. Then it was good. Now not so much. So they're afraid. They're afraid. Not only of the Johnson & Johnson, but also the Pfizer and the Moderna. The unknowns. What side effects? It's a war.”

Topic 5: Barriers to Vaccination

Concerning barriers and challenges, as the needs assessment progressed, participants felt that vaccines were easy to access and are available. Initially, appointments had to be scheduled which served as a barrier. However, as time progressed and “walk-in” appointments were honored (i.e. Hancock County Health Department designated “Tuesdays” for walk-in appointments) barriers to access and availability largely became resolved. The local community health center began to offer vaccines as well; however, it is only offered one day a week.

Transportation continues to be a theme of concern. Although transportation is provided upon request by local community organizations, homebound residents do not have much mobility outside of a hired home aid, or family member. Participants expressed a desire for more community- based vaccination opportunities and expanded hours for those who work. Standard hours of operation between 8:30 a.m. and 4:30 p.m. is not ideal for community members particularly for those who work outside of the county. Mobile vaccine clinics were helpful; however, the mobile clinics were temporary. Participants also expressed concerns towards the shortage of healthcare workers to administer the vaccine and the need for more access points.

Representative Quotes:

“I think some of the people who work also find it challenging because they have to leave work and get the shot.”

“You have to meet people where they are. Going into the community. Because we are a rural community so transportation is a concern, and sometimes you have to go to them to support their needs.”

“Uh, as far as I know there's only one person that... and you only have one location, that I'm aware of here in the town. When we do if for in other cities, there are multiple places you can go. And there is multiple people giving, uh, the shot. That, that, that's one of the arguments.”

Topic 6: Trusted Information

Doctors and healthcare workers were the most trusted sources of information, although there were very few who did not trust certain doctors in the community. The health department, educators, and to some extent law enforcement and elected officials were also trusted sources. Some also mentioned that they depend on close friends as trusted sources. While, in general, participants were skeptical of social media, they noted that many in the community view material they receive through social media as trusted. Majority of the participants trust their faith leaders (e.g., pastors) and faith, however, there were some participants who did not trust their pastor in delivering health information. It is noted that some pastors (from the faith leader focus group) did not promote or discourage their congregants to get the COVID-19 vaccine and felt it was a personal decision.

It was implied that trusted sources promoted the COVID-19 vaccine. However, one participant mentioned that not all healthcare workers were vaccinated and discussed their experience with a non-vaccinated, nurse. An issue identified among some participants with regarding their trusted sources (e.g., doctors) was the lack of communication (i.e., not giving enough information about COVID-19 vaccine's long-term side effects or general knowledge about the vaccine).

Discussion around trusted sources of information for the flu vaccine was overshadowed by the COVID-19 dialogue. It is implied that aforementioned trusted sources of information are the same for flu.

Representative Quotes:

“They'll listen to their friends, they'll listen to, uh, other health professionals that they know, okay. Uh... they trust, uh, sources from Facebook and from the internet and stuff like that.”

“We have a Doctor ma'am, I don't think anybody trust him too much.”

Topic 7: Untrusted Information

When asked about untrusted sources, almost all referred to social media (e.g., Facebook) and the previous presidential administration (Trump Administration). The media, in general, also came up in some responses with a few participants specifically referencing conservative media as an untrusted source. Word of mouth (e.g., “street committees”) was also a prominent theme for untrusted information. Of note, one participant drew attention to the individual nature of trusted and untrusted sources. They stated that a single source may be viewed very differently by two different individuals. Untrusted sources were saying not to take the COVID-19 vaccine, COVID-19 was a hoax, and they did not believe the vaccine was helpful. According to participants, untrusted sources largely spread conspiracy theories.

Representative Quotes:

“It's gonna wear out.”

“So, the same individuals that we list as trusted sources, depending on who you ask, can also be untrusted sources. Some distrust those spreading good info.”

“We've been bombard with so much information. Some people don't know what to believe anymore.”

Key Informant Interviews

Methodology

Throughout June and September 2021, the GRHIC conducted a total of eight interviews with key informants (pivotal community members) in Hancock County. Of the eight interviews, findings from two key informants will be discussed in the “Audience Testing of COVID-19 and Flu Messaging” section of the report. The audience testing phase was implemented between August and September 2021. The domains in which participants were active included, public health, government, education, and faith. Majority of key informants identified as African American and were female.

A semi-structured interview guide was employed to provide flexibility to engage more thoroughly with topics not identified in advance. Topics for discussion included, vaccine information in the community, trusted information, vaccine hesitancy, barriers to vaccination, and keys to success.

Interviews were recorded, transcribed, and analyzed using a thematic analysis (i.e. finding common and diverging themes and concepts). Two independent reviewers analyzed each interview to insure validity of analysis. Findings were then assessed across interviews for common and divergent themes.

Topic 1: Dissemination of Vaccine Information in the Community

Overall, key informants indicated that dissemination of vaccine information was pervasive in their community through a variety of modalities including word-of-mouth, radio, social media, school, websites, local papers, news, church, the health department, and local community organizations (such as HHIP and Family Connections). One key informant disagreed noting that they had not seen much information locally.

In addition, some of the participants mentioned that misinformation about COVID and Flu vaccines was being spread through many of the same channels as quality information. Social media was noted as a major source of misinformation.

Representative Quotes:

“I would say they probably [listen] to that social media more than they listen to that news.”

“But heavily, just word of mouth tend to get things... really get things out.”

Topic 2: Trusted Sources for Health Information

When asked about their trusted sources for health information, most noted their community trusted 1) healthcare professionals, such as the health department, physicians, and health officials, and 2) faith leaders. Others added that residents trust 3) news and social media, 4) personal experience.

In many responses, social media and “the media” were referenced as influential in the community while also being distrusted.

Representative Quotes:

“There is a lot of trust in the church but when it comes to people in the community they listen [to] social media.”

“I trust that, you know, our bishop, you know, has, you know, done his due diligence in, you know, finding answers to certain questions.”

Topic 3: Vaccine Hesitancy

Key informants were divided with some having no hesitancy and others voicing concerns. Most informants reported being vaccinated and vaccination status did not always correlate with a lack of hesitancy. Causes of COVID vaccine hesitancy was mainly due to a lack of understanding of the vaccine development process. This was indicated by comments referring to the speedy rollout, misunderstanding of the clinical trial process, the vaccine containing COVID-19, and the unknown long-term health effects. Some other reasons for hesitancy mentioned were 1) underlying health conditions, and 2) a trusted messenger advised against it (allergies to eggs). Despite some hesitancy, all key informants were supportive of vaccination efforts.

Interviews made it clear that misinformation about the process is actively being distributed on social media. When asked if they were aware of any conspiracy theories or misinformation being spread about Covid-19 and flu vaccination, all responded positively. Some participants mentioned malicious ingredients rumored to be in the vaccines (microchips, spider eggs, pathogens of the disease), others mentioned COVID-19 being a biblical event, the Illuminati, attempts to infect African-Americans, or that the vaccine given to people of color was a placebo and not a real vaccine. In addition, some mentioned cases of bad experiences with vaccines and inflate the minimal risk. This was predominately with flu vaccines with people believing the vaccine had given them the flu.

Participants were asked directly if they believe racism and/or discrimination play a role in COVID-19 and flu vaccine hesitancy. All participants said yes. Most referenced distrust in the government due to the historical context, including the United States Public Health Service Syphilis Study at Tuskegee, the birth control movement, and Margaret Sanger.

Some of the participants mentioned their fellow community members being scared that COVID-19 vaccinations might be a way to commit genocide.

Some of the mistrust in the government seemed transferable to the medical profession. One participant denied any mistrust as they felt their community generally trusted both government and medical professions.

All key informants agreed that they could understand hesitancy regarding vaccines against COVID-19 and flu. One person mentioned that for some, personal experiences weigh more than medical expert advice.

Representative Quotes:

“The last ones that I heard was the microchip, they're gonna trace you.”

“When you have, you know, personal experiences, you know, they-they tend to weigh a lot more than what the medical experts are saying.”

“I mean you look at, um, instances like the Tuskegee Experiments and all of that kinda stuff. And, you know, people can't help but wonder, um, the, what is really going on.”

Topic 4: Barriers to Vaccination

When asked about barriers and challenges that African Americans experience when getting COVID-19 and flu vaccines, most participants noted that vaccines are currently easy to access. Walk in vaccinations without appointments were discussed as very helpful. Most participants noted initial difficulties with availability of appointments, the scheduling system, and problems contacting the schedulers. All agreed that these problems had been resolved. Despite wide availability, key informants also noted that transportation remains a challenge for many in the community and more community-based vaccination opportunities would help.

Representative Quotes:

“Yeah the other big thing, you know, even though we have walk-ins, we still have transportation issues where people just don't have the means to get to the health department to get the shot.”

Topic 5: Keys to Success

In addition to barriers to vaccination, key informants were asked for factors that could increase the success of vaccination efforts in the African American community. Most mentioned that religious, medical, and educational leaders can be influential if they are local, relatable, and trusted.

Some mentioned that highlighting personal success stories from local trusted community members would help. In addition, emphasizing social responsibility to protect others was a common theme. Others suggestions included timely social media campaigns and incentives.

Various other ideas around transportation were also noted including mobile units, in home vaccination, and vaccinations at community events.

Representative Quotes:

“If you get a minister, and he's vaccinated, or she's vaccinated. To say that it's okay. This is what we need to do to look out for our congregation.”

Audience Testing of COVID-19 and Flu Messaging

Focus Groups

Methodology

Between August and September 2021, three focus groups were conducted with a total of 13 participants from Hancock County. Groups were convened with general community members. In total, 92% of participants were African American and 62% female.

A semi-structured interview guide was employed for focus groups sessions. The guide was designed to provide flexibility to engage more thoroughly with topics not identified in advance and to test the “Protect Loved Ones” message. The first focus group, consisting mainly of healthcare workers, was used to provide broad feedback on several messages and infographics to gauge their overall thoughts of vaccination messages. A few of the sample messages are highlighted in Appendix A. For the other two focus groups, two groups of messages were tested: a series of “Fake or Fact” images (total of seven), and a series of testimonials (total of three) in the context of “Protect Loved Ones”. Participants were asked about message clarity, identification and emotion, and suggested changes.

All sessions were recorded, transcribed, and analyzed using a thematic analysis (i.e. finding common and diverging themes and concepts). Two independent reviewers analyzed each interview to ensure validity of analysis. Findings were then assessed across groups for common and divergent themes.

General Vaccination Messages

Overall, participants in the healthcare worker focus group shared that vaccine messaging that focused on the safety and effectiveness of vaccines may be helpful to vaccine hesitant individuals who are skeptical of the vaccine’s efficacy (Appendix A, No. 1- 6). Participants also mentioned to help increase vaccinations, efforts should be geared towards having vaccine messages align with their target audience “mindset” and perspective in order for them to accept the message (e.g., ensure that the message is clear and that the information is relatable to their experiences and readability). Most focus group participants agreed that vaccine messaging should also encourage more caution relative to hand-washing/ sanitizing and mask wearing. Messaging that targets specific racial groups should proceed with caution because some racial groups may feel targeted or bullied into taking the vaccine; messaging should be more inclusive to all racial groups, while also highlighting racial groups with the highest adverse

outcomes (e.g., increased mortality rates). Lastly, all vaccine messaging needs to be clear and readable.

“Fake or Fact”

The purpose of the “Fake or Fact” messaging was to help dispel widespread misinformation regarding COVID-19 and flu as highlighted in the preliminary findings of the initial needs assessment. In general, most focus group members found the intent of the “Fake or Fact” messages (Appendix B, No. 1-7) to be clear. Almost all recognized the fake information as such and reported not identifying with that information. Generally, shorter and simpler statements were preferred highlighting the readability and literacy of messaging. The presentation of false and factual information together was identified as a strength, as well as the specificity. Less technical language was pointed out as a possible improvement.

Several participants specifically addressed the statement about side effects and a need for additional context. In general, the bulk of these comments were oriented toward expectation setting and transparency, recognizing that post vaccination symptoms are real and experienced by many (i.e., soreness, headache, fever). Some participants felt that messaging should be broadly inclusive of racial and ethnic groups to reduce a sense of singling out. Participants generally recognized the CDC as a reliable source of information, but some cautioned that this impression is not universal. A variety of small wording and technical changes were also suggested.

Community Testimonials

Among participants the testimonial messages were very well received, and the “Protect Loved Ones” resonated with them. In most instances they were viewed more favorably than the “Fake or Fact” messages. Participants generally saw the messages as clear, appreciated the relatability, their origins in the community, and the presence of a picture of the speaker. Of the few critiques almost, all were directed at a single instance where participants thought a certain testimonial statement was confusing and long. Participants also focused on the images of the speakers assigning concepts like warmth and compassion to the message.

Key Informant Interviews

Between August and September 2021, three key informant interviews were conducted with pivotal community members in Hancock County. In total, 100% of participants were African American and 67% were female.

As with the focus groups, the same semi-structured interview guide was employed for the key informant interviews. The guide was designed to provide flexibility to engage more thoroughly with topics not identified in advance and to test the “Protect Loved Ones” messaging. As with the first focus group, the first key informant’s feedback was used to gauge overall thoughts of vaccination messages. A few of the sample vaccine messages are highlighted in Appendix A. For the other two focus groups, two groups of messages were tested: a series of “Fake or Fact” images (total of seven), and a series of testimonials (total of three) in the context of “Protect Loved Ones”. Participants were asked about message clarity, identification and emotion, and suggested changes.

All sessions were recorded, transcribed, and analyzed using a thematic analysis (i.e. finding common and diverging themes and concepts). Two independent reviewers analyzed each interview to ensure validity of analysis. Findings were then assessed across groups for common and divergent themes.

General Vaccination Messages

Similar to the healthcare worker focus group findings, the initial key informant expressed comparable views relative to vaccine messaging: messaging needs to be clear, readable, relatable and inclusive to all racial groups while also highlighting racial groups that are experiencing the most adverse outcomes (e.g., higher mortality). Regarding message relatability, the key informant shared that it would be helpful to see community members encourage vaccination efforts, instead of medical experts, when viewed on governmental websites (e.g., Georgia Department of Public Health).

“Fake or Fact”

Key informant findings shared overlapping views as focus group participants.

Community Testimonials

Key informant findings share overlapping views with focus group participants. The consensus among participants was that the community testimonials were appreciated, and they could identify themselves in, and with, most of the messages. The “Protect Loved Ones” message was well received. A key informant particularly admired the honesty of the community members, however, would like to have seen (and would like to see in the future) one of the community members share testimonials of their COVID-19 vaccination status and if the individual, at some point, was vaccine hesitant and then changed their mind. According to the key informant, this would help with encouraging community members to get vaccinated.

Marketing Strategy of COVID-19 and Flu Vaccine Messaging

COVID-19 and flu messages were marketed via several modes of communication: radio, Targeted, paid advertisements (via social media), and word of mouth.

Radio

Between August to November 2021, needs assessment activities (e.g., promotion of the “Protect Loved Ones” messaging, recruitment efforts for community testimonials, key informant interviews, focus groups) were broadcasted on the Quentin T. Howell Radio Talk Show and was ran as a commercial on LOVE 103.7FM, WKVQ (Irwinton, Georgia). LOVE 103.7FM radio station broadcasts to Hancock County and other surrounding counties (Baldwin, Bibb, and Wilkinson). The paid commercial included a 30-second time slot on 140 commercial spots running for four weeks. Guest appearances on the Quentin T. Howell Radio Talk Show promoting needs assessment activities inclusive of COVID-19 and flu vaccine messages will continue being implemented throughout the duration of the grant period (until August 2022).

Similarly, paid commercials promoting needs assessment activities were broadcasted 1540AM Gospel, WKVQ radio station in October and November 2021. 1540AM is a relatively new station that broadcasts out of Sparta, Georgia. The paid commercial included a 30-second time slot on 120 commercial spots, running four weeks.

Targeted, Paid Advertisements

Targeted, paid advertisements via Facebook occurred from September to November 2021 for promotion of the community testimonials (total of three; Appendix C). All ads targeted men and women from ages 18 to 65 years and older and were set for a 7-day period within a 25-mile radius of Sparta, Georgia. Outlined in Table 5 are the results of the three testimonials assessed by *reach* (total number of individuals who “saw” the ad at least once), *clicks* (total number of individuals who clicked on the website link, re-directing to the “Hancock County Needs Assessment” web page on the Georgia Rural Health Innovation Center’s website), *engagement* (total number of individuals who “liked”, “shared”, or “commented” on the ad), *comments* (total number of individuals who commented on the add), *shares* (total of number of individuals who shared the add with others) and *reactions* (total number of individuals who provided an emotional response through emojis) .

Table 5: Targeted Paid Advertisements, Community Testimonials (N=3)

	Month		
	September	October	November
Reach	1,456	1,207	697
Clicks	16	28	48
Engagement	26	37	77
Comments	0	1	3
Shares	1	0	1
Reactions	9	7	25

Word of Mouth

Word of mouth proved to be an influential method of marketing and communication of COVID-19 and flu vaccine messaging and subsequent audience testing activities (e.g., recruitment for community testimonials, key informants and focus groups) creating a snowball effect of radio listeners (103.7FM and/or 1540AM) telling others about needs assessment activities. This snowball effect was confirmed by listeners via conversation, who attended several mobile vaccination events occurring from October to December 2021. Former key informants and focus group participants were encouraged to share all COVID-19 and flu vaccine messaging information (e.g., “Fake or Fact” posts, testimonials etc.) on their social media platforms. Emails were also sent to the Hancock Health Improvement Partnership (HHIP) email list for dissemination.

Findings

- “Fake or Fact” messaging is well received and effective but will need frequent updating as information and misinformation evolve. Goals should be set to produce updated and revised versions on a regular basis.
- Community testimonial messaging is well received and effective. Additional community perspective should be added to provide new and constantly updated stream of voices. Honesty of the message and trustworthiness of the community member giving the testimonial, inclusive of the community member revealing their vaccination status, were two of the items relayed to help motivate and encourage other community members to get vaccinated.
- The “Protect Loved Ones” is proven to be a helpful message to strengthen vaccination efforts.
- Vaccine messaging should be more inclusive to all racial groups while also

highlighting racial groups that are experiencing the most difficulty and adverse outcomes.

- Messaging should be cautious in ensuring that certain racial groups are not targets of perceived bullying, but instead, include providing culturally-relevant information that is helpful in preventing COVID-19 and flu (e.g., limit large family gatherings i.e. family reunions), in conjunction with the data statistics.
- A broad network for disseminating messages should be developed utilizing key organizations, community leaders, thought leaders and community gatekeepers, to saturate the community from multiple angles.
- Messaging should be adapted to several modalities including digital, print, radio, and in-person.
- The goal of this messaging should be saturation to compete with the prevalent misinformation in the community.

Summary of Overall Assessment Findings

- Faith leaders and healthcare workers are the most trusted messengers within the community although there were varying opinions about the influence of faith leaders (i.e., pastors) to promote vaccinations.
- Protecting others is a strong motivating factor for vaccination.
- Social media and word of mouth are influential. However, residents report that they are both the sources of trustworthy and untrustworthy information.
- There is a strong perception that vaccine information has been confusing and inconsistent. Discussions around the COVID-19 booster shots (e.g., whether or not to take the booster) are occurring.
- Barriers to vaccination are low but transportation remains an issue for many particularly among the elderly who are homebound.
- Prevalent themes identified include fear, misinformation, inconsistent vaccine messaging, perceived biological immunity, and mistrust (e.g., historical mistrust of government and healthcare system- United States Public Health Service Syphilis Study at Tuskegee).
- Lesser themes identified include COVID-related stigma (e.g., feeling ashamed of getting COVID, being ostracized by peers) and perceived invincibility among the adolescent population.
- Personal experience is a dominant factor in vaccine decision making.
- Vaccine messaging should be cautious in ensuring that certain racial groups are not targets of perceived “vaccine bullying”.

Overall Recommendations

1. Target the adolescent population and their parents/ legal guardians relative to not only promoting and encouraging the vaccine, but through culturally-appropriate vaccine education.
 - a. Partner with the Hancock County Board of Education to host a town-hall style meeting to have open and critical dialogue around the COVID-19, flu, and other vaccines.
 - b. Coordinate with the local Parent Teacher Student Association (PTSA) to help develop and implement a community and school-focused vaccine awareness and promotion initiative.
2. Approach vaccine messaging as a collaborative effort between community members and medical and healthcare experts.
 - a. Messaging should be culturally-appropriate and representative of the community.
 - b. Leverage the Hancock Health Improvement Partnership (HHIP) coalition.
 - c. Create a community advisory board of non-HHIP, lay community members identified through various channels.
 - d. Engage leaders (representative of the faith, community, government, health and community sectors) in educational opportunities so that they better understand the science behind vaccination.
 - e. Utilize existing toolkits as a starting point for messaging and strategies (e.g., <https://blackfaithvaccinetoolkit.org>).
3. Focus messaging on protecting others and care for the community.
 - a. Protecting others and social responsibility were consistently present throughout the assessment.
 - b. Messaging addressing this theme could be effective especially in the faith community.
4. Utilize community members to conduct narrative interventions.
 - a. Use a narrative ethics lens.
 - b. Create opportunities for community members to share their personal pro/anti-vaccination COVID-19/flu narrative via self-reflection
5. Leverage existing vaccination data to conduct more granular spatial analysis to guide focus areas.
 - a. Vaccine data at the census tract level is too general to accurately target intervention within the county.
 - b. Spatial analysis that provides more granular data would be helpful for planning interventions and for subsequent assessment.
6. Formulate a strategic transportation plan.
 - a. Transportation was a common barrier described in the assessment.

- b. More community-based, mobile vaccination opportunities might address this concern.
- 7. Target male populations and other hard-to-reach unvaccinated populations
 - a. Increase the frequency of mobile vaccination clinics among neighborhood communities.
 - b. Development a recruitment strategy with trusted, influential male community members to identify male populations. Provide vaccine education training to these trusted, influential messengers.

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APPENDICES

APPENDIX A. General Vaccination Messages

No.1

The vaccine is now fully approved.

Getting vaccinated is the best way to protect the ones you love.

Vaccines are safe and effective.

Millions of people have had the vaccine.


Vaccines are the best way to protect yourself.

Vaccines get us back to normal.

Love your neighbor, get vaccinated.


APPENDIX A. General Vaccination Messages

No. 2

 **ASK AN EXPERT**
BONZO REDDICK, MD, MPH
J.C. Lewis Primary Health Care Center

“ It’s critical for Black and Latinx communities to get vaccinated.
Getting vaccinated is the biggest thing we can do to end the pandemic.”

#ISaidYesGA
dph.ga.gov/covid-vaccine



APPENDIX A. General Vaccination Messages

No. 3



ASK AN EXPERT

BONZO REDDICK, MD, MPH

J.C. Lewis Primary Health Care Center



It's critical for Black and Latinx communities to get vaccinated.

Getting vaccinated is the biggest thing we can do to end the pandemic."

#ISaidYesGA
dph.ga.gov/covid-vaccine



APPENDIX A. General Vaccination Messages

No. 4

Protect your child from COVID-19.

Schedule a vaccine for your 12+ child at dph.ga.gov/covid-vaccine.



#ISaidYesGA



APPENDIX A. General Vaccination Messages

No. 5

Protect your child from COVID-19.

Schedule a vaccine for your 12+ child
at dph.ga.gov/covid-vaccine.

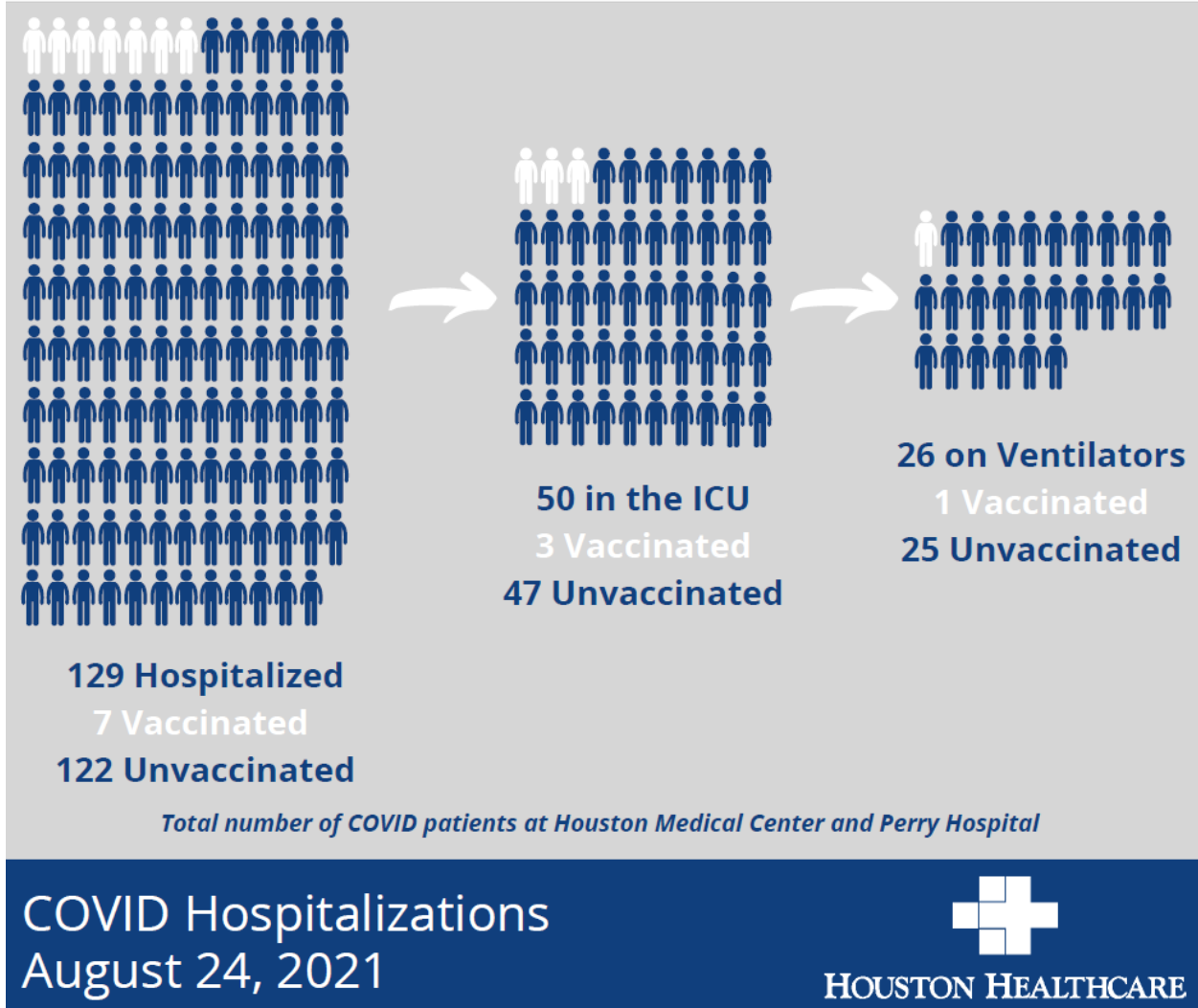


#ISaidYesGA



APPENDIX A. General Vaccination Messages

No. 6



APPENDIX B. “Fake” or “Fact” Message Post

No. 1

FAKE

There is a micro chip or tracking device in the COVID-19 vaccine.

FACT

There are no microchips or any other tracking device in the COVID-19 vaccine. The needle used to give a vaccine shot is much smaller than the smallest microchip.

Source: Centers for Disease Control and Prevention



APPENDIX B. “Fake or Fact” Message Post

No. 2

FAKE

The COVID-19 vaccine is being developed to 'kill off' racial and ethnic minority populations.

FACT

The COVID-19 vaccine has been developed to provide immunological protection (e.g. self-body protection) and safety to all human populations.

Source: Centers for Disease Control and Prevention



APPENDIX B. “Fake” or “Fact” Message Post

No. 3

FAKE

The COVID-19 vaccine will give me COVID-19 or make me sick.

FACT

The COVID-19 vaccine will not give you the virus. The purpose of any vaccine is to provide protection and lower the harmful effects of the disease such that the body can better fight off the virus and protect you. Sometimes this process can cause symptoms such as a fever which is normal. This is a sign that the body is building protection against the virus.

Source: Centers for Disease Control and Prevention



APPENDIX B. “Fake” or “Fact” Message Post

No. 4

FAKE

It is not safe for me to get a COVID-19 vaccine if I would like to have a baby one day.

FACT

There is currently no evidence that the COVID-19 vaccine causes any problems with pregnancy, including the development of the placenta. In addition, there is no evidence that female or male fertility problems are a side effect of any vaccine, including COVID-19.

Talk with your doctor about any specific concerns you may have.

Source: Centers for Disease Control and Prevention



APPENDIX B. “Fake” or “Fact” Message Post

No. 5

FAKE

Getting the flu vaccine will increase my risk of getting COVID-19.

FACT

There is no evidence that getting the flu vaccine will increase your risk of getting sick from COVID-19 or other coronaviruses.

Source: Centers for Disease Control and Prevention



APPENDIX B. “Fake” or “Fact” Message Post

No. 6

FAKE

I do not need to get the flu vaccine each year.

FACT

Yes you do. The CDC recommends a yearly flu vaccine for everyone 6 months of age and older with rare exception. The reason is because the person's immune protection from the vaccine declines over time and the virus is constantly changing meaning the previous year's vaccine composition is reviewed and updated as needed based on the flu virus type.

Source: Centers for Disease Control and Prevention



APPENDIX B. “Fake” or “Fact” Message Post

No. 7

FAKE

The flu vaccine will give me the flu.

FACT

Flu vaccines cannot cause flu illness. Flu vaccines are given with inactivated viruses or a single protein from the flu virus. The nasal flu spray contains live viruses that are weakened to not cause illness.

Source: Centers for Disease Control and Prevention



APPENDIX C. Community Testimonials

No. 1

"We're called by "The Bigger Picture" to serve one another Humbly in Love! In treating any virus, we must use multiple arms to attack & stay ahead of it. Take your freedom of choice to acknowledge the need to have a balanced response to this pandemic and protect your loved ones!"

-Makesha Brown

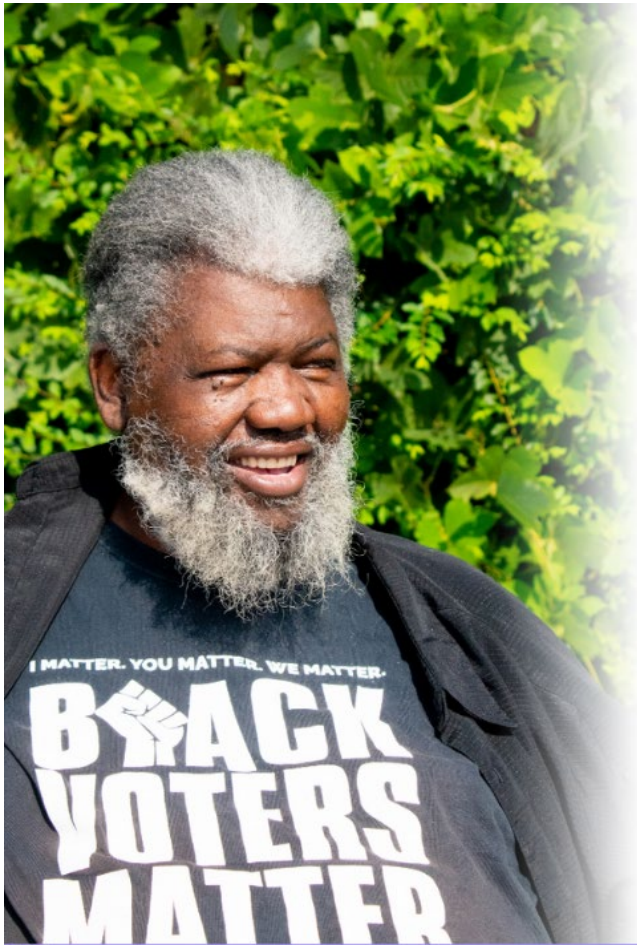


Protect your family, get vaccinated.



APPENDIX C. Community Testimonials

No. 2



"I don't particularly trust America's vaccinating system, but it seems to be working...I did it basically first when it came out 'cause wasn't no reasons not to logically...I did it basically for me and mine. Whether that's my immediate family, my community, whomever, it can flow out to be the whole community."

-Marion Warren

Protect your family, get vaccinated.



APPENDIX C. Community Testimonials

No. 3



"I was a little hesitant at first, I had to do a little studying, but I just prayed to God and said - I'm gonna take this shot. I took it because I have underlying conditions and I wanted to protect myself, my son and my family. I advise everyone to pray about it and go take that shot. We need everybody to be protected."

-Patricia Morgan

Protect your family, get vaccinated.

