EDITORIAL

Advancing Communication Strategies in Jamaica's Response to the COVID-19 Pandemic

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Communication is critical to an organised Public Health crisis-response including during epidemics like SARS-CoV2 (1). Previous pandemic responses, most recently for HIV/AIDS, have incorporated community engagement, participatory approaches and mass media campaigns to successfully influence risk perception and appropriate socio-behavioural trends. Since Jamaica's COVID-19 epidemic began (10th March 2020) the Ministry of Health and Wellness (MOHW) and public sector stakeholders have implemented several communication approaches with mixed results, including limited success convincing the target population to accept COVID-19 vaccines. The goal of vaccinating at least 65% of the population by 31st March 2022 has not been met with under 25% of the population fully vaccinated at 31st March 2022 (2).

Variations in COVID-19 vaccine uptake were expected given non-adherence by sub-sectors of the population to mitigation recommendations including mask wearing, isolation and quarantine, often correlated with younger age and low risk perception. However, the emergence of increasingly transmissible or immune-evasive variants makes overcoming vaccine hesitancy critical. Risk communication strategies utilized by the MOHW have ranged from traditional and social media to mass communications. What has been lacking in this risk communication process from early on is an easily understood, timely, clear rationale for vaccination that manages rumours and misinformation and creates a social norm for adult vaccination like the case made for early childhood vaccines. Commonly given reasons by Jamaicans for avoiding the vaccine is that it does not prevent virus transmission compounded by a plethora of conspiracy theories promoted via social media.

Communication by the MOHW and the political directorate does not occur in a vacuum, but in an environment where individuals and communities are in continuous dialogue with and between each other, locally and globally. The intensity and frequency of such discourse has increased through social media (3). Misinformation is best countered by avoiding restating the myth or misinformation but providing arguments from trusted sources that provide facts and dispel the misinformation (4).

An evidence-based framework, called 'the 5C model of the drivers of vaccine hesitancy' lists five individual person-level determinants for vaccine hesitancy: confidence, complacency, convenience (or constraints), risk calculation, and collective responsibility (5). Promoting COVID-19 vaccine uptake requires understanding whether people are willing to be vaccinated, reasons why they are willing or unwilling to do so, and the most trusted information sources influencing their decision-making (6).

Jamaicans have confidence in the local scientific community and not so much in the political directorate, yet much of the communication response has been delivered by politicians (7, 8). Additionally, the local trusted scientific community has not been effective in educating the population about the nature of a Coronavirus, the dynamic nature of the pandemic and the corresponding changes in what is known and applied. Simple ways of communicating this in jargon-free language using analogies that people can relate to is necessary using popular social media platforms accessible to all age and social groups, for example, Tik-Tok and YouTube (9). Talk shows are another common feature of Jamaican culture, listeners of specific programmes identify with the hosts and regard them as trustworthy. A key component of risk communication is trust. Trust in bodies such as the health sector or media minimizes the complexity and uncertainty about issues (10). This was achieved by the local HIV programme through stakeholder and community engagement including endorsement by media

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personnel, popular entertainers and persons affected by the disease.

Understanding how members of affected groups perceive risk and why some are complacent should influence public education and communication. Local evidence should inform how key messages are framed and choice of the bearers of the messages. Often persons most affected by an outbreak or health threat perceive their risk differently from the experts who moderate or prevent the risk (11). Bearers of the message must look like and sound like the target audience. In a multi-cultural society like Jamaica, vaccine promoters must come from a range of cultural, religious and social groups to enhance the acceptability of the message.

Convenience, the third communication shortcoming in the COVID-19 response is centred around the management of vaccine delivery and site access. People need to access the vaccine close to where they live or work. Vaccine Blitzes coordinated through a centralised MOHW response is the current priority roll-out measure. This is a constraint for those challenged by the distance and cost to travel to sites, long waiting times and sometimes poor crowd control. Registering online is a barrier for many of the aged, persons without suitable devices or Internet access. Local health centres and private physicians that people typically rely on and trust for other health and social services need to be far more engaged in the vaccine roll-out. In addition to risk perception, trust and credibility can greatly influence the ability to persuade at-risk persons to follow public health recommendations during an outbreak or public health response (12). The effective outbreak containment might hinge on established systems, relationships and coordination with key partners and stakeholders.

As breakthrough infections of fully vaccinated persons with new variants of Sars CoV2 occur and are reported widely in the media, it will feed vaccine effectiveness concerns. This must be handled realistically so the community understands why they should trust the protective value of immunization, nonetheless. We need local evidence on reasons for non-compliance, which may differ from the global experience. With under 20% coverage, there are likely to be many more citizens willing to be vaccinated. We should focus on reducing barriers for the willing constrained by real-access limitations. Many are employed as casual labourers, if they do not work, they get no pay, making the opportunity cost of vaccination too high. Services should go to them (*eg*, at bus parks, workplaces) or be available at hospitals and health centres in the evening.

Risk perception depends on how messages are framed, the message communicator and the approaches applied as persons perceive individual risks differently, depending on how likely they think the actual hazard will affect them personally and their beliefs about how severe the harm might be (13). Factors influencing risk perception include trust in the source of the risk message, personal exposure or experience with the effects of the disease or infection and subjective perceptions of the likelihood of being negatively affected.

Collective responsibility is often strongly correlated to risk perception (14). Persuading individuals to adopt preventive behaviours such as social distancing and vaccination for the common good should be related to economic effects of the pandemic such as loss of production and personal income. It requires messaging that persuades each citizen that he/she is responsible not only for himself/herself but also for others.

Finally, strategies to combat anti-COVID-19 vaccine messages cannot be developed by educated guesswork. Evidence-based approaches that effectively respond to the concerns of Jamaicans and facilitate communication of credible information about vaccination are vital to achieving high vaccination coverage. Research is urgently needed to identify factors contributing to low uptake of the COVID-19 vaccine in Jamaica. This evidence is essential for crafting messages that address the sources of hesitancy to be delivered from multiple, easily accessed media channels used by a variety of audiences. Messages must be culturally appropriate use easily understood language and be delivered by messengers who are well known and trusted, including media personnel who have already shared their encounters with COVID-19 infection.

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