From: Drucis, Abigail R. EOP/OMB
Sent: Wed, 3 Feb 2021 18:19:54 +0000
To: Spiro, Topher J. EOP/OMB; Garufi, Marc A. EOP/OMB; Reilly, Tom M. EOP/OMB; Hudgins, Kathy M. EOP/OMB; Bibo, David; Gorman, Chad; Despres, Sarah (HHS/IOS); O'Connell, Dawn (HHS/IOS); Webb, Cameron C. EOP/WHO; Shahpar, Cyrus (CDC who.eop.gov); Smith, Marcella N. EOP/OSTP; Aj.Pearlman@hhs.gov; Berger, Sherri (CDC/OCOO/OD); Hale, Jessica K. EOP/OMB; Lubar, Debra (CDC/DDID/NCEZID/OD); Cohn, Amanda (CDC/DDID/NCIRD/OD); Liburd, Leandris C. (CDC/DDPHSIS/OMHHE/OD); Johnson, Jo Linda; Hill, Walter F. EOP/OMB
Subject: RE: CDC-FEMA-WH Meeting - Next Steps
Attachments: Guide For Awardees for Community-Driven Strategies.pdf

All –

We appreciate the prompt follow-up on the action items from Tuesday's meeting. I am reaching out with CDC tools. Attached is a guidance (not yet posted online), and below are additional resources:

- Jurisdiction guide focused on planning for equitable distribution: COVID-19 Vaccination Program Interim Playbook for Jurisdictions Operations Annex (cdc.gov)

- Increasing COVID-19 Vaccine Uptake among Members of Racial and Ethnic Minority Communities: A Guide for Developing, Implementing, and Monitoring Community-Driven Strategies (attached)

- Below are all CDC communications toolkits, all with confidence components and speak to health equity issues. Future communication toolkits include those for health departments, as well as a number of HHS toolkits for specific communities that are more public-focused in coming weeks.

    - For health systems: >https://www.cdc.gov/vaccines/covid-19/health-systems-communication-toolkit.html<
    - COVID-19 patient education: >https://www.cdc.gov/vaccines/covid-19/hcp/index.html<
    - Long term care facility: >https://www.cdc.gov/vaccines/covid-19/toolkits/long-term-care/index.html<
    - Employers of essential workers: >https://www.cdc.gov/coronavirus/2019-ncov/vaccines/toolkits/essential-workers.html<
    - Community-based organizations: >https://www.cdc.gov/coronavirus/2019-ncov/vaccines/toolkits/community-organization.html<

Thanks to Debra and her team for sharing these resources with us.

Abigail Drucis
Office of Management and Budget, Health Division (HHSB)
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(iPhone)

From: Drucis, Abigail R. EOP/OMB
Sent: Tuesday, February 2, 2021 11:14 AM
To: Topher J. EOP/OMB Spiro (b)(6) <(b)(6)>; Marc A. EOP/OMB Garufi (b)(6) (b)(6); Tom M. EOP/OMB Reilly (b)(6) (b)(6)v>; Hudgins, Kathy M. EOP/OMB (b)(6); Bibo, David <David.Bibo@fema.dhs.gov>; Gorman, Chad <Chad.Gorman@fema.dhs.gov>; Despres, Sarah (HHS/IOS) <Sarah.Despres@hhs.gov>; O'Connell, Dawn (HHS/IOS) <Dawn.Oconnell@hhs.gov>; Webb, Cameron C. EOP/WHO <(b)(6) Shahpar, Cyrus EOP/WHO (b)(6); Smith, Marcella N. EOP/OSTP (b)(6)v>; Fitter, David L. (CDC/DDPHSIS/CGH/GID) <vid3@cdc.gov>; 'Aj.Pearlman@hhs.gov' <Aj.Pearlman@hhs.gov>; Pillai, Satish K. (CDC/DDID/NCEZID/DPEI) <vig8@cdc.gov>; Berger, Sherri (CDC/OCOO/OD) <sob8@cdc.gov>; Jessica K. EOP/OMB Hale (b)(6) <(b)(6)>; Lubar, Debra (CDC/DDID/NCEZID/OD) <dpl9@cdc.gov>
Subject: CDC-FEMA-WH Meeting - Next Steps

All –

Thanks for joining us this morning to kick-off the bi-weekly CDC-FEMA-WH meetings.

Next steps include:

- **Everyone:** Please let me know if you need someone from your team added to the Zoom invite.

(b)(5)

- **Debra:** Send around the CDC tools to this group.

See everyone on Thursday,

Abigail Drucis
Office of Management and Budget, Health Division (HHSB)
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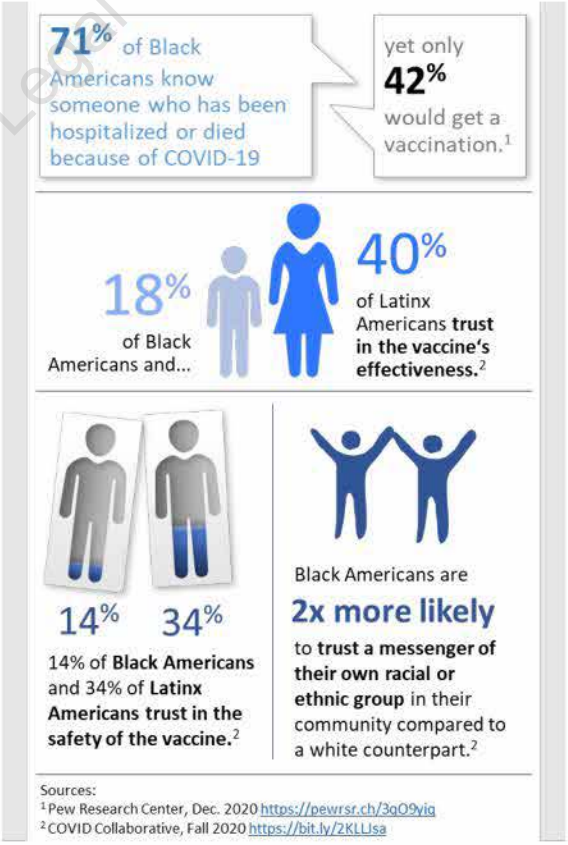
Increasing COVID-19 Vaccine Uptake among Members of Racial and Ethnic Minority Communities: A Guide for Developing, Implementing, and Monitoring Community-Driven Strategies

Purpose: The COVID-19 Vaccination Supplemental Funding to IP19-1901 requires use of 10% of total funding for high-risk and underserved populations. This guide aims to support immunization awardees in establishing a community-driven approach and work plan for developing, implementing, and monitoring strategies to increase vaccine uptake among communities of focus. The guide focuses on racial and ethnic minority communities as an example due to the disproportionate burden of COVID-19 among these groups, but it is applicable to other communities that are hard to reach, experience marginalization or discrimination, and/or demonstrate vaccine hesitancy. This guide may be supplemented with additional materials and resources as more is learned about effective strategies and interventions. When finalized, CDC-RFA-1P21-2108, "Partnering with National Organizations to Support Community-Based Organizations to Increase Vaccination Coverage Across Different Racial and Ethnic Adult Populations Currently Experiencing Disparities," can help support the partner network described in this guide; planned partnerships and organizations to be funded are still in development.

Figure 1: Statistics on the impacts of COVID-19 in Black and Hispanic/Latinx communities



Background: Medical and structural racism and discrimination have led to **mistrust of the medical system among racial and ethnic minority groups**.[i] Data consistently show health disparities among racial and ethnic minorities relative to white populations, including vaccination coverage among adults. These disparities persist even when controlling for other demographic, socioeconomic, and structural factors.[ii] Disparities in vaccination are associated with lack of both access to vaccination and vaccine acceptance. Historical events, such as the Tuskegee Syphilis Study, and **current lived experiences of racism and discrimination contribute to significant distrust** among racial and ethnic minority groups of both vaccines and vaccination providers, as well as the institutions that make recommendations for the use of vaccines.[iii] This skepticism extends to COVID-19 vaccine. It is compounded by the unprecedented speed with which COVID-19 vaccines were developed.[iv]

State data compiled by the Kaiser Family Foundation shows that COVID-19 vaccination rates for Black and Latinx populations are lower than their share of the population and their share of COVID-19 cases and deaths in some states.[v] Current vaccine hesitancy among members of racial and ethnic minorities is strong despite the **disproportionate impact of COVID-19 on these groups, particularly in Black and Latinx communities.** Black or African American, non-Hispanic persons are 3.7 times, and Hispanic/Latinx persons are 4.1 times, more likely to be hospitalized due to COVID-19 than white, non-Hispanic persons, and both populations are 2.8 times more likely to die.[vi] Even so, only 42% of Black Americans say they would get a COVID-19 vaccination if available.[vii] As Black and Latinx communities have faced a disproportionate burden of COVID-19, it is paramount that vaccine confidence and trust are strengthened in these communities.

A Community-Driven Approach for Increasing COVID-19 Vaccine Confidence and Uptake:

To build vaccine confidence and increase uptake among members of racial and ethnic minority communities, immunization awardees can establish or bolster existing partnerships with **community organizations, leaders, and other local partners to define barriers and assist in development and implementation of strategies**—offering them a seat at the table, providing support to help implement strategies, and continuously engaging their knowledge, insights, and lived experiences as a part of planning and engagement. This guidance provides a **community-driven approach to identifying partners and increasing vaccine confidence and uptake** using five steps, as seen in Figure 2 and the summary below.

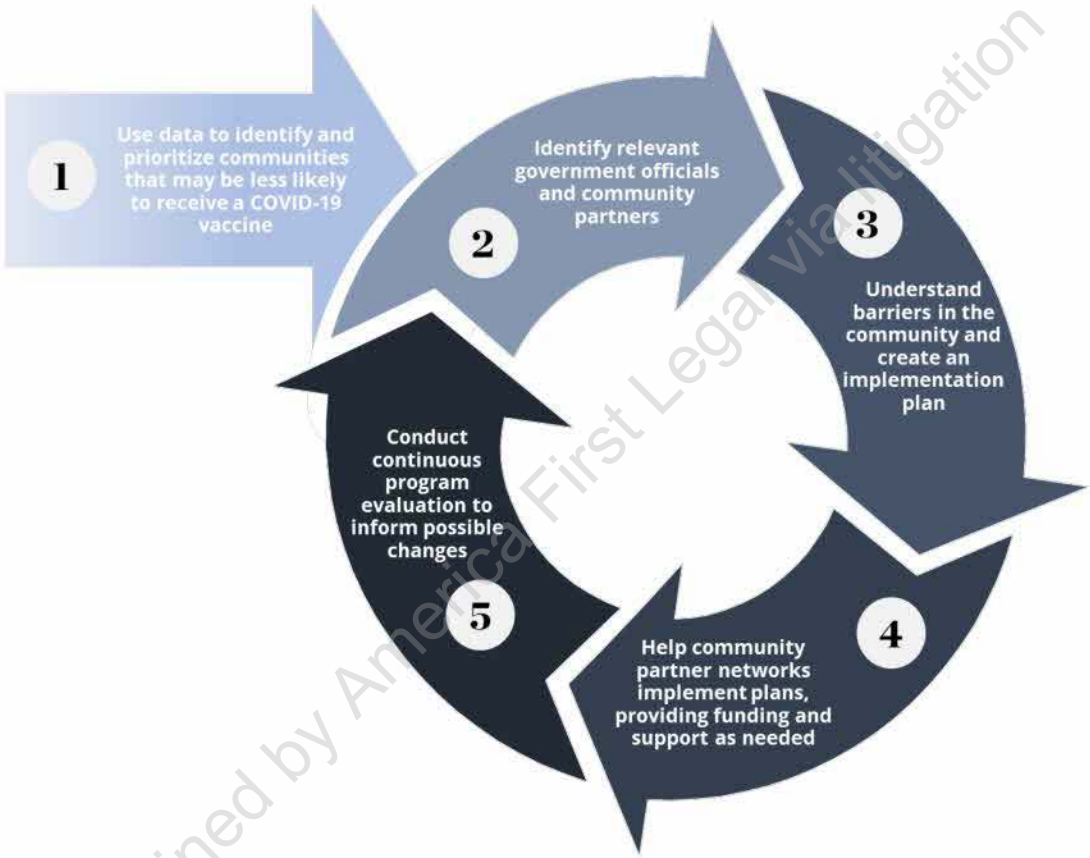


Figure 2: Community-driven approach

Step 1: Use data to **identify and prioritize racial/ethnic minority communities** that may be less likely to receive a COVID-19 vaccine.

Step 2: For each community of focus, **identify relevant government officials and community** partners to form a "community partner network."

Step 3: Work with the community partner network to **understand barriers** in the community and **create an implementation plan for vaccination messaging, outreach, and administration.**

Step 4: Help community partner networks **implement plans, providing funding and support** as needed.

Step 5: Conduct **continuous program evaluation** through data collection and analysis to **inform possible changes** to the ongoing strategies.

Step 1: Use data to identify and prioritize racial/ethnic minority communities that may be less likely to receive a COVID-19 vaccine

To identify racial/ethnic minority communities that may be less likely to get vaccinated and could benefit from additional support to develop tailored, community-based strategies, immunization awardees may wish to explore existing data sources. An **identified community of focus should be a specific racial/ethnic minority group in a specific geographic area** (e.g., specific Black community residing in a specific part of the city).

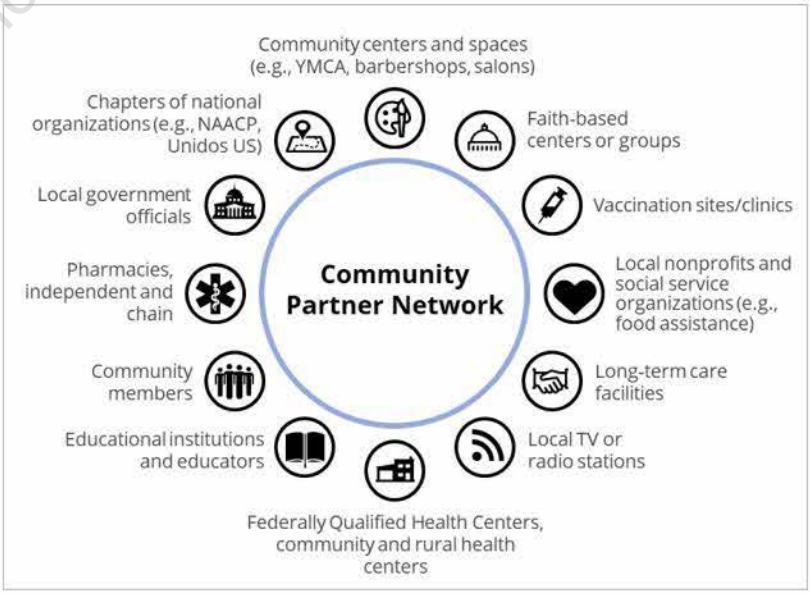
Potential data sources are provided in Table 4 in Appendix A. These data sources can either inform the location of racial/ethnic minority communities or provide insight into challenges around access to vaccination services or the prevalence or likelihood of vaccine hesitancy. Immunization awardees may have access to other local data sources that may be informative, including qualitative or anecdotal data on attitudes, beliefs, and lived experiences related to either COVID-19 or other vaccines among members of racial/ethnic minority communities.

In addition, CDC plans to support immunization awardees through "data-informed technical assistance"—a service that gives immunization awardees hands-on support in using data to identify priority communities and develop strategies to build vaccine confidence.

Step 2: For each community of focus, identify relevant government officials and community partners to form a "community partner network"

- For each community of focus, immunization awardees can define a **"community partner network" that comprises local public health officials (including health equity directors), community-based organizations and leaders, and community members** that serve, represent, and are trusted by the community of focus. See **Figure 3** for an example.
- Across all communities of focus, awardees can identify **other key groups for awareness, information-sharing, and coordination**; these can include groups receiving COVID-19 vaccine supply, officials with experience in community programs (e.g., food banks, homeless shelters, HIV prevention programs), healthcare agencies or systems (e.g., Medicaid agencies and their managed care organizations), first responders, or other groups.

Figure 3: Community partner network example for Black and Hispanic/Latinx Communities



- **Once the community partner network for a community of focus is created,** awardees can:
  - **Engage one or more local officials and health equity officers as "local leads"**—these leads can help identify and plan outreach to community-based organizations and leaders, especially new contacts, given their networks and proximity.
  - **Plan engagement of each partner and conduct outreach—** document the best person and method for outreach, how to message the "ask" for participation, their role expectations, and what preemptive questions or hesitations they might have to address in initial outreach.
  - **Clearly emphasize the group or individual's role, expectations, and the unique value they can provide.** Role and expectations may include:
    - Providing **insight on the different barriers to vaccine uptake** within the community
    - Supporting the **development and implementation of vaccination** outreach, messaging, and administration that is tailored to the community of focus**—for example,** in Black communities, barbershops and hair salons may be culturally trusted and relevant places for effective outreach and intervention.[viii]
    - Ensuring efforts and messaging/communication materials are **culturally and linguistically appropriate and leveraging existing health communication networks**. For example, as part of CDC's Racial and Ethnic Approaches to Community Health (REACH) program, Southern Nevada Health District, a REACH recipient, developed a multicomponent media campaign in English and Spanish to increase uptake of the influenza vaccine. The campaign reached over 602,000 individuals in the priority population.[ix]
  - Encourage local leads to **coordinate with other key local-level groups**, including first responders, major employers of the community of focus, and local health systems and plans, for planning and implementation.

> *"This is not only about convincing communities that a vaccine is safe; it is also about **following the lead of communities to deliver what is most needed in this moment to earn and rebuild trust** and ensure that the benefits of a vaccine will be felt where the need is most acute." – Trust for America's Health*

Step 3: Work with the community partner network to understand barriers in the community and create an implementation plan for vaccination messaging, outreach, and administration

Once a community partner network has been established, immunization awardees should work with each network to first understand the community-specific barriers to COVID-19 vaccination. These barriers could involve misinformation, a lack of confidence/trust in vaccines, and/or challenges involving access to vaccination services. From this, they can create a plan for increasing COVID-19 vaccine uptake in a way that is fully driven by community partners and incorporates required funded activities in a way that is tailored and adapted to the community's needs.

- **To understand barriers in a community-led way, local leads should hold workshops with the community partner network to fully engage their perspectives.** These workshops should: 1) clearly define the community of focus and the barriers and misinformation that exist, and 2)

prioritize the voices and perspectives of community groups/leaders/members to hear direct experiences and insight in their own words.

- To support these workshops, **immunization awardees can share with local leads the latest public health information and materials about COVID-19 vaccination** to be tailored and incorporated into plans for each community of focus, as appropriate.
- Make sure the **information is accurate, consistent, timely, and transparent** to avoid counteracting efforts in building trust.
- As community partners help develop plans, local leads should share this information regularly **and directly address community-specific concerns and questions,** including what is known about the vaccine, what is uncertain or not known, risks and benefits, who is able to receive the vaccine, where they can receive it or how they may best access it, what happens during and after vaccination, and other considerations that will facilitate their decision-making.

*CDC has launched **new grant programs to fund community-based organizations (CBOs) to build vaccine confidence in communities of color.** CBOs are working to educate and empower trusted voices in the community to support vaccine education and delivery and also build partnerships between vaccination providers (e.g., pharmacies) and the community to increase the number, range, and diversity of opportunities for vaccination (see Appendix B for more details).*

- **Local leads should use the first workshop to understand directly from community partners the key barriers and misinformation in the community of focus related to COVID-19 vaccination.** Effective strategies will depend on understanding barriers as voiced directly by the community related to lack of access, hesitancy/lack of confidence, or both.
  - **Discuss questions such as:** What barriers, needs, or concerns does the community face or have about COVID-19 vaccination? What beliefs, attitudes, misinformation, or lived experiences drive these? What gaps or questions in information exist? Where are community members most likely or willing to get vaccinated?
  - **Note:** For these workshops, local leads can use **Table 1** below for examples of questions and considerations, as well as research on vaccine hesitancy/misinformation and content/tools from CDC's upcoming Rapid Community Assessment Guide to support answering these questions.
- **In the same or subsequent workshop, local leads can use these insights to create a plan for increasing vaccination uptake, driven by community partners and tailored to the community**.
  - Plans could include defined barriers/needs in the community of focus, activities (including any required activities for funding) the community partner network plans to conduct, roles of different community partners, plans for tailoring information/materials, qualitative and quantitative measures, and requested support needed from jurisdiction (monetary and non-monetary, see **Table 2**).
  - It is recommended that immunization awardees **share with community partner networks a simple template for their plans** that can be submitted for feedback.

Table 1: Potential questions and considerations for workshops and implementation plans

Defining Barriers	Creating Plans	Example Ideas for Black and Hispanic/Latinx Communities and other Minority Groups
What barriers, needs, or gaps exist in the community **related to public health information or misinformation**?	**What specific information and materials** should be tailored and shared to address the community's needs both prior to and during vaccination in a culturally responsive and linguistically appropriate way?	• Images that include Black or Hispanic/Latinx individuals or **those in the community** • Information that is transparent and addresses concerns and misinformation–*Black adults may have more concerns about side effects, the newness of the vaccine, concerns of getting COVID-19 from the vaccine, and vaccine hesitancy in general*[x] • Messaging that is **culturally relevant** and in the right language • Information on vaccine **administration and cost**––including who will be delivering vaccine, languages offered at vaccination provider sites, and information to be requested—undocumented and/or uninsured individuals in the Hispanic/Latinx community may avoid vaccination due to concern around language accessibility, insurance requirements, and immigration status • Clarity on how **personal information** will be used • Clarity on vaccination provider site **times and locations** • Communication about available **transportation and costs**
What barriers, needs, or gaps exist to **disseminating information or addressing misinformation** in the community?	**What methods and platforms** should be used to disseminate messages and conduct outreach in a trusted way?	• Social media (e.g., Black Twitter) • Flyers at populated **community sites** • Public outreach by **trusted messengers** • Radio personalities—*Health and Hospital Corporation of Marion County created a media campaign using multiple local celebrities, including a DJ, a newspaper editor, a bestselling author, and a social media influencer, and successfully reached both the Black and Latinx communities with its annual flu campaign*[xi] • Bidirectional discussions with **trusted staff** at pharmacies or health centers/clinics
What barriers, needs, or gaps exist **in accessing public health information and services** in the community?	**What venues/locations** should be used to disseminate messages, conduct outreach, and deliver the vaccine in a trusted way?	• Community centers • Community spaces (e.g., barbershops/salons, grocery stores) • Churches or educational institutions • Independent, local pharmacies • Local health clinics or locations • Mobile clinics or temporary/off-site clinics • Employers where community members work, especially frontline essential workers
What barriers, needs, or gaps exist in **engaging and featuring trusted messengers** in the community?	**Who should be engaged, and how,** to disseminate messages, conduct outreach, and play a role in vaccine administration in a bidirectional, trusted way?	• Existing **local coalitions or groups** • Neighborhood or **recreational groups** • Racially concordant **providers** • Trusted **providers and staff** from local health centers/clinics—*about 70% of Black adults and 66% of Latinx adults say their provider does a very good or excellent job giving clear information and encouraging them to share questions and concerns*[xii] • Trusted **community leaders** (e.g., barbershop/salon owners, radio DJs, pastors, local leaders, social media personalities) • Employers where community members work
What barriers, needs, and gaps exist in **making sure community**	**What interventions** should be implemented to	• Non-traditional **clinic sites and hours** (e.g., nights and weekends) to mitigate work or family responsibilities—*the American Heart Association engaged a local network of providers in San Antonio for mobile vaccination clinics in accessible locations (e.g., Zoo)*[xiii]

members can access the vaccine?	ensure community members have access to, information about, and opportunities to receive the vaccine at clinics/sites?	• Locations in or accessible to community members • Coordinating sites with other **community services** (shelters, food banks, churches, etc.) • Subsidized and accessible **transportation options** • Training and scheduling providers or staff - who **represent the community** and speak the appropriate languages - to administer vaccine • Leveraging all healthcare staff who can legally administer the vaccine • Working with trusted or racially concordant providers or staff to **refer individuals to vaccination provider sites**

Step 4: Help community partner networks implement plans, providing funding and support as needed

Immunization awardees can provide feedback on plans and decide how to best support each network.

- **If community partner networks will need to compete for funding or support, apply simple criteria to assess plans**. Potential criteria can include:
    - *Quantitative factors* such as overall reach and number impacted by the plan; how many trusted messengers will be engaged; and diversity in population reached, etc.
    - *Qualitative factors* such as likelihood that plan will address identified barriers; role of community partners; ability to engage/reach community of focus; ability to tailor and disseminate culturally responsive and linguistically appropriate information; ability to partner with and elevate community messengers; ability to train informal leaders
- **Communicate back to community partner networks initial feedback on the plan** and what, when, and how jurisdiction support will be provided. See **Table 2** for examples of support.
- **Encourage each network to conduct "audience testing" with a small group of representative members from the community of focus** on initial materials/messaging, dissemination and outreach strategies, and plans for vaccination provider sites.
    - To improve implementation, this initial feedback collection should focus on confidence in, access to, and likelihood of choosing to take the vaccine—for example, community members might suggest communications need to acknowledge mistrust and raise awareness of the prior harm done to communities of color.[xiv]

Table 2: Examples of support provided by immunization awardees

Examples of non-monetary support	Examples of monetary support
• Feedback on submitted plans' strategies, activities, resources, and measures and outcomes • Compiling/analyzing data across networks • Sharing promising or effective ideas across networks • Disseminating/promoting information and materials • Addressing issues with vaccine supply • Helping with necessary approvals • Providing access to contacts or experts • Data storage and analysis support	• Paid time for community groups, leaders, and other trusted messengers • Creation and printing of materials • Funds for vaccination provider sites and/or mobile clinics, Personal Protective Equipment (PPE), and vaccine administration • Transportation for community members • General funding support for programmatic expenses

- **Set up a mechanism for regular and seamless sharing of critical new public health information and materials** across all groups—this will make it easier for all stakeholders to know what information needs to be tailored and customized.
    - This could be done through a common Sharepoint or access site, regular emails, and regular meetings/touchpoints to discuss informational and material updates.
- **Consider sharing submitted community partner network plans with other networks** to encourage collaboration across networks and generation of new ideas.

Step 5: Conduct continuous program evaluation through data collection and analysis to inform possible changes to the ongoing strategies

The urgent and unprecedent nature of the COVID-19 pandemic means that collecting, learning from, and quickly acting on the massive amount of data generated will be critical to supporting communities of focus. In addition to required data (disaggregated by race and ethnicity) on who is getting vaccinated, when, and where, immunization awardees can consider collecting real-time feedback from the community through social media and conversations with trusted messengers and leaders.

- **Before partners begin implementing their plans, quickly coordinate with local officials regarding the required data to collect**—specifically doses administered disaggregated by race, ethnicity, sex, age, and vaccination provider site.
    - Immunization awardees can also collect other Key Performance Measures as described in the COVID-19 Vaccination Supplemental Funding Guidance.
- **Validate with local officials how data will be most efficiently collected, stored, and analyzed to align with existing requirements and frequently see who is getting the vaccine and where.**
    - Methods could include central data files, Sharepoint or access sites, analytical tools, and/or involvement of jurisdiction-level staff. Where possible, leverage existing or required data sources, data collection, and reporting processes to reduce burden.
- **If some communities of focus are receiving less vaccinations than other communities, encourage community partner networks to collect anecdotal/qualitative insight/data.** This can be from social media monitoring or feedback directly from community members and individuals involved with implementing strategies at the local level**.** See **Table 3** for examples of whom to talk with and what to ask them —these data can be collected through conversations in the community with trusted messengers and community leaders or surveys and social media.
- **Create and communicate a flexible and low-burden process for reporting** that will allow for ongoing and rapid adjustments to plans based on feedback and effectiveness.
- **Set up frequent touchpoints (e.g., twice a week) that include all local leads and community partner networks to understand and learn from the data** and revise/change strategies.
    - Discuss questions like: *What racial/ethnic disparities exist? Are there disparities in who signs up to receive the vaccine and/or who shows up for appointments? Are there communities receiving more or less vaccine than planned? What interventions or sites are effective or promising? Are there community groups/leaders that are effective at outreach in the community? How are most people hearing about the vaccine?*
    - CDC plans to provide support for this through "data-informed technical assistance".
- **As new data findings suggest changes are needed, return to other steps** to quickly revise strategies, engage new partners, or engage a new community of focus.
- **Use common perspectives or effective interventions from communities to directly inform broader awardee-level plans** for vaccine outreach, messaging, and administration.

Table 3: Sample qualitative questions to supplement required vaccination data

INDIVIDUALS	INFORMATION TO GATHER – SAMPLE QUESTIONS
1. Receiving outreach and communication materials (persons to be vaccinated)	• Have you heard about the vaccine and ways to receive it? If so, how? • What did the outreach/communication make you think or feel? • Are there any fears/obstacles that may still prevent you from getting the vaccine? • Do you feel you have the information you need to make an appointment and receive the vaccine?
2. Receiving the vaccine (persons who were vaccinated)	• How did you feel after your first (or second) dose? How did this shape your experience of the vaccination process? • Did you feel comfortable receiving the vaccine? Why or why not? • Did you feel comfortable checking in for the appointment? Why or why not? • What concerns/fears did you have before getting the vaccine? • What helped or changed your mind? • How likely are you to make (or attend) your next appointment and receive a second dose? Why?
3. Disseminating outreach or administering the vaccine (trusted messengers and observers)	• How did vaccine recipients appear emotionally? • What questions or sentiments did they share? • What barriers, if any, did they experience or share? • How likely are they to receive the vaccine (or the follow-up dose)? • Did you experience any barriers to performing your responsibilities? • What else did you observe? Do you have any suggested improvements?
4. Sharing the experience with others (persons who were vaccinated)	• Did you share information on receiving the vaccine with your neighbors, friends, and family? If so, what did you share? • How likely are you to encourage others to receive the vaccine? • When explaining any parts of your experience, what would you mention?

APPENDIX A

Table 4: Example data sources to leverage

CATEGORY	DATA SOURCE TITLE	DESCRIPTION	WHAT TO USE FOR	HOW TO ACCESS
Immunization	**Jurisdiction-level immunization information system (IIS) data**	All 50 states and the District of Columbia have IISs that can collect and can generate reports of vaccine administration data. The availability of local-level data and data stratified by various demographic factors, such as race/ethnicity, will vary by jurisdiction.	Low influenza vaccine **administration data** may indicate challenges with access and/or hesitancy and may be used as a proxy for or indicator of COVID-19 vaccination challenges. Health equity concerns may be indicated if low vaccine **administration** is observed in locations with a substantial racial/ethnic minority population.	Varies by jurisdiction
Immunization	**CDC's FluVaxView**	CDC administers surveys to generate influenza vaccination coverage estimates by various demographic factors, including race/ethnicity, for every influenza season. Data are available nationally and for all 50 states and the District of Columbia through 2019–2020. County-level coverage estimates will be available soon.	Low influenza vaccination **coverage estimates** may indicate challenges with access and/or hesitancy and may be used as proxy for or indicator of COVID-19 vaccination challenges. Health equity concerns may be indicated if low **coverage** is observed in locations with a substantial racial/ethnic minority population.	Link to data
Immunization	**State reports of school vaccination requirement exemptions**	A subset of states publicly reported school vaccination requirement data—including those related to non-medical exemptions—at a local level (i.e., county, school district, or school).	A high rate of non-medical exemptions to school vaccination requirements may indicate general vaccine hesitancy within a community. In states that allow non-medical exemptions, identifying local areas with higher exemptions may point to the need to focus COVID-19 vaccination efforts. Health equity concerns may be indicated if a high rate of non-medical exemptions is observed in locations with a substantial racial/ethnic minority population.	Link to data

COVID-19 Disease Burden	**CDC COVID Data Tracker**	Non-vaccination tabs from the CDC COVID Tracker report various measures of COVID-19 disease burden down to the county level.	High COVID-19 disease burden may help focus vaccination efforts on disproportionately affected communities.	Link to data
COVID-19 Disease Burden	**Health Center COVID-19 Testing Dashboard**	Weekly health center data of total COVID-19 tests conducted and positive COVID-19 tests by race and ethnicity.	High COVID-19 disease burden may help focus vaccination efforts on specific racial/ethnic minority communities.	Link to data
Demographics and Social Vulnerability	**U.S. Census Bureau COVID-19 Site**	Impact planning reports and demographics at the county level.	Counties with high populations of racial/ethnic minority groups, as well as other socioeconomic demographics, may help focus vaccination efforts on specific communities.	Link to data
Demographics and Social Vulnerability	**Social Vulnerability Index**	CDC index of social vulnerability at the county level using 15 variables to measure social vulnerability.	Counties with high vulnerability scores may help focus vaccination efforts on specific communities.	Link to data
Demographics and Social Vulnerability	**County Health Rankings**	County-level data on demographics, health outcomes, and health factors to better understand individual counties.	Counties with low rankings for health outcomes and health factors may help focus vaccination efforts on specific communities.	Link to data
Demographics and Social Vulnerability	**U.S. Census Population Data**	Data on population density to see what areas have high prevalence of racial/ethnic minority communities.	Counties with high populations of racial/ethnic minority groups, as well as other socioeconomic demographics, may help focus vaccination efforts on specific communities.	Link to data
Demographics and Social Vulnerability	**HRSA Shortage Areas**	Data on HRSA's Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Populations (MUA/Ps) at county level.	Areas with high HPSA or MUA/P scores may help focus vaccination efforts on specific communities.	Link to data

APPENDIX B

Recent CDC funding for CBOs – including COVID-19 Vaccination Supplemental Funding to IP19-1901, and CDC-RFA-1P21-2108, "Partnering with National Organizations to Support Community-Based Organizations to Increase Vaccination Coverage Across Different Racial and Ethnic Adult Populations Currently Experiencing Disparities" - covers activities to increase flu and COVID-19 vaccination coverage. A summary of activities relevant to COVID-19 is below.

Work with communities to identify and address drivers of vaccine hesitancy, influential community messengers and partners, and community-acceptable approaches for improving vaccination availability, accessibility, and acceptability.

- Conduct surveys, interviews, town halls, or focus groups to identify drivers of vaccine hesitancy, influential messengers, and community-acceptable approaches.
- Document and share relevant findings from events, conversations, or convenings.
- Identify common drivers of vaccine hesitancy and collect other key information.
- Based on community interactions and findings, share tangible insights, common challenges, and key lessons learned with organization leadership to inform CDC's and organization's strategies for addressing racial and ethnic disparities in vaccination.

Educate and empower trusted voices in the community to support vaccine education and delivery.

- Conduct outreach to community members on COVID-19 vaccination.
- Develop and implement community-based and culturally and linguistically appropriate messages that focus on COVID-19 spread, symptoms, prevention and treatment, and benefits of vaccination.
- Identify and train trusted community-level spokespersons (e.g., faith leaders, teachers, community health workers, radio DJs, local shop owners, barbers) to communicate the burden of COVID-19 mitigation and vaccination through local media outlets, social media, faith-based venues, community events, and other community-based, culturally appropriate venues.
- Support non-funded local entities by sharing findings and materials.

Build partnerships between vaccination providers (e.g., pharmacies) and the community to increase the number, range, and diversity of opportunities for vaccination.

- Connect vaccination providers with places of worship, community organizations, recreation programs, food banks/pantries, schools and colleges/universities, grocery stores, salons/barbershops/beauticians, major employers, and other key community institutions to set up temporary and/or mobile COVID-19 vaccination provider sites, especially in high-disparity communities.
- Connect local health departments, community health centers, and/or trusted healthcare organizations, including pharmacies, with communities through mobile COVID-19 vaccination clinics in communities facing disparities to increase the number, range, and diversity of opportunities for vaccination.
- Build partnerships with healthcare providers to increase provider understanding of the populations of interest and interventions to increase vaccination rates for these populations.

- Work with vaccination service providers to expand and train the types of health professionals (e.g., community health workers, patient navigators, patient advocates) and administrative staff (e.g., front desk workers) engaged in promoting vaccination and increasing referrals of individuals to COVID-19 vaccination provider sites.

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From: Tumpey, Abbigail (CDC/DDPHSS/CSELS/OD)
Sent: Mon, 26 Jul 2021 21:35:45 +0000
To: Sams, Ian (HHS/ASPA); Wakana, Benjamin L. EOP/WHO
Subject: Vaccine confidence
Attachments: SoVC_report12_7.26.21.pdf

See page 4.

COVID-19 State of Vaccine Confidence Insights Report

Report 12 | **July 26, 2021** | Date Range: June 21, 2021 – July 12, 2021

Summary

Findings. Consumer concerns about the safety of COVID-19 vaccines were amplified by multiple, overlapping and widely circulating misinformation narratives. As a result, some consumers questioned the transparency of the government in reporting and addressing adverse events following COVID-19 vaccination. The Delta variant of the virus that causes COVID-19 continues to drive concerns about vaccine effectiveness, especially among those who are already vaccinated. However, those who remain unvaccinated are generally less likely to perceive the Delta variant as a threat, and vaccine intentions do not appear to be affected.

Ways to take action. Federal, state, and local partners should continue to work together to increase transparency around rationale for updated guidance, respond to gaps in information, and confront misinformation with evidence-based messaging. The goal of these efforts is to increase confidence in COVID-19 vaccines and expand vaccine uptake more broadly. Messages leveraging available data on vaccine safety and effectiveness should be disseminated, especially in relation to the Delta variant and circulating misinformation narratives. Public health agencies should partner with trusted messengers and healthcare personnel to further amplify these messages. Research efforts should be supported to further evaluate the effect of reported adverse events, side effects, and vaccine effectiveness on vaccination intent and motivation.

Contents

Centers for Disease Control & Prevention,
COVID-19 Response, Vaccine Task Force
Vaccine Confidence & Demand Team, Insights Unit

Aims and Methods

By rapidly reviewing and analyzing numerous sources and inputs (see Appendix), the biweekly COVID-19 State of Vaccine Confidence Insights Report emphasizes major themes that influence COVID-19 vaccine hesitancy and uptake. These are characterized by level and type of threat to vaccine confidence, degree of spread, and directionality. By examining how consumers think and feel, social processes, and the practical issues around vaccination, the Insights Report seeks to identify emerging issues of misinformation, disinformation, and places where intervention efforts can improve vaccine confidence across the United States.

The information in this report is only a snapshot, and certain populations may be underrepresented. Images and quotes are illustrative examples and are not meant to be comprehensive of all content related to the highlighted themes.

Theme Classification

How do you classify this theme/information?			
High risk	**Moderate risk**	**Low risk**	**Positive sentiment**
▪ May lead to vaccine refusals and decreased uptake ▪ Wide reach, pervasive	▪ Potential to trigger hesitancy to vaccination ▪ Moderate reach, modest dissemination	▪ Concerning, but low risk to vaccine confidence ▪ Limited reach, limited dissemination	▪ Could increase vaccine confidence, intent, or motivation ▪ Variable reach and dissemination

How has this theme/idea changed over time (since last report or over the course of multiple reports)?		
Increasing Information spreading rapidly	**Stable** Information remaining constant at prior level	**Decreasing** Information is not gaining further traction and there has been no indication of additional activity

Major Themes

Consumer concerns about the safety of COVID-19 vaccines were fueled by overlapping misinformation narratives.

Throughout the reporting period, vocal vaccine deniers circulated and amplified several misinformation narratives focused on discrediting the safety of COVID-19 vaccines. Major circulating false narratives included:

- False claims that Pfizer-BioNTech COVID-19 Vaccine contained graphene oxide, a supposedly poisonous ingredient, which can cause damage to immune systems, pneumonia, and vascular injury.[1,2,3]
- False claims that mRNA COVID-19 vaccines are "cytotoxic" and cause the body to produce spike proteins, which collect within organs causing damage, particularly to the ovaries.[4,5,6]
- COVID-19 vaccination disrupts menstrual cycles and has caused increased miscarriage rates.[7,8]
- A retracted journal article from *Vaccines* that falsely reported that for every three COVID-19 deaths prevented by vaccination, two injuries were caused. These claims continued to circulate despite the article being retracted.[9,10,11]

These narratives entered a digital landscape primed with concerns about the safety of COVID-19 vaccines as consumer fears about myocarditis and pericarditis following vaccination remained at top of mind for many.[12,13,14,15] Consumer fears about vaccine safety were then further fueled by FDA adding a warning on July 12, 2021, about cases of Guillain-Barré syndrome occurring following vaccination with Johnson & Johnson's Janssen COVID-19 Vaccine.[16,17,18] Consumers sought answers online for information about these safety concerns with online searches for "spike protein," "graphene oxide," and "covid vaccine miscarriage" increasing throughout the reporting period[a] and searches for "guillain barre" increasing significantly from June 2021 to July 2021.[b]

With the large volume of misinformation narratives circulating, vocal vaccine deniers, and some consumers questioned the transparency of the government in reporting and addressing adverse events following COVID-19 vaccination.[19,20,21,22] In addition to lack of trust in the government, recent polls and studies confirm that among those who remain unvaccinated the most common cited reasons are concerns about the safety of vaccines and their side effects.[23,24]

Ways to act:

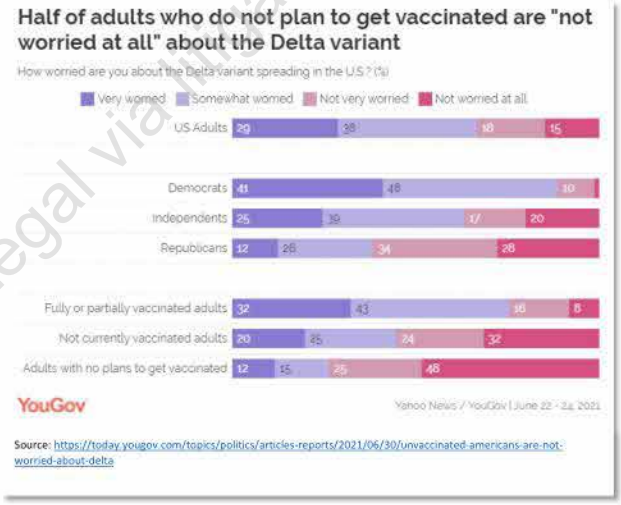
- Continue to disseminate messages about the safety of COVID-19 vaccines, highlighting the number of people who were vaccinated without adverse events and promoting awareness of the multiple layers of safety monitoring systems in place. Amplify messages about what Vaccine Adverse Event Reporting System (VAERS) is, how all the safety monitoring systems work, and how reported adverse events are investigated.
- Expand available online content to debunk widely circulating myths and misinformation, and ensure that web content is optimized for search engines.
- Partner with healthcare personnel, especially women's health providers, to address misinformation clearly and transparently about COVID-19 vaccines, fertility, and reproductive health.
- Support research to better understand consumer perception of vaccine safety, how they seek information about vaccine safety, and who are trusted sources for vaccine safety information.

[a] Google Trends
[b] SEMrush

Vaccinated consumers are concerned about vaccine effectiveness against the Delta variant while unvaccinated consumers remain mostly unconcerned about the variant's spread.

News coverage of the Delta variant of the virus that causes COVID-19 continued to increase from the last report.[c] Coverage ranged from the Delta variant becoming the most common cause of COVID-19 cases in the United States[25] to conflicting reports about whether additional doses would be needed as a result.[26,27,28,29] Despite a joint statement from CDC and FDA clarifying that additional doses are not recommended at this time for fully vaccinated individuals, some vaccinated consumers continued to question whether an additional dose will be needed to better protect themselves against emerging variants, including Delta.[30,31] Several vaccinated consumers also expressed frustration online that unvaccinated consumers are posing a threat to the return to pre-pandemic life and the health and safety of people who are unable to be vaccinated, such as children under 12 years old.[32,33,34] At the same time, several consumers called for mitigation measures, such as mask mandates, to return, even for the fully vaccinated to help slow the spread of the Delta variant[35,36]

Concern about the spread of the Delta variant appears to be far less common among those who are not vaccinated than it is among those who are already vaccinated. One recent poll found that almost half of adults with no plans to get vaccinated were not worried about the Delta variant and almost one-third of adults not currently vaccinated were also not worried.[37] Throughout the reporting period, vocal vaccine deniers amplified narratives that the Delta variant is less serious[38,39] and, in some cases, not even real.[40,41,42] Other vocal vaccine deniers spread misinformation that those who are vaccinated were at increased risk for severe illness from the Delta variant [43,44] and that vaccinated people caused the emergence of variants of the virus that causes COVID-19.[45,46]



Confusion about the effectiveness of available vaccines against the Delta variant was widespread. Consumers and news outlets online noted data from Israel that suggests vaccines are less effective against the Delta variant than previously believed.[47,48,49,50] Consumers also inquired online if a particular vaccine was more effective against the Delta variant, with several indicating they believed authorized vaccines do not provide any protection against this variant.[51,52] However, concerns about variants were not limited to the Delta variant; the frequency of news coverage and online conversations during this period also increased about the "Delta plus" variant and Lambda variant.[53,54,55,56]

Ways to act:

- Disseminate messages about the effectiveness of available COVID-19 vaccines against the Delta variant and other circulating variants in the United States. Continue to amplify messages about the benefits of vaccination, such as reducing the likelihood of severe illness causing hospitalization or death from COVID-19.
- Continue to partner with trusted messengers to amplify messages about the severity of COVID-19 illness and the benefits of vaccination, leveraging recent data that show a majority of people hospitalized for or dying from COVID-19 are not vaccinated.
- Evaluate how potential availability and authorization of additional doses affects intent to vaccinate or re-vaccinate among different consumers.

[c] Meltwater

Emerging Themes

Some consumers claim a COVID-19 treatment is being suppressed to unnecessarily promote vaccination.

Consumers on social media increasingly claimed that a COVID-19 "cure," ivermectin, is being "suppressed" by government agencies to promote vaccination.[57,58,59,60,61] This claim was further amplified by a former vaccine developer from a pharmaceutical company who has perpetuated a number of misinformation narratives over the past few months[62] as well as other prominent misinformation outlets and vocal vaccine deniers.[63,64,65] While there has been minimal coverage by mainstream news outlets,[66,67,68] the University of Oxford announced on June 23, 2021, that it had begun investigating ivermectin as a potential treatment for COVID-19.[69] The narrative around ivermectin appears to recycle earlier false claims about the hydroxychloroquine as a treatment.[70]

Ways to act:

- Continue to disseminate messages that vaccination is one of the many tools that we are using to help end the COVID-19 pandemic.
- Develop and disseminate content about research efforts for treatments of COVID-19 and what is known about available effective treatments in addition to promoting vaccination.

Consumers need answers about the safety and effectiveness of Johnson & Johnson's Janssen COVID-19 Vaccine.

Following the release of results from a recent study suggesting that mixing mRNA and adenovirus-based COVID-19 vaccines provided a good immune response,[71] experts speculated about whether people who have previously received a J&J/Janssen vaccine should receive an additional dose of an mRNA COVID-19 vaccine.[72,73,74] Prompted by the results from this new study and the Delta variant continuing to spread across the United States, some consumers inquired whether they should receive a dose of mRNA COVID-19 vaccine to improve their level of protection.[d,75,76] Some consumers also expressed concern about the safety of J&J/Janssen vaccine, with cases of Guillain-Barré syndrome after vaccination gaining news media coverage in early July.[77,78,79,80] On July 12, 2021, the FDA added a warning about cases of Guillain-Barré syndrome occurring following vaccination with J&J/Janssen vaccine. Additionally, some consumers who received the single-dose J&J/Janssen vaccine expressed frustration about the lack of messaging from health authorities on J&J/Janssen vaccine, compared to the volume of messages about mRNA COVID-19 vaccines.[81,82,83]

Ways to act:

- Disseminate messages about J&J/Janssen COVID-19 Vaccine, leveraging available safety and effectiveness data.
- Clarify what research is being done to evaluate additional doses for those who received J&J/Janssen vaccine.

[d] CDC-INFO

Some consumers are angered by the announcement of new "door-to-door" vaccination outreach efforts.

As President Biden's goal of vaccinating 70% of U.S. adults by July 4, 2021, drew closer, news coverage increased about the likelihood of missing this goal.[84,85] On July 6, 2021, the White House announced a tactical shift to increase COVID-19 vaccination by bringing vaccines directly to low vaccination coverage areas.[84] Some consumers reacted negatively to this news, claiming that such direct government action impinges on their liberty and self-determination.[86,87,88,89] Some vocal vaccine deniers and politicians falsely claimed that the federal government would send "strike teams" across the country to coerce or even forcibly vaccinate adults and teens.[90,91,92,93,94] According to a recent poll, lack of trust in the U.S. government remains a major reason why 38% respondents remain unvaccinated.[95]

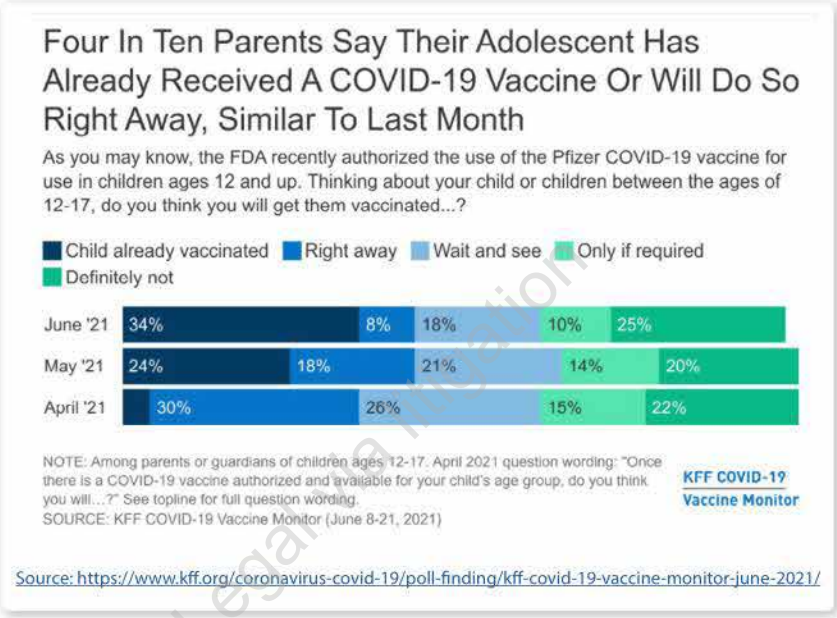
Despite the White House clarifying that "door-to-door" canvassing is similar to census-taking or a voter registration drive and just one element in a five-part strategy to improve vaccine availability, misinformation outlets and vocal vaccine deniers seized on the phrase "door-to-door."[96,97,98] Some consumers expressed confusion and dismay online that communities are being identified and questioned whether the federal government was secretly tracking individuals' vaccination status; others attempted to draw parallels with historical human rights abuses.[99,100,101] Some consumers felt that outreach might be an invasion of medical privacy if individuals are asked about their vaccination status,[102,103] and state-level medical freedom Facebook groups leveraged these fears to further amplify their claims of medical overreach, especially regarding vaccination.[104,105,106]

Ways to act:

- Partner with trusted messengers within communities to amplify messages about vaccination efforts, share how local health departments are making vaccination more convenient than ever, and promote the benefits of vaccination.
- Support research to better understand localized vaccination behaviors and trust in the United States vaccination program. Perform message testing to better understand message framing needs for reaching specific communities and demographics.

Update on Special COVID-19 State of Vaccine Confidence Insights Report on the Authorization & Recommendation of the Pfizer-BioNTech COVID-19 Vaccine for Adolescents Aged 12 through 15 Years

As the Delta variant of the virus that causes COVID-19 becomes more prominent in the United States, consumers continue to be divided about the urgency at which to vaccinate adolescents and children, if a COVID-19 vaccine is authorized for children under 12 years old.[107,108,109] Some consumers remain confused about children's risk of COVID-19, both about the risk of severe illness and how easily children could spread the virus.[110,111,112] Some parents who support vaccination expressed concern over the increasing number of cases among children[113,114] and felt population immunity would not be possible without vaccinating more adolescents and eventually children.[115] Parents of children too young for vaccination specifically asked for more information about when children 11 years old and younger would be able to get vaccinated,[116,117,118] especially as several schools announced they would not be requiring masks for students in the fall.[119,120]



Source: https://www.kff.org/coronavirus-covid-19/poll-finding/kff-covid-19-vaccine-monitor-june-2021/

On the other hand, some parents who do not support adolescent and child vaccination amplified messages about adverse events following vaccination among teens,[121,122] with myocarditis and pericarditis following vaccination continuing to be their paramount concerns.[123,124,125] Many of these parents expressed the belief that the risk for side effects or an adverse event following vaccination was greater than the marginal risk of severe illness from COVID-19.[126,127] These comments from parents and vocal vaccine deniers were met with support from some political leaders who feel children are not at risk and do not need to be vaccinated, with many citing the updated World Health Organization (WHO) guidance as justification.[128,129,130] Misinformation also circulated among vocal vaccine deniers that health departments were seeking to vaccinate adolescents without parental consent, furthering distrust in the United States vaccination system for some parents.[131,132,133]

Recent polls also highlighted a divide in attitudes among parents about risk of COVID-19 in adolescents versus younger children. One poll found that even though four in 10 parents said their adolescent received at least one dose of COVID-19 vaccine, five in 10 did not plan to vaccinate their child.[134] However, a different poll found that more than half of those surveyed with children 12 through 17 years old planned to fully vaccinate them, while the majority of those who did not plan to fully vaccinate their child indicated they were waiting on more research about the safety of COVID-19 vaccines.[e]

[e] Harris Poll for CDC

Continuing and Evolving Themes

Themes below have been noted in previous reports and continue to undermine vaccine confidence. The information highlighted below focuses on what is new or different from previous reports. For additional context and previous recommendations on these themes see previous *Insights Reports.*

Breakthrough cases. News coverage continues to highlight breakthrough cases of COVID-19 among fully vaccinated people, including among high-profile athletes.[135,136] Severe illness from COVID-19 among fully vaccinated people, resulting in hospitalization or death, received the most prominent coverage.[137,138] This coverage drove concerns for some consumers about the effectiveness of available vaccines,[139,140] asymptomatic spread by vaccinated people,[141,142] and how breakthrough cases are counted.[143,144] Several consumer concerns on this topic were directly linked to the circulating Delta variant of the virus that causes COVID-19.

People with compromised immune systems. Several consumers continue to comment online about a lack of guidance and support for immunocompromised people related to COVID-19 vaccination.[145,146,147] At the same time, news coverage highlighted the conflicting information consumers were seeing regarding the need for and timing of a potential third dose for immunocompromised people.[148,149,150]

Vaccine administration issues. CDC-INFO continues to field consumer inquiries about foreign vaccination and mixing vaccine brands. People who received an initial vaccine dose abroad are unsure if they should begin a new vaccination series or whether they are considered fully vaccinated if the vaccine series they received is not authorized in the United States. Other consumers sought guidance on mixing vaccine brands for those who had a reaction to the initial dose or whether they would be considered fully vaccinated if they received two doses of different COVID-19 vaccines.

Appendix: Inputs and Sources

Type	Input	Cadence	Sources	Tactics for Utilization
Social Media Listening & Media Monitoring	Communication Surveillance Report	Daily on weekdays	• Google news • Meltwater • CrowdTangle • Native platform searches	• Share of voice topic analysis to identify themes • Emerging topics
	Meltwater	Daily	• Facebook, Twitter, Instagram • Blogs • News media • Online forums	• Share of voice topic analysis • Emerging theme topics • Identify high reach/velocity topics
	CDC Social Meida Channel COVID-19 Comment Analysis	Daily on weekdays	• Native platform searches	• Sentiment analysis • Identify message gaps/voids
Direct Reports	CDC-INFO Metrics	Weekly	• CDC-INFO inquiry line list • Prepared response (PR) usage report	• Cross-compare PR usage with inquiry theme analysis • Sentiment analysis • Identify information gaps/voids
	Vaccine Task Force Media Requests	Weekly	• Media request line list	• Leading indicator for news coverage • Identify information gaps/voids
	Web Metrics	Weekly	• Top pages • Google search queries • Top FAQs • Referring domains	• Identify information gaps/voids, • Identify keywords/search terms, changes in web traffic
Research	Poll Review	Weekly	• Harris Poll, PEW research, Gallup Poll, Kaiser Family Foundation • New data related to vaccine hesitancy	• Identify socio-behavior indicators related to motivation and intention to vaccinate
	Literature Review	Weekly	• PubMed, LitCovid, ProQuest Central • New data related to vaccine hesitancy	• Identify current vaccination intention • Identify barriers to vaccination
Third Party Reports	Tanaq Social Listening +Media Monitoring Report	Weekly	• Meltwater • Sprout Social • First Draft • Native platform searches	• Trending topics • Demographic and geographic conversation monitoring
	CrowdTangle content insights report	Biweekly	• Facebook	• Top pages (voices), groups • General trends/sentiment analysis • News analysis through posts
	First Draft News Vaccine Misinformation Insights Report	Monthly	• Proprietary methods	• Media trends analysis • Emerging threats and data deficits • Online vaccine narratives
	Project VCTR	Weekly	• Proprietary methods	• National and regional trends in negative attitudes toward vaccination • Conversations around Legislation
	Virality Project	Weekly	• Proprietary methods	• Mis- and disinformation trends related to COVID-19 vaccine

From: Berger, Sherri (CDC/OCOO/OD)
Sent: Thu, 22 Apr 2021 15:21:19 +0000
To: Anderson, Charlie D. EOP/WHO
Subject: 1B Vax Campaign
Attachments: COVID Supp Agency Spend Plan 6 Narrative - CDC Vaccine Confidence Resp to OMB 4.16.21 - Additional OMB Questions - HHS 4.21.docx

Good morning, I was told by ASFR that this is back w/ OMB now. Thanks

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From: Weston, Emily (CDC/DDID/NCHHSTP/DSTDP)
Sent: Mon, 15 Mar 2021 19:57:10 +0000
To: Shahpar, Cyrus (CDC who.eop.gov)
Cc: Williams, Ian (CDC/DDPHSIS/CPR/OD); Gleason, Amy M. (omb.eop.gov); Gastfriend, Daniel (EOP.GOV); Shapiro, Craig (CDC/DDID/NCEZID/OD); Wolkin, Amy Funk (CDC/DDNID/NCIPC/DIP); Yoon, Paula (CDC/DDPHSS/CSELS/DHIS); Ritchey, Matthew D. (CDC/DDPHSS/CSELS/DHIS); Collier, Sarah A. (CDC/DDID/NCEZID/DFWED); Graff, Philip (jhuapl.edu); Nicholas, Paul (jhuapl.edu); Imbriale, Samuel (OS/ASPR/SIIM); Rebecca Siegel (OMB.EOP.GOV); Reese, Heather (CDC/DDID/NCIRD/DVD); Jarman-Miller, Hannah L. EOP/WHO; Peterson, Elisha (jhuapl.edu); Hackett, Liz (NIH/NHLBI) [E]; Fuld, Jennifer (CDC/OD/OADPS); Tumpey, Abbigail (CDC/DDPHSS/CSELS/OD); Lambrou, Anastasia S.; Yoon, Paula (CDC/DDPHSS/CSELS/DHIS); Bennett, Kelly (OS/ASPR/SIIM); Nakao, Jolene H. (CDC/DDPHSIS/CGH/DGHP); Weston, Emily (CDC/DDID/NCHHSTP/DSTDP)
Subject: CDB 16 Mar - Final
Attachments: COVID Daily Brief 20210316 vf.pptx

Hi Cyrus and colleagues,

Please find the CDB for 3/16 attached and card #s below. Please let us know if you have any questions.

Card for 3/15:
# of total cases in the United States: 29,269,590
# of total deaths in the United States: 532,355
# of deaths yesterday: 589
# of vaccine doses administered: 109,081,860 (as of 3/15 6AM EST)
in hospital for COVID on 3/12 (confirmed only): 31,028

Many thanks,
DSEW/ISA co-leads

COVID-19 Daily Insights

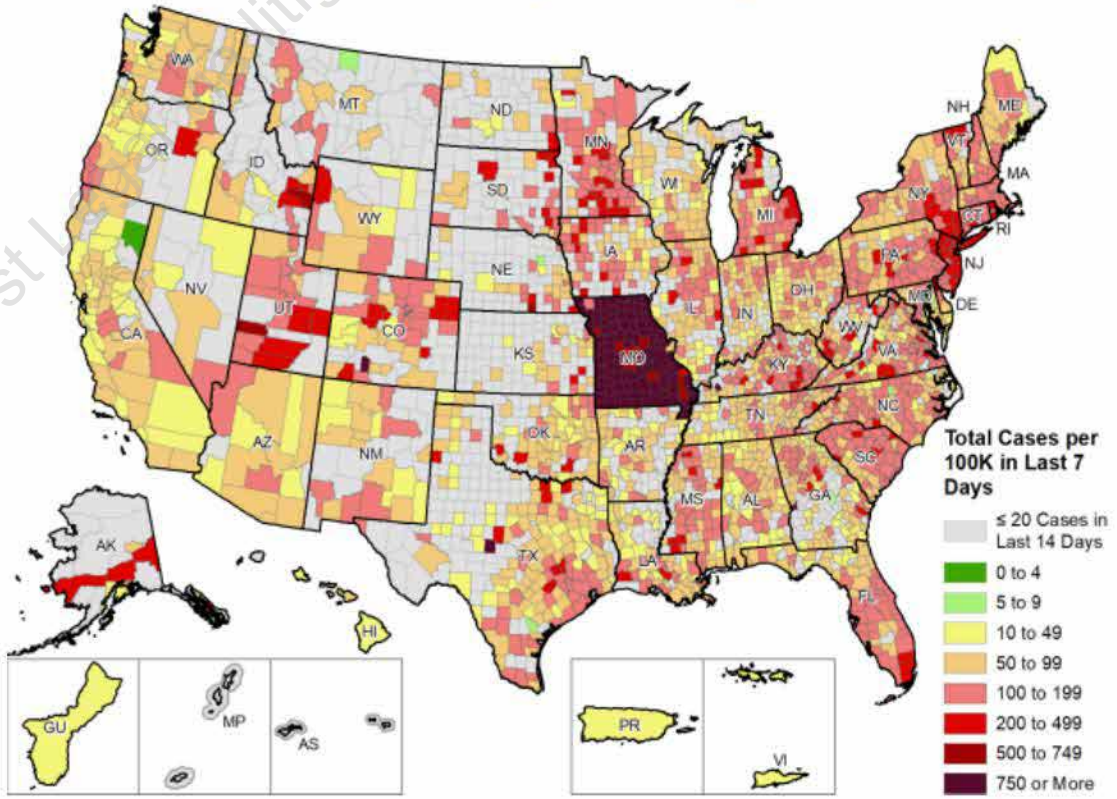
- The 7-day daily average of reported cases decreased by 9% for the week ending March 14, 2021 compared with the previous weekThere has been an 8-week downward trend in reported cases, which have declined by 79% since the peak on January 11, 2021 (from 249,378 to 52,343)According to community burden indicators developed by CDC, 40% of counties have high community transmission in last 7 days, a decrease from 45% last week Overall staffing shortages are decreasing; however, hospitals and long-term care facilities (LTCFs) continue to experience shortagesNationally, 15% of hospitals reported a current staffing shortage in the week ending March 13, 2021For the week ending March 14, 2021, 17% of LTCFs reported a staffing shortage, a 6% decrease from the peak on December 6, 2020The federal government is currently providing staffing support in AZ, NM, OR, and WAOverall, 109,081,860 COVID-19 vaccine doses have been administered in the United StatesIn total, 21% of the population (71.1 million people) has received at least one dose and 12% of the population (38.3 million people) is fully vaccinatedProgress towards 100M dose target (doses reported since January 20, 2021; Day 54): 92,556,57964% of adults 65 and older have received at least 1 dose and 36% have been fully vaccinatedTo combat misinformation, Facebook will label posts about COVID-19 vaccine with information from the World Health Organization (WHO) in multiple languages, and will also provide ways for users to obtain information about where and when they can be vaccinated

Disease Situation

Key Metrics

	Total to date	Most recent day*	7-day daily average	Week-on-week change
Cases	29,269,590	40,428	52,343†	-9.5%†
	confirmed only:			
COVID hospital admissions	1,871,111	3,606	4,541	-10.4%
	confirmed and suspected:			
	3,493,137	7,715	9,621	-8.1%
Deaths	532,355	589	1,165†	-31.4%†
RT-PCR test positivity**	8.7%	*omitted due to reporting lag*	4.3%	+3.3%

Case Rate by County through 3/14/2021***



***County map shows a spike in Missouri due to the inclusion of a backlog of probable cases reported on 3/8/2021

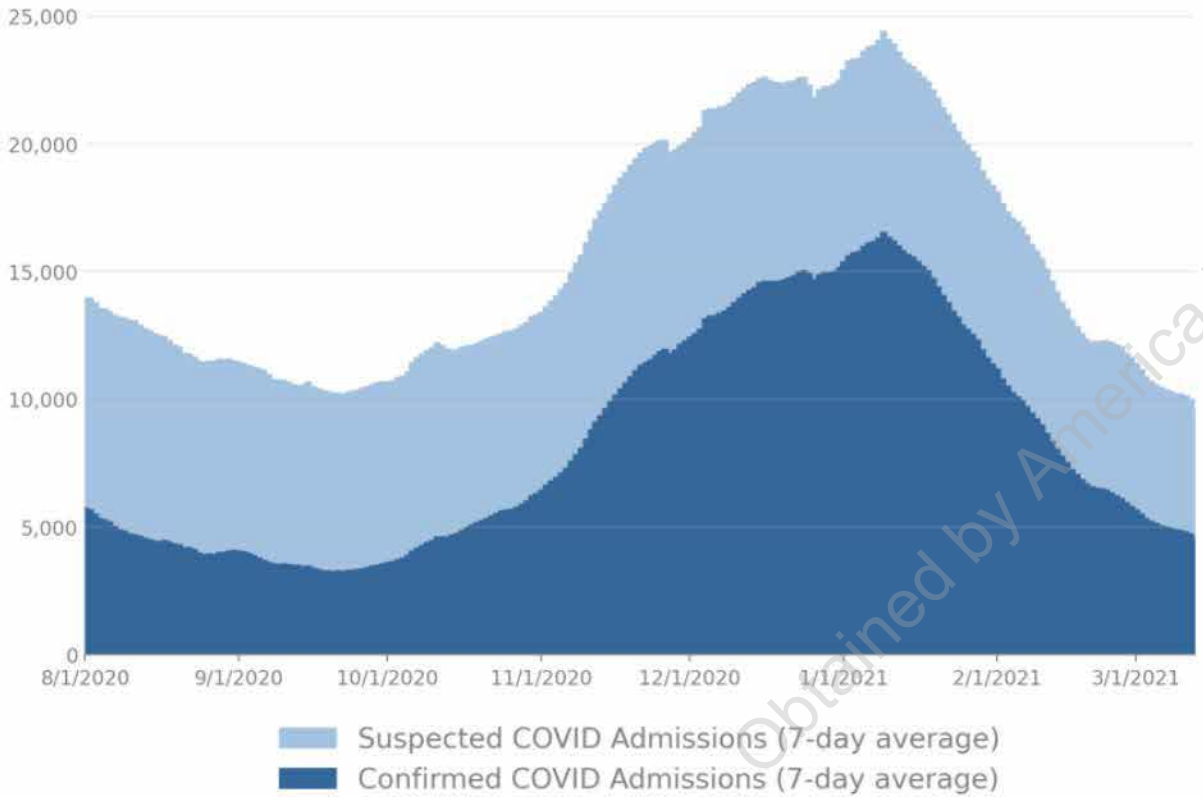
† Values exclude 87,670 cases and 333 deaths due to the inclusion of backlogged cases and deaths reported by CA, MI, MN, MO, TX, and WV in the 7-day period.

***Most recent day:** 3/14/2021 (cases/deaths), 3/13/2021 (hospital admissions), 3/12/2021 (tests). **Testing data may be incomplete due to delays and/or differences in state reporting. Data may be backfilled over time, resulting in week-to-week changes. **7-day daily average:** 3/8-3/14 (cases/deaths), 3/7-3/13 (hospital admissions), 3/6-3/12 (tests). Most recent days may have incomplete reporting. **Week-on-week change:** The 7-day daily average compared to the previous seven days. **Cases/Deaths:** CDC State-Reported Data, CDC Aggregate County Data. **COVID hospital admissions:** Total of confirmed and suspected, adult and pediatric hospital admissions, from Unified Hospital Dataset; total is value since 8/1 due to limited reporting before this date. **Tests:** Viral (RT-PCR) tests, from Unified Testing Dataset. **Test positivity:** Positive tests divided by number of tests performed and resulted. The week-on-week change increased 0.1 percentage points from 4.2% to 4.3% which equals a +3.3% relative change.

Hospitalizations

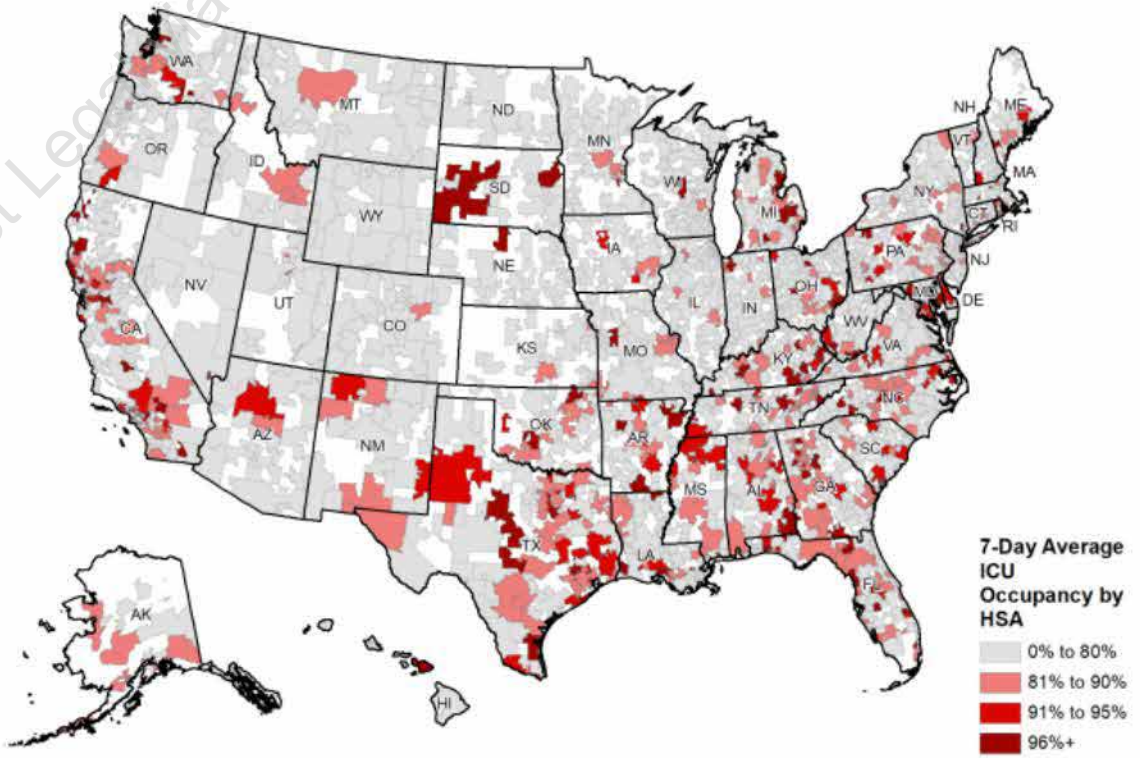
COVID Hospital Admissions through 3/13/2021

Daily average of 9,621 admissions in last 7 days (down 8.1% from prior week)



Adult ICU Occupancy through 3/13/2021

69.2% of staffed adult ICU beds are occupied (down 0.8% from prior week)



Last 7 days: 3/7-3/13. Most recent days may have incomplete reporting. **COVID Hospital Admissions:** Adult and pediatric, confirmed and suspected COVID-19 hospital admissions, from Unified Hospital Dataset. **Adult ICU Occupancy:** ICU utilization indicates average percentage of staffed adult ICU beds occupied, including both COVID and non-COVID patients, during the last 7 days, by Hospital Service Area (HSA).

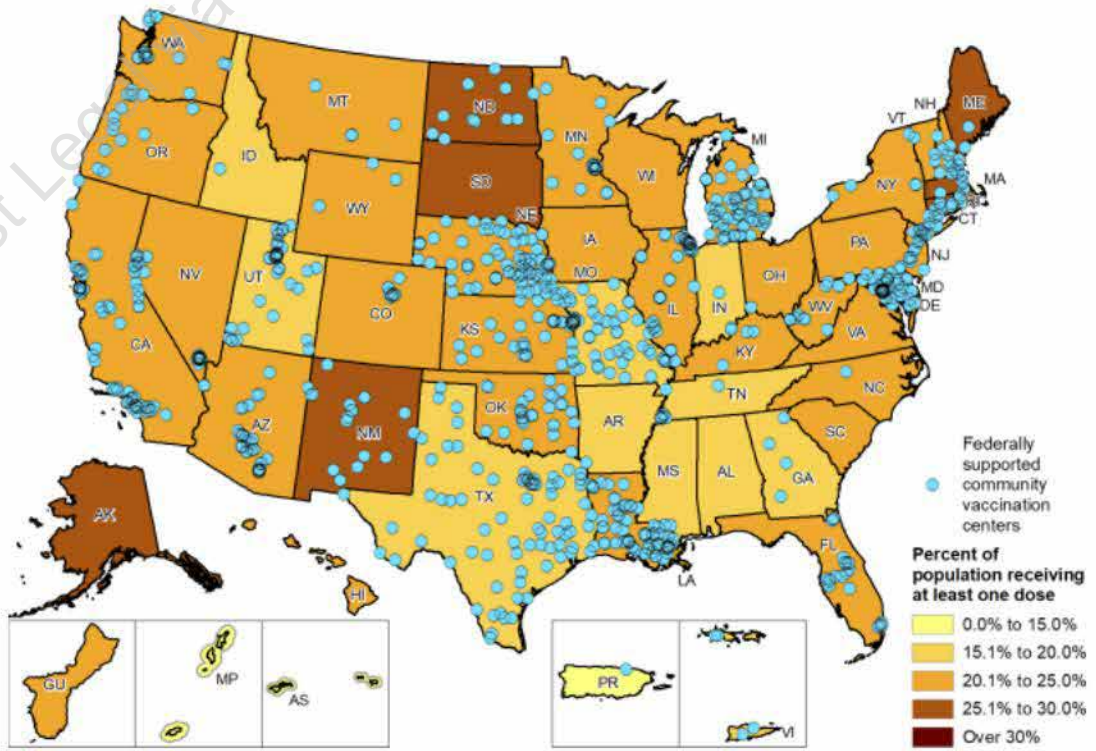
Vaccination Program

Progress Toward 100 Million Doses through 3/15/2021

Total doses administered to date	109,081,860
Increase since yesterday	+2,021,586
7-day daily average increase	+2,427,430
Administered vaccine doses reported since 1/20/2021	92,556,579 (day 54)
Progress toward 100M dose target	92.6%

Population with at least 1 dose through 3/15/2021

In total, 21.4% of the population* (71.1M) has received at least one dose



*Total population count used as denominator. Currently, few persons under age 18 are being vaccinated; this group represents ~22% of the US population.
Vaccines: Unified COVID-19 Vaccine Dataset. Data as of 3/15/2021 6am EST. Doses administered are the total number reported by states, territories, and organizations that received doses. Fully vaccinated includes those who received the second dose of Pfizer-BioNTech or Moderna vaccines and those who received one dose of J&J/Janssen COVID-19 vaccine. Values reflect total by report date, not administered date. The number of doses reported on 1/20/2021 at 12pm EST was 16,525,281; serves as baseline for assessing 100M dose target. **Federally supported community vaccination centers:** Federal support includes one or more of the following categories: on-site personnel (including federal deployments or national guard), materials (including medical equipment or consumable supplies, but excluding vaccine or vaccine kits) or funding (for personnel or materials; including project worksheets directly contributing to an operational vaccination site), Note: Funding from multiple federal agencies to the same site will be counted as one site. Additional details available in the "Defining Federally Supported Sites" Appendix in the Federal Community Vaccination Center Playbook.

From: Weston, Emily (CDC/DDID/NCHHSTP/DSTDP)
Sent: Tue, 16 Mar 2021 00:40:25 +0000
To: Shahpar, Cyrus (CDC who.eop.gov)
Cc: Williams, Ian (CDC/DDPHSIS/CPR/OD); Gleason, Amy M. (omb.eop.gov); Gastfriend, Daniel (EOP.GOV); Shapiro, Craig (CDC/DDID/NCEZID/OD); Ritchey, Matthew D. (CDC/DDPHSS/CSELS/DHIS); Yoon, Paula (CDC/DDPHSS/CSELS/DHIS); Imbriale, Samuel (OS/ASPR/SIIM); Graff, Philip (jhuapl.edu); Nicholas, Paul (jhuapl.edu); Rebecca Siegel (OMB.EOP.GOV); Reese, Heather (CDC/DDID/NCIRD/DVD); Peterson, Elisha (jhuapl.edu); Hackett, Liz (NIH/NHLBI) [E]; Wolkin, Amy Funk (CDC/DDNID/NCIPC/DIP); Jarman-Miller, Hannah L. EOP/WHO; Fuld, Jennifer (CDC/OD/OADPS); Tumpey, Abbigail (CDC/DDPHSS/CSELS/OD); Lambrou, Anastasia S.; Collier, Sarah A. (CDC/DDID/NCEZID/DFWED); Thompson-Paul, Angela M. (CDC/DDNID/NCCDPHP/DHDSP); Nakao, Jolene H. (CDC/DDPHSIS/CGH/DGHP); Bennett, Kelly (OS/ASPR/SIIM); Weston, Emily (CDC/DDID/NCHHSTP/DSTDP)
Subject: CDU 16 Mar - Final
Attachments: COVID Daily Update 20210316 vf.pptx, COVID Daily Update 20210316 vf.pdf

Hi Cyrus,

Please see the COVID Daily Update attached as a ppt and pdf for 3/16/21. Included in this evening's CDU is the weekly community transmission summary. Please let us know if you have any questions.

Many thanks and have a nice evening,

ISA/DSEW co-leads

From: Tumpey, Abbigail (CDC/DDPHSS/CSELS/OD)
Sent: Wed, 29 Sep 2021 17:16:54 +0000
To: Pearlman, Aj (HHS/IOS); Lovenheim, Sarah (HHS/ASPA); Despres, Sarah (HHS/IOS); Sams, Ian (HHS/ASPA); Phillips, Alexandria (HHS/OASH); Beckman, Adam (HHS/OASH); Hall, Bill (HHS/ASPA); Billet, Courtney (NIH/NIAID) [E]; Broido, Tara (HHS/OASH); Wakana, Benjamin L. EOP/WHO; Rowe, Courtney M. EOP/WHO; Munoz, Kevin A. EOP/WHO; Jefferson, Erica (FDA/OC); Caccomo, Stephanie (FDA/OC); Felberbaum, Michael (FDA/OC); Folkers, Greg (NIH/NIAID) [E]; Figueroa, Marvin (HHS/IEA); Perry, Sherice (OS/IEA); Allen, Kirsten (HHS/ASPA)
Cc: Salcido, Dorinda (CDC/OD); Berger, Sherri (CDC/OCOO/OD)
Subject: FYI: Health Advisory to promote vaccination of pregnant people
Attachments: CDC Media Statement: CDC Statement on Pregnancy Health Advisory

Colleagues,

FYI—below is our health advisory to promote vaccination of pregnant people (link). Attached is the media statement.

Regards,

Abbigail

From: Centers for Disease Control and Prevention <no-reply@emailupdates.cdc.gov>
Sent: Wednesday, September 29, 2021 1:07 PM
To: Tumpey, Abbigail (CDC/DDPHSS/CSELS/OD) <aws8@cdc.gov>
Subject: CDC Health Alert Network (HAN) Health Advisory: COVID-19 Vaccination for Pregnant People to Prevent Serious Illness, Deaths, and Adverse Pregnancy Outcomes from COVID-19

Health Alert Network (HAN)

CDC issued the following Health Alert Network (HAN) Health Advisory on September 29, 2021. You are receiving this information because you subscribe to Clinician Outreach and Communication Activity (COCA) email updates. If a colleague forwarded this email to you, but you would like to receive these emails directly, click here.

If you have any questions, please e-mail coca@cdc.gov

Please join us on Facebook

Distributed via the CDC Health Alert Network
September 29, 2021, 12:00 PM ET
CDCHAN-00453

COVID-19 Vaccination for Pregnant People to Prevent Serious Illness, Deaths, and Adverse Pregnancy Outcomes from COVID-19

Summary
The Centers for Disease Control and Prevention (CDC) recommends urgent action to increase Coronavirus Disease 2019 (COVID-19) vaccination among people who are pregnant, recently pregnant (including those who are lactating), who are trying to become pregnant now, or who might become pregnant in the future. CDC strongly recommends COVID-19 vaccination either before or during pregnancy because the benefits of vaccination outweigh known or potential risks. As of September 27, 2021, more than 125,000 laboratory-confirmed COVID-19 cases have been reported in pregnant people, including more than 22,000 hospitalized cases and 161 deaths.[1] The highest number of COVID-19-related deaths in pregnant people (n=22) in a single month of the pandemic was reported in August 2021. Data from the COVID-19-Associated Hospitalization Surveillance Network (COVID-NET) in 2021 indicate that approximately 97% of pregnant people hospitalized (either for illness or for labor and delivery) with confirmed SARS-CoV-2 infection were unvaccinated.[2] In addition to the risks of severe illness and death for pregnant and recently pregnant people, there is an increased risk for adverse pregnancy and neonatal outcomes, including preterm birth and admission of their neonate(s) to an intensive care unit (ICU). Other adverse pregnancy outcomes, such as stillbirth, have been reported. Despite the known risks of COVID-19, as of September 18, 2021, 31.0% of pregnant people were fully vaccinated before or during their pregnancy.[3] In addition, there are racial and ethnic disparities in vaccination coverage for pregnant people. Healthcare providers should communicate the risks of COVID-19, the benefits of vaccination, and information on the safety and effectiveness of COVID-19 vaccination in pregnancy. Healthcare providers should strongly recommend that people who are pregnant, recently

pregnant (including those who are lactating), who are trying to become pregnant now, or who might become pregnant in the future receive one of the authorized or approved COVID-19 vaccines as soon as possible.

Background

COVID-19 vaccination is recommended for pregnant people. CDC recommends COVID-19 vaccination for all people aged 12 years and older, including people who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future.[4] CDC recommendations align with those from professional medical organizations serving people who are pregnant, including the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine. Accumulating data provide evidence of both the safety and effectiveness of COVID-19 vaccination in pregnancy. CDC strongly recommends COVID-19 vaccination either before or during pregnancy, because the benefits of vaccination for both pregnant persons and their fetus/infant outweigh known or potential risks. Getting a COVID-19 vaccine can prevent severe illness, death, and pregnancy complications related to COVID-19.

COVID-19 vaccination coverage for pregnant people remains low. Despite recommendations for vaccination, uptake of COVID-19 vaccination by pregnant people has been lower than that of non-pregnant people.[5] In addition, vaccination coverage for pregnant people differs by race and ethnicity, with vaccination coverage being lowest for non-Hispanic Black pregnant people (15.6%) as of September 18, 2021.[3] Although the proportion of fully vaccinated pregnant people has increased to 31.0% (as of September 18, 2021), the majority of pregnant people remain unprotected against COVID-19, and significant disparities exist in vaccination coverage by race and ethnicity.

Pregnant and recently pregnant people with COVID-19 are at increased risk of severe illness, death, and pregnancy complications. Pregnant and recently pregnant people with COVID-19 are at increased risk for severe illness when compared with non-pregnant people. Severe illness includes illness that requires hospitalization, intensive care unit (ICU) admission, mechanical ventilation, or extracorporeal membrane oxygenation (ECMO), or illness that results in death. Although the absolute risk is low, compared with non-pregnant symptomatic people, symptomatic pregnant people have more than a two-fold increased risk of requiring ICU admission, invasive ventilation, and ECMO, and a 70% increased risk of death.[6] Pregnant people with COVID-19 are also at increased risk for preterm birth and some data suggest an increased risk for other adverse pregnancy complications and outcomes, such as preeclampsia, coagulopathy, and stillbirth, compared with pregnant people without COVID-19.[7-10] Neonates born to people with COVID-19 are also at increased risk for admission to the neonatal ICU.[9-11] In addition, although rare, pregnant people with COVID-19 can transmit infection to

their neonates; among neonates born to women with COVID-19 during pregnancy, 1–4% of neonates tested were positive by rRT-PCR.[12,13]

Recommendations

CDC recommends urgent action to help protect pregnant people and their fetuses/infants. CDC recommends urgent action to accelerate primary vaccination for people who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future. Efforts should specifically address populations with lower vaccination coverage and use approaches to reduce racial and ethnic disparities. CDC recommends ensuring tailored, culturally responsive, and linguistically appropriate communication of vaccination benefits. In addition, pregnant people should continue to follow all recommended prevention measures and should seek care immediately for any symptoms of COVID-19. Healthcare providers should have a low threshold for increased monitoring during pregnancy due to the risk of severe illness.

Recommendations for Public Health Jurisdictions

- Continue and increase efforts to reach and partner with communities to encourage and offer vaccination to people who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future.
- Leverage resources to promote vaccine equity: COVID-19 Vaccine Equity for Racial and Ethnic Minority Groups.
    - Include focused efforts to increase vaccination coverage in pregnancy among people from racial and ethnic minority groups.
- Encourage healthcare providers to offer and recommend COVID-19 vaccination to their patients and community members who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future.
- Work with community partners and employers to make vaccination easily accessible for unvaccinated populations, including those who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future.
- Continue to implement additional prevention strategies where SARS-CoV-2 transmission is high and vaccination coverage is low, including in groups at increased risk, such as pregnant people.
- Continue to monitor community transmission and vaccination coverage levels and focus vaccine efforts on populations with low coverage.
- Disseminate and communicate information to key partners about vaccination coverage, risks posed by the highly transmissible Delta variant, and local transmission levels. Partner and share messaging with programs serving pregnant and recently pregnant people.
- Communicate accurate information about COVID-19 vaccines, respond to gaps in information, and confront misinformation with evidence-based messaging from

credible sources. For example, there is currently no evidence that any vaccines, including COVID-19 vaccines, cause fertility problems in women or men.

Recommendations for Healthcare Providers

- Ensure all clinical staff are aware of the recommendation for vaccination of people before and during pregnancy and the serious risks of COVID-19 to pregnant and recently pregnant people and their fetuses/infants.
- Increase outreach efforts to encourage, recommend, and offer vaccination to people who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future. A strong recommendation from a healthcare provider is a critical factor in COVID-19 vaccine acceptance and can make a meaningful difference to protect the health of pregnant and recently pregnant people and their fetuses/infants from COVID-19.
- For healthcare providers who see patients who are pregnant, recently pregnant (including those who are lactating), who are trying to get pregnant now, or who might become pregnant in the future:
    - Review patients' COVID-19 vaccination status at each pre- and post-natal visit and discuss COVID-19 vaccination with those who are unvaccinated.
    - Reach out to your patients with messages encouraging and recommending the critical need for vaccination.
    - Remind patients that vaccination is recommended even for those with prior COVID-19 infections. Studies have shown that vaccination provides increased protection in people who have recovered from COVID-19.
    - Support efforts to ensure people receiving the first dose of an mRNA COVID-19 vaccine (i.e., Pfizer-BioNTech, Moderna) return for their second dose to complete the series as close as possible to the recommended interval.
        - Consider a booster dose in eligible pregnant persons.[4]
    - Communicate accurate information about COVID-19 vaccines and confront misinformation with evidence-based messaging from credible sources. For example, there is currently no evidence that any vaccines, including COVID-19 vaccines, cause fertility problems in women or men.
- Become a COVID-19 vaccine provider and vaccinate patients during their visit. More information can be found at How to Enroll as a COVID-19 Vaccination Provider.

For More Information

- Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Approved or Authorized in the United States
- COVID-19 Vaccines While Pregnant or Breastfeeding
- COVID-19 Vaccines for People Who Would Like to Have a Baby
- COVID-19 among Pregnant and Recently Pregnant People
- COVID Data Tracker

- Vaccination Among Pregnant People
- Data on COVID-19 during Pregnancy: Severity of Maternal Illness

- Toolkit for Pregnant People and New Parents
- Building Confidence in COVID-19 Vaccines

References

1. COVID Data Tracker. Data on COVID-19 during Pregnancy: Severity of Maternal Illness. (accessed September 27, 2021)
2. COVID-19-Associated Hospitalization Surveillance Network (COVID-NET) (unpublished data)
3. COVID Data Tracker. Vaccinations Among Pregnant People. (accessed September 27, 2021)
4. CDC Interim Clinical Considerations for Use of COVID-19 Vaccines. (accessed September 27, 2021)
5. Razzaghi H, et al. COVID-19 Vaccination Coverage Among Pregnant Women During Pregnancy — Eight Integrated Health Care Organizations, United States, December 14, 2020–May 8, 2021. *MMWR*. 2021:70(24);895–899.
6. Zambrano L, et al. Update: Characteristics of Symptomatic Women of Reproductive Age with Laboratory-Confirmed SARS-CoV-2 Infection by Pregnancy Status — United States, January 22–October 3, 2020. *MMWR*. 2020:69(44);1641–1647.
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9. Allotey J, et al. Clinical manifestations, risk factors, and maternal and perinatal outcomes of coronavirus disease 2019 in pregnancy: living systematic review and meta-analysis. *BMJ* 2020;370:m3320. (Published 01 September 2020)
10. Villar J, et al. Maternal and Neonatal Morbidity and Mortality Among Pregnant Women With and Without COVID-19 Infection: The INTERCOVID Multinational Cohort Study. *JAMA Pediatr*. 2021;175(8):817-826. doi:10.1001/jamapediatrics.2021.1050.
11. Woodworth KR, et al. Birth and Infant Outcomes Following Laboratory-Confirmed SARS-CoV-2 Infection in Pregnancy — SET-NET, 16 Jurisdictions, March 29–October 14, 2020. *MMWR*. 2020:69(44);1635–1640.
12. Olsen EO, et al. SARS-CoV-2 infections among neonates born to women with SARS-CoV-2 infection: maternal, pregnancy and birth characteristics. (pre-print accessed September 27, 2021)
13. Mullins E, Hudak ML, Banerjee J, et al. Pregnancy and neonatal outcomes of COVID-19: coreporting of common outcomes from PAN-COVID and AAP-SONPM registries. *Ultrasound Obstet Gynecol*. 2021;57(4):573-581. doi:10.1002/uog.23619

The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national, and international organizations.

Categories of Health Alert Network messages:

Health Alert - Requires immediate action or attention; highest level of importance

Health Advisory - May not require immediate action; provides important information for a specific incident or situation

Health Update - Unlikely to require immediate action; provides updated information regarding an incident or situation

HAN Info Service - Does not require immediate action; provides general public health information

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##This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations##

You have received this message based upon the information contained within our emergency notification data base. If you have a different or additional e-mail or fax address that you would like us to use please contact your State-based Health Alert Network program at your State or local health department.

Centers for Disease Control and Prevention

1600 Clifton Rd Atlanta, GA 30329 1-800-CDC-INFO (800-232-4636) TTY: 888-232-6348

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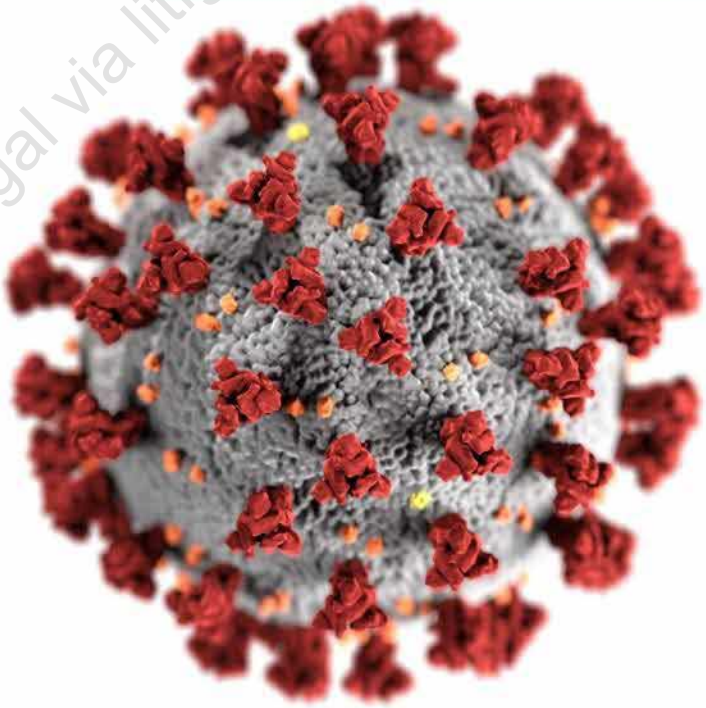
Adolescent COVID-19 Vaccination

Name, DegreesTitle

Event Title
Date



cdc.gov/coronavirus

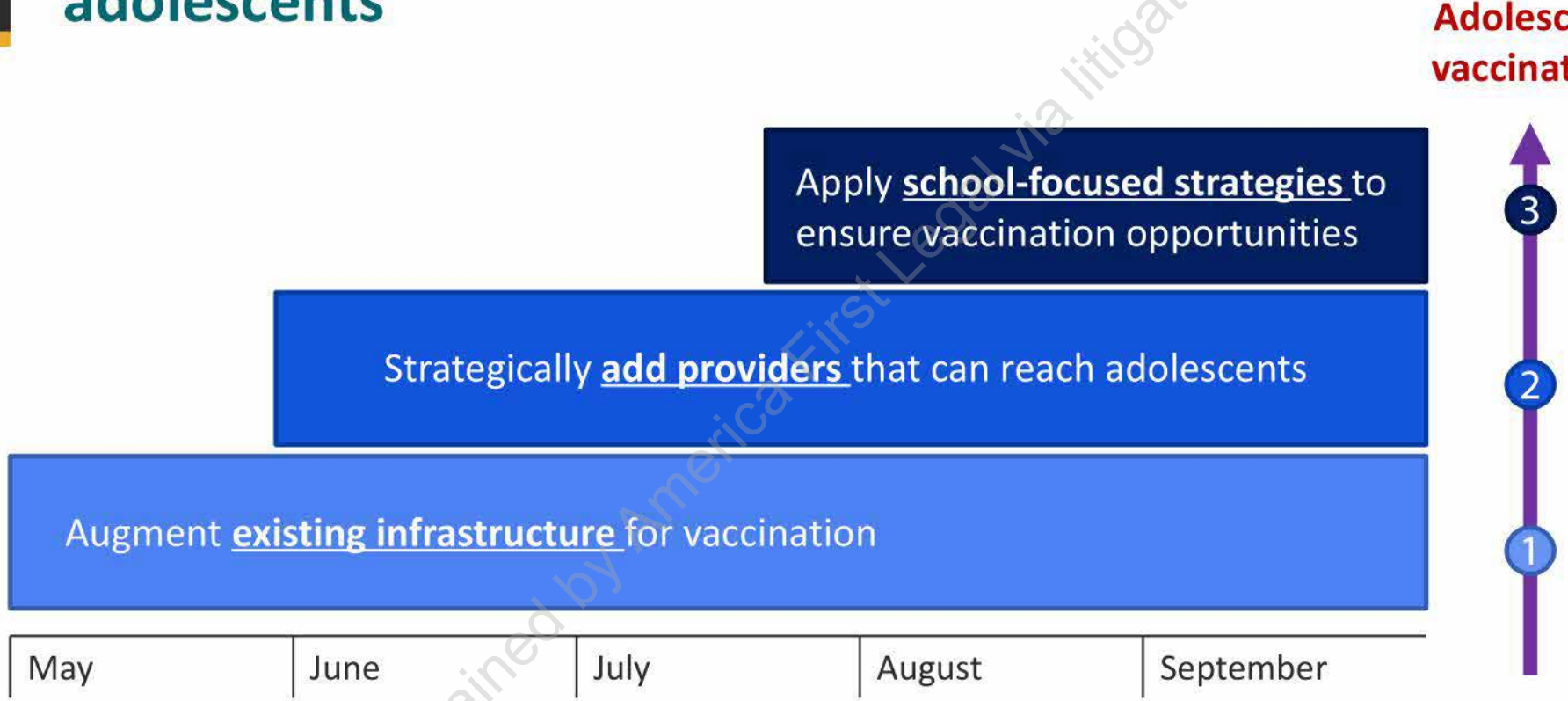
Background

- COVID-19 vaccination of adolescents is important to reduce transmission of SARS-CoV-2 and provide greater confidence in a safe return to school and institutions of higher education.A multi-pronged approach will be necessary to rapidly achieve high coverage of COVID-19 vaccines in the ~46 million adolescents and adults aged 12-22 years.Focused efforts needed to vaccinate adolescents aged 12-15 yearsEmergency Use Authorization (EUA) of Pfizer-BioNTech COVID-19 vaccine in this age group anticipated in May 2021 and later this summer for Moderna COVID-19 vaccine

Objectives

- Promote adolescent vaccination as quickly and equitably as possible through a multi-pronged approach.Leverage current COVID-19 vaccination infrastructure to adapt over time:Early summer sprint (May-June)Increase access (June-July)Back-to-school campaign (July-September)

Stepwise approach to increasing vaccine access for adolescents



Approach for reaching adolescents

Augment existing public health infrastructure and add new channels

Category	Approach
 Primary care and other providers serving adolescents	• Utilize primary care as trusted providers to notify, schedule, and vaccinate their patients, including managing routine immunizations, particularly as students return to school
 Pharmacies and HRSA sites[1]	• Leverage broad pharmacy footprint to administer COVID-19 vaccine to adolescents rapidly, as with adults
 School-based vaccination	• Partner with Federally Qualified Health Centers, pharmacies, public health, and adolescent provider networks to hold targeted programs to ensure equity and coverage, particularly as students return

1. Health Resources and Services Administration (HRSA) sites including: Federally Qualified Health Centers (FQHCs), Rural Health Clinics, Community Health Centers

Policy considerations

	Policy Question	Considerations for action
1	What is the safety profile and efficacy of COVID-19 vaccines in adolescents 12-15 years?	• ACIP review of Pfizer-BioNTech data
2	Can COVID-19 vaccine be co-administrated with routine vaccines?	• ACIP review to inform coadministration guidance
3	How do we limit barriers and best ensure parent assent/consent is obtained (especially in instances where a parent is not present)?	• Not expected to be a requirement for EUA[1], but may vary by jurisdiction

1. Emergency Use Authorization (EUA)

Ensuring equity – adolescents needing additional consideration

- Adolescents who may be at increased risk for severe COVID-19Adolescents with limited access to routine vaccination servicesAdolescents who are experiencing homelessness, live in rural areas, or have special healthcare needsAdolescents who experience systemic health or social inequitiesRacial and ethnic minority groupsAdolescents in households with lower incomeAdolescents with disabilitiesAdolescents living in congregate settings Additional potentially hard to reach populations Adolescents with mental illness Adolescents with substance use disorderLGBTQ+ adolescentsAdolescents who are immigrants or undocumented Adolescents who are non-English speakers

Stakeholder engagement

- Field surveys, which are underway, to assess adolescent and parental intent to receive COVID-19 vaccination and preferences of location.Schedule listening sessions and gain feedback from core partners.Perform outreach to critical partner organizations/stakeholders to encourage adolescent vaccination, disseminate educational material, and increase vaccine confidence.Conduct outreach to stakeholders for at-risk or hard-to-reach adolescentsWork with institutions of higher learning to promote vaccination on return to campuses for adolescents and young adults.

Communication

- Share toolkits with and communicate program strategies to jurisdictions, including expected supply, timing of supply.Share toolkits and messaging with other vital partners: healthcare providers, trusted adolescent vaccine advocates, other stakeholders.Engage public to boost confidence via paid and unpaid education campaign (parent and adolescent focused).Develop and implement peer-to-peer engagement program.Conduct Vaccinate with Confidence campaign for adolescent COVID-19 vaccines.

Vaccinate with Confidence **Adolescent Edition**

CDC's Strategy to Reinforce Confidence in COVID-19 Vaccines in Adolescents (12-18) and Their Families

Build Trust

Objective: Share clear, complete, and accurate messages about COVID-19 vaccines with parents, adolescents, and the schools and community institutions that support them.

- ✓ Communicate transparently about the process for authorizing, approving, making recommendations for, monitoring the safety of, distributing, and administering COVID-19 vaccines for adolescents.
- ✓ Provide regular updates on benefits, safety, side effects and effectiveness for adolescents; clearly communicate what is not known.
- ✓ Proactively address and mitigate the spread and harm of misinformation via social media platforms, partners, and trusted messengers, including those that target adolescents.

Empower Healthcare Providers

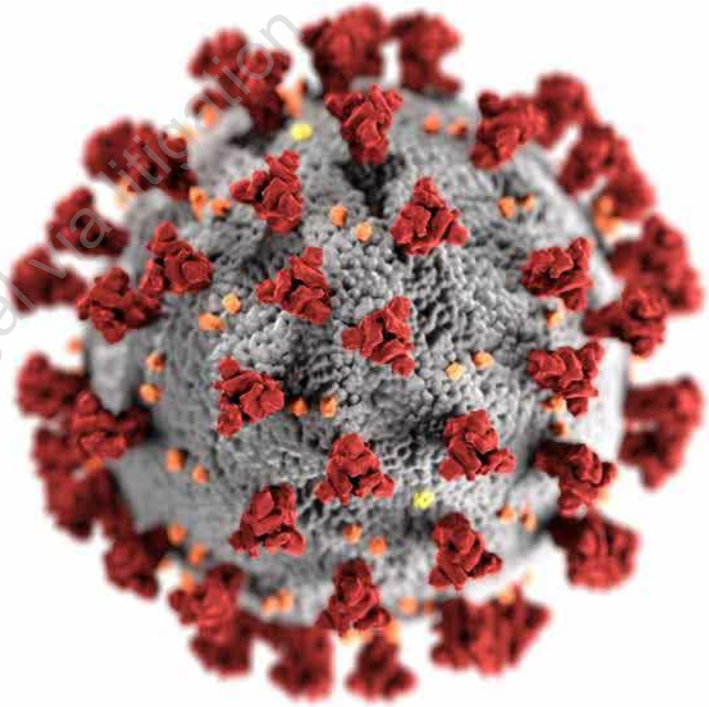
Objective: Ensure that healthcare providers are confident in COVID-19 vaccines and in their ability to recommend vaccination for adolescents.

- ✓ Engage national professional associations, health systems, and healthcare personnel often and early to ensure a clear understanding of the vaccine development and approval process, new vaccine technologies, and the benefits of vaccination for adolescents.
- ✓ Ensure that healthcare systems, community clinics, and school systems are equipped to create a culture that builds confidence in COVID-19 vaccination.
- ✓ Strengthen the capacity of healthcare professionals to have empathetic vaccine conversations with parents and adolescents, address myths and common questions, provide tailored vaccine information, and use motivational interviewing techniques when needed.

Engage Families, Communities & Schools

Objective: Engage families, communities, and schools in two-way communication to listen, address concerns, and create positive social norms.

- ✓ Educate parents and adolescents so they feel confident in the adolescent's decision to get a COVID-19 vaccine.
- ✓ Work with community-based organizations, camps, parent-teacher organizations, and school systems/administrators to engage families and expand access to vaccination.
- ✓ Collaborate with messengers trusted by adolescents and parents—such as teachers, faith-based and community leaders—to tailor and share culturally relevant messages and materials.



For more information, contact CDC
1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 www.cdc.gov

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

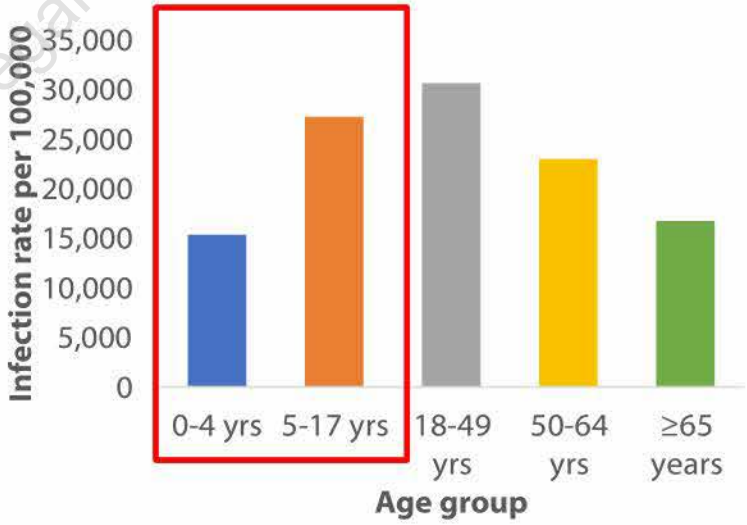
Back up slides

COVID-19 burden in children

National Estimate of COVID-19 Cases by Age Group – Data through April 22, 2021

Age Group	Percent of cases	Count of cases	Percent of US population
0-4 Years	2	504,924	6
5-17 Years	10	2,466,930	16.3
18-29 Years	22.4	5,560,778	16.4
30-39 Years	16.4	4,059,933	13.5
40-49 Years	14.9	3,687,943	12.3
50-64 Years	20.5	5,070,440	19.2
65-74 Years	7.6	1,884,070	9.6
75-84 Years	4	980,229	4.9
85+ Years	2.3	571,452	2

Estimating SARS-CoV-2 Infection Rates per 100,000 – Adjusting for Under Detection



https://www.cdc.gov/covid-data-tracker/index.html#demographics

https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/burden.html

Considerations for providers serving adolescents

- Process needed to streamline enrollment for current Vaccines for Children (VFC) providers Guidance is needed for prioritizing outreach and enrollment for adolescent providers, starting with large practices and expanding to smaller practices.Leverage ongoing efforts to distribute COVID-19 vaccines to primary care providers to address disparities in immunization1

1. https://www.cdc.gov/vaccines/covid-19/downloads/Guide-for-Jurisdictions-on-PCP-COVID-19-Vaccination.pdf

Considerations to enable adolescent providers to utilize 450-dose packs effectively

- Encourage adolescent providers to expand ‘vaccination days’. Encourage adolescent providers to vaccinate others in the community (e.g., parents, grandparents, nannies, older siblings) or expand office hours to increase access to vaccination.Identify adolescent providers with freezer capacity to store Pfizer-BioNTech longer term.Take advantage of multispecialty practices for 450-pack distribution.Explore redistribution potential (each 450-pack consists of 3x150 dose trays), especially if Pfizer-BioNTech 2-8C stability is approved.

Considerations for pharmacies

- Identify and address Pfizer-BioNTech COVID-19 vaccine deserts (mapping ongoing).Identify and engage states that have pharmacy practice restrictions in order to resolve barriers to adolescent vaccination.

Considerations for school-based clinics

- Promote equity and vaccine uptake through partnerships to facilitate school-located vaccination clinics during the back-to-school period, including with:Department of Education, state and local education agenciesHealth Resources and Services AdministrationPublic healthPharmaciesAdolescent provider networksSchool-located vaccination during the late summer also aligns with timing of Moderna vaccine availability for adolescents (benefits of smaller packaging).Efforts are ongoing to operationalize assent/consent when parents are not present.