

An illustration of several people of African descent wearing face masks. The background is dark blue with white abstract patterns. The text is in white and light blue.

COVID-19: Strengthening Partnerships for Equity and Accountability

FINAL REPORT

budgiti
SIERRA LEONE



**OPEN SOCIETY
FOUNDATIONS**

Table of Contents

Tables and Figures

Acronyms and Abbreviations

1.0 Introduction

2.0 Executive Summary

3. 0 Research Methodology

4.0 Vaccine Governance

5.0 Inequality and Accountability in Vaccine Governance

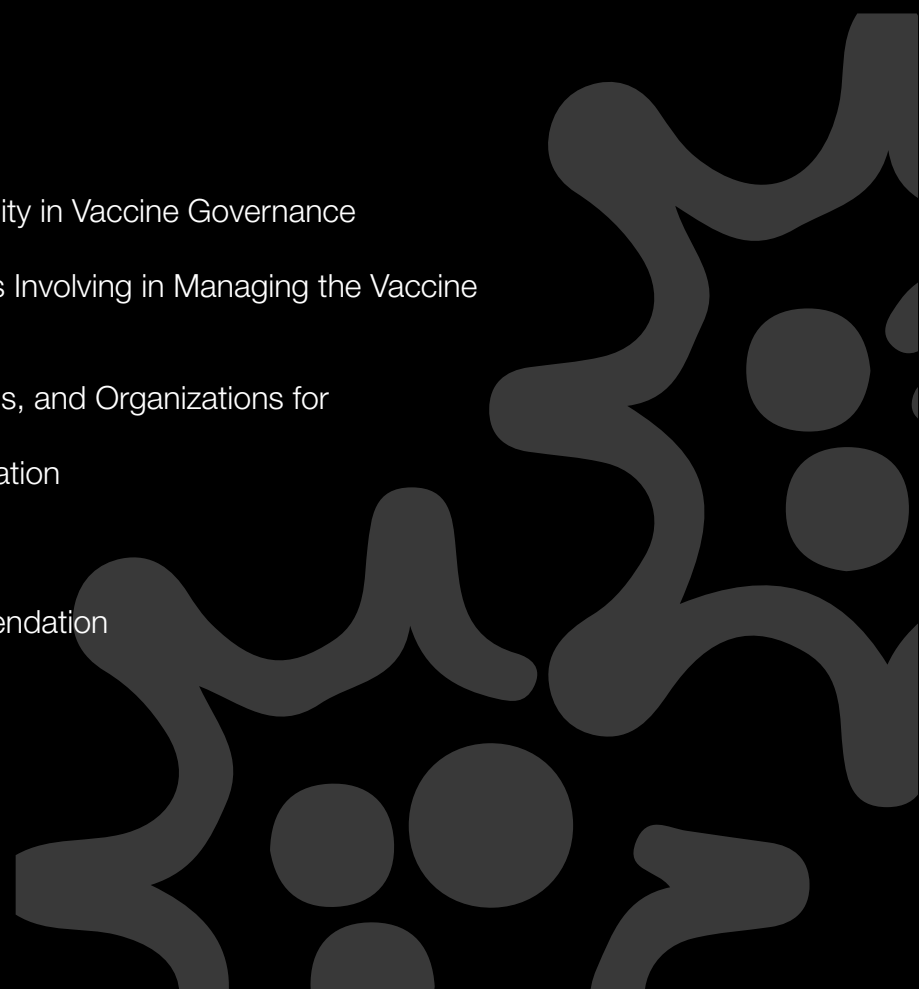
6.0 Citizen Monitoring Reports Involving in Managing the Vaccine Distribution

7.0 Existing Structures, Groups, and Organizations for
Fact-Checkers and Verification

8.0 Vaccine Hesitancy

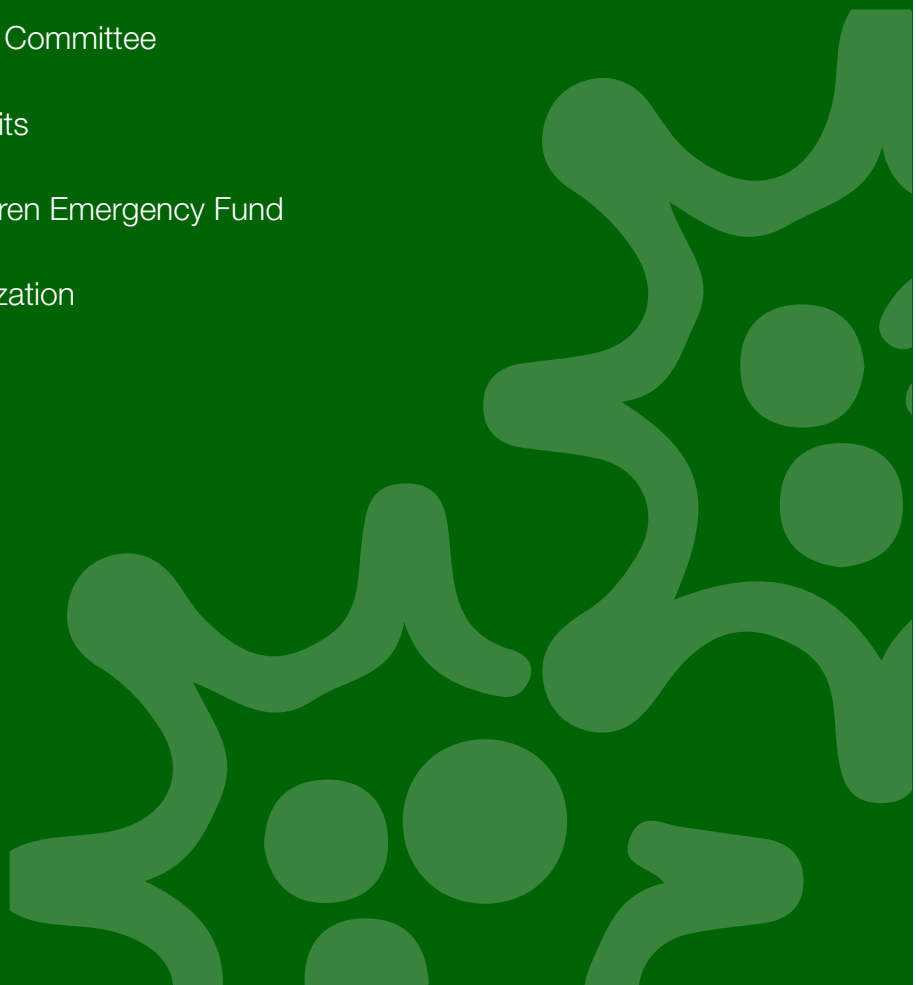
9.0 Conclusion and Recommendation

10. 0 Appendix



Acronyms and Abbreviations

CSOs:	Civil Society Organizations
CHCs:	Community Health Centres
CHO:	Community Health Officer
COVID-19:	Coronavirus Disease
DHMT:	District Health Management Team
DHIS:	District Health Information Software
EPI:	Expanded Program on Immunization
INGOs:	International Non-Governmental Organizations
IRC:	International Rescue Committee
PHUs:	Peripheral Health Units
UNICEF:	United Nations Children Emergency Fund
WHO:	World Health Organization



1.0 Introduction

Since its emergence in 2019, the COVID-19 pandemic, caused by the novel coronavirus SARS-CoV-2, has resulted in over 450 million confirmed cases and six million deaths globally. Population-wide lockdowns, social distancing, hand hygiene, and mask-wearing were the initial steps taken to control the pandemic. Vaccination is one of the most potent and cost-effective public health tools used in preventing communicable diseases.

Accordingly, the COVID-19 pandemic has accelerated the development of several vaccines that have proven safe and effective against SARS-CoV-2. Health authorities recommend vaccinating most people against COVID-19 and have identified people aged 65 years, immune compromised hosts, e.g., people with HIV (PWH), individuals with chronic



Studies from the United States and other high-income countries (HICs) have reported COVID-19 vaccine hesitancy rates of 30% in the general population.

morbidities, security forces, and healthcare workers as priority populations for vaccination.

Despite their proven safety and efficacy, vaccine hesitancy is posing a substantial threat to efforts seeking to combat the COVID-19 pandemic. Vaccine hesitancy has been defined as a delay in acceptance or refusal of vaccination despite the availability of vaccination services. According to the World Health Organization (WHO), vaccine hesitancy has been increasing in the last decade and was one of the top ten global health threats in 2019. Studies from the United States and other high-income countries (HICs) have reported COVID-19 vaccine hesitancy rates of 30% in the general population.

Vaccine hesitancy has been reported among Healthcare Workers (HCWs) and people who believe in the importance of vaccinations. Racial minority background, poverty, low educational status, lack of information, and especially misinformation, and fear and mistrust of the authorities have been identified as predictors of unwillingness to be vaccinated. Negative attitudes toward vaccination result in low vaccine uptake and are exacerbating longstanding health disparities that already disproportionately impact minority communities in developed countries.

There is a paucity of studies that have explored COVID-19 vaccine hesitancy in the general population in the Sub-Saharan African (SSA) context. In one of the earliest studies, Acre et al. reported that willingness to vaccinate

against COVID-19 was higher (67% to 88%) in five low and middle-income countries (LMIC) in SSA (i.e., Burkina Faso, Mozambique, Nigeria, Rwanda, Sierra Leone, and Uganda) compared with the United States (65%) and Russia (30%). Despite this, vaccination rates have remained low across SSA. The Africa Centers for Disease Control and Prevention (Africa CDC) estimates that, to date, about 16% and 21% of African populations have been fully or partially vaccinated, respectively. One explanation for this discrepancy lies in the widespread perception that the impact of COVID-19 on SSA has not been devastating, with the region reporting 2.5% of the global COVID-19 burden.

The COVID-19 policy conversation in SSA has, therefore, largely centered on equitable vaccine access, efficient supply chains, logistical and structural constraints, and funding. These complexities should be taken into account in trying to understand the determinants of vaccine hesitancy in SSA. Sierra Leone is a West African country with a population of eight million people. The country has recently experienced major public health challenges and was an epicenter of the West African Ebola epidemic of 2014–2016. The first confirmed cases of COVID-19 in

Sierra Leone were reported in March 2020. Similar to other countries in the region, the Government of Sierra Leone implemented a series of population-wide lockdowns in early April through June 2020 as part of the initial virus control measures. Although the incidence rate of COVID-19 has been reported as low (i.e., 80 cases per 100,000), a recent population serosurvey estimated the national SARS-CoV-2 antibody prevalence at 2.6%, which is 43-fold higher than the number of confirmed COVID-19 cases to date. While willingness to receive the vaccine has been reported as high (i.e., 80%) [16], about 30% of the population has been vaccinated.

As COVID-19 vaccination rollouts accelerate in SSA, establishing the determinants of vaccine hesitancy is essential to help inform an evidence-based public health policy response. Frontline HCWs and trainees interact directly with the public and are trusted sources of information, yet may harbor negative attitudes toward vaccination despite being at increased risk of COVID-19 exposure. In this study, we aimed to assess the prevalence and associated factors of COVID-19 vaccine governance, accountability, distribution, and hesitancy among the population in Sierra Leone.

2.0 Executive Summary

As the world continues to struggle to deal with the unparalleled strain of morbidity and mortality incurred by the COVID-19 pandemic, populations and economies continue to be severely disrupted. Various public health interventions have been proposed to stop disease transmission, including banning travel, imposition of social distancing, and curfews. However, the most promising control strategy is through large-scale, equitable access and distribution of safe and effective COVID-19 vaccines. Sierra Leone has, from January 3, 2020, to September 27, 2022, recorded 7,751 confirmed cases of COVID-19 with 125 deaths. As of September 18, 2022, a total of 4,258,299 vaccine doses have been administered. March 15, 2022, marked one year since Sierra Leone launched the COVID-19 vaccination, days after receiving the first doses from the COVAX




Sierra Leone recorded 7,751 confirmed COVID-19 cases and 125 deaths between January 2020 and September 2022.

Facility and others through bilateral partnerships.

As of March 15, 2022, 1.1 million of the country's eight million people have been fully vaccinated, and efforts are ongoing to increase vaccine uptake to reach a wider proportion of the population. As of August 2022, 2.1 million people have been vaccinated with at least one dose so far. Since the first shipments, Sierra Leone has so far received 3,418,690 COVID-19 vaccine doses, with 68% from COVAX, 19% from the African Vaccine Acquisition Trust and 13% from bilateral deals and donations. Of the total doses received, 2.1 million have been administered, with around 20% of the target population (12 years and above) having been fully vaccinated.

According to Dr. Steven V. Shongwe, WHO Representative in Sierra Leone, "Despite the major challenges with vaccine supplies and the slow vaccine uptake, the Sierra Leonean health authorities are making great efforts to increase vaccine uptake, including expanding vaccination sites, ensuring effective use of available stocks, mobilizing communities and addressing doubts and misinformation. WHO congratulates Sierra Leone on keeping the pandemic under control and will continue to support the government and its partners to achieve its goals."

The routine COVID-19 vaccination sites have increased from 72 to 724 nationwide to increase uptake and protect more people. The government has also initiated a strategic vaccination drive by introducing a monthly



five-day surge vaccination campaign. These efforts are paying off, several surge campaigns have been implemented so far, cumulatively accounting for an estimated 57.6% of the country's vaccination coverage since the beginning of the rollout on March 15, 2021. A COVID-19 vaccine delivery partnership has also been established, and an immunization plan for resource mobilization has been instituted to strengthen and increase COVID-19 vaccination and response.

There is also a well-structured governance system to administer the vaccine at the national, regional, district, and community levels with a well-organized reporting system. There is currently a high level of vaccine intake. Of the 713 people interviewed in ten districts, 70.5% have taken the vaccine, but only 4.5% have taken the full two doses and a booster. It was discovered that vaccines are not readily available in most communities, contributing to the low level of intake. About 52.6% of the respondents do not know if the vaccine is available or not available in their communities. The findings showed that an average of 40 teams are actively engaged in the vaccination process per district, and 60 people are targeted to be vaccinated daily.

However, most districts like Kenema get only about 40 out of the 60 daily targets, and 40% of the PHUs are not covered. About 119 general respondents, representing 16.7%, said they had never seen any vaccine in their communities, and 255, representing 35.8%, said they were unaware if the vaccines were available in their communities. Over 60% of the

PHUs have no electricity and cooling facilities for the vaccine, and logistics, including incentive pay for the vaccination team, are not always available. These are the reasons some communities are yet to be reached with the vaccine, a state of affairs that has slowed down vaccine intake among communities.

Trust in the vaccine is increasing, with 55.4% of 713 people having trust in it. However, information about the vaccine is limited to those in cities, which hampers decision-making and reinforces hesitancy. Half of the people reached in the survey, mostly from rural communities, indicated that they had not heard about the vaccine or that the vaccine information was insufficient.

Poor monitoring is also plaguing the accountability process of the vaccine administration. Only 96 people out of 713, with 13.5%, know of an ongoing monitoring of the process. The rest are either not aware of monitoring or have not seen any monitoring so far. Accountability is also marred by soliciting funds or selling vaccination cards. Despite the vaccine being free, 59 people, representing 8.3% of the 713 general respondents, said they paid money for it. It was also revealed that the vaccination team is not paid regularly, and there is a problem with getting the necessary logistics, including the transport to do their work, thereby encouraging the sale of vaccination cards by the team to travelers.

The initial year of the vaccination saw up to 70% vaccine hesitancy among Sierra Leoneans.

However, this survey saw that this hesitancy is reducing with more people's uptake of the vaccines and monitoring post-vaccine adverse effects. Three hundred and sixty-six respondents, representing 51.3%, said they had had hesitancy taking the vaccine, and 347 (48.7%) said they did not have any hesitancy taking the vaccine. Hesitancy is also reinforced by either a lack of or ineffective fact-checking groups. Fact-checking groups are lacking in most districts. Four of the ten districts surveyed did not have any fact-checking organization. And out of six districts, only two districts (Bo and Western Urban) have effective fact-checking organizations.

Two hundred and twenty-six people, representing 62.4%, said they hesitated

because they thought the vaccine would cause unforeseen problems in the future, 195 said it would lead to loss of lives, 96 said it would cause bareness, and 63 said it was money-making for government and countries overseas. Others cited rumors, fear of death, experience from Ebola, and not trusting some of the vaccines that were administered as reasons for their hesitancy.

The success of any COVID-19 vaccine program will depend on the public's desire and readiness to accept these and other vaccines. Meanwhile, vaccine hesitancy attributable to multiple causes appears to be a threat that could theoretically affect attempts to control the pandemic through vaccination and immunization.

3.0 Research Methodology

Here, both qualitative and quantitative methods of data collection and analyses were carried out. All data collection was focused mainly on COVID-19: Strengthening Partnerships for Equity and Accountability. The qualitative data collection took the form of descriptive studies that were intended to talk to people, conduct face-to-face interviews, focus group discussions, and paper desk reviews. Academic papers, journals, textbooks, and other sources will be consulted. This method was applied to help the researcher collect a higher proportion of exterior validity. That was the extent to which the results could be generalized for stakeholders operating within the health sector. A questionnaire was prepared and posted to the target groups for the quantitative research.

The qualitative and quantitative data gathered during the research process were also

analyzed. The first part discussed the fieldwork and data collected to understand the nature of vaccine distribution in Sierra Leone. The qualitative data highlighted the findings collected from the direct interviews with the focus study groups and from documents received from stakeholders. The quantitative data collected from the questionnaires was inputted and analyzed using graphs, tables, and charts.

The scope of the study was to cover the nature of COVID-19 vaccine distribution in Sierra Leone and its accountability over the last two years, covering five regions and ten districts. This research was organized as follows: an executive summary, research methodology followed by the findings, data analysis, research conclusions, and recommendations, including the appendix.



4.0 Vaccine Governance

From January 3, 2020, to September 27, 2022, there have been 7,751 confirmed cases of COVID-19, with 125 deaths reported. As of September 18, 2022, a total of 4,258,299 vaccine doses have been administered. March 15, 2022, marked one year since Sierra Leone launched the COVID-19 vaccination, days after receiving the first doses from the COVAX Facility and others through bilateral partnerships. As of March 15, 2022, 1.1 million of the country's eight million people have been fully vaccinated, and efforts are ongoing to increase vaccine uptake to reach a wider proportion of the population.

The findings revealed that 3,526,274 vaccines were donated to Sierra Leone, and four types of COVID-19 vaccines have been administered in Sierra Leone so far. These vaccines include



Sierra Leone received 3,526,274 donated vaccines, with four varieties of COVID-19 vaccines already administered.

Astra Zeneca, Pfizer, Sinopharm, and Johnson and Johnson. Astra Zeneca was donated by the Government of Japan via the COVAX Facility, Pfizer, and Johnson and Johnson by the United States Government to Sierra Leone, while England and China donated Sinopharm.

Findings revealed that there are structures ranging from international donor partners to the national medical team who take the vaccine from the cold rooms in Freetown. The National Logistics Team will then make a matrix and distribute it to the various districts, and the districts, in turn, administer the vaccines according to PHUs with cold chain facilities. The vaccination exercise was decentralized because an average of 40 teams work in the PHUs in all districts. Despite other PHUs not being involved in the vaccination exercise, some PHUs with vaccination teams extended their coverage to those PHUs without the vaccine facilities. There are three nurses and paramedics, with the inclusion of one data clerk in each team, which sometimes makes it up to four persons per team.

The Cold Chain Logistics Officer, who is the custodian of the COVID-19 vaccine management, gives feedback to the Expanded Program of Immunization (EPI) Program Manager at the national level, the District Operations Officer, who also manages the COVID-19 vaccines at the district level, reports to the District Medical Officer. The In-charge manages the vaccines at the Peripheral Health Units, PHUs level, and the Chiefdom Supervisor, who is the Community Health Officer (CHO), manages the vaccines at the Chiefdom

level.

The findings revealed that there are no requisite storage facilities for the vaccines, as one out of the 40 teams is not active in the vaccination process due to the lack of cold chain facilities. Reports showed that the vaccines are never sufficient to meet the targeted population of 70% of the eight million Sierra Leoneans, which is why the Surge 9 vaccination exercise was introduced with a plan to extend the Surge to 10 and 11. There is an existence of a strong relationship between the DHMT and PHUs as

the District Health Management Team identifies and deploys Vaccination Teams across various PHUs within the districts.

The reports revealed that international partners are regularly updated through a well-recognized server used in all parts of the world to send COVID-19 vaccination reports called the DHIS Server. According to the findings of this research, direct reports obtained at all district levels are then inputted and sent to the Server for the country's report to international partners.

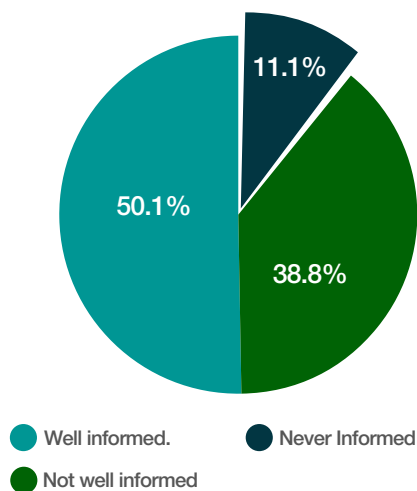


5.0 Inequality and Accountability in Vaccine Governance

The findings from the 48 healthcare workers interviewed revealed that locals are properly sensitized through focus group discussions about the vaccines by the Community-led Actions Group from within the community, and the Community Mobilizing Officer who is part of the vaccination team.

Figure 1: How well-informed are you and other residents regarding the COVID-19 vaccine?

713 responses



However, out of 713 general respondents who commented on this question, only 357 people, representing 50.1%, said they had enough information on the vaccine, while 277, representing 38.9%, said they did not have

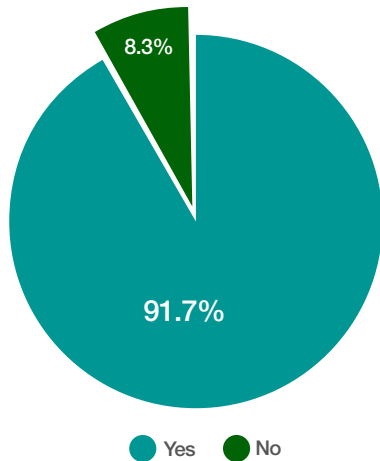
enough information on the vaccine. Seventy-nine people accounting for 11.1%, said they had never heard any sensitization on the vaccine.

The findings showed 40 teams actively engaged in the vaccination process per district, and 60 people were targeted to be vaccinated daily. However, most districts like Kenema get only about 40 out of the 60 daily targets, while 40% of the PHUs are not covered. About 119 general respondents, representing 16.7%, said they had never seen any vaccine in their communities. 255, representing 35.8%, said they were not aware if the vaccines were available in their communities. Over 60% of the PHUs have no electricity and cooling facilities for the vaccine, which is why some communities are yet to be reached.

The findings showed that the Pfizer vaccine was approved for children in Sierra Leone as young as 12 years old, and Astra Zeneca, Sinopharm, and Johnson and Johnson were all approved for Sierra Leoneans above 12 years. However, in the first phase of the vaccination exercise, only older people aged 60 and above, security personnel, and medical practitioners aged 40 and above were prioritized.

Figure 2: Have you or someone you know paid for the COVID-19 vaccine?

713 responses



Despite the vaccine being free, 59 people, representing 8.3% of the 713 general respondents, said they paid money for it. Findings revealed that some people who did not take the vaccine but needed the vaccination card to travel or access restricted

facilities in the country paid money to the vaccination team to provide them with the card. In Freetown, some people were arrested for selling vaccination cards for \$20. Rural communities that had little or no knowledge of the vaccine process were said to have given money to the vaccination team. There is no special approach for frontline workers and vulnerable populations to access the vaccine. Everyone who can access the vaccine, wherever it is, can take it.

Even though attempts were made to reach out to under-resourced communities by setting up mobile vaccination teams, this approach was hindered by a lack of mobility and remuneration packages to encourage the vaccination team to reach vulnerable populations. This is the reason why 16.7% of those interviewed said they have not seen any vaccine in their communities since the process commenced in 2020, and 35.8% said they are unaware that vaccines are available in their communities.

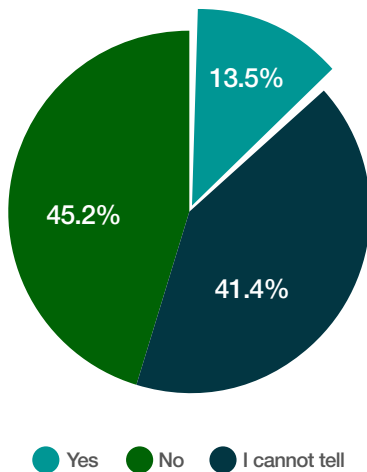


6.0 Citizen Monitoring Reports Involving in Managing the Vaccine Distribution

Healthcare workers interviewed pinpointed that because statistics on vaccines were provided to Civil Society Organizations (CSOs), this has necessitated the collective plans for Surge 10 and 11 as CSOs and partners are part of the development planning team for Surge 10 and 11. However, some CSOs employed to collect this data revealed that they are only aware of most information about the vaccination process through this research. Many CSOs are not provided information, nor do they ask or monitor the process.

Figure 3: Do people in your community, including yourself, have the opportunity to monitor the vaccination process?

713 responses



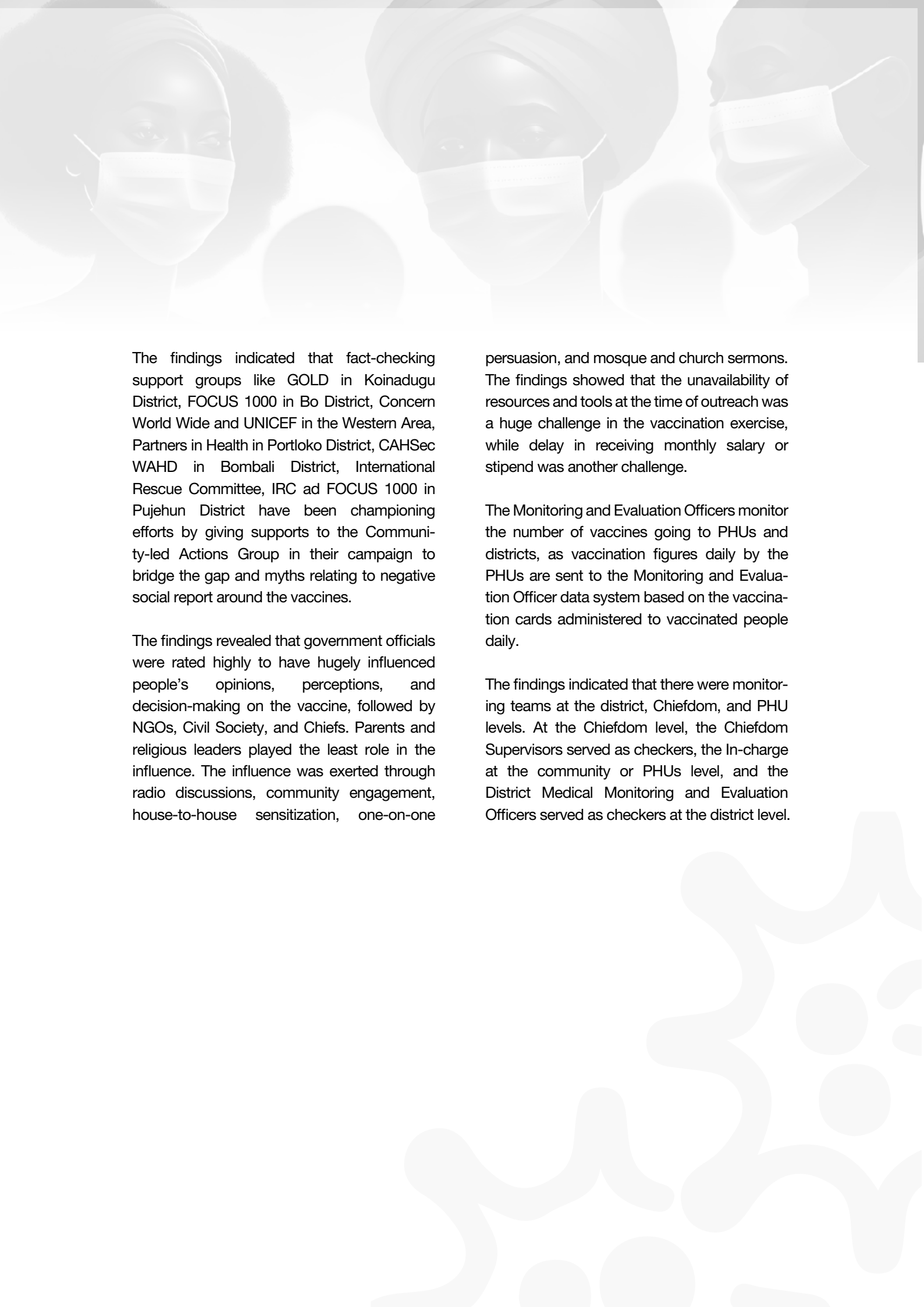
Three hundred and twenty-two general respondents, including civil society activists (45.2%) said they have never been given the opportunity to monitor the vaccination process. Two hundred and ninety-five (41.4%) said they cannot tell if monitoring takes place. Only 96 people (13.5%) said there is ongoing process monitoring.

Those who commented that no monitoring was observed gave the following as reasons they were not included: the vaccination did not

take place in their communities, they did not have time for it because of other schedules, they were mere residents and not considered stakeholders, they do not have interest in the vaccine itself, fear of the vaccine, the team came without their knowledge. Others gave old age as their reason. Those who said monitoring is ongoing said so because they heard it over the radio or saw local council members and security forces following the vaccination team and through participation in community mobilizations.

Despite the pluralistic civil society space in Sierra Leone, many civil society actors are always bought over by successive governments, encouraging those civil society sects to stay away from pushing for accountability in governance processes. Many under-resourced civil society groups depend on the government to allocate projects to them. Once this is done, they become praise singers for the government and even fight other civil society groups who criticize the government. Civil society leaders were seen to have accepted government-paid positions in the governance structures of the COVID-19 fight, just as was the case during the fight of Ebola. They become the subject of investigations, eroding their efficacy to engage in monitoring for accountability.

There is also a fear that because the vaccines are 100% donated by development partners, civil society criticism of the process might erode donor confidence, and this, the government would wish to prevent by limiting their involvement in the process. Independent funding of civil society groups can be one way to depoliticize the civil society space and encourage an efficient, independent civil society that can do its work without fear or favor.



The findings indicated that fact-checking support groups like GOLD in Koinadugu District, FOCUS 1000 in Bo District, Concern World Wide and UNICEF in the Western Area, Partners in Health in Portloko District, CAHSec WAHD in Bombali District, International Rescue Committee, IRC ad FOCUS 1000 in Pujehun District have been championing efforts by giving supports to the Community-led Actions Group in their campaign to bridge the gap and myths relating to negative social report around the vaccines.

The findings revealed that government officials were rated highly to have hugely influenced people's opinions, perceptions, and decision-making on the vaccine, followed by NGOs, Civil Society, and Chiefs. Parents and religious leaders played the least role in the influence. The influence was exerted through radio discussions, community engagement, house-to-house sensitization, one-on-one

persuasion, and mosque and church sermons. The findings showed that the unavailability of resources and tools at the time of outreach was a huge challenge in the vaccination exercise, while delay in receiving monthly salary or stipend was another challenge.

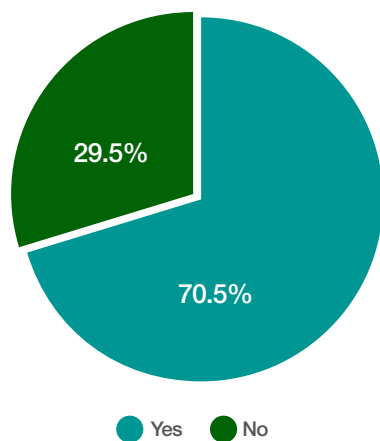
The Monitoring and Evaluation Officers monitor the number of vaccines going to PHUs and districts, as vaccination figures daily by the PHUs are sent to the Monitoring and Evaluation Officer data system based on the vaccination cards administered to vaccinated people daily.

The findings indicated that there were monitoring teams at the district, Chiefdom, and PHU levels. At the Chiefdom level, the Chiefdom Supervisors served as checkers, the In-charge at the community or PHUs level, and the District Medical Monitoring and Evaluation Officers served as checkers at the district level.

8.0 Vaccine Hesitancy

Respondents in this section were mainly service users, including CSOs, chiefs, and community stakeholders, vulnerable groups like pregnant women, lactating mothers, people living with disability, students, and eligible vaccine takers.

Figure 4: Have you taken COVID-19 Vaccine?
713 responses

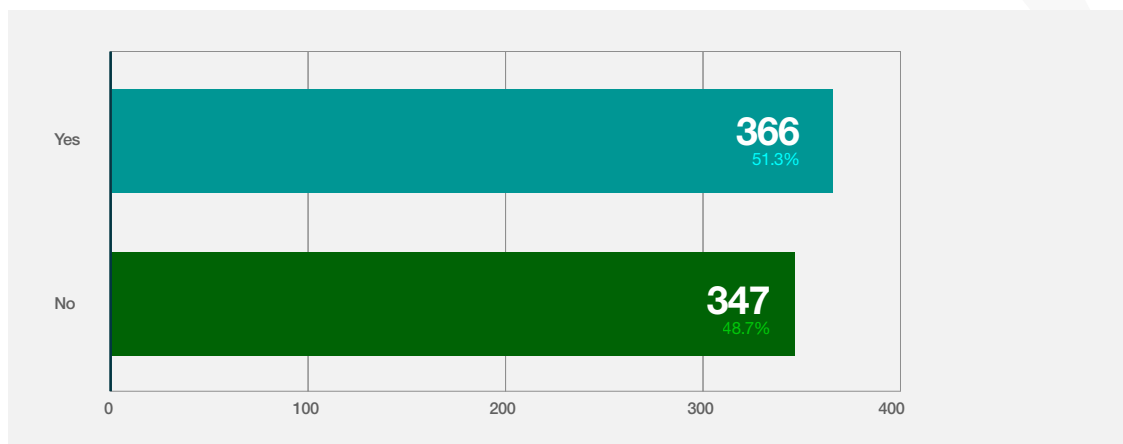


Of the 713 respondents, 503, representing 70.5%, said they had taken the vaccine. Two hundred and ten respondents, representing 29.5%, said they had not taken the vaccine. Of

the 494 who could remember the doses they had taken, only 22 people (4.5%) had taken two doses and a booster. Two hundred and seventy-nine (56.5%) have taken two doses, and 139 (39.1%) have taken one dose only. Of the many reasons respondents stated for taking the vaccine, 50% cited protection and minimizing the risks of contracting COVID-19. Over 30% cited wanting to obey government orders as they learned it was compulsory for everyone to take them, 20% cited parental and religious leaders' influence, and 10% cited peer influence.

Those who have not taken the vaccine cited fear of death and future adverse side effects on their health as the overriding reasons for not taking it. Others pointed to money-making reasons behind the introduction of the vaccine. Some were confused over which information to trust on social media. Educated relatives in the cities advised others not to take it. Pregnant women, lactating mothers, and sick people abstained because of their conditions. The rest complained of the inaccessibility of the vaccine or received information on the side effects from those who had already taken it.

Figure 5: Have you ever hesitated to take the vaccine?
713 responses

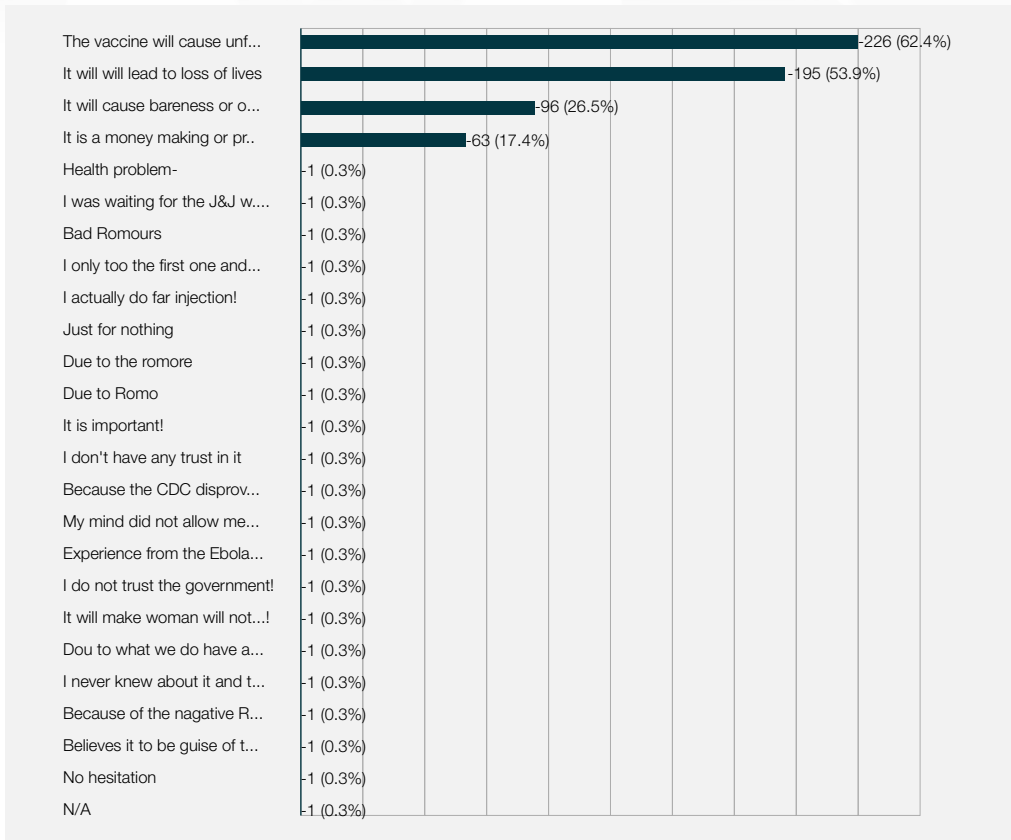


Three hundred and sixty-six respondents, representing 51.3%, said they have had

hesitancy taking the vaccine, and 347 (48.7%) said they did not have any hesitancy taking it.

Figure 6: If Yes, what was your reason based on?

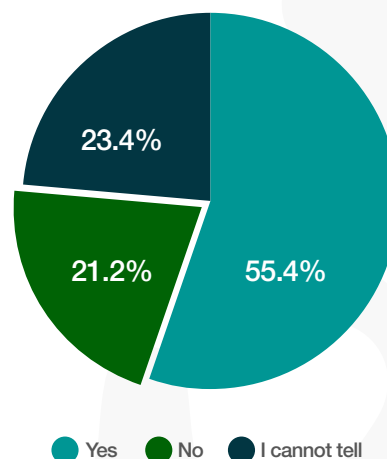
362 responses



Two hundred and twenty-six respondents, representing 62.4%, said they hesitated because they thought the vaccine would cause unforeseen problems in the future, 195 said it would lead to loss of lives, 96 said it would cause bareness, and 63 said it was money-making for the government and countries overseas. Others cited rumors, fear of death, experience from Ebola, and not trusting some of the administered vaccines.

Figure 7: Do you trust the COVID-19 vaccine?

713 responses



One hundred and fifty-one respondents said they have no trust in the vaccine because of the side effects complained about by vaccine users. One hundred and sixty-seven are confused as to whether to trust or not to trust the vaccine. However, 395 people (55.4%) said they trust the vaccine because nothing bad happened to them or to others after taking it.

The findings showed that during the start of the COVID-19 vaccination process, people had mixed feelings that the vaccines were dangerous for the body, which was a wrong perception, as compared to now, when there is a high level of acceptance resulting from the change of perceptions by the locals recently. The findings showed that there were problems of acceptance resulting from the myth of killer vaccines and money-making by locals within the research districts. While a few politicians also fueled this information in some districts, this was not so in many other parts where the research was conducted. Politics did not, to a large extent, influence people's hesitancy toward the vaccine.

Overall, the COVID-19 vaccine hesitancy levels in this study were higher than those reported in studies conducted in Higher Income Countries (i.e., France, United States, Qatar) but lower than findings reported in studies from other parts of Africa (i.e., Ethiopia, Nigeria, and South Africa). The difference in COVID-19 vaccine hesitancy levels between our study and previous African studies may be due to how COVID-19 vaccine hesitancy was measured, study populations and differences in study periods, as well as the impact the COVID-19

pandemic has had on the study populations.

The high levels of COVID-19 vaccine hesitancy reported among HCWs in our study are cause for concern, given that our study was conducted at a time when scientific evidence for various COVID-19 vaccines had already been made widely available.

This suggests that the availability of evidence in support of the efficacy and safety of vaccines in itself may not be enough to overcome apprehension toward COVID-19 vaccination. Instead, sociocultural factors may strongly influence vaccine uptake decisions.

In addition, the high levels of COVID-19 vaccine hesitancy observed in our study could cause an erosion of public confidence and trust, which may, in turn, lead to negative repercussions for vaccine uptake in the general public, given that priority populations like healthcare workers are considered role models and trustworthy sources of health information.

Worries about unforeseen future effects and a preference for natural immunity were proffered as the primary causes for concerns around COVID-19 vaccination among survey respondents. The effect of mixed messaging regarding COVID-19 vaccination, especially on social media platforms, might explain vulnerable populations' concerns. The effect of social media on COVID-19 vaccine uptake decisions in Africa has been documented. This underscores the critical need for an effective information communication strategy to dispel vaccine efficacy and safety misconceptions.

9.0 Conclusion and Recommendation

Over 50% of Sierra Leone's population had a favorable attitude toward COVID-19 vaccination. The primary reasons for their COVID-19 vaccination acceptance were to ensure personal and family safety and wellbeing. A key role in acceptance is the attitude of leaders. Denial of the COVID-19 reality, distrust in the COVID-19 vaccine and vaccine safety, and varying and false information in the media negatively influence vaccination acceptance.

Sensitizing the public about the vaccine development process through continuous communication and community engagement, as well as the independent role of regulatory authorities in safety and efficacy evaluation, will be helpful in alleviating these concerns. Efforts should be made to clearly communicate COVID-19 risks and identify and resolve determinants of COVID-19 acceptance for all population segments.

The Sierra Leone Government must ensure the implementation of the Surge 10 and 11 imminent vaccination process by extending its commitment to the fight to achieve Zero COVID-19 cases in Sierra Leone. The District Health Management Team must provide the requisite resources and tools the vaccination teams need to foster effective and efficient outreach.

Civic education should be prioritized by the government and civil society. Citizens should be educated about the availability of the vaccine and the need for citizens to get vaccinated. This could be more beneficial to areas with high rates of illiteracy and lack of access to information.

Key stakeholders like civil society, members of parliament, councilors, and local chiefs should

be included in the vaccination process. This is because they serve as strong direct influences on the local people.

The government should provide suitable storage that can keep the vaccines for a long period at all PHUs across the country. This is to ensure that vaccines stay longer in communities. In the same vein, the government should increase the number of health and social workers or counselors giving talk therapy to people with negative perceptions about vaccination.

Monitoring and reporting of safety signs should be at the core of the COVID-19 vaccine rollout activities, and it is critical for the government and civil society to educate the public in an open and timely manner to avoid the COVID-19 vaccines having a negative impact on the national immunization program. Importantly, leadership by example could have a big impact on acceptance.

False information and fake news are also issues in Sierra Leone; it is not always possible to overcome this with data. However, it is mainly the minority who believe in this, and it is questionable whether making vaccination mandatory would have a major benefit. Rather, the presence of these minorities makes it more important to achieve high coverage in those who accept vaccination so herd immunity can be established.

It is however recommended that civil society implement a wide pragmatic monitoring coverage and re-educative strategy through face-to-face, focus group discussions and media engagements on the essence of ensuring the continuity of equitable and accountable COVID-19 vaccination distribution across all districts within the country.

10.0 Appendix

Structured Research Questionnaire for service users

The survey sought to understand the nature of COVID-19 vaccine distribution in Sierra Leone (noting the internal and external factors) and the challenges of accountability and inequity, investigate and understand the drivers behind vaccine hesitancy, and provide platforms for organically-grown citizen awareness and

engagement with vaccine issues at various levels. This will entail the appraisal of the governance, normative environment, and social psychology of the citizens of Sierra Leone. This is in line with the global move to include social and behavioral data in the drive to contain and ultimately quell the pandemic.

Note: The law of confidentiality applies to all information provided by the respondents. This means that the information provided is kept confidential and will not be passed on to a third party except with your full consent.

- **District:**
- **Age of respondent:** 12-30 31-40 41-50 51-60 Above 60
- **Chiefdom/Community:**
- **Gender of respondent:** Male Female Prefer not to say
- **How do you identify yourself?** Person with disability Aged Pregnant woman
 Lactating mother None of the Above
- **Occupation of respondent:**
- **Have you taken the COVID-19 vaccine?** Yes No
If yes, how many doses? One dose Two doses Two doses and a booster
- **If you have taken the vaccine, what was your reason for taking it?**
- **If you have not taken the vaccine, what is your reason for not taking it?**
- **Have you ever hesitated to take the vaccine?** Yes No
If Yes, what was your hesitancy based on? Click all that apply.
 The vaccine will cause unforeseen problems in the future It will lead to loss of lives
 It will cause bareness or other illnesses in the body
 It is money-making or profit-making for the government and overseas countries
 Other:

- Please explain any other reason for hesitating to take the vaccine

- Do you trust the COVID-19 Vaccine? Yes No I cannot tell

- Explain your reasons for any of your answers above

- Have you or your friends, family, or anyone you know paid any money for COVID-19 Vaccine? Yes No

- Are you aware if COVID-19 Vaccines are readily available in your community?

Yes No I don't know

- Do people in your community, including yourself, have the opportunity to monitor the vaccination process? Yes No I cannot tell

- If Yes, please explain how. If No, please explain why

- Which groups, organizations, or individuals in your community influence people's opinions, perceptions, and decision-making on the vaccine? (eg. parents, NGOs, religious leaders, Government Officials, chiefs, civil society, etc)

- How do they carry out this influence on people?

- Are you and the people in your community getting enough information on the COVID-19 Vaccine? Yes No Not enough information

- If you get information about the vaccine, where do you get it, and from whom? If you don't get the information, why?

- What are your perceptions and experiences with vaccines generally? Whether yellow fever, hepatitis, COVID-19, etc

- **What is your general assessment of the COVID-19 vaccination process in your area and in the country generally?**
- **What do you recommend that the government do in the area of COVID-19 vaccine?**
- **What do you recommend civil society to do to improve the situation?**

Independent research done by:
Abdul Rahman M. Kowa

Disclaimer: This report has been produced by BudgIT Sierra Leone to provide information on budgets and public data matters. BudgIT Sierra Leone hereby certifies that all the perspectives expressed in this document accurately reflect our analytical views that we believe are reliable and fact-based. Whilst reasonable care has been taken in preparing this document, no responsibility or liability is accepted for errors or any views expressed herein by BudgIT Sierra Leone for actions taken because of the information provided in this report.



11.0 References

World Health Organization. WHO Coronavirus Disease (COVID-19) Dashboard. 2022. Available online: <https://covid19.who.int/> (accessed on 15 April 2022).

World Health Organization. In and Out of Lockdowns, and What Lockdown Anyway? Policy Issues in Transitions. 2022. Available online: <https://apps.who.int/iris/bitstream/handle/10665/336284/Eurohealth-26-2-93-98-eng.pdf> (accessed on 15 April 2022).

Polack, F.P.; Thomas, S.J.; Kitchin, N.; Absalon, J.; Gurtman, A.; Lockhart, S.; Perez, J.L.; Pérez Marc, G.; Moreira, E.D.; Zerbini, C.; et al. Safety and Efficacy of the BNT162b2 mRNA Covid-19 Vaccine. *N. Engl. J. Med.* 2020, 383, 2603–2615. [CrossRef] [PubMed]

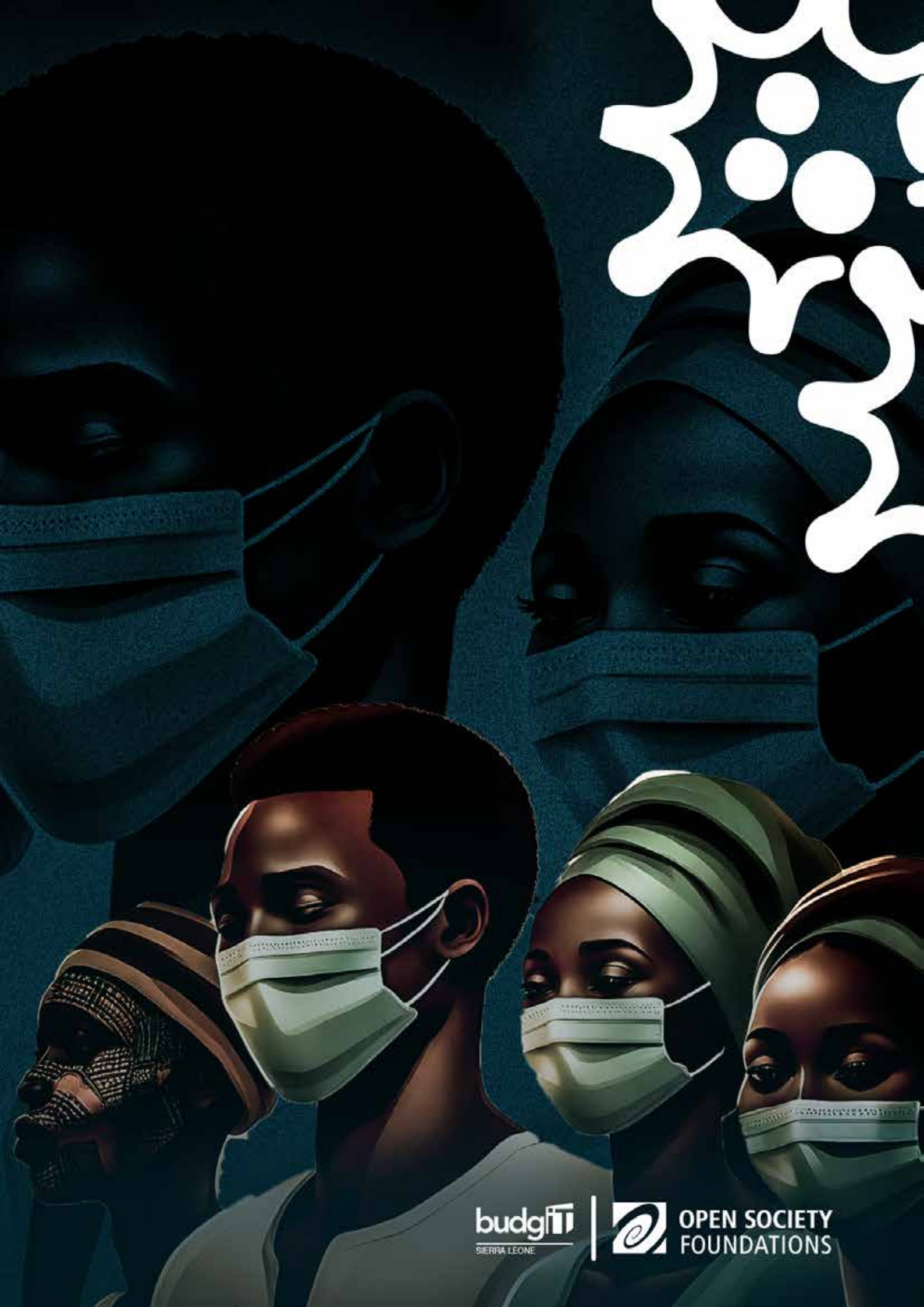
Bennett, H.; Pajon, R.; Knightly, C.; Leav, B.; Deng, W.; Zhou, H.; Han, S.; Ivarsson, M.; Miller, J.; Zaks, T.; et al. Efficacy and Safety of the mRNA-1273 SARS-CoV-2 Vaccine. *N. Engl. J. Med.* 2021, 384, 403–416.

World Health Organization. COVID-19 Vaccine Tracker and Landscape. 2021. Available online: <https://www.who.int/publications/m/item/draft-landscape-of-covid-19-candidate-vaccines> (accessed on 15 April 2022).

World Health Organization. COVID-19 Advice for the Public: Getting Vaccinated. 2021. Available online: <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/covid-19-vaccines/advice> (accessed on 15 April 2022).

World Health Organization. Report of the SAGE Working Group on Vaccine Hesitancy. 2021. Available online: https://www.who.int/immunization/sage/meetings/2014/october/1_Report_WORKING_GROUP_vaccine_hesitancy_final.pdf (accessed on 15 April 2022).

World Health Organization. Ten Threats to Global Health in 2019. 2021. Available online: <https://www.who.int/news-room/spotlight/ten-threats-to-global-health-in-2019> (accessed on 15 April 2022).



budgfi
SIERRA LEONE



**OPEN SOCIETY
FOUNDATIONS**