Building Resilient Communities:

HOW VACCINES ARE EMPOWERING DIVERSE COMMUNITIES TO achieve LASTING HEALTH

HEALTH EQUITY COLLABORATIVE

White Paper

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The Health Equity Collaborative

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About the Author

The Health Equity Collaborative (HEC) is a diverse community comprised of dozens of national, public health, patient advocacy, and multicultural organizations that are committed to supporting equity and combating disparities experienced by underserved populations. HEC is officially a project of MANA Action, a 501c4 not-for-profit organization.

Executive Summary

Vaccines are one of the most effective tools for advancing public health and reducing health disparities. They also drive "economic progress by reducing healthcare costs, increasing workforce productivity, and mitigating the burden of disease on societies."[1] Yet, current political and budgetary trends threaten funding for vaccine programs. At the same time, vaccine hesitancy is on the rise, particularly among historically underserved communities.

Vaccines have significantly reduced illness, death, and disparities in BIPOC communities. Failures to address misinformation through educational outreach have allowed vaccine hesitancy to persist, carrying inequitable health and economic costs. Furthermore, budgetary cuts to vaccine funding are disproportionately affecting low-income, rural, and minority populations.

This white paper outlines the overwhelming evidence in support of vaccines, identifies the causes of vaccine hesitancy, and makes the case for funding vaccines and culturally competent outreach to combat misinformation and protect community health gains.

Introduction: A Turning Point in Public Health Equity

In the early months of the COVID-19 vaccine rollout, a familiar sight began to emerge in communities across the country. The same buildings where people gathered for Sunday services, community meals, and support groups were transformed into clinics. For many, this simple act was a profound relief. The bureaucracy of online appointment systems and the long distances to large-scale vaccination centers were replaced by the reassuring presence of a trusted space. The pews and altar of the sanctuary gave way to rows of chairs and a sterile vaccine station. Here, familiar faces—the pastor, the deacons, the church matriarchs—served as guides and advocates, helping to alleviate fears and answer questions. This wasn't just a matter of convenience; it was a testament to the church's enduring role as a pillar of community health. By meeting people exactly where they were, both physically and emotionally, these faith communities didn't just distribute a vaccine; they restored a sense of care and hope.

Choose Healthy Life (CHL) stands out as a powerful example of how community-led organizations were on the front lines of the pandemic response. Instead of relying on a centralized, impersonal approach, the organization leveraged the deep-seated trust and physical presence of the Black church to bring public health services directly to the people who needed them most. CHL, a member of the Health Equity Collaborative, was founded in 2021 by a group of renowned Black clergy and immediately began leveraging the Black church's status as a trusted institution. Since launch CHL has administered more than 350,000 COVID-19 tests and vaccinations through its network of churches. This was a scalable and sustainable model. Governor Kathy Hochul's office highlighted the program's success in New York City, where 20 churches served over 100,000 individuals with a combination of vaccinations, health screenings, and social support referrals.[2]

This peer-to-peer model helped close the gap in vaccine uptake, saving lives and improving health outcomes in communities that were disproportionately affected by the virus. By bringing faith and science together, CHL not only increased vaccination rates but also created a sustainable model for addressing other long-standing health disparities.

OUR CHURCHES HAVE ALWAYS BEEN MORE THAN JUST PLACES OF WORSHIP; THEY ARE THE HEART OF OUR COMMUNITIES. IN THE FACE OF A CRISIS THAT DISPROPORTIONATELY AFFECTED US, CHOOSE HEALTHY LIFE CHURCHES DIDN'T JUST BRING VACCINES AND OTHER TREATMENTS TO COMMUNITIES THAT NEEDED THEM; WE WORKED TO BUILD A BRIDGE OF TRUST WHERE THERE HAD BEEN A CHASM OF DOUBT. CHOOSE HEALTHY LIFE IS WORKING TO MEET PEOPLE WHERE THEY ARE—IN A PLACE OF FAMILIARITY AND FAITH—TO NOT ONLY SAVE LIVES BUT TO LAY THE GROUNDWORK FOR A FUTURE WHERE OUR HEALTH IS NOT JUST AN AFTERTHOUGHT BUT A PRIORITY. THIS IS THE CRITICAL WORK OF HEALING, AND IT'S A POWERFUL TESTAMENT TO WHAT WE CAN ACHIEVE WHEN WE UNITE FAITH, SCIENCE, AND COMMUNITY.

—Choose Healthy Life President and CEO, **Dr. Kimberly Williams**

Building on the success of its pandemic response, CHL has expanded its focus to overall wellness, creating a sustainable framework for community health. The organization has hosted over 11,000 wellness events and provided more than 27,000 comprehensive health screenings. This peer-to-peer model continues to close critical gaps in care, connecting individuals with vital health services, from disease prevention education to social support referrals. CHL's evolution demonstrates that the trust built during a crisis can be a powerful catalyst for long-term, positive health outcomes in communities that have been historically underserved.

The Impact of Vaccines on Diverse Populations

The life-saving impact of vaccines is difficult to overstate. Vaccination has eliminated or radically reduced the incidence of one highly infectious and often deadly diseases, allowing a brighter future for countless people in the U.S. and the world over. Vaccinated individuals survive to have children who themselves have children, and so on—making the impact of vaccines exponential and more far-reaching than commonly understood. Several of the greatest achievements of vaccines and the communities who have successfully promoted them are vaccines for polio, measles, HPV, and the various COVID-19 vaccines.

POLIO

The poliovirus once caused physical disability, lifelong paralysis, and ultimately, death. Historically, polio disproportionately affected poor and rural communities with limited sanitation. Vaccination eradicated these disparities. Modern immunization programs ensure free or low-cost access, helping close gaps in preventive care. These efforts further increase trust in primary care infrastructure by linking vaccination to other essential health services.[3]

Underscoring the need for continued vaccine funding, the creation of polio vaccines required decades of research. Scientists began studying poliovirus in the early 1900s. Only in the 1950's did scientist Jonas Salk did develop a polio vaccine (inactivated polio vaccine (IPV), which was licensed in 1955. At this point mass immunization campaigns began. In 1961 Albert Sabin introduced the oral polio vaccine (OPV), making mass vaccination easier.[4]

Delaying vaccine research through funding cuts risks denying life-saving treatments for years, if not decades. Cutting funding intended for vaccination efforts would disproportionately harm underserved communities.

MEASLES

The measles virus prevents a highly contagious disease that can cause pneumonia, encephalitis, and death. The measles vaccine, which provides strong community protection through herd immunity, has reduced global measles deaths by more than 80 percent since 2000.

Vaccination efforts are particularly beneficial to underserved communities, as outbreaks are more likely to occur in areas with low vaccination coverage, including marginalized communities with limited healthcare access. Vaccination further reduces risk of school absences and family economic burden caused by outbreaks. Public health campaigns targeting low-income neighborhoods and immigrant communities have been shown to increase vaccine uptake and narrow health disparities.[5]

The measles virus was first isolated in 1954, sparking efforts to develop a vaccine. The first vaccine was not licensed until 1963, and the vaccine used today was not licensed until 1971.[6]

HPV

HPV vaccine distribution has shown tremendous potential to reduce poverty and race related disparities in cervical cancer, especially where screening and follow up care are limited, according to recent modeling studies.[7]

Although HPV vaccination rates have historically lagged among Black and Hispanic women, its preventative effect against cervical cancer is especially powerful for these groups, who face elevated incidence and mortality rates.[8] However, reviews show that vaccine awareness remains lower in disadvantaged communities—underscoring the need for trust building and education to boost uptake and reduce disparity.[9]

Like with polio and measles, development of the HPV vaccine took many years. Certain HPV type's link to cervical cancer was discovered in the 1980s, but the first publicly available vaccine was not licensed by the FDA until 2006.[10]

HEPATITIS B

The Hepatitis B virus (HBV) vaccine is a crucial tool in preventing chronic liver disease, a condition that disproportionately affects certain racial and ethnic groups. Chronic HBV infection can lead to life-threatening conditions like cirrhosis (liver scarring) and liver cancer.

Asian American and Pacific Islander (AAPI) communities bear a significant burden of chronic HBV infection in the U.S., with the prevalence of chronic infection being substantially higher compared to other racial and ethnic groups. It's estimated that Asians and Pacific Islanders account for over 50% of the world's population with chronic HBV infection, a pattern reflected in the U.S. where they account for approximately 58% of chronic HBV infections among foreign-born individuals.[11] For many foreign-born AAPI individuals, the infection was acquired at birth or in early childhood in countries where HBV is endemic.

Chronic liver disease and cirrhosis are also a major concern for American Indian and Alaska Native (AI/AN) populations, ranking as a leading cause of death. In 2021, AI/AN males were 3.4 times more likely, and AI/AN females were 4.5 times more likely, to die from chronic liver disease or cirrhosis than their non-Hispanic white counterpart.[12] While HBV and Hepatitis C Virus (HCV) are contributing factors to chronic liver disease in these communities—with newly reported cases of chronic Hepatitis B in 2022 being 1.8 times higher for non-Hispanic AI/AN people than non-Hispanic white people—alcohol-associated liver disease and HCV have also been identified as significant contributors to the overall chronic liver disease burden among AI/AN individual.[13]

Vaccination efforts targeting at-risk populations and ensuring universal infant and childhood vaccination have been instrumental in reducing new infections and ultimately lowering the burden of chronic liver disease, but disparities in screening and access to care remain. The first Hepatitis B vaccine was approved in 1981, and universal infant vaccination was recommended in the U.S. in 1991, with catch-up vaccination recommended for adolescents in 1995, highlighting that it took years to develop and implement these life-saving public health strategies.

COVID-19

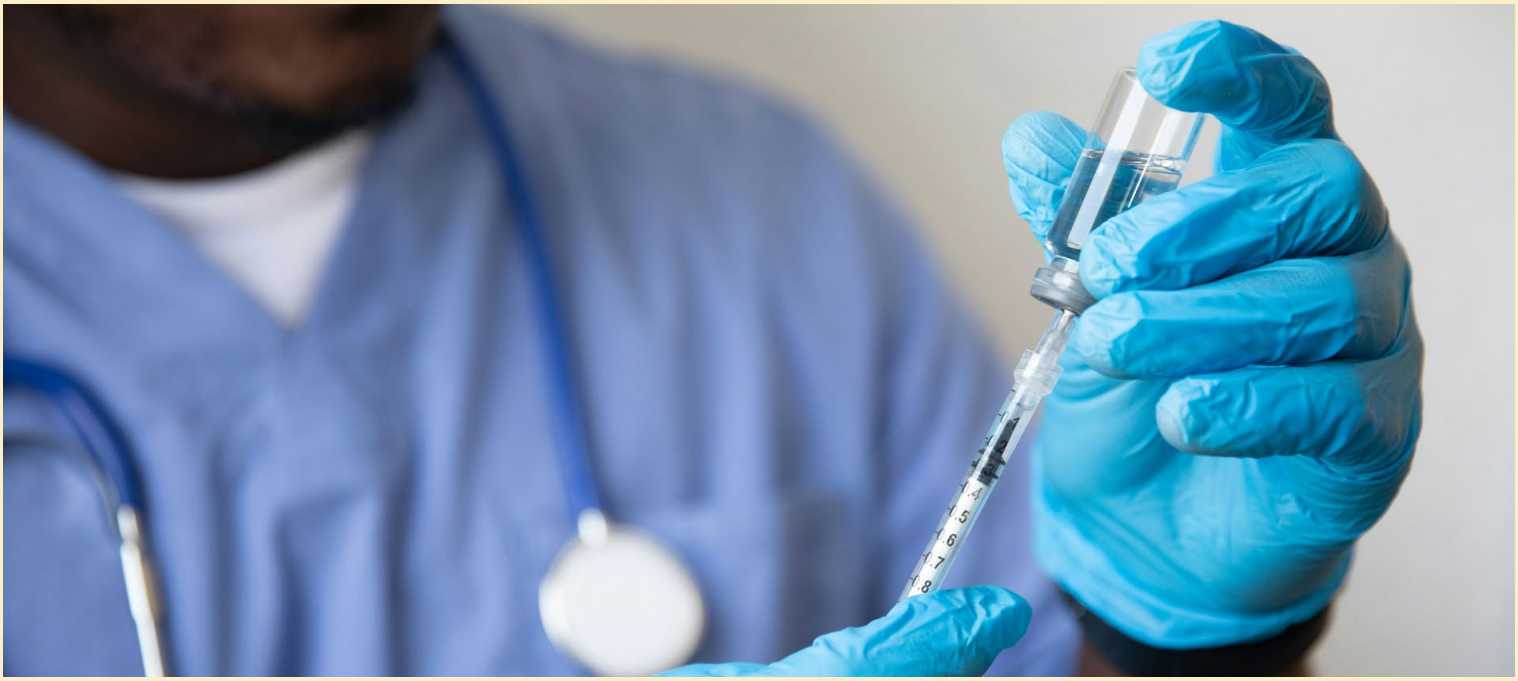
Analysis or mortality rates and other data have confirmed that BIPOC communities and low-income groups bore disproportionate COVID 19 burdens, especially in the early, most deadly stages of the pandemic. In many Black and Latino communities, early vaccine hesitancy was compounded by lack of culturally and linguistically appropriate information, and barriers (e.g., pharmacies asking for insurance or SSN), whereas wealthier and whiter neighborhoods had easier early access.[14]

Additional research has found that tailored outreach—such as mobile clinics and trusted messenger programs—was vital in closing vaccine gaps and reducing severe outcomes. In other words, when implemented with equity, vaccination efforts saved lives, including those of children, in marginalized communities.[15] [16] [17]

The COVID-19 vaccines were developed with comparably remarkable spead through the public-private partnership, Operation Warp Speed. SARS-CoV-2 was identified in January 2020, and its genetic sequence published within weeks. Phase II clinical trials were launched by launched by July 2020. Vaccines were authorized for emergency use in February 2021.[18] While the speed of vaccine development and authorization is impressive, it is important to remember this vaccine research built off many years of mRNA technology development that began in the 1990s, decades before the onset of COVID-19.[19]

Vaccines at Risk: Funding Cuts and Misinformation

Vaccination and community public health efforts across the country have seen budgets slashed. In April, Axios reported, “states and cities are losing over $2 billion in childhood immunization and vaccination funding as part of broader cancellations of pandemic-era federal public health spending, per government data.”[20] The Associated Press reported, “The Trump administration is cutting health spending on an unprecedented scale, experts say. It’s pulled $11 billion of direct federal support and eliminated 20,000 jobs at national health agencies that in part support local public health work. It’s proposing billions more be slashed."[21]



Due to the abrupt cancellation of about $11.4 billion in COVID-era grants, vaccination clinics across – including in underserved communities – were canceled. These cuts came amidst growing alarm over the increase in measles cases in the U.S.[22] Thus, at a time where higher vaccinations were needed to stem the spread of measles, community efforts to help in this effort were stifled. Now, states fear further cuts are on the horizon. Stateline reported, "President Donald Trump's budget proposal for fiscal year 2026 would cut the federal Centers for Disease Control and Prevention budget by more than half, from $9.3 billion to $4.2 billion."[23]

These severe cuts to vaccination efforts came just weeks before the Administration's *Make America Healthy Again (MAHA) Report* included language, under the guise of promoting freedom, that could further increase skepticism of vaccinations. The Associated Press reported:

> *Increased scrutiny of childhood vaccines — credited with saving millions of people from deadly diseases — figures prominently in the report. It poses questions over the necessity of school mandates that require children to get vaccinated for admittance and suggestions that vaccines should undergo more clinical trials, including with placebos.*
>
> *Kennedy, a longtime vaccine critic, has raised doubts about the safety of shots even as a measles outbreak has sickened more than 1,000 Americans. This week, Kennedy's health department moved to limit U.S. access to COVID-19 shots.*
>
> *The report does not provide any evidence that the childhood vaccine schedule, which includes shots for measles, polio and the chickenpox, is to blame for rising obesity, diabetes or autism rates, said Amesh Adalja, an infectious disease physician at Johns Hopkins University.*[24]

Alongside the promotion of vaccine skepticism in the MAHA Report, in June Secretary Kennedy dismissed all 17 members of the CDC's Advisory Committee on Immunization Practices (ACIP), replacing them with individuals including known vaccine skeptics (e.g., Robert Malone) and critics of public health norms. Former ACIP members condemned the move in *NEJM*, warning that science-based vaccine policy is being compromised and public trust destabilized.[25]

Secretary Kennedy has a history of making false or misleading statements about vaccines and vaccination. He once stated that "no vaccine is safe and effective," although he attempted to walk that statement back during a Senate confirmation hearing.[26] He has also claimed the MMR vaccine contains "aborted fetus debris"—a scientifically unfounded statement condemned as dangerous misinformation by vaccine experts.[27]

Secretary Kennedy has also shown a clear bias against mRNA vaccines. Under his leadership, the HHS canceled a $766 million grant to Moderna for bird flu mRNA vaccine development, and placed new limitations on eligibility and warning language for COVID 19 mRNA vaccines, even while rolling back public eligibility guidance for COVID shots in pregnant individuals and healthy children—actions signaling skepticism of mRNA platforms' future viability.[28] He has also replaced the CDC Advisory Committee members he fired with skeptics of mRNA vaccines.[29] And on August 5th, he announced plans to end $500 million in mRNA vaccine development projects to combat pathogens such as COVID 19 and H5N1. In a statement, he made the dubious claim that "mRNA technology poses more risk than benefits for these respiratory viruses."[30]

Though framed as health policies and fiscal responsibility, the Administration's statements and actions disproportionately harm communities already vulnerable to health inequities. Lower-resourced clinics in Black, Latino, and Indigenous communities are often the first to be affected. And for children, school-based immunization programs (especially in rural and immigrant communities) are clearly under threat.

THOUGH FRAMED AS HEALTH POLICIES AND FISCAL RESPONSIBILITY, THE ADMINISTRATION'S STATEMENTS AND ACTIONS DISPROPORTIONATELY HARM COMMUNITIES ALREADY VULNERABLE TO HEALTH INEQUITIES.

Consequences of Inaction: What We Stand to Lose

Recent changes in funding for, and attitudes, toward, vaccination threaten to undermine decades of advances toward equitable healthcare treatments and results. If funding is not restored and vaccine hesitancy persists, there will be further negative consequences for public health, the economy, and healthcare equity.

ADVERSE PUBLIC HEALTH OUTCOMES

Failure to sustain vaccine access and outreach programs leads to measurable increases in preventable diseases like measles, whooping cough (pertussis), and influenza. Recent studies show Black, Hispanic, and Indigenous adults in the U.S. experience 1.2 to 1.8 times higher influenza hospitalization rates and lower vaccination coverage compared to White adults.[31] Influenza hospitalization risks are amplified in underserved communities due to structural barriers like limited access to preventive care and distrust of health systems.[32]

Historical data reinforce these disparities. During the 1989–1991 U.S. measles resurgence, children who were poor, Black, Hispanic, or American Indian were 3 to 16 times more likely to contract measles than non-Hispanic White children—and accounted for most hospitalizations and deaths.[33]

Vaccination coverage remains persistently lower for Black, Hispanic, American Indian/Alaska Native, and rural children—even with federally funded safety-net programs like the Vaccines for Children (VFC) initiative; recent CDC reporting shows that VFC-eligible children in these groups still lag behind non-VFC peers by 9–38 percentage points in full series coverage.[34]

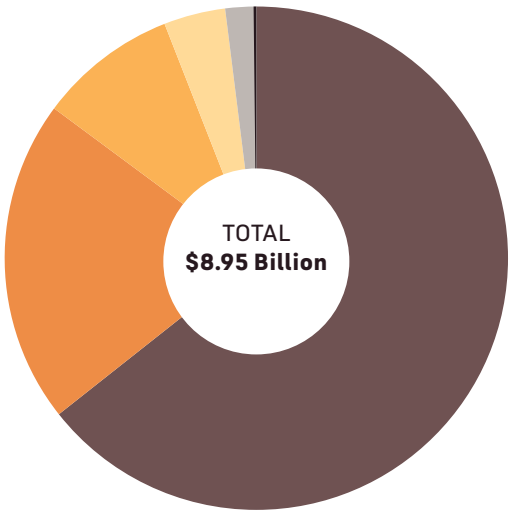
These gaps persist through adulthood. Underserved Latinx older adults, for example, report influenza vaccination rates of just 45%—despite 85% receiving provider recommendations, highlighting cost, coverage, and trust barriers.[35] Lower vaccine uptake in these communities leads to higher rates of hospitalization and severe outcomes for vaccine-preventable illnesses from childhood through elder years.

ECONOMIC COSTS

When vaccination coverage declines, the financial toll skyrockets—from increased hospitalizations and long-term care to lost income due to illness. A 2014 CDC estimate showed that *every dollar* spent on the MMR vaccine saves about $13.50 in combined direct and indirect costs, including avoided hospitalizations and outbreak control expenditures.[36] Moreover, routine childhood immunizations for individuals born between 1994 and 2023 are projected to avert $780 billion in direct healthcare costs and $2.9 trillion in societal costs, netting a positive return of approximately $2.7 trillion.[37]

Adult vaccine-preventable diseases (such as influenza, pneumococcal disease, shingles, and pertussis) also impose steep economic burdens. One study estimated that for adults aged 50 and older, these illnesses cost $26.5 billion annually, with more than half of that attributed to older adults—and influenza being the main driver of both case numbers and costs.[38] A separate Health Affairs analysis placed the overall cost of vaccine-preventable diseases in U.S. adults at around $9 billion per year, approximately 80% of which stems from unvaccinated individuals.[39]

These financial burdens disproportionately affect marginalized communities already suffering from systemic inequities. Even minor illnesses can trigger a cascade of costs—medical bills, missed work, and long-term care—that push low-income families toward economic crisis. When vaccine access erodes, it doesn't just perpetuate existing disparities—it compounds them.



Influenza	**$5.79 Billion**
Pneumococcal disease	**$1.86 Billion**
Herpes zoster	**$782 Million**
HPV	**$333 Million**
Hepatitis B	**$173 Million**
Other	**$12 Million**

Source: *Exhibit 3: Annual economic burden of vaccine-preventable diseases, by pathogen, 2015.* Ozawa, S., & Stack, M. L. (2016). Public trust and vaccine acceptance: International perspectives. *Health Affairs*, 35(11), 1994–2001. https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0462

DISEMPOWERMENT

Withholding vaccine access through underfunding and neglect represents a form of passive healthcare deprivation, signaling that the health of marginalized communities is not a societal priority. A vaccine equity framework produced during the COVID 19 response emphasized that true equity requires more than awareness — it demands sustained investment in infrastructure such as mobile clinics, trusted messenger networks, and community health workers (CHWs) embedded in underserved populations.[40]

Community health workers are widely recognized by the World Health Organization as essential to reducing health inequities. Evidence from both low- and middle-income countries and underserved U.S. communities shows that CHWs improve vaccination uptake, bridge cultural and language barriers, and enhance trust in health systems.[41] Similarly, mobile vaccine clinics and bus campaigns in US cities have significantly increased vaccination rates among Black and Latino populations—especially in neighborhoods with low healthcare access.[42]

Thus, patient empowerment is not achieved through education alone. Providing culturally resonant messages without the physical infrastructure to reach underserved groups fails to translate intention into action. Investing in community-based delivery systems ensures that vaccine awareness can materialize into equitable health outcomes.[43]

A Path Forward: Investing in Solutions

Reversing harmful trends in vaccination requires more than short-term fixes—it demands targeted, sustained investment. By restoring funding, empowering trusted messengers, and building community-led infrastructure, we can transform vaccine access from a fragmented response into a durable, equitable system.

RESTORE & PROTECT VACCINE FUNDING

The foundation of any effective vaccination strategy is stable and adequate funding.

- **Reinstate cuts to CDC immunization programs.** Reversing recent funding reductions to the CDC's immunization program is critical to maintaining vaccine access, especially in rural and underserved regions where public health departments operate with limited resources.

- **Establish federal and state emergency funds for community-based vaccination infrastructure.** Dedicated funds should be created to support rapid response during outbreaks and sustain long-term infrastructure, including mobile vaccine units, cold-chain storage, and staffing for local immunization clinics.

ENGAGE TRUSTED MESSENGERS

Building confidence in vaccines requires culturally competent outreach led by people who are trusted in their communities.

- **Restore the ACIP's previous vetted members.** The Advisory Committee on Immunization Practices (ACIP) must remain a science-driven body with members selected for expertise, independence, and trustworthiness to preserve public confidence.

- **Fund Community Health Workers (CHWs) as vaccine advocates.** CHWs are uniquely positioned to connect with hard-to-reach populations. Federal and state support for CHW programs would allow for training and sustainable employment to advance vaccine outreach.

- **Support bilingual, culturally attuned education campaigns.** Tailored messaging in multiple languages and formats should be deployed through local radio, community centers, and schools to ensure vaccine information reaches all populations, including immigrant and low-literacy communities.

BUILD COMMUNITY-LED INFRASTRUCTURE

Local voices must be central to vaccine delivery strategies.

- **Create vaccine equity task forces in underserved counties.** These task forces should include public health officials, community-based organizations, educators, and faith leaders to identify barriers and co-design solutions.
- **Empower local nonprofits through microgrants and partnerships with public health departments.** Microgrants can strengthen grassroots capacity, enabling small organizations to conduct outreach events, organize mobile vaccination clinics, and address logistical barriers.

LEVERAGE TECHNOLOGY RESPONSIBLY

Technology can both spread misinformation and solve it—policy must harness it strategically.

- **Counter misinformation on social media through influencer partnerships.** Public health agencies should collaborate with trusted local influencers and community leaders to share accurate, accessible vaccine information on platforms where misinformation is most prevalent.
- **Use data analytics to identify and target vaccine deserts.** Advanced mapping tools should be used to locate areas of low vaccine access and deploy mobile units, pop-up clinics, and CHWs accordingly, ensuring no community is left behind.

Conclusion: This Is Our Moment

The evidence is clear: vaccine access is not just a public health priority—it is a moral, economic, and societal imperative. Failing to act now would mean accepting preventable illness, deepening inequity, and unnecessary costs that weaken families and communities alike.

To policymakers: Fund prevention, not just crisis response.
Sustainable investment in vaccination infrastructure is far more effective and cost-efficient than responding to outbreaks after they occur.

To public health leaders: Include communities in the solution.
True progress will come from empowering local leaders, funding trusted messengers, and building vaccine access strategies rooted in cultural and regional realities.

To advocates: Keep empowerment at the center of your work.
Awareness alone is not enough. Turning knowledge into action requires the consistent, long-term investment in the tools and resources that allow every family to access life-saving vaccines.

This is our moment to shift from reaction to prevention, from neglect to empowerment, and from fragmented efforts to lasting solutions.

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