Vaccine Inequalities – underrepresented communities' framework

1. Purpose:

The purpose of the framework is to provide a robust and consistent basis for all partner organisations to approach how to improve uptake of the COVID-19 vaccination amongst underrepresented communities.

The framework adopted is one based on national research and guidance involving scientific evidence, ethics and deliverability, with a focus on the ethical principles of maximizing benefit and minimizing harm, promoting transparency and fairness, and mitigating inequalities in health in relation to underrepresented groups.

The core principles contained within the framework are to maximise benefit of the vaccination programme and reduce harm to others, being fair and transparent, and addressing health inequalities within underrepresented communities.

Further details can be found on the Government's website here.

2. Barriers to success:

- **Data** is limited on ethnicity as currently using the 2011 census data and is only available at a high level. Incomplete or inaccurate data and the need for complex data linkages or validation steps to identify and contact eligible people increase the likelihood of increasing existing inequalities, reducing public confidence, and slowing the pace of vaccine roll out.
- **Vaccine hesitancy** and confidence in vaccine efficacy and safety (given low trust experiences among minority ethnic groups, with lessons learned from historical examples, such as the side effects from previous fast-tracked vaccines such as Pandemrix during H1N1). Trust is particularly important for Black communities that have low trust in healthcare organisations and research findings due to historical issues of unethical healthcare research (Gamble, 1997). Trust is also undermined by structural and institutional racism and discrimination. Minority ethnic groups have historically been a under-represented within health research, including vaccines trials, which can influence trust in a particular vaccine being perceived as appropriate and safe, and concerns that immunisation research is not ethnically heterogenous (Forster et al., 2016). Distrust is linked to the spread of misinformation about the COVID-19 vaccine (Mills et al., 2020), and linked to the speed of the vaccine approval process for the COVID-19 vaccine (City of London LCFVSF Sub-Group 2020).
- **Lower perception of risk;**
- **Inconvenience and access barriers** (including location of vaccine delivery, relative cost, time and distance to access vaccine)

3. Interventions to increase vaccine uptake in minority ethnic communities:

Broad 'catch-all' type interventions that are not designed to meet the specific needs of a community may not be as effective for some groups and may exacerbate health inequalities (Lott et al., 2020).

A rapid review of interventions to promote vaccine uptake in minority ethnic groups indicates tailored interventions targeting minority ethnic groups can increase vaccine uptake using the following mechanisms and strategies:

- **Trust and confidence** can be improved through trusted general practitioners and community health centres recommending and offering vaccines. Therefore, it is important to understand vaccine uptake among healthcare workers from minority ethnic communities and to develop interventions that target concerns in this group. Including community leaders and community champions as partners and having visible representation at all levels can increase confidence in health systems where trust is low.
    - Community engagement can identify strategies to make the vaccine more accessible, including in settings outside of formal health service provision, and increases trust between formal organisations and community members. This requires involving community leaders as partners to promote local buy-in and develop community plans.
    - Clear information should be provided on potential vaccine side effects. Approaches should acknowledge the historical issues in healthcare research to address mistrust towards government and healthcare services experienced in Black communities in relation to vaccination. At all times the vaccine should be dis-associated from political figures.

- **Perceptions of risk for COVID-19, and perceived need of vaccination** can be addressed through a range of educational resources to increase awareness of risk, efficacy of vaccine and tackle disinformation.
    - Using educational videos in multiple languages can increase awareness (Hoppe and Eckert, 2011) leaflets which address misperceptions (Greenfield et al., 2015) and narrative films using characters that the target community can identify with to increase perceived severity of the virus and the perceived response efficacy of the vaccine, i.e. belief that getting the vaccine would reduce risk (Frank et al., 2015).

- **Access and convenience** will vary for different communities and engagement work is required to identify the appropriate settings and local barriers to accessing the vaccine. The workplace (for example for healthcare workers from minority ethnic groups), community centres and religious venues may be important settings for facilitating uptake. Practical support is important to ensure no financial disadvantage is incurred, e.g. loss of earnings due to travel or waiting time to obtain vaccine, transportation costs etc.
    - Providing immunisations in community-based settings, religious and community sites including their own general practice, outside of formal health service provision including workplace settings can improve access. This enables reach into communities that distrust government and medical professions, or were not registered with local services; it includes places of worship (Peterson et al., 2019) school-based programmes, community-based organisations, and door-to-door efforts (Hutchins et al., 2009; Rani et al., 2020).
    - Support with physical barriers such as booking appointments and transportation can improve uptake (Hoppe et al., 2011).
    - Prompts and reminders in the form of letters and text messages (Lott et al., 2020), and the perception of support from family and friends (Frew et al., 2014) can improve vaccine uptake.

- **Culturally tailored communication**, shared by trusted sources is vital for minority communities. The SPI-B and Ethnicity sub-group reports on how to develop tailored communication provide further details on how to achieve this. Health messages need to be co-designed and conveyed to individuals within family and community networks that influence health behaviours within families. This will vary between different communities, with e.g. in some places parents, others grandparents, men versus women having more say. Communication by HCWs, Community and Faith Leaders and Community Champions is essential to increase trust and confidence in the vaccination programme. It will also be important to communicate the importance of the two doses of the vaccination programme.
    - Training for healthcare staff (Hoppe et al., 2011) which includes strategies for culturally tailored conversations to address vaccine beliefs, recognising their distinctive role as the most trusted source of health information among many minority ethnic groups and the value of their making vaccine recommendations for improving uptake (Frew et al., 2014; Greenfield et al., 2015). Training for faith leaders to increase their understanding of vaccine research (Alio et al., 2014).

See table below for examples of interventions to increase vaccine uptake in minority ethnic communities.

Intervention	**Aims**	**Group**	**Strategies**
Tailored communication	Increase vaccine beliefs of safety and efficacy including concerns about "rushed approval" and importance of the two doses of the vaccination Address religious and concerns	Community members Trusted sources including healthcare providers from within the community and Community Champions Local authority	Culturally relevant Accessible (analogue, paper and digital) Specific Multiple languages Different types of media Co-designed Target disinformation / myth-busting Manage expectations Trusted and authentic sources Share evidence of successful vaccination campaigns in

			minority ethnic groups
Access	Provide equitable access to vaccine	Community groups Local authority NHS	Flexible vaccine delivery model with multiple settings including • community hubs • GP surgery • occupation • outreach Transportation Vaccine is free
Community Engagement	Increase trust Identify barriers and facilitators Enhance understanding of the uncertainty of COVID-19 vaccinations	Community members Community groups Community champions Youth ambassadors Faith leaders Local authority NHS particularly primary care Health and social care workers MHRA as independent regulator	On-going, open, transparent dialogue with community members Develop locally owned action plans
Training and Education	Develop strategies for tailoring conversations to address vaccine beliefs Recognise the importance of their role as a trusted source of health information	Healthcare workers - all HCWs plus targeted approach for HCWs within ethnic communities Community leaders Community champions Faith Leaders	Videos Presentations Materials that highlight evidence of successful vaccination campaigns in minority ethnic groups Communication skills training

4. Recommendations

On-going community engagement is essential as health messages and vaccine distribution strategies must be sensitive to local communities. Interventions should include ongoing open dialogue with communities to reassure people about the safety and efficacy of COVID-19 vaccines. It will be important to involve Community Champions to facilitate community engagement and specific decision makers within families should be identified for particular social groups.

Community forums should include engagement with trusted sources such as healthcare workers, in particular GPs, and scientists from within the target community to respond to concerns about vaccine safety and efficacy. This may increase confidence, trust, knowledge, acceptability, and uptake in minority ethnic groups. Approaches should acknowledge the historical issues in healthcare research to address mistrust towards government and healthcare services experienced in Black communities in relation to vaccination.

Credible sources from within target communities should be visible at all levels, including grassroots organisations, healthcare services and policy teams, as authentic representation at each of these levels is likely to increase trust and facilitate a cohesive national and local strategy.

Tailored communication shared by trusted sources can increase perceptions of risk for COVID-19 and perceived need of vaccination. Communication by healthcare workers, community and faith leaders, and community champions is essential to increase trust and confidence in the vaccination programme.

Information about vaccines should be available in various languages in both written and visual/video recorded formats to enable people from all ethnic backgrounds to make fully informed choices. See the SPI-B and Ethnicity group reports (SPI-B, 2020; SAGE ethnicity sub-group, 2020) for further details on how to develop tailored communication.

A consistent evidence-based approach to messaging about all aspects of vaccines, aligned across organisations will be important for public confidence, including for minority ethnic groups.

Governance systems should be established and used to ensure that all organisations delivering messages to the public on the vaccination programme are consistent and do not share mixed or conflicting messages.

Consideration of the "whole communication journey" for vaccine rollout, from current implementation to highest risk groups, to the potential need for repeat vaccination, is important for confidence among minority ethnic groups – including to ensure practice of broader COVID-19 measures and protective behaviours (see linked SPI-B paper on vaccines and NPIs) between and after vaccinations.

Messaging should be continuously reviewed, aligned and amended as new evidence and practical details emerge.

Avoid stigmatisation if there is lower initial uptake in some communities as stigma and shame are linked to negative mental health outcomes, and create lower likelihood of engagement with health services. Avoid unintended consequences of stigma and discrimination (similar to that experienced by certain communities in earlier stages of the pandemic) if segments of minority ethnic communities (e.g. older adults) are prioritised or by focusing on barriers specific to one community, e.g. issue of halal/kosher, the latter relates to the broader issue of disinformation experienced by many faith groups.

Practical support to address physical barriers such as transportation and ensuring no financial disadvantage such as loss of earnings due to travel or waiting time to obtain vaccine. Convenience will vary for different communities and engagement work is required to identify the appropriate settings and local barriers to accessing the vaccine. The workplace (for example for healthcare workers from minority ethnic groups), community centres and religious venues may be important settings for facilitating uptake.

Local delivery of vaccination, particularly within primary care, should be prioritised. The NHS should work collaboratively with local authorities who can help to identify the approaches and locations for vaccination based on local knowledge, community trust and ability to reach individuals who may not be registered locally within primary care.

Place-based priorities could be considered for the delivery of vaccines in the second phase (such as in trusted community settings and occupation-based settings, to reach groups who may not be registered within primary care).

Training is required for all healthcare staff, community leaders and community champions to recognise the importance of their role as a trusted source of health information for minority ethnic groups. Training which includes strategies to initiate discussions about vaccinations and how to tailor conversations to address vaccine beliefs is likely to result in more meaningful dialogue.

Interventions that address vaccine hesitancy in healthcare workers from minority ethnic groups is particularly important as they are influential credible sources that some community members are more responsive to than other healthcare workers.

Monitoring and evaluation will provide openness and transparency through regular reporting of progress on the vaccination offer, uptake and coverage by time, place and person (including by minority ethnic group) and will help to build confidence in the fairness of offer – as will updates on the actions being taken to address inequalities in access or uptake that are identified.

Monitoring by ethnic group and by use of local data sources can inform plans for later stages of delivery of the vaccination programme as it develops, including at the local level to support locally sensitive approaches to access, delivery, communication and engagement.

Evaluation of interventions to reduce vaccine hesitancy and/or improve uptake is essential to identify strategies that work well and can be scaled up and strategies that are less effective to understand components of the vaccination programme that need to be improved.

Figure 1: socioecological model of factors influencing inequality in vaccination (from immunisation audit) and potential actions to mitigate inequalities in planning and implementation (red)