

Vaccination: race and religion/belief



Headlines

1. **Vaccine hesitancy is highest for Black people, followed by Bangladeshi/Pakistani people.**
2. **National communications campaigns have not prepared the ground for vaccine hesitancy among ethnic minorities, although there is ample historical evidence to suggest these groups are resistant to other vaccination programmes, including seasonal flu vaccination.**
3. **Meetings between South East EDI Team, BME Networks and representatives working in providers and ICS/STP suggest that there is an urgent need to address this hesitancy, which includes changing the narrative to one that is about the safety of communities with technical information on data supplementing this.**
4. **So far, the spread of misinformation (as reported by national monitoring groups) has dramatically outpaced efforts at rebuttal.**
5. **If vaccine uptake remains low in poorer, and more ethnically diverse neighbourhoods, this could pose a public health risk.**
6. **Although there have been studies on the efficacy of programmes to address vaccine hesitancy among minority ethnic groups, these are rare, and therefore, a multi-pronged approach is recommended.**
7. **According to global studies barriers to vaccine uptake include perception of risk, low confidence in the vaccine, distrust, access barriers, inconvenience, socio-demographic context and lack of endorsement, lack of vaccine offer or lack of communication from trusted providers and community leaders. These issues have been reported from the South East.**

1. Introduction

The launch of new vaccines has historically been met by resistance, scepticism, fear and confusion. This has been recorded for lengthy period. A pattern that has always been prevalent is the higher levels of this resistance and fear from some sections of the population, particularly those in poorer income groups and those who are of the following ethnicities – Black, Asian, Eastern European and other minority ethnic groups and religious groups that have been marginalized.

A common term used to describe this phenomenon is 'vaccine hesitancy' - a delay in acceptance or refusal of vaccination despite availability of vaccination services. This phenomenon has contributed to the UK losing its measles-free status in 2019, although the driver here was largely the circulation of inaccurate data across social media platforms and blogs and the increased cultural traction of anti-vaxxer groups.

In terms of ethnicity, it has been theorised that vaccine hesitancy is primarily driven by a lack of trust in the medical profession due to historical discrimination, racist ideology and immoral experimentation on people of colour. History is replete with examples of this. Most recently, in October 2020 several White European doctors made the unfortunate recommendation that vaccines could be trialed on African populations as they were less likely to be social distancing, wearing masks or observing other COVID-19 safety measures. This led to several vaccine development centres in Africa being damaged and attacked. The head of the World Health Organisation (WHO) made a statement condemning the viewpoints of the doctors and reassured African nations that Africa would not be a testing ground for vaccines.

There has also been documented resistance to other vaccination programmes such as polio (Nigeria in the late 1980s), currently Tanzania is resisting the COVID-19 programme and this is led by senior government figures. This has an impact on populations of African origin around the world. Feedback from Sussex providers in early February highlighted this issue of concern and fear among Black and Caribbean population groups including those who are healthcare workers. This has substantial implications. For example, according to ONS figures up to late July in England and Wales, the COVID-19 death rate for Black African men was 62 per 100,000 compared with 12 per 100,000 for White men. The rate for Bangladeshi men was 61 per 100,000. Black African women had the highest under-65 death rate of any ethnic group, with 27 deaths per 100,000, compared with seven per 100,000 White women. The rate for Pakistani women was also more than three times as high as the rate for White women, with 26 deaths per 100,000.

In the UK, doctors (for example, the Director of Primary Care GP Nikita Kanani) and scientists have stated that vaccination uptake will need to reach 80% in each local area for the benefits to be felt. This puts neighbourhoods and communities with lower vaccine uptake at risk, not just of more serious COVID-19 illness, but of increasing pre-existing health and socio-economic inequalities. Analysis by the Office for National Statistics of deaths in England has found that those living in the most deprived areas are 2.5 times more likely to die from COVID-19 - further underlining the imperative of achieving high uptake in these groups.

2. What is the current situation, 8 weeks into the programme?

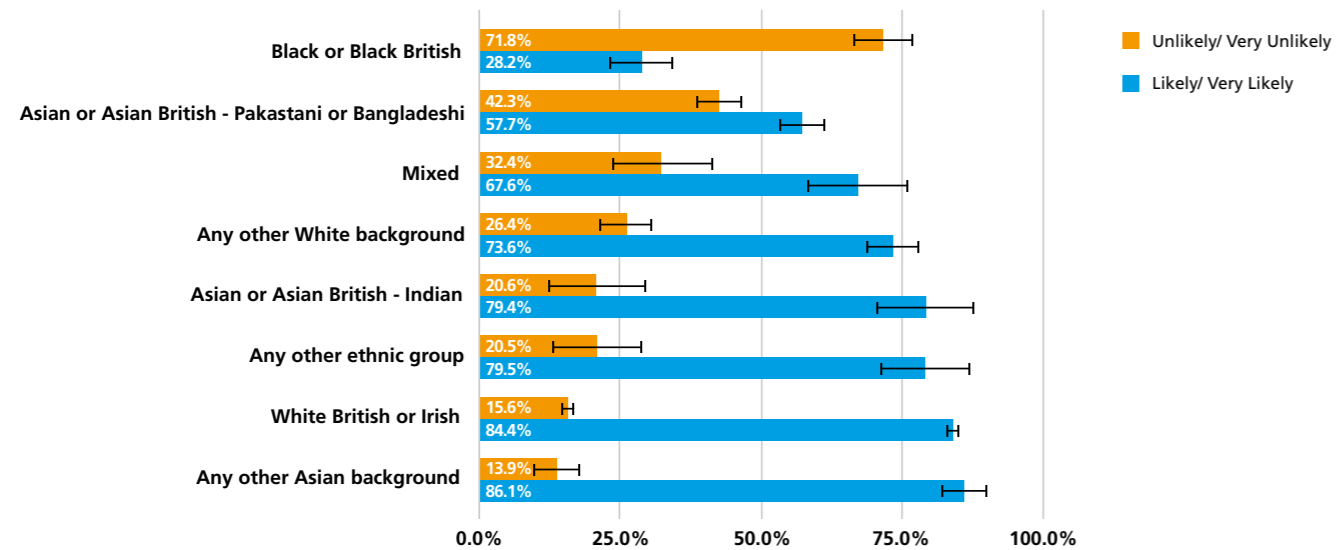
The Government has agreed to collect data on vaccination uptake by ethnicity, giving policy makers and strategists more granular data to develop targeted messaging and communications. It will also serve to highlight the fact that most major vaccination centres need to have wider representation by ethnicity.

Anecdotal evidence from local Directors of Public Health show that a significant proportion of people are declining the offer of a vaccine and there is variation in vaccination rates, notably in areas that are ethnically diverse. This is especially the case in cities such as London. Reports of the circulation of false news and misinformation continue. There is still considerable public confusion about the contents of the vaccine, how it has been developed, how it has been tested and how it works on the human body.

The onus is on local authorities to lead the outreach programme and national communications has not kept a pace with preparing the public for the vaccination roll out. Not all local authorities have culturally competent communications and outreach programmes, largely due to the lack of diversity and low opportunity for community engagement.

Primary care data analysed by QResearch on behalf of the Government indicates that, for several vaccines, Black African and Black Caribbean groups are less likely to be vaccinated (50%) compared to White groups (70%). Furthermore, for new vaccines (post-2013), adults in minority ethnic groups were less likely to have received the vaccine compared to those in White groups (by 10-20%). Recent representative survey data from the UK Household Longitudinal study shows overall high levels of willingness (82%) to take up the COVID-19 vaccine. However, marked differences exist by ethnicity, with Black ethnic groups the most likely to be COVID-19 vaccine hesitant followed by the Pakistani/Bangladeshi group. Other White ethnic groups (which includes Eastern European communities) also had higher levels of COVID-19 vaccine hesitancy than White UK/White Irish ethnicity.

Figure 1. Willingness to be vaccinated in the UK Household Longitudinal Study by ethnic group



3. What about healthcare workers?

Healthcare workers are a trusted source of health information for minority ethnic groups. Therefore, it is important to reduce vaccine hesitancy in this cohort. Vaccine hesitancy and uptake varies among Health Care Workers (HCWs), largely by occupation and regionally by NHS trust. Support staff have the lowest reported levels of uptake, which was as low as 37% in the case of H1N1. And 26.5% of NHS trusts did not reach 70% coverage for seasonal influenza among HCWs in 2019-2020, suggesting that targeted support could be beneficial. The strongest predictor of H1N1 vaccination among HCWs was having had previous vaccination for seasonal influenza. Ethnic minorities comprise a higher percentage of NHS workers compared to the working age population, suggesting that prioritisation of HCWs for vaccination will also provide higher coverage in Asian, Black, Mixed, Chinese and other ethnic groups.

4. Summary of recommendations from national advisors (including SAGE) and policy think tanks

1. Transparency and granularity of data – publish weekly including vaccination based on ethnicity, sex, precise age, and whether the vaccine was accepted or declined.
2. Regular monitoring and evaluation of interventions - publish ongoing, monthly assessments of the impact of interventions to tackle vaccine hesitancy.
3. Dedicated ethnic minorities communications strategy – concerted, monitored and audited effort to reach these communities, with additional resource from a national level directed towards a digital and conventional media campaign that brings trusted ethnic minority voices to national platforms. The communications strategy should adopt the principles of a general election campaign with sophisticated targeting of particular groups dependent on data held in the uptake.

4. Re-assess the current cohort prioritization - consider making changes to its recommendations to reflect new data regarding higher mortality risk. This should be cross-referenced with the data on refusal rates once made available.
5. Studies indicated that community outreach strategies should be based on the need and reasons for vaccine hesitancy for the targeted population. A multidimensional approach involving community members, families, and individuals is required to address this challenging issue.
6. Messaging on vaccination from political and religious leaders also imparted a positive impact on vaccination uptake.
7. Ensure to avoid stigmatizing those who are vaccine hesitant. This strategy is likely to push Black and Minority Ethnic communities even further from the locus of trust for medical professionals. It is also a strategy that ignores the population of anti-vaxxers who are predominantly White.

While it is difficult to predict the superiority of any intervention over the other, monitoring and audit of current strategies should be a priority to better use resources to target populations and demographic groups

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