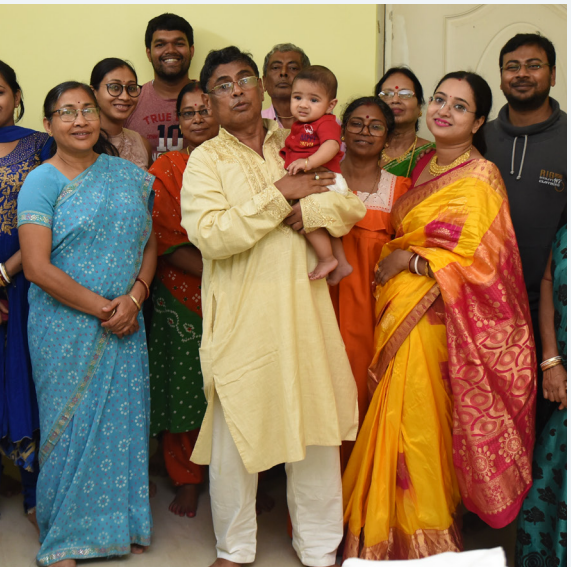
COLLABORATION FOR CHANGE

How does trust in organisations impact COVID-19 vaccine uptake in ethnic minority communities?



This document summarises discussions with community organisations about the level of trust in pharmaceutical companies, government and other bodies, how this impacts vaccination uptake in ethnic minority communities, and the evidence that supported the decisions made.

To read the full summary, visit www.collaborationforchange.co.uk

Evidence to decision framework - health system and public health

How important is trust in organisations as a factor affecting COVID-19 vaccine uptake by ethnic minority groups?

Problem: Uptake of the COVID-19 vaccines is lower in some ethnic minority groups
Factor influencing uptake: *Trust in organisations*
Main outcomes: Vaccine uptake
Setting: UK
Perspective: Population

Background: Although uptake of the COVID-19 vaccines in the UK is generally high, uptake is lower among some ethnic minority groups.[1, 2] For example, by 27/7/2021, 90% of White 50-54 year olds had been vaccinated, compared to, for example, 59% of those of Caribbean heritage, 70% of those of African heritage or 87% of those of Indian or British Indian heritage.[1] These differences persist across age groups, although the size of the difference varies. There is continuing debate about the factors that affect vaccine uptake (not just for COVID-19) among all ethnic groups, including ethnic minority groups.

	CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	COMMENTS
PROBLEM	**Is the factor a important?**	*Don't know* ☐ *Varies* ☐ | *No* ☐ *Probably no* ☐ *Probably yes* ☐ *Yes* ☒ ***Detailed judgements (see 'COMMENTS')***	• In a UK study done in 2020/21, 23 community leaders talking about the COVID-19 vaccines raised widespread distrust of government and the NHS as a problem, though it is more entrenched in some communities than others. Past policy ('hostile environment') contributed to this "[In the] Turkish speaking community, they have seen people die in hospital but not at home, so there is no trust in the NHS." [[#grey24; Focus groups; study quality high].[3] • A US study done between 2012 and 2014 with 119 adults, with a range of different ethnic groups talking about flu vaccination found trust in pharma to be low with almost all participants expressing concern that pharma favoured profits over the needs of the public. "These people, it's a business. They don't make money curing you. They make money selling you drugs. They're drug dealers" (African American). In some cases concerns about profits were larger than concerns about the vaccine. Trust in government varied with White people trusting institutions but questioning competency while African Americans were less trusting and questioned government motives "I have major trust issues with my government across the board…a lot of people are trust motivated. If you don't have my trust then I'm not going to pay you much mind no matter what you say" (African American). There was a suggestion that trust may be greater in younger people "However, most of us, I'm glad to say, or it seems, have loosened that mistrust. I trust people…I trust you, but I got to verify it." (African American). History was mentioned by African Americans as a reason to have less trust, pointing to racism and discrimination to justify these fears. [#258; Focus groups and interviews; study quality high].[4] • A UK study reported in 2019 that discussed a range of vaccinations with 20 Polish and	1. Personal experience is important: it can support or reduce trust, depending on whether it is good or bad. A central feature of trust re. vaccination is the consistent pattern of inequalty experienced by minority groups prior to Covid-19 (women in childbirth, cancer care etc). Improvement has been talked about for a long time but not addressed so why trust an organisation now? They did not deal with our previous concerns. 2. The 'hostile environment' rhetoric in the UK is an important influencer of trust regarding a person's position in society. This is not just about vaccines and NHS but e.g. Windrush scandal, Grenfell Tower fire. These set the tone for minority ethnic voices not being heard or believed. The growing far right movement and how this has been handled contributes to the mistrust. 3. Historical background inportant (e.g. British colonial background) and some mistrust (e.g. anti-vax movement) is deep-

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		10 Romanian community members and 20 health care workers found that community members raised trust in health authorities, pharma industry and healthcare workers as important. Some were sceptical of health care in England, leading to seeking care in Poland and Romania, or looking for Polish doctors in UK "I have more confidence in the doctor in Poland. Doctors in Poland are trained doctors. They study medicine for several years….Here, I have the impression that a doctor….they have everything on the computer. He's typing in a computer that you come, have a cold, a fever, and [it] jumps out [from the computer], what he has to give me." [#761; Interviews; study quality high].(5) • A US study reported in 2016 involving over 100 people (White and Black) talking about the flu vaccines also found distrust in the organisations that produce the vaccines and government particularly from African Americans "You don't trust a government vaccine" or "don't trust the government for nothing" [African American, Female] "Well, it means I trust that the vaccine is going to be effective, I trust that nothing dangerous is being given to me, and I trust the sources of the vaccine, meaning, I mean that's a lot of trust, but I'm trusting the makers of the vaccine, I'm trusting my doctor who recommends it, and I'm trusting the U.S. government who promotes it and subsidizes it to some extent. So it is a lot of trust. And I think if any of those factors were not in place, I would probably have some doubts about the vaccine and may or may not take it, so trust is key." [African American, Male] [#336; Focus groups and interviews; study quality high].(6) • A US study done in 2020 with 24 participants talking about COVID-19 vaccines found much the same as study [6], with considerable distrust of the medical establishment, scientific communication and pharma based on history and past unethical practice "I am already against it. I am paranoid, I keep getting, when I hear that Tuskegee experiment. But I stay away from that. I wouldn't get a vaccine." [#18; Focus groups' study quality high].(7) • A UK study done in late 2019 with 17 healthcare staff and 8 senior management of mixed ethnicity talking about COVID-19 vaccines, some minority ethnic staff raised distrust "BME staff have been less likely to opt into receiving the vaccine […] I think there's something around how…If you look at things historically, Black and Asian communities have been misused in research […] we have been abused and violated in previous vaccination trials and we can't deny that" [Asian] [#stgy372; Interviews; study quality high].(8) • A UK study done in 2013-2015 of 174 travellers (mainly Romanian Roma and Irish) talking about many vaccines, including in pregnancy and older people found that a small number of female participants reported feeling marginalised from health services but others reported being treated more kindly in Scotland than in Slovakia "normally like the others" [#469; Focus groups and interviews; study quality high].(9) • A US study done in 2020 with 101 Black Americans living with HIV discussing COVID-19 vaccines found considerable mistrust with government and healthcare providers	seated. Some believe that African countries have historically been used as guinea pigs for many vaccines and now the same is happening for COVID too. Some of this comes through social media (quite possibly in local languages spoken by those here in the UK). This mistrust is always there and can flare up at any time depending on policy. Ethnic minorities are now being blamed for not cooperating, but this is based on experience of poor behaviour by organisations and governments. 4. Mistrust is this context is entirely justifiable; it is based on past behaviour by organisations. This is not about reprogramming ethnic minority communities but reprogramming organisations. 5. Trust is layered and not based on a single thing. Past experience, government policy, general environment of antagonism creates a pattern. Although not always involving health services, this pattern does then affect attitudes to health care services and vaccines. 6. Not all organisations are the same: there is plenty of trust for some (e.g. a faith organisation) even where there is less trust for others (e.g. pharma industry). We should not tarnish all with same brush. Vaccine uptake may only happen *because* of link with a trusted organisation. We need to be concrete about the organisations that are trusted or not. 7. Some local community organisations have more trust with communities but have not traditionally been well-funded. 8. Who is communicating the message is important. People will trust some minority

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		[#57; Survey; study quality moderate].[10] • Mistrust in government was also reported in a US survey of 178 participants (mainly Mexican and Hispanic) [#979; Survey; study quality low].[11] • A UK 2021 survey of over 1000 ethnic minority people discussing the COVID-19 vaccines also reported mistrust of those advocating taking the vaccine [#grey10; Survey; study quality very low].[12]	media outlets because communities know them. Higher mistrust in more socieconomically disadvantged, e.g recent immigrants. Layered again. 9. Trust varies depending on people's circumstances. There is little trust in people who come from a particular community but no longer have the day-to-day challenges of being from that community. Simply getting a Black politician to say something is not enough for people from that politician's community to trust the message. 10. There is potential for conflation of NHS with government. It is possible that there may be some trust in, say, NHS, but it is seen as government, which then reduces trust. For others, NHS is equated with government and this reduces trust (e.g. asylum seekers, recent immigrants). 11. There may be trust distinctions between local vs national organisations with potentially more distrust of local authority and local services because they have more impact on local lives than central government. The distinction between the two re. trust may not always be that large though. 12. Ethnic minority groups are not homogeneous. Chinese, Indian, African etc – are different and their perceptions may also be different, with uptake varying accordingly. 13. Need better data and info to be local in delivery. There has been an historical lack of engagemennt with ethnic minority communities, not just linked to health inequalities but a general historical neglect of engagement. Need to change structures because it misses diversity and

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				lived experience. 14. US research data interesting but could UK data be broken down more locally?

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BENEFITS & HARMS OF THE FACTOR	**How big are the anticipated benefits?**	*Don't know* ☐ | *Varies* ☒ | *Trivial* ☐ | *Small* ☐ | *Moderate* ☐ | *Large* ☐ **Detailed judgements (see 'COMMENTS')**	• A US survey in 2020 found that greater unwillingness to take a COVID-19 vaccine was linked to general mistrust about government and providers, as well as conspiracy theories and belief about the origin of the virus [#57; Survey; study quality moderate].(10) • Government distrust was a significant predictor of intention to [not] take the flu vaccine in a 2014 study [#979; Survey; study quality low].(11) • A UK 2020 survey of a representative sample of 2076 adults asked about taking the COVID-19 vaccines found that the opinion of GPs, nurses, pharmacists and government were all trusted less by ethnic minority groups. The same groups were more likely to trust social media sources than White individuals [#grey 6; Survey; study quality very low].(13) • A UK 2021 survey of 334 Muslim respondents from a survey of over 1000 ethnic minority people found that mistrust and safety concerns were greater driver of vaccine hesitancy than conspiracy theories [#grey 17; Survey; study quality very low].(14)	1. The size of benefits from tackling problems of trust depends on where we are in timeline, becomes less important as time goes by. Becomes less and less of an issue. In January [2021], say, would be a larger issue than now. 2. Small to moderate impact because of trust in organisations. Perception of impact of taking/not taking the vaccine is also influenced by what is happening outside the UK (e.g. Bangledesh) and this influences views re. trust. Deaths in India will affect uptake by people with India links here in UK. 3. In any kind of engagement, especially if it affects a potentially life and death situation, trust in government, its agencies and organisations is vital. It will do more harm without trust. 4. There has been mixed messaging. Some groups (e.g. pregnant women) told not to take vaccine, but now are advised to. This changing narrative can feed into mistrust. E.g. boosters too, why do I need to go back for another one having just had two jabs? 5. Changes in legislation and conversations
	How big are anticipated harms?	*Don't know* ☐ | *Varies* ☒ | *Large* ☐ | *Moderate* ☐ | *Small* ☐ | *Trivial* ☐ **Detailed judgements (see 'COMMENTS')**		
	How certain are we about the above?	*No included studies* ☐ | *Very low* ☐ | *Low* ☐ | *Moderate* ☐ | *High* ☒		

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				about Vaccines Passports may lower the impact of mistrust on uptake because participation in society becomes constrained without the vaccine. It will influence people even if mistrust remains. 6. Mistrust does not always stop people using a service. People have gone to GPs despite issues around trust that have existed for a long time. The impact that mistrust has might be a bit less. 7. Who is the messenger? Health professionals not always the right messenger for some communities. Getting people from the community as messenger needed because of trust. The choice of messenger will affect the size of benefits of trust/harms of mistrust. [Might also be placed in Factors #3 'Trust in individuals'] 8. Moderate to High benefits/harms overall. The reasons for the possibility of High is because the potential consequence of not having the vaccine could be severe, or fatal. 9. Mistrust may have larger consequences for an individual than for society. An individual's choice to not have the vaccine because of mistrust could lead to that person's death. For society as a whole, the consequence may be more modest. 10. There are people who distrust data, what is source of virus, can't believe it, and for them mistrust will have a high impact on willingness to take the vaccine. 11. Where people have vaccine and get severe reactions, it gets heard about and puts people off. Small numbers of poor harms e.g blood clots can be perceived as having more importance than benefits in general. [Might also be placed in

	CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	COMMENTS
				Factors #4 'Harm vs benefit']. 12. People with, say, diabetes feel more scared because of this comorbidy. [Might also be placed in Factors #4 'Harm vs benefit].
VALUES	**Is there important uncertainty/ variability in how much people value the main outcomes?**	*Important uncertainty or variability* ☐ *Possibly important uncertainty or variability* ☐ *Probably no important uncertainty or variability* ☒ *No important uncertainty or variability* ☐ **Detailed judgements *(see 'COMMENTS')***	**The main outcomes for our work are 1) uptake of the COVID-19 vaccine and 2) avoiding getting COVID-19**. • Uptake of the COVID-19 vaccines remains lower for ethnic minority groups than for the majority White population in the UK, with uptake being more than 20% lower for some ethnic minority individuals depending on ethnicity and age group.(1) • By 15 March 2021, 93.2% of people living in England aged 70 years and over had received at least one dose of a COVID-19 vaccine. While vaccination rates differed across all factors considered apart from sex, the greatest disparities were seen between ethnic and religious groups. The lowest rates were in people of Black African and Black Caribbean ethnic backgrounds, where only 67.2% and 73.9% had received a vaccine. The proportion of individuals self-identifying as Muslim and Buddhist who had received a vaccine was 79.1% and 84.1%, respectively [Cohort, 6,829,643 adults aged ≥70 years].(15) • A UK study done in 2013-2015 of 174 travellers (mainly Romanian Roma and Irish) talking about many vaccines, including in pregnancy and older people, found that most travellers believed that the benefits of immunisation outweighed the risks "the way I look at it, the benefits outweigh it [the risks].." [#469; Focus groups and interviews; study quality high].(9) • A 2020 US study of 396 women from several ethnic groups talking about the COVID-19 vaccines found that non-Latina Black women were significantly less likely to report that they would be vaccinated compared with Non-Latina White women. When differences in beliefs about vaccine safety and efficacy were accounted for, the importance of these differences was reduced [#41; Survey; study quality low].(16)	1. Differentiate between individual and society: is this for me or for wider social response? Not only consequence for me re. getting COVID but also travel, being able to work and social events. Options will be weighed up as to why I need to take this. 2. Ethnic minority people have discrimination about many things and might in some cases just take the vaccine to avoid another reason for discrimination. 3. The proportion who are unwilling has decreased over the last few months, though there are variations. People more willing to take than they were earlier. 4. The narrative around uptake is now shifting to young people, which puts pressure on them. But in the past it was on minority community. We saw that we're getting targeted, must be a reason for it. Complexity around that.

	CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	COMMENTS
BALANCE	**Is the factor a barrier or an enabler?**	*Don't know* ☐ / *Varies* ☐ / *Favours barrier* ☐ / *Probably favours barrier* ☐ / *Does not favour either* ☐ / *Probably favours enabler* ☐ / *Favours enabler* ☒ **Detailed judgements (see 'COMMENTS')**	**See the research presented in the 'Is the factor important'? section.**	1. If trust is present it helps vaccine uptake, people are more likely to take it. Following from discussion earlier, where trust is lacking, then this does impede uptake. Trust can be an enabler (if present) or a barrier (if not present). 2. We are not all scientists and we do not all have the expertsie to really understand the research. In that situation, trust is all we have because we have nothing else on which to base my decision. We need to trust because we are not experts ourselves. All I have is faith in the people who work for organisations: it is the most important factor. 3. Trust is a key enabler of uptake. It has different dimensions, there's trust in government, organisations, or in the vaccine itself, e.g. it's ontents etc. For trust to really work, people need to have trust in all these things.

Conclusions

	We recommend that the factor be consider a barrier	We suggest that the factor be considered a barrier	We suggest that the factor is neither a barrier or an enabler	We suggest that the factor be considered an enabler	We recommend that the factor be considered an enabler
Type of recommendation	☐	☐	☐	☐	☒

Recommendation/decision

Evidence from the UK and the US, plus our own experience, suggests that having trust in the organisations promoting the COVID vaccine is among the most important factors linked to whether people from ethnic minority groups accept the offer of the vaccine. Conversely, not having trust in those organisations makes uptake less likely. There has been a historical neglect of engagement with ethnic minority communities by organisations that promote vaccine uptake. These organisations need to engage with community groups and members, listen to the concerns raised and move to make changes (including to vaccine delivery) as suggested by those communities.

Justification

Mistrust of organisations such as the Government, the NHS and the pharmaceutical industry by ethnic minority groups is based on many years of discrimination, and past failure, by these organisations towards ethnic minorities. There has been a historical neglect of engagement and interest in the views of ethnic minority groups. For many years UK health systems have said that ethnic minority groups have poorer health outcomes, demonstrating that the health system is failing ethnic minorities. But those poorer outcomes have persisted, Why should ethnic minority groups now trust that same health system with regard to COVID-19 vaccines?

In the UK, the 'hostile environment' rhetoric, and scandals such as Windrush and Grenfell Tower set the tone for minority ethnic voices not being heard or believed. This influences belief in health systems and vaccines promoted by organisations that have a history of racial, religious and other discrimination against ethnic minority communities. Some organisations are trusted (e.g. community and faith organisations) and work to improve vaccine uptake should identify and work with these organisations.

Subgroup considerations

The level of trust varies across ethnic groups; 'ethnic minority' does not mean a single homogenous group that shares the same values, beliefs and preferences. The concerns of individual communities need to be listened to and addressed. Differences between ethnic groups include language, culture, faith, education, place of birth, gender etc. There are important nuances that must be recognised and addressed.

Research priorities

1. How best to engage with communities to build trust.
2. Improved approaches to data collection linked to recording ethnicity and identify.
3. More meaningful collaboration with community groups/3rd sector at the start of research planning to support its design and planning, not once funding has been awarded and the research design is fixed.
4. Work to ensure that all health research is explicitly designed with diverse populations in mind (this does not happen on its own, as we have seen for decades). COVID has changed the path of some background illnesses, need to consider how this affects the new path of the pre-existing health condition.
5. Better assessment of the quality of care received by ethnic minority individuals and the health outcomes.

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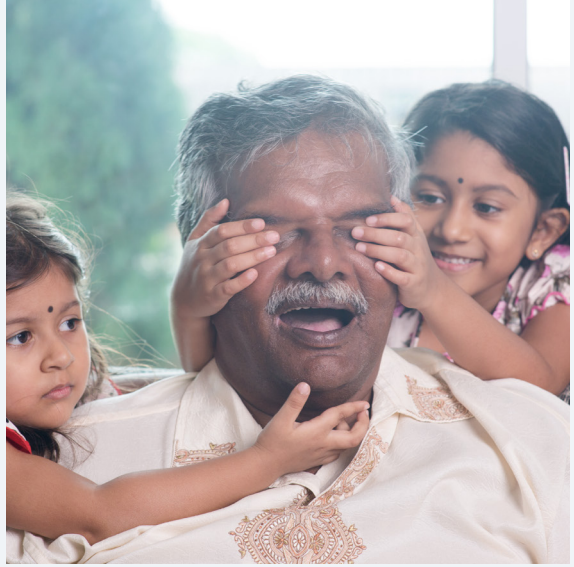
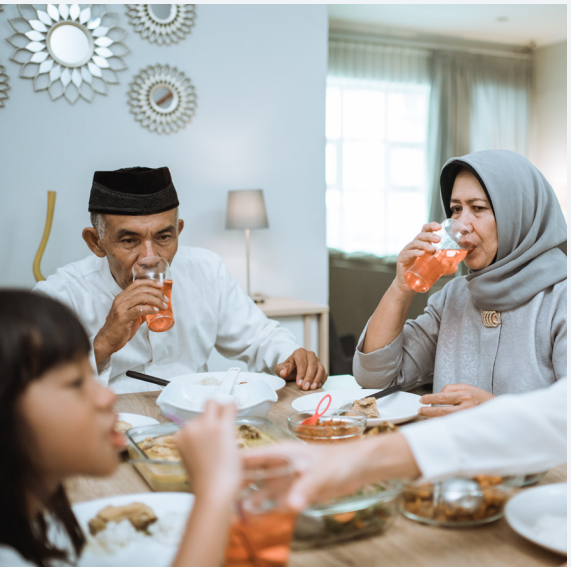


COLLABORATION FOR CHANGE

How does trust in individuals impact COVID-19 vaccine uptake in ethnic minority communities?



This document summarises discussions with community organisations about the importance of having trust in the individuals talking about vaccine uptake, how this impacts vaccination uptake in ethnic minority communities, and the evidence that supported the decisions made.

To read the full summary, visit www.collaborationforchange.co.uk

Evidence to decision framework - health system and public health

How important is trust in individuals as a factor affecting COVID-19 vaccine uptake by ethnic minority groups?

Problem: Uptake of the COVID-19 vaccines is lower in some ethnic minority groups

Factor influencing uptake: *Trust in individuals*

Main outcomes: Vaccine uptake

Setting: UK

Perspective: Population

Background: Although uptake of the COVID-19 vaccines in the UK is generally high, uptake is lower among some ethnic minority groups.[1, 2] For example, by 27/7/2021, 90% of White 50-54 year olds had been vaccinated, compared to, for example, 59% of those of Caribbean heritage, 70% of those of African heritage or 87% of those of Indian or British Indian heritage.[1] These differences persist across age groups, although the size of the difference varies. There is continuing debate about the factors that affect vaccine uptake (not just for COVID-19) among all ethnic groups, including ethnic minority groups.

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PROBLEM	**Is the factor a important?**	*Don't know* ☐ *Varies* ☐ *No* ☐ *Probably no* ☐ *Probably yes* ☐ *Yes* ☒ ***Detailed judgements*** **(see 'COMMENTS')**	• In a UK study done in 2013-2015 with 174 Traveller participants (mainly Romanian Roma and Irish) talking about many vaccines, including in pregnancy and older people, health professionals were identified as the key source of information about vaccines. "well the medical professionals…know what they're talking about rather than somebody that's talking about it on the news, 'cos they could be telling you anything." Travellers across all communities described the importance of relationships with health professionals, in particular GPs and health visitors "It's the same practice so we know the doctors and I really wouldn't want to move myself or my kids from them because they know us as if you're equal, if you know what I mean. [I'm] not just a patient, they know our history and get on with them" Positive encounters with health professionals regarding immunization were described. Travellers interpreted contact by GPs practices to remind families about vaccinations as evidence that they cared. Some negative encounters were mentioned but these were minimal. Family and community were also important, particularly through word-of-mouth, intergenerational relations or female community members. [#469; Focus groups and interviews; study quality high].[3] • A US study done in 2020 with 24 participants talking about COVID-19 vaccines found that a recommendation to take the vaccine from a trusted medical professional was a key facilitator to taking the COVID-19 vaccine. Most participants said there would be extremely low vaccine uptake among individuals in their social networks and recommendations to take if from famous individuals in the Black community would not persuade them to take it "I don't care who advocates for it, I mean at the end of the day, if they got to shoot the actual virus into your body to cure your body, that's - that will make no sense…" [#18; Focus groups' study quality high].[4] • A 2018/19 US study of 1666 pregnant women from under-served populations and linked to influenza vaccines found that women who were race discordant to their provider were	1. In Suffolk, community groups worked with GPs from different communities to front messaging about the vaccine. This allowed a conversation, 'I look like you, but I'm also a doctor. I know a bit more about the vaccine than many, and I've taken it. I wouldn't take it and suggest you do if I wasn't confident about it.' Being from the same background added weight to the message and people did trust those individuals from the same background. 2. Non-health individuals who are trusted also have a role, e.g. faith leaders, community leaders. If these work with the health system in, e.g. videos, where they look at the vaccine from e.g. a religious perspective this gives a different, trusted view. Use trust in health system but also use trust in individuals from communities [and recognise that some concerns about the vaccine are not health-related per se]. 3. Non-judgement is key. Being non-judgemental builds trust, we want to support discussions, talk about evidence and recommendations but listen to

CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	COMMENTS
		more likely to be vaccinated. Study authors noted that the 'association was weak and may reflect statistical and not clinical significance'. [#135; Survey; study quality high].(5)	concerns (and share your own with people). The message should not be 'Just take the vaccine.' 'You must' is unhelpful because it harms trust. 4. Trust need an individual to be clear about what makes them say what they say. There is a possiblity that it might look like a betrayal if a person with the same background as you starts advocating a particular behaviour without being clear as to why they are advocating it. People might worry that perhaps the person is being paid for this, undermining trust. If what you are saying is true, why are you saying it? If you want to encourage e.g. pregnant women to take the vaccine, show us pregnant women like us talking about the vaccine, why they think it is ok to take it. Not someone else, or only someone else, saying it's fine for pregnant women to take vaccine. We want to hear their own voices. 5. Sometimes we are challenged: have you been vaccinated yourself? To help justify promotion of the vaccine, you need to be vaccinated yourself to have trust. Can show it hasn't negatively affected me, it is safe etc. People want to know the motivations for promoting. 6. These conversations take time. People like honesty around uncertainties that you yourself had, hearing you talk about it, can make people feel more reassured. But takes time. 7. There is also time in the sense of let's see what happens to you first. We'll wait to see what happens to those who have had the vaccine before we have it. [Might also be placed in Factors #4 'Harm vs Benefit'] 8. Some healthcare professionals also had

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				hesitancy, which doesn't support community uptake. There are challenges among younger generation, and fears about impact on fertility for women; these have been regular topics of conversation in Leicester. Some people who had the AstraZeneca vaccine have had health events later (e.g. stroke) and have linked these to the vaccine, need to counter this. 9. The type of language used (e.g. very scientific, very articulate) is important. E.g. imams etc, speak a more articulated language, but often there is more impact with more normal language, language that sounds more like the lady from the next street. A person who is is like us and talks like us. 10. Trust re. vaccine may be linked to education (scientific in particular). May be educated in other fields but have little scientific education. Trust in an individual may then be very important. For people with more scientific education, trust in the messenger may be less important because they can lean more on their own views.

BENEFITS & HARMS OF THE FACTOR

CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	COMMENTS
How big are the anticipated benefits?	*Don't know* ☐ / *Varies* ☐ / *Trivial* ☐ / *Small* ☐ / *Moderate* ☒ / *Large* ☐ **Detailed judgements (see 'COMMENTS')**	• A US study done in 2009/10 involving over 30,000 people (mostly White but also Black) and discussing H1N1 flu vaccines found that the strongest predictor of vaccine uptake was a doctor's recommendation. There were still disparities between White and Black people, especially women. Black women were about half as likely as White women to receive the H1N1 vaccine. [#709; Survey; study quality moderate].(6) • An Australian study done in 2018 involving 500 Aboriginal pregnant women and discussing flu vaccines found that the single most important factor in vaccine uptake was advice from a healthcare professional (x12) [#1041; Survey; study quality moderate].(7) • A US study done in 2015/16 involving 1420 adults from a range of ethnic backgrounds discussing the flu vaccine found that for non-Hispanic Black people, those who had high confidence and trust in their doctor were more likely to be vaccinated compared with those who had low or medium trust (45% vs 20%) [#282; Survey; study quality moderate].(8) • A US study done in 2017/18 involving 281 African American patients with heart failure discussing flu vaccination found that patients who received vaccination information and recommendation from their physician were more likely to be vaccinated compared to those who didn't. This varied by health professional type from x8 for cardiologist to x5 for a GP [#224; Survey; study quality very low].(9) • An Australian study done in 2016 involving 537 women from 'culturally and linguistically diverse backgrounds' and discussing flu vaccines also found that a health professional recommendation increased uptake (x8). 23% of unvaccinated women had not received a healthcare provider recommendation, one of the most important reasons [#281; Survey; study quality very low].(10) • A UK 2020 survey of a representative sample of 2076 adults asked about taking the COVID-19 vaccines found that more ethnic minority individuals would be willing to take the vaccine if they were advised to do so by their GP or other health professional (79% vs 57%) [#grey 6; Survey; study quality very low].(11) • A UK 2021 survey of over 1000 ethnic minority people discussing the COVID-19 vaccines found that the most trusted messengers were familiar people such as friends and family, GPs and local doctors and nurses, and people's own gut instinct. Boris Johnson and celebrities were seen as least persuasive [#grey10; Survey; study quality very low].(12) • A sub-study of the above UK study with 334 Muslim respondents discussing the COVID-19 vaccines also found that 45% would be convinced by religious leaders to have the vaccine [#grey 17; Survey; study quality very low].(13)	1. Who is the messenger? Health professionals not always the right messenger for some communities. Getting people from the community as messenger needed because of trust. The choice of messenger will affect the size of benefits of trust/harms of mistrust. [From discussion on 5/8/2021 on Factors #2 'Trust in organisations']] 2. Benefits of having trust in the individual delivering the message is moderate. The individual might be trusted but what is the motivation for you doing this? Are you being paid, what is in it for you? Even if trusted, tempered by what people think of motivation behind it. 3. There is a level of misinformation that is publicised by individuals saying I should not take vaccine. People might come and ask whether they should have vaccine: people look to you as a leader in the community because they are getting mixed messages. For a person to make decision, they need a person who they trust to break confusion. The potential benefits of trust in an individual is moderate to large for these reasons [and it can work both for and against taking the vaccine]. 4. Trusted people need to explain reasons for taking it, suggest a person then does their own reasearch, and we can then talk again. A person could be trusted within a family but be less trusted within community because people think think are being paid to take vaccine. 5. Things like vaccine passports also create pressure to take the vaccine, meaning you need the jab to participate in society. It means other things exert pressure re.
How big are anticipated harms?	*Don't know* ☐ / *Varies* ☐ / *Large* ☐ / *Moderate* ☒ / *Small* ☐ / *Trivial* ☐ **Detailed judgements (see 'COMMENTS')**		
How certain are we about the above?	*No included studies* ☐ / *Very low* ☐ / *Low* ☐ / *Moderate* ☐ / *High* ☒		

	CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	COMMENTS
				the vaccine. The benefit of trust in an individual is therefore moderate.
BALANCE	**Is the factor a barrier or an enabler?**	*Don't know* ☐ / ***Varies*** ☐ / *Favours barrier* ☐ / *Probably favours barrier* ☐ / *Does not favour either* ☐ / *Probably favours enabler* ☐ / *Favours enabler* ☒ **Detailed judgements (see 'COMMENTS')**	**See the research presented in the 'Is the factor important'? section.**	1. Some people will trust people who are not in favour (e.g. individual family members, leaders in community) so in some case it can be a barrier. Depends on who has most trust.

Conclusions

	We recommend that the factor be consider a barrier	We suggest that the factor be considered a barrier	We suggest that the factor is neither a barrier or an enabler	We suggest that the factor be considered an enabler	We recommend that the factor be considered an enabler
Type of recommendation	☐	☐	☐	☐	☒

Recommendation/decision Evidence from the UK, the US and Australia, plus our own experience, suggests that having trust in the individual(s) promoting the COVID vaccine in an important factor linked to whether people from ethnic minority groups accept the offer of the vaccine. Conversely, not having trust in those individuals makes uptake less likely. To have the trust of ethnic minority groups, individuals talking about vaccines need to be seen as honest, non-judgemental, make clear why they support the vaccine, speak in a way that people can understand and be willing to spend time discussing individual concerns. Local GPs and trusted individuals from the non-health sector can play an important role.

Justification	Trust (or mistrust) of individuals such as scientists, health professionals and others regarding uptake of the COVID-19 vaccine is based on uncertainty around their motivations for promoting the vaccine, the language they use, which community they are from, their level of expertise in the issues being discussed, being honest and non-judgemental and taking time to discuss a person's concerns. Each of these can increase or decrease trust in an individual who is talking about the COVID-19 vaccine. Healthcare professionals, especially GPs and especially if they come from the same community as the community targeted by messaging have a clear and potentially beneficial role to play, as do trusted community members from the non-health sector. But the individual beliefs of these can also undermine vaccine uptake if, for example, they themselves have not taken the vaccine, or have their own doubts. Language is important and language that 'sounds like us' rather than being very scientific, or very prepared and articulate, can build trust. The most trusted messenger may be a community member who has had to make the same choice that others in the community are considering, the 'lady in the next street'. Finally, discussing concerns takes time and not having time for discussion undermines trust in the person promoting vaccine uptake.
Subgroup considerations	Exactly who the trusted individuals are will vary by ethnic group; 'ethnic minority' does not mean a single homogenous group that shares the same values, beliefs and preferences. That GPs have an important role seems true across many ethnic groups, although which GPs will depend on the community. It could be very local. The role of trusted non-health individuals is also likely to vary between ethnic groups. The concerns of individual communities need to be listened to and addressed. Differences between ethnic groups include language, culture, faith, education, place of birth, gender etc. There are important nuances that must be recognised and addressed
Research priorities	1. How best to engage with communities to build trust. 2. Improved approaches to data collection linked to recording ethnicity and identify. 3. More meaningful collaboration with community groups/3rd sector at the start of research planning to support its design and planning, not once funding has been awarded and the research design is fixed. 4. Work to ensure that all health research is explicitly designed with diverse populations in mind (this does not happen on its own, as we have seen for decades). COVID has changed the path of some background illnesses, need to consider how this affects the new path of the pre-existing health condition. 5. Better assessment of the quality of care received by ethnic minority individuals and the health outcomes.

References

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