COLLABORATION FOR CHANGE

How does the use of appropriate language affect COVID-19 vaccine uptake in ethnic minority communities?

This document summarises discussions with community organisations about the use of appropriate language, including different formats to share information, and how this impacts vaccine uptake in ethnic minority communities. This document also details the evidence that was used to form the decisions made.

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Evidence to decision framework - health system and public health

How important is appropriate language 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: *Appropriate language*
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 all commented about the language barriers influenced health-seeking behaviour. noted that some communities seek out other – private – sources of healthcare, despite NHS care being free, with language barriers being the main driver. Many migrant leaders said the older generation in their communities who do not speak English, or have lower language skills, were particularly susceptible to being hesitant or uncertain about taking the COVID vaccine ("Specifically, older people do not speak English." -Turkish and refugee community representative" [#grey24; Focus groups; study quality high].[3] • 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, found that communication with health professionals was hampered in some communities by language barriers. "I take my son twice…I didn't know what they were actual saying. I didn't know what it was for; I didn't understood. If I go somewhere I do manage to make myself understood; that time I didn't…I did not know exactly where to go to get the flu injection". "It's better to, if someone told them, like personally speaking, rather than a leaflet" [#469; Focus groups and interviews; study quality high].[4] • • A UK study reported in 2019 that discussed a range of vaccinations with 20 Polish and 10 Romanian community members and 20 health care workers found that community members struggled with medical terminology and jargon, and the inability of health services to provide information in languages other than English. To overcome language	1. The level of the information was not right (i.e giving confidence). Community groups have worked locally with comunity leaders (and individuals in community) to produce short videos and translated information. This connected more with people speaking in their own language, and used Facebook, twitter, WhatsApp. [From discussion 12/8/2021 on Factors #1 'Availability of appropriate information'] 2. Some people talk about information they have got from 'back home' saying we should do this or that, and this is different from UK gudiance. May choose to follow the guidance from 'back home' rather than UK, information easier to understand and access. A major issue. [From discussion 12/8/2021 on Factors #1 'Availablity of appropriate information'] 3. Information should be translated into a type of language that communities can understand. Not just about one or other

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		barriers, several healthcare workers reported using online translation tools to aide communication. Health are workers considered that more 'formal' modes of communication such as telephone or face-to-face interpreting services were difficult to organise, felt impersonal and created greater uncertainties around messages becoming lost in translation [#761; Interviews; study quality high].[5] • A UK study done in late 2019 with 17 healthcare staff and 8 senior management of mixed ethnicity talking about COVID-19 vaccines found language barriers to be a key area, leading to a reduction in trust "It's understanding people's cultures and being culturally competent, culturally aware. And having, you know, people speaking to their own communities. Um people who are in positions like myself speaking to your own communities and family members to give out positive messages to the family members and wider community to say actually, I would take the COVID vaccine and therefore you should be doing it as well. Um and these are the benefit and these are the risks. But if you're going to get somebody else who doesn't look like you, doesn't sound like you, doesn't speak your language; that trust is not there, necessarily." [Asian] [#stgy372; Interviews; study quality high].[6]	langauge (e.g. English vs another language). [From discussion 12/8/2021 on Factors #1 'Availablity of appropriate information'] 4. Messaging – translation is often not about translation into a different language but more about a spoken helpline. Often provision of this happens late. Spoken information is better for many. A lot of the COVID vaccine material was a straight regurgitation of existing material, not very practical, and need more verbal more and more visual presentations. The translation element may have miscommunicated the message. [From discussion 12/8/2021 on Factors #1 'Availablity of appropriate information'] 5. And some people can speak a language but not read it (and vice versa), which means a written translation is no good, want to speak about issues. We also want more lay langage. [From discussion 12/8/2021 on Factors #1 'Availablity of appropriate information'] 6. Information is often not culturally appropriate, a shortage of such information. [From discussion 12/8/2021 on Factors #1 'Availablity of appropriate information'] 7. [Careful use of terminology is useful because language means more than translation from one world language into another. Another useful term is 'heritage language' e.g. Urdu. Or perhaps 'Mother tongue' although that can be ambiguous. For cultural appropriate/tailoring content could talk about 'usage of language' rather than the language itself. Eg. Talk about how language is used rather than the language itself.]

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			8. Scientific language needs translation too. Need information in normal language, language as spoken by ordinary people. [Might also be placed in Strategies #2 'Tailoring the message'] 9. 'Language' is complex and we shouldn't forget this. It is hard to make a single judgement as to how important it is when it is multi-faceted. 10. Language has to be accessible. Communities are multi-generational, and some might be able to read a language, but not speak it. Others are the reverse. Accessibility is very important for this. The NHS is trying to help, with videos, conferences etc. But need to look at accessibility and how to engage with people linked to the community being that is being targeted. Also we shoudn't forget sign language, whch we haven't spoken about. We should look at the whole communication: what is the best way to get information to individuals. Might be pictures, not words. 11. There are levels to information provision for it to be useful: a) Right world language b) appropriate usage of language for individuals. c) How to make the language precise d) Where does it come from (e.g is the source trusted?) [Might also be placed in Strategies #2 'Tailoring the message'] 12. The right language for the generation targeted is important too. Young and old have have a different kind of language and this is relevant for both written and spoken usage. 13. We should also think about other communication than written, e.g. visuals and pictures. [Might also be placed in Strategies #2 'Tailoring the message']

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			14. In emergency situations like COVID, community organisations can help to build trust but their direct reach is modest. Large number sof others need to get the right message from general public health messaging. These general sources of public health information need to make sure that they too tailor their messaging because more people will see their information than work directly with community organisations. It can't be left to community organisations. 15. Translation is important but it's also important to think about where people get their information. For all channels but especially ones like Facebook, WhatsApp– these sources are best with natural, everyday people, not delivery of a formal corporate message. Natural is better received. The version delivered might be slightly different from formal translation, with accents and everyday language but it connects with people more. It's a person like me. [Might also be placed in Strategies #2 'Tailoring the message'] 16. Language can be very important for some communities, especially when combined with a trusted organisation/person to deliver the message. The message on it's own is not enough, it needs trust as well. The approach needs to capture the variation in how communties would like receive information. Using a channel (e.g. TV) is no good if the people you are targeting don't watch TV. [Might also be placed in Factors #1 'Availability of appropriate information' and Strategies #1 'Trusted messengers'].

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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')***	• No evidence from the two rapid reviews as to how large or small the effect of language has on vaccine uptake or thoughts about the effects of getting COVID-19.	1. Effect of world language can be over-estimated. For example, if we think about the Pakistani population in Glasgow (about 12% of total). What proportion have ok English? It's pretty high, the proportion that can't read/write English is low. It is easy to talk about world language but maybe it is not always as big a factor as might be thought. The impact world language has on decisions would then be small because English is understood. Where this is not the case, the impact will be moderate to large. 2. It is unlikely that language is the deciding factor for vaccine uptake but it does have influence and does have a role. But it is unlikely that a person would not take vaccine because of this. 3. The whole world language as a factor is a lazy excuse. Shouldn't be an issue– it should be something we should just do as a matter of course to be as inclusive as we can be, just accept that it is here. 4. There is a large South Asian population in Glasgow. Many from Pakistan, so you might think to translate into Urdu. But many speak Punjabi and can't read Urdu etc. Translation is a visible action but it more subtle than this. Also Indian Punjabi and Pakstani Punjabi are different. There is subtlety needed in getting message across that this goes beyond the idea of translating from one world language into another. 5. Language has an impact even though it shouldn't and how much varies. This
	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
				goes back to trust, where do people get information from.
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.**	

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

Research evidence from the UK and our own experience suggests that appropriate language (by which we mean language that is culturally acceptable and pitched at the right literacy level for its audience) is a factor affecting decisions to accept the COVID-19 vaccine. 'Language', however, does not just mean which world language, e.g. English or Urdu a document is written in but also includes consideration of language usage (culturally appropriate, not overly scientific, lay language) and, also, whether the most appropriate way to use language is to write it down, speak or sign it, or use a multi-mode delivery format.

Language itself is unlikely to be the dominant factor in a decision to accept or not accept the COVID vaccine. But when it comes to the effective transfer of information, language can be a dominant factor. The impact of language on decisions may be smaller than is often thought, with other factors (trust especially) dominating. Better use of language will, however, support more informed discussions among ethnic minority communities about the COVID-19 vaccine.

Justification	'Language' is complex and means more than whether a document is written in English or another world language. Efforts to simply translate a leaflet from English into another world language can be perceived as a lazy approach to language. Language usage can be more important, as can the cultural tailoring of the language used. Language that is tailored to generational usage is also important. Language is often used as a shorthand for considerations of whether a written document should be made available as another written document in additional world languages. This misses the point that the best way to use language for some may be to speak it or sign it rather than write it down. Not all those who can speak a language can read it and vice versa. Scientific language in written or spoken form needs to be put into a form that the non-scientific public (i.e. the majority) can understand and use in their decision-making. Translation is important but how that translation is delivered is equally important. A message that comes across as some form of corporate message, especially on channels such as Facebook and WhatsApp, is likely to fail. Delivery in natural, everyday language is likely to be better received because it connects better with its audience. The poor use of language, or the unavailability of materials in appropriate language means that some individuals will look elsewhere, including outside the UK, especially 'home countries'– countries with which there are strong family links. As with information in more general terms, knowing what is the best way to use language requires engagement with organisations that understand the communities being targeted. In emergency situations like COVID-19, community organisations can help to build trust but their direct reach is modest. Those responsible for general public health messaging need to make sure that they too tailor their messaging because more people will see their information than work directly with community organisations. The impact language itself has on decision-making may be over-stated, with decisions being dominated by other factors. For message transfer though, poor use of language can be an important factor that stops that message getting across. The impact of language on decisions may be smaller than is often thought, with other factors (trust especially) dominating. Better use of language will, however, support more informed discussions among ethnic minority communities about the COVID-19 vaccine.
Subgroup considerations	'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. Different ethnic groups get their information from different places, especially and most obviously linked to 'home countries'. The language (both world language and usage) must be tailored to the needs of specific ethnic groups.
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

1. OpenSAFELY. NHS Covid vaccination coverage 2021 2021. Available from: https://www.opensafely.org/research/2021/covid-vaccine-coverage/#weekly-report (Accessed 3 August 2021).

2. Robertson E, Reeve KS, Niedzwiedz CL, Moore J, Blake M, Green M, et al. Predictors of COVID-19 vaccine hesitancy in the UK household longitudinal study. Brain Behav Immun. 2021;94:41-50.

3. Crawshaw AF, Hickey C. Summary report: COVID-19 vaccination scoping workshops with migrant community leaders in Hackney: perspectives to inform future research [unpublished]. London: St George's,University of London Hackney CVS; 2021.

4. Jackson C, Dyson L, Bedford H, Cheater FM, Condon L, Crocker A, et al. UNderstanding uptake of immunisations in travelling aNd gypsy communities (UNITING): A qualitative interview study. Health Technol Assess. 2016;20(72):vii-175.

5. Bell S, Edelstein M, Zatonski M, Ramsay M, Mounier-Jack S. 'I don't think anybody explained to me how it works': qualitative study exploring vaccination and primary health service access and uptake amongst Polish and Romanian communities in England. BMJ Open. 2019;9(7).

6. Woodhead C, Onwumere J, Rhead R, Bora-White M, Chui Z, Clifford N, et al. Race, ethnicity and COVID-19 vaccination: a qualitative study of UK healthcare staff. Ethn Health. 2021:1-20.