COLLABORATION FOR CHANGE

How does the accessibility of vaccinations and appointments impact the uptake of COVID-19 vaccines in ethnic minority communities?

This document summarises discussions with community organisations about the barriers that make vaccination appointments less accessible, including time and distance to vaccination sites, and how this impacts vaccine uptake in ethnic minority communities. This document also outlines the evidence that was used to inform decisions.

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Evidence to decision framework - health system and public health

How important is good accessibility 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: *Good accessibility*

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***	• In a UK study done in 2020/21, 23 community leaders talking about the COVID-19 vaccines had concerns about how those 'outside the system' e.g. undocumented migrants might access vaccination. They felt that the vaccination plans do not consider migrants, refugees homeless etc well enough. [#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 several participants believed their housing situation facilitated uptake of vaccines as their families were more integrated into society and were close to the GP. Others reported vaccine letters going missing because the site [where they lived] had a communal post box. Being settled made keeping appointments easier. A minority of participants suggested that appointments were not part of their culture and drop-in clinics would be better "or a walk-in, if we have a walk-in we could just do it there and then and say right, we're walking in today, we're getting it done today" [#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 several community members reported challenges with registering with GPs due to uncertainties around entitlement and difficulties in	1. Much was made of multigenerational households for ethnic minorities but the vaccine invitations came by age, meaning some older people had no family help to get vaccine and costly to have multiple trips rather than a single trip for household. Would have been better with a more flexible system, with invitations from GP or primary care and for whole household, uptake would probably be more. [Might also be placed in Strategies #3 'Flexible venues/timing'] 2. We [a community organisation] were contacted by local NHS because they noticed uptake was lower in some groups and NHS needed help. The NHS leaders allowed the community organisation to take over control of registrations and transport, NHS concentrated on the jabs. Needed some bravery and confidence to do this from NHS side. Over 400 came. There was some door-to-door work and physical accessibility came up, we provided transport minbus, taxi, including from other charities that could help with vaccination transport. People are not anti-vax but because of accessibility or some other reason had not had vaccine. People came as a family and we could vaccinate 7-10 from a family in one go. In other words, different to the standard primary care approach. [Might also be placed in Strategies #3 'Flexible venues/timing'] 3. Also worked with NHS to commission a vaccine bus, also very succesful in terms of accessing communities. E.g. mosque, would have 300 waiting after prayers, also Chinese communities. Need

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		producing proof of address as requested by some practices. Community members found booking appointments with GPs easy but were not satisfied with the time allocated. The time restriction made some people feel rushed and not listened to, potentially leaving them with questions and vaccine concerns that were not addressed. Health workers said it was hard to provide information, administer vaccines and document delivery in the 10-15 mins they were given, something made more challenging by communication barriers [#761; Interviews; study quality high] [5]. • An Australian study done in 2017 involving 13 Aboriginal healthcare workers at their annual conference discussing flu vaccines thought that many general practices do not know how many Aboriginal patients they have and this is a problem when deciding who to offer a vaccine to "it's very important to educate and empower Aboriginal community members to not be ashamed of who they are and that it's for their own health benefit if they identify; they're not getting into trouble, as this is a common misconception when it comes to identification". Health workers thought the eligibility of Aboriginal adults should be more prominent in national promotions so that doctors would see them as an important group and promote vaccination. More education for community medicine was raised too, some people do not what the vaccinations are for and what protection they provide. [#232; Focus groups and survey; study quality moderate] [6]. • A US study reported in 2016 involving over 100 people (White and Black) talking about the flu vaccines found that people who didn't have a strong opinion on the vaccine, took it if external circumstances (i.e. convenience) made it an option "I got it because my doctor strongly, strongly encouraged me to. And it was right there and I was right in the doctor's chair. But I think if I had to make the effort to go out and do it myself, I wouldn't have gotten it." [African American]. The convenience of having the vaccine there and then can also reduce travel costs for people, which is important. [#336; Focus groups and interviews; study quality high] [7].	to fit into existing activity. Clearly popeole are willing but accessibility, trust etc stopping people. Accessibility is an important issue. [Might also be placed in Strategies #3 'Flexible venues/timing'] 4. There has been some intergenerational vaccination in one go but not a possibility across all areas. 5. Some GP practices have not chased unvaccinated people in age groups as program has moved down ages. E.g. Six months after 80+ age group some hadn't been, practice needed to chase but wasn't doing this. Some elderly need help to get to the centre. Organisations such as Uber offering free rides but not well promoted. Communication has been a challenge whether from NHS, public health, or local health, lack of communications or inconsistent communications. [Might also be placed in Strategies #3 'Flexible venues/timing']. 6. We [a community organisation] organised an intergenerational event with performers together with vaccine offer, went well, the artists also mentioned COVID and being ill, and giving experience of what it was like and why vaccine important. [Might also be placed in Strategies #3 'Flexible venues/timing']. 7. For migrants, or undocumented, it took a while to convince them that vaccination is not linked to immigration status. It also took a while for the government to accept this, they had to be lobbied to give vaccination to all. 8. For migrants/undocumented we had to do a lot of hand holding and support, they needed reassurance so went to vaccine centre with them. Some are hesitant because of past experience of being detained. Our presence at the vaccine centre, as a group they knew wanted to help them, was crucial for them to get vaccinated. [Might also be placed in Strategies #3 'Flexible venues/timing']. 9. What works – community organisation asked to do this. Use existing facilities, know where people are in their everday activities. But we were late in being commissioned to do this. Some of our offers were not taken up. Noone came back with a response. [Might also be placed in Strategies #3 'Flexible venues/timing'].

	CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	COMMENTS
BENEFITS & HARMS OF THE FACTOR	How big are the anticipated benefits?	*Don't know* ☐ | *Varies* ☐ | *Trivial* ☐ | *Small* ☐ | *Moderate* ☒ | *Large* ☒ Detailed judgements	• A US study reported in 2016 involving over 100 people (White and Black) talking about the flu vaccines found that people who did not take the vaccine cited personal beliefs or philosophical reasons and then described barriers (e.g. convenience) as a secondary justification. Those taking the vaccine were more likely to cite convenience as the reason they got the vaccine, while implying the true reason was obvious "it works". For those who are complacent [study authors' description], convenience could be the difference between taking the vaccine and not taking it "I've always been willing to take it. I've never had any resistance to taking it. The shift has just been convenience and that the awareness is right there in front of me." [African American] [#336; Focus groups and interviews; study quality high] [7].	1. Need to strike a balance, people generally comfortable to go to GP etc. So if go for other things to GP, why not vaccine? But for those who had not taken it up, some of those people could be vaccinated with the offer of a bus, or more convenient sites. Size of effect is moderate. 2. In Manchester GP was not an offer, and some community venues not allowed. Handled short-tem not long term. If there is a booster etc, delivery should invest in primary care so that accessibility would be less of an issue. Accessibility could be an enabler or a complete stop. People know where GP is but other places need to naviagte to it, which presents a barrier. Tranportation did help. Moderate to large effect.
	How big are anticipated harms?	*Don't know* ☐ | *Varies* ☐ | *Large* ☒ | *Moderate* ☒ | *Small* ☐ | *Trivial* ☐ Detailed judgements		
	How certain are we about the above?	*No included studies* ☐ | *Very low* ☐ | *Low* ☐ | *Moderate* ☐ | *High* ☒		

	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 the research presented in the 'Is the factor important'? section.**	1. Could be conditional on extent of impact, eg. People who are undocumented. They would be more selective in choice of site, more inclined to use a walk-in centre than a large site. In this case, would be very large as an impact. 2. For many undocumented, many went to community groups rather than the big NHS sites, where 'normal' vaccination done. Potential impact could be very large for undocumented, migrants/refugees. Wanted to go to sites with people who they trusted, people who they know are helping them. 3. Offer of vaccine at an unknown site, is inconvenient. Time too much, makes it a barrier. Balance about take/not take can be a fine one, and problems with accessibility can be enough to tip against. Even with a car, might not want to drive because of not knowing how the vaccine would affect you. 4. This factor links to access to information. If the community organisations promote walk-in centres, people will come. If not doing this, people would not have known about them. [Might also be placed in Strategies #3 'Flexible venues/timing']. 5. There has been a lot of demand on community organisations to do this sort of work but without compensation. There's only so much that can be done when reying on volunteers. Need some compensation. Patience is wearing thin. 6. Have health and public health but they don't talk to each other as much as they should. Some of their initiatives were working at odds with each other, not working as well as they should. Public health needs to reaslise that community organisations are doing part of their job for them. Needs resources. Also we notice differences between areas, locally had GPs, others had abuse, sometimes not. And some places with initiatives, others not. Told that local NHS England control what is to happen but community organisations need to have more flexibility and have more control. Public health leadership needs to be brave and start new initiatives together with community groups. [Might also be placed in Strategies #3 'Flexible venues/timing']. 7. There has been additional money to local authorities for community engagement and ambassadors. But this has not been shared around, it would be good to have audit of how accessed, because not sure where it has ended. It has been possible ot get some money but process has been slow and chaotic. Urgency has reduced, now dealing with more stubborn and more difficult challenges.

Conclusions

Type of recommendation	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
	☐	☐	☐	☐	☒

Recommendation/decision

Evidence from the UK, the US and Australia, plus our own experience, suggests that having good accessibility to vaccination, meaning location, transport options and/or time of the appointment, is an important factor in decisions about having the COVID-19 vaccine. For some poor accessibility is enough to prevent getting the vaccine even though, in principle, the person is open to the idea of getting the vaccine. NHS public health authorities need to work with community organisations to select alternative ways of delivering the vaccine and, importantly, cede control of delivery to the community organisation where needed because they may have a level of trust in the community that the NHS does not.

Justification

Accessibility, or lack of it, is an important factor linked to vaccine uptake. Large, centralised vaccination centres that are convenient for organisations to use for delivery may not be acceptable or convenient for many in ethnic minority communities. Where other barriers and doubts to vaccine uptake exist, access barriers may be the last straw that stops uptake. For low-income multigenerational households multiple trips to a venue that is distant and unfamiliar may be an expensive undertaking; the offer of transport may be all it takes to ensure vaccination. As with other factors, this is not about being anti-vax but about practical challenges that make getting the vaccine harder. Some unvaccinated people in older age groups have not been contacted to ask why they did not get vaccinated; often it is because getting to faraway venues is difficult. With help they may be willing to be vaccinated.

Community organisations have a good feel for the sort of locations and times that might work. Moreover, they have a good sense of what messaging will work, who should provide it and how. The presence of familiar faces from the organisation at venues is a reassurance, especially for migrants and undocumented individuals who are worried about contact with government (and the NHS is government for these individuals). NHS public health may need to cede control of all but the actual injection of vaccine to community groups for some of these alternatives to work best. Doing this needs resources and community organisations should not be expected to do the job of the NHS without compensation.

As the vaccine program progresses, the challenges of getting the last remaining people vaccinated gets harder. Addressing accessibility problems would be an enabler that is enough for some people to get vaccinated who otherwise may not.

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.

Concerns about accessibility of venues/times for COVID-19 vaccination will vary between specific ethnic groups; there is no universal set of concerns.

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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