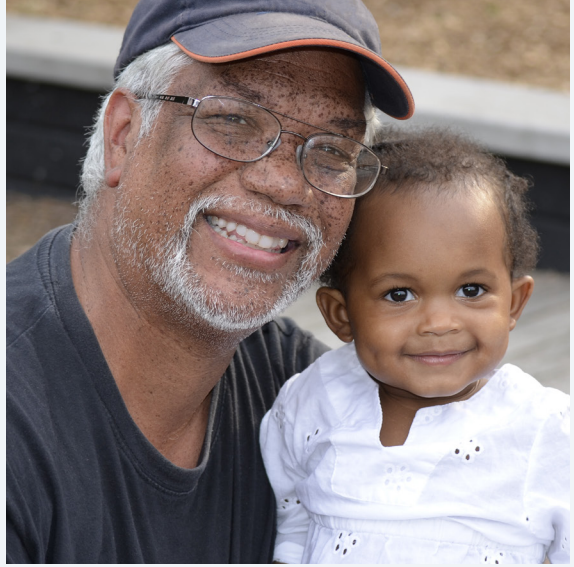
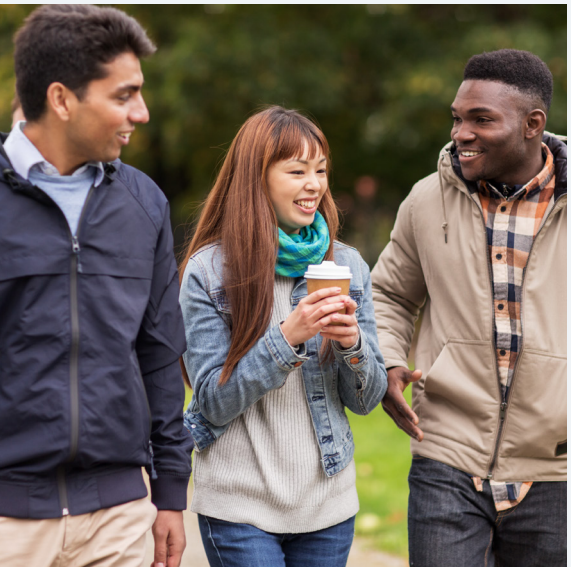


COLLABORATION FOR CHANGE

Could trusted messengers be used to increase COVID-19 vaccine uptake in ethnic minority communities?



This document summarises discussions with community organisations about the strategy of increasing COVID-19 vaccine uptake in ethnic minority communities through trustworthy messengers, culturally competent healthcare staff, and influential community leaders. This document also outlines the evidence that was used to inform decisions.

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

Evidence to decision framework - health system and public health

Should trusted messengers (people) be used to increase COVID-19 vaccine uptake by ethnic minority groups?

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

Strategy: *Trusted messengers*

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
BENEFITS & HARMS OF THE STRATEGY	**How big are the anticipated benefits?**	*Don't know* ☐ | *Varies* ☐ | *Trivial* ☐ | *Small* ☐ | *Moderate* ☒ | *Large* ☒ **Detailed judgements**	• Factors #3 (Trust in individuals) presents evidence from surveys regarding size of effect of on vaccine uptake for a range of messengers, generally around a trusted health professional or community member. Across all studies, the effect was almost always beneficial. Concrete strategies suggested from rapid reviews (but with no effect estimates): • Harness health professionals and other public figures from within communities to deliver messages. A key question is how to better support non-health 'trusted voices' to provide health information to their communities. The most common sources of information reported across all communities were GPs, internet, social media, family/friends and community organisations [#grey24; UK study done in 2020/21, 23 community leaders talking about the COVID-19 vaccines; Focus groups; study quality high].[3] • Health professionals delivering information should have cultural competency training and this should be a key performance indicator for improved practice. Target GPs, practices nurses, health visitors, specialist health workers and receptionists. [#469; UK study done in 2013-2015 with 174 Traveller participants (mainly Romanian Roma and Irish); Focus groups and interviews; study quality high].[4]	1. 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. [From Factors #5 discussion 26/8/2021]. 2. We [a community organisation] asked what was source of motivation to take up vaccine– distant 3rd was health professionals (1st was own views, 2nd was family opinions). A lack of trust, access to health professionals, maybe poor at selling the vaccine to people who have some questions. Perhaps they are too busy on the production line, are they able to take much time to overcome objections and give the time it needs? If not, missing a trick, are they
	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
			• There could be a named frontline person in a GP practice/health visitor (for outreach) to provide respectful and supportive service for Travellers [potentially other ethnic groups?]. [#469; UK study done in 2013-2015 with 174 Traveller participants (mainly Romanian Roma and Irish); Focus groups and interviews; study quality high] & [#761; UK study reported in 2019 that discussed a range of vaccinations with 20 Polish and 10 Romanian community members and 20 health care workers; Interviews; study quality high].[4, 5] • Health care workers and community members to discuss service expectations and acknowledge differences in systems. Encourage discussion around vaccine concerns [#761; UK study reported in 2019 that discussed a range of vaccinations with 20 Polish and 10 Romanian community members and 20 health care workers; Interviews; study quality high].[5] Strategies that have been evaluated experimentally: • US study on social media micro influencers (500 to 10,000 followers) to increase knowledge and positive attitudes toward the flu vaccine among African Americans and Hispanics. Influencers were asked to choose from vetted messages and create their own original content promoting flu vaccination, which was posted to their social media pages. Evaluation done in different geographical areas. **Result:** Self-report of did you get the vaccine: intervention (i.e. micro influencers) vs comparison= 44.4% vs 42.0% said yes. Of those who actually saw the posts, results were 50.9% vs 43.3%. Of the intervention group, 14% reported seeing the posts. [#225; Controlled Before-After; study quality high].[6] • Additional education for providers on the rationale for the vaccine, efficacy, recommended uses, how to document medical record alerts, record vaccination status and weekly emails reminding them which patients having appointments and to provide encourage to staff about promoting vaccines. **Results:** the frequency of missed vaccine opportunities pre-intervention was 47%, which was reduced to 23% after it. There were differences across ethnic groups with the non-Hispanic Black group not seeing a reduction in missed vaccine opportunities. Reduction in missed opportunities was not as large for patients with a non-English primary language [#277; US study done in 2013/14 involving around 220 individuals form a range of ethnic groups to increase uptake of the flu vaccine;	making every contact count, to overcome doubts. 3. Anticipated benefits of trusted messengers can be large in face of misinformation and doubts among groups. It is hugely beneficial to have someone who is able to talk to you and someone who you know and trust personally would be most beneficial. 4. Looking back to work on Covid and vaccine, Kevin Fenton (Regional Director Public Health England) gave lots of info around COVID and vaccine last year. Many in ethnic minority communities had doubts about vaccine because of lack of trust, Kevin gave information to target community leaders, which he did manage to convince leaders to promote. Once community leaders are convinced, this helps because there is a domino effect and this can cascade through to community organisations as a whole. Effects were driven by the person speaking as an ethnic minority individual with credibility, which spread to others with credibility. 5. We [a community organisation] didn't really prepare ourselves for community leaders who were not on board, some were against the vaccine. These leaders are influential in the community, they are gatekeepers in system. It became increasingly difficult to get around the trusted community leaders and we hadn't planned for this. It did cause problems, so need to work with them. It still remains a challenge. Some leaders felt that the NHS should promote other things as well as vaccine

	CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	COMMENTS
			Before-after; study quality low].[7] • US study on 30-minute lecture on pneumococcal disease delivered by a pharmacist, plus a 10-minute live actors' skit and action planning breakout sessions to promote vaccination in a predominantly older African American group. **Result:** Of those participants unvaccinated at Baseline, 42 (37.2%) self-reported having received vaccination by month 3 (including 18 participants who received onsite vaccination). Other outcomes regarding intentions and knowledge generally increased [#stgy 140; Observational before-after; study quality very low].[8]	to prevent COVID eg. healthy eating, healthy living. They wanted a mixed message that included other things than the vaccine. Some communities have looked after themselves and relied less on the vaccine. 6. Representation in trusted messengers: if use black GPs findings in CAHN [a community organisation] study show 40% increase in uptake of vaccine. Feedback was that 'people who look like you' can be effective. 7. Friends and family are influential as trusted messageners. There is often an assumption that if you get the local imam on board, all is well but it's not that simple. They are less influential than we might think. We [a community organisation] found it more useful to do individual calls, one to one, more effective. Can feel lazy to just jump to a community leader. 8. Sometimes people thought to be trusted, and those funded because of it, do not actually have community trust. So didn't work. An assumption is maded about who is trusted. Need to know who is trusted. 9. Trusted messengers not just community leaaders, broader than this. Not just public meetings, could be one-to-one. Verify that trust exists. Anyone who people trust. E.g. sometimes councillors could help, e.g. to knock on doors because they have influence in the community. 10. Verification of trust – e.g. look at churches and the congregation; the size of the congregation says something about the trust the pastor has, faith

	CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	COMMENTS
				plays a critical role, reach out to pastors. 11. Some might claim to be trusted but perhaps less than we think. Some leaders (faith) are vaccine hesitant, and trying to mitigate their influence is difficult to do. People have their own views too. Can be difficult for some communities. 12. Resources going to organisations can help with work, but Govt should do a bit more due diligence with regard to who in communties has trust and influence. 13. There is nuance around faith leaders and faith. E.g. for many practising Pakistani muslims, the imam is trusted on religious matters but not other matters. Seen as an academic on faith, whose opinion is worth hearing, but less on issues such as health. 14. We [a community organisation] had a forum with faith leaders but wanted support if the congregation asked questions about vaccine. Faith leaders said we have expertise on faith but not health. We identified GPs working with faith leaders and the GPs would come to conversations with congregations to answer health questions. 15. There is a subset of religious people who focus on spiritual things, want to know what God is saying on an issue. GP can't answer these questions. Depends on the faith groups.

	CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	COMMENTS
BALANCE	**Does the balance between benefits & harms favour the strategy or the comparison?**	*Don't know* / ***Varies*** / *Favours the comparison* / *Probably favours the comparison* / *Does not favour either the strategy or the comparison* / *Probably favours the strategy* / *Favours the strategy* ☐ ☐ ☐ ☐ ☐ ☐ ☒ **Detailed judgements**	• Evidence on harms and benefits from the two rapid reviews is limited– see above research presentation.	
RESOURCE USE	**How big are the costs/savings?**	*Don't know* / ***Varies*** / *Large costs* / *Moderate costs* / *Negligible costs or savings* / *Moderate savings* / *Large savings* ☒ ☐ ☐ ☐ ☐ ☒ ☐ ***Detailed judgements***	• The educational package tested in Study #stgy 140 [Observational before-after; study quality very low] cost 119 USD per attendee.[8] Total costs were just under 33,000 USD. There were 18 vaccinations through the program. The authors did think this cost could potentially be reduced • There was no other evidence on costs in the two rapid reviews for trusted messenger strategies.	1. Often a trusted individual/organisation is, expected to do this sort of work for free. But it needs planning and this has a cost. But sometiems the funding is for very specific things and the organisations needs support for wider activity. Can't keep trust of communities through transactional things based on, e.g. just the vaccine. [Might also be placed in Strategies #2 'Tailoring the message'] 2. The costs/savings could be moderate to large depending on benefits. If benefits mean pepole reached and they take the vaccine, then the benefit would outway the cost. [Might also be placed in Strategies #2 'Tailoring the message'] 3. Funding point re. specific vs ongoing, resonates. For costs linked to an online initiative, the initiative worked very well. Others then wanted to join in and they wanted to fund us but we quickly realised that others were now controlling the conversation and wanted to talk abot other things, e.g. food distribution, which was not what communities wanted. Hard to put a figure on what is being done. Need more flexibility in funding awards. 4. How to value saving people's

CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	COMMENTS
			lives/preventing serious illness? Information and work being done to save lives, and is therefore important. Government is doing things but it is haphazard. [Might also be placed in Strategies #2 'Tailoring the message'] 5. Community work cannot be thought of as a one-off transaction, it's better to think of it as a loyalty card. Trust is built over time on your card and then you can cash it in later. Services need to have been built up. Need long-term view, which we can tap into in the future. [Might also be placed in Strategies #2 'Tailoring the message']
How certain are we about the costs/savings?	*No included studies* ☐ | *Very low* ☐ *Low* ☐ *Moderate* ☒ *High* ☐	• See above.	
Does the cost effectiveness of the strategy favour the strategy or the comparison?	*Don't know* ☒ *Varies* ☐ | *Favours the comparison* ☐ *Probably favours the comparison* ☐ *Does not favour either the strategy or the comparison* ☐ *Probably favours the strategy* ☐ *Favours the strategy* ☐ ***Detailed judgements***	• There was no evidence on cost effectiveness in the two rapid reviews although Study #stgy 140 [Observational before-after; study quality very low] cost just under 33,000 USD for 18 vaccinations given through the program.[8]	
What would be the impact on health equity?	*Don't know* ☐ *Varies* ☐ | *Reduced* ☐ *Probably reduced* ☐ *Probably no impact* ☐ *Probably increased* ☒ *Increased* ☐ **Detailed judgements**	• There was no direct evidence presented in the two rapid reviews regarding the impact of a proposed strategy to increase vaccine uptake on health equity. • However, if a strategy was effective we could expect that this would increase health equity for ethnic minority groups. This would need to be evaluated.	1. Yes, if trusted messengers were effective then they are likely to increase equity. Groups who are disadvantaged get opportunity to experience the health service received by majority population, i.e. an increase in equity. 2. Even though the Black community is seen as vulnerable with virus, roll out of vaccine not seen as a priority

	CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	COMMENTS
				group. Done by age only. 3. There would be an impact on equity. Problem term is hard to reach: people from communities are not asked about how services need to be delivered, not specific for these communities and this creates inequalities. Trusted messengers provide a bridge between service and communities. Can engage and deliver services that better meet needs of the community. [Might also be placed in Strategies #2 'Tailoring the message'] 4. Need to consider the message itself, need to trust the message too. [Might also be placed in Strategies #2 'Tailoring the message'] 5. Talked about comorbidities: we haven't done any screening, so when people not invited, not always that they are hesitant but that they have not been invited. Some people have had side effects but these have been dismissed. If not taken seriously, this perception becomes their reality and spreads through the community. This impacts on trusted message and can dilute the message that we want to communicate. 6. Public health was not trusted. They said that Black people were impacted more, and were more at risk from COVID, but there was no offer of better housing, say, became less about a person-centred approach, and more about blame. Strategy changed from inequalities to blame shifted onto Black people themselves.

	CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	COMMENTS
ACCEPTABILITY	**Is the strategy acceptable to key stakeholders?**	*Don't know* ☐ *Varies* ☐ *No* ☐ *Probably no* ☐ *Probably yes* ☒ *Yes* ☐ **Detailed judgements**	• There was no direct evidence presented in the two rapid reviews regarding acceptability. However, since most strategies were suggested by key stakeholders we can assume that the strategies are acceptable to those stakeholders involved in the studies. • Study #225 [Controlled Before-After; study quality high] did mention that judging potential acceptability was one of their aims but they did not go on to present data on acceptability.[6]	
FEASIBILITY	Is the strategy feasible to implement?	*Don't know* ☐ *Varies* ☐ *No* ☐ *Probably no* ☐ *Probably yes* ☒ *Yes* ☐ **Detailed judgements**	• The authors of the micro influencer study (Study #225 Controlled Before-After; study quality high]) concluded that the approach was feasible although it could be improved.[6] • There was no direct evidence presented in the two rapid reviews regarding the feasibility of strategies suggested by stakeholders.	

Conclusions

	We recommend against trusted messengers	We suggest not using trusted messengers	We suggest using trusted messengers	We recommend using trusted messengers	
Type of recommendation					
	☐	☐	☐		☒

Recommendation/decision Based on evidence from the UK and the US, plus our own experience, we recommend the use of a trusted messenger to deliver public health messages on the COVID-19 vaccine. The choice of trusted messenger is non-trivial and care is needed to ensure that these individuals do indeed have the trust of the community and provide information that is accurate.

Justification

If an individual, or individuals, who holds the trust of a community is/are involved in discussing vaccines with members of that community, research evidence (though of generally low certainty) and our experience makes us confident that this strategy will most likely lead to an increase in vaccine uptake. However, identifying who has trust, and who can therefore be a trusted messenger, is not a trivial task and using individuals who are not known to have the trust of a community may well be counter-productive. Public health groups should avoid assuming that some types of individual must hold the trust of the community; instead this trust needs to be verified. Trust may also be limited to particular areas of discussion, which may not include health-related issues.

Where community concerns about vaccines cover multiple areas (e.g. health-related and faith-related) it is likely that teams of trusted messengers are needed, each trusted in their own area (e.g. GPs for health, faith leaders for faith). Trusted messengers have generally earned that trust over time by helping communities on many non-vaccine issues: trust is not transactional. It is useful to image trust being built up like a shop loyalty card, slowly and over time through repeated positive experiences. That can be cashed in later if needed on, for example, vaccine promotion. But without having built that trust over time, the message is likely to fall flat.

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.

The choice of trusted messenger, and how that trusted messenger delivers their message and supports a community will need to be tailored to the community being targeted. There is no universal solution.

Implementation considerations	The discussions that trusted messengers will need to have with individuals considering the COVID-19 vaccine may take time and need flexible implementation. There is unlikely to be a one-size-fits-all offering and working directly with communities and community-based organisations is the best way of shaping delivery strategies. This will take time and it is important that all concerned acknowledge this; it is not possible for an organisation to do this well overnight. At present, community organisations are often asked for help very late in the process, when things are already not working. Community organisations should not be thought of as rescue strategy but should be involved from the very beginning to design and plan implementation. Moreover, policymakers and other decision-makers need to make careful decisions about the organisations that are best-placed to help. Going to the most visible may not be the best choice. Public health organisations should be willing to cede control of planning and delivery when community organisations have greater expertise in knowing what sort of implementation will work in their community. Planning and organisation take resources and community organisations cannot be thought of a zero-cost option. They need funding to make their contribution and how that funding is used needs to be flexible.
Monitoring and evaluation	Any trusted messenger approach should be evaluated because the evidence base in support of any implementation format is at present extremely limited. At the very least, monitoring of vaccine uptake among the targeted group pre- and post-implementation in the area covered by the strategy should be routine. It is important to recognise that while essential, monitoring and evaluation may be challenging. The reasons for this may include a lack of data by which to measure change, or lack of access to these data, or because of a rapidly changing context, or multiple initiatives being run at the same time, making causation hard to claim for any single initiative. These evaluations may need external methodological support to avoid opportunities for evidence generation being wasted. The design of any evaluation needs to involve members of the community being targeted.
Research priorities	The priority is evidence generation for any implementation strategy: see above. Additionally, research on: 1. how to collect data that accurately reflect how people describe their ethnicity 2. how to ensure that these data are available ..is needed to ensure that efforts to improve vaccine uptake among ethnic minority groups can be evaluated. Research should involve community organisations and partners from the very beginning in meaningful collaboration to ensure that the research design is relevant to the needs of the communities that are the focus of the research.

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