COLLABORATION FOR CHANGE

Could tailored messaging 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 by tailoring information based on community insights, needs and values. 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

Should tailoring the message 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: *Tailoring the message*

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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	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 #1 (Availability of appropriate of information) and Factors #3 (Harms vs benefits) present evidence from surveys regarding size of effect of on vaccine uptake regarding poor information, or lack of information. Across all studies, poor/missing information reduces vaccine uptake. Concrete strategies suggested from rapid reviews (but with no effect estimates): • Information should be tailored according to community insights, needs and values. This must involve including community members in the co-design and co-production of resources and services, and considering what medium/formats, languages/literacy levels, channels/settings, messengers and types of messaging would be most appropriate for specific communities and demographics. Use 'home media' e.g. media from their native country, or in their native language to communicate with and reach these populations [#grey24; UK study done in 2020/21, 23 community leaders talking about the COVID-19 vaccines; Focus groups; study quality high].[3] • Information needs to be available in translated forms, including in forms with pictures/pictograms to help overcome literacy barriers. Interpretation and translation services needed. [#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]	1. As a strategy for reaching people, WhatsApp has been a good way to tailor messages, even for people who are not so tech savvy, or had low literacy. [From Factors #4 'Harms vs benefits' discussion 26/8/2021]. 2. Major public health organisations should have ongoing ways of countering messages and misperception but using the same platforms, may mitigate the impact. [From Factors #4 'Harms vs benefits' discussion 26/8/2021]. 3. Discussions of harm depend on where a person in their life, e.g. young people interested in future, pregnant women to unborn child, sometimes older people didn't share the concerns because they said we have lived our lives and whatever happens, happens. The message needs to be tailored to perception of harms. E.g. messages for teachers need to consider the potential harm from children. For people with pre-existing serious health conditions, information needs to address this. This will be heavily reliant on facts, countries, race,
	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
			• Messages should pay attention to the differences in decision making between African Americans and Whites– public health professionals may more effectively communicate information that addresses not just their judgments about disease and vaccine risk, but may also influence some of the family networks that appear to be important in establishing vaccine attitudes and behaviours [#336; US study reported in 2016 involving over 100 people (White and Black) talking about the flu vaccines Focus groups and interviews; study quality high].[5] Strategies that have been evaluated experimentally: • Messages framed to be persuasive for pregnant women on flu vaccine. Two different interventions, both videos. One of actors (being doctors) giving a recommendation and discussing concerns; the other of real doctors giving detailed Q&A information. **Result:** neither video led to an improvement in vaccine uptake; uptake was low in all groups (7-14%). Intention to be vaccinated also similar across all groups. [#323; US study involving 106 pregnant Black/African American women; Randomised trial; study quality moderate].[6] • A second study [#323; US study involving 106 pregnant Black/African American women; Randomised trial; study quality moderate][7] presented results for two interventions but these are actually just renamed versions of those in Study #323 and involved the same 106 participants.[6]	conditions, health, and hard to provide this without real evidence. [From Factors #4 'Harms vs benefits' discussion 26/8/2021]. 4. When we talk about harms in most instances it not so much about harm now as what sorts of harms might be possible. What might happen in 5, 10 years? Doubts about that can lead people to not take the vaccine because we don't know what the future harm might be. [From Factors #4 'Harms vs benefits' discussion 26/8/2021]. 5. The level of the information was not right (i.e giving confidence). Community groups have worked locally with communty 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 Factors #1 'Availability of appropriate information' discussion 26/8/2021]. 6. Scientists and others talk in media to encourage people to take the vaccine but often this is a 'just get it' message, there is less on the evidence of benefits of vaccine. Need more information coming forward on e.g. pregnant women talking about how they were affected (no ill effects from vaccine), child well, this would be more useful. A lot of of information is about people who don't have vaccine and the bad things that happen to them. More on the benefits. [From Factors #1 'Availability of appropriate information' discussion 26/8/2021]. 7. Information should be translated into a type of language that communities can understand. Not just about one or other world langauge (e.g. English vs another language). [From Factors #1 'Availability of

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				appropriate information' discussion 26/8/2021]. 8. Messaging – translation is often not about translation into a different language but more about offering 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 poor translation element may have miscommunicated the message. [From Factors #1 'Availability of appropriate information' discussion 26/8/2021]. 9. And some people can speak a language but not read it, which means a written translation is no good, want to speak about issues. We also want more lay language. From Factors #1 'Availability of appropriate information' discussion 26/8/2021]. 10. It is important who is talking about vaccine – trusted faith and community leaders, plus case studies about what happened with COVID and the vaccine. It is about how I protect myself and my family. [From Factors #1 'Availability of appropriate information' discussion 26/8/2021]. 11. The right messaging – lived experience is very powerful– people who have lost a family member may help with vaccine information. [From Factors #1 'Availability of appropriate information' discussion 26/8/2021]. 12. Information is often not culturally appropriate, a shortage of such information. [From Factors #1 'Availability of appropriate information' discussion 26/8/2021]. 13. Language can be very important for some communities, especially when combined

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				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 'Appropriate language' discussion 26/8/2021]. 14. Scientific language needs translation too. Need information in normal language, language as spoken by ordinary people. [From Factors #5 'Appropriate language' discussion 26/8/2021]. 15. We should also think about other communication than written, e.g. visuals and pictures. [From Factors #5 'Appropriate language' discussion 26/8/2021]. 16. 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. [From Factors #5 'Appropriate language' discussion 26/8/2021]. 17. 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?) [From Factors #5 'Appropriate language' discussion 26/8/2021]. 18. For questions linked to an individual's

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				specific health concerns, GPs are key. But if reservations are not health-related but, say, faith based, then other organisations become important. [From Factors #1 'Availability of appropriate information' discussion 26/8/2021]. 19. Information needs to be honest. A lot of COVID vaccine messaging is 'Get the vaccine'. It doesn't talk about benefits, the likely risks, what we know, what we don't. Honesty builds trust. It doesn't combat directly conspiracy theories that circulate and often it doesn't use the same channels as those theories. Need to aks why information flourishes in the face of more accurate information. [From Factors #1 'Availability of appropriate information' discussion 26/8/2021]. 20. Major public health organisations should have ongoing ways of countering messages and misperception but using the same platforms, may mitigate the impact. [From Factors #4 'Harms vs benefits' discussion 26/8/2021]. 21. Things are changing re. factors in favour of taking the vaccine, it's now not just health-related considerations. Other things abvout taking part in society are relevant now e.g. travel, going to events, being able to get or keep a job, attend university lectures. People weigh things up about the importance of vaccine, depending on background eg. Their religious background. Eg in some communities re. whether vaccine is halal, there is an emotional aspect attached to it. [From Factors #4 'Harms vs benefits' discussion 26/8/2021]. 22. Flexibility has to be responsive to the times and the mood. What we learn, we need to take into account. That flexibility needs to

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				be in the message and not just the physical location/time of vaccination. Some people feel bullied by the messaging approach, eg. People working in care industry, feeling pressurised, people feeling targeted in a negative way. The messaging has often been about blame rather than a message to persuade. This makes people defiant, they don't want to be forced. [From Strategies #3 'Flexibility venues & times' 16/9/2021].

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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***	• There was no evidence on costs in the two rapid reviews for tailoring messages 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. [From Strategies #1 'Trusted messenger' discussion 2/9/2021]. 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. [From Strategies #1 'Trusted messenger' discussion 2/9/2021].

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			3. How to value saving people's lives/preventing serious illness? Information and work being done to save lives, and is therefore important. Government is doing things but it is haphazard. [From Strategies #1 'Trusted messenger' discussion 2/9/2021]. 4. 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. [From Strategies #1 'Trusted messenger' discussion 2/9/2021].
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.	
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. 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

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				community. From Strategies #1 'Trusted messenger' discussion 2/9/2021]. 2. Need to consider the message itself, need to trust the message too. From Strategies #1 'Trusted messenger' discussion 2/9/2021].
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.	
FEASIBILITY	Is the strategy feasible to implement?	*Don't know* ☐ *Varies* ☐ *No* ☐ *Probably no* ☐ *Probably yes* ☒ *Yes* ☐ **Detailed judgements**	• There was no direct evidence presented in the two rapid reviews regarding the feasibility of strategies suggested by stakeholders.	

Conclusions

	We recommend against tailoring the message	We suggest not tailoring the message	We suggest tailoring the message		We recommend tailoring the message
Type of recommendation	☐	☐	☐		☒

Recommendation/decision

Based on evidence from the UK and the US, plus our own experience, we recommend the use of tailored messaging to deliver public health messages on the COVID-19 vaccine. Tailoring is not just (or even mainly) about choice of which language(s) are used to communicate, but about usage of culturally appropriate, jargon-free, accessible language that addresses questions and issues that are relevant to the individuals targeted by the message. Tailoring includes whether to deliver information in written or oral formats.

Messaging needs to take account of information coming from countries outside the UK because family and other ties make non-UK information more influential for ethnic minority communities than for the majority population.

Justification

If messages on vaccines are tailored so that the world language used, the usage of language itself (e.g. culturally, age, non-science background appropriate, spoken or written) and the questions and issues addressed are relevant to those targeted, research evidence and our own experience suggests that this is likely to improve uptake. Quantitative research evidence on the size of effect of such an intervention is extremely limited.

However, identifying the form of the message and how it needs to be tailored is not a trivial task and needs collaboration with organisations working with ethnic minority groups. Simply believing that it is a matter of translating one piece of information from English into, say, Punjabi is considered a rather lazy approach to tailoring information. The problem is more likely to be the issues discussed in the message, the usage of language (e.g. culturally inappropriate) and who is delivering the message (see Strategies #1 'Trusted messengers'). Issues change over time and messaging needs to follow those changes. The content of the message needs to be considered together with who will deliver it because a correct and appropriate message may not be effective if delivered by the wrong (i.e. untrusted) organisation or person. The reliance on written information is a problem for many and other forms of communication, especially spoken, should be considered.

Individuals from ethnic minority groups are more likely than the majority population to look for, and trust, vaccine information from outside the UK because of family and other ties to 'home countries'. Effective messaging needs to take account of this and counter any differences, or misinformation, between UK messaging and non-UK messaging where it exists.

The choice of platform for delivering the message is part of the tailoring. Public health organisations need to be aware of where ethnic minority individuals, by age and gender, often get their information, see what is being delivered there and counter any misinformation using the same channel. There is no point, for example, using TV messaging if most of the target group does not watch TV.

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. As the name of this strategy makes clear, messaging needs to be created together with the communities being targeted. There is no universal solution.
Implementation considerations	Message tailoring is by definition not a one-size-fits-all strategy. Doing this well will require working directly with communities and community-based organisations. 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 the message when community organisations have greater expertise in knowing what sort of message will work in their community. It is important to be aware of how messaging may need to change as new research and knowledge becomes available. Uncertainty should be acknowledged where it exists, including explicitly stating that the message is true based on current research and knowledge, but there is uncertainty and the message may need to change in the future. Messaging is unlikely to be static in the face of uncertainty. 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 tailored message 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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