COLLABORATION FOR CHANGE

Could enabling appointment flexibility in terms of venues and times 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 using community-based venues for vaccination, having flexible and diverse systems for booking appointments, and allowing longer time slots where there are language barriers. 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 flexible venues/times 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: *Flexible venue/times*

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 #6 (Accessibility) presents some evidence from surveys regarding size of effect of on vaccine uptake convenience. More convenience generally means greater uptake.	1. Some ethnic minority communities live in multigenerational households and this fact has not been used in public health information provision. Vaccine delivery did not recognise that many older people could not get to a vaccination centre so the family waits until everyone can go. The delivery system should be tailored to allow household vaccination, recognising how people live [From Factors #1 'Availability of appropriate information' discussion 26/8/2021]
	How big are anticipated harms?	*Don't know* ☐ *Varies* ☐ | *Large* ☒ *Moderate* ☒ *Small* ☐ *Trivial* ☐ **Detailed judgements**	Concrete strategies suggested from rapid reviews (but with no effect estimates): • Identify alternative, community-based venues for vaccination e.g. places of shelter, comfort and safety and worship. [#grey24; UK study done in 2020/21, 23 community leaders talking about the COVID-19 vaccines; Focus groups; study quality high].[3]	
	How certain are we about the above?	*No included studies* ☐ | *Very low* ☐ *Low* ☐ *Moderate* ☐ *High* ☒	• Have flexible and diverse systems for booking appointments, with reminders. SMS-based approaches for recall systems, bookings and reminders in addition to letter-based systems. This includes having systems to identify who may need tailored support. [#469; UK study done in 2013-2015 with 174 Traveller participants (mainly Romanian Roma and Irish); Focus groups and interviews; study quality high].[4] • Longer appointment slots where there are language barriers. [#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]	2. 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. [From Factors #6 'Accessibility'

	CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	COMMENTS
			Strategies that have been evaluated experimentally: • There were no evaluations of this strategy identified by the two rapid reviews.	discussion 2/9/2021] 3. 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. [From Factors #6 'Accessibility' discussion 2/9/2021]. 4. 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 to fit into existing activity. Clearly popeole are willing but accessibility, trust etc stopping people. Accessibility is an important issue. [From Factors #6 'Accessibility' discussion 2/9/2021]. 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

	CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	COMMENTS
				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. [From Factors #6 'Accessibility' discussion 2/9/2021]. 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. [From Factors #6 'Accessibility' discussion 2/9/2021]. 7. 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. [From Factors #6 'Accessibility' discussion 2/9/2021]. 8. 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. [From Factors #6 'Accessibility' discussion 2/9/2021].

	CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	COMMENTS
				9. 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. [From Factors #6 'Accessibility' discussion 2/9/2021]. 10. 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. [From Factors #6 'Accessibility' discussion 2/9/2021]. 11. People want flexibility, but they are also worried about being specifically targeted by a system they don't trust. Having a special vaccination locations/centre just for them may not always work. Creating protected time at an existing vaccinaation site, and making getting there easy (e.g. by providing transport) may be better. This is less likely to come across as directly targeting them, but rather providing a more sympatehtic

	CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	COMMENTS
				environment within the same vaccination process that everyone uses. 12. Flexibility has to be responsive to the times and the mood. What we learn, we need to take into account. That flexibility needs to 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. [Might also be placed in Strategies #2 'Tailoring the message']

	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.	

	CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	COMMENTS
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 flexible venues/time strategies.	
	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.	
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.	

	CRITERIA	JUDGEMENTS	RESEARCH EVIDENCE	COMMENTS
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 flexible venues & times	We suggest not using flexible venues & times	We suggest using flexible venues & times	We recommend using flexible venues & times
Type of recommendation	☐	☐	☐	☒

Recommendation/decision Based on evidence from the UK, plus our own experience, we recommend the use of flexible venues and/or appointment times for offering COVID-19 vaccinations to ethnic minority communities. The type of flexibility required will vary by ethnic group and, equally important, this will vary depending on the local ethnic minority community itself.

Justification

Being flexible about how vaccines are delivered comes up often as a potential strategy to increase vaccine uptake, both in UK research and our discussions. Though used reasonably often, quantitative research evidence on the size of effect of such an intervention is extremely limited. The type of flexibility required will vary by ethnic group and, equally important, this will vary depending on the local ethnic minority community itself. In other words, solutions are likely to be local with the national strategy being 'offer flexibility'. Exactly how flexibility is achieved is a local decision.

A common feature of programs is to offer the vaccine at places already used by members of the ethnic minority community. These can be faith-based but might not be and looking beyond faith-based options is important. Solving transport problems, especially for multigenerational families living on low incomes is another way flexibility has been offered. Offering the vaccine now, rather than at some future scheduled appointment time, is likely to be part of any strategy offering flexibility. Flexibility should also cover the content of vaccine messaging; it needs to react to new research and unfolding issues of concern (see Strategies #2).

Community organisations are well-placed to organise events and in some cases it is only the presence of community group members that means individuals feels sufficiently reassured to come forward for the vaccine. This is especially true for migrants and undocumented individuals. Public health organisations should be willing to cede control of planning and delivery when community organisations have greater expertise in knowing what will work in their community.

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 sort of flexibility required is something best understood and addressed by working together with the communities being targeted. There is no universal solution.
Implementation considerations	Flexibility in delivering the vaccine is likely to be very local and this means 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. 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 flexible venue/timings 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.

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).