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The Independent Scientific Advisory Group for Emergencies (SAGE)

# The Independent SAGE Report 41

# Vaccine Uptake, Ethnicity and Difference

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Submitted to The UK Government and the People of Great Britain & Northern Ireland by Sir David King, former Chief Scientific Adviser, UK Government, Chair of Independent SAGE

**Vaccine Uptake, Ethnicity and Difference**

The widespread roll out of COVID-19 vaccines is central to the country regaining ordinary social and economic life. Surveys showing that some people expressed reluctance to take up the vaccine when offered it were, therefore, often met with surprise and often disapproval and incomprehension at what some journalists and politicians considered as irresponsible attitudes that could damage the whole population by reducing immunity.

As the vaccine rollout has gathered pace, it has become clear that the vast majority of those offered the chance of the vaccination do take up the offer and are vaccinated, with over 90% of those offered vaccines receiving vaccinations. There were, however, different vaccine uptake rates for different ethnic groups. Widespread reports that black and Asian people are more likely than other groups to say that they would not accept the vaccine were frequently interpreted as due to ignorance. However, there is increasing media attention to more complex reasons for reported intention not to be vaccinated, including access. issues This briefing paper considers the multifaceted reasons for refusal of the COVID-19 vaccine and what is likely to encourage maximum uptake. It addresses three issues: intersectional factors in vaccine uptake; the dynamic nature of uptake, and effective strategies for maximising vaccine uptake.

**Key recommendations**

1. Government, media and health practitioners should avoid treating people as if their stated resistance to vaccines is 'mindless' or simply ignorant and instead listen to the issues they raise and address them respectfully.
2. Health practitioners should take time with people to discuss and to make up their minds about the vaccine if they are unsure whether to accept it and give repeat appointments if required.
3. Local authorities, health services and community groups should make concerted efforts both to support people who want more information on the vaccine.
4. Local authorities, health services and community groups should ensure that vaccination provision is accessible to local communities, rather than expecting everyone to attend / travel to vaccination centres.
5. Employers should be compensated to give employees paid time to have vaccinations and paid time off if they experience side effects.

## 1. Ethnicity in context: Intersectionality and vaccine uptake

One of the lessons from research on the outcomes produced by COVID-19 is that these are unequally distributed, so that black and Asian people are more likely than white people to get COVID-19 and to die from it. It is, however, equally clear that this is not because black and Asian populations are more susceptible to COVID-19. Instead, there is an intersection of social categories and issues that make them more susceptible. For example, they are more likely to work in 'frontline jobs' and to live in households with many people within them, as well as to live in poverty and so to be less able to take avoidant measures.

Intention to take up the COVID-19 vaccine and actual uptake are intersectionally patterned, rather than being confined to single categories of people. Those who report that they are unlikely to take up the offer of a COVID-19 vaccine are more likely to be black, Asian, and Eastern European, as well

as being younger adults, parents of 0-4-year-old children, living in socioeconomically deprived areas, working in frontline public-facing jobs (e.g., in care homes for elders), health care workers, and doctors working in areas with high levels of COVID-19. The reasons for stated intentions not to be vaccinated are numerous and multi-faceted., not single causes. These include:

- *Lack of trust in medical innovations* because there has been a racist history of testing medical interventions on black people without telling them (particularly, but not only in the USA).
- *Lack of trust in the ingredients of the vaccine and the process of trialling* because the rollout was faster than usual.
- *Communication and Vaccine disinformation* and insufficient opportunities to discuss openly and take time to decide, rather than having to attend vaccination queues in order to ask questions queues as well as a lack of information in community languages.
- *Lack of access and resources* Difficulty attending place or time because of employment/childcare commitments/money for transportation.
- *Lack of available vaccines accessible.*
- *Fears about its side effects,* particularly its *impact* on fertility or health
- *Loss of earnings* to go and get the vaccination and if side effects require taking sick leave for a day or two.

## 2. Effective strategies

The Secretary of State for Health has indicated that he will consider making vaccines compulsory for care staff in the same way that hepatitis B vaccines are compulsory for surgeons and yellow fever vaccines compulsory for travellers to various countries. Compulsion is, however, likely to ostracise the very people who already are distrustful or alienated from the authorities, and to stigmatise and to deepen inequalities. It can also serve to distract from the key task of ensuring that workplaces are safe. There are, however, strategies that are already being locally practised that have been shown to work. They require that the multiple, intersecting causes be taken seriously and effectively addressed. Strategies include the following:

REDUCING INEQUALITIES

- Avoidance of coercive, punitive measures that reinforce inequalities.
- Acknowledging the intersecting reasons for differential vaccine uptake and public addressing of how these differences arise.
- Vaccination of those with No Recourse to Public Funds

TAILORED, CULTURALLY SENSITIVE COMMUNICATION

- Serious, targeted addressing (rather than dismissal) of vaccine disinformation provided in a range of sources, including the internet and public health campaigns on vaccination (NHS, public health, religious and government). These should go beyond famous members of various ethnic groups being in advertising campaigns.
- Communication on community media such as on Sunrise Radio Unity FM, Bongo TV, Asian FM, ZTV, YouTube, WhatsApp and other social media etc., and not only in English.
- Time for those who attend vaccination centres to discuss and leave without being vaccinated and with the opportunity to return when they choose. This entails training health workers to act as trusted friends in the vaccination process.

- Avoidance of stigmatisation and treating groups as ignorant and mainstream information as the answer to lack of uptake, including avoiding the use of the term 'hesitancy'. Respectful treatment of those who do not wish to be vaccinated.
- Stressing the high uptakes and importance for the young who will be provided with vaccines soon (hopefully)

LOCAL ENGAGEMENT AND DELIVERY

- Local interventions There are now both mobile vaccination units in some areas and vaccine centres in mosques, community centres etc., that operate day and evening hours. This pattern should be emulated.
- Using community champions to promote vaccine uptake amongst minoritised ethnic groups.

### 3. Recognition that intention is not the end result: Dynamic processes in vaccine uptake

It is clear that people change their minds. The fact that increasing percentages of the population across all groups report that they are willing to be vaccinated demonstrates that behavioural, intention is not equivalent to behaviour.

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