

Lessons about COVID-19 vaccine hesitancy amongst ethnicity minorities in the UK

Seilesh Kadambari PhD^{1*} and Samantha Vanderslott PhD¹

Author Affiliations:

¹Oxford Vaccine Group, Department of Paediatrics, University of Oxford and the NIHR Oxford Biomedical Research Centre, Oxford, UK

*Corresponding author: Room 02-46-10, Department of Paediatrics, University of Oxford, Level 2, Children's Hospital, Oxford, UK, OX3 9DU. seilesh.kadambari@paediatrics.ox.ac.uk

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In the UK, ethnic minority groups were between two and four more times more likely to die due to COVID-19 compared with those from a white ethnic background (1). These outcomes are independent of age, sex, or socioeconomic factors. Moreover, at the start of the national vaccine rollout, routinely collected clinical data in England showed that Black people over the age of 80 were only half as likely as white people to have been vaccinated against COVID-19 (2). A UK-wide survey of 12,035 participants investigating attitudes toward COVID-19 vaccination showed that Black and Black British respondents had the highest rate of vaccine hesitancy (71.8%), followed by Pakistani and Bangladeshi respondents (42.3%) compared with white British or Irish respondents (84.8%) who were likely/very likely to take a vaccine (3).

Since the start of the COVID-19 vaccine programme, we have as health researchers sought to engage with over 200 community organisations that provide religious or social support for ethnic minority groups in order to offer information about available vaccines, answer questions and encourage dialogue. We have met with groups on online meeting platforms during lockdown to answer questions and discuss concerns. In our experience, the reasons for vaccine hesitancy are complex, multifactorial and vary according to age, sex, and ethnic group. However, two broad themes have been apparent.

The first relates to historical marginalisation and this gap appears to have widened during the pandemic. Distrust of government and public health bodies has arisen due to ongoing discrimination (cited earlier this year by the independent National Health Service Race Observatory Board), previous unethical research (e.g. in US Tuskegee syphilis study) and fears that groups are being misled about vaccines (4–6). All have contributed to current hesitancy amongst minority groups in receiving a COVID-19 vaccine. We found organisations supporting asylum seekers and migrants raise concerns regarding deportation through registering for a vaccine. These communities, in addition to ethnic minority groups who live in the most socio-economically deprived urban areas, also highlighted concerns about access barriers in receiving a vaccine.

Secondly, we identified a range of similar concerns across ethnic minority groups relating to safety and potential long-term effects on health, where they felt there was a lack of clear guidance and advice. The speed of COVID-19 vaccine development and under-representation of ethnic minorities in clinical trials exacerbated underlying hesitancy. In particular, older individuals discussed concerns regarding developing a rare blood clot after receiving the AstraZeneca/Oxford vaccine (7). Younger women frequently stated concerns about infertility after receiving a COVID-19 vaccine. Misinformation, through social media channels accessed by different minority groups, have amplified these anxieties and reduced confidence in COVID-19 vaccines. Furthermore, messaging from central government (through TV, social or written media) to address vaccine safety concerns had not reached various communities we had engaged with. This was due for several reasons, including communication only being delivered in English and by politicians or policymakers who did not appear relatable. Celebrity adverts promoting COVID-19 vaccination also provided only one-way communication and did not enable a dialogue to occur with individuals and groups whose concerns had not been addressed.

The WHO have noted a dramatic increase in misinformation during the pandemic, which has been challenging and onerous to monitor (8). It is therefore essential for information to be provided in different languages and is widely promoted through community champions. Local healthcare providers and national policymakers should be encouraged to engage in a direct and two-way dialogue with communities in order to address specific concerns and ensure individuals have sufficient information to make evidence-based decisions regarding COVID-19 vaccines. Forging conversations with ethnic minority communities, using non-stigmatising language and focussing on listening to anxieties would improve vaccine uptake and beyond could also engender trust in governmental institutions. Practical solutions to make vaccination more convenient, including “pop-up” vaccine clinics in community centres, places of worship and “door-to-door” administration should also improve uptake. In the long term, quantitative and qualitative data will be required to monitor the uptake of vaccinations across all communities and understand reasons for any decline.

The pandemic has disproportionality affected ethnic minorities, causing some of the highest rates of hospitalisation and death. Developing and rolling out COVID-19 vaccines has been

one of the biggest public health achievements in the last century. The success of the COVID-19 vaccine programme relies on ensuring all members of society can access and have confidence in receiving a vaccine. However, the increase of the B.1.617.2 ('Indian') variant cases amongst non-vaccinated cases means that ongoing surveillance in ethnic minority populations makes effective engagement an urgent issue (9). This will also mitigate further worsening of disparities caused by the pandemic in ethnic minority groups.

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