



Covid-19 vaccine hesitancy among ethnic minority groups

Tackling the reasons for hesitancy requires engagement, understanding, and trust

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With mass covid-19 vaccination efforts under way in many countries, including the UK, we need to understand and redress the disparities in its uptake. Data to 14 February 2021 show that over 90% of adults in Britain have received or would be likely to accept the covid-19 vaccine if offered.¹ However, surveys have indicated much greater vaccine hesitancy among people from some ethnic minorities.²⁻⁴ In a UK survey in December 2020, vaccine hesitancy was highest among black (odds ratio 12.96, 95% confidence interval 7.34 to 22.89), Bangladeshi, and Pakistani (both 2.31, 1.55 to 3.44) populations compared with people from a white ethnic background.⁵

Even more worryingly, data up to 15 January 2021 show substantially lower rates of covid-19 vaccinations among over 80s in ethnic minority (white people 42.5%, black people 20.5%) and deprived communities (least deprived 44.7%, most deprived 37.9%) in England.⁶ Similarly, data from an NHS trust show lower covid-19 vaccination rates among ethnic minority healthcare workers (70.9% in white workers v 58.5% in South Asian and 36.8% in black workers; $P < 0.001$ for both).⁷

These data follow a historical trend of lower vaccine uptake in areas with a higher proportion of ethnic minority groups in England.⁸ Cohort studies using a primary care database of 12 million people show consistently lower uptake of influenza and pneumococcal vaccines in black Caribbean and African populations (50%) than in the white population (70%)⁹; lower vaccine uptake was also observed in people from South Asian backgrounds.⁹

Reasons for vaccine hesitancy

This has serious implications. The pandemic continues to have a disproportionate effect on people from ethnic minorities, with higher covid-19 morbidity and mortality and greater adverse socioeconomic consequences.¹⁰ Without an effective vaccination strategy to mitigate the risks, the situation will worsen. Moreover, the differential uptake will further exacerbate pre-existing health inequalities and marginalisation of ethnic minority groups.

Vaccine hesitancy, characterised by uncertainty and ambivalence about vaccination, is a legitimate viewpoint, underscoring the failure or lack of effective public health messaging. People who are hesitant can still be convinced of the vaccines' safety, efficacy, and necessity,¹¹ and, most importantly, they are not "anti-vaxxers." Vaccination rates are also lower in population groups that change address frequently, making NHS records inaccurate, which is common among people from ethnic minorities.¹²

The most common reasons for hesitancy are concerns about side effects and the long term effects on health,² and lack of trust in vaccines, particularly among black respondents.⁵ Some have capitalised on these concerns to spread misinformation,¹¹ adding to the historical mistrust of government and public health bodies that runs deep in some ethnic minority groups.

Trust is eroded by systemic racism and discrimination,¹⁰ previous unethical healthcare research in black populations,¹³ under-representation of minorities in health research and vaccine trials,⁹ and negative experiences within a culturally insensitive healthcare system.¹⁰ The disregard for non-Christian religious festivals has further undermined trust. Residential segregation, a form of systemic racism, affects health and access to resources to enhance health in multiple ways, creating conditions that amplify mistrust.¹⁰ Segregation is rising in Europe, and in the UK the Bangladeshi and Pakistani communities are the most segregated.¹⁴ Ethnicity intersects with socioeconomic status and educational attainment, accentuating the effects.^{10 14} Access barriers, including location of vaccine delivery and time, are other factors that could aggravate the disparities in uptake.

Building trust is key

Trust could be established by funding and supporting community and primary care led vaccination efforts, as GPs are likely to be more trusted³ by the communities they serve because of relationships built over time. Engaging community groups, champions, and faith leaders, and resourcing targeted, culturally competent interventions would also help reduce vaccine hesitancy.¹⁵ For example, assuaging doubts regarding the religious acceptability of vaccines will require consistent non-stigmatising messages in targeted populations, co-designed, shared, and endorsed by people within the community, including health professionals and faith leaders.^{9 16}

Prioritising vulnerable members of minority communities, in particular healthcare workers, for covid-19 vaccination and recognising their roles as trusted sources of information could reduce the perceptions of risk of covid-19 vaccines among people from ethnic minorities. Such communications can be made more effective by providing educational resources in multiple languages.¹⁷ Vaccination could be made more convenient and accessible through measures such as providing transport, particularly for people who work in lower paid public facing roles,¹⁷ and using places of worship as vaccination sites.¹⁸

The legitimate concerns and information needs of ethnic minority communities must not be ignored, or worse still, labelled as “irrational” or “conspiracy theories.” We need to engage, listen with respect, communicate effectively, and offer practical support to those who have yet to make up their minds about the vaccine. Covid-19 vaccination is one of the most important public health programmes in the history of the NHS. Tackling vaccine hesitancy and ensuring that vaccination coverage is high enough to lead to herd immunity are essential for its success.¹⁹

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