Leaving No one Behind - Improving uptake of the Covid 19 vaccination in underserved populations: the critical role of local collaboration and engagement with communities.

Introduction

This paper seeks to examine and share a city-wide approach to improve vaccine uptake in a large metropolitan city in the UK. The paper offers commissioners and practitioners insights into how a gender and culturally sensitive Covid-19 vaccination clinic was set up in a local area that was experiencing lower uptake rates. The paper suggests the importance of local collaboration and engagement with communities and partners; the prominence of a visible and trusted venue in a convenient location; and a nuanced communication plan in increasing vaccine uptake. Albeit requiring further research and validation, this paper suggests some early successes and potentially some transferable learning for wider engagement with public health efforts and reducing vaccine hesitancy.

As noted, the paper focuses on a large UK metropolitan city based in the north of England (referred to now as *'the city'*). The impact of Covid-19 on this population, and other populations globally, does not need to be rehearsed here. Nonetheless, analysis of the response necessary to protect communities from Covid-19 has exposed significant inequalities in a myriad of areas. This includes vaccination uptake where there is emerging evidence that vaccine hesitancy is higher in particular groups due to a range of explicit and tacit assumptions (Abba-Aji et al., 2022) and studies have shown that many ethnic migrant communities experience lower immunisation rates for vaccine preventable diseases generally (Charania et al., 2019). It has been noted that ethnicity, religion, language and upbringing are all factors that facilitate or inhibit vaccination uptake (Forster et al., 2016) and culturally diverse communities and those living in deprived areas may be particularly sensitive to government or state intervention and may have levels of distrust in state action (Marmot et al., 2020).

Due to the scale and severity of the Covid-19 pandemic, tailored approaches were needed to support widespread vaccination uptake. In order to address health inequalities and improve uptake of the Covid-19 vaccine in the city, partners from across the local authority, NHS and the third sector formed a partnership group to identify geographical areas and population groups with low uptake. Through close monitoring of Covid-19 vaccination uptake rates, interrogation of data intelligence and local insight, one ward was identified with significantly lower uptake than the city average. This local area had a number of characteristics which added to the complexity of developing a local response, including being a densely populated setting with the majority of its residents living in the most deprived fifth of the city. The local area was more ethnically diverse as a whole and had a younger population, according to local data sources. The age profile of localities within the city varies considerably with some large, deprived areas having a much younger population thus impacting further on the vaccine uptake rates of communities with similar demographics, as these age groups were called much later in the vaccine programme rollout.

Covid -19 vaccine uptake data from unpublished local data sources for the city indicated that culturally diverse communities were not accessing the vaccine offer as well as other groups. This data indicated that uptake in the culturally diverse communities was 24.1% lower than in the female White population for the Joint Committee for Vaccination and Immunisation (JCVI) priority groups 2-9. Vaccination declines were also 2.2% higher in the female culturally diverse cohort compared to the female White population. Findings also showed that 72.9% of those with English as their main language had been vaccinated compared to 46.0% of those who do not speak English as their main language.

According to data collected by Public Health England, culturally diverse communities were between two and four times more likely to die due to Covid-19 compared with those from a White ethnic background (Public Health England, 2021). These outcomes are independent of age, sex, or

socioeconomic factors. This is compounded by lower Covid-19 vaccine uptake among ethnically diverse groups (Robertson et al, 2021). Routinely collected clinical data in England showed that Black people older than 80 years were only half as likely as White people to have been vaccinated against Covid-19. A UK-wide survey of 12 035 participants investigating attitudes towards 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 (15·2%) who were not likely or very unlikely to take a vaccine (Robertson et al., 2021). This is particularly evident among Black ethnicity groups, in which 1 in 3 report hesitancy in receiving the vaccine (Office for National Statistics, 2021). This data is in line with previous trends in vaccine hesitancy and vaccine uptake more generally in ethnically diverse groups in England (Scientific Advisory Group for Emergencies, 2021).

Kadambari and Vanderslott (2021) identifies a range of similar concerns in culturally diverse communities regarding safety and possible long-term effects on health, in which these groups felt that there was no clear guidance and advice. The speed at which the Covid-19 vaccine was developed and the perceived lack of clinical trials in culturally diverse communities exacerbated existing feelings of vaccine hesitancy. In particular, older people discussed concerns relating to developing a rare blood clot after receiving the Oxford–AstraZeneca vaccine and younger women frequently stated concerns about infertility after receiving a Covid-19 vaccine. Misinformation, through social media channels accessed by culturally diverse communities, have amplified these anxieties and reduced confidence in Covid-19 vaccines. Communication from central government (through television, social media, or written media) to address vaccine safety concerns had not reached various communities in the city. This was due to communication only being delivered in English and by political leaders not being perceived as people that could be related to (Kadambari and Vanderslott, 2021).

Disaggregating health reporting by gender is not always routinely done or analysed with rigour or intensity to inform policymaking (Nowatzki and Grant, 2011). Like in all developed cities there are always examples to be found of good work being done to proactively support the needs of girls and women. However, there are still many areas of women's lives that are negatively affected by prevailing socio-cultural factors that have limited women in many ways which need to be recognised and acted upon (Allen and Sesti, 2018).

Key consideration and findings

The following sections draws together some of the key approaches to improve and increase uptake in the community.

Importance of local collaboration and engagement

NHS and Local Authorities have been working in partnership with third sector to respond to local challenges posed by Covid-19 on communities. The importance of a return to a semblance of normality and to begin the journey of resetting to a fairer and more equal society, particularly in areas of deprivation, has been paramount in tackling poverty and reducing inequalities.

Experience gained by these local services, of increasing uptake of vaccination in other vaccine programmes, was built upon to develop local approaches in consultation with local communities backed up by national evidence (Bell et al., 2020, Rutten et al., 2021). This included asset-based working – a prominent approach in public health and more traditionally in community development approaches which focuses on strengths and capabilities of communities, rather than issues and deficiencies - with people and communities to ensure that the vaccination programme was targeted, and uptake maximised in areas of deprivation and by groups who are at increased risk of illness and mortality from Covid-19 infection.

Through analysis of local vaccine uptake data, consultation with the local community and feedback from local leaders, the need for a community-based women's only clinic situated in a large densely populated and deprived inner-city area was required. Local consultation highlighted concerns from women in certain parts of the city, that the main vaccine offer lacked an accessible approach due to a number of factors, namely: location (lack of transport being a factor) and cultural sensitivity including a safe and private space to expose skin. In order to progress the development of a locally tailored approach, a partnership group was established to develop and deliver a local convenient vaccine offer to women in a specified geographical area, building the model based on the evidence of best practice to increase uptake of vaccine. Working closely with a women's third sector alliance, who have been identified as a trusted locally based partner who would be crucial in helping inform discussions around how to shape the model. Councillors were invaluable in providing local insight and promoting the clinic offer in local communities through their networks, and via a community radio station as a trusted voice. Local healthcare organisations were also engaged to provide clinical leadership and vaccine supply. The Local Authority Communities Team were able to inform discussions with local insight and through their Community Champions who possess multilingual skills and have an existing reach into the target communities. Operations Leads from the Local Authority were engaged to carry out risk assessments for the venue and organise staff on the day. NHS Communications Team members helped design and disseminate a corporate promotional flyer for the vaccine offer and manage media interest. Local Authority Public Health led the partnership group and enabled partners to work collaboratively and carry through respective actions.

A local, familiar, visible and trusted venue was identified in a convenient location in the heart of the target area, which has a high representation of culturally diverse communities residing in and surrounding the area. The clinic was planned to take place in April 2021, but it was quickly recognised that this could potentially exclude some people due to an overlap with Ramadan and school holidays. This was taken into account and re-scheduled dates were identified for the clinic to the end of May 2021, so they aligned with the dates for the roving bus vaccine offer in the building next door, to enable signposting to both facilities by staff.

Nuanced communication plan

WHO (2021) noted a substantial increase in misinformation during the pandemic and it was recommended that information should be provided in different languages and to be widely promoted through Community Champions. Forging conversations with culturally diverse communities, with non-stigmatising language and focusing on listening to anxieties, would improve vaccine uptake and 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, were also recommended to improve uptake. Informed by the evidence and local intelligence the communications plan for the women's only clinic had a two-strand approach. This involved communication materials developed by local NHS partners, including social media graphics, a press release and support for media presence/enquiries, supported by strong third sector involvement who were able to build trusting relationships with communities and disseminate culturally sensitive promotional resources via third sector and primary care colleagues.

A dedicated women's third sector alliance comprising of a number of partners, further adapted and tailored local communication resources in response to local insight, for people who may be less receptive to a corporate message. The flyer contained imagery representing the local community. The flyers were shared widely amongst partners including the third and faith sectors, alongside being delivered in food bank parcels and via volunteers in the local area during the week of the clinic. The community engagement was largely targeted in the local area, but all women in the city were eligible to attend.

The specific measures that were put in place to create a conducive environment were a drop in system; private booths/pods; a children-friendly space; Social Prescribers and Debt Advisors in attendance to help signpost women to other services; a language support machine and Community Champions providing outreach and promotion to local businesses. Elected members were also visible in the community speaking to local residents to promote the offer throughout the week.

The weeklong drop-in vaccine clinic was set up in May 2021 attracting 116 women in total who had not accessed the vaccine through initial invites from the NHS. The demographic data (unpublished NHS data) indicates that the majority of women attended lived locally to the clinic, were from culturally diverse backgrounds, attended for their first vaccine, and were aged between 30-50. Thirty-five percent of the women identified as White British, 14% identified as Pakistani, 12% identified as Bangladeshi, and 9% as African. The remainder of the women were from a range of different ethnic backgrounds which is reflective of the diverse make-up of the area overall. This was a significant step forward as people had been eligible for the vaccine for some time and had not accessed through traditional routes. Amongst the vaccine takers, there was also a 90-year-old woman who presented for a first vaccine. Barriers were overcome around language and the drop-in approach encouraged women to speak with a healthcare professional about their concerns, without necessarily taking up the vaccine.

Learning and local insight from this clinic then informed next steps regarding future women's only offers in the city. Firstly, a second clinic at the same venue was delivered to support people in accessing their second dose in the same, familiar, location as their first, as well as offering first vaccines again for anyone who had not yet come forward. The same communications and engagement approach was utilised and at this clinic, a further 49 vaccinations were given.

Secondly, local women's organisations in the city were contacted to ask if they would be happy to host a vaccine clinic at their premises. There was a positive response from local organisations and following a site visit, a venue was chosen in the city. This venue was well established as a trusted venue in the community having been running since 1985. Some changes were made in the planning of the clinic this time. In response to feedback that people wanted options around which vaccine they can access – a healthcare organisation supported with the clinical elements as they were able to supply and offer two different vaccines. Harnessing the power of community networks, an addition to the communication plan was that the community centre staff contacted their members directly to encourage them to come for their vaccine. Finally, community centre staff supported on the day with the running of the clinic including offering language and translation support. There were 38 women vaccinated at the clinic in one day, and positive feedback was received regarding the local community offer. A second clinic was then arranged at the same venue and a further 18 women were vaccinated.

This settings-based approach, working specifically with third sector women's-only organisations, supported women to access the vaccine who had been previously invited for their vaccine in earlier months but did not attend. It was agreed to continue this setting-based approach: seeking existing community groups, events, and services in the city to offer supportive conversations and vaccinations to local residents. Additional clinics have been delivered in a food bank setting and a mother and baby group setting.

It became evident from the clinics so far that there were certain measures and considerations for the women's only clinics that were transferable to all vaccination clinics – not just women-only clinics. Whilst the focus at present was the Covid-19 vaccination, these same measures and considerations could be applicable to supporting women to access any type of vaccination. To support the sustainability of the approach going forward, a set of 'women friendly principles' were developed. The principles outlined actions in a checklist format encouraging vaccine clinics in any setting to consider what they can do to be more women friendly. The first section of the checklist

focuses on key basic requirements for what clinics can do while the second section highlights additional measures clinics could take. The aim is for these principles to be disseminated with services and organisations in the city that run vaccine clinics (including GPs, pharmacies, and community services). The principles will also be shared with staff as part of their vaccination training.

Concluding remarks

In mitigating inequalities and ensuring underserved populations have access to the Covid-19 vaccine, there is a need to work with communities to develop vaccine clinics that are gender and culturally sensitive and provide a local, convenient and trusted offer that meets the needs of residents. In the case outlined in this paper, a trusted and safe environment alongside a nuanced communication plan was of paramount importance to support women to access the Covid-19 vaccine who had not done so. Lessons learnt from delivering mass Covid-19 vaccination programmes shed light on the complexity of this unprecedented effort and the inequalities that can manifest. This paper also offers valuable insights on how vaccination campaigns need to be adapted to suit local needs, including the impact of providing flexible offers such as walk-in clinics that do not require digital access to book in advance, creating a friendly and accessible environment for women with childcare responsibilities and the opportunity for residents to engage in informal conversations with health care staff and local trusted community members in their own language.

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