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INVENTING FOR LIFE

Liverpool Vaccine Confidence Project

# UNLOCKING INSIGHTS

## VACCINE CONFIDENCE IN ETHNICALLY DIVERSE COMMUNITIES WITHIN LIVERPOOL

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# Contents



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At MSD, known as Merck & Co., Inc., Rahway, NJ, USA in the United States and Canada, we are unified around our purpose: we use the power of leading-edge science to save and improve lives around the world. For more than a century, we've been at the forefront of research, bringing forward medicines, vaccines and innovative health solutions for the world's most challenging diseases.

The MSD UK Medical Affairs Public Health team is committed to delivering public health initiatives that empower communities to live well for longer through collaborations with governments, academic researchers, and non-government organisations. Our public health activities include improving health literacy, addressing health inequalities, and improving access to healthcare.

Along with addressing vaccine inequalities, MSD is supporting other Public Health initiatives around the UK, including childhood immunisations, cancer, HIV, antimicrobial resistance, and Hepatitis C elimination.

For any queries relating to thie Liverpool Vaccine Confidence project please contact: corporateaffairsuk@msd.com

# Foreword

**‘After clean water, vaccination is one of the most effective public health interventions in the world for saving lives and promoting good health.’** [1]

**– UK Health Security Agency**

Vaccines save millions of lives across the globe each year by protecting against serious illness and death.[2] Despite this, many people remain unvaccinated and unprotected for various reasons. Even before the COVID-19 pandemic, vaccine hesitancy was listed as one of the 10 greatest threats to global health, and since 2019, global childhood vaccination rates have seen their biggest decrease in 30 years.[4] The potential of vaccines to protect global public health can only be fully realised if individuals and communities can understand, value and access them.

Vaccine confidence is underpinned by an incredibly complex spectrum of thoughts, decisions and behaviours with many layers to uncover. Vaccine confidence becomes even more complex and multidimensional in areas like Liverpool, because of inequalities in health and education, levels of deprivation, and diverse backgrounds and communities.[3,5]

National research from the last 10 years shows that there are lower levels of vaccine coverage for certain adult and child National Immunisation Programmes in areas of the UK with higher ethnically diverse and deprived populations.[6,7] Whilst recent UK Health Security Agency (UKHSA) data does not provide the demographic breakdowns of routine adult vaccine uptake, global research into influenza, pneumococcal and COVID-19 vaccines shows that uptake of vaccinations remains particularly low among older people from ethnically diverse groups.[8,9] This aligns with dedicated research undertaken in Liverpool, which shows that the city has one of the highest hesitancy levels in the UK for COVID-19 vaccinations. Additionally, Census data shows that Liverpool is in the top four lowest-income cities in England. This is key, as research shows ethnically diverse communities are more likely to remain unvaccinated and live in more deprived areas.[10,11,12,13]




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Exploring the ‘whys’ behind vaccine hesitancy in places like Liverpool requires time, empathy, commitment, and a shared goal for everyone involved.

As we embark on the post-COVID-19 recovery journey, it is important to refocus our thoughts towards catch-up programmes for routine childhood and adult immunisations, as well as COVID-19 vaccination efforts, whilst reminding ourselves that vaccinations are not only for a moment in time like COVID-19, but for protection throughout all stages of life.

This report begins to unpick some of the reasons for vaccine hesitancy in Liverpool and starts to consider where realistic and measurable action can be taken to build vaccine confidence. It aims to share key insights about hesitancy from a network of people involved in vaccine education and access, who have built long-term, trusted relationships with the diverse communities that they serve and represent, as well as insights directly from ethnically diverse communities themselves. While these perspectives may not always be relatable to others, we recognise that these insights reflect the legitimate concerns of people who face different barriers to accessing healthcare every day.

Exploring the intricacies of vaccine confidence, and the underlying factors that contribute to its increase or decrease, requires an unbiased approach that fosters an environment of open dialogue and conversations without judgement. This approach is crucial to preserve the remarkable progress made over the past four decades in eliminating life-threatening vaccine-preventable diseases. By acknowledging the opportunities for further positive transformation and continuing to fund and resource research and confidence programmes, we can continue to promote good health and equitable access for ethnically diverse communities in Liverpool.

We would like to thank everyone who has contributed to this project by giving their time, sharing their insights and ideas, and by inviting us into their communities to listen and learn.

There have already been several highly successful vaccine confidence projects undertaken and there are more underway in the Liverpool area. We hope to build on their success and be part of the ongoing drive to make positive change for communities in need.

# Foreword

### Professor Matthew Ashton | Director of Public Health, Liverpool City Council:

"Research which helps us understand how to recover our vaccination programmes is most welcome, and this research is helpful in its focus on our communities who are less likely to take up vaccination. We welcome the work done to listen to communities to understand the reasons behind low uptake of vaccinations, as well as with a range of stakeholders. The Unlocking Insights report adds to the considerable efforts in Liverpool to gain insight into vaccine hesitancy and work together including with communities to build confidence. The report acknowledges the role that many people have in promoting vaccine confidence, in addition to the issue of trusting relationships being invaluable. It also includes useful insights to inform how we can communicate effectively with diverse communities taking into account religious, cultural, gender and language issues, as well as consideration of access issues. The individual insights from specific ethnic communities are particularly interesting and the enabler sections are helpful in setting out solutions backed by insights."

### Amina Ismail | Community Mobiliser, International Public Health, Liverpool School of Tropical Medicine:

"The report sheds light on the paramount importance of trust and underscores the imperative of collaboration with communities as experts."

### Dr David Lewis | GP, Vauxhall Health Centre:

"We know that vaccines are effective but that lots of people are not keen to have them. This report helps us think about why that is and what we can do to encourage people to get vaccinated."

### Di Burbidge | Service Development Manager, Chinese Wellbeing:

"As a member of the Community Champions Programme, we have been pleased to share our insights for this report which has an impressive list of contributors and stakeholders. Thank you to MSD UK and CHC for producing such a comprehensive and detailed report. We look forward to working with you on the next steps to improving vaccine confidence in Liverpool."

### Professor Heather Brown | Professor of Health Inequalities, Lancaster University:

"As a researcher working in the area of health inequalities this report highlights not only barriers to vaccination but through discussions with communities provides innovation solutions to addressing these barriers. These co-developed solutions can help us to overcome these barriers and ensure that everyone can access the healthcare they need. In particular developing visual content that does not discriminate can help to overcome barriers to health literacy, and addressing solutions to different stakeholders in the community is important to knocking down some of the systematic barriers people face when trying to access health care."

### Farida Laeeq | Care Co-Ordinator, Brownlow Health, Central Liverpool Primary Care Network:

"An element that I really enjoyed within the report is the fact that a religious perspective has been considered. Religious beliefs and concerns not only impact vaccine confidence but many other aspects of healthcare too."

### Anna Kettle | Senior Communications and Engagement Manager, NHS Cheshire and Merseyside:

"This report is a really comprehensive piece of work and will be very helpful moving forward."

# Executive Summary

Throughout the development of this report, our intention has been to provide a helpful balance of insights about vaccine confidence in older people from ethnically diverse communities in Liverpool, and practical solutions that can be applied to other geographies and disease areas.

For those who wish to explore further, in-depth detail into the background of our insights is shared in full later in this report. We have also developed an overview of what we are calling 'Change Makers'.

## Change Makers

Change Makers are activities, approaches and initiatives identified during our research, which we believe have the potential to make a positive contribution to improving vaccine confidence and healthcare education among older people in ethnically diverse communities.

We hope that by sharing these, you will feel inspired to incorporate them into existing or future health programmes in your region. We recognise that some of these considerations may require financial resources and time commitments and may not be appropriate for now, but we hope that they have the potential to shape future work.

### Change Maker 1: Avoid assumptions about risk in at-risk populations

Rethinking what it means to be at risk and how individuals associate with this label can reframe conversations

We learnt that many people from ethnically diverse communities are unaware that they may be at greater risk of infection from vaccine-preventable diseases due to their age and existing health conditions, such as asthma or diabetes. As a result, they are less likely to actively seek, prioritise or accept vaccinations, which can be misinterpreted as hesitancy or rejection. Additionally, when at-risk labels are used in conversations or materials, they can cause fear, confusion and mistrust if the individual does not self-identify as at-risk. This can compound feelings of disengagement with the healthcare system.

### Change Maker 2: Enable concerns to be discussed without fear or judgement

Creating an environment of curiosity and trust as a starting point for conversations can build confidence

We learnt that some ethnically diverse communities have serious concerns about vaccinations, which can lead to rejection. Many of these fears stemmed from misinformation around COVID-19 vaccination programmes and included myths that theses vaccinations contained microchips for Government tracking, connecting to 5G networks, or was a form of ethnic cleansing or population control. This distrust builds on historical events, including clinical trials and eugenics programmes (outside of the UK) involving people from ethnically diverse communities. While these fears may seem unrelatable to others, it is important to recognise that they exist and to create a non-judgemental environment so that concerns can be discussed openly as a starting point for building confidence.

### Change Maker 3: Recognise how cultural and religious gender roles inform health boundaries

Designing programmes that respect gender boundaries can demonstrate understanding and respect

We learnt that in some ethnically diverse communities, gender roles can significantly influence healthcare decisions. Some religions and cultures have distinct boundaries regarding what can be shared and discussed between and within genders. For example, in some communities, it is not acceptable for male healthcare workers to provide women's health information directly to women, either through community groups, in-person, or through designated female-only group channels. In other communities, attitudes and behaviours towards healthcare interventions are determined by community matriarchs or male faith leaders.

### Change Maker 4: Respect religious and cultural boundaries

Understanding religious teachings and cultural norms can build trusted partnerships

We learnt that religious teachings and intergenerational households can have a powerful impact on attitudes and behaviours to healthcare, including decisions surrounding vaccinations. While teachings and opinions vary widely across different communities, there is a clear need for those involved in the design and delivery of health education to build positive trusted relationships with faith leaders. This requires commitment and time to better understand how religious teachings and cultural norms can be appropriately utilised to provide educational information and services that improve vaccine confidence.

### Change Maker 5: Invest in digital software and project planning

Piloting accessible platforms and processes that capture patient language preferences can support all users

We learnt that integrating digital software and extending access to translation services can help to overcome language barriers. Introducing digital software is currently proving to be a successful intervention for the Central Liverpool Primary Care Network. With an estimated 40+ languages spoken in Liverpool alone, digital software has been piloted in several areas and is enabling messages, appointment bookings and reminders, and prescription information to be delivered in the person's preferred language. Where possible, the use of multiple digital platforms and multifactor authentication steps should be avoided, to ensure digital health information and services are easy-to-access for those who have low digital literacy.

### Change Maker 6: Embrace non-traditional strategies for healthcare delivery

Moving health services into everyday community settings can increase familiarity and confidence

We learnt that non-traditional strategies used in the pandemic were well received by older people in ethnically diverse communities, as they responded to community needs and preferences around work and family commitments, travel limitations and physical abilities. Pop-up health bus clinics provided COVID-19 immunisations, health checks and women's health support. Community health days featured in supermarkets and mosques, and drop-in health sessions were arranged in hotels where asylum seekers were placed to bring health education to their doorstep. Family appointments spanning different generations were also trialled in other UK areas with some success.

### Change Maker 7: Identify keywords that magnify healthcare barriers

Understanding nuances in language and effective translation can reduce disengagement and increase trust

We learnt that unintentionally using certain words or phrases can immediately disengage some ethnically diverse communities. For example, some within Roma communities can feel disengaged when the term 'vaccination' is used, as they associate it solely with COVID-19 vaccinations. When applied to other vaccinations such as influenza or MMR, they assume that it includes COVID-19 vaccinations and, in many cases, reject other vaccinations by association. Additionally, many ethnically diverse communities disregard health information that includes the term 'citizen' as they believe it refers exclusively to British nationals or those born in the UK. It is essential to understand key terms and language preferences and tailor materials accordingly.

### Change Maker 8: Expand successful initiatives with confidence

Resisting pressure to create new campaigns can focus minds and resources on evaluating and amplifying existing successes

We learnt that the drive for health improvements can often become confused with a need to create new and different initiatives. However, the opposite is often true, as many of the most effective health interventions already exist. Their learnings must be reviewed and shared as best practice, so that successful projects can be evolved and implemented more widely. Contributors emphasised the impact of the Community Champions Programme as a vital healthcare connection for ethnically diverse communities. Initiated by the Department for Levelling Up, Housing and Communities, it was designed to support communities disproportionately affected by the pandemic and enhance vaccine uptake. The programme is now expanding its scope to address other important health priorities in Liverpool, such as childhood vaccination rates, obesity, and mental health.



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### Change Maker 9: Recognise the unique role of Community Health Workers within ethnically diverse communities

Investing in community health and social inclusion for the long-term can build sustainable benefits for all

We learnt that Community Health Workers, whether individuals or organisations, play a crucial role as intermediaries between communities and the services they require. The trust they have built with communities means they have become instrumental in the success of community engagement campaigns and health initiatives. Their deep understanding of community needs, ability to speak multiple languages and experience navigating the health and social care system, means they can identify seemingly insignificant nuances, needs and gaps that can have a significant impact on the communities they represent.

### Change Maker 10: Acknowledge ongoing reliance on native healthcare systems to address unmet needs

Providing education on how to navigate the UK health system can increase confidence and engagement

We learnt that older people from ethnically diverse communities often seek health information and services from their native countries, either in-person during visits or via word of mouth from family, friends and social media. Key drivers of this behaviour are a lack of familiarity, confidence and trust in the UK health system, language barriers in health messages compounded by frequent restructures and diminishing services. This can lead to increasing avoidance of local health services and an ongoing reliance on their native healthcare system.

### Change Maker 11: Recognise underlying socioeconomic and deprivation factors that impact vaccine uptake

Assuming everyone can prioritise health and access NHS services can undermine the realities of many communities

We learnt that low-income families may need to prioritise other more immediate needs to support themselves or their family e.g., additional work (out of traditional 9am-5pm working hours), food, and utilities. This may impact their prioritisation of health engagement and education and may impact their trust in local health services. Fundamental barriers of this nature are incorrectly perceived as hesitancy and must be overcome by adapting the way healthcare is delivered to allow for maximum access opportunities for all, no matter their socioeconomic or deprivation level.



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**Change Maker 12: Respect that one voice for ethnically diverse communities does not reflect the whole community**

Assuming that one voice can represent all voices can undermine the complexity and needs of a community

We learnt that when speaking to one person from an ethnically diverse background, it is important to remember that their insights and experiences cannot be applied with a broad brush to every other individual from the same community. Geography, experience and the way people live their day-to-day lives in line with their culture or religion can vary. Further exploration and time with communities allows for a more rounded approach and provides opportunities for further tailoring and adapting to communities' needs.



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# Acknowledgements

Over the past few months and throughout the development of this report, we have had the privilege of speaking to and working with 60 passionate and committed individuals across Liverpool, North West of England, and the wider UK.

Without their contributions, this project would not have been possible. We would like to thank everyone who shared valuable insights and experiences into the communities they work with, and we hope to continue supporting the valuable partnerships we have formed.

- Amina Ismail, Liverpool School of Tropical Medicine
- Dr Cathy Montgomery, Liverpool John Moores University
- Professor Marie-Claire Van Hout, Liverpool John Moores University
- Dr Daniel Hungerford, University of Liverpool
- Professor Heather Brown, Lancaster University
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- Liz Fisher, Liverpool City Council
- Professor Matthew Ashton, Liverpool City Council
- Pippa Tavriger, Liverpool City Council
- Shane Knott, Liverpool City Council
- Caroline O'Connell, Liverpool City Council
- Julie Anglesea, Liverpool City Council
- Dr Cait Taylor, Dingle Park Practice, Central Liverpool Primary Care Network (PCN)
- John Williams, Central Liverpool PCN
- Rakeeb Soufi, Central Liverpool PCN
- Farida Laeeq, Brownlow Health, Central Liverpool PCN
- Dr Fiza Salam, Brownlow Health, Central Liverpool PCN
- Dr David Lewis, Vauxhall Health Centre, Central Liverpool PCN
- Cathryn Bolton, Abercromby Family Practice, Central Liverpool PCN
- Dr Rob Barnett, Greenbank Road Surgery, Liverpool Local Medical Committee
- Linda Arends, Greenbank Road Surgery
- Dr Rob McGuire, Beacon Health
- Jessica Ashcroft, St James Health Centre
- Edna Boampong, NHS Shropshire, Telford and Wrekin
- Iain Brand, NHS Cheshire and Merseyside
- Louise McNee, NHS Cheshire and Merseyside
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# Introduction

The evidence to support vaccinations as a global health intervention is difficult to dispute – vaccines have the potential to reduce deaths, eradicate disease, and protect against serious illness that can cause death and damage livelihoods.[14, 15] While UKHSA data states that vaccines prevent up to three million deaths worldwide each year, the reality of accepting and accessing vaccines for so many communities is vastly different.[16] The gap between evidence and experience has resulted in a huge rise in global vaccine hesitancy.

Vaccine hesitancy and vaccine confidence are complex issues dependent on multiple factors. According to the World Health Organization (WHO), vaccine hesitancy can be defined as:

> ''A delay in acceptance or refusal of vaccines despite availability of vaccination services.'' [17]

On the other hand, vaccine confidence reflects the implied trust someone has in a vaccine, their healthcare professional and the policymaker who makes decisions surrounding the provision of vaccines. Although the two terms can, in most cases, be used interchangeably, the preferred term for this report is vaccine confidence.

The research conducted as part of this project and in line with previous COVID-19 research, demonstrates that some of the key barriers faced by ethnically diverse communities include access, education, language, culture, religion, and socio-economic circumstances.[8] Consideration of how these barriers have changed and become further engrained in a post-pandemic landscape formed a significant part of this research. Further exploration of these complexities, as well as insights into building vaccine confidence, are included later within the report.

## Why is new research on routine adult vaccinations needed now?

In 2019, the WHO highlighted that without action, global hesitancy 'threatens to reverse progress made in tackling vaccine-preventable diseases.

> The UKHSA's strategic plan 2023 to 2026, stated that 'our world is changing in multiple, compound ways that are amplifying the health security challenges the UK and other countries are likely to face. The COVID-19 pandemic has been a reminder of the impact that health hazards can have on our lives and livelihoods. It has also shown the great strides that can be made when government, industry, and academia work together, developing innovative solutions and harnessing the power of data and scientific insight to drive policy and response.'[15]

Efforts are now being made to bring vaccination rates back up to their pre-pandemic levels and utilise the significant learnings captured, and the new processes and partnerships created. Initiatives such as the UKHSA Strategic Plan 2023 to 2026 and the 'Immunization Agenda 2030', align with the NHS Vaccination Strategy, which aims to use behaviour and health service science to "maintain hard-won gains in immunisation, recover from the disruptions caused by COVID-19, and leave no one behind, in any situation or at any stage of life" [15, 18] Additionally, 'The Big Catch-up' was announced by the WHO in April 2023.[19] The initiative sees global health partners vowing to increase levels of childhood immunisations to pre-pandemic rates, and, ideally, to exceed these targets.[19]

While such initiatives place significant focus on children or clinically vulnerable adults, it is also important to steer attention and resources to vaccine-preventable diseases that are prevalent in adults in the UK. This is particularly important for those who are at risk or elderly, to ensure that as a country, we prepare for, prevent, and respond to health threats. For example, before and during the COVID-19 pandemic, levels of eligible populations receiving vaccinations for shingles and pneumococcal disease were below the national target. [20, 21] However, with the focus on recovering vaccination programmes following COVID-19, uptake is steadily and slowly increasing for eligible populations.[15, 21] In comparison, influenza vaccination coverage for 2022-2023 has decreased in those aged 65 years and over, with the UKHSA stating in their Seasonal Influenza Vaccine Uptake in GP Patients – Winter season 2022 – 2023, that no group achieved the national vaccination uptake ambitions, equivalent or higher in 2022-2023 vs 2021-2022. [22]

## Why does this report focus on ethnically diverse communities aged 50+?

Whilst current UKHSA data does not provide the demographic breakdowns of routine adult vaccination uptake, global research into influenza, pneumococcal and COVID-19 shows that uptake of vaccinations remains particularly low among older people from ethnically diverse groups.

These populations experience higher levels of vaccine hesitancy and lower levels of routine vaccination uptake. [8]

Older age is also a risk factor for contracting vaccine-preventable diseases, such as influenza, shingles and pneumococcal, and experiencing morbidity and mortality from them and there are a lack of interventions focusing on increasing vaccine confidence in this age group. [23, 24, 25]

As a result of increased hesitancy and lower uptake, older people from ethnically diverse communities who remain unvaccinated are at increased risk of serious illness. [5, 8]

**There is a significant amount of knowledge within local communities about the factors that influence uptake of routine adult vaccinations and how to tailor vaccine confidence initiatives to specific groups. However, as this has not been widely documented or shared in the UK, the potential success of policies or interventions to improve vaccine confidence may be limited.**

Inspiration can be taken from the success of local programmes delivered during the COVID-19 pandemic, which demonstrated the impact of delivering tailored interventions for ethnically diverse communities.[5, 8, 26]



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Therefore, this report has been designed to provide:

- New insights into some of the factors behind levels of routine adult vaccine hesitancy
- Recommendations about how vaccine confidence can be improved amongst older, ethnically diverse communities in the Liverpool area.

It is important to note that while evidence shows us that older people from ethnically diverse communities are at an increased risk of serious illness when remaining unvaccinated, and there is a higher level of hesitancy in ethnically diverse groups more broadly, they are not mutually exclusive. Low levels of vaccine engagement and confidence have also been reported across age ranges, and ethnic majority groups (e.g. white British communities with high levels of deprivation), in Liverpool and across the UK.[11, 12, 27] During the pandemic, there was dedicated research carried out within these groups, including a focus on white British males aged 50+, by organisations such as the Liverpool School of Tropical Medicine (LSTM). Whilst we acknowledge ongoing work is required to support all ages and ethnicities who are hesitant to health interventions like vaccinations, this project focuses on ethnically diverse communities, and older generations within these groups.

## Why is Liverpool the chosen pilot location?

Liverpool falls below the national average for vaccination uptake:

- Research published by the LSTM in 2022 showed that Liverpool has one of the highest hesitancy rates in the UK for COVID-19. Only 70% of people aged 18 years and above had their first COVID-19 vaccination dose, and there are stark disparities in vaccination uptake across different demographic groups.[28]
- Liverpool has the highest ethnically diverse population in Cheshire and Merseyside.[11]
- Across the city, there is a higher density of ethnically diverse groups compared with other regions of Cheshire and Merseyside, including, but not limited to, African, Pakistani, Chinese, Asian, Indian, Caribbean, Polish and Roma (ethnic group break down aligned to Census categories).[5, 11, 12]
- Within the Liverpool area there are varying levels of deprivation. Deprivation is affected by wider social determinants of health such as housing, working conditions, unemployment, healthcare access etc. In a 2021 report by Liverpool John Moores University, it was estimated that 21% of people over 60 years of age are income deprived.[29] In 2019 (data published in 2020), Public Health England (now known as UKHSA) listed Liverpool as one of the most deprived areas in England, with life expectancy for both men and women lower than the England average; 11.1 years lower for men and 8.9 years lower for women in the most deprived areas. In the same report, the Health Summary for Liverpool classed many health indicators (including life expectancy and causes of death, injuries and ill health, behavioural risk factors, child health, inequalities, wider determinants of health and health protection) as 'significantly worse' when compared to goal/England average. All can play a role in the ability to access, utilise and prioritise health interventions.[30]
    - The Census 2021 data shows Liverpool:
        - Has one of the highest levels of unemployment (age 16-65 years) in the UK. With a decline in the percentage of people 16 years and over (excluding full-time students) who were employed full time.[31]
        - Is ranked fourth most income-deprived out of the 316 local authorities in England. With 23.5% of the population being income deprived in 2019.[13]

## How will this research build on existing work in Liverpool?

Extensive work has been undertaken in the Liverpool and wider Merseyside area to understand the reasons behind low levels of COVID-19 vaccination uptake during, and as a result of, the pandemic. Notable work includes the Liverpool Vaccine Equity Project and the implementation of Community Champions,[32] as well as the Getting Under the Skin report.[11, 12] This work provided valuable insights into the barriers and enablers of COVID-19 vaccination programmes and must be acknowledged for its commitment to improve health across the city and its potential to create a long-lasting legacy.

We aim not to duplicate existing or ongoing work, but rather build upon it, and apply learnings to the challenges facing routine adult vaccinations. Whilst the benefits of the existing COVID-19 interventions are continually being seen, it is now time for low levels of vaccine confidence to be addressed in the city beyond COVID-19.

## What is our objective?

At the start of Unlocking Insights: Vaccine confidence in ethnically diverse communities within Liverpool, our primary objective was:

- To support healthcare professionals to have proactive, non-judgemental discussions with their older (50+) ethnically diverse populations about routine adult vaccinations, so that they can make informed decisions that are right for them. These discussions include:
  - The benefits and risks of routine adult vaccinations
  - Recognition of specific concerns an individual might have
  - Identification of specific barriers and enablers impacting vaccine uptake

However, as the project has evolved and since speaking to 60 individuals who have provided insights into what it is like for different communities who face the realities of barriers to healthcare every day, we rapidly discovered the extensive network of people involved in vaccine education and access, including healthcare professionals, NHS/public health leads, community leaders, faith groups, council representatives, academics, and community health workers. **As a result, we have updated our objectives as follows:**

- Understand the unique barriers and enablers to vaccine confidence amongst older aged individuals from ethnically diverse backgrounds in Liverpool.
- Utilise these insights to co-create and co-test educational outputs for healthcare professionals, community health workers and those that work with communities and/or people from ethnically diverse communities.
- Reduce vaccine inequalities by enabling healthcare professionals to have non-judgemental discussions around routine adult vaccinations within these communities, so that people can make informed decisions around vaccinations that are right for them.

We recognise the crucial role that community health workers, healthcare professionals, community representatives, local charities, and organisations play, and our report is designed to recognise and aid those who support people in making informed decisions about their health.

## Methodology:

Research shows that community involvement in positive behaviour change and vaccine confidence programmes provides the best outcomes for all.[5, 20] Tailored, hyper-localised initiatives that strive to understand and navigate key barriers have been proven to be the most effective. The very nature of these programmes depends on extensive insight gathering, genuine co-creation and community-led testing to see what works well and what needs improving. Learnings from previous studies have also highlighted how blanket, national approaches to understand and increase vaccine confidence are no longer effective in reaching the communities most in need. The methodology for this project was designed on learnings from other successful research projects, both within and beyond Liverpool, to maximise the potential for success.

### Initial research

Before initiating phase 1 of this project, it was important to conduct desk research into the Liverpool area to ensure that the appropriate location was identified for this pilot programme. In addition, it was important to understand the work already done in the area to minimise duplication and maximise the cross-pollination of insights and effective interventions.

This was followed by the identification of ethnically diverse communities in Liverpool, by cross-analysing data from the Getting Under the Skin report, Office for National Statistics 2021 census ethnicity prevalence data, and Cheshire & Merseyside ethnicity profile research.[5, 11, 12] We then mapped the key areas in which these priority ethnically diverse communities reside.[33] This research helped us to understand where key communities are primarily based and was vital in our process for identifying stakeholders to speak to. Before initiating our insight gathering, we also conducted a literature review and research into existing vaccine confidence interventions in Liverpool and surrounding areas, to further identify key stakeholders to contact.

**Phase 1:** Insight gathering
**When:** January – May 2023
**What:** A series of virtual and in-person meetings with 60 key stakeholders who live and work in the Liverpool area, including healthcare professionals, public health advisors, community health workers, faith leaders, community leaders and academics.

**Phase 2:** Insight collation, report, and recommendations development
**When:** April – August 2023
**What:** Collation and mapping of all insights from stakeholders, identification of commonalities and differences between communities and stakeholders. Development of the report and community specific infographics, including identification and development of Change Makers and recommendations on developing future communications/activities with ethnically diverse communities surrounding vaccine hesitancy and beyond. Review of report by key stakeholders and collation of feedback to ensure appropriate and accurate representation.

**Phase 3:** Co-development, co-testing, and dissemination of outputs
**When:** October 2023 – January 2024
**What:** Printed or digital resources to help healthcare professionals, community health workers and individuals working for local charities and community groups have non-judgemental discussions with people from ethnically diverse communities about routine adult vaccinations.



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## Potential for future expansion

If the outcomes of this pilot prove to be successful, we hope that the insights gathered from this work will contribute to future work in vaccine confidence in ethnically diverse communities across the UK, tailored to specific local regions. We also hope that the learnings will prove useful for other areas of healthcare, including routine cancer screenings and childhood immunisations.

## Terminology in this report

Within this report we refer to both 'vaccine confidence' and 'vaccine hesitancy', depending on the point being made. Vaccine confidence is defined as 'trust in the vaccine (the product), trust in the vaccinator or other health professional (the provider), and trust in those who make the decisions about vaccine provision (the policymaker)". Vaccine confidence is the preferred terminology vs 'vaccine hesitancy'.[34] 'Vaccine hesitancy' or 'hesitance' is defined as 'delay in acceptance or refusal of vaccination despite availability of vaccination services'.[35]

For the purposes of this report, we have chosen to use the term 'ethnically diverse'[36] to encompass the broad range of communities living within Liverpool. Where appropriate, specific ethnicities have been highlighted, in terms of insights and recommendations provided, and there is consistent recognition that there are many differences in concerns, beliefs and approaches and so a broad brush cannot be applied.

Although several insights reflected in our research concern COVID-19 hesitancy in a post-pandemic environment, for the purposes of this report we use the term "routine adult vaccinations" to include those which are offered by the NHS as part of the National Immunisation Programme to people aged over 50 years, to provide protection against the following vaccine-preventable infections: influenza, shingles, and pneumococcal disease.

In this report, we refer to 'Community Health Workers'. This includes, but is not limited to, roles such as Network Engagement Leads, Community Inclusion Teams, as well as individuals and organisations who play an active part in delivering vaccine education and access to the general Liverpool population in NHS and local Government-funded roles.



MSD

# Insights Analysis

The 12 Change Makers were developed based on the insights gathered from 60 virtual and in-person conversations with local contributors, including healthcare professionals, community health workers, local council representatives, academic researchers and community and faith leaders.

While these conversations set out to identify factors influencing routine adult vaccination decision-making among older ethnically diverse groups in Liverpool, the following caveats should be noted:

- While the insights focus primarily on older age groups, some perspectives are not age-specific and encompass various stages of life.
- Insights were gathered from ethnically diverse groups, however, barriers and enablers are not exclusive to these groups and subsequently may reflect other ethnicities such as white British.
- The insights cover a broad range of vaccination programmes, including routine adult vaccinations, COVID-19 vaccinations, and childhood immunisations.
- We have considered the diverse ethnic backgrounds within faith and cultural groups and have included religious and cultural beliefs as a separate category.
- Our intention was to speak with as many groups and communities as possible within the research period of the project and their contributions are highlighted where appropriate. However, for various reasons we were unable to speak to every group or community we reached out to and as a result, some groups are not fully represented in this report.
- Based on the insights we have heard and the people we have spoken to, we noted duplication within and between the ethnic, religious and cultural groups. There has been consistent recognition of the nuances between these communities. Where insights and examples are unique to a community or religious group, they have been pulled out separately.

We have structured our insight analysis into five key factors that have emerged as influential drivers of decision-making for routine adult vaccinations among our project demographic.

## Key factors that drive decisions about vaccination amongst ethnically diverse groups

| 1.0: Health Education | 2.0: Access to Healthcare |
|---|---|
| 1.1: Awareness and knowledge about vaccinations and vaccine-preventable diseases | 2.1: Primary care service access |
| 1.2: Trust in authority, health system and local communities | 2.2: Navigating the healthcare system |

3.0: Religious and Cultural Beliefs

4.0: Language Barriers

5.0: Socio-economic Factors

MSD

## 1.0 Health Education

Education is an essential part of improving vaccine confidence among ethnically diverse communities (particularly older people), as well as underserved and vulnerable groups.[8] To be successful, education must flow both ways. Organisations and individuals who share vaccine information must first strive to understand the needs, barriers, and enablers of different communities, before they can begin to provide effective education that will be well received. When done well, this can stimulate non-judgemental discussions that enable individuals, families, and communities to make informed decisions that are right for them.

### 1.1 Awareness and knowledge about vaccinations and vaccine-preventable diseases

**Barrier**

**Understanding of risk amongst at-risk groups**

Individuals reported that some at-risk (or vulnerable) people have low levels of understanding about the risks that vaccine-preventable diseases pose and are therefore less likely to engage with local immunisation programmes.

**Examples shared include:**

- Individuals are not always aware of all vaccine-preventable diseases, or the immunisation programmes associated with them.
- If they have not experienced the impact of a vaccine-preventable disease (either directly or indirectly), they are less likely to understand the risk it could pose to them or their family.
- As a consequence, individuals may feel more concerned about the potential risks of a vaccine than the potential risks of contracting the disease. Some at-risk individuals do not self-identify as at-risk. For example, they do not feel old enough to be at a greater risk, or do not fully understand the link between other comorbidities they live with.

**Chinese Community**

Influenza vaccinations are generally accepted amongst the elderly Chinese population, however many middle-aged/younger people remain unvaccinated. Although Chinese students tend to have a good level of English proficiency, this does not mean they necessarily understand more complicated health information.

Barrier

**Knowledge about how vaccines work**

Contributors shared that some people within the community have low levels of knowledge about how vaccinations work and are therefore reluctant to receive multiple vaccinations.

**Examples cited include:**

- Individuals may not understand that different vaccinations are required to prevent different illnesses. E.g., some individuals think COVID-19 vaccinations protect them from influenza as they believe they are similar viruses. This stemmed from the false narrative that contracting COVID-19 is a 'bad form of flu'.
- Some individuals felt they were 'well' prior to vaccination, and then experienced symptoms of the virus (for example, catching influenza after being immunised or having to take time off work for being ill) and now have a general belief that vaccinations do not protect against illness.
- Individuals sometimes do not understand the wider benefits of receiving a vaccine to protect themselves and their community (through herd immunity).
- Following the roll-out of COVID-19 vaccinations, many individuals felt 'fatigued' by the number of vaccinations that they were offered, and did not see the need to be vaccinated again.

**"Care needs to be taken in translating information to different languages – also taking into account levels of literacy in different communities."**

**– Liverpool City Council, Public Health Team**

**"Some people do not understand that they need multiple vaccinations to protect against different diseases, and so I sometimes have to explain how the immune system works."**

**– GP based in Liverpool**

Chinese Community

Shingles is often referred to as 'Sangse' which means body snake and represents the physical sensation of the condition.

Whilst there is an awareness of vaccines amongst the Arabic community, there is a low understanding of herd immunity and the impact of vaccines on the community/how they can protect others.

Arabic Community

Barrier

**Consumption of vaccine information**

Individuals consistently reported that a significant volume of misinformation is being shared within communities. This is particularly challenging to keep up to date with and assess for accuracy when coming from sources outside of the UK and from social media. In addition, much of this information follows anti-vaccination or negative COVID-19 narratives and leans into specific cultural and emotive fears, and ingrained areas of mistrust. Due to limited knowledge about vaccinations in some communities, the spread of negative information is often more powerful than the spread of positive information.

**Examples of how misinformation is being shared via multiple routes include:**

- Via short-form content e.g., videos (TikTok and Facebook), memes and voice clips through closed apps, which do not include sources or references for communities to check the accuracy.
- Between countries, whereby misinformation content is created in another country and shared in the UK, e.g., via social media and native broadcasting. As the content is developed in native languages it is easier to consume and is aligned with the perspectives of those in home countries.
  - This was amplified in Liverpool during COVID-19, with periods of frequently changing Government guidance.
- Via storytelling and word-of-mouth. If one community leader, or family leader shares a piece of misinformation, it is often trusted by others and distributed further within a community.
  - During the pandemic, anecdotal stories about potential vaccine side effects increased many people's hesitancy towards vaccination.

**"With the increasing popularity of broadcasting channels and social media, there is lots of misinformation prevalent which is relayed back to the older generations. Myth busting is a lot harder now that we are no longer in the 'unprecedented times' that COVID presented."**

**– British Islamic Medical Association**

Chinese Community

It is common for the Chinese community to listen to news from their home country. During the COVID-19 pandemic, vaccine hesitancy was heightened through the spread of misinformation via social media channels and online. This included the belief that vaccines weaken your immune system.

Barrier

**Consumption of vaccine information**

**Examples of misinformation narratives include:**

- Individuals fearing that they will be given COVID-19 vaccinations when receiving other routine adult vaccinations.
- Individuals' belief that the influenza vaccination is only given every year because 'it makes Bill Gates money'.
- COVID-19 vaccinations include microchips so that the UK Government can track people or connect them to newly launched 5G networks.
- Individuals are concerned that vaccinations are being offered by the Government as a way to 'manage certain populations', due to underlying racism.
- Negative narratives surrounding certain vaccinations and their location of development or manufacture e.g., Chinese mainland media promoting Chinese developed and manufactured vaccines and disparaging UK or US created vaccinations.

**"During COVID, there was a high level of vaccine hesitancy initially due to the spread of misinformation via social media channels and online – a lot of work was done [by the organisation] to try and encourage members to get COVID vaccinations and to break down their fears and concerns."**

**– Chinese Wellbeing**

Somali Community

A frequent concern that was raised amongst the Somali and Polish communities was the fear of childhood immunisations leading to autism.

Polish Community

Roma Community

Many Roma community members are digitally illiterate and are susceptible to believing fake news spread online and by word-of-mouth. Where many have experienced the spread of dangerous misinformation, they no longer engage with traditional healthcare.

The fear of microchips being implanted into vaccinations is a big concern amongst the asylum seeker/refugee community.

Asylum Seeker/ Refugee Community

Barrier

**Knowledge about vaccine ingredients**

Contributors shared that some members of local communities may have limited knowledge and concerns about the ingredients within vaccinations, which limits engagement with immunisation programmes.

For some faith groups, it is forbidden to receive medicinal products which include porcine gelatine and ingredients derived from human cell lines. While these may be present in some vaccines, there is a misunderstanding that they are included in all vaccinations. Low levels of knowledge and a lack of tailored information mean that some individuals are reluctant to discuss immunisations with their healthcare professional and seek appropriate alternative options.

**"Children are offered a nasal flu vaccination which contains porcine gelatine. In Scotland, Northern Ireland and some of the UK, parents are offered a porcine-free alternative [vaccination]. However, because parents in England and Wales are not always offered this alternative, there is now a generation of families that assume that childhood flu intervention or vaccination is pork-derived, or there is no alternative available."**

**– British Islamic Medical Association**

Pakistani Community

Within the Pakistani community, there are large concerns surrounding the implications of vaccines on women's fertility.

Barrier

**Preferences for self-care over other preventative measures**

Contributors shared that some individuals in the community prefer to focus on general 'self-care' (such as healthy eating or herbal remedies) and 'natural' means of boosting immunity (such as taking regular exercise) and being aware of how their body feels as a means to prevent illness, rather than relying on preventative healthcare interventions, such as vaccination.

**Some beliefs shared include:**

- Healthcare is only required for older people, or those who are seriously ill, so they do not need to visit healthcare professionals unless they are unwell.
- Older individuals may feel that they have lived through much worse than a vaccine preventable disease and believe they can deal with it in 'their own way'. They may also have lived to a certain age in relatively good health and do not see the need to have a vaccination at an older age.
- Immune systems are strengthened, and immunity is gained through infection vs vaccination.

Chinese Community

There are lots of different beliefs surrounding Chinese and Western medicine. Western medicine is believed to be able to cure but then cause other conditions.

Barrier

**Knowledge of vaccine eligibility**

Some individuals who represent ethnically diverse communities highlighted that there is a lack of knowledge on which immunisations people are eligible for, and how they can be accessed.

**Examples cited include:**

- Ethnically diverse communities who are native to countries with limited access to medical care, or are required to pay for care, may be unaware of free vaccinations they may be eligible for on the NHS.
- There is a general lack of awareness of which routine adult vaccinations are available for older people, who is eligible and where they can receive them e.g., at the GP or pharmacy.
- There have been conflicting public health messages between people's home countries and the UK on what vaccines are available, and who should have different vaccines.

Polish Community

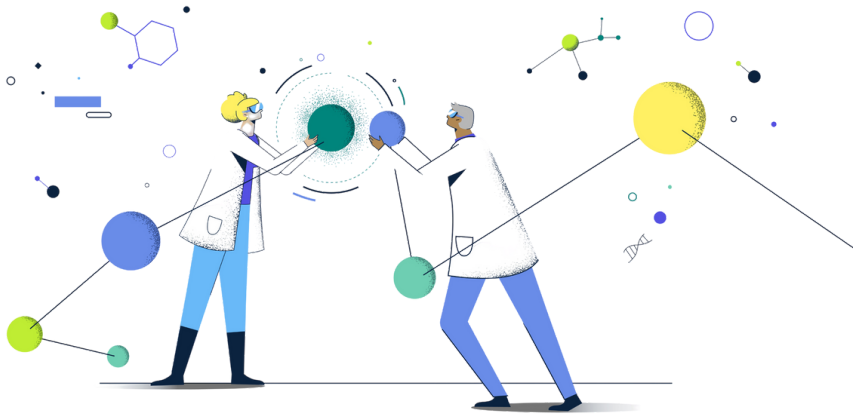
The Polish community will often pay for medication and healthcare, as there is the mindset that if they are paying for something it will be of a higher quality.

Many asylum seekers and refugees have to pay for vaccinations in their home countries, so when they enter the UK, they may not be aware that routine vaccinations are free.

Asylum Seeker/ Refugee Community

Somali Community

Somalia has been at war for many years, and a lack of government means that newer generations have come from places with no school/education and a lack of basic needs.



Enabler

**Open conversations with healthcare professionals**

Local contributors highlighted the importance of making time to discuss vaccine information with their patients. Healthcare professionals are highly trusted by some communities, so enabling open discussions about their concerns and answering questions about vaccination can help overcome fears and support informed decision-making. This includes answering questions about the ingredients in a vaccine, e.g., if it is haram, non-kosher or if it contains alcohol, the risks and benefits, and any additional concerns.

**Some healthcare professionals have encouraged open discussions about vaccination by:**

- Scheduling 'out-of-hours' or weekend vaccination drop-in clinics, so individuals can attend around other work / life commitments.
- Administration and clinical staff calling people who have missed a vaccination to discuss their concerns and schedule appointments.
- Building in additional time during scheduled appointments to create an opportunity for vaccine discussions.
- Hosting educational webinars (for example, during COVID-19 vaccination and booster roll-out).
- Working closely with trusted members or representatives of specific communities to understand more about specific community barriers and concerns.

Enabler

**Simplify communication about health information and risk**

Local contributors emphasised the benefits of creating simple, visual content to educate about health information and disease risk. For community members who have low levels of health knowledge, literacy or are non-native English speakers, information needs to be adapted and simplified so they can digest priority facts and figures that will enable them to make an informed decision.

**Contributors advised that the following approaches would be helpful to communicate complex information:**

- Data visualisations of risk – for example, instead of writing that 40% of people may require hospitalisation or further assistance due to illness, show an image of four people accessing care, and six people at home.
- Use visuals and diagrams – for example, simple illustrations of how vaccines help to build immunity against disease, with minimal words.

Asylum Seeker/ Refugee Community

In the South of Liverpool, there is a lack of awareness about what an asylum seeker/refugee is and who they are, which often leads to poor uptake of preventative care.

Parents may take their children to Poland for their childhood immunisations, as their eligibility for childhood immunisations is not well advertised to families living in the UK.

Polish Community

Enabler

**Community-based education**

Local contributors shared examples of community-led educational activities that delivered health education without the need for individuals to travel far from home. These educational activities were also often delivered by members of different communities, including from local charities, community groups and organisations, who were able to provide relatable experiences and information in native languages and who have a great influence over the people who use local services.

**Examples cited of this include:**

- Pop-up health bus clinics, delivered on-site information and services via healthcare professionals, including COVID-19 immunisations and health checks.
- Drop-in health sessions in hotels, to engage asylum seekers with healthcare discussions and general wellbeing checks.
- Health community days, during which healthcare professionals would go into community centres and locations such as supermarkets to have on-site discussions about health and deliver services, e.g., taking blood pressure and checking blood sugar levels.

Enabler

**Myth-busting content**

Local contributors discussed the importance of providing content that tackles some of the misinformation that community members engage with.

**Key steps to deliver this content for ethnically diverse communities include:**

- Identifying the common misinformation themes that are discussed within a community.
- Creating factual content that challenges the misinformation themes and references trusted sources.
- Delivering the content via preferred community channels (e.g., WhatsApp or WeChat) and appropriate native languages, to ensure it is easier to consume.

Contributors also highlighted the importance of utilising social media to positively influence/educate communities, for example harnessing widely used platforms (Facebook, WhatsApp, TikTok) to create content that shares accurate information and addresses myths.

For some community leaders, they also discussed the value of having ‘quick counteracting facts’, responses and appropriate information sources, so that if they were discussing a myth with a member of their community, they were prepared to counteract their beliefs with fact-based content. An example of this was delivered by the Liverpool City Council’s Community Champions Programme, which saw representatives from community groups attend COVID-19 vaccination events, to provide accurate information to members of their community in approximately 40 languages.

Enabler

**Sharing personal experiences and local stories**

Contributors highlighted that for individuals with lower written and reading literacy levels, stories told from person-to-person can be a powerful way to convey important information. Utilising storytelling appropriately to share vaccine information could help increase confidence.

Several successful examples of this were delivered during the COVID-19 pandemic, including:

- A young Muslim man who filmed a video of his dad, which documented each step of the process to receive a COVID-19 vaccination. The video was then shared with his local community.
- Imams in the Liverpool community who were vaccinated during the mosque pop-up clinics to build confidence and trust.
- The Liverpool Vaccine Equity Project "I did it for" pop-up exhibition which collated personal perspectives on why individuals in Liverpool decided to be vaccinated against COVID-19 – including photographs and commentary from members of ethnically diverse communities.

Roma Community

Seeing people from different age groups, backgrounds and ethnicities be vaccinated was helpful to the Roma community to alleviate some of their concerns.

## 1.0 Health Education

Trust is a crucial component of successful healthcare, particularly in vaccination programmes.[8] Trust is complex and multi-layered, and includes individual relationships with community health workers, pharmacists and GPs to anonymous relationships with organisations such as the NHS and the Government. In this report, we focus on trust at a community level. Building trust takes time, and when done with care and consistency, it can form a foundation for confidence and active engagement in managing one's own health and enable open communication with others, where concerns can be discussed without fear of judgement.[8, 12]

### 1.2 Trust in authority, health system and local communities

Barrier

**Trust in the Government at a local and national level**

One of the most prominent barriers raised by contributors was the trust individuals and communities have in the Government at a local and national level. Low levels of trust existed before COVID-19, and this has been further eroded by their experiences during the pandemic.

**Examples shared include:**

- Communities had unanswered questions as they were not provided with information or educational materials that aligned with their needs or were accessible e.g., translated into native languages, or easily consumable.
- Communities felt the information being shared from a national level was not representative of their local situation and they turned to local community and faith groups for support to provide the information they needed.
- Some individuals felt there was too much emphasis on receiving COVID-19 vaccinations and that they were being 'told' or 'forced' to have the vaccine. Because of this, there were suspicions that there were negative reasons behind the national push for high vaccination rates.
    - This was deepened further as there were barriers to accessing other services that they deemed a higher priority e.g., operations, hospital appointments, etc.
    - For some individuals and communities, it exacerbated misinformation rhetoric such as ethnic cleansing, or population control and trackers being included in vaccinations.

**"People are often worried that healthcare professionals are going to 'tell them off'. So they need to be able to establish a level of trust for patients to understand why vaccines are beneficial."**

**– GP and Director for a Liverpool Primary Care Network**

Barrier

**Trust in the Government at a local and national level**

- Some community members believe they must look after themselves as authorities do not look after them, spurred on by experiences in and outside of healthcare.
- Ethnically diverse communities do not always wish to disclose their identity and ethnic background to GPs, due to long standing trust issues about how their data will be used, why it is collected and what the 'system designed around the Government defines as ethnic minority'.
- Liverpool's longstanding history and formation of the port enabling the transatlantic slave trade means that many Liverpool-born ethnically diverse communities are suspicious of the motivations behind the Government and healthcare providers.[37]

Black African/ Caribbean Community

A lack of trust in the Government (and the vaccinations being offered) is prominent in British born Afro-Caribbean communities.

Eastern European community members, particularly men, have high levels of institutional mistrust due to bad past experiences with authorities.

Eastern European Community

Barrier

**Differences in how UK and native healthcare systems operate**

Contributors emphasised that trust plays a significant role in the understanding of healthcare systems in the UK and the acceptance of the way services are structured. Some individuals from ethnically diverse communities can find it challenging to understand the pathways and intricacies of the UK healthcare system if they differ from what they are familiar with in other countries. This can lead to scepticism, perceptions of unprofessionalism and feelings of mistrust, which can hinder willingness to engage in education and services.

**Examples cited include:**

- On-demand services such as self-referral systems, virtual consultations or chatbots can feel impersonal and raise questions about where and how the information is being used and who it is being shared with.
- If pharmacists and receptionists ask detailed health questions to make triaging decisions, it can raise suspicion as to why that information is needed before they see a nurse or GP.
- Lack of information shared as to why there are differences between healthcare systems and why the UK health system works the way it does.
- The Polish community often feel that healthcare advice, guidance and diagnosis should come directly from GPs rather than nurses or other healthcare workers.

Polish Community

Polish communities are unfamiliar with nurses being responsible for vaccine administration, and place greater trust in doctors.

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| Barrier |  **Lack of consistency and time with healthcare providers** | Contributors highlighted that some individuals feel they are unable to build strong, personal connections with their local GP or nurse, due to short appointments and rotating practice staff. These factors have a profound impact on trust and willingness to share personal information and engage in discussions about vaccinations or other health matters.<br><br>**Examples for this shared include:**<br><br>• Lack of extended face-to-face time with a GP, where a natural conversation could occur and not feel rushed.<br>• Individuals felt they were only able to discuss the immediate issue they booked the appointment for and there was no time allowance for discussing alternative options to certain vaccines.<br>• The disappearance of the long-term family GP in some practices.<br>• Language barriers experienced by practice staff and lack of easily available translation services.<br>• Healthcare professionals can become defensive or try to justify challenges faced by individuals instead of just listening and learning. | **"There is no substitute for face-to-face contact and the opportunity that this provides to build trust."**<br><br>**– Regional Communications Lead at research institution** |
| Barrier |  **Community representation and understanding of cultural nuances and needs** | Contributors reported that many communities feel there is a lack of representation and understanding about cultural nuances and needs within the wider healthcare system, which results in reduced trust and increased hesitancy to engage with healthcare services at a local level. Actively involving ethnically diverse communities in the design and development of healthcare systems requires micro and macro level changes.<br><br>**Examples of underrepresentation and lack of understanding of cultural nuances in healthcare include:**<br><br>• Reports highlighting limited diversity in clinical trials, including the early stages of COVID-19 vaccination trials. | **"People are not hard to reach, but instead it is often your interest in reaching them that forms a barrier. If you know where they are, and you can access them, then they are not hard to reach."**<br><br>**– Care Co-Ordinator** |

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| Barrier | **Community representation and understanding of cultural nuances and needs** | • Predominantly white British healthcare professionals with low level awareness of the nuanced backgrounds and experiences of ethnically diverse communities and how this could impact healthcare engagement.<br>• Insufficient representation in national and local health information campaigns.<br>• The use of 'token' community members, such as celebrities or local politicians, who may not be representative of the community's respected and influential leaders.<br>• Disconnection between regional and national initiatives, resulting in a generalised approach that fails to address specific local barriers and nuances.<br>• Lack of community input in health decisions, leading to campaigns that do not align with real needs.<br>• Some faith leaders and community health workers feel there are limited reliable, appropriate information sources, so they must conduct their own research in order to provide answers on vaccinations and other healthcare concerns that are being asked by the communities they serve.<br>• This lack of reliable, appropriate information extends to individuals seeking answers, who turn to friends, family, and social media instead.<br>• Many people from ethnically diverse groups are not registered with a GP due to healthcare professionals registering the wrong name or misspelling names. Middle names have been put as first names, and vice versa, due to cultural differences between the way names are formatted, and so the systems do not match up and their health information becomes unavailable or unusable. | **"There's no point mobilising the system if the access is not there."**<br><br>**- Community Engagement Officer** |

Chinese Community

Interpreters for Chinese patients are often known to the community, so there are fears that their personal information will be leaked or not passed on accurately.

Some Muslim patients do not wish to disclose certain information to healthcare professionals who are also Muslim due to fears of personal information being leaked. For example, they may not wish to disclose that they drink or smoke if they are speaking to a Muslim healthcare professional as this is frowned upon in their community.

Muslim Community

Barrier

**Longstanding systemic barriers and mistrust**

Contributors reported that deep-rooted racism and stigma across multiple ethnically diverse communities has created hesitancy to engage with healthcare generally. With the prominence of vaccine narratives in the past five years, there is a level of uncertainty, mistrust and rejection of mandates or 'forced' decision-making surrounding an individual's health.

**Examples cited include:**

- The Windrush generation, who emigrated from the Caribbean to Britain, fear policy changes may result in the threat of deportation.
- Ethnically diverse individuals who may illegally reside in the UK fear that engaging with healthcare may result in deportation due to their immigration status, particularly if they must share their location and personal information.
- Fear that there is a negative agenda behind the focus on increasing vaccination uptake (e.g., COVID-19 and influenza) among ethnically diverse groups, such as ethnic cleansing, population control or experimentation. This has stemmed from targeted media public health campaigns towards ethnically diverse groups as well as everyday structural and historic racism and discrimination, both in the UK and other countries.
- Questioning of the motives behind targeted campaigns and perceptions that organisations, governments (local and national) and companies have hyper-focused on ethnically diverse groups to make themselves 'look good' rather than addressing the underlying need to provide tailored support.

**"The NHS/Public Health were keen to include ethnic minority populations in vaccine hesitancy work during COVID, however this eagerness has since ceased which leaves communities questioning whether it was only offered to fill their mandate"**

**- British Islamic Medical Association**

**Barrier**

**Longstanding systemic barriers and mistrust**

- Historical experiences and generational trauma carried down through families and communities surrounding Liverpool's history and role in the monetisation of humans and free enforcement labour of African people through the international slave trade and the involvement of ethnically diverse individuals in drug development and unconsented testing.[37]
- Experience with initiatives that have been set up and then removed due to funding or re-prioritisation.
- Many ethnically diverse communities reside in the centre and south of the city. The north of the city is predominantly white British, and some areas have gained a negative reputation for racism. This has stopped some individuals from ethnically diverse communities from travelling to this part of the city or attending appointments here due to the fear of being verbally attacked.

**Somali Community**

Some members of the Somali community believe that the Government is using vaccines to make their community ill.

Many older generation Chinese residents are not registered with a GP, due to fears of their information being passed on if they are in the UK illegally. This is also seen in asylum seeker/refugee communities.

**Chinese Community**

**Roma Community**

Historical vaccine hesitancy (e.g. MMR) in the Roma community reignited during the COVID-19 pandemic. Due to the national strategy to vaccinate as many people as possible and focus on ethnically diverse communities, the Roma community felt they were pushed to receive COVID-19 vaccinations, leading to concerns about the motive of healthcare professionals. This is heightened by a high level of mistrust in the healthcare system due to previous experiences of discrimination by healthcare workers.

**Enabler**

**Increased opportunities for face-to-face time with healthcare professionals**

Contributors emphasised the importance of communities having in-person time with healthcare professionals who understand their specific needs and priorities, can speak (or effectively translate) their language, and take time to discuss their concerns or questions.

**Examples of how this has been achieved include:**

- Out-of-hours clinics dedicated to specific geographic locations or patient populations.
- Pop-up or touring clinics (shopping centres, hotels, schools and at local markets), supported by local multilingual community health workers from multiple backgrounds.
- Pop-up presentations or webinars delivered by GPs or nurses in native languages, in partnership with local community support organisations.
- Contributors highlighted that having this face-to-face time with healthcare professionals, with the support of a trusted individual from the community (e.g., attending appointments with a patient or individuals present during clinics or pop-up clinics etc) can further build engagement.

Enabler

**Community involvement in the development and delivery of health campaigns**

Contributors reiterated that to effectively engage communities, it is crucial to prioritise inclusivity and establish partnerships with key individuals and organisations from the outset of the design and delivery of health programmes. They emphasised that community leaders, respected individuals, and faith leaders continue to be instrumental in building trust, increasing engagement, and tailoring education to community-specific needs.

**Examples of successful community involvement cited include:**

- Community-led initiatives, like the Community Champions Programme, initially focused on increasing COVID-19 vaccination uptake and has now expanded to address broader healthcare challenges such as mental health and cancer.
- Individuals from ethnically diverse backgrounds who hold prominent community health worker roles in local practices, Government, charities, and support networks partnering together to hold events, attend pop-up clinics and travel on the Wellbeing Bus, and develop healthcare information.

**"There is a heart and mind concept; involvement and trust within the community means that you are already in their heart. It is therefore about reaching their mind to help communities make informed decisions.''**

**- Care Co-Ordinator**

**"COVID-19 harshly exposed health inequities affecting our local communities. The work that was done by Community Champions during the pandemic is a strong foundation of knowledge that we should use to build future health care.'**

**- Manager for Merseyside Polonia**

Chinese Community

There is a high level of trust between Chinese organisations (e.g. Chinese Wellbeing) and the Chinese community.

Somali community members have highlighted the importance of community support. For example, in cases of female genital mutilation (FGM), if their community is accepting of it and they chose not to go ahead with the procedure, they will be at risk of being outcast by their community.

Somali Community

Roma Community

Roma communities do not want events targeted at them specifically, but instead would like to be engaged with other community events to see that vaccines are for all communities.

## 2.0 Access to Healthcare

Limited access to primary care, which serves as the entry route for routine adult vaccination programmes, presents a significant barrier to engagement. Designing effective strategies to educate on immunisations and building a willingness to engage with them become redundant if individuals and communities cannot access the system intended to care for them. Community-led approaches have proven to be successful at increasing engagement with health information, education and services. Community health workers play a vital role in such initiatives, acting as a trusted point of contact during ongoing NHS restructures.

### 2.1 Primary care service access

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| Barrier | **Accessibility and location of primary care services** | Contributors shared that physical access to services can be one of the biggest barriers to actively engaging with primary care services, e.g., routine GP appointments (providing opportunities for healthcare professionals to identify missing vaccinations or discuss questions surrounding them) and in-practice vaccine clinics.<br><br>**Examples shared include:**<br><br>• Older individuals often have mobility issues and can struggle to travel to attend in-person appointments without support from families, caregivers or local transport services funded by local and national government initiatives.<br>• Older people in ethnically diverse communities often care for younger family members and therefore struggle to attend in-person appointments during standard clinic hours.<br>• Some individuals may not drive or be able to afford the travel costs required to reach in-person appointments.<br>• Some individuals are still working full time, managing multiple jobs and family responsibilities and often cannot attend appointments during traditional working hours e.g., the Chinese community with many people working beyond retirement age for six or seven days a week. | **“There is no point mobilising the system if the access is not there”.**<br><br>**– Senior Community Inclusion Worker** |

**Roma Community**

The Roma community do not tend to receive invitations to vaccinations through the post as they do not have a registered postcode. When they try to access primary healthcare services, their lack of postcode and health records mean that they are turned away.

Barrier

**Digital literacy and accessibility**

Contributors highlighted that many older individuals find it challenging to navigate access to primary care services where the entry points have been digitised and only provided in English. The combination of low levels of digital literacy, as well as English speaking and reading capabilities, can lead to confusion, frustration, and disengagement with health services.

**Challenges faced include:**

- Using online or app-based appointment booking platforms instead of calling the practice or visiting in-person.
- In some cases, there are multiple platforms for different services, e.g., booking and managing appointments, ordering repeat prescriptions, completing self-referrals, and attending video or chat consultations.
- Downloading multiple apps, navigating complicated websites, and completing multifactor authentication steps are a barrier to primary care engagement.
- Limited access to smartphones, tablets, computers, and the internet.
- A lack of digital services (e.g., GP practice websites and apps) provided in alternative languages.
- Attempts at reaching people through emails and texts were ignored because people were not sure if it was spam or people trying to steal their medical details, as they were not warned beforehand to expect contact from their GP/local health services.
- Essential digital support services such as translation are only open at specific time periods that do not always align to the time periods for appointment bookings e.g., 8am-9am.

**"If everything becomes digital, it will isolate those who cannot use technology."**

**- Chinese Wellbeing**

**"People often find that making an appointment at the doctors is too much hassle."**

**-Liverpool Arabic Centre**

**"People do not respond to things they do not recognise"**

**- Liverpool based GP**

Chinese Community

Chinese community members, particularly the older generations, are reluctant to spend time on the phone and are more likely to try and book an appointment in-person at a GP surgery, which can result in them being turned away. Patients will therefore resort to visiting A&E as this is the type of care they are familiar with accessing.

Enabler

**Community-based approaches to service delivery**

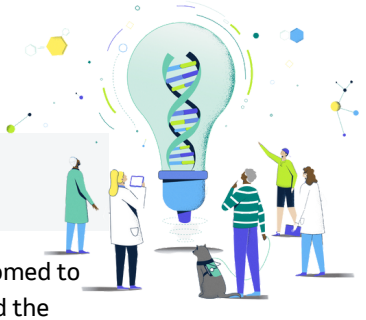
Contributors highlighted that community-led alternatives have proven to be a successful way to engage ethnically diverse communities and overcome physical and system barriers. The roll-out for COVID-19 vaccinations showcased the ability to mobilise these changes to ensure interventions like vaccinations can be delivered, and the impact they can have.

**Examples of such initiatives include:**

- In-community clinics and appointments, e.g., vaccination delivery, health checks or local community hubs, drop-in sessions (e.g., women's health booth at the Liverpool Women's Hospital), festival-style events (e.g., bowel cancer and cardiovascular/heart health events in Toxteth Park).
- Pharmacy-based consultations and delivery of basic health checks (e.g., blood pressure, cholesterol checks and over 60's health screenings)
- Extended or combined appointment slots to allow for multi-generation or family attendance (e.g., childhood immunisations, routine adult vaccinations, and asthma check-ups together)

**"One of our biggest successes was hosting 'walk-ins' where there were 'normal people' from the community who could have discussions and ask questions. Not Government or NHS officials. It was a clear community-based approach."**

**- Liverpool Arabic Centre**



## 2.0 Access to Healthcare

Navigating the UK health system can be complex, especially for older people from ethnically diverse communities who may be accustomed to different native healthcare systems. It is important to consider how the language used in communications surrounding healthcare and the differences in services offered may affect a person's ability to access the care that they need. Taking the time to ask older people from ethnically diverse communities what they need to better understand and access key NHS services is an important starting point for building confidence.

### 2.2 Navigating the UK healthcare system

Barrier

**NHS resources and restructures**

Contributors shared that the ongoing pressures faced by the NHS, combined with frequent restructures, most recently to Integrated Care Systems [ICSs], have led to people and service-level challenges. These factors contribute to the disengagement of many ethnically diverse communities who already find the NHS a challenging and unsupportive system to navigate and feel that the NHS is 'not for them' or 'working against them'.

**Examples cited include:**

- Reduced walk-in clinics, pop-ups, and community-specific clinics due to staff shortages and funding.
- Reduced access to translation services (phone and in-person).
- Shorter appointments, longer appointment waiting times, and limited routine appointment slots due to higher patient numbers, specifically in higher ethnically diverse populated locations e.g., Liverpool 8 (L8) postcode area.
- Reduced appointment reminders and re-engagement opportunities, e.g., influenza reminders and at-risk vaccine invitations.
- Backlogs and delays in access to 'at home' or 'community care'.
- Limited funding and capacity to be able to translate, print, and distribute health information amongst communities. In some cases, local communications teams receive minimal to no funding.

**"There are lots of access and equality schemes across Liverpool, however getting into the communities and having the funding available to sustain the schemes is an important consideration."**

**– Senior Project manager in Liverpool Integrated Care System**

Chinese Community

There is a big issue with 'ghost patients' in the healthcare system. Chinese residents will often come to the UK short term, for example for university, will register with a GP, and then return home. There is no effective system in place to remove GP records for patients that are no longer in the country.

Barrier

**Familiarity with UK versus native country healthcare system**

Contributors shared that depending on where some older community members grew up before moving to the UK, they can often find navigating the UK health system challenging and unfamiliar. This can lead to confusion and reluctance to engage with initiative such as vaccinations, and an ongoing reliance on native healthcare systems.

**Examples of this include:**

- Preferring to return to the individual's native country for annual health checks and vaccinations as they are familiar with the system and trust the guidance and services being provided.
- Not understanding which primary care services are accessible e.g., in some communities the norm back home is to go to hospitals directly, or people can attend any GP practice within a catchment area.
- The norm of paying for instant access to appointments (excluding private healthcare) or paying for a 'better' and faster service.
- There is a myth that when registering with a GP, you need to prove your residency, immigration status, ID or NHS number; this deters a lot of people, for example asylum seekers/refugees and the Chinese community, as they fear getting in trouble with the home office/did not know that this is not required.
- People view the NHS as a single entity, and do not always know the differences between primary, secondary, and tertiary care within the complex structure of the NHS. If they then have a bad experience in one area, they may be reluctant to seek care in another.
- Limited funding and capacity to be able to translate, print, and distribute health information amongst communities. In some cases, local communications teams receive minimal to no funding.

Chinese Community

Chinese communities will often go back to China for a full body check-ups. This is common practice in mainland China, where everything would be checked, from blood pressure, to your risk of diabetes. This tends not to be available in the UK, unless accessed through private health insurance.

Chinese communities will often adopt a culture where problems can be solved by money, for example paying for the hospital/GP care at the point of use. People in China are also provided with a 'family book' which outlines all the health information about you and your family in one place.

Chinese students are required to receive their vaccinations before studying in the UK, however, during COVID-19, overseas vaccinations were unable to be validated in the UK. A scheme was supported by Liverpool City Council to help manage this situation.

Chinese Community

Polish Community

Some people in the Polish community do not use UK GP practices and instead travel back to Poland to access healthcare. Alternatively, they will pay for private care in a specialised Polish healthcare clinic in Manchester.

Enabler

**Aligning communication channels to community preferences**

Contributors expressed the need for communications to align with the needs of the people being engaged. Taking the time to ask communities how best health information can be shared with them is the most effective route to achieve trust and engagement with health education and services.

**Examples shared include:**

- Ongoing funding of community-led support programmes, e.g., The Liverpool Vaccine Equity Project, and Community Champions Programme.
- Delivering information through community networks, via a trusted community representative.
- Utilising community network platforms, e.g., WhatsApp groups.
- Translated letters/materials (e.g., leaflets, websites).
- Alternative appointment booking capabilities (e.g., in-person and over the phone).

**"It is not the ethnic minority communities that are hard to reach, but it is that we [service providers] are hard to reach for them".**

**– Care Co-Ordinator**

## 3.0 Religious and Cultural Beliefs

Religion and culture play a significant role in shaping individual and community beliefs and attitudes towards health, such as disease prevention, including immunisations and treatment.[38] When layered with other factors, such as education, language and socio-economic background, religious and cultural beliefs can become powerful barriers to, or enablers of, vaccine confidence. Some of the most effective health intervention strategies for older, ethnically diverse communities have been designed and delivered in partnership with religious leaders in faith settings. Such partnerships require commitment and sensitivity to better understand how religious teachings can be appropriately utilised.

Barrier

**The role of faith in healthcare decision-making**

Local contributors emphasised that religion holds significant influence within ethnically diverse communities with regard to healthcare decision-making.

**An example of the impact of religion on vaccines include:**

- Individuals highlighted that within some (not all) communities there is a belief in fatalism. Individuals believe that their health 'is in God's hands'. They believe that God is the ultimate protector and vaccines are not required as God will choose their fate – 'He will save my life or take my life'.

**"Something that is often not talked about by medical professionals is faith. I've worked for the NHS for many years, yet the topic was avoided, even though there was a general acceptance that it causes issues to healthcare/vaccine uptake"**

**- Network Engagement Lead for Liverpool PCN**

Muslim Community

Ahmadiyya Muslims are not always considered 'mainstream Muslims' by other members of this faith group and so will not be found in the same place of worship.



MSD

Barrier

**Cultural and religious-based views on gender**

Contributors emphasised that in some ethnically diverse communities religious teachings, and cultural expectations around gender roles, can significantly influence healthcare decisions and interactions. Some religions and cultures have distinct boundaries regarding what can be shared and discussed between and within genders.

**Examples of this include:**

- Some women may not engage with local government or health service-funded groups and instead must create support groups within their own communities, e.g., mother and baby groups.
- Men and women may not be permitted to discuss health concerns with people of the opposite gender. It is therefore not appropriate for a male community leader of healthcare professional to discuss women's health with women or their partners, or share personal information to male healthcare professionals (e.g., phone numbers or addresses).
- Individuals highlighted that they found women do not always prioritise their own health and often focus on their families and husbands, e.g., not attending smear tests, mammograms or vaccination clinics but regularly attending children's health and early-age vaccination clinics.
- Some middle-aged men from ethnically diverse communities will often state they are fit and healthy and their immune systems 'can handle' getting ill. Men are expected to lead the family and be independent. This group often can be difficult to engage with for vaccinations, health screenings, appointment reminders etc.
- Some individuals do not like to discuss gender-specific issues like reproduction extensively when engaging with healthcare initiatives out of the clinic or one-to-one GP setting.

**"It has been observed that some individuals are sometimes less likely to socialise outside of their community and/or may not be fluent in English. This is not a significant group in terms of size, but the impact on individuals is not diminished. Anecdotally it has been noted that older people and women might be disproportionately represented in this category. Therefore, special care must be taken in teaching/providing information which reaches all groups within communities and translated materials which also align to roles (including gender-based roles) in the community are key."**

**– Liverpool Parish Church**

Polish Community

Many Polish men in the UK will tend to primarily work in labour or hospitality. Women will drive home health messages, but may still be living in their home country and may not have connections to the UK health services.

Within the Somali community, the role of matriarchs as the community compass and decision-maker for other women is strong and is often the difference between engaging with local NHS services or not.

Somali Community

Barrier

**The cascade of information and experiences through close-knit communities**

Contributors expressed the power of close-knit communities and the role they have in ethnically diverse populations. In Liverpool, many communities live in close proximity to each other and much of their everyday lives, social interactions and work happen within the community. This results in active information sharing between support networks, which can have a negative impact if the information is inaccurate or based on bad experiences.

**Examples cited of the challenges this can cause include:**

- Misinformation being actively passed between families, e.g., the belief that all vaccines include porcine gelatin or microchips.
- Negative experiences surrounding health services being shared and taken on by others, e.g., beliefs that certain GP practices are not welcoming of certain ethnically diverse communities and rude receptionists.
- Disengagement with unrepresentative, culturally insensitive campaigns as they are felt to be 'not for us'.
- Intergenerational influence within households or communities (e.g., matriarchs and/or patriarchs), whereby younger and older generations may share concerns about vaccinations that can impact the whole family unit.

South Asian Community

It is common for the mother-in-law to make decisions regarding what healthcare a pregnant mother should receive.

Enabler

**Partnerships with religious leaders and faith settings**

Contributors shared that one of the most impactful enablers to engaging with ethnically diverse communities who closely follow a religion, is to deliver health information and services in collaboration with religious leaders in a familiar faith setting. This approach was a success during roll-outs of COVID-19 vaccination programmes.

**Examples shared by contributors include:**

- Healthcare leaders and healthcare professionals engaging with Imams to share accurate health information and deliver it to the congregation at weekly prayer.
- Faith leaders receiving healthcare interventions, for example, COVID-19 vaccinations and healthcare check-ups such as blood pressure and diabetes checks, in front of their congregation.
- Alignment of health interventions and services at key times of day, e.g., the Wellbeing Bus and the breast screening mobile unit.
- Developing materials (written, video, audio, visual) in collaboration with religious leaders that can be shared by them within trusted community groups e.g., prayer groups or women's groups on WhatsApp.
- Religious leaders encouraging men who follow the faith to encourage their wives to attend appointments. For some cultures, approval or permission is required.

**"Communities need to see someone from their community take part in what you are asking them to take part in as this builds trust"**

**- Regional Communications Lead**

**"Using the voiceover of someone who is familiar to the community is a lot more effective than using a random person."**

**- Public Advisor**

Chinese Community

There is a need to consider timings for healthcare campaigns as there are a number of Chinese holidays - Chinese New Year, Dragon Boat Festival, Mid-Autumn Festival.

Enabler

**The power of close-knit communities and intergenerational cohabitation**

Contributors emphasised that whilst close-knit communities can amplify vaccine-hesitant rhetoric and behaviours, they can also be a significant enabler of vaccine confidence.

**Examples shared include:**

- The exchange of positive examples of receiving vaccines and accurate information. People do not want to be told what to do, they want to learn and make decisions in line with other people's positive experiences.
  - During COVID-19 this worked particularly well via short videos and voice clips of people's experience receiving the vaccine and the wider impact.
- Younger generations living in the same household as older generations, who can discuss the advantages and disadvantages of different vaccines and take older generations to appointments.

**"Every family and situation is unique and it is not uncommon for people within the same family to have different opinions surrounding vaccination."**

**- Healthwatch Liverpool Employee**

Enabler

**The positive impact of religious teachings**

Contributors shared that within some religions, there are teachings that express the importance of engaging with healthcare interventions that help to support the general health of the wider community. Engaging and aligning with these teachings can help to build and develop discussions surrounding vaccinations. It is vital to have a thorough understanding of these teachings and work closely with religious leaders to ensure they are respectfully utilised. They should be navigated sensitively, as it is not always appropriate for people outside of the community to use them to share their own agendas.

**"Discussing religion at the same time as healthcare can often lead to changed perceptions and a greater appreciation for looking after yourself when it is put into context."**

**– Liverpool Arabic Centre**

## 4.0 Language Barriers

Language was the most frequently cited barrier to delivering effective healthcare in older people from ethnically diverse communities. This is a challenge for health service delivery teams in Liverpool but also across the UK. Given that there are over 40 different languages spoken in Liverpool alone, it comes as no surprise that language was highlighted in every one of the 60 conversations we had. Addressing language barriers and ensuring equitable access to healthcare information is crucial for improving vaccine confidence within ethnically diverse communities.[11] While it may never be possible to cater for every dialect, in every language, prioritising and exploring approaches to traditional translation services, and innovative digital solutions can go some way to bridge communication gaps.

Barrier

**Multi-language capabilities**

All contributors referenced the challenges of navigating NHS services for older people in ethnically diverse communities who have limited English language skills. Such individuals will inevitably disengage from healthcare services if GPs, nurses, and administrative staff are unable to communicate with them effectively, leaving them feeling unheard, misunderstood and isolated.

**Examples cited of the most prominent language challenges:**

- The majority of healthcare professionals have English as their first language. In some cases, healthcare workers from ethnically diverse communities may also speak additional languages. However, this does not cover the multitude of languages and dialects estimated to be spoken in Liverpool.
- Receptionists are predominantly English speaking only, and as the first point of contact, it creates an immediate barrier to engagement with primary care services such as registering at the GP, receiving results, booking appointments and re-ordering prescriptions.
- Materials developed by the NHS and the Department of Health and Social Care are often created in English, and then translated into only a handful of languages. Insufficient care in the quality and formatting of translations (e.g., Arabic written from left to right) results in many community health workers being left to manage inaccuracies.
- Not all GP practices record the preferred language needs of every patient, and some practices record it more consistently than others. This results in the same communication issues occurring each time the person engages with the health system and adds a layer of complexity when it comes to planning projects and identifying what languages are required for the translations. Over time, this compounds feelings of frustration and anger that the NHS is 'not for them'.
  - Translation services are not always available in line with prime appointment booking times, or out of 'regular' working hours (outside of 9am-5pm).
- Within some communities, such as Arabic, Chinese, and Bengali, multiple dialects are spoken within one language.

**"It is impossible to create content that spans over 40 languages so other solutions are important to overcome barriers."**

**– Regional Communications Lead**

Barrier

**Translation capabilities**

Contributors explained that the availability of translators (in-person or via the phone) is not an immediate solution to language barriers for a number of reasons associated with trust. As a result, many middle-aged and older ethnically diverse individuals will rely on their children, family, or friends to translate letters, materials, website booking systems, prescriptions and attend appointment discussions. This can often include sharing sensitive information that may make them feel uncomfortable.

**Examples given were:**

- Individuals may not feel able to trust translators with their personal health information. They are concerned about the confidentiality of the conversation and whether the translator delivers the information back in the same depth as the healthcare professional explained it in.
- Translation services are often provided over the phone. This means individuals are unable to build a relationship with their translator, which is challenging given they are discussing private and often sensitive information.
- Many translators are not medically trained. Therefore, there is a concern that they might not be receiving the correct information.
- Translation services via the NHS are expensive and oversubscribed, resulting in long waiting lists for access to certain translators and the service not being available when needed – even when booked ahead of time.

Barrier

**Native language and literacy levels**

Contributors highlighted that within some ethnically diverse communities, for example the Chinese community, there are lower levels of literacy among older generations, which significantly limits their options for engaging with health services.

**Examples cited include:**

- Some older individuals can speak in their first language but are unable to read or write in their native dialect.
- Individuals may not be able to speak English at all, or at least minimally.
- Some languages spoken in Liverpool have, until recently, only been spoken e.g., Romani.

Chinese Community

Most of the Chinese Liverpool population speak Cantonese, however Mandarin is widely spoken in the student population.

Barrier

**Terminology and vocabulary differences**

Contributors shared that between communities there are different preferences in the terminology used surrounding health and vaccinations. Using the wrong word or phrase can inadvertently disengage people, therefore it is important to understand these nuances and ensure they are reflected in materials and discussions.

**Examples shared include:**

- The Roma community often disengages with the term 'vaccination' as they can associate it with COVID-19 vaccinations. When applied to other vaccinations such as influenza or MMR, they can assume it includes COVID-19 vaccinations and, in many cases, reject other vaccines by association.
- Additionally, many ethnically diverse communities disregard health information that includes the term "citizen" as they believe it refers exclusively to British nationals or those born in the UK.

Roma Community

People from the Roma community speak Romani, a language that is only communicated orally. They will also speak the language of their birth country, for example Romanian, Slovakian, Albanian etc.

Arab Community

Direct translations sometimes do not make sense, particularly where Arabic is read from right to left. The Arabic language also has a 'standard text', which the whole Arab community is able to understand. There are also many local dialects which are only present in spoken language.

Arabic is one of the most commonly spoken languages amongst ethnically diverse communities in Liverpool. Most Arabic-speaking communities are Yemeni.

Somali Community

The Somali community relies heavily on oral communication. When communicating in written language, WhatsApp is the main method.

Enabler

**Increased collaboration and increased presence of trusted community members, organisations and native language speakers**

Contributors highlighted that an increased face-to-face presence of native speakers is the best way to increase engagement of ethnically diverse communities who do not speak English. However, it is vital that they are trusted members of the community.

- Individuals we spoke to emphasise the positive impact that the Community Champions have had on the local community and increasing COVID-19 vaccination confidence and general healthcare service engagement. Many of these Community Champions work closely with the communities they serve and speak two – three languages, in addition to having a good understanding of how to navigate the health and social care system.

Enabler

**Visual and simple presentation of information and data:**

Contributors emphasised that if English is not the person's first language or they do not speak it at all, they cannot engage with lengthy, often complex materials that are full of jargon and unfamiliar scientific terms.

**Examples cited to navigate this include:**

- Consider the way data is presented, as simple visuals are often more powerful than complicated paragraphs.
- Images, videos, audio (in native languages) that break down complicated information are the gold standard and can be shared across communities, particularly on social media.
- Short and easy-to-digest pieces of information are vital to capture initial attention.
- Materials that can be used by communities and healthcare professionals to help guide conversations and open opportunities for questions can help create a safe space for non-judgemental discussions.

**"Organisations need to consider the way in which data is presented. People are often visual learners, and helping to visualise the facts and figures can help people to understand the information being presented to them."**

**- Public Advisor**

Asylum Seeker/ Refugee Community

Asylum seekers often watch YouTube in the hotels they reside in. There have been examples of individuals significantly improving their English through watching this content.

Enabler

**Creating accurately translated, culturally appropriate materials:**

Contributors shared that creating accurately translated materials is the biggest enabler. Individuals will gravitate to materials and content that are in their native languages. Whilst this can put increased pressure on resource-limited organisations, individuals shared ways to navigate this.

**Examples shared include:**

- Working with community initiatives and groups to develop materials from their conception.
- Working with external translators to ensure the quality of the translated content.
- Checking all translated materials with a native language speaker to check translations, formatting, and tone.
- Understand the nuances of key terms and phrases that trigger rejection.
  - The Roma community prefer the term injection over vaccination.
  - The Chinese community respond positively to the term health screening, as in mainland China, health screenings are a yearly ritual. They will often look for this phrase and engage well with content that includes it, when covering key health interventions e.g., diabetes and blood pressure checks etc.

Enabler

**Utilising new language support initiatives**

Contributors from the L8 postcode area in Liverpool highlighted that the implementation of an integrated language and customer management software (e.g., The Patient and Care Optimiser (PACO) developed by the Blinx Healthcare team in partnership with GP teams) has shown success in engaging with different communities that speak multiple languages.

A key benefit of this type of software is that messages, appointment bookings and reminders, and prescription information can be delivered in a person's preferred language at the touch of a button.

## 5.0 Socio-economic and Deprivation Factors

Socio-economic factors and related health inequalities play a central role in vaccine hesitancy and poorer health outcomes.[39] Assuming everyone can always prioritise health and easily access free NHS services undermines the harsh realities of many ethnically diverse communities, and people living in deprived areas. Low-income families and individuals must often prioritise more immediate needs to support themselves or their family e.g., additional work, food and utilities. This lack of engagement can be incorrectly perceived as a hesitancy. Thinking differently about ways to bring healthcare into deprived areas where people need it most merits greater consideration. It is also important to recognise that whilst socioeconomic challenges disproportionately effect those from ethnically diverse communities, they are not exclusive to them, and there are variances between different communities and different areas.[28]

Barrier

**The location of ethnically diverse communities and extended pressures on healthcare services**

Contributors highlighted that the location of communities can create both active and passive barriers to accessing and engaging with healthcare services. Individuals prefer to live close to others within the community. This creates a higher demand in the centre and south of the city, where historically ethnically diverse communities have chosen to settle. This increased demand does not match the housing supply levels causing additional challenges.

**Examples shared include:**

- There are higher levels of ethnically diverse communities in the south of Liverpool, particularly the L6/7/8 postcode areas. These areas have large populations and limited social housing, resulting in some larger families living together in inadequate housing. People are reluctant to move to more appropriate social housing in areas which may be closer to healthcare services due to fears of racism, discrimination, and harassment.
- Due to multiple occupancies in some houses, shared letter boxes are used. Combined with language barriers, it can mean that important health-related letters/information do not reach the right people.
- As more people move into the same area, it increases the pressure and needs of healthcare services in this area.

**"You must consider how deprivation and transport accessibility may affect a person's decision to access healthcare."**

**- Healthwatch Liverpool Employee**

**"It is important to understand the root cause of poor health outcomes. There is a very strong relationship between poverty and health inequalities. Health outcomes are poorer in the most deprived areas of Liverpool, including in the north of the city."**

**- Senior Public Health Team member, Liverpool City Council**



MSD

Barrier

**Managing healthcare priorities**

Contributors highlighted that due to the current cost of living crisis and longer-term levels of financial insecurity, some individuals may need to make difficult decisions to prioritise day-to-day existence, feeding their children, paying rent and bills, and attending work commitments vs travelling to, or taking time off work to attend appointments. For asylum seekers, many individuals will be directed to healthcare services to address more urgent needs, such as mental health.

Asylum Seeker/ Refugee Community

Vaccinations are not a priority for these communities due to the significant trauma they have faced. They are likely to prioritise dental care, mental health and communications with the Home Office. The current wait for mental health services can be six to eight months.

Barrier

**The impact of shift work**

Contributors highlighted that many individuals from ethnically diverse communities work in industries where shift work is the norm. This can have a direct impact on engaging with traditional primary care services and once again leave the impression that the NHS is 'not for them'.

**Examples shared include:**

- Working hours aligning to clinic and pharmacy opening hours meaning they do not have the opportunity to access healthcare outside of when they are working.
- Limited access to pop-up clinics and walk-ins that often happen during working hours vs evenings or weekends.
- Limited opportunities to engage with time-specific health interventions e.g., appointment booking slots between the hours of 8am–9am.

Enabler

**Bringing healthcare to the people**

Contributors emphasised that the biggest enabler to healthcare and vaccines was seen during the roll-out of COVID-19 vaccination programmes.

**Examples include:**

- Pop-up clinics, clinics in community centres and religious buildings.
- The Liverpool Wellbeing Bus.
- Local pharmacies delivering vaccines and providing health checks.

Enabler

**A deeper understanding of what communities need and increased focus on shared decision-making and distribution of power**

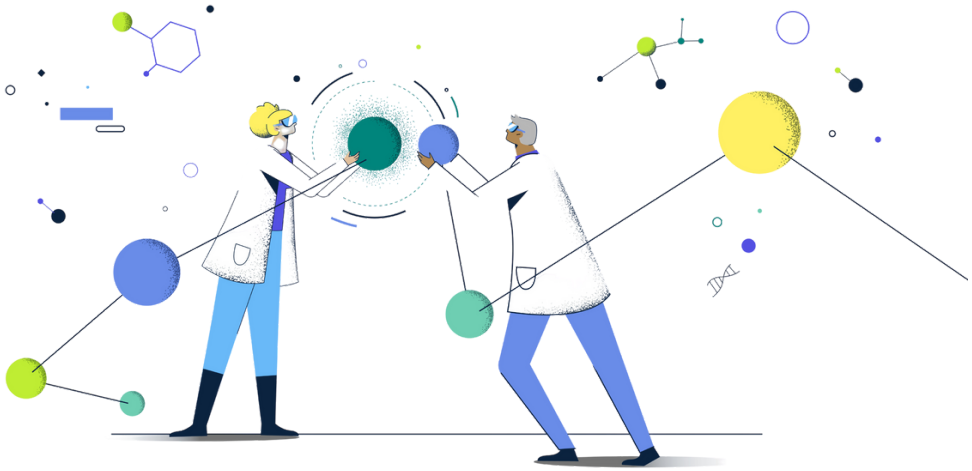
Contributors shared that working with communities to understand what they need and involve them in decisions about their own health is vital. Instead of organisations making decisions for them based on what they think is 'right for them', they should strive to better understand the realities of socioeconomic factors on healthcare and immunisation programmes and help communities feel empowered.

**Examples shared include:**

- Local government and NHS services to hold regular meetings with community leaders and representatives to understand their current and evolving priorities.
- Community members and representatives employed in key decision-making roles.
- Active and open feedback channels.

**"Top-down approaches do not work – people do not want to be told what to do. Therefore, in order to increase vaccine uptake, it must be a bottom-up approach."**

**– Senior Public Health Team member, Liverpool City Council**



# Concluding Thoughts

The breadth and depth of this project has evolved significantly since we started gathering insights in January 2023. As we began our initial discussions with stakeholders, we were soon introduced to a network of people, programmes and projects that reshaped the scope of our research and the direction of this report, for the better. We recognised early on that our objectives needed to evolve in line with the insights and learnings being shared with us. The flexibility to adapt the project as it developed was instrumental to building trust and being invited into communities to listen and learn. As we close this phase of the project, we have attempted to summarise some of the key takeaways that have shaped our research journey and reframed our thinking.

## Vaccine education involves a vast, complex and integrated network of stakeholders

We set out to speak with 30 stakeholders within the Liverpool and Merseyside area. However, this rapidly expanded to 60 stakeholders as we were introduced to a network of local healthcare professionals, community experts and faith leaders involved in both general health and vaccine-specific education. It is important to acknowledge that while we spoke to significantly more people than anticipated, we were unable to speak to everyone we had hoped to reach for various reasons. We acknowledge these gaps in our insights and recognise that some ethnically diverse communities within Liverpool are not represented in this report.

## Community health workers, charity and community groups play a pivotal role in the health and care of ethnically diverse communities

While our original objective focused on supporting healthcare professionals in primary care, we soon recognised the vital role that community health workers play in bridging the gap between underserved communities and healthcare services, providing unbiased information, establishing trusted, long-term relationships, and improving the health of ethnically diverse communities. We wish to acknowledge their unique role while also recognising the wider network of people involved in vaccine education across Liverpool.

## Creating non-judgemental spaces for vaccine education and discussions is key to building confidence and trust and underpins success

We structured our research findings around five key factors that drive decision-making among ethnically diverse communities – education (including awareness, knowledge and trust), access, language, religion and culture and socioeconomic and deprivation. Insights gathered from 60 stakeholders across all five areas confirmed that creating a non-judgemental environment for vaccine education is critical to ensuring concerns and fears can be discussed openly as a starting point for building confidence and trust. Enabling such conversations allows individuals, families, and communities to make informed decisions in alignment with their values and circumstances, fostering confidence and paving the way for future engagement with healthcare services. We learnt that asking 'why' can be as important as asking 'why not' when exploring barriers and enablers to vaccination.

## Finding the balance between new and old ideas to break down barriers

Throughout the course of the project, our assumptions about the value of traditional and digital educational materials were well challenged. While we were introduced to new digital innovations such as Blinx's Patient and Care Optimiser (PACO), which is already breaking down language barriers, we were also reminded about the importance of doing the basics well. Translated materials are a useful example of well-intended materials that can often fail to be effective due to a lack of planning and assumptions about what languages and dialects should be translated. We were reminded that however effective new solutions might be, they are only ever the first step in the vaccine education journey. Face-to-face discussions with trusted individuals or organisations remain the most powerful route to building confidence and trust.

## Health improvement programmes do not always require new initiatives

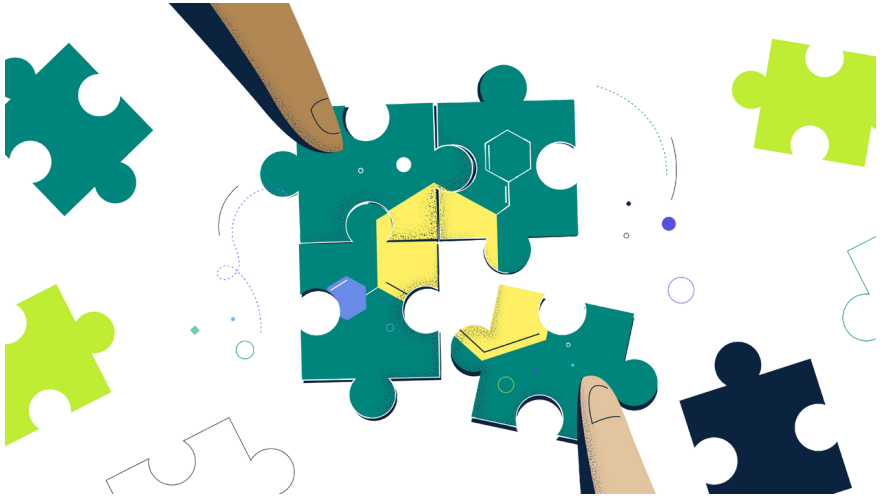
The drive for health improvements can often become confused with a need to create new innovative initiatives. However, the opposite is often true. Many of the most effective health interventions already exist, but their success needs to be captured, and evaluated so learnings can be applied and best practice shared. The Community Champions Programme is a helpful example of this. We learnt that a genuine commitment to better understanding the effectiveness of existing programmes and finding ways to amplify their success can be just as effective, if not more so, than designing new initiatives from scratch.

## Barriers and enablers are not mutually exclusive

It is perhaps easy to assume that barriers and enablers are at opposite ends of a scale – one preventing a person from choosing to be vaccinated and the other enabling it. However, insights from our stakeholders revealed a much more complex set of dynamics across the five key factors that drive vaccine decision-making. Religion is a useful example to illustrate this. Assumptions about religious teachings can too often focus on what is forbidden or expected, however, some of the most effective health intervention strategies for older, ethnically diverse communities have been designed and delivered in partnership with religious leaders in faith settings. We recognise that such partnerships require commitment and sensitivity to better understand how religious teachings can be appropriately utilised and this takes time to achieve.

In conclusion, it has been an immensely interesting journey. As we carry our learnings and connections into the next phase of the project, we hope that the outcomes of this pilot programme, if successful, could positively contribute to improving vaccine confidence among ethnically diverse communities throughout the UK. The insights gained may also inform efforts to address hesitancy in other communities and age groups, in addition to accessing other areas of healthcare, such as routine cancer screenings and childhood immunisations.

**By reducing inequalities and addressing the unique needs and concerns of ethnically diverse communities, we can work towards building vaccine confidence and promoting good health, not only in Liverpool, but also in other regions across the UK. This report serves as a reminder of the importance of ongoing efforts to empower people, bridge the information gap, and foster a healthcare environment that is equitable and accessible for all.**



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