BAME community hesitancy in the UK for COVID-19 vaccine: suggested solutions

COVID-19 vaccination drive has been launched throughout the world in the past months with the aim to initially cover healthcare professionals and elderly population who are at high risk of COVID-19 infection due to occupational exposure and comorbidities, respectively. The vaccination drive was launched in the UK on 8 December 2020. The UK has ordered 100 million doses of the Oxford-AstraZeneca adeno-virus vaccine and 40 million of the Pfizer-BioNTech messenger RNA (mRNA) vaccine—both are currently being rolled out in the UK. Another 17 million doses of the Moderna vaccine, an mRNA vaccine that has been approved by the Medicines and Healthcare products Regulatory Agency in early January, are expected in the spring.1 Vaccination for COVID-19 has multiple advantages as it helps to prevent COVID-19 infection, decreases the severity and transmission of the disease. It will provide a cost-effective intervention to achieve herd immunity.2 Thus, it is the right and duty of everyone to support the vaccination drive for COVID-19 as per guidelines laid down by each country depending on logistics and availability.

Vaccine hesitancy - Vaccine hesitancy is a known term and implies a delay in acceptance or refusal to take the vaccine, despite its availability.3 It is not restricted to any specific country or religion but is found across the population in the world. The Black, Asian and Minority Ethnic (BAME) communities in the UK have shown hesitancy4 for this vaccination drive, particularly the black community followed by members of the Asian lineage. This hesitancy has led to slow coverage and progress among this subset of the population. Concerns have been raised about the spread of vaccine hesitancy to other members of the society, especially among people who do not belong to the healthcare profession. Recent data from the UK evaluating the intention of vaccination revealed around 82% stating they were likely or very likely to take up a COVID-19 vaccine, and 18% unlikely or very unlikely. However, vaccine hesitancy was highest in black or black British ethnic groups, with 72% stating they were unlikely to be vaccinated followed by people of the Pakistani/Bangladeshi ethnicity (42%).5

Reasons for the hesitancy - The reasons for the vaccine hesitancy are manifold. The most common influencing factors which can be highlighted from the learnings of medical ethics are (a) complacency (eg, do not see the need or value for it), (b) convenience (eg, access to vaccines is not available) and (c) confidence (eg, mistrust in the efficacy of the vaccine and in the healthcare provider and its side effects). Out of this lower trust, confidence in vaccine efficiency (VE) along with lower perception of risk appear to be main drivers for vaccine hesitancy in the BAME communities along with various cultural and religious beliefs.

It is a known fact that vaccine efficacy of any approved vaccine is in the range of 70%–80% and no vaccine has 100% efficacy. Even though this is true for most vaccines, it seems sociodemographic variation, household decision making may be influencing uptake in the BAME community.6 Besides, concerns about adverse events following immunisation (AEFI) does tilt the mindset to avoid vaccination, although most AEFI reports indicate minor side effects with most vaccines. The major role in this, however, appears to be of the mistrust in the COVID-19 vaccine. Misleading reporting by the media, political interference along with lack of visible safety and efficacy data are considered as the primary reasons for this mistrust. While there have been efforts to recruit representative BAME groups in vaccination trials, probably there is simply not enough data to make meaningful assessment of VE in specific subgroups.

Suggested solutions -We believe that multitude of the reasons mentioned above need to be tackled. Respecting a person’s autonomy of self-determination—the duty to do good and greater Justice of protecting the community at large should be the driving force in achieving universal immunisation. To accomplish this purpose, engagement of the BAME community to reassure and propagate the need of COVID-19 vaccination in their local communities is necessary and possible through several ways:

1. By providing the details of the robustness of the processes involved in the vaccine development and approval of its use.
2. Safety and efficacy of the vaccine must be highlighted.
3. Multilingual non-stigmatising public health information about VE may be a highly effective solution.
4. Community education by healthcare workers and BAME healthcare professionals represent a trusted source of health information for minority ethnic groups. Local campaigns and involvement by these professionals will help build confidence in communities.
5. Training of healthcare staff for mass communication, easy access to vaccine sites at local sites, decentralised administration of vaccines in presence of local trusted family physicians can also help to escalate coverage.
6. Awareness campaigns by initially vaccinated healthcare professionals will help allay fear.6
7. Follow-up of people and transparent reporting of side effects or adverse events to the community at large can provide real-time safety data and monitoring.
8. Telehealth can also help in achieving community education on a large scale in a rapid span of time.9
9. Public health information to highlight that vaccine hesitancy may result in further disease outbreaks and disproportionate mortality from a preventable disease with use of vaccine10 in the BAME community will bolster confidence needed for mass immunisation. Proven significance and efficacy of effective large-scale vaccination programmes leading to eradication of dreaded diseases like Smallpox and Polio should reinforce faith in validated vaccines.

The biggest concern from ‘vaccine hesitancy’ is that the unvaccinated people could form a deadly reservoir of the coronavirus, which would cause further outbreaks of infection. Hence, it is imperative that a larger population (60%–90%) is vaccinated so as to reach the level of adequate protection, equaling herd immunity. Wallis11 suggested some innovative ways to tackle vaccine hesitancy. These include: (i) identifying and reaching out to ambivalent people, (ii) address the lack of trust among people, (iii) defuse mistrust of the BAME community by inviting the trusted people of their community to do canvassing for the vaccine, (iv) overcoming the practical barriers for low-income people by providing vaccine free of cost and extending the vaccination hours for them, (v) publicising the popularity and efficacy of the vaccines, (vi) suggesting vaccination of people who are visiting the clinics and hospitals for some other reasons and (vii) sending frequent reminders to the people.
Conclusion - Vaccine uptake is necessary and ideally should preferably be made mandatory for the wider community and the health of the nation. Reassurance, engagement and encouragement of the BAME community will support the efforts of the UK government to protect the individual getting vaccinated, the entire community through herd immunity with the possibility of preventing widespread recurrent outbreaks of COVID-19. The quote by H. Jackson Brown JR—"Nothing is more expensive than a missed opportunity" most aptly applies to the COVID-19 vaccination.

Karthikeyan P Iyengar,1 Raju Vaishya 2,3 Vijay Kumar Jain 4, Pranav Ish 5
1Southport and Ormskirk Hospital NHS Trust, Southport, UK
2Orthopaedics, Indraprastha Apollo Hospital, New Delhi, India
3Department of Orthopaedics, Atal Bihari Vajpayee Institute of Medical Sciences, Dr Ram Manohar Lohia Hospital, New Delhi, India
4Department of Pulmonary, Critical Care and Sleep Medicine, Vardhman Mahavir Medical College and Safdarjung Hospital, New Delhi, India
Correspondence to Karthikeyan P Iyengar, Southport and Ormskirk Hospital NHS Trust, Southport PR8 6PN, UK; kartikp31@hotmail.com

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REFERENCES


