Witness Name: Dr Salman Waqar
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UK COVID-19 INQUIRY - MODULE 4

WITNESS STATEMENT OF DR SALMAN WAQAR ON BEHALF OF THE FEDERATION OF ETHNIC MINORITY HEALTHCARE ORGANISATIONS ("FEMHO")

I, Dr Salman Waqar BSc(Hons) MBBS MRCGP DRCOG PgCert (MedEd) MSc RCPath (ME) DLM MFMLM, will say as follows: -

1. I am an NHS General Practitioner ("GP") by practice and have a background in academia, policy, medical leadership, education and training within the health sector. As well as my GP clinical work, I also hold a number of other roles and prior fellowships. I have an honorary position at Imperial College London through which I am investigating the relationship between faith and health, and currently hold several research grants in this area. I am also a GP Training Programme Director, Medical Examiner, Regional Education Lead for the Royal College of General Practitioners ("RCGP"), a Clinical Lead at the Thames Valley Cancer Alliance, and a Medically Qualified Tribunal Member. I was previously an Associate Medical Director for East Berkshire Primary Care, an urgent care and out-of-hours GP cooperative, during the Covid-19 pandemic where I was responsible for clinical leadership at a mass vaccination site and of our local Covid Medicines Delivery Unit. During that time, I also worked as a remote GP for the NHS 111 Covid-19 Clinical Assessment Service.

2. I am a founding member and the current President of the British Islamic Medical Association ("BIMA"), which is a FEMHO member organisation. I am joint-secretary, and was involved in the setting up, of FEMHO and am authorised by our membership to make this statement on behalf of the organisation. I hold both these roles in a voluntary unpaid capacity. I make this statement in response to the Inquiry's Rule 9 letter dated 9 November 2023, inviting one individual from FEMHO to produce a statement about the impact of Covid-19 on our members specifically in relation to issues concerning vaccines and therapeutics in the UK for Module 4.

3. I and my fellow FEMHO members have a range of serious concerns with how governmental and public bodies handled the development and roll out of Covid-19 vaccination and the use of new and existing therapeutics in treating Covid-19 across the UK. As I will explain in more detail below, our membership spans across the devolved nations and we have found that most of the issues and impacts experienced by our members are common across the UK, though of course every individual's experience differs and some regions and localities fared better than others.

4. In this statement I set out: (1) a brief description of FEMHO and how and why the organisation was established; (2) an overview of the impact of the Government's vaccine policy and roll out and issues pertaining to therapeutics on our members; (3) a summary of representations FEMHO made during the pandemic to core political and administrative decision-makers to influence decision making on these issues; (4) individual summaries as illustrative examples of the types of experiences FEMHO members had that are relevant to the scope of Module 4; and (5) recommendations FEMHO wishes the Inquiry to consider in relation to the matters under examination in this Module.

5. To the extent possible, the information contained within this witness statement is based on my own knowledge. Otherwise, it is based on the collective experiences of my colleagues within FEMHO. I would be happy to clarify or amplify the points addressed in this statement should that be of assistance to the Inquiry.

I. FEMHO: AN OVERVIEW

6. FEMHO is a voluntary multi-disciplinary consortium comprising of over 55,000 individual members belonging to 45 organisations and networks, the majority of which operate across the nations of the United Kingdom. Please see Annex 1 of this statement for the list of our member organisations. Acting as a consortium, the federation brings together existing organisations with shared interests and goals to form a united voice to advocate on behalf of Black, Asian, and Minority Ethnic health and social care workers ("HCWs") at all levels within the health and social care sectors. Our initial focus is to ensure that the disproportionate impact of the Covid-19 pandemic is addressed, with the long- term aim of eliminating systemic and underlying inequalities faced by our members and communities.

7. FEMHO was designed to be inclusive and all-encompassing such that its membership

would be fully representative across the sector. We represent a huge variety of roles and at all levels of seniority within the UK health and social care system including but not limited to doctors, nurses, midwives, dentists, pharmacists, biomedical scientists, physiotherapists, radiographers, speech and language therapists, healthcare assistants, paramedics, social workers, care workers, medical secretaries, public health practitioners, managers, IT staff, chaplains, cleaners, porters, catering and other support staff.

8. FEMHO believes minority ethnic communities should be able to equitably benefit from the level of care that the UK provides to all of its citizens. Unfortunately, inequalities rooted in structural racism and a lack of access and diversity mean that communities are missing out on the care they have the right to access. FEMHO aims to close the gap between minority ethnic health and social care organisations and communities to better deliver care. In doing so we hope that we will be able to achieve enhanced outcomes through the implementation of improved policies, as well as better informed regulators and commissioners both locally and nationally.

9. FEMHO's fundamental contention is that thematic within the government decision-making during the pandemic was a failure to seek and/or receive input from those of us on the frontline, who were representative of, and interacting with, ethnically diverse staff and communities. This culpable failure played a direct and compelling role in the disproportionate rates of infection, death and adverse health outcomes felt among Black, Asian, and Minority Ethnic HCWs and our communities. Indeed, this lack of meaningful engagement is a systemic and historic issue permeating society.

II. ESSENTIAL BACKGROUND CONTEXT

Austerity

10. It must be borne in mind that the UK entered the pandemic after a decade of austerity policies; the impact of these policies cannot be underestimated. Professor Sir Michael Bambra, in his report on health inequalities prepared for this Inquiry, describes the picture of health in the UK as: "*stalling life expectancy, increased regional and deprivation-based health inequalities, and worsening health for the poorest in society*" [SW/1 - INQ000195843]. Plausible explanations for this downward trend are cited to be a combination of changes in social determinants of health associated with austerity policies, substantial cuts to local authority, NHS and social care budgets, and cuts to welfare and benefits.

11. Thus, the UK was on a weakened footing when the pandemic arrived, with a depleted NHS which was ill-prepared and equipped for a pandemic. By 2015, £1 billion had been cut from healthcare and £6.3 billion from social care [SW/2 - INQ000414102]. Understaffed with overworked HCWs, and injured by the effects of mismanagement and harsh austerity agendas by successive governments, in my view, when faced with a similarly incompetent and uncaring pandemic response from central government, the NHS was doomed to struggle.

<u>Structural racism and pre-existing inequalities</u>

12. Equally important to bear in mind are the underlying socio-economic and health inequalities rooted in structural racism that continue to pervade UK society, including within our healthcare system. As with other areas under investigation in this Inquiry, we at FEMHO have identified structural racism as being of vital consideration to fully understand the issues that our members and communities faced in relation to vaccines and therapeutics during the pandemic. The inequalities I will come on to discuss in this statement are not new; once again they have been known and well-evidenced for many years but left unaddressed. The presence of structural racism within the NHS is something that has been particularly well versed in publications and press for many years. Former Health Secretary Matt Hancock confirmed in his oral evidence during Module 2 of the Inquiry that it was something he was well aware of.

13. The failure to take action and effectively address the issue in the years leading up to the pandemic, we say, had a direct impact on the disproportionate effects we experienced during the Covid-19 pandemic and the challenges we continue to face day to day in our professional and personal lives. We feel strongly that government knew, or at least ought to have known, that these pre-existing inequalities would influence the impact of their decision-making, yet they failed to take into account, proactively plan for and/or mitigate against the disparities that inevitably arose. This may be a reflection of institutional diffidence about how to deal with race/ethnicity and risk; or frankly, may indicate a lack of conviction about the importance of these issues.

<u>Historic distrust amongst ethnic minority communities</u>

14. One particularly important aspect of this failure when it came to vaccines and therapeutics was the absence of planning and effective early response to distrust amongst ethnic

minority people. Public trust is and was of course fundamental to the success of the government's response to the Covid-19 pandemic. It has been recognised and acknowledged in commentary for many years that individuals from ethnic minority communities are more wary of dealing with and less likely to trust in institutional powers; not surprising given our personal and passed-down experiences of discrimination and racism.

15. In relation to healthcare and therapeutics, for example, there remains a vivid lived memory of the drug trials carried out by Pfizer on Nigerian children in the 1990s, which were conducted without proper ethical clearance and consent and which led to a number of deaths and long term health problems and disabilities. Evidence of poor uptake of vaccines can also be seen in the sporadic outbreaks of vaccine-preventable diseases such as polio, measles, tetanus and diphtheria in Muslim-majority countries, for example. Similarly there have been many instances in which government bodies, such as the Home Office, have been said to misuse the personal data of ethnic minority people. Simultaneously, there has also been a historic issue of under-representation and lack of diversity in clinical trials and a lack of investment in research and development of tailored treatment plans despite it being recognised that pathophysiology can differ according to ethnicity.

16. These collective and individual experiences of structural racism and discrimination create and underpin distrust and fear amongst our communities. Despite this, in relation to the vaccination programme and rollout and the use of new and existing therapeutics to treat Covid-19 there appears to have been no consideration in the planning to combat the inevitable distrust there would be in uptake of the Covid-19 vaccination and treatments.

III. CONCERNS REGARDING THE COVID-19 VACCINATION PROGRAMME AND ROLLOUT IN THE UK

17. In this section of the statement I will attempt to summarise a range of our members' experiences from across the UK and our collective concerns about how governmental and public bodies handled the development and roll out of the Covid-19 vaccination programme under 5 thematic headings:
    i. Distrust and issues with take up of the vaccine;
    ii. Concerns regarding safety and post-surveillance monitoring systems;
    iii. Communication issues;
    iv. Lack of effective engagement; and
    v. Vaccination as a Condition of Deployment ("VCOD").

Distrust and issues with take up of the vaccine

18. For the historic reasons outlined at paragraphs 14-16 above, distrust was a significant issue for our members, colleagues and communities and one we consider had a direct impact on the lower uptake of the vaccine (at least initially) amongst ethnic minority groups.

19. Whilst there was talk of the urgent work on vaccine development from the early stages of the pandemic as "*a way out*", we as healthcare professionals know that ordinarily the development and approval of new vaccines takes a considerable period of time even when based on pre-existing studies, technologies and virology. The process is usually lengthy and expensive involving for example numerous bureaucratic processes, applications for funding and detailed ethical approval checks, recruitment of volunteers for trials, engagement and commercial negotiations with manufacturers and regulatory bodies. In particular, clinical trials and safety checks are a substantial and vital part of the development process. It is perhaps unsurprising therefore that even amongst medical professionals the speed at which the Covid-19 vaccine was developed created some scepticism and anxiety about its safety.

20. We also had concerns about whether legal safeguards were being abandoned, watered down or sidelined with non-compliance overlooked and excused "*due to the state of emergency*". There was a lack of transparency about those amendments that were made such as the temporary provisions inserted into the Human Medicines Regulations 2012 (S.I. 2012/1916) ("the HMRs") by the Human Medicines (Coronavirus and Influenza) (Amendment) Regulations 2020 (S.I. 2020/1125) and the Human Medicines (Coronavirus) (Further Amendments) Regulations 2020 (S.I. 2020/1594), which gave government the flexibility for vaccine administration across the NHS system. They also enabled the use of an extended workforce who are legally and safely able to administer the Covid-19 vaccine.

21. These provisions were purportedly put in place to enable Covid-19 vaccines to be safely deployed at speed and scale, and to ensure that there would be sufficient workforce to deliver the mass vaccination programme, yet the Department of Health and Social Care ("DHSC") Public Sector Equality Duty ("PSED") Equality Impact Assessment ("EIA") for these amendments (for example, to Regulations 3A, 19, and 247A of the Human Medicines Regulations 2012) and the DHSC public consultation appeared to be ineffectual

and more of a "tick box" exercise [SW/3 – INQ000414103][1]. It noted, for example, the disparity in Covid-19 vaccine uptake when disaggregated by race and ethnicity, yet the activity and output from the system was not commensurate with the facts and inconsistent with the data both the DHSC and the NHS had from ONS on coronavirus and vaccination rates in adults by socio-demographic characteristic and occupation [SW/4 – INQ000414104]. For example, the vaccine promotion campaigns continually lacked culturally tailored messaging that resonated with diverse ethnic communities. Effective communication would have considered language barriers, cultural beliefs and the all important element of trust from the outset; and certainly as a revisit once the disparity became clear. So too would it have involved genuine engagement with community leaders and organisations within communities, however this too was extremely limited and often late into the process.

22. The PSED did not appear to seriously address any identified disparity; the process lacked actionable outcomes. Some EIA reports identified problems that would affect certain ethnic groups but they failed to delve deep enough into the issues and/or to propose concrete solutions or mitigations for negative impacts. To my colleagues in FEMHO and I, this indicates a rushed approach focused on simply completing the EIA formality without thoroughly investigating the root causes or attempting to find potential solutions to problems identified. There was an apparent lack in the DHSC's EIAs of any in-depth statistical analysis or detailed consideration of specific impacts on ethnic minorities, indicating a cursory approach was taken. Effective EIAs would have involved proper consultation with stakeholders, especially those from disadvantaged and marginalised groups. To the best of our knowledge, the consultations that took place during the pandemic were very brief and inadequately advertised. We have not seen evidence that any feedback was meaningfully incorporated or, for example, that policy proposals were changed because of evidence identified about potential negative impact on ethnic minority groups. An effective implantation and adherence to the PSED would showcase transparent, participatory, inclusive and adaptive processes that are subject to ongoing monitoring. The DHSC's seemingly rushed EIAs, however, disappointingly did not fulfil that aim.

23. In February 2022, the National Audit Office ("NAO") published its evaluation of the Government's Covid-19 vaccine programme, focusing on events up to the end of October 2021 and assessing whether the programme was well placed to meet its objectives in full

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[1] Please note that this PSED is a later version, and the original is no longer available.

[SW/5 – INQ000065228]. During policy formulation, under Part 1 of the 2006 Act the Secretary of State has a duty to eliminate discrimination. However, the Regulations and the subsequent activity from the system were not tailored, targeted or commensurate to the impact and experiences amongst Black Asian and Minority Ethnic NHS staff and so this duty cannot have been discharged.

24. Meanwhile, during the period that the vaccine was being developed, ethnic minority HCWs and communities were experiencing disproportionate levels of infection and mortality, along with a myriad of wider disparate impacts from Covid. Our efforts to engage government and public bodies in effectively and urgently addressing these disparities often felt unheard or ignored and as I will cover in more detail later in this statement we felt there was a systemic and arguably diffident lack of engagement on a range of fronts. The poor statistical outcomes, combined with the wider socioeconomic disparities and pressures our members were facing and the lack of engagement somewhat predictably manifested in increased distrust in government and a reduced take up in the vaccination programme.

25. Prior to the pandemic it was known (and ought to have been known by decision-makers) that in relation to any vaccine uptake programmes, health screenings, and on all measures of health outcomes, ethnic minorities always fare poorer. Outcomes in every area of health are worse so it did not come as a surprise for any of us when this was clearly also the case for Covid-19.

26. Research on HCWs found that, compared to White British HCWs, minority ethnic HCWs were more likely to report being less confident in the vaccine than those of White British ethnicity. HCWs from White British backgrounds were found to be much more confident in the vaccine (21.3% non-confident), whereas HCWs from Black Caribbean backgrounds were found to have the highest proportion of individuals who were not confident (54.2% non-confident). Similar findings arose as regards HCWs from other minority ethnic backgrounds: Mixed White and Black Caribbean (38.1% non-confident), Black African (34.4% non-confident), Chinese (33.1% non-confident), Pakistani (30.4% non-confident), and White Other (28.7% non-confident). [SW/6 – INQ000302493] [SW/7 – INQ000414107] People from minority ethnic groups were found to be less likely than White British people to have received three shots of the vaccine, with 40% of African Caribbean adults not having received any Covid-19 vaccination accounting for age [SW/8 – INQ000224393].

27. It is important to note, however, that our members report disparities between different

minority ethnic groups and geographic locations as to their respective levels of vaccine confidence. For example, one of our members from the Filipino Nurses Association UK ("FNA UK") reports that there was very high vaccine confidence within the Filipino community at her hospital in Wales. Similarly, Mr Vipin Zamvar of BAPIO Scotland reports high confidence within the Indian population in Scotland, whereas Dr Shahzad Hanif of BIMA Scotland more closely mirrored my own experience in England, which was that there was low confidence throughout the Muslim population. BIMA Scotland member and GP Dr Shahzad Hanif recalls that the group had to spend a lot of time and resource persuading minority ethnic communities to trust the vaccine and that there was a high level of suspicion due to existing health inequalities amongst these communities, previous health injustices and cultural barriers. Dr Hanif states that a wide body of work was pursued by BIMA members without any government support, engagement or involvement.

28. Another of our member organisations, Muslim Doctors Cymru ("MDC"), developed a survey in early 2021 when it became clear there was a lack of confidence in the vaccine in order to establish where the concerns in the Muslim community lay. The survey was released in a webinar run by MDC and soon after, Public Health Wales ("PHW") asked for access to the survey. PHW then used the findings to guide their policy on communications regarding vaccine and MDC was given a seat at a monthly Welsh government meeting with their communications team, to discuss messaging around Covid-19 and vaccination. Some of the feedback was that Muslim women felt uncomfortable bearing skin in the open spaces within mass vaccination centres. MDC was able to recommend adjustments to the centres and curtains were provided for privacy.

29. In Northern Ireland, a frontline hospital social worker who wishes to remain anonymous attests to the fact that there were clearly lower levels of trust and rates of vaccination confidence amongst minority ethnic populations. They said: *"Lots of people were not keen to go for it: they were convinced about bad side effects around it, and a lot of my friends in the community didn't take it."* Some health trusts in Northern Ireland asked minority ethnic staff networks to create videos to help encourage uptake but our member felt that they were ineffective due to their poor quality and the lack of translation provided.

Concerns regarding safety and post-surveillance monitoring systems

30. Concerns regarding the lack of surveillance and follow up to those who received the vaccine compounded the issue of distrust. Had there been transparent safety information,

it is possible that some would have felt emboldened, reassured and thus more likely to get vaccinated.

31. This issue starts with the striking lack of diversity in vaccine trials; something that was of key significance for many of our members and communities when it came to questions of trust and confidence in the vaccine. The typical Randomised Control Trial (RCT) participants are overwhelmingly of Caucasian descent and not from diverse backgrounds [SW/9 – INQ000414109]. If individuals from Black, Asian and Minority Ethnic backgrounds are not included in vaccine trials in sufficient numbers then our communities cannot be satisfied of vaccine safety. The health needs of our communities are often substantially different than the majority population of the United Kingdom, in fact often being reflective of the health inequalities burdening our communities. If vaccine trial outcomes do not account for this reality, our communities are potentially more likely to see the vaccine as effectively untested and therefore untrustworthy. This, taken in the context of the widespread mistrust and historic injustice set out above, can prevent our communities from fully benefiting from the protection that vaccination can offer.

32. I turn next to the Yellow Card system, the MHRA's way of recording adverse effects to medicinal products. It is designed to work as a channel of communication for the public to report problems with vaccines, medicines and other healthcare products but we consider it to be flawed and in need of urgent reform despite so-called improvements made since the pandemic began.

33. Public knowledge of the Yellow Card programme is limited and narrow, as is access to it. The reporting system has until very recently only operated in English and it is located in a certain part of an online website which is not easy to navigate to. Whilst some guidance leaflets have now been translated this came at a very late stage and we do not consider it goes far enough; altogether it is not an accessible system and this discourages reporting.

34. The extent to which a lack of clear communications on risks and results – especially when negative outcomes from the vaccine such as blood clots began to be reported in the press – perpetuated fear and distrust amongst those who were undecided about taking the vaccine must be explored by the Inquiry. The reporting of adverse drug events was not well communicated to the public, particularly amongst our communities; nor was the UK Vaccine Damage Payment Scheme, which we consider requires reform to ensure equitable access to compensation for all communities.

35. Small steps could have made an enormous difference here, for example producing yellow cards in multiple languages and making them readily available tailored to demographic populations e.g. at pharmacies and community hubs. The yellow card system itself could be easily improved; at present for example it collects extremely limited demographic data making it difficult to identify disparities in drug reactions across different population groups. In the absence of official information, rumours spread for example about potential links between certain cardiovascular conditions (of which minority ethnic communities have statistically higher prevalence) and vaccine reactions; these must be explored, and the facts set out.

36. In addition to the issues with the Yellow Card system, we have concerns about the lack of transparency demonstrated by organisations such as the Medicine Healthcare Regulatory Agency ("MHRA"). It was unclear what role the MHRA was playing in the development and approval of vaccines and therapeutics and what safety checks were being carried out in the short time that they were being developed, manufactured and distributed for use in clinical settings. As I will go on to explain later in this statement, in addition to the lack of transparency there was also a troubling lack of willingness to engage with concerns and/or queries relating to inequalities and potential safety issues.

37. We are keen to explore what if any consideration and/or steps were taken by government (in particular the Joint Committee on Vaccination and Immunisation "JCVI") to address the above points and also whether those dealing with the vaccine manufacturers explored any action they could take (including market shaping strategies and post-market surveillance updates) to increase confidence and address the discrepancy in uptake amongst minority ethnic communities. Ethnic minority priority should we consider have been factored in, particularly for HCWs exposed on the front line and rostered disproportionately to the most infectious wards.

38. In addition to the above points, our members express concern with regards to the relationship between the Government and the vaccine manufacturers, and the arrangements in place to ensure the rollout of the vaccine. Using state funds, the Government via an amendment to Regulation 345 of the Human Medicines Regulations 2012, provided an indemnity to vaccine manufacturers effectively protecting them from civil liability arising from any injury caused by the vaccine and added the vaccine to the list of those covered by the Vaccine Damage Payment scheme, whereby individuals suffering

severe disability caused by the vaccine may obtain a one off £120,000 compensation payment. In the view of our members, that the public should foot the bill for any harm caused to those receiving the vaccine is a national scandal and further degrades the trust between our communities and the state. Our members believe that the Government should not have indemnified the manufacturers. It is in the interests of transparency, fairness and the trust of our communities that it be possible to scrutinise the actions of those manufacturers through the civil courts. It is crucial that trust is maintained, and for the Government to show goodwill towards our communities, as this will increase the likelihood that our communities enjoy the benefits that vaccination can offer. We invite the Inquiry to examine the motivations behind the indemnity, and whether one consideration was that the UK was scrambling to provide the vaccine to its population in record time to mitigate the effects of negative international appraisals of its overall response up to that point.

Communication issues

39. There was, in our eyes, an inexcusable paucity of accessible communications, including translation services, tailored to the needs of ethnic minorities and people who were known to be disproportionately more likely to lack confidence in relation to a Covid-19 vaccine. This was a significant failing given the overriding importance of public trust, and the resultant impact the lack of trust amongst many ethnic minorities had on the negative outcomes and disparities suffered. Such essential matters should have been identified and addressed via EIAs under the PSED.

40. Dr Shabi Ahmad, a FEMHO member from the Association of Pakistani Physicians of Northern Europe ("APPNE"), describes the climate of mistrust between government and many in minority ethnic communities at the point the vaccine rollout began: "*a huge proportion of the people that died during the pandemic were from minority ethnic backgrounds, but when people died, there was no initiative from the Government to reassure the community that this is a pandemic and not something that [has been deliberately engineered to] target minority ethnic communities…Whenever you leave a space like that, an environment of mistrust, whatever you start to provide, information wise, is looked at sceptically* […] *Anti-vaxxers took advantage of it.*" He, like other FEMHO members, is seriously concerned that the level of misinformation caused by poor public messaging and communication hindered the efforts of our members when they went out into their communities to try and encourage vaccine uptake.

41. The inadequacies in the accessibility and cultural competence of public messaging and communications are another pre-existing issue that has persisted unaddressed for many years and which government failed to adequately prepare for or address during the pandemic. As Dr Ahmad puts it, the issue was a simple one: *"once the Government knew the vaccine was coming, and they had much more information than we did, they should have started a media campaign and gone into the community."* Another member, Dr Talabani of MDC, similarly states that community groups shouldn't have needed to lobby for action to be taken: *"to tailor communications to a population that the Government already knew would be more vulnerable because of a lack of engagement to begin with, before the pandemic… When dealing with a community that is disproportionately singled out negatively by government and media, subject to systemic racism, this fosters a lack of trust in government, and they will be more sceptical regarding taking the vaccine."*

42. Dr Ahmad, along with others from our membership, reiterate that many in minority ethnic communities tend not to engage with mainstream English language media outlets and consume current affairs instead through local or minority ethnic run media outlets such as Asian Star Radio. Instead of engaging with and utilising those outlets, central government tended to focus its efforts on the BBC and other mainstream outlets, which overwhelmingly failed to invite minority ethnic doctors to speak with their communities through those channels in any event. There was no platform given to community leaders or medics from minority ethnic communities to increase awareness.

43. Even for NHS staff, culturally competent and sensitive information and guidance about the vaccine was unavailable, never mind for the general public. When the vaccine approval was announced HCWs who would, for the most part, follow medical advice without quandary were suddenly very hesitant, sharing wider concerns about the speed of the development and approval for the reasons I have outlined. The official messaging on timelines was unclear and expectations were not well managed.

44. In light of the concerning delays in Government action to address communication issues, and the spread of disinformation, FEMHO members' staff networks and organisations such as BAPIO, BIMA, Black Women in Health, CamDocUK, Sudan Doctors Union, Medical Association of Nigerians Across Great Britain and MDC among others took up the baton once more in effort to fill the gap and ensure that ethnically diverse communities were reached and properly informed. Examples of the marketing for these efforts can be seen in FEMHO's Rule 9 response to Module 2 [SW/10 – INQ000099685]. Between us, we

hosted numerous webinars, went on radio shows and "phone-ins" to field queries and produced a wide array of content and material which was available in many different languages and culturally sensitive formats and disseminated through networks, WhatsApp, Viber, Twitter and other social media and proved crucial in order to educate and protect our communities. Often these would be localised with faith leaders and/or respected community laypersons were invited to attend and/or chair webinars so that attendees could see there were trusted authority figures there to bring the community together and give legitimacy to the information being provided. The head of BAPIO Wales, Professor Keshav Singal, was able to arrange for the Health Minister and the Chair of the MHRA to attend such a webinar and dispel myths about the vaccine after he raised concerns with the government about low vaccine confidence in ethnic minority populations. Other groups, such as MDC, also ran pop-up vaccination clinics where people were invited to speak and address concerns about the vaccine.

45. Rather than being transparent and communicating how the UK obtained the vaccine, and what it meant to take it, there was a gap in public messaging and communications left vulnerable for exploitation. This vacuum was then unsurprisingly filled by conspiracy theories, many of which were lurid in nature and may have done lasting damage to the trust of many in our communities. Some such theories included the vaccine being a microchip inserted into the human body, and worse still the vaccine rollout being an attempt to cull certain minority ethnic communities. The spreading of this information throughout some sections in our communities was painful to see but not hard to predict. More promotional content, including myth-busting / fact-checking and transparent safety information, was required to improve trust and understanding within communities of how these processes work.

46. This was the first time that we had witnessed information and disinformation being imported and exported on such a global scale. Ethnic media and print in the UK were in some instances coming out with incorrect information and, although we couldn't influence the media output from other countries, greater efforts should have been made to assist with the consumption of that media when it reached our shores so as to mitigate its impact. Our communities could have been better told what to watch out for and how to distinguish fact from fiction when it came to vaccine media coverage from their home countries, or their ethnic country of origin or others.

47. One of our members who works within the DHSC did suggest that they could work with

NHS Digital to lead a "myth busting" campaign on social media, to debunk the myths surrounding the vaccine rollout that were infiltrating many minority ethnic communities. They also suggested material to provide transparency on how data and patient records are used within the NHS, and to explain the interplay between the health system and government, which is a common concern and deterrent to accessing healthcare amongst minority ethnic communities. However, they say this was met with a negative response from the department, who were apparently more concerned around the potential for the videos suggested generating negativity and comments from anti-vaxxers than dispelling the dangerous myths and rumours that were spreading; it felt as if the lack of engagement from the state apparatus just reinforced and exacerbated the conspiracy cycle. Actively engaging in promotional content to combat known misinformation that was spreading could have acted to improve trust and understanding; remaining silent only added to the sense that there was a lack of transparency around the issues and, for some, intensified feelings of distrust.

48. Generally, the steps taken to address misinformation and communication shortcomings by NHS and local organisations came too late. It is only this year that the National Institute for Health and Care Research ("NIHR") has commissioned work into the relationship between faith, public health, and messaging. This would have been so beneficial at the time.

49. As a minimum, the government should have ensured that public messaging was made accessible in languages to meet the needs of local and national communities. We could and should have enjoyed academic linguistic support to help with this effort and enrich the translations of infection control information many of our members were trying autonomously to disseminate among their communities. For example, some languages such as Kurdish do not possess the relevant lexicon to communicate English language concepts relating to vaccination. Through our members universal analogies and metaphors were employed to communicate that concept effectively. Translators in the BIMA similarly struggled at first to convey the concept of a social "bubble" into certain languages and there was no guidance or official support in doing so. A member of BAPIO Scotland, Vipin Zamvar, who was working at the Edinburgh Royal Infirmary was approached by an NGO and along with other colleagues asked to record messages in different languages including Hindi and Punjabi to improve communication with diverse communities. The NGO was said to be working with the Scottish government on this initiative.

Lack of effective engagement

50. Ethnic minorities are generally overrepresented within the lower ranks of the healthcare sector in the UK. The absence of diversity and representation in the top echelons of leadership, the so-called "Snowy White peaks" phenomena, breeds a culture of systemic lack of inclusivity which, coupled with lack of trust, formed the backdrop to the disparities at play during the pandemic. Not only was there a lack of representation, however, but we found there to be a lack of effective engagement.

51. Effective public health interventions require building and maintaining trust with community influencers. During the pandemic, however, there was little to no attempt to utilise the intimate connections as healthcare leaders within our communities to disseminate information about the vaccine to encourage uptake. Some of our members were asked to become "poster boys/girls" for the vaccination rollout but felt that beyond these token efforts there was no real desire to engage with them. Respected cultural leaders should have been at the forefront of the Government's efforts to increase uptake in our communities. Relevant organisations and individuals from our membership should have been consulted and involved earlier and in greater numbers. Our members are frustrated and disappointed by this shortsighted lack of engagement which meant that they were unable to be as effective as they could have been had they been properly supported.

52. The culture at DHSC and NHSE did not appear to take racial inequalities seriously. For example, DHSC seemed always to use the phrase '*hard to reach*' in relation to ethnic minority groups and "*hesitancy*" in relation to poor uptake in vaccination. FEMHO eschews these phrases and suggests instead that *vaccine non-confident* or *lack of confidence* is used. Using the term 'hard to reach' when referring to vaccinating ethnic minorities is problematic for several reasons:

    i. Implied lack of agency: The term "hard-to-reach" suggests that certain communities or ethnic minorities are passive recipients who are difficult to engage. On the contrary, our members who were trying to offer assistance and engage on these issues found that government was "hard to reach". This phrasing can overlook the agency and active participation of these communities in their healthcare decisions. It also places an artificially high level of responsibility on individuals in communities to consume accurate and objective information about their healthcare needs, and in doing so overlooks the state's responsibility to ensure vulnerable communities are properly supported in their consumption of healthcare information and advice by ensuring official communications are culturally competent and effective.

ii. Potential stigmatisation: The term may inadvertently stigmatise certain communities, implying that they are challenging to reach because of characteristics intrinsic to the community members rather than external factors such as systemic barriers, lack of resources, or historical mistrust. It places blame on individuals which is a reductive oversimplification.

iii. Overlooks systemic barriers: It does not adequately address the structural and systemic barriers that may contribute to lower vaccination rates in certain communities. These barriers may include issues like limited access to healthcare, language barriers, lack of confidence in vaccines due to historical injustices, and socio-economic disparities.

iv. Generalisation: using the term "hard-to-reach" can oversimplify the diversity within ethnic minority communities. It treats these communities as monolithic, ignoring the unique needs, concerns, and strengths of different groups.

v. Conveys a deficit model: the phrase can reinforce a deficit model perspective, focusing on what these communities lack rather than recognising and building on their strengths and resilience.

53. The specialist networks that engage with faith community-based organisations, which were deployed when it came to messaging about isolating about testing, were noticeably underutilised for vaccine rollout. Most government creativity in seeking to reach out to diverse populations such as going out into those communities and rolling vaccine delivery units in areas like Chinatown, high immigrant ethnic minority spaces, also in mosques and churches mostly came later on in the pandemic and after lobbying by our members and others.

54. The use of a large church in West London to administer the vaccine was one example of how a proactive and properly coordinated excursion into a community who needed increased vaccine support could be done in a way that was helpful and effective, but one that came so late in the day that its effectiveness, and its sincerity, was undermined. FEMHO member Abim Anyiam, a communications specialist at NHS England, states of this particular effort: *"those delivering the vaccines were going into the community to meet the people. At this [later] point the Government is now awake to the fact that it was needed. For example, a large church in West London was used as a vaccine site. At this point you are helping to rebuild some of the damage that has been done before. But because it took*

so long, some individuals thought it was a targeted or a calculated move by the Government to bring themselves back into favour with ethnic minorities, and looked to some like the Government was only doing it to make themselves look good."

55. Dr Shabi Ahmad of APPNE goes further: *"The involvement of religious spaces came a bit later in the whole process. […] when they saw uptake in communities was low, the realisation came that they have to be more forthcoming and go into the community and involve religious places to encourage people to come in. It appears it was reactive rather than proactive. They only came to [religious sites] once they realised the community was not coming forward – then they went into mosques and so on: if people saw it done in a mosque, they wouldn't think it was harmful."*

56. Another common concern amongst our members was the lack of support (financial and practical) for the efforts of voluntary and community-led work to address inequalities and racial disparities in the uptake of the vaccine. Where funding was made available, our members report that it disappeared into unknown or vague efforts, the effectiveness or point of which was not always clear. It is telling that when asked about the efficacy of central government's purported flagship effort to combat health inequalities via the "Community Champions Scheme", many of our members could not recall its existence. This signals that the communications around this scheme were inefficient and not widely publicised within member communities.

57. Meanwhile, the efforts of FEMHO organisations outlined throughout this statement were undertaken in our free time, after coming home from long medical shifts and there was usually no compensation, platforms or other support provided. This is perhaps an area where direct funding would have been well received. Funding was needed for zoom premiums to host webinars and some organisations had to invest in cameras and lighting to ensure that their educational material looked professional and credible to gain confidence of the audience; after all it is a natural human response to trust information from reputable and reliable sources. The cost of support would have been minimal in the grand scope of the pandemic spending, and some of our members have lamented that they were left to find and source budgets of their own, at times out of their own pockets, with no assistance from Government or the NHS to enhance or support their work.

58. While some groups would have benefitted from financial support to assist with their work on the ground, it is not always the primary objective of such groups. Indeed in some communities, receiving government funding can more often than not be seen as a "red flag" and create suspicion due to the existing climate of mistrust between those

communities and Government. Some may feel that if the money comes from government they will maintain control over how it is spent. Direct central government funding for, for example, communications initiatives is often not, therefore, the answer. Rather, our members would have benefited from a public health apparatus that recognised, reflected and supported the needs of our communities. There are a range of alternatives that would be helpful, and no "one size fits all" solution. It might, for example, come in the form of support in kind, such as protected time for employees to engage in BAME/EDI networks; in providing a platform and/or "seat at the table" for groups and making sure their voices are heard; administrative support for example for website hosting or translation facilities; or in some cases in redirecting funds through local organisations and charities to distribute. These steps can make significant differences to small networks and organisations who could, with this additional support, provide even more value and assistance in the wider response. This is a long-term solution that should have been entrenched in our health system well before the pandemic hit.

59. It is right to also return before I conclude this section to the lack of transparency and engagement by the MHRA touched on earlier in this statement. A FEMHO member shared concerns and information with the MHRA regarding racial disparity issues that had been identified with pulse oximeters, a key tool which records oxygen levels in the body using infrared technology and which was being utilised to monitor Covid-19 patients. The infrared technology was found to be less effective and to produce misleading results on darker skin pigmentations, having been designed, trialled and calibrated on White skin. Similar information was also being shared by the NHS Race and Health Observatory. The outcome of this exercise for our member was highly frustrating. For example, they recall that in the meeting where they advanced this information, this problematic and significant issue was denied by two White officials on the (false) basis that the evidence was unclear; they simply declined to accept these facts were true and/or worth urgent investigation given the significance.

60. The NHS delay in taking action on this issue we say was culpable and negatively impacted on health outcomes for ethnic minority people. In the absence of follow up or investigation work from government it was left to people like our members to raise awareness of the issue. Others, such as the NHS Race and Health Observatory also wrote letters and publicised information regarding the issue. They too report that the MHRA failed to engage or take the issue on board when they attempted to engage with them.

61. Conversely, there were some positive experiences reported by our members in respect to engagement, and it would be remiss if we were not to mention these. MDC, one of our member organisations based in Wales which I mentioned earlier in this statement, reported that the government led by First Minister Mark Drakeford proactively supported their and other grassroot community organisations' efforts to increase vaccine uptake from an early stage. The Welsh Health Boards helped to fund the pop-up vaccination clinics that MDC ran to provide a space for people to raise concerns and queries about the vaccine. Mr Drakeford even visited a mosque where the vaccine was being administered to show his face and support and referred to the programme in political debate. The group was also invited to join governmental meetings held online in relation to the vaccine and communication issues and they felt that concerns they raised were taken on board quickly. An early statement on twitter relating to the potential link between the AstraZeneca vaccine and blood clots was picked up by Mr Drakeford and retweeted by the CMO for Wales. MDC member Dr Bnar Talabani states: *"They listened, and culturally sensitive adjustments that worked were made promptly."* This reflects a receptive and responsive approach to minority ethnic concerns and problems that we consider should be a standard across the UK. It is a shame that this level of visible recognition, engagement and action was not always replicated by other leaders and, however positive this example of engagement was, it does not negate the fact that it should never have fallen to groups like MDC to pursue such basic actions.

Vaccination as a Condition of Deployment ("VCOD")

62. The advancement of the VCOD scheme was a further significant stressor and key issue for our members and added to the climate of fear and coercion. This came at a time when HCWs were already overstretched and overburdened, and those from minority ethnic communities were feeling and experiencing starkly disparate impacts.

63. There was little guidance or sensitive communication over the "heavy handed" VCOD mandate when it was announced, nor any time or space afforded to HCWs to discuss and consider the consequences of it. The overwhelming majority of staff felt they were just expected to comply and take the vaccine even if they had legitimate concerns or queries about the safety of doing so. Those of our members who felt able to voice concerns with their seniors report they were mostly met with hostility, passivity and/or silence; others in management positions were unclear as to the position they could take. This caused more distrust, with rumours circulating about staff being harassed and suspended and dismissal letters having been prepared for those who were as yet unvaccinated.

64. Notably, there were 18,500 NHS workers in London alone recorded as unvaccinated (and therefore who would have faced dismissal) around the time the deadline was impending. The insidious climate of coercion and fear of job repercussions persisted, with many feeling that confidence had been shattered between HCWs and their employers even after the VCOD mandate was scrapped at the 11th hour. A midwife was quoted in mainstream media as saying she felt "*stalked, bullied and harassed*" by messages from management threatening her job if she didn't get vaccinated. We have heard similar testimony from our members, and that the "*silent treatment*" was often given in response to simple requests for further information, and "*ominous*" lists were being kept of who was and wasn't vaccinated.

65. Our members who work in care settings, where VCOD was mandated, report that the situation was worse still for them and that it led to a loss of approximately 30,000 staff. We hope to share more about this within the scope of Module 6.

66. The success of VCOD policies in healthcare settings depends on a nuanced and culturally sensitive approach. We would suggest that engaging with HCWs, understanding and addressing their concerns, and ensuring equitable access to vaccines are all critical components of an effective VCOD strategy, especially in diverse and multicultural settings. VCOD policies without these actions will inevitably exacerbate concerns stemming from existing mistrust, historical injustices, and low vaccine confidence, leading to resistance or non-compliance.

67. Many of our members felt compelled to be vaccinated before VCOD was scrapped, purely out of fear of negative repercussion if they failed to do so. They were in effect coerced into relinquishing their autonomy to ensure that their livelihoods, those of their families and in some cases, visa status, were protected. The additional emotional toll and negative mental health consequences such an atmosphere of coercion took on individuals already suffering burn out from working and living under the immense pressures of the pandemic cannot and must not be underestimated. There were also barriers to overseas HCWs being recruited to fill staffing gaps as they didn't have the right "kind" of vaccine. Again, this perpetuated a highly divisive culture of fear and a lack of autonomy, feeding into distrust.

68. Not all experiences and efforts were, of course, purely negative and it would be wrong to suggest this was the case. As one FEMHO member, Abim Anyiam, shared with us some

senior leaders within the sector really wanted to help their staff and did not use VCOD to antagonise or harass staff. In her view: "*The spirit of VCOD was never intended to necessarily have people fired if they would not take the vaccine. The word "deployment" in VCOD meant that people would be redeployed if they refused to take the vaccine. If they refuse redeployment, then they might be made redundant.*" Unfortunately not all managers complied with this sentiment: "*Some people did not act within that spirit – and this was problematic. Within the culture of fear and suspicion that ensued some people did take pre-emptive action and left.*" Unfortunately, our wider membership recount many instances where managers abused the system and took the opportunity to ostracise and dismiss staff.

69. Another FEMHO member Dr Shabi Ahmad considers: "*it is human nature to try and resist anything forced upon you. Rather than being encouraged and supported, people were told that unless you get your vaccine you will not work.*" He recalls an "*extraordinary*" NHS circular that stated if the recipient was not vaccinated by a specific date, payment of wages would be withheld.

IV. Concerns regarding the development of new therapeutics and the repurposing of existing medications for treating Covid-19 during the pandemic

70. There were a number of new and alternative therapeutics, as well as existing medications and supplements, that were canvassed in relation to Covid-19 treatments including, for example, Vitamin D and medicines such as hydroxychloroquine and Ivermectin.

71. Minority ethnic HCWs are, for good reason, especially afraid of regulatory action in respect of their professional conduct and care. Historically we have experienced disproportionate regulatory outcomes and our members commonly report being threatened with disciplinary and regulatory action more regularly than their Caucasian colleagues.

72. Within the ethnic minority HCW community, there is a sense that this fear led to a reluctance in some practitioners to be bold, innovative and edgy when prescribing and using new therapeutics and existing medications to treat Covid-19 because of the ever-present threat of poor regulatory outcomes that are often seen as incommensurate to actions. For example, there was ample evidence at the time to suggest that minority ethnic individuals are more likely to be seriously Vitamin D deficient; and that increasing an individual's Vitamin D levels could help protect against harmful Covid-19 morbidity. HCWs

could therefore have been advising people to take higher doses of vitamin D supplements if they were from a minority ethnic background but there was concern that if harm came to the individual, disproportionate outcomes may have then manifested if the clinician was made subject to disciplinary action. In this climate, some clinicians may have been disinclined to prescribe this in the first place in the absence of clear guidance.

73. A similar picture was seen where usual stockpiles of new therapeutics or existing medicines ran low or ran out, for example in intensive care units where Covid-19 patients were being treated. Clinicians were often expected to use alternative medications in lieu of the usual therapies however our members report that there was a lack of guidance around how to use alternatives (which they were not necessarily familiar with) safely. This was significant for our members, again due in part to the fear of disproportionately harsh regulatory action experienced by many minority ethnic HCWs. The concern among many of our members was essentially: "*I might get this in the neck because of who I am, rather than because of the decision that needs to be made*." When our members are not given guidance on what to do for patients when the usual medicines run out, the decision process behind whether to use an alternative therapy was very much influenced by this fear.

V. Recommendations and lessons learned

74. Inclusive data, research and trials coupled with better informed messaging, will be vital to achieving effective communication with ethnic minorities and restoring dignity and respect in future. We are gravely concerned that it appears little to no lessons have been learned since the Covid-19 pandemic as the same disparities are reported in relation to the surge in measles and whooping cough cases recent months and issues with uptake of the Measles, Mumps and Rubella ("MMR") and pertussis vaccines.

75. On 31 January 2021, BIMA, BAPIO and a number of other organisations now a part of FEMHO (at the time united as "*A consortium of UK based ethnic minority healthcare organisations*") wrote to the then Health Secretary Matt Hancock MP, and the Minister for Covid Vaccine Deployment, Nadhim Zahawi MP, to express its concern that minority ethnic communities (including minority ethnic HCWs who felt vulnerable and exposed) were not being prioritised in the vaccine rollout by the JCVI [SW/11 – INQ000215518]. The requests made in this letter also amount to recommendations in this sphere and we echo their sentiment:

a) *It was said that this is unjustified given the sufficient evidence showing minority ethnic people have a higher risk of infection and death from Covid-19. This is placed in the* *context of the United Kingdom having one of the highest HCW death rates in the world, with minority ethnic people being overrepresented. A recommendation is made that minority ethnic people are prioritised for vaccination.*

b) *Funding be made available to Community and faith groups to carry out information dissemination work on the vaccine rollout: it was mentioned earlier in this statement that the Government's messaging had failed to effectively translate to many minority ethnic communities.*

c) *Media narratives perpetuating mistrust and stigmatising minority ethnic communities are effectively tackled. A recommendation is made for better standards and regulation of the media.*

d) *Data is collected and published weekly on vaccine uptake by disaggregated ethnic groups and faith groups to monitor inequalities and evaluate interventions.*

e) *Improved inclusion of the community leaders within the crucial decision-making process relating to vaccine rollout*

f) *The Government engages in constructive dialogue with HCWs to understand their concerns with Government policy.*

76. Whilst we are likely to make further submissions on recommendations at the end of this Module, with the benefit of having analysed the documentary and oral evidence to come with our legal team, we at FEMHO suggest the following recommendations as a starting point:

    a) Better communication regarding the vaccines, their development, and related factors.
    b) Better relations with community groups to give them a proper voice in decision-making.
    c) Better use of social media in amplifying responsive, culturally sensitive communications.
    d) Increased efficiency and easier access to safety monitoring systems such as the Yellow Card Scheme.
    e) Culturally competent, sensitive and accessible public health messaging that is made accessible to all.
    f) Introduction of a clinical trial diversity score card for pharma companies which grades how diverse the cohort of the controlled participants were, based on the latest census data.
    g) Red, Amber, Green ratings, based on diversity score, to incentivise and encourage pharmaceutical companies to ensure adequate representation in clinical trials.
    h) NICE (the body that manages clinical trials) to be provided with the capability to penalise pharmaceutical companies that repeatedly fail to improve on clinical trial diversity. Such data should be published and made accessible to the public.

i) Clear incentives to attract wider more diverse range of people to get involved in the trials in order to increase efficacy and to monitor how different medicines affect diverse people.
j) Increased transparency in relation to vaccine development and production.
k) Cultural competence training to be mandatory and embedded at all levels in decision-making and policy roles. This should be understood to be an integral part of complying with the existing PSED (Public Sector Equality Duty).
l) Translation of vaccine/therapeutics information and guidance into other languages.
m) Effective utilisation of dissemination of information via local, ethnic media (newspapers, TV, and radio outlets such as Asian Star Radio, and the Voice newspaper) including social media, and not just mainstream outlets such as the BBC. Information should be translated appropriately into relevant languages for those channels.
n) Adopting an inclusive approach to communications and ensuring that central government press teams have a channel of contact with more diverse media.
o) Adopting measures to address misinformation and disinformation around vaccines within ethnic communities, such as targeted education campaigns that are delivered through trusted community leaders and organisations in culturally sensitive manner.

VI. Conclusion

77. We consider there was an abject failure on the part of government and key decision-makers to properly anticipate, plan for and respond effectively to historic and inevitable issues of distrust and lower uptake amongst ethnic minority communities in Covid-19 vaccination. This resulted in further disproportionately negative experiences and outcomes for ethnic minority HCWs and communities.

78. Common underlying concerns amongst FEMHO members include an exacerbated lack of trust in government and employers, safety concerns due to the speed of vaccine and therapeutic development, lack of ethnic diversity in vaccine development, procurement, trials, and poor communication. All these factors are additional underpinned by a history of structural racism and discrimination created distrust and fear amongst minority ethnic HCWs and communities.

79. We submit that unequal uptake was a predictable outcome that ought to have been anticipated and pre-emptively addressed given what is already known and evidenced regarding uptake and confidence amongst ethnic minority communities in relation to

previous vaccines. Moreover, in real time the Government knew there was poor vaccine uptake date by race and ethnicity, yet its activity to increase uptake was not nuanced and ignored the facts that it knew at the time. This was a failure that could have been ameliorated had action been taken sooner.

80. There must be an examination of the extent to which, as government action failed, FEMHO members and others had to step in to fill the gap and play pivotal (voluntary) roles within their communities and networks by spreading information, giving reassurance, and debunking myths and misinformation. Communities put their trust in FEMHO members and consistent local organisations rather than government and looked to them for advice and guidance. Despite being already significantly overstretched by the burdens of the pandemic, many of FEMHO's members felt a duty to dedicate what little personal time they had to help their communities via extensive campaign and communication work, creating and sharing information videos, blog post, toolkits and posters on social media and hosting and speaking at webinars etc.

81. The weight and value of this work cannot be underestimated but notably government and public health bodies were extremely slow to engage and/or recognise the value of these interventions and failed to capitalise on the support we could offer despite relying heavily on it for the success of the rollout. Furthermore we submit that it should not have been necessary had historic and pre-existing issues been adequately addressed and government properly prepared to deal equitably with a public health crisis.

82. It should never have fallen to groups like FEMHO and our members to take action to fill the many basic gaps and failings in the response; doing so and taking on the responsibility has taken a significant additional toll on us in addition to the pressures we face in our professional work within the healthcare sector. We were forced to make further sacrifices on our limited downtime and our own physical and mental health, to take further time away from our loved ones and take on additional stress and responsibilities at an impossibly pressured time. Plans and systems should have already been in place to address these known issues and outcomes. It didn't need to be the way it was; it didn't need to be so hard.

83. It is self-evident that minority ethnic people face a disproportionately higher risk when it comes to outcomes but this need not be the case. We need to learn from the pandemic and take specific action now to ameliorate this disparity and its underlying root causes.

This is already required by equality law, but if robust and effective action is not taken come the next pandemic we fear we will be in the same position, ill-equipped with the same disparities arising and the same risks to a disproportionate and needlessly excessive loss of life. The real work needs to happen now and be sustained over time to achieve positive outcomes.

84. Achieving equitable vaccine distribution and uptake requires a multifaceted approach that addresses the complex social, cultural, and systemic factors that contribute to disparities in healthcare access and outcomes. By implementing the recommendations outlined and suggested here in this statement and continuing to prioritise equity in healthcare policy and practice, it is hoped we can work towards a future where all individuals have equal opportunities to live healthy and fulfilling lives, regardless of their race or ethnicity.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dr Salman Waqar

Dated: 6 June 2024

Annex 1

The Federation of Ethnic Minority Healthcare Organisations ("FEMHO")

Member Organisations

1. African Caribbean Medical Mentors (ACMM)
2. Asian Professionals National Alliance NHS (APNA NHS)
3. AskDoc
4. Association of Afghan Healthcare Professionals-UK (AAHPUK)
5. Association of Pakistani Physicians and Surgeons UK (APPS UK)
6. Association of Pakistani Physicians of Northern Europe (APPNE)
7. Bangladesh Medical Association UK (BMAUK)
8. Bangladeshi Doctors in the UK (BD Doc UK)
9. Better Health 4 Africa (BH4A)
10. Black Women in Health (BWIH)
11. British Association for Physicians of Indian Origin (BAPIO)
12. British Caribbean Doctors and Dentists (BCDD)
13. British Egyptian Medical Association (BEMA)
14. British Indian Nursing Association (BINA)
15. British Indian Psychiatrists Association (BIPA)
16. British International Doctors Association (BIDA)
17. British Islamic Medical Association (BIMA)
18. British Pakistani Psychiatrists Association (BPPA)
19. British Sikh Doctors Organisation (BSDO)
20. British Sikh Nurses (BSN)
21. British Somali Medical Association (BSMA)

22. Cameroon Doctors UK (CamDocUK)
23. Filipino Nurses Association UK (FNA UK)
24. Ghanian Doctors and Dentists Association UK (GDDA-UK)
25. Medical Association of Nigerians Across Great Britain (MANSAG)
26. Melanin Medics
27. Midlands Egyptian Society (MES (Medical))
28. Muslim Doctors Association (MDA)
29. Nepalese Doctors Association (NDA UK)
30. Nigerian Nurses Charity Association UK (NNCAUK)
31. PalMed UK
32. Seacole Group
33. Sikh Doctors and Dentists Association UK (SDDA(UK))
34. Sri Lankan Psychiatrists Association UK (SLPA(UK))
35. Sudan Doctors Union UK (SDU-UK)
36. Syrian British Medical Society (SBMS)
37. Uganda Nurses and Midwives Association UK (UNMA-UK)
38. UK Black Pharmacists Association (UKBPA)
39. UK Ugandan Medical Doctors Association (UK UMDA)
40. United Iraqi Medical Association (UIMA)
41. Zimbabwe Doctors Association UK (ZDA-UK)
42. Zimbabwean Allied Medical Professional Association (ZAMPA UK)
43. Society of African Caribbean midwives UK (SoAC)
44. Pamoja Network
45. Muslim Doctors Cymru

Individual members cover roles and specialisms including:

Administrative staff	Mental health nurses
Biomedical scientists	Midwives
Chaplains	Nurses
Chefs and catering staff	Nutritionists
Cleaners/domestic services staff	Occupational therapists and support workers
Clinical managers	Operational managers
Communications/public relations staff	Paediatricians
Dentists	Paramedics
Dieticians	Pharmacy staff
Doctors	Phlebotomists
Education trainers	Physiotherapists
Estates managers	Podiatrists
Finance managers	Porters
GPs	Project managers
Healthcare assistants	Public health practitioners
HR professionals	Radiographers
Information analysts	School nurses
IT help desk advisors	Social workers
IT support officers	Social care workers
Maternity support workers	Care workers
Medical secretaries	Theatre support staff
Speech and language therapy assistants	Switchboard operators