The SAGE Ethnicity Sub-group produced a synopsis of evidence (published January 2021):

- Barriers to vaccine uptake include perception of risk, low confidence in the vaccine, distrust, access barriers, inconvenience, socio-demographic context and lack of endorsement, lack of vaccine offer or lack of communication from trusted providers and community leaders. [high confidence]
- Practical support will be required to ensure no financial disadvantage is incurred through vaccine uptake (such as loss of earnings or travel costs).
- Transparent and regular reporting of progress on the vaccination offer, including uptake by minority ethnic groups and actions taken to address inequalities, will help to build confidence in the fairness, safety and efficacy of the vaccines.

Source: Factors influencing COVID-19 vaccine uptake among minority ethnic groups (publishing.service.gov.uk)

MIGRANT COMMUNITIES

This population is diverse and faces a broad range of mechanisms of exclusion from society, resulting in significant and varied challenges to accessing healthcare.

These groups should have specific consideration within the COVID vaccination strategy, as they can be at risk of worse COVID outcomes and lower vaccination uptake.

Barriers to vaccination for migrants can occur at multiple levels of the health care system. Challenges exist for healthcare providers delivering and for patients accessing vaccination and echo wider barriers to healthcare for these groups.

Entitlement to care: NHS Regulations (Charges to Overseas Visitors) can limit access to free NHS care for those from overseas and represent a formal barrier to vaccination.

Whilst testing and treatment for COVID19 (amongst other conditions) remains free regardless of immigration status, as does primary care, these policies have been seen to deter people from accessing care they are entitled to. Key factors contributing to this include wrongful refusal of care due to incorrect policy enactment and people`s fears that: data sharing with the Home Office will lead to detention or deportation, they will incur unaffordable charges, or that their debt to the NHS will impact future asylum applications. Furthermore, people`s immigration status is complex and changeable; with this their entitlement to NHS care and their risk of being reported to the Home Office are not static.

Administrative issues: Challenges to navigating the health system include incorrect refusal of GP registration on the basis of not having access to proof of address or identification. Changes in healthcare delivery due to COVID-19 may have further limited migrants' access to healthcare, partly due to 'digital poverty'.

NHS staff cultural awareness: Healthcare professionals require cultural awareness, an understanding of the wider determinants of health and an ability to provide trauma-informed care to meet the specific health needs of excluded groups and understand the complex set of factors that impact vaccination uptake. Lacking in this understanding, can result in staff contributing to stigmatization, marginalisation and discrimination, furthering mistrust in healthcare services. Meanwhile, community groups, grassroots and charitable organisations that support migrants` access to healthcare have been limited by COVID-19 restrictions preventing most face-to-face contact.

Socio-economic issues: migrants often face poverty and precarity, thus experience barriers to accessing healthcare associated with deprivation. Indirect healthcare costs, such as transportation fees, can prevent

reported difficulties registering as temporary residents at local general practice and financial remuneration for practices who do offer registration has historically been challenging to obtain. GRT people may fear discrimination by health services. Translation services may be required, yet there is a lack of professional translators to meet the needs of this community; this often results in consultations being undertaken in the patient's second language. Financial barriers can preclude patients from travelling to appointments or using phone or computer technology for remote assessment.

Many GRT people have a nomadic lifestyle, which can hinder the development of trusted relationships with healthcare workers. The prevailing norms of healthcare service design may clash with GRT culture. For example, some GRT people would prefer a large number of family members to attend appointments, but this is usually not allowed. Some topics are highly sensitive or taboo in GRT cultures, such as mental illnesses or discussing reproductive health with a member of the opposite gender. In some communities, attitudes of fatalism have been reported which may create barriers to seeking healthcare.

Interventions to improve vaccination uptake amongst GRT communities

There are several studies of successful vaccination programmes which were either directed towards, or included a substantial proportion of, GRT people. Five of these described measles vaccinations, and one, postpartum influenza vaccination. Vaccine hesitancy or refusal did not seem to be a significant hindrance, in keeping with observations that vaccinations are generally accepted by the community and – in one report – even more likely to be accepted than in other ethnic groups, if access is not a barrier. Instead, facilitating easy access to vaccinations seemed to be more important for successful programmes.

Successful interventions have designed outreach vaccination programmes based on pre-existing, trusted links between healthcare workers and the community. Several programmes used mobile vaccination clinics that were geographically located within, or near to, GRT settlements. Although there have been concerns that these could further distance GRT users from the 'mainstream' healthcare system: these services may be best-positioned as a pathway to accessing mainstream services for those with multiple barriers to access, rather than providing an alternative service entirely. Involving GRT representatives in the design of effective interventions seemed to be important. Flexible vaccination appointments, targeted invitations and reminder and recall systems are supported by healthcare workers who work closely with GRT groups and by the NICE recommendations on reducing inequalities in immunisation uptake in the under 19s. Streamlining temporary registration to allow for vaccine invitation may also be helpful.

Source: RCGP

PEOPLE EXPERIENCING HOMELESSLESS

Homelessness is associated with an increased risk of all causes of mortality and increased incidence of infection, mental health disease, cardiovascular disease and respiratory disease. People experiencing homelessness are also at increased risk of exposure to Covid-19 and increased risk of severe disease due to the high burden of chronic disease among this population.

The barriers to those experiencing homelessness accessing services are multifactorial and include stigma, perceived discrimination and mistrust. This group have much lower rates of GP registration and much higher cases of emergency department attendance. These are barriers which must be addressed and overcome to successfully deliver the Covid-19 vaccination to this group.

An example of the health inequalities in people experiencing homelessness is the poor uptake of the flu vaccine during the 2018 season. A cross sectional survey found significantly lower uptake (23.7%) in people experiencing homelessness who were aged 16-64 and were eligible for a free flu vaccine compared to the general population (53.7%).

Interventions aiming to improve vaccination uptake amongst people experiencing homelessness

There is a limited number of relevant academic papers mainly focusing on successful interventions to boost engagement across nutrition, drug and alcohol services, mental health and infectious diseases (hep B vaccination, TB, influenza vaccination). From those identified, some themes around the delivery of interventions can be drawn as summarised below.

- Peer support - Issues around trust could be mitigated by peer support run programmes, or utilising staff that know the service users (such as SHARPS). Peer support was also successfully used to support a Hepatitis C programme in London. A systematic review looking at interventions aiming to improve the management of conditions requiring long-term care for the homeless population, found ten studies from the US and only one from the UK. It found some limited evidence for educational case-management interventions which may improve knowledge and medication adherence. However, given the majority of these studies were from the USA, with a vastly different health system, this has limited generalisability to the UK.
- Outreach/Opportunistic encounters - There is evidence for the use of A&E departments as an encounter point to engage patients and ensure safe discharge, as well as a model for patient centred value-based care. A modelling study from 2020 found that providing additional housing, in the form of COVIDCARE in England during the pandemic, as well as increased infection control measures at homeless hostels, may have decreased the death rate among this population by up to 92%.
- Improving housing and financial support - A meta-analysis looked at the success of housing and financial support in increasing housing stability, highlighting the importance of long-term interventions with an aim to reduce homelessness being necessary to counter the health inequities faced by this group and increase the likelihood of accessing vaccinations.
- Increased access to primary care - Increasing access to primary care services is highlighted by a number of studies as a necessary step to improve health outcomes. A randomised control trial looking at a GP led enhance care hospital service has also shown improved quality of life and reduced homelessness. Such interventions may assist towards improving uptake of vaccinations by improving access to healthcare.
- Accelerated vaccine programme - A study looking at uptake of Hep B vaccine found a seven-fold increase in a completed course with an accelerated schedule.