HOUSE OF LORDS

Childhood Vaccinations Committee

Corrected oral evidence

Monday 13 April 2026

2.25 pm

Watch the meeting

Members present: Baroness Walmsley (The Chair); Baroness Cass; Lord Dholakia; Baroness Freeman of Steventon; Baroness Hodgson of Abinger; Baroness Neuberger; Baroness Nye; Lord Randall of Uxbridge; Baroness Ritchie of Downpatrick; Baroness Wyld.

Evidence Session No. 6 Heard in Public Questions 63 – 74

Witnesses

I: Michelle Gavin, Head of Development, Friends, Families and Travellers; Huda Hajinur, Director, Caafi Health.

USE OF THE TRANSCRIPT

1. This is a corrected transcript of evidence taken in public and webcast on www.parliamentlive.tv.

Examination of witnesses

Michelle Gavin and Huda Hajinur.

Q63 **The Chair:** Welcome to today's meeting. This is the sixth oral evidence session as part of the committee's inquiry into childhood vaccination rates in England. Thank you very much to Michelle Gavin, who is joining us in person today, and Huda Hajinur, who is attending online. The session is open to the public. It is broadcast, and it is subsequently accessible via the parliamentary website. A verbatim transcript will be taken of the evidence today, and it will be published on the parliamentary website. A few days after today's session, our witnesses will be sent a copy of the transcript, just so you can check it for accuracy. If there is anything wrong, please let us know as soon as you can. After the session, if there is anything you want to clarify or anything additional you wish to send us, please do; we would be very grateful for any further information you would like to send us.

I am going to start with the first question, and do introduce yourselves just before you answer. Could you tell us about the communities that you work with and their healthcare needs? What is the evidence on childhood vaccination uptake in the communities with whom you work? Could I go to you first, Michelle?

Michelle Gavin: Yes. I am Michelle Gavin and I work for an organisation called Friends, Families and Travellers, which is a national charity. We work across the country. My particular field in this is that I work specifically around a lot of health. I am the head of development at the organisation. I have worked there for 16 years, and I am embedded in the community because my husband was an Irish Traveller. Sadly, he passed away at the age of 48, back in 2010, and that will give you a little bit of an idea about our communities and what the issues are with their healthcare needs.

I am talking today generally across the different communities. I have to point out that it is not a homogenous group; there are many different communities that fall under the umbrella of Gypsy, Roma and Traveller. As I said, my husband was an Irish Traveller, a Mincéirs or Pavee person. There are a lot of problems around health. There are a lot of overlapping risk factors, including social exclusion, discrimination and poverty, which add to the health issues that come up. This all contributes to the poorer health outcomes and reduced access to healthcare services which many people from the communities have.

You asked about the evidence on the vaccination uptake in the communities, I believe. A lot of it is the very limited national data on the communities due to their exclusion from health coding systems. The data dictionary from the NHS still has no coding for Gypsy, Roma and Traveller, so a lot of the information we have will be local records from GP surgeries, et cetera, but it is not mandated to this point, so we have little written data evidence. There are a lot of smaller-scale studies, and they do consistently show lower uptake of vaccinations and other

preventative healthcare compared to the general population. So it does contribute to markedly poorer health outcomes, including reduced life expectancy. I have just said that my husband was 48 when he passed. That is kind of normal for Irish Traveller men. To be clear, we say that there is about 10 to 12 years' difference, but actually it is a lot more than that. A study done in the north of the country suggested around 52 years for Irish Travellers specifically. We know this from census data as well, but we have had to pick it apart. Until the data dictionary is up and running, we cannot be 100% clear on this.

We do know of those smaller-scale studies, and also there is our community engagement. I am particularly embedded in the community, as are my colleagues at Friends, Families and Travellers. Vaccination uptake is much lower among the Gypsy, Roma and Traveller communities than the general population. With that national data lacking, we know that the quality of local research does support this conclusion, particularly in relation to any preventative healthcare services.

Q64 **The Chair:** Thank you. We will be looking into all those issues in more depth as the session progresses. Huda Hajinur, could you tell us about the communities you work with and what the evidence is on vaccine uptake in them?

Huda Hajinur: Sure. Hi, my name is Huda Hajinur and I am the CEO and Co-Founder of an organisation called Caafi Health. We are based in Bristol, and we were formed during Covid to support communities across Bristol, North Somerset and South Gloucestershire around the Covid vaccine. That is how we started. Currently we support various other projects, including health literacy, health vaccination, building trust, and bridging the gap between the statutory services and the communities. I work closely with diverse and underserved communities, again in BNSSG—that is Bristol, North Somerset and South Gloucestershire. That includes the Somali community—I am originally from Somalia—and other African-Caribbean communities, eastern European groups and also, on occasions, those from the Roma communities.

Many of the individuals within these communities experience significant health inequalities. These include barriers to accessing healthcare, lower health literacy, and limited trust in statutory services, as well as social determinants of health, including poor housing and poverty. For these communities, there is a strong need for cultural competence and community-based approaches that focus on prevention, early intervention and improved navigation of the healthcare system. Language support and continuity of care from practices and trust in relationships are also essential to improving the health outcomes of the communities that we support that are facing these barriers and this poverty.

There is evidence of lived experience in these communities, which tells us that childhood vaccination uptake is lower in these communities compared to the general population. Also, the data shows that Black and African communities have a lower uptake of childhood vaccination. This is influenced by a combination of factors, including the access barriers, as I

said earlier, and misinformation and trust. In communities such as the Somali community, the Caribbean and African-Caribbean community, and eastern European communities, the uptake can vary widely but the disparity persists, particularly where services are not tailored or accessible. Community engagement work and outreach sometimes help; they have been shown to improve uptake when delivered in a trusted way and in a familiar environment. But we know things from outbreaks—for example, the data from Black Caribbean and Black African communities show significantly higher rates of measles, reflecting the lower vaccination uptakes or coverage. Also, it is really important to know that it is not ethnicity alone—that it is the reflection of a wider issue, such as the trust, the access and the language, and how services are designed to support these communities.

The Chair: Thank you very much indeed. In order to dig a little deeper into all those issues, I will hand over to Baroness Ritchie.

Q65 **Baroness Ritchie of Downpatrick:** Thank you, Lord Chair. You are both very welcome. This is a three-part question. First, what are the key drivers of childhood vaccination uptake in the communities you work with? Secondly, what attitudes do the people in these communities have to childhood vaccinations? Thirdly, how accessible are childhood vaccination services for people in these communities, including primary care, school and outreach services? It is a three-part question around the issue of attitudes. Can I come to Michelle first?

Michelle Gavin: Yes. Those are three very good questions, I have to say. There are key drivers for childhood vaccination uptake. It is definitely influenced by three main interconnected factors. We are looking at knowledge and informed choice; access to services; and, importantly, trust in healthcare systems and professionals. "Trust" is a word that runs through everything with the Gypsy, Roma and Traveller communities, for very good reason. If we look at those points, we can probably go straight to barriers, actually. The barriers from these areas significantly reduce uptake. The attitudes that people in the community have to childhood vaccinations are very mixed, but they are shaped by concerns around, first, side-effects, particularly based on lived or shared experiences. This has definitely increased since the Covid pandemic. Also, there is a perception—unfairly, probably—that vaccines are imposed rather than chosen, and that is due to a lack of informed dialogue. A lot of people feel that they are being forced into it, not really recognising that that is not the case. I have done quite a bit of work on that over time. There is definitely a mistrust of healthcare systems, which is often rooted in experience of discrimination and historical injustices. So it might be perceived, but it can be real in some cases as well because discrimination still happens regularly, I am really sad to say. I wish I could say that it did not, but it really does.

There is also the element of cultural beliefs and some family beliefs that have been passed down. There will be stigma around certain vaccinations, such as HPV, and any sexual health areas. That is a very

stigmatised area. It is about looking at how you reframe narratives for something like that.

There is a very fatalistic attitude towards illness. People do not expect a lot. If they are dying much younger, they just think, "Oh well; that's it then. It's normal to die in your 50s"—rather than looking at a longer term. It is really important to put that out.

There are also beliefs and things that have happened at key times—historical things that I remember as well—including people such as Dr Wakefield, who was very keen on linking autism with the MMR jab. That is still spoken about regularly, and that misinformation is shared by people in any way they can. So there is not an outright rejection of vaccines across communities. Hesitancy is often driven by the unmet information needs and negative experiences with healthcare providers. There is a real opportunity to change this. With the right type of programme, it definitely could be changed because that has happened in other places around the world.

How accessible are childhood vaccination services for people in the Gypsy, Roma and Traveller communities, including primary care, school-age imms and outreach services? Access is often limited due to structural and systemic barriers. Primary care barriers include GP registration, which is still frequently denied due to lack of ID or proof of address, particularly for nomadic people. But, even outside nomadism, some things are made quite difficult for people. There is a lack of ability to go online, for example—digital exclusion is a big problem.

I have to bring up how migrant Roma individuals face additional barriers linked to medical records being held abroad, which is a big problem. I have been in focus groups with the Roma community, with the Roma Support Group, and that is flagged up a lot.

On service engagement barriers, there is a higher reliance on accident and emergency services, because A&E is a welcoming place. No one is turned away—you are not discriminated against because you are from a particular group or you have no literacy. Everyone is welcome, as they are at walk-in services to a degree. But vaccinations are not routinely offered in these places. If people are going to these places to get primary care—albeit inappropriately—they will miss out on things such as vaccinations and screening services. So it is important to recognise that people, through no fault of their own, are being denied opportunities.

There are engagement barriers and lower engagement with ante-natal and post-natal care, which reduces early awareness of immunisation. That is a big issue. There are also possibly mobility-related barriers: Travelling communities might miss invitations or lack knowledge of where to access catch-up vaccines, which is really common with our service. In the past, we have managed to eventually get an imms team down to a temporary stopping site to get the family vaccinated, but that was a bit of good practice that does not happen nationally. A family wanted these vaccinations for the children and was unable to get them prior to us

intervening. During Covid, we had a hotline for people, and pockets of opportunity were missed because nobody could facilitate any vaccination programmes for their children, for sexual health or for the Covid vaccines. That will obviously reduce immunisation.

People do not know when they are due their next vaccines because they do not have personal handheld records any more, which is really important. The community really liked having red book records that they could proudly show off, or give to a healthcare provider if they are in a different area. You have to remember that some registration will be only temporary, which of course means you miss out on those opportunities. People do not know where to access these catch-up vaccines at all.

The Chair: Do a lot of families not have the red book?

Michelle Gavin: It has changed quite a lot and, although it is still available, it will be phased out, I believe.

The Chair: They are talking about going digital.

Michelle Gavin: They are. I have spoken to UKHSA about this. We produced some information that was relatable to the community and we still had the picture of the red book on it, because that is really important and people really recognise it—they hang on to it. They have limited space. Some people cannot access digital.

The Chair: So it is important.

Michelle Gavin: It is really important to have that record because people in the community really care about their children. They put their children first, and having that book is important.

The Chair: Can I move on to Huda, unless there was anything else?

Michelle Gavin: Just digital exclusion and school-based barriers, specifically for HPV—because a lot of children leave school before secondary level. It falls through the gaps because, if you are registered at a GP, you often do not get the offer. I have been working with people on HPV vaccination at the moment, and that is coming up a lot because people want it. Contrary to popular belief, if it is reframed as something that will prevent cancer, people are very keen to take that vaccination up. Most people do not know that it is available for boys as well. I conclude with that.

Huda Hajinur: Similar to what my colleague was saying, I think that trust in the healthcare system and professionals is one of the key drivers, as well as cultural communication and engagement. A lot of the communities that I support are the second generation or first generation in the UK, and therefore their health literacy and understanding of vaccines are very different to that of the general population. They need more tailored support to understand vaccines.

On the accessibility of services, location is really important, as is timing and flexibility. The traditional route of the NHS, primary care and school does not always work—I will go on to that a bit more in a minute. But consistent and clear messaging will counter misinformation, which is one of the key drivers of low uptake in the communities that I support. Barriers include misinformation and hearsay. The communities that I support are very much oral communities, so they share information with each other through oral routes, by talking to each other. Hearsay and unintended negative messaging from healthcare professionals themselves can significantly impact uptake.

By that I mean that, if people go to see a GP and say, "I want to wait until my child is five years old before they take their MMR vaccine" and the doctor says that that is fine, people think that the doctor agrees that you have to wait until you are five years old to have your vaccine. So the attitude of people in my community towards childhood vaccination varies. Some communities are supportive of vaccination while others are hesitant or resistant. Sometimes, that is because of a lack of confidence.

Common concerns include the belief that vaccines are linked to conditions such as autism or other diseases—I hear things such as cancer now as well—and a perception that vaccine programmes are profit-driven. There is a general lack of understanding about how the actual vaccine works. We learned a lot about that during Covid.

On trust, people will sometimes say, "What is being injected into my child might be different to what is being injected into another child". So there is a huge trust issue there. There is a belief that a single dose vaccine instead of a multiple one is the better route. There is also huge influence of misinformation within social networks and online platforms.

I have noticed that communities of the same origin country—say, Somalia or Sudan—who were brought up in other European countries such as Sweden, Holland or Germany, would come to this country having taken all their vaccinations, but when they have children here they automatically start to decline them. I do not know what is unique about the UK system that is different to Europe because they come in for the vaccine and somehow change their mind when they arrive in the UK. That is noticeable in the conversations we have with people.

In terms of how accessible childhood vaccination is, when the child has their vaccination through their eight-week check, that is accessible. Women go for their check and then their child has their vaccination, so that is fine. I think anything beyond that, when they have multiple children, is not that accessible. If the vaccine is being offered in a GP practice where they are given a fixed time, they may have multiple things happening and the times are not flexible.

My colleague talked about the childhood vaccine in terms of digital exclusion. For example, my daughter had the HPV vaccine recently and I was sent an email, and my daughter reminded me of that email. But if you are digitally not competent and digitally excluded you are more likely

to miss that information about the vaccine. There is no follow-up. No one calls you up and says, "Would you like your child vaccinated?". There is no pre-work or post-work on those people who do not go for their vaccination. I think those are the drivers.

We have learned from the Covid vaccine that places such as faith settings, community centres, pharmacies and even outreach clinics work really well within neighbourhoods to offer vaccinations, and that not just offering the traditional routes but having a more flexible and community-led model would significantly improve engagement and uptake. A lot of pre-work, such as calling parents and having that discussion, needs to happen before the child has their childhood vaccination. If you have that conversation with pregnant women before the baby is born and they can ask the questions beforehand and all the information is given to them, they are more likely to take the vaccine.

Q66 **Baroness Cass:** Huda, you support such a wide range of communities through your organisation and there are obviously lots of commonalities, but in terms of how much you have to tailor, is there any learning from differences between the various communities that you support? Are there any things that are strikingly different between them?

Huda Hajinur: Yes—for example, the Sudanese, the Somali and the African communities are not hesitant as such. It is more like community talk, so they are more worried about things such as autism. They will ask about the single vaccination as opposed to completely ruling out the vaccine. They would like more information. The more information you have and the more explanation you can give with a tailored approach, the more likely they are to say, "Okay, fine, I will have the vaccination".

There are other communities that you need a bit more work around. For example, in the Caribbean communities historical mistrust is still embedded. It is harder to have that conversation, but you just need to work with people. What we have learned is that it is not about tailoring a vaccine to a whole group; it is grouping people and working with them. So a Somali community would benefit from people from their own community working with them, as would a Caribbean community. It is more about belonging to that community to be able to support them, rather than one size fits all. We say that there are whole groups and bring in people, but it does not really work like that. It has to be people from their own communities who support them. That is one of the things we have learned. We work by having community members who represent each community. We will have someone who represents the Somali community, the Sudanese community, the Asian community and the eastern European—Polish and Romanian—communities. The beliefs in vaccination as a whole differ and vary between all of them but, in the end, it is mostly about misinformation.

Q67 **Baroness Neuberger:** Huda, you said that you had children who had been born in European countries and who had had the vaccinations in those countries, but when their families came to this country, quite often the parents then refused the vaccine for the next children. You said that

you did not know why. I wonder whether you have any anecdotal evidence, at least—not solid evidence—of what people say as to why, because that is so weird.

Huda Hajinur: It is. There are more people from communities of that background in this country, I think. For example, people in Sweden, Norway and Holland are happy to come to the UK for various reasons, but when it comes to the vaccine, they do not say anything. Most people reference autism, if I am honest. They say, "There are more children with autism in the UK than we have seen in Sweden, Norway or in other places, and therefore it must be something to do with the vaccine". That is because their friends or family might have discussions around these diseases. But they will ask for evidence that the vaccine does not cause autism—they want something concrete or something from the Government or the GP. You can refute and give information, and often, once you refute and you do some motivational interviewing and techniques, they are okay to have that discussion.

One of the ways in which we work with people who say that is to bring in people whose children have autism and have not had the vaccine and say, "Look, this family has children who have autism and they have not had the vaccine". In some cases, they have children who have had the vaccine and do not have autism. There are ways to work with families, but it needs to be a bit more consistent.

I do not know the reason. Some of the families from Sudan said things like, "When we came to the UK, suddenly there was a whole lot of conversation about a vaccine, but when we were in Sudan, we were just told to take it". So, again, maybe there is too much information.

Q68 **Baroness Freeman of Steventon:** You have started leading into this a bit, but my question is: how effectively have the NHS and local authorities worked with the communities that you are familiar with to build confidence in childhood vaccination and support uptake of it? Where that has not been effective, do you know what factors limited the effectiveness of the collaboration and how we might address those challenges? Perhaps we could start with Michelle.

Michelle Gavin: Engagement has had very limited effectiveness overall with the communities that I work with, particularly on the building trust and confidence side. Although there are pockets of good practice, such as outreach vaccination programmes or delivery, a lot of systemic issues persist, in particular a lack of culturally appropriate communication, insufficient coproduction with communities and failure to address underlying mistrust and discrimination.

On the issue of culturally appropriate communication, I spent a lot of time working with local authorities, the NHS and public health. They say, "We have these leaflets. We'll get them out. It's an easy read", but they do not resonate with the communities at all. When there is an outbreak or something has happened, people always come to us as experts within our communities to say, "Can you get this messaging out there?"

Once you get involved with a 21-person committee saying, "We can't use that word because this is what we are mandated to say", it becomes apparent that any communication, leaflet or whatever someone is trying to make is not going to resonate with the community. Actually, I have worked a lot with the UKHSA and I said a long time ago, "You've got to have some evergreen resources. You cannot just keep on doing the knee-jerk things". In all the work we have done over the years, that probably had the most impact on communities. We have recently done some work on vaccines and found that, from working with our lived-experience panels, our focus groups, our in-house Romanis and our partnerships with Roma and Traveller artists, we were able to come up with really relevant communications and get that messaging out to places where people actually look.

If you give someone a leaflet and they do not have any literacy, and it has nothing on it to say that it is for their communities, they will not even look at it. But if you go to something like TikTok, which is where these communities—the Gypsy, Roma and Traveller communities in this case—go for their health information, which is really interesting, then it suddenly becomes something that is shared, so that people have clear, jargon-free information. I have probably gone on too quickly about what that is but, if you are looking at that, insufficient co-production with the communities is massive.

Also, as I said before on the failure to address underlying mistrust and discrimination, I remember during Covid that a lot of people said, "We really want a programme to vaccinate Gypsies and Travellers". There was a piece in the *Irish Times* that was about inclusion health, which said—this is the sort of wording that came out—"We are looking to target inclusion health groups such as Gypsies, Travellers, street homeless, refugees, asylum seekers and sex workers". We know what inclusion health means, but then you get people going, "I am not a sex worker; why am I in this group?" They did not actually break that down, so people were ringing me up saying, "Michelle, they are trying to sterilise us. The boys spoke to a doctor the other day. Why are they targeting us for these injections?" There is a really recent memory of sterilisation within those communities, particularly Roma communities. The last case of forced sterilisations was in the 2000s in, I think, a Nordic country. So there is a real memory of mistrust that has to be looked at. You are going to get that only if you work with organisations such as us, which are able to unpick that.

There are also things like the papal ethics committee. A lot of people from the Irish Traveller community were anxious not to have certain injections because back in 1972, I think, the papal ethics committee said that taking that injection was one step towards evil, because it has come out of an unborn foetus. The Pope now and the Pope before have been very open and supportive, particularly of the MMR, chickenpox and zoster vaccines. But people have a memory and they will say, "Oh, Michelle, I can't take that injection. I just can't". I would say, "Why?" and they say, "I don't know, but I was told by my grandmother that I can't have that".

You realise that it is actually because of that particular papal thing. I remember once saying, "The Pope said that it is all right" and they said, "Yes, but he's just a man". So you have to be really cautious about this. You should have these arguments ready, but that article has come out in the *Irish Times*. How am I going to reframe that narrative?

The Chair: Huda, it is over to you.

Huda Hajinur: Can you repeat the question for me, please?

The Chair: It is about how effectively the NHS and local authorities work with the communities that you represent to build confidence in the vaccines.

Huda Hajinur: There has been some effort from the NHS and the local authorities, but these efforts lacked consistency and sustained investment, if I am honest. As an organisation, we have worked very closely with the PCNs—primary care networks—the NHS and local authorities to talk to people about vaccines, talk to parents about childhood vaccination and develop health coaches, vaccine coaches and health ambassadors to support people. We think that greater collaboration with community organisations is needed. It is not just a case of going to work with somebody, because we have found that there are sometimes people who say that they are working for communities but do not understand about vaccines themselves, so I do not know what information they will be giving to people who already do not have much confidence in that vaccine.

It is about working with people who have a health background or a literacy background, then co-designing the services with communities themselves. This is about moving away from what I said about one size fitting all, because it does not, and investing in long-term community-led intervention, rather than short-term initiatives.

Q69 **The Chair:** You both talked about how important it is to have culturally appropriate language and to have trusted people from the community to discuss these issues with other members of the community. How difficult is it to get enough properly qualified and informed people from the community to be able to work with other members of that community? Is it difficult to get enough people who can do that?

Michelle Gavin: We have been operating a health champions programme for quite some time, and I made it culturally pertinent. It was coming from the Royal Society for Public Health—you could become a health champion, levels 1 and 2. Most people are really interested in supporting their family networks and their wider networks to make good decisions, but people are scared to do that unless they have been given a badge to say that they can go ahead. By making those health champions in an environment where you get the information that is culturally resonant—so you are talking about people's communities and how they are living already—it is possible to do that. You do not have to be a health expert to give good advice or signpost advice about vaccinations,

or about why they are important. If you look at vaccinations historically without even framing them with what is happening here and now—if you talk about what happened back in the 1940s and 1950s with polio, and if you talk about smallpox—people will say, "Oh, I didn't know that". Then it becomes a different conversation and you can bring the other things in later. Those are the sorts of conversations that we have when we are training up health champions.

With things such as social prescribing, there is an opportunity to do work around that with communities. However, it seems to be more and more about how people need to have a qualification to become a social prescriber, embedded in their own local community. If those people come from a community that has very poor outcomes with regard to education, whereby they leave school early and do not have these things to put on the table, you will be taking away from the communities themselves.

To go back to collaboration with local authorities, my colleague Riyad, who works across London, is here. That engagement mechanism is really important for health needs, and there are people who are really driven to improve all these things for all marginalised communities. It is out there; it is just not out there across the country.

The Chair: Huda, do you find difficulty getting enough people from the community to have the right information to be able to go out and influence the community?

Huda Hajinur: At the beginning, when we did Covid, yes, because a lot of the people had questions about the vaccine. They were not confident about talking about something that they did not believe in, so it would be naive of me to say that we did not struggle to get people. But with the right training and information, and giving people a clear understanding, you can get people to talk about the vaccine to communities, but they have to have training. No one can just go out and talk about the vaccine. I was part of some research, not just in the UK but in Europe, whereby we looked at vaccine beliefs and how people approach them. We talked to individuals who had questions about the vaccine or who were not competent in that area, and we found that motivational training or interviews and being empathetic—but also being able to refute some of the information, even if people still went away not wanting to have the vaccine—meant that at least you had given them facts and information, so when they had conversations afterwards it would stay in their minds. So it is about people talking about the vaccine, and I would strongly suggest that anyone can do it, but with the right training beforehand.

The Chair: The need for training is coming over loud and clear. We will have to move on quickly now.

Q70 **Baroness Nye:** This is a request, really. Both of you have mentioned the co-design and co-production of information with communities. I would be really interested if you could give us an example of the pamphlets or leaflets that you have produced and that are relevant to your communities, because it is important that we understand good practice.

It would be great for the committee—certainly for me—to see examples of it.

The Chair: What a very good idea. Can you send them to us afterwards?

Michelle Gavin: I can indeed; I have plenty of them.

The Chair: We have three more questions but we will have only five minutes for each one, I am afraid. We will have to be brief. I turn to Lord Dholakia for the next question, which is about making services more accessible.

Q71 **Lord Dholakia:** My colleague asked a question about building confidence, which can result in increased uptake of childhood vaccinations. My question relates to the effectiveness of the NHS and local authorities. What could these authorities do to make services more accessible? I am very keen to find out about the barriers to childhood vaccination services tailoring their services to meet people's needs. What would be the best way to overcome these barriers?

Huda Hajinur: For me, the main barriers that we have seen are language barriers. To overcome them, you need people who speak the same language as the communities you are supporting. Language is the major barrier for the communities we serve.

On the lack of cultural relevance and engagement, which we have talked about, it is about talking about things that resonate with the communities themselves. This is one of the things we talk about when people come to us and want to travel to another country. They might say, "I'm going back to Africa", for example. They will come and talk to us about their holiday vaccines. We say, "Okay, how about measles and rubella? We know that your child did not have that vaccine but, if you go into that country, there might be an outbreak and you might be exposed to it. It is just the same as how you're okay with having holiday vaccines".

What happens is that people from the communities you support feel confident enough to talk to you in a way that they probably would not talk to their healthcare providers. There is something there about trust, where they feel as though they can talk to you openly without feeling judged or whatever. Therefore, you can innovate and start to make people see sense. You can say, "You're okay with yellow fever, typhoid or whatever else, because you are used to those, but what about these other things, which will have a more detrimental effect on your child?"

Ultimately, people want to protect their children, as my colleague said earlier on, but it is about stepping outside of the box and thinking differently about how you can approach people in a cultural way and a more relaxed way, such as by giving people more time so that you are not constrained to 20 minutes but have an hour or two in which you can discuss, debate and talk about things, as well as bringing in peers and other people. It becomes just a conversation. It is about having more of that engagement and those conversations. At the moment, we have a very inflexible service. We need our models of delivery to be a bit more

flexible. For me, it is not about having staff that look like you; communities want people who genuinely belong to their community and whom they can trust. Then the conversation becomes easier.

As I say, the solutions are tailored, community-specific approaches and the use of trusted community members. Sometimes, it is about having people who have a health background. Certainly, in the community I support, if you say, "I'm a nurse", or, "I know a bit more about vaccines because I've done research and read about them", you are more likely to be told, "Oh, so you know what you're talking about". It is that type of thing, although I appreciate that that is not the case in all communities.

A campaign to increase awareness is also important because, at the moment, the information goes out in very jargony language. It is not simple English; even underserved White British communities struggle with the NHS and our normal way of sending out campaigns because it does not resonate. Sometimes, we use a celebrity to talk about something when, actually, people want somebody from their own community, whom they are more likely to trust. I do not know whether that makes any sense, but I think that those approaches would support the uptake of the vaccine.

The Chair: That makes sense.

Michelle Gavin: We have covered quite a lot of the key barriers, but, again, for the Gypsy, Roma and Traveller community GP registration barriers still exist and there is digital exclusion. Some 60% or 70% of the people who take up a bit of casework with us—we have 4,000 pieces a year—are now saying that they have low or little literacy. That might be an indication. We are working with the most marginalised, but it has gone up from about 50%. Lack of flexible service delivery was mentioned, and inaccessible communication systems as well. If people who cannot read and write get a letter, and they are highly mobile, how are they going to receive that information?

The Chair: It is very difficult.

Michelle Gavin: It is, but everyone uses WhatsApp. There are ways around it—you can voice clip and take a photograph. School-based delivery models that exclude some children are another thing. But you can overcome it with flexible, drop-in, community-based services, mobile clinics and on some occasions outreach. Maintaining non-digital access routes is important as well. Paper-based records must remain. Those red books are really important, as well as just trying to get the GP registration. Huda just talked about time; sometimes just having someone talk to you for a few minutes is a really good thing. I have a really wonderful testimonial from elders in the community who said they were persuaded to have a vaccine because the doctor took a few minutes out to explain it. It was not, "Oh, they are Travellers so they will not want it". It was very much explaining it. That made the difference.

Q72 **Baroness Cass:** This is just a quick question which you have led into,

Michelle. Elders can be hugely influential. If there is a powerful elder who is very concerned, for some of the reasons you said, do you try to engage with them specifically?

Michelle Gavin: Whenever we do any focus groups, we look at this. Elders are really important in the Gypsy, Roma and Traveller community. If you are a young person, when an elder is in the room and they have a view, you would not go against that. You are always looking and very respectful. People are called aunt and uncle and that is the way things are done.

However, it depends on what type of health issue you are talking about. In this case, we did something around childhood vaccines and the elders were very positive and were able to put that message out. If it is something such as HPV, you might want to go to people of a different age group. When we do focus groups, we do not have anyone 10 years older than the age. So if you are 17, we will not have anyone older than 27. It goes up like that. We also have same-gender groups and look at it geographically and in terms of accommodation status. You have to look at all these things and mix through. But, yes, elders can be really good at promoting positive messaging.

The Chair: Huda, do you have the same attitude to using elders?

Huda Hajinur: I do not think so for my community, just because this is more of a childhood vaccine. Young people's understanding of the vaccine is hugely influenced by who takes it or not. For me, unfortunately, it is more through social media and social platforms. Nowadays, especially in the communities I come from, people look at elders as something from back home and not necessarily understanding anything that happens in the UK. Give or take—and maybe there are other things—I think the people who have huge influence over these things are faith leaders, like imams. A lot of young people are into religion and understanding beliefs and things like that. If the imams or the people in the mosque or the church were able to talk more about the vaccine, that would be a better approach for our community than elders.

Q73 **Baroness Neuberger:** You have answered a lot of my questions, but I will just pick something up. You have talked about the main barriers to effective communication and you have talked a bit about what the best ways to improve communication might be. I am hearing faith leaders in some communities, elders in others, and I am also hearing social media. Would healthcare professionals do better in talking to underserved communities if they used social media more to do their explanation? Huda, could you talk a bit about how social media could be used? I will then come to you, Michelle.

Huda Hajinur: The way I see social media is that you have all these young people now who are working as influencers. They get paid commission to promote stuff and to not promote stuff. They could get commissioned to not promote the vaccine, and they will be out there spreading all sorts of misinformation. I think it is better to find something

to counteract that by paying social influencers. Commission them to promote the vaccines, rather than it being the NHS. I think the NHS itself can be seen as just a profit-making thing; it is just opinion and what we hear from people. If local social media influencers were paid to promote vaccines and things like that, I do not know what that would look like, but I think something has to be tried. I do not necessarily think it needs to be the NHS; it could be local people who are happy to promote the vaccine and are out there to promote it.

Baroness Neuberger: Are you saying that, in a way, it does not necessarily need to be health professionals, but that local people who have probably learned from health professionals might be a better course of action? Is that what you are really saying?

Huda Hajinur: Yes, a lot of people share information on TikTok and on Instagram—not necessarily Facebook any more, because people see Facebook as the old thing. It is mainly TikTok, Snapchat and Instagram. and sometimes you find all these young people who are doing things that trend.

If the children who have their vaccine are saying, "Today I had my vaccine", it will encourage other children to talk to their family and say, "I want the vaccine". Instead of constantly tackling the family, we need to target the young people of the age when they are having the HPV vaccine themselves. That is how these things are taken, and young people understand messaging from people their age.

My daughter had her HPV vaccine the other day. She kept going on about how she had the HPV vaccine. They do all these TikToks and they will say, "I had my HPV vaccine". If that was promoted, I think somehow that would influence other kids to then go to their parents and say, "I want to have the vaccine".

The Chair: I can see how that could work, but if somebody was paid to influence young people, do you think people would just say, "Oh, they are only saying that because they have been paid to say it?".

Huda Hajinur: Not necessarily, because everything on TikTok is commission nowadays, and people buy it—even if it is a little pen that you think costs £2, there will be all these kids buying it. The thing with social media is that things get amplified very quickly from peers and from groups. I am forever telling the NHS that it needs to catch up with where it advertises and promotes. The traditional television, radio and all these things are just not going to work, and it needs to be in the game of what the young people are doing.

The Chair: Michelle, for the groups that you work with, is social media just as important or less important?

Michelle Gavin: It is really important and it is something that came out of focus groups I did a few years ago. People are finding health information through TikTok in our communities. The NHS does not use

TikTok and nor do government departments; it is not allowed. However, it is a really important avenue. For example, with the meningitis outbreak last week, we did some very quick reactive work on it. I contacted someone that does a lot of our steering group work—an Irish Traveller woman. She came and we videoed her. She was saying, "There's a terrible meningitis scare at the moment; if you are worried about it, do X, Y, Z". Then we had one of our Romani Gypsy people in. It got 35,000 hits within a couple of days, but it had to be done quickly.

The Chair: That worked.

Michelle Gavin: It did. When we do this, we work with the communities. We might pay them. They do not get paid for their influence; they get paid to make it authentic, so it is not about that. We might have someone who is a healthcare professional and they will be asking questions. It depends on what the format is, but it has to be someone authentic that people recognise—that is it, and it works.

Q74 **Baroness Nye:** As you know, the committee will make recommendations to the Government about how to improve the uptake of childhood vaccinations and reduce the disparities that you have both talked about so eloquently. In your view, what should we prioritise in our recommendations?

Michelle Gavin: Where do I start?

The Chair: What is top of the list?

Michelle Gavin: I have three: improving access to primary care and removing admin barriers, which continue, as well as access to preventive services for patients. That is really important in the 10-year plan, but there is nothing that talks about inclusion health.

We also need to be more flexible, including community-based vaccination services. One thing would be to build trust through trusted organisations, like ourselves, and to commission us to do that co-development work. That is where it will hit the spot. You might think that you can do it on your own, but you have been thinking that for many years and it has not been effective—look at another route.

You should look at cultural competence training for professionals as well. Within that, communication and information should address misinformation clearly and lack of jargon—get rid of jargon. People want simple English language, or they want Romanes. They might want Romanes for Polish people or for Romanian people. It is very different from the Romanian language.

There also needs to be better data. The data dictionary really has to be put forward soon. Targeted action on HPV vaccinations is definitely something that we should be looking at. At the moment, there is a massive gap.

Huda Hajinur: I think it is about working in a genuine way in partnership with community organisations. It should not just be an add-on but something that can be sustained. There should also be investment in trusted communities, with training, to deliver the message. It is not about the message; it is about the messenger. We should move away from this one-size-fits-all model towards a more tailored community or place-based approach.

We also need to really strengthen our workforce, particularly training—I talk about it a lot—in communication and cultural competence. Sometimes, people can feel patronised if they go to a person or doctor and say that they have not had their vaccine; they want to ask questions or could be pushed. The doctor or nurse might not know all the right information, which happens all the time. Building long-term trust, rather than short-term intervention, with communities is also needed.

The Chair: Excellent. Thank you very much indeed. Thank you both for your patience with our having to make a late start to this session. We are very grateful to you both. That brings us to the end of this session.