HOUSE OF LORDS

Childhood Vaccinations Committee

Corrected oral evidence

Monday 13 April 2026

3.25 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. 7 Heard in Public Questions 75 – 83

Witnesses

I: Dr Sakaria Ali, Advisory Board Member, British Somali Medical Association, Consultant Paediatrician, University College London Hospital; Riyad Karim, Assistant Director, Community Engagement and Vaccine and Screening Equity, London Region, NHS England.

USE OF THE TRANSCRIPT

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

Examination of witnesses

Dr Sakaria Ali and Riyad Karim.

Q75 **The Chair:** Welcome back to today's meeting. This is the seventh oral evidence session in the committee's inquiry into childhood vaccination rates in England. I thank Dr Sakaria Ali and Mr Riyad Karim for attending today.

The session is open to the public and is being broadcast live; it will subsequently be accessible on the parliamentary website. A verbatim transcript of the session will be taken and published on the website. A few days after this session, our witnesses will be sent a copy of the transcript. If you find any mistakes in it, please let us know as soon as you can. After the end of the session, if there is anything you want to clarify or any additional information that you would like to give us, we would be very grateful to receive it.

The first question is from me. Before answering, please introduce yourselves. Can you tell us about the different communities you work with and their healthcare needs? What is the evidence on childhood vaccination uptake in those communities?

Dr Sakaria Ali: Thank you for having me. I am a Consultant Paediatrician at University College London Hospital. I am also one of the co-founders of the British Somali Medical Association; I sit on the advisory board. I work in London and have two roles to mention today.

In my paediatric work at UCLH, I do general paediatrics and work on the ward as well as at a refugee health clinic, where I come across many different communities, including the Somali community. The British Somali Medical Association—BSMA—is a group of 500 British-Somali doctors who work in the NHS and many more medical students. It was established in 2018, initially as a response to how we serve the British-Somali community in the United Kingdom and how we work together to recognise the health issues that happen in this community.

On the British-Somali community, Huda has laid out some of the issues already. There are significant issues with preventive healthcare: immunisation, cancer screening, chronic health conditions and non-communicable diseases. There is a real gap there. On routine immunisations, we know from the research, as well as anecdotally, that the community does not take up immunisation as much as British White children do. Research focused not on the Somali community but on the Afro-Caribbean community in the United Kingdom highlighted 64% to 70% uptake. This was an England-wide study; I will share the details of it. It looked at 1 million children from 2006 to 2021, and there was 64% to 70% uptake in Afro-Caribbean children, as compared to 90% in White British children.

When we hear about these data and look at Somali communities in other western countries, we see similar trends in Finland, Norway and the

United States of America. The concerns are linked to the MMR vaccine and autism—that is a real question for the community—but, since Covid, there has been significant hesitation around immunisations with all vaccines. There are questions and concerns about vaccines in general.

In the United Kingdom, we have not had such a study focusing on the Somali community. A lot of Somalis in the UK ask about this. They say, "We know that Somalis here have higher autism rates, as compared to the average population, so what are the linkages with vaccination? Why is no research done on this?" This is a frequent stumbling block that we have come across.

At the BSMA, we have done a lot of workshops in the community and had discussions in mosques and community halls, thinking about how we can engage the community. The NHS can learn from this. The idea that a community or a group of people is anti-vaccination is problematic. It is much better to see it as a spectrum: there are those who take the vaccination, those who are against taking any vaccination, those who are sceptical and those who sit on the borderline. They might be ready but have not quite taken it up.

When we think of it in terms of this spectrum of people, there are different ways of engaging communities. Those who have questions about the MMR vaccine and autism have one set of questions that can be answered. Others want more detailed information about what exactly is in each vaccine and what diseases they cover. That, again, is a gap that has not been addressed by health providers and the NHS as a whole. So we really need to move away from an idea that people are against the vaccine and not willing to take the vaccine up. We need to break it down and ask, "Where does this person sit on the spectrum and how do we engage them?"

Thinking about these attitudes is important, as research has highlighted. What are the drivers of positive attitudes among people who might take up vaccination? One of those is people understanding what the diseases are. I had a patient on the ward whose daughter had measles. When the diagnosis was given, the mother was very upset because her brother had died from measles. She had been asked about vaccination and declined the MMR, but she said that she did not know that the MMR included protection against measles. She was angry because she wanted to have been told. If she had been told, "This will protect you against measles", she would have identified that and said, "Gosh, this is something I really want to protect my child from, having had that personal experience". So it is about moving away from saying "MMR" to talking about diseases: what are these diseases and how do we protect you from them?

After that conversation, she wanted to know about all the other vaccinations and what the protections were. We ended up going down a trajectory where I said, "Why don't we go into the community? There might be others like you". She organised a whole group of mothers and we talked about the conditions and the vaccinations. I was able to engage them, and very many of them have had the vaccinations. Others

have said, "Okay, I want to think about it. Is there an opportunity for us to have another discussion?" That continued conversation about vaccination, and normalising discussions around vaccination, is incredibly important.

Another aspect of that is tailoring the messaging. The mothers in many of these communities—Afro-Caribbean communities and, in particular, Somali communities—are the decision-makers. I once held a discussion with elderly men and powerful community leaders, I had been told, in the mosque. I held a one-hour session and everybody was very pleased. Then they said, "So when are you going to talk to our women? They're the ones who actually make the decision. We are very grateful that you came to spend time with us, but that's where you need to go". As Baroness Neuberger mentioned earlier, matriarchs are incredibly powerful.

Part of tailoring that discussion and normalising the conversation around vaccination is using opportunistic targeting. I had a neurology clinic this morning where I talked about vaccination. There was one patient where the parents had not vaccinated. When we had a discussion about it, the father said, "I had asked a question about vaccination. My child has a very complex neurological condition. The doctor shouted at me, so I stopped talking about it. After that, I did not go back to discussing it, because he was very dismissive. He said, 'How dare you not vaccinate your child?' Actually, I love my child, and I felt spoken down to". So tailoring the conversation is about normalising every opportunity and saying, "Okay, where are we at today?" We are going to have another meeting. He has not quite agreed to it, but he has gone back to speak to his wife about vaccination, so we will hopefully make some progress in the next clinic.

The Chair: Can I just clarify something before I come to Baroness Hodgson and Mr Karim? Am I right in thinking that what you said a few minutes ago was that there is a higher-than-average level of autism in the Somali community, which is seen as a causative factor preventing people wanting to have their children vaccinated? Is that specific to the Somali community? Is my understanding correct?

Dr Sakaria Ali: Yes, this is from studies done in Norway as well as the United States of America. The rate of autism in first-generation Somalis is higher than in the average population. Communities are aware of this. Communities, in particular the Sudanese, Somali and Eritrean communities, are transnational diaspora communities. People are aware of what has happened in Sweden. They recognise anecdotally, although there is no research that they can cling on to, that there are higher rates in the United Kingdom, and they recognise and tell me that the type of autism that happens in the first-generation diaspora communities is more severe. As part of that, they link it to the vaccination.

The Chair: Has any research been done to find out whether the children who are on the autism spectrum have or have not had the vaccines?

Dr Sakaria Ali: That research has not been done. We are part of a group that is starting a research project on this now. But the community has real questions about autism: "There is published data acknowledging that there are higher rates. Why are these higher rates there? We believe the reason to be the vaccine, even though the research has not established that yet"—that is what they tell me. Unfortunately, in the UK we have a long way to go until we do some research into this and can bring the community along as well. When we develop that research, we have to move away from paternalistic perspectives of "This is the research we've done; here you go. Will you take the vaccine?" to "What is it that you as a community would like researched? How do we involve you in the research agenda setting?" That will then contribute to the research being accepted as valid.

Q76 **Baroness Hodgson of Abinger:** Off the back of that, you were talking about research. Do you have specific ideas about what research exactly you would like to see done, obviously in connection with vaccines and autism? Am I hearing that you suspect that certain groups of people may have different reactions to the vaccine, some more severe and some not at all? Should there be other communities that this research should be done in, to reassure them?

Dr Sakaria Ali: The research question has two parts. One part is around autism itself, without any relation to vaccinations. What are the rates of autism in Afro-Caribbean communities, in particular the Somali community? That research has been done in Scandinavian countries but has not been done in the United Kingdom. People want to know that granular data. People also want information on research around vaccination. What is the uptake of routine childhood vaccination in Somali and Afro-Caribbean communities in the UK? What are the barriers to that? Communities want to be part of that discussion as well. These are relevant but slightly distinct parts of the research.

There was a parent who found out I was a paediatrician and said "Well, you'll have to come and speak at the community town hall", and they gathered a group of people. That became one session after another and, as the British Somali Medical Association, our voice was recognised as "Okay, you are part of the NHS and you are partly Somali but very British, so we are more willing to hear your perspectives, although we recognise you as being part of the system". So there is still the mistrust around the system and we are trying to bridge the gaps here, and hopefully doing some good work.

Baroness Cass: Just to clarify—I am sorry to labour this point—we are seeing higher rates of autism in the Somali diaspora, but we are not completely clear about the rates in Somalia itself because there are not the diagnostic facilities and it is not part of the system to make that diagnosis. Am I correct on that?

Dr Sakaria Ali: Yes. The research has been done on first-generation diaspora communities in Scandinavian countries. The infrastructure in Somalia is not there, and the significant infectious diseases and other

problems in that health system would not allow for that research to be done.

The Chair: That has clarified that. Thank you for your patience, Mr Karim. Can you introduce yourself and answer the first question?

Riyad Karim: I am Assistant Director of Community Engagement and Vaccine and Screening Equity for NHS England in London. I am a co-founder of the London Bangladeshi Health Partnership and a co-chair of the advisory board. I am also a co-founder and co-chair of the advisory board of the Romanian Health Equity Forum across London; that is a recent baby.

In effect, my role is to work across London and complement ICBs and local authority public health teams. As you know, we have 33 boroughs in London and four ICS systems. Our communities feel very connected across London and out of London. No one wakes up in the morning thinking that they are Eastern European, South Asian, Black African or Black Caribbean. On my journey of community engagement, I find that many people feel British-Jamaican, British-Bangladeshi, British-Pakistani, British-Ghanaian and British-Nigerian—Yoruba. This granularity has been really important on my travels, from leaving my role as Assistant Director of Primary Care in Enfield to getting involved in the engagement work during the pandemic.

It has been interesting to listen to Dr Sakaria. I am grateful to have met him at this auspicious place, because he is a trusted leader for his community. This is important. In the pandemic, we realised that we had data from many of our boroughs on high-deprivation, low-income and multi-generational Black African, Black Caribbean, Bangladeshi, Pakistani and Somali communities. At that time, when we started engaging with those communities and working with those who have engaged, it was clear through our conversations with our workforce leads. I remember a conversation with Cedi Frederick, the then chair of North Mid. He said that we have to redouble our efforts to engage with Black communities. That is really important. It is a recognition of the fact that, quite often, we put the NHS workforce on one side, and not actually understand that they have massive, vast repositories of lived experience. The diversity and rich tapestry of the NHS means that we have this inbuilt source of trust and bridge-building.

That was when I got involved. The data was saying that we needed to engage with Nigerian or Ghanaian communities—well, it was Black African; we were trying to work that out through the data—and that is when I started working with Pentecostal churches in Enfield. I realised that there was a trusted leader there in Pastor Nick Chanda, and there were also trusted clinical leaders who attended the church were working in the area—for example, Dr Oge Ilozue from Barnet, whose mum was one of the very first Nigerian-heritage GPs in Barnet.

So there are these trusted leaders—a medley of different people for different communities—working in trusted places: synagogues, masjids,

mosques, gurdwaras, temples, women's organisations and campsites. Then there are trusted voices. Invariably, for many of our communities—including where I was brought up in a pit village in Derbyshire—it is not always the BBC that is the trusted voice. It is the information that you get from the miners' welfare. As my dad was a pit GP, that is where I was brought up. It is really important to understand that, as Professor Kevin Fenton says, trust is built over time, just as a friendship is, but it is also about working it out for every community. We have the numbers and the diversity in our green and sceptred isle for us to have that granular approach, working in that way.

The Chair: Mr Karim, you work across lots of different communities. Is there different evidence on levels of uptake in different communities? For example, I have heard that the uptake in the Bangladeshi community is quite high as compared to other community groups. Do you know the reasons for that?

Riyad Karim: Yes, that is the case. It is not 95% but, certainly, when you look at the Bangladeshi community vis-à-vis other minority-ethnic groups, it is doing better on childhood vaccinations. Having said that, the Government of Bangladesh are struggling with an endemic measles situation at the moment, so people are influenced by travel, et cetera. What I am trying to say is that we need to get this high percentage into a much higher protective set of figures.

The Chair: Is that outbreak perhaps one of the reasons why Bangladeshi communities here want to be vaccinated against measles—because they know that there is a danger to it?

Riyad Karim: This is a very recent phenomenon. The best thing to do is read the paper *"It was Just the Given Thing to Do": Exploring Enablers for High Childhood Vaccination Uptake in East London's Bangladeshi Community*. The qualitative insights by Ifra Ali, Sadie Bell and Professor Sandra Mounier-Jack were instrumental in understanding that there are multilevel indicators that are quite specific to the Bangladeshi community; we can discuss those.

Having said that, when you look at deprivation, poor housing and overcrowding, these things set the Bangladeshi community very much alongside Somali, Eastern European-heritage, Black African and Black Caribbean communities, where we see that low vaccination uptake is strongly associated with that deprivation and exclusion. Communities that are experiencing the greatest inequalities in housing, income and access to services are often those with lower uptake. Vaccination will not always be the primary concern of families. They are navigating multiple priorities—work, childcare, housing and access to GPs—and vaccination becomes one of those competing priorities.

In a nutshell, I am trying to say that we need to understand our community health profile much better. As I said, we have a large number of boroughs across London, but there are nuances to our Somali, Bangladeshi and Romanian communities. We should understand that

10% of Romanians are of Roma heritage; that is the kind of information we need to share.

So, through my own agency and my colleagues and allies, I have mobilised the 3T model to set up non-recurrent funded and episodic vaccination screening groups, which are now graduating to health equity forums for these communities. Then, with local authorities, public health, the NHS and the region, we can do some hyperlocal delivery by tapping into that London-wide insight. Quite often, I go out of London to try to understand how Birmingham engages with the Pakistani community. In London, we tend to aggregate it as a Muslim community, which it is, but there are far more nuanced ways to engage the Pakistani community, based on ethnic nuances that may not be so visibly apparent. That is where I come in as a catalyst and an internationalist, with very inclusive wraparound. That is what you get from a lad brought up in a pit village. You cannot take the pit out of the lad. It is about being very tailored and enamoured with the fabric of London and our country, pulling us together.

The Chair: Indeed; it is very complex.

Q77 **Lord Randall of Uxbridge:** I am slightly confused because there seems to be a great deal of commonality between these various groups. I would have thought that there was also quite a lot of difference in their attitudes—cultural, religious and even geographical. You almost seem to indicate that there is the commonality of things, such as deprivation, as well as other things. I want to find out how accessible childhood vaccination services are for people in these communities, including in primary care, schools and outreach. Is that different for different communities?

Riyad Karim: There are similar issues, but there are differences.[1] If you are applying a 3T methodology, looking at each community and asking who the trusted leaders are, where the trusted places are and who the trusted voices are, that immediately opens up the difference. Tapping into those differences and nuances gives us an understanding of the differences in accessibility.

There are definitely differences in terms of attitudes to vaccination, differences in terms of languages: we may think that it is just Bengali, but there are differences between Bengali and Sylheti. There is a need for audiovisual in many communities, rather than just having, say, Somali leaflets. So it is about having that granularity of understanding around how to navigate and work with each community and in terms of their different perceptions.

For example, there are many Muslim communities, and there are differences in Jewish communities as well. So how we engage with Interlink and Haredi communities in Stamford Hill and Hackney will be different from how we engage with communities in Barnet. That level of

[1] Note by the witness: In terms of communities' attitudes to vaccinations.

sophistication is needed but, if you follow a 3T guide, that gives us a shortcut to understanding; it is also about realising that not many of us think London-wide.

Lord Randall of Uxbridge: That was exactly my point, because London is so diverse and some of the communities we are talking about are very small relative to the Somali, Bangladeshi and Pakistani communities. Do they get missed out because you are too widely spread all over the place? I am just wondering how it is done. Is the system at the moment good at making sure that all of the various diverse communities are catered for?

Riyad Karim: Boroughs and ICSs are doing the best they can within the envelope. I am working with those communities, based on the limitations of my role in catalysing and working alongside colleagues and communities. It is about understanding that you need to draw on insights out of London. Last week, it was International Romani Day. In the Roma community—obviously, Michelle talked very eloquently about the Gypsy, Roma and Traveller community—there are lots of differences within each of those constituent elements. In Enfield, we have a large community of Bulgarian Roma who are very close to Pentecostalism and have a pretty horrific feeling of ostracism from their place of origin. It is definitely interesting to see their reactions when, through the system, we develop local health stops where Bulgarian is spoken and which both encourage Bulgarian community organisers and work with Bulgarian VCSE organisations.

When one meets Romanian organisations such as RUDA in Birmingham, who are also trying to work with the Roma community on safeguarding and other educational matters, one begins to realise that, basically, there are lots of layers. It is really important for us to understand that there are many Roma communities.

What has been useful for me is working with the embassies. A lot of my undergraduate healthcare stuff has been brought in. For example, I work with place, system and region colleagues at the Brazilian embassy; we deliver health navigation leaflets and other stuff in the consular office, thanks to Ambassador João. At the same time, we work with the Romanian consul-general, Robert Marin, and the team in London, who help us engage and work with the Romanian community because they are trusted.

This is something that I have done out of the box because, again, it is about trying to understand who the trusted leaders in the Romanian community are. Then, when you go through the process of speaking to clinical colleagues with lived experience, local authorities and public health practitioners who have worked in this area much more than I have—I have just come in, having previously been a primary care assistant six years ago, and as of this year I have been in this kind of role for three years—you begin to understand what the sweet spot for each community is. That is when you can start making tailored interventions.

Dr Sakaria Ali: I want to make a couple of points. First, let me use the Somali community as an example. Over the past 20 years, more than 100,000 Swedish citizens of Somali origin and heritage with Swedish passports have moved to the United Kingdom. The data does not capture those British-Somali residents as being Somali. It recognises their nationality. Therefore, services do not recognise whom they are serving. That is really important. How do we capture ethnicity and at what point? In my clinic, for example, we have started capturing ethnicity data. You would be amazed at how complex it is to try to capture ethnicity data in the NHS, including the levels of barriers that you have to get through before you can even do so.

Secondly, speaking of the British-Somali community or any of the recent immigrant communities, I find that patients in my refugee health clinic are very keen to take up immunisations. They say, "Dr Ali, is this good?" I say, "Yes", and they say, "When are you going to give it to me?" There is hardly any difficulty in getting this particular group of recent immigrants, refugees and asylum seekers vaccinated. However, those who are from the first or second generation will have questions. They all say, "What are you giving me? I've heard about autism. What about it? What do you have to say on it?" They have a lot more questions. So the idea of paternalistic healthcare is not present in first-generation or second-generation ethnic communities; I should say that that goes beyond the Afro-Caribbean communities.

The other aspect concerns when and where. We have to think about accessibility when we have a community or communities that do not engage with preventive care, such as cancer screening and immunisations, and are more likely to engage with health services in an opportunistic way. This may be when they turn up to the emergency department for a one-off visit or see their GP once or twice a year. Is there an opportunity there for their health provider to have a conversation with that person in order to go through all this in detail and ask about their immunisation?

Then, if that patient agrees to immunisation, are you able to deliver it in the emergency department? You have heard previous panellists talk about the barriers to giving a vaccine in the emergency department. I am on call tonight. I am likely to have a conversation about immunisation, but ensuring that that child has been vaccinated will require two or three more steps. The question is: when you are dealing with communities where access to healthcare is limited to being very opportunistic, is the system serving such health-seeking behaviours? I think that, at the moment, it is not.

Additionally, there are lessons to be learned from Covid. During the pandemic, we were a lot more innovative and less bureaucratic in our approaches. When I go and do talks, patients in those communities and other BSMA members frequently tell me that they expect the health service to come to them. They know that getting an appointment with the GP will require either an email or a telephone call and that, when they get

there, they may have other issues but we will be able to deal with only one thing at a time. Even if they have the opportunity to talk about vaccination, if they have more than a couple of questions about vaccination, the health provider may not be able to answer those questions. That is then another opportunity lost yet again.

Access is very layered. Recognising not only heritage, religion and culture but generational differences is incredibly important. We now have a younger generation whose health-seeking behaviours are very different. Their approach to healthcare is less paternalistic, but the systems are not serving that.

To complicate the matter even more, we went and created a lovely patient leaflet with lots of information and all of the latest research on immunisation. It got a really wonderful Cochrane review, and we put it on our website. However, the first issue was that hardly any people were accessing it online. Digital exclusion remains a significant barrier. Secondly, the language used and people's understanding of complex medical terminology were another issue. Thirdly, people said, "This is great, Dr Ali—all six pages of it—but nobody is going to read it. What does it really mean? Does it answer the questions that you know are relevant? I have heard people in my social network asking questions about autism and what is in these vaccines. Does this address it?" Again, how we tailor the messaging and where we put it are incredibly important.

The Chair: It sounds to me as though we perhaps ought to be creating more opportunities with the right people in the right places. Let us move on to the question from Baroness Cass, who is joining us online.

Q78 **Baroness Cass:** You have both spoken a lot about multiple ways of building trust with communities and opportunistic approaches to vaccination. Can you say a bit more about how effective the NHS is being in working with communities on some of the approaches that you have described? What would your advice for it be in order to improve how it does that?

Riyad Karim: In the NHS, there is a strong partnership in place in terms of effective collaboration across agencies, particularly in London. The UKHSA, NHS partners, the 33 local authorities and the GLA provide co-ordination, data analysis, guidance and operational support to boroughs. That partnership is in place at the strategic planning and operational level. At the strategic level, it is achieved through the multi-agency approach in London, including via the London immunisation board, to which I report and which is chaired by Professor Kevin Fenton, who is London's regional director for public health and the statutory health adviser to the mayor.

The immunisation strategy is the overarching plan for delivering improvements across all vaccinations. Within that, there is a very important section on community engagement and working at place,

system and region in order to try to facilitate and allow for being more hyperlocal at the local level while tapping into the insights of London.

This has enabled us to do a lot more Bangladeshi health melas[2], because it is not just about vaccinations. As the research has shown us, it is about understanding the holistic health needs of a community. It cannot be just a call to arms; it has to be a call to the whole centre and the whole person. So those Bangladeshi health melas have been really helpful.

As well as this, it was recently Palm Sunday, and I was in back in Enfield at the revival church, where we had a faith and health service for the first time. This was not an ad hoc arrangement but one that was actually built in, with high footfall and where the pastor has come to that position of trust through working with the NHS, the local authority, public health and the school-age immunisation provider. The pastor has now started talking to his congregation about Corinthians, John and faith works, almost giving a nice easing platform to then have Dr Oge talk about vaccinations again in the context of a measles outbreak, and also worries about meningitis, as there were in Kent.

However, that did not happen in isolation. It happened because there was this multi-agency allyship, but also working at London level, which was where I came in.

Q79 **Baroness Cass:** Following on from that, we have got such a rich, diverse, multiethnic population in London and in several other of our big cities. But if you go back to where you were born, you are presumably going to be much more disadvantaged if you are in an ethnic minority group without the workers and the community leaders to support you to access the care you might need, be it vaccination or other things.

Riyad Karim: This is why the London Bangladeshi Health Partnership should not just be a London Bangladeshi health partnership. It needs to be national, like the Caribbean & African Health Network, because our communities are national. When I went to Bangla TV, Channel S and all the channels that beam out to the Bangladeshi community and reach about a million people, quite often we would get phone calls from folks in Gateshead. My dad is a retired GP. He still lives in Mansfield. He loves the place—and he bemoans me because I am a Nottingham Forest supporter. But the fact of the matter is that Bangladeshis are everywhere, as we are in society. So are Somalis. So we need to have that.

Let us be honest: the issue, I suppose, is about funding. It is about episodic non-recurrent funding. As Assistant Director, you are fixed-term, but our communities are not fixed-term, so we have to start having the vision. I am here because of the strength of allies who had the vision to ensure that we get this work done.

The problem is that, now we are not in a pandemic, we have to create a sense of urgency within communities, but do so in a non-stigmatising way. What better way than that of Nick's church? I went to Easter

[2] Note by the witness: Mela is a festival.

Monday in front of 400 women at the Easter ladies' breakfast assembly at Redeemed Church in Seven Kings. We are going to Chesterfield this Sunday to do another faith and health segment. It is that kind of innovation that I and other colleagues are working on.

I am also working very closely with Beth Fletcher, the engagement manager at Derbyshire ICB, who is trying to get that same kind of panel of public health, NHS and local faith leaders together, so we can test these interventions. A lot of it is to do with evaluation, getting the right work and then actually testing and scaling that innovation.

However, the structural issue is the fact that community engagement still feels very much like an afterthought. It needs to be sustained. We will be better off for it, and it will certainly provide value for money in terms of the 10-year plan and prevention if we actually have more tailored approaches, working with the community for the community.

Baroness Cass: That is a really clear message.

Dr Sakaria Ali: It has to be not just about how the NHS wants to engage with communities but what the community wants to know about and what the community concerns are. If there is a question about misinformation around the MMR vaccination, the NHS should not shy away from it. It has to address that type of misinformation and tackle it head on, in a language that is understandable and acceptable to the community.

People are saying they want the health services to come to them, and that they also want them to engage with them in conversation rather than expect them to take up immunisation as soon as it is offered, when it is offered, and in the place where it is offered. So, before we even get to system barriers, there is the discussion around vaccination. Who is having those discussions and on which terms, and what is the discussion about? Do we focus on that particular vaccine, or do we also talk about the diseases that we are protecting people from? People want to know about these diseases and the impact of them, and also that there is protection from the vaccine.

For a very long time, the NHS has focused on the vaccine and what is in the vaccine. What you will actually find is that many people in communities are not interested so much in that. That is the difference between childhood vaccination issues versus the Covid vaccine. There is a clear, distinct difference there. It is not what is in the vaccine but actually what it protects you from. People ask: "Why should I give it to my child when I am really worried about my child developing problems from this particular vaccine?" Herd immunisation and discussions about it need to be held too.

Secondly, moving on to developing a low-barrier system within the NHS, we need to have opportunities for drop-in clinics. If a parent has four or five children, they have to be able to access the services at a schedule that is amenable to them. We also need to ensure that there are trusted

and caring health providers. The perception is that the healthcare providers in the health system are not very caring if you have questions about vaccines. So we really have to win people over. We have to move away from thinking that a person who has not vaccinated their child is anti-vaccine to thinking that they might perhaps be vaccine hesitant, or they might be a sceptic. They also might be amenable but have not had them vaccinated. So seeing people across that spectrum is incredibly important.

If we as a system do not allow for that conversation and do not bring people with us, then that will create instant barriers that will then mean low rates of vaccination. This has actually been published. There was another similar Cochrane review that looked at racial and ethnic equity in childhood vaccination, which talked about the spectrum of what the barriers are to somebody seeking these health-seeking behaviours towards vaccination.

Lastly, there should be tailored messaging around vaccination. The last panel spoke about the power of using social media. We need to recognise that communities are increasingly using social media and that they are also transnational. These conversations are happening within the household, within the community and within the larger diaspora, within communities across different countries. Within the United Kingdom, we are able to tap into very tailored messaging. The vaccination rates in these communities in the United Kingdom will go up, but then we will also see similar transnational effects as well. So we could really be front leaders if we chose to be.

Baroness Cass: It sounds like we almost need a "Question Time" format, by the community, for the community, so that it is their questions and not what the person coming thinks they need to hear.

Dr Sakaria Ali: Exactly.

The Chair: We are getting a massive amount of really good information, but we are running a bit short of time, so we are going to have to speed up a little bit. I will move to Baroness Wyld's question now, please.

Q80 **Baroness Wyld:** You have started to answer a lot of my questions, so thank you. I wanted to come back to access, and barriers to access for services. You have both already said some very helpful and interesting things. I think Dr Ali said that access is very layered. If you take where we are today, how effectively, in your view—which you have touched on in many different areas—do you think the NHS and local authorities are being in terms of tackling some of the barriers you have recognised? Is there anything each of you would like to say about specific interventions you think are most valuable within some of the communities you work with? Apologies if I am making you repeat yourself; I have written a few things down, but could you summarise for us your take on where we are today?

Dr Sakaria Ali: In some ways, with some communities we are effective. I see excellent rates among recent asylum seekers and refugees. I am always amazed when I go to my refugee health clinic and everybody is so excited, but then when I do a general paediatric clinic or am on the wards—we are seeing a lot of measles—it is very different. We are looking at health literacy, but not that simplistic view that those who are economically disadvantaged are likely to be sceptics. It is much more layered and complicated than that. It is first and second generations who are probably university educated and speak the language but have specific concerns about certain conditions within their community. To break it down in a slightly more accessible way, health literacy is not only about language proficiency but also about engaging with people's questions in a manner that is acceptable to them. We are no longer practising medical clinical care where you say, "This is the evidence; therefore, will you take it?" It is a lot more layered. People will say, "Okay, that is great. That is that particular evidence, but my child is also at risk of this. What do you have to say about that?"

That aspect of health literacy links into trust and care. If your healthcare provider is not answering the questions you are interested in, you lose trust. If you lose trust, then you develop fear and perception, so you are less likely to believe them in other aspects of preventative care. If a mother who has been discouraged or has felt that her questions about routine vaccination were not listened to then gets a letter about breast cancer screening—and this is an example I have come across a number of times—I have seen mothers who have rejected that. They have said, "Well, the do-gooders do not apply to me. This is not a healthcare system that was designed for me and my child and community". So they are less likely to take up cancer screening.

Similarly, with the HPV vaccine, if families are concerned about sociocultural ideas of it making girls more promiscuous and the health system is not addressing that, then we lose out. We might say, "Why are you talking about promiscuity? This has nothing to do with it. This is about cancer. This is important". There is a very difficult conversation to be had there and it is really important that healthcare providers and the NHS have these challenging conversations.

Similarly with the misinformation about MMR, it might be really uncomfortable for us to do that, and I find it incredibly uncomfortable as a paediatrician—and again, that is when they might say, "Well, you are British", unless they are Somali—but it is a challenge we have to face and we have to tackle it. We must not shy away from it. That is when it comes to HPV and religion and culture and when we talk about autism and MMR and the misinformation around that. We have to manage that.

Lastly, if there is fear and perception, those people are then less likely to be health-seeking within that service, so you lose them. It is not that the system is not developed. You can run all the drop-in clinics that you want, but if people are not accessing them, you have lost them.

Q81 **Baroness Wyld:** Thank you. I know I need to speed up, but I have one

quick supplementary. You talked about a spectrum of people's attitudes, and I just wondered about those people at the more confident end of the spectrum. Do you feel that there are any straightforward delivery access barriers for them that we are not overcoming?

Dr Sakaria Ali: There are, and I will keep it very short. I have patients who say, "I have been thinking about it. I tried to make an appointment with the GP and I was not able to", or "I got a letter. I missed that appointment and then no other letters came and that was the end of that". What we do with the underrepresented communities that I work with is we send a letter and two text messages and then one of our admin staff calls them and says, "Do you realise you have an appointment with Dr Ali and he wanted to talk to you about this?" There are repeated opportunities to access it. When a person's life is so incredibly busy and there are layers of tension with accessing the health provider, the health provider has to come to you.

Riyad Karim: The *BMJ* paper I mentioned earlier gives a very clear and comprehensive response to the barriers and strategies to overcome these barriers—almost we need to mobilise it. It reinforced the need for multi-level vaccination enablers to be implemented across systems, GP practices and communities. The key to improving uptake is threefold: building and maintaining parental trust in vaccination healthcare professionals; a rigorous call and recall system in primary care; and thirdly normalising childhood vaccinations within the community and having culturally tailored and accessible services available. For example, with measles vaccinations for the Romanian, Bangladeshi and Somali communities, we are already doing it in a tailored way across London. But that should have been the done thing 10 years ago. We are trying to catch up.

But then it is about, for example, having a live conversation with 300 or 400 women and 70 pastors on an agenda that you have not influenced. It is about having those open conversations and talking about vaccine hesitancy and about sickle cell because, again, communities are not just defined by vaccinations.

It is about understanding for the Bangladeshi community. They are really worried. A case in point is my dad, who is a five years' undiagnosed diabetic who has microvascular and macrovascular complications. Diabetes is on the minds of Bangladeshis and many in our underserved communities. It is a silent killer, and that is why the Million Hearts and Minds programme in London is so important for cardiovascular risk prevention. It is building a much more sustainable model where we are looking at the whole lifespan, cradle to grave. I think it is great from not just an inclusion point of view but a community cohesion point of view. What better way than to mobilise good doctors like Dr Sakaria, who is already doing it himself? But is he getting the funding to enable him to do more?

This is the thing. It is the Pentecostal doctors who are now making alliances with pastors. Who better than a pastor who is a doctor to feel

the kind of magic and say, "Life, body, temple, soul—what can we do?" We need to have that conversation for each faith community in a non-linear way. It has to be organic and cannot compromise trust. We have to build the trust.

The Chair: We are moving on to communication with Baroness Neuberger's question.

Q82 **Baroness Neuberger:** I have a question to Dr Ali first and, of course, I have to declare an interest since I chair UCLH and he is one of our brilliant consultants. You have both answered to a very large extent about how effectively healthcare professionals communicate with parents and guardians in under-vaccinated communities. To some extent you are saying that is effective up to a point but it could be done very differently and very much better. I will go to you first, Dr Ali, and then to Mr Karim. What are the main barriers to effective communication? If you could pick out two things that we could do as a nation to make that better, what would they be? That would be very useful to us when we are writing our report.

Dr Sakaria Ali: Two things? I think if you had said 10 things that might have made it easier.

Baroness Neuberger: I am asking for the top of your list.

The Chair: Send us the other eight after this session.

Dr Sakaria Ali: There is quite a lot of research looking into health-seeking behaviours around vaccination and what the barriers as well as the drivers are. We are happy to share that as written evidence. I am happy to declare an interest that I am a University College London Hospital employee.

The first thing that comes to mind is tailoring communication to the approaches and messaging that patients and communities want. That is incredibly important. How do they want to be communicated with? Nobody was interested in my six-pager, which I thought was beautiful; they want me to come and meet them in environments in which they feel comfortable. Sometimes, it is in St John's library and, at other times, it is in a mosque. Most of the time, it is in a community hall with 20 or 30 mothers who have a million questions. That oral communication is incredibly important.

I know that, in the previous panel, Huda talked about the power of social media. I can see definite benefits, although I think that it has to be used in a careful way. If it is not used in a careful and measured way, it can have quite significant negative backlashes. So I would say that communicating orally in a manner that communities want is the first barrier. Improving communication is important.

The second thing is tapping into the resources that are already available. There are many community groups and charities that do wonderful work—they are unfunded most of the time—but the NHS does not engage

with them. We see clinicians and those who have a degree as being the best messengers, but sometimes the best messaging comes from people who are trusted by these charity and community groups. As a health system, we are a very long way away from tapping into this easily and readily available resource, which could do wonderful work. I will leave my two points at that.

The Chair: Mr Karim, do you agree with those two points, or do you have two different ones?

Riyad Karim: I chime with everything Dr Ali said, obviously, but I would add another two. Community spaces are really important. We recently had a dissemination event for the *BMJ* paper in Tower Hamlets. Around 50 or 60 women were there. It was really helpful to hear their concerns around vaccinations and other health issues. I remember speaking once: I had to pull up my rudimentary Bengali to engage with the elderly dynamic. When I did so, I was able to find out that they felt that the Covid vaccine was a magic bullet. They said, "Nephew, are you telling us that it wasn't a magic bullet? We thought it was a cure". I said in Bengali—this is verbatim—"No, uncle and auntie, it is not a cure. It is actually there for us to prevent hospitalisations and give us a fighting chance in the pandemic". They asked me, "Why didn't you say that to us before?"

We have had the same recently at the church. Once we have had enough discussion around the theology and other health issues, we can then circle back to asking, "Why do we take vaccines in the first place?" It should be about not shields, defence or bubble-wrapping children, which is a bit of a misnomer sometimes—perhaps I should not have said that—but teaching communities and working with them to help them understand how vaccines work and why they are amazing, because they teach the body. When it is done in that kind of trust-laden way, people really understand things, and they understand that each vaccine is for a different disease. That is what the pastors wanted to know, and they did not want to be rushed in a five-minute or 10-minute consultation. The same goes for the Bangladeshi women. They did not want to be rushed; they wanted to have an open discussion.

I think that the kind of panel that was assembled—with public health, the local authority, the NHS, faith leaders and community leaders—needs to be a mainstay. It should not be a one-off, hyperlocal thing that manages to get discrete funding here and there. It needs to be hard-wired into our NHS where we work at the neighbourhood level. I want a non-medicalised neighbourhood health model that really listens to communities and embeds them in the decision-making process. Only then can we visualise some of these changes, rather than just having another policy shift.

The Chair: I am going to have to rush you for an answer to our final question, I am afraid.

Q83 **Baroness Hodgson of Abinger:** You have answered most of this

question, I think, but the committee will make recommendations to the Government on how to improve the uptake of childhood vaccinations and reduce disparities. In your view, what should we prioritise?

Dr Sakaria Ali: It is important that we tackle misinformation, as well as answering the concerns that communities have. We must recognise that these are valid concerns, rather than avoiding thinking or talking about them at all. That is important.

It is about what communities want to know. They want the research that has been done into the uptake of a vaccination. They are very interested in research into autism because that is a significant concern. They want something that is local and produced with their community setting the research agenda, so that they feel a sense of ownership. That is the first aspect.

The second aspect is the more granular data. It is about looking at the demographic data to try to break up both intergenerational differences and the differences between recent migrants and British-born, British-grown ethnic communities. It is also about recognising the fact that ethnicity and country of origin can be quite different. You may have been born in Sweden but your ethnicity may be Somali, and you may identify with the British-Somali community and recognise yourself as a British person. So your citizenship and descent differ because you recognise that you have grown up here and you see yourself as a British person.

That demographic data is not available. If we, the health service and the Government were able to recognise the population we are serving and their concerns, we would be able to involve them and really bring them along with us in developing both the research and the services. We could recognise the questions that they have and understand whether those questions have been answered. That is the way to success and increased uptake of childhood vaccinations.

The Chair: Thank you. Mr Karim, what would be your top priority?

Riyad Karim: You need to develop core infrastructure so that community engagement is not campaign-based—for example, for just the flu campaign or a certain other campaign. It needs to be funded, embedded and accountable. It needs to be delivered through VCSE organisations and the voluntary sector, with community leadership. We need to move outreach into building that kind of infrastructure. I hope that that will be the stuff of neighbourhood health, and I remain really optimistic about that. There are lots of interesting models from Brazil in terms of CHWs and community health worker models that could be brought in.

We need to invest in sustained, multi-year funding. As my colleagues have said previously—my director, Will Huxter, has talked about this—under the current model, the funding is short-term and episodic. It undermines trust and workforce stability. As we all know, that becomes a lose-lose situation because we have a diverse workforce and we need to keep that positive there.

We also need to embed vaccination in neighbourhood health models, as I just said, including in family hubs, schools and faith settings. Why can we not have a monthly drop-in at the East London Mosque? Why can we not have one at synagogues? Rather than having just episodic funding, let us build in holistic, place-based care. Let us strengthen call and recall, given the fact that there are not many people who are not in that recall because they are unregistered.

We need to scale what is working, not reinvent the wheel. Multi-level, community-centred models work. Everything that you have said has been absolutely right, Dr Ali; it has been so insightful to be here with you and listen to you, Sakaria. It is really important for us to get this data right. What does "White Other" mean, for example? How can we effectively measure data improvement in the Romanian community when we have terminologies that are not cognisant? We have to do that work, and we have to get that data. We have "Black African", but we need to have "Nigerian" or "Ghanaian". We have to get things that are closer to communities. If they are giving that information to the ONS, why are they not giving it to the NHS? To me, we are not relaying it in the right way.

There are lots of recommendations on ethnicity collection. The Wellcome Trust has done heaps on this, as has the Race Equality Foundation, so it is not as though we do not have the data; it is just that we need the political will and policy that gets vaccines and health into an equity footprint.

The Chair: We will do our very best to do that. Thank you very much indeed for all the information you have given us today. If there is anything that you want to send us after this session, please do so, by all means. That is the end of the session.