

Women and Equalities Committee

Oral evidence: Take-up of the Covid-19 vaccines in BAME communities and women, HC 1224

Thursday 4 March 2021

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Members present: Caroline Nokes (Chair); Ben Bradley; Theo Clarke; Elliot Colburn; Angela Crawley; Alex Davies-Jones; Peter Gibson; Kim Johnson; Kate Osborne; Bell Ribeiro-Addy; Nicola Richards.

Questions 1 - 26

Witnesses

I: Zara Mohammed, Secretary General, Muslim Council of Britain; Dr Shola Adeaga, Chief Operating Officer and Executive Pastor, Jesus House; Dr Ranj Singh, NHS Doctor, ITV's *This Morning*; Dr Christine Ekechi, Consultant Obstetrician and Gynaecologist, Imperial College Healthcare NHS Trust.

II: Dr Mary Ross-Davie, Director for Scotland, Royal College of Midwives (RCM); Professor Lucy Chappell, NIHR Research Professor in Obstetrics, King's College London; Professor Nicola Stonehouse, Professor of Molecular Virology, University of Leeds.

Examination of witnesses

Witnesses: Zara Mohammed, Dr Shola Adeaga, Dr Ranj Singh and Dr Christine Ekechi.

Q1 **Chair:** Welcome to this afternoon's meeting of the Women and Equalities Committee in our inquiry into the take-up of Covid-19 vaccines in BAME communities and among young women. Can I start by thanking our witnesses for having joined us this afternoon and for the evidence that you are going to give to us? I would just like witnesses to indicate if they are happy that I introduce them by their full title and then I might use their Christian name, if everybody is content with that. Can I start by asking all of the panel to briefly introduce yourself and your role? Can I start with a very short question as to whether the lower take-up of the vaccine in some communities was predictable or not?

Dr Singh: Thank you for having me. My name is Dr Ranj Singh. I am an NHS emergency paediatrician based in London. I also have a media role; I am a TV presenter working across various channels.

Could the reduced uptake have been predicted? Yes, because we have certainly seen that mirrored in previous vaccination programmes, so you could say that it could have been predicted.

Dr Adeaga: My name is Dr Shola Adeaga. I am a retired consultant obstetrician and gynaecologist, and now the executive pastor at Jesus House, one of the Pentecostal churches in London.

The answer, like Dr Ranj said, is that it certainly would have been predicted, given the different inequalities that have fuelled a lot of what we find today. The answer is yes.

Zara Mohammed: I am Zara Mohammed, the Secretary General of the Muslim Council of Britain. Thank you for having me here today.

I would completely agree with that. The existing inequalities within the healthcare system, the disenfranchisement of minority ethnic communities, their relationship with decision-makers and the narratives around them have definitely not helped the case for vaccine uptake and would have indicated it was always going to be a difficult one.

Dr Ekechi: I am a consultant obstetrician and gynaecologist based in London. I am also one of the co-chairs of the Royal College of Obstetricians and Gynaecologists Race Equality Taskforce.

Although I may agree with what has been said, it is important to note that the BAME community is not a homogenous one. As such, thoughts, behaviours and beliefs, as well as the assessments and solutions, should be as heterogeneous as the people we are talking about. When we are trying to predict uptake towards the vaccine, it is more in relation to what has been happening over 2020 and lots of discussions about race and



health inequality, and not necessarily based on previous behaviour in relation to other vaccines.

Q2 Kim Johnson: Good afternoon. My first question is to Zara. Picking up on what Dr Ekechi just said about the black community not being a homogenous mass, I would like to know from you how your communities have been impacted by Covid-19 and what their response has been to the vaccination programme.

Zara Mohammed: It has been very clear from the outset that there has been a disproportionate impact on ethnic minorities and particularly the Muslim communities. We know that many of our demographic are on the front line—essential workers within the NHS—and we know that, of course, many of our community are in some of the most socioeconomically deprived parts of the UK. It is very clear that the poorest have been affected very differently to those in the wealthiest brackets. From burial, bereavement and loss to places of worship being closed and those within low-income jobs, such as taxi drivers and restaurant workers, there has been economic and mental health impact. It is a community that has really had very challenging times, with our holiest celebrations, such as Ramadan and Eid, being at home.

With regard to the vaccine uptake, there has definitely been a wider issue of misinformation and scaremongering around the vaccine. We have definitely seen that ourselves. Translating information has been a key part in that delivery process. People are still very far away from these very nice videos that we see, and so what we are really trying to do is get that message to them in the language that they understand, using people they trust to communicate that information, and really combating the fake news and the WhatsApp brigade that is really shaping a lot of the negative stereotypes. There are definitely challenges, as we see in all communities, but we are working very hard to tackle those.

Q3 Kim Johnson: Who is responsible for getting those positive messages out and demystifying some of the misinformation that is being spread on social media?

Zara Mohammed: At all levels, we have a part to play. The Government could definitely be doing better and more to make sure that those messages are going to intergenerational families in terms of how our communities interact and who they trust, as well as ourselves as faith leaders and everyday people, from people who interface with our neighbours or friends, such as shopkeepers. Everybody has a role to play in providing a relationship of trust, but definitely, from the top to the bottom, decision-makers could be doing a much better job of making sure that the relevant information gets to people in a way that they understand and in a vehicle of trust.

Dr Adeaga: I represent the Christian community, and particularly the black-majority churches and black Caribbean churches. Very similar to what Zara said, our communities have been impacted. Certainly in terms



of health, morbidities and mortalities, we have had quite a number of mortalities and quite a number of people with long-term effects recovering from Covid. There is then the social impact, similar to what Zara said. A lot of people are affected because our churches have been closed. They reopened about mid-year but a number of churches are still closed, because we thought that, as leaders, it is better to be safe than to gather our congregations. There has been an impact in that regard.

One of the particular things that I would like to mention is that, in terms of social impact, we have had an increase in domestic issues and incidents within our communities, exacerbated by the lockdown, and also an increase in mental illness, particularly amongst young people.

In terms of response to the vaccine, again, it is very similar. There has been a lot of hesitancy and fear. At a lot of our meetings what we have done is, rather than model everything together, to try to segregate them into different compartments, so that it is easier to understand and to tackle. For example, we know there are medical concerns and issues like, "How come the vaccine came out so quickly?" There are a lot of concerns about long-term side effects. That is probably the biggest challenge that we are having to deal with at this point in time: convincing people about side effects and issues with fertility. Those are the medical concerns.

There are faith concerns, as you can imagine, because we are people of faith, as in, "How does this marry with using the vaccine?" There are ethical concerns and a lot of questions about the contents of the vaccine and whether there are foetal tissues and so on. There are then the myths, which, incidentally, have been easier to deal with, but certainly the medical and faith issues are the biggest ones we have had to deal with.

Like I have said to quite a number of people, in the last year my respect for social media has gone out of the roof, because everything we are facing now is largely a problem with social media and disinformation.

Q4 Kim Johnson: Thank you for raising those important points about mental health and the increase in domestic abuse. Those kinds of issues have been dealt with by this Select Committee. Dr Ranj, would you like to add anything else?

Dr Singh: I want to thank Christine for bringing up the fact that what we call the BAME community is, in fact, several communities. I will, for want of a better term, use the term "BAME", but that is part of the issue here. Often, we lump these communities together and expect there to be a single solution and a single avenue, and there is not. That is why we get a different level of understanding and a different response to a lot of things that are happening.

Zara brought up the fact that mainstream content needs to be mindful of language. The language that we are using in our mainstream content that is being put out to the general population is very Eurocentric and often



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aimed at a middle-class, Caucasian audience. I can tell you that a lot of our communities do not understand it. It just does not speak to them in a way that they can engage with. We need to start creating mainstream content individualised to different BAME communities.

We need to start putting BAME people at the forefront of our campaigning. If we put the most disadvantaged community at the front, everyone else is going to do what they are doing anyway. The people already following the rules and getting the message will continue doing it. When you put BAME people at the forefront of your campaigns, messaging and public addresses, how many of the Government and parliamentary addresses that we have done around Covid have been led by people from those communities? I can probably count them on one hand. Part of the issue is that we are not prioritising the people who need it the most.

A lot of people have brought up regulation of the media generally, and social media especially. Fake news spreads faster than we can keep up at the moment, and BAME communities are being targeted specifically when it comes to, for example, anti-vaccination messages. We know that the Centre for Countering Digital Hate has done a lot of work around this, looking at what is happening. We need to be a bit more tailored to our approach and to use a lot of the suggestions that lots of people have made already, but just to be a bit more mindful of whether what we are creating and feeling like we are doing a good job of is doing any job whatsoever.

Q5 Kim Johnson: Some of those comments have been raised by other groups about the poor communication coming from the Department of Health, and maybe it is an issue that needs to be picked up going further.

Moving on to my second question, how have existing health inequalities impacted the way minority communities have responded to Covid-19 and the vaccination programme?

Dr Adeaga: The foremost thing is that existing health inequalities have engendered a sense of distrust from our communities. It has come to the fore in the last year of the pandemic. I was having conversations with representatives of nurses a while back. I am sure you know that our NHS is populated by a large proportion of people in the BAME community, and they feel that they do not trust the system. They feel that the system has not been fair to them. They feel that they have taken the brunt of what has happened. I am sure you have come across figures that suggest that mortality and morbidity has been a lot higher amongst the BAME community. Certainly, the inequalities have played a big part in the way people have responded to the pandemic itself, as well as to the uptake of the vaccine.

Zara Mohammed: I would certainly say that this has played a huge role in the way that Covid has affected our communities. In terms of the Muslim community in particular, some of the stats have shown us that,



for example, looking at women in England aged 65 and over having the worst health, Muslim women are in the 40% category. When it comes to very good health in women aged over 65, it is around 30%. These are some of the things that we are looking at. We know that many of our representatives are in lower-skilled jobs. There are multigenerational households, and other things like diabetes in the family and mental health issues.

There are loads of different things going on, so there are already barriers to accessing healthcare provision. It is about feeling comfortable and trusting the system, the doctors and the way they speak to you. I have had many council members saying that it is so hard to get an appointment, or elderly people not able to feel confident to access them. We are very virtual and online, but we have noticed that, during this pandemic, many people have been excluded because of inequalities in access to being virtual.

The healthcare system, from a holistic point of view, really needs to relook at the treatment of ethnic minorities, of cultural and religious sensitivities and of the language that is used, with the translation of information. Particularly with the vaccine, we were pretty critical in making sure that we got scholars, imams, faith leaders, mosques and institutions that were trusted to be at the forefront of that message, because, again, it was top-down; what we need is a bottom-up approach. What we found worked really well was a community-led, affiliate-led and faith-centred approach from our side, but one that really involved the community in the conversation.

I agree with one of the others when they said that misinformation is really easy to overcome when you have a conversation. Even some of my own friends and family who work within the NHS are very sceptical of taking the vaccine, whereas others feel that they have to take it. Even within families, there is not that agreed line on how we are going to approach this. We have to challenge those inequalities and see how this pandemic has played out. Then we have to do something with that evidence and not just talk about it, because all of us here know that ethnic minorities have been disproportionately impacted.

Q6 Kim Johnson: You are quite right, because, at the beginning of the pandemic, four times more black people died as a result of Covid. Could you say a little bit about where racism fits in in terms of this agenda?

Zara Mohammed: One of the things that was really upsetting for our community was the fact that there were media stories that were coming out in which Muslim communities in particular were shown as having gatherings during the pandemic and lockdown. These were factually incorrect images that we challenged, but they were used to perpetuate stories in tabloid journalism about, "Look who is breaking the rules". When it came to holy celebrations, we stayed at home, and people felt differential treatment around which occasions were allowed to be



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celebrated and which were not. I know that many festivals also came under this.

The point is that there is a wider narrative around race within Britain and around identity politics. We thought that the pandemic would be one in which we could all unify and come together, and these things would not be an issue, but yet again we were having to justify whether we were playing along in being part of that national effort. Race is really important for us to continue to look at, but many of us, especially myself—I am the third generation now—are also sick of answering the question, because we very much feel that we are part of the solution and are working hard on the front line to make sure that our communities are kept safe, and yet we are still having to justify ourselves in that process. There has been a negative impact on this.

Q7 **Kim Johnson:** Dr Ranj, do you have anything else to add in terms of the health inequalities?

Dr Singh: We all know that there are health inequalities. These studies and reports and this data have been around for a very long time. Towards the earlier part of the pandemic, reports were released by Public Health England that showed that our communities were at a disproportionate disadvantage from Covid. This is partly because of systemic, historical reasons. We have to acknowledge all of those and to be very careful, when we are talking about our communities, that we do not come off as overtly critical, because there are very good reasons for people to be hesitant, a little bit concerned and maybe wary, because of the way that things have gone traditionally and systemically and still happen.

My biggest issue is that we commission all of these reports, this data and this information, and then nothing happens. Why are we still having this conversation right now? Because very little seems to have changed. The Public Health England report led by Kevin Fenton came out towards the latter part of 2020, and showed these disproportionate effects that it was having on these communities. Unfortunately, we had no strategy after that. We had no answer. There was no real, active, visible response and there is no surprise, then, that communities that already feel othered, segregated or disenfranchised then think, "They do not really care about us".

Q8 **Kim Johnson:** The issue about vaccine hesitancy has been touched on by all three of you in terms of it being an issue not just for Covid but for other forms of vaccination. What needs to happen to improve that going forward? Covid is not going away, is it?

Dr Singh: No, Covid is not going anywhere, at least not in the short term. We know that vaccination uptake is lower than we would want it to be in our communities, regardless of which part of the BAME community you are from, but how can we change that? I have already talked about some of the reasons around the campaigning and the messaging.



One of the ways that we can improve some of the uptake, which Zara touched on, is by using existing community channels. I certainly know from my community that there are three main sources where my community get their healthcare information traditionally: school, their healthcare settings like general practice and primary care, and religious or faith settings or community centres. Those have all been shut during lockdown and people have not been able to access that, so it is no surprise that, with the added issue of social media, messages that are not accurate or helpful or that are actively harmful get propagated, because that is the only place that people are getting their information.

I am not just speaking to the older, slightly more vulnerable people in the communities; the messages on social media are coming through from their younger people, so we need to make sure that any messaging put out there speaks to younger people as well as the older sectors of our communities.

We need to make it more accessible and convenient, because, as Zara said, we tend to work in more disadvantaged and manual roles. My parents are both factory workers. They cannot just take a day off work and go and get a vaccine. They have to work it around what they are doing, as well as childcare on top of that. So many people have so many other responsibilities and roles that they need to be mindful of.

A lot of the concerns that I am hearing from my community, particularly the Indian community and particularly women in my community, is around messages around pregnancy and fertility in vaccination. That message does not seem to be getting through and I do not know why, because people are reiterating that and still concerned about it. That is one of the most hesitant groups in my community when it comes to the vaccine.

One of the best ways that we can generally make this all better is by building trust among our communities and the authorities. That can happen only through integrity, transparency and candour, which I am not sure that the authorities are always best at doing. There needs to be action with integrity and setting example. We have all seen the media show less-than-ideal examples where that has not happened, and these communities see that and often then think, "It cannot be one rule for them and another for us".

Q9 Kim Johnson: Thank you for that important point about vaccine hesitancy for women, and around fertility and childbirth; it is a really good point. Dr Shola, do you have anything further to add in terms of vaccine hesitancy and what needs to happen going forward?

Dr Adeaga: I agree entirely with what Dr Ranj has said. I would just emphasise that, in our communities, the biggest thing that we are having to overcome is just getting the correct information across to people. As we have said, social media has done a negative good job, if there is such a phrase, of getting all these things into people's minds. What we have



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been doing over the last few weeks and months is trying to undo the damage in getting the information. I was saying to some NHS colleagues involved in the vaccination in our church that, over the last week, for example, I could easily spend 30 to 45 minutes just trying to reassure somebody about the side effects. They say, "But social media said this and that". The biggest thing is just trying to get accurate information across, which leads me to the second thing.

I know the Government are doing the best they can, but it is almost like the narrative has been more "Get the vaccine; get the vaccine", which fuels a lot of the distrust, because it is like, "Why are you saying we should get the vaccine?" It is more, "Get the vaccine", rather than reassurance as to why you should have the vaccine. I know the narrative is getting better, because we have given feedback about this, but it is accurate information that will go a long way.

Again, as Ranj or Zara said, it is about information coming from the right people. Let me just give you a quick example. We have held workshops for our congregation and the local community. We brought experts in to speak and answer some of the questions. We had one about five weeks ago with a professor of virology, who was Caucasian. While the meeting was going on, we kept getting chat messages saying, "Why is he the one talking to us? We do not believe him. We do not trust him". We did exactly the same thing a week after with some of our in-house medical team, and the result was amazing: a lot of people changed their mind. It is about a lot of accurate information, but also the right narrative and the right people saying the right things to the right people.

Zara Mohammed: Most of it has already been covered but what we have done is make sure that language is really key. We have gone as far as translating into Urdu, Gujarati, Somali, Kurdish and German. We have had people from different countries, as far away as South Africa, using our guidance in different Muslim umbrella groups. We found that language is really important, as is appreciating the younger generation's role in that transfer of information, not just using the online platform but looking at where people speak and where conversations can still happen. We are really grateful to see that mosques have risen to the occasion and become vaccination centres as well as information points. It is these institutions of trust that are so pivotal, but it is so vital that we combat this, because these are communities that are already disenfranchised and vulnerable.

I would say that, on a positive, we know that many in our communities are taking on the vaccine. There is good uptake and we should not be too cynical around it. People are heading in the right direction on this. We just have to continue to do better.

Kim Johnson: No one is safe until we are all safe.

Dr Ekechi: I just wanted to add to Zara's points that we must remember that vaccine hesitancy is a fluid state, not a static state. A number of our



studies looking at desire for vaccine uptake was right at the beginning of rollout, when information was quite minimal. When we look at data on who is taking up the vaccine, particularly in the first two groups, although people from African and other black backgrounds—and, indeed, some of the Asian backgrounds—have a lower uptake, the rate of increase of uptake in those groups is highest. There is a lot to be said about the positivity of the interventions that have been put in place, but we must be careful not to try to reinforce a narrative that may be incorrect.

Again, just to follow on from what Dr Ranj said, hesitancy and questions are very different from anti-vaccine. Anti-vaccine within particularly the black community is not as significant an issue as it would be in non-BAME communities. Vaccine hesitancy is very valid, and it is important that, when we are having conversations, we validate questions around a vaccine that is new. For many of us, this is the first time we have ever had a vaccine be created in our lifetime at the speed with which it has been done, which is understandable and we all understand why, so it is important that, when we are trying to understand why some people may be slower to take up the vaccine, we take these points into consideration.

Chair: Thank you for that. That is a really important point to have made.

Q10 Bell Ribeiro-Addy: My first set of questions are to Dr Christine and Dr Ranj. You have already touched on health inequalities but we have seen reports that suggest that ethnic and religious minorities experience racism or discrimination when accessing healthcare, particularly in relation to equal access to treatment, pain relief and black maternal health, with very shocking figures there. Could you tell us more about the type of discrimination that BAME people are facing when they access healthcare, and your views on how it might be better tackled?

Dr Ekechi: It is important for us to, first of all, acknowledge that Covid-19 just lifted the lid on existing inequalities in healthcare. One that most of us will be aware of is the unfortunate and significant difference in outcomes in maternal mortality between black women and white women. We know that black women are four times more likely to die while pregnant or soon after. If we are to look at any other aspect of women's health, we will still see these same inequalities persist, both in women's health and men's health. Of course, we saw this same pattern repeat itself amongst those who contracted Covid and, unfortunately, amongst those who died.

I draw everybody back to the Public Health England report chaired by Kevin Fenton in the summer of 2020, which tried to understand why these inequalities, as they pertain to Covid fatalities, may exist. There was a discussion about the structural barriers as well as the individual factors. We know that black and Asian people are more likely to be in lower socioeconomic classes that will predispose them to pre-existing medical conditions that will put them at risk, not only from other issues outside of the pandemic but also from Covid itself.



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We also need to acknowledge the mistrust that exists within certain communities because of the poor treatment that they may have had previously, and also when there may be poorer recognition as to the degree of illness within people from certain communities. For example, how well are we able to detect low oxygen in somebody with a darker skin colour? Did this play a part, for example, in the higher fatalities at the beginning of the pandemic? For us within the medical professions, we understood that. One of the rapid improvements in advice, particularly within my sphere of interest, which is obstetrics and gynaecology, was to advise all clinicians to have a lower threshold for the admission of women with Covid-19 accounting for these factors, and also encouraging people to present at a much earlier stage of their disease course. This was something that significantly improved outcomes in one way.

Of course, we cannot quickly deal with some of the other, more entrenched issues, such as black people being more likely to be in conditions that increase their exposure, i.e. by way of their household, crowding or, indeed, their employment.

Dr Singh: Christine has done a brilliant job of highlighting how multifactorial this is. These are structural inequalities that have been there for a very long time and play out in all types of health cohorts. We see that children from disadvantaged backgrounds have poorer health outcomes, depending on where you are in the country or what your cultural background might be. Public Health England do a weekly Covid and flu surveillance report. Currently, Covid incidence is still highest for Pakistani, Indian and other Asian communities and the black community, above everybody else. We have seen poorer outcomes throughout the pandemic as well.

There are lots of reasons why we get poorer outcomes. Firstly, it is, as we have talked about, accessibility to healthcare. When I talk about accessibility, I am also talking about understanding and education. It is about understanding the information that is available. That is part of healthcare: healthcare messaging and being able to get on board with that. Our communities sometimes have more comorbid conditions that predispose them to poorer outcomes, but we cannot deny the effect of socioeconomic reasons like the kind of jobs we do, the way we live and the fact that we may live in different kinds of family units that may or may change our risk.

Talking about accessing healthcare from a logistical perspective and being able to get to them, depending on what job we do, we may not be able to access places or programmes of healthcare. Generally speaking, I am quite passionate about the topic of segregation. Some of these communities have never felt part of the mainstream. When a community feels segregated, the outcomes become segregated as well and they become different. They are treated as others. That happens in healthcare, just as it happens in the rest of society. We are starting to wake up to it a lot more, especially with the events of 2020, the other political events



that were happening around the world and a lot of the injustices that were highlighted, but we still have a long way to go, and that includes in healthcare.

Q11 Bell Ribeiro-Addy: You have touched on this slightly in previous answers, but I wanted to hear what you thought about how all of these factors—specifically, racism and discrimination in accessing equal healthcare—have had a direct impact on vaccine uptake in BAME communities?

Dr Ekechi: Where an individual has experienced racism, either directly or indirectly—we must remember that, when we are talking about racism in this context, we are very much talking about structural racism—this will impact a person's perceived experience within the healthcare setting. As such, this means that they will be less likely to have trust when presenting with concerns. That is why it is important for us who work within healthcare to be cognisant of that and to make sure that our language is open and inclusive to encourage people to see us.

There is very strong data to show that, where patients are able to pick up implicit biases within the healthcare profession, that will then impact the degree of information that they are able to take onboard and the degree and quality of that consultation. As a background to that, when we are looking at whether somebody would feel confident with regard to taking up the vaccine, it makes sense that they will require a much higher threshold for information regarding data for their own personal safety. This includes seeing that there is a significant proportion of people from their background and their cultural community included in vaccine trials. This will include seeing people who look like them involved in the development of the vaccine.

It is important to note that, in the UK, only 0.7% of university professors are from a black background. As of 2018, only 25 UK professors were black female. When we look within the healthcare setting, only 7.4% of people within higher pay bands are from a non-white background, and when we look at the board level in the NHS, it is 10%. All of these are significantly important when you have somebody sitting at home trying to make a decision for themselves as to whether to take up the vaccine. This is about the trust that they are able to form by seeing people who look like them advocate for them.

Dr Singh: I would absolutely echo that. This is part of a bigger problem. We know that BAME communities make up around 14% of our population, but make up only 8% of the vaccine uptake. We know that people from a black background are less than 50% likely to take up the vaccine, and people from an Asian background are only two-thirds as likely to take up the vaccine. There are long-term, inherent reasons for that, which Christine and everybody else has touched on in many ways. We have seen lots of concerns about side effects, long-term effects, ingredients and whether they are adequately tested and effective in our communities. Christine touched on being visible and seeing visible



examples of that. In terms of the way that information is presented, it is not always tailored to our communities. All of these things need to be addressed if we are going to improve vaccine uptake.

Q12 Bell Ribeiro-Addy: Why do vaccine trials often not include a proportionate number of black and Asian people particularly?

Dr Ekechi: We have strong evidence to show that, first of all, women are least likely to be invited or participate in research trials overall. That proportion is greater and higher when we look at women from black, Asian or other ethnic minority backgrounds. We also have to understand that, particularly among black people, there is a historical mistrust and hesitancy that is valid around participation in trials. If you speak to many people, they will point to historical, validated experiences of poor treatment, normally without consent, or experimental treatment of black people within trials. We could look across to America, with Henrietta Lacks, for example, the Tuskegee trial and so many others.

There is also the current state that we are in now. It comes back to my point earlier about visibility of scientists, researchers and professors who are as diverse as the population that they wish to treat. It is about having the confidence that they will be treated equally. Some people feel that, where they know that there are unequal outcomes as it pertains to their health outcomes, they do not then have the confidence to enter a trial, worried about whether they would have the same treatment.

Dr Singh: You absolutely hit the nail on the head there. Also, it is about having enough information to be able to make those decisions in a way that you can understand. That is hugely important.

There is a problem from the mainstream in acknowledging these historical issues that have happened with trials with certain parts of the BAME community. The fact is that, when you do not acknowledge that, people think that you are not taking that seriously or into account. That is where acting with integrity, honesty and transparency is really important. We need to acknowledge that there is a very valid reason for people from certain communities not taking part in trials, aside from education or being physically able or having access to them, historically, longitudinally speaking, and to some extent right now, with comments that were made by an authority figure in France about testing the Covid vaccine out in Africa; that was poorly placed and really misjudged. These sorts of things do not help, but we have to remember that we need to acknowledge what has happened in the past in order to be able to truly understand and move forward with something.

Q13 Bell Ribeiro-Addy: You have touched on acknowledging what has happened as a way of moving forward. We have had BAME Government Ministers participating in vaccine trials and videos of Members of Parliament and other senior figures in the BAME community, in entertainment, et cetera, encouraging communities to participate in vaccine trials and get vaccinated. What more could Government and



healthcare professionals be doing to promote BAME participation in vaccine trials?

Dr Ekechi: From a Government perspective, all information and participation is welcome. It is important that the language used is one that is translatable, following on from what Dr Ranj said about candour and transparency, and also one that validates people's concerns. It is important that we do not slip into a narrative that shifts from focusing on the structural issues that may cause people to have an increased risk of Covid and, indeed, die, to an individual and, as such, we then end up blaming the individual for contracting Covid and, inadvertently, for their own death.

When we look at studies that try to unpick what supports uptake of all types of vaccines, what we find is that the importance is around a bond of trust that is formed between the individual and the person they are talking to. What we have found is that local interventions are more likely to have a greater positive effect than Government intervention. That is not to say that Government videos and interventions are not needed—they are—but it has to go hand in hand, making sure that we provide adequate information to healthcare professionals and anybody else who comes into contact with individuals on a day-to-day basis, so that we have the right information. It allows that space for a more open dialogue and exploration of some of the concerns that might be particular to the individual, where Government adverts and targeted advice may not work because it is broader, as it would have to be.

Dr Singh: It is the same from my perspective. Individualised, mindful content that is created for specific communities and involving those communities and putting them at the forefront in terms of spokespeople, with campaigns led by them in the media, giving that message out there to people that, "There is no decision about me without me," is hugely important.

We need to be using existing community channels, as lots of us have spoken about, and existing BAME media, so TV channels and online spaces where people are already congregating and going to. When we cannot physically congregate in places like schools, healthcare or religious settings, people are going to more of those online and on-screen sources of information. We need to be mindful that they have a huge part to play as well. I work with a lot of healthcare professionals in the media, and we have realised just how powerful some of those messages are. We have to put people from our communities at the forefront of a lot of that messaging to get it out there.

Q14 **Bell Ribeiro-Addy:** Just extending that question slightly to Zara and Dr Shola, have there been any anti-disinformation campaigns that you have seen that have been particularly effective in BAME communities in promoting vaccinations? Is there any more that the Government can do to help reduce disinformation?



Zara Mohammed: We have been working with our affiliate, the British Islamic Medical Association, on a national platform, bringing in a whole variety of actors, and what we have found has been really effective is the translation: getting information to communities through different media, including WhatsApp and social media, as well as videos, conversations and online webinars. The best source of campaigning has been through doing it in people's languages and making sure that they get the information in bitesize visual infographics and audio. Written text is sometimes quite difficult and is a lot of information to process. People's online literacy is not as great as we think it is, especially within our communities, other than forwarding messages without reading them fully.

That translation and visual and audio, using all the different means, is really good and simplistic and brings in that partnership. A key theme that everybody has talked about is trust. On the topic of the Government, what we always bring it back to is what our objective here is during this public health crisis, and that is to save the public in the crisis. As the Muslim Council of Britain, we have been quite disappointed that the Government have not been working with grassroots organisations and representative bodies like ours on the ground that are trusted to deliver the message, and has had a bit of a homogenous approach, as Dr Christina said. Maybe some of it is relevant, but the reality is that our communities are so diverse.

One of the shortcomings is not bringing faith-centred data into the picture, so that we can see the impact on religious communities and how they have been severely impacted, especially during bereavement and loss, which has been a really big area. We know that, with over 50,000 Muslims within the NHS, people have taken the virus home and, unfortunately, that has resulted in their loved ones passing away and young people having to bury their parents. It has a cross-generational impact. The Government have to understand who the champions of the community or the trusted ambassadors are, and utilise them. It is a completely missed opportunity and a disservice to the work that we are all trying to achieve in getting through this pandemic, as well as the recovery piece that we will have to do after it.

Q15 **Bell Ribeiro-Addy:** Dr Shola, have you seen any particularly good anti-disinformation campaigns?

Dr Adeaga: Yes, certainly. Like I said earlier, over the last few months, we have put a lot of effort into trying to bring correct information, but the key for us has been not just correct information but coming from trusted sources, as has been said earlier. In a particular instance, we recognised the role of faith leaders in society and our communities, and that a lot of our communities trust their pastors in their church context, for example. We ensured that we got a lot of faith leaders in the Christian community to come together, first of all saying, "We are together in this", so we are stretching across our various communities. Last weekend, we got 60 such



senior faith leaders to do videos talking about their confidence in the vaccine and encouraging their members to do this.

Specifically to answer your question, over the last few weeks—and Dr Christine mentioned this—we have started to see a positive change in people's attitudes. We have done lots of workshops with information. Some have been purely medical, as in addressing the medical concerns that are quite a big chunk. Others have been addressing the faith concerns. It has been quite encouraging, because we have seen ranges of people. One that touched me the most, if you do not mind my mentioning it, was about two weeks ago, when an 85-year-old lady had made up her mind that she was not going to get the vaccine at all. She just said that she has no trust. She listened to one of the workshops that we did with some of our team bringing correct information and answering questions. She then called round to say that she is now ready to take her vaccine. That really touched us and showed us that this working.

I could give you other examples. There was a particular person in our congregation who was very adamant—she was like, “Never”—and, after watching some of those workshops, she was able to change her mind. Things are working, but it is all down to trusted sources of information that people in our communities can trust.

Bell Ribeiro-Addy: It is definitely good to hear that it is working.

Q16 **Kate Osborne:** Good afternoon to the panel. Do you have a lot of key workers in your respective communities? How has this impacted Covid rates and vaccination levels?

Dr Ekechi: Of course, I can only speak as a key worker myself and among my place of work. Again, it is important, first of all, to acknowledge what the risk factors are for contracting Covid. As we know, exposure and certain jobs and employment will increase that risk over and above everybody else. We also have to remember that people who are key workers are still drawn from main society, so whatever hesitancy and questions are in main society, they will also be in existence within the key worker group. In this particular setting, I am talking about healthcare workers.

It is also important, however, to try to make sure that what we are not looking at is anti-vaccine sentiment that is static, and maybe what we are looking at is a lower and slower uptake. As such, we are seeing a very slow curve, which will finally pick up maybe a little bit later and peak in people from a white background.

Saying that, within the healthcare setting, we have found, with initial data, that there has been some discrepancy in uptake, where we have found higher uptake amongst healthcare workers from a medical background—i.e. doctors—compared to nurses and midwives. However, that is more a rate of change rather than a static picture. As we have more people take up the vaccine, irrespective of their role within the



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healthcare setting, we are finding that uptake is high, irrespective, as I said, of their role or their ethnic background.

Zara Mohammed: According to September statistics from the NHS, we know that around 50,000 Muslims are employed by NHS trusts and clinical commissions in England, and that Muslims make up 5% of the 900,000 who hold a religious belief. It is such a priority that we look at our essential workers, and especially those with a faith-community background. Just as in any community, there will be those same hesitations and risks. What we found at the start of this pandemic was that some of the first who passed away were Muslims and ethnic minorities on the front line.

They really are at risk, and the protection of lives is so important in this case in making sure that we do understand the conversations and the same issues that they are probably facing in a very intense and heightened way compared to many of the rest of us. What is really important is to say that it is a sizable amount of our front line who have a faith background, and a sizable amount of the Muslim community, and what we are seeing is that their lives really are at risk as essential workers.

In terms of the uptake of the vaccine, as Dr Christine said, it is mixed, based on hesitancy, but we hope that many do encourage, with us, many others within the faith communities to take on the vaccine, and people are already doing that. It is a really important demographic for us to pay attention to and to continue to support at this very difficult time.

Dr Adeaga: Similar to what Zara and Christine have said, again speaking on behalf of the communities that I represent—the church community, the faith community and the larger black African community—we are surprised to find that we have a large percentage of our members who are key workers on the front line. Quite a large number work in the NHS itself. Right from the beginning of the pandemic, we were assailed with information about challenges that people were facing, because they were key workers. Remember when the first lockdown happened, all these key workers had to go out there to serve, both in the NHS and in other areas.

We have quite a lot of information about how people have been affected. As I said at the very beginning, lots of people, unfortunately, were infected by the virus. Again, a significant number were working in the hospitals and in the NHS. Sadly, some lost their lives or their loved ones, and a number are still battling with the aftermath. The first answer is that, yes, we have quite a lot of key workers in our community. Zara mentioned the figures that, in the NHS, over 40% of workers are from BAME communities.

In terms of the impact and the response to vaccination, it has been quite interesting, because there is a segment of key workers who were happy to receive the vaccination because of the risks that they were exposed to in going out there to work. One of the segments that has got my



interest—I was going to say this earlier when questions were being asked about historical racial discrimination—is the group of nurses who themselves are healthcare professionals. The reason why it got my attention is that I would have thought that, as a healthcare professional, you knew the medical facts and you knew that the vaccine was safe, and, therefore, that the uptake of vaccines would be high amongst that group, but I was shocked to find out that it was very low in that group.

Just digging a bit deeper to find out the reasons why, it brought us back to what we were saying earlier about racial challenges. The big thing for that community, particularly the association of nurses—we are having to have numerous meetings with them to encourage them—was this whole thing about discrimination in the workplace, not trusting the NHS, if I might say it directly, things like being passed up for roles, and being the people who were at the forefront in terms of receiving patients. All of this has, unfortunately, negated whatever medical knowledge they might have had that would have encouraged them to take the vaccine, given the fact that they are also the ones who are at the most risk, facing patients. It has been a very interesting but challenging journey in trying to carry people along and to convince them about uptake for the vaccine.

Dr Singh: The only thing I would say in addition is that it is interesting that 21% of all healthcare staff are from black and ethnic communities, despite being 14% of the population, so we have an over-representation within healthcare. Unfortunately, the other over-representation we have is that 63% of deaths that we saw in healthcare workers were from these communities.

University Hospitals of Leicester NHS Trust did a study recently in its own trust, and found that, even though over 70% of their white staff were vaccinated, only 60% of their south Asian staff were, with lower representation among Pakistani and Bangladeshi communities, and around 35% of their black staff were. My trust has taken on the learning over the last year of what has happened with regard to the Covid impact on our communities, as well as events such as Black Lives Matter, and they have actively made an effort to engage their black and minority ethnic community workers. They have made listening and information exercises. They have made it as easy as possible for them to not only get information but then to also get their vaccines.

Christine spoke about this so eloquently. We see that initial hesitancy among our communities, but we are seeing an increased rate of change. There may have been a lag, but we are starting to see a bit of the catch-up. I feel like these are the people in healthcare who are going to go back to their communities and tell them about it. They are often trusted voices within their communities, and we perhaps need to put a lot more effort into our healthcare workers from these communities, so that they can then go and cascade that information out within their respective communities.



Q17 Kate Osborne: Dr Christine and Dr Ranj, we have already spoken about healthcare workers, including from BAME communities, being more hesitant than their white colleagues in terms of receiving the vaccine. If that is the case, what impact does this have across the whole community? What are the wider consequences of BAME healthcare staff refusing the vaccine?

Dr Ekechi: I would like to reiterate that “BAME” is too broad and does not tell us anything. There are different rates among different groups. Studies in January found that there was greater hesitancy amongst Africans compared to people from the Caribbean, for example. It is also less about healthcare professionals not wishing to take up the vaccine; I would not want that to be the take-home message. I can talk from my trust, and we have a high uptake of the vaccine. This is just more about people wishing to find out more information, and that information source being local, hearing very well about the work that Dr Shola is doing within his church, for example, which will allow for a greater dissemination of validated information, but also confidence, which they would then bring back to work.

It is also important to remember that vaccine hesitancy and low uptake also occurs in non-black, Asian and other ethnic minority healthcare workers. Sometimes, there has been almost too great a focus, particularly around black and Asian. Of course, they have a lower uptake rate from the studies in January—that cannot be denied—but the hesitancy cuts across all ethnicities and is not necessarily specifically within healthcare workers.

However, finally, wherever there is low uptake, there is always that risk of increased infection and, following on, morbidity, which causes pressure on the NHS, and so we are always encouraging people to take up the vaccine.

Dr Singh: I do not have much more to add to that, because that pretty much says most of it. One of the important things that we need to recognise, which many of us have brought up so far, is the impact of media, particularly social media, and misinformation that spreads very rapidly. Certainly, one of the issues I have seen within my community is how quickly misinformation is spreading, and the fact that we are not keeping up with it. That is especially the case when it comes to vaccination and misunderstanding around it.

While we are actively trying to put out useful and accurate information to these communities, we have to tackle the other side of the coin at the same time; otherwise, the result is that fewer people take it up and we get poorer outcomes. That is what it is on a basic level. Unless we are tackling social media and fake news, and making companies more responsible and more reactive, and we are being actively more reactive, this issue is going to continue for a while, I worry.

Q18 Kate Osborne: There have been reports in the media that the



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Government are considering introducing a vaccine passport as a way to help the economy recover from the pandemic and to allow international travel. How can we ensure that those who refuse the vaccine are, first of all, not stigmatised? How might the vaccine passport impact on BAME communities, taking onboard what has already been said about the differences across the communities?

Zara Mohammed: The idea of a vaccine passport is a bit of an interesting concept. Maybe the starting place of the conversation is what we have already covered about where our communities are at and how they feel in this conversation. It is really important that, when you introduce another label, box or identification, that is going to have an impact on relationship, trust, meaning and symbolism. Whether it is a good or a bad idea is probably not my place to say, but what I can say is that, with these things, it is really important to empower communities and to make them feel that they are valued and that we are trusting them to make the right decision.

Like we said, we do not want to stigmatise one part of the population based on maybe their own sound judgment; it is what Dr Christine said about hesitancy and not antivaxx. It is really important that, for communities like ours, which are already stigmatised, marginalised and feeling like they are on the backfoot in this conversation, we include them in this conversation and understand what it means for them.

Our approach would be one in which it is a community-led conversation and approach. We should really move away from labels and towards championing those who are doing excellently, inviting that best practice and encouraging what people are already doing to champion the efforts to overcome this pandemic, rather than focusing on who is good or bad, or who is right or wrong. It is a slippery slope, to be honest.

From our perspective, it is important to continue the work that we are already doing in making sure communities feel that they are making choices that they are making, inclusive of them and part of what matters to them, and that we do not move the conversation into a direction where it just becomes a tick-box exercise and it does not really matter who you are, with those other inequalities that you faced and the perceptions around you and your role in this pandemic. It is a challenging one but we should focus on the positive and on building communities, not on separating them.

Dr Singh: We should make clear the difference between a vaccine passport and mandatory vaccination. We do not have mandatory vaccination in the UK. Often in the media, the two get confused, and that does it a disservice. We need to remind people also that many countries that are not the UK do have vaccine requirements for you to be able to enter them, to go and visit them. This is not a new concept, but the way it is being framed in the media is as if it is akin to mandatory or enforced vaccination, which will automatically get people's backs up. You have to explain to people why we are recommending something and why it is so



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important. I have spoken to lots of people who said, "I am not going to have the vaccine". I said, "What if you needed it if you wanted to go on holiday?" They say, "In that case, I will get it", because it directly applies to them, because then it has a meaning, rather than just being a blanket mandatory thing.

Kate Osborne: That is a good point.

Dr Ekechi: I agree with what has been said so far, but we have to remember that every time we try to look at access to a resource, those who will have greatest and easiest access will normally be people at the top of our social ladder. First of all, just looking at social class, we know that those of us who are in the lower social classes will always have difficulty in access. We also know that black, Asian and other ethnic minority people are over-represented in the lower social classes.

Where we create something that allows people to have greater access to a resource—in this context, being able to travel—then we have to make sure that we put in the frameworks that allow people at the bottom of the social classes to have that same access. For example, I am talking about people who come from immigrant populations and who may not have an NHS number or be registered with a GP. They will then be less likely to have access to a vaccine and, therefore, will be left out of any vaccine passports. It is important that we consider those particular types of populations, so that they are not inadvertently left behind.

Dr Adeaga: Again, I agree with what has been said. It is a very interesting place to be. On the one hand, one understands the concept and the principle behind it, but, like Dr Ranj said particularly, the narrative is critical. At the moment, with all the disinformation, misinformation and scepticism, it is just going to fuel all that. I am sure that you are already aware of the people who are part of the myths and misinformation about the motive behind this whole vaccination programme.

The critical thing is the narrative and how it is presented. Again, like Dr Ranj said, there are some countries for which, if you want to visit them, you are required to have vaccinations. I have been to one such country, where I forgot to have the vaccination before leaving London, and the option was either to take the vaccine at the point of entry or to come back to London. Once you understand that, it is easier to accept. We just have to be careful about the narrative and to make sure that explanations are adequate in informing people.

Q19 **Elliot Colburn:** Zara, coming back to the point you were making earlier about language, could you expand on what you meant there? Above and beyond physically translating public health messages into different languages, you seemed to indicate that what needed to be considered was the content of the language itself. Could you expand a little more on what you meant there?



Zara Mohammed: What we were saying is that, while written content is important in different languages, what we found to be particularly effective was the use of infographics, breaking down that information into more bitesize visual learning. Even within languages, there are cultural differences and nuances. Our translators had a fun time with all the different regional dialects. There is only so much you can do, but adding that pictorial aspect to it really went a long way. We would break down our guidance into nine steps, such as reopening your mosque, health and safety, how to do your risk assessment or reasons for taking the vaccination, so just chunking that information into different stages and parts. That has been really effective. People just share those messages. They print them on to posters. They hang them up and share them in places of worship. That has been really good.

Videos have also been really important, as have short clips and soundbites, as well as audio messages that have been verified and shared. Someone just gives an update on what something means, explaining the information. We assume that, if they just read it, they will understand, but there actually a bit of a step in helping people understand even the context of where this is coming from and that it is trusted. Having some partnership in that process is really important, so that it is not just a leaflet that we give to someone but a conversation that we are having with them.

Q20 **Elliot Colburn:** You were also talking about the important role that faith leaders have in communities to encourage vaccine uptake. Could you give us some examples of how faith leaders have been working together to encourage vaccine uptake? Above and beyond them being important, what are some of the physical examples and steps that you have seen and that we can learn from and apply?

Zara Mohammed: One of the things that we did that was really important was to look at who the community listens to. They listen to places of worship, their local imam and scholars, and people of authority and trust. We got joint statements from them and got them to share the messages to the community. Sometimes it was through phone calls. We have had maybe 40 to 50 webinars—I have lost track—throughout the pandemic, particularly on dispelling vaccine misinformation and understanding what the vaccine is about.

We needed to include those faith leaders, not just at our level of a national umbrella but locally, the local voices, to bring them into the conversation. We had joint statements that were circulated and got them to do Facebook livestreams with their communities and online sermons. The places of worship that have been open had that as part of the Friday sermon, where they share that message to the congregation, encouraging young people where the elderly generation were not able to access it online, and giving them that information as well.

Faith leaders have played a really important part in working with different aspects of the community, bottom-up and top-down, and looking to



where we listen and where the conversations are happening. With the limitations that we have, they cannot physically go talk to people, but we looked at who they listen to, appreciating that we all have our limitations. We are not here to impose what people should do, but to listen to them, invite them into the conversation and understand where their concerns are coming from. As has been mentioned, some were about faith and spiritual procedures: "Is this allowed? Is this permissible? Can I take this vaccine?" Others were like, "Family members are saying I should not because they are worried. What do you think?"

There were lots of different conversations happening and, once we were able to get through those points, we were then able to take them to the place of being open to changing their mind or coming on board. It is a multi-pronged approach, but bringing in people of trust was really critical. We facilitated a national platform to bring in lots of different actors from healthcare, burial and bereavement, the charity sector and mental health to come together and work together, which was really important.

Q21 Elliot Colburn: Dr Shola, can I bring you in on that question about actual examples we might be able to draw from?

Dr Adeaga: Very similar to what Zara said, in the Christian community, what we identified right from the onset was that people would listen to and trust their pastors and church leaders. If I use my local church as an example, the pastor would talk about it during the sermon. I gave an example earlier where we invited some medical experts to the sermon and gave members of the congregation opportunities to ask questions. That was quite helpful.

The other thing we identified at the same time was not just pastors working in isolation but coming together as a unified voice. As I mentioned earlier, just last weekend, we got 60 senior Christian leaders together to endorse the vaccine and encourage congregations to take it. I have also mentioned the workshops. A lot of these, like Zara said, were webinars to bring information to people, just to bring reassurance. It is ongoing.

What we have experienced is that it is a combination of the big public meetings, but also the private conversations. Again, I gave examples of how I have had to call members of the congregation myself. They trust me, as one of their leaders, to speak to them and answer their questions as compared to maybe somebody else. A lot of that has been going on in the community, but the biggest win for us is the collective of the senior leaders of the Christian community coming together to endorse the vaccine and say, "We are behind this".

Lastly, in terms of what we have found has been quite effective, in one of the very first conversations that we had, one of the questions that came up was, "Are you going to take the vaccine?" They want to see that their leaders are taking the vaccine as well and that you are not just telling them but leading by example. That is what we have been doing quite a



lot, making sure that we capture when each one of us has taken the vaccine and then letting them know that it is safe to do so.

Q22 Ben Bradley: Thanks, everyone, for your contributions. It has been really fascinating to listen to. I do not want to make you go over old ground in terms of some of the really positive examples of things that are happening in your communities and around the country, but I was interested particularly in the Community Champions programme, which was a scheme of Government funding that went to 60 local authorities and some other groups. Is that something that you have seen? Have you seen an impact? Do you know who these community champions are in your particular communities? I will give one example. Birmingham has 645 volunteers across the city. One vaccination centre is in a mosque and some of the volunteers are working there and trying to get some of this information out there. I wondered if that was something that you had seen or experienced, particularly from that funding stream or local-authority-led example.

Dr Singh: I know that different people's experience will be different, but I have not seen much happening on that front in my community. I know that that is area-specific and community-specific. My biggest concern when that was announced was that it seemed like the Government were paying people to spread vaccine information, which was not a useful perception. Again, it is language and the way things are framed. I know that services need funding to create things like this, but I remember the media reporting it as if people were being paid to go to their communities and talk about vaccination or convince them to vaccinate, which was really not helpful.

Ben Bradley: That is really interesting, and perhaps a backfiring rather than a positive example.

Dr Adeaga: I heard the term for the first time two days ago. I had never heard about it before. On the back of what Dr Ranj said, right from the beginning, we volunteered as what you might call community champions, but not in the sense that I am beginning to understand them to be. One of the immediate kickbacks was that we were being asked, "Are the Government paying you to do this? Are the Government paying you to talk about vaccines in the vocal way that you have been doing?" I have not heard the term "community champions", but a lot is happening in our local communities in that regard.

I forgot to mention, incidentally, that one of the things that we have also done is that we volunteered our church premises as a pop-up clinic, because we thought that would also encourage people to take up the vaccine. That has been working quite well, because it has given people a lot more reassurance that the church is doing something. I do not know if that is what "community champions" means.

Zara Mohammed: One of my colleagues on the MCB had mentioned the Birmingham programme, but we had already formed a group of 60



mosques that had been working on these issues. Maybe what we are all trying to say, to some extent, is that it has not been something that has been really prominent in our work and in making a difference at the local level. So many communities have been championing the cause, so maybe it is a little tokenistic to call some of them champions and not others. The community has already, through need, generosity and charity, come together and saw that space to make a difference.

These programmes hark back to what we said earlier, where the Government have not really understood what is happening on the ground and are not making those partnerships that they really need to do the vital work that they are trying to deliver and, as a result, are not working with the people who have that visibility. It is a bit of an oversight there that this programme has not been as prevalent as maybe they had desired, at least from my perspective.

Q23 Ben Bradley: The thing that has struck me during the conversation over the last hour or so has been the community-level element and the trust factor that have been so important. I guess that means that it needs to be from the ground up rather than from the top down. That is really interesting.

I will move on, given that clearly has not been hugely impactful, to the next question, which is more about the data. I very much welcome the fact that you have all talked about "BAME" being this overarching label that can be quite unhelpful; there are lots of nuances and different backgrounds and views within that. It is something that I have said as well and is a really important lesson for policy-makers across all sorts of sectors. It leads to some interesting problems in terms of data.

I wonder what you make of how much data the Government collect on vaccination. It is only very recently that we have moved to local-authority-level vaccination data. We talk about data around BAME vaccinations, but I do not see that it goes more in-depth or more nuanced than that. Zara, you mentioned something earlier on about faith-based as opposed to race or ethnicity-based data, and I wondered if you wanted to expand on that.

Zara Mohammed: One of the challenges that we have had around the conversation of disproportionate impact on BAME communities is the segregation of that data and understanding what it means particularly for faith. There was a point at which we were getting views from the Government saying, "No, there is no disproportionate impact. Oh wait, there is a disproportionate impact but we are not really sure how that disproportionate impact is playing out". On the ground, imams were telling us how many funeral prayers they were doing in a day—15, 20 or 25, especially at the height of the pandemic. We were getting these numbers coming in, and also getting number from the front line as well, from affiliates like medical doctors saying, "You will be astounded by the numbers. The numbers are crazy. So many people are passing away and we see so many from our communities."



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The data does not take faith into account, and that faith metric is really important for us to see what the impact is and then make those different correlations. In some ways, we are not clear on what the strategy has been on that data and its use. What are the Government trying to do with that information when they are collecting it? If we already know there have been omissions and it is not clear, and we knew that our communities had been disproportionately impacted from the start, what was done about it? What has been done about it now?

For us, it is a conversation in which we know that there is a disproportionate impact. We would like to see a further breakdown of that data, but where is it driving in terms of policy change? Our communities want that data to inform something, not for it just to be collected as another mass of data about them. That is the problem. It is just becoming, "Why do they need to know that?" I remember, particularly when people were going for testing, the feedback we got was, "Why are they asking?" There were a lot of questions around test and trace and the data collection: "What is it about? Is it securitisation of state? What is going on?" We know that there are different reasons for that data and what it would tell us. These are the things that come into our minds: "What is happening and what is it being used for?"

Dr Ekechi: That is a very important question. The first thing is that, when we try to unpack why certain groups have vaccine hesitancy, one of the reasons that very often comes back is a lack of long-term data and data that is reflective of them. We touched on this earlier, in terms of needing diverse participation in research trials.

When we are then talking about data, first of all we need to be sure about the question that we are trying to answer with the data that we collect. Sometimes, we get that very wrong. For example, we may collect data by race, but what conclusions can we really draw from that, apart from how society, societal structures and societal racism impact on people who are defined by that race, as opposed to, for example, collecting data by ethnicity that may give us some more nuanced data about cultural behaviours and beliefs?

The OpenSAFELY database run by the University of Oxford and the London School of Hygiene and Tropical Medicine breaks this data down into more discrete groups, which is why I am able to say, for example, that, up to the week of 24 February, there was lower uptake amongst Africans compared to Caribbeans. Just to circle back, it is really important that, when we are talking about data collection, we are first clear in our head as to what data we want to collect and what question we want to answer.

Finally, with my obstetrics and gynaecology hat on, we have been calling for very nuanced linkage of pregnancy data, having the denominator of how many pregnant women have been vaccinated amongst the wider population. This allows us, hopefully, to flag if there are any negative side



effects—and there is no evidence that there are—and to pick that up in real time and respond very quickly to it. This is something that my colleagues will speak to a little bit later. Data is very important.

- Q24 **Chair:** Could I have one final question? I apologise and I know that we have already overrun really badly already. It is a question for Zara in particular, but I am really happy to hear thoughts from other panellists. When looking for trusted voices within communities, how much focus has there been on including women as part of those community leaders and trusted voices?

Zara Mohammed: That is a spot-on and very timely question, with my election. I would say that there has been an absence of that, absolutely. Women are always the most disproportionately impacted; they are the most marginalised and most unheard and yet most impacted. We saw that with the rise of domestic abuse, economic impact and loss of jobs. Family life was completely turned upside down: the capacity to work, be a mum and take care of all these other things. Mental health has been a particularly big one. There has been a huge lack of women in this conversation from a leadership level and from the grassroots—everyday women and what they are going through.

Part of my leadership and strategy, and what I am absolutely determined to do, is to make sure that I am part of changing that and making sure that the voice of women is not just heard but part of that representation throughout all of the work that we do at the MCB. I will be promoting it. I am so glad International Women's Day is coming up. There is lots to do there.

We are really suffering during this pandemic, as 50% of this population, and that story needs to be told as well and championed by women. That will be really important as well. Thank you for that question, and I am certainly happy to be part of the campaign.

- Q25 **Chair:** Did any of the other witnesses want to come in on that?

Dr Singh: I do not think any of the men have a right to speak there, to be honest. It is important, when we are talking about women, to let them speak first and foremost. My perceptions and experiences probably do not prove to be that helpful, but Zara pretty much hit it all on the head. There has been a massive under-representation, and that is true, and that is coming from a bloke.

Dr Ekechi: It is important for us to recognise women, diverse women and our pregnant population. Again, we will speak to that later.

Chair: Thank you very much. Can I thank all of the witnesses for taking part in this first panel? I am sorry that it went on a little longer than expected, but your views were really helpful and appreciated. Thank you very much.